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IMPLEMENTATION OF THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS

Initial reports submitted by States parties to the Covenant, in accordance with Council resolution 1988 (LX), concerning rights covered by articles 10-12

TUNISIA

[11 June 1987]

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CONTENTS

INTRODUCTION

Tunisia has based its policy since independence on man, the means and ultimate objective of its development. Economic, social and cultural reforms are all geared to the advancement of the Tunisian citizen.

Tunisia's adoption of the International Covenant on Economic, Social and Cultural Rights reflects its determination to further consolidate these achievements and to bring them to the notice of the international community.

The present report is intended to inform the distinguished experts of the Committee on Economic, Social and Cultural Rights of Tunisia's achievements in regard to:

Protection of the family, mothers and children (article 10 of the Covenant);

Right to an adequate standard of living (article 11 of the Covenant);

Right to physical and mental health (article 12 of the Covenant).

It should be noted that the rights granted and the practical measures taken in Tunisia for the economic, social or cultural advancement of the individual are of benefit to all Tunisians, without any distinction as to sex, race or religion.

PART I

ARTICLE 10: PROTECTION OF THE FAMILY, MOTHERS AND CHILDREN

A. Protection of the family

The adoption of the Personal Status Code immediately following independence (13 August 1956) served to improve protection of the family in Tunisia.

The Code reflected the desire to evolve towards a new type of family based on greater equality of rights and duties as between the two spouses. At the same time, it defines a new social ideal more consistent with the spirit of Islamic law and more receptive to the requirements of progress.

One of the fundamental innovations of the Personal Status Code is the abolition of polygamy, which was "an affront to human dignity". The Code took a strong line against this practice and the legal ruses devised to circumvent its prohibition. On several occasions, and particularly in 1958 and 1964, the Personal Status Code (article 18) has prohibited bigamy and made it an offence punishable by imprisonment and/or a fine, and it has created an offence of complicity for the bigamist's second wife and an offence of concubinage for spouses continuing or resuming cohabitation after their union has been declared null and void by reason of bigamy or non-observance of the legal provisions for the contracting of marriage.

The establishment of the National Office for the Family and Population under Act No. 84/70 of 6 August 1984 serves to improve protection of the family. The responsibilities of the Office include preparing action programmes designed to promote the family and safeguard its balance; monitoring the achievement of national objectives in the areas of population policy and family policy in conjunction with the institutions concerned; undertaking training and retraining activities for health, social and educational personnel in co-operation with the institutions and structures concerned, particularly in the fields of family planning, communication and protection of the family; and constantly seeking to inform and educate the population, particularly at the family, school, professional and associative levels.

1. Guarantee of the right of men and women to enter into marriage freely and to establish a family

In Tunisia, the marriage ceremony is performed in the presence of two notaries or of the civil registrar with two reputable witnesses in attendance. Marriages are recorded in the marriage register. Marriage may be entered into only if certain conditions are met: the mutual consent of the prospective spouses is obligatory, the right to forced marriages having been abolished.

On 13 August 1965, Habib Bourguiba, President of the Republic, stressed that "marriage is not a business transaction, only the happiness of the household counts ... The decision should therefore be left to those concerned by the marriage: the husband and the wife".

Before the promulgation of the Personal Status Code, the consent of the tutor was required for a girl's marriage to be valid. The father of a girl refusing to be married could use his right of compulsion (jabr) and oblige her to marry (Malekite rite predominant in Tunisia). In the event that the girl was invited to give her opinion, her silence was taken for consent by virtue of the adage "silence gives consent". As to the expression of consent, no particular form of words was previously required.

This discrimination between the sexes regarding capacity to enter into marriage was the logical corollary of the former article 7 of the Code of Obligations and Contracts, which stated: "For the purposes of the present Code, any individual of the male sex over 18 years of age shall be deemed to have attained his majority. A child of the female sex shall remain under tutelage until two years after her marriage." This discrimination was eliminated by the decree of 3 August 1956 which repealed article 6 of the Code of Obligations and Contracts, establishing the legal age of majority for both sexes at 20 years. At the same time, forced marriages have been abolished and article 3 of the Personal Status Code provides that "marriage is formed only with the consent of the two spouses".

2. Measures to facilitate the establishment of a family

Under Act No. 80-36 of 28 May 1980 supplementing Act No. 60-30 of 14 December 1960 organizing social security schemes, an insured person who has dependent children entitling him to family allowances and whose spouse does not have an occupation has a right to a "supplementary single-salary benefit" payable at the following quarterly rates:

D 9,375, in the case of a household with one dependent child;

D 18,750, in the case of a household with two dependent children;

D 23,475, in the case of a household with three or more dependent children.

The supplementary single-salary benefit is paid to the person who has custody of the children.

Incentives for the acquisition or construction of housing:

Under Act No. 73-24 of 7 May 1973, a housing savings scheme was introduced under which loans are granted to individuals entering into a housing savings contract who undertake to apply the full amount of the savings and the loan to financing housing intended to serve as principal residence for themselves, their ascendants or their descendants.

Act No. 77-54 of 3 August 1977 establishing a Housing Promotion Fund for Wage-earners helps wage-earners whose monthly earnings are between the guaranteed minimum wage (SMIG) and one and a half times the SMIG to obtain a loan for the construction of housing or the acquisition of new housing.

In addition, members of the National Retirement and Social Welfare Fund can obtain loans for the acquisition of new housing, the construction of housing or the acquisition of land with a view to the construction of housing by virtue of Decree No. 76-54 of 23 January 1976, as amended and supplemented

by Decree No. 78-624 of 6 July 1978. Decree No. 72-1109 of 20 December 1974 grants certain types of civil servants the right to be housed in accommodation belonging to the State or to receive a housing allowance.

3. Measures aimed at maintaining, strengthening and protecting the family

Family allowances

Under Act No. 60-30 of 14 December 1960, family allowances were limited to the first four children for wage-earners in the private sector.

Wage-earners in handicrafts and agriculture were excluded. This restriction was rectified by Act No. 63-26 of 15 July 1963, which provided that if any of the first four children die, they can be replaced by those immediately following them in due order, still up to a maximum of four.

As regards the public sector, Act No. 65-46 of 31 December 1965 also limited the number of children for which a family allowance can be claimed to four. However, it is not possible to replace any of the first four children who die by those following up to a maximum of four. It should be emphasized that the restriction of four applies to all children taken into care as a result of an informal guardianship, placement with a family or a judgement awarding custody.

Allowances are an entitlement only in the case of children below the age of 14. In the case of children aged 14 and above, the allowance is granted:

(a) Up to the age of 16, for children regularly attending an institution of primary education;

(b) Up to the age of 18, for children in apprenticeship whose remuneration does not exceed 75 per cent of the statutory minimum wage for building labourers;

(c) Up to the age of 20, for children regularly attending an institution of secondary or advanced technical or professional education, whether public or private, as long as such children are not in gainful employment;

The allowance is also payable:

- For girls who act in loco parentis in respect of their brothers and sisters when the mother dies or is crippled or divorced or widowed and such girls are in full-time gainful employment.

- Above the age of 20, for disabled children (article 54 of Act No. 60-30).

Family allowances continue to be granted in the event of the wage-earner's death from industrial accident or occupational disease, provided that the children are of an age carrying entitlement thereto, on the terms established in article 54 above. Family allowances are also granted for children born within 300 days following the wage-earner's death (article 56). The allowances are paid to the person who has custody of the child (article 64).

Maintenance after retirement:

Act No. 73-71 of 19 November 1973 provides that "the retirement pension or corresponding settlement or the proportional pension shall be supplemented, as appropriate, by dependency allowances. Such allowances shall be granted at the same rates, on the same terms and in accordance with the same procedures as those applying to serving staff".

Tax exemption:

Granted in respect of the Tax on Wages and Salaries (ITS), pensions and annuities (decree of 29 March 1945 and Act No. 62-75 of 31 December 1962) and the compensatory levy (compensation personnelle de l'Etat - CPE), (decree of 31 March 1932, Act No. 62-75 of 31 December 1962, Act No. 65-46 of 31 December 1965, Act No. 67-57 of 31 December 1967, Act No. 69-64 of 31 December 1969, Act No. 70-66 of 31 December 1970, Act No. 73-83 of 31 December 1973, Act No. 74-101 of 25 November 1974; in respect of registration fees: Act No. 62-81 of 31 December 1962).

Tax exemptions on income are granted for:

(a) Supplementary retirement or pension benefits for dependants;

(b) Family allowances and single-salary benefits paid solely by employers to their staff in respect of dependent children;

(c) Allowances, grants and benefits furnished by the State, the public authorities and public institutions in pursuance of welfare and insurance legislation;

(d) Old-age, disability and survivor's pensions granted under Decree No. 71-452 of 17 December 1971;

(e) Allowances and annuities provided to accident victims and damages paid by virtue of a sentence ordering financial compensation for substantial bodily damage (standard third-party liability insurance);

(f) Life annuities paid in exchange for perpetuities.

As regards direct taxation, provision is made for deductions for large families. The State contribution is basically determined (decree of 31 March 1932) by the taxpayer's status (unmarried, married, widowed, etc.) and family and social situation. In this connection, a series of measures have been introduced in favour of large families:

Exemption for married taxpayers with dependent children whose net taxable income after all deductions is 100 dinars or less;

Exemption of gross income (before any deductions) earned by households, with or without dependent children, deriving from wages and pensions and not exceeding 360 dinars per year;

Similarly, taxable income for the purposes of the CPE is calculated allowing for the deductions indicated below;

With the same reservation, children adopted by the taxpayer in the conditions provided for by the legislation in force;

Professional expenses at a fixed rate of 10 per cent of income from wages and pensions. In the case of some specifically designated occupations, this rate is higher;

Schedular taxes due or paid on taxable income;

Life insurance premiums guaranteeing the surviving spouse, descendants or ascendants a fixed capital in the event of the policy-holder's death;

Interest on debts and arrears in compulsory or voluntary annuities, to which alimony is assimilated;

Deductions at a set amount of 45 dinars for married or non-remarried taxpayers with one or more dependent children;

Deductions for dependent children at a set amount of 45 dinars per child up to a maximum of four children born after 31 December 1962 and under 20 years of age on 1 January of the tax year. Children over the age of 20 pursuing their studies without a scholarship are also regarded as dependants of the taxpayer, who is entitled to a deduction of 45 dinars per child;

In the same conditions, disabled children who are living under the same roof as the taxpayer and to whom the taxpayer owes support by virtue of personal status, are also exempt from the CPE;

Allowances (on a family wage, family allowances) paid by employers or groups of employers to their staff;

Interest on amounts entered in savings bank deposit books (Postal Savings Bank and Housing Savings Bank) and special savings accounts opened with banking establishments;

Maintenance granted to dependent ascendants of the taxpayer without being court-ordered, up to a limit of 5 per cent of such income with a maximum of 90 dinars per dependant.

Deductions in respect of family dependants are also provided for under the ITS, a schedular tax on wages and salaries.

In addition to a general rebate of 100 dinars and a reduction of 10 per cent of gross income for professional expenses, married taxpayers receive a special deduction under this tax, which is applied generally to all wage-generated income, including pensions and annuities.

Lastly, it should be mentioned that, before 1983, a wife who was also a wage-earner received the same deductions as her spouse for dependent children.

The 1984 Finance Act (article 7) changed the method for taxing spouses' income by introducing the principle of separate taxation. Up until 1983, the spouses' income had formed a single taxable unit, although up to 50 per cent of the wife's income was taken into account.

Article 7 of the 1984 Finance Act introduced separate taxation for the spouses, amending article 2 of the decree of 31 March 1932 to read:

"New article 2: All individuals are taxable in respect of their net personal resources. However, the income of under-age children shall be taxed in the name of the head of family."

Day nurseries:

The entry of women into the job market has led to the emergence of institutions which help by minding their children during working hours.

The proliferation of day nurseries, particularly in urban areas, prompted the Ministry of Social Affairs to supervise their functioning.

Day nurseries are regulated by Decree No. 82-1598 of 15 December 1982, which regulated the conditions for opening day nurseries, while a joint decree of the Minister for Public Health and the Minister for Social Affairs dated 24 May 1983 established the operating conditions and supervisory arrangements for day nurseries.

B. Maternity protection

1. Principal laws, administrative regulations and collective agreements governing the various aspects of maternity protection

There is no basic law regulating all maternal and child welfare activities nation-wide. However, various regulations have been introduced which directly or indirectly govern each aspect of this subject. The first basic text in this field is Decree No. 69-364 of 6 October 1969 on the establishment and organization of the National Child Health Institute, which grants this establishment overall nation-wide responsibilities for maternal and child welfare and paediatric care.

The Institute's essential tasks are as follows:

To codify appropriate preventive and curative educative measures applicable in all maternal and child welfare centres in the Tunisian Republic and to supervise their application;

To monitor the quality of the care dispensed in all paediatric services of the Republic;

To oversee the preventive and curative care dispensed in schools;

To ensure the training, specialization and retraining of medical and paramedical personnel in the paediatric services, maternal and child welfare centres and school health services, to participate in the planning of staff training programmes and the extension of curative and preventive services concerning children;

To participate in formulating the paediatric part of national health and health education campaigns;

To participate with interested services in the preparation and implementation of programmes regarding pre-pregnancy and pregnancy;

To act as a centre for all statistical data and documentation concerning children;

To promote preventive and curative epidemiological research;

To organize information and training seminars at the Institute and outside.

2. Pre-natal and post-natal protection and assistance, including appropriate medical and health care and maternity and other benefits, irrespective of marital status

The Fifth (1977-1981) and Sixth (1982-1986) Health Development Plans attach prime importance to the continued implementation of the family planning policy and the strengthening of health protection for mothers and children, with a view to furthering the goal of health for all by the year 2000, as proclaimed by the World Health Organization. In order to bring the services closer to the population, a Regional Health Authority coming under the Ministry of Public Health and a Regional Family Planning Unit coming under the National Office for Family Planning and Population (now known as the Family and Population Office) have existed in each Governorate since 1973. Since 1973, the network of maternal and child welfare/family planning centres has steadily expanded. The number of such centres rose from 99 in 1977 to 132 in 1984, and there are also 11 maternal welfare centres without family planning. This reflects a development in maternal and child welfare and family planning activities (for instance, the number of family planning consultations increased from 273,000 in 1973 to 630,000 in 1982) and the training of large numbers of midwives (approximately 400) and obstetric nursing assistants.

In addition, the rural areas suffering from a shortage of staff have been given special attention:

Incentives have been provided to induce doctors and midwives to go and work in these areas (provision of housing, transport and installation facilities, etc.);

Sixty-three mobile teams with qualified health and social workers have been set up in these regions, as well as nine mobile clinics with the equipment and staff needed to ensure improved health coverage for the most disadvantaged groups.

Pre-natal and post-natal protection and assistance are the responsibility of maternal and child welfare centres in Tunisia. These public health institutions for mothers and children are generally frequented by the less well-to-do segments of the population. Better-off people tend to use private establishments.

In 1982, the number of pre-natal consultations in maternal and child welfare centres and family planning centres amounted to 106,135; of these, 19.3 per cent took place during the first three months of pregnancy, 32,754 during the second three months and 48,932 during the last three months, or 46 per cent of the whole. In 1982, post-natal consultations were recorded at 19,887, 44 per cent of which took place following childbirth, 11.9 per cent following abortion and 44 per cent unspecified.

3. Special protection and assistance accorded to working mothers, including paid leave or leave with social security benefits and guarantees against dismissal during a reasonable period before and after childbirth

Article 18 of the Labour Code, as promulgated by Act No. 66-27 of 30 April 1966, stipulates that pregnant women may leave their employment without prior notice and without having to pay compensation for breach of contract. Article 20 of the Labour Code provides that a woman's temporary absence from work during the period preceding and following childbirth cannot be a ground for termination of her contract by the employer; non-observance of this provision gives rise to payment of damages to the woman. The woman must notify the employer of the reason for her absence. In the event that the woman is absent because of a duly certified illness, resulting from pregnancy or childbirth and is thereby incapacitated from returning to work for a period longer than that laid down in article 64 of the Labour Code but not exceeding 12 weeks, the employer cannot discharge her during that absence.

Following childbirth, a female wage-earner is entitled to 30 days' maternity leave. This leave may be extended for successive periods of two weeks when justified by medical certificate. She is allowed one hour per day for one year from the date of childbirth to nurse her baby (article 64 of the Labour Code). A special nursing room must be provided in any business employing 50 or more women.

Female civil servants are granted two months' maternity leave on full pay, which may be combined with convalescence leave following the maternity leave. On her request, she may be granted post-natal leave of not more than four months on half pay for the purpose of bringing up her children (article 48 of Act No. 83-112 of December 1983).

Under Decree No. 85-266 of 15 February 1985 concerning post-natal leave, such leave, which was introduced by the above-mentioned Act No. 83-112 of 12 December 1983, may be granted to female civil servants, workers and temporary personnel (article 1).

Post-natal leave can be granted only following maternity leave. The application for post-natal leave must be submitted to the chief of personnel not later than two weeks before the expiry of the maternity leave (article 2).

Post-natal leave is granted on a one-time basis and in respect of one particular birth for a non-renewable period of one to four months.

While on post-natal leave, the beneficiary is entitled to half pay, including all regular allowances and bonuses with the exception of family allowances, which are paid in full (article 4).

C. Protection of children and young persons

1. Protection of children and young persons

Following birth, a child is entitled to maintenance. Article 46 of the Personal Status Code stipulates that "an ascendant in whatever degree has a maintenance obligation in respect of young descendants of whatever degree who are incapable of earning their own living. Maintenance shall continue to be provided to girls until the time when they marry." A defaulting father is

liable to criminal prosecution for desertion of family: "Anyone who, having been ordered to pay maintenance or an allowance ... wilfully refrains from discharging his appointed obligations for a period of one month shall be punished by a prison term of three months to one year and a fine of 100 to 1,000 dinars" (article 53 bis of the Civil Status Code, as revised by Act No. 81-7 of 18 February 1981).

The right to education:

There can be no denying the considerable efforts made by the public authorities to promote education. Nevertheless, children do not possess an actual right to education, non-observance of which gives rise to legal penalties. Under Act No. 118-58, the doors of educational institutions are open to all children from the age of six years (article 2).

Education in Tunisia is provided free of charge at all levels (article 3). Although it is not compulsory, almost all children of school age do receive a schooling. The State continues to allot more than one third of its budget to education.

Right to social security:

Tunisia has also made considerable efforts to ensure real national solidarity in this area; it has introduced a sickness insurance and family allowance scheme which, within the country's means, provides coverage against the risks of modern life.

However, children do not benefit from social security directly but through their parents, the Tunisian system being designed to safeguard a certain concept of the family.

Family allowances are limited to the first four dependent children or adopted children (article 52 of Act No. 60-30 of 14 December 1960 organizing social security schemes). These allowances are an entitlement only in the case of children below the age of 14. In the case of children aged 14 and above, the allowance is granted:

(1) Up to the age of 16, for children regularly attending an institution of primary education;

(2) up to the age of 18, for children in apprenticeship whose remuneration does not exceed 75 per cent of the statutory minimum wage for building labourers;

(3) Up to the age of 20, for children regularly attending an institution of secondary or advanced technical or professional education, whether public or private, as long as such children are not in gainful employment;

- For girls who act in loco parentis in respect of their brothers and sisters when the mother dies or is crippled or divorced or widowed and such girls are in full-time gainful employment;

- Above the age of 20, for disabled children (article 54 of Act No. 60-30).

Family allowances continue to be granted in the event of the wage-earner's death from industrial accident or occupational disease, provided that the children are of an age carrying entitlement thereto, on the terms established in article 54 above. Family allowances are also granted for children born within 300 days following the wage-earner's death (article 56). The allowances are paid to the person who has custody of the child (article 64).

Supplementary single-salary benefit:

Under Act No. 80-36 of 28 May 1980 supplementing Act No. 60-30 of 14 December 1960 organizing social security schemes, an insured person who has dependent children entitling him to family allowances and whose spouse does not have an occupation has a right to a "supplementary single-salary benefit" payable at the following quarterly rates:

D 9,375, in the case of a household with one dependent child;

D 18,750, in the case of a household with two dependent children;

D 23,475, in the case of a household with three or more dependent children.

Civil protection for children:

The father - or, following her husband's death, the mother - bear civil responsibility for damage caused by their children under the age of 18 when under their care (Article 93 of the Code of Obligations and Contracts). Children under the age of 13 have absolute legal incapacity, while their legal capacity is limited between the ages of 13 and 20 (Article 5 of the Code of Obligations and Contracts). Children above the age of 13 may perform acts favourable to them without authorization from their guardian (Article 9 of the Code of Obligations and Contracts). Guardians may dispose of the property of their wards only with the authorization of the competent judge (Article 15 of the Code of Civil Obligations and Contracts).

Rights of children born out of wedlock and deserted children:

Natural children inherit only from their mother or their mother's family and bear her name.

Foundlings without property are supported by the person who takes them in hand, following authorization from the judge, until they are capable of earning a living (Article 77 of the Personal Status Code).

Foundlings cannot be removed from the custody of the person who took them in care save by decision of the judge when their father and mother appear (Article 78 of the Personal Status Code). Property found with the child belongs to him (Article 79 of the Personal Status Code). Where a foundling has no heir, his property passes to the Exchequer. However, the person who took him in care may sue the State for recovery of the sums spent by him, up to the value of the property left by the foundling (Article 80).

Right of adoption:

The legal framework for adoption in Tunisia is laid down by the Act of 4 March 1958. Children for adoption must be minors of either sex (Article 12 of the Act of 4 March 1958). The adoptive parent must be a married man or woman of full age enjoying full civil capacity. Where the interests of the child so require, the judge may dispense a widowed or divorced adoptive parent from the marriage requirement (Article 9 of the aforementioned Act). At all events, the consent of the spouse is needed if the adoptive parent is not widowed or divorced (Article 11).

In addition to these provisions and measures designed for children in the custody of a family, measures for children without a family and delinquent minors should also be reviewed.

2. Care and education of children without a family and delinguent minors

(a) Children without a family:

The Bourguiba children's villages:

The first groupings of deserted children were constituted by the Bourguiba children's villages. On 30 June 1956, a National Children's Fund was established by decree for the financing of these units. Today, there are 19 such villages distributed throughout the Republic. The aim is not only to ensure these children shelter and decent food but also to facilitate their integration in social life by establishing, within the Bourguiba children's villages, an environment resembling a family atmosphere as closely as possible. These villages are placed under the supervision of the Ministry of Youth and Sports, which decides on the admission of children.

What are the procedures for such admission?

Originally, any abandoned or needy child in moral or physical danger was systematically taken into care by a children's village. In the case of needy children, an investigation of the family background is conducted. Admission is based on a number of official criteria and on the availability of places and the capacity of the Bourguiba children's villages.

There have been considerable changes in admission procedures: until October 1973 there was only one form of assistance, namely institutional admission involving a break with the family. A study covering a period of one and a half years demonstrated that the majority of children admitted had a family who merely wanted assistance in meeting their responsibilities without wanting to separate from their children. In the light of this information, the idea of open-environment education was introduced to prevent children from being uprooted from their natural surroundings.

Children admitted to an open-environment scheme can spend the whole day at the village. They eat there, participate in classes and recreational activities and receive a school outfit and school supplies, but they return home in the evening.

It was decided to extend the open-environment education system to all centres. As of 30 June 1984, a total of 1,457 resident children and 2,474 children coming under the open-environment schemes had been admitted to the Bourguiba villages.

The National Child Welfare Institute (INPE):

The Institute was set up by Decree No. 73-8 of 8 January 1973. Its tasks are as follows:

1. To conduct studies and research on appropriate measures for ensuring conditions conducive to the healthy and harmonious development of children;

2. To recommend preventive measures and appropriate actions to ensure conditions conducive to the healthy and harmonious development of children;

3. To manage any social or educational institutions;

4. To promote the adoption and placement of abandoned children in accordance with the legislation in force;

5. To provide technical and financial assistance to private associations for aid to children;

6. To ensure technical control of such private establishments;

7. To co-operate in training specialized educational personnel.

Because of a shortage of appropriate human and material resources, the National Child Welfare Institute has had to limit itself to functions 3, 4 and 5 above and it is within the framework of item 3, mainly the management of public institutions, that INPE's activities are planned.

It should, however, be emphasized that a studies and research bureau was set up in July 1983 in accordance with INPE's first function. This bureau has really been functionning only during this year and not surprisingly therefore, studies and research on assumption of responsibility for such children by the Institute, the profile of the mother who abandons her child and of the abondoned child himself, etc. have been inadeqaute.

At what point can a child be said to have been abandoned? What are the reasons for abandonment? What future does the abandoned child have?

Although there has not been any thorough study of the reasons for abandonment, it would appear to be linked primarily with the break-up of values and of the family mentioned earlier. Ninety per cent of cases are natural children permanently abandoned by the mother from their birth and the remaining 10 per cent are children who are "temporarily" placed by the parents (a placement which usually endures) pending regularization of their situation: marriage, housing, occupation, etc.

These children are abandoned either in maternity clinics throughout Tunisia or on the street.

Admissions:

According to a report on the Bourguiba centres' activities for 1981, admissions of abandoned children varied from a maximum of 25 to a minimum of 6, amounting to 168 over an 11-month period, or a monthly average of 15.27. Admissions of vagrant children amounted to 12 for an 11-month period, or a monthly average of 5.8. It should be noted that these children were found during the months of finest weather (May, June, July and August). Temporary placements amounted to 24 for an 11-month period, or a monthly average of 2.18. Total admissions varied between a maximum of 28 and a minimum of 11; they amounted to 204 for an 11-month period, or a monthly average of 18.54.

Discharges:

These involve children placed with a view to adoption, adopted children, children placed with families, children taken back by their family and deceased children.

Adoption:

The number of adopted children for Tunisia as a whole is not yet known; the figures for the interior of the country are not yet available. However, in 1981, adoption decisions rendered in Tunis varied from a maximum of 34 to a minimum of 11. They amounted to 180 for an 11-month period, or a monthly average of 16.36. According to a recent study, the number of children adopted during the first half of 1984 was 199.

Placement with families:

The 1981 report draws attention to a marked lack of information on the subject among public opinion, which prevented placement from being carried out. However, according to a more recent edition of the same study, 61 children were placed with families by 30 June 1984. The host families receive a monthly State allowance which has increased from 15 dinars to 45 dinars per child.

Staff:

The National Child Welfare Institute has a total staff of 244. The children's education is entrusted to working mothers who are mostly illiterate and untrained but are full-time employees, constituting 42.3 per cent of the total staff. The quality of the care provided to these children can now be assured.

Child care:

Care is provided in a closed environment. Particularly adoption but also placement with a family are rightly regarded as the two methods most likely to achieve the child's fulfilment. For that reason, INPE's basic function was previously to facilitate adoption procedures. In this connection, it is significant to note the discrimination between the sexes in terms both of abandonment and of adoption.

As at 7 December 1981, the Institute had 142 inmates, consisting of 42 boys and 100 girls; girls thus represented 70.42 per cent of the total.

As for the distribution of adopted children by sex, girls reportedly account for some 65 to 75 per cent of the total. Children temporarily entrusted to the Institute constitute the virtually entire number of INPE inmates. They are known as wards of the State, are generally admitted to elementary schools and are subject to psycho-educational monitoring by staff appointed for the purpose.

Efforts were made to place children with a schooling in the Bourguiba children's villages, and in 1983 some 15 children joined the villages.

However, with the advent of SOS children's villages in Tunisia, preference went to this environment, which offers an attractive alternative to family life.

Moreover, the strengthening of the psycho-educational team during this year, the introduction of the studies and research bureau and the varied but convergent efforts of paediatricians, psychiatrists, dietitians, educators, community leaders and nurses will doubtless permit progress towards better child care and, especially the integration of abandoned children into society.

SOS children's villages:

These are institutions intended for children who have lost their parents or are in need. They bring such children together in small groups - SOS families - and give them a permanent home. They complement the formula applied in the Bourguiba children's villages and are based on the following educational principles:

Education of children by a mother;

Formation of families in which boys and girls live together like brothers and sisters under the authority of an SOS mother;

Accommodation of families in single-family houses;

The group of houses constitutes a common village.

An SOS children's village comprises 6 to 20 houses under the supervision of a director who acts as counsellor to the SOS mothers and represents the masculine element as far as teaching is concerned. Education at an SOS children's village is supplemented by socio-educational and psychotherapeutic assistance.

There are two SOS villages in Tunisia, set up under an agreement of 26 March 1983 between the Government of Tunisia and SOS Kinderdoff International. The villages started up on 1 November 1983 with 42 children and 12 mothers at Gammarth and 26 children and eight mothers at Siliana. The Gammarth village is currently composed of 10 family houses with 90 children, while the Siliana village has 6 houses with 54 children. The two villages are administered by the Tunisian Association for SOS Children's Villages which was set up in 1982 for that purpose and also to foster an awareness among the population and public institutions of the problems of orphaned and abandoned children.

(b) Delinquent minors:

The law in force affirms the principle of the lack of criminal responsibility for minors. This principle is absolute as regards juveniles under the age of 13, who can never be convicted (article 38 of the Penal Code). The principle is of limited application in the case of minors between the ages of 13 and 18. Judges may depart from the the principle when "in their view, the circumstances and the personality of the offender so require" and impose a penalty (article 225 (2) of the Code of Penal Procedure). If a penalty is imposed, the juvenile automatically benefits from the excuse of his minor status, which is treated as a mitigating circumstance for the purpose of the sentence (article 43 of the Penal Code).

Specialized legal institutions for minors:

There are two institutions at the hub of all criminal legislation relating to children: the children's judge and the minors' criminal court.

The children's judge:

This judge is a member of the bench appointed by the President of the Court of First Instance. In theory, he must be chosen for his interest in children's problems and his abilities. In practice, particularly in the interior of the country, he acquires his training in office, after taking up his position.

The very broad ratione loci competence of this judge is determined by the location of the offence, residence or placement or where the subject is found (article 226 of the Code of Penal Procedure) (the same applies to the Criminal Court). Ratione materiae, he is competent to try offences (articles. 224 and 249 of the Code of Penal Procedure) and lesser offences (committed by minors between the ages of 7 and 13 - article 224).

The children's judge also serves as a special investigating authority (article 234 of the Code of Penal Procedure). This is an exception to the principle of separating investigating authorities and trial judges. The information provided to this examining magistrate, instead of being used only for the purpose of assessing guilt, is geared to two main objectives: greater knowledge of the subject and the adoption of appropriate social rehabilitation measures.

The Criminal Court for Minors:

This court is composed of a divisional president of the Court of Appeal, assisted by four counsellors chosen, where possible, from among the counsellors with designated responsibility for child welfare or former children's judges (article 249 of the Code of Penal Procedure). The court is competent to deal with offences committed by minors between the ages of 13 and 18.

Proceedings instituted by the public authorities:

In no circumstances may the flagrante delicto or direct summons procedures be used against minors (article 228 (3) of the Code of Penal Procedure). The institution of public proceedings lies exclusively within the

competence of the Attorney-General of the Republic (article 228 of the Code of Penal Procedure). The Attorney-General's monopoly in this respect is reinforced by the fact that certain Government departments (taxation, customs, water and forests) traditionally empowered to bring legal actions are debarred from doing so in such cases and are limited to lodging a preliminary complaint (article 232 (2) of the Code of Penal Procedure). These departments are so debarred lest their concern for public funds should defeat the object of the reform introduced by the legislature in 1955.

Within each court of first instance, one or more prosecutors have special responsibility for cases involving minors (article 227 (3)) while in the case of the criminal court, this role is performed by a judge attached to the Attorney-General's Office (article 249 (3)). The public prosecutor may decide not to take action on the case or refer it to the children's judge or the examining magistrate for minors (article 228). Referral to the examining magistrate is obligatory in the case of a crime (article 228 (1)) and often when there are co-principals or major accessories, in the event of a serious offence or when there are complex problems of information (article 233).

Preliminary investigation:

One essential principle observed is the requirement that the minor's personality should be studied. In the interests of the minor, the personality study is obligatory. It involves collecting all kinds of information on the material and moral situation of the minor's family, his character and background, his school attendance record and attitude at school, the conditions in which he has lived, where he has been brought up, etc. As appropriate, the children's judge may order a medical or medico-psychological examination (physical, psychological and psychiatric condition of the child) or order the minor to be placed in a reception or observation centre (doctors, instructors) (article 234).

After the minor has been kept under constant observation for a period which should not normally exceed three months (classroom, workshop, sport, etc.), a report is drawn up following consultations among the observers, who may express their opinions on the measures recommended. It can be seen that judges working in this field no longer limit themselves to seeking evidence of the acts which prompted his intervention and categorizing them in law. They seek to know the personality of those in respect of whom it is their task to take appropriate measures and, for that purpose, they must draw on investigations by experts in the human sciences. Research is no longer merely "factual" but becomes personal and social. The approach to problems is no longer merely "essential", it becomes "existential".

During the preliminary investigation, the rules of the Code of Penal Procedure (particularly those of articles 69 to 72) are applicable (article 234 (2)). The procedure is extremely flexible and straightforward, without essential procedural safeguards being ignored. This entire preparatory phase is subject to strict respect for the principle of "audi alteram partem", which extends not only to the minor but also, in accordance with article 237, to his family group: parents, tutor or known guardian. This article also makes it obligatory for the children's judge and the examining magistrate automatically to appoint defence counsel where none exists in the case. However, defence counsel's involvement in matters

pertaining to the law of minors is in practice limited to the trial phase (articles 239 et seq.). Another safeguard afforded is that an appeal may be lodged against orders of the children's judge and the examining magistrate concerning provisional measures provided for by article 237 which the said judge or magistrate may issue during this preparatory phase (article 247). These measures, which in principle are extremely varied, result in the minor being entrusted either to an individual or to an institution (article 237). Exceptionally, minors over the age of 13 may be temporarily placed in a public gaol. In this case, however, they will be housed in special quarters and, to the extent possible, have private sleeping accommodation (article 238). At the end of the investigation, the children's judge has two options: either to take up the case himself as the substantive judicial authority or to bring the minor before the examining magistrate if the case requires action exceeding his competence (article 235).

Judgement:

The minor's guilt having been established, the responsible judicial authorities shall pronounce one of the following measures:

Handing over of the child to his parents, tutor or guardian or some trustworthy person;

Placement in an institution or public or private education or vocational training establishment;

Placement in a competent medical or medico-educational establishment;

Handing over of the minor to the child assistance service;

Internment in an appropriate establishment for delinquent minors of school age (articles 241 and 250 (3)).

(Tunisia has a few observation and rehabilitation centres: Mguira, set up in 1969 solely for observation; Gammarth, 1950; Sfax, 1952; La Manouba, an institution for girls established in 1959; Sidi El Heni, set up in 1972 for rehabilitation but also acts as an observation centre).

Cases are generally heard in camera. The only persons entitled to attend the proceedings are the child's parents or tutor, lawyers and representatives of children's associations and institutions (articles 240 and 250 (1)). It should also be noted that the identity and personality of the child must be kept strictly confidential throughout the proceedings and even afterwards. For example, it is forbidden for press, radio or television to reveal the proceedings. This procedure has considerable psychological advantages for the child.

Exceptionally, minors above the age of 13 may be the subject of a criminal conviction which can be accompanied by probation (articles 244 and 250 (2)). The judge in such a case must ascertain whether criminal conviction is appropriate and whether the minor's personality renders this penalty necessary or preferable; if he finds such conviction inappropriate, he may opt instead for precautionary measures, even if the minor was able to distinguish between right and wrong.

Modification of judgments:

Although the decision is final (res judicata) the judicial authorities for minors may at any time modify the educative content of the decision taken. Article 254 mentions the parents, the tutor or guardian, the minor and the Office of the Attorney-General as being able to refer such a matter to the children's judge. Another person who can take action is the expert in charge of the case, namely the probation officer. (There are two sorts of probation officers: permanent paid officers and volunteers chosen and appointed by the children's judge). The probation officers monitor the child's education and regularly submit reports to the children's judge, thus contributing supplementary information to the probation procedure (articles 251 and 252).

The same article also grants the judge the right of taking the initiative himself. The judge "must have the flexibility to be able periodically to adjust his order to developments in the case so as to ensure that a suitable fabric of legal relations exists at all times".

The children's judge who handed down the original decision is competent to rule on applications for modification.

Where the original decision derived from the criminal court for minors, competence lies with the children's judge of the parents' place of domicile or the minor's place of residence.

Three main cases of modification are provided for (article 254):

Supplementary information bearing on probation (article 252 (2): the probation officer submits a report to the children's judge in the event of misconduct, moral danger to the minor or systematic obstruction of the probation system, as well as in cases where he deems a change of placement or custody to be desirable);

Modifications at the request of the minor, the parents, the public prosecutors or the judge;

Application for resumption of custody (where the child has been separated from his family, a period of nine months needs to elapse before the minor, his parents or his tutor can make an application to the children's judge. In the event of rejection, a further nine months must elapse before a new application can be submitted).

Whoever the author of the application is, the children's judge is free to adopt any measure provided for by the law of minors and even to increase the severity of the original measure. However, in the event that a rehabilitation measure fails, he cannot resort to penal sanctions. For instance, in the event of persistent misconduct, continuing indiscipline, dangerous behaviour or failure of previous protection or surveillance measures, a minor who has shown himself to be incapable of rehabilitation by such measures may, by a substantiated decision, be sentenced by the children's judge, if he is over the age of 15, to placement in a specialized institution up to the age of 20 at the most (article 254 (3)).

3. Protection of children and young persons

Economic and social protection for children and young persons takes a great variety of forms. In the light of developments in the field of child labour, provision has been made for the physical, educational and moral protection of children.

Tunisian legislation on obligations and contracts contains various provisions protecting minors - for instance, provisions concerning legal capacity and the management of property belonging to children.

The Penal Code severely punishes offences against minors.

The crime of rape, even if unaccompanied by violence, is punishable by death if it is committed against a child under the age of 10.

A person guilty of sexual acts with a child under the age of 15 is liable to five years' forced labour, while indecent assault against such children carries a sentence of 10 years' forced labour. The penalty is increased if the culprit is an ascendant of the victim or his teacher, servant or doctor (articles 227-229 of the Penal Code).

Incitement of minors to commit immorality carries a penalty of three to five years' imprisonment and a fine (article 233 of the Penal Code).

The Penal Code also prescribes aggravated penalties for persons guilty of abducting children.

4-5. Work by children and young persons and legal protection for young persons in employment

The Labour Code establishes the minimum age for employment at 15 years for industrial establishments (article 53). Only establishments managed by the child's family can employ children below the age of 15 (article 54 of the Labour Code) and, if the work is harmful to the child's health, the appointed age is over 15 (article 58 of the Labour Code).

In agricultural enterprises and activities, the minimum age for employment is reduced to 13 years, provided that the work done by the child is not harmful to his health and normal development and provided also that school attendance is not thereby affected (article 55).

In the case of non-industrial and non-agricultural activities, it is possible to employ children over the age of 13 in light work not harmful to their health and normal development, provided that school attendance does not suffer (article 56 of the Labour Code).

However, children below the age of 14 cannot be employed in light work for more than two hours per day, whether on weekdays when they are pursuing their studies or during their school holidays. The time spent in performing light work and in following classes must in no event exceed seven hours per day. Children of 14 to 15 years of age must not work for more than four and a half hours per day (article 56 of the Labour Code).

A medical examination to determine the fitness for work of children and adolescents below the age of 18 must be carried out in all public enterprises (article 61). Night work is prohibited for children and women. Underground work or work in scrap metal recovery or storage plants is forbidden for children under the age of 18 and for women (articles 65, 77 and 78 of the Labour Code).

Children may engage in artistic or scientific activities with the authorization of the regional labour inspector.

The inspector must take account of the health, physical development and moral conduct of the child before issuing an authorization. Children are not permitted to engage in such work after midnight and must have at least 14 consecutive hours of rest.

All employers are required to keep at the disposal of the labour inspectorate a register indicating the names and birth dates of all employees below the age of 18, as well as their working hours.

If, in the course of a medical inspection, a particular job is deemed to be beyond a child's physical capacity, the labour inspectorate shall require the enterprise to stop having such jobs performed by children.

Employers who violate the provisions regarding the protection of children and the rules concerning work by young persons under the age of 18 are liable to a fine. If the offence is repeated, the penalty is doubled.

If the violation relates to the health and safety of workers, the judge shall establish a deadline for the implementation of safety or health measures. Non-compliance shall entail closure of the establishment.

PART II

ARTICLE 11: RIGHT TO AN ADEQUATE STANDARD OF LIVING

A. As indicated above, the ultimate objective of progress in Tunisia is man. The aim of Tunisian development plans is to raise the population's standard of living by promoting this objective. The Sixth Development Plan (1982-1986) attached particular importance to the creation of employment opportunities as a means of improving the standard of living of job-seekers by guaranteeing them a steady income. The Seventh Development Plan attaches great importance to steady and sustained agricultural development not only for the purpose of raising the standard of living of Tunisian citizens in general and guaranteeing them adequate food, but also for the purpose of increasing the income of farmers, who constitute a sizeable population group.

The specific measures taken with a view to raising the standard of living of Tunisian citizens have been referred to in earlier paragraphs and will be described below in the chapters on articles 11 and 12 of the Covenant, as well as in later reports on other articles of the Covenant.

B. Right to adequate food

1. Tunisian law guarantees the right of persons without any means of support to adequate food.

The Personal Status Code contains legal provisions to protect the right to means of support.

In addition to divorced women, whose right to alimony is not subject to prescription, the following persons are entitled to means of support:

Parents and paternal grandparents;

Descendants, however distantly related. It is stipulated that well-to-do children must provide means of support for their needy parents and paternal grandparents, whereas ascendants must provide means of support for their young descendants who are incapable of earning a living.

The right to means of support may also arise out of a contractual obligation. A person who undertakes to provide alimony is bound to do so.

2. Agrarian reform

The agricultural sector continues to sustain land structures which are incompatible with agricultural development objectives. Major problems still exist and they can be solved only by means of a long-term policy of structural change. In this connection, it is planned to pursue the efforts being made with a view to eliminating all former land tenure systems and gradually clearing up the agricultural land tenure situation, particularly the one to be promoted on a short-term basis.

In order to bring about structural changes to make farms viable, activities are being carried out to eliminate smallholdings and parcelling; to draft regulations relating to rural leases; to regroup land; and to establish farm enterprises.

3. Improvement of production methods

(a) Research:

If agricultural production is to be increased, an effective research programme has to be set up. Our research policy is designed to reorganize and strengthen our ability to innovate and to make practical results available to the largest possible number of producers in the agricultural sector. Long-term development requirements mean that top priority has to be given to the establishment of a research programme that is able to sustain advances in agricultural development, particularly in the animal husbandry, irrigated crops, cereals and water and soil conservation sectors.

The aim will therefore be to increase central research capabilities, to strengthen existing regional stations and to set up new stations in regions where in-depth studies have not yet been carried out.

The strengthening of regional stations is intended to give development units an outlet for their advisory, demonstration, training and recycling activities and to make it possible to compare research work done by farmers and to establish an ongoing dialogue with them concerning their experiments.

(b) Advisory services:

Progress in advisory services will depend on research findings and the ability of the Farm Administration to disseminate such findings. The activities to be carried out will take various forms:

Maximizing contact between advisers and farmers by setting up and strengthening territorial advisory units;

Developing "spin-off" advisory services by bringing in young technician-farmers;

Strengthening mass advisory services in order to reach the largest number of farmers with the fewest possible means in the shortest possible time.

This approach to advisory services will call for:

The reorganization of the training system for the persons most closely involved in advisory services (experts and engineers);

The co-ordination and sharing of work by the various advisory services on the basis of the one-on-one approach.

4. Food conservation and action to combat resource depletion

In order to make the country less dependent on food products, especially cereals, special efforts will be made to reduce post-harvest losses by gradually introducing bulk sacks during harvesting, handling, transport and storage. In the case of such strategic products as cereals, a food security policy has been adopted and a master plan for the storage of cereals has been drawn up. Requirements have been estimated at 350,000 additional tons of storage capacity, the first 100,000 of which are now being made available.

Owing to natural conditions, Tunisian soil is particularly prone to erosion. The problem of erosion is, in many cases, even more serious because land is not always used for the right purpose and crop-growing techniques are unsuitable. Activities to protect and develop the environment will serve two purposes:

To guarantee the long-term future of agriculture through soil protection and economic investments;

To help reduce imbalances between the various regions in the country;

Protection activities relate primarily to dams, groundwater supply and flood control. Water and soil conservation measures are designed to prevent erosion in catchment areas.

5. Marketing, supplies and prices

Major investments have been planned to improve the internal marketing system by increasing storage and refrigeration capacity; establishing milk collection points; and increasing the agri-food industries processing capacity. The following measures have also been taken:

Establishment of a reserve fund for some market-garden crops with a view to ensuring steady supplies and reducing price fluctuations so as to stabilize and sustain incomes;

Incentives for the establishment of co-operative services;

Encouraging inter-occupational bodies to play a more active, more regular and better organized role;

Promotion and development of the system of crop contracts.

It is planned to reorganize food supply structures by:

Increasing the storage capacity of food distribution centres;

Setting up new food storage centres in areas where storage capacity is inadequate; and

Increasing retailers' profit margins to encourage them to open businesses in remote areas.

With regard to prices and products whose prices are set by the Government, periodic adjustments are made prior to each harvest on the basis of changes in production costs, the volume of subsidies and international exchange rates. Account is also taken of profit margins as incentives that will ensure producers a guaranteed income. Productive investments are made in accordance with expected production cost levels, which must offer some security in order to encourage investment in a high-risk sector. However, the prices of agricultural products have to be brought into line in order to ensure the balanced development of the sector.

6. Improvement of food consumption levels

Action to improve food consumption levels, particularly of the most underprivileged population groups, takes several forms.

The implementation of the employment policy, the initiation of family planning, education and regional development programmes are bound to help improve food consumption levels.

The Government has, however, always supported and maintained basic food prices at levels that the most underprivileged groups can afford.

Although canteen facilities are provided for by the collective bargaining agreements which govern certain enterprises and university canteens are available to students, the Equalization Fund is the most far-reaching measure, since it benefits the entire Tunisian population.

The Fund intervenes to keep the prices of certain products within the reach of low-income citizens by supporting oil, bread, pasta (staple Tunisian food items), sugar and milk prices. The burden borne by the State increases each year. The Fund cost the State 67 million dinars in 1980 and 165 million dinars in 1982.

7. Measures to prevent food contamination

Measures to conserve food intended for consumption are taken by several agents.

Some measures are taken automatically, prior to consumption.

The Act of 6 August 1982 established the Standardization and Industrial Property Institute and assigned it, inter alia, the task of certification. The Institute issues a certificate or stamp attesting to the conformity of a product or service with certain technical standards and specifications.

It should be noted that certification differs from the usual type of checks carried out by various ministerial departments in accordance with specific texts. It is done well before a decision is taken to put a product on sale and usually at the manufacturer's request.

Ministerial departments automatically make after-sales checks by sampling products that are on sale. The central laboratory of the Ministry of Industry and Commerce is equipped for these tasks. The city markets and retail trade are often checked by the municipal services.

In the past few years, many hospitals, university canteens, hotels and other major establishments have employed full-time nutritionists to guarantee food quality.

8. Knowledge of nutritional principles:

Developing the educational system is without any doubt the best means of promoting knowledge of nutritional principles. Primary-school pupils learn such principles in theoretical and practical courses. This training continues in the natural science courses given in high school.

The work of the Nutrition Institute in Tunis is nevertheless brought to the public's attention in the newspapers and the media. A radio programme prepared by a medical school professor who is the Director of the Nutrition Institute is broadcast daily on Tunisian radio (channel 1).

C. Right to adequate clothing

1. Promotion of the right to adequate clothing

The Labour Code guarantees wage-earners the right to adequate clothing.

On 1 May each year, wage-earners whose activities are covered by labour legislation are given two sets of overalls, two shirts, one pair of shoes and a cap by their employers.

If collective bargaining agreements or custom make provision for more favourable conditions, the latter apply. Any employer who fails to provide clothing may be fined.

The National Social Solidarity Committee also provides clothing for needy citizens through donations by private individuals and institutions.

2. Improvement of clothing production

The production and availability of textiles and clothing have increased greatly in Tunisia. The opening of textile and clothing factories has been encouraged because they require modest investments and offer job opportunities.

This trend has also been encouraged by a long-standing tradition of weaving. At present, output by the SOGITEX holding factories is more than adequate to meet the country's textile needs.

Despite the economic crisis, moreover, the introduction of increasingly effective methods has made it possible to stabilize textile prices. Between 1981 and 1983, for example, the prices of wool and cotton yarn, wool cloth and gingham remained stable (National Statistical Institute, 1984).

The price of finished garments increased slightly between 1981 and 1983:

Men's outer garments:	119.0 to 141.2
Lingerie and hosiery:	119.8 to 140.8
Footwear:	140.6 to 164.7.

(Family consumer price index, National Statistical Institute, 1984.)

Production also remained steady and supplies were normal. The industrial production index for textiles and clothing was 127.9 in 1981 and 127.2 in 1983 (base 100 : 1977).

D. Right to housing

1. Main legal provisions

The many legislative and regulatory measures that have been taken since independence are a reflection of the importance the Government attaches to the production and improvement of housing in general and to construction and the sale of dwellings to low-income social groups in particular.

Thus, in order to promote housing construction and the sale of dwellings to low-income population groups:

The Decree of 30 March 1956 provided for Government assistance, primarily in the form of long-term loans at low interest rates, for the construction of workers' housing;

The Decree of 30 March 1957 established a scheme to enable workers' co-operative building societies (SCOL) to build and manage workers' dwellings, which are made available to the beneficiaries under the hire-purchase system. The sale price is paid off over a 30-year period at an interest rate of 2 per cent per year;

The Act of 31 May 1961 provided for tax reductions for companies, associations and co-operatives for the construction of residential dwellings and low-cost rental units;

Decree Law No. 2 of 4 February 1963 included special provisions for the sale to low-income families of low-cost dwellings, to be built by the Government or by the local authorities with funds made available to them in the form of loans from the National Housing Improvement Fund, by granting the beneficiaries Government assistance calculated on the basis of the sale price, as well as long-term interest-free loans;

Act No. 63-17 of 27 May 1963 providing for State assistance to the agricultural sector established very favourable terms for the granting of loans for the construction of dwellings on farms and in order to promote the construction and improvement of housing in rural areas in general.

With a view to encouraging the construction and improvement of housing:

The Decree of 3 August 1956 set up the National Housing Improvement Fund to do repair, maintenance and improvement work on residential, professional and administrative buildings by giving subsidies to owners, granting loans and loan guarantees and taking over either all or part of the interest payments on the capital invested in repair work;

Act No. 19 of 10 September 1957 established the National Real Estate Company of Tunisia, which is, inter alia, responsible for the construction and development of the housing sector with the assistance of the Government and the authorities;

The Order of 20 June 1960 granted a subsidy for the construction of new dwellings. The subsidy, which applied only to dwellings meeting health, safety and planning standards, was granted for a period of 20 years as from the date of the dwellings' completion. In 1976, the time limit for the subsidy was reduced to 10 years and, in 1980, the subsidy was abolished, since Government incentives took a new form on that date.

Although these measures were not far-reaching enough to increase the number of dwellings to meet additional demand and the needs of population groups without adequate housing, they did help to revitalize the housing sector, as shown by the steady increase in the number of households for which housing has been provided. A total of 109,384 dwellings were built during the period 1956-1968 (end of the Second Development Plan), including 55,309 by the public sector (of which 37,160 - over 66 per cent - were built for underprivileged groups prior to the first year of the First Development Plan) and 54,075 by the private sector (including 27,800 - over 50 per cent - built during the period of the Second Plan).

As a result of economic growth, increased employment, higher wages and a better standard of living, as well as of population and urban growth, demand for housing continued to increase and became one of the population's main concerns early in the Second Economic and Social Development Plan (1969-1972) and, in particular, during the Fourth and Fifth Development Plans (1973-1976 and 1977-1981).

In order to deal with this situation and solve the alarming problem of the large number of rudimentary dwellings (44 per cent of the total number of dwellings in 1966), the Government formulated a new strategy for intensive housing construction. This strategy calls for:

Greater efforts by the Government to finance construction for low-income population groups. The National Real Estate Company of Tunisia was thus entrusted with the task of implementing Government programmes for the construction of rural, suburban and low-cost housing at a rate of 5,000 dwellings per year in 1969 and 10,000 dwellings per year in 1972;

More active participation by households in the financing of their dwellings: the National Housing Savings Bank was set up under Act No. 24 of 7 May 1973 to channel household savings for housing (estimated in 1980 at 44 per cent of savings for the satisfaction of family needs) and to provide more credits for the purchase and construction of dwellings;

The involvement of economic agents in general and of financial institutions in particular in the housing promotion circuit through, for example, the granting of loans to private individuals on favourable terms for the construction or purchase of a dwelling;

Bringing the supply of and demand for building plots for housing construction into line with the needs and financing possibilities of low-income groups: the establishment of the Land and Housing Agency (AFH) under Act No. 21 of 14 April 1973 is intended to achieve this objective and counteract speculation by means of a price policy that takes account only of cost;

The involvement of more agents in the housing sector as a means of ending the housing crisis and enabling the National Real Estate Company of Tunisia (SNIT) to focus primarily on the implementation of Government programmes for low-income population groups: Act No. 47 of 2 July 1977, which governs the occupation of real estate developer, is designed to achieve this objective and to increase the private sector's contribution to the construction of low-income housing through advantages and incentives offered by the Government for this purpose;

The active participation of National Social Security Funds in the financing of housing intended for their members.

The National Retirement and Social Security Fund was authorized to help finance dwellings purchased or built by its members by granting loans (repayable over 15 years at relatively low interest rates) intended to supplement their savings with the National Housing Savings Bank (CNEL), as well as additional credits for the purchase of land for the construction or purchase of a new dwelling.

Act No. 54 of 3 August 1977 set up the Housing Promotion Fund (to which employers contribute the equivalent of 2 per cent of the total wage packet) for wage earners whose monthly wages are equal to or up to one and one-half times higher than the guaranteed minimum wage to provide loans enabling them to build or purchase a new dwelling, as well as loans to bring their savings up to the level required under the housing-savings scheme.

In order to counteract real estate speculation resulting from heavy demand for rental dwellings, the Government has taken the following measures:

Granting of priority to tenants for the purchase of the dwelling they actually occupy, provided, however, that they do not own a dwelling in the Governorship where the building in which they live is located (Act No. 39 of 7 June 1978);

Establishment in 1977 by the National Social Security Fund and the Old Age, Disability and Survivors' Insurance Fund of the Low-Cost Housing Promotion Company, which is responsible for building and managing dwellings to be rented at low cost to their members;

Establishment of housing offices within three large ministerial departments, namely, the Ministry of the Interior, the Ministry of National Defence and the Ministry of National Education, which have many staff members who are frequently required to change administrative residence.

2. Specific measures and programmes

(a) Housing finance policy: savings

The housing savings scheme instituted under Act No. 24 of 7 May 1973 is designed, inter alia, to create a tradition of savings among citizens and to find a solution to the housing finance problem.

Pursuant to this Act, Decree No. 224 of 28 March 1974 established regulations for the activities of the National Housing Savings Fund by assigning it three basic functions:

Mobilizing savings by collecting the deposits of holders of housing-savings contracts;

Granting loans to the holders of housing-savings contracts to finance the construction of or additions to residential buildings, as well as the purchase of new dwellings built by authorized real estate developers; and

Granting pre-financing credits to authorized real estate developers for the implementation of housing programmes for holders of housing-savings contracts.

The housing-savings scheme is characterized by the fact that it entitles the saver, during the contractual period, to benefit from the interest paid to him on the amounts deposited in his account and, at the end of this period, from credits equal to twice the total amount of savings (principal and interest). This scheme also provides for various categories of credits which depend on the saver's earnings.

The interest earned by the saver before the credit is granted is now calculated on the basis of the following rates:

	Savings in dinars	Savings in foreign currency
During the contractual period	6.75%	7.5%
When the contract reaches maturity (i.e., after the contractual period)	8.75%	10.5%

With regard to the credit scheme, the categories of credits provided for at the time of the establishment of the National Housing Savings Fund were amended in 1986 by the addition of three new categories, which raise the credit ceiling to 13,000 dinars, and by the elimination of the lower categories, which were replaced by the establishment of the Housing Promotion Fund for Wage-Earners (FOPRPLOS). This change was made as a result of the increase in the cost of housing and in earnings and is more in line with savers' wishes.

The repayment period is 10 years for a 4-year savings plan and 15 years for a 5-year savings plan. The interest rate is 8.25 per cent per year in both cases and the amount to be repaid cannot in any case be more than one third of the borrower's earnings.

With a view to making the credit scheme more flexible and enabling the National Housing Savings Fund to play a more active role in housing finance, three types of credit were authorized and one is of a temporary nature.

Immediate credit: This credit scheme was established in 1976 during the period between the date of the establishment of CNEL (1974) and the time when the first housing-savings contracts reached maturity (1978). During this transitional period, the scheme was intended to promote the financing of the construction or purchase of a dwelling from an authorized real estate developer. It ended with the establishment of normal housing-savings credits.

Anticipated credit: This form of credit was instituted by a circular issued by the Central Bank of Tunisia on 24 February 1977 and is intended for savers who have had a subscribed contract for two or three years (depending on whether the savings plan is for four or five years) and who wish to purchase a dwelling from an authorized real estate developer. In July 1981, this form of credit was made applicable to the financing of owner-built dwellings. The interest rate is now 11.5 per cent per year.

Pre-financing credit: This type of credit is extended exclusively to authorized real estate developers for the financing of programmes intended for savers and involving a dwelling cost corresponding to the amount of subscribed savings.

The interest rate for this type of credit is 10.5 per cent per year and the proportion is 90 per cent for "urban" dwellings and 70 per cent for "low-cost" dwellings.

In order to benefit from this type of credit, the real estate developer undertakes to reserve at least 70 per cent of low-cost dwellings and 90 per cent of suburban dwellings for savers with the National Housing Savings Fund.

The Housing Promotion Fund for Wage-Earners was set up under Act No. 54 of 3 August 1977. Intervention by this Fund takes two main forms:

(a) For wage-earners with an income up to twice the guaranteed minimum wage, the Fund extends direct credits for the purchase or construction of a suburban dwelling at an interest rate of 5 per cent, provided that the saver is able to make a down payment of at least 10 per cent of the price of the dwelling, as authorized by the Ministry of Housing.

In view of the increase in the cost of construction, a 1983 decree amended the financing scheme adopted in 1977 and raised the price of a suburban dwelling, which was 3,600 dinars, to between 8,000 and 10,000 dinars.

(b) For wage-earners whose income is between two and three times higher than the guaranteed minimum wage, the Fund extends two types of credit: credit to supplement the required amount of savings, at an interest rate of 8.25 per cent, and direct credit, at an interest rate of 5 per cent.

In order to encourage enterprises to channel their employees' savings and in order to provide more assistance for its savers, CNEL has established tripartite conventions which involve the National Real Estate Company and some public utilities (Electricity and Gas Company, Water Development and Supply Company, National Transport Company), and provide for housing finance on special terms for employees of the enterprises in question who are CNEL savers.

The savings policy has produced very good results:

Savings:

Between 1974 and mid-1986, 190,900 contracts were concluded for a total savings of 186 million dinars;

Credits:

From 1974 to mid-1986, 36,505 credits (immediate, anticipated, normal) were extended to CNEL members for a total of 244 million dinars;

Pre-financing:

CNEL pre-financing of 44,879 SNIT dwellings (18,996 suburban and 25,883 low-cost dwellings) amounted to a financial package of 258 million dinars and its pre-financing of 3,827 dwellings built by authorized real estate developers amounted to a financial package of 16 million dinars;

FOPROLOS credit:

Between the time of its establishment in 1977 and 30 June 1986, the Housing Promotion Fund for Wage-Earners (FOPROLOS) extended 21,795 credits for a financing package amounting to about 64 million dinars.

With regard to the pre-financing of SNIT programmes, this Fund has spent 50 million dinars for the construction of 32,829 dwellings.

The table below shows the results of the institutional, regulatory and financing policy measures that have been taken.

(b) The national slum clearance project

On the initiative and instructions of the Head of State, President Habib Bourguiba, the Government undertook, during the period 1986-1988, to implement a programme to eliminate all remaining rudimentary dwellings ("gourbis" and other types of slums) in Tunisia.

With a view to the implementation of this programme, Decree No. 438 of 12 April 1986 set up a national monitoring committee and some regional monitoring committees and allocated resources for its financing.

The regional census conducted in March 1986 enabled the national programme monitoring committee to determine that, of the existing 135,000 rudimentary dwellings, 92,000 should be torn down and replaced and 43,000 should be repaired and improved.

These data served as a basis for a building programme and a financing scheme to replace the 92,000 dwellings to be demolished by new dwellings before the end of 1988.

There are plans for the construction:

Of 30,000 new dwellings at an estimated cost of 61 million dinars in 1986;

Of 40,000 new dwellings at an estimated cost of 82 million dinars in 1987; and

Of 22,000 new dwellings at an estimated cost of 42 million dinars in 1988.

At present, 20,000 dwellings are being built (1,000 have already been completed) and the necessary credits for the remaining 10,000 dwellings for 1986 have been made available to the Governors concerned.

Decree No. 438 allocated the following resources for the financing of the programme:

Budget appropriations;

National Housing Improvement Fund (FNAH) appropriations;

Appropriations from any other special programme relating to housing (such as the regional development programme);

Participation by the banking system;

Donations and bequests in cash and in kind made directly by natural and legal persons.

3. Measures taken in connection with housing and water supply problems in rural areas

The Integrated Rural Development Programme (PDRI) was and is intended to raise standards of living in rural areas by creating job opportunities and supplying agricultural raw materials, housing and basic equipment. It has thus helped to improve the living standards of rural population groups through the construction and improvement of rural housing and tracks, the establishment of health centres, the introduction of drinking water supplies, electrification and the construction of primary schools.

During the period 1973-1984, the results of the programme were as follows:

In the health field, the financing of the construction of 366 dispensaries, 31 basic health centres and 182 first-aid stations;

With regard to roads: the construction of 12,000 km of unpaved roads, 200 km of paved roads and 43,600 km of rural tracks;

With regard to drinking water supplies: the financing of 107 wells, 40 water towers and 2,000 water supply points, as well as contributions to the financing of work to bring drinking water supplies to 500 villages;

With regard to electricity supplies: the connection of 1,300 villages to the national electricity network;

With regard to social and community facilities: the construction of some 900 social and community facilities, 400 of which are new (109 telephone booths, 81 socio-cultural clubs, 83 sports grounds, 38 classrooms, etc.);

With regard to housing: assistance to some 90,000 households through participation in the financing of the purchase of new rural dwellings and the improvement of dwellings; 19.5 million dinars were appropriated for this purpose.

For the period 1973-1984, total credits for this programme amounted to 256.6 million dinars, 60 per cent of which were earmarked for less developed areas in the western part and 40 per cent for areas in the eastern part of the country. Activities to improve living conditions accounted for 50 per cent of the credits allocated for the programme.

The rural development programme's originality lies in the method adopted for its formulation, management and implementation:

The programme is formulated annually by the local rural development commissions at the delegation level. It is approved by the regional commissions at the Governorship level and adopted by the Ministry of Planning and Finance at the national level;

The rural development department in each Governorship is responsible for programme management and follow-up, as well as for local, regional and national co-ordination;

Programme implementation is the responsibility of the regional technical units in the ministerial departments and Government agencies concerned.

In order to promote its integration aspect, PDRI gave priority to infrastructure, community facilities and, in particular, the improvement of the standard of living of persons without adequate housing by setting aside 37 per cent of investments for them. There are plans to build 3,472 dwellings, to assist 3,075 heads of household to improve their dwellings, to provide drinking water supplies for 100 towns (by building 142 public wells and 24 boreholes, 92 springs, 77 km of drains, 43 public water tanks and 890 private water tanks), to build 1,832.4 km of agricultural tracks and 76 drains, to electrify 80 towns and to build 86 dispensaries and first-aid stations.

4. Measures for the protection of tenants

Article 2 of Act No. 76-35 of 18 February 1976 on relations between owners and tenants of residential premises provides for the right of persons occupying residential premises to remain in such premises as of right and without any formalities. The Act, which was valid until 31 December 1981, was extended until 31 December 1986 by Act No. 81-100 of 31 December 1981 containing the Finance Act for the 1982 financial year.

The right to remain in premisess, which applied to buildings built prior to 1 January 1954, was extended to those built prior to 1 January 1970 by Act No. 78-19 of 1 March 1978.

Article 17 of Act No. 76-35 prohibited any rent increase of more than 5 per cent per year after 1 January 1976.

5. Statistical data

Despite the problems it inherited from the Protectorate, Tunisia's adoption of general and specific measures has enabled it not only to meet the population's immediate needs by providing shelter for all citizens, but also to make great strides in terms of economic and social development.

The general population and housing census of March 1984 shows that:

In terms of quantity: The number of dwellings is larger than the number of households, since, for a population of 6,966,173 inhabitants forming 1,273,390 households (an average of 5.5 persons per household), there are 1,316,588 dwellings.

These are, however, only absolute figures which do not take account of households with more than one dwelling or of the dwelling's condition and amenities.

In terms of quality: The analysis of the results in terms of quality makes it possible better to understand the efforts that have been made and to determine what action still has to be taken to satisfy the additional needs of a population whose growth rate is still high (2.6 per cent per year).

DISTRIBUTION OF DWELLINGS BY TYPE AND BY AREA

Type of dwellings	Urban areas		Rural areas		Total	
	Number	%	Number	%	Number	%
Concrete construction	704 800	97	493 200	84	1 197 000	91.2
Traditional houses	460 900	64	471 100	80	932 000	71
Villas	172 000	24	20 500	3	192 500	14.6
Apartments	71 900	9	600	1	72 500	5.6
Rudimentary apartments	21 000	3	95 100	16	116 100	8.8
Total dwellings	725 800	100	587 300	100	1 313 100	100

DISTRIBUTION OF POPULATION AND DWELLINGS BY AREA

	Urban areas		Rural areas		Total	
	Number	%	Number	%	Number	%
Population	3 680 830	52.8	3 285 343	47.2	6 966 173	100
Households	694 100	54.5	578 910	45.5	1 273 010	100
Dwellings	725 800	57	587 300	43	1 313 100	100
Dwelling/population ratio	1.04		1.01		1.03	

PART III

ARTICLE 12: RIGHT TO PHYSICAL AND MENTAL HEALTH

A. On the eve of independence, the country's health care resources were limited to one Tunisian doctor for every 22,000 inhabitants (1 for every 7,000 if expatriate doctors are included), 5,500 hospital beds, including the 1,000 clinic beds, i.e. 1.5 beds per 1,000 inhabitants, and one analysis laboratory, belonging to the Institut Pasteur.

This clearly illustrates the immensity of the task facing the new State and the people in rescuing the floundering health-care system.

The re-organization of this sector called for the establishment of infrastructures and a system of general or specific services, as described below.

B. Specific information

1. Measures taken to reduce the infant (up to one year of age) mortality rate

The estimated infant mortality rate was 200 per thousand in 1952 and 180 per thousand in 1961. By 1975, it had fallen to 120 per thousand and today stands at between 50 and 60 per thousand, according to the preliminary results of a national survey on infant mortality and morbidity (children's hospital - Tunis 1986). On this basis, it is possible to project an infant mortality rate of between 18 and 28 per thousand by the year 2000.

The UNICEF annual report for 1985 gives an infant mortality figure for Tunisia of 60 per thousand for the period 1975-1981 and shows the situation in Tunisia as much better than in most other countries at a similar stage of development.

To achieve this, Tunisia implemented a number of positive measures, the most significant of which were:

The enactment of maternal and child welfare legislation (pre-marital medical examination, minimum marrying age);

The launching of a maternal and child welfare policy which led to the establishment of 89 centres distributed throughout the country by 1966. Further centres were added during the 1970s. Technical management of the centres is the responsibility of the National Child Health Institute. In 1985, there were 119 maternal and child welfare centres;

The establishment in 1975 of a special university course in preventive paediatrics.

Action to combat malnutrition takes a number of forms: improvement of living conditions, education in nutrition, and promotion of baby foods. This has brought a decline in a number of childhood diseases: rachitis has virtually disappeared, the incidence of poliomyelitis has fallen from 525 cases in 1959 to 19 in 1985, and whooping cough from 262 cases in 1976 in maternal and child welfare centres to 28 in 1980.

Vaccination

In addition to vaccination against smallpox (actually eradicated by WHO), which has been compulsory since 5 May 1922, there are six main diseases for which vaccination is compulsory: tuberculosis (1959), poliomyelitis (1963), diphtheria, tetanus, whooping cough and measles.

Child mortality (one to four years)

While infant mortality was estimated at 77 per thousand from 1975 to 1978, child mortality stood at 28 per thousand. This rate can now be said to have steadily declined.

These measures have had an impact on life expectancy at birth. Life expectancy has arisen from 47 years in the 1950s to a current average of 62 years for men, and one year longer for women. The forecasts are that it will reach 70 years (between 68 and 71) by the year 2000.

2. Measures to ensure proper child development

Health education

Education and health have been Tunisia's two overriding priorities since independence. Accordingly, the improvement of the health of schoolchildren through school health programmes has been accorded special importance.

Set up in 1948, this form of preventive medicine was the responsibility of the Office of School and University Medical Examinations (Tunis) and was generally performed by freelance physicians backed up by peripatetic nurses or social workers.

The first development in this important area came under the Third Development Plan with the strengthening of mobile school health teams responsible for the systematic diagnosis and treatment of common diseases and communicable diseases, as well as for the vaccination programme.

At the end of the 1960s, the school medical programme received a second boost with the creation of the Sub-Directorate for Preventive and Social Medicine, with responsibility for school hygiene, nutrition and food hygiene, health education, the provision of prosthetic appliances and rehabilitation of the handicapped, and accident prevention.

The school and university medical programme is currently the responsibility of a Directorate (DMSU) which has three major tasks:

Assessment of the situation in schools and universities and the definition of precise objectives;

Programming of plan objectives in the regional school medical programme;

Creation of national technical commissions for the improvement of school and university health programmes.

The results of this experiment speak for themselves:

From the logistical point of view, the school medical programme today covers all regions of the country and involves nine regional centres in Tunis, Sfax, Sousse, Bizerte, Monastir, Kasserine, Gafsa, Kairouan and Mahdia; 21 full time school doctors and 417 public health officers working on a part-time basis, mainly in low population-density areas; 196 full-time and 510 part-time nurses.

In 1985, 90 per cent of pupils in compulsory education, who are required to undergo a systematic and thorough medical examination, and 80 per cent of the students in the Tunis area were covered by this programme. The vaccination programme has also undergone a steady expansion, to the point where, by 1985, 80 per cent of pupils had been immunized against tuberculosis, diphtheria, tetanus and poliomyelitis, a level which is adequate to present a collective barrier against diseases which are traditionally widespread, disabling, or the cause of school absenteeism.

3. Environmntal health protection

(a) Action by the Ministry of Public Health

Initially, because of its health aspect, this function was carried out by an epidemiology unit (attached to the Preventive Medicine Department), which concentrated on insect control and disinfection in cases of communicable diseases.

In 1969, the duties of the Ministry of Health in this area were assigned to a service responsible for water quality and pollution controls and environmental sanitation and health, particularly in rural areas.

In 1974, this service was replaced by a Sub-Directorate for Environmental Sanitation and Health, and subsequently, in 1981, by a Department whose principal duties are: health controls in local communities and in public and private hospitals and health-care establishments; controlling the quality of drinking water and thermal waters and improving public water supply; inspection of sewerage networks and of treatment and disposal plants, as well as of waste water for irrigation; control of disease-carrying rodents and insects; participation in the preparation of development plans and housing schemes; protection of the environment and pollution control; ensuring observance of health standards in areas of activity within its competence, in co-operation with the bodies and services concerned.

To ensure the attainment of all these objectives, the Department employs 2 sanitary engineers, 1 public works engineer, 4 assistant engineers and 300 sanitation officers.

Testing of drinking water:

In urban areas:

Water treatment control: 82,750 days of testing;

Bacteriological tests of water supply networks: 22,810 analyses;

Physical and chemical tests of water supply networks: 360 analyses.

In rural areas:

Disinfection of public water supply points: 34,275 operations;

Bacteriological tests (wells, springs and cisterns): 9,923 analyses.

Testing of water in bathing areas:

Swimming pools: 1,199 analyses;

Beaches: 4,159 analyses.

Testing waste water disposal: 12,505 analyses.

Other activities include monitoring of the recycling of treated waste water for agricultural use at Soukra, Nabeul, Sousse and Kairouan, inspection of public establishments and foodstuffs, supervision of the use of pesticides, insect control, supervision of household refuse disposal and monitoring of hospital sanitation.

All of these activities are designed to restrict the spread of water-borne and faeces-borne diseases.

They are backed up by other activities such as the provision of latrines and public water-supply points, mainly in rural areas. Thus far, 859 water-supply points and 810 latrines have been provided in the northern and central areas of the country as part of the Tunisia-Care Medico project. In addition, a Tunisia-UNICEF "drinking water supply and sanitation" project has been initiated in Kairouan.

Since 1982, the Ministry of Public Health has taken other measures in connection with the International Drinking Water Supply and Sanitation Decade (IDWSSD) for the protection of the health of rural populations and the control of water-borne diseases, by ensuring a clean water supply and proper sewage-disposal methods.

(b) Action taken by other departments

The Ministry of Agriculture is engaged in the control of a number of animal-hosted or animal-borne infectious diseases such as brucellosis, hydatidosis and rabies. It is also responsible for providing drinking water supply points for centres with populations of less than 500.

This Ministry, which is responsible for treatment of the public water supply, improvement of housing, provision of roads and electrification in rural areas, is therefore also involved in sanitation and water-pollution control and thus plays an essential role in raising health standards. To assist them in performing their functions, bodies such as SONEDE and the Agricultural Commissions have at their disposal numerous legislative instruments including: the Water Code, instituted by the Act of 13 March 1975, defining the useful and harmful effects of water and setting out relevant offences and penalties; the Act of 26 July 1966, governing the slaughter of animals for human consumption and the transportation and marketing of meat and offal under veterinary supervision; and finally, the Act of 7 July 1961 governing the sale and use of agricultural pesticides.

The Ministry of Housing and Infrastructural Development, which is responsible for public and infrastructure and facilities, is also involved in the health programme through its activities in urban sanitation, the provision of water mains, urban flood protection, and water-pollution control. The National Sanitation Office (ONAS), established by the Act of 3 August 1974, is responsible for the management, operation, maintenance, replacement and construction of all urban sanitation facilities, including sewage-treatment plants, sewage outlets at sea, sewerage and storm-water drains in communes and tourist and industrial areas. The Office also provides assistance to communities for the treatment of household refuse. Still in the area of the protection of individuals against pollution, the Ministry of the Economy is responsible for protecting the environment from industrial pollution and taking action in cases of misrepresentation or adulteration of foodstuffs or agricultural produce.

For example, under the Act of 24 December 1964, the production, processing and marketing of milk, an ingredient of many staple foodstuffs, are subject to strict control.

An unpolluted environment, drinkable water and wholesome foodstuffs are inconceivable without clean housing and coherent town planning. The Ministry of Housing and Infrastructural Development is responsible for the enforcement of housing standards, as well as for the vast slum-clearance programme, which involves all the country's resources. The Act of 15 August 1979 instituted a town-planning code regulating and harmonizing the development of urban centres. The Ministry assisted in this field by the Ministry of Transport and Communications, which plays a major role in road safety (highway code laid down in the Act of 6 July 1970), with regard to both the physical health of drivers and the proper maintenance of vehicles, as well as in the control of pollution and potential public nuisances.

It is within this best possible of all physical environments that social activities with an indirect bearing on health can be undertaken. Educational establishments and the workplace play a pivotal role in the accurate assessment of the health situation. Through the Labour Code promulgated on 30 April 1966, the Ministry of Social Affairs prescribes, among other things, industrial hygiene and safety measures and requires a medical service to be established in any non-agricultural enterprise with 40 or more employees or apprentices. It requires every employer to declare worksites with a labour force of 50 or more and to report suspected cases of infectious diseases. The Ministry of Education is also responsible for providing and promoting education, as the best means of preventing many diseases which are spread through ignorance, and also for ensuring the good health of teaching staff through compulsory medical examinations and the health of students by measures ranging from vaccination to temporary exclusion from school in cases of highly contagious diseases. Since 1980, the school medical programme has been co-ordinated by the Ministries of Health and Education.

Like a genuine connective tissue, the Ministry of the Interior is involved in many areas related to health, through local communities, at both the central and peripheral levels. Municipal regulations in accordance with the Organizational Act of 14 May 1975, deal with sanitation - street cleaning and removal of household and other refuse, lighting, burial, fire prevention, rounding up of stray animals, mosquito control (Decree of 23 February 1933), and rabies control (Decree of 19 February 1966) by detection and vaccination.

4. The control of epidemic, endemic and occupational diseases

Vaccination. Although practised for many years, vaccination did not become compulsory in Tunisia until the end of the 1950s, with the exception of smallpox vaccination which had been compulsory since 5 May 1922.

At present, there are six main diseases for which vaccination is compulsory: tuberculosis "BCG" (20 February 1959), poliomyelitis (4 January 1963), diphtheria, tetanus, whooping cough "DTC" (22 September 1978) and measles (8 May 1981).

Because of the inadequate coverage of health services, the vaccination policy was carried out, following independence, through mass campaigns the pace of which varied depending on the vaccine concerned and the target population. Today, there is a continuous vaccination programme aimed mainly at children as the most susceptible to disease. It is an integral part of the activities of all permanent health facilities and is also carried out at assembly points which are visited regularly on set dates by mobile health officers.

As a result of these efforts and the intensification of the national vaccination programme in recent years, Tunisia has attained a level of vaccination very close to the world target set by WHO and UNICEF, namely the vaccination of all children by 1990.

The level of vaccination achieved is 88 per cent for BCG, 82 per cent, 73 per cent and 61 per cent respectively for the first, second and third doses of DTC polio, and 63 per cent for measles.

The experience of Tunisia is highly enlightening. Firstly, it shows that it is possible to combat a number of killing or disabling diseases effectively. A case in point is diphtheria, the incidence of which has fallen spectacularly from 128 cases in 1955 (with certainly a large number of cases unreported, particularly in rural areas) to 101 in 1965, 6 in 1975 and 1 in 1985. It is also true for poliomyelitis, where the result would have been similar had it not been for the failure of some families to return after their initial dose and who should be further motivated and educated. The number of cases fell from 525 in 1959 to 192 in 1962, 78 in 1978 and 19 in 1985. In 1965, as a result of the mass participation of the population, which had just experienced the nightmare of an epidemic, the number of cases fell to as few as two.

The experience of Tunisia also shows that the success of a large-scale vaccination programme involves the intensive education of the population; the inclusion of vaccination in all preventive and curative paediatric activities, whether in permanent centres or at "assembly points" catering for scattered populations; the "prevention" of defections in the case of vaccines requiring more than one injection by vigilant monitoring of the target populations; the prior or concomitant identification of geographical, cultural or other factors which might impair the enthusiasm of either the population or health officers; perseverance with the programme, since any relaxation of the vaccination campaign inevitably results in a resurgence of the target diseases.

Like a number of developing countries, Tunisia has decided to step up its national vaccination programme. The progress achieved over the last few years and the wholehearted commitment of public health authorities to promoting the welfare of children are two factors which afford the operation every guarantee of success.

Tuberculosis control. Tuberculosis has also been the target of a particularly vigorous control programme. Throughout the first half of this century, tuberculosis victims numbered in the thousands and were mainly to be found in Muslim communities, where it was difficult to obtain curative or preventive treatment.

The strategy adopted in order to combat this disease comprised three main stages:

Before 1959, apart from the international BCG vaccination campaign conducted from 1949 to 1951, the main features were the lack of any real control strategy, a very high incidence of endemic tuberculosis and an inadequate health infrastructure concentrated in Tunis and essentially of a curative nature.

The main features of the phase from 1959 to 1975 were the introduction of compulsory vaccination, the launching of mass campaigns and, in particular, the adoption of more specific objectives, namely the screening and treatment of all persons affected, regular monitoring of all persons with apparently stabilized lesions, and the protection of children and young adults by vaccination (BCG).

This approach lasted until 1975 and involved a succession of procedures - the national BCG vaccination campaign; the "mass radiography" campaign in the Governorates of Sousse, Kairouan, Gabès, Bizerte and Nabeul; the campaign of detection by identifying the source (bacilloscopy) in the Governorates of Sfax and Kef.

Alongside these operations, Tunisia developed its health infrastructure and increased the number of specialist physicians.

Between 1975 and 1985, a period which marked the transition from the campaign strategy to a programme of continuous control based on the decentralization of services and, in particular, the integration of some activities at all health centres; the inclusion of BCG vaccination into the national vaccination programme; selective screening in all health units through bacteriological examination of sputum, particularly among suspect consultants and individuals who had come into contact with diagnosed cases; the fullest possible reporting of cases; treatment of all diagnosed cases in accordance with a standard procedure until full recovery; the provision of services free of charge.

The following measures were envisaged in order to achieve these objectives: the equipment of all centres with facilities for screening, treatment and monitoring; the assignment of one phthisiologist to each region and one co-ordinating physician to each district; increase in the numbers of bacilloscopy and culture laboratories and in the number of beds for tuberculosis patients.

These combined efforts produced a sharp decline in the incidence of tuberculosis throughout the country, as illustrated by the decrease in the number of patients under treatment from 130,000 during the 1960s, to 11,310 in 1978, 7,454 in 1984 and 6,514 in 1985.

The most spectacular results were achieved among the infant population.

One of the most significant effects of this success has been the conversion of the Ariana preventorium intended in 1959 to be used exclusively for children (500 beds) into a pneumophthisiology hospital for patients of all ages in 1965. At present, children occupy only a small proportion of the beds in this large university hospital complex. Furthermore, they are admitted for a wide variety of respiratory ailments.

The virtual disappearance of serious cases of tuberculosis among children (tubercular meningitis and miliaria) demonstrates unequivocally that vaccination against tuberculosis is a necessary weapon in third world countries.

All in all, and despite the fact that much remains to be done in order to liberate the Tunisian population completely from the danger of tuberculosis, the Koch bacillus campaign has been effective. In future, the campaign will focus on strengthening existing procedures and also on stepping up patient education, since in some cases, failure can be explained largely by the casual attitude of patients - mainly adults - who discontinue their treatment prematurely.

Malaria eradication. This parasitic disease, which has long been endemic in Tunisia, has been the target of specific measures since 1903, when the Institut Pasteur in Tunis first set up its malaria control department. At that time, chemo-prophylactic techniques involving the use of quinine and larvicides were used in and around the main urban centres.

Despite these efforts, epidemics, many of them of devastating proportions, occurred throughout the country, with most of the victims being members of the Muslim population. In 1931-1932, for example, 20 per cent of the whole population was affected. The post-war epidemics were no less severe.

It was not really until independence that any large-scale offensive was undertaken against this disease. In 1957, a pre-eradication survey was conducted in the northern part of the country. This was followed by an eradication programme in a pilot area with a population of 620,000. The spectacular success of this operation prompted the authorities to extend the experiment to virtually the whole country (1968) then to the remainder (1972). Some years later, the interruption of the transmission of the disease became an indisputable fact. Since 1979, this success has been regularly confirmed by the absence of any indigenous cases.

This achievement makes Tunisia one of the first Arab, Muslim and African countries to have succeeded in overcoming this age-old menace, although there seems to be a resurgence of the disease in a number of third-world countries, where it continues to present serious problems because of the apparent resistance of the parasite and the mosquito carrier to the weapons available. Nevertheless, despite this achievement, the authorities continue to exercise vigilance and to conduct systematic efforts to detect imported cases. The present programme is based on the passive detection of cases as a routine procedure in outlying areas. Every year, thousands of slides are examined by technicians assigned to the units of the malaria laboratories scattered throughout the various governorates.

Since 1980, no indigenous case - i.e. contracted in Tunisia itself - has been reported.

Bilharziosis control. Since the beginning of the century, southern Tunisia had been regarded as one of the areas where urinary bilharziosis was endemic. But there too, the control measures were proving unsuccessful.

It was not until the 1950s and the 1960s that the beginnings of a large-scale programme to eradicate this parasitosis, transmitted to man by a fresh-water mollusc, began to emerge.

The real campaign against this disease began after this period, in 1970 to be exact, when an eradication programme was launched with the aid of WHO.

As with other programmes, this offensive passed through a number of phases:

Study of the data on the disease in Tunisia;

Training of personnel to participate in the programme;

Organization of a parasitological survey in endemic areas;

A census of water supply points and the identification of the breeding-grounds of the mollusc carrier;

Selection and implementation of control methods;

Evaluation of results.

Using this approach, it was possible to identify high-risk areas, interrupt the transmission of the disease, treat and monitor sufferers and finally control the disease itself. In 1982, the last breeding-ground at Gafsa was brought under control. Since then, the number of residual cases has steadily declined, with 20 cases being reported in 1984, compared to 4,856 in 1971.

(b) Protection against occupational diseases

The promulgation of the Decree establishing occupational health services only a few months after independence may rightly be regarded as one of the major events of the social policy of post-independence Tunisia. This apparently simple measure was actually highly significant given the fact that occupational health was a recent innovation at that time. It illustrates the continuous and deep concern of the Supreme Combatant, Habib Bourguiba, for the protection of the health of workers. This Decree has been reinforced promptly and regularly by other equally important measures such as the introduction of occupational health examinations (20 September 1955); the revision and strengthening of regulations governing occupational health examinations and services and the promulgation of the Labour Code (30 April 1966); the description of the functions of the Ministry of Public Health in respect of occupational health (19 January 1970); the transformation of the central occupational health service attached to the Ministry of Social Affairs into a department attached to the Ministry of Public Health (1981); the appointment of public health officers to conduct occupational health examinations at regional health departments from 1983 onwards; the creation of a technical unit to supervise the medical and technical prevention of occupational hazards, namely the Centre for Occupational Health and Occupational Diseases,

established in 1970 and converted into an Institute for Occupational Health and Ergonomics in 1985; the promulgation of legislation on the handling of toxic substances, exposure to dust, etc.

These combined measures and the succession of investments which accompanied them resulted in a very substantial improvement in the health and protection of workers, despite the country's rapid entry into a phase of constantly expanding industrialization. They gave occupational health a prominent role in social and preventive medicine policy.

The units at present responsible for the protection of workers' health and the improvement of working conditions are part either of the Ministry of Public Health or of independent or inter-company medical services.

In the Ministry of Health, the Department of Occupational Health and Occupational Diseases has a number of additional tasks: it participates in the preparation, promotion and development of legislation and regulations relating to occupational hygiene and the protection of workers' health and monitors their implementation; in conjunction with psycho-technical services and bodies, it conducts medical examinations of workers with a view to occupational guidance, reassignment and retraining; it monitors occupational health services and the treatment administered to victims of industrial accidents and occupational diseases; it carries out surveys and studies and gathers data for use in improving safety at places of work.

At the regional level, medical examinations and monitoring of the health of workers are performed by the regional departments of the Ministry of Public Health, specifically by public health physicians responsible for occupational health inspections.

In addition to all the above are the tasks performed by the Centre for the Prevention of Industrial Accidents and Occupational Diseases which plays an essential role in training and research and provides logistical support to the Department of Occupational Health. It provides medical and technical assistance to all bodies and persons with an interest in the prevention of occupational hazards, such as young people under 18 years of age, candidates for occupational training centres or applicants for emigration, workers exposed to toxic substances, persons enrolled in the social welfare scheme involved in insurance disputes, or victims of industrial accidents or occupational diseases. It also monitors environmental factors (ventilation, heat, noise, etc.) and develops a sense of safety through its educational programmes.

These activities are supplemented by those of the independent or inter-enterprise services set up under the provisions of article 153 of the Labour Code.

According to statistics compiled in January 1985, Tunisia has more than 200 independent services and 50 inter-enterprise occupational health associations employing 36 full-time doctors, 156 free-lance doctors and 251 paramedical staff. These services are able to monitor the health of more than 100,000 workers in non-agricultural sectors.

Tunisia is thus in the forefront of developing countries in the area of occupational health. The programme is to be strengthened over the next

few years by both quantitative and qualitative improvement of services provided to workers so as to be able to deal more effectively with the harmful effect of handling chemical and toxic substances which are a necessary part of continued industrialization, and the introduction of increasingly complex equipment and machinery into workplaces. A number of provisions of current legislation are also due for review, since medical care must now be extended to agricultural workers.

5. Overall Plan for Adequate Health Services

The public health system has diversified and expanded by leaps and bounds every year, which has led to the creation of new categories of health facility:

(a) Specialized institutions

These institutions admit persons suffering from a specific illness (e.g., the Carcinology Institute) or from a disorder of a given organic system (e.g., the Neurology Centre), or patients in a specific age-group (e.g., children's hospital).

(b) University hospital centres

These institutions provide a wide range of treatments for patients of various ages and suffering from a variety of disorders. They provide the ideal environment for medical teaching and training programmes.

(c) Regional hospitals

These are situated mostly in the chief towns of governorates. They provide an average of five services.

(d) District (or auxiliary) hospitals

These cover one or two districts and provide a maximum of three services (general medicine, maternity and paediatrics).

These hospitals, which used to be attached to regional hospitals, achieved budgetary autonomy in 1980.

(e) Maternity units

These are the last link in the hospital infrastructure. In addition to performing deliveries, they participate in providing mother and child care.

The expansion of the hospital and health system has of course been accompanied by an increase in the number of beds, which virtually doubled between 1957 and 1985, from 7,560 to 15,452.

Also significant is the creation of new areas of medical and surgical specialization which provide the public with a further range of health services, raising Tunisia's health standards to a high level in international terms.

The number of medical and surgical specializations in Tunisia increased from only 8 in 1962 (general medicine, contagious diseases, tuberculosis,

maternity, ophthalmology, otorhinolaryngology, psychiatry and surgery) to 32 in 1984, including: paediatrics, orthopedics, urology, gastro-enterology, dermatology, cardiology, neurology, neuro-surgery, nephrology, stomatology, toxicology, radiotherapy, haemodialysis, cardio-vascular surgery and thoracic surgery. Also worth noting is the establishment of burns units and of a complete network of emergency services covering a large proportion of the country.

While it is true that the public sector has remained the main component in the Tunisian health system, the expansion of the national health infrastructure has also extended to the private sector. From 114 private establishments in 1970, and 102 dispensaries, 7 laboratories and 5 private clinics and 262 private practices in 1972, the private sector underwent prodigious growth, increasing by 1985 to 818 dispensaries, 53 laboratories, 35 private clinics and 974 private practices.

With regard to regional hospitals, the conversion of a number of auxiliary (district) hospitals resulted in the establishment of:

Four regional hospitals at La Marsa, Siliana, Sidi Bouzid and Tozeur (1974);

Two regional hospitals at Khereddine and Jerba (1976);

A regional hospital at Zaghouan (1977);

A regional hospital at Metlaoui (1978).

The district hospital network has been expanded with the creation of four additional units at Chebba in 1974, at Soliman in 1975 and at Nefta and Mareth in 1978.

Three maternity/mother-and-child care units have been set up at Nefza (1971), Ksour Essaf (1974), and Dégache (1977).

Hospital bed capacity has increased from 12,532 in 1970 to 13,077 in 1976 and to 13,445 in 1979.

This expansion appears slower than the population growth rate since, in 1970, there was one hospital bed for every 399 inhabitants.

One reason for this is the time sometimes required for the construction of new hospitals. Taking into account the bed capacity of projects in progress, the bed/population density can be expected to improve drastically, as will be seen later.

This increase in hospital capacity (1,000 beds in 10 years) will reduce regional disparities and strengthen some specialized services. For example:

The Governorate of Gabès has been provided with 75 more beds (53 for general medicine and 22 for paediatrics);

The Governorate of Sfax received 73 additional beds, increasing the number from 909 in 1970, to 982 in 1979;

The Governorate of Médenine received 119 additional beds: 40 for general medicine, 43 for paediatrics, 24 for ophthalmology, etc.

The Tozeur health region was provided with 52 additional beds following the establishment of the Nefta district hospital and the Dégache maternity hospital.

The hospital capacity of the Governorate of Tunis increased by 586 beds, from 4,980 in 1970 to 5,566 in 1979.

These additions concern, in particular:

Orthopaedics (210 beds in 1979, compared to 96 in 1970);

Cardiology (266 beds in 1979, compared to 196 in 1970);

Gastro-enterology (197 beds in 1979, compared to 105 in 1970);

Neurology (55 new beds).

Finally, new hospital capacity was created to meet the requirements of family planning. In 1979, the number of new beds was 152, including 8 at Nabeul, 35 at Sousse, 32 at Sfax, 15 at Kasserine, 12 at Jendouba, and 30 at Kef.

In all, 20 regional hospitals existed in 1979, (compared to 12 in 1970), while the mumber of district hospitals decreased from 54 in 1970 to 50 in 1979 as a result of the changes described earlier.

The number of private clinics increased in the major urban centres, particularly in Tunis, Bizerte and Sousse. In 1980, they numbered 32 (21 in Tunis, 2 at Bizerte, 2 at Sousse, 4 at Sfax, 1 at Nabeul, 1 at Kairouan and 1 at Jendouba).

As regards health-care facilities in outlying districts, there were 638 clinics in 1979, including 10 tuberculosis units, compared to 379 in 1970. This means that 259 clinics were built and equipped during the second decade, mainly under the rural development programme. The number of first-aid stations increased from 60 in 1970 to 124 in 1979.

Fourteen health centres were also set up, in addition to the 13 existing in 1970.

As a result, the infrastructure has been strengthened appreciably since 1970, particularly with regard to out-patient units set up in clinics and mother-and-child care centres. In 1979, the breakdown of such units was as follows: 873 initial consultation units in clinics and 299 in mother-and-child care centres.

The number of secondary consultation units in hospitals increased to 502.

Almost one third of these consultation units (601 out of 1,674) were devoted to general medicine. This illustrates clearly the degree of specialization in medicine in Tunisia at the initial level of out-patient consultation (clinics and mother-and-child care centres).

The beginning of the third decade saw the completion of the university hospital centres at Sfax, Monastir and Tunis and of the regional hospitals at Jendouba, Mahdia, Gabès, Médenine, Jerba and Kasserine, as well as of the district hospitals at Menzel Témime, Moknine and Ras Jebel.

This period will also see the completion of projects launched at the beginning of the Sixth Plan. These include the university hospital centres at Sousse and La Marsa and the paediatrics unit at Sfax; hospitals at Siliana, Sidi Bouzid, Kébili and Métlaoui; and district hospitals at Boumerdès, Ouled Chamak, Chorbane, Sidi Alouane, Zeramdine, Bekalta, Teboulda, Sidi Makhlouf, Béni Khadech, Remada, Tamaghza, Hazoua, Bazma, Souk El Ahad, Douz, Chbika, Gbollat, El Jem, Midoun.

Other units include the maternity facilities at Skhira, El Hencha (Sfax), Jérissa (Kef), and Didi Bourouis (Siliana) and four type-4 units (multi-purpose health-care centres with day hospitals) at Sidi Alouane (Mahdia), Souk El Ahad (Kébili), Hazoua (Tozeur), and Zéramdine.

Tenders have been invited for the construction of seven primary health-care centres, type-4 (multi-purpose health-care centres plus day hospital facilities) at Ariana, Agareb, Sakiet Ezzit north (Sfax), M'hamdia (Ben Arous), Bouhjar (Monastir), Ksour Essaf and Mellouleche (Mahdia).

All of these urban structures, known as intermediate district health-care centres, are financed totally from the State budget. Other projects launched partly with external financing - or under special programmes - have helped to improve the health-care network.

Rural community health-care project in central Tunisia. Financed mainly by a USAID loan, this project began in 1977. It involves two Governorates in central Tunisia - Siliana and Sidi Bouzid. Under the Sixth Plan, the project has been extended to two other central Tunisian Governorates - Kasserine and Gafsa.

Health care and population project. The health care and population project was launched in 1981 with the aid of an IBRD loan. Eight governorates are involved: Béjà, Jendouba, Kairouan, Sousse, Mahdia, Monastir, Zaghouan and Kef.

The project involved the construction of primary health-care centres, health-care schools and functional housing in rural areas. Of the 65 first-aid facilities and 95 primary health-care centres to be provided under this project, 53 first-aid facilities and 80 centres have already been completed and are 60 per cent and 67 per cent operational respectively.

Rural development programme and integrated rural development programme. The contribution of these projects to the development of the health infrastructure and the improvement of the health-care situation is now an established fact.

In the course of the Sixth Plan, consolidated decentralization and more relevant and rational programming of projects have enabled a better balance to be achieved between needs and services. At the same time, the maximum development of health priorities has been made possible by the work of health

councils in making local authorities aware of the close links existing between health and social and economic factors such as roads, drinking water supply, schools, occupational training, job creation, etc.

In addition to the considerable efforts made with regard to the outlying infrastructure, improvements and extensions have been made to major university centres and institutes during the Fifth and Sixth Plans to enable them to meet modern medical standards.

The beneficiaries of these efforts have been:

The Charles Nicolle Hospital: nephrology, dermatology, surgery, gastro-enterology and otorhinolaryngology services;

The Rabta Hospital: cardiovascular, cardio-surgery, otorhinolaryngology, urology, gastro-enterology, infectious diseases (in progress), laboratory (in progress), and X-ray (in progress) services;

Aziza Othmana Hospital: blood diseases, neurology, emergency and maternity services;

Children's hospital: laboratories, X-ray and child-surgery services;

Abderrahman Mami Hospital at Ariana: X-ray, resuscitation and exploration and hospitalization services;

The Institute of Opthalmology: consultation service;

Marsa Hospital: surgery and X-ray services;

Neurology Centre: scanner service and general services;

Razi Hospital: consultation services, laboratories, in-patients, hospitalization service;

Sousse University Hospital: consultation, emergency and heart surgery services, laboratories, dispensary and hospitalization services;

Kairouan Hospital: emergency services, laboratories;

Souassi Hospital: maternity care, surgery service;

Béjà Hospital: surgery and otorhinolaryngology (in progress);

Bizerte Hospital: consultation services and laboratories.

Further efforts have been made in another sector of paramount importance, namely, emergency services. An emergency medical aid centre was set up in 1980 with all the necessary facilities (medical equipment, heavy ambulances, telecommunications equipment).

Three new emergency services have been set up at the Charles Nicolle, Rabta and children's hospitals.

A programme involving the setting up of emergency services on major highways and in areas with high traffic accident rates has been carried out with the establishment of a fund for improvement of emergency services. Such services are available in the regions of Menzel Bourguiba, Medjez El Bab, Béjà, Tabarka, Kef, Nabeul, Grombalia, Enfidha, El Jem, Kébili, M'Dhilla, and Moularès. They will all become operational during 1986.

These infrastructural projects have been accompanied by the preparation of an equipment programme covering both the acquisition of equipment for the new university hospital centres and the regional hospitals and the replacement in particular of heavy equipment in almost all hospitals (X-ray tables, operating tables, monitoring equipment, laboratory equipment, dentists' chairs, etc.).

Most university hospital centres and institutes have been provided with sophisticated equipment which can be used for detailed diagnosis and for providing the best training for students: catheter equipment in cardio-vascular services (in Tunis, Sfax, Sousse and Monastir), radio-therapy equipment at the Salah Azaiez Institute, head scanner at the Neurology Centre; laser equipment for opthalmological services and medical equipment for microsurgery (cardio-vascular surgery services at Tunis and Sousse and neuro-surgery services at Tunis, Sfax and Monastir).

These facilities are due to be improved, the equipment already installed under the Fourth and Fifth Plans having been well and truly amortized. Accordingly, beginning in 1985, a phased equipment plan was drawn up. In addition to the package of credits apportioned and allocated each year (D2 million) to the various hospitals for the purchase of equipment at the regional level, special credit lines were included for the provision of high-performance medical equipment to university hospital and health-care centres. These credits will be used to replace existing X-ray equipment (D2.5 million) with appliances ranging from the most simple to the most sophisticated, such as digital vascular tables; for the acquisition of three whole body scanners (D3 million); and for the replacement of laboratory equipment (D1 million).

There is a yearly programme of replacement and upgrading of ambulances, goods vehicles, minibuses and vans. A special effort has been made in this regard during the first four years of the Sixth Plan, with the purchase of 536 units including 188 standard all-terrain ambulances.

The new emergency services and the university and regional hospitals - particularly those inland - have been equipped with emergency ambulances fitted with heavy medical treatment and resuscitation equipment. This vehicle pool replacement programme is continuing with a view to upgrading transport facilities to meet the needs of all the regions, in particular those which are not easily accessible.

6. Medical care system

(a) Basic schemes

There are four basic schemes - free medical assistance, the CNRPS scheme, the CNSS scheme and the industrial accident and occupational diseases scheme.

Free medical assistance. This is governed by Act No. 81-12 of 2 March 1981. It is aimed at low-income segments of the population not covered by a social benefits scheme. Under this scheme, health care provided in public establishments is more or less free, depending on the patient's income.

Before the reform of 2 March 1981:

The number of free treatment cards granted in 1973 was 432,270. This had increased to 668,110 by 1978.

The number continues to increase, reaching almost 720,000 in 1980.
After the reform of 2 March 1981:

The quota of health-care books granted by the Ministry of Public Health in 1983 was 500,000;

By 1984, this number rose by 48,229 in response to further applications, bringing the total to 548,229;

In 1985, following 102,242 additional applications, the total number of books granted up to that date rose to 650,471 for the three categories.

The CNRPS scheme. This was instituted by the decree of April 1951. The scheme covers long-term illnesses and surgical operations. It is financed by contributions equivalent to 2 per cent of wages (1 per cent payable by the participant and 1 per cent by the employer). The scheme was reorganized under the Act of 15 February 1972, supplemented by the decree and order of 12 March 1973, to enable participants to choose between keeping the old system, possibly with voluntary enrolment in a scheme for reimbursement of costs pertaining to ordinary illnesses, and a system of direct health care services in public hospital-health-care units.

Since independence, the number of participants in this scheme has increased ninefold (41,290 in 1953 and 374,483 in 1985, representing 6 per cent and 23.6 per cent respectively of the national population).

The revenues of this scheme have grown considerably over the past 10 years, rising from D3,488 million in 1976 to D12,245 million in 1985, an increase of 350 per cent. Similarly, expenditures have more than quintupled, rising from D1.778 million in 1976 to D9.3 million in 1985. A large proportion of these costs is accounted for by treatment received abroad. Payments made abroad increased from D0.824 million in 1976 to D2.089 million in 1980 and D3.700 million in 1985, representing 46 per cent, 54 per cent and 40 per cent respectively of the scheme's total expenditures.

The CNSS scheme. In the private sector, the scheme set up by Act No. 60-30, of 14 December 1960, and administered by CNSS provides solely for the direct provision of treatment in public health units and hospitals.

The number of participants in this scheme has risen from 148,654 in 1965 to 600,966 in 1985, a fourfold increase in 20 years. This increase in participants means that the proportion of the population covered by this scheme has risen from 16.6 per cent in 1965 to 37.9 per cent in 1985.

The revenues of CNSS in the form of sickness insurance are not known exactly since members contribute at a flat rate of 26.5 per cent of wages to cover all risks, without itemization of the portion allocated to sickness insurance.

With regard to expenditures relating to sickness insurance coverage, CNSS paid the public treasury an annual lump sum subsidy set at D0.3 million in 1962. This increased to D1 million in 1966, D3 million in ... (illegible), D5.5 million in 1980 and D17 million in 1985, of which D2 million represented a contribution to hospital revenues.

The health costs of CNSS also cover participants' health expenditures abroad. Payments made in this connection increased from D0.847 million in 1977 to D2.914 million in 1980 and D6.113 million in 1985.

Finally, CNSS health expenditures since 1975 include the cost of building and managing six polyclinics. This programme has involved an investment of D13.8 million, including payments of D0.363 million and D8 million in 1980 and 1985 respectively.

Total CNSS health expenditures rose from D5.147 million in 1977 to D9.614 million in 1980 and D31 million in 1985.

Industrial accident and occupational diseases scheme. The sickness insurance scheme, which is obligatory, was instituted by the Act of 11 December 1957. Every enterprise must insure its workers against industrial accidents and occupational diseases. This risk is covered by private insurance companies. In the public sector, the State itself covers this risk on behalf of its employees, so that it is its own insurer.

Health-care payments under this scheme rose from D4.223 million in 1976 to D5.7 million in 1980 and D7.4 million in 1984.

(b) Conventional health insurance schemes

In addition to these basic schemes, a conventional health-care cost reimbursement scheme administered by insurance companies and mutuals has developed.

Group insurance scheme. This is a contract concluded between an employer and an insurance company whereby upon payment of a premium (approximately 10 to 15 per cent of wages at the present time), the company undertakes to insure the employees of the enterprise against the risks of sickness, disability and death. However, the contracts differ from one enterprise to another. In 1980, 170,000 workers were covered by this scheme. This number rose to 220,000 in 1984. Payments under the scheme rose from D9.540 million in 1980 to D18.600 million in 1984, almost doubling in five years.

The mutual insurance scheme. Instituted by the decree of 18 February 1954, this scheme is financed by participants' contributions, which vary from 1 per cent to 3 per cent of wages.

The number of mutuals increased from 30 in 1979 to 36 in 1984. At the same time, the number of participants rose from 93,616 in 1979 to 110,000 in 1984.

The expenditures of insurance mutuals doubled between 1979 and 1984, from D4 million to D8 million.

In accordance with the social aspect of development policy, the aim has always been to have the whole population covered for the various risks, in particular, sickness. In both 1976 and 1985, more than 90 per cent of the population had health insurance coverage under one of these basic schemes.

However, the changes which have occurred over the last 10 years have clearly defined the role of each of these schemes in the health insurance system.

As a result of the socio-economic changes which have taken place, only 32 per cent of the population qualified for free State medical assistance in 1985, compared with 42.4 per cent in 1976.

Many of those previously covered by the State scheme are now covered by the CNRPS and CNSS schemes.

Those schemes covered approximately 61.5 per cent of the population in 1985, compared with 39.5 per cent in 1976. However, the health expenditures of those bodies - 17 per cent of public health expenditures in 1976 and 24 per cent in 1985 - bear no relationship whatsoever to the number of persons that they cover.

C. Statistics

1. Number of doctors per capita of population:

1956: 548 doctors - 1.4 doctors per 10,000 population

1985: 4,000 doctors - 4.2 doctors per 10,000 population.

2. Number of hospital establishments:

Public hospitals: 1956: 52

1985: 139

Private clinics: 1970: 5

1985: 35. */

3. Number of hospital beds in use:

1979: 13,449 beds - 21.6 beds per 10,000 population

1985: 15,452 beds - 21.6 beds per 10,000 population

During this period, the population of Tunisia increased from 6,238,200 to 7,143,800

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*/ N.B. Clinics, mother and child care centres and first-aid stations are not included in these statistics.