A. Basic Information

A.1 Beneficiary Country   Tunisia

A.2 Grant Recipient    Republic of Tunisia as represented by Ministry of Development and International Cooperation (MDCI)Place Ali Zouaoui - 1069 Tunis - TunisiaPhone : (+216) 71 240 133 or (+216) 71 350 753The MDCI is traditionally involved as the loan and grant recipient in Ban

A.3 Name and Address of Implementing Agency    Ministry of Public Health (Ministere de la Sante Publique)Adresse : Bab Saadoun 1006 Tunis - TunisiaPhone : (+216) 71 577 000

A.4 Is the Implementing Agency a Government entity? #(in case of joint implementation by government and NGO(s), please provide details on the legal status of each agency under Grant Implementation Arrangements below)    Yes

A.5 Administrator    International Bank for Reconstruction and Development

A.6 Grant Name    ROUND 31: TUNISIA COMMUNITY HEALTH COLLABORATIVE PROJECT

A.7 Grant Amount in USD (includes incremental Bank costs)    964,050

A.8 Does this grant proposal qualify for the special allocation for Africa?    Yes, for enhancement of health management and health services

B. Grant Development Objectives

The main objective of this Grant is to improve the quality and responsiveness of health service delivery for reproductive health through community involvement and empowerment in planning and delivering health services in underserved areas of the Republic of Tunisia's peri-urban and rural governorates in the poorer, southwestern region of the country.

C. Eligible Expenditures

List all applicable eligible expenditures below in one or more categories as necessary. Eligible expenditures include consultant services (including audits), local training and workshops, small civil works, goods, sub-grants and incremental Bank costs.

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount (US. Dollars)</th>
<th>Percentage of Expenditures to be Financed</th>
<th>Percentage of Grant Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOODS</td>
<td>270,000</td>
<td>100%</td>
<td>28%</td>
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<tr>
<td>CONSULTING</td>
<td>162,550</td>
<td>100%</td>
<td>17%</td>
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<tr>
<td>TRAINING</td>
<td>446,000</td>
<td>100%</td>
<td>46%</td>
</tr>
<tr>
<td>Total Grant to Recipient</td>
<td>878,550</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incremental Bank Cost</td>
<td>85,500</td>
<td></td>
<td>9%</td>
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<tr>
<td>Total Grant Amount</td>
<td>964,050</td>
<td></td>
<td></td>
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</table>
Grant Supplementary Information

<table>
<thead>
<tr>
<th>Section 1 - Administrative Information</th>
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</thead>
<tbody>
<tr>
<td>Trust Fund No. (For CFPTO Use Only)</td>
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<tr>
<td>Resubmission</td>
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<tr>
<td>JSDF Grant Type</td>
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<td>Sector Code</td>
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<td>Grant Approval Date (For CFPTO Use Only)</td>
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<td>Task Team Leader</td>
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<td>TTL Email</td>
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<td>TTL Phone Number</td>
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<td>Was a JSDF Seed Fund used to prepare</td>
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<td>this grant?</td>
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Section 2 - Details of the JSDF Grant

Section 2.1 - Grant Components and Activities

Briefly describe the specific activities (limit 300 words) to be carried out under each component

<table>
<thead>
<tr>
<th>Component 1</th>
<th>Component / Output 1 - Community Education and Mobilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost (USD)</td>
<td>446,300</td>
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</table>

The Grant is intended to finance community-driven development activities centered around maternal health care, in terms of the creation of new Community Health Collaborative (CHC) citizen groups, and to build the capacity of the CHCs to bring about improvements in maternal care. The CHCs comprise primarily citizens including reproductive age women, pregnant women, mothers and caregivers, as well as, local health care and social workers involved in the welfare of women and children. As such, the project addresses demand-side barriers to the use of reproductive health services by increasing the role and voice of citizens at the local district and village level. The project also supports the Health Sector Reform Program (HSRP) led by the Ministry of Public Health (MoPH). It is intended to support the health sector reform program which aims to improve the availability of reproductive health services, notably in the area of obstetrics and gynecology and related maternal primary care, for the nearly 1 million women living in Tunisia’s seven underserved, “priority” regions.

The MoPH has identified seven underserved governorates largely in the interior of the country, known as ‘regions prioritaires’, or priority regions. The project is proposed to be piloted in two of these governorates, including the governorates of Gafsa and Tataouine, before future scale-up in other governorates such as Gabes, Kasserine, Tozeur, Mednine and Kebili. The choice of these regions primarily reflects the relatively low per capita income and poorer maternal and child health outcomes as compared to the rest of Tunisia. Poverty rates in these regions are estimated to be twice that of the national average of 4%; approximately 8% of households in priority regions fall below the $1.25/day poverty line, nearly the highest in the country. While the national average of child stunting is estimated to be approximately 12%, rural rates in the pilot regions are nearly double that of urban areas (11% as compared to 6%). The rate of births attended by skilled personnel is estimated to be at least 30% lower in these regions than in urban, coastal zones, and this has been attributed to the lower availability of: skilled medical personnel and, to an extent, necessary medical supplies to address high-risk pregnancies in these regions; as well as the level of awareness amongst women regarding the importance of seeking adequate prenatal care and education that would stimulate demand for attended deliveries.

The CHCs are an innovative approach in Tunisia and as community-driven groups comprised of citizens and local municipal representatives work in conjunction with local non-governmental organizations to: (i) improve community education and awareness of importance of maternal and early childhood health and health care and (ii) facilitate the feedback and participatory process of policy making amongst citizens, health care providers and policy-makers through frequent and systematic elicitation of feedback, complaints and needs regarding local public health services. The CHC approach is based on the notion of mobilizing community and professional associations to bring about improvements in health care. CNCs have recently been launched in countries in Eastern Europe, Latin America and Sub-Saharan Africa. The CHCs aim to improve access to vital health care services for reducing maternal and infant mortality and ensuring positive early childhood development, critical to future social and economic growth including poverty reduction. The CHCs will benefit
from communicating with the National Office of Family and Population as well as local NGOs such as La Fondation El Kef pour le Développement Régional (Fekdr) and Association Tunisienne des Meres, reputable and active NGOs in the area of reproductive health and development. These groups have historically been instrumental in bringing health services and goods to these communities, and the National Office of Family and Population have coordinated a number of initiatives in consultation with local health care authorities, demonstrating a strong collaborative spirit in Tunisia for governmental cooperation with NGOs active in local initiatives.

The activities that fall under this component are:
(i) the establishment of new CHCs in pilot regions of Tunisia, which are a type of volunteer citizen support group that would be established in underserved governorates; and
(ii) the creation of public educational programs regarding maternal health.

The goods and services that will be provided to support these activities include: (i) national and international consultant services for mobilizing; and (ii) training workshops, computer equipment and audiovisual materials such as paper supplies and video equipment for community training and education.

The component will support assembling at least two CHCs in each pilot governorate, in order to assess and compare experiences prior to scaling up after the term of the grant ends. Educational awareness campaigns will consist of mobilizing CHCs to both educate other citizens about the need for adequate prenatal and maternal health and health care behaviours, and to support CHCs in leveraging communication campaigns with local health care authorities to raise awareness of gaps in health care service delivery. Communication with local NGOs will be used to contact and establish a community network and support public awareness campaigns, including training, materials and services necessary to establishing the CHCs and targeted methods to reaching mothers, pregnant women, and women's health needs.

The target communities are located in the lowest-income governorates in Tunisia with relatively poor maternal health outcomes. For example, the governorate of Gafsa has a population of approximately 324,000 and a per capita expenditure likely approximating the non-coastal regional average of 1000 Tunisian Dinar (TND, 2005 values), or nearly half that of the upper-richest commune of Tunis at nearly 1800 TND. Two main hospitals (regional hospitals) and ninety primary health care centers provide services to this relatively large population, equating to nearly one physician per every 1,711 inhabitants. As Gafsa is made up of 11 sub-regional districts, or ‘delegations’, and 9 rural councils, the CHCs would be set up in approximately half of the rural councils. Another region, Tataouine, also located in the southwest region of Tunisia with a general average per capita expenditure of 1000 TND, has a population of approximately 144,000. One regional hospital and approximately fifty-nine primary health centers provide services to its population (no such information as to physicians per population is available). Seven delegations and five rural councils are found in Tataouine. The CHCs would be established by communicating with rural councils.

The creation of public educational programs will include both the preparation of educational information and materials as well as a training component for CHC members to communicate this information effectively to local community members. The CHCs will therefore play an important role in empowering citizens by both informing them of their rights as patients and mobilizing women to demand the necessary maternal health care they should be receiving to reduce the risk of complications and post-partum health consequences. An important tenet of the MoPH HSRP is to better ensure the rights of patients are adhered to by increasing the distribution of Patient Information Booklets that contain the patient's charter, information about their rights and channels for voicing their preferences and complaints, particularly as pertains to maternal health services.

Training under this component will consist of (i) workshops coordinated and designed by citizens with the technical support of national and international consultants as well as members of the MoPH, CHCs and the Bank team as needed; working groups for participants to exercise apply public education and communication methods; and the dissemination of documents for reference; and (ii) individual and small group day-to-day advisory meetings by national and international consultants in the field throughout the duration of the grant.

Quarterly progress indicators that would be monitored include:

PARTICIPATION: Proportion of women reporting attending a CHC meeting within the last 3 months.

PATIENT EMPOWERMENT: Proportion of health care facilities in pilot regions that provide 100% of new patients with Patient Information booklets.
This indicator is a central tenet of the MoPH HSRP aimed at increasing patient awareness and education towards re-orienting the health system as a citizen-centered system. This result would follow from the collaboration of CHCs and health care managers in augmenting access to patient information about services and health care recommendations.

**Monitorable Deliverables/Outputs**

CHC created as evidenced by their having held bi-monthly meetings, representatives selected and list of members; Public education campaign launched.

**Component 2**

**Component/Output 2 - Community Outreach and MasterPlanning**

| Cost (USD) | 195,000 |

The activities in this component are:

(i) training of CHCs on MasterPlanning methods for health services, which are resource planning models based on health needs, and

(ii) preparation of local regional programmatic budget for local health services that incorporate MasterPlans.

The goods and services that will be provided to support these activities include: (i) international and national consultant services for training community representatives and local municipal representatives; and (ii) training workshops, computer equipment and audiovisual materials such as paper supplies and video equipment for community training.

CHC representatives are to take part in training on resource planning using MasterPlanning methods for health services. MasterPlanning has not been introduced in Tunisia either at the central or local levels. It will be necessary to first establish the CHCs in the first component before conducting training for the CHCs on health services planning in the second component.

MasterPlanning is a form of prospective resource planning based on matching health needs to required services, typically based on the guiding principles of efficiency, equity and at as high a quality as possible. It is anticipated that introducing this tool in Tunisia will help to increase the number of needed resources to meet the unmet health needs of underserved communities, particularly by increasing the availability of maternal health care personnel and mobile outreach clinics. A key area of the HSRP that would be led by CHCs is the organization of maternal health units, goods, personnel and supply within hospitals and PHCs to ensure that these wards and units comply with preferences of patients and standards of care laid out by the MoPH. As such, it is anticipated that by better coordination of CHCs with local health care authorities, more and more maternal health units will comply with basic standards of infrastructure such as the availability of necessary ultrasound equipment and medications for maternal care.

As a measure of the effectiveness of outreach planning, it is expected that this process would improve: (i) the prioritization of health care resource requests between local and central administrations as per burden of disease needs and cost-effectiveness principles for reaching the largest number of the rural poor, and (ii) the availability of the most urgent medical services, goods and equipment, including improved staffing patterns according to case mix and load. As such, interim progress will be measured according to those indicators most likely to be influenced by improved outreach planning in underserved communities.

Training under this component will consist of (i) workshops designed by community members with technical support from national and international consultants as well as members of the MoPH, CHCs and the Bank team; working groups for participants to exercise MasterPlanning methods using associated electronic software; and the dissemination of documents for reference; and (ii) individual and small group day-to-day advisory meetings by trained community members and national and international consultants in the field throughout the duration of the grant.

Bi-annual progress indicators that would be monitored for services deemed ex-ante within the CHC catchment area include:

**INFRASTRUCTURE AVAILABILITY:** Proportion of maternity wards that conform to quality operational standards (goods, medical equipment and patient flow).

**BUDGET PREPARATION:**

**Monitorable Deliverables/Outputs**

Training workshops on MasterPlanning held for CHCs; Local regional health care budgets prepared that incorporate MasterPlans.

**Component 3**

**Component/Output 3 - Health Services Performance Monitoring**

| Cost (USD) | 237,250 |

The activities in this component are:
training of CHCs on survey approaches to monitoring and evaluation of health system responsiveness and quality of care, and

(i) training of CHCs on survey approaches to monitoring and evaluation of health system responsiveness and quality of care, and
(ii) design, placement and analysis of a health system responsiveness and quality of care survey.

The goods and services that will be provided to support these activities include: (i) national and international consultant services to assist CHCs on the design, placement and analysis of a health care responsiveness survey, (ii) training workshops, computer equipment and audiovisual materials such as paper supplies and video equipment for community training, data collection, analysis and dissemination of survey results.

The component will therefore support quantitative and qualitative assessments using tools such as Quality of Service Delivery and Community Scorecard surveys. The surveys incorporate participatory methods by which communities take part in the evaluative process and actively contribute to improving health system responsiveness. As a central tenet of the MoPH HSRP, monitoring the satisfaction of citizens with health services, particularly underserved, rural poor communities, is at the heart of the forward-looking health system improvement plan (2008-2013). The Scorecard approach is defined as such in order to emphasize the accountability underpinning of the tool: following collection and analysis of data, the critical phase relevant to improving governance is that of communication of results amongst all key stakeholders, including citizens, health care providers and policy-makers. The role of the National Office of Family and Population and local NGOs such as Fedkr and Association Tunisienne des Meres will be instrumental in launching this process and advancing dialogue with governmental counterparts for ensuring that relevant parties are held accountable to patient needs and responsiveness of the system towards the underserved, poorer communities.

Training under this component will consist of (i) approximately three 2-day workshops which will include: presentations by national and international consultants as well as members of the MoPH, CHCs and the Bank team; working groups for participants to apply survey design and impact evaluation methods using associated electronic software; and the dissemination of documents for reference; and (ii) individual and small group day-to-day advisory meetings by national and international consultants in the field throughout the duration of the grant.

Quarterly progress indicators that would be monitored include:

- **MONITORING AND EVALUATION PROCESS**: Survey of patient feedback and quarterly brief surveys conducted at sampled, representative health care facilities.

**Monitorable Deliverables/Outputs**

| Training workshops on health services monitoring and evaluation held for CHCs; Health services performance survey conducted and results disseminated. |

**Summary Description for Grant Agreement**

**Component 1 - Community Education and Mobilization:**

The activities that fall under this component are:

(i) the establishment of new CHCs in pilot regions of Tunisia, these voluntary citizen support group would be established in underserved governorates; and

(ii) the creation of public educational programs regarding maternal health.

The goods and services that will be provided to support these activities include: (i) national and international consultant services for mobilizing; and (ii) training workshops, computer equipment and audiovisual materials such as paper supplies and video equipment for community training and education.

**Component 2 - Community Outreach and MasterPlanning for improving delivery of maternal care:**

The activities in this component are:

(i) the training of Community Health Collaboratives on MasterPlanning methods for health services, which are resource planning models that improve the efficiency of health care delivery to meet basic health needs, and

(ii) the preparation of local regional programmatic budget for local health services that incorporate MasterPlans.

The goods and services that will be provided to support these activities include: (i) international and national consultant services for training community representatives and local municipal representatives; and (ii) training workshops, computer equipment and audiovisual materials such as paper supplies and video equipment for community training.

**Component 3 - Health Services Delivery Performance Monitoring:**

The activities in this component are:
(i) the training of Community Health Collaboratives on survey approaches to monitoring and evaluating health system responsiveness, delivery and quality of care, and

(ii) the design, placement and analysis of a health system responsiveness and quality of care survey upon initiation and completion of the project, thereby influencing the first component's activities as well as providing a baseline for a follow-up impact evaluation of the project.

The goods and services that will be provided to support these activities include: (i) national and international consultant services to assist community health collaborative on the design, placement and analysis of a health care responsiveness survey, (ii) training workshops, computer equipment and audiovisual materials such as paper supplies and video equipment for community training, data collection, analysis and dissemination of survey results.

### Section 2.2 Incremental Bank Costs

The costs of normal supervision are expected to be covered through the administrative budget and fee provision. Under exceptional circumstances, if additional resources are needed to facilitate community participation or NGO collaboration under particularly difficult conditions, incremental Bank costs can be requested up to 9 percent of the total grant amount.

<table>
<thead>
<tr>
<th>Amount requested in USD</th>
<th>85,500</th>
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</table>

Additional resources are requested in order to provide sufficient Bank supervision in mitigating risks related to implementation capacity and to provide technical guidance to the Ministry of Public Health and the two associated NGOs. 9% of the grant amount is kindly requested, equal to approximately $85,500, with which to carry out necessary supervision.

### Section 2.3 - Rationale and Participatory Approach

Briefly present (a) the origin and rationale for the proposal; (b) participatory activities which led to the proposal concept; (c) its innovative features in responding rapidly to the needs of the poor and vulnerable groups; (d) describe the intended beneficiaries and provide an estimated number of beneficiaries and cost per beneficiary.

As part of the President's 2008-2013 Development Plan, the 11th Five-Year Plan of its kind, the MoPH has launched a 2008-2013 HSRP which features as a priority in the national development plan. This JSDF-supported proposal would be the first of its kind in health in Tunisia and the Maghreb region of MENA. As this JSDF grant proposal applies to the health management window for Round 31, the grant is intended to support capacity building in this domain in Tunisia, which can help to reduce disparities within the the Tunisian health sector and serve as an example to the broader African community.

At a population of approximately 10 million, Tunisia has been engaged in several phases of health sector development since the birth of its modern health system in the 1960s, including the development of financial protection schemes, the establishment of public providers for health care, the growth of a relatively small but active private market, and investment in public health programs. The population has a life expectancy rate of approximately 74 years, yet infant mortality rates are more in line with lower-middle-income countries, at 21 per 1,000 live births. Moreover, infant and maternal health indicators vary considerably between eastern and western provinces, with western, interior provinces generally lagging behind. Adult literacy rate is nearly 74%, with the population largely urban at 65%. However, the burden of disease attributed to non-communicable chronic health conditions is rising. This is largely associated with three main factors: (i) an aging population, (ii) insufficient attention given to the prevention of chronic conditions, and (iii) insufficient attention given to promoting healthy lifestyles. Health-related MDGs are largely on track to be achieved. Rapid progress has been made as far as infant and maternal mortality rates. However, achieving universal access to sanitation in rural areas remains a constraint.

Amongst the main challenges faced by the Tunisian health system are the following: (i) outstanding geographic disparities in health status and health-related services particularly in the country's interior provinces, such as high infant mortality and high maternal mortality rates, low rates of skilled personnel-assisted birth deliveries, and as relatively low access to sanitation; (ii) an increase in the burden of disease attributed to non-communicable chronic health conditions, largely attributed to insufficient attention given to preventative measures, outreach and services in the midst of an aging population; (iii) rising household, out-of-pocket payments for health care despite the existence of health insurance coverage; and (iv) rising dissatisfaction amongst citizens with the perceived and technical quality of health service provision.

The objectives of the Government of Tunisia's Five-Year HSRP are: (i) improving efficiency in the allocation and utilization of health resources, particularly in public hospitals; (ii) improving equity in terms of improving the scope of benefits covered by health insurance coverage and reducing the financial burden on the poor; (iii) improving the quality of public
services; and (iv) improving management of the health system and the regulatory environment. The reform program includes five pillars, which include: (a) quality improvement for hospital and ambulatory care; (b) reinforcing financial sustainability and efficiency of the health system; (c) strengthening health information systems; (d) development of autonomy for human resource management to improve performance and personnel satisfaction; and (e) reinforcing governance and accountability by addressing legislative framework.

The JSDF would actively support strengthening the availability of services (HSRP pillar ‘a’) and reinforcing governance and accountability (HSRP pillar ‘e’) for underserved communities in the interior of the country. The World Bank is currently preparing a Health DPL which would support the government’s HSRP, the aim of which is to improve the quality and efficiency of service delivery. The Bank and the Government of Tunisia have been involved in extensive field visits and assessments of underserved regions as a result, engaging with public- and private-sector counterparts and drawing upon citizen surveys and qualitative information. The Bank has a long-standing dialogue with other development partners in Tunisia on the issue of health system responsiveness, notably the resident missions of the African Development Bank, the European Commission and the World Health Organization.

The CHCs are an innovative approach for the Tunisian context which builds upon the experiences of such “collaboratives” recently initiated in countries in Eastern Europe, Latin America, Sub-saharan Africa, and the United States. The approach provides a systematic avenue by which to improving targeting services towards unmet needs and empowering underserved communities in voicing their needs. The CHC approach is an innovative approach that re-orient the continuous quality improvement process from one that is provider-, “top-down” oriented to one that is community-driven and citizen-centered. Evidence in other low-, middle- and high-income countries shows that the Collaborative approach to continuous quality improvement contributes to improvement in access to several maternal health services and health outcomes where traditional 'top-down’ approaches have not succeeded. Experience from projects funded by the United States Agency for International Aid (USAID) provides information on the applicability of the approach to rural and lower-income communities that face constraints to accessing services.

The main innovative feature of the grant is the introduction of a community-driven and participatory approach to health education outreach and services planning. Although the grant would be executed by the MoPH, the funds would be used to finance community activities facilitated by local NGOs. Within the Tunisian context, specific constraints limit the introduction of other innovative features such as endowments made directly to community associations. The health system remains highly centralized, as the regional delegations of the ministry have limited administrative and fiscal autonomy. As such, the role of the two local NGOs described in this proposal will be to facilitate the establishment and participation of CHCs as prime stakeholders with funding managed by the MoPH. As the health sector undergoes its reform program with support from the Bank’s Health DPL to the Government of Tunisia, it is anticipated that future reforms will help to pave the way to advance innovations initiated through this grant.

The grant would support the establishment and training of CHCs to facilitate the feedback process between citizens, health care providers and policy makers, with an initial focus on maternal health services to address high maternal mortality rates and high out-of-pocket health care payments currently observed in lower socioeconomic communities living in the country's remote southern and eastern non-coastal regions. Approximately 35% of the Tunisian population live in rural communities where maternal mortality rates are at least twice as high as those found in urban communities living in Tunis and its environs. A reinforcement of community participation and health services assessment would help strengthen health system governance towards improving health system performance, including patient and community responsiveness, and health outcomes in the future.

The targeted governorates of Gafsa and Tataouine have an estimated census population of approximately 324,000 and 144,000, respectively. Collectively, these two governorates represent amongst the lowest socioeconomic regions and account for nearly 500,000 people, or 5% of the total population of Tunisia at 10 million as of 2009.

The community education component intends to enrol approximately 1000 members per year per each of 10 pilot CHCs for three years, or 30,000 persons (approximately 10% of the governorate population representing the most vulnerable). The cost per person of establishing CHCs is approximately $350,000 divided over 30,000 members, or approximately $12 per person.

The community outreach and performance monitoring components collectively intend to improve education and access in each of the regional hospitals governorate-wide, or 3 regional hospitals in total over both governorates, each with a catchment area of approximately 150,000 persons, with an estimated 30,000 patient visits per year. The outreach component is also intended to reach at least 50% of the satellite primary health care facilities in each governorate covering this population. At 30,000 patient visits per year, the total for these components (approximately USD 650,000) equates to approximately $8 per capita over three years. However, it is assumed that some patients would be re-admitted patients, making this a general estimate.
In total, the project would cost an estimated $20 per capita and directly reach approximately 90,000 users. Externalities are expected that would likely spill over to other members of the communities. The project may therefore prove to be highly cost-effective at improving access to services at low cost.

Section 2.4 - Sustainability
Indicate the mechanism for sustainability of the proposed activities after the completion of the grant. This should include a description of the exit strategy and mechanism for long-term sustainability with specific measures and cost.

By piloting the CHCs in two regions, lessons for scaling up will be assessed prior to the completion of the program and an action plan will be developed in conjunction with policy-makers and key stakeholders for institutionalizing CHCs and appropriate monitoring and evaluation of health system responsiveness. The local participation of NGOs and health care administrators alike would encourage ownership and long-term sustainability, which is supported directly by the Government of Tunisia as it looks to stimulate investment and continue its current program of incentives to developers in these regions.

Section 2.5 - Safeguard Issues
Describe any significant adverse impacts related to environment and social safeguard policies, and how they will be addressed.

No foreseeable environmental or safeguard issues are expected for this Grant, given that the Grant largely finances educational and technical activities regarding community outreach.

Section 3 - Linkage to Country Strategy and Associated Bank Financed Operation

Section 3.1 - Country/Sector Background
Provide any specific information related to country and sector strategies which may support this proposal.

The Progress Report on the Country Assistance Strategy (CAS), issued August 2007, reinforced the key development challenges established in the CAS published in June 2004, consistent with the Government’s development agenda. These development challenges include: (a) employment growth and (b) maintenance of macro stability and social achievements. The three strategic objectives set out in the CAS respond directly to the goals of the Eleventh Plan and are: (a) strengthened investment climate and competitiveness, (b) improved education quality and graduate employability for an increasingly knowledge-based economy, and (c) improved social services through more efficient public expenditure. The CAS 2004 includes a proposed health sector lending project as part of its indicative FY05-FY08 plan (CAS 2004, Table 4), and the Country Partnership Strategy 2010-2013 reiterates the importance of pursuing reforms for improved social services through more efficient use of public resources. The FY10-FY13 CPS includes investment lending support to the health sector, including indicators for improving efficiency of the health system and completion of accreditation for hospital facilities, reflecting the request received in July 2009 from the MoPH for the Bank’s support. Other international donors are providing relatively limited support in implementing the health upgrade program as part of the government’s 11th Five-Year Plan, including the European Community and the Spanish Government. The GoT have requested the Bank’s support as a key development partner in implementing the reform program in coordination with other donors given the Bank’s long involvement and experience in the Tunisian health sector and international experience in implementation of reform programs.

Section 3.2 - Bank Financed Operation the Grant will Complement

Project Name: Tunisia Health Services Strengthening DPL (HSS DPL)
Project ID: P118509
Board Date: March 2011

Project Development Objectives: The project aims to improve the quality and efficiency of health services through strengthening institutional capacity for quality assurance and financial management.

The DPL components, or the main policy areas, included in the project are:
Component 1: Institutionalization of policies to enhance quality assurance of health services, particularly in underserved regions.

Component 2: Introduction of policies to ensure a more equitable distribution of resources to underserved regions.

Component 3: Strengthening of financial management for improved efficiency.

Component 4: Introduction of policies to promote evidence-based decision making in health care planning and resource allocation.

Section 3.3 - Rationale for Grant Funding versus Bank Lending

Briefly describe why the proposed JSDF activities could not be financed under the Bank-financed operation or by other sources.

This proposal would introduce and pilot an innovative, community-driven approach to community outreach and performance monitoring based on enhancing accountability of the health system towards underserved populations. The Bank lending project currently in preparation in Tunisia is a development policy operation aimed at reforming macro-policies for shifting the health system towards patient-responsiveness in terms of national quality assurance institutions and resource allocation at the country-level. The proposed JSDF grant will be necessary in reinforcing the community's center role and voice in ensuring that services follow a new model of "citizen-centered care", thereby reorienting the health system in Tunisia by putting the patient (citizen) in a leading role, marking a shift away from a process by which health services are traditionally planned with the health care provider or planner in the leading role. By allowing citizens themselves to design an organized and systematic model of communication and planning through the CHC approach, communities can better mobilize themselves in a way as to ensure sustainability in the future and greater attention is paid to their needs. These activities are currently not being financed through the Bank operation or other sources as these initiatives focus on supply-side, institutional reforms and as such, the JSDF will be needed to finance community-driven development initiatives outside the scope of these supply-side reforms.

Section 4 - Grant Implementation Arrangements

Section 4.1 - Name and Address of Implementing Agency

Ministry of Public Health (Ministere de la Sante Publique)
Adresse : Bab Saadoun 1006 Tunis - Tunisia
Phone : (+216) 71 577 000

Please provide the rationale for the selection of the implementing agency

Briefly describe the organization's mission, country/sector experience, program of activities, sources of financing, and evidence of financial management capacity to assure appropriate use of JSDF funds.

If the grant will be implemented by more than one entity, briefly describe the responsibilities of each implementing agency.

The MoPH is currently overseeing the implementation of its Five-Year Plan to improve health service responsiveness and has identified a number of underserved regions as priority areas. The MoPH in Tunisia would be the implementing agency, although other key stakeholders would be consulted and involved where possible, such as the Ministry of Women and Family Affairs, Ministry of Social Affairs, Solidarity and Tunisians Abroad and non-governmental organizations, particularly in underserved regions.

A unit at the MoPH has recently been established as the dedicated project implementation unit to ensure implementation of reform measures designed to be sustainable and institutional and is currently involved in dialogue with the Bank regarding improvement of health system responsiveness.

The MoPH would consult with local NGOs in implementing the grant such as Fondation El Kef Pour Le Developpement Regional (Fekdr) and Association Tunisienne des Meres. Fekdr was established in 1985 and is affiliated with the Tunisian Network of NGOs and the United Nations Economic and Social Council (ECOSOC). Its mission is to promote local development; rural women's promotion; promotion of community participation and intercultural dialogue and development. Its recent project in the domain of reproductive health included maternal and child health services improvement in Bir Heoldi, Tunisia, having been the recipient of external donor financing. Fekdr has previously collaborated with the Ministry of Public Health and represents a strong advocate of health and development.

Association Tunisienne des Meres is an NGO founded in 1992, operating at the national and sub-national levels. A member
of the World Family Organization and ECOSOC, its primary mission is to support mothers and future mothers to reconcile their family, professional and civil roles; to assist mothers in need and integrate them in the process of development with the support of micro-credit schemes; and to promote solidarity among mothers in conflict regions. A recent project included the creation of a community hotline center for legislative, medical and social consultation for mothers with specific needs.

Not applicable.

Section 4.2 - Consultation with Other Development Partners
Describe consultations with Japanese embassy, JICA, as well as other MDBs (e.g., ADB, IDB, AfDB, EBRD) in the design of grant activities (indicate names of officials contacted at Japanese embassy and dates).

Explain the division of labor among the various partners in order to avoid overlap between programs.

The Bank team consulted with the Japanese embassy and with JICA in Tunis, Tunisia on June 2, 2010, regarding the scope and preparation of this grant proposal. At the Japanese embassy in Tunis, a meeting was held on June 2, 2010, with Mr. Hajime Nishimura, Third Secretary of International Cooperation. The Japanese embassy representative supported the proposal concept and recommended harmonizing the design and implementation of the grant with JICA activities that also support reinforcing reproductive health services in Tunisia. The Japanese embassy representative fully supported the need to reduce maternal mortality particularly in underserved regions and recognized the importance of the present JSDF proposal within the realm of improving maternal health service responsiveness. At the JICA office in Tunis, a meeting was held on June 2, 2010 with Ms. Ritsuko Yamagata, Representative, JICA Office Tunisia. The team agreed to continue communication in order to harmonize the activities of the grant with those supported by JICA and the National Office of Family and Population (Office National de la Famille et de la Population) regarding capacity building activities they are currently assisting.

Other development partners in Tunisia have been and will continue to be consulted during the forthcoming mission to prepare the JSDF activities, notably the resident missions in Tunis for the African Development Bank, the European Commission and the World Health Organization.

Not applicable.

Section 4.3 - Monitoring and Evaluation
List and quantify the performance indicators (maximum 5) and explain how the grant activities will be monitored and evaluated against these indicators. Please use outcome-level indicators in line with the project objectives (e.g., productivity enhancement; increased access to social and community services and infrastructure; and improvement in the living conditions of the poor and vulnerable groups). Please indicate targets and performance indicators for monitoring the measures.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Base Value</th>
<th>Base Date</th>
<th>Target Value</th>
<th>Target Date</th>
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<tr>
<td>Proportion of citizens satisfied or very satisfied with maternal health services (% of women satisfied or very satisfied)</td>
<td>55%</td>
<td>10/01/2010</td>
<td>70% or higher as measured by periodic patient surveys</td>
<td>07/01/2013</td>
</tr>
<tr>
<td>Births attended by skilled personnel in rural regions (%)</td>
<td>65%</td>
<td>10/01/2010</td>
<td>85% or higher. National average is 95%. Rural maternal and infant mortality is estimated to be double that of urban areas, reflecting a likely lower rate of skilled births of approximately 65%.</td>
<td>07/01/2013</td>
</tr>
<tr>
<td>Proportion of women waiting 4 hours or less</td>
<td>30%</td>
<td>10/01/2010</td>
<td>80%. It is estimated that the figure is</td>
<td>07/01/2013</td>
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</table>
for ambulatory care (general; obstetrics and gynecology) currently much lower at approximately 30%, with nearly 70% of patients having to wait over 4 hours to access care.

| Proportion of women receiving antenatal care (4 visits) | 40% | 10/01/2010 | 70% or higher. Only 68% of Tunisian women receive 4 visits at the national average. It is estimated that the urban and national average are similar, while the rural average is approximately 40%. | 07/01/2013 |

Section 4.4 - Risk Affecting Grant Implementation
See attached Risk Assessment Sheet

Section 4.5 - Retroactive Financing
If retroactive financing is envisaged, the automatically generated grant agreement will specify the grant approval date as default retroactive financing date. This date can be manually set in the grant agreement to a later date but not earlier, if desired.

| Is retroactive financing needed? | No |
| Retroactive financing amount, if needed. | |

Section 4.6 - Financial Arrangements
This section should be filled out in consultation with the Financial Management Specialist.

Are interim unaudited financial reports required? If yes, indicate frequency. Note: These reports should normally be used to support disbursement. The project IUFR should include data on financial position. The reports will include: (i) statement on sources and uses of funds for the reporting period and cumulatively, including a statement on project balances of accounts; (ii) a statement on use of funds by component and expenditure type; (iii) conciliation statement of designated account, and (iv) budget analysis indicating execution forecasts and discrepancies. The Project has to submit an IUFR every six months after the end of the period no later than 45 days after the end of the semester.

Describe the audit requirements. The project accounts annual audit will cover all project aspects, sources and uses of funds. It will also relate to financial operations and internal control, and financial management system. The audit will be conducted by an auditor acceptable to the Bank and will cover all operations implemented under the project; the audit will be conducted in compliance with internationally accepted audit professional standards. The auditor will produce: a) an annual audit report including his opinion on the project annual financial statements, and b) a report on internal control weaknesses checked while performing his task. The reports will be addressed by the Ministry of Public Health to the Bank within six months starting from closing date of each fiscal year.
### Section 4.7 - Disbursement Arrangements

This section should be filled out in consultation with the Finance Officer.

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<th>Question</th>
<th>Response</th>
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<tr>
<td>Will advances to a Designated (e.g., Special) Account be required?</td>
<td>All applications to withdraw proceeds from the loan will be fully documented, except for: (i) US$100,000 equivalent or less for goods contracts; (ii) US$100,000 equivalent or less for consulting companies; (iii) US$50,000 for individual consultants or training contracts which may be claimed on the basis of certified SOEs. Documentation supporting expenditures claimed against SOEs will be retained by the Ministry of Public Health and will be available for review when requested by Bank supervision missions and project auditors. All disbursements will be subject to the conditions of the Grant Agreement and the procedures defined in the Disbursement Letter. To facilitate disbursement of eligible expenditures for services, material and training the Ministry of Public Health will open and establish at the Central Bank of Tunisia (CBT) a Designated account in US$ to cover the Grant’s share of the eligible project expenditures. This DA will be managed by the CBT and will cover eligible expenditures. The authorized allocation of the DA will be US$100,000 covering four months of eligible expenditure financed by the Grant. The CBT will be responsible for submitting replenishment applications with appropriate supporting documentation for expenditures incurred including reconciled Bank statements. Proceeds of the Grant would be disbursed in accordance with Bank Guidelines and will be used to finance Project activities through traditional Bank disbursement procedures for direct payment, and/or reimbursement accompanied by appropriate supporting documentation or using Statement of Expenditures (SOEs) in accordance with procedures described in the Disbursement Letter and Bank’s Disbursement Manual. Following the standard disbursement procedures of the Bank, disbursement will be completed four months after the project closing date.</td>
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<tr>
<td>What is the proposed ceiling for advances? (This can be a specific amount or a period if interim unaudited financial reports are used to support disbursement.)</td>
<td>The authorized allocation of the DA will be US$100,000 covering four months of eligible expenditure financed by the Grant. The CBT will be responsible for submitting replenishment applications with appropriate supporting documentation for expenditures incurred including reconciled Bank statements.</td>
</tr>
<tr>
<td>If a Designated Account will not be used, specify how disbursements will be made (e.g., direct payments, reimbursement for prefinanced expenditures).</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>Specify the type of documentation that will be provided to support disbursements, e.g., interim unaudited financial report, SOE, or copies of records (e.g., actual invoices).</td>
<td>Proceeds of the Grant would be disbursed in accordance with Bank Guidelines and will be used to finance Project activities through traditional Bank disbursement procedures for direct payment, and/or reimbursement accompanied by appropriate supporting documentation or using Statement of Expenditures (SOEs) in accordance with procedures described in the Disbursement Letter and Bank’s Disbursement Manual. Following the standard disbursement procedures of the Bank, disbursement will be completed four months after the project closing date.</td>
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### Section 4.8 - Additional Obligations

Covenants drafted by the lawyer can be inserted in this space when, exceptionally, any additional obligations of the Recipient need to be specified.

Not applicable.

### Section 5 - Financing Plan

Not applicable.

### Section 6 - Detailed Cost Table

Please consult with Procurement Accredited Staff on the proposed procurement methods.

See attached Cost Table
Section 7 - Technical Review & Clearances

Section 7.1 - Technical Review

SDV Technical Reviewer (Please insert comments below)

SDV Technical Reviewer:
Comment on a) technical feasibility/appropriateness of the grant from the SDV perspective; b) relevance of the proposal to JSDF requirements for innovative approaches to provide direct benefits to disadvantaged/marginalized groups.

Directions for TTLs:
Indicate in capital letters, after each comment, where in the proposal the comment has been reflected. Please provide tab and field references.

Heba,

Be forewarned….I know almost nothing about Tunisia and little about the health sector. I already mentioned this to you. I do have a fair bit of experience on CDD operations, but as you realize these operations, though based on some pretty widely accepted principles (some might even say "sacred"), are very contextual. In other words, what works well, for example, in Indonesia, might not in Tunisia. I was able to glance at your proposal and will give a few thoughts. You decide if they are of any benefit.

1. I congratulate you on the proposal and its emphasis on governance and accountability of the users of health services, in poor and under-serviced regions. This "rights-based approach" should be the touch stone for validating all components, activities and allocation of funds. As I understand it, with a Health Sector DPL being finalized, this JSDF funded project, with its emphasis on governance and accountability, can play an extremely important complementary role and ensure greater sustainability. One would assume one of the triggers for the DPL would be directly related to this 'e' pillar of the HSRP.

2. The idea of establishing ten community health collaboratives I understand and support (though I am not sure if this is new to Tunisia and being piloted in these two regions or whether these exist elsewhere in Tunisia and these two regions lag behind "institutionally" in this regard). I assume these groups are both for voicing citizen demand, exercising control on public services and as a focus for efficient public health education and service delivery.

3. Master planning and M & E…who can argue with these activities. What I am unclear about is whether these are new to Tunisia in the health sector or whether these two regions specifically lag in this regard or whether the planning and M &E are directly tied to activities and the results funded by the proposed JSDF. If it is the last, then I am a bit puzzled by the sequencing of proposed activities. The majority of the funds of this JSDF are for these two components, right?

TTL: THIS COMMENT HAS BEEN ADDRESSED IN THE TAB "COMPONENTS/OUTPUT", UNDER POINT "2. GRANT COMPONENT/OUTPUT #2", IN "DESCRIPTION/DETAILS." THE SEQUENCING HAS BEEN EXPLAINED BY STATING THE ROLE OF THE COLLABORATIVES AND THE SEQUENCING OF THE COMPONENTS THAT FOLLOW.

4. I did tell you I am not very well informed on the health sector in Tunisia. For example, as I read the proposal, it became clearer but still not completely so, as to why in these two regions the rate of assisted births is low or lower than elsewhere. Is this due to low demand (women do not want to do so or their husbands or mothers/mothers-in-law do not allow them to do so) or doctors and midwives are not available or willing to do so or the costs are too high or a combination of these reasons? It is hard for me to picture what might be the "treatment" without being clear what the ailment is.

TTL: THIS COMMENT HAS BEEN ADDRESSED IN THE TAB "COMPONENTS/OUTPUT", UNDER POINT "1. GRANT COMPONENT/OUTPUT #1", IN "DESCRIPTION/DETAILS." THE FACTORS ASSOCIATED WITH LOW RATES OF ATTENDED BIRTHS IN THE TWO PILOT REASONS IS EXPLAINED MORE FULLY, INCLUDING THE AVAILABILITY OF SKILLED PERSONNEL AS WELL AS THE AWARENESS AMONG WOMEN REGARDING THE NEED TO SEEK PRENATAL SERVICES THAT INCREASE THE LIKELIHOOD FOR ATTENDED BIRTHS.

5. What I do not see here and what I usually expect to see if the discussion is about an "innovative community-driven approach" is funds controlled directly by community groups, funds with which community groups can buy services and co-finance needed additional services from the public sector. I thought I would find mention of this linked to component one, the community health collaboratives. My recent experience with health care and CDD is with a large pilot in Indonesia implemented along with the Kecamatan Development Project or actually its successor, PNPM Mandiri Rural. This
pilot gives block grant funds to communities for investments which the community, with facilitation and input from local health agencies, NGOs, and community facilitators hired by the project, feels will help them to improve achievement of a few MGDs on which Indonesia lags, for example, maternal mortality rates. If a community improves its performance, then more block grant funds are provided the following year. The funds and the decisions on the funds are used rests with the community. I understand this is only half the equation and does not address service delivery per se or only indirectly. But without funds in the control of community groups (not NGOs, but community groups themselves), the results would seem to be limited to increased knowledge and public service delivery. Not the whole equation either and possibly not the part of the equation most closely related to citizen rights, governance and accountability.


Heba, good luck on your proposal. These comments were done quickly and are not meant as criticism but rather just something to think about, perhaps input to clarify and tighten your proposal so those of us who do not really understand Tunisian health needs can do so better. Thanks for asking me to comment.

Directions for TTLs:
Please provide the name and area of specialization of the SDV Technical Reviewer.

John Victor Bottini, Sr. Social Development Specialist, EASIS

Thematic Technical Reviewer (Please insert comments below)

Thematic Technical Reviewer:
Comment on a) the technical approach from a country/sector viewpoint and b) the relevance of the proposal to JSDF requirements for innovative approaches to provide direct benefits to disadvantaged and marginalized groups.

Directions for TTLs:
Indicate in capital letters, after each comment, where in the proposal the comment has been reflected. Please provide tab and field references.

Dear Heba,

Thank you for sending me the JSDF proposal. I have reviewed it and have the following comments.

Overall this proposal is well thought through and covers several areas that appears to be gaps in service provision that if covered will lead to considerable improvements in health services received by those residing in these underserved areas.

The establishment of community health collaborative groups are a great idea as this, if successful, can be a bridge between the population and health services, thus serving a larger goal than that related to reproductive health alone. The aims of this component (Component 1) - I see as being - establishing such a group with appropriate membership and provided with the necessary training and support so that the group can both facilitate improved access to reproductive health services. This while it may seem simple on paper is not an easy task and as mentioned before, getting this in place itself will be a major achievement.

In measuring the success in achieving what is set out in this component, I would suggest that the team be more modest especially in terms of achievement especially that related to improving “antenatal coverage”. Given this is a focused three year project, I would suggest that the limit the indicators to what the activities supported with achieve under this component i.e. set up a target number of collaboratives with appropriate membership and provided with the necessary training and support. The current indicators listed do not reflect standard measures of antenatal care coverage (as defined under MDGs) - one visit per live birth or at least 4 visits per live birth - and so may be difficult to measure and if measured may not be particularly meaningful. It would be good however if possible to set up a system to follow and measure this MDG goal in the area as a whole though I am not sure if that can be achieved within the scope of this grant.

TTL: THIS COMMENT HAS BEEN ADDRESSED BY INCLUDING THE STANDARD DEFINITION OF THE ANTENATAL CARE COVERAGE IN THE TAB ON "OUTCOMES" AS AN OUTCOME OF THE GRANT AS A WHOLE AND DESIGNATING THIS AS THE INCREASE IN THE PROPORTION OF WOMEN RECEIVING AT LEAST 4 VISITS. THIS IS DUE TO THE OBSERVATION THAT THE RATES FOR WOMEN RECEIVING AT LEAST 1 VISIT ARE RELATIVELY HIGH AT OVER 95%, BUT THAT THE RATE OF GREATER ACCESS LAGS WHICH MAY BE CONTRIBUTING TO LOWER RATES OF ATTENDED BIRTHS IN RURAL REGIONS AND HIGH MATERNAL MORTALITY RATES.
THIS COMMENT HAS ALSO BEEN ADDRESSED BY INCLUDING BENCHMARK INDICATORS RELATED TO DOCUMENTING THE NUMBER OF COMMUNITY HEALTH COLLABORATIVES ESTABLISHED UNDER THE TAB "COMPONENTS/OUTPUTS", SECTION "1. GRANT COMPONENT/OUTPUT #1". THIS IS A PROCESS-RELATED INDICATOR THAT HELPS TO ENSURE PROGRESS AND MORE IMMEDIATE RESULTS OF THIS COMPONENT.

On component 2, while ensuring availability of adequate health personnel is important, supply changes may not occur within a short period of time if the key human resource issue in the country is lack of supply and not poor distribution of existing supply. If poor distribution, one may need changes in incentive structures which I understand are already in place for working in underserved areas. The key would be to think in the masterplan of an appropriate mix of personnel that could ensure that there is proper service coverage. In some countries midwives, traditional birth attendants, nurse practitioners etc. can be trained at least to identify high risk cases. Not sure if this is appropriate in the Tunisian context. Here too care should be taken with respect to the indicators chosen. What is the current workload of GPs or specialists? If already stretched, one may not get quality services if one increases population served by a GP. After a certain level, one would expect diminishing returns. I would therefore see if you can get some worker productivity measures in addition to these ratios. Reducing absenteeism is a good indicator and this should be measured. Waiting time is a good indicator here too.

TTL: THIS COMMENT IS VALID AND THE SUPPLY INDICATORS HAVE BEEN REVISED TO REFLECT THOSE THAT ARE MORE LIKELY TO BE ATTRIBUTED IN PART TO THIS COMPONENT, RESOURCE PLANNING AS INDICATED BY RATES OF ABSENTEEISM. UNDER THE TAB "COMPONENTS/OUTPUTS", POINT NO. 2, "GRANT COMPONENT/OUTPUT #2", THE RATIOS OF POPULATION PER PHYSICIAN HAVE BEEN REMOVED. THE MAIN INDICATOR FOR THIS COMPONENT IS THE AVAILABILITY OF SUPPLIES AND GOODS FOR MATERNAL SERVICES AND THE RATES OF ABSENTEEISM AMONGST STAFF. THE INDICATOR ON WAITING TIME WAS PREVIOUSLY INCLUDED AS AN OUTCOME OF THE OVERALL GRANT AND REMAINS SO GIVEN THAT THIS IS AN OUTCOME THAT CAN BE INFLUENCED BY A NUMBER OF FACTORS BEYOND RESOURCE PLANNING.

All the best with this work and look forward to hearing about its progress.

Directions for TTLs:
Please provide the name and area of specialization of the Thematic Technical Reviewer.

Rekha Menon, Sr. Economist, EASHD

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<th>Section 7.2 - Clearances and Comments</th>
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<td>Team Member</td>
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