HEALTH SITUATION

Life expectancy at birth is among the highest in Africa and the Near East. Nevertheless, there are regional disparities: life expectancy is higher in coastal regions than in western and southern regions. The mortality rate is changing very slowly due to a combination of decreasing fertility and an ageing population.

The epidemiological and demographic transitions, taken together, have brought about a profound structural change in the national morbidity profile and ranking of causes of death, with a concomitant decrease, indeed the elimination of, a number of communicable diseases (the incidence of water-borne diseases is very low, and measles, poliomyelitis and neonatal tetanus are in the eradication or pre-eradication phase). There has also been a significant decrease in under-five mortality. Non-communicable diseases (NCD) now account for a higher proportion of morbidity and causes of mortality, representing 60% of the burden of disease according to WHO (NCD profile 2011) and accounting for almost five sixths of all deaths (82.3% according to WHO’s overall estimate for 2015). All the Millennium Development Goals have been met except for MDG 5 (maternal mortality).

Tunisia’s main challenge is to effectively control the increase in NCDs including chronic NCDs (partly linked to the ageing of the population), such as cancer, diabetes and cardiovascular diseases, while working to reduce regional health disparities. In doing so, the country has to especially focus on significant and persisting socio-economic and geographic disparities in health outcomes.

HEALTH POLICIES AND SYSTEMS

Human development has long been a government priority and this was re-emphasized in 2014, when health was instated as a right in the new constitution.

Tunisia’s health system is characterized by a relatively balanced geographical distribution of public infrastructure, in primary and secondary health care, and by a dynamic private health-care sector. Specialized resources are unevenly distributed (western parts of the country are disadvantaged in this respect), and primary and secondary health care services in the public sector are not always adequate and effective. Two thirds of consultations and 90% of hospital admissions occur in the public sector, yet most of the human resources (specialists) and funding are increasingly being diverted to the private sector. This weakens the public sector’s capacity to provide an adequate level of service, thereby leading to greater inequality in access to high-quality health care.

Financial protection mechanisms in health are well developed and cover over 80% of the population. However, their fragmentation and the relative under-development of strategic purchasing mechanisms do not enable additional efficiency, quality and equity gains.

The principal challenges to be addressed in reforming the system will be (1) to guide the development of health services to ensure Universal Health Coverage, while reducing regional disparities, facilitate patient procedures, regulate the private and public sectors, and control the use of medical products; (2) to recognize the role of the patient as a partner in health care; (3) to provide more equitable financing; (4) to mainstream health in all public policies; and (5) to adapt governance to new realities, particularly decentralization, community involvement, tackling corruption and implementation of International Health Regulations. On the last point, Tunisia is making significant progress in terms of complying with the International Health Regulations in 2016 and has set up an inter-ministerial commission to monitor and implement the International Health Regulations.

COORDINATION FOR HEALTH

Many organizations of the UN system are present and active in Tunisia and cooperation in health is well structured and fruitful. The 2015-2019 UNDAF is structure around 3 strategic dimensions, health is part of the “equitable social services” one. A joint-program in support of a reduction of maternal and neonatal health is implemented with the assistance of WHO, UNICEF, UNFPA and UNAIDS. A joint UN plan for the support of the monitoring and reporting of SDGs was launched in December 2016.

Other multi and bilateral agencies are present: the UE, as well as the French, Italian and Spanish cooperation agencies; all with a renewed interest in health as demonstrated by their commitments during the recent Tunisia 2020 development forum, as well as, for the EU, by their long-term support to policy dialogue through the EU-WHO Partnership for UHC, since 2012.

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## WHO COUNTRY COOPERATION STRATEGIC AGENDA (2016–2020)

<table>
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<tr>
<th>Strategic Priorities</th>
<th>Main Focus Areas for WHO Cooperation</th>
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| **STRATEGIC PRIORITY 1:** The reduction of social inequity and protection of the most vulnerable | • Leveraging more financial means and incentives to improve the level of solidarity and equity.  
• Improving capacities of advocacy, of analysis and of action on social determinants of health.  
• Improving the institutional framework for taking in charge elderlies. |
| **STRATEGIC PRIORITY 2:** The reorganization and rationalization of health services | • The promotion of a culture of quality, security and attention given to the patient.  
• Maternal and neonatal health, through the joint program 2015-2019.  
• The availability, quality and rational use of medicines. |
| **STRATEGIC PRIORITY 3:** The reinforcement of the role of patients and citizens as actors of the health system | • Evidence generation and its actual use for decision-making.  
• Accountability and citizens’ participation as key pillars to reach higher hospital autonomy.  
• Promoting a policy of proximity (among others for NCDs and mental health). |
| **STRATEGIC PRIORITY 4:** Acting on the behaviors and risk factors of NCDs in targeting youth and adolescents in priority | • Mental illnesses and their environmental and individual causes  
• Taking in charge specific needs of the youth and adolescents  
• Prevention and fight against obesity |
| **STRATEGIC PRIORITY 4:** Risk-prevention and management and the implementation of the IHR | • The surveillance of emerging and re-emerging illnesses and of mandatory declaration  
• The capacity to answer to humanitarian crisis  
• The surveillance of atmospheric and noise pollution |