World Health Organization

WHO Contribution in Tunisia (2019-2023)

Evaluation report

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Cover page photo credit: WHO / Diego Rodriguez

Caption: Public Health, Environmental and Social Determinants of Health in Tunisia

Contents

List of tables

List of figures

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Acronyms

AMR: Antimicrobial Resistance
BP: Biennial Programming
CCS: Country Cooperation Strategy
CHU: University Hospital Center
CNAM: National Health Insurance Fund
CNTS: National Blood Transfusion Center
CO: Country Office
COVAX: COVID-19 Vaccination
COVID-19: Coronavirus Disease 19
CSO: Civil Society Organization
CSSB: Primary Health Care Center
DGSSP: General Directorate of Public Health Structures
DHMPE: Directorate of Environmental Hygiene and Environmental Protection
DSSB: Directorate of Primary Health Care
EMRO: Eastern Mediterranean Region Office, WHO
EMT: Emergency Medical Teams
ERG: Evaluation Reference Group
FAO: Food and Agriculture Organization
FCTC: Framework Convention on Tobacco Control
GDP: Gross Domestic Product
GPW13: 13th General Programme of Work
HIV: Human Immunodeficiency Virus
HQ: Headquarters
HR: Human Resources
IHR: International Health Regulations
IMF: International Monetary Fund
INS: National Institute of Statistics
IPC: Infection Prevention and Control
KPI: Key Performance Indicator
LB: Live Births
LNOB: Leave No One Behind
MENA: Middle East and North Africa
MJS: Ministry of Youth and Sports
MoH: Ministry of Health
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
PPE: personal protective equipment
PNLS: National AIDS Control Policy
RBM: results-based management
RG: results group
RNA: Ribonucleic Acid
RO: Regional Office
RRT: Rapid Response Teams
SDGs: Sustainable Development Goals
SO: strategic objective
SWOT: Strengths, Weaknesses, Opportunities, and Threats
TCU: Technical Cooperation Unit
THES: Tunisian Health Examination Survey
ToC: Theory of Change
ToR: terms of reference
UHC: Universal Health Coverage
UN: United Nations
UNCT: United Nations Country Team
UNDAF: United Nations Development Assistance Framework
UNDP: United Nations Development Programme
UNEG: United Nations Evaluation Group
UNSDCF: United Nations Sustainable Development Cooperation Framework
UNS: United Nations System
WB: World Bank
WHO: World Health Organization
WHO FCTC: WHO Framework Convention on Tobacco Control

Executive summary

Introduction

This evaluation of the World Health Organization's (WHO) contribution focuses on the results achieved at the country level, drawing on inputs from all three levels of the Organization. It also assesses WHO's contributions in relation to Tunisia's public health needs and the objectives outlined in WHO's general work programs and key strategic frameworks for the country.

The evaluation covers WHO's activities in Tunisia from 2019 to 2023, organized through biennial work plans, though not guided by a formal Country Cooperation Strategy (CCS). This period spans three biennia and two General Programmes of Work (GPW) – GPW12 (2014-2019) and GPW13 (2019-2023), which has been extended until 2024. In budget terms, WHO's planned contribution was US$ 28,782,261, with US$ 22,783,263 executed as of October 20, 2023. Notably, the Emergency Fund for Outbreak and Crisis Response (OCR) used for the COVID-19 response accounts for 59% of the total budget executed during the evaluation period.
Through its biennial planning, WHO in Tunisia has focused on:

i) Improving access to quality essential health services, reducing financial hardships, and enhancing access to medicines, vaccines, diagnostics, and essential devices, all part of health system reforms toward universal health coverage (UHC);
ii) Strengthening preparedness, detection, and management of health emergencies, as well as improving the prevention of epidemics and pandemics;
iii) Addressing health determinants, reducing risk factors, and applying a health-in-all-policies approach to improve population health and well-being.

In addition, WHO has adapted its efforts in Tunisia to address emerging challenges, such as the COVID-19 pandemic, with both immediate crisis responses and follow-up actions during the 2020-2021 and 2022-2023 biennia.

Methodology

The evaluation is structured as a non-experimental assessment, guided by participation and utilization principles, and serves both summative and formative purposes. It uses a theoretical framework to evaluate what works and what doesn't, while identifying the factors that explain these outcomes.

The evaluation criteria include relevance, coherence, effectiveness, efficiency, and sustainability. The main evaluation questions, which are aligned with these criteria, are derived from the terms of reference (ToR) and the reconstruction of the theory of change (ToC). These questions are further broken down into eight sub-questions in the evaluation matrix.

Three levels of analysis were considered: i) Strategic analysis, which focuses on coherence; ii) Programmatic analysis, which looks at progress towards expected results and addresses effectiveness, efficiency, and

sustainability; and iii) Organizational analysis, which examines WHO's internal structure, the Results-Based Management (RBM) system, and the technical support provided by the Regional Office (RO) and headquarters (HQ).

The evaluation follows a human rights-based approach, incorporating gender perspectives and health equity as core principles, in line with the guidelines of the United Nations Evaluation Group (UNEG) and WHO. Data collection used a mixed-methods approach (qualitative and quantitative), which included: i) semi-structured interviews with 75 participants, 53% of whom were women; ii) a review of approximately 435 documents, including a budget analysis; iii) field observations during visits to health facilities and local stakeholders in Sfax, Sousse, and El-Kef; and iv) timeline development.

The validation process was structured around three key stages: i) review of the initial draft of the evaluation report; ii) two workshops for presenting and validating results and co-creating recommendations with the Country Office (CO) and the Evaluation Reference Group (ERG); and iii) final review of the report's final version. The evaluation adhered to the ethical guidelines set by UNEG and WHO's five evaluation principles.

Findings

Relevance - How well are WHO's interventions adapted to the context and the evolving health needs and rights of the Tunisian population, as well as the needs, policies, and priorities of national and regional partners and institutions? And do they remain relevant as circumstances change?

WHO's objectives in Tunisia have been clearly aligned with national health priorities, structural needs, and emerging challenges. Since the 2020-2021 biennium, there has been increased visibility for noncommunicable diseases (NCDs), social and environmental determinants of health, health emergency preparedness, and data generation and innovation. WHO's support, which began in 2012, is widely recognized for its key role in the Social Dialogue process, leading to the publication of the 2014 White Paper, "For Better Health in Tunisia: Let's Walk the Path Together," (Original in French: *Pour une meilleure santé en Tunisie: Faisons le chemin ensemble*) and the drafting of the National Health Policy (NHP) for 2030, validated in April 2021.

While WHO has historically enjoyed strong collaboration with the Ministry of Health (MoH) at the central level, its presence has been more limited at the regional level, particularly in the most disadvantaged areas. Strategic but sporadic partnerships have also been initiated with other actors to address the multisectoral nature of health.

WHO's country strategic vision was developed in collaboration with the Ministry of Health (MoH) at the central level, aligning with key national health priorities and reforms. However, this vision has not been adequately reflected in the biennial programming documents, where the list of activities appears disconnected from a medium-term strategic planning document. The lack of a governance mechanism, a consistent monitoring framework, context analysis, needs and challenges identification, and stakeholder mapping further weakens the link. The planning methodology used does not enable stakeholders to fully understand this vision or consider

how it aligns with their own strategies and objectives. Additionally, it lacks a joint assessment process, leading the Country Office (CO) to sometimes undertake dispersed and less relevant actions.

WHO's contribution to the COVID-19 response was highly valued for its relevance and close coordination with the Ministry of Health (MoH), other UN agencies, and civil society organizations (CSOs). Following this, the Country Office (CO) capitalized on the heightened interest in public health issues that arose from the COVID-19 crisis, enhancing its efforts to transition toward a holistic approach aimed at building a resilient health system.

Coherence - To what extent are WHO's interventions coherent and do they present synergies with each other and with interventions by other actors in Tunisia?

The interventions of the UN system in Tunisia and WHO's vision are closely aligned with the health priorities outlined in the United Nations Sustainable Development Cooperation Framework (UNSDCF), which emphasizes a multisectoral approach.

WHO's collaboration is generally well-regarded by other UN agencies due to its focus on complementarity. However, the Country Office lacks sufficient visibility in the field of health, not fully reflecting the organization's significance. The Health Group, recently launched and promoted by WHO as a platform for exchange, coordination, and synergy among actors, is still too new to demonstrate its effectiveness.
WHO's contribution in Tunisia is also aligned with the regional strategy of the WHO Eastern Mediterranean Region Office (EMRO), Vision 2030, and globally with the actions programmed and developed in the biennia, as they align with the GPW12 and GPW13 results frameworks. The CO adheres to the organization's guidelines based on the health themes it addresses.

In both the global and national context, WHO's strategic role is clear, particularly in its ability to support the generation, transmission, and application of knowledge, where it holds significant comparative advantages. Its mission, normative role as a reference, and position as an information provider for health actors are well-established. However, these advantages are somewhat diminished by a lack of visibility and limited awareness among key health actors in Tunisia regarding WHO's priorities and the opportunities for collaboration.

Effectiveness - To what extent have the results of WHO's contribution (at the outcome level) been achieved or are likely to be achieved, and what factors have influenced (or not) their realization?

The planning and monitoring system does not provide a clear overall view of WHO's contributions or their impact on the health system in Tunisia. It also falls short in visualizing the adjustments made during implementation. The RBM in place appears to prioritize internal accountability over fostering learning for informed decision-making.
The budget execution effort (BASE[1] budget) was aligned with the prioritization set by the CO during the evaluation period, focusing on UHC, health emergency preparedness, and a multisectoral approach to prevention. However, with the onset of the COVID-19 crisis, the CO shifted its focus to this new priority, using OCR funds (received for the first time in Tunisia), which accounted for 59% of the committed funds during the evaluation period.

[1] The "BASE budget" is the most crucial component of the "Biennium Programme Budget," with its scope determined by the WHO.

For each of the four Strategic Objectives (GPW13), key "flagship" actions were identified. These actions, designed to address national challenges and respond to emerging issues, have had a catalytic impact. They encompass areas such as communicable diseases, reproductive health, noncommunicable diseases (including new themes like mental health and risk factors like tobacco), and initiatives to strengthen essential health system functions. This includes improving drug supply and advancing the digitalization of health information systems, particularly in vaccination. Leadership and advocacy, especially in promoting a multisectoral approach and involving civil society, were hallmarks of the evaluation period.

Key issues like governance, financing, human resources (HR) in health, and the impact of climate change on health were less developed, despite their importance to building resilient health systems. Topics such as violence against women and children, elderly care, nutrition, and evidence generation based on health information systems had actions planned or initiated, but they appear to have lacked follow-through.
WHO's performance during COVID-19 in Tunisia made significant contributions to mitigating the impact on the national health system, its professionals, and the population. Notably, WHO demonstrated strong scientific leadership, effective political and institutional engagement, and robust support for national response coordination. Their technical assistance in areas like cold chain management and laboratory capacity was especially commendable.

The evaluation identified several contextual factors that impacted the implementation of actions: the macroeconomic situation, the political transition with changes in MoH leadership, challenges in fostering cross-sector collaboration, bureaucratic hurdles in public procedures, structural weaknesses in the national health system during COVID-19, and the onset of the socio-economic crisis caused by the pandemic. The latter had a direct effect on the execution of the 2020-2021 and 2022-2023 biennia, leading to disruptions like global supply chain failures and stockouts.

Technical visits from the RO and HQ are generally highly appreciated for their content, the level of expertise, the motivation they generate, and the opportunity to better understand WHO's role. The same goes for the opportunities offered to participate in regional or international events and networking. However, a perception of confusion about the roles played by WHO's three levels, the visions and priorities of headquarters and the RO versus a CO vision adapted to the national context, and long response times have created misunderstandings internally, but also among national partners.

Efficiency - To what extent have WHO's interventions produced, or are they likely to produce, results efficiently and in a timely manner?

The fragmented nature of planning—evident in nearly 400 main activities, each with a very low average budget—does not support resource optimization from a performance standpoint. The budget execution rate is much higher for the OCR and Non-Programme Budget (Non-PB) categories than for the BASE budget. The analysis indicates alignment between funds allocated to human resources and efforts to implement activities.

Despite a continuous increase in the planned BASE budget over the three biennia, the committed funds have remained stable. This could be due to the prioritization of the COVID-19 response (OCR funds during the 2020-2021 and 2022-2023 biennia) and the fact that 2023 was not yet closed at the time of the evaluation.

The budget execution level dedicated to staff (BASE budget) is higher and more closely aligned with the planned budget than that dedicated to activities. However, when factoring in the OCR budget, it becomes clear that the executed budget for activities increased by 5.6 times and 3.3 times in the 2020-2021 and 2022-2023 biennia, respectively, while the budget for staff remained constant throughout the evaluation period.
All interviewed stakeholders expressed strong appreciation for the CO's understanding of the national context, its ability to listen, its proactive approach, its search for better alternatives, and its commitment beyond its formal responsibilities.

In response to COVID-19, the CO asserted its role as a health authority, while adapting and supporting the government's crisis management plan. Organizationally, the pandemic prompted the CO to establish new partnerships, diversify its donor base, and seize opportunities for change. However, challenges with operationalizing the supply chain and the COVAX mechanism (COVID-19 vaccination) hindered WHO's response efficiency in Tunisia.

The planning and monitoring system used by the CO and the MoH for the biennia does not appear to be a structured or formalized joint strategic collaboration mechanism, as it lacks key elements of strategic planning. WHO's internal RBM system is primarily characterized by fragmentation in both planning and reporting. Without a comprehensive document outlining all actions taken and their connection to the budget, monitoring appears more focused on budget execution and deliverables rather than on the quality of the outcomes achieved.

Several internal organizational factors have been identified as limiting efficiency: the small size of the CO team relative to the large number of tasks, the complex procedures, short planning and budgeting cycles, and language barriers.

Sustainability - To what extent has WHO contributed to strengthening national capacities and ownership to meet Tunisia's health humanitarian and development needs and priorities?

Most of the interventions supported by WHO have contributed to strengthening the national health system’s capacities and show good potential for continuity. They align with current national priorities and projects, as well as emerging issues, even in a context marked by turnover within the Ministry of Health (MoH) and the pandemic.

However, several factors have hindered the consolidation, national ownership, or sustainability of some interventions. These include the absence of a sufficiently developed administrative or legal framework, limitations in material or financial resources due to the economic crisis, and bureaucratic hurdles within public administrations and WHO. Additionally, the fragmentation of joint action plans and the low predictability of funding have posed challenges to programming actions and implementing reforms in the national health system that require medium- to long-term continuity.

The assessment of national capacity-building for a resilient and sustainable health system indicates that the results are primarily concentrated in governance, service delivery, and population health, with less focus on medicines and technology, as well as personnel. Health system financing, a critical challenge for the national health system, has seen more limited contributions from WHO.

Cross-Cutting Principles: Human rights approach, gender, and health equity

From a strategic perspective, human rights, health equity, and gender considerations are central to WHO and are reflected in the principles and guidelines of the Tunisian National Health Policy. However, since the biennia lack specific indicators, it is difficult to analyze progress at this level. Some initiatives targeting vulnerable populations and direct engagement with the most disadvantaged regions have been launched. Nevertheless, in a context where women's socio-economic empowerment remains a challenge, the integration of a gender perspective in WHO's contributions does not seem clear or systematic.

Conclusions

At the strategic level

SF1. WHO has successfully reinforced its role as the leading health agency in Tunisia, despite the growing presence of national actors. This achievement is due to decades of strong institutional and political dialogue with the Ministry of Health (MoH), its technical expertise, its ability to mobilize during the Social Dialogue process, and its reasonably effective and swift response to COVID-19.

SF2. By aligning its actions with national priorities and needs, as well as with the UN system, WHO has developed strategic partnerships to promote the implementation of a multisectoral approach to health. However, the absence of a strategic document for Tunisia and the limited human resources within the Country Office (CO) have hindered its visibility and made it difficult for key international actors and partners to fully understand its priorities.

At the programmatic level

PF1. The CO is recognized for its strong collaboration, both strategically and operationally, with national partners, especially the Ministry of Health (MoH). However, the fragmentation caused by the biennial planning and implementation system hampers both efficiency and effectiveness, while also diminishing strategic visibility.

PF2. During the evaluation period, key public health issues for Tunisia, such as noncommunicable diseases (NCDs), gained renewed attention. This included promoting a multisectoral approach to risk factors, addressing mental health, and improving drug supply. Advocacy and community involvement played a crucial role in driving this progress, resulting in lasting changes, such as in tobacco control. While significant actions were initiated to

advance universal health coverage, these efforts are still ongoing and remain highly dependent on contextual factors and the development of medium-term strategic partnerships. Additionally, WHO's interventions did not sufficiently address the structural changes required to enhance essential public health functions or strengthen the foundational elements of the health system.

PF3. WHO's support for the national COVID-19 response was timely, swiftly activating national response mechanisms and providing essential scientific information, coordinating efforts, and reinforcing certain capacities within the national health system. Much of the emergency aid provided during the pandemic was later transformed into strengthening regular health services and building capacities to respond to future crises. However, inefficiencies were noted in supporting the national response, particularly in constructing and operationalizing hospital services, providing biomedical equipment, and ensuring the timely deployment of the national vaccination strategy.

At the organizational level

OF1. The professional and personal dedication of the CO team has been a key factor in enabling a small office to consistently provide technical support and manage a large number of projects. The team showed remarkable efficiency and adaptability during the COVID-19 response, taking on new roles and managing a budget five times larger than usual. However, the increased workload led to technical and reputational risks, as some partner demands could not be fully addressed. Strengthening the CO is a critical step to reduce the burden on staff handling multiple roles and tasks, better align the team with upcoming strategic planning, and reinforce WHO's leadership in the health sector.

OF2. The RBM system used by the CO does not give WHO a comprehensive view of its contributions in Tunisia during the biennia. Fragmentation, lack of visibility of changes made during implementation, and the absence of clear result indicators, along with changing report formats, are major issues that complicate the CO team's analytical work, while also consuming a significant amount of time.

OF3. The added value of the Regional Office and headquarters was clear in terms of their expertise, adaptable tools for the national context, and international networking opportunities. However, this was somewhat undermined by a lack of clarity regarding the roles of each of the three levels of WHO, complex administrative procedures, and the "misalignment" of EMRO and HQ with the specific needs of the Tunisian context.

Key recommendations

At the strategic level

SR1. To ensure alignment with international commitments (such as Agenda 2030, GPW13, and GPW14) and address national health challenges, WHO's role and strategic partnership with the Ministry of Health should be captured in a collaborative, multisectoral Country Cooperation Strategy (CCS).

SR2. WHO should broaden its partner portfolio to enhance (i) the multisectoral approach to health, (ii) collaboration with technical and financial agencies and partners, (iii) direct engagement with regions or areas facing greater inequities, and (iv) the implementation of more ambitious strategies and actions to reduce vulnerabilities and barriers to healthcare access for specific population groups.

SR3. WHO should enhance its participation and visibility in key United Nations Country Team (UNCT) forums, solidifying its role as a strategic and technical leader for all international actors involved in health in Tunisia.

At the programmatic level

PR1. WHO's portfolio of actions and projects in Tunisia should focus on priority areas and themes that promote Universal Health Coverage and strengthen a resilient health system.

PR2. The new technologies, tools, and systems introduced during the pandemic emergency response should be fully integrated into routine health services and programs.

PR3. Biennial planning should be the outcome of a collaborative, multi-actor, and multisectoral effort led by the MoH and the CO.

At the organizational Level

OR1. The CO should strengthen its team to improve communication and partnership management while reducing the administrative workload.

OR2. The roles and contributions of the HQ and the RO in supporting the Country Office CO and MoH initiatives should be clearly defined and integrated into the new Country Cooperation Strategy (CCS).

1. Introduction

1.1 Background and national context

Background

1. WHO's country-level contribution evaluations are included in the Organization-wide biennial evaluation work plans, which are approved by the Executive Board at the start of each biennium. These evaluations focus on the outcomes and results achieved at the country level, utilizing input from all three levels of the Organization. They also assess WHO's contributions in relation to the country's public health needs and the objectives outlined in WHO's general work programs and key strategic instruments, including the CCS, WHO country office biennial work plans, and national health strategies.

Political and Socio-Economic Context

2. As of early 2023, Tunisia, with a population of nearly 12 million, experienced an improvement in its Human Development Index (HDI) from 0.567 in 1990 to 0.740 in 2019—a 30.5% increase—placing the country in the "high human development" category and ranking it 95th out of 189 countries and territories. However, in 2022, the HDI saw a slight drop to 0.731, due to the impact of the COVID-19 pandemic, political transition, and economic difficulties exacerbated by both national and international factors (such as the war in Ukraine and cross-border conflicts). A United Nations Development Programme (UNDP) report highlighted a gender gap of 0.078 points, primarily driven by inequalities in empowerment and access to employment.

3. Since the Revolution on January 14, 2011, Tunisia has made significant political strides, including the adoption of the Second Republic's Constitution in 2014,[2] the regular holding of municipal, parliamentary, and presidential elections, and advancements in human rights, political participation, and governance. Despite these achievements, the country continues to face several challenges. The economic recovery remains sluggish due to persistent structural issues and an economy highly dependent on external factors. Political parties are deeply polarized, complicating the adoption of structural reforms and a strong national budget. The declining quality of basic services, corruption, widening inequality between coastal and inland regions, rising youth unemployment, and increasing social unrest have led to lower voter turnout, widespread protests, and growing disillusionment with the political elite.

4. Tunisia is classified as a lower-middle-income country,[3] with an economy that has steadily contracted. Between 2011 and 2019, GDP fell by 1.7%, leading to higher unemployment and a "brain drain" of

[2] Republic of Tunisia. Constitution. Official Gazette of the Republic of Tunisia- 20 April 2015.
[3] World Bank report. 2020-2021 fiscal year.

young, educated Tunisians. Many young people have either attempted or are hoping to migrate to Europe, often taking the perilous sea route to Italy.

5. According to data from the National Institute of Statistics, high inflation (9%) has severely reduced the purchasing power of the poor and middle classes, further widening inequalities and weakening social cohesion. Unemployment remains consistently high, particularly affecting young people and women, with significant regional disparities. The highest poverty rates—exceeding 33%—are found in rural areas, particularly in the northwest and southwest. A June 2023 World Bank report revealed that informal employment in Tunisia had reached 43.9% (49.5% for men and 32% for women), a rate higher than in most other MENA countries, except for Egypt and Morocco *(5)*.

6. Additionally, regional conflicts, heightened tensions at the Libyan border,[4] and the porous borders of Sahel countries have led to a continuous influx of migrants and refugees, contributing to social and political instability. The effects of the COVID-19 crisis in 2020, coupled with the more recent war in Ukraine, have further worsened the situation.

7. In 2021, the elected president suspended Parliament and, following a referendum, introduced a new bicameral presidential system aimed at implementing reforms. Tunisia has now entered a new political phase.

8. The Finance Bill for the 2024 fiscal year will enable the Tunisian government to establish the main directions and priorities of its program, addressing current challenges while strengthening the sustainability of public finances. In line with this, the Tunisia Development Plan for 2023-2025, presented in January 2023, emphasizes a new development model to restore economic stability and combat rising poverty, which affects 20% of the population.[5] The plan focuses heavily on private sector investments, the resumption of phosphate production, and a move towards "greener" agriculture.[6] Recent statistics from the Central Bank of Tunisia[7] show positive signs in terms of repaying external debt and improving tax revenues, though financial rating agencies continue to express uncertainty about the government's ability to meet its substantial budgetary financing needs.[8]

9. The Tunisian government has also officially adopted the Sustainable Development Goals (SDGs) set by the United Nations General Assembly in September 2015, with a particular focus on the third goal (Target 3.8), which seeks to "ensure access to universal health coverage, including financial risk protection and access to quality essential health services, as well as safe, effective, high-quality, and affordable essential medicines and vaccines."[9] As a member of the United Nations since 1956, Tunisia is committed to leveraging its resources for inclusive, sustainable, and resilient socio-economic development that creates jobs, especially for the most vulnerable. The government is also dedicated to reducing inequalities and improving the country's resilience to crises and climate risks.[10]

[4] Since the conflict broke out in 2011 in Libya, Tunisia has been facing a massive influx of displaced populations, estimated in 2018 by the International Organization for Migration (IOM) at nearly 75,000 people.
[5] Ministry of Economy and Planning, presentation of Tunisia's Development Plan for 2023–2025 on 3 January 2023.
[6] Tunisia's Development Plan for 2023–2025 – January 2023.
[7] CBT: Tunisia has managed to repay nearly 74% of its external debts: https://lapresse.tn/167833/bct-la-tunisie-est-parvenue-a-rembourser-pres-de-74-de-ses-dettes-exterieures/.
[8] Fitch Affirms Tunisia at 'CCC-': https://www.fitchratings.com/research/sovereigns/fitch-affirms-tunisia-at-ccc-08-12-2023
[9] Goal 3 of the Sustainable Development Goals: Ensure healthy lives and promote well-being for all at all ages
[10] United Nations Tunisia – Website – 2023.

Donated ambulance: With support from the Government of Canada, WHO is working to strengthen newborn health care in Tunisia as part of its ongoing work in the area of reproductive health, March 2021. *Credit: WHO*

Health System and Health Situation

10. After the events of 2011, the right to health for all was enshrined in the new constitution adopted by the National Constituent Assembly[11] [12] in January 2014, emphasizing inclusion, equality, transparency, and non-discrimination. A new constitution, enacted on August 16, 2022, through a constitutional referendum, reaffirms these rights in Article 43.[13]

11. Although health sector expenditures in Tunisia have been rising (6.97% of GDP in 2021, US$ 3,807 per capita), (6) a significant portion of the burden still falls directly on households. In fact, 17% of the population remains without health coverage,[14] and direct household spending accounted for 38% of total health expenditures in 2019 (7) (compared to 39.8% in 2015). Nearly all these out-of-pocket expenses (91%) go toward private sector healthcare, particularly for the purchase of medicines and

[11] Constitution of January 27, 2014 - Republic of Tunisia - Tunisian Legislation Portal - French Version.
[12] Article 38 of the 2014 Constitution - "Every human being has the right to health. The State guarantees prevention and healthcare for every citizen and ensures the necessary means for the safety and quality of health services. The State guarantees free healthcare for individuals without support or sufficient resources. It ensures the right to social coverage in accordance with the provisions of the law."
[13] Article 43 of the 2022 Constitution – "Every human being has the right to health. The State guarantees prevention and healthcare for every citizen and provides the necessary resources to ensure the safety and quality of health services. The State guarantees free healthcare for individuals without support or sufficient resources. It ensures the right to social coverage under the conditions set by law."
[14] The National Health Insurance Fund (CNAM) is facing a cash flow crisis that is affecting the quality of health services and access to medicines and basic products, particularly for the most disadvantaged and/or vulnerable populations (youth, migrants, women in general, and women victims of violence). This has had serious consequences on the functioning of the public sector and has reduced its attractiveness compared to the private sector.

health products (8). This heavy burden of catastrophic healthcare costs presents a major barrier to universal access to quality healthcare and often forces people, especially the poorest, to either forgo care or fall into poverty. The COVID-19 pandemic in 2020 further strained the already weakened social protection system *(9)*.

12. Tunisia's national health system is structured into three sectors: the public sector, [15] which is the main provider of care, especially for primary care, preventive medicine, and hospital services; the semi-public sector; and the private sector. Although 80% of Tunisians rely on the public health system, it employs only half of the country's doctors and has just 28% of advanced diagnostic medical equipment,[16] which is unevenly distributed across regions (coastal vs. inland) and between urban and rural areas. The public sector provides two-thirds of consultations and 90% of hospitalizations, but the range of services remains limited due to rationing and shortages linked to budgetary constraints.[17]

13. Over the past few decades, Tunisia has made significant progress in improving the health of its population. Life expectancy at birth reached 77 years in 2019, compared to 74.1 years in 2000, with men living an average of 74.88 years and women 79.19 years. Tunisia often surpasses other lower-middle-income countries in the Middle East and North Africa (MENA) region, including Morocco, Libya, and Egypt, in health outcomes.

14. Thanks to widespread vaccination against infectious diseases such as measles, tetanus, and polio, the infant mortality rate has decreased by 56% since the 2000s, reaching 14 per 1,000 live births in 2020 (compared to 10 per 1,000 in Libya and 18 per 1,000 in Morocco).[18]

15. Despite widespread access to prenatal consultations and assisted childbirth by qualified personnel, regional inequalities remain significant. For instance, maternal mortality (37 per 100,000 live births in 2020)[19] can vary by up to twice as much between regions.[20] [21] Family planning indicators have also shown a sharp decline between 2014 and 2018, with a 12% drop in contraceptive use (from 62.5% to 50.7%) nationally and a 15.2% drop in the central-west region, accompanied by a rise in unmet family planning needs, which grew from 9% to nearly 20% during the same period.[22]

16. Prevention and health promotion, though critical, have been marginalized in the public sector, which has become very hospital-centric and focused on curative care. These services are largely absent from the private sector and are not covered by the National Health Insurance Fund (CNAM). This has contributed to a significant rise in noncommunicable diseases (NCDs), a trend expected to continue as Tunisia's population evolves in the coming years. According to projections by the National Institute of Statistics (INS), the share of the population aged 15 to 60 will continue to decline, reaching 57% by 2044, while the share of those aged 60 and older will increase to 24.2% by the same year.[23]

[15] The public health system is organized into three levels: Level 1 consists of basic health care centers, district hospitals, and peripheral maternity units. Level 2 is made up of regional hospitals, which provide services in general medicine, general surgery, obstetrics, pediatrics, ENT, and ophthalmology. Level 3 is represented by university hospital centers that offer specialized care.
[16] National Health Portal of Tunisia – Health Map.
[17] Budget Analysis: Health, 2010-2021 period. Ministry of Finance, Tunisian Republic
[18] Eastern Mediterranean Health Observatory – WHO/EMRO.
[19] World health statistics 2023 – Monitoring health for the SDGs. WHO 2023.
[20] National Maternal Health Strategy 2020-2024. Ministry of Health, Tunisian Republic.
[21] 27.9/100,000 live births for the North-East region and 67/100,000 live births for the North-West region, INSP 2008, 2011 health map, DPM, Ministry of Health (more recent disaggregated data)
[22] National Office of Family and Population, Ministry of Health, updated on 11/22/2022.
[23] National Institute of Statistics – Updated November 2022.

17. Tunisia, like other countries undergoing demographic and epidemiological transitions, is experiencing a decline in communicable, deficiency-related, maternal, and perinatal diseases and a rise in noncommunicable diseases. NCDs now account for 82% of mortality, 60% of morbidity, and two-thirds of total health spending. More than 26% of the population over 18 years old is obese (35% of women and 18% of men), and smoking prevalence is 25% (2.6% for women and 48.3% for men).[24] High rates of hypertension (34.7% in 2019), overweight (61.6% in 2016), obesity (26.9% in 2016), and diabetes (12.5% in 2014)[25] also persist. Cardiovascular disease is the leading cause of death, with a 16% probability of dying between the ages of 30 and 70 from cardiovascular disease, cancer, diabetes, or chronic respiratory diseases (2019). (11).

18. According to the 2016 "Tunisian Health Examination Survey" (THES),[26] conducted by the National Institute of Health with support from the Ministry of Health and WHO, the prevalence of physical and/or mental disability in Tunisia was 2.8%, higher in the Tunis district (3.3%) and among the most disadvantaged groups (4.0%). The survey found that 10.1% of people with depressive disorders had suicidal thoughts (9.1% among men and 10.6% among women), with 3.8% reporting a suicide attempt in the twelve months preceding the survey.

19. Road traffic accidents are a significant cause of death and disability in Tunisia, responsible for 16.5 deaths per 100,000 people in 2019 (compared to 17 in Morocco and 20.9 in Algeria), down from 23 deaths per 100,000 in 2016. Men are disproportionately affected, with road accidents representing the seventh leading cause of death overall (fourth for men, though not in the top ten for women)[27] [28] and the fourth leading cause of death and disability (6).

20. Since 2010, Tunisia has passed several laws to strengthen the rights of people with disabilities, a commitment renewed in the new Constitution of July 25, 2022, which obligates the State to protect people with disabilities from discrimination and to take measures to ensure their full integration into society. Tunisia's approach to promoting the rights of people with disabilities focuses on prevention, care, and inclusion. However, in March 2023, when the United Nations Committee[29] reviewed Tunisia's initial report on the Convention on the Rights of Persons with Disabilities, members expressed concern about the gap between legislation and its implementation. They recommended the adoption of a more effective mechanism to ensure the proper application of these laws and to uphold the State's commitments.

21. Regarding migrants, access to healthcare is guaranteed for all refugees and asylum seekers in public health centers and hospitals at the same rates as uninsured Tunisians.[30] Migrants with regular administrative status receive free emergency care, sexual and reproductive health services, and vaccinations. However, access to healthcare is difficult in 67% of cases, primarily due to a lack of

[24] WHO Tunisia – Overview of the Cooperation Strategy – Data Source: Global Health Observatory, 2017.
[25] WHO – Regional Office for the Eastern Mediterranean- Health System Country Profile – 2018
[26] The Health of Tunisians - Results of the "Tunisian Health Examination Survey-2016" - National Institute of Health - Ministry of Health Tunisia – Final Report – February 2019.
[27] World Health Estimates 2020: Deaths by cause, age, sex, by country and region, 2000-2019. Geneva, World Health Organization; 2020.
[28] Men aged 10 to 24 were the most affected, with 23.6 deaths in 2019 (28.9 in Morocco and 28.1 in Algeria) compared to 9.6 for women (5.2 in Morocco and 13.6 in Algeria).
[29] Review of the initial report on the measures taken by Tunisia under the provisions of the Convention on the Rights of Persons with Disabilities by the members of the Committee on the Rights of Persons with Disabilities at the United Nations – March 2023.
[30] ONU, Common Country Analysis Tunisia, 2020.

information, followed by the fear of arrest, imprisonment, and deportation, particularly among those with irregular administrative status.[31] [32]

22. According to WHO data, Tunisia recorded the highest COVID-19 death toll in the Eastern Mediterranean and Africa in 2021, with over 20,000 deaths. The health crisis severely strained the healthcare system and had a profound impact on all segments of the population.[33]

23. The National Health Policy for 2030 was developed during the second phase of the social dialogue on national health policies, strategies, and plans (2017-2019) through a participatory and inclusive process aimed at reforming the healthcare system to achieve Universal Health Coverage. The policy was officially adopted by the Tunisian government, civil society, and professional organizations on April 7, 2021, following the signing of the National Charter for Health System Reform. It is based on five strategic priorities: (i) family and community health as the foundation of the healthcare system; (ii) a package of essential services for all; (iii) a unified basic regime for all; (iv) a strong public sector equipped to fulfill its roles in training, research, and innovation; and (v) the protection of citizens' health. Three key factors support the success of these priorities: (a) regulation based on UHC principles; (b) active citizen participation as partners in health; and (c) transparency and the fight against corruption. Population and health statistics are shown in Table 1 below.

Table 1 Key population data and health indicators in Tunisia[34] (2019)

Statistics on Population and Health	
Population (2023)[35]	12.5 million
Proportion of the population aged 0-14 years	3 125 million
Proportion of the population aged 10-19 years	1 875 million
Proportion of the population aged over 65 years	1 125 million
Life expectancy at birth (2019)[36]	74.9 (hommes); 79.2 (femmes)
Social-economic indicators [37]	
Gender Inequality Index (GII)	0.259 (65/152)
Ranking according to the Human Development Index (HDI)	0.731 (95/189)
Indicateurs de santé[38]	
Neonatal mortality rate (2021)	12/1000 live births
Under-five mortality rate (2021)	16/1000 live births
Maternal mortality rate (2020)	37/100,000 live births
Antenatal care coverage (4+ visits)	84.1%

[31] IOM Côte d'Ivoire, Return Migration Study, 2020
[32] Irregular border crossing is penalized. Furthermore, government decree No. 2017-1061 sets a late penalty for illegal presence in Tunisian territory at 20 dinars for each period of 1 to 7 days, with a maximum threshold of 3000 dinars.
[33] See annex for an overview of the impact of the Covid-19 pandemic in Tunisia, government and WHO response.
[34] WHO EMRO. Monitoring Health Systems Performance in the Eastern Mediterranean Region. Core indicators and indicators on the health-related Sustainable Development Goals at: https://applications.emro.who.int/docs/WHOEMHST247E-eng.pdf?ua=1; and Global Health Observatory Data Repository at: https://apps.who.int/gho/data/node.main.SKILLEDBIRTHATTENDANTS?lang=en and https://data.who.int/countries/368
[35] World Population Dashboard. https://www.unfpa.org/data/world-population/TN: extrait le 25/06/2023.
[36] The Global Health Observatory, https://data.who.int/countries/788: extrait le 11/12/2023
[37] UN Women Country snapshots, https://data.unwomen.org/arab-states/country/tunisia: extrait le 11/12/23.
[38] World health statistics 2023 – Monitoring health for the SDGs. WHO 2023.

Health system indicators[39]	
Density of doctors (2013-2021, primary data)	12.6/10 000 population
Density of nurses and midwives (2013-2021, primary data)	24.3/10 000 population
Births attended by skilled personnel (2013-2022, primary data)	100%
Measles vaccination (MCV2) covered by the recommended age at the national level (%) (2021)	98%
Health financing indicators[40]	
Current health expenditure per capita (CHE) (US$) (2021)	265.5
Government health expenditure as a % of total public expenditure (2021)	12.4
Out-of-pocket health expenditure as a % of current health expenditure (CHE) (2021)	33.74

1.2 Scope of the evaluation: WHO actions in Tunisia, 2019 - 2023

24. During the evaluation period, WHO's activities in Tunisia were organized through biennial planning, but they were not guided by a formal Country Cooperation Strategy. Although provisional documents were drafted multiple times, the most recent version, intended for the 2016-2020 period, was completed in mid-2016.

25. The evaluation covers three biennia, spanning two General Programmes of Work (GPW): GPW12 (2014-2019) and GPW13 (2019-2023), which has been extended until 2025. As a result, the activities and outcomes of the 2018-2019 biennial program follow a different results framework from those used in the 2020-2021 and 2022-2023 biennia (see Table 3).

26. Through biennial planning, WHO in Tunisia worked[41] to:

(1) Improve access to quality essential health services, reduce the financial burden on individuals, and enhance access to medicines, vaccines, diagnostic products, and essential devices for primary healthcare (health system reform);

(2) Strengthen preparedness, detection, and management of health emergencies, while improving the prevention of epidemics and pandemics (protection against emergencies); and

(3) Tackle the determinants of health, reduce risk factors through multisectoral action, promote healthy environments, and adopt a health-in-all-policies approach (improving population health and well-being).

27. Strengthening Tunisia's capacity in data and innovation, along with enhancing leadership, governance, health promotion, and results-based, transparent management within WHO, has been essential in achieving these outcomes. This work has been supported through capacity building and training, technical assistance, the provision of equipment and supplies, as well as data generation and studies.

[39] Ibid.
[40] The Global Health Observatory, https://www.who.int/data/gho/data/indicators/indicator-details/: extrait le 11/12/23.
[41] See annex – Reconstructed Theory of Change.

28. WHO's contributions in Tunisia have been flexible, adapting to emerging challenges, including the COVID-19 pandemic,[42] through crisis response efforts and ongoing actions during the 2020-2021 and 2022-2023 biennia.

29. A review of these biennial work plans shows a total of 387 planned activities (key tasks), with an average of thirty outputs per biennium (see Table 2).

Table 2 Summary of outputs and activities scheduled by biennium

	2018-2019	2020-2021	2022-2023	TOTAL
Outputs	33	25	31	
Top task	286	38	63	**387**

[42] Also polio at the border with Algeria, Ebola, measles, or health risks related to migratory flows.

Table 3 Results frameworks for the 2018-2019 biennia (GPW12) and the biennium 2020-2021 and 2022-2023 (GPW13)

PB 2018-2019	PB 2020-2021 and 2022-2023
CAT.1. COMMUNICABLE DISEASES 1.1. HIV and Hepatitis. 1.2. Tuberculosis. 1.4. Neglected tropical diseases. 1.5. Vaccine-preventable diseases. 1.6. Antimicrobial resistance. **CAT.2. NON COMMUNICABLE DISEASES** 2.1. Noncommunicable diseases. 2.2. Mental health and substance abuse. 2.3. Violence and injuries. 2.5. Nutrition. **CAT.3. PROMOTING HEALTH THROUGH THE LIFE COURSE** 3.1. Reproductive, maternal, newborn, child, and adolescent health 3.2. Ageing and health 3.5. Health and the environment. **CAT.4. HEALTH SYSTEMS** 4.1. National health policies, strategies, and plans. 4.2. Integrated people-centred health services. 4.3. Access to medicines and other health technologies and strengthening regulatory capacity. 4.4. Health systems, information, and evidence. **CAT.6. CORPORT SERV. / ENABLING FUNCTIONS** 6.1. Leadership and governance. 6.4. Management and administration. **E. HEALTH EMERGENCIES PROGRAMME** E.1. Infectious Hazard Management. E.2. Country Health Emergency Preparedness and the International Health Regulations (2005).	**SG1. UHC** Outcome 1.1. Improved access to quality essential health services. Outcome 1.2. Reduced number of people suffering financial hardships. Outcome 1.3. Improved availability of essential medicines, vaccines, diagnostics and devices for primary health care. **SG2. EMERGENCIES** Outcome 2.1. Country health emergency preparedness strengthened. Outcome 2.2. Emergence of high-threat infectious hazards prevented. Outcome 2.3. Health emergencies rapidly detected and responded to. **SG3. BETTER HEALTH AND WELL BEING** Outcome 3.1. Determinants of health addressed leaving no one behind. Outcome 3.2. Reduced risk factors through multi sectoral approaches. Outcome 3.3. Health and well-being realized through Health in all policies and healthy settings interventions. **CG. IMPROVED WHO SUPPORT FOR TUNISIA** Outcome 4.1. Strengthened country capacity in data and innovation. Outcome 4.2. Strengthened leadership, governance, and advocacy for health. Outcome 4.3. Improved financial, human, administrative resources management towards transparency, efficient use of resources, and effective delivery of results.

30. In budgetary terms, the contribution—covering biennial program budgets, emergency funds (OCR),[43] and off-biennium (Non-PB)[44] funds—totals US$ 28,782,261 planned, with US$ 22,783,263 executed as of 20 October 2023. The emergency fund (OCR), primarily allocated for the COVID-19 response, accounts for 59% of the total budget executed during the evaluation period (see Table 4).

[43] Outbreak and Crisis Response: these are WHO emergency response funds that are specifically mobilized in public health crisis situations.
[44] Non-PB Budget: during the evaluated period, this refers to project funds financed by the WHO Framework Convention on Tobacco Control, FCTC (English acronym).

Table 4 Summary of planned, received, and utilized funds by biennium and total

	2018-2019			2020-2021			2022-2023			TOTAL PERIOD		
	Planned Cost	Funds Received	Utilization	Planned Cost	Funds Received	Utilization	Planned Cost	Funds Received	Utilization	Planned Cost	Funds Received	Utilization
BASE	4,135,250	3,280,624	3,180,114	4,517,389	3,302,766	2,857,684	5,835,677	5,181,715	3,085,770	14,488,316	11,765,105	9,123,568
OCR				9,718,534	9,615,450	9,226,732	4,339,411	4,339,411	4,244,987	14,057,945	13,954,861	13,471,719
Non-PB				100,000	60,000	59,991	136,000	136,000	127,985	236,000	196,000	187,976
TOTAL ($)	4,135,250	3,280,624	3,180,114	14,335,923	12,978,216	12,144,407	10,311,088	9,657,126	7,458,743	28,782,261	25,915,966	22,783,263

1.3 Characteristics of the evaluation: purpose, objectives and scope

31. The evaluation of WHO's contribution in Tunisia aims to:

(i) Strengthen accountability for results; and

(ii) Enhance organizational learning for informed decision-making, particularly for the design of new strategies and programs in the country.

32. This evaluation is based on an analysis of existing documents and data, supplemented by the perspectives of key stakeholders, to:

a) Evaluate achievements against the objectives outlined in national strategies and the expected outcomes defined in the CO's biennial work plans, while identifying challenges and opportunities for improvement;

b) Assist the CO and its partners in developing future strategic planning tools and refining WHO's operational planning mechanisms, by incorporating independent insights into past successes, challenges, and lessons learned; and

c) Extract lessons from the evaluation results at all three levels of the Organization. Understanding successes and challenges at the global, regional, and national levels can provide valuable insights for future national, regional, and global support, contributing to a more systematic approach to organizational learning.

33. The evaluation encompassed all activities carried out by the WHO—specifically, the Country Office, Regional Office, and headquarters—in Tunisia from 2019 to 2023, with data available until October 2023. This assessment was based on the relevant programmatic instruments that outlined activities conducted during this timeframe. While the geographical scope included the entire national territory, field visits were specifically conducted in Sfax, Sousse, and El-Kef (see Methodology). The demographic focus included both the Tunisian population and residents in Tunisia, particularly highlighting the most vulnerable groups, such as the migrant population.

34. The primary user of this evaluation is the WHO Country Office in Tunisia, as the results will guide the development of upcoming biennial programs and may inform the creation of a Country Cooperation Strategy, if relevant to the local context. The RO and HQ can leverage the findings to inform other country offices in the region, aid in designing regional health strategies, and offer strategic insights to promote the implementation of best practices across countries. The assessment of the level and quality of coordination among the three levels of WHO will also be of internal interest to the organization. WHO's partners in Tunisia, notably the Ministry of Health, the primary counterpart, can

utilize the evaluation findings to enhance collaboration—both strategically and programmatically—and to gain a clearer understanding of WHO's operations in the spirit of accountability and transparency. Furthermore, UN agencies, financial institutions, and technical partners will likely focus on the effectiveness, efficiency, strategic positioning, and added value of WHO's contributions to Tunisia's health sector.

Arrival of One Million Doses of Moderna Covid-19 Vaccines Provided by the United States to Tunisia, July 2021. *Credit: WHO*

2. Methodology

This section provides an overview of the key methodological elements of the evaluation. A detailed description of the methodology can be found in the accompanying annex.[45]

2.1 Evaluation criteria and questions

35. The evaluation criteria addressed, as outlined by the OECD-DAC, include relevance, coherence, effectiveness, efficiency, and sustainability (see Table 5). The main evaluation questions align with these criteria and are derived from the Terms of Reference (ToR) and the reconstructed Theory of Change, which was developed during the scoping phase.[46] These core questions are further broken down into eight sub-questions within the evaluation matrix.[47]During the scoping phase, the evaluation questions proposed in the ToR were adjusted to ensure clarity and precision by eliminating terms that could blur the distinction between evaluation criteria. These changes aimed to avoid overlaps or redundancies in responses and better fit the specific context. The modifications were presented and validated in the Inception Report.

Table 5 Evaluation criteria and key questions

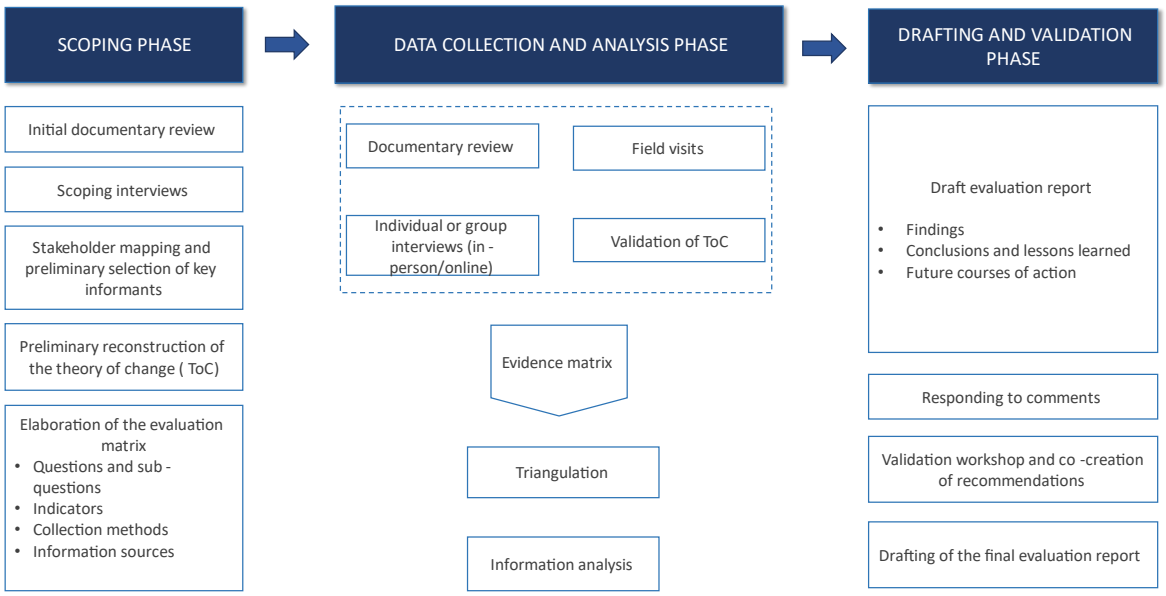
RELEVANCE	**Q1.** To what extent are WHO interventions aligned with the context, evolving health needs, and rights of the Tunisian population, as well as the needs, policies, and priorities of national institutions? Moreover, do these interventions remain adaptable as circumstances change?
COHERENCE	**Q2.** To what extent are WHO interventions coherent, and do they foster synergies both among themselves and with the interventions of other actors in Tunisia?
EFFECTIVENESS	**Q3.** To what extent have the outcomes of WHO's contributions been achieved, or are they likely to be achieved? Additionally, what factors have influenced, or hindered, their realization?
EFFICIENCY	**Q4.** To what extent have WHO interventions produced results efficiently and in a timely manner, or are they likely to do so?
SUSTAINABILITY	**Q5.** To what extent has WHO contributed to strengthening national capacities and ownership in addressing Tunisia's humanitarian and development health needs and priorities?

[45] See Annex 4. Summary of data collection methods and sources used.
[46] See chapter 2.2
[47] See Annex 2. Evaluation Matrix.

2.2 Methodological framework: approach and methods

36. This evaluation follows a non-experimental design. The overall approach, developed in the ToR and adopted by the evaluation team, is summarized below (see Figure 1). It illustrates the sequence and interrelation of activities across the three main phases of the evaluation. The proposed methodology ensures impartiality and minimizes bias by drawing from a diverse sample of information sources (involving various stakeholder groups and authors) and employing a mixed-method approach that incorporates both quantitative and qualitative data, enabling effective triangulation of information.

Figure 1 Methodological Approach to the evaluation process



37. The evaluation adopted Tunisia's biennial work plans for 2018-2019, 2020-2021, and 2022-2023 as its primary basis. In the absence of a formal logical model or Theory of Change to frame WHO's contributions in Tunisia during this period, the evaluation team developed a ToC during the design phase (see Figure 2). The ToC[48] helped refine key evaluation questions, identify data gaps, and explore opportunities for additional data collection. It outlines the relationship between strategic priorities, intervention areas, activities, and budgets in the CO's biennial work plans. Additionally, it clarifies links to the Thirteenth General Programme of Work (GPW13) and program budgets,[49] and identifies key assumptions. The CO then revised the ToC during the field mission. Based on the ToC, the team developed an evaluation matrix that outlined specific indicators for each evaluation question, along with the data collection methods and sources used.[50]

[48] See Annex 3. Reconstruction of the Theory of Change (ToC)
[49] The program budget is a crucial tool that enables Member States to set and approve WHO's priorities, outline the objectives to be achieved, and oversee their progress. It also determines the necessary resource levels to accomplish this work, allowing Member States to monitor and manage them effectively. This ensures a balanced approach to the organization's responsibilities across various sectors. The biennial program budgets are derived from the General Programme of Work, which is approved by Member States and establishes the strategic direction for WHO.
[50] See Annex 4. Summary of data collection methods and sources used.

38. The evaluation primarily relied on existing data produced by WHO and its partners, as well as strategic and technical documents, including national statistics (approximately 435 documents in total). This was complemented by primary data obtained through semi-structured interviews with pre-selected key informants and field visits to Tunis, Sfax, Sousse, and El-Kef (see Annex 4) during a two-week mission in Tunisia (13-24 November 2023). Due to the limited timeframe and the number of interviews required, several were conducted remotely, particularly those involving donors, UN agencies, and WHO staff from the RO and HQ. A total of 75 individuals, 53% of whom were women, participated in 56 interviews.[51]

39. Three levels of analysis and three cross-cutting principles were considered (see Figure 2):

(i) **Strategic analysis:** This addressed the relevance and coherence (both internal and external) of WHO's contributions in Tunisia.

(ii) **Programmatic analysis:** This focused on progress towards expected results, support for long-term national objectives, and the contribution to a resilient national health system. It addressed the criteria of effectiveness, efficiency, and sustainability. The effectiveness analysis used budgetary data to develop a framework for measuring WHO's performance in Tunisia, cross-referencing and triangulating data on goal achievement and budget execution. Efficiency was assessed using standard budget execution data categorized by major budget lines.

(iii) **Organizational analysis:** This examined WHO's internal organizational structure, including planning and budget execution processes, coordination mechanisms with the MoH, the RBM system of GPW13, and technical support from the RO and HQ.

40. The cross-cutting principles across the different criteria align with the three core WHO principles specified in the ToR: (a) a human rights-based approach, (b) gender integration, and (c) health equity ("leaving no one behind").[52] A dedicated chapter presents the main findings based on document analysis and interviews ((in cases where data disaggregation has been made available),[53] which include searches for disaggregated data by vulnerable groups, activities targeting specific populations, references in descriptions and reports, and interview content addressing these dimensions either directly or indirectly.

41. This evaluation is both summative, promoting accountability and encouraging learning through lessons learned, and formative, aimed at supporting decision-making by providing recommendations.

42. The evaluation also adopted a contribution approach, focusing on WHO's support for reforms, implementation of health strategies and programs, and responses to health emergencies, such as COVID-19 and the resurgence of infectious diseases, rather than attributing specific health developments in Tunisia solely to WHO interventions. The evaluation analyzed WHO's work across all areas covered by the three biennial plans to strengthen the national health system. Given that these actions were aligned with major national priorities, the evaluation focused on strategic-level analysis

[51] See annex 5.
[52] WHO Policy and Strategy on Health Equity, Gender Equality and Human Rights, 2023 – 2030, 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).
[53] See Limitations in the following section.

rather than on the technical details of the approximately 400 activities or interventions carried out by WHO in various areas.

2.3 Limitations faced and mitigation measures

43. The evaluation encountered several key limitations:

(i) **Availability of key informants**: In the context of political transition, some key informants from national institutions refused to participate, while others were newly appointed and had limited knowledge of the entire evaluation period. Among other partner groups, certain key informants did not respond despite multiple follow-ups. This challenge was mitigated by using the "snowball" method, which involved identifying and interviewing other key informants suggested by the CO.

(ii) **Fragmentation and quality of available information**: The lack of a Country Cooperation Strategy document between Tunisia and WHO, along with the lack of a ToC, made it difficult to establish a strategic vision for the evaluation period. Additionally, no comprehensive monitoring documents—such as those combining narrative explanations and budget data—were available. Instead, the evaluation encountered a fragmented RBM system with no performance indicators, making it impossible to directly link completed activities to existing key performance KPIs (see details in Q3 on effectiveness and Q4 on efficiency). The assessment of WHO's COVID-19 response in Tunisia was hindered by the lack of budget execution data for each pillar of the response plan; only budget planning data could be used, which were triangulated with interviews and other documentary sources. Despite this, a thorough analysis of shared documents, the linking of qualitative and quantitative data (mainly budget data), and triangulation of all available information helped mitigate this limitation, leading to findings that informed recommendations.

(iii) **Data disaggregation:** The monitoring and reporting documents provided for the evaluation by both WHO and the MoH offered limited data disaggregation by sex, age, and diversity. This limitation affected the analysis of WHO's contributions to specific individuals or groups, particularly those targeting vulnerable populations.

(iv) **Online survey:** The aim of this survey was to gather information on the added value of the RO and HQ in achieving Country Office results in Tunisia. However, the survey was not conducted due to an insufficient number of respondents to produce meaningful results. In consultation with WHO, the number of remote interviews with key informants from RO and HQ was slightly increased to compensate.

(v) **Short evaluation timeframe, particularly the field phase**: The field phase lasted only 10 working days, constrained by budgetary considerations and WHO's internal schedules (CO and RO). As a result, several interviews were conducted remotely before, during, and in the two weeks following the team's visit to Tunisia. All interviews with national institutions and organizations were conducted in person, and three field visits took place outside of Tunis.

(vi) **Evaluation period selected**: Given that the evaluation covered only half of the 2019 biennium and included the current year of 2023, it was not possible, with the available documents, to distinguish actions and budgets for 2019 from those of October 2018 or to obtain consolidated data (activities and budgets) for 2023. Without going into exhaustive detail, the 2018-2019 biennium was analyzed. For the current year, 2023, the available data (as of October) were included in the analysis and incorporated into the findings.

2.4 Ethical considerations

44. The evaluation was conducted in line with the Ethical Guidelines for Evaluation, as defined by UNEG, 2020. These guidelines emphasize four core ethical principles—integrity, accountability, respect, and beneficence—which were fully adhered to by both WHO and the evaluation team.

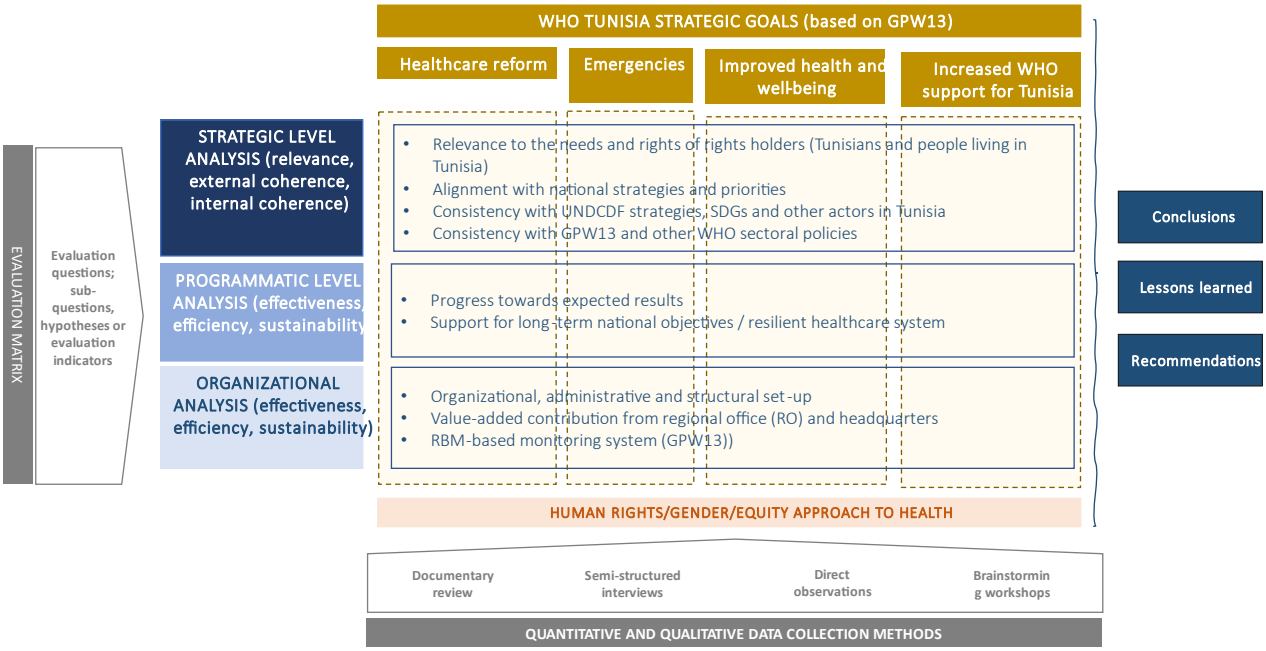
45. Special attention was given to respecting dignity and diversity, ensuring confidentiality, preventing harm, maintaining anonymity, and carefully managing the data and information collected during the evaluation.

46. During the data collection phase, all respondents were informed that their participation was voluntary, in accordance with informed consent practices, and that all collected data would remain confidential and be used exclusively for the purposes of this evaluation.

47. The documentation provided to the evaluation team was used solely for the evaluation and remains confidential.

48. The evaluation adhered to WHO's five key evaluation principles: impartiality, independence, utility, quality, and transparency. To ensure this, the evaluation team implemented internal quality assurance measures for all evaluation activities and deliverables. The team worked closely with WHO's evaluation manager, who provided the first layer of quality assurance, ensuring adherence to the schedule and flexibility in adapting to the process and field realities. A second layer of quality assurance was provided by WHO's Evaluation Office in Geneva, which participated in regular meetings, facilitated the evaluation process, and reviewed the main evaluation findings. The methodology applied was the one presented and validated prior to the start of data collection. Throughout the process, the evaluation team maintained ongoing communication with various WHO stakeholders and key informants, ensuring independence, impartiality, and confidentiality through the anonymization and triangulation of data and information.

Figure 2 Levels of Analysis of the WHO Contribution, Tunisia (2019-2023)



3. Findings

3.1 Relevance

Q1. To what extent are WHO's interventions tailored to the context and the evolving health needs and rights of the Tunisian population, as well as to the needs, policies, and priorities of national and regional partners and institutions? Additionally, do these interventions remain relevant as circumstances change?

Finding 1. WHO's objectives in Tunisia during the evaluation period were clearly aligned with the country's national health priorities, structural needs, and emerging demands. From the 2020-2021 biennium onward, there has been increased focus on noncommunicable diseases (NCDs), social and environmental health determinants, emergency preparedness, and advancements in data generation and innovation. WHO's contribution is widely recognized for its support of the Social Dialogue process, which began in 2012. This support played a key role in the production of the White Paper *For Better Health in Tunisia: Let's Make the Journey Together (2)* in 2014 and the drafting of the National Health Policy for 2030, which was officially validated in 2021.

Finding 2: There is a strong history of collaboration with the MoH at the central level; however, this collaboration remains limited at the regional level, particularly in the most disadvantaged areas. While strategic

partnerships have been formed with other actors to address the multisectoral nature of health, these collaborations have been sporadic.

Finding 3: WHO's country strategic vision is not clearly articulated in its biennial planning documents. The list of programmed activities appears disconnected from a thorough contextual analysis, the identification of needs and challenges, or a mapping of stakeholders. This planning approach makes it difficult for different stakeholders to understand WHO's vision, assess how it aligns with their own strategies and objectives, or participate in joint assessments. As a result, the CO has undertaken actions with limited relevance.

Finding 4: WHO's contribution to Tunisia's COVID-19 response was highly valued, particularly for its relevance and close coordination with the MoH and its departments, other UN system agencies, and civil society organizations (CSOs). Following this, the CO successfully capitalized on the increased attention to key public health issues, enhancing its contributions in these areas.

The findings in this section are organized according to the following themes: alignment of WHO's contributions with the needs of the Tunisian population, alignment with national priorities, and the relevance of partnerships.

Q1.1. To what extent have WHO's objectives, including any adjustments made, and interventions addressed the needs and rights of Tunisian beneficiaries, particularly the most marginalized populations? Additionally, how well have these objectives aligned with the country's policies and priorities?

49. WHO's objectives in Tunisia during the evaluation period were clearly aligned with national health priorities and structural needs, such as combating infectious diseases, reducing maternal and infant mortality, addressing antimicrobial resistance (AMR), and developing strategies to manage the epidemiological transition, particularly with regard to NCDs, emergency preparedness, and health system reforms for better governance and improved health financing. WHO's objectives also addressed emerging needs such as epidemic threats (e.g., Ebola, measles, health risks related to migration flows, and COVID-19).[54]

50. WHO's actions in Tunisia have taken the General Programme of Work (GPW)[55] as a reference for defining its cooperation with the MoH and its overall role in the health sector. However, the adaptation of the global strategy to the specific context, priorities, capacities, and opportunities of Tunisia's health system and its key national and international actors has not been formally documented. The absence of a country-specific strategic document does not imply that there is no medium-term vision for WHO agreed upon with the MoH; rather, it indicates that this vision has not been reflected in a structured governance mechanism, nor has a coherent monitoring and learning framework been established. Additionally, the biennial plans, while serving as an operational planning tool through dialogue with the MoH, do not contain enough strategic elements to function as comprehensive planning tools.

51. There is continuity across the three biennia regarding national priorities, but a visible evolution in the main activities. Starting from the 2020-2021 biennium, there was greater focus on NCDs, social and environmental health determinants, emergency preparedness, and data generation and innovation.

[54] Workplans, biennium planning documents, Annual Reports, and End of Biennium Reports for 2018-2019, 2020-2021, and 2022-2023, as well as the presentation on the response to COVID-19, WHO
[55] The strategic frameworks for WHO globally are GPW12 (biennium 2018-2019) and GPW13 (2020-2021 and 2022-2023 biennia).

This shift can largely be attributed to the transition from GPW12 to GPW13, which places greater emphasis on health systems, multisectorality, and health promotion and prevention.[56] [57]

52. The COVID-19 crisis served as a catalyst, heightening interest in topics like infection prevention and control, surveillance, preparedness, response to health emergencies, and the multisectoral nature of health. The WHO CO leveraged this opportunity to promote a gradual transition towards more resilient health systems, which continued into the 2022-2023 biennium and the ongoing formulation of the 2024-2025 biennium.[58]

53. WHO's contribution is widely recognized for its relevance and support—through advocacy and funding—beginning in 2012, following Tunisia's 2011 revolution and the adoption of its new constitution in 2014. This support culminated in the development of the White Paper *For Better Health in Tunisia: Let's Walk the Path Together, (2)* as part of the Social Dialogue. This participatory and inclusive process continued into the second phase of the Social Dialogue, leading to the National Health Conference in June 2019, where the National Health Policy (NHP) for 2030 was presented. The NHP aligns strategically with WHO's vision,[59] prioritizing: (i) placing citizens at the center of the health system, (ii) ensuring equitable access to care, (iii) strengthening health protection, and (iv) improving governance towards universal health coverage. Although the NHP was not officially validated until April 2021 due to political instability and the emergence of COVID-19, WHO has remained committed to supporting its implementation.

54. Interviews and document reviews reveal a strong historical collaboration and close communication with the MoH at the central level. However, this collaboration, while beginning to extend to the field (particularly since the COVID-19 response), remains limited in supporting the capacities of certain regional directorates.[60] These regions face significant challenges, including (i) funding for operations, such as indigent care in areas with high poverty rates (e.g., El-Kef governorate) and care for migrants in cities like Sfax where they are present in large numbers; (ii) the adequacy of care provision, such as the shortage of specialized personnel and medical equipment; and (iii) governance issues, including outdated regulations, overwhelmed tertiary hospitals, and rural primary healthcare centers (CSSB) operating only one day a week.[61]

55. In line with the global "One Health" approach and the regional "Health for All and by All" approach (EMRO Vision 2023), WHO has occasionally formed strategic partnerships with actors beyond the MoH to promote intersectoral action on key public health issues. These partnerships include awareness campaigns on physical activity and healthy behaviors for NCD prevention, in collaboration with the Ministry of Youth and Sports and civil society.[62] WHO has also worked with FAO and the Ministry of Agriculture on a national plan to combat antimicrobial resistance, developed through a "One Health" lens, approved by the Ministry of Agriculture and the MoH,[63] [64] and covering the period from 2019-2023. Another notable collaboration was the national workshop on the International Health

[56] And this was made possible through the recruitment of two individuals for this purpose.
[57] See details in Q2.1.
[58] Internal and external interviews
[59] GPW12 and GPW13
[60] See 1.1. Background and national context: Health system and health situation, specifically point 15.
[61] Internal and external interviews, and field visits.
[62] Ibid.
[63] Interviews and document review.
[64] See 1.1. Background and national context: Health system and health situation, specifically point 17.

Regulations (IHR) (2005) and the Performance of Veterinary Services (PVS) process in December 2023, which involved nine ministries.[65]

56. The CO has also seized opportunities to contribute to key public health issues, such as tobacco control, which has become a national priority since 2020 despite political transitions. Tunisia has received funding from the WHO Framework Convention on Tobacco Control (FCTC) to support these efforts. However, a challenge remains regarding HIV/AIDS. Despite a low incidence rate (7,100 people living with HIV in 2022) (13)[66] and the existence of a National AIDS Control Policy (PNLS), Tunisia has one of the lowest 90-90-90 cascade results in the region, with only 32% of infected individuals receiving treatment.[67] Limited data, coupled with treatment availability issues, have exacerbated the situation. Despite the involvement of UNAIDS and the Global Fund, WHO's role in addressing HIV/AIDS has been reported as limited, with a need for stronger advocacy and more catalytic initiatives to achieve sustainable results.

57. Given these findings, WHO's country strategic vision is difficult to discern from the biennial planning documents, which largely consist of lists of activities. These activities are not clearly linked to a contextual analysis, an assessment of needs and challenges, or a documented mapping of stakeholders. There is no joint document with the Tunisian government, to the evaluation team's knowledge, that illustrates this strategic vision for Tunisia and for the period concerned.[68]

58. Although WHO's strategic vision may be clear internally, and the biennial plans do address real needs and national priorities, several key informants[69] have indicated that the methodology used for planning does not provide sufficient time for stakeholders—particularly MoH directorates and agencies—to understand this vision, assess how it aligns with their own strategies, and evaluate its relevance to Tunisia's context.[70] This reflection period is especially important in a national context of instability and high turnover within the MoH, which impacts national capacity to achieve results. Furthermore, the absence of a joint assessment of achievements, challenges, and lessons learned at the end of each period limits stakeholders' ability to understand WHO's proposals and identify actions to be prioritized. This has led to situations where long-supported programs continued without an analysis of progress (e.g., tuberculosis control), or where activities not considered priorities by the MoH were funded (e.g., seminars on general inspection). Additionally, while biennial plans reflect MoH priorities, they lack the data and analysis needed to explain how these priorities were established, particularly with regard to targeting vulnerable populations. The limited availability of disaggregated data[71] has also hindered consistent documentation of WHO's contributions to reducing health disparities.

59. Tunisia is home to several WHO collaborating centers[72] and reference centers for priority health issues, such as infectious diseases (Department of Dermatology at La Rabta University Hospital, Faculty of

[65] Workshop jointly organized by the Ministries of Health, Agriculture, Water Resources and Fisheries, and Environment, in partnership with the Ministries of Interior, Defense, Finance, Higher Education, Transport, and the Quadripartite: WHO, OIE, FAO, and UNEP.
[66] Fewer than 500 new infections reported in 2020. UNAIDS
[67] In 2020, the estimated number of people living with HIV (PLHIV) was 4,500, among whom only 2,300 (51%) knew their serological status, 1,401 were receiving antiretroviral treatment (32%), and 1,015 (22%) were reportedly in viral suppression. UNAIDS and HIV Testing Strategy - Operational Plan 2022-2023.
[68] The latest Country Cooperation Strategy (CCS) dates from 2010-2014, and the draft prepared in 2016 did not come to fruition.
[69] Key external and internal informants
[70] "Do WHO's proposals suit them because they worked in other countries?" "We know our own context." Interviews
[71] See section on Limitations encountered.
[72] WHO Collaborating Centres are institutions, research institutes, or university departments designated by the WHO Director-General to be part of an international network, supporting the Organization's activities at all levels. These centres serve as valuable resources, providing

Medicine, Al Manar University for leishmaniasis control), vaccination (Institut Pasteur Tunisia), and blood transfusion (National Blood Transfusion Center, CNTS). WHO has supported these centers through the biennial plans and in the context of the COVID-19 response,[73] facilitating exchanges with EMRO and WHO Headquarters.

60. Faced with the challenges of the COVID-19 pandemic, WHO provided a highly relevant response in close coordination with the MoH, other UN agencies, and CSOs. WHO's proactive presence and its ability to provide timely information—on risks, protocols, protective measures, virus variants, vaccine developments, and more—before the pandemic was officially declared and the first case was detected in Tunisia, was widely appreciated and recognized by all stakeholders.[74]

3.2 Coherence

Q2. To what extent are WHO's interventions coherent, and do they foster synergies both among themselves and with interventions by other actors in Tunisia?

Finding 5. The UN system's interventions in Tunisia are fully aligned with WHO's vision through the health priorities of the UNSDCF, which integrates a multisectoral approach (external coherence).

Finding 6: WHO's collaboration is generally appreciated by other UN agencies for its focus on complementarities. However, the Country Office lacks sufficient visibility relative to WHO's broader role in the health sector. The Health Group, recently launched and promoted by WHO as a platform for exchange, coordination, and synergy among actors, has yet to demonstrate its full effectiveness.

Finding 7: WHO's contribution in Tunisia is aligned with the EMRO regional strategy Vision 2030 and the global strategy through the actions planned and implemented in the biennia. These actions align with the results frameworks of GPW12 and GPW13, and the CO adheres to WHO's guidelines and recommendations based on the topics addressed (internal coherence).

Finding 8: In both the global and national contexts, WHO's strategic role is evident in areas where it offers clear comparative advantages—particularly in supporting knowledge generation, transmission, and application. Its mission and role as a key reference and information provider for health actors are well-established. However, this advantage is somewhat diminished by a lack of visibility and limited awareness among key actors regarding WHO's priorities in Tunisia and the opportunities for collaboration.

The findings in this section are presented according to three main themes: external coherence and collaboration, particularly with the UN system; WHO's role among health actors in Tunisia; and internal coherence with the regional office and WHO's global guidelines and strategies.

strategic support to WHO in implementing its mandate and in developing and strengthening institutional capacities across countries and regions. As of November 2023, the Eastern Mediterranean Region has 59 Collaborating Centres, covering over 30 areas of activity. The designation of a WHO Collaborating Centre is based on an application process and is granted for renewable four-year terms.

[73] Institut Pasteur Tunisia

[74] See details in Q2.2., point 68, on WHO's comparative advantage, Q3., points 83 and 84, on effectiveness, and Q4.1., point 99, on efficiency.

Q2.1. To what extent are WHO's interventions in Tunisia aligned with the strategies and priorities of international organizations, such as the UNSDCF, and other actors in the country, as well as with WHO's GPW13 and other sectoral policies of the organization?

External Coherence

61. In the United Nations Sustainable Development Cooperation Framework (UNSDCF) 2021-2025 for Tunisia (November 2020), WHO co-chairs Outcome 3, which focuses on health, education, and social protection. In terms of health, the UNSDCF prioritizes "a resilient system that can ensure equitable access to quality services, particularly for vulnerable populations, while fostering effective population engagement." These priorities fully align with WHO's global vision and the Country Office's objectives in Tunisia for the period.[75] The UNSDCF also incorporates lessons learned from the COVID-19 pandemic, such as the importance of institutional and service preparedness for health crises. Furthermore, multisectorality is emphasized as a fundamental aspect for Tunisia to progress toward sustainable development and achieve the 2030 Agenda goals,[76] reflecting WHO's alignment with the "One Health" approach in Tunisia, a key priority for the country.

62. WHO's collaborations with other UN agencies are generally well-regarded, with a clear focus on seeking complementarities rather than competition.[77] Examples include coordination with UNICEF on vaccination issues (e.g., cold chain logistics and communication) and coordination with FAO, UNEP, and OIE on antimicrobial resistance and the intersectoral "One Health" approach.[78] During the evaluation period, WHO participated in a single joint program, *Promoting Women's and Girls' Leadership in the Socio-Economic and Health Response to COVID-19 in Tunisia*, alongside UNDP and UN Women. This ongoing program, initiated in 2021, aims to build on the agencies' experiences during the early stages of the COVID-19 crisis. Although several ministries are involved as key partners, the program appears to be structured in a way that limits interaction between the agencies, with each working in parallel. It is worth noting that, during the previous UNDAF 2015-2020 framework, joint programs involving WHO were reported to be successful[79] (15).[80]

63. Beyond WHO's role in the COVID-19 response (discussed in question Q2.2), several factors suggest that the CO is not sufficiently visible in relation to WHO's broader role in the health sector, either within the UN system or among other key actors. For instance, WHO's contribution is barely mentioned in the 2022 Annual Report of the UN system in Tunisia, aside from noting its purchase of vaccines and ventilators as part of the COVID-19 response. Similarly, WHO is not mentioned in the health section of the 2021 report. WHO's leadership role in health also seems less apparent within the UN system, as

[75] Workplans, biennial programs, and End of Biennium reports. WHO.
[76] In accordance with the guidelines of the Tunisian Government during the preparation workshops for the UNSDCF, and in alignment with Tunisia's 2019 Voluntary National Review and the national context, the UNSDCF has prioritized 10 SDGs: SDG 16 on peace, justice, security, and inclusion; SDG 10 on reducing inequalities; SDG 5 on gender equality; SDG 1 on poverty; SDG 3 on health and well-being; SDG 4 on education; SDG 6 on clean water and sanitation; SDG 8 on sustainable economic growth; SDG 13 on addressing climate change issues; and SDG 17 on partnerships
[77] Several key informants.
[78] See point 55.
[79] Joint Program on Maternal and Neonatal Health, Joint Program on Improving the Care of Women and Girls Victims of Violence in Tunisia, Development of the Multisectoral Strategy for Adolescent Health (UNFPA, WHO, UNICEF, UNAIDS)
[80] Government of Tunisia, UNCT Tunisia (2020). Management Response to the Mid-Term Evaluation of the UNDAF 2015-2020.

evidenced by its absence from meetings of Outcome 3,[81] which it co-chairs.[82] This may, however, be due to limited staffing capacity and the inability to attend all programmatic meetings and coordination forums.

64. Building on the momentum generated during the COVID-19 response—which sparked significant interest among political, social, and development actors in health issues—WHO recently launched the Health Group.[83] This group is intended to serve as a platform for exchange, coordination, and synergy among health actors in Tunisia.[84] The launch meeting, held at a high level (with attendance by the Director-General of Health at the MoH and the UN Resident Coordinator), was widely appreciated and deemed highly relevant. However, the group still requires an agreed work agenda, validated terms of reference, and a governance mechanism to prove its effectiveness and meet the expectations it has created.

Internal Coherence

WHO's contributions in Tunisia, through the actions planned and implemented in the biennia, are aligned with the EMRO regional strategy Vision 2030 and GPW12 and GPW13, as these actions are tied to the corresponding results frameworks. GPW13 introduces a new approach focused on the impact of WHO's actions on people, where for the first time, "people are counted" through the three-billion targets (see Figure 3).

65. This strategic shift in WHO's work involves a new operational approach. GPW13, reflecting the World Health Assembly's focus on measuring the impact of WHO's actions in achieving health-related SDGs equitably, tracks progress at global, regional, and national levels through defined indicators (key performance indicators, KPIs). The CO in Tunisia is responsible for reporting KPIs at the national level.[85]

66. Regarding sectoral policies, the CO follows and applies WHO's guidelines and recommendations based on the themes addressed. In recent years, the CO has contributed to Tunisia's health sector by establishing or updating areas such as maternal and newborn health, health security (including the National Action Planning for Health Security (NAPHS)), AMR, International Health Regulations (IHR (2005)), infection prevention and control (IPC), and NCDs, including mental health (mhGAP Initiative).[86]

Table 6 Alignment of WHO's two results frameworks during the evaluated period with the corresponding biennial plans for Tunisia

GPW12 2014-2019	GPW13 2019-2023
(i) UHC (ii) IHR	**SG1**. 1 billion more people benefitting from universal health coverage (**UHC**), **SG2**. 1 billion more people better protected from health emergencies (**EMERGENCIES**),

[81] Results Groups (RG): coordination groups for the outcomes of the UNSDCF; Group 3 corresponds to education, health, and social protection.
[82] During the 2015-2020 UNDAF, WHO did not co-chair the Health Results Group. Mid-Term Evaluation Report (2015-2018) of the Tunisia UNDAF 2015-2020.
[83] September 2023
[84] The functional review conducted by EMRO in 2019 recommends the creation of a health partner coordination mechanism in the country. Country Functional Review, Tunisia, 23-26 September 2019.
[85] See Q3.1
[86] WHO (2018). mhGAP Intervention Guide

(iii) Increasing access to essential, high-quality and affordable medical products (iv) Addressing the social, economic and environmental determinants, (v) Addressing the challenge of noncommunicable diseases (vi) Addressing unfinished health-related Millennium Development Goals and SDG.	**SG3**. 1 billion more people enjoying better health and well-being (**BETTER HEALTH AND WELL BEING**). **CORPT. G**. More effective and efficient WHO better supporting countries (**IMPROVED WHO SUPPORT FOR TUNISIA)**
WHO Strategy for EMRO 2020-2023: Translating Vision 2023 into Practice	
Four regional strategic priorities interrelated: 1. Expanding universal health coverage 2. Addressing health emergencies 3. Promoting healthier populations 4. Making transformative changes in WHO	**Six approaches to enhance WHO's impact at country level:** 1. Building public health capacity 2. Enhancing preparedness 3. Strengthening partnerships 4. Effectively advocating for health 5. Mobilizing resources 6. Fostering innovation
BP 2018-20	**BP 2020-2021 and 2022-2023**
CAT.1. COMMUNICABLE DISEASES 1.1. HIV and Hepatitis. 1.2. Tuberculosis. 1.4. Neglected tropical diseases. 1.5. Vaccine-preventable diseases. 1.6. Antimicrobial resistance. **CAT.2. NON COMMUNICABLE DISEASES** 2.1. Non communicable diseases. 2.2. Mental health and substance abuse. 2.3. Violence and injuries. 2.5. Nutrition. **CAT.3. PROMOTING HEALTH THROUGH THE LIFE COURSE** 3.1. Reproductive, maternal, newborn, child and adolescent health 3.2. Ageing and health 3.5. Health and the environment. **CAT.4. HEALTH SYSTEMS** 4.1. National health policies, strategies and plans. 4.2. Integrated people-centred health services. 4.3. Access to medicines and other health technologies and strengthening regulatory capacity. 4.4. Health systems, information and evidence. **CAT.6. CORPORT SERV. / ENABLING FUNCTIONS** 6.1. Leadership and governance. 6.4. Management and administration. **E. HEALTH EMERGENCIES PROGRAMME** E.1. Infectious Hazard Management. E.2. Country Health Emergency Preparedness and the International Health Regulations (2005).	**SG1. UHC** Outcome 1.1. Improved access to quality essential health services. Outcome 1.2. Reduced number of people suffering financial hardships. Outcome 1.3. Improved availability of essential medicines, vaccines, diagnostics and devices for primary health care. **SG2. EMERGENCIES** Outcome 2.1. Country health emergency preparedness strengthened. Outcome 2.2. Emergence of high-threat infectious hazards prevented. Outcome 2.3. Health emergencies rapidly detected and responded to. **SG3. BETTER HEALTH AND WELL BEING** Outcome 3.1. Determinants of health addressed leaving no one behind. Outcome 3.2. Reduced risk factors through multi sectoral approaches. Outcome 3.3. Health and well-being realized through Health in all policies and healthy settings interventions. **CG. IMPROVED WHO SUPPORT FOR TUNISIA** Outcome 4.1. Strengthened country capacity in data and innovation. Outcome 4.2. Strengthened leadership, governance, and advocacy for health. Outcome 4.3. Improved financial, human, administrative resources management towards transparency, efficient use of resources, and effective delivery of results.

Q2.2. What was WHO's comparative advantage in Tunisia, especially in relation to other United Nations agencies?

67. The evaluation identified several key dimensions around which there is strong consensus regarding WHO's comparative advantage in Tunisia. These dimensions have been structured to reflect the virtuous circle of health approach (see Figure 4). Additionally, three cross-cutting dimensions were highlighted: WHO's strategic role in providing information[87] and coordinating health actors, its unique position as the only organization addressing health in its entirety, and its specialized technical expertise:

(i) Knowledge generation:

- The normative role in producing strategic documents and protocols, such as those for reducing maternal and neonatal mortality, mental health, or the International Health Regulations (IHR);
- Research and evaluation, including methodologies like the investment model for tobacco control in Tunisia (June 2021) and evaluations of public strategies or initiatives;
- Knowledge management, exemplified by information systems such as the E-vax system, which was initiated for tracking COVID-19 vaccinations and aims to be expanded for all vaccination programs; and
- Anticipation of emerging and re-emerging health issues (measles, Ebola) or health emergencies (such as the CO's widely recognized anticipation of the COVID-19 crisis), based on global and national data.

(ii) Knowledge transmission:

- Guidelines and tools, such as those related to biosafety and infection prevention and control (IPC);
- Networking and benchmarking, including sharing experiences in comparable contexts—such as securing reagents for COVID-19 detection before they became commercially available—participating in national or international forums, and establishing connections with foreign organizations to foster fruitful collaborations.[88]

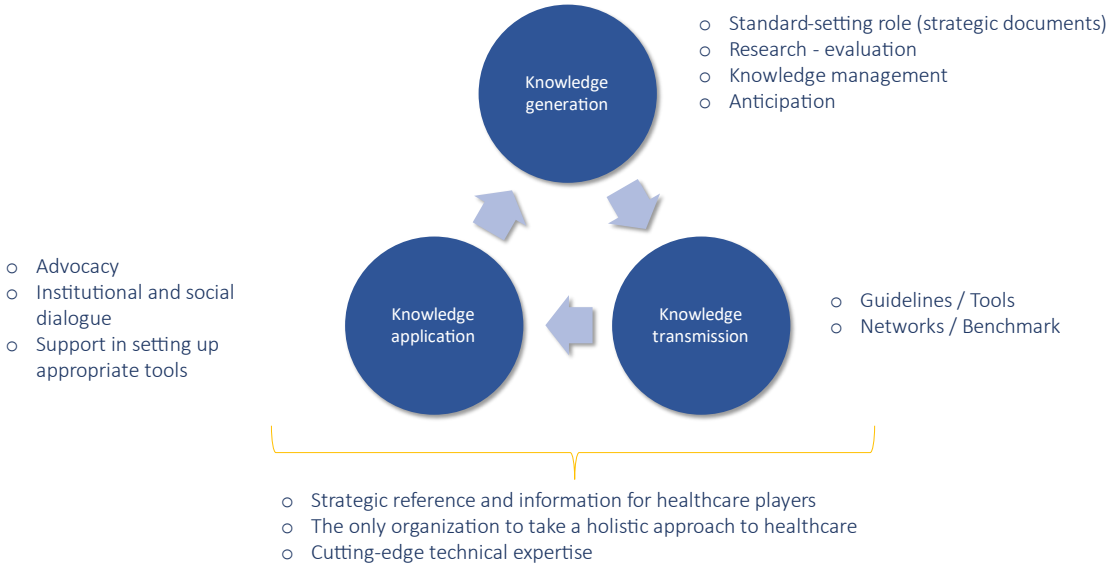
(iii) Knowledge application:

- Advocacy on public health issues, promoting healthy behaviors and holistic approaches such as "health for all and by all" and "One Health." This advocacy led to the development of the national multisectoral strategy for NCD prevention and control, its action plan signed by four ministries, and the inclusion of an operational plan for NCDs in the Ministry of Youth and Sports' physical activity development plan;
- The combination of institutional dialogue and social dialogue, as demonstrated in the Social Dialogue process, or the involvement of civil society in raising public awareness on key issues (e.g., various COVID-19-related messages); and
- Support for the implementation of adapted tools, recommendations from studies and evaluations, and analyses derived from data (e.g., action plans, internal procedures within health structures).

[87] https://www.un.org/youthenvoy/fr/2013/09/oms-lorganisation-mondiale-sante/:"It is responsible for leading global health efforts, setting health research agendas, establishing norms and standards, presenting evidence-based policy options, providing technical support to countries, and monitoring and assessing public health trends. In the 21st century, health is a shared responsibility that requires equitable access to essential care and collective defense against transnational threats."

[88] For example, the connection between the microbiology laboratories at Charles-Nicolle Hospital in Tunis and the clinical virology department at the Pasteur Institute of Tunis (MS) with the Istituto Zooprofilattico Sperimentale dell'Abruzzo e del Molise "G. Caporale" in Teramo, Italy, to formulate a project and with the Italian embassy to secure funding: the result materialized in March 2023 with the MED-NET research project, focused on COVID-19 and the "One Health" approach, aimed at diagnosing and analyzing pathogenic microorganisms circulating in the Mediterranean region that cause infectious diseases in humans, also through the use of next-generation technologies, as well as significantly increasing research capacities

Figure 3 Virtuous circle of health



Source: Evaluation team

68. The collected data confirm that WHO is recognized as the primary technical partner in the health sector by bilateral actors and UN agencies. Additionally, all stakeholders acknowledge the CO staff for their expertise in standards and guidelines, as well as their commitment and dedication to improving health in Tunisia. This finding is consistent with the analysis from the 2019 functional evaluation.

69. WHO's strategic role in providing information and coordinating health actors was widely demonstrated during the COVID-19 crisis response. The CO was highly recognized and appreciated for its availability and efforts to find solutions and foster collaboration among actors to meet national needs.[89]

70. However, this clear added value is diminished by a lack of visibility and awareness of WHO's priorities in Tunisia and the potential for collaboration, as expressed by UN agencies and key informants from the MoH, regional health directorates, and other ministries. WHO's involvement in numerous topics makes it difficult to discern its priorities. Additionally, the absence of a strategic document and limited communication about its actions contribute to this challenge.[90]

[89] See details in point 99, Q4.1 on efficiency.
[90] This is likely due to the heavy workload of the team and the absence of a staff member dedicated to or responsible for communication, who was in the process of being recruited at the time of the evaluation (see Q4.2.).

Infant Incubators. With support from the Government of Canada, WHO is working to strengthen newborn health care in Tunisia as part of its ongoing work in the area of reproductive health, March 2021. *Credit: WHO*

3.3 Effectiveness

Q3. To what extent have the results of WHO's contributions, at the outcome level, been achieved or are likely to be achieved, and what factors have influenced or hindered their achievement?

Finding 9. The planning and monitoring system does not provide a comprehensive overview, making it challenging to link the execution of activities to WHO's contribution in Tunisia. Additionally, the system does not allow for tracking adjustments made during implementation. The RBM system in place appears to prioritize internal accountability over fostering learning for informed decision-making.

Finding 10. The budget execution for the BASE budget was aligned with the priorities set by the CO during the evaluation period, focusing on UHC, emergency preparedness, and a multisectoral approach to prevention. However, when breaking down the budget by Strategic Objectives (SOs), SO1 and SO4—which focus on UHC and enhancing the quality of WHO's support to Tunisia—received and utilized the largest portion of the budget. In contrast, SO2, which pertains to health emergencies, saw its budget allocation increase gradually over time.

Finding 11. With the onset of the COVID-19 health crisis, the Country Office shifted its focus to this new priority, utilizing OCR funds received for the first time in Tunisia. These funds accounted for 59% of the total funds committed during the evaluation period.

Finding 12. "Flagship" actions were identified for each of the four Strategic Objectives (GPW13), addressing national challenges and responding to emerging issues with a catalytic impact. These actions targeted areas such as communicable diseases, reproductive health, and noncommunicable diseases, including new themes

like mental health and risk factors such as tobacco. Efforts were also made to strengthen essential health system functions, improve the supply of medicines, and support the digitization of health information systems, particularly in vaccination. Institutional leadership and advocacy, especially in promoting multisectorality, along with the involvement of civil society, were key features of the evaluation period.

Finding 13. Key areas essential to building a resilient health system, such as governance, financing, human resources in health, and the impact of climate change on health, were underdeveloped. Topics like violence against women and children, elderly care, nutrition, and evidence production based on the health information system were programmed or initiated, but they appear to have lacked follow-up.

Finding 14. WHO's performance during the COVID-19 pandemic in Tunisia made a decisive and significant contribution to mitigating the impact on the national health system, its professionals, and the population, even though quantitative data is not available. Key aspects that stood out include its role in scientific leadership, the capacity for political and institutional dialogue, support for national response coordination mechanisms (such as the scientific committee and crisis cell), and technical assistance on critical issues like the vaccine cold chain and laboratory capacity. Additionally, the emergence of new working methods, good practices, and the potential for innovation are particularly noteworthy.

Finding 15. The evaluation identified several contextual factors that influenced the implementation of actions: the macroeconomic situation, the political transition with frequent changes in MoH leadership, the challenge of operationalizing multisectorality, bureaucratic hurdles in public procedures, and the structural weaknesses of the national health system in the face of the COVID-19 pandemic. Additionally, the pandemic itself and the resulting socio-economic crisis had a direct impact on the execution of the 2020-2021 and 2022-2023 biennia, leading to disruptions such as global supply chain failures and shortages of essential medical supplies.

Finding 16. Technical visits from EMRO and HQ are generally well-regarded for their content, expertise, and the motivation they inspire, as well as for providing a clearer understanding of WHO's role. The same is true for opportunities to participate in regional or international events and to be part of WHO's expert networks, such as collaborating centers or reference centers. However, there is a widespread perception of confusion regarding the roles of WHO's three levels, with differing visions and priorities between global HQ, EMRO, and the CO, which is adapted to the national context. Additionally, long response times have led to misunderstandings both internally and among national partners.

The findings in this section are organized according to the following themes: implementation of programmed activities to achieve expected results; external and internal contextual factors and the CO's adaptation to the COVID-19 pandemic; and the added value of contributions from WHO's regional office and HQ in achieving results.

Q3.1. To what extent have the evaluated program results (including any adjustments) been achieved, and how have they contributed to progress toward the expected outcomes? What contextual factors, if any, have been identified as influencing their achievement or non-achievement?

71. Planning during the evaluation period was based on biennial programming[91] structured around a list of activities linked to the results framework of the General Programme of Work (GPW12 for 2018-2019 and GPW13 for 2020-2021 and 2022-2023). However, this programming lacked shared monitoring indicators with partners, primarily the Ministry of Health (MoH) directorates and departments, and occasionally other institutions. Monitoring focused mainly on budget execution and deliverables. At the same time, WHO tracked the progress of the Tunisian health system using key performance

[91] The global WHO programming system is based on biennial Program Budgets approved by Member States

indicators (KPIs) specific to the regional office's Vision 2030 strategy, aligned with GPW13 outputs. As a result, this system did not provide an overall vision or establish a clear link between the execution of activities and WHO's contribution to improving the health of Tunisian citizens. Additionally, it did not allow for tracking adjustments made during implementation. The internal reporting tools used by WHO—Mid-term reviews, Annual reports, and End of biennium reports—addressed major themes, challenges encountered, and next steps, but they did not offer a detailed account of all activities or results achieved. Moreover, these reports did not align with budget execution, which was tracked in separate documents. Consequently, the RBM system seemed more focused on internal accountability than on fostering learning for informed decision-making.[92] This perception was widely shared by key informants and impacted the effectiveness analysis possible in this evaluation.

The prioritization exercise conducted by the Country Office (CO) for the evaluation period (2019-2023)[93] at the Outcomes level, using WHO-specific tools in collaboration with the Ministry of Health (MoH), clearly highlighted the emphasis on universal health coverage, preparedness for health emergencies, and a multisectoral approach to prevention.[94] This prioritization remained consistent during the 2020-2021 and 2022-2023 biennia. These priorities were also reflected in budget planning and execution, with an average of 76% of the budget allocated to high-priority outcomes and 83% of the budget committed (see Table 6).

Table 7 Budget distribution (%) according to outcomes prioritization (2020-2021 and 2022-2023 biennia) (Base funds dedicated to Tunisia).

	PLANNED (%)		UTILIZATION (%)	
OUTCOME PRIORITY LEVEL	2020-2021	2022-2023	2020-2021	2022-2023
HIGH	84%	69%	85%	81%
MEDIUM	8%	26%	6%	14%
SUB TOTAL (H+M)	92%	95%	91%	95%
LOW	8%	5%	9%	5%
TOTAL	100%	100%	100%	100%

Source: Planned & Expenditures for Activity & HR costs 2018 to 2023, WHO (for the budget) and Country prioritization 2020-2021 and 2022-2023 (for the prioritizations).

72. With the onset of the COVID-19 health crisis, the Country Office received crisis and emergency funds for the first time. This resulted in a shift in the budget, with the CO redirecting its efforts to focus on this new priority. Over the entire evaluation period, **OCR funds made up 59% of the committed budget** (as of October 20, 2023), with most of these funds concentrated in the 2020-2021 and 2022-2023[95] [96] biennia (see Figure 1).

[92] This observation is also echoed in the *Independent Evaluation of WHO's Results-Based Management Framework. Final Report. WHO Evaluation Office - January 2023*. Although WHO refers to the definition of the United Nations Development Group, which states: "a management strategy by which all actors, contributing directly or indirectly to the achievement of a set of results, ensure that their processes, products, and services contribute to the achievement of the desired results (outputs, outcomes, and higher-level goals or impact). In turn, the actors use information and evidence on actual results to inform decision-making regarding the design, resource allocation, and execution of programs and activities, as well as for accountability and reporting." (UNDG, 2011).

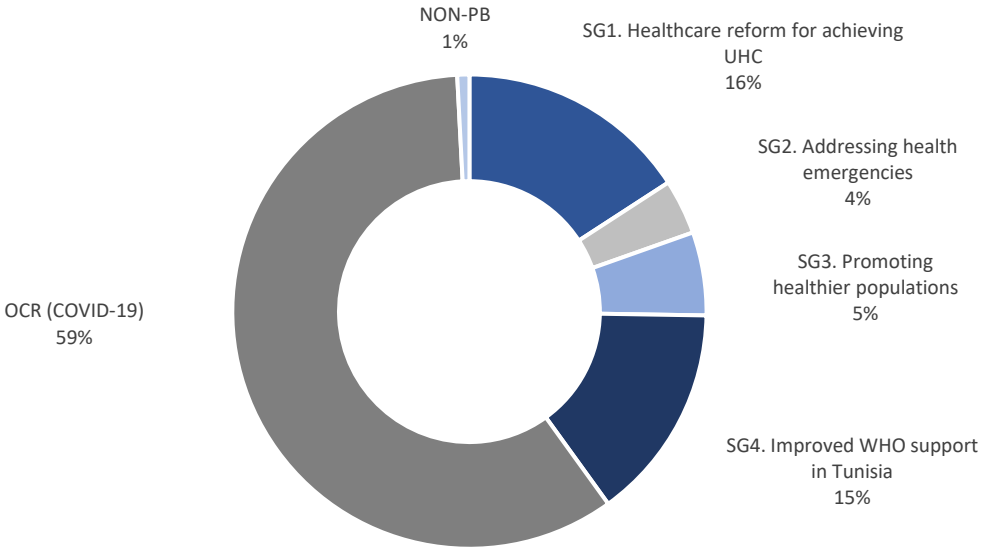
[93] A participatory exercise was conducted with the Ministry of Health as part of the presentation and launch of the GPW13 and the results-based management (RBM) system established on this occasion by EMRO.

[94] Country Prioritization for GPW13, 2019-2023: Tunisia, WHO. Document signed in July 2018.

[95] The 2018-2019 biennium did not have any OCR funds, neither committed nor planned.

[96] See Figure 1.

Figure 4 Percentage distribution of the total committed budget (Utilization) by strategic priority (2018-2019, 2020-2021, and 2022-2023).

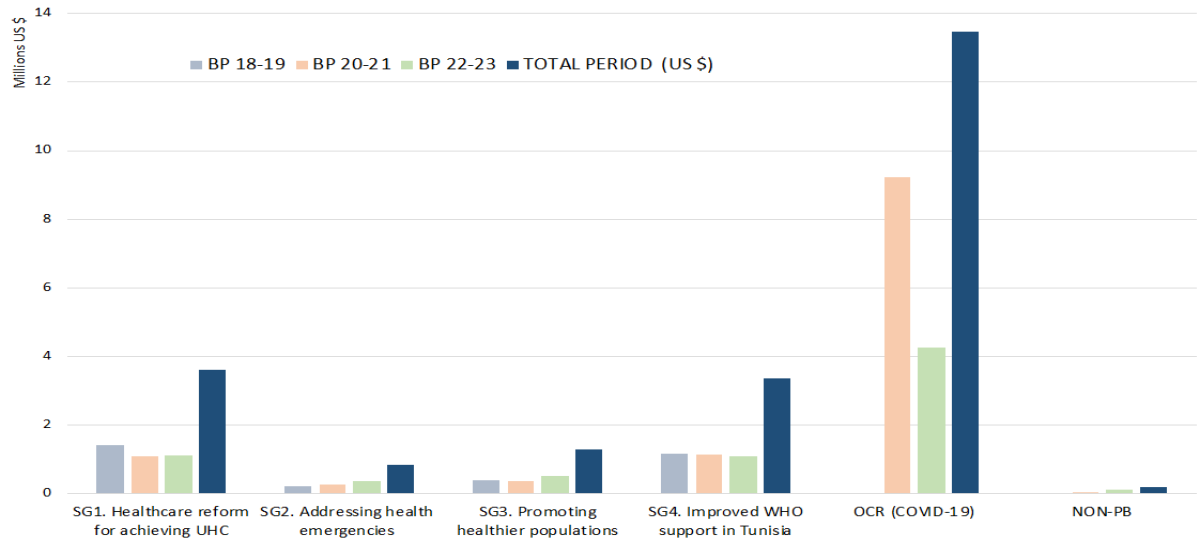


Source: Planned & Expenditures for Activity & HR costs 2018 to 2023. (excel document) xlsx. WHO.

73. When examining the budget evolution for Strategic Objective 2 on health emergencies, it represents just 4% of the total committed budget. However, there has been a consistent increase—from $213,449 in 2018-2019 to $374,677 in 2022-2023, a rise of 75%. This growth is likely due to increasing awareness of the issue, especially as the COVID-19 crisis exposed weaknesses in the system.

74. Despite the gradual increase in the budget allocated to OS2, it is OS1 and OS4, which focus on Universal Health Coverage (UHC) and enhancing the quality of WHO's support to Tunisia, that have received and utilized the largest portion of the budget compared to the other four OSs in GPW13 (Base Budget) (see Figures 1 and 2).

Figure 5 Distribution of the total committed budget (US$) by strategic priority and by biennium.



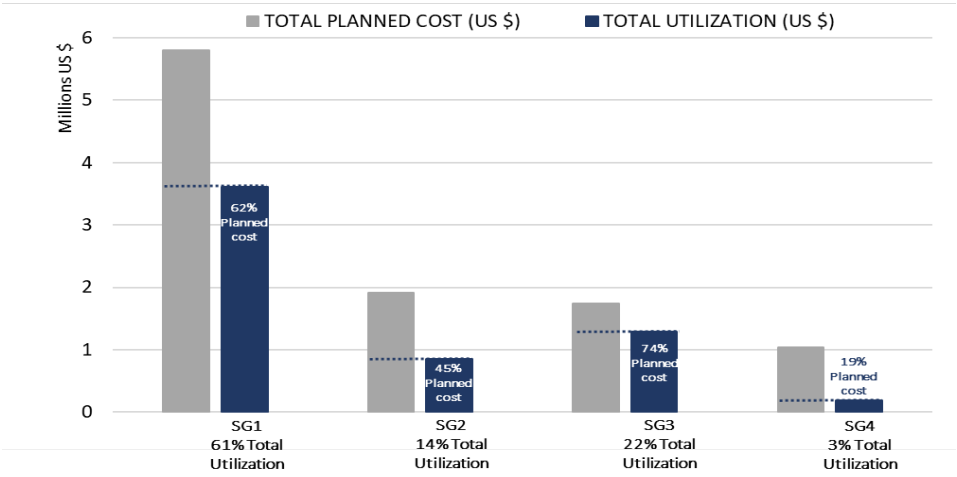
Source: Planned & Expenditures for Activity & HR costs 2018 to 2023. (excel document) xlsx. WHO.

75. In terms of the BASE budget directly allocated to Tunisia's contribution—specifically Outcome 4.1 of Strategic Objective 4, as the other two outcomes focus on internal WHO strengthening—the effort aligned with the prioritization exercise. Strategic Objective 1 (OS1), identified as a high priority, accounted for 61% of the committed BASE budget (see Figure 3).[97] A closer look reveals that Outcome 1.1, "Improving access to quality essential health services," consumed nearly 50% of the BASE budget dedicated to Tunisia.[98]

76. It was also noted that the portion of OS4 allocated to Tunisia is relatively small, at just 3%.[99] Additionally, there is a significant gap between the initial budget planning and actual execution, as the budgeting process has not yet been completed.[100]

[97] See Figure 3.
[98] See Annex 9
[99] Ibid.
[100] See Figure 3.

Figure 6 Distribution of BASE budget execution by Strategic Objective (amount and percentage) compared to the planned distribution (2018-2023).



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

"Flagship" actions were identified for each of the four Strategic Objectives (GPW13), aimed at addressing national challenges and responding to emerging issues with a catalytic effect.[101] Below are some examples, though the list is not exhaustive:

(i) Strategic Objective 1: Universal Health Coverage:

- To strengthen communicable disease prevention, tools and capacity-building initiatives were provided to frontline professionals in six hospitals. Protocols were updated, medications for diseases such as leishmaniasis and tuberculosis were supplied, IPC teams were established in eight hospitals, and advocacy efforts supported the creation of a central unit.

- Reproductive health protocols and guidelines were updated to address geographic and social inequalities in maternal health, despite challenges in securing adequate funding for this area.

- Through advocacy and leadership, WHO's Country Office successfully highlighted the impact of NCDs on the health of the Tunisian population, adopting a multisectoral approach[102] as a key strategy for NCD prevention and control, elevating it to the top of the national agenda. WHO supported the Ministry of Health in developing and finalizing the 2018–2025 National Multisectoral Strategy for NCD Prevention and Control. Further efforts included: (a) the adoption of a mental health action plan, integrating mental health into primary healthcare in line with the mhGAP initiative,[103] involving both the public and private sectors; and (b) the development and implementation of a national road safety strategy and action plan, including an evaluation of the emergency system.

[101] The actions mentioned, which do not represent an exhaustive list, were identified by triangulating various WHO reporting documents, biennial programming, available deliverables, KPI trends, and interviews with key informants. There is sufficient evidence based on the triangulation conducted.
[102] The strategy on noncommunicable diseases (NCDs) was developed to ensure the participation and commitment of all sectors involved in the prevention and control of associated risks, including education, trade, environment, youth and sports, agriculture, international cooperation, and defense. - End of Biennium Report Tunisia – 2020–2021, CO, WHO
[103] Mental Health Gap Action Plan 2013-2030, WHO.

- To strengthen the essential functions ("building blocks") of the health system, an evaluation of the health human resources sector was conducted, aiming to develop a strategy. Actions were taken to improve regulation (strengthening the national regulatory authority for medicines, which had been hampered by fragmented competencies), manage drug supplies (amid significant shortages), and introduce family medicine, with a two-year training program launched in 2023.[104]
- WHO supported the Social Dialogue through various phases to establish a national health policy based on Universal Health Coverage, identifying key reforms in governance, health financing, and the healthcare delivery model. At the time of evaluation, this support was contributing to the finalization of the National Health Policy's strategic plan and a certified capacity-building program for its implementation, in collaboration with the University of Montreal.

(ii) Strategic Objective 2: Health Emergencies:

- Support was provided for real-time detection of communicable diseases by enhancing capacity for analysis and improvement (e.g., sentinel influenza surveillance), assessing upgrades for event-based surveillance (EBS) within the National Observatory for New and Emerging Diseases (ONMNE), building frontline staff capacity for pandemic prevention, especially in the context of significant immigration, and validating the National Action Plan for Health Security (NAPHS).

- Contributions were made to establish genomic surveillance, introducing virus and bacteria sequencing capabilities for the first time in Tunisia at the Charles Nicolle University Hospital and the Pasteur Institute of Tunis.

(iii) Strategic Objective 3: Improving Population Health and Well-being

- Actions targeting risk factors were developed using a multisectoral approach, such as tobacco control. This included implementing the WHO Framework Convention on Tobacco Control (FCTC) through a medical-economic investment model and national awareness campaigns like "Family Move." The leadership of the Country Office was recognized as key to the success of this initiative, involving multiple sectors such as the Ministry of Health, the Ministry of Youth and Sports, and the Tunisian Alliance Against Tobacco.
- Work commenced under the "Urban Governance for Health and Well-being" initiative, with strong involvement from local authorities and communities.

(iv) Strategic Objective 4: WHO Functions and Support in Tunisia

- Advocacy and support were provided to advance digital development in data management and analysis, including the ongoing expansion of a vaccine database.[105]

- Visible leadership and institutional advocacy were combined with civil society engagement, particularly on issues related to social and environmental health determinants and the One Health approach (intersectorality, antimicrobial resistance, tobacco control).

[104] EMRO and the Arab Board of Health Specializations launched a two-year regional professional diploma in family medicine, aimed at promoting practice in the region and strengthening the resilience of the health system by building capacities in community medicine.
[105] The E-vax system was created for managing COVID-19 vaccination and is currently being rolled out for broader use.

77. Based on the information collected, several areas were underdeveloped in terms of performance:

(i) Governance, financing, and health personnel—critical components of the health system impacted by the economic crisis—received limited attention. While the COVID-19 pandemic shifted the focus, WHO-supported interventions during the last two biennia provided valuable data and guidance for these building blocks (e.g., strategic planning capacity building, national health accounts, development of a national health system financing strategy, and labor market analysis in the health sector), but systemic reforms to address the major challenges facing the national health system have yet to materialize.

(ii) Actions addressing the impact of climate change on health were underdeveloped, despite the importance of these issues in building resilient health systems. External factors, such as the Ministry of Health's focus on other priorities like the COVID-19 response, and internal factors, such as the lack of dedicated staff within the Country Office, contributed to this gap.

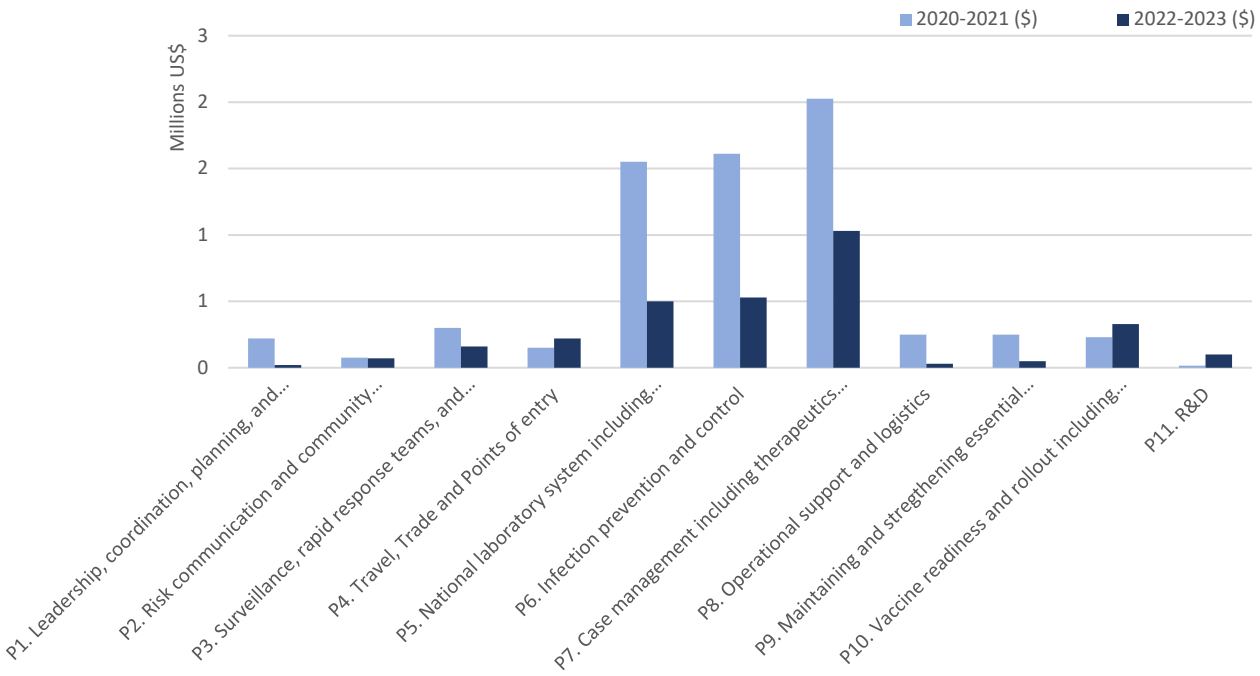
(iii) Topics such as violence against women and children, elderly care, nutrition, and evidence generation through the health information system were areas where actions were planned or initiated during the 2018-2019 biennium, but these initiatives appear to have lacked follow-up.[106]

(iv) Although not specifically included in the biennia, support for networking could have been stronger. Networking is recognized as a key value-added element of WHO, and its potential is widely appreciated by national institutions.[107] For example, a notable mention is the connection with regional laboratories to conduct necessary quality controls for the certifications of the National Blood Transfusion Center (CNTS).

78. Regarding the budget allocated by WHO for the COVID-19 response (OCR budget), the evaluation could only assess the planning phase, as detailed budget execution by pillar was not available.[108] Pillars 5, 6, and 7 accounted for most of the budget (75%), especially in the early phase of the crisis (2020-2021 biennium). This primarily covered equipment, infrastructure rehabilitation and construction, and consumables (such as reagents and personal protective equipment (PPE)) (see Figure 4).

[106] See point 86 for the identified explanatory factors.
[107] See Q3.2.
[108] The WHO's global response to the COVID-19 pandemic is structured around eleven pillars:
P1. Leadership, coordination, planning, and monitoring,
P2. Risk communication, community engagement, and infodemic management,
P3. Surveillance, epidemiological investigation, contact tracing, and adaptation of social and public health measures,
P4. Points of entry, international travel and transport, mass gatherings, and population movements,
P5. Infection prevention and control, and protection of health workers,
P6. Infection prevention and control,
P7. Case management, including the deployment of therapies,
P8. Operational and logistical support,
P9. Maintenance and strengthening of essential health services,
P10. Vaccine preparation and deployment, including equitable access,
P11. Research and development (R&D).

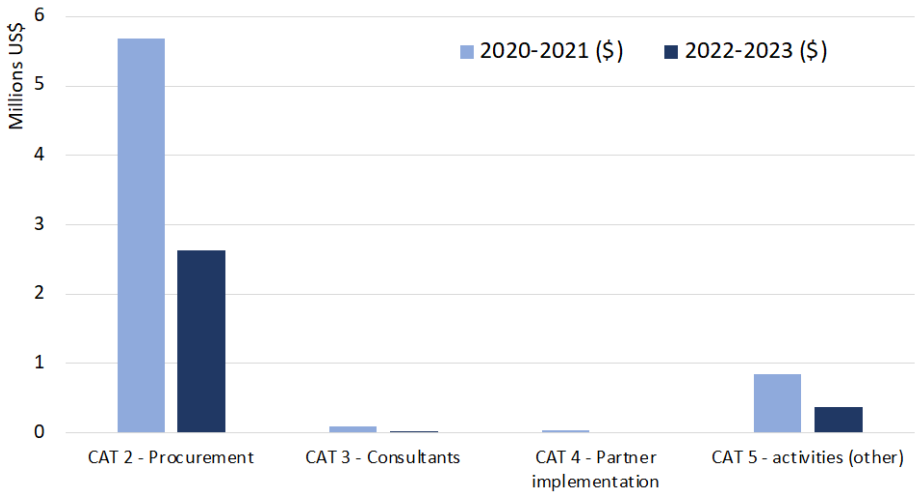
Figure 7 Distribution of budget planning (US$) by biennium and by pillar of the COVID-19 response plan



Source: OCR Workplan 2020-2021 and 2022-2023 (Excel document).

79. A large portion of the budget was allocated to supplies, which becomes evident when analyzing the budget planning by expenditure category, with supplies accounting for 85% of the total. Other activities (excluding consultants) make up only 13% of the planned budget (see Figure 5).

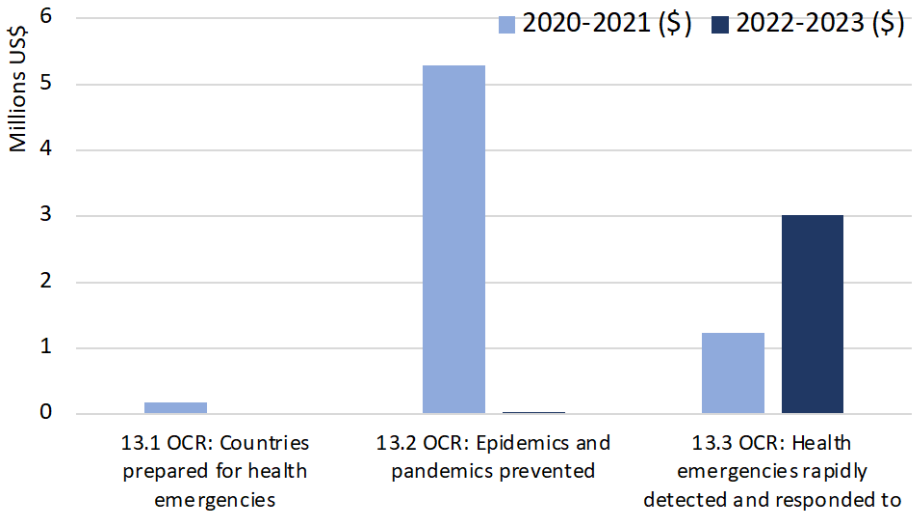
Figure 8 Distribution of budget planning (US$) by expenditure category for the COVID-19 response plan



Source: OCR Workplan 2020-2021 et 2022-2023, (Excel document)

80. An analysis of the budget distribution by OCR outcomes reveals a strong emphasis on epidemic prevention and emergency detection and response, which accounted for 55% and 44% of the planned budget, respectively. In contrast, health emergency preparedness received significantly less attention, with only 2% of the budget allocated (see Figure 6).

Figure 9 Distribution of budget planning (US$) by OCR outcomes



Source: OCR Workplan 2020-2021 and 2022-2023 (Excel document).

81. From a qualitative perspective, WHO performance during the pandemic in Tunisia made decisive contributions to mitigating the health impact on the national health system, its professionals, and the population (despite the lack of quantitative data). The limitations and gaps in WHO's support, as documented during the evaluation, do not overshadow its achievements, especially considering the global health crisis, which overwhelmed not only a single agency's capacity but also the international humanitarian system and individual states.[109] Some of the evaluation's conclusions align with findings from the assessment of WHO's response to the COVID-19 outbreak in the Eastern Mediterranean region.[110]

82. The Country Office responded promptly (a month and a half before the first case was reported in Tunisia) and effectively utilized its mandate (legitimacy) and expertise (credibility) to position itself as a key player during the pandemic response.[111] WHO's notable contributions to the national response included:

- WHO's scientific leadership and dialogue, which were crucial in political and technical decision-making at pivotal moments during the pandemic (e.g., the Scientific Committee, Shock Room). WHO served as a reference point for national coordination mechanisms, national actors, the UN system, technical and financial partners, and the media, helping combat misinformation through a prime-time TV program.
- The ability to link global pandemic data with local needs, sharing relevant information and best practices from other countries that could be adapted to Tunisia's context and health system.

[109] See Annex – Impact of the COVID-19 pandemic, national and WHO response.
[110] WHO's Response to COVID-19 in the Eastern Mediterranean Region | Independent Review. February 2023.
[111] See the Efficiency section for more details on the explanatory factors behind the performance of the biennial program during the pandemic.

- Strengthening inter-agency communication and joint efforts during the pandemic, which fostered greater collaboration among health-sector agencies, particularly with UNICEF.
- Rapidly activating Emergency Medical Teams (EMT) as part of the swift health crisis response, deploying them to various regions across the country. This built on WHO's previous work with the Ministry of Health in emergency preparedness, crisis response, and the gradual implementation of the International Health Regulations.[112]
- Providing ongoing scientific and technical support for managing and operating the Shock Room, the crisis cell responsible for overseeing the operational response to the pandemic.
- Enhancing diagnostic and technical capabilities at the national reference laboratory and regional labs, while fostering collaboration among different laboratories. This helped establish a network of professionals and facilities better prepared for future health crises.[113] The initiation of COVID-19 genomic surveillance and the skills developed in this area will enable more ambitious investigations in the future.
- Establishing guidelines and standards for infection prevention and control in hospitals, including the development and accreditation of training modules by the national commission responsible for training.
- Rehabilitating and upgrading healthcare facilities, particularly intensive care units (e.g., a 9-bed unit at the regional hospital in El-Kef) and an isolation unit at Farhat Hached Hospital in Sousse (the first hospital to receive a COVID-19 case).
- Modernizing and professionalizing the cold chain for vaccine storage as part of WHO's support for the national COVID-19 vaccination strategy.

83. The pandemic also introduced new methods and opportunities for innovation, such as home care (e.g., the Ben Arous experience), telemedicine for providing remote care to underserved populations, the One Health approach, the collection of indicators in crisis situations, and the development of national technological capacity for producing mRNA vaccines. These early-stage initiatives present valuable lessons for further developing the national health system.

84. WHO's performance during the pandemic also revealed challenges where it was unable to respond adequately, due to internal factors (e.g., bureaucracy, delays, procedures unsuited to large-scale emergencies, staff shortages) and external factors (e.g., global supply chain disruptions, shortages of essential medical supplies, public sector bureaucracy, and hospital capacity limitations).[114]

85. Several contextual factors during the evaluation period (2019-2023) impacted the implementation of actions:

(i) A period of political transition, with frequent changes in Ministry of Health leadership at both decision-making and technical levels. For instance, the ministry underwent three leadership changes in one year for departments such as DSSB and Family Planning and lacked focal points for issues like reproductive health and essential healthcare services for several months. This made it difficult to maintain continuity in commitments and operations. Additionally, while ministry staff are well-qualified, there are not enough personnel to address the many challenges at hand.

[112] Joint External Evaluation of IHR Core Capacities of the Republic of Tunisia. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO

[113] At the start of the pandemic, only two laboratories were able to perform PCR tests. Subsequently, with the support of WHO, a total of 28 public laboratories were equipped to diagnose COVID-19 via PCR testing.

[114] See the Efficiency section for further details.

(ii) A difficult national economic situation and limited fiscal space, exacerbated by the COVID-19 crisis, international events like the war in Ukraine, and national challenges such as drought. This situation has particularly affected health system reforms related to financing, hospitals, and human resources strategy, though recent macroeconomic data suggest some progress.

(iii) The operationalization of multisectorality remains a challenge, largely driven by individual motivation with limited intersectoral collaboration due to historical siloes. Frequent political instability and leadership changes further complicate efforts to maintain stability.

(iv) The COVID-19 pandemic directly impacted the execution of the 2020-2021 biennium, particularly activities involving travel and gatherings (some activities were adapted, while others were suspended), and influenced the formulation of the 2022-2023 biennium.[115]

86. As of the last quarter of 2022,[116] 51% of KPIs had been achieved, while 27% showed no progress (see Table 7). Based on this data, the areas requiring the most attention are achieving Universal Health Coverage and improving population well-being (Strategic Objectives 1 and 3).

Table 8 Summary of the status of Tunisia's KPIs at the end of 2022 by strategic objective of GPW13

SG (GPW13)	Q4 2022		
	AVAILABLE	IN PROGRESS	DOES NOT EXIST
SG1	45%	25%	30%
SG2	62%	15%	23%
SG3	33%	22%	44%
SG4	59%	24%	18%
AVERAGE	51%	22%	27%

Source: Tunisia KPIs performance 2019 to date, WHO.

87. Additionally, during the period from 2019 to the last quarter of 2022, only 29% showed progress, mainly in Strategic Objectives 1 and 2, while 20% regressed, and 51% showed no change (see Table 8).

Table 9 Summary of the progress of Tunisia's KPIs between 2019 and the end of 2022 by strategic objective of GPW13

SG (GPW13)	Q4 2022		
	INCREASED	STABLE	DECREASED
SG1	35%	40%	25%
SG2	38%	46%	15%
SG3	22%	67%	11%
SG4	18%	59%	24%
AVERAGE	29%	51%	20%

Source: Tunisia KPIs performance 2019 to date, WHO.

Q3.2. What has been the added value of the contributions from the WHO regional office and headquarters in achieving results in Tunisia?

88. Technical visits, mostly from EMRO but also in collaboration with headquarters, are highly appreciated for their content, expertise, the motivation they generate, and the opportunity they provide to better understand WHO's role, which is often not well known outside the Ministry of Health at the central

[115] See details in Q4.1.
[116] Tunisia KPIs performance 2019 to date.xlsx. WHO and Annex 8. List of Key Performance Indicators (KPIs) for Tunisia.

level. Visits related to the FCTC tobacco control project, health financing, or health system assessments were cited as particularly valuable.

89. Participation in regional or international events is also highly valued by Ministry of Health institutions for the learning, exchange, and networking opportunities they provide. This is especially true for tobacco control efforts within EMRO or the scientific writing workshop in the UAE for microbiologists. Two scenarios were identified: initiatives proposed by the Country Office for regional or global activities, or suggestions made by EMRO or headquarters, facilitated by the Country Office.

90. The opportunity to be part of WHO's regional or international expert networks, such as collaborating or reference centers, is considered highly valuable for institutions that can access them. For example, the virology lab at Sahloul University Hospital in Sousse is in the process of being recognized as a regional reference lab, with complementarity between EMRO and the Country Office being particularly well recognized. The Pasteur Institute of Tunisia is another example, involved in mRNA vaccine production for emerging and re-emerging viruses (a research and development project supported by WHO-HQ).

91. However, several barriers to this added value were identified:

(i) Delays in responses from the regional office, particularly concerning contractual procedures, which can cause delays and affect the implementation of activities.

(ii) A general perception of confusion regarding the roles of WHO's three levels (headquarters, regional office, and country office), despite the internal Transformation Agenda (WHO, 2021). Communication and complementarity between WHO's three levels are inconsistent and often rely on personal relationships, with unclear decision-making and action processes. Global priorities and visions from HQ and EMRO sometimes conflict with the country office's vision, which is adapted to the national context. This can create misunderstandings internally and with national partners.

92. On the other hand, all key informants from EMRO expressed a very positive perception of the Country Office team, praising their collaboration, responsiveness, and communication with the regional office.

3.4 Efficiency

Q4. To what extent have WHO's interventions produced, or are likely to produce, results efficiently and in a timely manner?

Finding 17. The fragmented planning, evidenced by the large number of actions with a low average budget per action, does not optimize resources from a performance perspective.

Finding 18. The budget execution rate compared to planned and received funds is much better for the OCR and Non-PB categories than for BASE. While the analysis is not exhaustive, there is coherence between financial resources allocated to human resources and the efforts to implement activities, as the total proportion of the budget allocated to staff remains consistent between planned and committed budgets.

Finding 19. Despite continuous increases in BASE budget planning over the three biennia, the committed funds have remained stable. This may be due to the focus on responding to the COVID-19 crisis (OCR funds during the 2020-2021 and 2022-2023 biennia) and the fact that 2023 is still ongoing.

Finding 20. When analyzing only the BASE budget, the budget execution dedicated to staff is higher (and closer to the planned budget) than that for activities. However, when the OCR budget is included, the budget for activities increased 5.6 times in the 2020-2021 biennium and 3.3 times in the 2022-2023 biennium, while the budget for staff remained the same.

Tunisia received the first batch of 93 600 doses of Pfizer COVID-19 vaccines through the COVAX Facility, March 2021. *Credit: WHO*

Finding 21. The Country Office team was highly praised by all interviewed health actors for their deep understanding of the national context, their ability to listen, their proximity, proactivity, search for alternatives, and their commitment beyond their roles.

Finding 22. Faced with the COVID-19 pandemic, the Country Office effectively asserted its leadership in health while supporting the government's crisis management plan. The pandemic also enabled the Country Office to develop greater autonomy by establishing new partnerships, expanding and diversifying donors, and seizing opportunities to drive change and learn from experiences.

Finding 23. Challenges related to the operationalization of supply chain modalities and the functioning of the COVAX mechanism were identified as obstacles that affected WHO's response efficiency.

Finding 24. The biennial planning and monitoring mechanism between the Country Office and the Ministry of Health does not appear to be a joint mechanism for strategic collaboration. Additionally, the gap between biennial deliverables and WHO's KPI) is too wide to establish a clear link.

Finding 25. WHO's internal RBM system is characterized by fragmentation, both in planning and reporting. Without a comprehensive document that details all actions taken and their connection to the budget, monitoring seems more focused on budget execution and deliverables rather than on the quality of results achieved.

Finding 26. The small size of the Country Office team, the heavy procedures, short planning and budgeting cycles, and language barriers were identified as internal organizational factors that limited efficiency.

The findings in this section are organized around the following themes: efficient use of financial and human resources, comparison between planning and budget execution, comparison of execution for different budget categories, adaptability to the COVID-19 crisis, limiting factors, the results-based management system, and monitoring and evaluation systems used.

Q4.1. To what extent have WHO interventions reflected an economically and operationally efficient use of resources, including in response to new and emerging health needs that require adaptation of intervention priorities?

Credit: WHO

93. Analyzing the distribution of programmed funds across activities reveals fragmented planning, and the overall finding is that this fragmentation does not contribute to resource optimization from a performance perspective. The average programmed budget per activity is only US($) 25,088, with an extreme low of US($) 8,886 per activity for the 2018-2019 biennium (see Table 9). When calculated based on committed budgets, the averages are even lower. While some activities with moderate budgets can be relevant and efficient (e.g., when the Country Office acts as a convener, catalyst, or initiator of new partnerships), many activities were one-off, had small budgets, and lacked continuity or significant impact. The need to optimize resource allocation and aim for greater, more significant effects on the health system was frequently mentioned during interviews.

Table 10 Base budget programmed by biennium and average distribution per activity (US$)

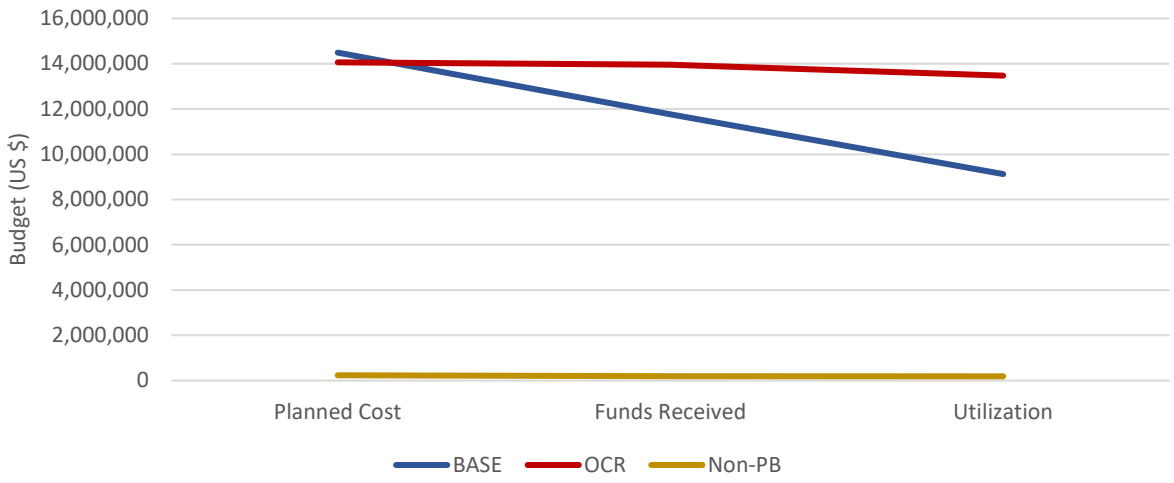
	2018-2019	2020-2021	2022-2023	TOTAL
Outputs	33	25	31	
Top task	286	38	63	387
Planned cost BASE (US$)	4,135,250	4,517,389	5,835,677	14,488,316

Budget average top task (planning) (US$)	14,459	118,879	92,630	**37,438**

Source: Workplans 2018-2019, 2020-2021 and 2022-2023 and Planned & Expenditures for Activity & HR costs 2018 to 2023, WHO.

94. In terms of budget execution, the rate of fund usage compared to planned and received funds is much higher for the OCR and Non-PB categories (97% and 96% of received funds) than for the BASE category (78% of received funds, noting that 2023 is still in progress).[117] [118] This difference likely stems from the nature of these categories—OCR and non-PB funds are allocated to address specific, immediate needs rather than being planned biennially under WHO's Program Budget. Moreover, OCR funds are rare in Tunisia, and non-PB funds are limited.

Figure 10 Comparison of the utilization of the three budget types (BASE, OCR, and Non-PB)



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

95. The proportion of the total budget allocated to staff has remained consistent between the planned and committed budgets, at 17%.[119] This is viewed as a positive indicator, and while the analysis is not exhaustive, it demonstrates clear alignment between the financial resources dedicated to human resources and the efforts to implement activities (see Table 10).

Table 11 Summary of budget distribution (in percentage) between activities and staff

	TOTAL ACTIVITIES (%)	TOTAL STAFF (%)	GRAND TOTAL (%)

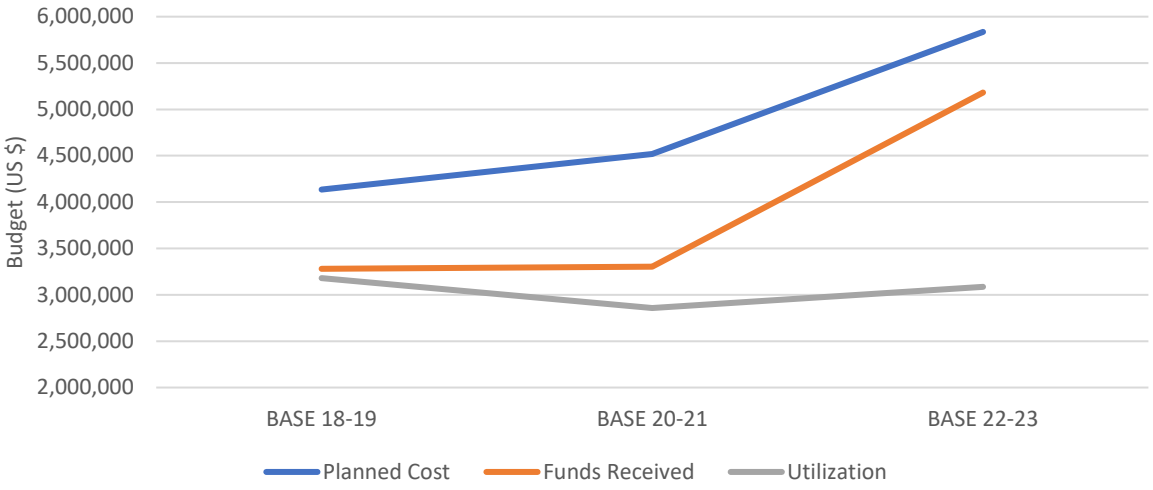
[117] Calculations based on Planned & Expenditures for Activity & HR Costs 2018 to 2023. Xlsx. WHO.
[118] See Figure 7.
[119] Calculations based on Planned & Expenditures for Activity & HR Costs 2018 to 2023. Xlsx. WHO.

Planned Cost	83%	17%	100%
Funds Received	84%	16%	100%
Utilization	83%	17%	100%

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

96. In terms of BASE category budget planning (programmed biennially based on the Program Budget), a steady increase was observed over the three biennia. However, the committed funds have remained stable, likely due in part to the prioritization of efforts toward the COVID-19 response during the 2020-2021 and 2022-2023 biennia, as well as the fact that 2023 was still ongoing (see Figure 8).

Figure 11 Evolution of the BASE budget (US$) over the three biennia

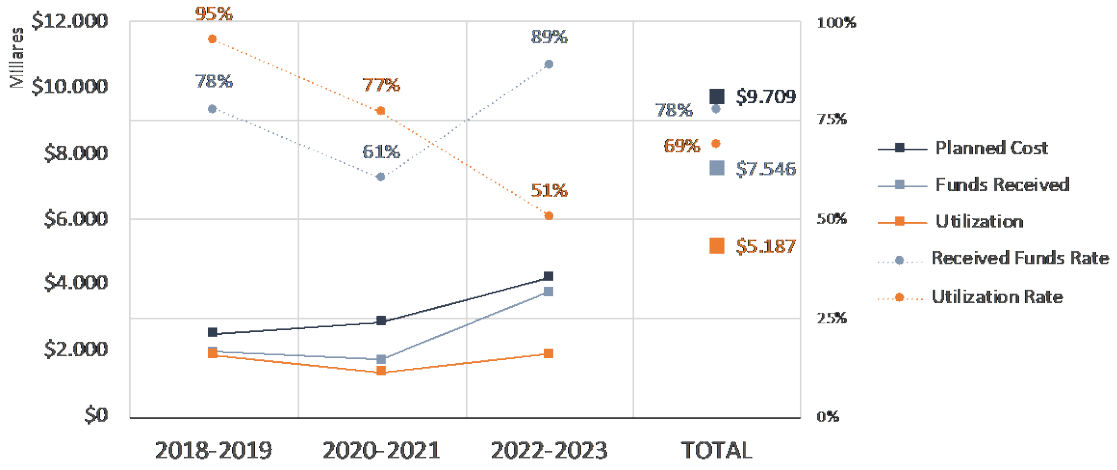


Source: Planned & Expenditures for Activity & HR costs 2018 to 2023, WHO.

97. When examining the use of BASE funds allocated directly to activities,[120] in comparison to planning and availability, the 2018-2019 biennium showed a strong budget execution rate—95% of received funds and 75% of planned funds—marking it as a "normal" biennium. However, the rates for the 2020-2021 and 2022-2023 biennia were much lower. This decrease can be attributed to the prioritization of the COVID-19 response during 2020-2021 and, to some extent, in 2022-2023, with the added factor that 2023 was still ongoing (see Figure 9).

Figure 12 Evolution of the BASE budget (US$) dedicated to activities (planned, received, and committed) over the three biennia

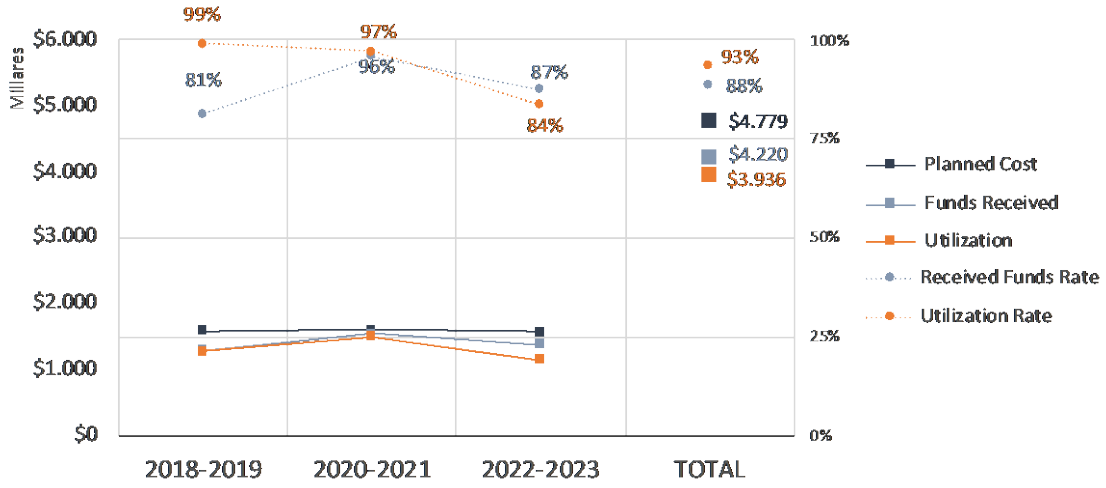
[120] The funds are structured into activity funds and staff funds.



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

98. During the first two years of the COVID-19 response (2020-2021 biennium), a small portion of the budget allocated to staff was covered by OCR funds, but by the 2022-2023 biennium, this had fully shifted to BASE funds.[121] Given this, the budget execution rate for staff has been satisfactory and higher than for activities, with 93% of received funds and 82% of planned costs (see Figure 10). The first two biennia achieved near 100% execution rates relative to received funds. The 2022-2023 biennium shows a slightly lower rate, but execution for 2023 is still ongoing, and the data had not been finalized at the time of evaluation.

Figure 13 Evolution of the BASE budget (US$) allocated to staff (planned, received, and committed) over the three biennia



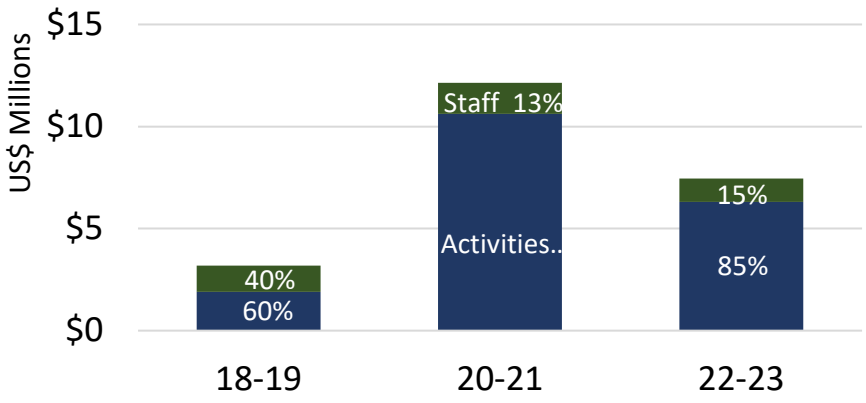
Source: Planned & Expenditures for Activity & HR costs 2018 to 2023, WHO.

99. It was observed that budget execution for staff over the entire evaluation period was much closer to the planned budget compared to the execution for activities—82% for staff versus 53% for activities (see Figures 9 & 10). This suggests that the level of activity execution was not directly tied to the cost of the human resources employed for that execution. In essence, human resources remained constant regardless of the activity execution. However, when considering the budget used for the COVID-19 response (OCR budget, which covers only activities and not staff), it becomes clear that, with the same

[121] During the 2020-2021 biennium, 2% of the Staff budget used (representing 1% of the planned Staff budget) was allocated to OCR funds. Planned & Expenditures for Activity & HR Costs 2018 to 2023. Xlsx. WHO.

staff budget (an average of US$ 1,300,000 per biennium), the budget for activities increased by 5.6 times during the 2020-2021 biennium (US$ 10,617,713 vs. US$ 1,893,922) and by 3.3 times during the 2022-2023 biennium US$ 6,304,738 vs. US$ 1,893,922)[122] (see Figure 11). While this analysis does not tackle the specific types of activities (technical assistance, procurement, construction) or execution methods (contracting procedures, tenders, direct or indirect execution), it demonstrates that the CO team made a significant effort during the last two biennia, particularly in 2020 and 2021, showcasing its efficiency during that period.

Figure 14 Breakdown of the committed budget per activities and staff.



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

100. From a qualitative standpoint, the operational performance of the Country Office was highly recognized during the implementation of activities by all health stakeholders interviewed. Key attributes noted included their ability to listen, their proximity, proactivity, search for better alternatives, and going beyond their formal duties. With a team primarily composed of local staff,[123] the office's deep understanding of the national context and ability to act accordingly was particularly emphasized. Despite the findings of the 2019 functional review,[124] the Country Office adapted fully to the emergency situation caused by COVID-19,[125] albeit with significant effort. Furthermore, close collaboration between the Country Office team and the Ministry of Health facilitated strong technical execution, even amidst a complex political environment and staff rotations. However, at the decentralized level, partner perceptions were more mixed, with some reporting instances where their requests went unanswered.

101. In response to the COVID-19 pandemic, the Country Office asserted its role as a health leader, adapting to and supporting the government's crisis management plan. The office anticipated the risks of COVID-19 before the pandemic was officially declared and coordinated information sharing throughout the crisis[126] with health stakeholders, particularly public institutions such as the Ministry of Health and its departments, other UN agencies, CSOs, and technical and financial partners. Coordination between WHO and UNICEF in supporting the national COVID-19 vaccination strategy was positively received by national actors.

[122] Planned & Expenditures for Activity & HR costs 2018 to 2023. Xlsx. WHO.
[123] Only two positions were filled by international staff at the time of the evaluation, with one of them having been filled for just one year.
[124] "...limited capacity to respond to emergency situations, which could have a negative impact on WHO's reputation." Country Functional Review Tunisia, 23-26 September 2019, EMRO, WHO
[125] See Q3.1 and Q4.1 for previous findings.
[126] WHO guidelines, national epidemiological situation, COVAX mechanism, etc.

102. In 2019, the Country Office did not have a resource mobilization strategy or donor mapping for the country.[127] However, it demonstrated its ability to mobilize resources specific to the pandemic by establishing connections with new donors. Based on available information, approximately US$ 2 million was received through projects. This resource mobilization helped supplement the funds channeled by the regional office and headquarters for activities and contributed to strengthening human resources.[128]

103. The Country Office proved its ability to seize opportunities for initiating change, such as introducing oxygen production in Tunisia.[129] It also demonstrated the capacity to learn from previous biennia and the COVID-19 crisis, moving towards more targeted actions (with less fragmentation) that deliver greater value. This approach began to be implemented during the 2022-2023 biennium and continues with the ongoing development of the 2024-2025 biennium.

104. A broad consensus was reached regarding certain limitations of WHO's support for the national response to the pandemic,[130] which represent areas for potential improvement:

(i) Some WHO systems and tools were not well-prepared or suited for an agile and effective response to a large-scale health crisis, complicating the management and access to certain medical products (e.g., WHO's emergency product catalog, internal logistics, procurement systems). Operationalizing the supply modality proved difficult, which limited the response to urgent needs. In some cases, national institutions turned to other partners, such as UNICEF. Equipment deliveries were delayed, and in some cases, arrived after the crisis had passed (e.g., ambulances).

(ii) The management of interventions with significant logistical, procedural, and coordination components exceeded the available capacity and tools at the Country Office. A clear example is the project to construct a COVID-19 patient unit at the Regional Hospital in El-Kef (approximately 100 m²), which was not completed during the two years of the pandemic and failed to meet its initial goal.

(iii) Efforts to strengthen national oxygen production capacity, initiated during the pandemic, faced difficulties but will ultimately enable greater autonomy and more effective management of this critical hospital supply.

(iv) The arrival of vaccines through the COVAX mechanism was delayed and in limited quantities due to Tunisia's classification as a middle-income country, gaps in the COVAX algorithm, global allocation and distribution criteria (17), and logistical challenges in global supply chains (18). These difficulties impacted the expectations of the Ministry of Health and partially delayed the planned timelines for the national vaccination strategy.

(v) Initial interactions between WHO and international financial institutions, particularly the World Bank, which approved several projects for the Ministry of Health, did not develop into structured joint actions.

[127] Country Functional Review Tunisia, 23-26 September 2019, EMRO, WHO.

[128] The proportion for project formulation should be 60% activities and 40% staff.

[129] In response to the shortage of medical oxygen during the COVID-19 pandemic, in addition to providing ventilators, WHO acquired oxygen generators. This was a first in Tunisia, where the legislation does not account for the production of medical oxygen. The generators are not yet operational, but the process of regulatory updates, technician training, and equipment maintenance determination is underway. Once these barriers are overcome, Tunisian healthcare facilities will have the tools for autonomy in terms of medical oxygen (currently a monopolized market).

[130] Internal and external informants, document review, observations.

Q4.2. To what extent are the organizational, administrative, and structural arrangements (results-based management system) aligned with the needs of the biennial work plan development and implementation process?

105. The biennial planning mechanism between the Country Office and the Ministry of Health evolved over the three evaluated biennia. However, the biennial planning document does not fully reflect the characteristics of a strategic planning document, as designed by WHO.[131] Despite close collaboration, there seems to be a disconnect between the strategic and operational levels, without a joint space for building common priorities and actions. At the Ministry of Health, the Technical Cooperation Unit (UCT) centralizes everything but does not promote internal dialogue between the ministry's key departments and other entities. This makes it challenging to construct the biennium with a strategic approach, maintain coherence over time, and balance EMRO's regional directives with national context and priorities.

106. The results-based management system used by the Country Office is set by the regional office, based on its Vision 2030 Strategy.[132] Performance indicators are selected from a predetermined list, depending on the actions carried out in the country. The measurement and monitoring of these indicators are also provided by the regional office.[133] However, based on the available information, these indicators are not agreed upon or monitored jointly with national partners, including the MoH.

107. While performance indicators illustrating progress at the GPW13 output and outcome levels largely depend on national progress and are not solely WHO's responsibility, the gap between biennial deliverables and these KPIs makes it difficult to assess WHO's contribution. Some KPIs have been met or show progress, but WHO's contribution has not been clearly identified (e.g., scientific publications).

108. Additionally, there is no formal mechanism established with the Ministry of Health to discuss, analyze, and measure the implementation of the biennia.[134] [135] However, efforts are underway to improve the biennial monitoring system, which will be implemented in the 2024-2025 biennium currently being developed.

109. WHO's internal monitoring system is characterized by fragmentation, both in planning[136] and reporting.[137] Reports for the regional office, technical and financial reports for donors, and deliverables produced by external consultants are managed separately, with no single document summarizing all work completed during a given period, nor the results achieved according to initial planning and adjustments made. Additionally, based on the information obtained, activity monitoring appears to focus more on budget execution and deliverables than on the quality of results achieved. For instance, in the context of the COVID-19 crisis response, initiatives were launched to promote and continue essential services, such as the development of a national Psychological Assistance Unit for healthcare workers, COVID-19 patients, and the general population. However, details such as the geographic and time coverage of this service, the number of calls received and processed daily, and whether the

[131] WHO Country Cooperation Strategy Guide 2023
[132] See details in Q3.1.
[133] Three-color system for indicator status (red, yellow, or green) and level of progress over a given period (stable, increasing, or decreasing).
[134] Internal and external interviews and document review.
[135] This observation was already made in the EMRO functional review, Country Functional Review Tunisia, 23-26 September 2019, EMRO, WHO.
[136] Biennium programming (joint document with the Ministry of Health), budget allocation, workplan.
[137] Three different formats were used during the evaluation period for descriptive activity reporting, including specific reports for internal WHO programs like NAPHS.

service is still operational are not addressed in any monitoring document.[138] No document links the description of completed actions with budget execution. Additionally, feedback indicated that the monitoring formats required by the regional office are cumbersome, time-consuming, and provide limited added value.

110. The documents and data available for the evaluation did not allow for an analysis of execution efforts by the pillars of the COVID-19 response plan, nor a comparison with the planning, in terms of either budget or activities.

111. Although the team was reinforced during the evaluation period,[139] it still seems insufficient given the range of topics and issues to be addressed, with technical staff also performing time-consuming administrative work. The lack of personnel forced Country Office professionals to take on multiple new roles in areas for which they were not individually or organizationally prepared (e.g., logistics, procurement, administrative procedures), leading to increased workloads, fatigue, and some frustration. This staffing shortage was widely recognized by health actors in Tunisia, including the Ministry of Health, as well as technical program staff at EMRO. Additionally, in the post-COVID-19 context, where WHO's strategic role is widely acknowledged, the Country Office does not yet have specialized staff for communication or partnerships (though this was being addressed at the time of the evaluation).[140]

112. Other internal organizational factors, not directly dependent on the Country Office, were identified as limiting WHO's contribution efficiency in Tunisia, including:

(i) The biennial planning and budgeting cycles are short, and the Country Office team has little time to plan within the budgeted resources, which are highly uncertain. New budgets must be prepared before there is a realistic opportunity to synthesize lessons learned from ongoing implementation. This can lead to misunderstandings with national partners and rushed implementation, without necessarily achieving the desired improvements in national health plans, programs, or services[141].

(ii) Bureaucracy and procedures: In general, these led to delays and frustration among both staff and national partners. They are perceived as more cumbersome than those of other agencies. Particular delays were noted in recruitment (staff and consultants) and procurement, with procedures ill-suited for emergency situations.

(iii) Language: Challenges in finding French-speaking experts on specific topics or WHO tools available only in English, which the Country Office must quickly translate to make accessible to partners and stakeholders in Tunisia.

[138] The publication *Impact on the ground: WHO's action in countries, territories and areas*, WHO, 2021, which presents case studies as part of GPW13, describes this experience for Tunisia and provides some information on the process and the ownership of the national system. However, it is a communication document, not an internal technical document.
[139] The health systems team has been strengthened with the creation of a Programme Officer position.
[140] The 2019 functional review already recommended strengthening communication about WHO's actions in Tunisia. *Country Functional Review Tunisia*, 23-26 September 2019, EMRO, WHO.
[141] This observation was also made at the global level of the organization in the evaluation Independent Evaluation of WHO's Results-Based Management Framework. Final Report. WHO Evaluation Office - January 2023, WHO. Attempts to modify the budget cycle duration, when previously proposed, were reportedly met with opposition from member states, who were reluctant to commit to contributions for periods longer than two years.

3.5 Sustainability

Q5. To what extent has WHO contributed to strengthening national capacities and ownership in responding to Tunisia's health-related humanitarian and development needs and priorities?

Finding 27: Most interventions supported by WHO, even those with a short-term focus on addressing the pandemic, have contributed to strengthening the national health system in certain areas. They have shown potential for continuity, opened new avenues, or served as catalysts. These interventions align with national priorities and emerging issues, despite a context marked by significant turnover within the Ministry of Health and the pandemic. WHO's expertise, recognized particularly by the Ministry of Health, and the long-standing close collaboration between the two institutions were key factors in creating a stable and trusting working environment at both political and technical levels.

Finding 28: Factors hindering the consolidation, national ownership, or continuity of some interventions include the lack of a sufficiently developed administrative or legal foundation, material or financial limitations (due to the economic crisis), and bureaucracy within public administrations and WHO. Some interventions heavily relied on external resource mobilization, raising concerns about their long-term impact. Additionally, the biennial planning approach, fragmented action plans, and low predictability of available funds have made it difficult to program medium- or long-term actions and health system reforms that require continuity.

Finding 29: National capacity-building efforts aimed at creating a resilient and sustainable health system have concentrated mainly on governance, service delivery, and population health, with lesser focus on pharmaceuticals, technology, and human resources. However, WHO's contribution to health system financing appears more limited, even though this is one of the national health system's main challenges.

The findings in this section are organized around the following themes: national ownership of contributions, the national administrative and legal framework, available resources, limiting factors, and national capacity-building efforts toward a resilient and sustainable health system.

Q5.1. To what extent have WHO's interventions during the evaluation period contributed to sustainability and national ownership of the results achieved, aiming for a resilient health system in Tunisia (including for emergencies), universal health coverage, and improved population health?

113. The assessment of sustainability and national ownership of WHO's interventions was based on three main parameters: (i) political or institutional commitment, (ii) the organizational, legal, or administrative framework (laws, decrees, circulars, standards), and (iii) the specific allocation of national resources (primarily through state budgets, staffing, or dedicated resources).[142]

114. Political or institutional commitment was evident in all WHO-supported interventions due to their alignment with national priorities and strategies (see the section on relevance) and the consensus-building process between WHO and the Ministry of Health in establishing biennial action plans. Additionally, WHO's technical expertise and its neutral nature[143], combined with a long and close collaboration with the Ministry of Health, fostered a stable and trusting working environment at both political and technical levels. Between 2019 and 2023, WHO played a central role in reforms and

[142] The identification of the findings presented in this section is based on information gathered from interviews (with internal and external informants), document review, and field visits to selected interventions or projects.

[143] External informants.

modernization processes promoted by national health authorities, including the Social Dialogue, the National Health Policy (PNS), and other thematic strategies (e.g., NCDs, NAPHS, mental health, One Health, antimicrobial resistance, tobacco control, and health multisectorality), all of which aimed to transform the health sector to meet new health and social needs in a rapidly evolving national context.

115. Many WHO-supported interventions were not only integrated into the political framework but also into existing legal, organizational, or administrative structures. Examples include:
(i) support for the upcoming establishment of the new National Public Health Agency,
(ii) technical and logistical support for various Ministry of Health departments and programs (e.g., legal texts for tobacco control, standards and guidelines for infection prevention and control),
(iii) capacity-building for health structures (e.g., genomic sequencing at Charles Nicolle Hospital, the laboratory network, hospital rehabilitation and equipment during the COVID-19 pandemic, training health professionals, triage systems in emergency departments, activation of Emergency Medical Teams),the introduction of new vaccines (e.g., pneumococcal conjugate vaccine, hepatitis A vaccine),[144] and donations of equipment and supplies (e.g., medicines for leishmaniasis and other neglected diseases, ambulances), all fully integrated into the national health system's management and organizational structures.

116. Regarding the pandemic response, WHO's contributions[145] not only supported immediate crisis management but also strengthened key areas of the health system (e.g., diagnostic capacities in reference laboratories, Emergency Medical Teams, the Shock Room, hospital care units, among others),[146] ensuring sustainability and resilience for future crises. These contributions continue to be operational post-pandemic.

117. However, some interventions lacked a well-defined organizational, administrative, or legal foundation. While this did not necessarily threaten their sustainability, it highlighted the need to formalize or consolidate interventions that have proven useful to the national health system. For instance, the Shock Room, a fundamental body within the Ministry of Health for emergency response, lacks visibility in the organizational chart. Additionally, regulatory and administrative clarification is needed for oxygen generators[147] and the construction of the COVID-19 unit at the Regional Hospital of El-Kef, which involves multiple public administration levels.

118. Mobilizing national resources to ensure ownership and sustainability of WHO-supported interventions after external resources are depleted is difficult to quantify.[148] However, the vast majority of WHO's interventions relied on existing capacities and resources within the national health system. WHO often transferred knowledge, tools, and expertise to national entities so they could be integrated into regular health programs and work mechanisms. Overall, ownership levels and the prospects for continuity after external support ends appear favorable, although certain interventions face sustainability challenges.

119. Material and financial resource limitations (as well as public administration and WHO bureaucracy) have affected the continuity or deployment of interventions, such as oxygen generators, ambulances,

[144] WHO Country Functional Review Tunisia 2019.
[145] See Efficiency section.
[146] See Efficiency section.
[147] Only 5 of the 25 generators acquired during the pandemic have been put into service so far, although procedures are still ongoing, and they are expected to be finalized during 2024.

[148] Limitations exist in linking WHO-supported interventions with the public health sector budget or the allocation of state resources.

or the server for computerizing the vaccination program (insufficient maintenance resources). In some cases, the lack of resources hindered the continuity of new technologies or techniques (e.g., laboratory equipment maintenance). Ensuring adequate maintenance has been a recurring challenge, not only affecting WHO's technical cooperation but also reflecting a broader issue within the national health system. Additionally, the lack of specialized human resources in certain fields has limited the commissioning of biomedical equipment (e.g., MRI machines).

120. Similarly, capacity-building or continuous training activities for health system professionals—such as the organization of numerous workshops—were largely dependent on WHO's resource mobilization. Some of these activities raised questions about their utility and medium-term impact. For instance, to what extent has the acquisition of new knowledge or tools been integrated into practice and operations within the health system? Has it led to improvements in quality, best practices, or innovations? Has it contributed to professional development or enhanced the stability of roles and responsibilities for those trained? The 2023 launch of the Regional Diploma in Family Medicine seems to mark a shift in the "traditional" approach to capacity development for health professionals, although there is currently insufficient information about the professional prospects for future family doctors within the health system.

121. Other factors affecting the continuity of certain interventions include:

- Institutional instability and staff turnover: Cycles of change and shifting priorities led to re-prioritizations during the evaluation period, which impacted the continuity of joint work between the Ministry of Health and WHO and raised concerns about the sustainability of interventions.
- Impact of the pandemic: The pandemic caused an almost total interruption of interventions planned for the biennial period, with funds being reallocated primarily to emergency response. However, some pandemic-related interventions contributed to capacity-building and resilience in key areas of the national health system, despite their initial focus on crisis response (see the effectiveness section).
- Fragmented planning approach: The planning for biennial periods, based on fragmented exchanges at various levels within the Ministry of Health and the WHO Country Office, did not include a joint review of the previous biennium. This approach appeared less conducive to ownership than a participatory and joint evaluation and development process, which could also favor the formulation of mutually beneficial activities.
- Fragmentation of joint action plans: Joint WHO and Ministry of Health action plans were fragmented, with activities, reports, workshops, and studies lacking follow-up. These plans relied heavily on external funding (e.g., for continuous training, health communication initiatives), and there were no systematic accompanying measures to implement reference frameworks and tools.
- Low predictability of available funds: This unpredictability hindered the programming of structural reforms and medium- to long-term actions, leading to wasted efforts, frustration among national officials, and discouragement among health personnel directly involved.
- Economic challenges: The national economic context, which has exacerbated existing gaps, impacted the resources and capacity of the health system to undertake large-scale reforms or initiatives.

122. The evaluation of national capacity-building efforts toward a resilient and sustainable health system considered the seven regional priorities for establishing resilient health systems[149] and was based on the Health System Sustainability and Resilience Framework (PHSSR),[150] which is structured around seven areas:
(i) governance,
(ii) financing,
(iii) human resources,
(iv) medicines and technology,
(v) service delivery,
(vi) population health, and
(vii) environmental sustainability.

Table 11 below illustrates the relationship between the main results reported by WHO and the seven areas of the PHSSR. The results were extracted from grouped outputs, and not all results carry the same weight. Therefore, the summarized relationship should be interpreted cautiously. However, it provides a general overview of WHO's contributions to the seven areas essential for sustainable and resilient health systems. The table shows that the results achieved mainly focus on governance, service delivery, and population health, with lesser contributions to medicines and technology, and human resources. The area of health system financing reflects a more limited contribution from WHO, which suggests a need for increased attention and partnerships with international financial institutions or other technical and financial partners to address one of the major challenges facing the national health system. This analysis aligns with some of the KPIs from the GPW13 of the Country Office.[151]

123. Recent contacts between the Country Office and the IMF, along with the office's participation in discussions with the Ministry of Health and the Ministry of Finance to promote national funding for key health sector projects, appear to align with this approach, though detailed information has not yet been collected.

Table 12 Relationship between the main biennial results and the health system sustainability and resilience framework.

Results	Governance	Financing	Workforce	Meds & Tech	Service delivery	Population health	Environ. Sustainability
National Health Strategy	●						
NRA action plan for improvement	●			●			
IPC trainings, SOPs, IPC teams hospitals			●	●	●		●
Sequencing virus and bacteria in Charles Nicolle hospital - genomic surveillance					●		●
National Action Planning for Health Security (NAPHS)							●
Studies food borne diseases + poultry feed production			●				●
Budgeted operational plans, medico-economic studies, legal texts, protocols	●					●	

[149] WHO Regional Office for the Eastern Mediterranean. Eastern Mediterranean Regional Committee Sixty-Ninth Session, Agenda item 3(a). EM/RC69/4, September 2022. Establishing resilient health systems to advance universal health coverage and ensure health security in the Eastern Mediterranean Region.
[150] The member organizations of the PHSSR (Partnership for Health System Sustainability and Resilience) include the London School of Economics, the WHO Foundation, the World Economic Forum, AstraZeneca, KPMG, Philips, the Center for Asia-Pacific Resilience and Innovation (CAPRI), and other regional and national organizations. The PHSSR is a global, non-profit collaboration between academic, non-governmental, life sciences, healthcare, and business organizations. Its common goal is to improve global health by creating more sustainable and resilient health systems for the future.
[Source](https://www.phssr.org/home)
[151] See the Efficiency section.

Plan NCDs physical activity Min Youth and Sports	•					•	
Trainings municipality leaders NGO Academics, urban governance, community	•		•				•
Web vaccine management platform				•	•		
Integrating mental health into PHC			•		•		
Regional Diploma in Family Medicine			•		•		
Surveillance and immunization at Argelia border						•	•
Enhancing preparedness and response COVID-19 pillars	•				•	•	•
Evaluation of the health insurance scheme		•					
Public health emergency operation centre and rapid response teams.	•				•		
WHO's Urban Governance for Health and Wellbeing initiative to address health determinants	•					•	
Patient Safety Friendly Hospital Initiative (PSFHI) self-evaluation at four sites and plan					•		
Conceptualization of primary health care reform	•					•	
Supplies to manage visceral leishmaniasis, other neglected diseases				•			
National health accounts 2016 and 2017		•					
Assessment of the labour market for health care workers			•				
AMR action plan					•	•	
Societal dialogue	•						
Control of health care associated infections in priority regions, migrants, Libyan crisis					•	•	
National Multisectoral Strategy Prevention and Control NCDs 2018-2025						•	
Evidence generation: survey on antibiotic use; Knowledge survey AMR and antibiotic, etc				•			•

Source: BP and PHSSR annual and biennial reports

3.6 Cross-cutting principles: human rights, gender and health equity

Finding 30: From a strategic perspective, human rights, health equity, and gender approaches are integral to WHO's work and are embedded in the principles and guidelines of the National Health Policy. However, due to the absence of specific indicators for the biennia, an in-depth analysis at this level cannot be conducted.

Finding 31: Specific initiatives aimed at vulnerable populations and disadvantaged regions have been launched. However, in a context where women's socio-economic empowerment remains a challenge, the integration of a gender perspective in WHO's contributions is neither evident nor systematic.

The findings in this section are organized around the following themes: cross-cutting integration of the three principles (contributions and monitoring and evaluation systems) and specific actions targeting vulnerable population groups.

124. Strategically, the human rights, health equity, and gender perspective approaches are integral to WHO's work and are embedded in the principles and guidelines of the National Health Policy (universal health coverage, equitable access). The PNS vision is inspired by human rights values, such as respect for dignity, equity, quality, and solidarity. These principles are generally reflected in the formulation of strategic objectives, outcomes, and outputs (GPW13), to which biennial activities are aligned. However, without specific indicators for the biennia, a detailed analysis cannot be conducted at this level.

Additionally, since the evaluation does not cover the content of all approximately 400 actions during the period (excluding the COVID-19 response), analyzing these approaches in every product (e.g., evaluations, studies, advocacy, training, tool implementation) is beyond its scope.

125. Specific initiatives for vulnerable populations were identified, such as:

- **(i)** efforts to combat stigma in mental health awareness,
- **(ii)** the inclusion of disability in the "Family Move" initiative documents, and
- **(iii)** the joint program *"Promoting the Leadership of Women and Girls in the Socio-Economic and Health Response to COVID-19 in Tunisia"* with UNDP and UN Women, focused on two of the most disadvantaged regions (El- Kef and Kebili). However, WHO's activities in this joint program were mainly related to the purchase of biomedical equipment and vehicles, establishing an infection prevention and control system, and providing continuous training for medical and paramedical staff. The gender mainstreaming aspect was not visible through the program's indicators. Regarding the "Family Move" initiative, information from field visits suggested that the participation of girls in physical and sports activities was not seen as a limitation, though disability issues appeared to be overlooked.

126. After historically focusing on central-level interventions, WHO began specifically targeting more vulnerable regions (inland and southern parts of the country) during the COVID-19 response.[152] This focus has continued into the 2022-2023 biennium and in the ongoing planning for 2024-2025.[153]

127. Despite significant progress in women's rights in Tunisia, socio-economic empowerment for women remains a challenge (19).[154] [155] In this context, the National Health Plan 2030 vision barely addresses health disparities between men and women (e.g., geographical, cultural, and financial access to health services, incidence, and prevalence of major causes of mortality and morbidity), with the issue of violence against women and children being one of the few mentions. The *National Multisectoral Strategy for the Prevention and Control of NCDs 2018-2025*, developed with WHO's support, does not incorporate a gender perspective, with no disaggregation of data or indicator tracking, despite the fact that risk factors, determinants, and disease incidence often show sex-specific differences. In this regard, the 2019 functional review[156] recommended that the country office take the opportunity to mainstream the three cross-cutting principles of gender, equity, and human rights into the new national health strategic plan. The internal analysis conducted by the country office for the 2020-2021 biennium (Scorecard) aligns with this recommendation.

128. The country office has effectively leveraged its "neutral" role to coordinate with the Ministry of Health on migrant health, a challenge in cities with significant migrant populations, such as Sfax, where hospitals bear the costs of care for individuals with irregular administrative status, despite limited human and financial resources. This remains a challenge, but WHO, with its experience, position, and mandate, has the potential to act as a facilitator among UN agencies and technical and financial partners. WHO's long-standing work on health and migration in localities and border areas with high migrant presence has underscored the importance of a public health approach and the right to health. Joint advocacy with other UN agencies has facilitated access to COVID-19 vaccination for migrant and refugee populations (with UNHCR and IOM). More recently, this collaboration led to the establishment

[152] Governates of El Kef, Sfax (Kerkennah Island), Sousse, Siliana, for example. See details in Annex 7: Overview of the Impact of the COVID-19 Pandemic in Tunisia, Government and WHO Response.
[153] Internal informants.
[154] Global Gender Gap Report 2023. World Economic Forum, 20 June 2023.
[155] https://successfultunisia.com/fr/2023/11/13/la-tunisie-se-positionne-au-deuxieme-rang-mondial-en-termes-de-nombre-de-femmes-diplomees-en-sciences-technologies-ingenierie-et-mathematiques/
[156] Country Functional Review, Tunisia, 23-26 September 2019. EMRO.

of a roadmap[157] for the first half of 2024 with local health authorities in Zarzis and Medenine to improve access to health services, safe drinking water, and sanitation (WASH) for refugees and asylum seekers (with UNHCR and UNICEF).

4. Conclusions

Strategic level

SC1. WHO successfully reinforced its position as a leading health agency in Tunisia, capitalizing on decades of institutional political dialogue with the Ministry of Health (MoH), its technical expertise, and its capacity to mobilize during the Social Dialogue process, culminating in the National Health Policy towards 2030. Additionally, WHO responded swiftly and effectively to the COVID-19 pandemic, despite internal and external challenges. The crisis enabled WHO to broaden its institutional and technical scope, demonstrating the added value of its mandate and sectoral expertise, even in the face of the pandemic's health, social, and economic impacts. *(*Related to Q1, Findings 1, 2, and 4*).*

SC2. Through actions aligned with national priorities and UN system goals, WHO developed strategic partnerships to strengthen advocacy and promote a multisectoral approach to health. However, the absence of a strategic document outlining WHO's contributions in Tunisia, combined with limited human resources at the country office to engage in multiple coordination forums and maintain consistent communication with agencies and national actors, has hindered its visibility and the understanding of its priorities among key international and health partners. *(*Related to Q1, Findings 2 and 3; Q2, Findings 5, 6, and 8*).*

Programmatic level

PC1. The country office is recognized for its strong collaboration, both strategically and operationally, with national partners, particularly the Ministry of Health. However, the biennial planning and implementation framework, though based on meetings between the MoH and WHO, does not sufficiently reflect joint prioritization efforts or results-oriented monitoring. The mechanism used, along with the resulting fragmentation, does not promote efficiency or effectiveness and does not contribute to strategic clarity. This may have led to misunderstandings among partners and difficulties in accurately assessing the impact of actions, complicating the review and adjustment of programming as needed. *(*Related to Q3, Findings 9, 10, 13; Q4, Findings 17, 21, 24, 25; Q1, Finding 3; and Q5, Findings 30 and 31*).*

PC2. The evaluated period saw the launch of key public health initiatives for Tunisia, such as NCD prevention, multisectoral risk factor treatment, mental health improvements, and drug supply enhancements. Advocacy and community involvement were critical in driving these changes, with lasting impacts like tobacco control. Significant steps were made toward UHC by strengthening the health system, though efforts remain ongoing and highly dependent on the country's political and economic situation and stable, medium-term strategic partnerships. However, WHO's actions have not adequately addressed structural improvements needed for public health functions and health system building blocks. The strengthening of the health systems team in 2023 highlights the importance of intensifying technical cooperation and adopting a systemic vision, though it is

[157] The roadmap was established following a joint mission conducted at the end of November 2023.

too early to document progress. *(*Related to Q3, Findings 12, 13, 14, 15; Q4, Findings 18, 19, 26; and Q5, Findings 27, 28, and 29).

PC3. WHO's support for Tunisia's national COVID-19 response was timely, mobilizing health authorities in advance, rapidly activating national response mechanisms, and playing a key role in providing scientific information, coordinating efforts with international organizations, and strengthening national health system capacities. WHO and the MoH capitalized on experience from the H1N1 response, implementing Rapid Response Teams (RRT), enhancing International Health Regulations (IHR), and providing support for hospital emergency services. This enabled the deployment of Emergency Medical Teams (EMTs) and the operation of the Shock Room. Much of the emergency aid has since been transformed into support for regular health services, contributing to a resilient health system. However, inefficiencies in supporting hospital services and delays in the national vaccination strategy revealed areas where WHO was not adequately prepared to respond, highlighting national limitations. *(Related to Q3, Findings 11, 12, 13, 14, 15; Q4, Findings 18, 19, 22, 23, 26; and Q5, Findings 27 and 28).*

Organizational level

OC1. The significant effort and commitment of the country office team were essential in enabling a modestly sized office to provide consistent technical support across the national health system and manage a large number of projects. The team demonstrated remarkable efficiency and responsiveness during the COVID-19 response, managing a budget five times larger than usual. However, the increased workload occasionally created technical or reputational risks, as some partner requests could not be addressed promptly. The ongoing process of strengthening the country office is crucial to alleviating role overload, aligning the team with future strategic planning, and enhancing WHO's leadership and visibility in the health sector. *(*Related to Q3, Findings 11; Q4, Findings 18, 19, 20, 21, 22, 26; Q1, Findings 6 and 8).

OC2. The Results-Based Management (RBM) system used by the country office, while focused on internal accountability, does not provide a comprehensive view of WHO's contributions in Tunisia during the biennial periods. Fragmentation—particularly between narrative aspects and allocated resources, the lack of visibility regarding changes made during implementation, the absence of outcome indicators, and frequent changes in reporting formats—makes it challenging for the country office to analyze its work effectively, while the system remains highly time-consuming. *(*Related to Q3, Finding 9; Q4, Findings 17, 24, and 25; Q5, Findings 30 and 31*).*

OC3. The added value of the Regional Office and headquarters was evident in terms of expertise, adaptable tools, and opportunities for regional and international networking. However, this was offset by a lack of clarity regarding the roles played by each of WHO's three levels (despite the Transformation Agenda), cumbersome administrative procedures, and misalignment with the Tunisian context. In some cases, priorities set by the Regional Office did not align with national priorities, leading to misunderstandings internally and externally. *(*Related to Q3, Finding 16; Q1, Findings 7 and 8; Q4, Findings 26 and 28*).*

5. Recommendations

At the strategic level

Development of the CCS	
SR1	In line with international commitments (Agenda 2030, GPW13, GPW14) and national health challenges, WHO's positioning and its strategic partnership with the Ministry of Health are reflected in a Country Cooperation Strategy (CCS) developed in a participatory and multisectoral manner.
Priority Actions	1. The CCS is aligned with the Ministry of Health (MoH) and is disseminated within the health system at various levels, including both central and local bodies. 2. The CCS reflects its multisectoral approach in the identification of partners as well as in its actions. 3. The CCS has a joint governance mechanism between the MoH and WHO that is both operational and realistic for its implementation and monitoring, at both the technical and strategic/decision-making levels. 4. The CCS places greater emphasis on visibility throughout its lifecycle, ensuring coordination, synergy development, and accountability both internally (among historical partners) and externally (with key health stakeholders). 5. The launch of the CCS, biennial programming, mid-term evaluation, and final evaluation are key governance milestones that are used to enhance visibility (with the UNCT and health actors), capitalize on lessons learned, and adapt to the changing national and international context.
Link to Conclusions	CS2, and CS1
Recipients	WHO Country Office, Ministry of Health (and other WHO partners for the CCS)
Timeline	Since 2024 for its development, and throughout its entire 5-year cycle

Diversification of partners	
SR2	WHO has expanded its partner portfolio, enhancing (i) the multisectoral approach to health, (ii) collaboration with agencies and technical and financial partners, (iii) direct engagement with regions and areas experiencing greater inequities, and (iv) the implementation of more ambitious strategies to reduce vulnerabilities and improve healthcare access for specific population groups.
Priority actions	1. The stakeholder mapping developed during the development of the new CCS is used to identify synergies and foster joint initiatives, both institutional and operational, with new organizations. 2. Successful partnerships, such as those in antibiotic resistance and the "health in all policies" approach, are being consolidated and strengthened. 3. Collaborations are being formalized with civil society organizations specializing in specific areas, focusing on vulnerable populations (such as migrants, refugees, survivors of gender-based violence, and key populations), as well as with youth organizations (to harness human capital) and the academic sector (for research and knowledge-sharing). 4. Collaborations with international financial institutions and the Ministry of Health are facilitating medium-term reforms in the national health system, particularly in governance, financing, and workforce development. 5. WHO-supported initiatives ensure that health structures and professionals from priority disadvantaged regions are actively involved.
Links to conclusions	CS2, and CS1
Recipients	WHO Country Office, MoH (and other WHO partners for the CCS)

Timeline	Starting in 2024, for the implementation of the 2024-2025 biennium (if flexibility permits), the development of the new CCS, and continuing throughout its 5-year cycle.

Active coordination within the UNCT and strengthening WHO's role as a health reference	
SR3	WHO is enhancing its participation and visibility in key UNCT forums, solidifying its role as a strategic and technical leader for all international actors involved in health in Tunisia.
Priority actions	1. The WHO country team maintains a consistent and active presence in UNCT coordination and planning spaces, while effectively communicating its focus areas, progress, and challenges across its various interventions and areas of action in Tunisia. 2. Collaborations with other UN system agencies are facilitating more comprehensive and efficient interventions, both in advocacy and operations, in areas of shared interest (e.g., gender, migrants and refugees, One Health, HIV/AIDS). 3. The "Health Group" is evolving into a key space for multi-stakeholder exchange and coordination, aligned with existing mechanisms, and combines both strategic and technical levels through specialized sub-groups. The frequency of meetings is set at a realistic and reasonable level.
Links to conclusions	CS2, and CS1
Recipients	WHO Country Office, UNCT, MoH
Timeline	Short term and mid-term

At the programmatic level

Programmatic Focus	
PR1	WHO's portfolio of actions and projects in Tunisia is focused on key areas and priorities that drive progress towards universal health coverage (UHC) and a resilient health system.
Priority actions	1. The upcoming CCS and biennium take a more concentrated approach, compared to previous biennia that covered a broader range of actions and themes. They focus on key structural areas, with priority given to strengthening the health system through the "building blocks." 2. The next CCS and biennium prioritize cooperation methods where WHO has the most added value, with particular attention on linking evidence-based data, decision-making, and practical implementation to ensure sustainability. 3. Leveraging WHO's strength in knowledge production and management, the country office collaborates with national universities and research centers to tap into their expertise. 4. Gender considerations and specific vulnerabilities are systematically integrated, with data disaggregated where relevant.
Links to conclusions	CP2, CP1 and CP3
Recipients	WHO Country Office, MoH
Timeline	Starting from the development of the CCS, followed by the next biennium.

Response to COVID-19	
PR2	The new technologies, tools, and systems introduced during the pandemic emergency response are now fully integrated into regular health services and programs.
Priority actions	1. The diagnostic and technical capabilities of the national reference laboratory and regional laboratories for genomic surveillance are in place, with studies and analyses conducted regularly. 2. The E-vax system is widely used as a tool for ongoing monitoring and management of the national vaccination program. 3. Hospitals have fully operational systems and trained staff, allowing for self-sufficient oxygen production. 4. The ambulances provided are routinely used for patient transport and care.
Links to conclusions	CP3, also CP2 and CP1
Recipients	WHO Country Office, MoH
Timeline	As of 2024 and in the coming years

Biennial Planning	
PR3	**Biennial planning** is the result of a collaborative, multi-stakeholder, and multi-sectoral effort led by the Ministry of Health (MoH) and the WHO Country Office.
Priority actions	1. Biennial planning is conducted jointly with the MoH, based on a review of the previous biennium. 2. The process includes other partners, aligned with the new CCS. 3. It establishes a dedicated governance mechanism, both operational and realistic, at technical and strategic levels, complementing the new CCS. 4. The biennium incorporates a monitoring and evaluation system to track actions, budget execution, and results. This system also accounts for any modifications and adjustments made during implementation, with explanations for those changes.
Link to conclusions	CP1, also CP2, CP3, and CO2
Recipients	WHO Country Office, MoH
Timeline	During the 2024-2025 biennium for the monitoring and evaluation system, if feasible. Starting with the 2026-2027 biennium planning.

At the organizational level

Sizing of the Country Office Team	
OR1	The Country Office has been strengthened with an expanded team to enhance communication, manage partnerships, and reduce the administrative workload
Priority actions	1. Communication and partnership development officers are in place, providing strong support for expanding partnerships and collaborations, while increasing the visibility of WHO's vision and priorities in Tunisia. 2. The health systems team operates with a stable, multi-year framework and funding to effectively support the Ministry of Health in implementing major structural reforms to the national health system
Links to conclusions	CO1
Recipients	WHO Country Office, EMRO
Timeline	Short and medium term.

Alignment between the three levels of WHO	
OR2	The roles and contributions of WHO headquarters and the regional office (RO) in supporting the interventions of the country office (CO) and the Ministry of Health (MoH) are clearly defined and incorporated into the new CCS.
Priority actions	1. The CCS and biennial plans outline in advance the technical, material, and, where possible, financial contributions from the regional and central levels to help achieve WHO's objectives in Tunisia. 2. Clear communication with the regional office and headquarters ensures effective coordination with Tunisian organizations, particularly collaborating centers, as well as with international opportunities that could benefit Tunisia, such as networking, training, and research.
Link to conclusions	CO3
Recipients	WHO Country Office, EMRO, HQ
Timeline	Development of the CCS and throughout its five-year cycle.

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