

HEALTH SYSTEMS REVIEW: The Post COVID-19 Situation in Tunisia

March 2024

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This study was prepared by the Right to Health program team of the Social and Economic Justice Unit at the Egyptian Initiative for Personal Rights (EIPR) in partnership with the African Alliance and the support of International Alert - Tunisia and Skander Essafi as the lead researcher.

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ABOUT THE PROJECT

Why a “Post-COVID” review?

While the COVID-19 global pandemic burdened healthcare systems worldwide, it also helped to shed light on their deficiencies and weaknesses and, in some cases, it may have even accelerated a number of reform processes – not only in terms of pandemic preparedness but also with regard to the strength of the healthcare system as a whole.

This paper is part of comparative evaluation of the ramifications of the COVID-19 pandemic on the healthcare systems and the changes brought by it in three North African countries (Egypt, Tunisia and Morocco). The evaluation aims to provide an overview of the key changes and effects of the pandemic on the functioning of healthcare systems in each of these countries.

The ultimate objective of this evaluation is to help unmask interventions needed to improve the working conditions of healthcare workers, increase their retention and, naturally, build healthcare systems that are capable of addressing different health crises (pandemics included). The evaluations and interventions that will stem from it are also attuned to the short, medium and long-term objectives of closing the gap on the Sustainable Development Goal of securing Universal Healthcare Coverage to all. This should also provide decision-makers and civil society

actors with the knowledge needed moving forward in health systems reform efforts.

The COVID pandemic shed light on a number of deficiencies and vulnerabilities in the global and national healthcare systems alike. On the other hand, attention to those vulnerabilities was accompanied by a sense of urgency to act quickly, with new challenges of social justice and equity surfacing particularly when it comes to access to vaccines. A quick reaction is still needed to handle the distribution of healthcare services and resources that may have been unjust in many cases. Conducting a post-pandemic assessment of the healthcare sector will provide our societies with a possible roadmap moving forward. Not only in terms of pandemic preparedness, but also the strength, effectiveness and state of governance of the healthcare system as a whole.

The assessment will take stock of effective measures and interventions that were rolled out and given the green light in the context of the pandemic, but that can also give us a multitude of lessons learnt. The aim is to make this pool of experiences, successes, and failures available to be shared on a regional level and then across the continent for mutual learning and collaboration.

To summarise, the objective of this series of papers is to understand the changes and effects of the pandemic on the healthcare systems and highlight needed interventions to strengthen them. The research partners of this project will use these insights in identifying specific policy recommendations in each of the papers and advocate for them.

Sources and Methods

In light of the general limitations in accessing reliable, up-to-date data about healthcare systems performances in the region, the research team opted for a research methodology that relies on two main sources of data:

1. Literature and official sources released by government data made public and data from international development agencies (namely the World Health Organization (WHO) and the World Bank).
2. Experts' and stakeholders' consultations, providing their reviews, observations, and analysis of this data in light of practical experiences, implemented policies and observed realities on the local grounds.

Study Tool

To carry out this exercise, a study tool was created detailing the different review questions to examine during the experts' consultations. This study tool is based on the framework of the Health Systems Building Blocks created by the WHO and its indicators and measurements for the monitoring of those building blocks¹. It also includes components that are based on the Epidemic Preparedness Index published in 2019 in the BMJ Global Health journal². Both of these frameworks have been used as a guide for the researchers who added details about each indicator and measure, its recommended sources and a brief explanation of their key characteristics. All these served as the basis for the expert review upon which the paper's conclusions are drawn.

A summarized version of this study tool is available **on this link** providing a succinct reference for readers interested in the methodology underpinning our investigation.



¹ World Health Organization, Monitoring the Building Blocks of Health Systems, A handbook of indicators and their measurement strategies, 2010
<https://apps.who.int/iris/bitstream/handle/10665/258734/9789241564052-eng.pdf>

² Oppenheim B, Gallivan M, Madhav NK, et al. Assessing global preparedness for the next pandemic: development and application of an Epidemic Preparedness Index. BMJ Glob Health 2019;4:e001157.doi:10.1136/bmjgh-2018-001157
<https://gh.bmj.com/content/bmjgh/4/1/e001157.full.pdf>



Limitations

The study methodology was specifically designed to address the inherent difficulty of acquiring reliable data for forming objective opinions. The reviews and analysis provided strive to be based on nationally approved data whenever available. However, reaching a consensual conclusion for some of the review components was impossible. This was clearly highlighted in the studies with the underlying reasons.

All efforts were exerted to provide a systematic review that reflects objective opinions about the healthcare systems.

Yet, this paper presents the potentially subjective opinions, reviews and recommendations of its authors and consulted experts within the context of short consultations. Consultations that in turn were part of a series of overview papers that provide a bird's eye view of healthcare systems without digging into the details of each component.

To guide the experts and stakeholders consultation process, quantitative data reflecting the WHO health systems review framework were diligently sought to cover the three points in time covered in this study (2019 or before COVID-19, 2021 (during COVID-19) and 2022 (post COVID-19)), however the available official data were scarce and in all cases did not provide the capacity to make any comparisons. This makes the comparison increasingly difficult and justifies the challenge faced by the consulted stakeholders to deliver evidence-based inputs.

About the Peoples Vaccine Alliance Africa

PVA Africa is a regional movement of organisations and networks supported by Nobel Laureates, Heads of State, health experts, economists, world leaders, faith leaders and activists working together to ensure Africans everywhere have equitable access to vaccines. Housed in the African Alliance, PVA Africa, under the guidance of the Steering Committee, comprises leaders of five regional networks and never loses sight of our collective desire for the decolonisation of public health and rights-based access to products and science that saves lives, keeps us healthy and accelerates our right to dignity as Africans. PVA Africa's role is to ensure that the voices, priorities and work of African activists and communities, in all our diversity, are meaningfully reflected in the global work of PVA. PVA Africa also works to ensure that interventions, strategies and approaches to addressing the lack of access to COVID-19 vaccines, tests and treatments, as well as gender and economic inequalities in relation to vaccine equity and access, are addressed in our (African) terms.



THE TUNISIAN HEALTHCARE SYSTEM REVIEW



ABSTRACT

Since the COVID-19 pandemic, many observations have been made regarding the Tunisian Healthcare System, which can be inherent to the nature of the pandemic or to other concomitant developments. A review of available quantitative data and an experts' qualitative analysis has been conducted to map the changes in the building blocks and indicators in the Tunisian Health System and their causes. To do so, a literature review was conducted, several official documents were consulted, and a study tool was developed based on the framework of the Health Systems Building Blocks created by the WHO to guide the discussion with experts from the field at the national level.

The results of the study show that most of the Health Systems' Building Blocks' indicators tend towards a deterioration in their status, and this has been the case even before the start of the COVID-19 pandemic, caused by other external factors such as the economic crisis. There were some positive measures that evolved during the pandemic response and that should be sustained. Finally, the discussion highlighted a call for a better implementation of national health policies and strategies.

EXPERTS' AND STAKEHOLDERS' CONSULTATION WORKSHOP

Through the pan-African project's local research partners, a list of 8 to 10 local healthcare systems experts and stakeholders representatives was compiled for each of the study countries. Each list included a diverse set of key experts representing the different stakeholders concerned with the healthcare system, these included government representatives, service provider representatives, policy-makers, parliamentarians, members of civil society, academics and private healthcare service providers among others.

These experts were then invited to an immersive consultation to provide their expert's opinions about the situation of each of the components of the health systems pillars in the corresponding national context, answering a standard question for each of the health systems components: "Comparing the situation now with that of 2019 (before COVID-19), did this component improve, regress or stay the same?"

For the Tunisian study at hand, a highly diverse and representative pool of experts were invited to participate in this exercise. They included:

1. A general practitioner and representative of the Ministry of Health
2. A retired manager from the National Social Sickness fund
3. A retired head of the department of preventive and community medicine at a university hospital
4. A general practitioner and president of a health and human rights organization
5. A retired general practitioner and activist for the protection of health service consumers
6. A young doctor active in civil society
7. A young dentist active in civil society
8. A young pharmacist active in civil society

Facilitators would then ask the participants to start with an initial vote to detect if there is a consensual answer followed by a discussion to provide justification for each expert's opinion. The outcome of these discussions were then documented and summarized into a short rationale provided in this paper below each question.

RESULTS

A. Health service delivery

Indicators	2019	2020-2021
Number and distribution of health facilities per 10,000 people	First line: 1.97 (missing private practices) Second line: 0.03	<ul style="list-style-type: none"> • First line: 1.89 (missing private practices) • Second line: 0.03 • Tertiary line: 0.03
Number and distribution of inpatient beds per 10,000 people	2.83	2.23
Number of outpatient department visits per 10,000 people per year	1,452.72	916.43 (2020) 898.91 (2021)

Source: National health reports (Carte Sanitaire)

1. Comprehensiveness

“A comprehensive range of health services is provided, appropriate to the needs of the target population, including preventative, curative, palliative and rehabilitative services and health promotion activities.”



Expert's Consensus



Worse than 2019

Healthcare services are becoming less and less comprehensive, due to the lack of continuity of essential services and overall healthcare coordination and collaboration between all the health workforce and stakeholders involved.

Overall, services have experienced a decline in their comprehensiveness and quality since 2019. This is a consequence of the lack of accessibility and overall decline of health service quality even before the start of the COVID-19 pandemic, and can mainly be attributed to budget cuts, personnel shortage and the economic crisis. This has particularly affected services such as family planning services, antenatal and postnatal care, pediatric care, HIV/AIDS services, management of chronic disease, surgeries and mental health services.

Scattered private efforts to expand specific service provision through online tools amid COVID-19 have not been sufficiently studied, explored or developed by the government, ultimately maintaining gaps in services accentuated by the pandemic.

2. Accessibility

“ Services are directly and permanently accessible with no undue barriers of cost, language, culture, or geography. Health services are close to people, with a routine point of entry to the service network at primary care level (not at the specialist or hospital level). Services may be provided at homes, the community, the workplace, or health facilities as appropriate.”



Expert's Consensus



Worse than 2019

There is a consensus among the consulted experts that the barriers towards accessibility to health system delivery have increased in the past years compared to 2019. This has been largely attributed to national economic challenges. The COVID-19 pandemic has also contributed towards this declining trend.

3. Coverage

“ Service delivery is designed so that all people in a defined target population are covered, i.e. the sick and the healthy, all income groups and all social groups.”



Expert's Consensus



Worse than 2019

Since 2019, increasing the healthcare coverage of the general population has been a priority in the national plans. The national sickness fund was set to expand its coverage with a basic healthcare package that would target a significant proportion of the population which hasn't had this access so far (approximately 2 million citizens). However these plans were hampered by the COVID-19 pandemic, political developments as well as the economic crisis that has been increasingly hampering the capacity of the fund to achieve this goal. This has led to an aggravation of out-of-pocket expenditures on both insured and non-insured individuals and families.

4. Continuity

“Service delivery is organized to provide an individual with continuity of care across the network of services, health conditions, levels of care, and over the life-cycle.”



Expert's Consensus



Worse than 2019

The continuity of care has been considerably affected, even before the start of the COVID-19 pandemic, due to the lack of healthcare personnel (e.g doctors leaving their position, not being replaced), absence of continuity in medicines (especially for chronic diseases) and the capacity to sustain services, maintain healthcare equipment and ensure availability of medications. The economic crisis has also made it more difficult to access specialized services for chronic care and therefore aggravated the continuity of care. This may have been aggravated by COVID-19 but cannot be attributed to it solely since this drop has been noticeable even before the onset of the pandemic.

5. Quality

“Health services being of high quality means they are effective, safe, centered on the patient’s needs and given in a timely fashion.”



Expert’s Consensus



Same as in 2019

There are no defined national criteria for acceptable quality of healthcare services, so it was difficult to reach a consensus in this regard. The experts could agree, however, that there are ongoing trials to develop evidence-based guidelines for healthcare management, through the national health accreditation institution (INEAS), to provide official accreditation to healthcare facilities according to a set of measurable standards. There are also ongoing efforts aiming towards improving the training of healthcare professionals. However, these initiatives are still isolated and did not yet translate into noticeable improvement in healthcare service quality. Acknowledging the lack of reliable data on that front, the experts agreed quality of services remains largely unchanged compared to 2019.

6. Person-centeredness

“Services are organized around the person, not the disease or the financing. Users perceive health services to be responsive and acceptable. There is participation from the target population in service delivery design and assessment. People are partners in their own health care.”



Expert’s Consensus



Worse than 2019

Despite the potential to shift the focus on the patient in primary healthcare, thanks to the development of the family medicine medical specialty since 2017, this has not yet been sufficiently deployed. It is worth noticing the defects in availability of services and coverage negatively affecting any efforts towards patient-centered care. Also, due to the increasing congestion of healthcare institutions, and the defects in healthcare personnel, it has been observed that less time and

attention are being given to the patient, leaving a focus mainly on the disease, temporarily solving health issues, and in a less coordinated approach.

7. Coordination

“Local area health service networks are actively coordinated, across types of provider, types of care, levels of service delivery, and for both routine and emergency preparedness. The patient’s primary care provider facilitates the route through the needed services, and works in collaboration with other levels and types of provider. Coordination also takes place with other sectors (e.g. social services) and partners (e.g. community organizations).”



Expert's Consensus



Slightly better than 2019

The rapid deployment of COVID-19 protocols and the need for national coordinated efforts to contain the disease paved the way for better coordination in healthcare service provision. There is also a potential to better coordinate the management of healthcare services at the national level through the development of digitalized platforms and their interoperability that depend on further investments for a more efficient medical data sharing process. Yet, these opportunities are still not explored in a satisfactory way.

8. Accountability and efficiency

“Health services are well managed so as to achieve the core elements described above with a minimum wastage of resources. Managers are allocated the necessary authority to achieve planned objectives and held accountable for overall performance and results. Assessment includes appropriate mechanisms for the participation of the target population and civil society.”



Expert's Consensus



Same as in 2019

Still in line with the quality and coordination of services, there are no defined benchmarks for accountability, as there are no incentives or mechanisms to encourage institutions managers and the health workforce to constantly improve their services to any external organization. This has been the case since before 2019. The recent increasing difficulties facing civil society and challenges regarding communication with civil servants and decision-makers is also threatening to lower the bar on that front in the upcoming period.

B. Health workforce

Indicators	2019	2020-2021
Number of health workers per 10 000 population (by profession and in the public and private sector)	<ul style="list-style-type: none"> • General practitioners: 6.6 • Specialists: 6.6 • Pharmacists: 2.37 • Dentists: 4.8 	<ul style="list-style-type: none"> • General practitioners: 5.8 • Specialists: 7.7 • Pharmacists: 2.45 • Dentists: 3.76

Source: National health reports (Carte Sanitaire)

1. Strategic Planning and Medical Human Resources Management system

“The way the health authority manage and develop plans regarding human resources in health systems. Recruitment and deployment systems including incentive schemes to ensure that health-care facilities meet their nationally recommended staffing norms”



Expert's Consensus



Same as in 2019

There is no clear planning nor vision on the health workforce recruitment, which is explained by the absence of needs assessment in terms of disciplines and specializations in each governorate and region. The situation has been worsening since before 2019. There doesn't seem to be sufficient coordination with the demand side and supply of healthcare professionals through new cohorts in faculties and schools for healthcare sciences.

2. Size

“The size of the national health workforce, include recruitment and training”



Expert's Consensus



Worse than 2019

The number of doctors and paramedics has declined due to the brain drain and workforce migration, especially for nurses. There is no clear indicator on the distribution of the workforce across the regions. Some experts claimed that the numbers shared in previous national health reports seem to be biased and inconsistent to draw comparisons across years. The number of specialists seems to have increased, but this is due to the development of the new family medicine

specialization. Significant deficiencies have been observed in healthcare workforce in regions and specialities which used to be covered in the past.

3. Capacity

“The capacity of health professions educational institutions, including the quantity and quality of instructors and auxiliary staff”



Expert's Consensus



Worse than 2019

The healthcare educational institutions are facing a more significant shortage in the training standards and equipment. More and more University professors are leaving universities and are not being replaced, which has an impact on the academic training of the students in theory and practice. Deficiencies in capacity have naturally been observed during COVID-19, specifically the need for highly specialized and trained healthcare workers for advanced care. Furthermore, defects in capacity have been more noticeable even after 2020 and beyond.

4. Private Sector

“Interaction with or regulation of the private sector requiring accurate knowledge of the numbers, types and qualifications of private sector providers”



Expert's Consensus



Same as in 2019

There is some collaboration on a local level with private institutions and healthcare professionals, to fill out deficiencies in some disciplines. However, these initiatives are always temporary and have not been capitalized on into national plans or strategies. The COVID-19 pandemic saw the involvement of the private sector in testing and vaccination measures, but they have not been consolidated by any concrete public-private partnership policy so far.

5. Management of health workforce migration

“Managing health workforce market among countries that witness large numbers of health workers migration, efforts may be undertaken to manage the pressures of the international health workforce market on migration”



Expert's Consensus

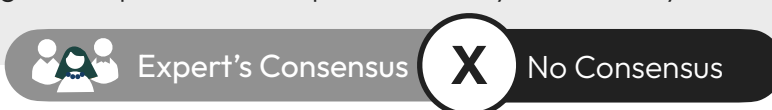


No Consensus

It has already been stated that there is a larger flow of healthcare workforce migration. This migration is either framed into a multilateral cooperation that is monitored at a governmental level, or in many cases as a “non-organized migration”, especially with medical doctors, nurses and dentists. There are still discussions to regulate this overall flow of migration, and to increase the multilateral country collaborations. This, however, is so far managed by temporary solutions, such as retention measures from Tunisia’s side, and recruitment tailored to the needs within the country at the regional level as well as with destination countries recruiting from the health workforce.

6. Management of inefficiencies

“Inefficiencies may include identifying and reducing worker absenteeism that is known to be a significant problem in the public health system in many contexts”



In the light of absent reliable data, it was difficult to reach a consensus about this aspect of healthcare workforce management.

7. Motivation and staff performance

“Health worker motivation and productivity, which may include strengthening of supervision. Potentially one of the most effective instruments to improve the competence of individual workers and effective management of performance of health workers.”



Consulted experts could not identify improvements or setbacks regarding staff motivation and performance management.

C. Health information systems

COVID-19 and international obligations regarding its management by states imposed a number of measures regarding the provision of regularly updated and standardized data about COVID-19 mortality, morbidity and vaccination. The question remains on whether these measures have continued or scaled-up post COVID and whether they were sufficiently accurate.

1. Data generation

“Data generation capacity using core sources and methods (health surveys, civil registration, census, facility reporting, health system resource tracking). These reflect country capacity to collect relevant data at appropriate intervals and uses the most appropriate data sources. Benchmarks include periodicity, timeliness, contents of data collection tools and availability of data on key indicators.”



Expert's Consensus



Same as in 2019

General data and health-related data are generally centralized at a governmental level. However, it is not always clear when this data is collected and at what frequency is it shared.

2. Data analysis and validation

“Country capacities for synthesis, analysis and validation of data. These measure key dimensions of the institutional frameworks needed to ensure data quality, including independence, transparency and access. Benchmarks include the availability of independent coordination mechanisms and the availability of microdata and metadata



Expert's Consensus



Same as in 2019

Since data is not always available and accessible, it is only analyzed for specific ad-hoc and internal purposes. There is not a standardized strategy to use and implement initiatives using this data.

3. Existence of Health surveys

“Country has a 10-year costed survey plan that covers all priority health topics and takes into account other relevant data sources.”



Expert's Consensus



Same as in 2019

Some national health surveys exist, and have increased temporarily in the context of the COVID-19 pandemic. However, this ended up becoming a missed opportunity to develop a strategy for regular health survey generation.

4. Existence of birth and death registration

“The target goals are: birth registration of at least 90% of all births, death registration of at least 90% of all deaths, ICD-10 used in district hospitals and causes of death reported to national level.”



Consulted experts agreed that registration data are generally centralized and there is no specific, predictable pattern to how or when they are shared.

5. Existence of censuses

“Census completed within the past 10 years with population projections for districts and smaller administrative areas available for the next 10 years, in print and electronically, and well documented.”



No particular change has been noticed on that front.

6. Existence of Health facility reporting

“Special emphasis on system for reporting of notifiable diseases and how much it makes use of modern communication technology, and reporting of statistics from district to national levels.”



Reports of health facilities are becoming less available even upon request. There isn't a clear culture of health data generation and databases yet, despite efforts and technical support from the World Health Organization.

7. Existence of health system resource tracking

“This includes at least one national health accounts exercise completed in the past five years, a national database with public and private sector health facilities and geocoding, available and updated within the past three years”



Expert's Consensus



Same as in 2019

The latest published National Health Accounts was in 2015 with no further updates or developments on that front since then.

D. Access to essential medicines

1. Access to essential medicines as a right

“Access to essential medicines/technologies as part of the fulfillment of the right to health, recognized in the constitution or national legislation as part of the progressive realization of the right to health and/or as a specific entitlement of all citizens.”



Expert's Consensus



Same as in 2019

The right to health is stated in the national constitution and any citizen is entitled to this right. This enables generally an access to essential medicines, however there isn't an official national list of essential medicines, therefore the recognition of “access to essential medicines” as a right can only be understood as an implied, extrapolated component of the citizens' rights to health.

2. Published national medicines policy

“Existence and year of last update of a published national medicines policy (an official National Medicines Policy (NMP) and updated within the past five years)”



Expert's Consensus



Same as in 2019

There is a national medicines policy that exists, which includes support for the development of generic medicines, however it is not published. This is mainly because it is still open to discussion and has not been validated at a high policy level.

3. Published national list of essential medicines

“Existence and year of last update of a published national list of essential medicines and updated within the past five years.”



Expert’s Consensus



Same as in 2019

There was still a plan, at the time of authoring this report, to vote on a national list of essential medicines in 2023. There is a list of essential medicines shared by the national sickness fund, for reimbursement purposes, which in theory should be aligned at a governmental level.

4. Practical availability of essential medicines

“In practice, are essential medicines available and accessible at all levels of care?”



Expert’s Consensus



Worse than 2019

There has been a significant disruption of provision of essential medicines, which has increased in the past few years. This is due to several factors including the lack of representation of multinational pharmaceutical companies, mainly in the local call for tenders since it is not profitable especially compared to local manufacturers capable of providing many cheaper generic drugs. However, the gap in the production does not necessarily respond to the needs of the population. In other cases, where no generic drugs exist, there are issues of reimbursement from the national central pharmacy.

With limited budgets and struggles from financial constraints, the national central pharmacy is forced to alter the treatment protocols of some chronic conditions, replacing indicated medicines with more basic essential medicine and reduced effectiveness. Overall, this situation was expected even from before 2019, due to the large debts to the national central pharmacy.

E. Health systems financing

Indicators	2019	2020-2021
Total expenditure on health (in M USD)	189.75	2020: 221.68
General government expenditure on health as a proportion of general government expenditure (GGHE/GGE)	5.47%	2020: 6.34%
The ratio of household out-of-pocket payments for health to total expenditure on health	42.9%	2020: 36.4%

Sources: National Health Accounts (NHA), World Health Organization Registry

1. Government expenditure on health

“General government health expenditure as a proportion of general government expenditure”



Expert's Consensus



Worse than 2019

There is a considerable decline in the government expenditure on health, in 2022 and even more in 2023 (decline of 25%). This is mainly due to general budget cuts linked to the economic crisis, and as a consequence of the extra expenditures for health system management during the pandemic.

2. Financial risk protection and coverage for vulnerable groups

“Population covered by health insurance. Mechanisms made available to ensure coverage of the most vulnerable populations”



Expert's Consensus



Worse than 2019

Due to the general economic crisis and following the COVID-19 pandemic response, it has been observed that less risk protection is provided to the general population, specifically to vulnerable groups.

3. Financial transparency

“Financial transparency at operational and managerial levels”



Expert's Consensus



Same as in 2019

The national health accounts and detailed health expenditures are not regularly published, which raises questions about the transparency and sustainability of the general health system finances. The numbers shared on the website of the World Health Organization from 2020 and 2021 seem to be an estimation and not an official figure that has been shared at the national governmental level.

4. Out-of-pocket payments

“The ratio of household out-of-pocket payments for health to total expenditure on health”



Expert's Consensus



Worse than 2019

In light of the general economic crisis and following the COVID-19 pandemic response, it is expected to see out-of-pocket payments for health purposes increase, even though no national figure is available to confirm this assessment.

F. Leadership and governance

A recent national strategy has been issued but is not yet well operationalized. Civil society representation in decision making processes has been inconsistent in the past few years

1. National health strategy

“How is it made? Is it publicly available? Is it regularly updated? Is it binding?”



Expert's Consensus



Better than 2019

The development of the first national health strategy since the launch of the health societal dialogue (launched after the Tunisian Revolution) has begun, aimed for 2030 and is currently enforced into the operationalization. This has been accelerated especially after the COVID-19 pandemic. However, the implementation roadmap remains vague.

2. Representation

“Are all relevant stakeholders regularly represented in decision-making? How participatory is the decision-making process? On service provision level, district level and national level?”



Expert's Consensus



Same as in 2019

The health societal dialogue included different actors and civil society members. This initiative has been praised, however it is not always participatory and deemed inclusive enough towards all stakeholders and minorities, especially with regard to advanced decision-making processes and the operationalization of the national strategy.

3. Transparency and 4. Accountability

“Is information made available in a transparent, precise and timely way? Are national health data accessible to all? On all levels? Are there mechanisms for local and national accountability towards service providers and regulators?”



Expert's Consensus



Same as in 2019

There is a general problem in the implementation and follow-up of national strategies, which had been observed for a long time. Accountability mechanisms are also still lacking. There is a need for a governing body which should be multisectoral, between health authorities and other institutions, while also being supported by external and international organizations and funds. These defects lead to dispersion efforts of the different stakeholders and the lack of transparency of the monitoring of these strategies.

5. Grievance redress mechanisms

Could not be evaluated.

G. Epidemic preparedness

1. Public Health Infrastructure



Some improvement has been noticed (EVAX 2.0 vaccination platform for general vaccination beyond COVID for example), but otherwise status quo on the preparedness infrastructure remains.

2. Surveillance



There is a surveillance system and a national institution looking at emergent epidemics. This institution has developed more structure and gained more recognition with the COVID-19 pandemic.

3. Immunization



The capacity to produce, roll-out, register and administer vaccinations has seen a dramatic improvement since before 2019.

4. Hospital capacity



The overall hospital capacity has not improved (some new units have opened, but not for the purpose of epidemic preparedness).

5. Labs



More labs have opened and brought new diagnosis techniques – especially in the private sector – for COVID diagnosis as well as for other infectious diseases.

6. Coordination



There is a discussion happening currently at the ministry of health level to develop a strategy for emergency response and preparedness, in line with global efforts to combat future health threats and pandemics.

H. Public health communication

After the major COVID-19 waves (2020 and 2021), there are less health protection measures and generally speaking there are fewer public health awareness initiatives.

1. Public education and 2. Risk education



After the COVID-19 major peaks, there are no current public health educational campaigns taking place. It was reported that health professionals have become less lenient towards the application of health measures. Furthermore, there is a general feeling that no other pandemic would hit as much as the COVID-19 pandemic in 2021. Some educational initiatives are taking place, such as the bronchiolitis education advertisement in the previous winter, but they do not fall under any public health and epidemic preparedness strategies.

3. Communication with healthcare workers



Generally, there are no official communication platforms among healthcare professions (e.g mailing lists) whether within the same discipline or within hospitals and their respective departments. This hampers the flow of information regarding epidemic preparedness and protection measures that should be implemented at all levels and sectors.

I. COVID specific measures

Improvements have been noted in testing measures and vaccination coverage. No consensus has been reached regarding continuous transparency of data, estimation or underestimation of morbidity, and the issue of non-affordability of testing measures and hospitalization in the private sector

1. COVID data available (incidence, mortality, morbidity)?



COVID data across the pandemic was generally available and accessible through the main communication channels and social media.

2. COVID data credible? 3. COVID data regular and 4. COVID data accessible?



Data was overall credible, but sometimes it was delayed or scattered due to regional and sectoral disparity in their collection, especially in the first waves (end of 2020–beginning of 2021). Data credibility can be questioned on morbidity especially because of the use of COVID-19 rapid tests, which leads to an underestimation of cases.

5. Vaccine coverage ensured? 6. Vaccine equity realized? 7. Vaccine outreach to high risk population and target groups achieved?



Vaccine coverage was ensured across the country, after a period of settling and having enough doses to cover the entire country. Equity was one of the main principles of coverage when organizing the vaccination campaigns, and vaccines were accessible to the high risk population first followed by the rest of the population, including immigrants. Special caravans were organized to access hard-to-reach populations in rural areas, thanks to military mobilization.

8. Boosters were available? 9. Boosters coverage achieved?



Boosters were available and people were invited to join their closest vaccination center as soon as the recommended period after the first dose elapsed. However, there was a relative reluctance to receive booster shots, especially from people that were vaccinated with some vaccines that were perceived to cause more side-effects. As a consequence, there was a decline in the expected booster coverage (mainly in the second and third dose).

10. Access to testing guaranteed? 11. Affordability of testing ensured?



During the first COVID-19 waves, access to testing was quite difficult as only a few testing centers were allowed to perform the RT-PCR. This has been followed by giving permission to more private labs and clinics to organize and provide testing, as well as the development and commercialisation of rapid tests. However, the latter were not always trust-worthy, and RT-PCR is deemed very expensive in the private sector for the general population.

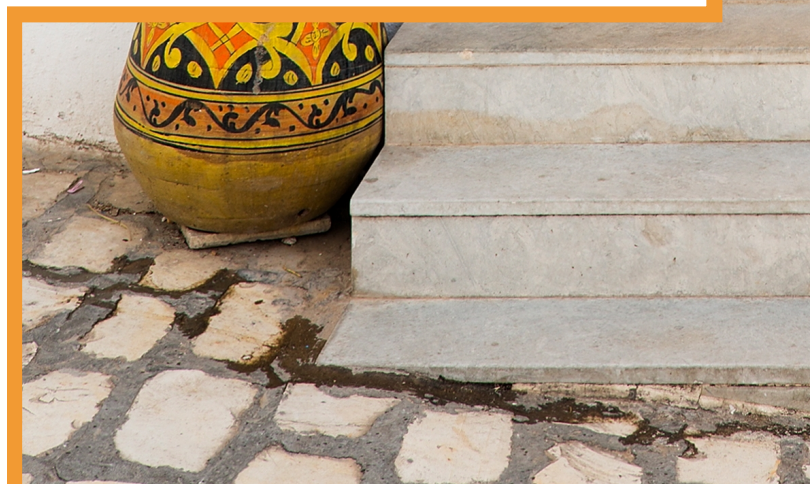
12. Access to treatment realized? 14. Affordability of treatment ensured?



Treatment for COVID-19 patients varied from symptomatic (mild form) patients to advanced and oxygen-dependent form of COVID-19. Treatments of mild symptoms were generally available in private pharmacies, however not all of them were recommended nor affordable to the general public. On the other hand, patients who needed to be hospitalized had to wait at home or at the emergency room to find a bed at the medical ward or the intensive care unit. The July 2021 wave has been very critical with a congestion of hospitals and wards, and even a disruption of oxygen supply and availability in some hospitals. This has obliged patients to be transferred to other hospitals and private clinics, only if this was possible and manageable as well as financially viable.



CONCLUSION AND RECOMMENDATIONS



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- Even before the COVID-19 pandemic, which had a considerable impact on the Tunisian healthcare system, the general trend before 2019 onwards was tending towards a worsening of most of the indicators of the health system building blocks. This is due to the persistent economic crisis in the country and the shortage in budgets across national institutions, such as the national sickness fund, and the national central pharmacy.
- After the end of major peaks of the COVID-19, in 2021 and 2022, a relapse into a general lack of discipline towards hygiene and epidemic preparedness measures was noted among healthcare professionals and citizens, which seemed to be based on the belief that no similar major pandemic could hit the country.
- There was an opportunity to build on initiatives implemented during the COVID-19 pandemic, such as the use of new equipment and facilities that were dedicated to COVID-19. However, it has been observed that these resources have not been used optimally after the pandemic.
- There is still hope to follow on successes from the actions targeted at COVID-19 such as the digitalization of the vaccination platform of child routine immunization, the development of an emergency preparedness prevention and response plan, as well as the operationalization of the national health strategy.
- Beyond external donor support and funding, there is a need to centralize health systems operations into more independent and sustainable solutions that could thrive on their own once the funding comes to an end.
- There is a need to consistently improve health information and data in order to develop evidence-based strategies. This can be done as a lesson learnt from COVID-19 reporting.
- Tunisian health officials should put more focus on building strategies and policies, based on surveys and health information available, the implementation of which can be closely monitored. Special attention should also be given to reducing unnecessary bureaucratic barriers facing the creation and implementation of these strategies. This is especially needed in the case of the national health strategy, the strategy for healthcare professionals recruitment and the national policy for essential medicines.

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The Egyptian Initiative for Personal Rights has been working since 2002 to strengthen and protect basic rights and freedoms in Egypt, through research, advocacy and supporting litigation in the fields of civil liberties, economic and social rights, and criminal justice.



Founded in 2012, the Alliance seeks to strengthen and amplify civil society voices working on solutions to the current and future pandemics as well as those working in the health sector addressing access and quality of services, impacting inadequately served populations in one of the most unequal regions on earth.

To achieve this, the Alliance focuses on developing and implementing public education and engagement strategies, advocacy, policy reform and research translation to ensure that all people across the continent are informed about their rights and have the skills and access to platforms to hold others to account for violations.



For over 30 years, International Alert has been working to build positive peace and reduce violence, working across conflict lines and with all parties to conflicts. Its vision is that people and their societies can resolve conflicts without violence, working together to build sustainable and inclusive peace.

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