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RIGHT TO HEALTH IN TUNISIA

The challenges of universal healthcare

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This report is published as part of the Arab NGO Network for Development's Arab Watch Report on Economic and Social Rights (AWR) series. The AWR is a periodic publication by the Network and each edition focuses on a specific right and on the national, regional and international policies and factors that lead to its violation. The AWR is developed through a participatory process which brings together relevant stakeholders, including civil society, experts in the field, academics, and representatives from the government in each of the countries represented in the report, as a means of increasing ownership among them and ensuring its localization and relevance to the context.

This 6th edition of the AWR focuses on the Right to Health. The AWR 2023 on the Right to Health is a collaboration between the Arab NGO Network for Development and the Faculty of Health Sciences at the American University of Beirut. Through this report we aim to provide a comprehensive and critical analysis of the status of the Right to Health in the region and prospects in a post COVID-19 era. It is hoped that the information and analysis presented in this report will serve as a platform to advocate for the realization of the right to health for all.

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METHODOLOGY

This report aims to assess progress toward realizing the right to health in Tunisia according to the criteria of availability, accessibility, acceptability, quality, participation, freedoms, and entitlements while adopting a gender approach. After presenting a review of the current situation, the basis for the right to health and its consolidation in Tunisian law will be assessed. This will be followed by an examination of the right to health and its application by ascertaining the status of criteria and indicators related to this right.

CURRENT SITUATION

POLITICAL TRANSFORMATIONS

In 2011, following the emergence of a popular movement, Tunisia witnessed several political transformations. The regime was overthrown, and a Constituent Assembly was elected in October of that year. However, the political environment faced several disturbances throughout the transitional period. It was subjected to several crippling social, economic, and security pressures that impacted the right to health.

A national dialogue over these difficulties and the 2014 constitution produced a new political system. Legislative and presidential elections were organized in 2014 and 2019. Nevertheless, the political crisis continued to escalate. On 25 July 2021, the President of the Republic suspended Parliament and announced a new political path that led to the promulgation of a constitution approved by referendum on 25 July 2022.

DETERIORATING SOCIOECONOMIC SITUATION

The country's economy has faced difficulties for years, especially indebtedness and deflation. According to recent Central Bank indicators, Tunisian public debt increased from 40% of GDP in 2010 to about 90% in 2020. Moreover, the economic growth rate did not exceed 0.6% over the past ten years, widening the financial gap and discouraging investment. In addition, the political situation made economic and social conditions even worse. Unemployment levels rose, particularly among women (20.5%) and higher-education graduates (30.1%) (المعهد الوطني للإحصاء في تونس 2022), resulting in the growth of informal migration (Forum Tunisien pour les Droits Economiques et Sociaux 2021). At the same time, precarious work was spreading, especially among women in agriculture. These women lack adequate health and social coverage (السفير العربي 2019) and face risks in transportation and the workplace in light of the ineffective implementation of Law No. 51 of 2019. Finally, high inflation rates led to a decline in citizens' purchasing power (البنك الدولي 2022) and a shortage of essential goods such as vegetable oil, flour, sugar, rice, and medicines.

COVID-19 deepened the social crisis. World Bank estimates for June 2021 indicated that the pandemic led the poverty rate to rise to 21% of the total population of Tunisia, compared to 15.5% before the pandemic. The poverty map in Tunisia (Banque Mondiale et Statistiques Tunisie 2020) confirmed the growing disparity between regions. The highest poverty rates were concentrated in rural areas, especially in the country's northwest and southwest regions.

The ongoing pandemic highlighted the need to strengthen efforts to address the social determinants of health as an integral part of the national, regional, and international response to social health crises. Despite the decline in severity, the pandemic's effects are still tangible. Today, Tunisia's economy continues to suffer from the repercussions of the pandemic, similar to many other countries. Moreover, the Russian-Ukrainian war exacerbated the economic crisis in the country due to global shortages in essential goods imported from the conflict zone (especially wheat).[1]

On the other hand, worldwide, global warming and climate change affect the economy in general and the social status of citizens in particular. However, they mainly impact the situation of those belonging to the poorer classes. Tunisia is not immune to this impact. Climatic changes are causing severe droughts and a decline in the water level, leading to a potable water shortage. In addition, many fires have broken out in several mountains, destroying parts of the forests in the north of the country, and threatening the interests and status of many citizens.

ACCESSION TO REGIONAL AND INTERNATIONAL TREATIES AND AGREEMENTS

Tunisia has ratified most international treaties.[2] The texts, which have become part of its legal system, are more binding than domestic laws but do not supersede the Constitution.

THE RIGHT TO HEALTH IN TUNISIAN LAW

Indeed, the right to health remains one of the most pertinent rights, requiring an examination of its establishment in Tunisian jurisprudence.

The right to health in Tunisia was enshrined and consolidated gradually, from mere care for citizens to their access to health services, to a fundamental right for all, which the state is

[1] Tunisia imports 30% of its need of durum wheat and more than 90% of common wheat. 80% of its imported grains come from the Russian and Ukrainian markets—984,000 tons from Ukraine and 111,000 from Russia.

[2] For example, the Tunisian state ratified the CEDAW 1985, which obliges the ratifying states to eliminate all forms of discrimination against women and provide ways to empower them in various political, economic, social, and civil fields. All reservations were lifted by 2014. In 1991, Tunisia was also one of the first countries to ratify the Convention on the Rights of the Child (CRC) issued in 1989. Tunisia signed the 1965 International Convention on the Elimination of All Forms of Racial Discrimination on April 12, 1966, and ratified it on January 13, 1967.

committed to guaranteeing and respecting. The Tunisian state considers health an essential sector and a right to be supported. The seeds of the right to health first appeared in the Preamble to the 1959 Constitution, promulgated at the dawn of independence. It expressed the choices of the emerging state at that time and considered health as a sector that the state should embrace and protect. However, despite its mention in the Preamble as a right for all citizens, its nature remained a matter of debate and controversy, and it did not establish a strict obligation for protection of this right by the state.

In 1974, as health concerns continued to arise, the Tunisian state established a Ministry of Public Health (MoPH) independent from the Ministry of Social Affairs through Decree 1064/1974, which defined the roles of interventions and officials in the field. Based on the decree's first article, the primary mission of the health ministry was to "watch over the health of the population to help them achieve a harmonious development of their physical and mental energies and find compatibility between them and the natural surroundings and the social environment of the country, by resisting all causes of deterioration of their physical or intellectual well-being, which may affect them individually or collectively." Thus, the MoPH would prepare the government's public health policy and planning, ensuring these are put into practice and monitoring their implementation in prevention, treatment, and occupational rehabilitation through a set of services to be enjoyed by citizens.

Article One of the Organic Law on Health Regulation No. 63 of 1991 (dated 29 July 1991) recognized the right to health. It stated that "every person has the right to protect his health in the best possible conditions." It also sought to protect fundamental human rights, especially human dignity, [3] during treatment. Furthermore, the first point in the Ministerial Circular No. 36 of 2009,[4] which adopted the Patient's Charter, established citizens' rights to protection and healthcare. It stated that:

> "*Every person has the right to protect his health in the best possible conditions without discrimination based on religion, gender, color, age, or socioeconomic status, taking into account the specific nature of some patient categories whose health situation requires priority under enforced legislation, such as emergency cases, persons with disabilities, older people, children, and pregnant women.*"

[3] Article 5 of Organic Law 63/91, dated 29 July 1991 states: "Public and private health structures and institutions must operate in conditions that guarantee fundamental human rights and the safety of patients who avail themselves of their services."

[4] Related to the issuance of the Patient's Charter.

On the other hand, the Patients Charter, required by the Circular to be posted in public and private facilities,[5] states in its first item that "every citizen has the basic right to health protection, regardless of social status, within the limits of what is guaranteed by enforced legislation." Nevertheless, unless adopted as a Ministerial Decree, the obligatory nature of the Charter remains limited to being a code of conduct that defines workflow in health structures without being strictly mandatory.

The explicit consecration of the right to health as a fundamental right was one of the features of the 2014 Constitution. Article 38 of this Constitution recognized health as a "right for every human being." As a specific right, its protection and guarantee became a state obligation. [6] Thus, Tunisian legislation has adopted the right to health, laid its foundations, and included it at the top of the hierarchy of legal texts. This constitutional nature of the right to health entails appropriate and consistent laws, meaning that no law may be adopted that diminishes or denies this right, or it would be considered unconstitutional, and could be challenged before the Constitutional Court. Furthermore, recognizing health as a fundamental right supports calls to access services and obtain treatment in appropriate conditions. It also pushes for adopting explanatory texts.

Finally, the 2022 Constitution consecrated the right to health further in Article 43, adopting the same content as Article 38 of the 2014 Constitution. According to Article 43 in the 2022 Constitution, the state guarantees prevention, care, and treatment, free to people with limited income and those who lack a supporter. It continues that the state shall provide services of adequate quality that take into consideration the situation and needs of citizens. The 2022 constitution preserved the rights stipulated in the 2014 constitution, such as the right to water, a healthy environment, protection of physical inviolability, and human dignity, supporting the right to health. In this regard, Article 24 of the Constitution considers that "the right to life is sacred. It may not be violated except in extreme cases determined by law." Article 25 adds: "The state protects the human person's dignity and the body's inviolability, prohibiting moral and physical torture. The crime of torture is not subject to a statute of limitations." These two articles implicitly refer to the right to health since the protection of the right to life and the protection of human dignity is through guaranteeing the right to health.

[5] Every health institution must place the charter's summary at patients and their companions' disposal in the reception desk, in addition to posters in highly crowded areas (such as reception hall, waiting rooms, etc.).

[6] Contrary to the 1959 constitution referring to the right to health in the preamble only, without defining the responsibilities of the state in this regard.

In addition, Article 47 of the 2022 Constitution guarantees the "right to a healthy and balanced environment." Furthermore, it adds that "the state must provide the necessary means to eliminate environmental pollution." The exact text appeared in Article 45 of the 2014 Constitution. It was considered a significant victory for Tunisia, which is one of the few countries that guarantee a safe environment in their Constitutions. Finally, Article 48 of the 2022 Constitution stresses the state's obligation to "provide clean water for all, equally," and that it "must preserve water resources for future generations," which are the elements of a sound environment and good health.

On the other hand, public health could be used to justify restrictions on rights and freedoms (Article 55 of the 2022 Constitution). For example, if public health is threatened, the legislator may adopt the necessary measures, even if these measures limit freedom of movement, freedom of trade, or the protection of personal data, such as the limitations decreed during the COVID-19 crisis. It may also entail limiting the protection of physical inviolability, such as in mandatory COVID-19 vaccines through Decree 1/2021.

ACHIEVING THE RIGHT TO HEALTH IN TUNISIA

CRITERIA

The extent to which the right to health in Tunisia is respected shall be assessed based on several criteria since its consecration entails implementing health policies, strategies, and programs according to several indicators and the necessary accountability and follow-up.

These criteria include:

- **Availability:** The state must provide facilities for public health and healthcare, as well as goods, services, and programs, according to the specific needs.
- **Accessibility:** Everyone should access health-related facilities, goods, and services without discrimination. Accessibility includes four interrelated dimensions: non-discrimination, physical accessibility, affordability, and access to information.
- **Acceptability:** All health-related facilities, goods, and services should respect medical ethics, cultural differences,[7] people's requirements throughout life, and confidentiality.
- **Quality:** All health-related facilities, goods, and services must be scientifically and medically appropriate and of good quality, achieved by providing all the necessary drugs and supplies subject to the highest quality standards; health and medical sector employees must be highly skilled and responsible.
- **Participation:** Healthcare beneficiaries should have a say and be able to make their voice heard in formulating and implementing relevant health policies.
- **Freedoms:** Individuals should be free not to be subjected to non-consensual medical treatment, such as medical experiments, forced sterilizations, torture, and other cruel, inhuman, or degrading treatment or punishment.
- **Entitlements:** People have the right, among other entitlements, to enjoy the highest attainable standard of health, prevention, treatment, disease control, access to essential medicines, and reproductive, maternal, infant, and child health.

[7] The culture of individuals, minorities, and peoples.

MANIFESTATIONS AND APPLICATIONS

Although Tunisia achieved several health gains, shortcomings remain and are growing. In 2020, for example, life expectancy at birth (المعهد الوطني للإحصاء التونسي 2021) was 75.3 years (72.7 years for males and 77.5 years for females), compared to 71.5 years in 1995 (69.5 years for males and 73.3 years for females). The development was due to improved healthcare, on the one hand, and better living conditions, on the other. However, life expectancy in 2020 was lower than in 2019 (76.3), possibly due to the COVID-19 pandemic.

National programs to combat infectious diseases eradicated deadly ailments such as malaria, schistosomiasis, ophthalmia, tuberculosis, infectious diarrhea, polio, neonatal tetanus, and diphtheria. In addition, integrated national programs for preventive and curative services were set up, making it possible to achieve reasonable coverage rates. As a result, under-five mortality rates declined (المعهد الوطني للإحصاء التونسي 2021) from 15.7 per 1,000 live births in 2013 to 13.3 per 1,000 live births in 2020. However, the gap between rural and urban settings remained (19/1,000 in the countryside compared to 11/1,000 in urban areas), as indicated by the cluster survey data (Le Ministère du Développement, de l'Investissement et de la Coopération Internationale (MDICI), l'Institut National de la Statistique (INS) et l'UNICEF 2019).

On the other hand, a rise was recorded in non-communicable diseases such as diabetes, [8] cardiovascular diseases, chronic lung diseases, and mental health ailments, pointing to risk factors [9] related to physical inactivity, pollution, and improper diets (such as those rich in sugars and salts). In addition, the number of cancer cases has also increased, with more than 19,000 new cases recorded in 2020 (The Global Cancer Observatory 2021), despite the national program to combat cancer. The leading cause of death is related to late diagnosis, which reduces the chances of survival.

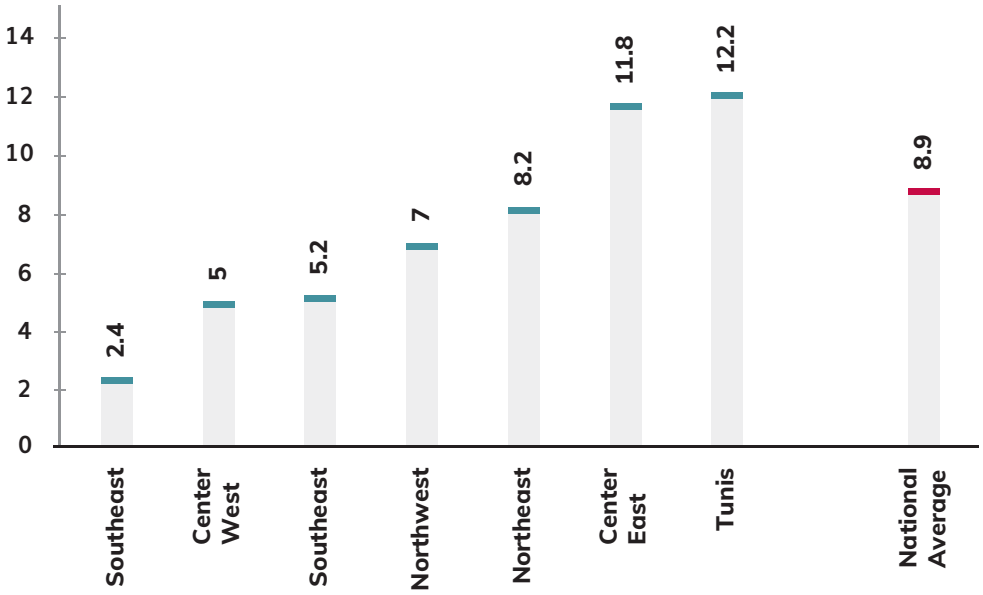
The 2016 National Health Survey (Ministère de la Santé en Tunisie et al. 2019) shows that only 8.9% of women over 30 have had a mammography in the last two years. The regional variation is striking, standing at 4% in rural areas compared to 11% in urban areas. As shown in **Figure 1**, access to the procedure is highest in Greater Tunis (12.2%) and lowest in the southeast (2.4%). Furthermore, the demand for examination is highest among women who can afford it (the wealthiest), as it exceeds 16.3%, compared to only 3% among the poorest women. This discrepancy is due to the imbalance in the

[8] According to the National Institute of Public Health, more than one in six older people have diabetes (15.5%) and more Available at this link. than one in three have hypertension (28.7%).

[9] Among those aged 15 to 17, 60% are overweight, and 30% are obese. Smoking is prevalent among more than 30% of youth.

distribution of mammography machines (Ministère de la Santé en Tunisie 2021), despite the capacity-building program in the public sector. In 2017, there were only 20 machines available in the public sector; the number increased to 28 in 2019 and covered some internal regions.

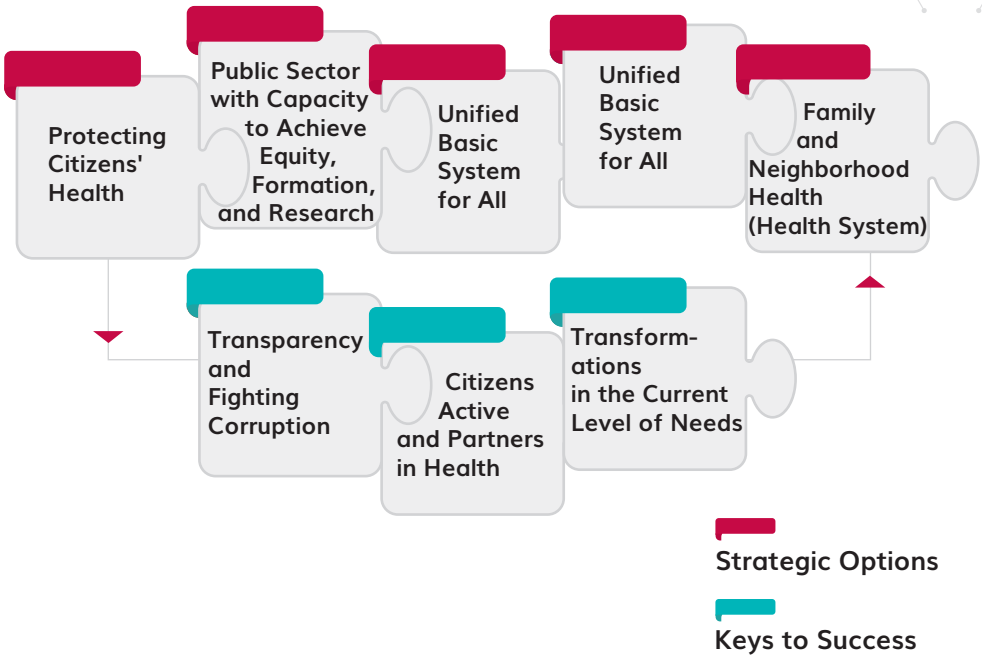
Figure 1. Rate of mammography examinations in the past two years by region (2016)



THE NATIONAL HEALTH POLICY FOR HORIZON 2030

On 7 April 2021, the National Charter for Health System Reform was signed within the framework of the National Health Policy for Horizon 2030, prepared according to the societal dialogue involving various stakeholders in the sector, including national organizations, representatives of professionals, and civil society. The National Health Policy is based on the 2030 vision for universal health coverage, inspired by universal human rights values. It would allow everyone fair access to opportunities to enhance their health and well-being in the service of sustainable development. The national health policy includes strategic options and keys to universal health coverage (**Figure 2**). The five strategic options are related to reorganizing the health system, centering it around citizens, and effectively protecting their health, in addition to fairness, solidarity, and quality in access to services. The three keys to success are adjustment in the context of guiding an increasingly complex system, transparency and anti-corruption, and citizen participation.

Figure 2. Strategic options and keys to success



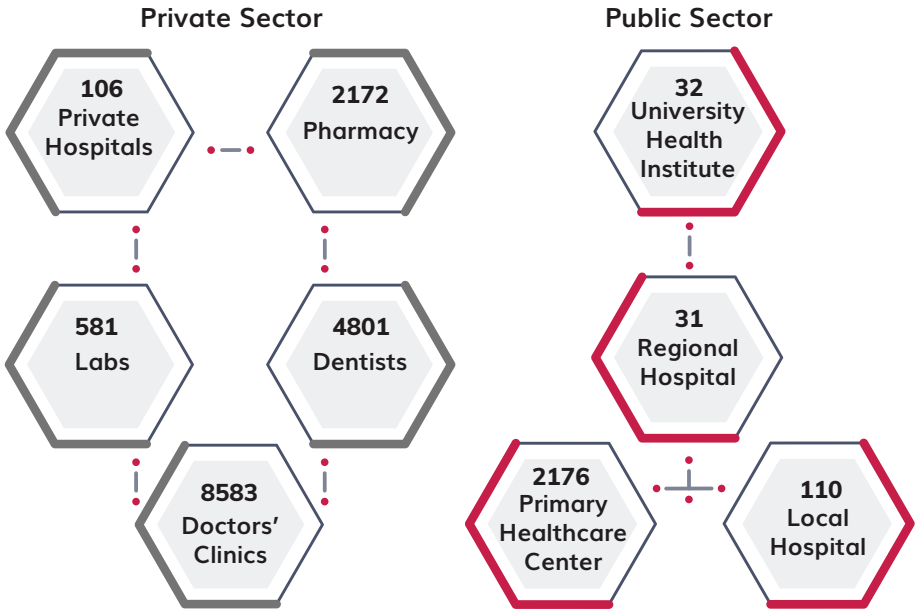
A DUAL HEALTH SYSTEM

The health system covers all territories through a public sector distributed into three lines and an active private sector (**Figure 3**). In addition, some specific services are also provided through the military, internal security services, and social security clinics.

According to Article 3 of Organic Law No.91-63 of 29 July 1991, related to health regulation:

> *"Public and private health structures and institutions provide preventive, curative, and sedative services as well as those related to diagnosis and functional rehabilitation, whether with or without accommodation, in exchange for a fee or free of charge."*

Figure 3. Organization of the health system in Tunis (2019)



The public health sector, which has witnessed continuous development since independence, provides a set of structures that guarantee adequate coverage for the population. However, it suffers from several shortcomings. In this context, Article 4 of Law 63/91 stipulates that public health structures and institutions are based on the health map, which must be reviewed periodically at the beginning of each national development plan. Nevertheless, the health map is merely a statistical guide, not a planning tool. For example, in recent years, the concentration[10] of health structures was subjected to political demands without ensuring suitability for needs and actual operational capacity.

Moreover, health departments and structures were built without ensuring the necessary human resources. As a result, these departments and structures remain unused and do not provide the necessary care. According to Article 10 of Law No.63/91, public health structures are classified by function, equipment, technical level, and territorial jurisdiction, as defined in Ordinance No.846 of 2002, and are divided into three intertwined lines.

The first line consists of primary health centers and local hospitals. Primary health centers are the entry point to the health system, providing preventive[11] and curative health services and health education. Their geographical distribution is the least uneven between the regions, set at one center for every 5,000 people, with a variation coefficient estimated at 0.94 in 2019. Nonetheless, primary healthcare centers lack health

[10] Nealy 5000 hospital beds will be added.

[11] "Protection of motherhood and childhood, including family planning, prevention and control of communicable diseases, especially through vaccination, pre-school medical services, school and university health" (Article 11 of Law 63/91).

services, which are limited to a morning session, most do not provide daily medical clinics,[12] and there are disparities between the regions.

For example,[13] primary healthcare centers in the capital, Tunis, are open throughout the week (6 working days). However, in the Medenine governorate, only 8 out of the 119 centers in the district, a mere 7%, provide daily clinic services. On the other hand, vaccination takes place in primary healthcare centers and at schools, which guarantees equality among all children, regardless of their financial ability or area of residence (in the countryside or the city, in the interior or coastal areas), reducing disparities between regions.

In addition to services provided at primary healthcare centers, local hospitals provide general medical services, maternity units for regular deliveries, outpatient clinics, emergency services, and a primary technical platform (radiology, laboratory, dental chair, and pharmacy warehouse). Beds in local hospitals and maternity units represent 10% of the total in the public sector. However, they only cover 3% of regular deliveries. The scale of the activities is so small that it can affect the maintenance of professional skills and negatively affect patient safety. In 2019, 62,742 people were admitted, a decrease of 13% from 2017. As for efficiently utilizing human and financial resources, services in local hospitals are considered high cost. Moreover, although several of these facilities were promoted into regional hospitals for various reasons, they could not meet the criteria of this transformation, leading to wasted rare professional resources available and low usage rates.

Regional hospitals (the second line) play a dual role. On the one hand, they provide nearby services to citizens and act as a reference for the first line. On the other hand, they are responsible for referral to university hospitals, when necessary, and for reducing overcrowding. However, regional hospitals suffer from a mismatch between the allocated human resources and the available equipment, on the one hand, and the uneven distribution of medical specialists between the main coastal cities and the rest of the country, on the other.

Some measures were adopted to address the shortcomings. These included developing a support program for the regions based on the voluntary contribution of university hospital doctors to ensure continuity through paid service upon request. In the same context, university hospital medical assistants must spend one year in a public health facility in health-priority regions.[14] In addition, doctors practicing in priority areas may receive patients in specially-designated clinics in the

[12] According to the data of the 2019 health map: only 20% of the centers open their clinics for 6 out of 6 days (of which more than 60% are in coastal areas), while 49% of the centers open their clinic for only one day in 6 (90% of which are in the so-called deprived states).

[13] See the first line health map for 2015 at this link.

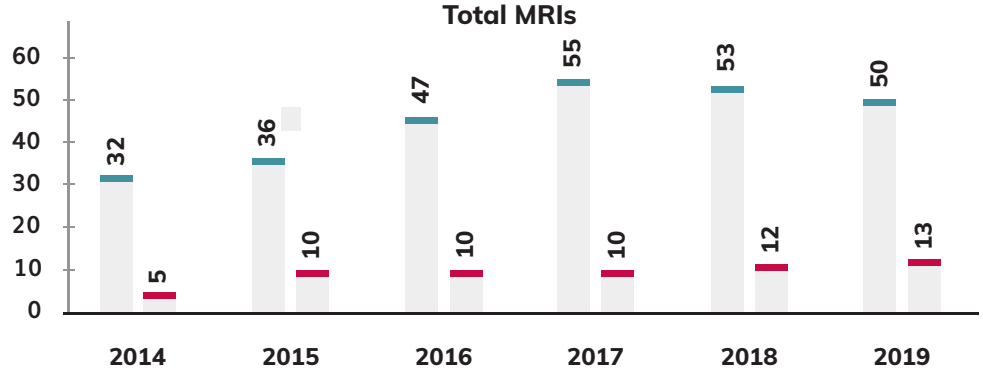
[14] Article 19 of Law 3353/2009 dated November 9, 2009, completing Law 772/2009 dated March 28, 2009, relating to the organization of medical, hospital, university staff.

institution.[15] This incentive aims to retain qualified doctors in the public sector to ensure a minimum level of quality and equal opportunity. However, it resulted in wasting public hospitals' human and material resources and redirected patients to the private sector. Moreover, many public-sector doctors licensed to undertake profitable activities are violating the regulations guiding these activities (Forum Tunisien pour les Droits Economiques et Sociaux 2021).

The primary mission of university health institutions (third line) is to provide highly specialized care. These institutions also contribute to university and post-university education (medical, pharmaceutical, and dental), the training of health professionals, and scientific research. However, given the cumulative failure of the first and second lines, this third general line is burdened with problems that could have been dealt with in the early stages, which are likely to affect the quality and continuity of care and limit the educational and training role that these hospitals are supposed to play. Furthermore, the structures of the third line are concentrated in 13 districts. They are absent in the northwest and south. Only one facility is available in the center-west (Kairouan) and the southeast (Medenine), adding to regional inequality.

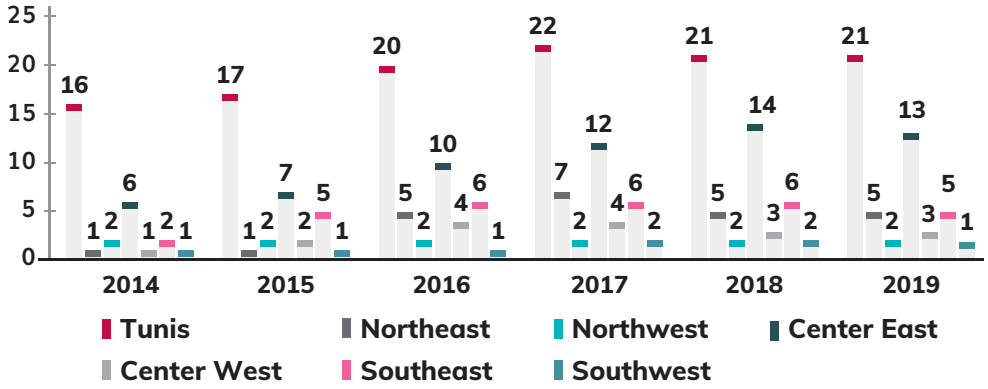
The private sector saw significant development in the last few decades[16] due to external demand, especially from neighboring countries like Libya and Algeria, and financial and tax incentives. According to the 2019 health map, the private sector employs 54% of the country's doctors, 79% of its pharmacists, and 86% of its dentists. In addition, the sector operates most of the sophisticated equipment and advanced technologies.[17] **Figure 4** and **Figure 5** illustrate the severity of disparities between the public and private sectors and among the regions through data on availability and distribution of magnetic resonance imagining (MRI) machines.

Figure 4. Availability of MRI machines (2017 and 2019 health maps)



[15] Law 2156 and 2158 dated October 17, 1994.
[16] For example, in 1987, there were 28 private clinics with a capacity of 796 beds. In 2019, the number was 106 private clinics with a capacity of 6,704 beds.
[17] For example, of the 63 MRI machines in Tunisia, 50 are in the private sector.

Figure 5. Distribution of MRIs in the private sector (2017 and 2019 health maps)



Despite their role in improving the availability of health services, most private sector facilities are concentrated in coastal districts, adding to regional disparities. For example, 61% of private hospitals are in Greater Tunis (43), Souse (7), and Sfax (15).

Article 17 of the 2022 Constitution states, "The state guarantees coexistence between the public and private sectors and works to achieve integration based on social justice." Law No. 49 of 2015 defines the general framework for partnership between the public and private sectors. Health professionals in the private sector (doctors, pharmacists, dentists, and technicians) can practice in public health structures, specifically in priority areas, according to the salary scale (which is a weak financial incentive).[18]

Presidential Decree No. 318 of 2022 also recognizes the possibility of medical cooperation between the public and private sectors when practicing telemedicine.[19] However, this partnership remains limited today without agreements between the two sectors. Still, there are some signs of cooperation, such as the measures against the COVID-19 pandemic, where free vaccination took place in pharmacies and involved some doctors and dentists voluntarily.

Justice in the distribution of services remains a theoretical goal to be achieved. However, specialized health services provided by the private sector remain concentrated in coastal cities at the expense of the interior regions. For example, the only hospital specializing in tumors and cancerous diseases is in the capital, though surgery is possible in some other hospital departments. Thus, those living outside the

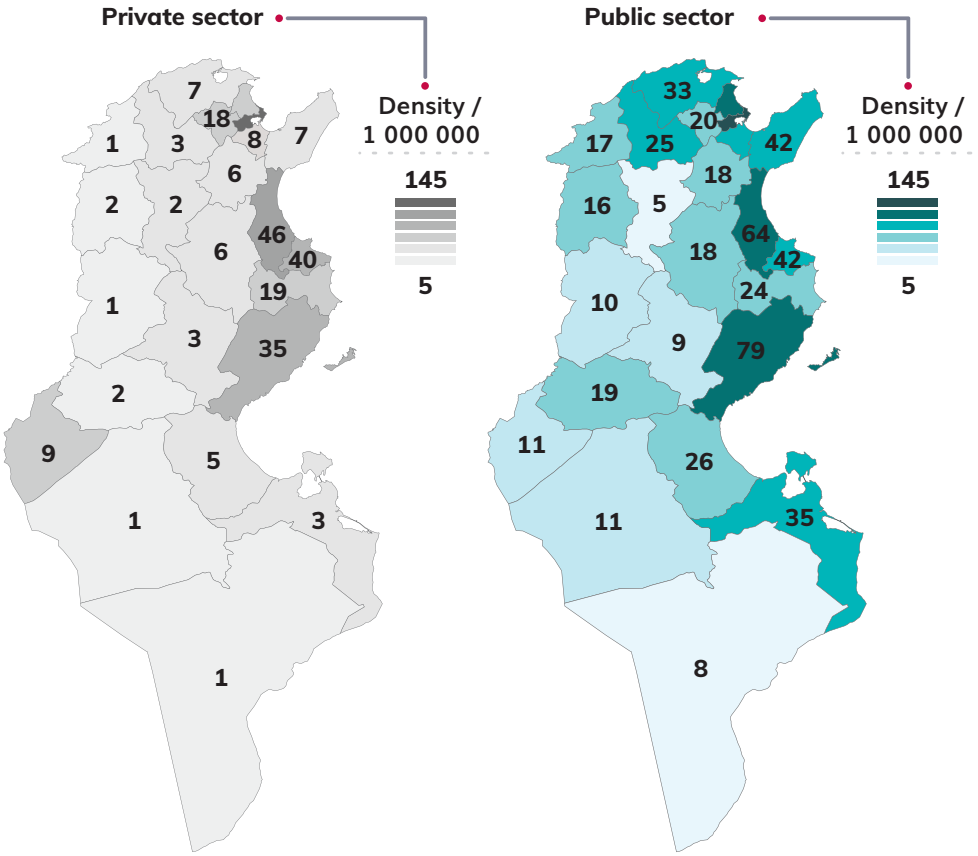
[18] Decree issued by the ministers of finance and public health dated 14 March 1992, defining the requirements, remuneration, and duration of practice for doctors, pharmacists, dentists, and senior technicians directly in the free sector in the public health structures, as revised and completed by the March 9, 1995, December 24, 2009, and December 31, 2015, Decrees.

[19] Article 20 states that "Telemedicine is carried out in the public and private sectors within the framework of a platform, or within the framework of medical cooperation between public health facilities, between a public health facility and another public facility, or between a public health facility and a private health institution."hospital, university staff.

capital face difficulties accessing health services. Moreover, the concentration of these services in one hospital leads to overcrowding and poor quality (long waiting times for appointments and long waiting times in clinics).

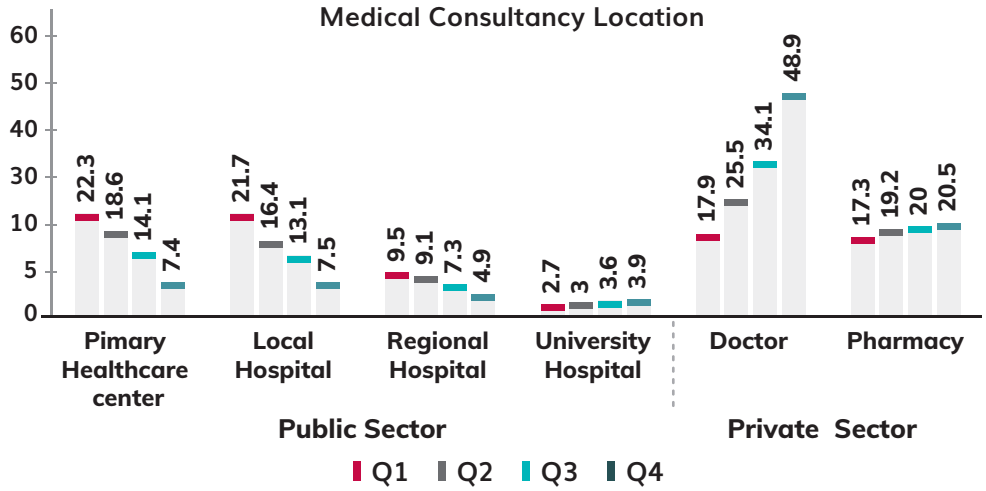
Many studies documented regional disparities (Banque Africaine de Développement 2014), such as in investigations carried out in the framework of the societal dialogue in 2014 (Le Comité Technique du Dialogue Sociétal 2014a). Imbalances and disparities also appear in the distribution of health professionals, in particular of specialized doctors, whose number exceeded 5,407 in the private sector, compared to 2,318 in the public sector in 2019. Notably, the number of health professionals in the private sector increased, while that in the public sector decreased compared to 2018 (5,212 in the private sector and 3,005 in the public sector). The decline is due to the growing emigration of physicians, especially in recent years, exacerbating the disparity between the two sectors and regions (**Figure 6**) (Forum Tunisien pour les Droits Economiques et Sociaux 2021). Furthermore, with the improvement in incomes more doctors are attracted to the private sector (Banque Mondiale 2016).

Figure 6. Proportion of specialized physicians per 100,000 residents



Differences in economic and social status, whether on an individual basis or between regions, increase disparities in access to health services, as indicated by a study conducted by the Tunisian Forum for Economic and Social Rights in 2021. The study found that the location of medical consultation is linked to wealth (expenditure segments) (Forum Tunisien pour les droits Economiques et Sociaux 2021). Moreover, a study conducted in 2015 on financing care for poor and low-income groups showed that these groups tend to use primary healthcare centers and local hospitals due to their geographical proximity compared to other facilities, which entails travel and additional expenses (**Figure 7**).

Figure 7. Choice of medical consultation facility according to expenditure bracket



Source: National Survey on household expenditures, consumption, and livelihoods, 2015

SEXUAL AND REPRODUCTIVE HEALTH: GAINS AND CHALLENGES

Family planning in Tunisia has always been a fundamental approach in politics and health. For decades, the country was an example to follow in reproductive and sexual health. Polygamy was abolished in 1956, and the right to abortion was allowed at a later stage. In 1965, married women with at least five children were allowed abortions upon their husbands' consent. The law was amended in 1973 to allow terminating pregnancies for all women in the first trimester, regardless of their civil status and the number of children they have. The law also enabled women to terminate a pregnancy outside the first three months and without any time limit in the event of a threat to the mother's physical and mental health or an expected risk to the newborn's health.

In this regard, Tunisian law is considered to be advanced compared to some Arab, Islamic, and even some developed countries. The procedure is conducted in public health and family planning centers for free or in the private sector for a fee. Doctors must ensure the mother's prior and informed consent, regardless of the father's consent. However, the consent of a guardian is required for minors.

Nonetheless, the actual application of this right has faced several difficulties in the past few years due to refusal by health professionals to perform the procedure or lack of required medication. Disparities by region and socioeconomic status are also present, as indicated in a 2022 study (انكفاضة 2022). Furthermore, a study by the National Office for Family and Human Population in 2020 (UNFPA et al. 2020) showed that 60% of nurses, 50% of midwives, and 30% of doctors in primary healthcare centers in rural areas are against abortion for religious reasons.[20] Total rejection is increasing in such centers in the south of the country. In the same context, single women are considered the most vulnerable to discrimination in the right to abortion. Testimonies refer to the humiliation and "moral lessons" that single women undergoing abortions are subjected to in some health institutions (Maffi 2022). In the face of this refusal, some women resort to the private sector, where violations are registered. They include disrespecting the actual cost of the operation, encouraging the most profitable surgical abortion, and sometimes performing abortions after three months without a health cause.

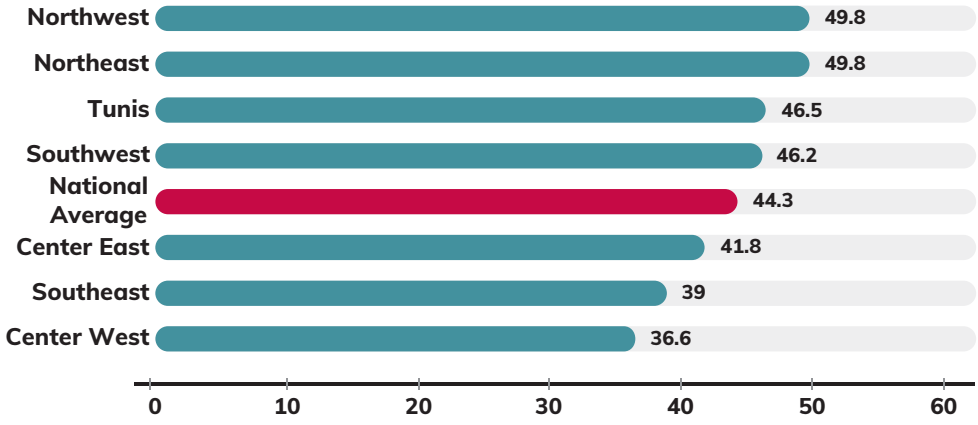
Although years have passed since the establishment of the right to abortion, there is a lack of knowledge about services that provide abortion free of charge among young people. A study by the TAWHIDA Ben Cheikh group found that around 50% of young people do not know that abortion is available and legal in the first trimester of pregnancy (53% of young women and 43% of young men said that abortion was illegal) (Groupe TAWHIDA Ben Cheikh Recherche & Action pour la Santé des Femmes 2019).

Since independence, Tunisia has pursued a policy of family planning and birth control. In the early 1960s, the colonial-era law forbidding the advertising and sale of contraceptives was repealed. The first family planning campaign was launched in 1966. Mother and childcare centers and permanent and mobile family planning centers affiliated with the National Office for Family and Human Population were established to reach rural and remote areas. Awareness campaigns were conducted, and contraceptive methods were provided to women for free.

[20] The religious and ideological components were emphasized as a reason to refuse abortion in the cited study.

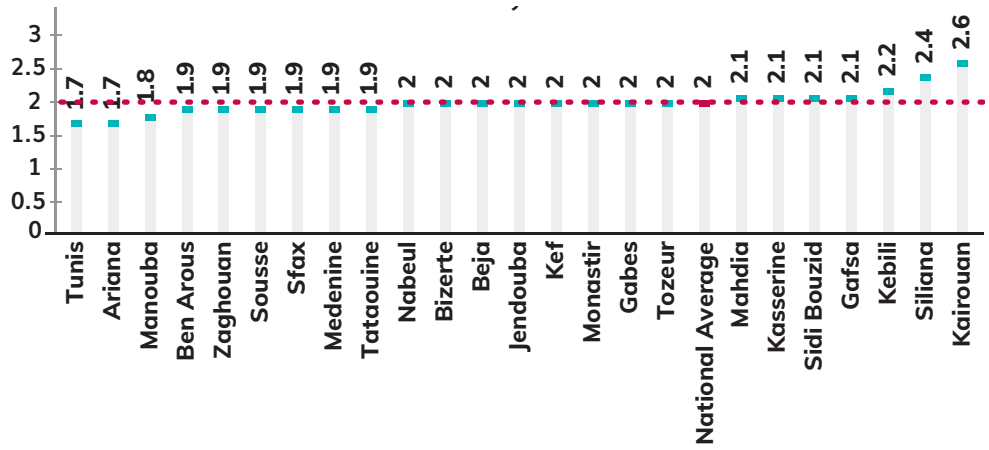
The 2019 cluster survey data also indicated that the rate of demand for family planning using modern methods, monitored through SDG 3.7.1, is estimated at 62.8% (61.4% in urban and 65.7% in rural areas). The use of modern contraceptive methods shows a disparity with data available from the authorities, as shown in **Figure 8**. The intrauterine device is the most used method in urban areas (21.9%). In rural areas, the pill is the most used method (21.2%) (UNICEF 2019). The difficulties encountered in accessing contraceptive methods are similar to those related to abortion.

Figure 8. Use of modern contraception (2019)



Due to these measures, fertility rates in 2020 (**Figure 9**) were close to replacement rates, estimated at two children per woman during her fertile age,[21] despite some regional disparities (L'Institut National de la Statistique 2020).

Figure 9. Fertility rates (2020)



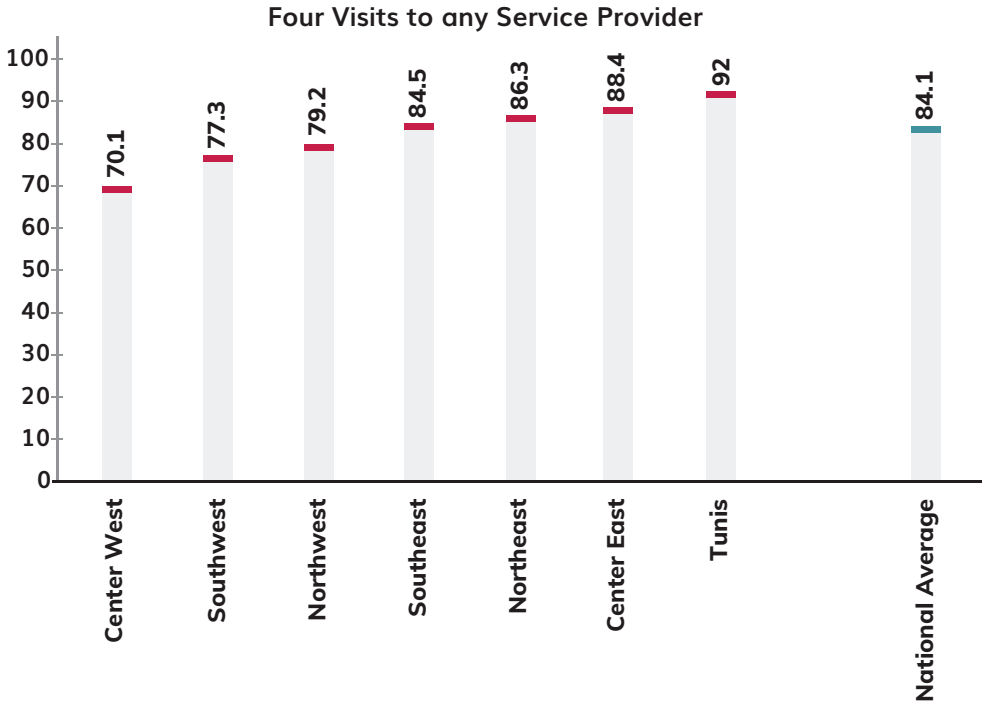
Reproductive health also includes monitoring pregnancy and post-partum follow-up through the National Plan to Reduce Maternal Deaths. These services are provided for free in Mother

[21] Every woman between 15 and 49.

and Child Care Centers, Family Planning Centers, and Primary Healthcare Centers and for a fee in the private sector[22] (UNFPA et al. 2018). Thus, 84.1% of women between 15 and 49 years received four or more checkups by qualified health workers during their most recent pregnancies (**Figure 10**). However, according to the 2019 Cluster Survey, access to these services varied between urban (88.5%) and rural areas (76.6%). Regional disparities were more pronounced in western regions, where women's access to pregnancy monitoring clinics was the lowest (UNICEF 2019).

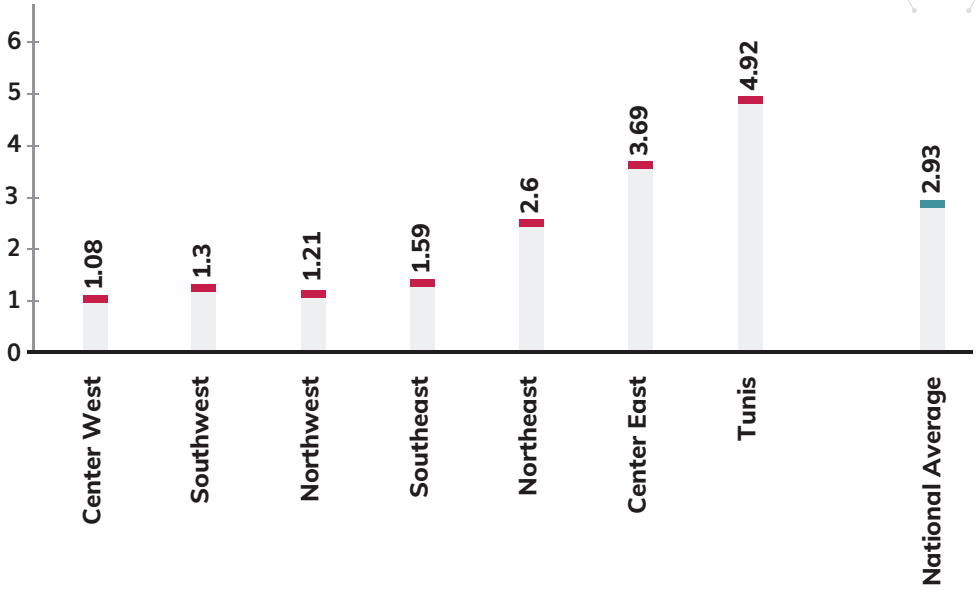
On the one hand, the above situation is due to the working hours of public health facilities, which coincide with working hours. Women who need to visit the clinics could lose a day's work and their daily wages. On the other hand, those areas do not have enough obstetricians, whether in the public or the private sector. While the national average is 2.93 obstetricians for ten women of fertile age, regional disparities are enormous (**Figure 11**). According to the 2019 Demographic Health Map, the average for the district of Tunis is 4.92 per 10 women. However, it drops to 1.08 in the center west (Ministère de la Santé en Tunisie 2019).

Figure 10. Percentage of women receiving four or more checkups by qualified health workers during their most recent pregnancies



[22] For those with social security, 150 Tunisian Dinars are added to the annual ceiling, which does not cover the 5 recommended clinical visits for pregnancy follow-up.

Figure 11. Average number of obstetricians per 10 women of fertile age (2019)



More than 99% of women between 15 and 49 were assisted by qualified health staff during live births. A similar number applies to deliveries in health facilities without significant disparities between rural (99.2%) and urban (99.7%) regions. However, cesarean births were more prevalent in urban areas (46.4%, compared to 37.7% in rural areas). The discrepancy is attributed to the higher number of specialists in urban areas and affordability. The 2019 Cluster Survey indicated that 58% of women from the wealthiest families prefer cesarean sections, compared to 32.5% of women from the poorest families.

Nevertheless, surveys reveal a significant decline in the proportion of breastfeeding women. According to the 2019 Cluster Survey, only 13.5% of women resorted exclusively to breastfeeding. The percentage was as low as 5% in the northwest. Wehile women staff and workers in the public sector are granted[23] maternity leave and paid "nursing" breaks for an additional six months after giving birth, allowing them to arrive to work one hour late and leave one hour early, this right does not extend to women in precarious sectors who get paid on a daily basis, such as those working in agriculture.

THE HEALTH SECTOR AND PROTECTION FROM VIOLENCE AGAINST WOMEN

The health sector may also contribute to protecting women from violence through prevention and early detection. The law on violence against women prescribes[24] a role for the MoPH

[23] Article 48-bis of Law 83/97, dated 20 December 1997.

[24] Law 58/2017 dated 11 August 2017 on the elimination of violence against women states in its first Article that "this law aims to put in place measures to eliminate all forms of violence against women based on gender discrimination in order to achieve equality and to respect human dignity, by adopting an integrated approach based on addressing its various forms through prevention, monitoring and punishing the perpetrators, and protecting and entrusting the victims."

in supporting women victims of violence and establishing an integrated policy to combat such practices and provide the necessary care.[25] In theory, the law was a significant gain for Tunisian women. Through its text, lawmakers intervened to combat violence against women and protect them from all forms of violence (physical, moral, sexual, and political). It also ensured the establishment of an integrated system for women victims of violence, including healthcare.[26]

Due to the vulnerability of women victims of violence, their preliminary medical reports are provided for free. They are also exempt from paying hospital deposits and provided with payment facilities when discharged, [27] specifically in the case of spousal violence, based on Circular 39 of 2014. In 2022, Circular 5/2022 expanded[28] the list of women who could benefit from the above to include women victims of violence. However, obtaining the preliminary report, which proves the harm, still requires an endorsement from a police station. The cooperation of security forces is not guaranteed[29] since, contrary to the law, units specialized in violence against women have not been established in all security facilities. Similarly, the stipulation of employing women to interview victims is not respected in several facilities.

Associations and NGOs are also highly involved in protecting women victims of violence since most public institutions do not have the financial capacity to provide services and shelter for victims. These associations play an essential role in sheltering women victims of violence and their children in secure locations. They also offer mental health services, legal support, and guidance on filing criminal complaints or civil claims for compensation or divorce. Volunteer lawyers provide the latter services for women in difficult financial situations. A report by the Ministry of Women, Children and Seniors points to the significant contribution of associations and NGOs of most services to women victims of violence during the COVID-19 pandemic in 2020 and the related lockdown (2021 وزارة المرأة والأسرة وكبار السن التونسية).

HEALTH SERVICES WITHOUT DISCRIMINATION

According to Article 19 of the 2022 Constitution, discrimination on any basis is a crime punishable by law."[30] In this regard, Law

[25] Article 8: "The Ministry in charge of health shall set up integrated programs to fight violence against women in medical and paramedical teaching, as well as covering the training of health workers at all levels to detect and evaluate all forms of violence against women and its prevention, examination, treatment, and follow-up to support women and children under their care. It shall also establish spaces for receiving victims of violence and providing them with health and mental health services."

[26] A framework convention was signed between the relevant ministries, including the MoPH. See link.

[27] Circular 39/2014 relating to the free initial medical certificate for women victims of intimate partner violence, and the facilitation of procedure for obtaining medical examination and residency fees.

[28] Joint Circular 5/2022 issued by the Minister of Health and the Minister of Women, Children, and Seniors, dated 14 March 2022.

[29] Article 10 of this law states: "The Ministries of Justice and Interior shall establish integrated programs to combat violence against women in teaching and training in the institutions under their jurisdiction, in order to develop methods to deal with complaints and cases of violence against women."

[30] Article 19 of the 2022 Constitution states that "Public administration and all state services are available to the citizen based on impartiality and equality. Any discrimination between citizens because of any affiliation is a crime punishable by law."

No. 71 of 27 July 1992, related to communicable diseases, states in its first article that "no person can be subject to discrimination in treatment in the field of prevention or treatment of communicable diseases." Moreover, Decree No. 1155 of 17 May 1993, relating to the physician's duties, states that patients must be treated without discrimination. Furthermore, the Patients Charter[31] refers to the need for non-discrimination in its first point. It states that "every person has the right to protect his health in the best possible conditions without discrimination because of his religion, sex, color, age, or socioeconomic status."

The Constitution calls for the mandatory protection of specific groups: children,[32] women,[33] older people,[34] and people with disabilities.[35] The Patient Charter also seeks to protect vulnerable groups whereby it stipulates the need to "take into account the privacy of some groups of patients whose health condition requires priority under the legislation in force, such as urgent cases, people with disabilities, older people, children, and pregnant women."

Directive Law No. 83 of 2005, related to the advancement of persons with disabilities, also affirms the protection of this group from all forms of discrimination[36] and the need to provide the necessary mechanisms to monitor disabilities and develop scientific research in the field of disability and prevention, which is a way to protect the health of citizens. In addition, the state guarantees social welfare and free treatment or treatment at a low cost for persons with disabilities.[37] Finally, the decision by the public health and finance ministers, issued on 25 April 2006, set the cost of treatment, residency in public health facilities, prosthetics, and rehabilitation for persons with disabilities who meet the conditions for free or low-cost treatment."

On the other hand, Law No. 114 of 1994 protects older people by "protecting their health and guaranteeing their dignity"[38] and "resisting all forms of discrimination and exclusion in the family and social milieu." They also benefit from "social and health services at their place of residence" or "old people's homes, which must provide adequate sanitary conditions." Moreover, older persons "who benefit from social and health services at their residence are also exempted from contributing to the costs of these services."[39]

[31] Government's Circular N° 2009-36 relating to the Patients Charter.
[32] Article 52 of the 2022 constitution: "The state protects the rights of the child and takes care of abandoned children or those of unknown parentage. The rights of the child depend on the parents, and the state must guarantee dignity, health, care, and education. The state must also provide all kinds of protection to all children without discrimination according to the best interests of the child."
[33] Article 51 of the 2022 constitution: "The state commits to protecting women's established rights and works to strengthen and develop those rights. The state guarantees equal opportunities for women and men to access all responsibilities and domains. The state seeks to achieve parity between women and men in elected councils. The state takes measures to eliminate violence against women."
[34] Article 53 or the 2022 constitution: "The state guarantees assistance to elderly people without support."
[35] Article 54 of the 2022 constitution: "The State protects persons with disabilities against all discrimination and takes all appropriate measures to guarantee their full integration into society."
[36] According to Article 1 of the law herein.
[37] Article 15 and 14 of the law herein.
[38] Article 2 of Law 114/94.
[39] Article 16 of the law herein.

The National Program to Control acquired immunodeficiency syndrome (AIDS) and sexually transmitted infections (STIs) focuses on providing prevention and care services for groups most vulnerable to human immunodeficiency virus (HIV) infection. These include intravenous drug users, sex workers, men who have sex with men, prisoners, and immigrants. The services include education, distribution of prevention tools, prophylactics, and clean syringes through associations financed by the Global Fund. In addition, the state provides free treatment in four medical centers.

The 2007 revision[40] of the 1992 Law on Communicable Diseases[41] approved the possibility of conducting an anonymous voluntary test for HIV and other communicable diseases. The measure is expected to encourage those infected or suspected of being infected to visit health centers and use clinics anonymously, where doctors are not required to divulge their patients' names. However, despite the free treatment, the availability of means of prevention, and the gradual transition towards new services such as the provision of Dolgitravir DLG and Pre-Exposure Prevention (PrEP) services, the targeted groups are still victims of stigma and discrimination by service providers, which makes access to services difficult and leads to high rates of lack of access to services.

MULTIPLE COVERAGE AND FINANCIAL DIFFICULTIES FACED BY VULNERABLE GROUPS

The health sector has enjoyed significant support since independence. It was primarily oriented towards free treatment. In the 1990s, however, it experienced a fundamental transformation through the Health Regulation Law. The law retracted the option of universal free care and began to distinguish between free and low-cost users. It aimed to secure revenues to allow hospitals to become financially independent.[42] Today, the law guarantees the right to treatment, free of charge for some vulnerable groups and at a low cost for others. All Tunisians in need, their spouses, and their children under their care[43] are assigned a free treatment and hospitalization card to be used in public health facilities. Free treatment is also provided to all resistance fighters,[44] soldiers,[45] internal security officers,[46] and customs officials.[47] In addition, the right to free treatment was accorded to those injured in the 2011 Revolution.[48]

[40] The law was amended on February 12, 2007.
[41] Law 71 dated 27 July 1992, relating to the above STIs.
[42] Primarily institutions with legal personality, that is, public health institutions.
[43] Article 1 of Decree 1812/98 on the requirements and methods of issuing and acquiring the free health card.
[44] Law 9/74, dated 9 March 1974, relating to reforming the pension scheme for resistance fighters.
[45] Law 20/67, dated May 31, 1967, on the general status of military personnel.
[46] Law 70/82 of 6 August 1982 on the general status of the internal security forces, amended and supplemented by Law 58/2000 of 13 June 2000.
[47] Law 46/95 of 15 May 1995 on the general status of civil servants, amended and complemented by Law 102/96 of 18 November 1996.
[48] Decree No. 2011-97 of 24 October 2011 on compensation for martyrs and wounded of the revolution of January 14, 2011 (Article 8 - Paragraph 2).

The 2022 Decree also set forth the right to free treatment and care for victims of terrorist operations, including military personnel, internal security officers, civil servants, and those entitled to justice among the martyrs and wounded of the Revolution.[49] In addition to free treatment in public facilities, the decree also allowed referral to private facilities or abroad based on a medical committee's recommendation.[50]

Finally, Decree 409 of 1998 grants low-income families the right to low-cost treatment if they are not covered by a social security scheme. However, although such schemes cover more than four out of five people, about two million remain without coverage. According to Part 3 of the 2015 National Survey on Household Budget, Consumption, and Standard of Living, 16.7% of the population did not benefit from health coverage and 0.5% of the population did not answer the survey (Statistics Tunisia).

SICKNESS INSURANCE SCHEME

Social health insurance was established in the 1950s. The first compulsory health insurance system in the public sector was established in 1951, extending to the private sector in 1960. In 2004, a compulsory sickness insurance scheme was established for those benefiting from social security and dependents[51] based on "principles of solidarity and equality within the framework of an integrated health system that includes services provided by the public and private health sectors."[52]

The scheme determined medical and paramedical specializations and tasks, medications, machinery, and health transportation expenses incurred by grassroots systems, administrations, and services requiring prior approval.[53] The grassroots sickness insurance system covers health services according to the beneficiary's preferred[54] formula[55] under an annual ceiling.[56] Following is an overview of the systems available to social security beneficiaries:

[49] Decree 22/2022 of 9 April 2022 concerning the Fidaa Foundation for the support of victims of terrorist attacks among the military, internal security forces, and civil servants, as well as beneficiaries among the martyrs and wounded of the revolution.

[50] Article 11 of Decree 20/2022 of 9 April 2022 states that "Victims benefit from free healthcare in public and military health facilities and those under the responsibility of internal security forces and customs, in accordance with an agreement concluded for this purpose with the Fidaa Foundation. The Fidaa Foundation may, if necessary, cover the costs of care in private health facilities or abroad based on the advice of a competent medical committee. The right to care includes all types of treatment, psychological support and the acquisition of medication as well as medical devices and prosthesis facilitating reintegration".

[51] Non-divorced spouses who do not benefit from compulsory health insurance, children of social health insurance beneficiaries including: minor children provided that they do not benefit from compulsory health insurance, girls regardless of their age as long as their guardian's obligation does not fall on their husbands or as long as their husband does not have a source of income, children with a disability rendering them incapable of carrying out a remunerated activity and who do not benefit from compulsory health insurance in case of illnesses in respect of their activity, beneficiaries of a survivor's pension under a legal social security scheme and who do not enjoy compulsory health insurance in respect of their activity, and dependent relatives not subject to compulsory health insurance.

[52] Article 1 of Law 71/2004.

[53] Joint Decision Between the Minister of Social Affairs and the Minister of Public Health on 13 April 2007.

[54] The choice of health plan remains valid for at least one year as long as a request to change it is not submitted before September 30 of each year. Beneficiaries who do not declare a preference are registered in the public system.

[55] According to Article 4 of Decree 1376/2007.

[56] On 8 February 2021, Article 2 of the Minister of Social Security decision sets the annual ceiling at 300 Dinars for beneficiaries with no dependents, 375 Dinars for beneficiaries with 1 dependent, 450 Dinars for beneficiaries with 2 dependents, 525 Dinars beneficiaries with 3 dependents, 600 Dinar for beneficiaries with 4 dependents or more. Pregnant women enjoy free external health services related to pregnancy follow-up up to 150 Dinars throughout the pregnancy.

- **Public Medical Health System:** This system enables social security beneficiaries to access all external treatment services provided by public health facilities, the military hospital, and social security clinics, according to paying party's formula and payment of the difference.
- **Private Medical Health System:** Social security beneficiaries may choose a family doctor contracted with the Fund in this system. However, the system obliges beneficiaries and their registered dependents to visit the contracted doctor before visiting other practitioners unless the clinics are exempted from referral.[57] Moreover, beneficiaries who contract a severe or chronic disease from the designated list[58] may visit specialists directly without referral by the family doctor. Incurred expenses are paid by the Fund based on the chosen formula. In that case, social security beneficiaries pay the difference based on the contractual tariff[59] and percentage of coverage. The Fund is obliged to pay the difference directly to the service providers.
- **Reimbursement System:** The reimbursement system enables social security beneficiaries to be treated by contracted public and private health service providers. Accordingly, beneficiaries pay the total amount of the contractual tariff and then apply for reimbursement.

Hospitalization in public or private facilities is based on the same conditions and procedures regardless of the treatment scheme. For example, the National Fund for Sickness Insurance (CNAM) covers all hospital stays in public hospitals up to the scheme's ceiling. In private clinics, however, CNAM covers surgeries based on the specified official list[60] and deliveries. In this case, beneficiaries must obtain CNAM's prior approval. A range of outpatient therapeutic services such as scans and MRIs, medical machines, particular medicines, and hemodialysis are also uniformly covered.

The WHO (2023) estimated public spending on health in 2019 at 4570 million Dinars,[61] equivalent to 3.9% of GDP, 57.1% of health expenditures, and 12.6% of total government expenditures.[62] This public money comes mainly from CNAM (51.3%), followed by the state budget (7.48%). The percentage of public spending on health is less than the approved recommendations,[63] although public health spending falls within the framework of the state's commitment to perpetuating

[57] Ophthalmology, pediatrics, gynecology, and dentistry.
[58] Joint Decision between the Minister of Social Affairs and the Minister of Public Health on 25 June 2007 defining a list of 24 chronic illnesses that are entirely taken care of by the National Health Insurance Fund.
[59] Governmental Decree381/2021-381 of 4 May 2021 amending Decree 2007-1367 of 11 June 2007.
[60] Joint decision between the Minister of Social Affairs and the Minister of Public Health dated 29 June 2007. Governmental Decree N°. 2021-318 of May 4, 2021 amending Decree N°. 2007-1367 of June 11, 2007 defining the formulas, procedures and percentages of health services coverage within the basic National Health Insurance Fund Framework. See link.
[61] Domestic General Government Health Expenditure GGHE-D.
[62] Domestic General Government Health Expenditure (GGHE-D) as % General Government Expenditure GGE.
[63] According to the Abuja Declaration, public spending on health should be at least 15% of government spending.

the right to health and providing the health system with the necessary resources for quality health services and achieving equity.

Consequently, public health facilities suffer from an imbalance between increasing tasks,[64] political pressures, and public demands on the one hand, and the failure to provide the required financial resources, recent liquidity problems,[65] and the ceiling set for each public health facility on the other hand. However, the recently established Public Health Support Fun [66] provided additional funding to patients holding free or low-cost treatment cards.

HIGH RISKS IN DIRECT HEALTH PAYMENTS

In 2019, out-of-pocket (OOP) spending by households accounted for 37.9% of current health expenditures (CHE) compared to 42.5% in 2005 (WHO 2023).[67] The decrease could be due to the health system's coverage. However, the rate remains high, increasing the risk of catastrophic spending[68] and falling into poverty for the most vulnerable groups.[69] In addition, the inability to cover the costs could lead some to avoid the necessary treatment and fall into a spiral of illness and dangerous complications that may be more expensive. The increase in OOP spending is due to several factors. They include the unavailability of all services in the public sector and their high cost in the private sector, even for those with social security who have to pay the difference,[70] reducing their access to health services.

RIGHT TO HEALTH INFORMATION AND PRIVACY

The 2014 constitution recognized the right to access information protected by a state institution.[71] It also established the right to health. Their dual application leads to the right to access health information. The only limitation is found in another constitutional principle regarding the protection of privacy and personal data. Consequently, the 2014 Constitution[72] and prior[73] and later laws established the right of all citizens to access health information as long as it does not violate the protection of personal data.

[64] Equitable access to quality care for all and in all areas, with training of health professionals and development of research.
[65] The liquidity squeeze is due to the non-transfer of sickness insurance contributions by the National Social Security Fund and The National Fund for Retirement. Debt accumulated due to structural deficits within the pension systems, despite the direct deduction of contributions in the public sector since 2017 according to Law 47/2017.
[66] Government Decree 383/2019 and 381/2019.
[67] Out-of-pocket (OOP) spending as a % of Current Health Expenditure (CHE)
[68] Approximately 200,000 people in 2014.
[69] More than 100,000 people in 2014.
[70] Under the Private sector and Reimbursement systems.
[71] Access to Information Authority.
[72] The 2022 constitution maintained the principles herein.
[73] The 2004 Law on the Protection of Personal Data.

Doctors are required to inform patients of everything related to their illness, diagnosis methods, and treatment. Although the right to information is not enshrined in the Physicians Code, many of its articles lead in that direction.[74] Most prominently, the code defines cases where doctors may refrain from informing patients, such as fatal and urgent cases. In addition, the dentists' Moral Code and the law regulating pharmacology adopted the same principles.[75]

The right to information was also addressed in some texts. For example, the law related to communicable diseases obliges doctors to inform patients of the infection,[76] its symptoms, and its risks.[77] It also obliges health professionals to inform the health authorities tasked with such cases. The notification is compulsory, and its violation entails a penalty.[78] However, it considers the "privacy of voluntary, anonymous examinations."

Furthermore, the Doctors' Duties Code emphasizes the respect of obligatory notifications. The Patient Charter also recognizes the right to information. Finally, the presidential decree on telemedicine stressed the need to respect patients' right to information and obtain their free, informed consent.[79]

QUALITY ASSURANCE AND CONTROL

The third clause of the Patient Charter stipulates that "health facilities and institutes [are obliged to welcome patients and their companions and provide them with the best possible services while respecting their rights and freedoms." Moreover, the Doctors' Duties Code prohibits the practice of the profession in circumstances that may prejudice the quality of treatment and medical work, except when justified by the patient's interests.[80]

Quality is monitored through internal structures set up at the MoPH. They include medical supervision, pharmacy supervision, and financial and administrative control. On the other hand, CNAM monitors the quality of services provided by its contracted health professionals.

On 6 September 2012, Decree No. 1709/2012 established the National Health Accreditation Authority. The Authority was charged with developing the quality of services through "the

[74] Articles 35 and 36. Article 36 lays out the cases where the prognosis may be concealed from the patient. Or by interpreting several provisions contained in this code that regulate the freely given informed consent of patients to therapeutic or non-therapeutic trials (Article 106 to 111 of Decree No. 1155/93 on 17 May 1993 relating to the obligations of doctors).

[75] Law No. 73-55 of 3 August 1973 on regulations of pharmaceutical industry, amending and supplementing the Law No.76-31 of 4 February 1976, Law No. 76-62 of 12 July 1976, Law No. 89-24 of 27 February 1989, Law No. 89-101 of 11 December 1989, Law No. 92-75 of 3 August 1992, Law No. 2008-32 of 13 May 2008, and Law No. 2010-30 of 7 June 2010.

[76] Law 71 of 27 July 1992, amended on 12 February 2007.

[77] Article 6.

[78] Articles 7, 8, and 17.

[79] Article 21 of the presidential decree No. 318/2022 of April 8, 2022, setting the general conditions of practice of telemedicine and its application fields. "Before performing any telemedicine work, the free and informed consent of the patient or his legal guardian must be obtained, after informing him of the necessity, importance, results and scope of that work, in addition to the means designated for carrying it out."

[80] Article 4.

external evaluation of the functioning of public and private health institutions and their services and applying accreditation procedures by independent experts." Article 3 of this decree establishes the need to "set rules, standards, and procedures for good professional practices in all phases of prevention, detection, and treatment, and approving them, including setting quality standards that must be available in the health sector."

Government Decree 792/2020 assigned the Authority the additional task of "evaluating health technologies and interventions" and considered it "the only national structure for assessment and accreditation in the health field." The above allows it to conduct international evaluations "according to international evaluation and accreditation standards and the principles of neutrality, transparency, and integrity." Moreover, the Authority has already established 24 treatment paths and professional recommendations, albeit optional and unmonitored. Thus, safety and quality in the health sector were enshrined in 2016 through a system to manage the quality of services in 31 health facilities (16 public and 15 private).

The Accounting Department also prepares an annual report that monitors financial and quality of service violations, including in public and private health services. For example, report 32 indicated that monitoring private institutions (by mandated structures) is lacking with regards to "establishment and installation of heavy and radioactive instruments." It also mentioned the "lack of oversight over hygiene, hospital waste, medicines, and medical supplies in those facilities." On the other hand, the Audit Court identified several violations in private hospitals related to sterilization, maintenance, and medical and hospital waste disposal.

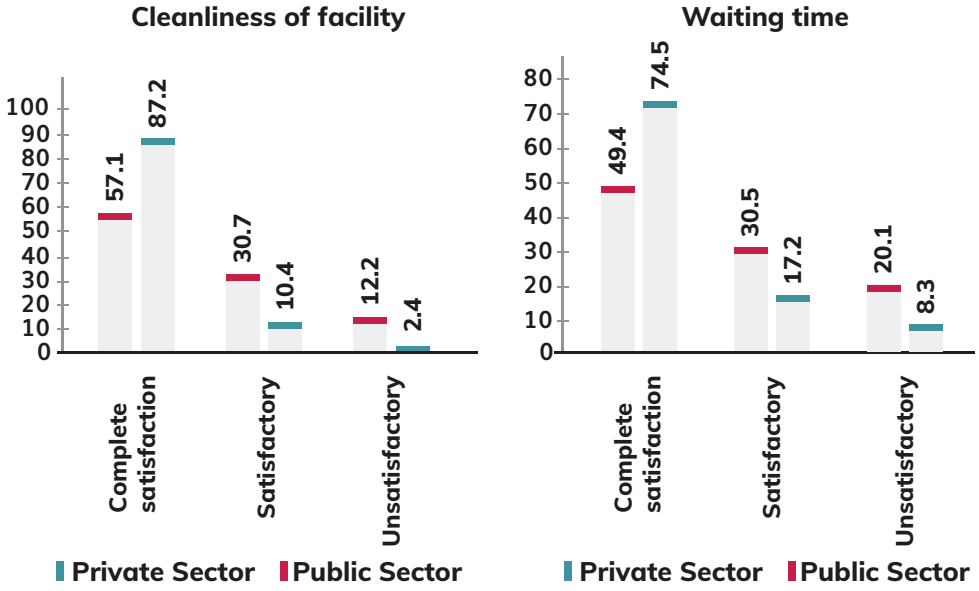
Several factors impede the health sector's response to individual and social needs. The excessive centralization of decision-making and the decline in the MoPH's role in providing services could be the most prominent. The existing healthcare system is fragmented, uncoordinated, and not wholly digitized. It focuses on curative services and neglects prevention. Moreover, public sector services are provided in a limited timeframe. For example, outpatient clinics are only open in the morning. Finally, public health facilities remain less attractive due to a lack of organization and governance.

In 2017, research in areas targeted by the European Support Program highlighted the lack of services, predominantly medication, and difficulties obtaining additional checkups. Sessions usually involve many patients, and appointments for specialized consultations need to be booked far in advance. The

research also registered dissatisfaction with available services (including ER, reception, communication with staff, waiting time, the long booking time for specialized consultation, and infrastructure issues).

The above results confirm the findings of a 2016 survey[81] where users above 15 were asked about their satisfaction level with various health services and facilities (**Figure 11**). The survey found that 13.1% of users were unhappy with the time spent in the waiting room. The dissatisfaction was much higher in the public sector (20.1%) than in the private sector (8.3%). In addition, 6.4% of patients mentioned problems related to the facility's cleanliness. Dissatisfaction with public facilities (12.2%) was also higher than with private ones (2.4%).

Figure 12. User satisfaction with healthcare facilities (%)



Several reports[82] documented the mistreatment of patients, the lack of respect for their data, the difficulty in obtaining medical records, the loss of paper medical files, the lack of communication between different departments of the same hospital or between hospitals, and the presence of bacteria, which could spread to many.

MANIFESTATIONS OF CORRUPTION AND INEFFICIENCY

The health sector in Tunisia has some of the highest corruption levels (UNDP 2011), whose impact falls on vulnerable groups. Field studies have shown the prevalence of bribery,

[81] Surveys on 7 elements: (1) waiting time between arrival at the health facility and treatment (2) general respect for the patient by health personnel (3) clear explanations given by the doctor (4) participation in decisions about care or treatment (5) respect for confidentiality (6) selection of health workers and (7) cleanliness of the health facility. See link.

[82] For example: see link. (Link is invalid)

corruption, and nepotism in the health sector when obtaining appointments, treatment, and medicine. Moreover, public deals and employment processes do not always consider the needs of health structure facilities. Thus, In November 2016, a project to "Strengthen Democratic Governance and Public Accountability in Tunisia" was launched in the public health sector (برنامج الأمم المتحدة الإنمائي 2020).

The project followed a diagnosis of the sector's governance. The first stage focused on evaluating corruption risks in various services provided by public facilities and the drug supply chain. The second stage established a model experience for developing governance and combating corruption through the "islands of integrity" approach.[83] The "*Sehha*" (health) project, signed between the MoPH, the US Embassy, and the International Center for Private Enterprises (CIPE), is also concerned with the same issues. As a result, the CIPE monitored corruption and governance needs in the health sector in a report issued in October 2021 (WEBMANAGERCENTER 2021).

There is also a trend towards excessive medical treatment in the public and private sectors, such as cesarean sections, representing 43.2% of all deliveries (46.4% in urban areas and 37.7% in rural areas) due to profit opportunities.[84]

TUNISIA DURING COVID-19

Like the rest of the world, COVID-19 was included in the list of communicable diseases to control and limit its spread.[85] Tunisia adopted a dynamic strategy to combat the pandemic based on the epidemiological situation, the spread of the virus on the national level, and its socioeconomic dimensions. It established coordination mechanisms based on several committees.[86] Several measures were adopted regarding border health control, monitoring incoming passengers, full and partial curfews, [87] and banning travel between cities. On the other hand, it enhanced its investigative activities, testing in the public and private sectors, and patient care and vaccination capacities. [88] These measures were implemented despite the absence of a proactive strategic plan and the sector's

[81] Surveys on 7 elements: (1) waiting time between arrival at the health facility and treatment (2) general respect for the patient by health personnel (3) clear explanations given by the doctor (4) participation in decisions about care or treatment (5) respect for confidentiality (6) selection of health workers and (7) cleanliness of the health facility. See link.

[82] For example: see link. (Link is invalid)

[83] This experiment included 3 hospitals: Rabat University Hospital, Jendouba Regional Hospital and Djerba Regional Hospital. After evaluation, the experiment will hopefully be implemented in other health structures.

[84] According to the recommendations of the World Health Organization and UNICEF, the percentage of cesarean deliveries should not exceed 10% to 15% in any country.

[85] According to Governmental Decree 152/2020.

[86] A multi-sectoral national body was first established comprising the relevant ministries and chaired by the prime minister, and a scientific committee under the supervision of the MoPH, which provided scientific opinion to the national body and sub-committees in the MoPH. Operation rooms were then established to manage the COVID-19 pandemic by Presidential Decree No. 77/2021 under the leadership of the Director General of Military Health and with the participation of some ministries.

[87] A total lockdown was approved from March 22 to May 4, 2020.

[88] For example, the number of intensive care beds in the public sector was increased from 96 in September 2020 to 504 in June 2021.

structural problems, particularly in public facilities. Moreover, the response was partially digitized through the "*e7mi*" (protect) application, which monitored the infected population to reduce spread, and the EVAX platform to organize vaccination, which allowed setting vaccination priorities, transparency in implementation, and reducing nepotism.

As each wave peaked, the state suffered from poor material and human capacities, preventing public health facilities from treating COVID-19 patients in appropriate conditions. Thus, the health sector received global support[89] from international organizations, other states, and civil society organizations. They provided the needed support to public facilities, either directly (medical equipment, oxygen concentrators, and PPE) or by donating to a special fund.[90]

The COVID-19 pandemic also shed light on the inflexibility of regulatory texts related to public procurement, which hinders the health sector from responding promptly and effectively in times of crisis. Current regulations require submission to the Public Procurement Law, which establishes complex procedures and slows the acquisition of medical supplies. However, public procurement rules do not conform to the medical field's needs, and the speed facilities require to respond to crises.

COMMUNITY PARTICIPATION AND THE ROLE OF CITIZENS

Tunisian law includes many texts establishing good governance in several fields, including health. For example, Framework Decree No. 120/2011 aims to "combat corruption in the public and private sectors, in particular by developing efforts for its prevention, facilitating its detection, ensuring that perpetrators are tracked and deterred, and supporting the international effort to limit corruption, reduce its effects, and work to recover its revenues." Article 1 of the Decree emphasizes the participatory dimension in combating corruption.[91] Another example is the Government Decree regarding the creation of the "Citizen Oversight" team, which assigns citizens a role in monitoring the quality of services (including health).[92]

Community participation in health matters was established through the social dialogue involving the sector's various participants, including the ministries, national organizations,

[90] A special account (06) was established for the COVID-19 response, called the Prevention and Response to Health Epidemics (Fund 18-18), by the Finance Minister's Decree on 25 March 2020, amended on 22 July 2020 and 9 November 2020. See link.

[91] Article 3: "The state guarantees the inclusion of combating corruption as a main theme in human, economic, and social development programs based on an approach that is (1) comprehensive, directly or indirectly covering all areas of intervention, (2) participatory, allowing the mobilization of all social potentials from individuals, organizations, and the public and private sectors, (3) interactive, enabling the exchange of information among the various stakeholders and coordinating their efforts.

[92] Government Decree No. 1072/2016 of August 12, 2016, amending Decree No. 147/93 of 18 January 1993, creating the "citizen oversight" team.

professional associations, and prominent civil society components. Arbitration committees were chosen from among participating citizens in both stages of the dialogue. They presented their recommendations (Le Comité Technique du Dialogue Sociétal 2014b) to the national seminars in September 2014 and June 2019. The WHO considered the initiative a pioneering experience and an example to be followed (WHO 2019). The dialogue was supposed to be institutionalized in the framework of health law and the promotion of citizen participation in monitoring the National Health Policy's implementation.

RECOMMENDATIONS FOR UNIVERSAL HEALTH COVERAGE

ACCELERATE THE IMPLEMENTATION OF THE NATIONAL HEALTH POLICY

The indirect and specific measures urgently taken in recent decades did not change the situation, and instead, in some cases, created more problems. Thus, the achievement of the constitutional right to health requires a policy "that adopts references to respect for human dignity, fairness, quality, and solidarity, and represents the basic values on which it is built" (مشروع السياسة الوطنيّة للصحة في أفق 2030 2019). However, the policy's strategic options and keys to success are contingent on major political decisions, which entail consultations with the concerned parties and arbitration processes without prejudice to the complementarity between the options. Therefore, the directive law for health must be issued to legitimize these options and avoid tensions.

In this context, the Health Sector Development Plan 2023-2025 chose four main intervention spheres: prevention and health promotion, developing health services and health insurance coverage, developing the pharmaceutical sector, and the leadership and governance of the health system. The plan is a phased implementation mechanism for the National Health Policy.

The aforementioned plan and policy inspire many of this paper's recommendations. However, the National Health Policy focuses on current priorities in the Tunisian health sector, mainly covering solutions and measures clearly and efficiently supporting the right to health.

ADOPT THE ONE HEALTH APPROACH

The state's general policy must prioritize health and sustainable development by including health in all sectoral policies and integrating human, animal, and environmental health in health strategies. In addition, awareness and prevention programs must be boosted[93] to protect health, reduce the spread of diseases, and limit their impact on the state's economy. For example, activities could include providing "public spaces suitable for positive health practices and behaviors such as

[93] Implement existing strategies, for example: the National Strategy for the Promotion of Mental Health and Combating Addiction and the National Multisectoral Strategy for the Prevention of Noncommunicable Diseases and its Action Plan for 2020-2025.

walking, sports, and recreational activities for children" and educating young people on health-friendly behavior (2030 مشروع السياسة الوطنيّة للصحة في أفق 2019). In addition, awareness and educational programs should encourage citizens to detect fatal diseases like cancer at an early stage.

ENHANCE HEALTH SECURITY

The COVID-19 pandemic demonstrated the critical nature of the health sector and the need to prepare a comprehensive and integrated national strategy for prevention, response to disasters and health emergencies, and monitoring through international health regulations. The continuous availability of essential medicines must also be ensured. The role of Tunisia's Central Pharmacy must be strengthened. Furthermore, drug security must be promoted through the local pharmaceutical industry, including vaccines.[94] Finally, a legal framework is required for dealing with health crises and emergencies.

IMPROVE THE AVAILABILITY OF QUALITY HEALTH SERVICES BASED ON NEED

According to the National Health Policy, "it is necessary to make family and neighborhood health the focus of the health system and to ensure the provision of a set of high-quality basic services for all" (2030 مشروع السياسة الوطنيّة للصحة في أفق 2019). These choices are expected to improve availability over time, fulfill health needs throughout the life cycle, and facilitate appointments remotely, reducing overcrowding and improving reception conditions, especially in public health facilities.

A unified, integrated digital health record[95] must be adopted to reduce the spread of bribery and nepotism. It entails using family and neighborhood health as the main entrance to the healthcare system through a close-contact network linking the public and private sectors. It also requires establishing a regulatory framework for family medicine, institutionalizing it with incentives, and strengthening continuous training and undergraduate curricula. Telemedicine[96] is also a way to enhance coordination and integration between different service providers. Moreover, to ensure quality, oversight of all health institutions (private and public) must be strengthened and subjected to a system of evaluation and gradual accreditation. Finally, accreditation must become mandatory, which would upgrade services and improve their quality.

[94] The WHO selected Tunisia as a candidate for the coronavirus vaccine industry. A feasibility study was carried out and production was decided to be in the form of a public-private partnership (PPP).

[95] Some public hospitals started using digital medical records and the MoPH is preparing a decree in this regard, a step forward towards transparency, fighting corruption, and improving quality.

[96] Presidential Decree No. 318/2022 of 8 April 2022, setting the general conditions of practice of telemedicine and its applications.

ENSURE ACCESS TO HEALTH SERVICES BASED ON NEED THROUGHOUT A PERSON'S LIFE CYCLE

Reproductive and sexual health must be strengthened in the primary health package by ensuring that the rights guaranteed by law are protected and supported in practice. These include the right to abortion and access to contraceptives while continuing to adopt the family planning and health education approach pursued since independence by providing the necessary financial and human resources in coordination with civil society organizations.

Breastfeeding should also be encouraged through ongoing media campaigns to raise awareness of the issue. Furthermore, the circular banning the promotion of formula milk in public and private health structures must strictly be applied with its related penalties.

In addition, the provisions of Law No. 58, establishing an integrated system to combat violence against women, must be implemented. It includes establishing medical briefing centers in all health facilities to cover all forms of violence against women while continuing to provide listening services by health professionals and expediting tests and certificates. In this context, the training of health professionals in caring for women victims of violence must be accelerated and increased.

An effective monitoring system medicines and their path and how they are used must be introduced. The consumption of generic drugs could also be encouraged. In parallel, citizens must be educated about the dangers of self-prescribing (especially antibiotics) and the need to rationalize consumption, which would benefit citizens' health and the country's economy.

PROVIDE MORE EQUITABLE HEALTH SERVICES

A universal basic system for all would allow benefiting from health services without entailing financial risks. It involves integrating those who enjoy free or low-cost treatment through CNAM with informal sector workers. In parallel, a complementary insurance scheme would cover treatments not included in the basic universal system.[97] The basic system would be funded sustainably by expanding the contribution base and taxes earmarked for health. In this regard, the Public Health Support Fund should be enhanced, and its administration handed over to CNAM. On the other hand, the "*Aman*" and

[97] Article 19 and 20 of Law No. 71/2004.

"*Labas*" cards could be expanded to cover the health sector, allowing control over actual expenditure and further efficiency. It could also help to find radical solutions to the pensions scheme so that the CNAM can obtain its dues and recover its debt from various health service providers.

PROTECT THE RIGHTS OF PATIENTS AND PROFESSIONALS

A draft law was prepared to enshrine patients' rights and medical responsibility,[98] which adopts patients' rights unequivocally. It also defines health professionals' civil and criminal liability under specific rules that consider professional requirements. Most prominently, the draft law states the following:

> *"In addition to the patients' rights stipulated in this law, health professionals, facilities, and institutions must take into account the rights enshrined in the Constitution, the treaties and agreements ratified under the legislation in force, and the rights contained in special texts related to some segments of patients such as children, older people, people with disabilities, and those with mental illnesses."*

The draft also sets the scope of the right to be informed in Article 15, which states:

> *"The treating doctor or dentist must inform patients, their legal guardians, or representatives before the various examinations, proposed treatments, and necessary preventive measures. They must listen to their opinion and honestly inform them of the possibilities, methods, and means available for treatment and the systematic and grave risks associated with the condition."*

This text also enshrines the principle of participation, recognizing the involvement of professional associations in some decisions (such as determining the composition of some committees).

In 2015, a draft law was prepared to protect health professionals from violence in health facilities. It establishes criminal penalties for attacks against doctors and health staff in public health facilities while performing their duties. The draft also aims to reduce violence, which would improve conditions and, thus, the quality of services.

[98] It was discussed by successive health committees in the House of Representatives, and a vote was imminent. However, the changes in the political system and the suspension of Parliament on July 25, 2021, prevented the decision.

Nevertheless, a fundamental law must be issued to organize biomedical research, adopting regulations to protect the bodily sanctity and human dignity of patients and anyone who undergoes such experiments.[99]

ENGAGE AND EMPOWER PATIENTS AND CITIZENS

The National Health Policy includes some recommendations to make citizens active partners in health. The recommendations include establishing listening units and committees of health facility users, representatives of health professionals, and the administration to enhance communication between the various stakeholders. Civil society organizations could also play an essential role in the matter. In addition, citizens must take ownership of the health service and feel responsible for public facilities and maintenance. This feeling of belonging and responsibility could be developed by involving citizens in decision-making, providing them with a space to express their opinions, and allowing their participation in running health facilities through representation in its governing bodies and boards.

PROVIDE HEALTH PROFESSIONALS WITH INCENTIVES

The COVID-19 pandemic reminded everyone of the crucial function of the health system. Thus, its health professionals must be encouraged and supported through continuous professional development. They should also be incentivized to perform and innovate, providing them with the needed equipment. Best practices, processes and standards developed by the National Committee for Health Assessment and Accreditation should become the reference framework for their activities, which must be protected to reduce the temptation of corruption.

BUILD AN EFFECTIVE HEALTH SYSTEM BASED ON GOOD GOVERNANCE

The right to health is achieved by strengthening the MoPH's leadership and corrective role. Services must meet quality standards and the requirements of users and health professionals. On the other hand, some decisions and actions must be handed to local and regional structures through

[99] A related draft law brings together the various texts and unifies the rules applicable in this field.

decentralization. The 2023-2025 Development Plan suggests several examples of activities in this regard:

- Develop a forward-looking health map and review health-regulation texts to update the roles of the three lines and include regional health hubs;
- Develop a Health Gazette to ensure the coordination and the integration of legal texts, which are numerous[100] and vary in obligatory powers,[101] leading to confusion and difficulties when provisions intersect or contradict each other. The situation calls for a Health Gazette to develop the health sector's legal framework;
- Establish the National Agency for Medicines and Medical Supplies to improve their flow;
- Support partnerships between the public and private sectors (PPPs) by establishing transparent and framed cooperation formulas to reduce regional disparities and conflicts of interest.

Digitization is the most effective means to ensure good governance and combat corruption. Therefore, planned projects related to hospital information systems in all public facilities must be expedited, along with expanding the digital platform for vaccination by integrating children's and seasonal influenza vaccines for adults.

PROVIDE THE HEALTH SYSTEM WITH THE REQUIRED CAPACITY

The health system's performance could be enhanced by providing financial resources. Therefore, the MoPH's budget should be raised and geared towards performance. In addition, public financing could be mobilized by expanding the contribution base, raising tax allocations for health, and establishing efficient PPPs. On the other hand, the needed human resources could be mobilized by developing capacities and supporting training in all fields, especially new professions. Furthermore, public service in health facilities should be organized by law, and scientific research must be encouraged. Finally, special texts should be adopted regarding public procurement related to health, considering its specific requirements and the speed of acquisition.

[100] More than 700 legal texts.
[101] Varying between Texts, Laws, Decisions, Decrees.

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