

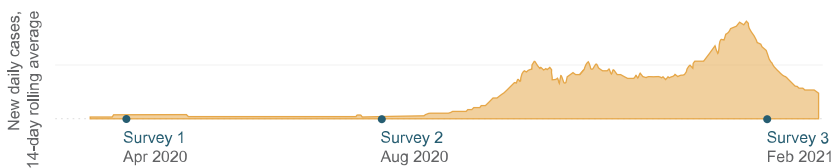
# Finding the Balance: Public Health and Social Measures in Tunisia

## What is the purpose of this report?

This report describes findings from a telephone survey with 1,219 people conducted in February 2021. The survey examined how people respond to public health and social measures (PHSMs) to prevent COVID-19. The sample is representative of households with access to a landline or cell phone, but does not include people without access to phones. As phone penetration varies by country, findings should be interpreted with caution.

Survey data are analysed alongside epidemiological, mobility, and media data. Triangulating these data sources offers valuable context to better understand the acceptability, impact and effectiveness of PHSMs.

This is the third survey and analysis conducted since the pandemic began (see the [first](#) and [second](#) reports).



### National COVID-19 Data Snapshot on 26 February 2021

Total reported cases	232,615
Cumulative incidence rate per 100,000 people	1,971
Test positivity rate	18.8%
Proportion of people who test positive for COVID-19 among all people who took a test, averaged over 7 days	
Total confirmed COVID-19 deaths	7,974
Case fatality ratio	3.4%
Proportion of total reported deaths among all people reported as testing positive for COVID-19	

## What are the highlights from this report?

### Disease Dynamics and PHSM Implementation

Tunisia has experienced one of the largest outbreaks of COVID-19 on the continent. After the reimplementing of PHSMs in October 2020 amidst a second wave of cases, unrest among younger populations escalated throughout the country due to the economic burden of PHSMs. One in five survey respondents said they or someone in their household had a confirmed or likely COVID-19 diagnosis.

### PHSM Support and Self-Reported Adherence

Support and self-reported adherence were low for individual measures, as well as for measures restricting economic activities and social gatherings, with younger populations reporting the lowest rates. Satisfaction with the government's response to COVID-19 was among the lowest of all surveyed African Union Member States. Respondents in Tunisia had higher trust in their military than any other government or international institution.

### Risk Perceptions and Information

Compared to August, fewer respondents believed COVID-19 would affect many people in Tunisia or that the virus would seriously affect their health; however, there has been an increase in people believing that their risk of catching the virus is high. Only one-third of respondents said they would likely take a COVID-19 vaccine when it becomes available, the lowest proportion of all surveyed Member States. Information campaigns about the safety and quality of the vaccine will be critical with distribution expected to begin imminently.

### Secondary Burdens

Half of those in need of health care reported skipping or delaying services—significantly lower than in August, but markedly high compared to other Member States. Lower-income households and those in rural areas were more likely to report disruptions to health care, income loss and barriers to food access.

**Disease Dynamics and PHSM Implementation**

# What is the relationship between PHSMs and cases reported?

The political and social context influences how well PHSMs are implemented and adhered to, which affects COVID-19 disease transmission and mitigation.

## Situational Awareness

Tunisia experienced a first significant wave of COVID-19 cases starting in September and peaking between mid-October and mid-November, with 1,600-2,000 new cases reported per day. This surge in cases was [reportedly](#) linked with the relaxing of PHSMs in June, including the reopening of borders, increased tourism and the loosening of restrictions on gatherings. In response, Tunisia re-implemented strict PHSMs throughout the month of October. A surge of unrest followed, with young people protesting against the economic burden resulting from lockdowns—in 2020, youth [unemployment](#) climbed past 30%.

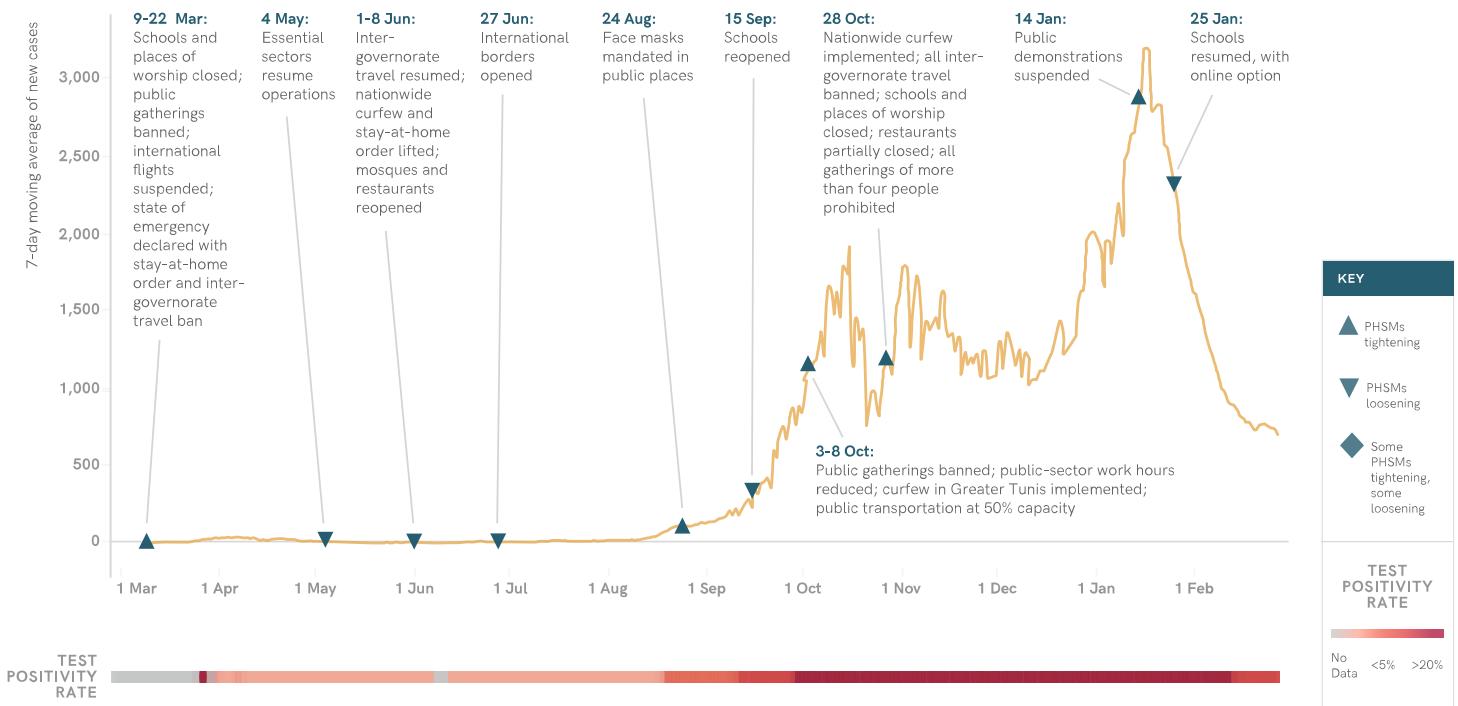
A second wave, with approximately 3,000 reported cases per day, peaked at the end of January 2021 but has since dropped to below 1,000 per day. At the time of the survey, most of the PHSMs put in place in October were still active, including a curfew and closures of places of worship, restaurants, public events and public gatherings.

Many cases during both the first and second peaks likely went undetected. According to survey results, more than 20% of respondents said they or someone in their household had a confirmed or likely COVID-19 diagnosis. This is the highest of all surveyed Member States and much higher than the 14% reported in South Africa, which had the highest number of reported cases. Further, social media users expressed concerns in early January that hospitals had run out of COVID-19 tests, and the media [reported](#) critical care beds were rationed to accommodate the surge of COVID-19 hospitalizations.

Since October, the test positivity rate in Tunisia has ranged from 20-30%, much higher than the WHO-recommended 5%. Due to limited availability of testing kits, Tunisia limited tests to people with symptoms or who had been in close contact with confirmed cases—likely contributing to the high positivity rate.

As a part of the [COVAX facility](#), vaccine distribution is expected to begin in early March, first prioritizing health care workers; however at the time of this writing, rollout had yet to begin.

## Despite re-implementing PHSMs in October, cases continued to rise until February with very high test positivity rates.



## PHSM Support and Self-Reported Adherence

# Do people support and follow measures?

PHSM effectiveness relies on widespread acceptance and behavior change.

### What the data say

Less than half of survey respondents in Tunisia reported support for measures that restrict public gatherings, and only a quarter supported measures that restrict movement, which is associated with a higher economic burden. Self-reported adherence was also low, despite numerous restrictions in place.

- Analyses of social media data show that mentions of non-adherence to PHSMs, such as flouting of public gathering bans, were common, driven by reports of public defiance and civil unrest against government-imposed measures.
- Support and self-reported adherence were higher among in older age groups, reflecting discontent among younger populations towards the burden PHSMs impose.

### In the media

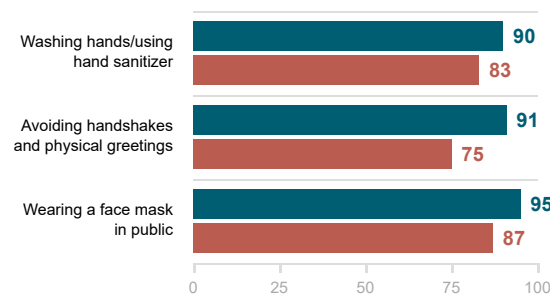
“In Tunisia, masks wearing is almost 30%, very far from the required 95%!!! ... wear your masks and save [lives]! #covid #masks #Tunisia”

—Twitter user, 15 October, 2020

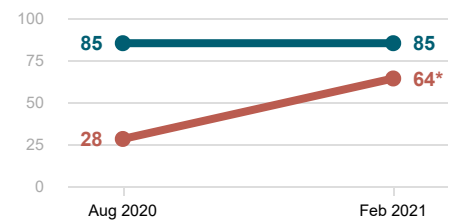
## Individual measures

While support for individual measures did not change between August and February, adherence increased 40 percentage points due to stronger communications from the government about their importance, accompanied by [enforcement](#) of mask-wearing.

Percent that **support** and **adhere** to each individual measure in Feb 2021



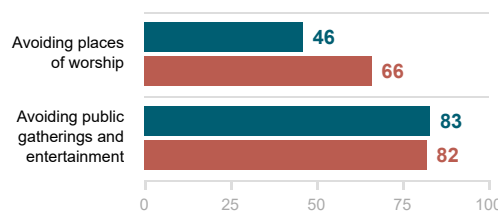
Trend in percent that **support** and **adhere** to all individual measures (composite score)



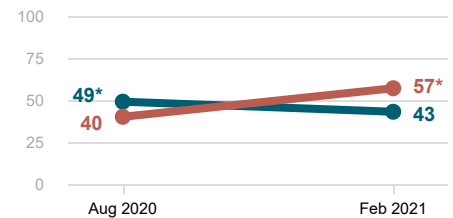
## Measures restricting social gatherings

While adherence to measures restricting social gatherings increased as a result of the October lockdowns, support for them decreased—a sign of public opposition to all restrictive measures.

Percent that **support** and **adhere** to each social measure in Feb 2021



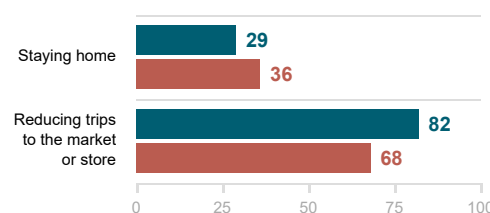
Trend in percent that **support** and **adhere** to all social measures (composite score)



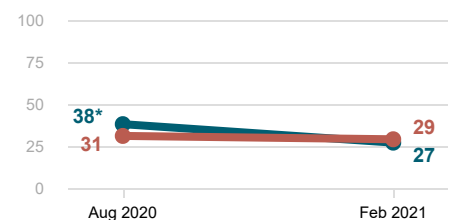
## Measures restricting movement

Compared to August 2020, support for measures restricting movement declined. While self-reported adherence was comparable across time, it was much lower than in Egypt (43%) and Morocco (39%).

Percent that **support** and **adhere** to each movement measure in Feb 2021



Trend in percent that **support** and **adhere** to all movement measures (composite score)



## PHSM Support and Self-Reported Adherence

# Whom do people trust?

Public trust in government and institutions is a key driver of support for and adherence to PHSMs.

### What the data say

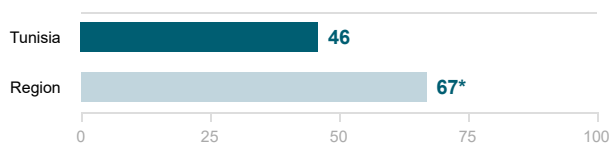
Less than half (46%) of survey respondents in Tunisia were satisfied with the government's pandemic response, the lowest of all Member States and a substantial drop since the August survey (61%). Notably, the military was the most trusted institution in Tunisia, with no other government entity in the top most trusted institutions. Tunisia has changed its health minister three times since the beginning of the pandemic.

- Respondents aged 18-35 were among the least satisfied, aligning with reports of increasing unrest and criticism of the government's response and subsequent [economic deterioration](#) exacerbated by the [pandemic](#).
- There are also marked differences in trust for institutions by age group. Those under 35 years of age were significantly less satisfied with the military than those over (77% and 86%, respectively). Age breakdown of trust in the Ministry of Health also revealed similar trends—only 60% of those under 35 trusted the Ministry of Health, versus 67% of those over 36.
- Notably, the survey found that the media was one of the least trusted sources of information for the COVID-19 pandemic, at 44%—with youth averaging around 30% and those over 36 averaging 52%.

### What do people think about their country's institutions?

Less than half of all survey respondents in Tunisia were satisfied with the government's pandemic response, compared to almost 90% in Morocco (the other Member State surveyed on this question in the Northern region).

#### 46% are satisfied with the government's pandemic response



#### Top five most trusted institutions and individuals

Percent of people reporting trust in each source

Army/military	83%
Community health workers	75%
Religious institutions	68%
Police	67%
Family doctor	66%

### What are people saying in the news and on social media?

While traditional media coverage of the government response to COVID-19 in Tunisia was positive overall—both from state-affiliated as well as independent news outlets—discontent was frequently expressed on social media platforms. Negative sentiments towards the government surged in October 2020 and January 2021 when “hundreds of people took the streets to protest the lack of food and other essential items during COVID-19 lockdown,” said a Twitter user on 16 January. Unemployment, which has increased during the pandemic, was widely cited on social media as a key driver of social unrest.

Negative sentiment towards the government continued to rise in February, particularly about the vaccine rollout slated to begin in early March. Social media users widely amplified conspiracy theories around Bill Gates and vaccine distribution, contributing to undermined trust in international organizations. Finally, consistent with survey results, social media coverage of military units was positive, with users praising the army for its disinfection operations in the cities of Remada and Dhehiba.

#### In the media

“For the fourth day in a row .. Violent clashes between security in #Tunisia and dozens of protesters against imposing a curfew as part of anti-Corona measures, and the army is spreading to secure public facilities.”

- Rassed News, Twitter, 18 January, 2021.

## Risk Perceptions and Information

# How do people understand risk?

Perceptions of risk are influenced by the epidemiology of an outbreak as well as the type and quality of information disseminated by trusted sources.

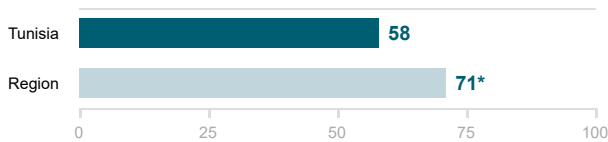
### What the data say

While almost 60% of respondents in Tunisia agreed that COVID-19 would affect many people in the country, personal risk perceptions were low, with only 22% saying they were at high risk of contracting the disease and 32% believing their health would be seriously affected. These low perceptions of personal risk and severity of COVID-19 are troubling given the seriousness of the most recent wave of the epidemic.

- Perceptions of risk to the country were among the lowest of all surveyed Member States, on par with Morocco in the Northern Region (21%).
- Low perceptions of personal risk were reported more frequently in rural communities (50% versus 32% in urban zones) and in lower-income respondents (48% versus 31% among those with higher incomes).
- Belief in misinformation is high, with nearly half (46%) of respondents reporting that COVID-19 can be cured with herbal remedies—up nine percentage points since August.
- Rates of stigmatization are also high; two-thirds of respondents believe that recovered people and health care workers should be avoided for fear of catching COVID-19.

### How do people understand the risk of COVID-19?

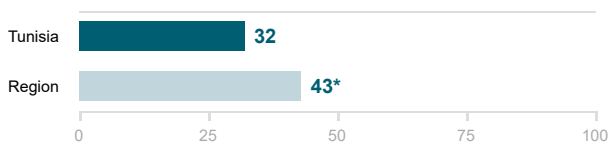
**58%** believe that COVID-19 will affect many people in their country



**22%** believe that their personal risk of being infected with COVID-19 is high



**32%** believe that their health would be seriously affected by COVID-19



### Do people stigmatize others?

**67%** think they should avoid health care workers because they could get COVID-19 from them

**66%** think they should avoid people who have had COVID-19 in the past because they remain infectious

### Do people believe accurate information?

**94%** understand that infected people may never show symptoms but could still infect others

**81%** understand that infected people may not show symptoms for five to 14 days

**46%** believe that COVID-19 can be cured with herbal remedies

## Risk Perceptions and Information

# How are perceptions of risk informing actions?

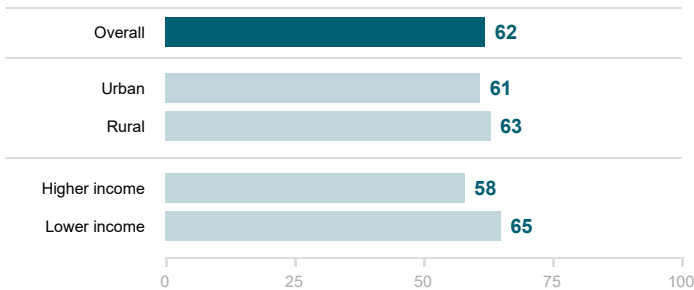
How people understand risk influences key behaviors and decisions that could mitigate disease transmission, including adherence to PHSMs and vaccine uptake.

### How do people feel about resuming day-to-day activities?

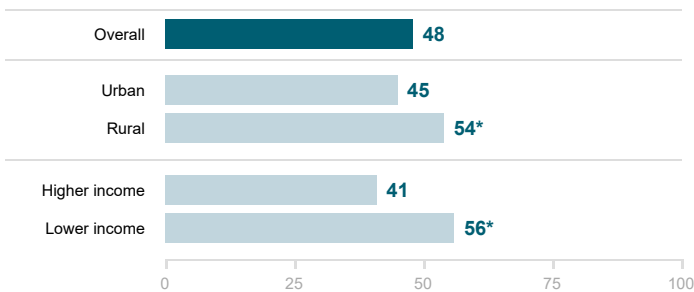
About 60% of respondents reported that returning to normal activities made them anxious; about half had resumed normal activities. Less than 15% were comfortable taking public transportation.

- More lower-income respondents (56%) reported resuming normal activities even though they were anxious to do so (65%), suggesting that the economic burden of not going to work far exceeds the risk of COVID-19 exposure.
- Rural respondents were more likely to report having resumed activities and feeling comfortable taking public transportation; this group also reported substantially lower perceptions of personal risk (14% vs. 25% of those in urban areas).

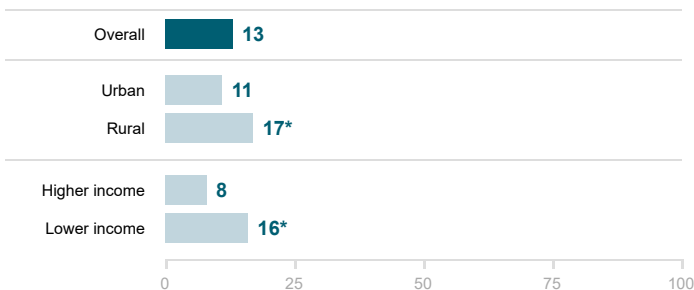
#### 62% feel anxious about resuming normal activities



#### 48% have already resumed normal activities because they believe COVID-19 risk is low



#### 13% feel comfortable taking public transportation

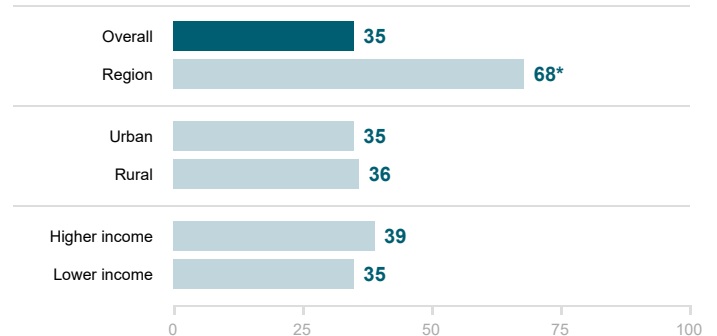


### What do people think about vaccines?

Only one-third of respondents said they would likely take a COVID-19 vaccine when it becomes available, the lowest among all surveyed Member States.

- Vaccine hesitancy was significantly higher among those aged 45 years old and above compared to those under 45 (66% vs. 55%).
- As expected, respondents who did not plan to get vaccinated had lower risk perception than those who did. One-fifth reported they did not plan to get vaccinated because they do not think they were at risk of catching the virus.
- With vaccine distribution expected to begin in early March 2020, information campaigns about the safety and quality of the vaccine will be critical; the most commonly reported reason for not getting the vaccine was lack of information.

#### 35% plan to get a vaccine when available



#### Top reasons people would not get the vaccine

Among people who said they would not get the vaccine, their reasons were:

I do not yet know enough about the vaccine to make a decision	30%
I do not feel I am at risk of catching the virus	20%
I do not trust vaccines/health authorities	15%

#### In the media

"Coronavirus (Covid-19) Vaccine. The Arab countries do not have the budget to buy the vaccine, nor to equip scientific laboratories to manufacture it...."

– Twitter user, 2 March 2021

## Secondary Burdens

# Are people skipping or delaying health care?

Mobility restrictions, overburdened health care facilities, and fear of catching COVID-19 can prevent people from seeking essential health care; understanding the barriers to access can help improve linkages to care.

### What the data say

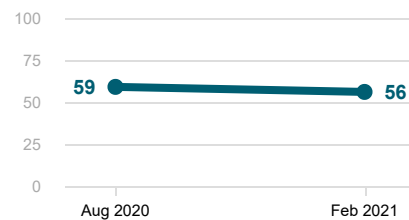
In Tunisia, about half of households in need of health care reported skipping or delaying visits to health services in the previous six months. This is a 35 percentage point decrease since August, but still higher than in other Member States surveyed. Skipped services and medication access issues were more common among rural and lower-income households. While public health facilities in Tunisia provide free services to all, survey findings point to the [social inequality](#) between the rural interior and urban coastal regions in Tunisia.

- The most common reasons for skipping a health care visit were fear of catching COVID-19 (56%) and health facility disruption (21%). These findings are in line with the size of the epidemic as well as reports of health care facilities being overwhelmed with COVID-19 patients at the time of the survey.
- Among respondents who skipped care, more than half reported it was for non-communicable diseases, with cardiovascular issues and diabetes most commonly reported. Additionally, 6% of respondents who skipped care reported having respiratory problems, a symptom of COVID-19.

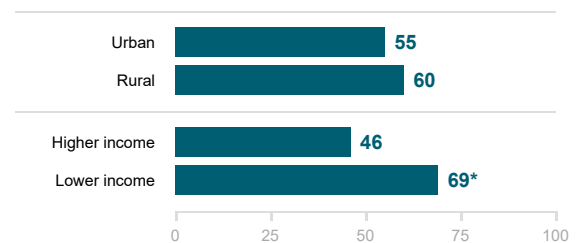
### Difficulty getting medicines

The percentage of households reporting difficulty accessing needed medication was comparable between the two surveys. However, issues accessing medication remain much higher among lower-income households.

Trend in percent of households having difficulty getting medicines in the past three months



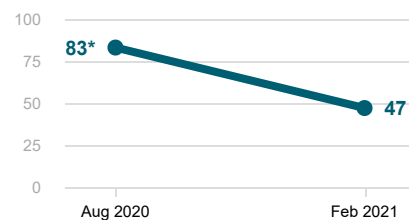
Percent having difficulty getting medicines by category



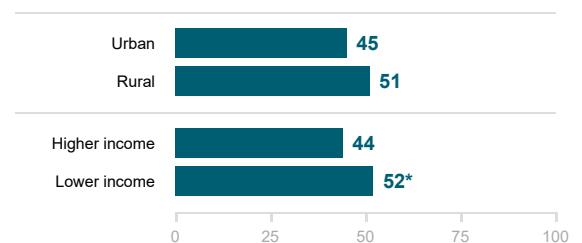
### Skipping or delaying health visits

Reports of skipped or delayed health services dropped significantly in Tunisia. Health service delivery disruptions were higher among lower-income households.

Trend in percent of households skipping or delaying health care visits in the past six months



Percent skipping or delaying health care visits by category



#### The reasons why visits were skipped or delayed

People could choose multiple responses

Worried about catching COVID-19	56%
Health facility disruption	21%
Cost/affordability	19%
Mobility restrictions/transport challenges	12%
Self-isolating with Suspected COVID-19	2%

#### The types of visits which were skipped or delayed

People could choose multiple responses

Non-communicable diseases	52%
General/routine check-up	32%
Diagnostic services/symptoms	19%
Reproductive, maternal and child health	9%
Communicable diseases	1%

## Secondary Burdens

# Are people experiencing income loss or food insecurity?

Measures restricting economic activities can severely disrupt livelihoods and access to markets; understanding the type and extent of these burdens can help inform policy changes and identify people who need support.

## What the data say

Three-quarters of respondents reported losing income, with one quarter reporting complete loss of income. Overall, [unemployment](#) in Tunisia was projected to be almost 22% by the end of 2020. Only 3% of respondents stated they had received support from the government, a decrease of eight percentage points since August consistent with the fact that no additional government support programs have been announced since the August survey.

- Younger respondents (aged 18-45) reported higher rates of income loss than those aged 46 and older, aligning with reports that [unemployment](#) among younger populations has climbed past 30%. According to social media analysis, unemployment is a key driver of social unrest, particularly among Tunisian youth.
- Income loss is also significantly higher among those in the lowest-income group and in rural areas.
- More than 80% of respondents experienced barriers to food access in the previous week, the highest rate in the Northern Region. The most prevalent reasons were loss in income and rising prices—with low income respondents reporting significantly higher rates than higher income respondents (85% vs. 44% for loss of income, and 82% vs. 46% for rising prices).

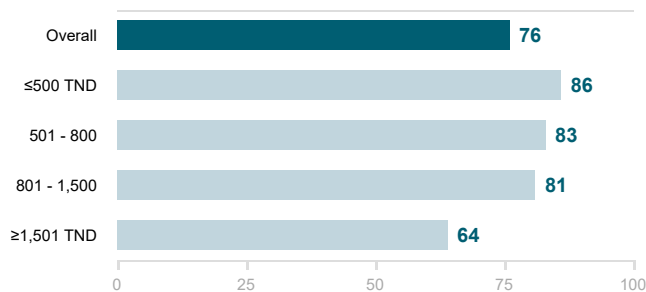
### Reported barriers to food access

Percent of people reporting each barrier

Less income	64%
Higher food prices	63%
Food markets closed	23%
Mobility restrictions	26%
Food market supply shortages	31%

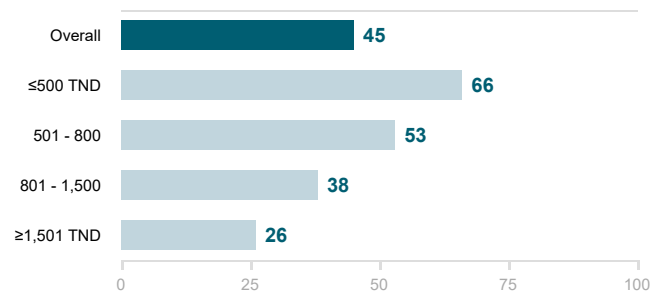
## Household income

Percent of households experiencing **income loss** by category



\*Household income is significantly associated with income loss.

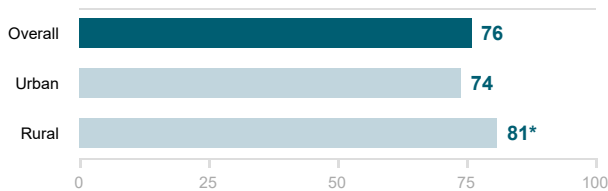
Percent of households **missing meals** by category



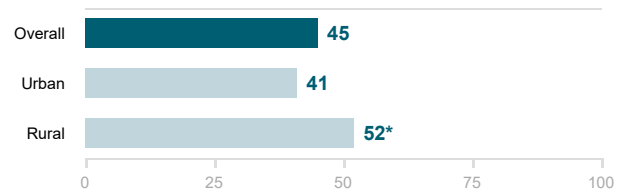
\*Household income is significantly associated with missing meals.

## Location

Percent of households experiencing **income loss** by category



Percent of households **missing meals** by category





## Appendix

## Endnotes

### Report notes

Regional comparisons were conducted as per the following categories: East Africa (Ethiopia, Kenya, Uganda, Sudan); West Africa (Ghana, Nigeria, Liberia, Guinea Conakry, Senegal, Côte d'Ivoire); Northern Africa (Tunisia, Morocco, Egypt); Central Africa (Cameroon, Democratic Republic of Congo); and Southern Africa (Mozambique, South Africa, Zambia, Zimbabwe).

Two-tailed t-tests to compare two categories, and chi-square tests to compare more than two categories were conducted to assess whether there were statistical differences. An asterisk (\*) indicates statistical significance where  $p < 0.05$ .

The figure on page 2 of the report shows the 7-day rolling average of new cases alongside test positivity and mobility data from March 2020 to February 2021. Where test positivity data and/or mobility data are missing, the data are unavailable.

Full survey results are available here and on the PERC online [dashboard](#). For full details on data sources, methods and limitations, see [preventepidemics.org/perc](https://preventepidemics.org/perc).

- Ipsos conducted a telephone survey of a nationally representative sample of households with access to a landline or cell phone. Results should be interpreted with caution as populations without access to a phone are not represented in the findings. The percentages reported in Ipsos charts may be different from percentages reported in other PERC products and communication of these data. Differences may be reconciled by investigating the denominator and/or weights used.
- Novetta Mission Analytics conducted research to collect insights from *traditional and social media* sources using online, open-source African media, and geolocated African Twitter and Facebook sources. These qualitative data reflect public narratives in online media sources and among social media users. Quotes have been edited where necessary for clarity, with modified text in brackets. Content from social media sources in the public domain should be interpreted with caution given that views reflected might be extreme in nature and are not representative of the population of a given country or demographic.
- Africa Centres for Disease Control and Prevention (Africa CDC) provides *epidemiological* data daily for African Union (AU) Member States. Africa CDC receives case, death and testing data from each AU Member State. Because not all AU Member States report daily, numbers could be delayed, especially for testing data which is more commonly reported late, or in periodic batches (e.g. weekly).
- Other Data is drawn from publicly available sources.

Findings reflect the latest available information from listed sources at the time of analysis, and may not reflect more recent developments or data from other sources. Data vary in completeness, representativeness, and timeliness.

### Country notes

The survey sampled from Tunisia consisted of 1,219 adults (818 urban, 401 rural), collected between 11 to 21 February 2021.

Income classifications were based on existing data on local income distributions, which were used to create four income bands, defined as:

- Low income: Monthly household income 500 TND and below
- Low-middle income: Monthly household income 501 TND - 800 TND
- High-middle income: Monthly household income 801 TND - 1,500 TND
- High income: Monthly household income 1,501 TND and above