World Health Organization

Country Cooperation Strategy *at a glance*

Tunisia

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Total population (2004)[1]	**9 910 872**
% under 15 (2004)[1]	**26**
Population distribution % rural (2005)[2]	**35.1**
Life expectancy at birth (2004)[3]	**73.4**
Under-5 mortality rate per 1000 (2004)[4]	**25**
Maternal mortality ratio per 100 000 live births (1994)[5]	**68.9**
Total expenditure on health % GDP (2004)[6]	**5.9**
General government expenditure on health as % general government expenditure (2004)[6]	**7.1**
Human Development Index Rank, out of 177 countries (2003)[7]	**89**
Gross National Income (GNI) per capita US$ (2004)[8]	**2630**
Adult (15+) literacy rate (2000-2004)[1]	**79.4**
Adult male (15+) literacy rate (2000-2004)[1]	**87.9**
Adult female (15+) literacy rate (2000-2004)[1]	**71.8**
% population with sustainable access to an improved water source (2002)[7]	**91.3**
% population with sustainable access to improved sanitation (2002)[7]	**80**

Sources:
[1] General census of the Tunisian population 2004: Report of the National Institute of Statistics Tunisia
[2] United Nations Population Division
[3] Report on the Tunisian population projection 1999 – 2029- the National Institute of Statistics Tunisia
[4] World Health Report 2006
[5] Maternal mortality survey 1994
[6] Mid-term evaluation report from the 10th development plan: Ministry of Economical Development and International Cooperation
[7] Human Development Report 2005
[8] World Development Indicators 2005 (World Bank)

Tunisia has an area of 154 350 km² divided into seven large socioeconomic regions with 24 governorates and 263 administrative delegations. The coastal regions cover a third of the country, with 67% of the population and 90% of industrial activity[a]. Improvements in living standards have resulted in demographic and epidemiologic transition.

Since the Structural Adjustment Plan (1986), Tunisia has sustained remarkable economic development with progressive liberalization and integration into global markets (General Agreement on Tariffs and Trade (GATT), 1990; European Union (EU) agreement, 1995)[b]. The country moved from an agricultural (wine, wheat, oils) and minerals (phosphates production) economy to diversification and industrialization. Although there has been dynamic resurgence in growth, development is concentrated in the coastal regions with inequalities in western and southern regions and in disadvantaged rural and periurban areas. Education, health and the environment are Government priorities. By 2015, Tunisia should achieve almost all the United Nations (UN) Millennium Development Goals (MDGs).

HEALTH & DEVELOPMENT

Health system is efficient and effective despite modest resources; improvements in all health indicators have been achieved. The public sector provides 66% of consultations and 90% of hospitalizations in basic health-care facilities and university hospitals, but it is less effective at regional (reference) hospitals. Management remains centralized despite decentralization efforts; the private sector has grown since the 1990s. The Government's financial contribution has remained almost steady while household contributions have increased. The current reform of the health insurance system will involve compulsory coverage for basic health services. Inequalities in the improvement of health indicators are based on geographical disparities in economic and social development, and vulnerable groups (women, children, adolescents, elderly people).

Communicable diseases have declined. With adequate control measures, indigenous cases of bilharzia schistosomiasis and malaria disappeared 20 years ago and measles, neonatal tetanus and poliomyelitis are in the pre-eradication or eradication phase; the number of HIV/AIDS cases has been stable since 1990.

Maternal and child health have greatly improved but regional disparities persist. Remarkable reductions in national maternal and infant mortality rates have been achieved. Coverage rates for antenatal and postnatal care, attended deliveries and immunizations have improved nationwide following implementation of maternal and child health programmes within the basic healthcare framework (SSB programme). Higher rates of maternal mortality, anaemia in women and children, perinatal mortality, diarrhoea and acute respiratory infections in under-fives persist in rural and deprived suburban areas and in the western and southern regions. Women are fully recognized as social development partners; the average age of marriage and the proportion of single adults have risen.

Noncommunicable diseases are increasing; cardiovascular diseases are the first cause of adult mortality followed by cancers, accidents and injuries. Hypertension, diabetes and stroke are the major causes of death in women with excess mortality rate for hypertension (11.3% versus 6.4% in men) and diabetes (8.1% versus 5.7%). Excess mortality in men is seen for ischaemic heart disease (6.6% versus 3.4%), pulmonary diseases (5.1% versus 2.7%), lung cancer (5.2% versus 0.6%) and traffic accidents (6.2% versus 1.6%).

Lifestyle factors involve health risks. Overweight and obesity are higher in adult women (62.5%) than in men (48.3%)[c] and twice as high in urban areas, as is the prevalence of diabetes (6.7% versus 3.6% in rural areas). The overall prevalence of smoking is estimated at 30% (52.8% men, 5.2% women),[d] but is decreasing in educated young people.

Environmental health is a government priority, focusing on scarce water resources, air pollution, waste management, chemical safety, cleanliness of recreational areas and food safety. A Ministry and National Agency are responsible for pollution control and waste management and a multisectoral Agenda 21 and a national strategy for health and environment.

Economic growth is remarkable but the population remains young (average age 28.34 years); the proportion of 15–19 year olds has increased, causing demands on the job market. Unemployment is high among young people and in women more than men, with regional disparities; western regions have higher rates particularly in some provinces (Beja, Siliana, Le Kef, Kasserine, Gafsa and Tozeur)[e].

[a] *Bilan commun de pays.* Tunisie. New York, Nations Unies, 2001.
[b] Country profiles 2003, Tunisia. London, The Economist.
[c] *Évaluation de l'état nutritionnel de la population*. Enquête nationale de nutrition, 1996–1997. Rapport. Tunis, Institut National de Nutrition, 2000.
[d] Fakhfakh R, Hsairi M, Maalej M, Achour N, Nacef T. Tobacco use in Tunisia: behaviour and awareness. *Bulletin of the World Health Organization*, 2002, 80(5).
[e] *Enquête nationale sur la population et l'emploi*. Tunis, Institut National de la Statistique, 1999.

OPPORTUNITIES	CHALLENGES
• Health Insurance System reform • Network of Basic Healthcare Centres readily accessible nationwide • The Free Medical Assistance scheme covers the poverty-stricken and low income populations (Health Card I and II respectively) • The 10th Economic and Social Development Plan.	• Maintaining achievements in healthcare despite reduced financing • Strengthening public sector capacity for stewardship, policy making, strategy, planning, training and research • Achieving equitable access to healthcare, particularly for vulnerable populations and attaining all MDGs • Measures to reduce high out-of-pocket payment • Establishing regulatory mechanisms for healthcare provision in public and private sectors • Improving quality of care and patient referral system in the public sector • Protecting scarce water sources and avoiding contamination of surface water from pollution.

PARTNERS

Increasing gross domestic product (GDP) and improving social indicators reduced Tunisia's eligibility for external aid. Most cooperation will be as loans and technical partnerships. Various international organizations and UN agencies and other international organziations are present in Tunisia (FAO, IOM, UNDP, UNFPA, UNICEF and UNIDO). The World Bank supported hospital reform and sectoral investment in 1992-1996.

The main sources of external finance for health are the European Investment Bank, Islamic Development Bank and the Saudi Development Fund. Bilateral partners include the European Union-Mediterranean Economic Development Aid (MEDA) programme and technical cooperation with Argentina, Belgium, Bulgaria, China, France, Germany, Islamic Republic of Iran, Italy, Mali, Niger, Poland, Senegal, and South Africa.

Cooperation with Arab and Maghreb countries, either bilaterally (Algeria, the Libyan Arab Jamahiriya, Mauritania, Morocco, the Syrian Arab Republic, etc.) or multilaterally (Arab League and the Arab Maghreb Union) led to the development of action programmes in these regions.

OPPORTUNITIES	CHALLENGES
• Long history of bilateral cooperation with countries in different regions • The WHO Mediterranean Centre for Vulnerability Reduction (WMC) contributes to global and national health development.	• Harmonization and coordination of international aid for health development.

WHO STRATEGIC AGENDA (2005-2009)

WHO will contribute strategically to strengthen the health system through advocating health promotion policies, providing technical leadership and enhancing the stewardship capacity of the Ministry of Public Health (MoPH) to work with other partners in making the health system more responsive to the needs of the population.

- **Strengthen the health system** to preserve and promote the country's public health objectives in the context of economic liberalization and openness. Strengthen MoPH information management and strategic analysis capacity, define policies and communication, and regulate the public and private sectors ensuring adequate public-private mix. Support the Health Insurance Reform particularly in relation to the information system (ensuring compatibility with health information system), the planned observatory, financing and methods of payment of providers. Provide support to specific aspects of organization, financing, access to drugs and vaccines, and quality of services based on equity, effectiveness and efficiency.

- **Respond to the health challenges of the Tunisian people** presented by the socioeconomic, demographic and epidemiological transitions. Support the MoPH in its efforts regarding adolescents, young people and the elderly, chronic and degenerative diseases, and risk factors. Improve the knowledge base, provide guidelines, support development consensus over treatment protocols, and promote innovative approaches such as population laboratories. Promote healthy lifestyles and create supportive environments for health through promoting healthy cities and villages.

- **Promote partnership and advocacy for health** including intersectoral collaboration and beyond the country. Supporting MoPH establishing dialogue with other Ministries and public institutions, civil society, the universities and the media; establishing national and international partnerships.



ADDITIONAL INFORMATION

WHO country page **http://www.who.int/countries/tun/en/**
EMRO country profile page **http://www.emro.who.int/emrinfo/index.asp?Ctry=tun**