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OPERATIONAL PROGRAM GRANT PROPOSAL

Total OPG Request: ASAP

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 Raddiffe, Country
Director

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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 ~~52,000~~ ^{435,000} ~~beneficiaries~~ ^{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 percent of the 0 to 6 population will be covered by the project. All of the target population falls within the lower socio-

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economic strata residing in rural ~~and urban low income~~ areas. The feeding program beneficiaries are 98,000 children below the age of six years. The mothers and pres-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
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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 wastage 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.

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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. ~~There~~ 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

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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 ensure that the appropriate immunization of the enrolled beneficiaries is accomplished either by immunization at the center itself or by referral to another facility.

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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 counselling 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 PMI's (MCH centers) 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

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the following concepts:

1. Important notions of child care:
 - a. The importance of immunizations
 - b. ^{Pro?} 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 haome 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} ~~Information regarding~~ child spacing and family planning.

~~The purpose~~
 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 thier homes.

D. Conditions Expected at the End of the Project

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1. All of the existing feeding centers to have improved their feeding performance and facilities by the end off the third project year.
2. All of the existng feeding centers will have integrated basic health screening and referral measures into center activities by the end of the third project year.

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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

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

~~Abstract~~ The study was undertaken and a report was submitted to USAID/Tunisia on March 12, 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.
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CARE 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

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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 ~~establishing~~ ^{improving the} use of PL480 food commodities distributed to school canteens and MCH centers. This Division was staffed until recently with a Tunisian nutritionist employed by the Ministry of Public Health and seconded to CARE.

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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

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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 counselling, ~~and devices.~~

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.

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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), 13 skin disease centers, 12 rabies centers and 12 border health posts.

III. PROJECT ANALYSIS

A. Economic Effects of the Project

The overall economic effects of such a program range 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 a chronic nature including ~~wake~~ 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:

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Poor health status = lowered energy output = lowered production = bare subsistence income = meager education = ~~malnutrition~~ poor diet and sanitation = decreased resistance to disease = high infant and child mortality rates = lower life expectancy

However, the ~~xxx~~ 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 again is seen only after some time. The benefits of applied health education are, in some areas, immediate, such as increases in adult labor productivity.

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.

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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 pre-illness status. With this same amount between 9,000 and 14,000 children could be immunized. The implications of such a preventive health approach 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 targetted activities utilizing existing personnel. Thus the emphasis of this project will be on the utilization of resources available within the existing health infrastructure.

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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 NCSS and the NIN are ideal 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:

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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 NCSS 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. Provision of adequate furnishings and equipment for better functioning of the centers.
 - e. 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.

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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 ICSM in various ways.
- b. The introduction of local flavorings.
- c. The alternative use of ICSM with WSB.
- 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 teaining of social workers will begin and educational materials will be developed for the non-formal education in the centers.

The preventive halth 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 e xtended 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 interpretation 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 ~~xxxx~~ 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 educational 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

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 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 by Dr. Rejeb in 1967-68 for UNICEF and the Ministry of Public Health also revealed significant



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 preschool population are being effectively immunized.

Infant diarrhea and dehydration ~~and~~ with accompanying malnutrition occur with needless frequency, particularly during the summer months. The Manuel de Puericulture, Project Avicenne, Cooperation Canado-Tunisienne, reports that gastroenteritis and pneumopathies combined account for four-fifths of the deaths of ~~children~~ 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, 80/1000 Tunis), due to the fact that care is more accessible in Tunis, especially for the ~~dehydration~~ 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~~ interaction of malnutrition and infection and simply does not

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 composition 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 a 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.

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 hygeinic practices in the home and improved child feeding 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 USAID) 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~~ 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. It should also strengthen the role of the social worker in the family ~~and~~ 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 MCH 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 MCH 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 MCH centers.

The project also has the potential to spread to a larger number of people over a period of time through ~~the~~

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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 budgetted 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~~ ministries' budgets by the end of the project.

However, there is scope for duplication ~~of~~ 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.
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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 CARE/MEDICO. The principal host counterpart will be the National Committee of Social Solidarity (NCSS). In addition to its role of participating with CARE/MEDICO in the overall coordination the NCSS 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 shall assist in an advisory capacity in all phases of the project and shall insure 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 ~~xxxxxxx~~ 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 ~~xxxxxxxxxxxx~~ 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 indigenous 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.

B. Personnel

All operational personnel will be provided by the ~~national~~ National Committee for Social Solidarity and the Ministries of Social Affairs and Public Health. The Project Director will be an employee of CARE/MEDICO. 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 CARE/MEDICO.

During the transitional or implementation phase of the project six Peace Corps Volunteers will be assigned to assist in the execution of their 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 CARE/MEDICO and NCSS staff who will eventually have the responsibility for ~~their~~ ~~operations~~ 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 ~~xxx~~ 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 and in its present methods of operation and the addition of new activities it will be necessary ~~maximally~~ 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

there 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 programs functioning and ultimate success. Provision has been made for the training of the social workers, public health nurses and the NCSS 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 ~~xxxxxxx~~ training or orientation of these people the program can gain increased community ~~xxxxxxx~~ acceptance and support.

The project staff in cooperation with the counterpart agencies will have the responsibility of designing~~and~~, 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 ~~xxxxxxxxxxxx~~ 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 childrens' growth and project impact evaluation will also be provided.

Eleven vehicles will be purchased for the project. ~~XXXXXXXXXXXXXXXXXXXXXXXXXXXX~~ 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. CARE/MEDICO will be responsible for the scheduling and utilization

of these vehicles. Five 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 ~~types~~ 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 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 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 this 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 ~~xxxxxx~~ 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 ~~discuss~~ discussed above. Responsibility for evaluation will rest with CARE/MEDICC. 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. CARE/MEDICO - 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, CARE/MEDICO-Tunisia is required to submit an evaluation report to its headquarters. This report will also be submitted to AID.

V. 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 Consultation 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
NCSS	506,614	1,013,227	1,013,227	506,614	3,099,682
MOSA	---	14,758	21,454	8,878	45,090
MOPH	---	9,564	58,746	32,789	101,099
NIN	---	1,440	1,440	---	2,880
Peace Corps	---	87,000	87,000	---	174,000
CARE/MEDICO	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 A

PROJECT COST BREAKDOWN: USAID FUNDEDFIELD BUDGET

	<u>FY 77</u>	<u>FY 78</u>	<u>FY 79</u>	<u>FY 80</u>	<u>TOTALS</u>
1. <u>Personnel Costs</u>					
Project Director	\$ 12,500	\$ 25,000	\$ 25,000	\$ 12,500	\$ 75,000
Field Nutrition- ist	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>
2. <u>Training Costs</u>					
In-service training for 137 Social Workers, 275 Public Health Nurses, 275 Feeding Center Organizers, and 12 NCSS Regional Directors	---	21,568	19,588	---	41,156
	<u>---</u>	<u>21,568</u>	<u>19,588</u>	<u>---</u>	<u>41,156</u>
3. <u>Commodity Costs</u>					
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>

4. Other Costs

Local travel expenses	750	1,500	1,500	750	4,500
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	<u>15,991</u>	<u>40,565</u>	<u>30,117</u>	<u>8,328</u>	<u>95,001</u>
	34,873	78,329	67,881	27,210	208,293
Subtotal -Field Expenses	95,947	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 (240 days x \$45)	2,025	4,050	4,050	2,025	12,150
Subtotal - NY Consultation/support	<u>8,775</u>	<u>16,550</u>	<u>16,550</u>	<u>7,775</u>	<u>49,650</u>
Subtotal - Field and New York	104,722	259,942	197,253	57,745	619,662
CARE Administrative Recovery 5.5%	5,760	14,297	10,849	3,176	34,082
TOTAL USAID FINANCED	<u>110,482</u>	<u>274,239</u>	<u>208,102</u>	<u>60,921</u>	<u>653,744</u>

ATTACHMENT 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>
<u>1. Personnel Costs</u>					
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>
<u>2. Training Costs</u>	---	---	---	---	---
<u>3. Commodity Costs</u>					
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>
<u>4. Other Costs</u>					
National Operation- al expenses	17,820	35,640	35,640	17,820	106,920
Regional operation- al 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 admin- istration	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>
TOTAL	506,614	1,013,217	1,013,217	506,614	3,309,682

ATTACHMENT C

PROJECT COST BREAKDOWN: SOCIAL WELFARE 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>					
3490 Social Worker months x .10 mos. x 45 Dinars x 2.4	---	11,059	17,755	8,878	37,692
	---	<u>11,059</u>	<u>17,755</u>	<u>8,878</u>	<u>37,692</u>
2. <u>Training Costs</u>					
137 Social Workers x .50 months x 45 Dinars x 2.4	---	3,699	3,699	---	7,398
	---	<u>3,699</u>	<u>3,699</u>	---	<u>7,398</u>
3. <u>Commodity Costs</u>	---	---	---	---	---
4. <u>Other Costs</u>	---	---	---	---	---
TOTAL	---	14,758	21,454	8,878	45,090

ATTACHMENT D

PROJECT COST BREAKDOWN: MINISTRY OF PUBLIC HEALTH FUNDED

	<u>FY 77</u>	<u>FY 78</u>	<u>FY 79</u>	<u>FY 80</u>	<u>TOTALS</u>
<u>1. Personnel Costs</u>					
5106 Public Health Nurse-months x .15 months x 55 Dinars x 2.4	---	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
	---	<u>1,440</u>	<u>1,440</u>	---	<u>2,880</u>
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>
1. <u>Personnel Costs</u>					
10 Volunteers x 2 years x \$8,700	---	87,000	87,000	---	174,000
	---	<u>87,000</u>	<u>87,000</u>	---	<u>174,000</u>
TOTAL	---	87,000	87,000	---	174,000

ATTACHMENT G

PROJECT COST BREAKDOWN: CARE/MEDICO 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 OF SOCIAL SOLIDARITY
MOSW	MINISTRY OF SOCIAL WELFARE
MOPH	MINISTRY OF PUBLIC HEALTH
NIN	NATIONAL INSTITUTE OF NUTRITION
RCSS	REGIONAL COMMITTEE OF SOCIAL SOLIDARITY
GOVERNORATE	- ADMINISTRATIVE SUB-DIVISION OF NATIONAL GOVERNMENT OR PROVINCE
DELEGATION	ADMINISTRATIVE SUB-DIVISION OF GOVERNORATE
MCH	MOTHER CHILD HEALTH
MCHC	MOTHER CHILD HEALTH CENTER
PHN	PUBLIC HEALTH NURSE
ICSM	INSTANT COR SOYA MIX
CSM	CORN SOYA BLEND
WSB	WHEAT SOYA BLEND
OPG	OPERATIONAL PROJECT GRANT
PVO	PRIVATE VOLUNTARY ORGANIZATION
VOLAG	VOLUNTARY AGENCY
P.I.E.	PLAN IMPLEMENTATION EVALUATION

APPENDIX "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 NCSS. 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 ICSM.

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

- Flour 100 Grams
- Oil 10 grams
- ICSM 40 grams

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

APPENDIX "5"

BACKGROUND INFORMATION

SOCIAL 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 Regional or local social development centers, or in rural centers for young girls.

It could be note 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.