

OPERATIONAL PROGRAM GRANT PROPOSAL

Total OPG Request : \$420,254

Project Title : Integrated Pre-School Feeding Program  
 Project Location : Tunisia  
 PVO Name and address : Catholic Relief Services USCC  
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I. PROJECT PURPOSE AND DESCRIPTION

A. Project Purpose

To improve the effectiveness of the pre-school feeding program and to integrate preventative health, sanitation, nutrition, pre- and post-natal mother and child care and domestic education within the existing program, over the course of 5 years.

B. Relation to Sectoral Goals.

Given the present U.S. strategy of relatively straight-line bi-lateral assistance through the current Tunisia 5-year plan with possible termination thereof in FY 1981, it is particularly important to maximize the effectiveness of on-going activities in priority areas, which

include rural development, training for women, environmental health (including sanitation, nutrition and preventative health programs), and long-term planning and management development.

This project will correlate, in the aspect of health screening, immunizations and referral, with current efforts to develop a cadre of community health workers. The 1970 Family Health care team report indicates a physician dependence in the rural health system that can be detrimental in response to patient needs and care continuity.

A current project to assist in the refinement of a national nutrition policy and planning, will include data development on localized nutrition deficiency problems. This Pre-School Feeding project can provide a vehicle to aid the described data development, the amelioration of the problem, and for implementation of appropriate policy and planning decisions.

C. Target Group of Beneficiaries

The target beneficiaries are the family units that have children enrolled in the Pre-School Feeding Program. The 62,011 enrollees, in the 3-6 age group, represent a total of 944,001 persons on a family-unit basis or 11.5 percent of the total population and 13.7 percent of the 0-6 age group in the project area. This latter age group has been designated as a high priority group by the Government of Tunisia. The mothers and under-six children will be benefited by the health-care and

educational activities of the project, as indirectly will the fathers and older children. The project will not necessarily be restricted to the mothers who have children enrolled in the Pre-School Feeding Program, thus presenting a potentially broader beneficiary base.

D. General Description of the Project.

- 1) The project purpose of improvement of the infrastructure and effectiveness of the pre-school feeding program will include :
  - a) Improvement of the quality of meals served, through recipe variation, attention to the cooking operation, and promotion of the increased local donation and/or growing of other foods.
  - b) Providing sufficient furniture and kitchen/dining equipment for orderly and timely serving of meals.
  - c) Improving, augmenting, or reestablishing the physical plant necessary for proper storage, preparation and serving of foods.
  - d) Analysis of localized dietary deficiencies for the purpose of providing appropriate nutritional supplements, principally through promotion of parent-operated vegetable gardens.
  - e) Analysis of the commodity logistics system to effect timely delivery and usage and reduce feeding interruptions and wastage through overstocking.

- f) Improve the monitoring and surveillance of feeding center operations by the NCSS staff in coordination with CRS.

These improvements will be effected by the NCSS staff, local NCSS committees, social assistants of the Ministry of Social Welfare, the CRS personnel and project staff and Peace Corps nutritionists. The centers plant and equipment improvements will be based on a complete center by center pre-project situation assessment to be carried out during April-June 1977. This evaluation will examine the administrative and logistical system and establish the framework for management improvements.

- 2) The project purpose of integration of environmental health (including sanitation, nutrition and preventative health), and training for women will include :
- a) Periodic age-weight and anthropomorphic measuring of the children enrolled in the pre-school feeding centers, their younger brothers and sisters, and other children to the extent the mothers of non-enrollees will participate.
  - b) Institution of a regularized immunizations program for the children.
  - c) Periodic and to-need health assessments of the participants, and doctor referrals as is required.

- d) Pre- and post-natal counseling and examinations for mother and their new-born children.
- e) Group nutrition education classes for women, including dietary considerations during and after pregnancy and illness.
- f) Environmental sanitation, including food hygiene education.
- g) Food preparation demonstrations based in local low-cost nutritionally-sound foods,
- h) Child-care classes and counseling including the importance of breast-feeding, and proper weaning foods.

This phase of the project entails the integration of two classes of in-place para-professionals, the public health nurses and social workers. The PHNs in rural areas are involved to a large extent in curative practice of minor ills and injuries. The formalization of group activities based in existing feeding centers will enable these nurses to practice preventative health to a greater extent and will assure more constant and earlier contact of a high-risk group of children and their mothers with required medical care.

The social workers operate largely on a house to house contact basis. Integration of their activities into an established-center framework will help to optimize their productivity and constancy of contact with their target population.

These feeding centers have not been used for these projected purposes heretofore. The on-going feeding program will continue, with utilization of the same facilities for the amplified program of environmental health, thus avoiding the sometimes detrimental relating of food distributions to attendance. A sampling of local NCSS committees indicates that no attendance problem will obtain.

Similar programs of environmental health exist in a relatively small number of Government MCH and health centers located principally in urban and semi-urban areas. This project therefore will concentrate on semi-rural locations, and in urban and semi-urban areas to the extent the mothers of feeding program enrollees are not accomodated in existing centers.

E) Conditions Expected at End of Project

1. All of the existing feeding centers will have adequate and properly equipped locations and will have upgraded their feeding operation by the end of the project.
2. All of the target beneficiaries will be receiving health screening consultation and referral services by the end of the project.
3. All of the target beneficiary mothers will be participating in preventative health, nutrition, sanitation, child-care and food preparation budgeting education by the end of the project.

4. Realization of a Government of Tunisia long-range operational plan for continuation of a pre-school feeding/environmental health/women's training program by the end of the project.

## II. PROJECT BACKGROUND

### A. History of Proposal Development

This project had its origin in the results of a review of the Pre-School Feeding program which was sponsored by ORSTOM-UNICEF, in late 1975- early 1976. This report made a series of recommendations that included :

- 1) Improve organizational structures,
- 2) Improve physical state of feeding centers,
- 3) revise system of distribution,
- 4) Improve quality of meals served,
- 5) expand services offered.

These recommendations are solidly based in the findings of the study, and have, in this project application, been translated into a positive program, with emphasis given to the offered services that will be located in the existing but under-utilized center facilities.

### B. Prior experience in Project and related Areas.

In some 17 years of operating feeding programs in Tunisia, ORSTOM has garnered experience in almost every feeding category. This has included the operation of MCH feeding/training programs under the direction of a Tunisian staff nutritionist, which also involved

off-shore consultive nutrition support. Present CHS staff experience includes the design and implementation of a village health worker/mobile health teams (OIG) project, MCH environmental health education/women's training programs, and the administration of a wide variety of projects involving both OIG and Sec. 204 funds.

C. Host Country Activity in Project/Program areas

The Tunisian Government nutrition activities were originally spread over the Ministries of Health, Social Affairs, Education, Agriculture, and Planning. To provide more coherent nutrition planning the National Institute of Nutrition and Food Technology was established in 1969 with USAID assistance.

In terms of preventive health, there exists within the Ministry of Public Health a Division of Preventive and Social Medicine which has the following functions :

1. Conducts campaigns against specific diseases (malaria, trachoma, tuberculosis, schistosomiasis).
2. Vaccination, ambulatory treatment and detection of communicable diseases.
3. Environmental sanitation including drinking water, campaigns against insects and other pests, sanitary conditions of public places.
4. School health education.

This division has about 1,000 employees, almost all with a low level of training who are supposed to visit every house within their area of jurisdiction every

fifteen days. However, only about 8% of the total MOPH budget is devoted to preventive medicine.

The above personnel operate out of rural hospitals and dispensaries, anti-tuberculosis dispensaries, 90 MCHC's (which are now mostly curative in nature), 15 skin diseases centers, 12 rabies centers and 12 border health posts.

### III. PROJECT ANALYSIS

#### A. Economic Effects of the Project

The project effects in relation to the intended beneficiaries are principally long-term, in the project goals of improved nutrition and health and women's training. The improved education capacity, increased work-life productivity, greater life expectancy and the assertion of a more meaningful role for women in society will be a gradual but entirely logical result. While the project deals with a pre-set though large beneficiary numbers base, the inclusion of non-feeding program mothers and the time-based turnover will provide an even significantly larger beneficiary involvement. The low per-capita project cost will be thereby even lower than herein projected.

In the short-term, the project will promote the development of a more efficient rural environmental health delivery system and education utilising in-place personnel more efficiently at a lesser per-capita cost

than is possible in the existing house to house visiting approach.

Better nutrition for the family units will have the short-term result of reducing the incidence of debilitating illness and consequent loss of school and work time and the economic loss therewith to the family and the state. Earlier diagnosis of acute and chronic illness, more timely treatment, and greater continuity of patient care will also result.

B. Technology to be used and its implementation

The general scheme of this project is two-fold. It will rectify a series of delineated problems, and it will provide a coordinative focus for a series of services related to the person, family and community needs. These actions will be undertaken in basically two but interrelated steps.

The first step will relate to the on-going pre-school feeding program. The problems have been surveyed in the CARE-MEDICC contract study in late 1975 - early 1976. An evaluation of this study, including consultations with Government of Tunisia organs, led to the conclusion that the projected rectifications are fully within the administrative capabilities of CMS, relate completely to its general objectives and prior and concurrent undertakings in other countries, comply fully with the objectives and personnel capabilities of the GOT counterparts concerned with said program

operations, and are budgetarily realistic.

The problems and the rectification methodology are :

1. Physical plant, which varies from excellent to unsuitable for program purpose, and will require :
  - a) repairs, often of a minor nature
  - b) Addition to existing plant, which varies from minor to major changes
  - c) Replacement wherein the present facilities cannot be renovated.
2. Meal quality, particularly in the unvariableness by :
  - a) Promoting the preparation of ICSM in a variety of ways
  - b) Introducing various flavorings
  - c) Balancing the use of ICSM with local foods
  - d) Alternating ICSM with other PL 480 blended foods
  - e) Periodic control of the cooking methodology
3. Distribution, from late deliveries to overstocking.
  - a) Close coordination with Regional NCSS committees, to establish improved delivery schedules
  - b) Correction of the current over-stocking by interdicting new deliveries and/or redistributing stocks if warranted.
  - c) Improve the receipt and use of stock inventory/ use rate data.
4. Equipment deficiencies, which vary from pots and cookers to tables and benches.

- a) Providing sufficient equipment based on beneficiary numbers requirements
- b) Periodic repairs/replacements to maintain minimum standards.

5. Management Supervision

- a) Promote improve control of attendance keeping
- b) Coordination feeding recipient selection with the local NCSS committees to assure selection always on a most-needy basis.
- c) Periodic control of center personnel, to assure proper hours of operation, proper food preparation, hygienic conditions and full rations.

The second step of the Project will be the development of health care and environmental health education. This will begin during the first project stage wherein training seminars for the social workers and the educational materials for use in training mothers in the centers will be developed. Also, health screening activities will be initiated utilizing the Public Health Nurse infrastructure in rural areas.

Generally, physicians are not available for mass programs in preventive health on a regular basis. The use of nurses at the feeding centers, who are assigned to rural stations in far greater numbers than physicians, has the advantages of :

1. Maximizing the utilization of the nurses time, as opposed to their house to house rounds.
2. Promoting a greater dependence on para-professionals for preliminary health care, with the corollary of maximizing the utilization of the fewer physicians for

established or suspected graver illnesses.

3. Provide a more regular preliminary health care for the ill.

The public health nurses will be assigned to the feeding centers on a scheduled basis to perform these services :

1. Establishing health records of the children including their immunization record and anthropomorphic measurements charted on a regular schedule.
2. Screening the children for suspected illnesses or nutrition-related physical deficiencies and performing first aid as required.
3. Referral of the children to competent medical facilities when medical problems are suspected and for required immunizations.
4. Providing consultive service to pregnant and lactating mothers.

Environmental health education will be directed at the mothers of feeding program enrollees, utilising the cadre of female social workers presently assigned to regional or local social development centers or to rural centers for young girls. These social workers have had training in a series of subjects which include home economics and home management, gardening, aviculture, sewing, cooking, child care, health, methods of social action, social legislation and human relations.

As the instruction in preventative health, nutrition, sanitation and related subjects is classroom-oriented, a series of seminars for the practical application of these subjects, and to establish activity norms, will be conducted by the KCSB, the NIN, and CRS. The seminars will emphasize nutritionally-sound diets related to local, low-cost food availabilities, environmental sanitation and food hygiene, food preparation demonstration techniques, pre- and post-natal dietary requirements, the importance of breast feeding and proper weaning foods, childcare and the planting of home vegetable gardens. These subjects will form the basis of the educational efforts for the women at the centers.

The social workers are assigned to rural posts for five years and while the assignments are not necessarily to a single post, the time period will engender continuity and the development of local relationships that will assist in the success of the educational program.

As the Ministry of Social Assistance has offered to revise their curriculum to conform to the emphases of this project, social worker assignees arriving in the latter phases of the project and beyond will be even better prepared to carry these works.

The social assistants currently in the field number approximately 1,200, with a minimum of 50 in each governorate (province). This project will utilize 37, or 1 for each two centers in the 8 provinces with which it is concerned.

Six Peace Corps Volunteers will be assigned to the project consisting of 3 couples with nutrition education backgrounds. Their purposes will range from teaching in a series of representative centers in coordination with the social assistants, and development of base-line data, established dietary habits and taboos, and locally-acceptable centers meal variations and flavorings, to promotion of home gardens and working with groups of fathers to further promote participation in and utilization of the project services and education.

C. Socio-Cultural Factors.

The "Yale Project" studied nutrition and development of Tunisian children of urban, low socio-economic families and dietary practices of pregnant and lactating mothers. Women in three communities were surveyed by means of household surveys and oral questionnaires. The study found that from 26 percent to 50 percent of the women questioned actually ate less during their pregnancies than they normally did. Twenty percent of the lactating mothers drank only one serving of milk per month. Lactating mothers consumed only 25 % of the calcium recommended during this time, and only 50 % of the recommended quantity of riboflavin. Thirty percent of the mothers did not breastfeed, or stopped before 6 months ; 40 % of the Medina (central city) mothers breastfeed their children up to the age of one and a half years, compared

to 75 % of the mothers in Saida Manoubia, a community of families more recently arrived from rural areas. Twenty-three percent of the women who stopped breastfeeding did so because they have "insufficient milk", 22 % because of another pregnancy, and 20 % due to illness. About half of the children 18 months old never or rarely get eggs (one egg or less per month) and about a third never or rarely get meat. It is probable that the prevailing myths about the adverse effects of eggs and meat for infants are responsible for this (for example there are beliefs that eggs cause stuttering and meat causes stubbornness).

A study conducted for UNICEF and the Ministry of Public Health also revealed significant information concerning diets during pregnancy and lactation. In the regions studied -- Sfax, Baja, and Kasserine -- through interviews with women, it was found that 55 % of the women did not change their diets during pregnancy. Seventy percent to 72 % did not increase their food intake during the period of lactation.

Both the Yale study and the UNICEF study indicate that many Tunisian women receive inadequate nutrition during pregnancy and lactation. One reason for this may be that they are not aware that an increase in calories and other nutrients is necessary. Another factor may be the women's traditional role in the family which requires that she serve her husband first, her children next and herself last.

The food consumption survey studied infants under 2 years of age in rural areas (villages and countryside) in order to establish the composition of infants diets according to age. It was found that just over half of the children between the ages of 0 and 9 months, the age when supplementary foods should be introduced, ate no supplementary foods in addition to milk. Twenty-one percent of the children between 1 and 1.1/2 years still received no supplementary foods. Fifteen percent of all children under two did not get any milk at all but only various semi-solid foods. Although 59 % of the mothers continued to nurse their children until they were 1.1/2 - 2 years old it is likely that this percentage has since fallen as the result of the increasing trend away from breastfeeding in favor of artificial feeding which is due in part to the persuasive propaganda of companies which market infant formulae.

Health statistics for Tunisian children further illustrate the pressing need for education in hygiene and preventive health measures and their relationship to good family health and nutrition.

In a recently published paper by Dr. Bechir Hamza, director of the National Institute of Child Health indicates that only fifty percent of the pre-school population are being effectively immunized.

Infant diarrhea and dehydration with accompanying malnutrition occur with needless frequency, particularly during the summer months. Le Manuel de Puericulture reports that gastroenteritis and pneumopathies combined account for four-fifths of the deaths of children aged 0-1 year. The estimated prevailing infant mortality rate is two and a half times higher in rural areas than in Tunis and its suburbs (200/1000 rural, 80/1000 Tunis), due to the fact that care is more accessible in Tunis, especially for the cases of dehydration which result from the epidemics of summer diarrhea. Much evidence has been accumulated to indicate that the excessive postneonatal mortality among young children in developing countries, as compared with industrialized ones, is almost entirely the result of the synergistic interaction of malnutrition and infection and simply does not occur if the children are well nourished. The observance of basic hygienic practices can be encouraged through community education. The preliminary summary of results of the Tunisian National Nutrition Survey contains the following statements concerning nutrition in Tunisia :

" It is clear that significant growth retardation exists in Tunisian children. The problem is nationwide. During the second year of life, Tunisian children undergo a particularly great

food deficit and weight relative to height drops considerably below that of European and North American children. The problem appears to be of a long-term nature, there being no anthropometric evidence that there have been major changes in general dietary adequacy in past decades, in that young adults are not markedly different from older adults. Although the retardation is not as severe as observed in some developing countries, it nevertheless is sufficiently marked to warrant major attention in future planning.

"The absence of evidence of major protein deficits suggests total calorie and micronutrient deficits as principal causative factors. There is a need to develop educational programs aimed at improving childhood nutrition, and to develop nutritional well-balanced feeding supplements for post-weaning infants and toddlers.

"ickets as indicated by clinical signs continue to exist in Tunisia. There is a strong tendency for the prevalence to decrease from north to south. On the basis of clinical observations alone, 5 to 10% of the children in the northern and northwestern parts of the country suffer from vitamin D deficiency.

"... it is reasonable to conclude that : (1)  
Tunisia has major nutrition problems, placing

the country in many respects between developing and technologically developed nations ; (2) Most of the problems are amenable to satisfactory solutions at modest expenditures provided reasonable efforts in fact are made."

Through this program the center health and health education activities may have socio-cultural effects on the community beyond the improvement of nutritional and health practices per se. The community social worker will now be seen as someone knowledgeable in preventive health measures and good dietary practices in addition to her present capabilities and should acquire enhanced stature and credibility among the people. One importance of this is that it strengthens the image and role of women in a male-dominated society.

D. Statement of Project Relationship to Other Considerations

The project is based in reaching feeding program enrollees who have been selected by local committees on the basis of their being the poorest in any given area. Existing health care programs emphasize the child age 0-2 years and have an urban bias. The relatively undeveloped state of a rural community health worker infrastructure guarantees that the majority of the enrollees do not normally have access to an acceptable level and constancy of medical care. In one example in (the province of) Nshdia there is one doctor for every 25,000 inhabitants. Also, a fairly recent study pointed out that out of the

18 Tunisian gynecologists, 10 are located in the capital city.

While the centers are being specifically related to food program enrollees, there is an acute potential for utilizing the services to be developed on a community-wide basis.

Presentation of a realistic plan for Duplication and Institutionalization with Domestic Resources.

The project is of itself a logical duplication of Ministry of Public Health efforts in a smaller number of MCH centers located principally in urban and semi-urban areas, and which cater to mothers and their children, aged 0-2 years. The more completely equipped and expensive MCH Centers are not budgetarily realistic for more sparsely populated regions of Tunisia. This promotion of existing, country-wide pre-school feeding program centers infrastructure as a low-cost extension of the MCH program provides a wider child age-spread more efficiently utilises in-place para-professional personnel and to a majority degree the operational expenses are presently budgetted. The operational expenses created by this project will absorbed by the government budget by the end of the project.

The effects of the project will be duplicatory in :

- 1) The more complete use of community centers,
- 2) Increased coordination and non-duplication of efforts between government ministries, and

- 3) Other efforts to as effectively utilize the para-professionals.

## VI. PROJECT DESIGN AND IMPLEMENTATION

### A. Implementation plan

The implementation will be divided into a series of time frames wherein the two basic purposes of the project will be carried forward concurrently.

The baseline data for the improvement of the pre-school feeding program will be developed separately and will be available by the end of June, 1977, in the areas of information on :

1. Current center facilities and equipment inventories with consideration of their adequacy for (a) the pre-school feeding program activities, and (b) the health screening environmental health education activities.
2. A report on the current logistics surveillance record-keeping and reporting systems.
3. General-operations observations which could contribute to improvements in cooking, serving menu variation and sanitation at the centers.

The implementation schedule will be :

#### 1. Month 1-6

As the project is both developmental and operational, the normal feeding program will be operated, while a series of developmental plans are initiated.

These latter will include :

- a) Evaluation of the pre-project survey baseline data, and will include :
  - i) Development of improved logistics, reporting and records-keeping systems.
  - ii) Plans for center renovations/replacements and augmentation of equipment.
- b) Development of recipe variations and an evaluation of locally-produced food input potentials.
- c) Surveys of the types and frequency of medical care normally available to families of feeding enrollees, and of the numbers of mothers who have/had environmental health education.
- d) Preparation of training seminars for the field personnel, including the public health nurses, social assistants, and NCSS regional personnel.
- e) Design and production of educational materials.
- f) An evaluation of the foregoing activities in the final month.

2. Months 7 - 16

The implementation of the various program activities will commence in this period, as (1) training seminars for the social workers will be held, (2) organizational courses for the PHNs will be scheduled, (3) orientation of NCSS regional and center responsables will take place, (4) initiation of health screening and environmental health education, (5) field trials of feeding program recipes, (6) promotion of locally-produced food inputs to (4) the

feeding program, (7) initiation of logistical and reporting improvements and (8) equipping and renovating the feeding centers.

At month 9 the PCV couples will be inserted, at representational geographical points, as the coastal, desert and agricultural regions, will begin a period of learning about the region and its project-relevant problems, and will initiate their assigned activities. At approximately month 10, 11 or 12, an offshore nutrition-education consultant will review the project progress, its directions, and aid in formulating further planning.

The final month of the period will include an evaluation of progress.

5. Months 19 - 30

The project period will be a continuation of the above activities and will reach full implementation of center renovation, health, and educational activities. A second seminar will be held for social workers and will be a refresher for those who remain on-station. The IHNs will receive a re-orientation.

The month 16 evaluation report and the constant monitoring findings will be used to modify the program where warranted. Also, special efforts will be made to augment educational training beneficiaries and to initiate similar programs in non-feeding center locations, in coordination with the MOH, the MSW and the NIN.

4. Months 31 - 36

The PCVs will terminate their assignments in the initial month and will file end-of-tour reports for evaluation. Where warranted, indigenous replacements will be sought through the involved GOV ministries. In many of the centers a second cycle of educational activities will have started due to new mothers entering and original participants leaving as their children mature. With the required subjects for education incorporated into the curriculum of the training school for social assistants together with their in-record experiences, the need for continued seminars is not foreseen. Exit arrangements for continuation of the program with in country resources will be effected. A terminal evaluation will give particular attention to longitudinal nutritional effects.

B. Technical Staff and Assistance

The technical staff inputs will be provided by :

1. The MOH : Public Health Nurses
2. The PSW : Social Assistants
3. The NIN and the Child health Institute : Technical program guidance.
4. The NCSS : National, regional and local personnel of the distribution and the operations staffings.
5. The Peace Corp : Volunteers.
6. CWS, via the project : Project manager, nutritionist translator/secretary and offshore technical consultants.

7. CRS : Administrative and Center Inspection Staff personnel on a time percentage basis.

Technical assistance inputs will include educational materials, seminars for training of the various field level personnel, vehicles, infant weighing scales, health and weight record cards, and furniture equipment requirements from project sources. The delivery logistics and centers records and reports, center renovation/ replacement costs, and the cooking fuel, etc., will be a NCSS input. First aid medical supplies will be provided by the MOH, as will medical facility costs engendered by the regularization of medical care. Specialized training and certain of educational training equipment will be provided by the MSW.

C. Equipment, Commodities and Materials

A major project activity is improving the feeding centers, which are underequipped in varying degrees. These improvements will also permit fuller utilization of locales which at present are used only 3 to 4 hours per day, for the health screening and environmental health education activities. This will be accomplished through providing furnishings and equipment such as tables and chairs and food preparation and serving equipment. Additional equipment to be provided for the health and educational activities include beam weighing scales for infant growth progress measurement. Project administration support will include a minimum of office supplies and equipment as one desk and a stencil and photocopy

While the social workers are equipped with some educational materials, the range is very limited and not adapted to the range of instruction they will perform. As the centers will become a health care and education focal point for the communities, it will be necessary to produce materials for these purposes for the centers and the communities and to provide a fuller range of audio-visual materials. Various media will be employed. Ten vehicles will be purchased for the project. Two vehicles will be used on a project area-wide basis for administrative control and monitoring, and 8 will be used on a province area-wide basis, corresponding to the program administrative and distributional organization, for remoter area access, transport of equipment, and for fact-finding investigations. Eight will be light, durable, economical cars and two will be heavy-duty for use in two particular provinces wherein the road conditions require a heavier vehicle, and for carrying more persons and heavier equipment. CNS will be responsible for scheduling the use of the vehicles.

Waiver request

A waiver of purchase of U.S. origin is requested for the vehicles so that third country vehicles which have a parts availability can be purchased. Their use in rural areas and eventual assignment thereto requires this arrangement if the vehicles are to be kept in running order.

A waiver of purchase of U.S. origin is also requested for the furniture and equipment so that these items can be purchased locally or in a third country. Almost all of this furniture and equipment will be purchased locally but some items of a mechanical nature as weighing scales may have to be purchased in a third country. The F.L. 460 title II commodities to be donated by the people of the U.S.A. are not herein evaluated, as the ongoing pre-school child feeding program will not be altered to provide for feeding/dry distributions of foods for other than the enrollees. This method was specifically considered to avoid the sometime confusion of attendance at education for food purposes, and is considered motivationally superior.

D. Consultation and Evaluation Support

Budgetary provision has been made for technical consultation in a series of disciplines. As the project will treat a series of technical subjects, from commodity handling, distribution and storage and food processing and preparation to construction, preventative health, and statistical techniques, expert guidance and training for these to varying degrees, currently low-technology operations will be required.

Similarly, the evaluations have been budgetted for the use of local contract consultancy to achieve a professional usefulness.

E. Measurement and Evaluation of Project Accomplishment

The bases for measurement of accomplishment will largely be established by the pre- and initial project activities, will range from establishing overall center facility and equipment requirements, and the health care status to the health card/weight card records and dietary patterns, and will be used by the evaluators and by the project personnel monitoring activities to measure :

1. Improvements in the feeding program
2. Effectiveness of the preventative health screening
3. Effectiveness of the environmental health education.

The CRS, provincial and center level records will provide the principal basis for accomplishment measuring. The scheduled evaluations will be included with and used as a basis for periodic reports to the counterparts, CRS headquarters and USAID.

V. FINANCIAL PLAN	<u>FY 77</u>	<u>FY 78</u>	<u>FY 79</u>	<u>FY 80</u>	<u>Totals</u>
a. <u>Grand total</u>	79,131	166,846	129,121	45,156	420,254
b. <u>Project costs</u>					
Personnel	59,400	267,665	318,413	145,636	824,596
Training	--	27,539	20,666	--	54,195
Commodities	110,224	218,514	184,256	76,874	596,168
Other costs	85,201	170,828	171,308	89,522	517,509
US Consulta- tion support	<u>3,820</u>	<u>11,460</u>	<u>7,040</u>	<u>3,820</u>	<u>26,740</u>
TOTALS	298,967	690,106	706,663	316,252	2,016,308
c. <u>Sources of funding</u>					
Grant (US/AID)	79,131	166,846	129,121	45,156	420,254
NCSS	198,236	396,474	396,474	198,236	1,189,420
MSW	--	12,894	19,679	8,143	40,716
MOH	--	34,242	64,309	30,067	128,618
NIN	--	1,650	1,650	--	3,300
Peace Corp	--	29,150	52,200	12,050	104,400
CRS-USCC	<u>21,000</u>	<u>43,200</u>	<u>43,200</u>	<u>21,000</u>	<u>129,600</u>
TOTALS	298,967	694,456	706,663	316,252	2,016,308

This plan is predicated on operations for half of FY-77, All of FY-78 and FY-79 and half FY-80. As the implementation date remains to be established, some adjustments of the expenditure time periods may be required.

VI. CONDITIONS

The agreement in principle to the project by the Government of Tunisia is on file in letter form with the USAID Mission to Tunisia, as is subsequent correspondence relating to establishing the overall administrative direction of the project. This correspondence represents the GOT commitment to required inputs, which cannot be formalized into an agreement without project approval.

For points of reference in the specific areas of preventative health and the social worker participation/special training, project-specific discussions have been held with the National Director of Preventative Health, MOH and the Chief Inspector of the MSW.

APPENDIX "1"

GLOSSARY OF TERMS

CARE	COOPERATIVE FOR AMERICAN RELIEF EVERYWHERE
CRS	CATHOLIC RELIEF SERVICES - USCC
NCSS	NATIONAL COMMITTEE FOR SOCIAL SOLIDARITY
MSW	MINISTRY OF SOCIAL WELFARE
MOH	MINISTRY OF PUBLIC HEALTH
MIN	NATIONAL INSTITUTE OF NUTRITION
MCH	MOTHER CHILD HEALTH
PHN	PUBLIC HEALTH NURSE
VOLAG	VOLUNTARY AGENCY

APPENDIX "2"

A BRIEF HISTORY OF THE PRE/SCHOOL FEEDING PROGRAM

The current pre-school feeding program was started in 1957. It was jointly sponsored and supported by the U.S. Government through USAID and the Government of Tunisia through its Ministry of Youth, Sports and Social Welfare. Its initial beneficiary target was 150,000. This was expanded to 170,000 by the 1960's.

Until FY'72-73, the implementation of the program tested with the municipal governments and in rural areas the "Social Welfare Service" (delegation level).

In 1974-5 the entire program was turned-over to the NCSS. As a result, the management of the program improved substantially and a unified structure and monitoring system was developed. The number of beneficiaries peaked at 180,000.

Initially, the program provided a ration of :

Milk powder	20 grams
Butteroil	20 grams
wheat flour	100 grams.

In the late sixties butteroil was replaced by vegetable oil and in 1970 milk was replaced by ICS.

The FY'77 program is for 100,000 beneficiaries with the following ration :

Oil	10 grams
ICS	40 grams
wheat flour	100 grams

The flour is baked into bread at local bakeries and the ICS and oil mixed to produce a hot gurel or drink.

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4. CARE-MEDICO Contract Survey of Pre-School Feeding Program
5. Family Health Care Team report
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7. The Yale Project - Dr. H.B. Young, 1972-74
8. UNICEF Study - Dr. Nejeb, 1967-68
9. "La Protection Maternelle et Infantile en Tunisie"  
Dr. Bechir Hamza
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Coopération Canado-Tunisienne
11. Tunisian National Nutrition Study - NIN/USAID 1973-75

## ATTACHMENT A

PROJECT COST BREAKDOWN : US AID FUNDINGFIELD BUDGET :

<u>1. Personnel Costs</u>	<u>FY 77</u>	<u>FY 78</u>	<u>FY 79</u>	<u>FY 79</u>	<u>Totals</u>
Project Director	10,000	20,000	20,000	10,000	60,000
Field Nutritionist	2,152	4,781	5,259	2,843	15,035
Translator/Secretary (1/2 time)	<u>1,580</u>	<u>3,470</u>	<u>3,824</u>	<u>2,003</u>	<u>10,883</u>
	13,732	28,257	29,083	14,846	85,918
<u>2. Training costs</u>					
Training Seminars for 87 Social Assistants, 174 Nurses, and NCSS Field staff	--	18,370	17,387	--	35,757
<u>3. Commodity costs</u>					
Production of educational materials, and purchase of audio-visual materials and equipment	--	13,250	9,500	4,750	27,500
Vehicles (8 x 3000, 2 x 7,800)	44,400	--	--	--	44,400
Furniture and equipment for 174 centers x 526	--	<u>61,016</u>	<u>20,208</u>	--	<u>91,224</u>
	44,400	74,266	40,008	4,752	163,426
<u>4. Other Costs</u>					
Local travel expenses	800	2,000	2,000	1,000	5,800
Fuel	5,184	10,368	10,368	5,184	31,104
Vehicle repair, maintenance and insurance	7,080	15,510	16,760	8,230	48,180

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34

	<u>FY 77</u>	<u>FY 78</u>	<u>FY 79</u>	<u>FY 80</u>	<u>Total</u>
Administrative support for consultants 150 days x .50	750	2,250	1,500	750	5,250
Administrative support for personnel	2,705	1,515	1,525	876	6,681
Evaluation fees	<u>—</u>	<u>2,850</u>	<u>2,850</u>	<u>(2)5,700</u>	<u>11,400</u>
	<u>17,175</u>	<u>34,433</u>	<u>35,003</u>	<u>21,740</u>	<u>108,415</u>
Subtotal Field expenses	75,311	155,380	121,481	41,336	393,514

U.S. CONSULTATION/SUPPORT

Salary (105 days x .125)	1,875	5,625	3,750	1,875	13,125
Travel (7 x 1000)	1,000	3,000	2,000	1,000	7,000
Per Diem (147 days x .45)	<u>945</u>	<u>2,835</u>	<u>1,890</u>	<u>945</u>	<u>6,615</u>
Subtotal -U.S. Consultation/support	3,820	11,460	7,640	3,820	26,740
TOTAL US/AD FINANCED:	79,131	166,840	129,121	45,156	420,254

35

## ATTACHMENT B

PROJECT COST BREAKDOWN : RCSS FUNDING \*

<u>1. Personnel costs</u>	<u>FY 77</u>	<u>FY 78</u>	<u>FY 79</u>	<u>FY 80</u>	<u>Totals</u>
National	5,940	11,880	11,880	5,940	35,640
Regional	13,800	27,720	27,720	13,800	83,160
Center Level	142,652	297,384	297,384	142,652	892,152
	<u>168,452</u>	<u>336,984</u>	<u>336,984</u>	<u>168,452</u>	<u>1,010,952</u>
	( 65,930)	(131,861)	(131,861)	( 65,930)	( 355,582)
<u>2. Training Costs</u>	--	--	--	--	--
<u>3. Commodity Costs</u>					
Food Purchases	<u>184,320</u>	<u>368,640</u>	<u>368,640</u>	<u>184,320</u>	<u>1,105,920</u>
	<u>184,320</u>	<u>368,640</u>	<u>368,640</u>	<u>184,320</u>	<u>1,105,920</u>
	( 72,214)	(144,248)	(144,248)	( 72,124)	( 432,744)
<u>4. Other Costs</u>					
National Operational expenses	17,820	35,640	35,640	17,820	106,920
Regional Operational expenses	41,580	83,160	83,160	41,580	249,480
<u>Center Level</u>					
Rent	23,370	46,752	46,752	23,370	140,256
Maintenance	8,100	16,200	16,200	8,100	48,600
Renovation	10,960	21,931	21,931	10,960	65,794
Utilities	3,960	7,920	7,920	3,960	23,760
Program Administration	48,000	96,000	96,000	48,000	288,000
	<u>153,802</u>	<u>307,603</u>	<u>307,603</u>	<u>153,802</u>	<u>922,810</u>
	( 60,182)	(120,365)	(120,365)	( 60,182)	(361,094)
Total	500,614	1,013,227	1,013,227	500,614	3,039,682
% for CRS Project Area.	(198,238)	( 396,475)	(396,475)	(198,238)	(1,189,426)

\* Represents national budget. That portion that relates to CRS project area is calculated at 39.13 % in parentheses.

## ATTACHMENT C

PROJECT COST BREAKDOWN : MINISTRY OF SOCIAL WELFARE FUNDING

<u>1. Personnel Costs</u>	<u>FY 77</u>	<u>FY 78</u>	<u>FY 79</u>	<u>FY 80</u>	<u>Totals</u>
2175 Social workers months x 10 mos. x 65 dinars x 2.4	--	9,501	16,286	8,143	33,930
	--	9,501	16,286	8,143	33,930
<u>2. Training Costs</u>					
87 Social workers x 50 months x 65 Dinars* x 2.4	--	3,393	3,393	--	6,786
	--	3,393	3,393	--	6,786
 Total		12,894	19,679	8,143	40,716

\* Average against scheduled 4 year salary raise plan.

PROJECT COST BREAKDOWN : MINISTRY OF PUBLIC HEALTH FUNDING

<u>1. Personnel Costs</u>	<u>FY 77</u>	<u>FY 78</u>	<u>FY 79</u>	<u>FY 80</u>	<u>Totals</u>
4,176 Public Health nurse - months x 15 months x 80 dinars * x 2.4	--	30,000	60,133	30,007	120,266
	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
	--	30,000	60,133	30,007	120,266
 <u>.. Training Costs</u>					
174 Public Health nurse-months x .25 months x 60 dinars x 2.4	--	4,176	4,176	--	8,352
	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
	--	4,176	4,176	--	8,352
 Total	--	34,242	64,309	30,007	128,618

\* Averaged against scheduled  
4 year salary raise plan.

## ATTACHMENT E

PROJECT COST BREAKDOWN : NATIONAL INSTITUTE OF NUTRITION FUNDING

<u>1. Personnel Costs</u>	<u>FY 77</u>	<u>FY 78</u>	<u>FY 79</u>	<u>FY 80</u>	<u>Totals</u>
<u>2. Training Costs</u>					
a. Trainers x 4 months x 175 Dinars x 2.4	<u>    --</u>	<u>  1,650</u>	<u>  1,650</u>	<u>    --</u>	<u>  3,300</u>
	<u>    --</u>	<u>  1,650</u>	<u>  1,650</u>	<u>    --</u>	<u>  3,300</u>
Total	<u>    --</u>	<u>  1,650</u>	<u>  1,650</u>	<u>    --</u>	<u>  3,300</u>

ATTACHMENT F

PROJECT COST BREAKDOWN : PEACE CORPS FUNDING

	<u>FY 77</u>	<u>FY 78</u>	<u>FY 79</u>	<u>FY 80</u>	<u>Total</u>
<u>1. Personnel costs</u>					
o Volunteers					
x 2 years x 8,700	--	39,150	52,200	13,050	104,400
		<u>          </u>	<u>          </u>	<u>          </u>	<u>          </u>
	--	39,150	52,200	13,050	104,400
Total	--	39,150	52,200	13,050	104,400

ATTACHMENT G

PROJECT COST BREAKDOWN : CRS FUNDING

1. Personnel Costs

U.S. Personnel	8,500	17,000	17,000	8,500	51,000
National Personnel	5,100	10,200	10,200	5,100	30,600
	<u>13,600</u>	<u>27,200</u>	<u>27,200</u>	<u>13,600</u>	<u>81,600</u>

2. Training Costs

-- -- -- -- --

3. Commodity Costs

-- -- -- -- --

4. Other Costs

Administrative  
Support

8,000	16,000	16,000	8,000	48,000
<u>8,000</u>	<u>16,000</u>	<u>16,000</u>	<u>8,000</u>	<u>48,000</u>

Total	21,000	43,200	43,200	21,600	129,600
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OPERATIONAL PROGRAM GRANT PROPOSAL

Total OPG Request: \$653,744

Project Title: Integrated Pre-School Feeding Program  
Project Location: Tunisia  
PVO Name and Address: CARE/MEDICO, 18 Avenue Docteur Conseil,  
Tunis, Tunisia  
Central Headquarters: CARE, Inc., 660 First Avenue, New York,  
New York 10016, USA  
Contact Person: CARE-New York: Ralph Devone, Program  
Director  
CARE-Tunisia: George Radcliffe, Country  
Director  
Date of Submission:

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I. PROJECT PURPOSE AND DESCRIPTION

A. Project Purpose

To improve the infrastructure and the effectiveness of the pre-school feeding program and to integrate preventive health and health education components within the presently existing program.

B. Target Group of Beneficiaries

This project proposes to reach 435,000 persons residing in ten Gouvernorates (Districts) of Tunisia. Twelve and a half percent of the population of the project area will

be directly affected by the project and approximately 29 per cent of the 0 to 6 population will be covered by the project. All of the target population falls within the lower socio-economic strata residing in rural areas. The feeding program beneficiaries are 98,000 children below the age of six years. The mothers and pre-school age siblings of these children will benefit for the project's health and educational activities. The children in this age group have been designated by the Government of Tunisia as a high priority group.

C. General Description of the Project

The broader objective to which this project will contribute is to improve the nutritional and health status of the population of the target area.

Specifically, it seeks to upgrade the feeding program currently conducted by the Tunisian National Committee for Social Solidarity (NCSS) and to integrate into it preventive health and health education components. The initial focus will be on the feeding program itself to upgrade the quality of the meals served and to adapt the feeding facilities, where necessary, in an effort to make them more suitable for their designated purpose.

The upgrading of the existing program will consist of:

1. Improving the present program facilities through the provision of furniture and equipment necessary for the proper storage, preparation and consumption of

nutritional supplements and for adequately providing preventive health and health education activities.

2. Surveying the existing facilities in order to determine the amount of structural changes and alterations which need to be made to those centers which are found to be partially or completely inadequate for the effective functioning of the program and designing a plan for effecting these alterations and changes.

3. The design and implementation of a revised logistical system to ensure timely commodity flow and turnover, thus avoiding feeding interruptions and commodity waste due to infestation and long storage.

4. In coordination with the NCSS, a system will be developed for improved program monitoring and surveillance. This activity will be carried out by the existing NCSS staff with the assistance of CARE.

Feeding alone is but a stop-gap measure in dealing with the problems of under- and malnutrition. Other measures which contribute to the improvement of health status and overall socio-economic development have to be included. Towards this end, in addition to the improvement of the existing feeding program there will be the creation and inclusion of preventive health and health education components.

The preventive health component will be provided through the involvement of two groups of para-professionals, rural public health nurses and rural social workers. At present,

these workers carry out their duties to a large extent using the house to house visiting approach. Their role would remain essentially the same, however utilizing the infrastructure of the pre-school program would enable them to reach their target population in a more effective manner.

The Public Health Nurses (PHN's) will check the nutritional and health status of the enrolled beneficiaries making referrals when necessary to the appropriate higher level health facility. They will also insure that the appropriate immunization of the enrolled beneficiaries is accomplished either by immunization at the center itself or by referral to another facility.

The rural social worker will motivate mothers of beneficiaries as well as other women from the surrounding area to attend nutrition and health education sessions at the feeding centers. This represents a new dimension to the use of these centers which heretofore have not been used for community activities. In addition to conducting these training sessions the social workers will provide individual counseling for the mothers. The education imparted to the women will affect the entire family unit but the education will be directed in particular to the needs of the pre-school child and the mother during pregnancy and lactation. The individual consultations will directly benefit the below 3-year old child through improved feeding practices and early referral to medical services. As the existing FMI's (MCH centers)

45

are located mainly in the urban and semi-urban areas this innovation in rural areas will provide a valuable service to this most vulnerable group of the population.

The social workers will work with the mothers stressing the following concepts:

1. Important notions of child care:
  - a. The importance of immunizations
  - b. Proper diet during illness
  - c. Food hygiene
  - d. The role of direct sunlight in the prevention of rickets.
2. How to plant, grow and maintain a home garden
3. How to prepare least-cost nutrient-rich meals using local foodstuffs
4. The principles and importance of breast-feeding
5. The importance of introducing supplementary foods into the child's diet from the age of five months
6. How to best utilize the family food budget
7. The importance of child spacing and family planning

The purpose of this education will not be merely to teach the mothers but to motivate them to put their knowledge to regular use in their homes.

D. Conditions Expected at the End of the Project

1. All of the existing feeding centers to have improved their feeding performance and facilities by the end of the third project year.

4/6

2. All of the existing feeding centers will have integrated basic health screening and referral to services into center activities by the end of the third project year.

3. All of the existing feeding centers will have integrated health and nutrition education into their regular activities by the end of the third project year.

## II. PROJECT BACKGROUND

### A. History of Proposal Development

CARD's interest in this program developed when it was invited in the fall of 1975 by the TCSB and USAID/Tunisia to undertake a study of the existing pre-school feeding program and to make recommendations in regard to possible program improvements.

The study was undertaken and a report was submitted to USAID/Tunisia on March 17, 1976. The main points of the report were:

1. The present feeding program requires drastic improvement.
2. Actual consumption is falling due to the declining acceptability of the food served.
3. The pre-school center itself is under-utilized. Each center is used only for pre-school feeding and is open only three to four hours per day.

CARD then approached government officials on the governorate level during February 1976 in order to obtain their

opinions concerning a linkage between the feeding centers and health activities. The response was positive without exception. Many government administrators expressed the view that many of the public health nurses and social workers could be better utilized through such an arrangement. (See Appendix 2 for background information on the Pre-School Feeding Program).

B. Prior Experience in the Project and Related Areas

CARE has had considerable experience in the administration of nutrition and health programs in Tunisia since its establishment here in 1962. CARE/Tunisia has administered feeding programs for the past ten years. In 1971 it created a Division of Applied Nutrition for the purpose of improving the use of P1480 food commodities distributed to school canteens and health centers. This Division was staffed until recently with a Tunisian nutritionist employed by the Ministry of Public Health and seconded to CARE.

An American Peace Corps Volunteer nutritionist has worked together with the Tunisian nutritionist during the past three years to develop a nutrition/health education project (Tunis Sud Project) and to experiment with and encourage the use of enriched blended foods among recipient children, and pregnant and lactating women.

Other programs directed by CARE/Tunisia have been in the field of health. These include a successful 12-year orthopaedic surgery training project and several water wells reconstruction and renovation projects in different regions

of the country.

C. Host Country Activity in Project/Program Areas

The Tunisian Government nutrition activities were originally spread over the Ministries of Health, Social Affairs, Education, Agriculture, and Planning. To provide more coherent nutrition planning the National Institute of Nutrition and Food Technology was established in 1969 with USAID assistance.

The Tunisian Government's official support of family planning was translated into action in 1964 when the Ministry of Public Health, working with the Ford Foundation and the Population Council launched a pilot project providing information on birth control techniques. There are presently 90 Family Planning Centers (usually in conjunction with MCHC's) which provide family planning counseling.

In terms of preventive health, there exists within the Ministry of Public Health a Division of Preventive and Social Medicine which has the following functions:

1. Conducts campaigns against specific diseases (malaria, trachoma, tuberculosis, schistosomiasis)
2. Vaccination, ambulatory treatment and detection of communicable diseases.
3. Environmental sanitation including drinking water, campaigns against insects and other pests, sanitary conditions of public places.
4. School health education.

This division has about 1,000 employees, almost all with a low level of training who are supposed to visit every house within their area of jurisdiction every fifteen days. However, only about 8% of the total MOI budget is devoted to preventive medicine.

The above personnel operate out of rural hospitals and dispensaries, anti-tuberculosis dispensaries, 90 MOIC's (which are now mostly curative in nature), 13 skin disease centers, 12 rabies centers and 12 border health posts.

### III. MOI COST ANALYSIS

#### A. Economic Effects of the Project

The overall economic effects of such a program emerge from the reduction in mortality and morbidity to a general improvement in the health status of the population. To increase the level of health is one way to increase Tunisia's effective labor supply.

Premature deaths and disabling disease alter unfavorably the ratio of working population to dependents. Disease entities of chronic nature including under- and malnutrition take their toll in physical and mental vitality, thereby increasing the number of persons needed to do a job. This condition often prevails in areas associated with sub-optimal living leading to a chain of events described as follows:

Poor health status = lowered energy output = lowered production = bare subsistence income = meager education = poor diet and sanitation = decreased resistance to

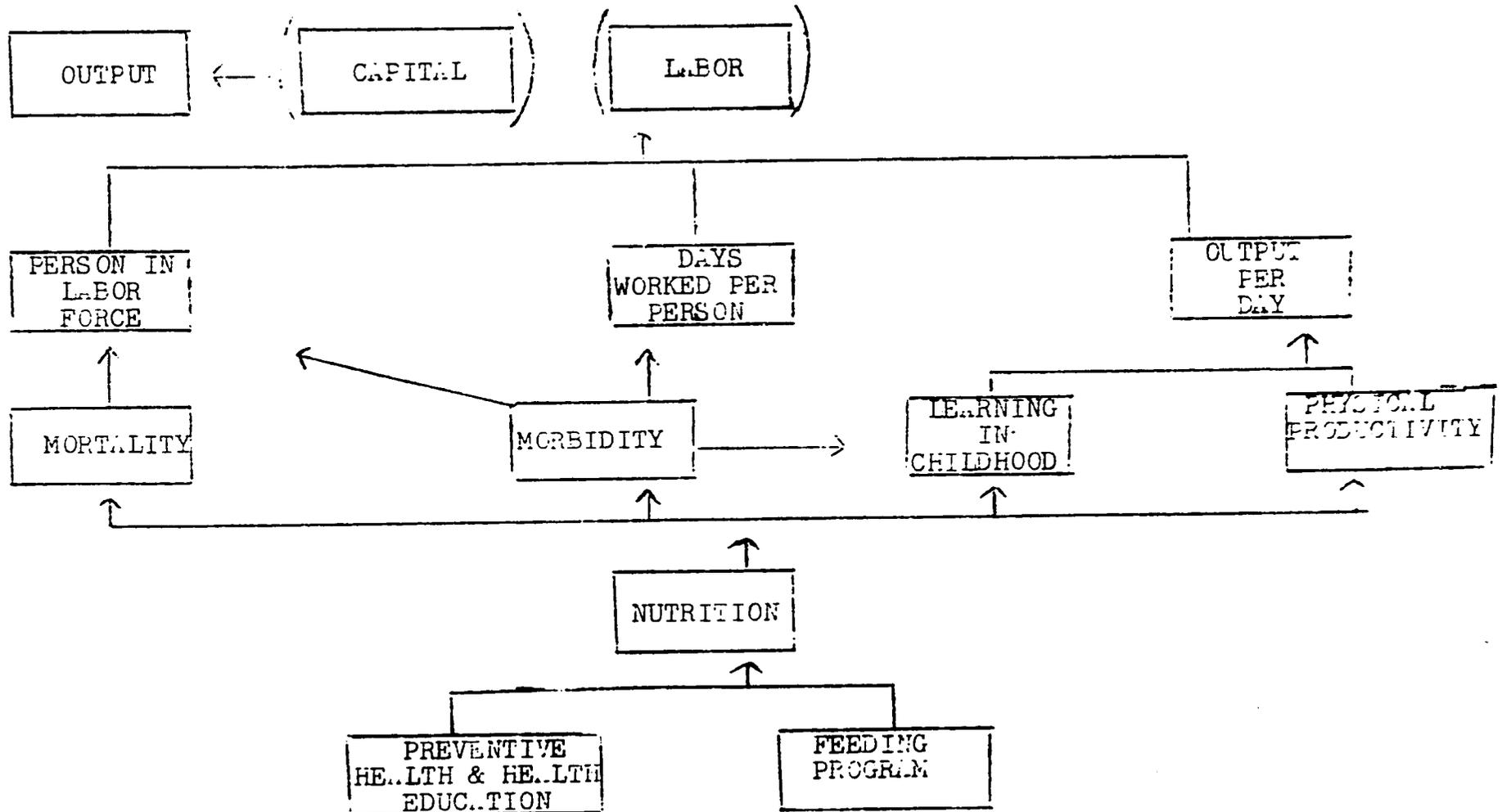
disease = high infant and child mortality rates = lower life expectancy.

However, the true benefits of nutrition programs, such as the feeding program, will not come for some years. The social benefits of lower infant mortality ultimately bring about a decision to conceive fewer children, but this is seen only after some time. The benefits of applied health education are, in some areas, immediate, such as increases in adult labor activity.

The greatest economic effect will be seen only as the child grows, finishes school, and becomes a vital part of the labor force. On the following page is a schematic representation of the feeding program with integrated preventive health and health education as an investment in human capital.

The economic effects of the preventive health aspect of this program are most demonstrable when one views the curative segment of a nation's health care delivery system. It costs more to rehabilitate one case of acute malnutrition than to enrich the diet of several hundred children over the same period of time. In terms of immunization against poliomyelitis, for example, the cost saved is astronomical. The primary series of tivalent oral polio vaccine costs \$0.85 per child whereas curative treatment of the disease is anywhere from \$7,500 to \$12,500 the end result of which can never be illness status. With this same amount between 9,000 and 14,000 children could be immunized. The implications of such a

Adapted from NUTRITION  
NATIONAL DEVELOPMENT AND  
PLANNING, Berg, Scrimshaw  
Call (ed)., page 138.



15

preventive health approaches are more than obvious not only in terms of immediate and long-term savings but increased productivity as well as increased numbers in the labor force.

B. Technology to be Used and its Appropriateness

This project has been carefully planned to keep it within the scope and technology and expertise of CARE and the cooperating host country agencies. Provision has been made for a limited amount of outside consultancy to assist in areas where local expertise may not be available. It is not the intention of this project to change the health delivery system in Tunisia but rather to optimize its efficiency in the preventive health sector through coordinated and targeted activities utilizing existing personnel. Thus the emphasis of this project will be on the utilization of resources available within the existing health infrastructure.

Administratively, it is within the capabilities of CARE-Tunisia to implement this project. Its experience in the administration of health and nutrition related programs will contribute greatly to the successful implementation and success of this project.

The Tunisian Ministries of Public Health and Social Welfare as well as the MOJ and the Municipal counterparts due to their orientation and adequate staffing. Collaboration on this project and future efforts to expand this program should prove to be no problem.

Essentially this project will be implemented in two steps:

1. Improving the current feeding program.
2. Integrating the above program with preventive health and health education components.

To attain the first step the following actions will be taken:

1. A reinforcement of the feeding program structure through:
  - a. Improved communication among the implementing agencies.
  - b. Greater endeavors to motivate NCCS Regional Administrators.
  - c. Increased field inspections and improved program monitoring operations.
2. An improvement of the physical state of the feeding program centers through:
  - a. Greater budgetary allocations for renting centers
  - b. Increased allocation for maintenance and repair of centers.
  - c. Development of ways and means for improving the physical structures of the centers.
3. A revision of the system of distribution through:
  - a. Correction of the current stocking problem.
  - b. The establishment of a system based on timely feedback and realistic allocations and call forwards in order to insure fresh stocks at the centers.
4. The improvement of the quality of meals served through:

- a. The preparation of ICSI in various ways.
- b. The introduction of local flavorings.
- c. The alternative use of ICSI with USB.
- d. The allocation of additional sugar.
- e. The integration of imported foods with local foods and recipes.

Concurrently with the above-mentioned activities the preventive health services and the training of social workers will begin and educational materials will be developed for the non-formal education in the centers.

The preventive health components will be directed primarily to the enrolled beneficiaries. After the project is operational and on the basis of experience and further investigation the health services might be extended to children who are not enrolled as feeding beneficiaries. This would be a positive development.

The health services to be performed in the centers will include health screening and referrals as well as control of the effectively immunized pre-school population. The screening will be carried out on a periodic basis.

Initially, this task was to be delegated to physicians. However, after a closer examination of the health manpower resources in Tunisia, this plan was found to be unrealistic for the following reasons:

1. The health manpower situation in Tunisia is characterized by an acute shortage of physicians, particularly

in the rural areas.

2. The above outlined tasks will require a large time input which would divert physicians from hospitals and other institutions.

Therefore, the services of the trained PHN's will be utilized. The activities in which they will be involved are more definitely described below:

1. Reception, inspection and screening of children.
2. First aid when necessary.
3. Casefinding with subsequent referral to nearest competent medical facility for further diagnosis and treatment of suspected illnesses.
4. Periodic anthropometric measurements (height, weight and arm circumference) and careful recording and interpretations of the measurements made.
5. Maintenance of individual performance charts and health and attendance records.
6. Checking immunization status of the children with subsequent referral of those needing immunization.

The appropriateness of employing the PHN's in these centers to perform these tasks is due to the following reasons:

1. They exist in greater numbers than physicians and are located in all regions of the country.
2. Working through these centers will save precious time spent in the tedious and often inefficient door-to-door approach. These centers will serve as important gathering points.

3. They are capable of carrying out the aforementioned activities without additional technical training.

The health education activities, on the other hand, will focus primarily on the mothers. In general, they will be taught elementary principles of foods and nutrition, and relating this to the most economic use of the family food budget. The mothers will also receive instruction in home sanitation, hygiene and elements of child care. The educational activities will include not only theoretical instruction but practical demonstrations as well. In addition, where possible, mothers will be visited in their homes to permit observation of the application of the knowledge gained.

The proposed education sessions at the centers will be conducted by social workers. The appropriateness of their employment for this activity is seen as follows:

1. There are many social workers presently placed in the rural areas.
2. They know and usually enjoy good relations with many of the women in the area to which they are assigned and have come to be respected and have cultivated a degree of confidence among their clientele.
3. They have had some health and nutrition training but, most importantly, they have an excellent theoretical and experiential knowledge of interpersonal relations and communication.

Training seminars will be jointly organized and conduc-

ted by the CHSS, NIE and CIE for the social workers. These will serve to strengthen and widen their knowledge base in the area of health education. For the purpose of this project on the average of one social worker for every two centers (or a total of 137) will participate in the training activities which will be kept simple and practical in both content and presentation.

It should be mentioned that CIE is gaining Tunisia-specific experience through the ongoing implementation of the Health/Nutrition Education project in Tunis Sud. The same techniques which prove to be successful in this project will be utilized in training the social workers.

### C. Socio-Cultural Factors

The "Yale Project", directed by Dr H.S. Young in 1972-74 studied nutrition and development of tunisian children of urban, low socio-economic families and dietary practices of pregnant and lactating mothers. Women in three communities were surveyed by means of household surveys and oral questionnaires. The study found that from 36 percent to 50 percent of the women questioned actually ate less during their pregnancies than they normally did. Twenty percent of the lactating mothers drank only one serving of milk per month.

Lactating mothers consumed only 35% of the calcium recommended during this time, and only 50% of the recommended quantity of riboflavin. Thirty percent of the mothers did not breastfeed, or stopped before 6 months; 40% of the Medina (central city) mothers breastfed their children up to the age of

one and a half years, compared to 70% of the mothers in Saïda Manoubia, a community of families more recently arrived from rural areas. Twenty-three percent of the women who stopped breastfeeding did so because they have "insufficient milk", 22% because of another pregnancy, and 20% due to illness. About half of the children 18 months old never or rarely get eggs (one egg or less per month) and about a third never or rarely get meat. It is probable that the prevailing myths about the adverse effects of eggs and meat for infants are responsible for this (for example there are beliefs that eggs cause stuttering and meat causes stubbornness).

A study conducted by Dr Rejeb in 1967-68 for UNICEF and the Ministry of Public Health also revealed significant information concerning diets during pregnancy and lactation. In the regions studied (Sfax, Béja, and Kasserine) through interviews with women, it was found that 55% of the women did not change their diets during pregnancy and 70% to 92% did not increase their food intake during the period of lactation.

Both the Yale study and the UNICEF study indicate that many Tunisian women receive inadequate nutrition during pregnancy and lactation. One reason for this may be that they are not aware that an increase in calories and other nutrients is necessary. Another factor may be the woman's traditional role in the family which requires that she serve her husband first, her children next, and herself last.

The food consumption survey studied infants under two years of age in rural areas in order to establish the composi-

tion of their diets according to age. It was found that just over half of the children between the ages of 6 and 9 months ate no supplementary foods in addition to milk. Twenty-one percent of the children between the ages of one and one and a half years still received no supplementary foods. Fifteen percent of all children under two years did not get any milk at all but only various semi-solid foods. Although 39% of the mothers continued to nurse their children until they were one and a half to two years old it is likely that this percentage has since fallen as the result of the increasing trend away from breastfeeding in favor of artificial feeding which is due in part to the persuasive propaganda of companies which market infant formulae.

Health statistics for Tunisian children further illustrate the pressing need for education in hygiene and preventive health measures and their relationship to good family health and nutrition.

In a recently published paper by Dr Bechir Hamza, Director of the National Institute of Child Health, ("La Protection Maternelle et Infantile en Tunisie") He indicates that only fifty percent of the pre-school population are being effectively immunized.

Infant diarrhea and dehydration with accompanying malnutrition occur with needless frequency, particularly during the summer months. The Annual de Puericulture, Project Avicenne, Cooperation Canado-Tunisienne, reports that gastroenteritis and pneumonathies combined account for four-fifths

of the deaths of children below one year of age. The estimated prevailing infant mortality rate is two and a half times greater in rural areas than in Tunis and its suburbs (200/1000 rural, 80/100 Tunis), due to the fact that care is more accessible in Tunis, especially for the cases of dehydration which result from the summer epidemics of diarrhea. Much evidence has been accumulated to indicate that the excessive postneonatal mortality among young children in developing countries, as compared with industrialized ones, is almost entirely the result of the synergistic interaction of malnutrition and infection and simply does not occur if the children are well nourished (Nevin S. Scrimshaw, "Myths and Realities in International Health Planning", American Journal of Public Health, Vol. 64, No. 8, P. 795). The observance of basic hygienic practices can be encouraged through community education.

The preliminary summary of results of the 1973-1975 Tunisian National Nutrition Survey (a joint undertaking of the Tunisian National Institute of Nutrition and US.I.L.) contains the following statements concerning nutrition in Tunisia:

"It is clear that significant growth retardation exists in Tunisian children. The problem is nationwide. During the second year of life, Tunisian children undergo a particularly great food deficit and weight relative to height drops considerably below that of European and North American children. The problem appears to be of a long-term nature, there being no anthropometric evidence

that there have been major changes in general dietary adequacy in past decades, in that young adults are not markedly different from older adults. Although the retardation is not as severe as observed in some developing countries, it nevertheless is sufficiently marked to warrant major attention in future planning.

... The absence of evidence of major protein deficits suggests total calorie and micronutrient deficits as principal causative factors. There is a need to develop educational programs aimed at improving childhood nutrition, and to develop nutritional well-balanced feeding supplements for post-weaning infants and toddlers.

"Rickets as indicated by clinical signs continue to exist in Tunisia. There is a strong tendency for the prevalence to decrease from north to south. On the basis of clinical observations alone, 5 to 10% of the children in the northern and northwestern parts of the country suffer from vitamin E deficiency.

"...it is reasonable to conclude that: (1) Tunisia has major nutrition problems, placing the country in many respects between developing and technologically developed nations; (2) Most of the problems are amenable to satisfactory solutions at modest expenditures provided reasonable efforts in fact are made;"

Through this program the center health and health education activities may have socio-cultural effects on the communi-

62

ty beyond the improvement of nutritional and health practices per se. The community social worker will now be seen as someone knowledgeable in preventive health measures and good dietary practices in addition to her present capabilities and should acquire enhanced stature and credibility among the people. One importance of this is that it strengthens the image and role of women in a male-dominated society. It should also strengthen the role of the social worker in the family planning campaign.

D. Statement of Project Relationship to Other Considerations

The present beneficiaries of the pre-school feeding program are between the ages of 3 and 6 years and belong, for the most part to the lower socio-economic group whose income is less than \$75 per month per family. Often the meals served at the centers are basic rather than supplemental rations for these children. Their mothers are either illiterate or have benefited only from a minimal amount of formal education.

Furthermore, no current specific health programs are aimed at the 3 to 6-year old group as opposed to the 0 to 3-year old group who benefit from the ICI system and the 6 and above age group covered under the primary school health program. These two programs are primarily curative in nature. Theoretically, the 3 to 6 age group is entitled to health care services provided at the ICI centers, however, field discussions indicate that, practically speaking, children above the age of three do not use these centers. Moreover, there appears to

be an urban and semi-urban bias in the distribution of the present and creation of new HCH centers.

The project also has the potential to spread to a larger number of people over a period of time through expanded coverage of the educational and health activities within the center and the creation of new centers. In addition, the preventive health, health education and referral activities may eventually be extended to all members of the community residing near the center.

E. Presentation of a Realistic Plan for Duplication and Institutionalization with Domestic Resources

Since this project proposes to have a country-wide scope utilizing chiefly existing activities and personnel on a continuing basis the question of duplication does not arise. Almost all the program's operational expenses are presently covered and budgeted as recurring expenses by the various Ministries concerned and those operational expenses not presently provided for which will be created as a result of the project will be adequately provided for in the Ministries' budgets by the end of the project.

However, there is scope for duplication or expansion of some of the projects activities such as:

1. More effective use of paramedical personnel.
2. More effective use of existing community facilities.
3. Increased cooperation among government agencies with a decrease in duplicated efforts.

4. A more meaningful dialogue among the Ministry of Public Health, the Ministry of Social Affairs, the National Institute of Nutrition and the National Committee of Social Solidarity.

IV. PROJECT DESIGN AND IMPLEMENTATION

A. Implementation Plan

Since this project is both developmental and operational it will be necessary to properly phase these activities and to delineate the roles of the various agencies and Ministries involved. The project will be carried out under the supervision of CAHE/AMNICO. The principal host counterpart will be the National Committee of Social Solidarity (NCCS). In addition to its role of participating with CAHE/AMNICO in the overall coordination the NCCS will be responsible for the day-to-day operation of the feeding program, the provision of the centers and their upkeep, and coordination of the material inputs of other cooperating agencies.

The Ministry of Social Welfare will provide the social workers who will be responsible for the health and nutrition education component. The Ministry of Public Health will provide public health nurses for conducting the preventive health activities. The American Peace Corps will provide six volunteers who will assist in the developmental and operational phases of the project.

The National Institute of Nutrition will assist in an advisory capacity in all phases of the project and shall in-

sure the nutritional integrity of the project activities.

The schedule of implementation will be as follows:

Months 1 through 6

This period will be devoted primarily to the project's planning and developmental activities which will include:

1) the development of an improved logistic and reporting system for the feeding program; 2) preparation for the training of the social workers, public health nurses, center organizers and CNSS Regional Directors; 3) the development of improved recipes for the feeding program; 4) a survey of existing program facilities and development of plans for their improvement and 5) the design of a basic evaluation system and collection of base-line data.

Months 7 through 18

The basic training and program implementation activities will be conducted during this period. Among these activities will be: 1) the commencement of training of social workers, public health nurses, center organizers and CNSS Regional Directors; 2) the introduction of the new logistics system; 3) the commencement of the development of indigenous alternatives to imported foods; 4) the equipping of centers; and 5) evaluation of nutrition education techniques.

Months 19 through 30

Although the program will be fully operational during this period the project will proceed in effecting changes and modifications based on feedback received from the monitoring and evaluation activities. Included in this period's activities will be: 1) refresher training for social workers;

- 2) evaluation and modification of the logistics system;
- 3) continuation of indigenus food development; 4) continued equipping of centers; and 5) continued orientation of public health nurses.

Months 31 through 36

This period will be devoted primarily to evaluation and report preparation activities.

3. Personnel

All operational personnel will be provided by the National Committee for Social Solidarity and the Ministries of Social Affairs and Public Health. The Project Director will be an employee of CINE/ALMICO. In addition to the Project Director there will be a supportive staff which will assist in the project implementation. The salaries and expenses of this supportive staff will be borne by CINE/ALMICO.

During the transitional or implementation phase of the project six Peace Corps Volunteers will be assigned to assist in the execution of the training and operational activities. These Volunteers will serve as an active link between the project staff and the field helping to translate the project's concepts into program activities. These Volunteers will work closely with selected members of the CINE/ALMICO and ICSS staff who will eventually have the responsibility for the program's field operations and activities after the conclusion of this project.

Another important personnel input is that of a Field

Nutritionist who, at the outset, will have the responsibility for developing and field-testing improved preparations utilizing the existing commodities. After this has been accomplished this person will be responsible for the continuous testing and improvement of the rations served. It is expected that this Field Nutritionist will work closely with the National Institute of Nutrition and will have a continuing role with the Institute even after the end of this project.

C. Training

Since the main thrust of the project is to revitalize an existing program through changes in its present methods of operation and the addition of new activities it will be necessary to insure that those responsible for the effective operation of the program be fully aware of these changes and additions and, above all, comprehend the scope and importance of their role in the overall program operation. In order to accomplish this it will be necessary to develop relevant training techniques and materials and impart training to those responsible for the program's functioning and ultimate success. Provision has been made for the training of the social workers, public health nurses and the NCSL Regional Directors who will have specific program duties. There is also provision for the training of those members of the local communities who have some degree of responsibility for the centers day-to-day operation. Through the training or orientation of these people the program can gain increased community acceptance and support.

The project staff in cooperation with the counterpart agencies will have the responsibility of designing, implementing and evaluating the necessary training activities.

D. Commodities, Equipment & Materials

One of the main components of the new program will be the addition of nutrition and health education to the feeding centers present activities. The major thrust of this activity will be aimed at the mothers who have enrolled themselves or their children in the center but it is also envisioned that the center will develop into a source of nutrition and health information for the surrounding community at large. Provision has been made in the project budget for the preparation, printing and distribution of educational materials aimed not only at the mothers but to the children as well and the community at large. Various media will be employed to impart these educational messages.

Another major project activity is the upgrading of the existing centers. This will be accomplished through the provision of furnishings and equipment such as tables, chairs, and food preparation and serving equipment. Additional equipment will be provided for the educational and preventive health activities which will be conducted in the centers. Weighing scales which are essential for the preventive health activities and the monitoring of children's growth and project impact evaluation will also be provided.

Eleven vehicles will be purchased for the project. One

of these vehicles will be assigned to a national coordinator appointed by the National Committee for Social Solidarity, the remaining ten will be for the use of the project staff for field operations. UNICEF will be responsible for the scheduling and utilization of these vehicles. Nine of the vehicles should be medium-sized, station wagon types capable of carrying personnel and light equipment and suitable for prolonged operation in the rural areas of Tunisia. The remaining two should be heavier vehicles capable of carrying larger numbers of personnel and/or bulky equipment and suitable for operation in the rough terrain of the desert areas in the south and of the mountainous northwest.

Waiver Request

A waiver of purchase of U.S. origin is requested for the project vehicles so that they may be purchased in a third country. Since the vehicles will be used primarily in rural areas and will eventually be assigned permanently to these areas there is little likelihood that U.S. vehicles can be maintained in proper running condition.

A waiver of purchase of U.S. origin is also requested for the furniture and equipment for the feeding centers. It is requested that these items be purchased in either a third country or locally. While almost all of this furniture and equipment will be purchased locally, some, especially that of a mechanical nature such as the weighing scales, may have to be purchased in a third country.

E. New York Consultation Support

It is proposed that funds be provided for multi-disciplinary consultative support for the project. Since a major part of the project is developmental and innovative it will be necessary to obtain advice and assistance of a technical nature in a number of disciplines for its proper execution. Consultation may be required in the following areas to name a few: nutrition and health education; food storage and distribution; monitoring and evaluation; construction techniques; food processing and preparation; and public health. Provision has been made for several consultations of short and medium-term duration throughout the project.

F. Measurement and Evaluation of Project Accomplishments

Evaluation will consist of pre- and post-project measurement and monitoring the project in terms of the goals and targets discussed above. Responsibility for evaluation will rest with CAG/UNICEF. All project participants will assist in the evaluation.

Specifically, the evaluation will measure:

1. Improvement in the feeding program.
2. Effectiveness of the nutrition/health education component.
3. Effectiveness of the preventive health component.
4. Increase in knowledge of the social workers.

Much of the information for evaluation will be gathered from program records at the governorate and center level.

CAI/UNESCO-Tunisia is required by its headquarters to submit Project Implementation and Evaluation reports every four months. Information from these reports will be used for evaluation purposes.

Upon completion of the project, CAI/UNESCO-Tunisia is required to submit an evaluation report to its headquarters. This report will also be submitted to AID.

FINANCIAL PLAN

	<u>FY 77</u>	<u>FY 78</u>	<u>FY 79</u>	<u>FY 80</u>	<u>TOTALS</u>
A. <u>Grant Total</u>	110,482	274,239	208,102	60,921	653,744
B. <u>Project Costs</u>					
Personnel	206,566	521,169	577,503	248,919	1,554,157
Training	---	26,707	24,727	---	51,434
Commodity	230,820	482,573	431,856	191,820	1,337,069
Other Costs	204,435	420,229	406,333	194,188	1,225,185
NY Consulta- tion support	8,775	16,550	16,550	7,775	49,650
	<u>650,596</u>	<u>1,467,228</u>	<u>1,456,969</u>	<u>642,702</u>	<u>4,217,495</u>
C. <u>Sources of Funding</u>					
Grant (USAID)	110,482	274,239	208,102	60,921	653,744
MASS	506,614	1,013,227	1,013,227	506,614	3,039,682
LOSA	---	14,758	21,454	8,878	45,090
MOHE	---	9,566	58,716	32,789	101,099
MIN	---	1,440	1,440	---	2,880
Peace Corps	---	87,000	87,000	---	174,000
CA 1/1000	33,500	67,000	67,000	33,500	201,000
	<u>650,596</u>	<u>1,467,228</u>	<u>1,456,969</u>	<u>642,702</u>	<u>4,217,495</u>

ATTACHMENT APROJECT COST BREAKDOWN: US AID FUNDEDFIELD BUDGET

	<u>FY 77</u>	<u>FY 78</u>	<u>FY 79</u>	<u>FY 80</u>	<u>Totals</u>
<b>1. Personnel Costs</b>					
Project Director	\$ 12,500	\$ 25,000	\$ 25,000	\$ 12,500	\$ 75,000
Field Nutritionist	2,074	4,562	5,018	2,760	14,414
	<u>14,574</u>	<u>29,562</u>	<u>30,018</u>	<u>15,260</u>	<u>89,414</u>
<b>2. Training Costs</b>					
In-service training for 137 Social Workers, 275 Public Health Nurses, 275 Feeding Center Organizers, and 12 NCSE Regional Directors	---	21,588	19,588	---	41,156
	<u>---</u>	<u>21,588</u>	<u>19,588</u>	<u>---</u>	<u>41,156</u>
<b>3. Commodity Costs</b>					
Preparation, printing & Distribution of educational materials	---	17,500	15,000	7,500	40,000
Vehicles (9 x \$3500, 2 x \$7500)	46,500	---	---	---	46,500
Furniture and equipment for 275 centers x \$526	---	96,433	48,216	---	144,649
	<u>46,500</u>	<u>113,933</u>	<u>63,216</u>	<u>7,500</u>	<u>231,149</u>

d. Other Costs

Local travel expenses	750	1,500	1,500	750	3,500
Fuel	7,128	14,256	14,256	7,128	42,768
Vehicle repair & maintenance	9,504	19,008	19,008	9,504	57,024
Administrative support for consultants (180 days x \$50)	1,500	3,000	3,000	1,500	9,000
20% Price fluctuation	15,991	40,565	30,117	8,328	95,001
	<u>34,873</u>	<u>78,329</u>	<u>67,831</u>	<u>27,210</u>	<u>208,293</u>
Subtotal -Field Expenses	95,917	243,392	180,703	49,970	570,012
<u>N.Y. CONSULTATION/SUPPORT</u>					
Salary (180 days x \$125)	3,750	7,500	7,500	3,750	22,500
Travel (15 x \$1000)	3,000	5,000	5,000	2,000	15,000
Per diem (2.0 days x \$15)	2,025	4,050	4,050	2,025	12,150
	<u>8,775</u>	<u>16,550</u>	<u>16,550</u>	<u>7,775</u>	<u>49,650</u>
Subtotal - NY Consultation/support	8,775	16,550	16,550	7,775	49,650
Subtotal - Field and New York	104,722	259,942	197,253	57,745	619,662
CMR Administrative Recovery 5.5%	5,760	14,297	10,849	3,176	34,082
	<u>110,482</u>	<u>274,239</u>	<u>208,102</u>	<u>60,921</u>	<u>653,744</u>
TOTAL USG.I. FUNDED	110,482	274,239	208,102	60,921	653,744

APPENDIX B

PROJECT COST BREAKDOWN: NCSS FUNDED

	<u>FY 77</u>	<u>FY 78</u>	<u>FY 79</u>	<u>FY 80</u>	<u>Totals</u>
<b>1. Personnel Costs</b>					
National	5,940	11,880	11,880	5,940	35,640
Regional	13,860	27,720	27,720	13,860	83,160
Center Level	148,692	297,384	297,384	148,692	892,152
	<u>168,492</u>	<u>336,984</u>	<u>336,984</u>	<u>168,492</u>	<u>1,010,952</u>
<b>2. Training Costs</b>	---	---	---	---	---
<b>3. Commodity Costs</b>					
Food purchases	184,320	368,640	368,640	184,320	1,105,920
	<u>184,320</u>	<u>368,640</u>	<u>368,640</u>	<u>184,320</u>	<u>1,105,920</u>
<b>4. Other Costs</b>					
National Operational expenses	17,820	35,640	35,640	17,820	106,920
Regional Operational expenses	41,580	83,160	83,160	41,580	249,480
<u>Center Level</u>					
Rent	23,376	46,752	46,752	23,376	140,256
Maintenance	8,100	16,200	16,200	8,100	48,600
Renovation	10,966	21,931	21,931	10,966	65,794
Utilities	3,960	7,920	7,920	3,960	23,760
Program administration	48,000	96,000	96,000	48,000	288,000
	<u>153,802</u>	<u>307,603</u>	<u>307,603</u>	<u>153,802</u>	<u>922,810</u>
<b>Total</b>	<b>506,614</b>	<b>1,013,227</b>	<b>1,013,227</b>	<b>506,614</b>	<b>3,039,682</b>

ATTAC UNIT C

PROJECT COST ESTIMATE: SOCIAL WELFARE FUNDED

	<u>FY 77</u>	<u>FY 78</u>	<u>FY 79</u>	<u>FY 80</u>	<u>Totals</u>
<b>1. <u>Personnel Costs</u></b>					
3490 Social Worker months x .10 mos. x 15 Dinars x 2.4	---	11,059	17,755	8,878	37,692
	---	11,059	17,755	8,878	37,692
<b>2. <u>Training Costs</u></b>					
137 Social Workers x .50 months x 15 Dinars x 2.4	---	3,699	3,699	---	7,398
	---	3,699	3,699	---	7,398
<b>3. <u>Commodity Costs</u></b>	---	---	---	---	---
<b>4. <u>Other Costs</u></b>	---	---	---	---	---
<b>Total</b>	---	14,758	21,454	8,878	45,090

11

## ATTACHMENT D

PROJECT COST BREAKDOWN: MINISTRY OF PUBLIC HEALTH FUNDS

	<u>FY 77</u>	<u>FY 78</u>	<u>FY 79</u>	<u>FY 80</u>	<u>Totals</u>
1. <u>Personnel Costs</u>					
5106 Public Health Nurse-months x 15 months = 53 Nurses x 2.1	---	9,564	58,746	32,789	101,099
	---	9,564	58,746	32,789	101,099
TOTAL	---	9,564	58,746	32,789	101,099

## ATTACHMENT E

PROJECT COST BREAKDOWN: NATIONAL INSTITUTE OF NUTRITION FUNDED

	<u>FY 77</u>	<u>FY 78</u>	<u>FY 79</u>	<u>FY 80</u>	<u>TOTALS</u>
1. <u>Personnel Costs</u>	---	---	---	---	---
2. <u>Training Costs</u>					
2 Trainers x					
4 months x					
150 Dinars x 2.4	---	1,440	1,440	---	2,880
	---	---	---	---	---
		1,440	1,440	---	2,880
3. <u>Commodity Costs</u>	---	---	---	---	---
TOTAL	---	1,440	1,440	---	2,880

## ATTACHMENT E

PROJECT COST BREAKDOWN: NATIONAL INSTITUTE OF NUTRITION FUNDED

	<u>FY 77</u>	<u>FY 78</u>	<u>FY 79</u>	<u>FY 80</u>	<u>TOTALS</u>
1. <u>Personnel Costs</u>	---	---	---	---	---
2. <u>Training Costs</u>					
2 Trainers x 4 months x 150 Dinars x 2.5	---	1,440	1,440	---	2,880
	-----	-----	-----	-----	-----
	---	1,440	1,440	---	2,880
3. <u>Commodity Costs</u>	---	---	---	---	---
TOTAL	---	1,440	1,440	---	2,880

ATTACHMENT F

PROJECT COST BREAKDOWN: PEACE CORPS FUNDED

	<u>FY 77</u>	<u>FY 78</u>	<u>FY 79</u>	<u>FY 80</u>	<u>TOTALS</u>
<b>1. <u>Personnel Costs</u></b>					
10 Volunteers x 2 years x \$8,700	---	87,000	87,000	---	174,000
	-----	-----	-----	-----	-----
	---	87,000	37,000	---	174,000
<b>TOTAL</b>	---	87,000	87,000	---	174,000

61

## ATTACHMENT G

PROJECT COST BREAKDOWN: CAME/ALBICO FUNDED

	<u>FY 77</u>	<u>FY 78</u>	<u>FY 79</u>	<u>FY 80</u>	<u>TOTALS</u>
1. <u>Personnel Costs</u>					
U.S. Personnel	12,500	25,000	25,000	12,500	75,000
National Personnel	11,000	22,000	22,000	11,000	66,000
	<u>23,500</u>	<u>47,000</u>	<u>47,000</u>	<u>23,500</u>	<u>141,000</u>
2. <u>Training Costs</u>	---	---	---	---	---
3. <u>Commodity Costs</u>	---	---	---	---	---
4. <u>Other Costs</u>					
Administrative support	10,000	20,000	20,000	10,000	60,000
	<u>10,000</u>	<u>20,000</u>	<u>20,000</u>	<u>10,000</u>	<u>60,000</u>
TOTAL	33,500	67,000	67,000	33,500	201,000

APPENDIX "1"  
LIST OF TERMS

CARE	COOPERATIVE FOR AMERICAN RELIEF EVERYWHERE
NCSS	NATIONAL COMMITTEE FOR SOCIAL SOLIDARITY
MOSS	MINISTRY OF SOCIAL WELFARE
MOH	MINISTRY OF PUBLIC HEALTH
NIH	NATIONAL INSTITUTE OF NUTRITION
RCSS	REGIONAL COMMITTEE FOR SOCIAL SOLIDARITY
GOV. ENCLAVE	ADMINISTRATIVE SUB-DIVISION OF NATIONAL GOVERNMENT OR PROVINCE
DELEGATION	ADMINISTRATIVE SUB-DIVISION OF GOVERNORATE
ICM	INSTITUTE CHILD HEALTH
ICHC	INSTITUTE CHILD HEALTH CENTER
PHN	PUBLIC HEALTH NURSE
ICSI	INSTANT CORN SOYA MIX
CSM	CORN SOYA BLEND
MSB	WHEAT SOYA BLEND
OPG	OPERATIONAL PROJECT GRANT
PVO	PRIVATE VOLUNTARY ORGANIZATION
VOLAG	VOLUNTARY AGENCY
P.I.E.	PLAN IMPLEMENTATION EVALUATION

ANNEX "2"A NOTE ON THE PRE/SCHOOL FEEDING PROGRAM:

The current pre/school feeding program was started in 1957. It was jointly sponsored and supported by the U.S. Government through USAID and the Government of Tunisia through its Ministry of Youth, Sports and Social Welfare. Its initial beneficiary target was 150,000. This was slowly expanded to 170,000 by the 1960's.

Until FY'72-3 the implementation of the program rested with the municipal governments and in rural areas the "Service of Social Welfare" (delegation level).

In 1972-3 the entire program was turn-over to the NCSB. As a result the management of the program improved substantially and a unified structure and monitoring system was developed. The number of beneficiaries rose to 186,000.

Initially, the program provided a ration of:

Milk Powder	20 grams
Butter	20 grams
Wheat Flour	100 grams

In the late sixties butter was replaced by vegetable oil and in 1973 milk was replaced by ICSL.

In FY'76 program calls for 186,000 beneficiaries with the following ration:

Flour	100 grams
Oil	10 grams
ICSL	40 grams

The flour is baked into bread at local bakeries and the ICSL and oil mixed to produce a hot gruel or drink.

APPENDIX "3"BACKGROUND INFORMATIONSOCIAL WORKERS (RURAL EXTENSION AGENTS)

The program leading to a rural extension agent is a two year program for young women 18 years or older who have completed the fourth year of secondary school (tenth grade). Candidate must pass a physical and an entrance exam consisting of a written essay dictation in Arabic, sewing, and an interview; student reside in the dormitory and receive TD. 4,000 (\$10,00) a month pocket money. The student signs a contract for five years and agrees to work anywhere in Tunisia. Training includes theory and practical courses and several "stages in Tunisia and in the interior". The school catalog lists the following subjects in the curriculum: Methods of Social action, human relations, social legislation, health, child care, food, family planning, gardening, aviculture, sewing, cooking, home management, and economy in the house. "Stages" are held in local social development centers, MCH centers, day nurseries and family planning center services.

After certification, the extension workers go to work in regional or local social development centers, or in rural centers for young girls.

It could be noted that health and nutrition are little emphasized in the curriculum for the social workers. The extension agents have more exposure to health, nutrition and related subjects, but because of a somewhat text-oriented approach to the subject, the girls could benefit from additional instruction in the practical application of nutrition and preventive health concepts.

45