World Health Organization

WHO contribution in Tunisia (2019-2023)

Web annexes

WHO/DGO/EVL/2025.44

Cover page photo credit: WHO / Diego Rodriguez
Caption: Public Health, Environmental and Social Determinants of Health in Tunisia

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Acronyms

AMR: Antimicrobial Resistance
BP: Biennial Programming
CCS: Country Cooperation Strategy
CEDAW : Convention on the Elimination of All Forms of Discrimination Against Women
CNAM: National Health Insurance Fund
CO: Country Office
COVAX: COVID-19 Vaccination
COVID-19: Coronavirus Disease 19
CPD: Convention on the Rights of Persons with Disabilities
DGSSP: General Directorate of Public Health Structures
DHMPE: Directorate of Environmental Hygiene and Environmental Protection
DSSB: Directorate of Primary Health Care
EMT: Emergency Medical Teams
EOC : Emergency Operations Centre
ERG: Evaluation Reference Group
FAO: Food and Agriculture Organization
FCTC: Framework Convention on Tobacco Control
GBV: Gender-based violence
GDP: Gross Domestic Product
GPW13: 13th General Programme of Work
HIV: Human Immunodeficiency Virus
HR: Human Resources
IHR: International Health Regulations
IMF: International Monetary Fund
INS: National Institute of Statistics
IPC: Infection Prevention and Control
KII: Key informant interviews
KPI: Key Performance Indicator
NAPHS: National Action Planning for Health Security
NCDs: noncommunicable diseases
NHP: national health policy
OCR: Outbreak and Crisis Response
OECD DAC: OECD Development Assistance Committee
ONMNE: National Observatory of New and Emerging Diseases
PB: programme budget
PCR: polymerase chain reaction
PHC: primary health care
PHEOC : Public Health Emergency Operations Centre
PPE: personal protective equipment
RBM: results-based management
RNA: Ribonucleic Acid
RO: Regional Office
RRT: Rapid Response Teams
RT-PCR: Reverse Transcription Polymerase Chain Reaction
SDGs: Sustainable Development Goals
SO: strategic objective
UHC: Universal Health Coverage
UN: United Nations
UNCT: United Nations Country Team
UNDAF: United Nations Development Assistance Framework
UNEG: United Nations Evaluation Group
UNHCR: United Nations High Commissioner for Refugees
UNSDCF: United Nations Sustainable Development Cooperation Framework
UNS: United Nations System
WB: World Bank
WCO: WHO Country Office
WHO: World Health Organization

Annex 1: Terms of Reference

Evaluation of World Health Organization (WHO) contribution in Tunisia

Terms of reference, June 2023

I. Introduction

Evaluations of WHO's contribution at country level are included in the biennial WHO organization-wide evaluation workplans, approved by the Executive Board. These evaluations focus on the outcomes/results achieved at country level using the inputs from all three levels of the Organization. They also assess WHO's contributions towards public health needs of the country and the objectives formulated in WHO General Programmes of Work and key country-level strategic instruments, including Country Cooperation Strategies (CCS), biennial WHO Country Office (WCO) workplans and national health strategies. They document good practices and provide lessons that can be used in the design of new strategies and programmes in-country going forward.

For the biennium 2022-2023, the WHO Evaluation Office has planned the Evaluation of WHO's Country Office (WCO) contribution in Tunisia. The is a timely evaluation as WCO is undergoing rapid transition, is embarking on new processes of support to the Tunisian Ministry of Health and will aim to inform WCO's planning going forward.

II. Country and health context

Tunisia is a country of about 12 million people, the vast majority living in urban coastal areas *(1)*. Whilst Tunisia's population is still very young (around 21% are children and youth 10-24 years old in 2023), the demographic transition has taken place at a fast rate, with the total fertility rate decreasing from almost four children per woman in 2000 to two children in 2023, and a population growth rate of 0.8% (*2*). Since the enactment of a new Constitution in 2014, important gains have been made to strengthen the political and social contract, consolidating the social dialogue on human and political rights and gender equality, improving the security situation, revitalizing the national economy and adopting a decentralized system of governance to improve the service disparities between coastal and inland communities *(2)*.

However, the country is facing a multidimensional crisis, which is eroding such democratic advances. Even after the establishment of the "Pacte de Carthage"[1], political parties remain polarized, missing opportunities to enact structural reforms and a sound national budget. Declining quality basic services, endemic corruption and clientelism, increasing inequality between communities in the coastal areas and the interior, a growing unemployed youth population and social unrest have led to decline in voter turnout, mass protests and disenchantment with the political élite[2]. Currently at lower-middle income status, the national economy has contracted regularly with a GDP decline to 1.7% between 2011 and 2019, increasing unemployment levels and a "brain drain" of Tunisia's young, educated population *(3)*. Many young Tunisians have tried or hope to migrate to Europe, often attempting the very

[1] This was envisaged to be a consensus-driven political model to bring the country towards political stabilization

[2] UNRCO 2020, p. 12

dangerous sea route to Italy *(3)*. In addition, regional conflict and increased tensions at the border with Libya and the porous Sahelian countries, have led to a constant influx of migrant and refugees and contributed to instability, insecurity and vulnerability to terrorism threats and organized crime *(3)*. The impact of the Covid 19 crisis in 2020 and, more recently, the war in Ukraine have further exacerbated the situation. In 2021 President Kais Saied suspended Parliament and, after a referendum, a new bicameral presidential system was introduced to bring about reform. Tunisia has now entered a new political phase.

Tunisia has made progress in basic health indicators and health system performance. Life expectancy is among the highest in the Eastern Mediterranean region, and infant mortality has significantly reduced, thanks to extensive vaccination coverage for infectious diseases such as measles, tetanus and polio, which have been almost eradicated, and despite disparities between urban and rural areas[3]. The demographic transition (whereby by 2036, one in five persons in Tunisia will be over 60) is mirrored by concurrent epidemiological changes, which are already affecting the health system[4]. There is a growing burden of non-communicable diseases (NCDs), which accounted for 82% of total deaths in 2018: obesity among females, tobacco-related cancers especially among males and cardio-vascular and chronic diseases due to insufficient physical activity for elderly individuals of both sexes are most prevalent *(4)*.[5] For male 10–24 years old, road injuries, exposure to mechanical forces and interpersonal violence are the leading mortality causes; for females 15-19 years old, road injuries, interpersonal violence and self-harm are leading causes, whereas for females 20-24 years old road injuries, maternal conditions and self-harm are leading causes *(4)*. These nuances are important to consider in the health profile of the country.

Table 1: Tunisia key population and health statistics (5), (6)	
Population (2023) *(7)*	12.5 million
Population proportion 0-14 years	3.125 million
Population proportion 10-19 years	1.875 million
Population proportion over 65 years	1.125 million
Life expectancy at birth (2020)	74 (male); 78 (female)
Socio-economic indicators *(8)*	
Gender inequality index	0.259 (65/152)
Human Development index rank	0.731 (95/189)
Health (2020)	
Neonatal mortality rate	12/1000 live births

[3] OMS Tunisie, *Stratégie de coopération. Un aperçu*. May 2018

[4] Comité technique du dialogue sociétal (n.d.). *Projet de la Politique Nationale de Santé à l'horizon 2030*, Tunis., p.3

[5] and WHO (n.d.), Tunisia Country Profile, Health and Migration Programme.

Infant mortality rate	14/1000 live births
Maternal mortality ratio	43/100.000 live births
Antenatal Care Coverage (4+ visits)	84.1%
Health systems (2020)	
Physician density	13.2/10.000 population
Nursing and midwifery density	24.1/10.000 population
Births attended by skilled personnel	99.5%
(MCV2) measles immunization coverage among 1-year-olds (%)	93%
Health financing (2018)	
Per capita current health expenditure (US$)	252
General government expenditure on health as % of total government expenditure	14
Out-of-pocket expenditure on health as % of per capita current health expenditure	39

Humanitarian and migration health context

Tunisia is a major country of origin and transit for many migrants, asylum seekers and refugees. Alongside young Tunisians, in 2021 the United Nations High Commissioner for Refugees (UNHCR) registered over 9000 refugees and asylum seekers from Cote D'Ivoire, Syria, Sudan, Guinea, Cameron, Eritrea, Libya, Somalia and Sierra Leone aiming to travel to Europe[6]. Access to healthcare is guaranteed for a fee to all migrants and asylum seekers at Public Health Centres and government hospitals although discrimination towards Sub-Saharan refugees and migrants has been reported in public health structures and fear reporting to authorities prevents many illegal migrants from seeking health care[7]. Delays in the set-up of special protection legislation and policies to support migrant and refugees' right to health means that UNHCR, in collaboration with the Tunisian Red Crescent, is the main health provider of health services, covering some expenses to recognized refugees and asylum-seeker in extreme cases of vulnerability or in life threatening situations[8]. Overall studies of the situation of people on the move report severe mental health and psychosocial support needs, refugee women's vulnerability to gender-based violence (GBV) and a need for increased assistance to those travelling with children.[9]

Health system and financing

The decentralization reforms after the municipal elections of 2018 promised to bring much needed services,

[6] WHO (n.d.), Tunisia Country Profile, Health and Migration Programme.
[7] Ibid.
[8] Ibid.
[9] Ibid.

including healthcare, to underserved communities in inland areas, where 30% of the population live. However, the set-up of decentralized multisectoral service provision failed to materialize. In the 24 governorates, multiple layers of regional and district governance overlap, complicating processes of decision-making, coordination and cooperation between districts and municipalities *(9)*. This situation keeps affecting health system performance and financing.

Tunisia has instituted the National Health Insurance system (Caisse Nationale d'Assurance Maladie - CNAM) for employees and free medical assistance (Assistance Médicale Gratuite - AMG) for vulnerable citizens[10]. It also has a strong pharmaceutical industry, which produces both generic and bio-equivalent drugs, and a national accreditation in healthcare (INAsanté) with growing capacity of health professionals *(10)*. However, 2 million citizens (17%) still do not benefit from social security, and do not have access to basic services or medicines: out of pocket expenditures in the private health system remain high and can be catastrophic for deprived families *(11)*[11]. Primary Health Care (PHC) centres' functioning is very limited to mornings only, with one centre over five able to ensure daily consultations, and regional hospitals are also partially functioning *(12)*. Despite a relatively good medical infrastructure in both private and public sectors, only half of available doctors' work in the public health system, which serves 80% of the population, and hospitals operate with less than 30% of advanced diagnostic medical equipment[12]. Also, the health information management system, which is part of Tunisia's ongoing wider digitalization reform, is lagging behind. The situation has deteriorated with the impact of Covid 19: Tunisia was among the top worst affected African countries, with more than 20,000 pandemic-related fatalities, and significant consequences felt by particularly vulnerable groups such as migrants, rural women, and women victims of gender-based violence (GBV) *(13)*.

Legal and political framework for health in Tunisia

Tunisia legal and policy framework provides for public health management, in line with the demographic and epidemiological transition. Firstly, the Right to Health and people-centered Universal Health Coverage are enshrined in Art. 38 of the new 2014 Constitution and the propositions included in the White Book (Livre Blanche) on the health system's reform *(14)* *(12)*. Also, Tunisia is signatory to a number of international agreements and covenants including World Health Assembly declarations, the SDG agenda, the WHO Framework Convention on Tobacco Control (FCTC), the International Health Regulations 2005, as well as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of Persons with Disabilities (CPD) and continental covenants such as the African Union African Charter on Human and Peoples' Rights and its Maputo Protocol.

Tunisia has developed a five-year National Development Plan 2016 to 2020 framed around five priorities: good governance, public administration reform and anti-corruption; Tunisia as an economic hub; human development and social inclusion; positive discrimination to achieve greater regional equality; and sustainable development based on a green economy *(15)*. Within the Plan, the Ministry of Health has identified five priorities to strengthen health systems: prioritize prevention and act on key determinants; set up a territorial service of health through health centers structured around a coherent health project; betting on innovation; putting in place new

[10] OMS Tunisie, *Stratégie de coopération*. Un aperçu. May 2018

[11] and OMS Tunisie, *Stratégie de coopération*. Un aperçu. May 2018

[12] Ibid

governance for a more effective health policy; and strengthening the public sector. This is in line with Tunisia Vision 2030 for the achievement of the SDGs.

Tunisia's National Health Policy 2021- 2030 prioritizes the following areas for its citizens: people-centred services through a focus on family and localized services and developing a package of basic services for all; increasing accessibility to all through the creation of a unified basic health system for all and ensuring that the system has sufficient means to fulfil its public service mission; and ensuring citizen's protection of their health *(12)*. Tunisia has also a fully funded National Intersectoral Strategy and Action Plan for the Prevention and Control of NCDs (2021- 2025), which includes a Monitoring and Evaluation (M&E) plan, as well as a the implementation plan of the WHO Framework Convention on Tobacco Control 2021[13]. Across all national and sector-specific policies, there is a strong focus on, reducing discrimination and achieving gender equality, with clear commitments to Leaving No One Behind.

III. Evaluation object

WHO has supported health development in Tunisia since 1956. Whereas the current UN Sustainable Development Cooperation Framework (UNSDCF) is valid until the end of 2025, WCO does not currently have a Country Cooperation Strategy (CCS). The latest strategy (2016-2020) remained in draft form. WHO is part of the UN Country Team's Development Assistance Framework 2015-2019 (UNDAF) and its set of interventions, under strategic priority 2 focusing on supporting health, education, and social protection systems. Under the DAF, WCO is supporting the government in setting in place appropriate health policies and strategies and regulatory frameworks, including to address emergencies and disease outbreaks *(16)*. Key priorities for WCO in Tunisia between 2019 and 2023 have been on health system reform and financing, the emergency context and strengthening better health and wellbeing.

Another component of WHO's work in Tunisia in the past years focused on responding to the Covid-19 crisis and setting up a pandemic surveillance and infection prevention, response and preparedness system. During 2020 the entire WHO team concentrated support on providing the Ministry of Health with epidemiological guidance and coordinating partners to support Tunisia's response. This included purchasing of lab kits, PPE, medical and IT equipment for health infrastructures, capacity building of health workers including for contact tracing and surveillance and support community mobilization for prevention and awareness raising. Table 2 summarizes key health areas, interventions and achievements[14]

[13] See: MdS, RTI International, PNUD, Secrétariat du CCLAT de l'OMS, OMS (2021). *Argumentation en faveur de l'investissement dans la mise en œuvre de la CCLAT en Tunisie*. Tunis and MdS. *Stratégie Nationale MNT 2018-2025.* Tunis

[14] WHO Tunisia, WHO priorities 2022-2023; 2020 and 2022 Mid Term Review TUN Budget Assessment Centre

Table 2: WHO Country office key interventions

Health area	Key interventions	Key achievements
Health system reform	• Reorientation of health financing to support NCDs actions, emergencies and PHC; • strengthening the family health workforce at Primary Health Care (PHC) level; • strengthening the National Regulatory Agency; • support the information management system; • strengthening the Universal Health Coverage (UHC) approach; • addressing shortages of medicines; • supporting the introduction of the HPV vaccine; • creation of new WHO Collaborating Centres;	• Design and approval of the National Health Policy and NCDs Policy, strategy and action plan • Prevention and control strategy for leishmaniasis including introduction of new treatments • Evidence generation, training and capacity building in 26 hospitals on AMR and antibiotic consumption • Detection of polio cases at border with Algeria and strengthening of immunization at border
Emergency	• implementation of Public Health Emergency Operations Center (PHEOC), increase capacity of the SHOC Room and create a multisectoral Emergency Operations Center (EOC) with different ministries involved in the response to public health emergencies; • establish a Risk Communication and Community Engagement (RCCE) unit at the Ministry of Health; in the framework of "One Health" establish a strategic partnership on emerging health issues through the Project MED-NET; • strengthen the sequencing in Tunisian laboratories;	• COVID emergency preparedness and support plans, training and capacity building of health professionals on infection control and prevention • Equipment purchase for 6 health facilities • Capacity building of health personnel on control of health care associated infections in priority regions (Medinine and Tatatouine) for potential influx of migrants due to the Libyan crisis • enhanced genomic surveillance to be enhanced for high threat pathogens through procurement of equipment and reagents as well capacity building at Charles Nicole hospital
Enjoying better health and wellbeing	• preventing NCDs by addressing its risk factors through a multisectoral approach (strengthening research and national capacity to monitor and follow up on the WHO FCTC); • mental and brain health (with a focus on Alzheimer's disease); • urban governance for health and wellbeing (focus on local leadership and community engagement).	• Integrating mental health into PHC and training 400 PHC staff in public and private centres to deliver integrated mental health care in line with the mhGAP initiative of WHO Health system • Government adoption of graphic health warnings on 70% tobacco packages

Tunisia WHO country office budget

Table 3 shows the biannual budget breakdown by category of interventions. BASE categories include WHO's four core areas of mandate and focus: UHC, Health Emergencies, Building Healthier Populations and WHO enabling functions (evaluation, compliance, audits, ethics etc.). Emergencies refer to both COVID and non-COVID emergencies under the 'outbreak, crisis response and scalable operations' budget line.

Table 3: WHO Country office Funding information

	2018/2019			2020/2021			2022/2023		
Category	Allocated PB	Funds received	Utilization	Allocated PB	Funds received	Utilization	Allocated PB	Funds received	Utilization
BASE	4,212,100	3,389,091	3,253,372	4,541,700	3,482,840	2,857,684	6,261,500	4,493,793	1,666,906
Emergencies				14,290,000	9,568,722	9,226,732	4,416,957	4,378,185	3,273,448
Non PB				100,000	60,000	59,991			
Total	**4,212,100**	**3,389,091**	**3,253,372**	**18,931,700**	**13,111,562**	**12,144,407**	**10,678,457**	**8,871,978**	**4,940,354**

Results-based monitoring system

Globally, each WCO reports towards a set of indicators linked to WHO's current Global Programme of Work and its Results Framework. The results-based monitoring system in Tunisia is thus linked to WHO's Global Programme of Work 13 2019-2023 (GPW13) Results Framework to reach the triple billion target[15]. It reports against all GPW13 output indicators linked to the global 12 outcomes. Each output has key performance indicators and related definitions with a red-yellow-green rating to assess status. The full reporting framework will be shared during inception. Tunisia WHO country office mid-term review reports and End of Biennium assessment reports will also be available for review at inception stage.

IV. Evaluation purpose

The main purpose of the evaluation of WHO's contribution in Tunisia is to:

a. enhance accountability for results towards external and WHO stakeholders (including, inter alia, governing bodies, Member States, donors and Tunisia partners and the Tunisians, as well as the WHO Regional Director for the Eastern Mediterranean, the WHO Representative in Tunisia, and the programmes in WHO Regional Office for the Eastern Mediterranean) through an impartial and comprehensive assessment of the results of WHO's work in Tunisia;

b. strengthen organizational learning for informed decision-making processes, particularly in the design, resourcing and implementation of new strategies and programmes in-country going forward.

The evaluation will be both summative and formative. Summative aspects will seek to achieve a better understanding of the types of results and achievements, both intended and unintended, stemming from WHO interventions. For the formative part of the evaluation, the goal is to identify lessons learned and core areas of work to the design and implementation of WHO interventions in Tunisia.

V. Evaluation objectives

This evaluation will build on an analysis of existing documents and data of relevance to the purpose of the

[15] This uses a sub-set of 46 outcome indicators: 39 SDG indicators and seven Member State-approved indicators covering a range of key health topics.

evaluation, complemented with the perspectives of key stakeholders, to:

a) assess the achievements against the objectives formulated in country-level strategic instruments and corresponding expected results developed in the WCO biennial workplans, while pointing out the challenges and opportunities for improvement.
b) assess past successes, challenges and lessons learnt from WHO's work, to support the WCO and partners in the development and resourcing of the next strategic instruments and refine WHO operational planning mechanisms.
c) assess communication and coordination approaches among the three levels of the organization and in-country stakeholders, to identify the strengths and areas for improvement of WHO's modalities of technical assistance as well as case studies that demonstrate strong co-ownership, collaboration, and good use of funding.

VI. Evaluation scope

The evaluation will cover all development and humanitarian interventions undertaken by WHO (Tunisia WCO and supported by the WHO Regional Office for the Eastern Mediterranean, and headquarters) over the last three biennia (2019 – 2023) and as framed in the relevant strategic instruments (such as UNSDCF, UNDAF, any relevant national policies) as well as operational planning and reporting mechanisms, covering activities which took place over this period. The geographical scope will include initiatives implemented across the country and any specific regional interventions, if any. This evaluation will focus mainly on the health sector, with cross linkages to collaborating sectors like finance, environment, and education. The selected timeframe not only corresponds to WHO's GPW13 period of implementation, but also corresponds to pre, intra and post-COVID-19 Phases of the response. The focus of the evaluation will be both at policy level, programme level, and specific operations (such as COVID-19 response).

VII. Stakeholders and users of the evaluation

Table 4 shows the role and interest of the main evaluation stakeholders and expected users of the evaluation.

Table 4: Preliminary stakeholders' analysis

Internal stakeholders	Role and interest in the evaluation
WCO Tunisia	The results of the evaluation will inform the design and implementation of the next country strategy as well as future interventions and strategic shifts to improve future contributions.
WHO Eastern Mediterranean Regional Office	The Regional Office has a direct stake in the evaluation in ensuring that WHO's contribution at country level is relevant, coherent, effective and efficient. The evaluation findings and best practices will be directly useful to inform other WCOs in the Region as well as regional approaches in health.
Headquarters management	Headquarters management is in charge of the strategic analysis of the content of country-level strategic instruments and their implementation and is responsible for promoting application of best practices in support of regional and country technical cooperation.

Executive Board	The Executive Board has a direct interest in being informed about the added value of WHO's contribution at country level and being kept abreast of best practices as well as challenges through the annual evaluation report.
External Stakeholders	
Government of the Republic of Tunisia	As a recipient of WHO's action, it has an interest in the partnership with WHO, and an interest to see WHO's contribution to health in-country independently assessed. Will be engaged at ERG, validation, stakeholder workshop, and use of evaluation.
All individuals in Tunisia	WHO's action in-country must ensure that it benefits all population groups, prioritizes the most vulnerable and does not leave anyone behind. The evaluation will look at the way WHO pays attention to equity and ensures that all population groups are given due attention in the various policies and programmes. Will be engaged during data collection as respondents.
UN Country Team	WHO as part of the UN Country Team contributes to UN strategic frameworks alongside other UN agencies. There is therefore an interest for the UN Country Team to be informed about WHO's achievements and be aware of the best practices in the health sector, a identify opportunities for partnership. Will be engaged as part of ERG or key informants during data collection.
Donors and partners	Donors (multilateral and bilateral agencies) and philanthropic foundations have an interest in knowing whether their contributions have been spent effectively and efficiently and if WHO's work contributes to their own strategies and programmes. Will be engaged through WHO publications on completion of the evaluation.

VIII. Gender, equity, and human rights considerations

This evaluation will adhere to the United Nations Evaluation Group (UNEG) norms and standards for evaluation and WHO guidance and policies, including, the WHO Policy and Strategy on Health Equity, Gender Equality and Human Rights, 2023 – 2030 and the WHO Policy on Disability, WHO Evaluation Policy (2018), UNEG Guidance on Integrating Human Rights and Gender Equality in evaluations (2011 and 2014) and UNEG Guidance on Integrating Disability Inclusion in Evaluations (2022). The evaluation is expected to integrate gender, equity and human rights considerations in its conceptualization, design and analysis, ensuring that principles of 'leave no-one behind' and 'do no harm' are duly considered. This involves analysis of inclusion of human rights principles and alignment with SDGs as applicable to the subject of the evaluation, as well as appropriate ethical approaches and risk assessments in the design and execution of the evaluation.

IX. Evaluation questions

This evaluation will look at relevance, coherence, effectiveness, efficiency, and cross-cutting issues. The key questions for this evaluation will be formulated based on the OECD Development Assistance Committee (OECD-DAC) criteria even though not all DAC criteria are included because not all criteria are equally important as regards to the purpose and objectives of this evaluation. Additional cross-cutting areas have been added to assess gender, human rights and equity considerations. The evaluation will be guided by the following four Key Evaluation Questions:

Criterion	Key evaluation questions	Sub-questions
Relevance	1. To what extent are WCO's interventions relevant to the context and the evolving needs and health rights of the Tunisian population as well as country and regional partners and institutions' needs, policies and priorities, and continue to do so if circumstances change?	1.1 To what extent have WHO's objectives (including any adjustment of objectives), and interventions responded to Tunisia's beneficiaries' needs and rights, including those of the most marginalized populations, as well as the country's and partners' policies and priorities?
Coherence	2. To what extent are WHO interventions coherent and demonstrate synergies and consistence with one another as well as with interventions carried out by other partners and institutions in Tunisia?	2.1 To what extent are interventions aligned to country and regional partners' (UNCDF) and institutions' policies and priorities as well as to WHO GPW13 and other sector-specific policies? 2.2 What has been WHO comparative advantage in Tunisia, especially in relation to other UN agencies, and what adaptations and refinements are needed to improve its positioning?
Effectiveness	3. To what extent were WHO results (including contributions at outcome and system level) achieved or are likely to be achieved and what factors influenced (or not) their achievement?	3.1 To what extent were programme outputs (including any adjustment) delivered and did they contribute to: (a) progress toward the stated programme outcomes (b) the adoption and implementation by the national health system of interventions, programmes and services aimed at reducing the inequalities and exclusion, related to socio-economic and environmental determinants of health? 3.2 What factors influenced their achievement or non-achievement, and to what extent has WHO demonstrated a reasonable contribution at the outcome or health system level? 3.3 What has been the added value of WHO regional and headquarters contributions to the achievement of results in Tunisia?
Efficiency	4. To what extent did WHO interventions deliver, or are likely to deliver results in an efficient and timely way?	4.1 To what extent do WHO interventions reflect efficient economic and operational utilization of resources, including in response to new and emerging health needs that require adjustment or re-prioritization of interventions? 4.2 To what extent are the internal controls and results-based management (RBM) systems adequate to ensure efficient operational and timely allocation of resources and adequate measurement of results including in changing circumstances?
Sustainability	5. To what extent has WHO contributed towards building national capacity and ownership for addressing Tunisia's humanitarian and development health needs and priorities?	5.1 To what extent has WHO supported Tunisia's national longer-term goals and a resilient, shock-responsive health systems including building national capacity in view of ongoing and future health needs (including emergencies)?
		5.2 To what extent have WHO interventions supported national ownership for health system strengthening, as well as national capacity to deliver on and achieve the results as planned in the relevant national health policies and strategies? Is there evidence that the benefits will be sustained over time?

X. Methodology

The evaluation will be based on a rigorous and transparent methodology to address the evaluation questions in a way that serves the dual objectives of accountability and learning. We welcome proposals that include real time evaluation/learning approaches which are participatory, and utilization focused. The evaluation team should strive to provide immediate feedback to WCO, so that learning can be iterative, and improvements can be easily identified and absorbed.

Overall evaluation design and approach

The methodology described in this section is indicative and participating evaluators are expected to adapt and integrate the approach and propose adjustments needed to accomplish the initiative. These can include additions to the evaluation design; approaches to be adopted; appropriate sampling strategy; data collection and analysis methods; and an evaluation framework. The proposals should also refer to methodological limitations and mitigation measures.

The design of the evaluation will be non-experimental, utilization focused, and theory based in assessing the effectiveness of the WHO interventions between 2019 and 2023 against their intended aims. With a **strong focus on utilization**, the approach of the evaluation will concentrate on engaging with the principal users of the evaluation process and report – WHO CO and regional office, key stakeholders and focal points in national government' ministries and departments, representatives at sub-regional and national level as far as possible, and UN partner organizations in Tunisia. Mixed data collection methods will be used as far as possible. Discussions with stakeholders from Tunisia will largely provide qualitative evidence. The evaluation team will draw from the available quantitative data from recent evaluations, progress reports and other sources. Participating evaluators can consider the "**contribution analysis approach**" particularly around questions of effectiveness, and other relevant approaches for stakeholder consultation that could generate useful qualitative and quantitative data on key issues. The evaluators will assess the options and describe in detail the suitable methods to meet the purpose, scope and objectives of this evaluation. The methodology will be further refined in the inception phase, based on the findings of the inception report and consideration of constraints posed. Participatory approaches will be adopted as far as possible, but given the potential access constraints, these may also including virtual means.

During the **design phase** the evaluation team will design the methodology which will entail the following:

a. Develop a **theory of change** for the evaluation of WHO's presence in Tunisia. The theory of change to frame the evaluation of WHO's contribution in Tunisia will: i) describe the relationship between the priorities of the relevant strategic instruments, the focus areas and the activities and budgets as envisaged in the biennial WCO workplans; ii) clarify the linkages with the WHO General Programme of Work and programme budgets; iii) describe how WHO secretariat outputs would be expected to contribute to Tunisia health outcomes; and iv) identify the main assumptions underlying it.

b. Develop and apply **an evaluation matrix** [16] geared towards addressing the key evaluation questions, considering the data availability challenges, the budget and timing constraints.

c. Follow the principles set forth in the WHO ***Evaluation Practice Handbook***, the United Nations Evaluation Group (UNEG) ***Norms and Standards for Evaluation*****,** and its ***Ethical Guidelines****.*

d. Adhere to WHO cross-cutting strategies on **gender, equity, disability, and human rights** and include to the extent possible disaggregated data and information as well as gender balanced teams and gender- and disability-sensitive and human rights informed approaches for data collection.

e. Include ethical considerations: confidentiality**;** no-harm to the respondents, use of the right protocols, especially if interviewing or conducting qualitative data collection with vulnerable/marginalized populations

The methodology should demonstrate impartiality and lack of bias by relying on a cross-section of information sources (from various stakeholder groups) and using a mixed methodological approach to ensure triangulation of information through a variety of means. The evaluation of WHO's contribution in Tunisia will rely mostly on the following mixed **data collection methods**:

i. Document review. This will include a wide range of key strategic documents, including but not limited to: general programmes of work; relevant programme budgets; WCO programme budget and workplans; budget, financial, audit and closure reports; annual programme reports and budgets; and relevant national policies and strategies. For humanitarian crises faced over the period under evaluation, documents may include the International Health Regulations (IHR), Joint External Evaluations (such as Joint external evaluation of IHR core capacities) and the IHR State Party Self- Assessment Annual Reports.

ii. Quantitative data from the WCO monitoring system to assess progress against key health indicators, including in the context of responding to the humanitarian and displacement crisis.

iii. Stakeholder interviews. Interviews will be conducted with external and internal stakeholders at WHO headquarters, Eastern Mediterranean Regional Office and Tunisia country office levels. External stakeholders for this evaluation are: ministry of health officials and officials of other relevant governmental institutions; healthcare professional associations and other relevant professional bodies; relevant research institutes, agencies and academia; health care provider institutions; UN agencies; other relevant multilateral organizations; donor agencies; other relevant partners; non-State actors and civil society.

iv. FGDs with a selection of male and female health services users, including migrant and refugees, and service providers, to assess perceptions of WHO-supported services. Separate FGDs with male and female migrant and refugees can be conducted either directly by evaluators or, if budget allows, through collaboration with field partners.

v. Mission in-country. Following the document reviews and initial stakeholder interviews,

[16] An Evaluation Matrix is an organizing tool to help plan for the conduct of an evaluation. The Evaluation Matrix forms the main analytical framework for the evaluation. It reflects the key evaluation questions and sub-questions to be answered and helps the team consider the most appropriate and feasible method to collect data for answering each question. It guides analysis and ensures that all data collected analysed, triangulated and used to answer the evaluation questions, and make conclusions and recommendations.

the country visit will be the opportunity for the evaluation team to develop an in-depth understanding of the perspectives of the various stakeholders around the evaluation questions and collect additional secondary data, in particular from external stakeholders and health service users. The visit will depend on prevailing security situation.

vi. Stakeholders' consultation. In addition to acting as key informants during the evaluation process, key internal and external stakeholders will be consulted at the drafting stages of the terms of reference, inception note and evaluation report and will have the opportunity to provide comments.

Triangulation

To ensure credibility and validity of evaluation findings, evaluators will triangulate emerging evidence. Evaluation evidence collected from different sources and/or by different methods will be compared to ensure that the data is valid, conclusions and recommendations are solely derived from evidence.

Validation workshop

Initial findings will be presented to stakeholders (Evaluation Reference Group) in a (in country or virtual) workshop to assess the validity / accuracy of the findings and their relevance to the Tunisia context and programmes at the end of the in-country visit (or remote field work). Stakeholders will be invited during the workshop to help the evaluator to identify and prioritize recommendations so that relevance, usefulness, and usability of these can be maximized. The feedback will be documented including where any divergent views arise from the findings. The conclusions will be based as far as possible on triangulated evidence.

Limitations

No major primary quantitative data collection is envisaged to inform this evaluation. The evaluation team will mainly use data (after having assessed their reliability) collected by WHO and partners during the timeframe evaluated. Absence of a valid country cooperation strategy between WHO and Tunisian government would be a limitation and the evaluators should make reference to other available strategic documents like UNSDCF. Another limitation might be related to security fluctuations; this will be advised by WCO security teams. Where field travel will not be feasible for whatever reasons, remote data collection will be done using national consultants as enumerators.

Ethical considerations

Due diligence will be given to effectively integrating good ethical practices and paying due attention to robust ethical considerations in the conduct of evaluation of WHO contribution in Tunisia. Evaluators are expected to outline in their proposal how they will adhere to ethical considerations including: confidentiality and anonymity, do no-harm approaches, use of the appropriate ethical protocols, gender and human rights consideration in the conduct of interviews and FGDs with respondents and users of services, especially if interviewing or conducting qualitative data collection with vulnerable/marginalized populations, data management and storage, and integration of appropriate cultural/language considerations.

XI. Evaluation phases, timelines, and deliverables

The evaluation is structured around five phases summarized in Table 5 below.

Table 5: summary tentative timeline – key evaluation milestones

Phase	Timeline	Tasks and deliverables
1. Preparation	June, 2023	Background research Draft and final TOR Evaluation team constituted
2. Inception	September - October, 2023	Desk review of existing literature Draft and final inception report Evaluation matrix Quality Assurance
3. Data collection and analysis	November, 2023	Document review Briefings WHO Headquarters/ Eastern Mediterranean Regional Office /Tunisia WCO Key informant interviews with HQ and RO staff Country visit Data analysis
Report drafting	December	First draft Quality assurance
4. Validation and finalization	January 2024	Draft and final evaluation report Quality assurance of report Validation workshop (virtual)
5. Dissemination and learning	February, 2024	Debriefings Dissemination via publication/internet Evaluation Brief Management response

Design phase

The **design phase** will start with a first review of key documents and briefings with WHO headquarters, WHO Regional Office for the Eastern Mediterranean, and Tunisia WCO key stakeholders. During the design phase, the evaluation team will assess the various logical/results frameworks, if they exist and their underlying theory of change. The inception report will close this phase. Its draft will be shared with key internal stakeholders (at the three levels of the Organization) for their feedback. The inception report will be prepared following the Evaluation Office template and will focus on methodological and planning elements.

Considering the various logical/results frameworks and the evaluation questions, it will present a detailed evaluation framework and an evaluation matrix. Data collection tools and approaches will be drafted as part of the inception report, alongside consent forms and ethical protocols.

First deliverable: Inception Report

Data collection and analysis.

This phase will include additional document review, key stakeholders' interviews at headquarters and regional levels and a country visit. Tunisia in-country mission will start with a briefing to the Tunisia WCO followed by key partners and will end with a debriefing with the same group at the end of the mission. During inception, WCO will advise the evaluation team as to the possible locations for field work, accounting for security and any movement and access restrictions, including for national consultants.

Report drafting, validation and finalization phase

This phase is dedicated to the in-depth organization of key findings and results, and identification of key lessons learned and recommendations. These will be presented in the draft evaluation report, which will be shared with key internal and external stakeholders and the joint Evaluation Management Group for fact-checking. Prior to the finalization of the recommendations, the WHO Representative (WR) in collaboration with the evaluation team lead might consider organizing a workshop with the main counterparts in-country to discuss the findings and conclusions of the evaluation team. A draft management response could also be presented at the workshop to ensure buy-in and commitment for all parties

Second deliverable: draft evaluation report

A final evaluation report, an evaluation brief and a short evaluation video will be prepared according to the WHO Evaluation Practice Handbook and implementation frameworks. The evaluation report, brief and video will provide an assessment of the results according to the evaluation questions and methodology identified above. It will include conclusions based on the evidence generated in the findings and draw actionable recommendations. Additional summary products could include infographics, visual summaries or video interviews with key Tunisia Country Office (CO) staff and stakeholders involved in the evaluation.

Third deliverable: final evaluation report, evaluation brief and evaluation video

Note: The revisions of any of the deliverables produced by the evaluation team will be accompanied by feedback on each comment provided. This feedback will succinctly summarize if and how comments were addressed, and if they were not, it will justify why.

Management response and dissemination of results phase

The management response will be prepared by the Tunisia WCO prior to the finalization of the evaluation report. To ensure transparency as envisaged in the WHO Evaluation Policy and the UNEG norms and standards for evaluation, the reports of evaluations of WHO's contribution at country level and their management responses will be made publicly available and summaries will be reported in the annual evaluation report to the WHO Executive Board.

XII. Evaluation Team

The evaluation will be conducted by a consortium of consultants, offering a mix of evaluation experience and expertise. The team will include a Team Leader/Senior Evaluator and two national junior evaluators.

The **Team Leader/Senior Evaluator** should demonstrate:

- Relevant professional qualification, preferably at the academic (Master's or PhD) level.
- At least 10 years of experience in conducting evaluations preferably in the areas of public health/economics or development and experience in country-level programme evaluations, with a focus on North Africa
- Demonstrated knowledge of public health and humanitarian programmes and country response to public health epidemics and NCDs, e.g., COVID-19, HIV, Tuberculosis etc.
- Proven experience in conducting Realtime evaluations, qualitative and quantitative data collection methods, analysis of data and experience in handling data limitations
- Experience in evaluating incorporation of health equity, gender equality, human rights and other equity issues in programmes
- Previous experience with evaluation for UN and/or other multilateral organizations
- Strong interpersonal skills and ability to work with people from different backgrounds to deliver high quality products within a short time period
- Excellent writing, analytical and communication skills in French and, preferably, Arabic. Good knowledge of English.

Two **national consultants** should support the data collection at the country level as needed. The national consultants should demonstrate the following skills:

- Relevant professional qualification, preferably at the academic (Master's) level.
- At least five years of experience in conducting evaluations or data collection preferably in the areas of public health/economics or development and experience in country-level programme evaluations
- Demonstrated knowledge of public health and humanitarian programmes
- Proven experience in understanding evaluation principles, collecting qualitative and quantitative data collection, analysis of data and experience in handling data limitations
- Understanding of health equity, gender equality, human rights and other equity issues in programmes
- Previous experience with evaluation for UN and/or other multilateral organizations
- Strong interpersonal skills and ability to work with people from different backgrounds to conduct data collection in different settings
- Excellent analytical and communication skills in French, Arabic, and good knowledge of English.

It is expected to have a gender-balanced evaluation team for this evaluation.

XIII. Evaluation management

To ensure the independence and credibility of the evaluation, this evaluation will be conducted by an external independent evaluation team and managed by the WHO Evaluation Office in collaboration with WHO Regional Office for the Eastern Mediterranean. The evaluation team will have appropriate knowledge and skills of the evaluand with relevant experience in performing similar evaluations involving organizational reform in multilateral or United Nations organizations.

The Regional Evaluation Officer will serve as the Evaluation Manager and will provide the necessary support to the evaluation team during the evaluation exercise (such as finalization of methodology, facilitation of the evaluation process, identification of relevant documents and stakeholders). WHO country office in Tunisia will facilitate access to data and relevant documents in a timely manner, provide logistic support during in-country mission, and provide feedback on draft deliverables.

The headquarters Evaluation Office will be part of the management group and will support the regional office in the management of the evaluation including funding the evaluation and contracting of the consultants. Additionally, headquarters Evaluation Office will provide overall quality assurance (both process and products) of the evaluation in adherence with United Nations Evaluation Group (UNEG) norms and standards.

An Evaluation Reference Group (ERG) will be established to ensure the evaluation's relevance, accuracy and utility through a consultation and validation process. The ERG will include relevant staff from WHO Regional Office for the Eastern Mediterranean and Tunisia WHO country office; representatives from both the Government of Tunisia and Ministry of Health, implementing partners, and UN agencies in Tunisia whom the country office has closely worked with over the period under evaluation. The ERG will review the key deliverables (the TOR, inception report, the draft and final reports) of the evaluation including validation of the technical findings.

Annex 2: Evaluation matrix

EVALUATION SUB-QUESTION	HYPOTHESES	SOURCES D'INFORMATION	DATA COLLECTION METHODS
RELEVANCE: Q1. To what extent are WHO interventions adapted to the context and changing health needs and rights of the Tunisian population, and to the needs, policies and priorities of national institutions, and do they continue as such if circumstances change?			
Q1.1. To what extent have WHO's objectives (including any adjustments) and interventions responded to the needs and rights of Tunisian beneficiaries, including the most marginalised populations, and to the country's policies and priorities?	- WHO's contribution is consistent with and fits into the institutional framework of public policies and national/local health strategies, in particular the National Health Policy (NHP) 2030. - WHO's contribution has clearly identified the challenges facing public health strategies in terms of their operationalization at national and regional level, and proposes actions accordingly. - WHO's contribution focused on the health situation in Tunisia, the various challenges to the health of its population and the barriers to access to quality health services, particularly for the most vulnerable populations.	- Biennial programmes 2018-2019, 2020-2021 and 2022-2023 - Documents produced by the biennial programmes - Mid-term (MTR) and final reports for the 2018-2019, 2020-2021 and 2022-2023 biennial programmes (Scorecard) - Financial reports for the biennial programmes and to donors - Institutional texts, in particular the regulatory and legal framework relating to the areas supported by WHO contributions - Public health strategies, policies and programmes from official sources - Public strategies, policies and programmes incorporating a health component or cross-cutting approach - Statistics and data available from the national information system.	- Literature review - Semi-structured interviews - Observation

		- Team from the WHO office in Tunis, the WHO Regional Office for the Eastern Mediterranean and headquarters - Institutional and implementation partners - International organizations - Donors	
COHERENCE: Q2. To what extent are WHO interventions coherent and do they present synergies with each other and with interventions carried out by other actors in Tunisia?			
Q 2.1. To what extent are WHO interventions in Tunisia aligned with the strategies and priorities of international organizations (UNCDF) and actors present in the country, as well as with WHO's GPW13 or other sectoral policies of the organization?	- WHO's contribution in Tunisia is aligned with WHO directives, in particular the 13th General Programme of Work (GPW13), WHO regional directives (WHO Regional Office for the Eastern Mediterranean) and sectoral policies such as mental health, non-communicable diseases and tobacco control. - WHO's contribution in Tunisia is aligned and in synergy with the actions of the UNS, in particular through the UNCDF. - The partnerships established to implement actions are relevant to the themes and context. - There is coordination and a search for synergies with the other cooperation actors in Tunisia at the time of development and implementation of actions.	- Biennial programmes 2018-2019, 2020-2021 and 2022-2023 - Documents produced by the biennial programmes - Mid-term (MTR) and final reports for the 2018-2019, 2020-2021 and 2022-2023 biennial programmes (Scorecard) - Financial reports for the biennial programmes and to donors - Institutional texts, in particular the regulatory and legal framework relating to the areas supported by WHO contributions - Public health strategies, policies and programmes from official sources - Public strategies, policies and programmes incorporating a health component or cross-cutting approach - Statistics and data available from the national information system.	- Literature review - Semi-structured interviews - Observation
Q2.2. What has been the comparative advantage of WHO in Tunisia, particularly in	- WHO's comparative advantages at global level (benchmarking, technical expertise, regional collaboration, Tunisia's participation at		

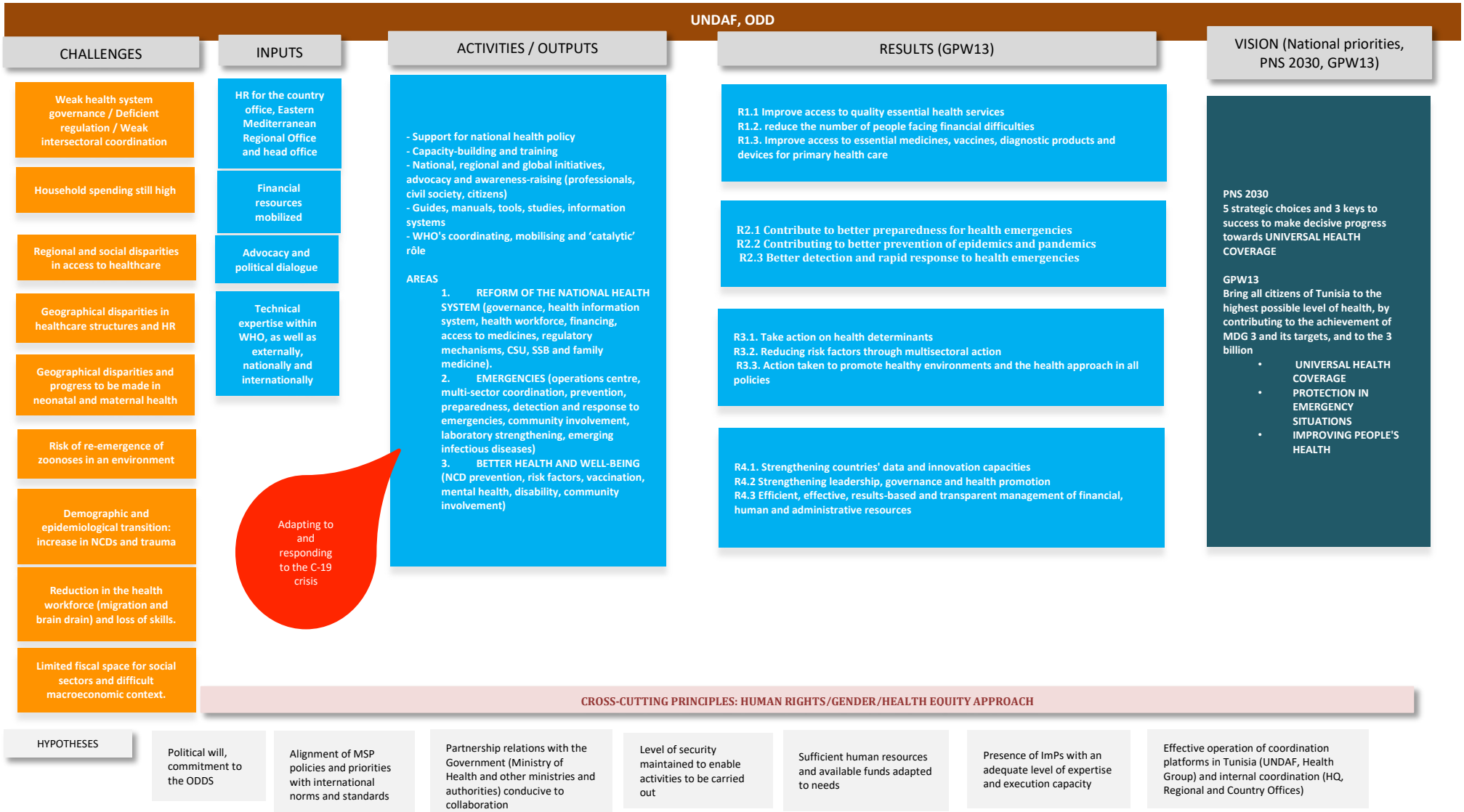
relation to other United Nations agencies?	international level, implementation methods, etc.) compared with other players in cooperation in the field of health are evident in its contribution in Tunisia. - WHO's contribution in Tunisia allowed for a coordinated response to COVID-19 with the other UN agencies.	- Team from the WHO office in Tunis, the WHO Regional Office for the Eastern Mediterranean and headquarters - Institutional and implementing partners - International organizations - Donors	
EFFECTIVENESS: Q3. To what extent have the results of WHO's contribution (in terms of outcomes) been achieved or are likely to be achieved, and what factors have influenced (or not) their achievement?			
Q3.1. To what extent have the results of the programmes evaluated (including any adjustments) been achieved and have they contributed to progress towards the expected results? Were there any contextual factors identified that influenced their achievement or non-achievement?	- WHO's contribution in Tunisia has made it possible to strengthen the equitable access of populations to quality services at an affordable cost, with a view to moving towards universal health coverage. - WHO's contribution in Tunisia has made it possible to strengthen health security - WHO's contribution in Tunisia has enabled progress to be made towards improving the health and well-being of the Tunisian population by addressing the social and environmental determinants of health, multisectorality and the health approach in all policies. - Cross-cutting themes are taken into account in the formulation and implementation of WHO actions in Tunisia.	- Biennial programmes 2018-2019, 2020-2021 and 2022-2023 - Documents produced by the biennial programmes - Mid-term (MTR) and final reports for the 2018-2019, 2020-2021 and 2022-2023 biennial programmes (Scorecard) - Financial reports for the biennial programmes and to donors - Institutional texts, in particular the regulatory and legal framework relating to the areas supported by WHO contributions - Public health strategies, policies and programmes from official sources - Public strategies, policies and programmes incorporating a health component or cross-cutting approach - Statistics and data available from the national	- Literature review - Semi-structured interviews - Questionnaire - Timeline - SWOT analysis - Observations
Q3.2. What added value did the contributions of the region			

and the WHO headquarters bring to the achievement of results in Tunisia?	- Contributions from the region and headquarters arrived on time and in response to the needs identified by the country office in Tunis. - Direct contributions from the WHO Regional Office for the Eastern Mediterranean and headquarters are made in consultation and coordination with the country office in Tunis (e.g. collaborating centres).	information system. - Team from the WHO office in Tunis, the WHO Regional Office for the Eastern Mediterranean and headquarters - Institutional and implementation partners - International organisations - Donors	
EFFICIENCY: Q4. To what extent have WHO interventions produced, or are likely to produce, results in an efficient and timely manner?			
Q4.1. To what extent do WHO interventions reflect an economically and operationally efficient use of resources, including in response to new and emerging health needs that require adjustment or reprioritization of interventions?	WHO's contribution in Tunisia was able to redirect its actions to meet the most urgent health needs resulting from the COVID-19 pandemic (containment, decontainment, prolongation of the situation). The response arrived on time. - WHO in Tunisia had the capacity to react and adapt, as far as possible, to changes and emerging needs. - WHO was able to respond to additional requests requests from national partners.	- Biennial programmes 2018-2019, 2020-2021 and 2022-2023 - Documents produced by the biennial programmes - Mid-term (MTR) and final reports for the 2018-2019, 2020-2021 and 2022-2023 biennial programmes (Scorecard) - Financial reports for the biennial programmes and to donors - Institutional texts, in particular the regulatory and legal framework relating to the areas supported by WHO contributions - Public health strategies, policies and programmes from official sources - Public strategies, policies and programmes incorporating a health component or cross-cutting approach	
Q4.2. To what extent are the organizational (results-based management system), administrative and structural arrangements appropriate to the needs of the biennial programme development and implementation process?	- The country office in Tunis has sufficient human resources to develop and implement biennial programmes or other actions. - WHO's own administrative procedures and those of the national partners enable the biennial programmes to be implemented smoothly and on schedule. - The funding mechanisms used enable the biennial programmes to be implemented smoothly		

	and on schedule. - Organizational, administrative and HR arrangements can be adapted to emergency and humanitarian situations (different implementation methods to development).	- Statistics and data available from the national information system. - Team from the WHO office in Tunis, the WHO Regional Office for the Eastern Mediterranean and headquarters - Institutional and implementation partners - International organisations - Donors	
SUSTAINABILITY: Q5. To what extent has WHO contributed to strengthening national capacity and ownership to respond to Tunisia's humanitarian and development needs and priorities in health?			
Q5.1. To what extent have WHO interventions during the evaluation period contributed to the sustainability and national ownership of the results achieved towards a resilient health system in Tunisia (including for emergency situations), universal health coverage and better population health?	-The actions in place include mechanisms to ensure proper national ownership of the products and processes and to promote the sustainability of those actions (capacity building, tools, sufficient resources). - The partners/beneficiaries have the capacity and means to continue or maintain the actions implemented as part of the collaboration with WHO (implementation of strategies and programmes, use of tools and information systems, etc) without external support.	- Biennial programmes 2018-2019, 2020-2021 and 2022-2023 - Documents produced by the biennial programmes - Mid-term (MTR) and final reports for the 2018-2019, 2020-2021 and 2022-2023 biennial programmes (Scorecard) - Financial reports for the biennial programmes and to donors - Institutional texts, in particular the regulatory and legal framework relating to the areas supported by WHO contributions - Public health strategies, policies and programmes from official sources - Public strategies, policies and programmes incorporating a health component or cross-cutting approach	- Literature review - Semi-structured interviews - Observation

		- Statistics and data available from the national information system. - Team from the WHO office in Tunis, the WHO Regional Office for the Eastern Mediterranean and headquarters - Institutional and implementation partners - International organisations - Donors	
CROSS-CUTTING THEMES o Human rights approach o Gender perspective o Health equity (‘leaving no-one behind’)			

Annex 3: Reconstruction of the theory of change



Annex 4: Summary of data collection methods and sources used

During the scoping phase, and in agreement with WHO and the evaluation team, minor changes were made to the evaluation questions initially set out in the terms of reference. These changes involved merging some of the evaluation sub-questions and rewording others to improve their clarity and precision.

The evaluation team used a mixed (qualitative and quantitative) approach to data collection and analysis. This approach enabled information to be cross-referenced and therefore ensured its reliability through a variety of tools (document review, data analysis, interviews, etc.).

Data collection

Five main data collection methods were used:

1) Exhaustive and retrospective literature review

The evaluation matrix contains the key documents identified and examined prior to the fieldwork, during the scoping phase. Other documents were added as we went along (bibliographical research, sharing of key informants) and used subsequently, during the data analysis and drafting process. The key documents identified are classified as follows:

- Planning, monitoring and budgeting documents for WHO's contribution in Tunisia, including the 2018-2019, 2020-2021 and 2022-2023 programme budgets;
- Documents on the various programmes or projects implemented under the biennia (consultants' reports, programmes and attendance lists for seminars, training courses, articles published in the media, etc);
- WHO strategic and thematic documents;
- Mid-term and final technical and financial reports of the biennials and monitoring of GPW13 indicators;
- Strategies, programmes, reports and evaluations of the United Nations Country Team (UNCT) in Tunisia, including the UNSDCF, and in relation to the monitoring of the SDGs;
- Public health strategies, policies and programmes from official sources.
- Public strategies, policies and programmes incorporating a health component or cross-cutting approach;
- Statistics and data available from the national information system.

2) Semi-structured interviews

The semi-structured interviews were mainly individual, but some were grouped (see Table 6 and Annex 5). All interviews were treated confidentially. An interview guide based on the evaluation questions and sub-questions was drawn up beforehand and adapted to the different types of organizations and interviewees (WHO staff, public administration, civil society partners, donors, international organizations and UN agencies).

Most of the interviews were carried out during the field phase and were therefore mainly face-to-face. However, in the interests of flexibility and efficiency, some interviews were conducted virtually, either during the field phase or during the two weeks before and the two weeks after. The interviews held in virtual mode involved staff from the RO and WHO headquarters, UN agencies and people who were travelling.

The selection of people to be interviewed was based on the mapping of stakeholders involved in the design, management and/or supervision of WHO contribution (drawn up on the basis of an initial documentary review and the scoping interviews; scoping report), and in agreement with the WHO Office in Tunis. The preliminary selection represented around 70% of the organizations and institutions mapped (see Table 6.)

1). The selection of the sample was deliberate. The selection criteria concerned (i) the importance of the theme in relation to the planning and implementation of WHO's actions and in relation to WHO's regional and general priority themes; (ii) the importance of the role of the institution or organization in emerging health issues in Tunisia; (iii) the theoretical level of involvement during the implementation of actions with WHO; (iv) the multisectoral approach to health; (v) the representativeness of the different types of WHO partners.

Table 6. Synthesis of the mapping and the stakeholders and interviewees.

STAKEHOLDERS	MAPPING	INTERVIEWS	Males	Females	TOTAL KEY INFORMANTS	TYPE OF INTERVIEW
WHO	13	19	8	11	19	virtual/in person
Partners and national institutions	47	24	21	22	43	in person
UN agencies	13	9	3	6	9	virutal/in person
Financial and technical partners	13	4	3	1	4	virtual
TOTAL	86	56	35	40	75	in person/virtual

Within each institution or organization, priority was given to the person(s) who were most directly involved and able to bring a critical vision, either at the strategic level or at the programmatic or organizational level. Particular attention was paid to cultural specificities, promoting integration and ensuring anonymity and confidentiality. The "snowball" method was applied during the data collection phase to replace unavailable key informants or even to complete the initial screening.

3) Ground observations

During the field phase, visits to WHO-supported facilities and services in Greater Tunis and Sousse are planned. Preliminary identification led to visits to three hospitals that received equipment and materials to support the COVID-

19 response and infectious diseases, as well as a youth centre for actions related to the promotion of the activity and tobacco control. Pre-identification was carried out in collaboration with the country office team on the basis of the importance of WHO-supported interventions in these localities, the ease of access, given the limited duration of the field phase, and some security concerns which could make it difficult to visit other areas. The initial identification of the services or interventions to be visited may be modified once in the field depending on the progress of the schedule, unforeseen events such as the unavailability of local actors, or even the possibility of not being able to proceed, for contextual or scheduling reasons. In the same way, there may be visits to other localities where WHO action has been significant, particularly in the centre or south of the country, if agendas and conditions allow.

Once the concretion of the field visits has been confirmed with the PB team, an observation grid will be prepared. In all cases, in the case of visits to health facilities that have received equipment for the response to the COVID-19 crisis, these observations will concern the adequacy of the equipment received in relation to the needs identified, the time taken to receive it, its adaptation to local resources in relation to its use (available staff, fungibles, reagents, etc) and the use of this equipment today.

5) Timeline

A timeline was drawn up, based on data extracted from the literature review and interviews, on the evolution of the COVID-19 pandemic in Tunisia, the national response and the WHO response.

6) Brainstorming workshop

On the basis of the first draft of the report, a workshop to 'co-create' the recommendations was held in virtual format with the WHO country office team (29 January 2024). Another workshop was held with members of the extended ERG and other key informants from the Ministry of Health, the UNS and donors (14 February 2024). This exercise reinforces the importance of the evaluation process, encourages participation and ownership by the teams.

Data analysis

The data collected using the various methods described above were analysed to identify the main findings and conclusions. During this analysis, the context of both the development and implementation of WHO's contribution was taken into consideration, in particular that linked to the COVID-19 pandemic and its repercussions on the various actions.

The data collected was analysed through a process of triangulation, in other words, by cross-checking the information obtained from different sources and using different methods. This triangulation makes it possible to validate the findings, - on the basis of evidence and recurring points of view, - from which the main conclusions are drawn and recommendations made.

The qualitative analysis was carried out on the basis of notes collected during individual or group interviews and working meetings. The qualitative data was coded and classified according to the key themes linked to the evaluation questions and sub-questions. Two evidence matrices were used, one for the review of the most significant documents providing answers to the evaluation questions and sub-questions, and the other for the semi-structured interviews. Cross-referencing and synthesising this information and data provided the answers to the questions in the evaluation matrix.

For the analysis of the quantitative data, basic statistics and graphs were carried out using various software. Budget data were analysed to compare planning with implementation, distribution between activities and staff, and between strategic priorities and results, and to link to qualitative data and progress in performance indicators used by WHO. In addition, the data analysis focused on identifying evidence or evidence that supports the conclusions and recommendations of the evaluation.

Report validation

The validation process was structured around three key moments. First, the review of the first draft of the evaluation report by the Evaluation Advisory Group, as well as other Regional Office and headquarters resource persons and all operational members of the Country Office. Secondly, the two workshops for presentation, validation of results and co-creation of recommendations (with WHO and the extended ERG). Finally, the final revision of the final version of the report. The evaluation report was validated through WHO's own review, quality control and internal discussion mechanisms. The members of the ERG carried out an external review through a summary document that was shared with them for the preparation of the workshop to present and validate the results and main recommendations.

The final version of the report submitted by the evaluation team considered the responses to the comments and relevant amendments jointly agreed upon by the advisory group.

Annex 5: List of key informants interviewed

WHO COUNTRY OFFICE	
Hela Ben Mesmia	Health system strengthening
Henrik Axelson	Health System Advisor
Ibrahim El-Ziq	WHO Representative
Imen Gouader	Programme Management Officer
Ines Fradi	Health system strengthening
Kaouther Oukaili	Technical Officer Country Emergency Preparedness
Olfa Said	Technical Officer Health promotion and well being
Ramzi Ouhichi	Technical Officer Public Health
Salma Blouza	Financing assistant
Saloua Selmi	Operations Officer
WHO REGIONAL OFFICE FOR EASTERN MEDITERRANEAN AND HEADQUARTERS	
Ahamed Tijjani Remawa	Eastern Mediterranean Regional Office business operations support to Tunisia
Amarnath Das	Compliance & risk management, Eastern Mediterranean Regional Office
Amr Nagui El Tarek and team	Regional Planning, Budgeting, Monitoring & Evaluation unit, Compliance & risk management, Eastern Mediterranean Regional Office
Awad Mataria	Director, Universal Health Coverage/Health Systems , Eastern Mediterranean Regional Office
Elizabeth Tayler	Technical Specialist / Communicable diseases division, Eastern Mediterranean Regional Office
Fatimah El Awa	Regional Advisor, Tobacco Free Initiative, UHC/NMH / Non communicable diseases & Mental Health, Eastern Mediterranean Regional Office
Hala Sakr	Regional Adviser, Violence, injuries and disabilities / Health population division, Eastern Mediterranean Regional Office
Indrajit Hazarika	Senior Public Health Officer – Country Cooperation Strategy Unit, HQ
Rosa Mae Acosta	Regional Planning, Budgeting, Monitoring & Evaluation unit, Eastern Mediterranean Regional Office
NATIONAL PARTNERS AND INSTITUTIONS	
Abelrrazzel Bouzouita	General Director of Health, Ministry of Health
Agnes Hamzaoui	Member of the technical committee of the Societal Dialogue, Head of Pneumology Department , Mahmoud el Matri Hospital
Amel Letaief	Head of Infectious Diseases department, Hospital Farhat Hacched
Awatef Saghrouni	General Director of the Tunisian National Television
Dhafer TEMIMI	Communication Manager, Scouts Tunisiens
Faycal Samaali & Zedini	National Focal Point for Tobacco Control Coordinator of the Non-Communicable Diseases Unit, Director Primary Health Care Department, Ministry of Health
Hajer Skhiri	Head of the National Health Institute, Ministry of Health
Halim Trabelsi	Head of virology Department, Hospital Sahloul
Hatem Bouzaienne	President of ACT, Alliance contre le tabac

Hatem Cherif	Regional director of Health in Sfax, Ministry of Health
Hechmi Louzir	General Director, Pasteur Institute
Henda Chebbi	Deputy Director, UMU, Ministry of Health
Hmida Slama	Director of National Blood Transfusion Centre of Tunis, Ministry of Health
Ilhem Boutiba	Head of microbiology & Virology Department, Hospital Charles Nicolle
Khalid Bacchoucche and team	Regional Commissioner for Youth and Sport, Sousse
Lotfi Ben Hamouda	Director of School and University Medicine, Ministry of Health
Maha Zaoui and team	in charge of Mission in the Office of the Ministry of Youth and Sport/In charge of the General Direction of the National Observatory of Sport, Ministry of Youth and Sports
Mondher Kassis	Epidemiologist, Hospital Habib Bourguiba and Hospital Hedi chaker
Myriam Razgallah Khrouf	General Director of Pharmaceuticals and Medicines, WHO Collaborating Centre, Ministry of Health
Myriem Khrouf	Medical Research Director, Ministry of Health
Nadia Assili	Deputy Director of Multilateral and Technical Cooperation, Ministry of Health
Naoufel Somrani	Director of Public Health facilities, Ministry of Health
Sina Hadj Amor	Director of Technical Cooperation Unit, Ministry of Health
Tarek Rajhi	Regional Director of Health in Kef, Ministry of Health
UNITED NATIONS AGENCIES	
Arnaud Peral	UN Resident Coordinator
Boutheina Ghram	Veterinarian, FAO
Isadora De Moura	Representative, ONU Femmes
Lassad Soua	Country Director, UNAIDS
Mohamed Chakroun	Chair of CCM-Tunisia & Alternate Board Member at Global Fund, Fonds Mondial
Monica Noro	Representative, HCR
Nathalie ANGIBEAU	Representative, UNOPS
Rym Fayala	Cheffe de Bureau, UNFPA
Sandra Martins	Early Childhood Manager, UNICEF
DONORS	
Anne Nicolay	Cooperation Officer - Health and Social Inclusion, European Delegation Tunisia
Jan-Christopher Castilhos França	Senior Country Manager, Country Engagement, GAVI
Patrick LUHINDI	Technical Officer FCTC - based in WHO HQ
Yassine Kalboussi	Health Specialist, Middle East and North Africa Region, World Bank

Annex 6: Continuity of the 2020-2021 and 2022-2023 biennia

	2020-21			2022-23		
	TOP TASK	PLANNED COST (US$)	UTILIZATION (US$)	TOP TASK	PLANNED COST (US$)	UTILIZATION (US$)
GRAND TOTAL	**38**	**4.517.389**	**2.857.684**	**63**	**5.835.677**	**3.085.769**
Goal 1: 1 billion more people with coverage of essential health services		**1.770.621**	**1.092.039**		**2.359.659**	**1.113.757**
Outcome 1.1. Improved access to quality essential health services		**1.334.337**	**828.599**		**1.686.303**	**987.372**
1.1.1. Countries enabled to provide high quality, people-centered health services, based on PHC strategies and comprehensive essential service packages	Support for developing accreditation norms and other instruments for quality improvement	445.500	415.242	Support for developing accreditation norms and other instruments for quality improvement	651.362	261.361
	Support the implementation of the new expected national health policy with a focus on strengthening primary health care and the continuum of care			Support the implementation of new national health policy in relation to primary health care, hospital care and the continuum of care		
	Support to develop and implement a multisectoral plan and programmes to prevent injuries					
	Strengthen surveillance of and response to communicable diseases	327.779	203.810	Support the implementation of new strategies (HIV, Leishmaniasis, Tuberculosis)	336.136	254.050

1.1.2. Countries enabled to strengthen their health systems to implement condition- and disease-specific programmes	Support the country by purchasing reagents, equipment and medicine to prevent, diagnose and manage some communicable diseases			Support on equipment, medicine, and reagent to prevent, diagnose and manage some communicable diseases		
	Support the implementation of the new Immunization multiyear plan (2019-24)			Support the reinforcement of expended program of immunization (Cold chain, HR, Coverage, data collection)		
	Update strategies, policy guidelines and technical tools to prevent, control and treat communicable diseases			Update guideline and technical document and existant strategies		
				Support to develop and implement a multisectoral plan and programmes to prevent injuries for road traffic.		
				Support to develop (for health workers) and implement (for women) a multisectoral plan and programmes to prevent violence including health system response in coordination with other UN agencies.		
				Support strengthening national capacity on implementation of the national multisectoral strategy on mental health		
				Capacity building on the management of substance use.		
1.1.3. Countries enabled to strengthen their health systems to address population-specific health needs and barriers to equity across the life course	Country capacity strengthened to implement and monitor integrated policies and strategies for promoting adolescent health and reducing adolescent risk behaviours	191.901	86.502	Country capacity strengthened to implement and monitor integrated policies and strategies for promoting adolescent health and reducing adolescent risk behaviours	275.476	183.575
	Support the implementation of the maternal and neonatal health strategy 2019-2023			Support the implementation of the maternal and neonatal health strategy 2019-2023		

	Update strategies, policy guidelines, technical tools to improve the health of mothers, newborns, children, adolescents and elderlies			Update strategies, policy guidelines, technical tools to improve the health of elderlies		
1.1.4. Countries enabled to ensure effective health governance	Support Phase 3 of the Societal Dialogue for health policy, including institutionalization of the process and policy dialogue to monitor implementation	159.096	77.397	Support Phase 3 of the Societal Dialogue for health policy as well as other governance reform instruments	70.329	50.036
1.1.5. Countries enabled to strengthen their health workforce	Strengthen capacity for and producing analytical work on human resources for health	210.061	45.647	Strengthen policy dialogue and strategic work on evidence related to human resources for health	353.000	238.350
Outcome 1.2. Reduced number of people suffering financial hardships		**149.534**	**116.954**		**156.500**	**20.946**
1.2.1. Countries enabled to develop and implement equitable health financing strategies and reforms to sustain progress towards UHC	Advocate for improved efficiency of the health system, including through defragmentation of the health financing system	99.097	86.116	Advocate for improved efficiency of the health system, including through defragmentation of the health financing system	86.000	4.907
1.2.2. Countries enabled to produce and analyze information on financial risk protection, equity and health expenditures, and to use this information to track progress and inform decision-making	Strengthen capacity for production of key health expenditures data	23.819	9.196	Strengthen capacity for production of key health expenditures data	54.500	2.024
1.2.3. Countries enabled to improve institutional capacity for transparent decision-making in priority-setting and resource allocation, and analysis of the impact of health in the national economy	Promotion of evidence-based policies and health technology assessment to adjust benefit package covered by public financing	26.618	21.642	Promotion of evidence-based policies and health technology assessment to adjust benefit package covered by public financing	16.000	14.015

Outcome 1.3. Improved access to essential medicines, vaccines, diagnostics and devices for primary health care		**286.750**	**146.486**		**516.856**	**105.439**
1.3.2. Improved and more equitable access to health products through global market shaping and supporting countries to monitor and ensure efficient and transparent procurement and supply systems	Support evidence-generation for reforms related to improving access to medicines, including pricing, procurement, and supply-chain reforms	58.550	0	Support evidence-generation for reforms related to improving access to medicines, including pricing, procurement, and supply-chain reforms	78.159	19.380
1.3.3. Country and regional regulatory capacity strengthened and supply of quality-assured and safe health products improved	Strengthen country capacity for assuring the quality of health products	60.000	14.743	Strengthen country capacity for assuring the quality of health products	72.455	14.137
1.3.5. Countries enabled to address antimicrobial resistance through strengthened surveillance systems, laboratory capacity, infection prevention and control, awareness-raising and evidence-based policies and practices	Support the implementation of the new AMR action plan (2019-2023)	168.200	131.742	Support the implementation of the new AMR action plan (2019-2023)	366.242	71.922
Goal 2: 1 billion more people better protected from health emergencies		**651.966**	**265.562**		**865.593**	**374.676**
Outcome 2.1. Countries prepared for health emergencies		**496.765**	**113.874**		**287.239**	**75.498**
2.1.1. All-hazards emergency preparedness capacities in countries assessed and reported		554	554	Conduct National Risk Assessment using STARtool	30.887	2.460
				Develop All Hazard Emergency Response Plan		
2.1.2. Capacities for emergency preparedness strengthened in all countries	Strengthen capacities in emergency preparedness (guideline development, capacity building and simulation)	40.648	37.774	Conduct Health Emergency Preparedness and response course (ToT)	176.205	60.236
				Update and implement National Action Plan for Health Security (NAPHS)		

				Assess and enhance prehospital emergency care system		
2.1.3. Countries operationally ready to assess and manage risks and vulnerabilities	Strengthen the health emergency operational center (HR, training, and equipment), including hospital and emergency units well prepared and rapid response teams operational	455.563	75.546	Enhance EOC capacities through training and operational support	80.147	12.802
	Support development and implementation of a public health emergency multisectoral plan to prevent, assess, reduce risks and to manage health emergencies			Conduct a SIMEX to assess country preparedness in terms of health emergencies management		
Outcome 2.2. Epidemics and pandemics prevented		**155.201**	**151.689**		**174.433**	**68.933**
2.2.1. Research agendas, predictive models and innovative tools, products and interventions utilized for prevention and management of high-threat health hazards		0	0	Enhance national laboratory capacities at national and regional levels, especially for quality diagnostic testing of high-threat pathogens adhering to biosafety and biosecurity standards.	74.113	22.108
				Promote One Health approach and conduct Zoonotic diseases prioritization		
2.2.2. Proven prevention strategies for priority pandemic/epidemic-prone diseases implemented at scale	Support country to implement the strategy for prevention and response to epidemic prone diseases	139.201	137.004	Enhance influenza surveillance system	40.365	36.028
				Support the implementation and functionality of Event Based surveillance and promote implementation of integrated surveillance system		
2.2.3. Risk of the emergence/re-emergence of high-threat infectious pathogens mitigated	Update policy guidelines and technical tools to support Country to reduce and	16.000	14.684	Enhance the prevention and control of priority epidemic/pandemic diseases, high-	59.955	10.797

	mitigate risk of infectious outbreak and epidemic			threat pathogens and other public health emergencies (West Nile, CBRN…)		
Outcome 2.3.		0	0		403.921	230.245
2.3.1. Acute health emergencies rapidly responded to, leveraging relevant national and international capacities and networks		0	0	Enhance RRT at the subnational level	403.921	230.245
				Support the implementation and accreditation of national EMTs		
Goal 3: 1 billion more people enjoying better health and well-being		**580.935**	**372.298**		**598.166**	**525.209**
Outcome 3.1. Determinants of health addressed		118.132	62.246		26.838	16.096
3.1.2. Countries enabled to address environmental determinants of health, including climate change	Capacity strengthened to assess environmental risks for health and develop and implement policies, strategies for prevention, mitigation and management of the health impacts of environmental risks and climate change	118.132	62.246		0	0
3.1.2. Countries enabled to strengthen equitable access to safe, healthy and sustainable foods		0	0	Support the celebration of the global food safety day	26.838	16.096
				Strengthen National capacities in terms of food safety and enhance the national network involved in food safety activities		
				Support strengthening national capacity on social determinants of health across the life course		
Outcome 3.2. Risk factors reduced through multi-sectoral action		364.803	296.593		515.209	478.710

3.2.1. Countries enabled to develop and implement technical packages to address risk factors through multi-sectoral action	Implementation of the national multisectoral strategy on NCDs	318.303	255.945	Support strengthening national capacity on implementation of the national multisectoral strategy on NCDs	494.709	448.660
				Strengthening national capacities for surveillance and monitoring of the WHO framework convention on tobacco control.		
				Strengthening Surveillance of NCD including risk factors surveys, Cancer registry, Health system responses in particular NCD indicators at PHC level as part of UHC coverage indicators.		
3.2.2. Multi-sectoral risk factors addressed through engagement with public and private sectors as well as civil society	Supporting the creation and functioning of a coordinating body on intersectoral action	46.500	40.648	Support strengthening of national capacity on implementation of a multisectoral governance mechanism to fight against NCDs	20.500	30.050
Outcome 3.3.		**98.000**	**13.459**		**56.119**	**30.403**
3.3.1. Countries enabled to address environmental determinants, including climate change		98.000	13.459	Support the development of national guide on health and climate change	56.119	30.403
				Support a national assessment on the governance role of the health system in terms of control of health impact of climate change		
				Support the celebration of the annual workshop of Hygiene		
				Enhance best practices of hand hygiene and promote Infection, prevention and control (IPC) measures through printing materials		

3.3.2. Countries enabled to create an enabling environment for healthy settings		0	0	Support strengthening of national capacity on intersectoral collaboration and urban governance for health and well-being.	0	0
Corporate Goal: More effective and efficient WHO better supporting countries		**1.513.867**	**1.127.785**		**2.012.259**	**1.072.127**
Outcome 4.1. Strengthened country capacity in data and innovation		**135.000**	**43.463**		**755.410**	**38.941**
4.1.1. Countries enabled to strengthen health information and data systems, including at the subnational level, and to use this information to inform policymaking	Development and implementation of digital health platforms, including an integrated robust health information system for civil records, individual health and facility data	66.768	40.784	Support for developing integrated information systems	357.410	28.681
4.1.2. WHO impact framework and triple billion targets, global and regional health trends, SDG indicators, and health inequalities and disaggregated data monitored		27.000	2.478	Strengthen national capacities in tracking progress towards health-related SDGs in line with WHO impact framework and the triple billion targets.	0	0
4.1.3. Countries enabled to strengthen research capacity and systems, conduct and use research on public health priorities, and scale effective innovations in a sustainable manner		41.232	201	Policy dialogue and strategic support for advancing the use of digital health technologies	398.000	10.260
Outcome 4.2. Strengthened WHO leadership, governance, and advocacy for health		**729.906**	**636.836**		**733.454**	**524.407**
4.2.1. WHO's leadership and governance enhanced to implement GPW13 to drive impact at the country level, including through strategic communications, and in support of the Sustainable Development Goals and in the context of UN reform	Coordination with UN and other partners	666.676	596.306	Effective leadership and coordination of WHO's work at the country level achieved including briefings, and country intelligence on political, diplomatic, policy and strategic issues, and support of national efforts to accelerate progress toward the health-related SDGs	694.050	488.541
	UN Days celebration, WHDs					

	WR support activities			Support to WR Activities		
				Health Priorities incorporated into the UNSDCF in line with CCS and Biennial Collaborative Agreement		
				Participation in headquarters/Regional WR/WHO meetings		
				Programme for briefing and support and preparing Member States delegations in their preparation and follow-up for regional and global governing body meetings and processes		
4.2.2		3.000	0		0	0
4.2.3.		6.600	0		21.320	19.813
4.2.4. Planning, allocating resources, implementing, monitoring and reporting based on country priorities, achieving country impact, ensuring value-for-money, and the strategic priorities of GPW 13	Ensuring smooth coordination with key stakeholders and national counterparts	2.000	0		18.084	16.053
4.2.5. Cultural change fostered and critical technical and administrative processes strengthened through a new operating model to optimize organizational performance and enhanced internal communications	Country Office Communication strengthened	51.630	40.530		0	0
				WHO Transformation agenda implemented in alignment with scope of GPW13 at CO, RO and Global level		
				Aligning staff with programmatic priorities. CO HR plan implemented and monitored in line with Performance monitoring; Learning Programmes		
Outcome 4.3. Financial, human, and administrative resources managed in an efficient, effective, results-oriented and transparent manner		**648.961**	**447.486**		**523.395**	**508.779**

4.3.1. Sound financial practices and oversight managed through an efficient and effective internal control framework and in line with the principle of value-for-money	Building maintenance and utilities	56.483	48.701		38.283	38.998
				VfM for monitoring and managing expenditures and cash/bank through imprest accounts.		
4.3.2. Effective and efficient management and development of and investment in human resources to attract, recruit and retain talent for successful programme delivery	Support staff training	17.988	20.890		500	954
4.3.3. Effective, innovative and secure digital platforms and services aligned with the needs of users, corporate functions, health technical programmes and health emergencies operations		95.388	94.202	Manage the local IT infrastructure and related services of the Country Office	114.366	108.066
4.3.4. Safe and secure environment, including duty of care, with efficient infrastructure maintenance, cost-effective support services, and responsive supply chain	IT equipment purchase and maintenance	479.102	283.692	Manage the day-to-day activities and operations of the Admin. unit	370.246	360.761
	Operations and logistics, maintenance, fuel, car insurance			Provide Facility management services and maintenance		
	Security management			Coordinate with the United Nations to ensure security of premises and staff		
	Staff travel			Manage Transport and Meetings services		

Source: *Workplans* 2020-2021 and 2022-2023 for the list of activities (Top tasks) and *Planned & Expenditures for Activity & HR costs* 2018 to 2023, for the amounts (planned and utilized budget).

Reading note: It has been noted that in some cases, outputs are not programmed in the workplan and appear in the Excel budget document. Examples include outputs 4.2.2 and 4.2.3

Annex 7: Overview of the impact of the Covid-19 pandemic in Tunisia, government and WHO response

1. Introduction

In December 2019, an outbreak of pneumonia initially of unknown cause occurred in Wuhan, China. This severe flu-like syndrome quickly spread around the planet. The pathogen responsible was confirmed as a novel coronavirus and the disease was officially named COVID-19. On 11 March 2020, the WHO classified COVID-19 infection as a pandemic constituting a global public health threat *(17)*. Health systems around the world have faced challenges due to the COVID-19 pandemic. This unprecedented global health crisis has revealed the shortcomings and dysfunctions of any health system, regardless of the country's level of development.

In Tunisia, the COVID-19 pandemic began in March 2020. Despite a political context considered unstable, Tunisia was initially described as having a "successful response" in its management of COVID-19 cases before facing the peak of incidence in June 2021. Indeed, there has been a tangle of economic, political and health crises, aggravated by the COVID-19 epidemic: the head of government had resigned in February 2020 and the second head left the government in September 2020, during the first wave of the epidemic. The third head of government was dismissed in July 2021, during the fourth wave of the pandemic *(18)* following the suspension by the President of the Republic of the activities of Parliament *(19)*. The head of government had covered the position for a few months as an interim, before the appointment of the fourth head of government who held this position until August 2023 before being replaced. More specifically, at the level of the Ministry of Health, five ministers of health succeeded each other during the year 2020 and three ministers during the year 2021.

In terms of health, pre-COVID-19 Tunisia faced the burden of non-communicable diseases (NCDs): 83% of all deaths were attributable to NCDs, including 49% for cardiovascular causes, 12% for cancers, 5% for chronic respiratory diseases, 5% for diabetes and 11% for other NCDs[17].

In terms of morbidity and risk factors, the results of national surveys have revealed increasing prevalences for diabetes and high blood pressure. Other risk factors such as smoking, alcohol consumption, overweight, physical inactivity, and salt consumption are on an upward trend over the past 20 years compared to previous studies. In addition, the cancer registry in northern Tunisia reports an increase in the incidence of cancers for both sexes.

In this context, the health system began to face several challenges *(20)*:

- A healthcare system with a traditional taxonomy respecting a public/private dichotomy and reduced control by the Ministry of Health over the private sector in relation to compliance with standards *(21)* and a need for a legal framework, including for dual membership of the public and private sectors
- Basic health care is available in Basic Health Centres (BHCs) and is well distributed across the country, but the presence of care in these facilities is low *(22)*, which contributes to overloading the emergency departments of tertiary hospitals *(23)*.

[17] WHO - Country Profile NCD, 2014

- There are major disparities in the availability of and access to healthcare in the different regions of the country *(24)*. involving inequalities in healthcare consumption and major differences in the state of health of populations between governorates *(25)*.
- Prevention and promotion activities are marginalized, and the public sector is very hospital-based and oriented towards curative care. According to the national health accounts, the budget allocated to prevention in Tunisia is marginal *(26)*.
- The current organization of the healthcare system is centralized, which complicates certain aspects of local governance and optimization of resources *(26)*.
- The lack of genuine computerization intensifies administrative compartmentalization, the lack of traceability and the lack of data.
- The migration of doctors has been mentioned on several occasions as one of the causes of the fragility of the healthcare system *(27)*.
- Lack of health budget: per capita health expenditure is around USD 252 *(28)*. Tunisia has also tried to meet the conditions of the structural adjustment programmes enabling it to benefit from International Monetary Fund (IMF) loans, which, according to some studies, have led to a decline in health and social protection *(29)*.
- Inequalities in access to healthcare are marked, with a significant proportion of the population not having access to social cover[18]. Indeed, the rate and quality of social security cover is lower for the most economically vulnerable.

To achieve universal health coverage (UHC), Tunisia had embarked on a wide-ranging programme of 'societal dialogue on national health policies, strategies and plans', with the aim of building a common understanding of the major challenges to improving health in Tunisia and developing the health system, and moving towards a consensus between all stakeholders on the direction of the reform and the means of implementing it. The first phase of this process culminated in the publication of the 'Livre Blanc' in 2014. Phases two and three of the Societal Dialogue have not yet been implemented *(30)*.

At the start of the COVID-19 pandemic, Tunisia was striving to achieve the targets set under various health priorities and was trying to put in place the premises for universal coverage and health for all by focusing on the most vulnerable populations.

2. Overview of the impact of Covid-19 in Tunisia

2.1 Direct impact of COVID-19 on health and the healthcare system

The epidemic has officially been spreading in Tunisia since 2 March 2020. Initially, the number of imported cases exceeded the number of local infections, but this trend was reversed in March with the arrival of local infections[19] : the start of the spread of the virus was caused by a series of horizontal contaminations in coastal areas towards the end of March *(31)* reaching the whole country by mid-April 2020.

The authorities introduced a series of increasingly strict preventive measures until May 2020, when these restrictions began to have social repercussions *(32)*, *(33)*. In this context, the deconfinement and reopening of the borders seemed necessary.

[18] Monitoring the socio-economic impact of COVID-19 on Tunisian households Analysis of data from the first wave (29 April 2020 – 8 May 2020) INS and World Bank published on 28 May 2020

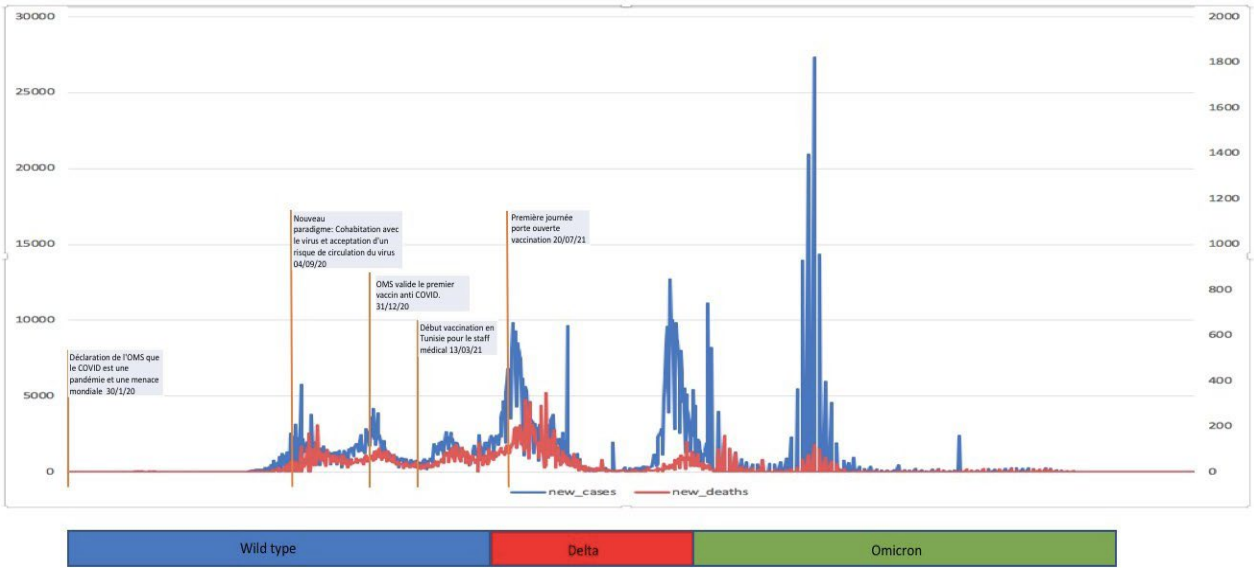
[19] Consultancy Report 1st of July 2020 WHO Tunis Office: COVID-19 Response (OMS document interne)

From September 2020 onwards, there was a paradigm shift and a decision to definitively open the borders, ending the use of general containment solutions in favour of one-off measures geographically limited to active outbreaks. The new paradigm implied cohabiting with the virus and accepting the risk of its circulation[20], as stipulated in the global consensus in favour of lifting general confinement and opening up borders, even in countries with an evolving epidemic[21]. The virus continued to circulate and spread over the entire country in October 2020, with high to very high alert levels.

The first three waves of COVID-19 were well managed, but the fourth epidemic wave coincided with the new Delta variant *(34)*, which occurred in July 2021 and was three times more severe than its predecessor.

The following graph shows the number of new daily cases (patients testing positive for COVID-19) and new deaths attributable to COVID-19 infection since the start of the pandemic.

Figure 1: Number of new daily COVID-19 cases and new daily confirmed deaths attributed to COVID-19 according to the different virus variants (35)



(Source : Evax.tn)

[20] Preparation and Response Plan for the Risk of Introduction and Spread of SARS-CoV-2 in Tunisia

[21] Monitoring report SARSCoV-2-Tunisie 10 OCTOBRE 2021 (ONMNE)

The number of daily cases had reached more than 9,200 by July 2021, and this was the deadliest month with 5,338 new deaths attributed to COVID-19 infection recorded. The highest average daily number of deaths (189.7 deaths/day) occurred during epidemic week 28[22]. The following table shows the number of new cases per day and the number of deaths per day during the peaks of the different waves since the start of the pandemic.

Table 7: Numbers of new daily COVID-19 cases and new daily deaths attributed to COVID-19 during peaks in contamination and mortality.

Wave	Event	Date	New cases per day	Number of confirmed deaths per day
First wave	Peak level of contamination	31/10/2020	3751	100
	Peak mortality level	07/11/2020	1584	205
Second wave	Peak level of contamination	16/01/2021	4170	50
	Peak mortality level	23/01/2021	2389	103
Third wave	Peak level of contamination	16/04/2021	2649	73
	Peak mortality level	29/04/2021	1729	119
Fourth wave	Peak level of contamination	11/07/2021	9286	194
	Peak mortality level	24/07/2021	5624	317
Fifth wave	Peak level of contamination	20/01/2022	12698	35
	Peak mortality level	09/02/2022	5122	131
Sixth wave	Peak level of contamination	18/07/2022	27340	119

Source : Evax.tn

Tunisia was the highest placed country in Africa *(36)* for COVID-19-related mortality. In December 2023, 29,341 deaths attributed to COVID-19 were reported, with a mortality rate that has varied between 1.3 and 4.7% and is currently estimated at 2.5%. Mortality had reached 69.1 per 100,000 inhabitants by 2021.

Table 8: Incidence and fatality rates attributed to COVID-19

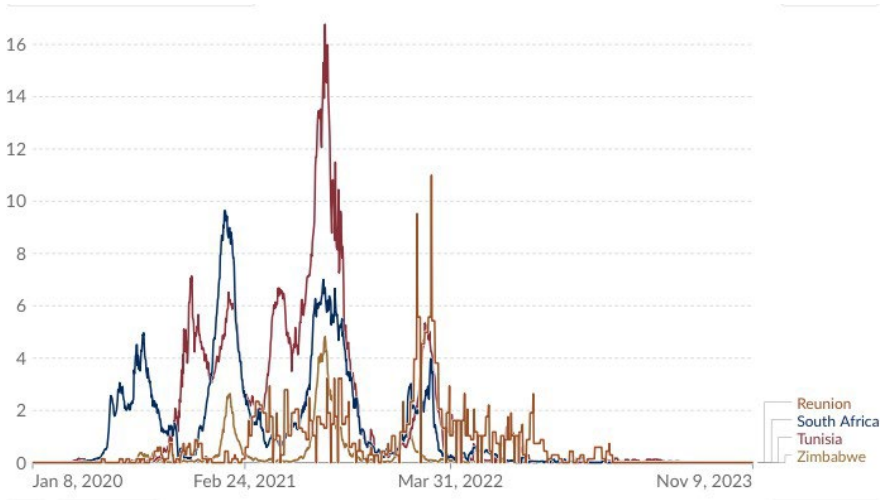
Year	2020	2021	2022	2023
Population *(37)*	11 688 499	11 763 857	11 803 588	11 850 232
Cumulative cases *(35)*	147 061	727 843	1 147 571	1 151 126
Number of new yearly infections	147 061	580 782	419 728	3 555
Cumulative total of deaths *(35)*	4 934	25 576	29 284	29 341
Number of new deaths per year	4 934	20 642	3 708	57
Incidence rate ratio (%)	1.2	4.9	3.5	0.2
Case fatality rate (%)	3.35	3.55	0.88	1.60

Source : Coronavir.org

[22] Monitoring report SARSCoV-2-Tunisie 10 OCTOBRE 2021 (ONMNE)

The following figure shows the number of new confirmed daily deaths due to COVID-19 per million people in Tunisia compared with the three African countries with the highest COVID-19 deaths on the continent (South Africa, Reunion and Zimbabwe) *(38)*.

Figure 2: New confirmed daily deaths due to COVID-19 per million people in Tunisia, South Africa, Réunion and Zimbabwe



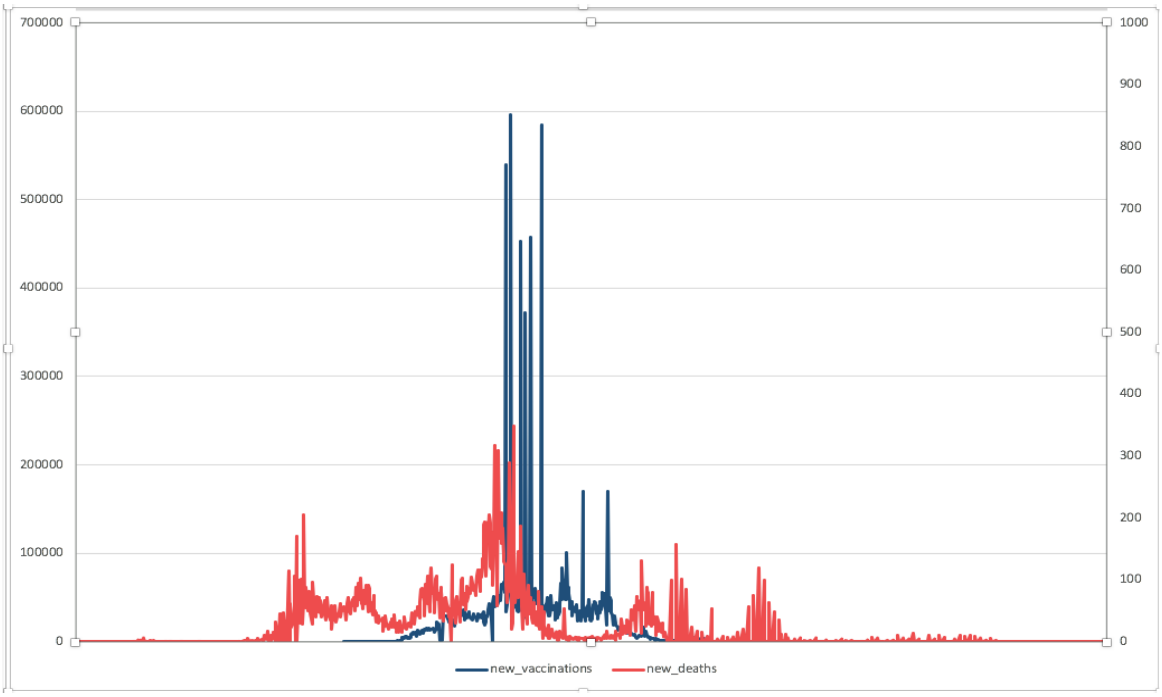
Source : Ourworldindata.org

The health system and health workers were under enormous pressure and were unprepared for the prolonged crisis caused by COVID-19. In general, the Tunisian healthcare system was unable to cope with the challenges imposed by the COVID-19 epidemic *(39)*: the fragile hospital situation and the weakness of the first line of healthcare affected the effectiveness and efficiency of the response to the challenge of the pandemic; in addition to the insufficient number of hospital beds and especially intensive care beds *(40)*, there were other material limitations such as the lack of oxygen *(41)*.

Within this challenging context, the spokeswoman for the Ministry of Health also announced the bankruptcy of the Tunisian health system *(42)*. In the aftermath of this high-impact wave, the Ministry of Health decided to make vaccination the central pillar of the fight against the virus, and efforts were made to provide vaccines and organize mass vaccination.

Figure 3 shows the trend in the number of confirmed daily deaths linked to vaccination. The decline in mortality despite high morbidity supports the effectiveness of mass vaccination in combating severe forms of COVID-19 infection.

Figure 3 : New deaths attributed to confirmed COVID-19 infection, and number of people vaccinated per day



Source : Evax.tn

The fifth wave arrived in the wake of mass vaccination against COVID-19, with a high number of cases but fewer deaths. The Tunisian authorities (hospitals, local authorities, the army, etc.) had acquired significant experience and developed their skills and knowledge. These players were better able to provide an appropriate response in coordination with the partners.

2.2 Vaccination against COVID-19 in Tunisia

In the course of 2020, as the pandemic continued to evolve and record more and more deaths, the vaccine seemed to be the only answer, launching an unprecedented race by pharmaceutical laboratories throughout the world, with enormous financial stakes and in terms of equity in access to vaccines on the world market *(43)*.

Against this backdrop, the WHO Director-General, together with government partners, the European Commission and the Bill & Melinda Gates Foundation, launched the ACT Accelerator in April 2020 *(44)*. COVAX was one of the three pillars of the Accelerator for Access to COVID-19 (ACT) tools, and focused on COVID-19 *(45)* vaccines. Tunisia was one of the countries enrolled in the COVAX initiative. A few months later, WHO validated the first vaccine on 31 December 2020 *(46)*.

At the national level, Tunisia has accelerated the process for granting exceptional provisional marketing authorizations (EPAMs) for COVID-19 vaccines (a period of 27 days for validation compared with 869 days for conventional marketing authorizations (MAs)). A national vaccination plan was published by the Ministry of Health in January 2021 with the aim of vaccinating at least 50% of the population by the end of the year in order to curb the local epidemic and reduce associated mortality.

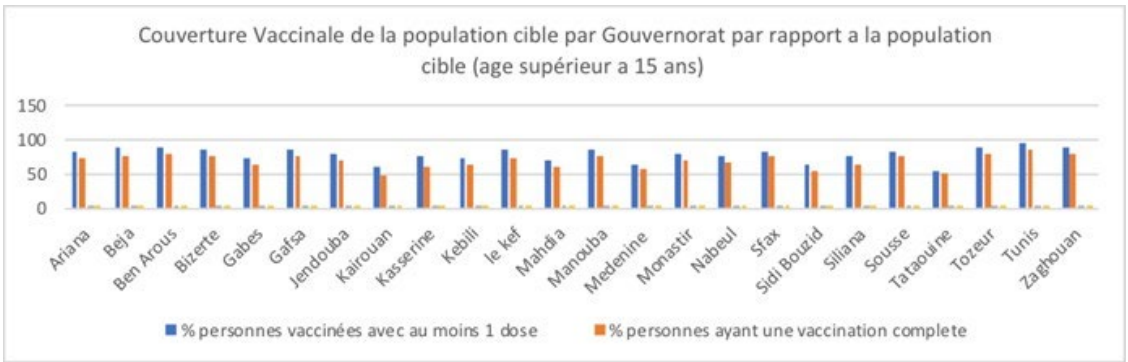
Vaccination was officially launched in mid-March 2021, before the first batch of vaccines arrived from COVAX. The COVAX programme was somewhat late in getting vaccine distribution up and running. The batches that arrived later made it possible to extend the campaign and organize open days from August 2021. Organizing the first open day ran into organizational problems. After receiving the batches, the national health authorities continued to organize open days for the vaccination of second doses. The Ministry of Health also planned to make vaccination available one day a week in 1,000 small health centres, following the recommendations of experts, and vaccination was also started in 600 private pharmacies.

After a good start to vaccination activities, there was a drop in the performance of the vaccination strategy:

- The obligation to use the EVAX platform, which requires an internet connection that is not available in remote areas of the country.
- The requirement to have a telephone to register on EVAX and the complexity of the procedure.

People living in remote areas faced obstacles when travelling to vaccination centres. This contributed to inequalities in vaccination coverage. By November 2023, 79% of the target population had received at least one dose of vaccine and 70% had been fully vaccinated. The following figure shows the vaccination coverage of the target population by governorate in November 2023.

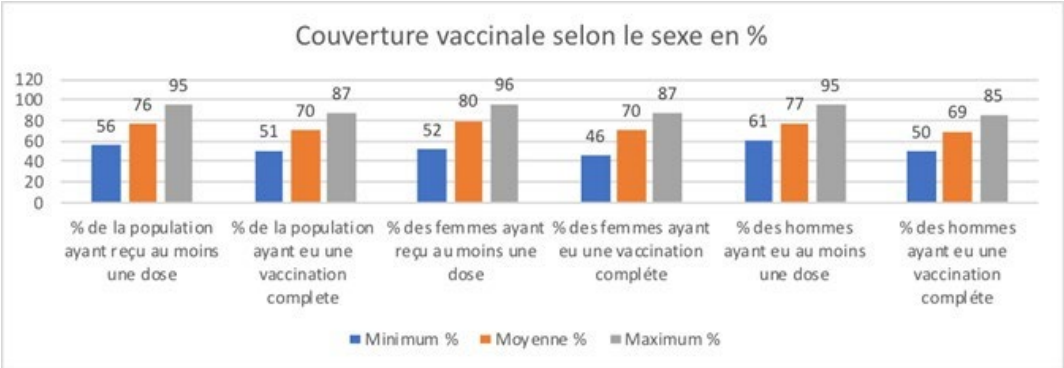
Figure 4 : Percentage vaccination coverage of the target population by Governorate in relation to the target population (over 15 years of age) in Tunisia



Source : Evax.tn – Novembre 2023

Vaccination coverage was satisfactory in terms of gender equity of access. The national figures even showed significantly better coverage among women for single-dose and full vaccination, as shown in Figure 5.

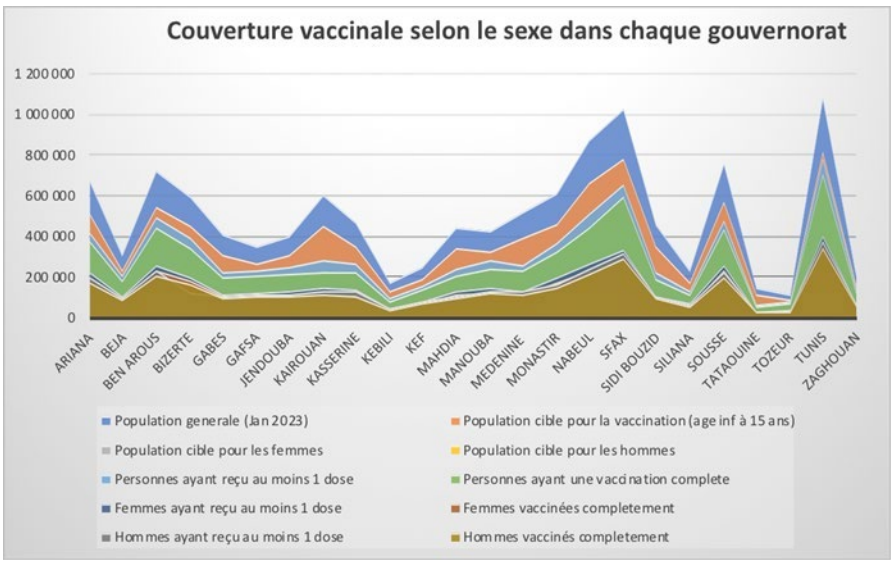
Figure 5 : Percentage vaccination coverage by gender according to type of vaccination (full or 1 dose) in Tunisia



Source : Evax.tn – Novembre 2023

There are variations between the governorates in terms of vaccination coverage, which are in line with the distribution of inequalities in availability and access to healthcare documented in the different regions of the country *(47)* and which respect the gender distribution. Governorates located in coastal areas with a high level of urbanization had better vaccination performance than governorates with a predominantly rural population. The three governorates with the best performance were: Tunis (95%), Ben Arous (90%) and Zaghouan (89%) and the worst performers were: Tataouine (56%), Kairouan (61%), Sidi Bouzid (63%) and Médenine (65%) as can be seen in the following figure.

Figure 6 : Vaccination coverage by gender in each governorate in November 2023



Source : Evax.tn

2.3 Socio-economic impact of COVID-19 in Tunisia

The health crisis had socio-economic repercussions, not only because of the restrictive measures, but also because of their impact on the movement of people and products[23]. As a result, economic activity was significantly reduced for the vast majority of workers, and a decline in income was observed: unemployment rose sharply (only one-third of people were able to continue working) and family production units were also affected.

There was a drop in the supply of certain basic products. These shortages affected all classes of the population relatively equally. Rising food prices and job losses led to food insecurity, especially in rural areas, with some people falling into debt and changing their eating habits.

In addition, access to health products was made more difficult by the difficulties in accessing care during the confinement for all categories of the population. This was mainly due to difficulties in travelling and in finding available medical staff during the containment period. In addition, for people with a lower standard of living, economic and social vulnerabilities made these services almost twice as inaccessible for the poorest quintile as for the richest quintile of the population.

The study published by the Tunisian Ministry of the Economy in 2021 shows that nominal expenditure on health in 2021 reached 2,840 million dinars, which represents a nominal increase of 5 per cent compared with 2020, and a total increase of 182 per cent compared with 2010 *(48)*. Between 2019 and 2020, there will be a sharp increase of 21% in response to the shock imposed by the pandemic. However, in real terms, this represents an increase of 13% over the same period, with an average annual growth rate of 2%.

3. Brief chronology of the government's response

Following the announcement of the pandemic, travellers arriving in Tunisia were screened as a first preventive measure. The Tunisian government introduced public health measures very early on, to avoid overloading the health system. When there were only 39 cases in the country, strict public surveillance and health measures were put in place to limit the spread of the epidemic. Measures initially included the closure of borders, schools, mosques, shops and offices, and the introduction of a curfew. This was quickly followed by a complete lockdown on 20 March 2020. This was gradually eased. The borders were opened on 27 June 2020.

The COVID-19 crisis exacerbated Tunisia's weak macroeconomic performance and economic and social vulnerabilities *(49)*. Export-oriented sectors, tourism and other services, which account for a large share of employment income and foreign currency, have been severely affected by border closures, social distancing and containment measures. During the month of March, there was a 14.2% drop in the stock market index *(50)* and losses in the tourism sector exceeded 4 billion Tunisian dinars in April 2020. The impact of the pandemic on public finances has been estimated at five billion Tunisian dinars by the end of July 2020.

In order to avoid a worsening of the social situation and reduce the economic risks, the government took a series of emergency

[23] Monitoring the socio-economic impact of COVID-19 on Tunisian households Analysis of data from the first wave (29 April 2020 – 8 May 2020) INS and World Bank published on 28 May 2020

measures: exceptional allocations, deferral of part of the payment of taxes and social security contributions for businesses and the introduction of transfers for the most disadvantaged households *(51)*.

4. WHO response to the Covid-19 pandemic in Tunisia

On 30 January 2020, WHO declared the COVID-19 outbreak a public health emergency of international concern (PHEIC) and on 11 March 2020 *(17)*, identified it as a pandemic. The first patient infected with COVID-19 was recorded in Tunisia on Monday 2 March 2020 *(52)* and the first death on 19 March of the same year *(53)*. In line with its international mandate, the Country Office activated a response to support Tunisia in dealing with the expected impact of the pandemic; it alerted the Ministry of Health and shared available data in a context of global uncertainty, activated the purchase of PCR kits and supported the preparation of the national health system during January 2020, before the first case appeared in the country[24].

WHO support for the response of Member States was framed by the WHO Strategic Preparedness and Response Plan for COVID-19 *(54)*, initially structured around nine pillars of response (later updated to incorporate the pillar of vaccination and the pillar of research and data). The Country Office mobilized to engage new partners in supporting the national response (e.g. the governments of the Netherlands, Denmark, Italy, Japan, the United States and Canada), which enabled the Country Office's regular budget to be increased more than fivefold [25]. The contribution of these donors, mobilized locally by the Country Office, amounted to approximately USD 2 million, which represents approximately 17% of the total funds allocated by the WHO for the COVID-19 response in Tunisia. The available budget data show that WHO concentrated its support efforts on the Case Management pillar, including the deployment of therapeutics (31% of the budget allocated by the Country Office for the response), and, to a lesser extent, the Diagnostics and Testing pillar (22% of the allocated budget) and the Infection Prevention and Control pillar (21% of the allocated budget). In total, these three pillars accounted for 75% of the budget allocated by the Country Office to the response. [26].

In addition, and in order to meet the needs of the pandemic and mitigate the impact on other health programmes, the Country Office was reinforced in terms of human resources by the recruitment of a *National Professional Officer* (*Emergency Preparedness & Operations*) to manage activities related to the COVID-19 epidemic and the mobilization of human resources from other country offices [27] Despite the increase in resources, the Country Office had to support the response to the pandemic with limited staff and strengthen its management and implementation capacities to absorb a rapid and intense growth in the budget (from USD 2 million to around USD 10 million in a short period of time)[28].

In summary, the main actions, achievements and shortcomings of WHO support for the government response for each of the pillars (including the planned budget) are summarized in the following paragraphs.

[24] Internal and external informants
[25] Output Scorecard Tool Assessment for EM_TUN WHO Representative's Office, Tunisia - Output: Leadership, governance and external relations enhanced to implement GPW 13 and drive impact in an aligned manner at the country level, on the basis of strategic communications and in accordance with the Sustainable Development Goals in the context of United Nations reform (4.2.1) 2020-2021 - End of Biennium
[26] WHO figures for the OCR budget. See more details on the OCR budget – Response to COVID-19 in the Efficiency section.
27 KII
[28] KII

Pillar 1 - Leadership, coordination, planning and monitoring (USD 240,000; 2%)

From the outset, the Country Office participated in the national coordination mechanisms, supporting and strengthening the role of the Ministry of Health; in particular, the WHO Representative was a member of the Scientific Committee led by the Minister of Health and two members of the Country Office staff were part of the crisis unit at the 'emergency room' (unit for the management of public health crises and major events) throughout the pandemic. During these meetings, WHO guidance documents were used as a basis to support the analysis of the national situation and to decide on subsequent well-founded public health measures (as far as the uncertainty and gaps in knowledge of the new virus allowed). The global guidelines and data on the virus shared by WHO and its adaptation to national circumstances were viewed positively by the members of the Committee[29] and the emergency room.

In order to facilitate the management and coordination of the response by the Ministry of Health, the Country Office strengthened the communications equipment of the Ministry's emergency room.

During the early stages of the pandemic, a thorough assessment of national emergency preparedness capacities was carried out[30] based on a standardized methodology and 56 health facilities were evaluated[31], which provided a clear picture of the gaps and needs in these facilities for the establishment of COVID-19 units. The assessment enabled decision-makers to plan, prioritize and implement the most necessary actions with the greatest impact. This assessment contributed to the development of the National Action Plan for the Response to COVID-19 *(55)* as well as the Strategic Preparedness and Response Plan for Partners *(56)*, published in September 2020.

Within the framework of the specific obligations of WHO under the International Health Regulations and its role as the *Global Health Cluster Lead Agency* within the global humanitarian architecture (*Inter-Agency Standing Committee - IASC*)[32], the Country Office played a central role in leading and coordinating international technical and financial partners, participating in meetings of the Scientific Commission for the Fight against Coronavirus 19 and facilitating bilateral and multilateral meetings with technical and financial partners[33] in close collaboration with the Office of the Resident Coordinator of the United Nations System (UNS). This role (including liaising between the Ministry of Health and a number of international partners and donors) made it possible to optimize the rapid use of funds in line with national priorities and to reduce duplication[34] and has been positively recognized by most of the national and international actors interviewed during the evaluation ('*WHO as an interface between Ministry of Health and donors*').

The coordination efforts and the results of the inter-agency work did not exclude the possibility that some support, particularly in terms of equipment, materials and infrastructure, may arrive late and could not be used at the right time and in the right place[35]. Within the framework of the architecture of the UNS, the evaluation was able to highlight synergies and good levels of inter-agency interaction during the response to the pandemic, but was not able to find evidence of the same intensity of interaction with

[29] Consultancy Report 1st of July 2020 WHO Tunis Office: COVID-19 Response

[30] Output Scorecard Tool Assessment for EM_TUN WHO Representative's Office, Tunisia - Output: All-hazards emergency preparedness capacities in countries assessed and reported (2.1.1) 2020-2021 - End of Biennium.

[31] Consultancy Report 1st of July 2020 WHO Tunis Office: COVID-19 Response.

[32] The response to COVID-19 was the IASC's first global emergency activation.

[33] Internal informant

[34] Internal informant

[35] See Pillar 8 – Operational and logistical support.

international financial institutions. The development of situation analyses and national response plans at the beginning of the pandemic formed the basis for defining the initial financial support from the International Monetary Fund (IMF) and the World Bank (WB) to the health sector[36]. However, the evaluation did not document continuity and other joint initiatives between WHO and international financial institutions; for example, the support provided by the World Bank is particularly important because, between 2020 and 2022, it approved three projects related to the response to the pandemic and for a total amount of 223.80 million USD intended for the Ministry of Health[37] *(57)*.

Under the COVAX initiative, collaboration between UNICEF and WHO country offices in Tunisia has intensified to support the national COVID-19 vaccination strategy, facilitating joint communication with the Ministry of Health, strengthening the cold chain, procuring vaccines and rolling out the vaccination campaign. However, the delivery of vaccines to Tunisia through the COVAX mechanism has been affected by global constraints (as has been the case in other middle-income countries).

Pillar 2 - Risk communication, community engagement and infodemic management (USD 145,000; 1%)

On 29 January 2020, the Ministry of Health launched a preventive awareness campaign via the mass distribution of messages relating to hygiene measures using both public (television, radio, social networks) and private (text messages) means of communication. This awareness-raising was stepped up following the classification of Italy as the second most affected country by the epidemic after China, on 20 February 2020 *(58)*. The Country Office contributed by recruiting a communications consultant [38], with the production of a roadmap for public and internal communication (with the various departments of the Ministry of Health)[39]. This facilitated the development of the communication campaign with advocacy guidelines and tools (guides for different target groups[40] and audiovisual material) disseminating clear and precise messages[41]. WHO and UNICEF supported community engagement campaigns to raise public awareness of transmission and prevention.

The contribution of the Country Office in terms of disseminating scientific and substantiated information is one of the recognitions that has been widely recognized by all stakeholders[42]. In a context of global pandemic, with little scientific knowledge about the virus and effective therapeutic and diagnostic tools, the role of the Country Office was crucial in supporting political and technical decision-making in public health (Scientific Committee; emergency room), in providing verified information to national media (e.g. daily and weekly prime-time programmes on Radiotélévision Tunisienne - RTT), United Nations agencies, national and international organizations, and in taking action against false and misleading information. WHO became a leading organization during the pandemic and strengthened its credibility by sharing the constantly-generated data and evidence, rigorous situation analyses, and good practices identified in other contexts that could be applicable in Tunisia.

[36] Consultancy Report 1st of July 2020: WHO Tunis Office. COVID-19 Response.

[37] Second Additional Financing to Tunisia COVID-19 Response Project (P178540) 23.80 M USD Additional Financing for Tunisia COVID-19 Response Project (P175785) 100 M USD. Tunisia COVID-19 Response project (P173945) 120.00 M USD. Other World Bank funding was allocated to the Ministry of Social Affairs.

[38] Overall report Kuwaiti Fund, Tunisia. WHO Health Emergencies Programme (WHE) Final report to Kuwait "(Support of the WHO's efforts in combating the spread of COVID-19 in Tunisia)"

[39] External informant

[40] Overall report Kuwaiti Fund, Tunisia. WHO Health Emergencies Programme (WHE) Final report to Kuwait "(Support of the WHO's efforts in combating the spread of COVID-19 in Tunisia)".

[41] External informant

[42] Internal and external informants

Pillar 3 - Surveillance, epidemiological investigation, contact tracing and adaptation of social and public health measures (USD 460,000; 5%).

In 2020, an initiative by WHO Regional Office for the Eastern Mediterranean to strengthen the national surveillance system was adopted and Tunisia expressed its willingness to join this initiative. The Country Office contributed to strengthening surveillance with the donation of equipment, the extension of the surveillance network, the development of biosafety capacities and quality management[43]. Several initiatives were launched, such as the development of the EIOS (Epidemic Intelligence from Open Sources) platform[44] for Tunisia. WHO's *event-based surveillance* (EBS) tool was also been presented to national counterparts with plans to integrate it into the national platform (EPI-surveillance).

In order to ensure the collection of epidemiological data, the Country Office collaborated with the National Observatory for New and Emerging Diseases (ONMNE) and a communication, information and training platform on epidemiological surveillance was set up within the ONNME[45].

In terms of emergency preparedness, the response to the COVID-19 pandemic was integrated into the continuity of actions that were already underway during the biennium. These actions, aimed at strengthening the healthcare system, were implemented at an accelerated pace[46]. Thus, the process of creating national emergency medical teams (*Emergency Medical Teams - EMT*), which were the evolution of the *Rapid Response Teams* (*RTT*) previously supported by WHO, was approved by the Ministry of Health and other sectors such as defence and civil protection[47]. The EMTs corresponded to the country's human and economic capacity needs[48] and helped to strengthen the response mechanisms of the public health emergency operations centre and rapid response teams[49] through several interventions such as strengthening the emergency room in terms of IT, software and training to play a better role in the management of the emergency response to COVID-19[50]. RRT teams were set up throughout the country, in collaboration with the Tunisian scouts, and benefited from a training programme on the EIOS platform to conduct field investigations and search activities for contacts[51]. These teams were thus able to participate in contact tracing activities thanks to the logistical and technical support of the country office[52] and epidemiological data entry[53].

[43] Output Scorecard Tool Assessment for EM_TUN WHO Representative's Office, Tunisia - Output: Countries enabled to address antimicrobial resistance through strengthened surveillance systems, laboratory capacity, infection prevention and control, awareness- raising and evidence-based policies and practices (1.3.5) 2020-2021 - End of Biennium.

[44] The 'Epidemic Intelligence from Open Sources' (EIOS) initiative is a collaboration between various public health actors around the world. United around a common vision, it brings together new and existing initiatives, networks and systems to strengthen public health intelligence by creating a unified (OneHealth) approach to the early detection, verification, assessment and communication of public health threats using accessible information.

[45] Overall report Kuwaiti Fund, Tunisia. WHO Health Emergencies Programme (WHE) Final report to Kuwait "(Support of the WHO's efforts in combating the spread of COVID-19 in Tunisia)".

[46] External informant

[47] Output Scorecard Tool Assessment for EM_TUN WHO Representative's Office, Tunisia - Output: Country level technical assessment (Country.Assessment.Technical) 2020-2021 - End of Biennium.

[48] External informant

[49] Output Scorecard Tool Assessment for EM_TUN WHO Representative's Office, Tunisia - Output: Potential health emergencies rapidly detected, and risks assessed and communicated (2.3.1) 2020-2021 - End of Biennium.

[50] Output Scorecard Tool Assessment for EM_TUN WHO Representative's Office, Tunisia - Output: Capacities for emergency preparedness strengthened in all countries (2.1.2) 2020-2021 - End of Biennium

[51] Output Scorecard Tool Assessment for EM_TUN WHO Representative's Office, Tunisia - Output: Potential health emergencies rapidly detected, and risks assessed and communicated (2.3.1) 2020-2021 - End of Biennium.

[52] External informant

[53] External informant

In addition, the Country Office supported actions for the implementation of integrated disease surveillance and strengthening of national capacities for a robust event-based surveillance system[54]: Workshops were organized to improve the recording and reporting of the total number of deaths by age, sex and geographical distribution, in order to have reliable data and to improve the drafting and identification of the underlying causes of death with a focus on deaths due to COVID-19[55].

As part of the promotion of the One Health approach, genomic surveillance was to be strengthened for high-threat pathogens. Thanks to the negotiation efforts of the Country Office, funding for equipment and reagents for the Charles Nicolle Hospital enabled the facility to acquire a sequencer[56]. The Country Office facilitated the strengthening of national technical capacities through the coordination of training by IZS-TERAMO[57] in Italy during July 2021[58]. The sum of these efforts enabled the start of genomic surveillance of COVID-19 and the skills acquired will allow for broader surveillance of viruses and bacteria in the future[59].

Pillar 4 - Points of entry, international travel and transport, mass events and movement of populations (USD 370,000; 4%)

In a context where the number of imported cases was higher than the number of local infections at the start of the pandemic[60], the implementation of preventive measures at the country's points of entry was crucial, especially in view of the decision to lift the curfew *(59)* and reopen the borders completely *(60)* in June 2020. Awareness-raising actions for travellers were therefore carried out at the points of entry with poster campaigns and the distribution of materials by scouts supported by the Country Office[61]. In addition, a project to provide accommodation for people returning from trips, allowing them to be preventively isolated for two weeks in hotel rooms, was set up with the support of the Country Office[62].

Pillar 5 - Prevention and control of infections and protection of healthcare workers (USD 2,050,000; 21%).

The responsiveness of the Country Office enabled the national reference laboratory to make the technical adjustments necessary to receive the reagent for performing PCR tests for COVID-19 in January 2020[63] and to move from one laboratory to around twenty laboratories ready to carry out PCR tests in three months[64], which was one of the WHO's most remarkable contributions to the national response. From February 2020[65], following the launch of diagnostic activities, the Country Office continued to support public reference laboratories with donations of kits, reagents, consumables, PPE and other laboratory equipment.

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[54] Output Scorecard Tool Assessment for EM_TUN WHO Representative's Office, Tunisia - Output: Mitigate the risk of the emergence and re-emergence of high-threat pathogens and improve pandemic preparedness (2.2.3) 2020-2021 - End of Biennium.

[55] Output Scorecard Tool Assessment for EM_TUN WHO Representative's Office, Tunisia - Output: Countries enabled to strengthen data, analytics and health information systems to inform policy and deliver impacts. (4.1.1) 2020-2021 - End of Biennium.

[56] External informant

[57] Istituto Zooprofilattico Sperimentale dell'Abruzzo e del Molise "G. Caporale".

[58] External informant

[59] External informant

[60] Consultancy Report 1st of July 2020 WHO Tunis Office: COVID-19 Response

[61] Overall report Kuwaiti Fund, Tunisia. WHO Health Emergencies Programme (WHE) Final report to Kuwait "(Support of the WHO's efforts in combating the spread of COVID-19 in Tunisia)"

[62] External informant

[63] External informant

[64] Internal informant

[65] Consultancy Report 1st of July 2020 WHO Tunis Office: COVID-19 Response.

As diagnostic activity was initially centralized in reference laboratories, the Country Office strengthened the human resource teams (36 laboratory professionals) to cope with the increased workload[66]. This support was then extended to include other regional structures, which also began to carry out diagnostic tests for COVID-19 infections.

In parallel with the donations, virtual and face-to-face training courses were organized on laboratory techniques and biosafety: these training courses covered laboratory staff performing the RT-PCR technique for COVID-19 to ensure that they applied biosafety measures when handling samples[67].

Pillar 6 - Infection Prevention and Control (USD 2,140,000; 22%).

During the COVID-19 epidemic in Tunisia, a large number of healthcare workers were infected: it is estimated that around 15% of COVID-19 cases were healthcare professionals[68]. This demonstrated the need to step up training in infection prevention and control (IPC) and to ensure the availability of personal protective equipment (PPE) in healthcare facilities. The Country Office was mobilized to provide surgical masks, FFP2 masks and gloves to healthcare facilities.

The WHO Regional Office for the Eastern Mediterranean hospital checklist tool was adapted and used to assess the level of preparedness of health facilities for the pandemic. A joint Ministry of Health and WHO team assessed hospitals across the country to identify IPC gaps and propose solutions. Following this assessment, the country office implemented systematic IPC capacity building programmes in six hospitals. An IPC manual was finalized and training courses organized (including training of trainers - ToT) in these six hospitals in collaboration with key institutions: Directorate of Environmental Hygiene and Environmental Protection (Direction de l'Hygiène du Milieu et de la Protection de l'Environnement, DHMPE); General Directorate for Public Health Facilities (Direction générale des établissements de santé publique , DGSSP); National Observatory of New and Emerging Diseases (l'Observatoire National des Maladies Nouvelles et Emergentes, ONMNE) and; The Emergency Medicine Unit (L'Unité de Médecine d'Urgence, UMU), as well as support in the form of disinfectant products[69]. The National Commission in charge of training has endorsed the curriculum developed during the pandemic.

This collaboration with the Country Office was positively perceived by the teams, as it enabled the creation of the IPC units, but the implementation of the recommendations faced challenges in the field due to equipment limitations. [70]

Pillar 7- Case management, including the deployment of therapies (USD 3,054,900; 31%).

The Country Office made numerous efforts to prepare the Tunisian health system for the multiple and major challenges associated with an increased demand for care during the COVID-19 pandemic.

a. Management of hospital beds, infrastructure and equipment:

[66] Overall report Kuwaiti Fund, Tunisia. WHO Health Emergencies Programme (WHE) Final report to Kuwait "(Support of the WHO's efforts in combating the spread of COVID-19 in Tunisia)"

[67] Output Scorecard Tool Assessment for EM_TUN WHO Representative's Office, Tunisia - Output: Capacities for emergency preparedness strengthened in all countries (2.1.2) 2020-2021 - End of Biennium.

[68] Consultancy Report 1st of July 2020 WHO Tunis Office: COVID-19 Response.

[69] Output Scorecard Tool Assessment for EM_TUN WHO Representative's Office, Tunisia - Output: Countries enabled to address antimicrobial resistance through strengthened surveillance systems, laboratory capacity, infection prevention and control, awareness- raising and evidence-based policies and practices (1.3.5)

[70] External informant

In the context of a shortage of hospital beds (24.29 hospital beds per 10,000 inhabitants - public and private combined[71]) and intensive care beds (0.6 intensive care beds per 10,000 inhabitants), the Country Office supported the Ministry of Health in several areas.

- Reduction of the burden on hospitalization services during the first phase of the epidemic through the support of the isolation of patients with a mild form of the disease in hotels[72].
- Attempt to increase the number of beds through construction[73] and rehabilitation projects for intensive care units (e.g. Ariana, Sousse) and the installation of an appropriate triage system for patients (e.g. Siliana and Kef)[74].
- In some cases, the Country Office worked with other partners by providing equipment to ensure the functionality of new structures (Sousse, Ariana).
- In addition to the shortage of beds, certain issues affecting specific populations emerged, such as pregnant women infected with COVID-19 and newborns of COVID-19 mothers. The Country Office supported the strengthening of three neonatal departments[75] as well as donations of equipment for the care of pregnant women who are COVID-19 positive[76].
- Faced with the crisis in oxygen availability, the Country Office launched an innovative initiative in agreement with the Ministry of Health for the installation of oxygen generators[77] in certain hospitals. This investment was appreciated and has the potential to solve problems of public spending and oxygen availability once the barriers to use are overcome[78].
- The demand for healthcare was accompanied by an increased need for medical consumables such as PPE, which the Country Office helped to meet.
- In terms of coordination, in order to manage beds optimally at the national level, the Country Office supported connectivity between the Ministry of Health Hospital Directorate and the regional level.

The challenge encountered in accessing certain products was due to delays in the logistics supply chain, which was blocked globally because of the pandemic. These delays were also explained by the limited availability of raw and finished products on national and international markets, as well as certain shipping issues.[79]. In addition, at the WHO level, supply management was centralized globally via a specific portal in order to ensure equitable distribution. However, as this system was used for the first time during the pandemic, the WHO's emergency product catalogue was insufficient and WHO's internal logistics and procurement system was not ready to respond.

Similarly, the development and implementation of new services to meet the demand for hospitalization of COVID-19 cases presented various challenges, explained by factors both internal and external to the WHO. The evaluation documented delays

[71] 2019 Health Map. Republic of Tunisia Ministry of Health Directorate of Studies and Planning; 2021

[72] Overall report Kuwaiti Fund, Tunisia. WHO Health Emergencies Programme (WHE) Final report to Kuwait "(Support of the WHO's efforts in combating the spread of COVID-19 in Tunisia)"

[73] External informant

[74] External informant

[75] World Health Organization Report to (Canadian Embassy in Tunisia) 'Supporting Tunisia's response to COVID-19: strengthening care services for newborns of mothers infected with SARS-COV2' March 2021

[76] Netherlands Ministry of Foreign Affairs funding during COVID-19 in Tunisia.

[77] Technical Report Fund from Government of Netherlands COVID-10 Response Strategy.

[78] External informant

[79] KII

resulting from public administration bureaucracy and tendering processes, difficulties in coordination between various international actors and different levels of public administration, limitations and inadequacies in construction budgets, and oversight of private companies' work, among other factors. A prime example of these difficulties was the construction of a unit for the comprehensive care of patients suspected or confirmed to have COVID-19 at the Le Kef Regional Hospital, which was unable to become operational during the pandemic, although it is now being converted into an intensive care unit.

b. Access to reliable data:

In order to compensate for the lack of knowledge around the new virus, the country gave health and academic professionals access to the WHO database in order to disseminate the most relevant and scientific information. Subsequently, training courses were organized for healthcare professionals on the prevention, diagnosis and burial of patients infected with COVID-19. The Country Office also attempted to address specific issues such as the development of guidelines for preventing COVID-19 in care homes for the elderly[80].

Pillar 8 - Operational and logistical support (USD 280,000; 3%)

Operational support for the national response appears to have been a cross-cutting element in all pillars of the current response plan. Some elements of logistical support are mentioned in the analysis of the other pillars, but the evaluation did not have disaggregated information or data specific to this 8th pillar.

In general, certain elements of logistical support were decisive for the agility and effectiveness of the response (e.g. IT for the emergency room, hospital beds and equipment, laboratory equipment, transport, etc.). However, the evaluation also identified 'logistical' support that did not arrive on time or was not implemented and therefore did not contribute to its initial objective of being useful for the emergency response (e.g. vehicles, equipment, construction[81], oxygen). Some calls for the acquisition of medical equipment (even if included in the funded period) were launched in April 2023[82].

Pillar 9 - Maintaining and strengthening essential health services (USD 300,000; 3%)

During the first phase of the government's COVID-19 response, several preventive measures were put in place, including the cancellation of non-urgent consultations, hospitalizations and surgeries, thus creating a barrier to access to care, especially for non-communicable diseases and sexual and reproductive health services.

The Country Office actively participated in the advocacy that led the Ministry of Health to commit to ensuring the continuity of services in primary health care (PHC) and sexual and reproductive health care (SRHC) facilities throughout the pandemic. The Ministry of Health requested technical support from the Country Office to examine the situation on the ground[83], following which a ministerial circular was published with clear guidelines for the regions to resume or reschedule essential and emergency health activities during the COVID-19 epidemic, putting in place the necessary preventive measures and committees in the

[80] Netherlands Ministry of Foreign Affairs funding during COVID-19 in Tunisia.

[81] See pillar 7

[82] Promoting women and girls' leadership in the socio-economic and health response to COVID-19 in Tunisia.

[83] Consultancy Report 1st of July 2020 WHO Tunis Office: COVID-19 Response.

regions to organize essential services.

A strategy on continuity of care in a COVID-19 situation has been developed by the working groups and published in a medical journal[84]. This resulted in a gradual resumption of consultations with additional time slots to reduce congestion and respect social distancing. Hospitalizations also gradually resumed. A meeting was also held with the Medical Council for the resumption of surgeries. The Country Office collaborated with the Ministry of Health to develop tools to monitor the continuity of essential services during COVID-19 and other potential crisis situations.

In the context of the cooperation between the Ministry of Health and WHO during the 2020/2021 biennium, a dynamic was observed to be raising the issue of non-communicable diseases (NCDs) to the level of national priority. Despite the health crisis, this commitment has resulted in a strategy in the form of a multisectoral budgeted operational plan with sector-specific measures[85].

WHO also supported the implementation of the Patient Safety Friendly Hospital Initiative (PSFHI) in Tunisia by providing introductory training on the PSFHI to staff from six hospitals. Following the training, WHO supported four sites in conducting a self-assessment and then developing a detailed plan to address the issues identified[86].

In this context, WHO also supported the creation and initial operation[87] of the Psychological Support Unit, aiming to provide remote psychological support to COVID-19 patients, health workers and people affected by stress due to the epidemiological context[88]. Subsequently, a capacity-building intervention for 400 frontline mental health professionals was organized (Mental Health Gap Action Programme).

Pillar 10 - Vaccine preparation and deployment, including equitable access (USD 560,000; 6%)

Following the paradigm shift with the acceptance of the circulation of the virus, the fourth pandemic wave in Tunisia produced a significant mortality rate and the health authorities decided to make vaccination the central pillar of the fight against the epidemic. Following the validation of the first vaccine by WHO and the start of vaccine production, Tunisia began by validating two vaccines: Pfizer and Sputnik, with the rapid implementation of marketing authorizations[89]. WHO supported the process to obtain import authorizations, but the slow pace of implementation did not develop into a timely and large-scale vaccination rollout, delaying the intended impact on reducing transmission and mortality.

Vaccination faced delays in implementation due to the unavailability of sufficient quantities of vaccines, the slow adoption of the draft laws required by vaccine suppliers and delays in delivery from the COVAX programme. Vaccination began on 13 March 2021 thanks to 30,000 doses of the Sputnik vaccine *(61)*.

[84] Consultancy Report 1st of July 2020 WHO Tunis Office: COVID-19 Response.

[85] Output Scorecard Tool Assessment for EM_TUN WHO Representative's Office, Tunisia - Output: Countries enabled to address risk factors through multisectoral actions (3.2.1) 2020-2021 - End of Biennium.

[86] Output Scorecard Tool Assessment for EM_TUN WHO Representative's Office, Tunisia - Output: Countries enabled to provide high- quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages (1.1.1) 2020-2021 - End of Biennium.

[87] Netherlands Ministry of Foreign Affairs funding during COVID-19 in Tunisia.

[88] Output Scorecard Tool Assessment for EM_TUN WHO Representative's Office, Tunisia - Output: Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results (1.1.2) 2020-2021 - Mid-term Review.

[89] External informant

The most valued contribution of WHO, as reported, was the advocacy within the COVAX mechanism for Tunisia to gain access to vaccines. This advocacy enabled Tunisia to receive the first batch of 93,600 COVAX COVID-19 vaccines on 17 March 2023 *(62)*. The arrival of subsequent vaccine batches has enabled the consolidation of the vaccination campaign. WHO supported the National Commission in implementing the vaccination strategy with the Directorate of Primary Health Care (DSSB) through the recruitment of experts, but also supported the implementation of the vaccination strategy[90].

At the organizational level, the Country Office supported the national vaccination rollout plan through several initiatives, such as the functionality of the web platform for vaccine management between central, regional and district warehouses through the acquisition of a new server for the Health IT Centre[91] and equipment support to ensure cold chain compliance[92] [93].

Support continued after the launch of the vaccination programme when the pace slowed down and the strategy was not achieving its objectives. The Country Office collaborated with the Ministry of Health by supporting a study on the perception of COVID-19 infection and vaccination by the population, producing recommendations to improve prevention measures[94].

During the pandemic, the production of messenger RNA vaccines was incorporated into the project to support Tunisia in the production of vaccines. Tunisia had previously been identified by WHO as a potential candidate for vaccine manufacturing. The WHO GBT (Global Benchmarking Tool) assessment found a level of institutional maturity of 1. The Country Office and WHO Regional Office for the Eastern Mediterranean are supporting the Ministry of Health to acquire a level of maturity 3, which would optimize national capacities to produce on an international scale.

Pillar 11 - Research and Development (R&D) (USD 115,000; 1%)

The COVID-19 pandemic has opened the door to the introduction of new technologies in Tunisia. Strengthening national capacities in technology and equipment, as well as collaboration with academics, has made it possible to develop capacities and carry out research with scientific publications corresponding to different stages of the response. For example, WHO supported modelling exercises to predict the evolution of the COVID-19 epidemic and COVID-19 seroprevalence surveys for monitoring and forecasting[95].

Following the introduction of the genomic sequencing technique, a scientific publication was produced on the subject of circulating viral genomes in Tunisia *(63)*, and support was provided for the seroprevalence survey conducted with the ONMNE.

Following the launch of the vaccination programme, the Country Office collaborated with the Ministry of Health through the

[90] Output Scorecard Tool Assessment for EM_TUN WHO Representative's Office, Tunisia - Output: Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results (1.1.2) 2020-2021 - Mid-term Review

[91] Activity Report "Covid 10 delivery Support programme CDS " 1/12/2021 To 31/5/2022 UNICEF et Organisation mondiale de la Santé

[92] Netherlands Ministry of Foreign Affairs funding during COVID-19 in Tunisia

[93] Activity Report "Covid 10 delivery Support programme CDS " 1/12/2021 To 31/5/2022 UNICEF et Organisation mondiale de la Santé

[94] Report on the qualitative study 'Assessment of people's knowledge, attitudes and practices regarding Covid-19 prevention and vaccination' - April 2022

[95] Output Scorecard Tool Assessment for EM_TUN WHO Representative's Office, Tunisia - Output: Proven prevention strategies for priority-/epidemic-prone diseases implemented at scale (2.2.2) 2020-2021 - End of Biennium.

Pasteur Institute on a study of the immunogenicity of the six vaccines used in Tunisia, which resulted in a scientific publication.[96]

[96] External informant

Annex 8: List of performance indicators for Tunisia

SG	Output	KPI Id	KPI Definition
1	1.1.1	1.1.F	Percentage of health care facilities that have implemented UHC essential package of services
1	1.1.1	1.1.G	Status of implementation of the WHO primary health care quality indicators
1	1.1.2	1.1.D	Status of integration of cardiovascular risk factors assessment and management at primary health care level
1	1.1.2	1.1.E	Status of adoption of the UNGA political declaration and multi-sectoral accountability framework
1	1.1.2	1.1.I	Status of implementation of the mental health gap action programme
1	1.1.3	1.1.A	Status of adoption/update of WHO reproductive and maternal health guidelines
1	1.1.3	1.1.B	Status of implementation of key community and facility-based interventions for newborn and child health & development
1	1.1.3	1.1.C	Status of achievement of the EMVAP (Eastern Mediterranean Vaccine Action Plan)) targets
1	1.1.3	2.2.D	Status of development of the polio transition plan
1	1.1.4	1.1.J	Status of implementation of governance actions to develop/recover the health system
1	1.1.5	1.1.K	Status of implementation of the health workforce strategic plan
1	1.2.1	1.2.A	Status of development of the health financing strategy
1	1.2.2	1.2.B	Status of implementation of national health accounts
1	1.2.3	1.2.C	Status of the explicit national Universal Health Coverage-Priority Benefits Package (UHC-PBP),tailored to country needs and level of socioeconomic development and by involving all stakeholders.
1	1.2.3	1.2.D	Status of institutionalization of HTA (health technology assessment) process in the decision making for allocation of resources on technologies
1	1.3.2	1.3.E	Status of medicines pricing policies and monitoring systems.
1	1.3.2	1.3.F	Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis.
1	1.3.3	1.3.C	Existence of an institutional development plan for drug regulation

1	1.3.3	1.3.D	Status of development of national control testing policy for medical products
1	1.3.5	1.3.A	Status of national AMR surveillance reporting in GLASS (GLASS (Global Antimicrobial Resistance and Use Surveillance System)
2	2.1.1	2.1.A	Status of implementation of simulation exercises using WHO tools and guidelines
2	2.1.1	2.1.F	Status of country State Party Self-Assessment Annual Reporting (SPAR) on IHR implementation.
2	2.1.2	2.1.G	Status of using findings from the IHR monitoring and evaluation framework to develop or update the national action plans
2	2.1.3	2.3.A	Status of implementation of the Emergency Operation Centre
2	2.2.1	2.2.F	Status of implementation of novel epidemiological Tools (techniques and forecasting) to prevent and respond to high-threat pathogens, including One Health for priority zoonotic diseases.
2	2.2.1	2.2.G	Status of the National agenda to implement innovative research for the prevention and control of high-threat pathogens.
2	2.2.2	2.1.B	Officially nominated rapid response teams at all levels (national, regional)
2	2.2.2	2.2.H	Status of implementation of capacity building on Field Epidemiology (such as RRT training) to prevent potential disease outbreaks caused by high-threat pathogens.
2	2.2.2	2.2.I	Percentage of health facilities covered by the implementation of the national prevention strategic plans for priority pandemic and epidemic prone diseases (e.g. cholera, Dengue fever, influenza…)
2	2.2.3	2.2.J	Status of National Plan for laboratory systems and networks strengthening especially for quality diagnostic testing of high-threat pathogens adhering to biosafety and biosecurity standards.
2	2.3.1	2.3.B	Status of completion of event risk assessments (rapid risk assessments/public health situation analysis for events) within recommended timeframe
2	2.3.1	2.1.D	Status of adaptation and implementation of the real-time early warning surveillance framework
2	2.3.1	2.1.E	Percentage of signals detected by the Regional Office which have been verified within 72 hours
3	3.1.2	3.1.A	Status of development/review of national strategies and action plans on nutrition and diet-related risk factors
3	3.1.2	3.1.D	Status of implementation of actions related to food safety
3	3.2.1	3.2.B	Utilization of STEPS survey findings to develop evidence-based policies, and set national targets on NCDs
3	3.2.1	3.2.C	Status of enforcement of total bans on advertising promotion and sponsorship of tobacco
3	3.2.1	3.2.D	Status of introduction of the regional package of inter-sectoral policies and interventions into their national health systems
3	3.2.2	3.2.A	Status of implementation of the national multi-sectoral action plan
3	3.3.1	3.1.B	Status of implementation of a surveillance mechanisms (surveys) for reporting on drinking water safety
3	3.3.1	3.1.C	Status of development and implementation of the national action plan on health resilience to climate change
3	3.3.1	3.1.E	Status of implementation of the health impact assessment of air pollution
4	4.1.1	4.1.B	Status of implementation of actions included in the health information system improvement plan based on the assessment findings.

4	4.1.2	4.1.C	Status of required high quality annual analytical reports of health sector progress and performance that includes relevant disaggregation of health-related SDG data.
4	4.1.3	4.1.A	Number of public health research papers published by institutions based in the Country in peer-reviewed journals anywhere in the world
4	4.2.1	4.2.A	Status of fulfilment of the key strategic communication resources
4	4.2.1	4.2.B	Percentage of leadership and health diplomacy events organized with the support of WHO
4	4.2.2	4.3.A	Overall score of the managerial KPIs
4	4.2.3	4.2.C	Percentage of allocated budget mobilized (This refers to both base and Outbreak and Crisis Response (OCR) funding. Funds mobilized at all three levels (CO, RO and HQ). All sources i.e. AC, AS, VC, CVCA, etc. are included)
4	4.2.3	4.2.D	Percentage of partnerships established to cover gaps for preparedness and response activities (This KPI could be considered on broader partnerships established at regional and/or country level and not just emergencies related ones)
4	4.2.4	4.2.E	Status of submission of the OSC and KPIs reports
4	4.2.4	4.2.F	Status of the Country Cooperation Strategy
4	4.2.5	4.2.J	Operational and maintenance service contracts are executed through negotiated Long Term Agreements
4	4.3.1	4.3.B	Percentage of the funds utilized out of the total available per Budget Center
4	4.3.2	4.3.C	ePMDS: Prior year performance reviews, establishment of current year objectives and mid-year performance review are fully executed for all staff members within the established timeframes (28 February and 31 July respectively)
4	4.3.2	4.3.D	Inter/national Staff recruitments are completed, from Vacancy Notice to Selection Report, within 15 weeks of the initial request
4	4.3.3	4.3.E	Guarantee high availability of IT network services
4	4.3.4	4.2.I	Annual goods procurement plans prepared and submitted to PSS by latest 31 Jan of every year
4	4.3.4	4.3.F	The annual self-assessment of Security Risk Management (SRM) and compliance with UNDSS security policies is submitted (by FSO / Security Focal Point) to SSS by 15 October

Annex 9 : Detailed Base budget tables

Table 9: Details of the distribution of the BASE budget by Activities and Staff, by Strategic Objective (SO) (GPW13) and by Outcome (Segment/Category/Program) – Biennium 2018-2019 (GPW13 equivalence) *

		2018-2019 (equivalence GPW13)								
	SEGMENT / CATEGORY / PROGRAMME	Activities			Staff Costs			Total Sum of Planned Cost	Total Sum of Funds Received	Total Sum of Utilization
		Planned Cost	Funds Received	Utilization	Planned Cost	Funds Received	Utilization			
SG1	01.001	770,870.80	646,558.53	641,370.13	496,600.00	407,952.80	409,005.27	**1,267,470.80**	**1,054,511.33**	**1,050,375.40**
	01.002	166,840.00	138,326.15	134,431.48	24,900.00	20,264.15	20,103.43	**191,740.00**	**158,590.30**	**154,534.91**
	01.003	183,604.40	170,346.15	170,058.72	32,100.00	26,991.95	27,176.61	**215,704.40**	**197,338.10**	**197,235.33**
SG2	02.001	213,069.10	86,849.24	86,848.36	60,500.00	22,554.00	22,553.61	**273,569.10**	**109,403.24**	**109,401.97**
	02.002	0.00	0.00	0.00	0.00	0.00	0.00	**0.00**	**0.00**	**0.00**
	02.003	79,452.70	74,320.25	73,266.08	41,350.00	30,455.05	30,781.01	**120,802.70**	**104,775.30**	**104,047.09**
SG3	03.001	119,374.30	83,783.20	81,456.10	8,700.00	6,408.00	6,592.49	**128,074.30**	**90,191.20**	**88,048.59**
	03.002	303,770.00	269,280.45	255,673.64	82,050.00	32,208.05	32,765.52	**385,820.00**	**301,488.50**	**288,439.16**
	03.003	47,056.10	19,009.03	19,006.40	0.00	0.00	0.00	**47,056.10**	**19,009.03**	**19,006.40**
SG4	04.001	140,033	108,904	108,594	5,800	4,272	4,395	**145,833**	**113,176**	**112,989**
	04.002	73,318.70	49,891.80	49,585.04	625,000.00	568,555.00	563,149.91	**698,318.70**	**618,446.80**	**612,734.95**
	04.003	444,133.50	336,247.40	273,631.76	216,727.00	177,447.00	169,668.64	**660,860.50**	**513,694.40**	**443,300.40**
TOTAL (US $)		2,541,523.00	1,983,516.00	1,893,922.16	1,593,727.00	1,297,108.00	1,286,191.48	4,135,250.00	3,280,624.00	3,180,113.64

Source: Planned & Expenditures for Activity & HR costs 2018 to 2023.xlsx

* The 2018-2019 biennium being between GPW12 and GPW13, and therefore structured according to GPW12, the equivalence with GPW13 was calculated according to the criteria facilitated by the WHO to be able to compare this biennium with the two subsequent biennia.

Table 10: Details of the distribution of the BASE budget by Activities and Staff, by Strategic Objective (GPW13) and by Outcome (Segment/Category/Programme) – Biennium 2020-2021

		2020-2021								
	SEGMENT / CATEGORY / PROGRAMME	Activities			Staff Costs			Total Sum of Planned Cost	Total Sum of Funds Received	Total Sum of Utilization
		Planned Cost	Funds Received	Utilization	Planned Cost	Funds Received	Utilization			
SG1	01.001	839,052.00	369,339.00	351,422.61	495,285.00	501,173.00	477,176.42	**1,334,337.00**	**870,512.00**	**828,599.03**
	01.002	98,898.00	72,272.00	72,271.83	50,636.00	46,363.00	44,682.30	**149,534.00**	**118,635.00**	**116,954.13**
	01.003	237,550.00	113,275.00	112,000.23	49,200.00	36,005.00	34,485.36	**286,750.00**	**149,280.00**	**146,485.59**
SG2	02.001	463,265.00	461,530.00	84,519.44	33,500.00	29,356.00	29,354.28	**496,765.00**	**490,886.00**	**113,873.72**
	02.002	123,201.00	122,328.00	122,327.02	32,000.00	32,044.00	29,361.49	**155,201.00**	**154,372.00**	**151,688.51**
	02.003	0.00	0.00	0.00	0.00	0.00	0.00	**0.00**	**0.00**	**0.00**
SG3	03.001	118,132.00	62,496.00	62,246.08	0.00	0.00	0.00	**118,132.00**	**62,496.00**	**62,246.08**
	03.002	270,803.00	201,809.00	199,681.15	94,000.00	100,674.00	96,911.75	**364,803.00**	**302,483.00**	**296,592.90**
	03.003	98,000.00	13,459.00	13,458.98	0.00	0.00	0.00	**98,000.00**	**13,459.00**	**13,458.98**
SG4	04.001	119,000	27,849	27,848	16,000	16,315	15,615	**135,000**	**44,164**	**43,463**
	04.002	52,000.00	25,835.00	25,834.61	677,906.00	613,344.00	611,001.40	**729,906.00**	**639,179.00**	**636,836.01**
	04.003	492,236.00	292,051.00	289,843.07	156,725.00	165,249.00	157,643.10	**648,961.00**	**457,300.00**	**447,486.17**
TOTAL (US $)		2,912,137.00	1,762,243.00	1,361,453.09	1,605.252.00	1,540,523.00	1,496,231.06	4,517,389.00	3,302,766.00	2,857,684.15

Source: Planned & Expenditures for Activity & HR costs 2018 to 2023.xlsx

Table 11: Details of the distribution of the BASE budget by Activities and Staff, by Strategic Objective (GPW13) and by Outcome (Segment/Category/Programme) – Biennium 2022-2023

		2022-2023								
	SEGMENT / CATEGORY / PROGRAMME	Activities			Staff Costs			Total Sum of Planned Cost	Total Sum of Funds Received	Total Sum of Utilization
		Planned Cost	Funds Received	Utilization	Planned Cost	Funds Received	Utilization			
SG1	01.001	1,226,144.00	1,192,456.00	721,767.78	460,159.00	391,737.00	265,604.33	**1,686,303**	**1,584,193.00**	**987,372.11**
	01.002	156,500.00	142,966.00	20,946.88	0.00	0.00	0.00	**156,500**	**142,966.00**	**20,946.88**
	01.003	427,656.00	416,406.00	64,047.59	89,200.00	39,163.00	41,391.89	**516,856**	**455,569.00**	**105,439.48**
SG2	02.001	260,887.00	102,941.00	49,894.16	26,352.00	28,122.00	25,604.60	**287,239**	**131,063.00**	**75,498.76**
	02.002	149,113.00	48,781.00	43,039.23	25,320.00	28,413.00	25,894.27	**174,433**	**77,194.00**	**68,933.50**
	02.003	403,921.00	240,199.00	230,245.11	0.00	0.00	0.00	**403,921**	**240,199.00**	**230,245.11**
SG3	03.001	26,838.00	26,262.00	16,096.34	0.00	0.00	0.00	**26,838**	**26,262.00**	**16,096.34**
	03.002	457,959.00	482,799.00	400,155.62	57,250.00	75,325.00	78,554.24	**515,209**	**558,124.00**	**478,709.86**
	03.003	56,119.00	69,699.00	30,402.98	0.00	0.00	0.00	**56,119**	**69,699.00**	**30,402.98**
SG3	04.001	739,910	727,606	20,485	15,500	17,221	18,456	**755,410**	**744,827**	**38,940**
	04.002	33,000.00	33,000.00	24,064.00	700,454.00	590,782.00	500,342.15	**733,454.00**	**623,782.00**	**524,406.15**
	04.003	317,422.00	316,639.00	310,620.95	205,973.00	211,198.00	198,157.80	**523,395.00**	**527,837.00**	**508,778.75**
TOTAL (US$)		4,255,469.00	3,799,754.00	1,931,765.34	1,580,208.00	1,381,961.00	1,154,004.86	5,835,677.00	5,181,715.00	3,085,770.20

Source: Planned & Expenditures for Activity & HR costs 2018 to 2023.xlsx

Table 12: Total BASE budget distribution by Strategic Objective (GPW13) and by Outcome (Segment/Category/Programme) – Biennia 2018-2019, 2020-2021 and 2022-2023.

		GRAND TOTAL		
	SEGMENT / CATEGORY / PROGRAMME	Total Planned Cost	Total Funds Received	Total Utilization
SG1	01.001	4,288,110.80	3,509,216.33	2,866,346.54
	01.002	497,774.00	420,191.30	292,435.92
	01.003	1,019,310.40	802,187.10	449,160.40
SG2	02.001	1,057,573.10	731,352.24	298,774.45
	02.002	329,634.00	231,566.00	220,622.01
	02.003	524,723.70	344,974.30	334,292.20
SG3	03.001	273,044.30	178,949.20	166,391.01
	03.002	1,265,832.00	1,162,095.50	1,063,741.92
	03.003	201,175.10	102,167.03	62,868.36
SG4	04.001	1,036,243	902,167	195,393
	04.002	2,161,678.70	1,881,407.80	1,773,977.11
	04.003	1,833,216.50	1,498,831.40	1,399,565.32
TOTAL (US$)		14,488,316.00	11,765,105.00	9,123,567.99

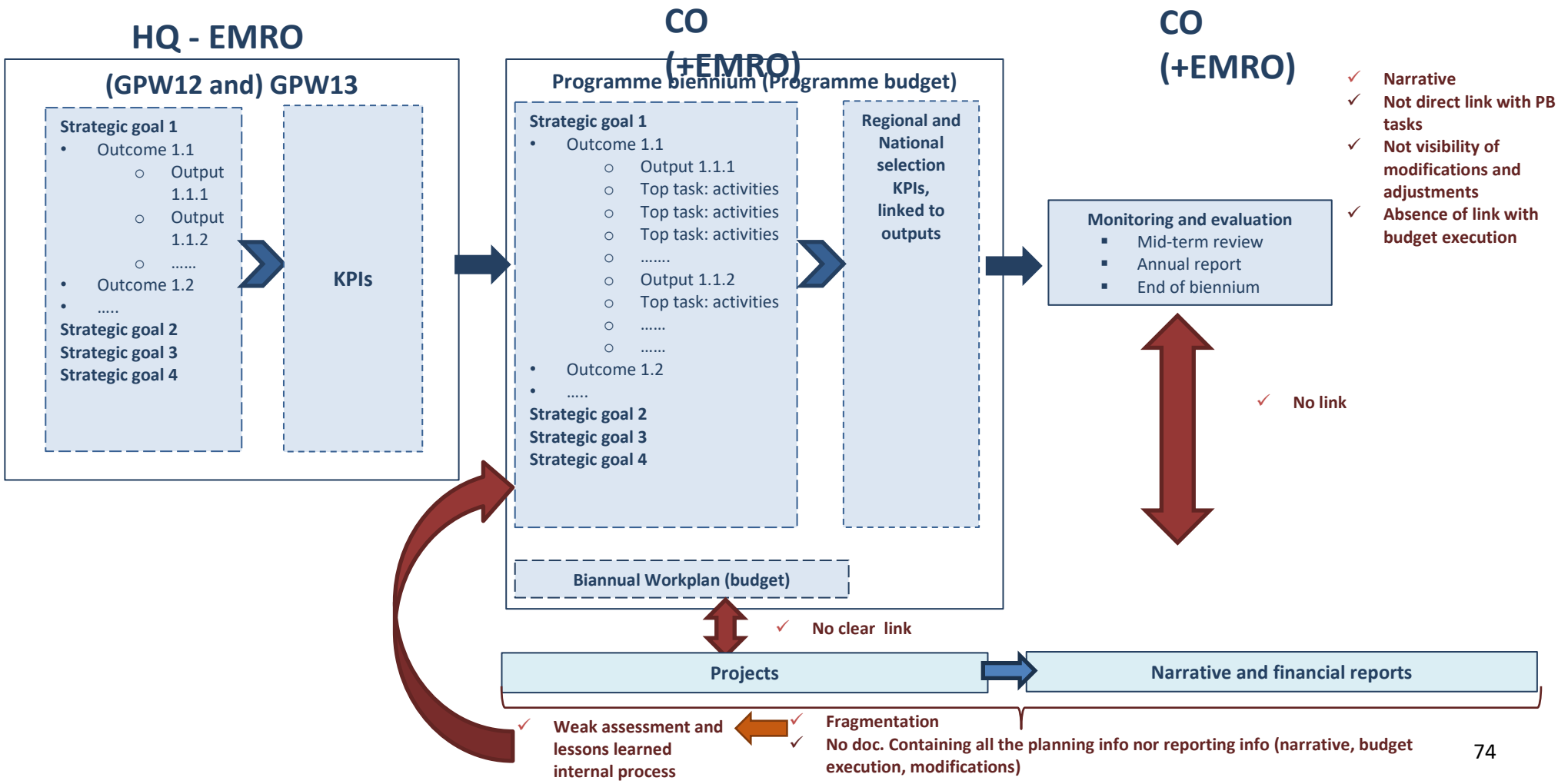
Source: Planned & Expenditures for Activity & HR costs 2018 to 2023.xlsx

Table 13: Summary of the distribution of the BASE budget dedicated to Tunisia (excluding Outcomes 4.2 and 4.3) by Strategic Objective (GPW13) and relationship between the committed budget and the planned budget - Bienniums 2018-2019, 2020-2021 and 2022-20

SG (GPW13)	TOTAL PLANNED COST (US $)	TOTAL UTILIZATION (US $)	TOTAL UTILIZATION (%)	UTILIZATION/PLANNED
SG1	5,805,195	3,607,943	61%	62%
SG2	1,911,931	853,689	14%	45%
SG3	1,740,051	1,293,001	22%	74%
SG4 (4.1)	1,036,243	195,393	3%	19%
TOTAL BASE TUN	10,493,421	5,950,026	100%	

Source: Planned & Expenditures for Activity & HR costs 2018 to 2023.xlsx

Annex 10: Representation of the different planning, monitoring, and evaluation tools and the linkages between them



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