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The Landscape of Social Protection in Tunisia

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THE LANDSCAPE OF SOCIAL PROTECTION IN TUNISIA

Khaled Nasri,[1] Mohamed Amara,[2] and Imane Helmi[3]

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Abstract

This paper aims to provide a comprehensive overview of the social protection system in Tunisia based on discussions with policymakers and civil society actors as well as a document review of academic literature and reports produced by the government, international organizations, and other stakeholders. After presenting information on the economic, demographic, and social factors influencing social protection strategies in Tunisia, the first part of this paper covers the legal framework related to contributory social protection schemes in the public and private sectors. We also identify the coverage of these schemes, the contributions and benefits provided, and the conditions for granting these services. We then discuss the non-contributory system of social protection in Tunisia, particularly the Assistance to Needy Families program, the school allowance program, the free medical assistance program, energy and food subsidies, and the Amen Social program, among others. Finally, we identify the gaps in ensuring the delivery of social protection to all Tunisians, as well as the expectations of and recommendations for the civil society and international organizations and the key issues for moving forward.

Keywords: Social protection system, overview, strengths, challenges, Tunisia.
JEL Classifications: J1, I15, H2.

ملخص

تقدم هذه الورقة البحثية لمحة عامة عن نظام الحماية الاجتماعية التونسي بنظاميه القائمين على الاشتراكات وغير الاشتراكات. حيث تسلط الضوء في كلا النظامين على التقدم المحرز من حيث التغطية ومستوى الفوائد والنفقات، فضلا عن الثغرات التي لا يزال يتعين سدها. حيث تشدد الورقة أيضا على الجهود التي تبذلها الحكومة لحماية الفئات الأكثر ضعفا (من حيث الصحة والوظائف والدخل) في الاستجابة لجائحة كوفيد-19. تم تحديد عدد من التحديات، بما في ذلك خفض العجز في التمويل، وتحسين تغطية فعالة، والحد من أوجه عدم المساواة في الحصول على خدمات الرعاية الصحية، وتحسين فعالية البرامج المستهدفة غير القائمة على الاشتراكات، وتوسيع نطاق الدعم المقدم للعاطلين عن العمل وغيرهم من الفئات المستبعدة. ولمواجهة هذه التحديات، تقترح الورقة عدة توصيات عملية نوقشت مع خبراء الحماية الاجتماعية والأكاديميين والجهات الفاعلة المدنية. وبالتالي، فإن هذه الدراسة تأتي في الوقت المناسب وستعمل على إطلاع صناع القرار على بعض المسارات الممكنة لنظام حماية اجتماعية أكثر شمولا في تونس.

1. Introduction

Social protection is a fundamental human right connected to poverty reduction, economic development, and social peace (Merrien, 2013; Damon, 2016; Aleksynska et al., 2019). In this framework, Article 22 of the Universal Declaration of Human Rights of 1948 states that "everyone, as a member of society, has the right to social security." In this same vein, if the absolute number of people currently affected by human rights violations is taken as a benchmark, we find that there is a particularly wide gap in the rights to health and social security between what is legally required and what is actually implemented (Kaltenborn, 2020).

The International Labour Organization (ILO) also shows that despite significant progress in extending social protection in many parts of the world, the human right to social protection is not yet a reality for most of the world's population. Only 45 percent of the world's population is effectively covered by at least one social protection benefit, leaving 55 percent (four billion people) unprotected (ILO, 2017). Further, only 30 to 40 percent of MENA populations are covered by formal social protection systems, and large segments of the population are excluded, such as agricultural workers, the self-employed, and informal sector workers (Jawad, 2015).

Since its independence, Tunisia, like several countries in the Middle East and North Africa (MENA) region, has implemented a set of public measures based on a so-called "authoritarian bargain" social contract between the State and the society (Assaad, 2014; Devereux, 2015; Loewe and Jawad, 2018; El Haddad, 2020). Under this social contract and in exchange for political quiescence, the State offered free and universal services, such as healthcare and education, subsidized food and energy, and job guarantees in the public sector for graduates. However, this State-society relationship began to erode due to economic and structural reforms in the 1980s and 1990s. These reforms led to the hollowing out of the middle class, the concentration of poverty and unemployment in interior regions, and the emergence of the informal sector (Gelb and Marouani, 2020; Ben Cheikh and Moisseron, 2021). They led to the exclusion of a large portion of the population, including informal workers and the unemployed, from any form of formal social protection. These groups are considered vulnerable given their low resilience to shocks such as health crises and natural disasters. Ultimately, frustrations with the broken social contract fed into the social tension and gave rise to a popular revolution in 2010.

Despite the different social and economic entitlements anchored in the 2014 constitution, the implementation of a comprehensive and inclusive social protection system has remained a major challenge for Tunisia in the post-revolution period and in the context of the growing population and limited resources.

This paper aims to provide a comprehensive overview of the social protection system in Tunisia based on discussions with policymakers and civil society actors and a document review of

academic literature and reports produced by the government, international organizations, and other stakeholders.

This paper begins by presenting information on the economic, demographic, and social factors influencing social protection strategies in Tunisia. The second section covers the legal framework related to contributory social protection schemes in the public and private sectors, including the national pension and social insurance funds as well as the National Health Insurance Fund. We then identify the coverage of these funds, the contributions and benefits provided, and the conditions for granting these services. The third section discusses the non-contributory system of social protection in Tunisia, particularly the Assistance to Needy Families (PNAFN) program, the school allowance program, the free medical assistance (AMG) program, energy and food subsidies, and the Amen Social program, among others. We also provide details on different aspects of the programs, including target groups, targeting mechanisms, coverage, and design features. The fourth section identifies the gaps in ensuring the delivery of social protection to all Tunisians, as well as the expectations of and recommendations for the civil society and international organizations and the key issues for moving forward.

2. Background

2.1. Economic, demographic, and social factors influencing social protection strategies in Tunisia

The ILO Social Protection Floors Recommendation, 2012 (No. 202) is the first international standard on social protection floors reflecting an emerging international consensus on the crucial role of social protection in the promotion of human dignity, social cohesion, equality, and social justice as well as sustainable social and economic development (ILO, 2012). Such social protection systems, as defined by Recommendation 202, enable governments, especially those of developing countries, to reduce chronic poverty and promote inclusive growth more effectively and efficiently (Cashin, 1994; Perotti, 1994; OECD, 2019). It also strengthens the national capacity to respond to crises. Other studies suggest that the effect of social protection on economic growth and poverty reduction remains limited (Arjona et al., 2002; Atkinson, 1999; Hansson and Henrekson, 1994).

Although Recommendation 202 has become an international standard, each country is called upon to implement an approach that best suits its needs and capacities to make social protection a reality for all so that no one is left behind (ILO, 2017, p.8). Thus, the implementation of a social protection system, as defined by the ILO, largely depends on the economic, demographic, and social characteristics of each country. This section provides an overview of Tunisia's economic, demographic, and social achievements and progress in order to assess its ability to set up a social protection system that meets the main objectives of Recommendation 202.

Slow economic recovery will continue impacting the resilience of poor and near-poor households

Gross domestic product (GDP) growth in Tunisia has fluctuated substantially over the last two decades. It was 1.7 percent in 2002 and peaked in 2007 at 6.3 percent before slowing down significantly in 2008 (4.5 percent) and 2009 (3.1 percent) as a result of the global financial crisis coupled with the mining basin uprising.[4] The four to five percent annual GDP growth during the 2000s was mainly driven by strong public investment and domestic demand, combined with more dynamic exports and a significant increase in FDI inflows (World Bank, 2015). The average inflation rate, which was close to five percent in the 1990s, fell to less than three percent between 2000 and 2007. The budget deficit, as a percentage of the GDP, also decreased from an annual average of almost five percent in the 1980s to less than three percent between 2000 and 2008. Employment growth accelerated, leading to a decrease in unemployment from almost 17 percent in 2000 to 13 percent in 2010. Following the revolution on 14 January 2011, Tunisia was exposed to several internal and external shocks, which aggravated the already difficult social and economic situation. Growth in 2011 fell dramatically to -1.9 percent, and it did not exceed 2.5 percent over the entire period from 2011 to 2019 (except for 2012, where it reached 3.9 percent). Successive terrorist attacks and the disruption in Tunisia's phosphate production, which accounts for nearly 15 percent of the GDP, slowed growth from 2015 to 2017. With a GDP growth rate of 1.2 percent in 2015, Tunisia's economic recovery has been slow in comparison to Morocco (4.5 percent), Egypt (4.4 percent), Algeria (3.8 percent), and Jordan (2.4 percent) (IACE, 2017).[5] The external sector was marked by deterioration in the deficit of the balance of payments, reaching a record of 11.1 percent of the GDP in 2018 compared to 10.2 percent in 2017. Simultaneously, the rate of savings as a percentage of the GDP, which remains low compared to other MENA countries, has been almost frozen (nine percent of the gross national disposable income (GNDI) in 2018 compared to 8.9 percent in 2017), leading to a widening of the financial gap between investment and savings.[6] The COVID-19 pandemic has deepened existing challenges, and real GDP growth fell dramatically to -9.2 percent in 2020 (INS, 2020) (Figure 1).

[4] In early January 2008, following the announcement of the results of a recruitment competition of the Gafsa Phosphates Company, citizens of the main villages and towns of the mining centers of the region (Al-Mitlawi, Al-Rudayyif, Moularès, and Mdhilla) engaged in a series of protest actions for six months, leading to the detention of several hundred people and causing many injuries and three deaths.

[5] IACE (2017). Rapport sur la compétitivité de la Tunisie.

[6] Central Bank Annual Report, June 2019.

Figure 1. Real GDP growth rate (%) 2001-20 (year-on-year)

Source: Authors' calculations using INS data.[7]

Despite the difficult situation, Tunisia's social spending[8] has greatly increased from 9.846 billion Tunisian dinars (TND) in 2008 (17.82 percent of GDP) to TND 20.953.6 billion in 2018 (19.72 percent of GDP),[9] with key spending directed toward subsidies. The volume of subsidies administered by the General Compensation Fund (CGC, created in 1970) amounted to TND 4.788 billion in 2019 compared to only TND 1.5 billion in 2008.[10] This universal subsidy policy aims to stabilize price fluctuations, which are highly dependent on the prices of primary products in world markets. It also aims to maintain the purchasing power of the poorest and most vulnerable households. For its part, the Central Bank of Tunisia has spared no effort to stabilize prices and curb inflation.

In 2012, the base wage in the public and private sectors increased for almost all workforce categories before stabilizing in 2013 following a joint agreement between the Tunisian General Labor Union (UGTT), the Tunisian Union for Industry, Commerce, and Craftwork (UTICA), and the government as part of a policy of State spending rationalization and reduction. Wage negotiations between the government and its social partners were relaunched in 2014, which led to a six percent increase in the guaranteed interprofessional minimum wage (SMIG) for the 48-hour work week and a 5.8 percent increase for the 40-hour work week, amounting, respectively, to TND 319.904 and TND 274.559 per month (Central Bank, 2013).[11] Negotiations continued after 2014, giving rise to several wage raises, the most recent of which happened in December 2020 and set the SMIG at TND 429.312 per month for the 48-hour

[7] Tunisia National Account from 2000 to 2021.

[8] Social spending is defined as on-budget government spending on social protection (social insurance and social assistance), education, and health (IMF, 2019).

[9] Budget économique 2013-2019 (MDICI).

[10] Budget économique 2013-2019 (MDICI).

[11] The ratio between the minimum wage and the poverty line has reversed since the 2000s, falling from 140 percent in 1990 to around 65 percent in 2015 (CRES and BAD, 2017).

work week and TND 365.732 for the 40-hour work week.[12] The guaranteed minimum agricultural wage (SMAG) increased from TND 8.380 to TND 16.512 per day between 2010 and 2021, an increase of around 97 percent.[13] The monetary policy followed by the central bank in response to the depreciation of the currency and inflation pressures during the 2017-19 period has been successful in stabilizing prices (World Bank, 2021). Indeed, according to data from the National Institute of Statistics, the inflation rate remained stable at around 4.9 percent during the first quarter of 2021, after reaching 5.4 percent in October 2020 (Figure 2). This stagnation in the inflation rate is mainly the result of a decline in the price indices for food and non-alcoholic beverages (from 8.9 percent in May 2018 to 4.1 percent in March 2021) and transport (from 13.4 percent in November 2018 to 3.1 percent in March 2021). In contrast, the price index for health services increased by 8.1 percent by the end of the first half of 2021. However, an upward trend has been observed since May 2021 (the inflation rate increased from five percent in May 2021 to 6.4 percent in November 2021). It is important to note that part of this decrease in the inflation rate during 2019 and 2020 is due to disinflationary pressures caused by the rapid spread of COVID-19 and the multiplication of its shocks following the measures taken by the main developed economies to contain it (Central Bank, 2020).[14]

To measure the impact of inflation and price fluctuations on the level of welfare in Tunisia, we calculate purchasing power gains as the difference between the growth of gross disposable household income (GDHI) and the growth of the consumer price index (Figure 3).[15] If the growth rate of the GDHI increases faster than the growth rate of prices, the purchasing power increases. Figure 3 shows that after the 2000-10 period of stability, purchasing power experienced a slight decline from 2011, caused mainly by the increase in the inflation rate, especially during the three years following the 2011 revolution. It worsened after 2011 from five percent in 2010 to one percent in 2015 before rising by two percentage points in 2017 because of the increase in the GDHI (from six percent to eight percent between 2015 and 2017) and the stabilization of inflation.

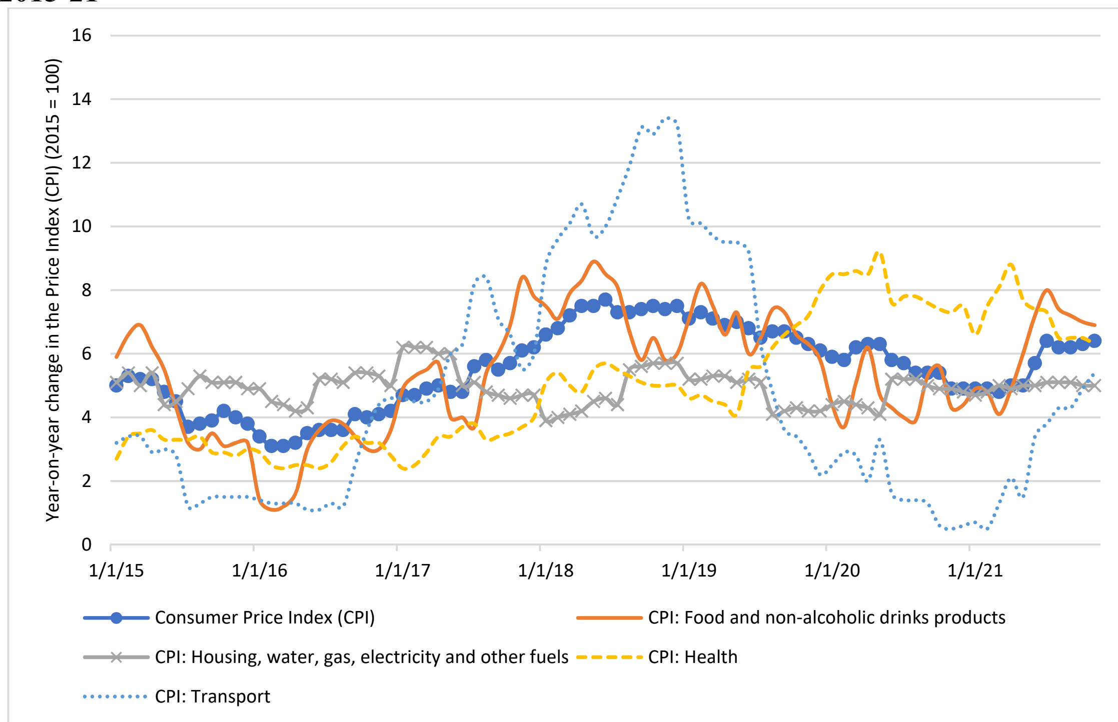
[12] Governmental Decree No. 2020-1069 of 30 December 2020, published on 5 January 2021 in the Official Journal of the Tunisian Republic (JORT).

[13] The SMIG is the minimum wage below which it is not possible to remunerate a worker for work that does not require a professional qualification (Article 134 of the Tunisian Labor Code). Minimum wages are set by government decree based on consultations with employers and employees (collective bargaining). These wages are applied to workers (without distinction of gender) at least 18 years of age in formal sectors. Young workers under 18 years of age cannot have a salary lower than 85 percent of that of adult workers.

[14] Between January and December 2020, inflation rates fell from 1.4 percent to -0.3 percent in the Eurozone, from 2.4 percent to 1.4 percent in the US, from 1.8 percent to 0.8 percent in the UK, from 0.7 percent to -1.4 percent in Japan, and from 5.4 percent to 0.2 percent in China (2020 Central Bank Report).

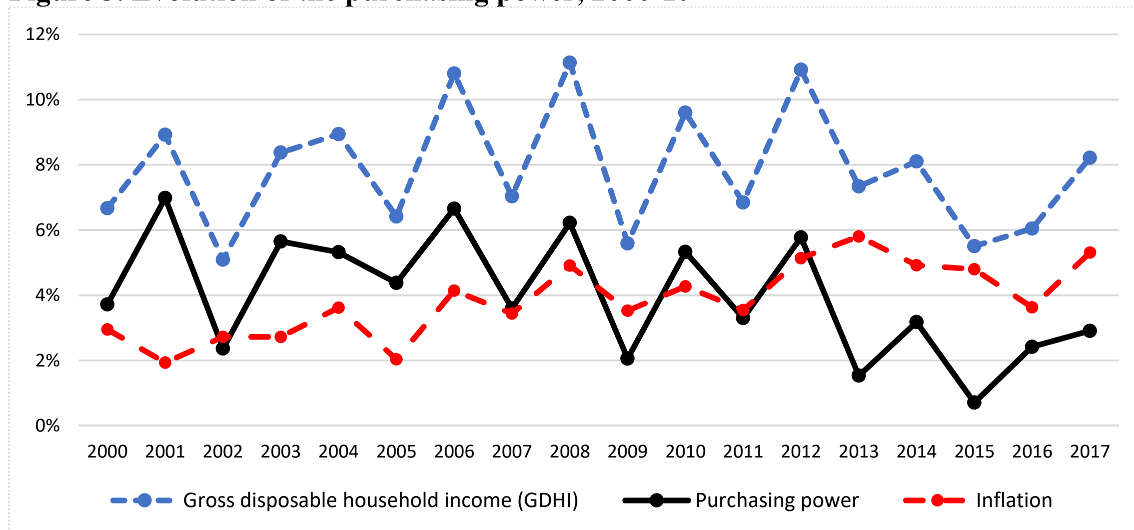
[15] We use the same methodology employed by Ayari et al. (2015) to calculate purchasing power.

Figure 2. Year-on-year percentage change (%) in the price index (CPI) (2015 = 100), 2015-21



Source: Authors' calculations using INS data on price index.

Figure 3. Evolution of the purchasing power, 2000-17



Source: Authors' calculations using INS data.

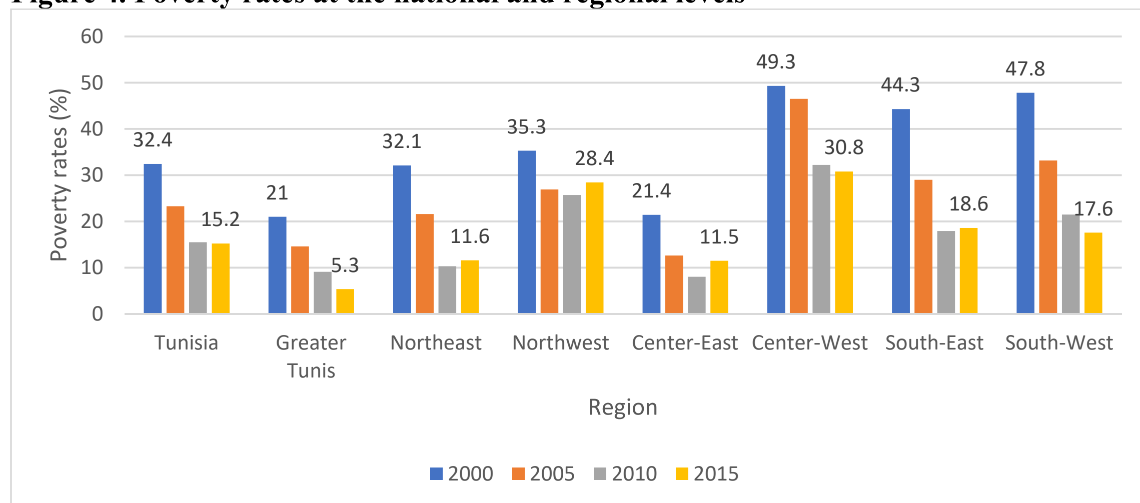
The decrease in poverty and inequality achieved in recent years is likely to be reversed due to the COVID-19 crisis

The GDP per capita at constant prices increased by 6.4 percent between 2010 and 2019, reaching TND 6,305. The poverty rate is constantly decreasing. It was 15.2 percent in 2015 compared to 23.3 percent in 2005 and 32.4 percent in 2000 (Figure 4). The extreme poverty indicator also shows a decrease from 12 percent in 2000 to 2.9 percent in 2015 (Figure 5).

Along with this decrease in income poverty, inequality also decreased between 2000 and 2015 from 37.5 percent to 32.8 percent. The share of national income held by the poorest 10 percent rose from 2.5 percent to 3.5 percent between 2000 and 2015, while the share held by the richest 10 percent fell from 31.6 percent to 25.6 percent over the same period (Boughzala et al., 2020). However, despite the significant reduction in poverty at the national level, rural areas continue to have more than double the poverty rates of urban areas (26 percent versus 10.1 percent in 2015). In addition, the interior and southern regions of the country are much more affected by poverty than the relatively more prosperous coastal regions (Nasri and Belhadj, 2017). For example, the poverty rate reached 22.4 percent in the governorate of Jendouba and exceeded 34 percent in Kairouan (the highest level in the country in 2015).

The decrease in poverty and inequality achieved in recent years is likely to be reversed due to the COVID-19 crisis. A series of telephone interviews conducted jointly by the National Institute of Statistics and the World Bank show that the poorest households have reduced their food consumption (World Bank, 2021).[16] The results also show that more than half of households report worsening living standards relative to the pre-pandemic period, and for around 40 percent of the poorest, welfare levels have continued to deteriorate. In addition, extreme poverty – measured using the international poverty line of USD 1.9 purchasing power parity (PPP) – is expected to remain below one percent throughout 2023, while that measured using the USD 3.2 PPP line will not return to the pre-crisis level of 2.9 percent; declining to 3.4 percent in 2021 compared to 3.7 percent in 2020 (World Bank, 2021). In Tunisia, income declines were similar (20 to 23 percent) for workers in both the formal and informal private sector. The decline in the income of private sector workers risks increasing poverty and inequality in Tunisia.

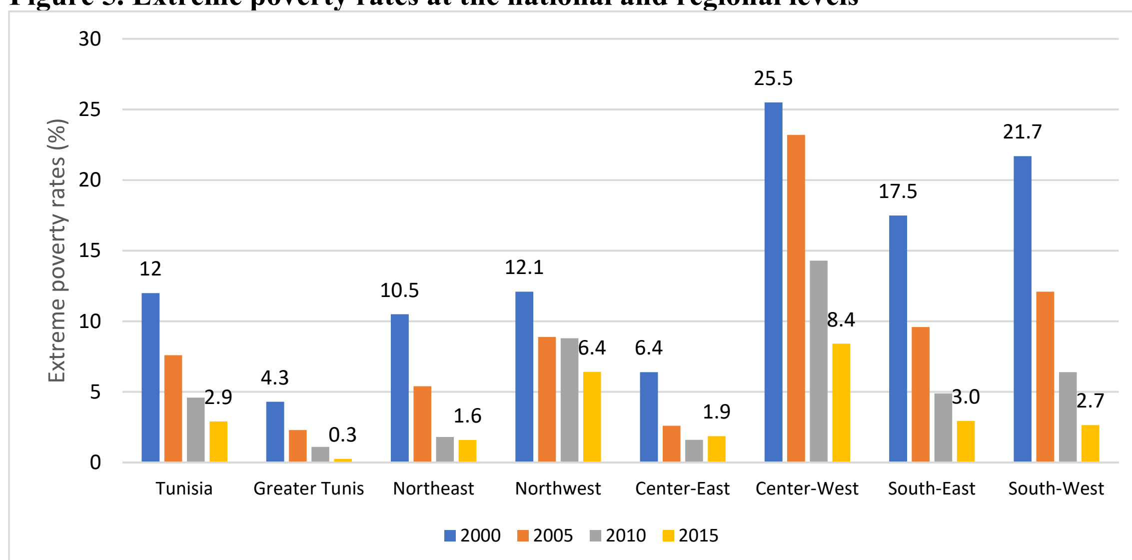
Figure 4. Poverty rates at the national and regional levels



Source: Authors' calculations using INS data.

[16] World Bank (2021). Tunisia's Economic Update, April 2021.

Figure 5. Extreme poverty rates at the national and regional levels



Source: Authors' calculations using INS data.

Economic participation and unemployment

Like most of the non-oil MENA countries,[17] Tunisia suffers from high unemployment, which mostly affects university graduates and young and educated women (Haouas et al., 2012; World Bank, 2014b; Assaad et al., 2016). After peaking at 18 percent following the socio-political upheavals of 2011, the unemployment rate fell slightly to stabilize at around 15 percent in the first quarter of 2020 before rising again to 18 percent in the second quarter of 2020. The shutdown of many companies after the revolution (due to frequent strikes and subsequent instability), the relocation of some multinational firms to Morocco, and the return of Tunisian workers who were employed in Libya may explain the sharp rise in the unemployment rate in 2011. Unsurprisingly, the COVID-19 pandemic further increased the unemployment rate from 15 percent to 18 percent (the second peak) in the second quarter of 2020, returning to the levels seen during the 2011 revolution. In fact, the pandemic resulted in the loss of 69,300 jobs due to lockdowns, of which 29,000 people have not gone back to work even after their employers resumed their activities. The number of unemployed workers in the total labor force in the third quarter of 2021 is estimated at 762.6 thousand, compared to 746.4 thousand in the first quarter of 2021. The unemployment rate reached 18.4 percent compared to 17.9 percent in the second quarter (INS, 2021).[18] This loss of employment caused by the pandemic is mainly observed in the private sector. A recent study by Krafft et al. (2021) on the impact of COVID-19 on MENA labor markets shows that, in general, public sector workers experienced fewer difficulties compared to those in the private sector. In Tunisia and Egypt, layoffs affected 29 percent of private sector employees, compared to 11 percent in Jordan.

[17] Egypt, Jordan, Lebanon, Morocco, Syrian Arab Republic, Tunisia, and Yemen

[18] INS (2021). Indicateurs de l'emploi et du chômage, troisième trimestre 2021.

Higher education graduates, particularly women, are more affected by unemployment. In 2011, the unemployment rate among higher education graduates was 33.6 percent. This rate gradually declined but remained high in 2019 at 28 percent, with a 1.6 percent increase in the gap between men and women. One possible reason for the high rate of graduate unemployment is that the Tunisian education system is still unable to meet the needs of the private sector (skill mismatch) and the public sector is saturated (650 thousand employees in 2012, which represents 22.8 percent of the labor force). A second reason concerns the weak demand for skilled labor, which characterizes not only the Tunisian labor market, but also most of the MENA countries.[19] In addition to these constraints (on both the supply and demand sides), the Tunisian labor market suffers from an increase in the informal sector, which directly impacts the quality of work and reduces the participation rate in the formal labor market, especially for women. According to the 2019 National Employment and Population Survey conducted by the National Institute of Statistics, of the 3.566 million employees, 1.598 million are employed in the informal sector (44.8 percent, and 38.3 percent if we exclude the agricultural sector).

Women's participation in the labor market remains low, not exceeding 27 percent and less than 19 percent for married women, even though they represent more than two-thirds of higher education graduates. Women's low participation in the labor market is mainly caused by patriarchal social norms that impose a gendered pattern of time use within the family. Women are expected to prioritize unpaid domestic work and family care, which makes it difficult for them to find time to engage in income-generating activities outside the home (El Lahga and Amara, 2020).

Unemployment and economic participation are also characterized by strong regional disparities between coastal and non-coastal areas. In the coastal areas, the unemployment rate declined from 12.5 percent in 1980 to 10.9 percent in 2010, but it increased by almost two percentage points (from 15.2 percent to 17 percent) during the same period in non-coastal areas. Following the 2011 revolution, the gap between the regions became even greater. According to the Tunisia Population and Housing Census 2014, the unemployment rate stands at 25.5 percent for the governorate of Jendouba in the North West Region, compared to only 9.1 percent for the coastal governorate of Monastir. In addition, regions that are lagging such as Tataouine, Kasserine, and Kairouan display low levels of female labor participation (18.5 percent, 19.7 percent, and 19.7 percent, respectively) compared to leading coastal regions (Sousse (34 percent) and Ariana (37 percent)).

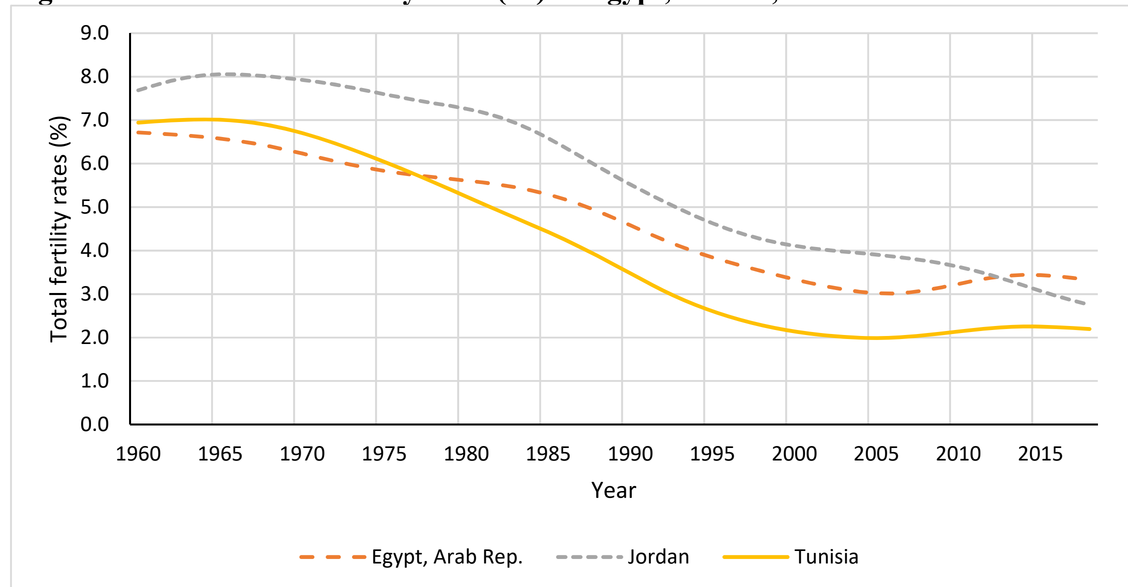
Population growth

The age structure of the population is fundamental to understanding the dynamics of social protection in Tunisia, and it is also closely linked to how the workforce has expanded. Considerable efforts have been put into implementing sectoral policies (health and education, among others) at the legal and institutional levels to curb population growth, promote fertility

[19] See Assaad et al. (2018) for a comparison study on the mismatch between the output of the higher education system and the needs of the labor market in Egypt and Jordan.

control, and reduce the urban-rural gap. In addition to achievements in health, education, employment, social security, and regional development, a national family planning program has been implemented since 1966. The first in African and Arab countries, this program has enabled Tunisia to reduce its fertility rate. Peaking at more than seven children per woman in 1965, the fertility rate decreased below two children per woman 40 years later, placing Tunisia among the countries with rapid demographic transition and at the top of those with similar income levels in the MENA region, such as Jordan and Egypt (Figure 6) (Amara, 2015).

Figure 6. Trend in total fertility rates (%) in Egypt, Jordan, and Tunisia



Source: Author's calculations with data from the World Development Indicators (WDI).

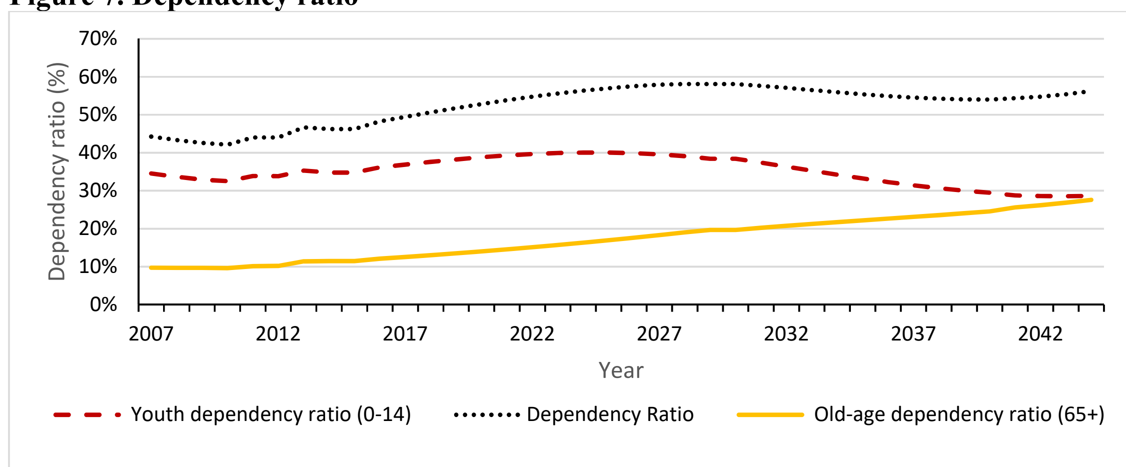
According to the most recent estimates of the National Institute of Statistics, Tunisia had a population of around 11.72 million in 2019, almost two-thirds of whom lived in urban areas. The percentage of the population living in urban areas increased from 61 percent in 1994 to 67.7 percent in 2014. Historically, the total annual population growth rate increased rapidly between 1960 and 1983, rising from 1.28 percent to 2.88 percent. Since the year 2000, it has declined to less than one percent, reaching its lowest level in 2003 (0.75 percent) and increasing again to 1.15 percent in 2018.

The decrease in the population growth rate indicates major changes in the age structure of the population. According to INS statistics, the share of the population that is working age (15-64 years) decreased from approximately 73 percent in 2010 to 66 percent in 2019 (INS, 2015). This decrease was the result of a substantial drop in the proportion of youth (aged 15-29) against a slight increase in the share of the 30-44 and 45-64 age groups. Indeed, from 2010 to 2019, the population share of youth dropped from 32 percent to 21.5 percent, while that of individuals aged 30-44 and 45-64 increased slightly from 22 percent to 23 percent and from 19 percent to 22 percent, respectively. The shrinking of the working-age population, specifically youth, combined with decreasing fertility and mortality rates, shows that Tunisia has reached the final stage of the demographic transition, known as the demographic dividend. This stage

occurs when a falling birth rate changes the age distribution (Bloom et al., 2003; Bloom and Freeman, 1986; Bloom and Williamson, 1998; Boom et al., 2017).

According to the most recent population projections for Tunisia, a quasi-doubling of the old-age dependency ratio (the ratio of the population aged 65 years or over to the population aged 15-64) is expected by the year 2044 (from 14 percent in 2020 to 28 percent in 2044) compared to a downward trend in the dependency ratio of young people under 14 years of age (from 39 percent in 2020 to 29 percent in 2044), as shown in Figure 7. This aging process inevitably creates significant budgetary constraints in terms of social protection and health spending.[20]

Figure 7. Dependency ratio



Source: Authors' calculations using INS data.

2.2. The current state of social protection in Tunisia

Social protection and health rights in the Tunisian constitution

Tunisian legislation places the country in the vanguard in regards to the protection of vulnerable groups (children, children without family support, women in rural areas…etc.) and those with special needs (the elderly, the handicapped…etc.). The inclusion of social protection and health rights in the constitution is a major guarantee of their promotion given that the provisions of the constitution are the highest form of Tunisian legislation. Ratified on 27 January 2014, the new constitution recognizes a vast list of rights related to health (Article 38); education (Article 39);[21] work (Article 40); the rights of children, women, and the disabled (Articles 46, 47, and 48);[22] and the principles of social justice, sustainable development, and positive discrimination (Article 12). Compared to its predecessor, the new constitution undoubtedly gives greater prominence to health and issues directly or indirectly related to it, including human dignity. It also emphasizes the importance of adopting a human rights-based

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[20] See Karshenas et al. (2014) and Kuhn (2012) for the consequences of the demographic transition on the development of social protection in the selected MENA countries.

[21] See the Education and School Education Orientation Law, 2002-30 of 23 July 2002.

[22] See the Child Protection Code (1995), Law no. 98-75 of 28 October 1998 and Law no. 2003-51 of 7 July 2003 relating to children without family support, abandoned, or of unknown parentage. Orientation Law no. 2005-83 of 15 August 2005 includes seven decrees and six orders relating to disabled persons.

approach in care management methods. In particular, Article 38 states that "every human being has the right to health. The State shall guarantee prevention and health care to all citizens and provide the necessary means for the safety and quality of health services."

Tunisia's International commitments in terms of social protection

Tunisia is doing well in terms of the legal aspects of social protection. It has ratified several international instruments, including human rights,[23] prevention of discrimination,[24] health,[25] access to education,[26] rights of the child,[27] and employment and forced labor.[28] In addition, the adherence of Tunisia to the standards of the International Labour Organization (ILO) on 12 June 1956 reflects a deep commitment to the guidelines, principles, and objectives of the ILO. Even before that date, Tunisia ratified ILO Convention no. 19 on equality of treatment on 25 March 1930. Until 2019, Tunisia ratified 63 international labor conventions, including eight conventions on fundamental rights at work. This commitment of the State has contributed to the promotion of these rights and the creation of decent work opportunities, as well as the reduction of disparities between social categories and the revaluation of work as a civilizational and human value. Overall, Tunisia is ranked first in terms of adherence to the international standards of social dialogue compared to its neighboring Arab states in the MENA region. Its average ratification rate is 82 percent, compared to 73 percent and 45 percent for Morocco and Jordan, respectively (Ben Sedrine, 2017). Tunisia ratified all the conventions related to freedom of association and collective bargaining, except the Rural Workers' Organizations Convention, 1975 (no. 141).

Recently, the Tunisian government officially adopted the Sustainable Development Goals (SDGs) adopted by the United Nations General Assembly in September 2015. According to the latest report published by the Center for Sustainable Development Goals for Africa in 2020, Tunisia is ranked first in Africa out of 52 countries in the field of achieving sustainable development goals (SDGs).[29] The report states that Tunisia's SDG achievement rate reached 67.1 percent, ahead of Mauritius (66.8 percent), Morocco (66.3 percent), Algeria (65.9 percent), and the average of the rest of the African countries (53.8 percent).

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[23] International Covenant of Economic, Social and Cultural Rights, 18 March 1969.

[24] International Convention on the Elimination of all Forms of Racial Discrimination, 13 January 1987; Convention on the Elimination of all Forms of Discrimination against Women, 20 September 1985.

[25] International Covenant of Economic, Social, and Cultural Rights, 18 March 1969. Article 12 of this convention stipulates that "States' Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."

[26] Convention Against Discrimination in Education, 29 August 1969.

[27] Convention on the Rights of the Child, 30 January 1992; Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflicts, 2 January 2003; Conventional concerning the Prohibition and Immediate Action for the Elimination of the Worst Forms of Child Labor, 28 February 2000.

[28] Convention concerning Forced or Compulsory Labor, 17 December 1962; Equal Remuneration Convention, 11 October 1968; Abolition of Forced Labor Convention, 12 January 1959; Discrimination (employment and occupation) Convention, 14 September 1959; and Employment Policy Convention, 17 February 1966.

[29] The Sustainable Development Goals Center for Africa and Sustainable Development Solutions Network (2020): Africa SDG Index and Dashboards Report 2020. Kigali and New York: SDG Center for Africa and Sustainable Development Solutions Network.

Programs, actors, and stakeholders

The government and its centralized and decentralized structures remain the main actors in social protection in Tunisia. The main social protection programs are under the control of the Ministry of Local Affairs, which coordinates with other ministries for the provision of services related to these programs (such as the Ministry of Health, the Ministry of Education, and the Ministry of Women). Tunisia has set up a network of social protection institutions distributed across the entire Tunisian territory[30] and provides all kinds of assistance (medical, psychological, social conditions…etc.) for all categories with special needs.[31]

The role played by the government does not exclude the role of civil society organizations, non-governmental organizations (civil society, associations), and donors (the United Nations Development Programme (UNDP), the World Health Organization (WHO), and the World Bank) in providing financial and technical support (Hagerman, 2015).

UNDP support for Tunisia focuses on three priorities: (1) democratic governance; (2) an inclusive, sustainable, and resilient economic model; and (3) social protection and equitable access to quality social services. With the support of the WHO and the European Union (EU), Tunisia implemented a health sector reform. The priorities of this reform are to improve the sector, strengthen primary care capacities, particularly in disadvantaged areas, and take charge of non-transmissible diseases linked to the demographic transition.

A grant titled *Support for Social Protection Reforms in Tunisia* was signed by the World Bank and the Tunisian government on 5 November 2013 to support inclusive growth and poverty reduction efforts in Tunisia. The grant aims to strengthen the institutional capacity to design social protection reforms and improve the targeting of safety net programs (Hagerman, 2015).

Social spending over time compared to relevant selected countries

Tunisia's public expenditure on social protection was 10.4 percent[32] of the GDP in 2011 (CRES, 2015),[33] which was slightly higher than the regional average of nine percent for North

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[30] Decree no. 2011-4650 of 10 December 2011 establishing the organization and powers of the regional directions of social affairs.

[31] According to the 2014 annual social statistics of the Ministry of Social Affairs, in 2014, the network of social protection included 20 social defense and integration centers; three social supervision and orientation centers; one social observation center for delinquent children; 295 special education, rehabilitation, and vocational training institutions for the disabled managed by associations for the disabled; three housing centers for the disabled without family support; and 12 living units for children without family support managed by civil society associations. For more details, see Law no. 93-109 of 8 November 1993, fixing the attributions of the centers of social defense; decree no. 2000-1449 of 27 June 2000 on the administrative and financial organization and operating procedures of social defense and integration centers and their advisory councils; and Article 2 of Law no. 2001-74 of 11 July 2001 related to the social protection centers.

[32] Social protection expenditure for children (0.15 percent); social assistance (0.7 percent); public social protection expenditure for working-age people (excluding social assistance) (3.36 percent); public social protection expenditure for the elderly (4.7 percent); and public health expenditure (1.5 percent).

[33] CRES (2015). Les socles nationaux de protection sociale: Emergence du concept, meilleures pratiques internationales et pertinence pour la Tunisie, La Lettre du CRES, No. 7, December 2015.

Africa (Hagerman, 2015). According to the latest available ILO statistics, the expenditure on social protection, including health, was 11.7 percent of the GDP in 2020 and 7.5 percent when excluding the portion directed to public healthcare (Table 1). With the exception of Algeria, which spends 13 percent of its GDP on social protection, Tunisian public spending on social protection is considered generous compared to other Arab countries in the MENA region (Table 1). These expenditures cover the following programs: employment injury, maternity benefits, old age benefits, health coverage, income support, and school feeding (Hagerman, 2015). More details on these programs will be presented in the next two sections.

Table 1. Expenditures on social protection and health as percentage of GDP, for selected countries

Country name	Sub-region_ILO	Income level	Expenditure on social protection, % of GDP (excl healthcare), latest available year (1)	2018 domestic general government health expenditure (GGHE-D) % of GDP, WHO (2)	Total expenditure on social protection, % of GDP (1 + 2)	Expenditure source
Algeria	NA	UMI	8.9	4.1	13	ILO/National
Egypt	NA	LMI	9.5	1.4	10.9	IMF
Morocco	NA	LMI	4.5	2.1	6.6	ILO
Sudan	NA	LMI	0.7	1.0	1.7	ILO/National
Tunisia	NA	UMI	7.5	4.2	11.7	ILO/National
Jordan	AS	UMI	5.7	3.8	9.5	IMF
Yemen	AS	LMI	7.1	0.0	7.1	IMF
Arab States (2020)			3.5	3.2	6.7	
Africa (2020)			3.8	2.0	5.8	
World (2020)			12.9	5.8	18.7	

Source: ILO, World Social Protection Database. https://www.social-protection.org/gimi/WSPDB.action?id=40
Note: NA: Northern Africa, AS: Arab States, UMI: Upper-middle income, LMI: Lower-middle income.

Tunisia is well advanced in terms of effective social protection coverage compared to other countries in the MENA region. Table 2 shows that 85.4 percent of older persons in Tunisia are protected by social protection systems compared to 63.6 percent for Algeria, 60 percent for Jordan, and 57.6 percent for Egypt. In addition, 74.9 percent of the labor force (active contributions) are covered by a pension scheme, compared to 52.5 percent for Jordan and 47 percent for Egypt. In terms of universal health coverage (UHC) that provides effective access to at least essential care, including long-term care (LTC), Tunisia shares the third position with Morocco (70 percent) after Algeria (78 percent) and Jordan (76 percent). Tunisia should, however, focus on improving the coverage of social protection for workers in case of workplace injuries and those with severe disabilities. Only 28.9 percent of workers are protected by Tunisian social protection systems in case of workplace injuries (compared to 57.5 percent in Jordan, 53.8 percent in Algeria, 39 percent in Morocco, and 39 percent in Egypt). Moreover, only five percent of people with severe disabilities are protected (compared to 37 percent in Egypt and 20 percent in Jordan).

Table 2. Social protection effective coverage, 2020 or latest available year (%)

	SDG 1.3.1	People protected by social protection systems								SDG 3.8.1
Country name	Population covered by at least one social protection benefit (excluding health)	Children	Mothers with newborns	Workers in case of workplace injury	Persons with severe disabilities	Unemployed	Older persons	Labor force covered by pension scheme (active contributors)	Vulnerable persons covered by social assistance	Universal health coverage (UHC)
Algeria			11.2	53.8	3.6	8.8	63.6	41		78
Egypt	34.7	14		36	37	0.1	57.6	47	19.9	68
Morocco	20.5	13.4		39	6.8		23.4	38		70
Sudan	9.3	8.1	4.2	3	0.7	0	9.4	4	7.4	44
Tunisia	50.2	28.6	25.3	28.9	5	3	85.4	74.9	21.3	70
Jordan	27.8	8.8	4.8	57.5	20	5.3	60	52.5	9.7	76
Yemen	2.8	0		9.9	0.1	0	7.4	10.2	0	42
Arab States (2020)	40	15.4*	12.2	63.5	7.2	8.7*	24	29.2	32.2	63.5
Africa (2020)	17.4	12.6	14.9	18.4	9.3	5.3	27.1	13.4	9.3	47.9
World (2020)	46.9	26.4	44.9	35.4	33.5	18.6	77.5	53.7	28.9	66

* To be interpreted with caution. Estimates are based on reported data covering less than 40 percent of the population

Source: ILO, World Social Protection Database. https://www.social-protection.org/gimi/WSPDB.action?id=40.

Section Two: Overview of social protection contributory schemes in Tunisia

1. Contributory social insurance system in Tunisia: Private and public sectors[34]

In Tunisia, the contributory social insurance for pension and other kinds of benefits differs in the public and private sectors and is implemented through two schemes managed by two distinct funds. The National Pension and Social Insurance Fund (CNRPS)[35] covers the public sector, while the National Social Security Fund (CNSS)[36] serves the private sector. Both funds are run by the Ministry of Social Affairs (MAS).

1.1. Overview of the national pension and social insurance funds (CNRPS and CNSS)

The CNRPS was created in 1975 and has civil personality and financial autonomy. Its administrative board is composed of a chairman, a chief executive officer, and 12 administrators. The CNRPS covers permanent, temporary, seasonal, and casual workers in the public sector. The total spending of the CNRPS increased from TND 1.778 billion (i.e., the equivalent of 2.8 percent of the GDP in 2010) to TND 4.949 billion (i.e., the equivalent of 4.7 percent of the GDP in 2018). The contribution rate to the CNRPS under the general pension scheme is 23.7 percent[37] of employee wages, of which 14.5 percent is paid by the employer[38] and 9.2 percent by the employee. Contributions are paid either monthly or quarterly. It is worth

[34] All information is derived from the legal texts initiating and organizing social funds in Tunisia. The initial texts were amended and/or supplemented by several legal texts.

[35] Caisse nationale de retraite et de prévoyance sociale (CNRPS).

[36] Caisse nationale de sécurité sociale (CNSS).

[37] This contribution rate is exclusively payable by the employee if they are working abroad (under the technical cooperation framework) with remuneration greater than or equal to double that obtained in Tunisia before the secondment.

[38] The employer can be the State, State-owned enterprises, or non-administrative public establishments.

noting that the CNRPS also covers members of government and governors, members of Parliament, and former members of the House of Councilors through the special retirement scheme. In this scheme, the contribution rate is 33.7 percent, 20.5 percent of which is paid by the State and 13.2 percent of which is paid by the affiliates. On the other hand, private sector employees are covered by the CNSS fund. The CNSS was established under Act no. 60-30 of 14 December 1960. Although the CNSS is a public establishment with civil personality and financial autonomy, it is overseen by the Ministry of Social Affairs. The CNSS has an administrative board whose members are appointed on a tripartite basis: three members represent the State, four members represent the most representative employers' organizations,[39] and four members represent the most representative trade union organizations.[40] The CNSS covers workers in the private sector against a range of risks including old age, disability, and accidents at work and occupational injuries (but those two can be voluntary in some schemes). A number of schemes exist under the CNSS fund and they vary in terms of contributions according to the individual's occupation as presented in Table 3.

Table 3. Contribution rates for the CNSS schemes

CNSS Affiliates	Type of risk covered	Contributions	Contribution base	Participation method
Non-agricultural private-sector scheme	• Old age and disability • Accidents at work and occupational injuries	• 25.75% (employer 16.57% and employee 9.18%). • (0.4%, 4%) Employer	➢ All elements of the employee's salary	• Mandatory and paid quarterly
Employees in the agricultural sector	• Old age and disability • Accidents at work and occupational injuries	• (12.29%, 19.47%) • (0.6%, 0.8%)	➢ All elements of the employee's salary or the lumpsum wage[41]	• Mandatory and paid quarterly
Employees in the fishing sector	• Old age and disability • Accidents at work and occupational injuries	• (19.47%, 25.75%) • (0.6%, 0.8%)	➢ All elements of the employee's salary	• Mandatory and paid quarterly
Self-employed, including in agriculture	• Old age and disability • Accidents at work and occupational injuries	• 14.71% • (0.5%, 0.6%)	➢ Lumpsum income[42]	• Mandatory and paid quarterly • Optional
Domestic and site workers and low-income earners	• Old age and disability • Accidents at work and occupational injuries	• 7.5%, between employer 5% and the employee 2.5% • (0.5%, 1%)	➢ 2/3 of the SMAG (SMIG)	• Mandatory and paid monthly or quarterly • Optional for low-income earners
Tunisians living and working abroad	• Old age and disability	• 13.30%	➢ Individual's earnings	• Optional and paid quarterly
Students and interns	• Accidents at work and occupational injuries	• Sum of TND 5	➢ Symbolic payment	• Mandatory and paid per year
Artists, intellectuals, and creators	• Old age and disability • Accidents at work and occupational injuries	• 14.71% • (0.5%, 0.6%)	➢ Lumpsum income	• Mandatory and paid quarterly • Optional

Source: Compiled by the authors based on legal texts organizing social funds in Tunisia.

[39] Tunisian Confederation of Industry, Trade, and Handicrafts (known as UTICA).

[40] Tunisian General Labor Union (known as UGTT).

[41] Lumpsum wage calculated on the basis of the guaranteed minimum agricultural (interprofessional) wage, SMAG (SMIG).

[42] Lumpsum income determined on the basis of the guaranteed minimum interprofessional wage (SMIG) linked to the 48-hour work week scheme.

All salaried employees in the non-agricultural sector are covered by the CNSS social insurance scheme. Participation in this scheme is mandatory, with a contribution rate set at 25.75 percent. For this group, the contribution to the workplace accidents and occupational disease scheme varies between 0.4 and four percent depending on economic activity. However, some employees in the non-agricultural sector can participate in a supplementary pension scheme[43] as well.

The CNSS also provides social insurance to agricultural employees working in cooperatives or associations with at least 30 permanent workers. In this scheme, the contribution rate is 19.47 percent. If agricultural employees work for at least 45 days during a quarter with the same employer, the rate is set at 12.29 percent of a lumpsum wage. In the fishing sector, the CNSS provides social security to ship owners and fishermen. The contribution rates in this scheme vary between 19.47 percent and 25.75 percent according to the gauge of the boat. The contribution rate for the accidents at work and occupational diseases scheme is exclusively payable by employers. This rate is set at 0.6 percent of the declared salary.

The CNSS also provides a mandatory social insurance scheme for the self-employed workforce. The contribution in this scheme is set at 14.71 percent. For this group, membership in the accident at work scheme is optional.

The CNSS also covers domestic workers and site workers along with low-income earners. This coverage is mandatory, and the contribution is set at 7.5 percent of two-thirds of the SMAG (or SMIG). The rate of contribution under the compensation scheme for damages resulting from workplace accidents and occupational diseases for employees in domestic work is mandatory and exclusively payable by the employer. However, the participation of low-income earners in this scheme is optional.

Individuals engaged in artistic and creative cultural activities on a full-time basis are covered by the CNSS if they are not enrolled in another social insurance scheme. Contributions to this scheme are paid at a rate of 14.71 percent of the artist's earnings. Membership in the workplace accident scheme is optional, and the related contribution rate is set at 0.5 percent of the income of the insured.

Tunisians living and working abroad who are not covered by a bilateral social security agreement may enroll in a social insurance scheme under the CNSS. The level of contribution is 13.3 percent of the individual's earnings, paid quarterly.

[43] This CNSS supplementary pension scheme mitigates the loss of income observed following retirement for employees whose remuneration is greater than six times the guaranteed minimum inter-professional wage (SMIG) per year. Participation in this scheme is optional and the contribution is set at nine percent.

The CNSS also covers students and interns against the risks caused by accidents at work and occupational diseases. The student or trainee must pay TND five per year.

1.2. Different kinds of benefits and conditionality

Social security benefits are provided according to the specificities of each scheme in each sector. In the public sector, workers receive old age, disability, and survivorship pensions. In addition to death grants and family benefits, public sector workers are insured for workplace injuries and illnesses. Further, the CNRPS provides its members with other benefits, such as support benefits and temporary pensions for orphans.

Civilian State employees receive pension benefits upon retirement[44] and completion of the minimum period of service required. In Tunisia, the legal retirement age is set at 62 years for all categories of staff, and it is set at 57 years for active staff and workers who perform painful tasks or ones that cause health risks. The minimum length of service required to receive a retirement pension is set at 10 years for casual workers and 15 years for other categories of staff. In the case of military pensions, the age of retirement is 52 for soldiers and it increases with rank, going up to 62 for senior officers and generals. In addition, the military has the right to retire early, with immediate pension benefits in the event of physical incapacity, regardless of their age and effective seniority.

Pension benefits are calculated as a percentage of the reference salary (employee's end-of-career salary, based on which they have paid contributions for at least two years). Pension benefits represent 0.5 percent of the reference salary for each quarter during the first 10 years of contribution (i.e., equivalent to two percent per year) and 0.75 percent per quarter for the 10 years after that (i.e., equivalent to three percent per year). For other years, another 0.5 percent per quarter is added (i.e., equivalent to two percent per year). In no case must the pension exceed 90 percent of the reference salary on which contributions were paid or be less than two-thirds of the guaranteed minimum interprofessional wage (SMIG).

Under certain conditions, such as if the insured individual has stopped working while having achieved seniority (work experience) of at least five years, then they can opt for the benefit of an old-age allowance at the legal retirement age. The old-age allowance is equivalent to 50 percent of the guaranteed minimum interprofessional wage (SMIG).

[44] In Tunisia, retirement occurs in the event of completion of the legal retirement age, resignation, invalidity, request by the employee, job cuts initiated by the employer, professional insufficiency or dismissal, retirement application by a mother with at least three children whose age has not exceeded 20 years, or retirement application by a mother with a child having a severe disability.

Table 4. Social security benefits in the public sector

Type of benefit		Eligibility conditions	Liquidation basis
Pension benefits		• Legal retirement age: 62 years (57 years, for painful tasks or ones with health risks). • Minimum length of service required: 10 years for casual workers, 15 years for other categories.	➢ Percentage of end-career salary: Two percent per year for the first 10 years in addition to three percent per year for the 10 years after that and two percent per year for other years.
Old age allowance		• Legal retirement age: 62 years. • Agents have stopped working and achieved seniority (work experience) of at least five years.	➢ 50 percent of the guaranteed minimum interprofessional wage (SMIG).
The surviving spouse's pension		• Death of the insured person.	➢ 75 percent of the retirement pension of the deceased spouse (reduced according to the number of children).
Temporary pension for orphans		• Orphans up to the age of 21 (up to 25 for students) and disabled orphans. • Orphans who are unmarried or divorced women deprived of resources.	➢ Varies from 10 percent to 50 percent of the retirement pension according to the number of orphans.
Death benefit		• Non-divorced spouse of the deceased member. • Dependent children. • Dependent ascendants aged 55 or above.	➢ The sum of the annual remuneration (basis for the payment of retirement pension) and a remuneration for one month, increased by 10 percent for each dependent child and doubles if the death results from an accident at work.
Family benefit	Children allowance	• Dependent children, up to a maximum of three.	➢ TND 7.320 for the first child, decreasing to TND 5.603 for the third child
	Single income allowance	• Family allowance recipients with unemployed spouses.	➢ Maximum is TND 7.825.
Social and university loans: Housing loans, vehicle loans, personal loans, and university loans.			

Source: Compiled by authors based on legal texts organizing social funds in Tunisia.

The CNRPS provides survivorship benefits on the death of the insured individual. The spouse receives 75 percent of the retirement pension of the deceased on a monthly basis. This percentage is reduced according to the number of children. Surviving spouses with three children receive 70 percent of the survivorship benefit value and those with five or more dependent children receive 50 percent of the pension. If the survivorship pension is not awarded for any legal reason, this pension is shared equally among orphans in addition to their temporary pensions.

The temporary pension for orphans is granted to orphans younger than the age of 21(25 if the orphan is a student without a scholarship, and no age limit if the orphan is disabled or an unmarried daughter without income). The temporary pension for orphans is calculated on the basis of the retirement pension from which the insured individual had received or from which they could have benefited at the date of their death.

It varies from 10 percent to 50 percent of the retirement pension according to the number of orphans.

Under certain conditions, the CNRPS also provides a death grant (one-off payment) to the dependents of the insured deceased. If the insured individual is in employment at the time of their death, the death grant is the annual remuneration serving as the basis for the payment of the retirement pension. Added to this is the amount of the remuneration for one month for each year of contributions made, up to 18 years. This death grant received is increased by 10 percent for each dependent child and doubled if the death was a result of a workplace accident.

If the deceased was retired, the death grant amounts to 50 percent of the allocated pension benefits, reduced in percentage if the individual was over 70 years old. The amount of the death grant cannot be less than the guaranteed minimum annual interprofessional salary.

Family allowances are allocated to CNRPS affiliates with dependent children up to a maximum of three (more than three in the case of a child with disabilities). The family allowance is TND 7.320 for the first child, gradually decreasing to TND 5.603 for the third child and TND 4.880 for the disabled child classified after the third child. Family allowances are paid directly by the employer[45] and can be combined with the temporary pension for orphans, where applicable.

Family allowance recipients with unemployed spouses are entitled to a single income allowance according to the number of children they have. The minimum monthly single income allowance is TND 3.125 (one child) and the maximum is TND 7.825 (three or more children).

The CNRPS can also provide social and university loans to insured individuals working in the public sector. In the private sector, several kinds of benefits are accorded to CNSS affiliates under certain conditions. They include pension benefits, death benefits, family benefits, social actions, and loans.

Insured private sector employees receive pension benefits at the age of 60 (at the age of 65 for some groups), after having paid at least 120 months of contributions. The pension amount varies between 40 percent and 30 percent of the reference salary,[46] and it is adopted for each activity and increased by 0.5 percent for each additional quarter above 120 months for which contributions were paid, up to a maximum of 80 percent of the reference salary.

In addition, under certain conditions (presented in Table 4), workers in the private sector are entitled to benefit from early retirement for four reasons: personal convenience, premature wear and tear of the organization, economic redundancy, or employed woman with three children. Employees in the private sector also become eligible for a disability benefit if the working capacity is reduced by at least two-thirds due to a disability and after 60 months of contributions. Disability benefits for private sector employees vary, according to the sectors of

[45] The State, State-owned enterprises, or non-administrative public establishments.

[46] The reference salary is taken as the average salary on the basis of which contributions were paid over the last 10 years of employment. For some worker groups, the reference salary is linked to the SMIG/SMAG.

activity, between 30 percent and 50 percent of the reference salary (or SMAG/SMIG) over a period of 60 to 180 months of contributions. It is increased by 0.5 percent for each additional quarter of contribution, up to a maximum of 80 percent of the reference salary.

The CNSS also provides survivorship pensions on the death of the insured individual who paid a minimum of 60 months of contributions equivalent to at least two-thirds of the quarterly SMIG.

Spouses married at the time of death and dependent children younger than 16 years of age (25 years of age if the child is a student without a scholarship, and no limit if they are disabled or an unmarried daughter without income) are eligible to receive benefits. Survivorship pensions are divided between eligible persons on the basis of old age and the invalidity pension that the deceased was receiving or should have received at the time of their death. The distribution of this benefit differs according to the sector. In case of the death of employees in the non-agricultural private sector, dependents receive 100 percent of the benefit. This amount is reduced to 75 percent for the spouse if there are no dependent children. If the deceased is a worker in the agricultural sector or self-employed in the private sector, the surviving spouse receives 50 percent of the total old age or invalidity pension regardless of the number of dependent orphans, and the orphans receive 20 percent of the total amount of the benefit.

Table 5. Benefits provided in the private sector

Kinds of benefits	Conditionality	Liquidation basis
Pension benefits	• Legal retirement age: 60 years (62 years for self-employed and some categories). • Contribution: minimum of 120 months.	➢ Forty percent (30 percent for low-income earners) of the reference salary (or income) adopted for each activity, increased by 0.5 percent for each additional quarter.
Disability benefit	• Working capacity is reduced by at least two-thirds due to a disability in addition to 60 months of contributions.	➢ From 30 to 50 percent of the reference salary (or income) adopted for each activity and sector.
Survivor pension	• Married spouses and dependent children of deceased employees who had paid contributions for a minimum of 60 months.	➢ From 50 to 100 percent of the total of the retirement or the invalidity pension (adopted for each activity and according to the number of dependent children).
Early retirement benefit	• Employees at least 55 years old for personal convenience with at least 360 months of contributions and aged at 50 years for premature wear and tear of the firm or economic redundancy, with at least 60 months of contributions. • Employed women at least 50 years old, with three children, and who have paid at least 120 months of contributions.	➢ 40 percent of the reference salary for the first 40 quarters of contributions, increased by 0.5 percent for each additional quarter.
Death benefit	• Non-divorced spouse of the deceased member, and dependent children and dependent ascendants, with a period between 50 and 90 working days depending on the sector of activity.	➢ The annual average of salaries subject to contribution and increased by one month of salary for each year of contributions, increased by 10 percent per dependent child (if the insured was active).
Death allowance	• Socially insured (in the event of the death of the spouse or one of the dependent children that is not caused by an accident at work or an occupational disease) with at least 50 working days during two quarters.	➢ Two-thirds of the average daily wage multiplied by a coefficient varies between 10 and 90.
Family allowances and family benefits for single wages, birth leave, and leave of young workers. Personal loans, home/construction loans, and loans to acquire land or a vehicle.		

Source: Compiled by the authors based on legal texts organizing social funds in Tunisia.

The CNSS also provides a death grant (one-off payment) to the dependents of the insured deceased. If the insured individual is in employment at the time of their death, the death grant is the annual average of salaries subject to contribution and increased by one salaried month for each year of contributions, increased by 10 percent per dependent child. If the deceased was disabled or retired under the age of 70, the death grant amounts to 50 percent of the allocated pension benefits and reduced in percentage if the individual was over the age of 70. The amount of the death grant cannot be less than the guaranteed minimum annual interprofessional salary.

On the other hand, a death allowance is granted by the CNSS to the socially insured in the event of the death of the spouse or one of the dependent children that is not caused by an accident at work or an occupational disease. This death allowance amount is two-thirds of the average daily wage multiplied by a coefficient that varies between 10 and 90.

Family allowances are allocated to CNSS affiliates with dependent children, up to a maximum of three, and more than three for children suffering from infirmity or an incurable disease and for disabled card holders. Family allowances are paid based on the total quarterly remuneration of the employee.

Moreover, employees in the private sector are entitled to other family benefits for single wages, birth leave, and leave of young workers. The increase for a single salary is granted to an employee with dependent children and whose spouse does not earn an income. Regarding birth leave, the employee can avail one day of leave within seven days of each birth. In addition, on the 31st of December of each year, workers under 18 years of age gain two leaves for each month of work, and the maximum limit is 24 days per year. Similarly, workers aged 18-20 gain 1.5 leaves for each month of work, with the maximum limit being 18 days per year.

The CNSS can also provide certain categories of insured persons in the private sector with personal loans, home/construction loans, or loans to acquire land or a vehicle.

Under certain conditions, the CNSS can also accord employed mothers with a childcare contribution (to pay crèche fees) if the monthly salary does not exceed two and a half times the minimum wage. In addition, dismissal indemnities and legal rights are granted to workers who have lost their jobs due to economic or technological reasons or following the permanent and unexpected closure of the company. These allowances cover unpaid wages and accessories within the limits of the sums set in accordance with the provisions of the labor code.

On the other hand, assistance is granted by the CNSS to non-agricultural sector workers who have lost their jobs for reasons beyond their control without benefiting from compensation. For example, workers can avail such assistance if their company halts operations for economic or technological reasons or if it suddenly and unexpectedly shuts down. This assistance is capped at 12 monthly paid activity wage payments.

In addition, the CNSS also participates, under certain conditions, in the costs of holiday camps for the children of insured persons.

1.3. COVID-19 contributory response

The Tunisian government has taken a set of exceptional decisions to protect businesses and individuals from the repercussions resulting from the application of COVID-19 quarantine measures. These measures concern certain self-employed workers, contract workers, and "damaged" firms and their employees. Firms affiliated with the CNSS and registered with the tax authorities are considered damaged if their activities have been totally or partially suspended due to the quarantine.

According to Decree no. 3 of 2020, an exceptional one-time monthly grant of TND 200 is granted to certain self-employed workers affiliated with the National Social Security Fund and registered within the discretionary tax system, or who have a professional card as proof of profession (Krafft, Assaad, and Marouani, 2021).

Throughout the period of the work stoppage, a monthly exceptional grant of TND 200 was granted to the employees of damaged companies working with open-ended contracts or fixed-term contracts operative on the date of Decree no. 4 of 2020, dated 15 April 2020. Employees who were temporarily suspended from work (due to the pandemic) were also eligible for this grant.

Damaged firms were asked to keep all workers, register them in the CNSS, and declare their salaries for the fourth quarter of 2019 or for the first quarter of 2020. The amount of the assigned grant and the part of the wage obtained from the employer during the period of work suspension cannot exceed the declared wage.

Throughout the period of the work stoppage, permanent or contract workers, employees who have been temporarily suspended from work, and the beneficiaries of exceptional grants continue to benefit from the care services provided by public health structures, as well as from family allowances and the increase in the single salary.

Damaged firms that kept all their workers and have not completely closed can postpone the payment of the employer contributions for the second quarter of the year 2020 for three months without penalty.

In addition, workers of companies not affiliated with the National Social Security Fund can benefit from an exceptional grant if the company registers within one month.

Moreover, an exceptional grant of TND 100 has been awarded to 140,000 retirees in the public and private sectors whose pensions do not exceed TND 180.

The government has allowed workers earning a monthly wage of less than TND 1,000 (USD 322) to defer loan payments. It also issued a new decree (Decree no. 2 of 14 April 2020)

suspending Article 21-12 of the labor code to offer employees legal protection against the termination of employment contracts for reasons related to COVID-19.

Furthermore, the debts of professionals in the cultural and artistic sectors were rescheduled under contributions to the social security system. The retirement allowance of professionals, namely artists, creators, and intellectuals, will also increase to double the usual amount.

2. Contributory health insurance system

Health insurance is one of the main components of social protection in Tunisia. The contributory health insurance system exclusively covers workers in both the public and private sectors and their dependents, and it is administered by the National Health Insurance Fund (CNAM). The CNAM is the latest version of social health insurance that has existed in Tunisia since 1958. It was introduced to unify health insurance schemes and health benefits in the country, as previously provided by the CNSS and CNRPS. In this section, we present a general overview of the CNAM, including its legal framework, the composition of its administrative board, and the contributions of these affiliates. We then discuss the health services and reimbursement schemes provided by the fund and their response to the COVID-19 health crisis.

2.1. Overview of the social health insurance system in Tunisia

The CNAM, a non-administrative public establishment, was created in 2004 and became operational in 2007. It has legal personality and financial autonomy, and its administrative board has a tripartite structure.[47] The CNAM covers socially insured employees in the public or private sectors and their dependents. The CNAM also covers pension recipients who are under a legal social security scheme and their dependent parents. A fixed annual sum is paid by the CNAM to the State budget to cover the costs of outpatient and inpatient care at public health facilities for insured persons.

Contributions made to the CNAM are 6.75 percent of the individual's salary or income, with four percent payable by the employer and 2.75 percent by the employee. This rate is paid in full by self-employed contributors. The contribution rate for pensioners is four percent.

According to official data, the CNAM covered more than eight million individuals (8,064,733), including workers and their dependents, in 2018, which is equivalent to 70 percent of the total population. Moreover, the number of workers contributing to health insurance increased by 32 percent during the period 2008-18, from 2,817,473 in 2008 to 3,713,485 in 2018.

In parallel, the total expenditure of the CNAM, all schemes included, increased by 147 percent during 2008-18; increasing from TND 905 million (i.e., the equivalent of 1.63 percent of the GDP in 2008) to TND 2.244 billion (i.e., the equivalent of 2.11 percent of the GDP in 2018).

[47] The State, the most representative employers' organization, and the most representative trade union organization.

In addition to the health insurance scheme, the CNAM manages legal schemes for compensation for damages resulting from workplace accidents and occupational diseases in the public and private sectors. The fund also grants sickness benefits for insured persons working in the private sector and diaper allowance for salaried women suspending their work due to childbirth.

2.2. Healthcare and reimbursement schemes

The CNAM provides health coverage under several schemes presented in Table 6.

The general basic scheme guarantees the coverage of essential public/private healthcare costs incurred by insured persons and their dependents. The CNAM's insured must choose between three streams operating differently in terms of care and reimbursement procedures.

Table 6. Different health insurance schemes managed by the CNAM

Health insurance scheme		Features
General basic scheme	Public stream	• The insured and their dependents benefit from all healthcare (outpatient and hospitalization) from all public and para-public heath structures affiliated with the CNAM.
	Private stream	• Affiliates benefit from outpatient care included in the basic health insurance scheme using the coordinated care pathway, which consists of consulting the family doctor who the socially insured person previously chose before consulting any other doctor.
	Reimbursement stream	• The socially insured person pays the entirety of real fees and can access all contracted care providers from the public and private sectors. Expenses are subsequently reimbursed according to the coverage rates as in the private scheme.
Workplace accidents and occupational diseases scheme (known as ATMP)		• The contribution rate under this scheme is payable exclusively by the employer. The contribution rates are set according to the branches of activity and vary from 0.4 percent to four percent.
Social assistance scheme	Sick leave benefits	• The sick leave is paid twice a month in arrears to any insured worker for each day of leave from the sixth day of illness until the eight-day maximum.
	Maternity leave benefits	• Maternity leave is paid monthly in arrears to insured female wage workers, as income replacement during the time off from work due to pregnancy and maternity.
Public agents abroad scheme		• This scheme concerns certain public sector employees working abroad and their dependents residing in Tunisia.

Source: Compiled by the authors.

The CNAM's public stream allows the insured and their dependents to benefit from all healthcare (outpatient and hospitalization) from all public health structures affiliated with the fund as well as in the outpatient clinics of social security. The CNAM does this by making a co-payment capped over one year at one and a half times the value of the beneficiary's monthly salary or pension. In 2018, the number of beneficiaries of this public stream represented 49 percent of the total number of CNAM insured (all schemes combined).

Under the private stream, affiliates benefit from outpatient care included in the basic health insurance scheme using the coordinated care pathway, which consists of consulting the family

doctor who the socially insured person previously chose. Under these conditions, the insured person only pays the user fee at their expense and the CNAM makes a direct payment to the care provider. The number of affiliates under the private stream increased by approximately 129 percent during 2008-18, from 273,770 insured in 2008 to 629,250 insured in 2018.

Under the reimbursement stream, the socially insured person pays the entirety of the real fees and can access all contracted care providers from the public and private sectors. The insured person is subsequently reimbursed with annual limits set at TND 200 per insured person and at TND 50 per dependent. The reimbursement stream accounted for 13 percent and 21.4 percent of insured persons in 2008 and 2018, respectively.

The CNAM also provides workplace injury and illness coverage through the *Accidents de travail et maladies professionnelles (*ATMP) scheme. This scheme covers all workers in all sectors of activity and students in technical or vocational education establishments. In the case of workplace injury or illness, insured workers receive a daily allowance throughout the period of illness or treatment, in addition to comprehensive medical care. In the event of partial or total disability following an accident at work, the ATMP pays an income calculated according to the degree of disability and the annual salary of the person before the injury.

Furthermore, the CNAM provides social assistance, including sick leave benefits that are separate from workplace injuries and maternity leaves. The sick leave is paid twice a month in arrears to any insured worker for each day of leave from the sixth day of illness until the eight-day maximum. However, maternity leave is paid monthly in arrears to insured female wage workers, as income replacement during the time off from work due to pregnancy and maternity. Female workers are entitled to 30 days of paid maternity leave upon the birth of a child. In case of illness or complications resulting from pregnancy and childbirth, the female worker is entitled to an additional 15 days of leave. Female civil servants are entitled to two months of maternity leave. Postnatal leave can be extended up to four months after the expiration of maternity leave. The full salary is paid during maternity leave and 50 percent of the salary is paid during the optional period of additional postnatal leave. The amount of cash benefit for women working in agriculture is 50 percent of the flat daily rate wage, calculated based on the guaranteed minimum wage in agriculture.

The public agents abroad scheme concerns certain public sector employees working abroad and their dependents residing in Tunisia. Under this scheme, the mandatory contribution rate is four percent of the gross remuneration served abroad, and employees can voluntarily subscribe to additional coverage covering 80 percent of the incurred costs for healthcare beyond surgery and long-term illnesses. The contributions of these additional services are six percent of gross remuneration paid abroad.

Section Three: Overview of non-contributory social protection schemes in Tunisia

The non-contributory system in Tunisia is administered by MAS, but important social assistance programs are implemented in cooperation with the Ministry of Education and the Ministry of Health (Machado et al., 2018). The Ministry of Commerce manages the universal food and energy subsidy program, which is an important component of social protection in Tunisia. This section presents the main non-contributory programs in Tunisia: cash transfers, healthcare provision, social assistance, and universal food and energy subsidy programs.

1. Cash transfer programs

The most important cash transfer program in Tunisia is the National Program of Aid to Needy Families (PNAFN). It accounted for around half (53 percent) of the total expenditures of the MAS, 1.9 percent of government spending, and around 0.5 percent of the GDP in 2016 (UNICEF, 2020). Established by the MAS in 1986, it aimed to accompany the structural adjustment program to provide regular, permanent, and unconditional assistance to needy families. It also provided them with free access to public healthcare (AMGI). The three main objectives of the PNAFN were to: (1) lower the negative social impact of the structural adjustment program; (2) reduce the impact of the price liberalization measures and the gradual withdrawal of the State from the General Compensation Fund (CGC); and (3) subsidize energy and basic commodities and prevent the kind of social unrest that occurred in 1984. Eligibility for this program is based on questionnaire surveys conducted by social workers with families eligible for such assistance. The list of eligible families is then submitted to a regional commission[48] for approval with the involvement of representatives of the National League for Human Rights and Civil Society (Elgazzar et al., 2013). The regional commission was supposed to consider the eligibility criteria and the quota system set by MAS. The following criteria were adopted by the MAS as eligible for the PNAFN program:[49]

- Annual income below the poverty line (low threshold), estimated at TND 400 in 2005 and TND 685 in 2011 by the National Institute of Statistics.
- Inability to work due to a physical or mental impairment.
- Family size and the number of disabilities or chronic illnesses in the family.
- Lack of support among descendants with income or the inability of family support to provide for the family's basic needs
- Poor household living conditions, such as poor dwelling…etc.

The number of families receiving PNAFN benefits has grown over the years from 78,000 in 1987 to 100,000 in 1990 and then to 131,839 in 2010, with an average annual growth rate of 2.3 percent over 23 years. In 2011, the size of the PNAFN rapidly increased to 177,294 (a 34.5 percent increase compared to 2010). Since 2011, this upward trend reached 235,000 beneficiaries in 2014, representing 7.3 percent of the total population and 60 percent of the

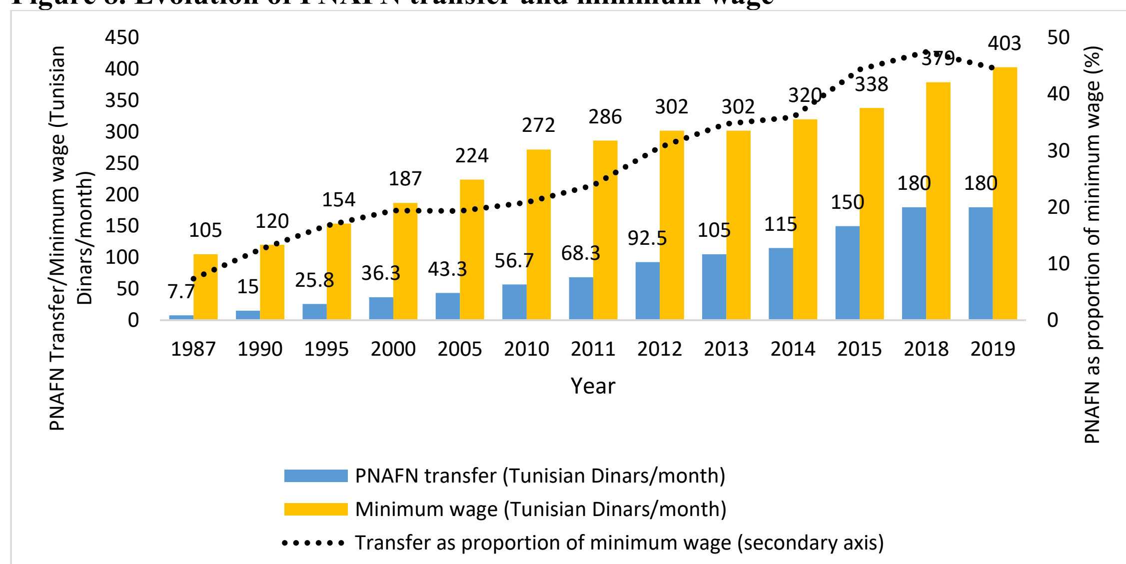
[48] MAS has a large regional network of 24 regional divisions and 264 social promotion units spread over the 264 delegations (administrative units) in the country.

[49] MAS (2011). Les programmes sociaux de lutte contre la pauvreté et d'amélioration des conditions de vie.

poor in Tunisia (ESCWA, 2016). In 2020, a total of 260,000 families received benefits from the PNAFN program, with an average annual growth rate of seven percent from 2010 to 2020.[50]

The monthly amount of financial assistance also increased from TND 7.7 in 1987 to TND 36.3 and TND 56.7 in 2000 and 2010, respectively. In 2013, the monthly amount was TND 105, and the total budget of the PNAFN reached TND 292 million, equivalent to 0.47 percent of the GDP (ESCWA, 2016). In 2020, the monthly amount reached TND 180, which is more than triple the amount in 2010. Beneficiary families with children in school receive an allowance of TND 10 per child per month (up to TND 30) (Nasri, 2022). This allowance is doubled for children with special needs (TND 20). Figure 8 shows that, over the years, the value of the PNAFN benefit has increased faster than the minimum wage (SMIG). The transfer (not including the supplement) is currently 45 percent of the minimum wage compared to seven percent in 1987 (ESCWA, 2019).

Figure 8. Evolution of PNAFN transfer and minimum wage



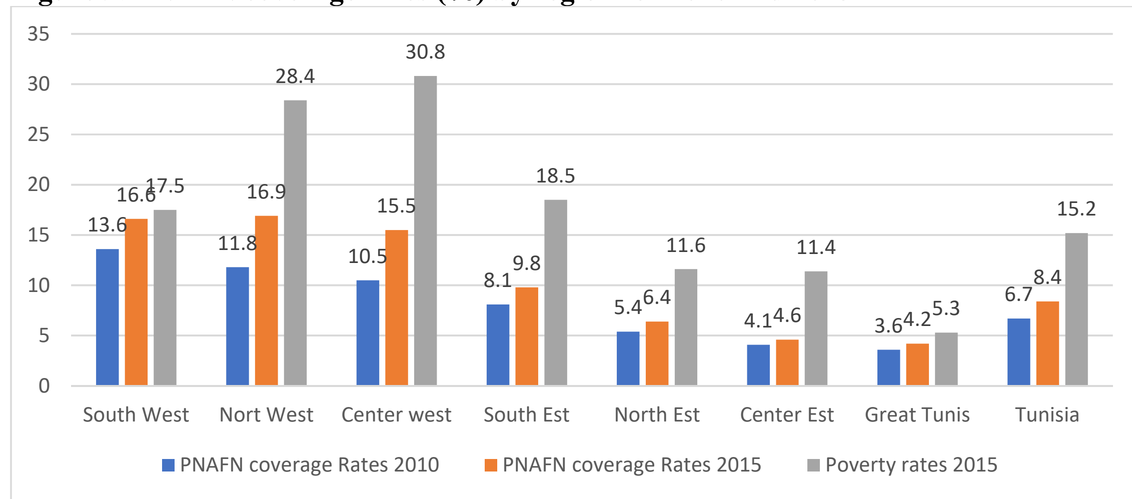
Source: Economic and Social Commission for Western Asia (ESCWA, 2019).

The coverage rate of the PNAFN program evolved from 6.7 percent in 2010 to 8.4 percent of Tunisian households in 2015. The evolution of this coverage rate differs from one region to another. It has recorded an increase of five percentage points for the North West and Central West regions, from 11.8 percent to 16.9 percent and from 10.5 percent to 15.5 percent, respectively (Figure 9). The North West (e.g., 34.2 percent in Al-Kef and 32 percent in Beja) and the Central West (e.g., 34.9 percent in Kairouan and 32.8 percent in Kasserine) are historically plagued by the highest poverty rates (28.4 percent and 30.8 percent in 2015, respectively) and are often characterized by difficult living conditions and limited access to basic services. The coverage rate for the South West also improved from 13.6 percent to 16.6 percent between 2010 and 2015. For the coastal regions, the increase in coverage remains low

[50] Administrative data from MAS.

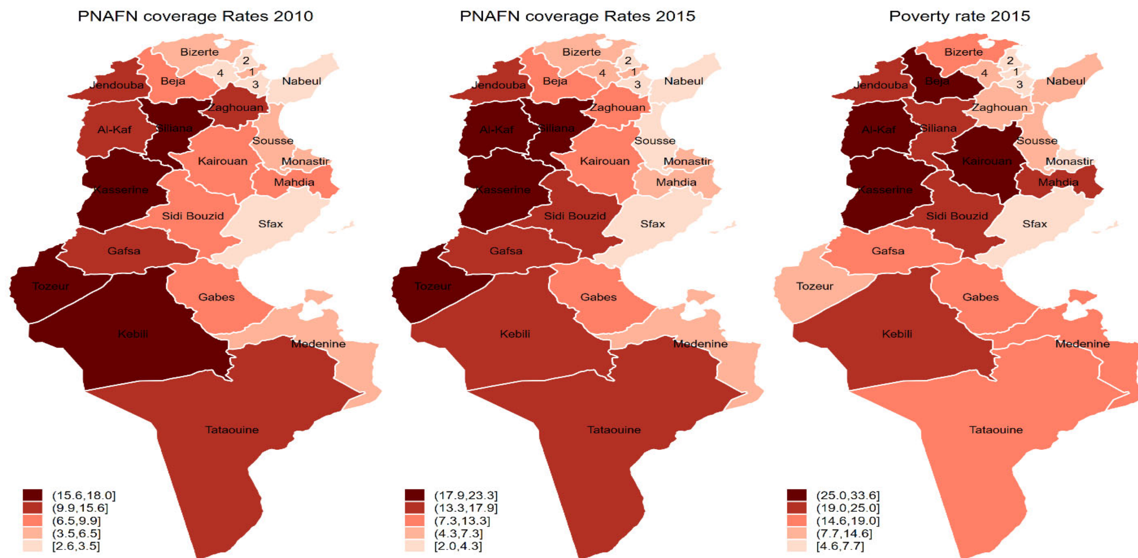
and does not exceed one percent for Greater Tunis, the North East, and the Central East, and it is less than two percent for the South East (see Figure 10 for coverage rates by governorate).

Figure 9. PNAFN coverage rates (%) by region for 2010 and 2015



Source: Authors' calculations using the National Survey on Household Budget, Consumption and Standard of Living, (EBCNV 2010 and EBCNV 2015) and MAS data.

Figure 10. PNAFN/AMGI coverage rates (2010 and 2015) and poverty rate by governorate



Note: Numbers in the maps correspond to the following governorates: 1: Tunis, 2: Ariana, 3: Ben Arous, 4: Manouba.
Source: Authors' calculations using MAS data and the poverty map report (INS and Banque Mondiale, 2020).

Table 7 shows that the Central West and North West regions included 41 percent of beneficiaries in 2015 (20.8 percent and 19.8 percent, respectively) and that they also had the second and third highest coverage rates (13.5 percent and 12.8 percent, respectively) after the South West. However, these two regions accounted for 45 percent of the poor population according to the EBCNV (2015), which indicates that there are challenges in targeting poor

and vulnerable households in these regions. Table 7 also shows that 57 percent of the heads of households benefiting from the PNAFN are without education, while 32 percent have primary level education and 10 percent have secondary level education. The average age of the head of the household was 62 years.

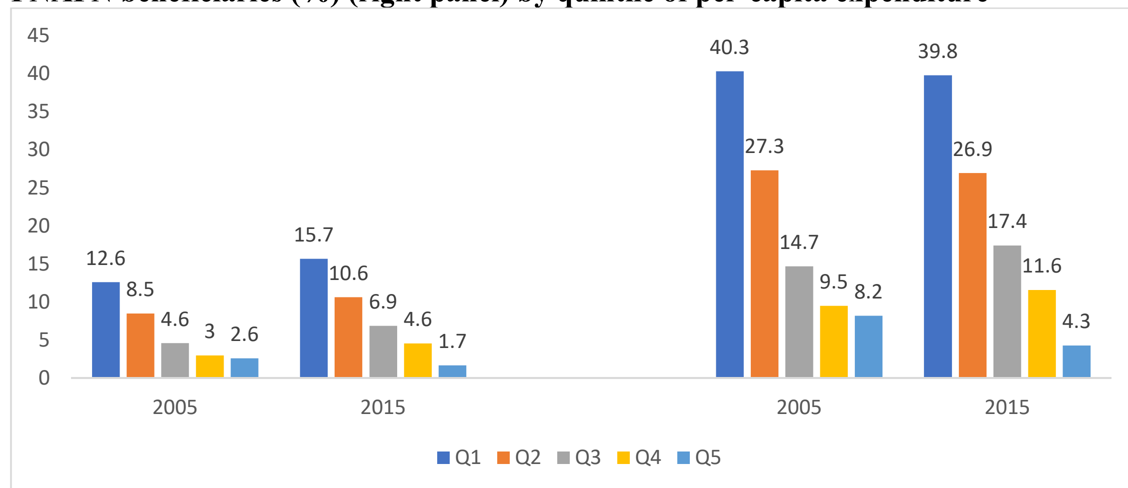
Table 7. Profiles of PNAFN beneficiaries

Variables	Number of households	Distribution (%)	Coverage (%)
Region			
Great Tunis	31630	13.7	4.3
North East	23178	10.1	5.4
North West	45582	19.8	12.8
Central East	38246	16.6	5.6
Central West	47852	20.8	13.5
South East	23013	10.0	9.7
South West	20723	9.0	14.7
Education level of Household Head			
No education	131905	57.3	17.7
Primary	74058	32.2	7.4
Secondary	22693	09.9	3.7
Tertiary	1479	0.6	0.6
Socio-professional Category of Household Head			
Senior/Middle-level executives and liberal professionals	5633	2.5	1.8
Other employees	15231	6.6	4.6
Managers of small trades in industry, commerce, and services	700	0.3	1.1
Crafts persons and self-employed in industry, commerce, and services	4596	2.0	5.1
Non-farm workers	35620	15.5	6.6
Farm operators	15734	6.8	7.9
Farm workers	5252	2.3	12.5
Unemployed	7964	3.5	11.2
Pensioners	12588	5.5	3.3
Other non-working persons	126817	55.1	22.0
Average age of household head	**230223**	**61.6** (14.7)	
Average household size	**230223**	**3.8** (2.1)	

Source: Authors' calculations using the EBCNV (2015). Numbers in brackets are the standard deviations.

Figure 11 depicts the PNAFN coverage rates (left-hand curve), as well as the distribution of beneficiaries of the same program (right-hand curve) for the 2005 and 2015 dates by standard of living approximated by per-capita expenditure. The PNAFN covers only 15.7 percent of the poorest (the first quintile) in 2015, compared to only 12.6 percent in 2005. The distribution of PNAFN beneficiaries by standard of living shows that 40 percent of these beneficiaries belong to the first quintile, i.e. the poorest households, and 27 percent belong to the second quintile (the left-hand side of Figure 10).

Figure 11. Coverage rate of the PNAFN program (%) (left panel) and the distribution of PNAFN beneficiaries (%) (right panel) by quintile of per-capita expenditure



Source: Authors' calculations using the EBCNV (2015). Statistics for 2005 are from the World Bank report (Banque Mondiale, 2013).

Despite improvements in monthly allowance (especially after 2011) as well as in coverage rates by region and by household standard of living, the coverage of the poorest remains relatively low, with less than 16 percent of the first quintile receiving the transfer in 2015.

The selection criteria used by the PNAFN are extremely complex (e.g., estimation of household income, verification of the socioeconomic and demographic situation of the households), which has a negative impact on its targeting. Indeed, the results of the performance evaluation of this program conducted by the MAS in collaboration with the African Bank (CRES and BAD, 2017) showed that of the 8.3 percent of households that were supposed to be covered by the PNAFN, 4.6 percent were not, which represents an exclusion rate of 53.1 percent. This study also highlights the difficulties associated with identifying needy families. Institutional weaknesses, poor coordination between different government services, and the growing importance of informal sector workers[51] make it difficult to identify low-income families.

In terms of discrimination, the PNAFN program pays particular attention to women by providing them with privileged access to the benefits allocated to single mothers. However, less than 47 percent of the households that received financial assistance under the PNAFN were headed by women in 2010 (Nasri, 2022).

In response to this situation, the government launched the reform of social protection in 2013 to create an integrated, financially sustainable, and better-targeted national system. To this end, in January 2019, the Parliament adopted the first law on social assistance. The organic "Amen

[51] The lack of information on vulnerable households, including informal sector workers, makes the identification of beneficiaries a challenge.

Social" law sets the principles of identification and registration of beneficiaries of social programs using fair, objective, and transparent criteria (the proxy means test (PMT) model).[52]

The school allowance program

School-age children from needy families covered by the PNAFN receive monthly cash transfers under the School Allowance Program (PPAS) launched by the MAS in 2007. It is a conditional cash transfer of TND 10 per month (TND 120 per year) per child, with up to three children per household. This program aims to help children from poor households continue their schooling and improve their academic performance. The number of PPAS beneficiaries in 2013 was 79,363 children from 41,482 families benefiting from PNAFN compared to 60,365 children from 31,539 families in 2011 (MAS, 2014). In parallel, annual aid of TND 50 for school children and TND 120 for university students from families benefiting from the PNAFN and families with limited incomes registered with the social assistance system (AMGII) are provided at the beginning of the school and university year (MAS, 2019).

COVID-19 cash assistance

Like most countries in the world, the negative consequences of the COVID-19 pandemic on Tunisia's economic and social plan are now tangible (UNICEF, 2020). Thus, some of the gains made in the past in terms of job creation and poverty reduction will be lost as unemployment increases and the vulnerable population falls into poverty. Specifically, poverty is estimated to have increased from 14 percent to 21 percent of the population in 2020 (World Bank, 2020). The poorest households in deprived regions (the North West, Central West, and South of Tunisia) as well as women who live in large households without healthcare and working without a regular contract are the most affected (World Bank, 2020). UNICEF research also shows that children may pay the highest price for the effects of the COVID-19 crisis (UNICEF, 2020).

To cope with the repercussions of the confinement of citizens[53] and reduce its impact on the poor population and vulnerable groups, the government has taken a set of exceptional social measures. According to the MAS, TND 300 million have been allocated to support workers in technical unemployment[54] as well as TND 150 million in the form of subsidies to families covered by the PNAFN in the form of direct cash assistance under the supervision of the MAS. Specifically, these allocations benefit the following groups (Gentilini et al., 2020; World Bank, 2020):

- Temporary cash transfer of TND 200 (around 36 percent of the poverty line estimated at TND 550 per month per household in 2015) to 770,000 households (28.1 percent of the

[52] MAS order of 19 May 2020 on the determination of the scoring model.

[53] The first COVID-19 case was identified on 2 March 2020. To fight the spread of this pandemic, the government applied a first sanitary lockdown period from 22 March to 3 May 2020.

[54] Partial unemployment, or technical unemployment, is a measure that allows the employer to temporarily reduce or suspend business activity due to exceptional circumstances and allows employees to avoid finding themselves without any income due to the temporary suspension of their work contracts. It is regulated by Article 21 of the Tunisian Labor Code.

population), including 470,000 households benefiting from subsidized healthcare programs (eligible for two transfers in April and May 2020) and 300,000 vulnerable households (eligible for one transfer in May 2020).
- Temporary cash transfer of TND 50 to 260,000 households receiving a permanent cash transfer program (PNAFN) to bring total transfers to at least TND 230 per beneficiary (for one transfer in April 2020).
- Temporary cash transfer of TND 200 to households hosting the elderly (111 households) (one transfer in April 2020).
- Temporary cash transfer of TND 200 to households fostering children without parental support (382 households) and a temporary cash transfer of TND 200 to households hosting a person with a handicap (286 households) (one transfer in April 2020).

Although the government's measures were swift, their implementation faced several difficulties. According to the MAS, there were shortcomings and abuse in the distribution of social assistance, including 6,000 subsidies that were not paid out to their recipients. To rectify this situation, MAS performed two cross-checks to identify truly eligible households. The first check was based on the ministry's own dataset and led to the elimination of 123,000 families from the 623,000 families under the AMGII program before March 2020. The second check was based on inter-ministerial databases (cross-referencing of administrative data) and led to the elimination of 30,000 families. In April 2020, the number of families eligible for the AMGII program was set at 470,000. In December 2020, MAS reported that more than 1,150,000 people have benefited from social assistance provided by the government to cope with the COVID-19 crisis.

2. Medical assistance schemes

Social medical assistance or free medical assistance (AMG) allows access to healthcare in public hospitals for needy and low-income families, disabled people, and children without family support. AMG provides care through two programs: Free Medical Assistance and Reduced Free Medical Assistance (AMGI and AMGII, respectively). Access to these two programs is administered by the MAS through a large regional network of 24 regional commissions, and 264 social promotion units spread over 264 delegations (administrative units) of Tunisia. Public health structures provide free healthcare to AMGI and AMGII beneficiaries, but the Ministry of Health is not involved in the management and monitoring of these programs.

In terms of eligibility, AMGI coverage is granted to all families receiving cash transfers from the PNAFN (coverage data for AMGI is equal to PNAFN coverage). The eligibility criterion for the AMGII is annual income,[55] which must not exceed the SMIG for families of less than two people, one and a half times the SMIG if the family includes three to five people, and twice the SMIG if the family includes more than five people (Nasri, 2022). The AMGII allows access to healthcare in public hospitals for a fixed annual fee (stamp) of TND 10.

[55] Article 2 of Decree No. 2005-2886 of 24 October 2005.

Table 8 shows the evolution of the number of social assistance beneficiaries (AMGI and AMGII) from 2010 to 2017 using administrative data from MAS. The number of families receiving the AMGII program grew from 557,900 in 2010 to 607,697 in 2017, with an average annual growth rate of 1.2 percent (Table 8).

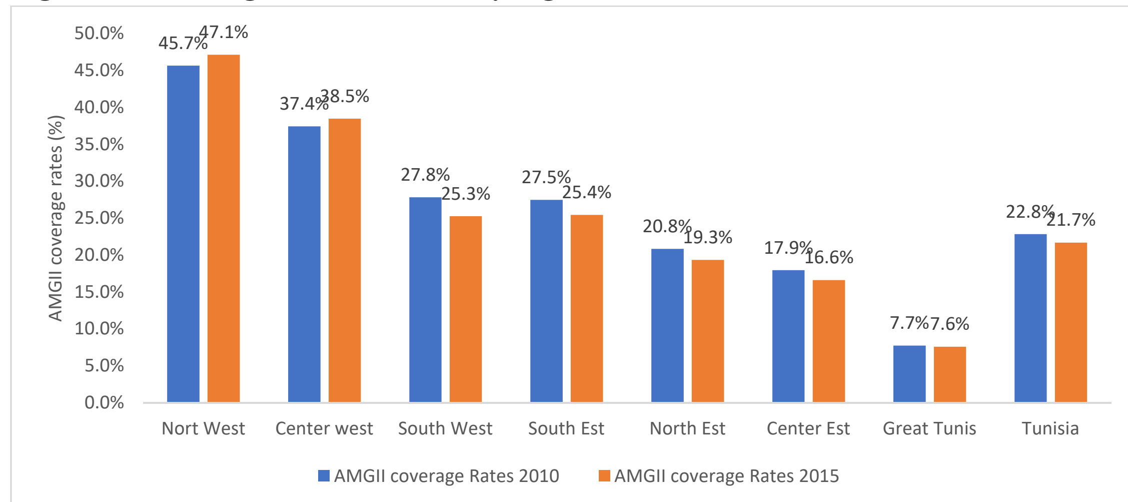
Table 8. Evolution of the number of social assistance beneficiaries, 2010-17

Year	2010	2011	2012	2013	2014	2015	2016	2017
AMGI	164,108	177,244	200,708	220,794	222,107	233,591	239,059	241,632
AMGII	557,900	576,700	577,900	602,900	592,763	602,900	598,624	607,697
Total	722,008	753,944	778,608	823,694	814,870	836,491	837,683	849,329

Source: Authors' calculations using MAS administrative data.

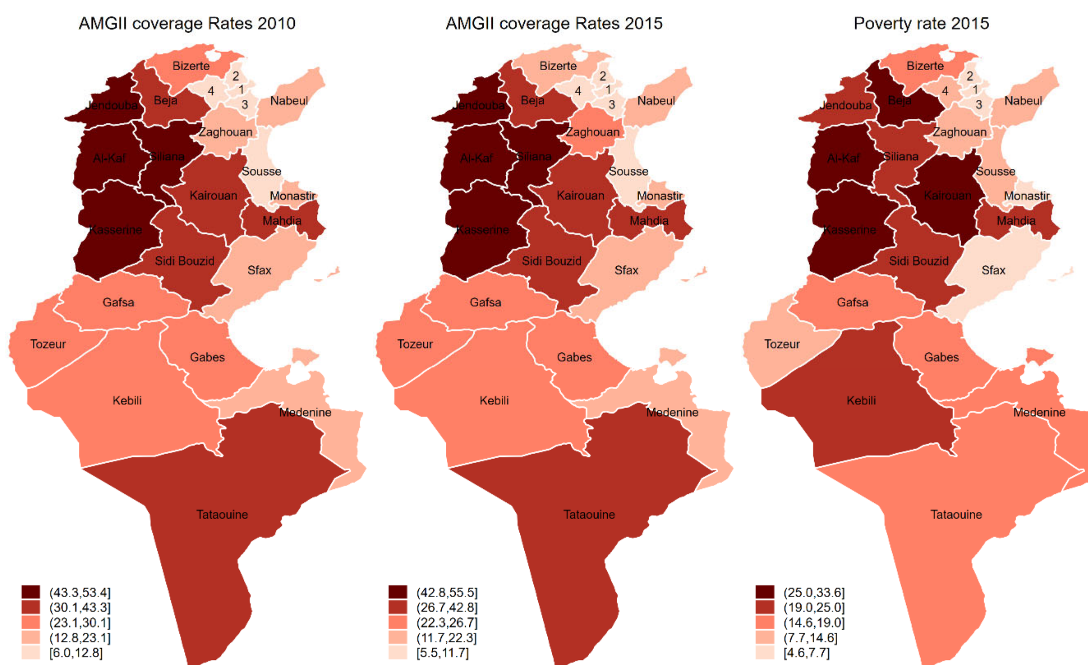
In 2015, AMGII beneficiaries accounted for 21.7 percent of all households (Figure 12) compared to 8.4 percent for AMGI (Figure 9), which, together, represented 30.1 percent of households and 24.8 percent of the total population. Figure 12 also shows that the poorest regions have the highest coverage rates (47.1 percent for the North West and 38.5 percent for the Central Region) (see Figure 13 for the coverage rate of AMGII by governorate). Public expenditure on AMGI was TND 276 million and TND 242 million for AMGII (TND 518 million for both programs).

Figure 12. Coverage rate of AMGII by region 2010-15



Source: Authors' calculations using Household Budget and Consumption Surveys (2010 and 2015) and MAS administrative data.

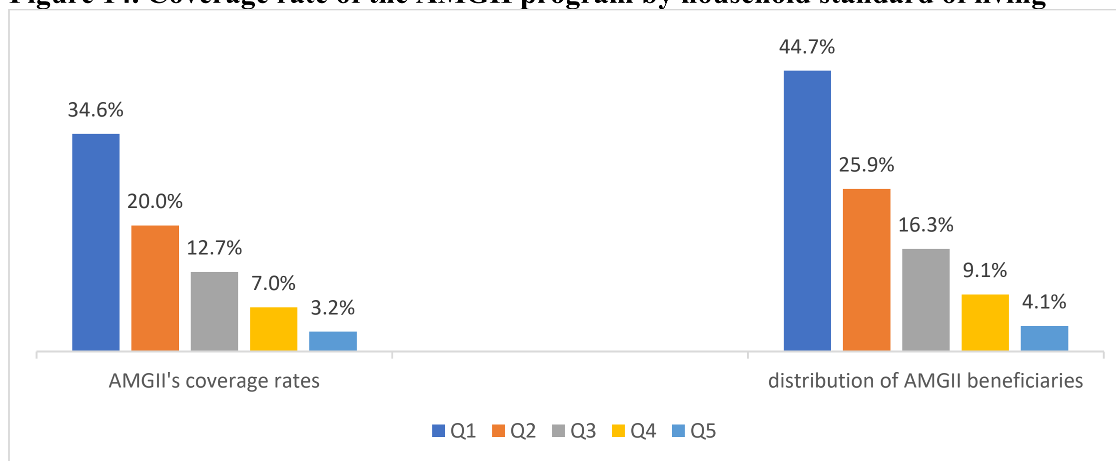
Figure 13. AMGII coverage rates (2010 and 2015) and poverty rate (2015) by governorate



Note: Numbers in the maps correspond to the following governorates: 1: Tunis, 2: Ariana, 3: Ben Arous, 4: Manouba.
Source: Authors' calculations using MAS data and poverty map report (INS and Banque Mondiale, 2020).

Figure 14 depicts the AMGII coverage rates (left-hand curve), as well as the distribution of beneficiaries of the same program (right-hand curve) for 2015 by standard of living. The AMGII covers only 34.5 percent of the poorest (first quintile) in 2015. The distribution of AMGII beneficiaries by standard of living shows that 44.7 percent of these beneficiaries belong to the first quintile of the poorest households and 26 percent to the second quintile (the left-hand side of Figure 13).

Figure 14. Coverage rate of the AMGII program by household standard of living



Source: Authors' calculations using the 2015 Household Budget and Consumption Survey (2015 EBCM).

Table 9 shows that 39 percent of beneficiaries had no education, and 46 percent had primary education, the majority being non-farm workers (39 percent) and non-working persons (46 percent). The average size of families receiving AMGII medical assistance was 4.5, which is higher than that of families receiving AMGI.

Table 9. Profiles of AMGII beneficiaries

Variables	Number of households	Incidence (%)	Coverage (%)
Region			
Great Tunis	33,548	8.66	5.23
North East	47,278	12.20	12.37
North West	87,945	22.70	32.58
Central East	73,042	18.85	12.15
Central West	80,968	20.90	27.27
South East	44,174	11.40	20.91
South West	20,445	5.28	15.78
Education level of household head			
No education	150,917	38.98	25.80
Primary	177,804	45.93	18.64
Secondary	54,120	13.98	8.03
Tertiary	4,299	1.11	1.51
Socio-professional category of household head			
Senior/middle-level executives and liberal professionals	7,307	1.89	2.43
Other employees	35,867	9.26	10.89
Managers of small trades in industry, commerce, and services	2,880	0.74	6.04
Crafts persons and self-employed in industry, commerce, and services	11,671	3.01	12.30
Non-farm workers	119,332	30.82	21.53
Farm operators	49,357	12.75	27.28
Farm workers	15,247	3.94	37.12
Unemployed	23,560	6.08	33.44
Pensioners	16,173	4.18	4.68
Other non-working persons	105,857	27.34	22.52
Average age of household head	**387,126**	**54.36** (14.79)	
Average household size	**387,399**	**4.47** (1.89)	

Source: Authors' calculations using EBCNV 2015. Numbers in brackets are the standard deviations.

3. In-kind social assistance

In addition to the monthly cash transfers to needy families (PNAFN and PPAS programs), MAS provides a range of in-kind social assistance, usually linked to the provision of certain goods (e.g., school meals, school supplies, clothing) or services (e.g., childcare, adult learning). Unlike cash transfers and medical assistance, in-kind social transfers are not clearly regulated because they are usually planned as temporary interventions deployed in response to emergencies. The most important in-kind assistance allocated to low-income and needy families is as follows: aid to school children and students, aid during cold waves, occasional and periodical aid, and aid in case of disasters (such as flooding and the COVID-19 crisis).

School feeding activities began in Tunisia in 1956 in public schools, and the National School Feeding Program (NSFP), launched in 1997, was made mandatory by education reform

legislation in 2002. The NSFP is under the responsibility of the Ministry of Education and is fully funded by the national government (USD 26.55 million in 2017-18).[56] Since 2013, the United Nations World Food Programme (WFP) has provided the government with technical assistance to enhance the NSFP program, which reached a total of 240,000 children in 2014-15 from 2,500 public schools in the poorest Tunisian regions: Zaghouan, Jendouba, Beja, Siliana, Kairouan, Kasserine, Sidi Bouzid, and Medenine (WFP, 2016).[57] For the school year 2017-18, the total number of primary and secondary school-age children receiving school food reached 360,000 (16 percent of the total number of school-age children). The coverage rate remains relatively low compared to other MENA countries (Morocco-Cantine Scolaire 18.94 percent, Algeria-Cantine Scolaire 45 percent, and Egypt School Feeding Program 75.02 percent). The national school feeding program aims to support local development and employment in rural areas, in line with a home-grown school feeding approach.[58]

Periodic assistance is also provided to needy and low-income families during the month of Ramadan. According to MAS, the amount allocated is TND 37.1 million in 2021 intended for 263,000 families (TND 31.6 million under the MAS program and TND 5.5 million under the Tunisian Union of Social Solidarity (UTSS)). The UTSS also distributes Ramadan baskets (25 kilograms of food each) for 36,000 families who do not receive assistance from the MAS, with a budget estimated at TND 2.592 million. A total of 6,000 poor families also benefit from food packaging (a total volume of 132 tons). In addition, the UTSS distributes new clothes and shoes to 10,000 poor families on the Eid holiday.

4. Persons with disabilities

Tunisia has an advanced legislative framework for the promotion of the rights of persons with disabilities (PWD). The 2005 Orientation Law on the promotion and protection of PWD aims to strengthen their inclusion in society through positive discrimination measures. An improvement in the recruitment quotas for PWD is set by Law no. 41 of 2016, which allocates two percent of annual recruitments to PWD in the public sector and sets two percent of employees for all public and private companies with more than 100 employees to be PWD. In addition, Article 48 of the new Tunisian Constitution, adopted in January 2014, guarantees protection for PWD against any discrimination.

The number of PWD is estimated at 241 thousand in 2014, which represents 2.2 percent of the population (INS, 2017), 18.5 percent of them have a total disability and 37.2 percent have great difficulties in their daily lives.[59] The number of people who only have minor difficulties in carrying out tasks in their daily lives is 106,934, representing 44.3 percent of the total number of PWD. The proportion of people aged 60 and over represents 41.7 percent of all PWD, of which 54 percent are women. Of 241 thousand PWD, only 45 percent had a disability card

[56] https://gcnf.org/wp-content/uploads/2021/01/CR_Tunisia_09_2020.pdf.

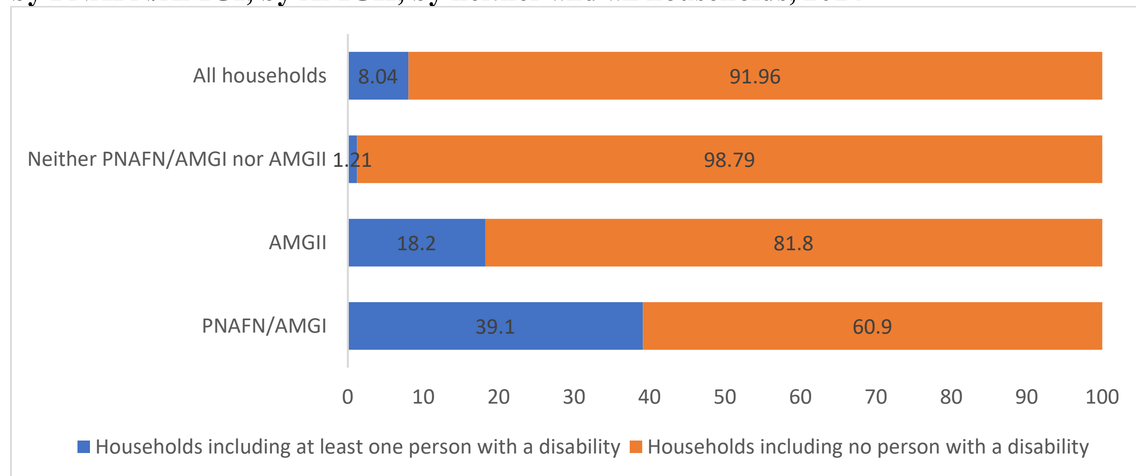
[57] WFP (2016). Capacity Development for School Meals in Tunisia. Tunis: World Food Programme.

[58] https://gcnf.org/wp-content/uploads/2021/01/CR_Tunisia_09_2020.pdf

[59] INS (2017). Recensement général de la population et de l'habitat 2014, Volume 7: Données Sociales.

(also referred to as disability ID). According to the most recent MAS statistics in 2019, approximately 276,000 people in Tunisia are holders of a disability ID. However, it is difficult from such statistics to have the total number of PWD covered by social assistance. Available statistics on social protection for PWD go back to 2014. At this date, 39.1 percent of the 225,525 households benefiting from PNAFN included at least one PWD (CRES and BAD, 2017; ESCWA, 2017). This is a relatively high coverage rate for PWD, given that only 8.04 percent of all Tunisian households have one or more PWD (Figure 15). Since beneficiaries of the PNAFN program also have free access to non-contributory health insurance program (AMGI), we can say that 39.1 percent of the households benefiting from PNAFN that included at least one PWD were covered by the AMGI (ESCWA, 2017). In addition, the CRES and BAD (2017) study shows that among the 588,199 Tunisian households benefiting from AMGII, which provides heavily subsidized health insurance, 18.2 percent included at least one PWD.

Figure 15. Households including at least one PWD as percentage of households covered by PNAFN/AMGI, by AMGII, by neither and all households, 2014



Source: CRES and BAD (2017) and ESCWA (2017).

5. Energy and food subsidy programs

In addition to the direct social transfer component (PNAFN/AMGI, AMGII), Tunisia provides an additional indirect and universal transfer component available to anyone who chooses to purchase subsidized commodities in any quantity desired.[60] The compensation system aims to control the prices of basic products, particularly cereals, to mitigate price increases, which are highly dependent on the prices of primary products in world markets. The organic law of the 1967 budget foresees the possibility of creating special funds to mobilize adequate financial resources. In this sense, Law no. 26 of 29 May 1970 established the CGC, which was confirmed by finance Law no. 65-1970 of 31 December 1970. Subsidies for public transport are granted to the *Societé Nationale des Chemins de Fer* and to public transport companies in exchange for the preferential tariffs granted to students, the military, and the internal security forces. Energy

[60] The subsidies cover basic consumer products, transport for public companies, and energy. The origin of the basic consumer product subsidies goes back to 1945, following the creation of the compensation fund by the beylical decree of 28 June 1945 (Ministry of Commerce).

subsidies date back to 2004 in response to the decline in national hydrocarbon production and the upward trend in import prices. Since its creation, the aim of the CGC subsidy program has been to redistribute income toward the poor and protect the purchasing power and nutritional status of low-income groups.

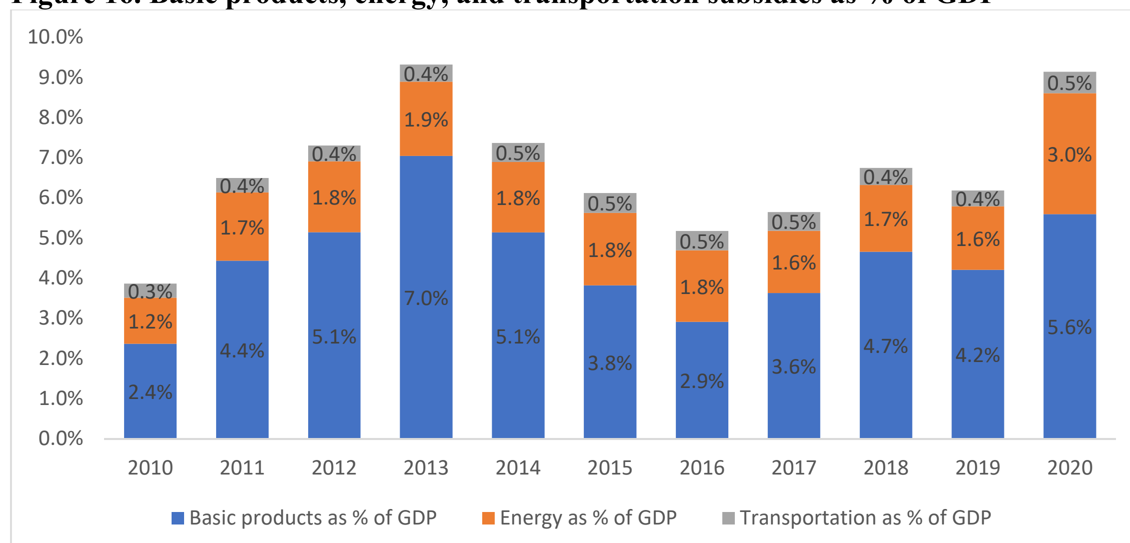
Table 10 shows the evolution of subsidies by type, as well as their share in GDP and in the State budget for the last 10 years. The volume of subsidies reached TND 6.236 billion in 2020 (5.6 percent of the GDP and 12.1 percent of the State budget), whereas they did not exceed TND 1.5 billion in 2010 (2.4 percent of the GDP and 8.4 percent of the State budget); that is, an average annual growth rate of 15.3 percent. The largest share of these subsidies is spent on food subsidies (4.4 percent of the GDP on average over the last 10 years against 1.8 percent for energy and only 0.4 percent for transport (Figure 16)).

Table 10. Evolution of the subsidies

Year	Subsidies in MD				GDP at market prices (MD)	State budget (MD)	Subsidies as % of GDP	Subsidies as % of budget
	Basic products	Energy	Transportation	Total				
2010	730	550	220	1,500	63,441	17,907	2.4%	8.4%
2011	1,100	1,536	233	2,869	64,730	20,750	4.4%	13.8%
2012	1,242	1,688	278	3,624	70,491	23,287	5.1%	15.6%
2013	1,451	3,734	330	5,515	78,334	26,792	7.0%	20.6%
2014	1,417	2,353	384	4,155	80,865	27,318	5.1%	15.2%
2015	1,531	1,286	416	3,233	84,689	26,862	3.8%	12.0%
2016	1,600	579	433	2,612	89,789	29,250	2.8%	8.9%
2017	1,494	1,550	448	3,492	96,298	32,400	3.6%	10.8%
2018	1,750	2,700	450	4,900	105,269	37,750	4.6%	13.0%
2019	1,800	2,538	450	4,788	113,845	43,021	4.2%	11.1%
2020	3,350	2,286	600	6,236	111,463	51,699	5.6%	12.1%

Source: Ministry of Finance.

Figure 16. Basic products, energy, and transportation subsidies as % of GDP



Source: Authors' calculations using data from the Ministry of Finance.

The INS-CRES-BAD study on the performance of the Tunisian CGC shows that the food subsidy program is not pro-poor as the poorest 10 percent have eight percent of the total subsidies, while the richest 20 percent have 22 percent; thus, the middle class, who represent 70 percent of the total population, share 70 percent of the food subsidies (INS, CRES, and BAD, 2013). The study also shows that food subsidies reduced social inequality (measured by the Gini index) by only one percentage point, from 38.5 percent without food subsidies to 37.4 percent with subsidies.

6. Amen Social

As previously discussed, the current social protection system is based on two components: social security, which is becoming increasingly important and currently covers 85 percent of the working population, and social promotion programs for those who do not benefit from social security (MAS, 2019). Despite its diversification and achievements, this system has many shortcomings and excludes a large part of the population that does not have health and social coverage or a decent income. Therefore, genuine reform of the existing social protection system is necessary to achieve the goals of the revolution and to realize the rights enshrined in the new 2014 constitution. Within this framework, the Tunisian partners (the government, UGTT, and UTICA) – in collaboration with the ILO – have committed to implementing a new project (Social Contract) to promote social dialogue in Tunisia in accordance with Recommendation 202 of 2012.[61]

To meet these objectives, the Amen Social program ("safety" in Arabic) was created according to Organic Law no. 10-2019 of January 2019 (Amen Law) for the promotion of poor and limited-income categories whose lack of resources affects their income, health, education, access to public services, and living conditions. It is a new and integrated social safety net program that covers most social assistance programs in Tunisia (such as PNAFN/AMGI and AMGII) provided by the MAS. The purpose of Amen Social is to expand coverage and achieve greater transparency, equity, and efficiency among social protection programs.

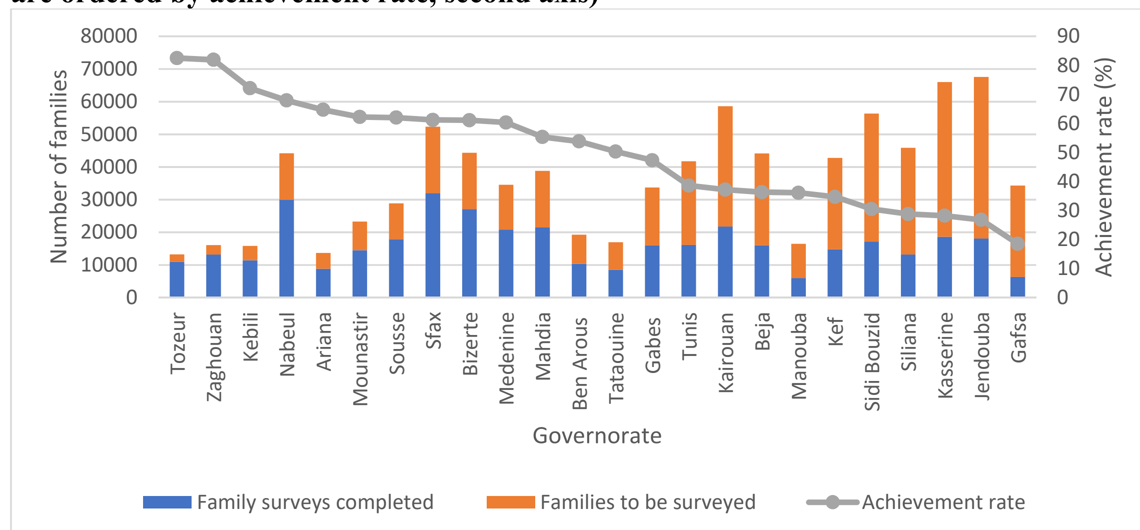
The Amen Law clearly defines, for the first time in Tunisia, the concept of "poor" and "limited income" categories as individuals or families whose lack of resources affects their income, health, education, access to public services, and living conditions (Article 2 of the same law). The first strategic orientation of the Amen Social program was to develop and implement a social identifier number (SIN) at the national level. This SIN will be used as a unified global reference for the identification of social protection system affiliates and beneficiaries of social

[61] In 2013, the Social Contract defined the main guidelines for a comprehensive reform of the national social protection system, which should eventually lead to the establishment of the National Protection Floor (SNPS) (CRES, 2015). The SNPS has been included as one of the main axes of the structural reforms in the framework of the Five-Year Development Plan 2016-2020. The new social protection floor plans to have the following four pillars in place by 2021: (1) the guarantee of access to universal care, (2) the guarantee of a minimum income for those who are deprived of it, (3) the guarantee of a minimum income for the elderly and the disabled, and (4) minimum income guarantee for children. In parallel with the reform of social protection, a reform of the health system was also launched to implement the right to health and social protection enshrined in Article 38 of the constitution.

security services and social assistance programs. It is a mega database grouping all information about each citizen and company already contained in the databases of the *Madania* platform for civil status, national identity cards (ID cards); tax information from the Ministry of Finance and other platforms related to social security and insurance at the CRES, CNSS, CNRPS, and CNAM; and the Computer Center of the Ministry of Public Health (CIMSP) (since the Ministry of Health and the MAS are already fully linked through health insurance and the social security management systems). This SIN allows for the verification, monitoring, and continuous updating of data on these families and cross-referencing between different information systems (see Banque Mondiale, 2019, for more information on the SIN).

Through its social workers, the MAS has continued, since 2013, to collect exhaustive information from families receiving or applying for direct cash transfers and free and reduced-cost health cards (about 30 percent of the Tunisian population). The database for these families will soon be finalized. The Amen Social program targets 868,700 families or almost one-quarter of the total population. Even though data collection started in July 2017, several difficulties (such as strikes of social workers in some governorates, COVID-19…etc.) have prevented the finalization of the survey. Consequently, only data on 391,000 families were collected by the end of 2019, an almost 45 percent achievement rate. The progress in collecting data on poor- and limited-income families shows a significant regional disparity (Figure 17). The poorest governorates had the lowest achievement rates (Gafsa, 18.5 percent; Jendouba, 26.8 percent; Kasserine, 28.2 percent; Siliana, 28.8 percent; Sidi Bouzid, 30.5 percent; and El Kef, 34.7 percent).

Figure 17. Distribution of families surveyed and in progress by governorate (governorates are ordered by achievement rate, second axis)



Source: Authors' calculations using data from MAS.

The procedures used to identify and validate the beneficiaries of direct cash transfers (PNAFN/AMGI) or the reduced-cost or free medical assistance (AMGII) as part of the Amen Social program are based on the PMT, which is officially selected as the basic targeting model

(Article 8 of the law of the Amen Social program). The PMT aims to identify which households are poor and hence eligible for social programs, particularly PNAFN/AMGI and AMGII. Better targeting can ensure lower subsidy costs and reduced inclusion and exclusion errors. The PMT model works well for developing countries, where there are large informal sectors and the vast majority of households pay no tax, as opposed to developed countries, where governments can target based on incomes reported through the tax system (Banerjee et al., 2020).

Section Four: Main social protection challenges in Tunisia and existing gaps

Although the Tunisian social protection system has long been regarded as one of the best in the MENA countries, it also faces several challenges, including reducing the deficit in funds, improving effective coverage, reducing inequalities in parallel schemes, improving the effectiveness of targeted programs, and expanding support for the unemployed and other excluded categories.

1. Social protection challenges in Tunisia

Contributory fund deficits

Since 2005, the National Pension and Social Security Fund (CNRPS) and the National Social Security Fund have experienced an imbalance in their financial results. This imbalance has evolved exponentially from TND 30 million in 2005 to TND 789 million in 2015, reaching TND 911 million and TND 2.511 billion in 2016 and 2017, respectively. The series of negative results recorded is mainly due to the imbalance of the pension branch in both the public and private sectors (Chérif and Essouissi, 2018). In this regard, it should be noted that the resources and expenditure of the pension branch represent approximately 92 percent of the total resources and expenditure of the two funds. A certain number of structural factors have contributed to the financial imbalance of pension systems, specifically a deterioration of the demographic indicator, a notable improvement in life expectancy, an economic slowdown fueling rising informality, and a double-digit unemployment rate for more than 15 years, which are exogenous factors. In addition, the existence of other endogenous factors is explained by a poor setting of the pension, since the benefit served is at a level that greatly exceeds the contribution revenue (Chérif and Essouissi, 2018).

The CNRPS deficit exponentially increased from TND 32 million in 2005 to TND 346 million in 2015, and it was estimated at TND 441 million in 2016 and TND 645 million in 2017. If no reform takes place in the future, the financial gap under the pension branch of the CNRPS will increase from TND 409 million in 2015 to TND 6.913 billion in 2030, which is the equivalent of 2.4 percent of the GDP against 0.5 percent of the GDP in 2015 and therefore a multiplication of the deficit by 17. To cope with financial pressures, the CNRPS had to resort to advances from the State budget, but the extent of the financial pressures forced it to withhold the contributions it collected on behalf of the CNAM, and the cumulative debt to the CNAM reached TND 1.5 billion at the end of 2017 (Chérif and Essouissi, 2018).

The financial deficits of the CNSS originate in the pension branches of almost all the schemes, particularly the general scheme for non-agricultural employees (RSNA). In 2013, CNSS affiliates represented 75 percent of the total affiliates of the social security system and the RSNA represented the most important regime in the private sector (Ben Othman and Marouani, 2016). The deficit of the RSNA represented 86 percent of the total deficit of the CNSS, reaching TND 678 million in 2015 and TND 746 million in 2016, while that of all pension branches was TND 791 million in 2015 and TND 837 million in 2016. In this regard, it should be noted that in 2016, the pension beneficiaries under the RSNA scheme represented 71.31 percent of all pension beneficiaries, while the contributors under this scheme represented 58.44 percent of all the CNSS affiliates. This imbalance is mainly due to the significant improvement in life expectancy at age 60, where pension beneficiaries receive an average of 20 years of benefits, not taking into account the period during which the pension is paid to those who are entitled to it. In addition, a significant portion of the liable population, estimated at 25 percent, is outside the social coverage system (Chérif and Essouissi, 2018). The under-declaration of wages and the under-recovery of contributions declared to the CNSS fund – which reached TND five billion until the end of 2017 – also explain this imbalance (Chérif and Essouissi, 2018). If no reform takes place in the future, the financial gap of the pension branch of the RSNA scheme will drop from TND 678 million in 2015 to TND 5.65 billion in 2030, which is the equivalent of 1.9 percent of GDP against 0.5 percent of GDP in 2015, thereby translating into an eight-fold increase in the deficit. This situation eroded the fund's financial reserves until the beginning of 2016, forcing fund managers to withhold a significant portion of the contributions to be transferred to the CNAM from April 2016. This attitude resulted in a flow to the CNAM of TND 1.5 billion at the end of 2017.

In turn, the CNAM experienced a regular increase in the deficit explained by the increase in expenses relating to chronic diseases fully covered by the fund (CRES, 2014). Since the outbreak of the COVID-19 crisis, the CNAM has experienced a liquidity problem that is growing exponentially. The total contributions not collected by the CNAM from the CNSS and the CNRPS amounted to approximately TND 5.4 billion in October 2020. This adds to the overall deficit of the contribution's payment from many private and public economic institutions that are currently in a difficult situation. This caused a significant drop in the payment of contributions and subsequently worsened the liquidity crisis of the CNAM, which amounted to TND 600 million in October 2020. These debts affected the ability of the CNAM to honor its commitments on time vis-à-vis healthcare providers (public hospitals, clinics, central pharmacies…etc.) and healthcare beneficiaries, with an average delaying payment going from 15 to 90 days. Hence, there is a risk of leaking the entire social and health system of the country if no action to restore the situation is taken.

Inequality in access to benefits

The existence of different schemes by occupation has led to a series of inequities that give some groups more benefits than others. For example, the public sector system uses the highest final salary to calculate benefits, while the private sector system uses an average of salaries over the last 10 years of employment. In addition, the minimum pension is equal to two-thirds

of the minimum wage for those working in the public and non-agricultural wage sectors, while it is only 30 percent for the self-employed.

In addition, the Tunisian labor code provides standards for maternity leave, but these show some inequality. Maternity leave has been set at one month for most female workers, with the exception of civil servants, who receive two months of maternity leave. Most women receive 67 percent of the average daily wage, while women working in agriculture receive 50 percent of their daily flat rate wage based on SMAG. Civil servants receive full pay during maternity leave.

In Tunisia, women are underrepresented in the labor market (25.5 percent) and thus are often unable to benefit from contributory social insurance. In addition, rural farming women are more likely than men to have precarious arrangements that are generally less covered by social protection than stable jobs (UN Women, 2019). Furthermore, the persistence of the gender pay gaps penalizes women's contributions, leading to lower benefit levels for doing work of equal value. Moreover, as women are substantially more likely to perform care and domestic tasks, they tend to experience greater interruptions in their work and contribution histories (Hagerman, 2015).

Under the non-contributory system, less than 13 percent of households with a reduced rate health card are headed by a woman, while beneficiaries whose heads of household are men constitute more than 87 percent of the total number of beneficiaries in 2010 (Nasri, 2020). Theoretically, each beneficiary of the AMG programs (AMGI and AMGII) has the right to access all medical services provided by the public health system[62] (ambulatory care, hospitalization, radiology procedures…etc.). In practice, several health system failures make access to this right very limited. The unequal distribution of medical services between regions, the quasi-absence of specialized doctors, and the lack of medication in public hospitals seriously limit the effectiveness of the healthcare offered to AMGI and AMGII beneficiaries, especially in the interior regions.

According to the 2018 Ministry of Health statistics, the poorest regions, such as the North West and Central West (where most AMGI and AMGII beneficiaries are located), are the least served in terms of the number of doctors, specialized doctors, and dentists in the public sector per 100,000 inhabitants (Table 11). In 2018, 90 percent of public sector specialists were concentrated in the coastal area (North East, Greater Tunis, Central East, South East). The consequences for people living in the interior regions are heavy. They are forced to move over long distances to access public healthcare services or to turn to the private sector and pay the associated costs, which remain too expensive compared to the public sector. The consequences

[62] Article 38 of the new 2014 Tunisian Constitution states that "Health is a right for every human being. The State shall guarantee preventative health care and treatment for every citizen and provide the means necessary to ensure the safety and quality of health services. The State shall ensure free health care for those without means and those with limited income. It shall guarantee the right to social assistance in accordance with the law."

can sometimes be drastic, with deaths that could have been avoided. A World Bank study (Banque Mondiale, 2016) on free medical assistance showed that despite free or reduced-cost coverage, the average direct payments of AMGI and AMGII beneficiaries amounted to TND 577 (approximately USD 285) and TND 664 (USD 325) per year, respectively (comparable to those of contributory schemes).

At the start of the pandemic, Tunisia only had an estimated 700 beds in intensive care units (public and private institutions combined) for around 12 million inhabitants (Nasri et al., 2022). Moreover, not all these beds were functional, and few beds could be allocated exclusively for COVID-19 treatment. Furthermore, not all Tunisians have the same level of access to these facilities. The crisis has indeed highlighted the regional disparities in access to healthcare, with most medical services, particularly intensive care units, concentrated in the capital and coastal regions. A total of 13 out of 24 governorates have no reanimation beds, which are considered essential for COVID-19 patients. Furthermore, laboratories authorized to conduct COVID-19 testing are concentrated in the capital and the coastal regions.

This situation has led to inequalities in social and regional access to care, poor governance of the health sector, particularly in the management of public/private relations, and the overall inefficiency of the health system. In addition to these constraints of access and lack of adequate health infrastructure in disadvantaged regions and rural areas, the health system in Tunisia is poorly managed and shows major shortcomings in terms of management and modernization.

Table 11. Number of doctors (general, specialized, and dentists) and paramedics per 100,000 inhabitants, 2018

Region	Total population	General doctors	Specialized doctors	Total doctors	Paramedics	Dentists
Great Tunis	2,815,102	35	47	82	356	204
North East	1,618,772	24	12	37	256	99
North West	1,184,709	38	10	48	405	77
Central East	2,755,887	33	38	71	353	164
Central West	1,493,701	28	8	36	298	62
South East	1,054,189	29	12	41	327	86
South West	629,088	49	10	59	560	86
Tunisia	11,551,448	33	26	59	347	131

Source: Authors' calculations using data from the Ministry of Health.

Targeting adequacy

The social assistance system in Tunisia suffers from several weaknesses (targeting, funding, program evaluation, and sustainability issues in particular). The lack of transparency seems to be a major element that has made the system inefficient and hampers program effectiveness. However, its benefits have not been sufficiently targeted. Many people who were entitled to receive benefits did not receive them, while others who were less in need received multiple benefits, owing to a number of factors such as political orientation, clientelism, and/or administrative difficulties (ILO, 2011). The results of the evaluation study of the main social assistance programs (PNAFN and AMG) carried out by the CRES/BAD (CRES and BAD, 2017) highlighted the existence of a relatively high level of identification errors. The exclusion errors for access to the AMGII program are worrying; around 61.9 percent of poor families and

53.3 percent of families are living below the extreme poverty line. In addition, only 37.2 percent of the total direct cash transfer program (PNAFN) was allocated to the poorest 20 percent and 60.7 percent of the poorest 40 percent in Tunisia. In addition to targeting problems, the PNAFN program is based on a quota policy (by governorate) that necessarily excludes people in need (Nasri, 2020). It is not based on the universal right to a decent living, which is one of the objectives of a human rights-based approach (Ben Brahem, 2013). The declarative approach guiding the PNAFN program may reduce access for some groups of the population in need, especially for the elderly and those in disadvantaged areas who do not have easy access to information (Nasri, 2022).

School feeding programs have a limited coverage rate that does not exceed 16 percent of the total number of school-age children (for the school year 2017-18). This coverage rate remains relatively low compared to other MENA countries. Indeed, only 34 percent of the households benefiting from PNAFN have children of school age, representing only two percent of all Tunisian school-age children, even though one-fifth of children lived in poverty in 2016 (MAS, 2019). In addition, the assistance provided is very small (TND 120 per year) and has a limited and unsustainable impact on school attendance. The PPAS is limited to three children per household, and the zero to five age group is excluded. Moreover, children from families receiving AMGII, which are low-income families, are not eligible for this program despite the relatively high presence of children in these households (MAS, 2019).

Although the subsidy system is universal and does not exclude anyone, it makes sense for the poor to benefit from it more than the rich. However, the distribution of food subsidies among the different classes of the population is quite egalitarian (INS, CRES, and BAD, 2013).

Exclusion of some categories

While the majority of the working population is legally covered by the Tunisian social protection system, social assistance programs are also available for those who cannot benefit from the insurance system in place for workers.

Despite these strengths, several challenges remain, as the actual rate of insurance coverage is well below the legal rate, meaning that many citizens do not receive any benefits. In 2017, the rate of social coverage of the working population employed in the private sector was estimated by CNSS at 80.34 percent. However, there are contradictory rates and no indicators of the percentage of workers who lack social insurance by institutional sector/employment status.

Social insurance in Tunisia does not protect workers from unemployment. In both the private and public sectors, there are no regular mechanisms to guarantee a minimum income for unemployed workers. In some cases, severance pay exists, although very limited, and income support is provided to first-time job seekers with high qualifications under the Amal program. Even with the financial assistance, healthcare, and family allowances provided to the unemployed during periods of job loss or crisis, the conditions for receiving benefits are quite

restrictive; only those who lose their jobs for economic and technological reasons and who have worked for at least three years in the same company can benefit. In addition to the eligibility criteria, other procedural conditions make it difficult for the unemployed to obtain support (e.g., in case of job loss, the employer is the one in charge of managing the support request of their former employees). Such conditions lead to a low coverage rate.

Yet, Tunisia has tried to integrate informal workers into the social protection system through the creation of several schemes for self-employed workers in 1982 and the low-income workers' scheme for small farmers and fishermen in 2002. However, a significant proportion of mobile workers have found themselves involuntarily engrossed in informal employment (particularly in the agricultural and fishing sectors, with seasonal or casual jobs) and excluded from the social security system, unless they benefit from programs for vulnerable families.

In fact, the size of the informal economy in Tunisia represents between 35 and 40 percent of the GDP (Gatti et al., 2014). In 2014, the national informal employment rate in Tunisia was estimated at 25.8 percent; 31.7 percent of which was for men and 10.7 percent for women (Ben Cheikh and Moisseron, 2021). In addition, Ben Cheikh and Moisseron (2021) argue that informal employment is a phenomenon particularly concentrated among young people in the labor market since 60 percent of men and 86 percent of women in informal employment in 2014 are under 40 years of age.

On the other hand, Bonnet et al. (2019) estimate that the rate of informality in the MENA region among the self-employed (36 percent) is lower than that estimated among employees (44 percent) in 2016. However, in Tunisia, the informality rate of the self-employed reached 58.5 percent compared to only 18.6 percent for employees. This means that the self-employed in Tunisia are particularly less resilient than wage earners and would therefore be more exposed to macroeconomic fluctuations and the vagaries of life (Ben Cheikh and Moisseron, 2021).

Recently, Decree no. 2002-916 of 22 April 2002 was also revised and supplemented concerning the social security system for certain types of workers in the agricultural and non-agricultural sectors to include a large group of women in rural areas, estimated at around 500 thousand who do not have a permanent employer and do not have social coverage. The social protection system for this population "Ahmeni" (Protect Me) is based on a mobile application to facilitate the registration process of rural women and pay their contributions to the CNSS (TND 0.7 per day) without moving to the social security offices. According to data from the National Social Security Fund, the number of women who have applied to join the system has reached around 15 thousand workers out of an estimated 500 thousand workers in the agricultural sector (OCDE, ILO, and CAWTAR, 2020).

On the other hand, migrants in Tunisia working under a contract can enjoy equal access to social benefits as Tunisian workers, except for the old age pension, which requires residence criteria. This restriction does not apply to nationals of countries linked to Tunisia through

bilateral social security agreements. Migrants from countries not covered by a social security agreement with Tunisia may enroll in a voluntary contribution scheme. However, the coverage of this system is still low, probably due to weak incentives. In addition, temporary migrants and undocumented migrants have almost no social security coverage, which increases their vulnerability. Although nondiscriminatory in principle, Tunisian social security excludes those without a formal employment contract. Given that foreigners' access to labor contracts is difficult, this means that access to the social security system is also difficult (Gelb and Marouani, 2020). Looking at health more specifically, access is not easy for irregular migrants, although some solutions are found through NGOs or international organizations. As for the assistance components (such as PNAFN), without formally excluding foreigners, they seem de facto dedicated to resident nationals.

1.1. The expectations of and recommendations for civil society and international organizations and the key issues for moving forward

To cope with the challenges and issues presented in the previous section, several options and reform paths have been recommended by academic researchers, civil society, and international organizations.

With regard to the social insurance system, the recommendations mainly focus on the appropriate methods to bring the social security funds out of their financial deficit, reduce inequality in access to benefits, and include some categories in social security.

In order to diversify the sources of social security financing, the current contribution system based on employee and employer contributions can be replaced by another tripartite system (State, employee, and employer) (Ben Othman and Marouani, 2016).

Another useful way to bring the CNSS out of its financial deficit is the improvement of its governance by tightening the registration controls of workers, especially the self-employed, by monitoring the rate of payment of their social contributions. Only 27 percent of self-employed affiliates have paid their contributions during the four quarters (Chérif and Essouissi, 2018). Also, it is necessary to better control certain affiliates' respect of their real schemes, particularly between the self-employed and Law no. 32-2002, the contribution of which to this scheme is low. In addition, an increase in the number of contributors, thanks to the integration of informal workers, can contribute to improving the budgetary conditions of the CNSS.

In order to encourage informal workers to participate in the social security system, the recommendations focus on two broad policy approaches (ILO, 2017). These approaches are reflected in both the ILO Recommendation on Social Protection Floors, 2012 (no. 202), and the Recommendation on the Transition from the Informal to the Formal Economy, 2015 (no. 204). The first approach is based on the extension of coverage through contributory mechanisms, which includes not only a change in legislation, but also measures to remove administrative obstacles to contributions by facilitating administrative processes as well as

adapting contribution rates and benefit packages. The second approach could be summarized as the "extension of social protection independently of status" based on the expectation that "investing in people" through social protection helps facilitate access to health and social services, enhance income security, and enable workers to take greater risks. Positive results on human capital and productivity can be generated to facilitate the formalization of employment in the medium and long term (ILO, 2017).

For the Tunisian case, Ben Cheikh and Moisseron (2021) suggest increasing the benefits and decreasing the cost of formality while minimizing the cost of the transition to more productive formal, stable, and decent jobs, and supporting workers during this transition. This approach would generate the intended consequences without the unintended negative ones.

On the other hand, the optimization of the targeting of social programs (PNAFN and AMGII) can contain and limit the disincentive effects of social assistance on insurance programs according to Ben Cheikh and Moisseron (2021).

Furthermore, the World Bank (2015) suggests aligning investment code and labor regulations with targeted schemes for unemployment benefits to improve the quality of jobs among the vulnerable self-employed and small and medium-sized enterprises in lagging regions. In this regard, introducing a job loss insurance system may be useful (Vodopivec, 2013). This new insurance scheme can be managed by an independent fund bringing together employees made redundant for economic or technological reasons, as well as another group of graduates who have completed their higher education and have been unemployed for some time by supporting and accompanying them in the implementation of projects. Although these unemployment benefits may seem costly for the time being, their positive effects on social and economic conditions are highly important in the long run. They keep the unemployed linked to the labor market and therefore prevent more costly economic and social consequences in the future.

From a human rights-based approach, civil society organizations such as UGTT and FTDES propose that gender and undocumented migrants be considered in social protection laws (Veron, 2020).

In addition, they advocate for an overall social development strategy in order to foster a social protection system resilient to unforeseen crises and overcome disparities in access to health services between regions and between public and private sectors within the same region. In order to ensure universal access to education and healthcare, as mentioned in the new 2014 constitution, the government must implement the necessary means (financial, human…etc.). Timely access to quality healthcare services can avoid the travel costs to coastal areas borne by households in interior areas.

From a legal point of view, several laws have been proposed to avoid tax evasion and to better control certain affiliates' respect of their real schemes (law lifting professional secrecy of

liberal professions) and to promote job creation (Self-Employed Law and Social and Solidarity Economy Law). These legislative proposals are blocked due to political instability and sometimes by pressure from certain professional categories. On the other hand, the lack of official data and transparency of information also blocks any reform proposal.

Moving to the non-contributory system, the recommendations and expectations are focused on several points. Firstly, the adaptation of a new targeting approach to select new beneficiaries of social assistance programs based on scientific criteria will reduce inclusion and exclusion errors. It is necessary to note that the application texts of a new targeting approach (PMT) were published in May 2020 (Amen law) and its implementation has not yet been launched. For this purpose, we recommended accelerating the finalization of the MAS database (register of beneficiaries). Despite the progress made since 2013, the MAS has complete information on only 46 percent of PNAFN and AMGII beneficiaries (equivalent to 411 thousand households, or 13 percent of the total population). This rate remains low and may further delay the implementation of the target model. It is therefore essential to overcome the obstacles and difficulties encountered in the field by social workers (mobilization of additional human resources and accelerated training to help social workers adapt to new data collection methods such as the use of tablets). In the first phase of implementation, the PMT needs to be carefully accompanied, evaluated, and adjusted to test its performance in the field.

Second, the MAS is called to expand the coverage of its programs to reach more vulnerable groups, such as the less poor but fragile population, women in rural areas without support, and formerly non-poor groups that have lost their sources of income due to the COVID-19 crisis. Therefore, the MAS database should integrate all the information available in other ministries, such as the ministries of finance, education, health…etc. Cross-checking with different interdepartmental databases is a prerequisite for establishing a unique identifier in Tunisia.

Moreover, it is highly important to improve the coverage and quality of school lunch programs. Such programs are very important for the education of students, especially in disadvantaged areas. Although the impact studies of this program remain limited, international experience confirms its importance as a means of combating school dropouts and ensuring balanced nutrition for school-age students (Acham et al., 2012; Adelman et al., 2008; Ahmed, 2004). The coverage rate of this program in Tunisia remains low compared to that of neighboring countries (such as Algeria and Egypt in particular). It is important to increase the coverage of this program and to coordinate with civil society, which works a lot on this issue in elementary schools in disadvantaged areas.

Finally, we recommend progressively reducing CGC spending. Universal subsidy spending is a major constraint in reforming the systems. Therefore, it is useful to review the list of subsidized products and target subsidies to the most vulnerable groups. Several successful experiences can be followed (Iran, India, and Morocco). Iran replaced the universal subsidy with direct transfers for poor families (Salehi-Isfahani et al., 2018). In Morocco, geographic

targeting was chosen based on a poverty map that identified the poorest areas. India followed a progressive targeting program in several stages over the period 1992-2011. Based on a multidimensional approach, a synthetic indicator was used in the assessment of living standards to classify households according to their order of merit for social assistance. The transition from a universal subsidy system to a direct transfer system must be gradual and well-studied to minimize the negative effects that may accompany this transition.

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