



**COMMUNICATION BREAKDOWN:
LESSONS FROM TUNISIA'S SECOND WAVE OF COVID-19, 2020**

Mariam Ghanem and ISS staff researched and wrote this case based on research conducted during May, June, and July 2021. Case published May 2022. This case study was supported by United Nations Development Programme Crisis Bureau as part of a series on center-of-government coordination of the pandemic response.

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SYNOPSIS

In mid-2020, Tunisia stood out as a star within its region. The first wave of the COVID-19 pandemic had taken a high toll in the Middle East and North Africa. But by the end of the second week of August, as the first wave ebbed, Tunisia had recorded 149 cumulative cases per million people—compared with more than 800 per million in Algeria, Egypt, Morocco, and most of the rest of the region. Tunisia's epidemic curve was almost flat. However, the good news was short-lived. By mid-August, the number of COVID-19 cases had started to rise, and by October the number of cases per million in Tunisia matched that of other countries in the area. A year later, Tunisia was a regional hot spot. This case study profiles the difficulty of containing the spread of disease when local governments are new and have limited capacity, when public health guidance from a national government modulates or weakens, and when political distrust runs high.



INTRODUCTION

On January 4, 2020, via a World Health Organization (WHO) social media alert, the first news about a cluster of mysterious pneumonia cases in Wuhan, China, reached Tunisia's National Observatory of New and Emerging Diseases, a semiautonomous agency established in 2005 to support the health ministry's disease surveillance function.¹ At the time, Tunisia was in the midst of a political transition after national elections that had taken place in the previous September and October.

The new president, Kais Saied, a constitutional law professor with little experience in politics, had struggled to nominate a prime minister who could secure parliamentary support. After parliament rejected Saied's first choice, he tapped Elyes Fakhfakh, a former minister of finance, and tasked him with organizing a new government. Acting under his authority as prime minister-designate, Fakhfakh directed the health ministry to start mobilizing in late January—just before the WHO declared COVID-19 a public health emergency of international concern.

But Fakhfakh was unable to win legislative approval for the full slate of ministers until the end of February, just days ahead of Tunisia's first confirmed case of the virus. As the new government took office, it immediately confronted the urgent demands of defending Tunisians from a fast-spreading global pandemic. Without a vaccine and with no known therapy at the time, infection control depended on effective testing, isolation, contact tracing, masking, and physical distancing—a complex response that required cooperation and coordination across government ministries and with 24 provinces (called governorates), private health providers, and the public.

Article 38 of Tunisia's 2014 constitution declared health a human right and obligated the government to secure and provide health services for citizens, including those with low incomes. In 2018, health expenditure per capita in purchasing-power-adjusted terms was US\$912—among the highest in the region of North Africa.² In total, the country had 23 university hospitals, 3 regional hospitals, 2,085 primary care centers, and an advanced pharmaceutical industry.³ It had about 13 physicians per 10,000 people—more than neighboring countries such as Egypt and Morocco but still low compared with world averages.⁴ The government was the main health-care provider, and public health facilities accounted for 87% of hospital bed capacity.

On February 28, based on advice from the national disease observatory, the newly confirmed Council of Ministers issued orders to begin health screenings at airports and to quarantine travelers coming from high-risk countries.⁵ The government also began setting up a COVID-19 National Coordination Committee to pilot the country to safety under the direction of its chair, Health Minister Abdellatif Mekki, a politician with a degree in biochemistry.⁶

THE CHALLENGE

Mekki's committee was responsible for developing a strategy that would align priorities across agencies in a context that was far from favorable. In Tunisia, the pandemic struck during a period of political turbulence, economic distress, financial austerity, declining health resources, and uneven local government capacity.

Tunisia was the only country in North Africa with a democratic system of government. Mass demonstrations in 2010 had deposed a longtime authoritarian leader and resulted a coalition government led by a moderate Islamist party. After the assassination of two prominent politicians and as partisan division intensified, prominent unions and civic organizations pressured political parties to appoint a short-term technocratic caretaker government at the end of 2013. A new constitution, adopted in 2014, enshrined a commitment to democratization, but the reality fell short of the aspiration. In such a polarized political context, the effort to reach broad agreement on policy yielded little action on important issues. The high levels of cabinet instability that had beset the country since 2011 persisted.⁷ Tunisians' trust in political leaders ebbed even further, falling to 16% in 2019 from 40% at the time of regime transition a decade earlier, reported Arab Barometer, a nonpartisan research network.⁸ Those circumstances paved the way for independents and lesser-known political movements to dominate the 2019 parliamentary and presidential elections (text box 1).

Text Box 1. An Unsettled Political Landscape

When the COVID-19 pandemic began, Tunisia was mired in an extended period of political wrangling and cabinet instability. After mass demonstrations in 2010 to overthrow longtime President Zine El Abidine Ben Ali, Tunisia was the only country in the region that successfully navigated a transition to multiparty elections. But polarization between modernists and Islamists challenged the democratic experiment. Moderate Islamist party Ennahda, which had won a majority of seats in parliament in October 2011, worked with secular parties to draw up the country's new constitution. However, tensions persisted, and in 2013, two secular opposition leaders—Chokri Belaïd and Mohamed Brahmi—were assassinated, sparking nationwide protests and prompting the resignation of then Prime Minister Hamadi Jebali.

To avoid further destabilization, Ennahda ceded power and participated in a national dialogue that eventually led to the creation of a short-term technocratic caretaker government, followed by the adoption of a consensus model: a coalition between secular party Nidaa Tounes, which won the most parliamentary seats, and Ennahda. In 2019, when Ennahda fractured, Nidaa Tounes partnered again with two of the breakaway factions: Tahya Tounes and Machrouu Tounes. The parties found it difficult to agree on policy, however. In the October 2019 elections—not long before the COVID-19 global pandemic erupted—Kais Saied, a former law professor allied with Ennahda, won the presidency, with 72.71% of the vote.

Tunisia's economic troubles were significant and persistent. In 2019, the country's overall unemployment rate was 15%, the youth unemployment rate was 35.8%, and inflation topped 6.7%.⁹ About 32% of Tunisia's 11.69 million people worked in the informal sector and subsisted on what they earned day to day.¹⁰ In the cities, where about 70% of the population lived, frequent street demonstrations protested deteriorating economic conditions. Under all of those circumstances, public cooperation with nonpharmaceutical infection-control measures such as lockdowns would be difficult to secure because they would inevitably take at least a short-term toll on employment and household incomes. Tunisia might negotiate the first wave of infection successfully, but successive waves that triggered repeated closures could decrease public compliance and render response plans unworkable.

Tourism, one of Tunisia's main sources of jobs and revenue, was highly vulnerable to a global pandemic. The government had recently launched a campaign to revive the industry, which had declined in the wake of past terrorist attacks. That program succeeded, and in 2019, 9.5 million people visited the country—a significant increase over previous years.¹¹ The travelers generated about US\$2 billion in revenues in 2019, as well as crucial foreign exchange reserves, according to Tunisia's central bank.¹² If tourism shut down, the country would lose close to 3% of its GDP and more than 6.45% of its jobs.¹³ Taking into account the impact on suppliers and indirect employment painted an even more dismal picture.

The government had little leeway to spend money on a pandemic response or on social support to help those affected. Its predecessors had secured a US\$2.9-billion loan from the International Monetary Fund (IMF) on condition that it implement economic reforms and balance the budget. The previous government had tried to reduce the deficit by freezing hiring in the public sector and suspending increases in salaries that had already been promised to the Tunisian General Labor Union. But when the union protested, the government changed course, and the IMF withheld the second installment of its loan.¹⁴ To increase revenue, the government increased a value-added tax that raised consumer prices for some kinds of goods and services. Coupled with an increase in fuel costs, the step spawned more protests across the country.¹⁵

Partly because of fiscal austerity, the country's health-care system was on increasingly unstable footing. Just before the start of the pandemic the Tunisian government had finalized and approved a budget that included major cuts to the health sector. Moreover, access to health care was already constrained in many places, with significant geographic disparities in the distribution of resources between coastal cities and inland cities and with the majority of health professionals and specialists concentrated in the former. An African Development Bank report noted that although inequalities in government health spending had diminished, care facilities were concentrated in more-heavily-populated areas, and differences in average life spans between urban and rural communities persisted.¹⁶

Finally, management capacity at the municipal (commune) level was weak. Tunisia had embarked on the region's most ambitious decentralization initiative just two years earlier, with elected local councils assuming responsibility for a number of functions previously the preserve of the central government. However, the language of the new statutes contained many ambiguities and generated friction between local and national authorities, and a number of local governments were not fully functional at the time the pandemic hit.¹⁷

MANAGING THE FIRST WAVE

On March 2, authorities announced the country's first confirmed COVID-19 case: a Tunisian man returning from a trip to Italy, one of Tunisia's major trade partners, where the virus had established an early foothold. The newly established Tunisian government quickly suspended ferry service from Genoa, Italy, and tightened control measures on maritime travel—specifically, travel by cruise ship. One of two terminals at Tunis–Carthage International Airport was transformed to enable officials to conduct health checks of passengers arriving from Europe.

On March 9, the health minister, who served as the government's spokesperson, announced that sea and air travel to and from Italy was suspended—except for flights between Tunis and Rome, which were reduced to 3 per week from 14. At that point, Tunisia had five people with confirmed cases of COVID-19, four of whom had arrived from Italy. The minister also announced reductions in flights to countries experiencing confirmed community transmission of the virus and a weeklong holiday for all schools while the government assessed the risks of classroom gatherings.

The Tunisian government implemented stricter measures as it received more and more information about the virus. On March 13, it canceled all flights to Italy and enforced 14-day quarantines for incoming travelers. It also suspended religious gatherings and ordered all restaurants and cafés to close at 4 p.m. daily. Three days later, the prime minister said Tunisia would block all international flights and close its borders indefinitely. He also announced a ban on all gatherings, closure of marketplaces, suspension of domestic travel, reductions in government employees' working hours, and postponement of two previously scheduled local elections.

On March 18, a presidential decree imposed a nightly curfew from 6 p.m. to 6 a.m., and to enforce the curfew, military forces were deployed to patrol the streets. In a few areas, the BBC reported that the Tunisian government was using robots to assist and to inspect permits.¹⁸ At that time, Tunisia had a total of 24 confirmed cases and was averaging 3 or 4 new cases per day.¹⁹

Two days later, the government imposed a nationwide lockdown, during which only essential businesses were permitted to remain open. The lockdown, originally set to expire April 4, was extended twice until early May while the government worked to decentralize testing, with a view to ensuring that governorates outside the capital city had means to track the spread.

Up to that point, the president and the prime minister, Fakhfakh, had led policy decision making in consultation with the health minister and the interior minister, whose staff handled logistics and other aspects of incident management. The health ministry worked closely with the national disease observatory, which provided data support and advised on response plans; and it also headed up communications, serving as a bridge between decision makers and the public.

But the pandemic threat clearly demanded a broader approach. Containing a pandemic meant regulating transportation, business practices, social gatherings, and schools, as well as procuring supplies. And responsibility for public health was shared by the health ministry and the country's 6 geographic regions and 24 governorates, as well as 264 districts and roughly 350 municipalities.

The response structure evolved rapidly by necessity. In late March, three weeks after Tunisia's first case was announced, the government established the National Coronavirus Response Authority, an interministerial task force chaired by the prime minister and also comprised the ministers of health, interior, justice, finance, trade, local affairs, social affairs, and communication and transportation technologies, as well as other senior officials working in ministries.²⁰ The prime minister's chief of staff, the director general of the military hospital, and the director general of the new and emerging diseases observatory supported the prime minister and the health minister in their roles.²¹

The coronavirus authority's purposes were to set policy and strengthen coordination across ministries and between levels of government. The group met regularly via videoconference to determine appropriate measures early in the pandemic, and it coordinated with the national security and defense council, which the president led. An advisory group of scientists, researchers, and physicians—called the Scientific Committee to Fight the Coronavirus—proposed evidence-based courses of action for the authority to consider.

Implementation rested with the interior ministry's Permanent National Committee for Disaster Prevention, Response, and Relief in conjunction with the health ministry.²² The permanent committee was responsible procuring supplies, expanding isolation and treatment facilities, and enforcing travel restrictions, among other tasks. It worked with its regional branches to help support local governments' efforts to contain the spread of infection. The health ministry continued coordinating disease surveillance and the medical aspects of the response, which it managed through its network of public hospitals and clinics. The ministry also handled public communications, including press briefings that were broadcast on television and radio and used social media to announce safety precautions and new health measures.²³ Nongovernmental organizations and UN agencies that supported the response coordinated primarily with the health ministry.

During these opening phases, the president drew on Article 80 of the constitution, which, during times of imminent threats to national security, granted the head of state expansive powers to issue decrees imposing curfews,

restricting movement, and deploying the army to enforce the measures.²⁴ The prime minister used constitutional authority in the forms of Articles 91, 92, and 94 to work with parliament in centralizing control at the national level.²⁵ On March 25, Fakhfakh began requiring that subnational governments clear any COVID-related decisions with the central government and comply with any instructions sent to them.²⁶ In addition, he requested the activation of Article 70(2) of the constitution, which permitted him—for a limited duration in response to exceptional circumstances—to issue decrees without parliamentary approval.²⁷ Parliament granted the prime minister that power on April 4.

To support pandemic response measures, the government appropriated US\$860 million, some of which would cover onetime payments to low-income households, informal-sector workers, and vulnerable persons.²⁸ The government also postponed corporate tax payments and introduced support to help private firms remain in business. The IMF made US\$745 million available, and other development partners such as the World Bank and bilateral aid agencies assisted in a variety of ways—from procuring emergency supplies to supporting businesses and people with low incomes.²⁹

To assist households unable to earn livelihoods as a result of the health measures and to support other aspects of care, the government expanded its existing cash transfer program, and the finance ministry established a fund to receive donations from Tunisians no matter where they resided. The COVID-19 Solidarity Fund 1818—so named because Tunisians could use their cell phones to donate to the fund by addressing text messages to 1818—was managed by the prime minister’s office.

Local authorities worked with businesses and civic groups to control overcrowding, to close establishments where risk of transmission was high, and to encourage adoption of other safety measures while also trying to help local businesses and vulnerable people. Many local authorities formed crisis committees that included representatives from civic groups and political parties to provide support for households experiencing hardships and to introduce safety protocols.

During the opening weeks of the response, the division of responsibilities between levels of government was sometimes unclear. On April 4, in response to ambiguity about who was in charge of what, the Ministry of Interior and Ministry of Local Affairs issued a publication that outlined a coordination strategy between local authorities and the central government. The guidance supplemented daily coordination calls between the central government and the emergency coordination centers each governorate had set up. But there were no communication links between some of the municipalities and the central government—a problem partly remedied later through external assistance.³⁰

The measures were painful for many Tunisians: revenues from exports and tourism fell, and about 80% of private-sector industrial workers were without jobs—at least temporarily.³¹ Tunisia’s volume of trade was estimated to have dropped by 60%.³²

The number of daily new infections reached 59 on March 24 and then declined. The initial, strict lockdown appeared to have worked, enabling Tunisia to contemplate a gradual reopening that would help minimize the impact of the pandemic measures on incomes, though the scientific committee cautioned the government not to reopen borders without taking precautions. Significantly, the first wave established clear coordination between the prime minister and the president, and the disparate elements of the response system appeared to have learned how to work together. Moreover, an April survey conducted by private polling and market research firm Ipsos found that an overwhelming majority of Tunisians both approved of most of the health measures introduced and supported the government's approach, though a similarly large share of respondents said they thought workplaces should remain open.³³

The strict phase of the lockdown lasted only a short time. Increases in fuel prices and deteriorating economic conditions led to social unrest, and the government began a gradual reopening on May 4.³⁴ To minimize hardships for lower-income Tunisians and for small businesses, policy makers opted to let local officials decide which rules to impose and how long to keep them in place, and the national government focused on border controls and other matters clearly within its constitutional authority. A May 20 government decree permitted the central government to second personnel to the local level in order to assist governments whose public health offices were inadequately staffed.³⁵ And bilateral donors helped finance the training of rapid-response teams.

The national government was struggling to maintain some of its own operations. At the pandemic's start, Tunisia was not optimally positioned to sustain some of its key functions during a crisis that limited travel and office occupancy levels.³⁶ Inadequate broadband connections impeded the flow of communications between the field offices of key ministries and their central headquarters. For example, when the pandemic hit, the finance ministry could not connect its regional offices with the central office and therefore could not transmit data securely. External assistance later helped alleviate some of those difficulties.

REOPENING—AND THE SECOND WAVE

Tunisia's gradual reopening, which it called a *deconfinement strategy*, was intended to revitalize the economy. The first of three phases lasted about three weeks: from May 4 to May 24. During that phase, financial institutions, essential services, and public agencies that could not carry out business remotely were permitted to reopen their offices at 50% occupancy capacity while abiding by strict health protocols that included physical distancing and mask wearing. Industrial and construction services were also permitted to return at 50% capacity but were required to provide employees with safe transportation to work sites. On May 11, people employed in commercial activities were permitted to resume travel to their jobs every other day based on their national

identification card numbers, with those who had even numbers working certain days and those who had odd numbers working other days.

The second and third phases of the reopening each lasted less than two weeks. During the second, services and institutions together with sports, entertainment, and tourist-related activities, including restaurants, cafés, and weekly markets, were permitted to operate at 75% occupancy capacity. During the third week, which began on June 5 and lasted until June 14, services opened at full capacity.

The revival of international tourism was among the government's priorities. From mid-May to mid-June, Tunisia appeared to have halted person-to-person transmission within its borders. In preparation for the reopening of tourism in late June, the Tunisia National Tourist Office developed health protocols for tourist establishments, including masking rules and capacity limits. Overall, the tourism industry had dismissed a little more than 30% of its labor force,³⁷ but some establishments had laid off more than 70% of employees and had to rehire before they could undertake preparations.

On June 27, Tunisia announced the reopening of its borders for the first time since the lockdown. In an attempt to mitigate the transmission of COVID-19 across borders, the Ministry of Health announced requirements for international visitors. The requirements were based on a three-color system that classified every country in the world based on the severity of COVID-19 transmission within each country's borders. Travelers from green countries could enter Tunisia without many precautionary measures, whereas those from orange countries had to have negative polymerase-chain-reaction tests, and those from red countries were banned from entry. But applying the system was difficult in the face of a fast-shifting global pandemic because conditions in other countries changed quickly. The scientific committee that created the color coding noted that several European countries with alarming COVID-19 case numbers nonetheless had been classified as green. Moreover, it took time to learn how to best set up screening and testing at points of entry so that the processes went smoothly and all passengers complied.

As decision makers tried to manage the reopening, political turbulence further challenged continuity and coordination. A dispute broke out about Fakhfakh's alleged financial stake in companies that had procured government contracts. An opposition party, Ennahda, filed a no-confidence motion, and in mid-July, before the vote took place, Prime Minister Fakhfakh resigned.³⁸ The president nominated Interior Minister Hichem Mechichi to assume Fakhfakh's post. Mechichi, a political independent and a lawyer by training, pledged to put together a government that would meet the interests of all political parties, and he promised to focus on supporting the tourism sector in order to stimulate economic growth. He appointed a new health minister, Faouzi Mehdi, a physician, a former director general of health in the military and an associate professor of preventive and community health at the Faculty of Medicine in Tunis.

The Mechichi government broke with the approach of its predecessor despite rising numbers of COVID-19 cases since the reopening of borders on June 27. In September, after the new government took office, it prioritized economic needs, set a goal of learning to live with the virus, and adopted a hot-spot strategy that many other countries began introducing at about the same time. To some in the medical and scientific communities who saw fewer of their recommendations implemented, the government’s commitment to health care was appearing to waver.

As the national government tried to avoid broad lockdowns and blanket restrictions and instead to focus on hot spots and other targeted measures, local governments—already struggling with shortages of resources—found themselves asked to take on bigger roles. But many of the districts and municipal governments were hard-pressed to respond. Under a decentralization initiative that had begun in April 2018, Tunisia had recently held its first municipal elections and started to devolve selected responsibilities from the central government to local authorities—despite weak capacity in parts of the country. Some municipalities (communes) had yet to fill important posts or had installed people who lacked the training needed to fulfill their responsibilities.³⁹ And a May presidential decree that authorized the central government to second personnel to assist local governments did not fully solve the problem.

Moreover, even though some municipalities had earlier received central government financial assistance for enforcing restrictions, cleaning public facilities, and helping affected families, the flow of supplies occasionally lapsed. In some municipalities, such as Kairouan in the northern part of Tunisia, the promised medical supplies did not arrive on schedule. Civil society and development partners stepped up to help out, but tensions between citizens and local officials grew, as did conflict between subnational governments and the central government.⁴⁰

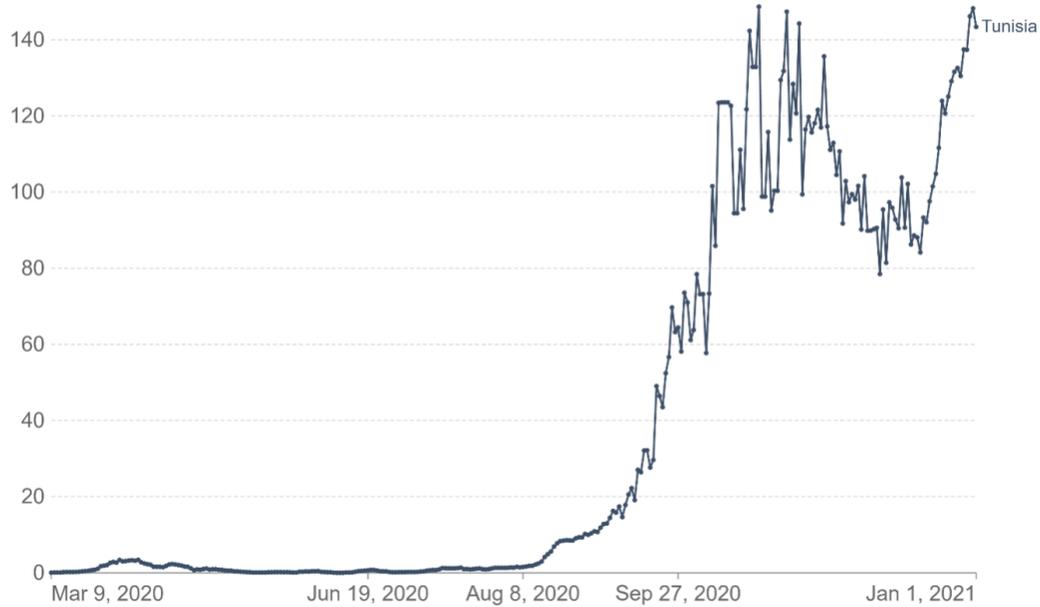
On August 14, Tunisia for the first time exceeded 100 new infections per million daily, and the numbers continued to escalate the following month, reaching more than 120 new confirmed cases per million in September and more than 140 in October. Public confidence in the government’s COVID response diminished, and a late September poll conducted by US nonprofit, nonpartisan International Republican Institute found that 55% of Tunisians surveyed thought the government was doing a bad job of managing the pandemic response. An even higher proportion held negative views of public service delivery, government corruption, and government efforts to improve the economy and create jobs.⁴¹ The results showed a substantial downturn from March, when a survey indicated 88% of the public thought the government was handling the pandemic well.⁴² (Figures 1 and 2)

As the second COVID-19 wave intensified, local governments also struggled to secure residents’ compliance with some of the infection prevention measures and to meet central government expectations. The governorates to which the municipalities and districts reported conveyed those concerns to

Figure 1: Cases per Million Population

Daily new confirmed COVID-19 cases per million people

7-day rolling average. Due to limited testing, the number of confirmed cases is lower than the true number of infections.



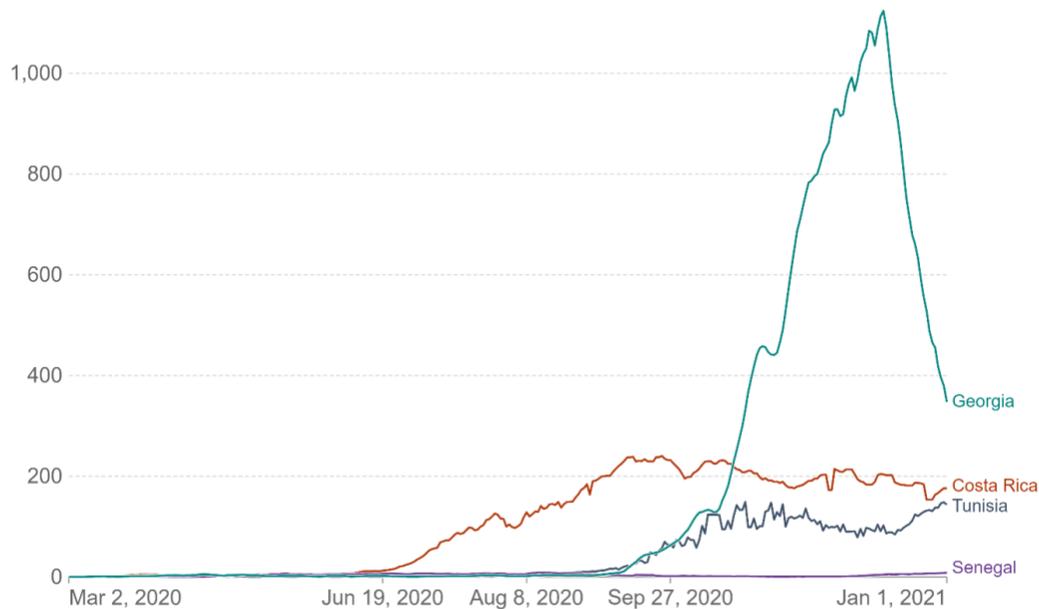
Source: Johns Hopkins University CSSE COVID-19 Data

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Figure 2: Cases per Million Compared with Selected Countries

Daily new confirmed COVID-19 cases per million people

7-day rolling average. Due to limited testing, the number of confirmed cases is lower than the true number of infections.



Source: Johns Hopkins University CSSE COVID-19 Data

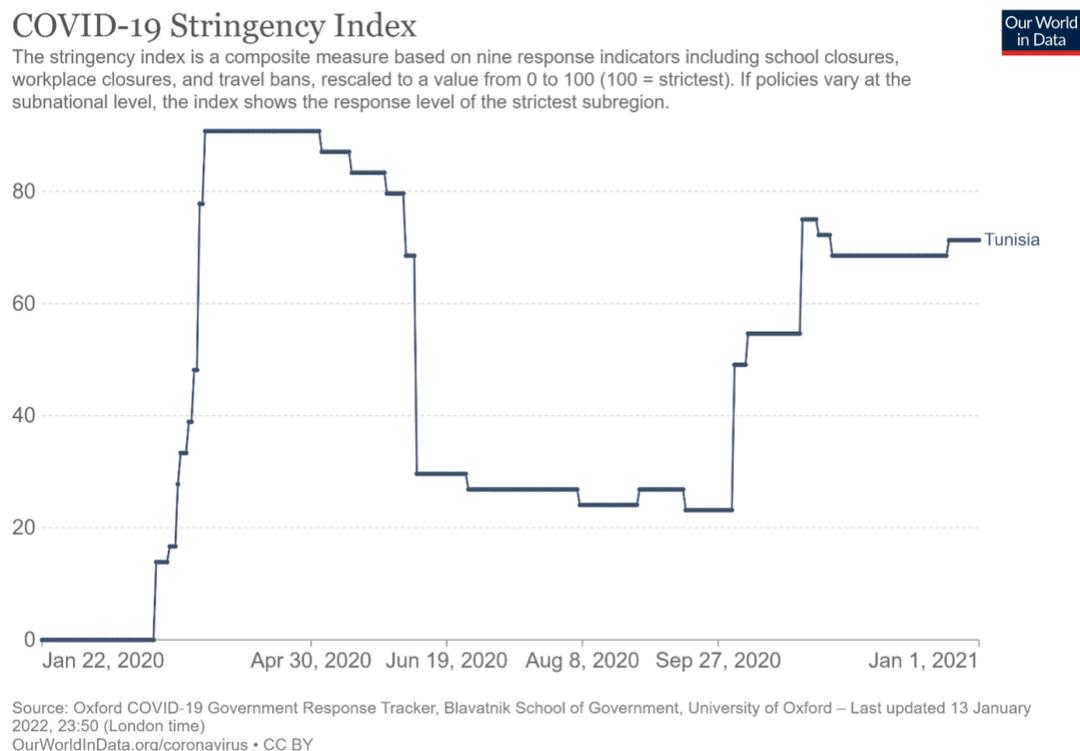
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national authorities, and on October 7, four governors demanded that the central government undertake stricter national measures to curb the spread of the virus. The governors proposed instituting a curfew from 8 p.m. to 5 a.m. daily and suspending Friday prayers in mosques so as to limit gatherings. The central government declined the requests.

It was not until late October, when daily new confirmed cases topped 1,000, that the Mechichi government decided to implement new national restrictions. The prime minister announced a ban on domestic travel, set a nationwide curfew, and made mask wearing mandatory.⁴³ The government’s policies were only slightly less stringent than those put in place during the initial response in March (figure 3).

Lack of central government transparency began disrupting essential partnerships between government and civil society. For example, civic groups, business associations, and unions had contributed resources to the 1818 fund and made other direct investments of time and money. In September, government officials announced that the 1818 fund had raised more than 200 million dinars—about US\$69 million—for allocation directly to COVID-19 relief. However, some of the statements regarding the way the government disbursed the money contradicted one another, which generated public suspicion that officials had mismanaged the funds.⁴⁴ Civil society organizations called for an audit, which began in April of the following year.

Figure 3: Stringency of Government Policies



RESULTS AND REFLECTIONS

Tunisia was able to limit COVID-19 transmission successfully during the first wave of 2020. The number of cases per million compared favorably with the numbers in other countries that also experienced relative success in preventing the spread of infection during that period. Although testing was limited—as it was almost everywhere—hospitals did not report becoming overwhelmed. The government initially imposed stringent measures—including lockdowns—but they were neither as severe nor as sustained as they were in China and other countries. The measures taken, together with a warm climate that enabled Tunisians to work and play outdoors, likely accounted for the favorable trends in Tunisia’s COVID-19 cases.

Moving to a hot-spot strategy, which required deft coordination with local governments and strong cooperation from residents, proved more difficult because of a combination of uneven local capacity, inconsistent or scrambled communication with members of the public and the media, low levels of public trust in all levels of government, and inadequate linkages between national implementers on one hand and local officials on the other. As a result, Tunisia had less success in preventing and containing its second wave. Its performance was nonetheless stronger than that of several comparable countries if measured in terms of the number of confirmed cases per million inhabitants, although it was unable to rapidly bring the second surge under control (figures 1 and 2).

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¹⁴ See <https://www.bbc.com/news/world-africa-42644326>

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