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The decriminalisation of abortion in Tunisia: From Neo-Malthusian to conservatism

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Abstract

To date, Tunisia remains a unique North-African and Arab country because it has legalised abortion on demand. The decision to decriminalise abortion was made under the post-colonial state's demographic policies to lower the natality rate rather than a result of women's struggles, although some women's organisations promoted the procedure. With the support of various international agencies, frontal campaigns of family planning – which included several forms of coercion – started in the late 1960s following the neo-Malthusian rationality that the United States imposed on the Global South during the Cold War. The assumption of the Tunisian modernist elite was that the country's socio-economic development was possible only if the population did not exceed the available resources. This chapter traces the history of abortion depenalisation by setting it in the larger history of the Tunisian state's demographic and public health policies from the colonial era to the present. It highlights that access to abortion care in the public sector has progressively become more troublesome after the demographic transition took place at the end of the 1990s. The 2011 revolution and the pandemic have contributed to making the situation even more complex, although the law was not changed and, officially, government facilities should continue to offer free abortions to all Tunisian citizens. The chapter describes first the rationale of demographic colonial policies and later examines the reforms that the independent political elite launched to modernise local society and favour the country's economic development. It also analyses the obstacles women attending government facilities must face to receive abortion care, especially after the 2011 revolution. The conclusion

focuses on remarks on abortion care access since the beginning of the pandemic, which are based on two preliminary studies conducted in 2020 and 2021.

1 Introduction

To date, Tunisia remains a unique North-African and Arab country because it has legalised abortion on demand.[1] The decision to decriminalise abortion was made under the post-colonial state's demographic policies to lower the natality rate rather than a result of women's struggles, although some women's organisations promoted the procedure. Indeed, in 1966 the total fertility rate (TFR) in Tunisia was 7,2,[2] a rate deemed too high to allow for the country's socio-economic development and modernisation. The discourse of Habib Bourguiba, the first President of independent Tunisia, is well-known, in which he stated that it was necessary to contain 'the human tide relentlessly rising at a speed largely outreaching the increase of the means of subsistence'.[3]

With the support of various international agencies, frontal campaigns of family planning – which included several forms of coercion[4] – were started in the late 1960s following the neo-Malthusian rationality that the United States imposed on the Global South during the Cold War. The assumption of the Tunisian modernist elite was that the country's socio-economic development was possible only if the population did not exceed the available resources. In 1965 abortion was decriminalised first for women with at least five living children and with marital consent. In 1973 access to abortion was extended to all categories of women, unmarried and married, without marital consent. Abortion was made available and free in all clinics of the *Office National de la Famille et*

1 J DeJong and others *Regional advocacy tool: Sexual and reproductive health and rights advocacy in Egypt, Lebanon, Morocco, Oman, Syria, Tunisia and Yemen* (2015); I Maffi & L Tonnessen 'Editorial: The limits of the law: Abortion in the Middle East and North Africa' (2019) 21 *Health and Human Rights* 1.

2 J Vallin & T Locoh (eds) *Population et développement en Tunisie: La métamorphose* (2001).

3 B Gastineau & F Sandron *La politique de planification familiale en Tunisie* (2000) 11.

4 AM Foster 'Women's comprehensive health care in contemporary Tunisia' PhD thesis, University of Oxford, 2001; I Maffi *Abortion in post-revolutionary Tunisia: Politics, medicine and morality* (2020).

de la Population (ONFP), the government institution created in 1973 to oversee the Tunisian state's demographic policies, and government hospitals. Various contraception methods were offered in these facilities, as well as in the network of regional dispensaries and primary health clinics created during the first decades after independence.

Despite the abuses of the 1970s and 1980s, during which women were forced to accept contraception and sometimes sterilisation,[5] abortion became one of the methods available in government healthcare facilities to control reproduction beginning in the early 1970s. Family planning campaigns and several other social reforms – discussed below – changed the reproductive behaviours of Tunisian families. The demographic transition took place in the late 1990s, causing a decrease of state concerns for Tunisian (female) citizens' reproductive behaviours.

After the 2011 revolution, a strong conservative religious-based movement took centre stage, threatening women's rights to abortion. On the one hand, an attempt was made to change the law in 2013.[6] On the other hand, many healthcare providers working in government facilities began to refuse abortion care and to turn women away.[7]

Except for an unpublished 2011 study,[8] no data is available about the number of abortions performed in the private sector. The study was based on fragmentary data because of private clinics' resistance to disclose statistics, and the author argued that, in 2011, the private sector performed at least double, if not three times, the abortions to those performed in the public sector. Statistics on abortions performed in public facilities show that the amount has been more or less stable

5 Association tunisienne des femmes démocrates *Le droit à l'avortement en Tunisie – 1973 à 2013* (2013).

6 I Maffi 'Abortion in Tunisia after the revolution: Bringing a new morality into the old reproductive order' (2018) 13 *Global Health Journal* 680.

7 Association tunisienne des femmes démocrates (n 5); S Hajri and others '"This is real misery": Experiences of women being denied legal abortion in Tunisia' (2015) 10 *PLoS ONE* e0145338; I Maffi & M Affes 'La santé sexuelle et reproductive en Tunisie: Institutions médicales, lois et itinéraires thérapeutiques des femmes après la révolution' (2017) 17 *L'Année du Maghreb* 151; I Maffi & M Affes 'The right to abortion in Tunisia after 2011: Legal, medical and social arrangements seen through seven abortion stories' (2019) 21 *Health and Human Rights* 69; Office National de la Famille et de la Population, Ministère de la Santé, UNFPA *Etude sur l'accès et la qualité des services SSR/PF en Tunisie* (2020).

8 A Ben Hamida *Etude sur l'IVG/Avortements à risque dans le secteur de libre pratique en Tunisie* (2011) unpublished report.

since the early 2000s.[9] The total was approximately 12 000 in 2004 and 17 000 in 2016,[10] out of a population of 9,8 million in 2000, and reached 11,9 million by 2021.[11] However, several studies have reported access limitations in the government sector related to structural and human factors: difficulties in supply, staff shortage, lack of facilities and conservative attitudes of the personnel.[12] Contraceptive prevalence has also drastically decreased in the last decade, from 62,5 to 50,7 per centage.[13] However, the TFR has remained stable since the early 2000s,[14] estimated at 2,01 children per woman in 2021.[15]

Despite difficulties in accessing abortion care in several regions of Tunisia,[16] which the state has neglected over several decades, such as the south, west and north-west, the latest national surveys on maternal and child health[17] have not reported illegal and unsafe abortions.[18] Therefore, many women probably attend private physicians or clinics to receive abortion care when they are unable to access a public facility, although it is possible that poor women living in rural areas either keep the pregnancy or illegally purchase Misoprostol, a medication originally used for gastric ulcers, which is now administered for pharmacological abortion. Even if

9 *Avortement médicamenteux: 15 ans d'innovations au service de la femme en Tunisie* (2016).

10 Office national de la famille et de la population *Annual Report of the Board's Activities* (2016).

11 UNPF 'World population dashboard: Tunisia', https://www.unfpa.org/data/world-population/TN (accessed 4 January 2023).

12 Association tunisienne des femmes démocrates (n 5); Hajri and others (n 7); S Hajri & H Belhadj 'The role of midwives in first-trimester abortion care: A 40-year experience in Tunisia' (2020) 150 *International Journal of Gynecology and Obstetrics* 43; Maffi & Affes 'La santé sexuelle et reproductive en Tunisie' (n 7); Maffi & Affes 'The right to abortion in Tunisia after 2011' (n 7); Maffi (n 6); Maffi (n 4); Office National de la Famille and others (n 7).

13 Institut National des statistiques & UNICEF *Enquête par grappes à indicateurs multiples (MICS) 2018* (2019) 175.

14 The World Bank Data 'Fertility rate, total (births per woman) – Tunisia', https://data.worldbank.org/indicator/SP.DYN.TFRT.IN?locations=TN (accessed 4 January 2023).

15 UNPF (n 11).

16 Hajri & Belhadj (n 12); Maffi (n 4); I Maffi 'The production of ignorance about medical abortion in Tunisia: Between state policies, medical opposition, patriarchal logics and Islamic revival' (2022) 14 *Reproductive Biomedicine and Society Online* 111; Institut national des statistiques & UNICEF (n 13).

17 Ministère de la santé and others *Stratégie nationale de la santé maternelle et infantile 2020-2024* (2019); Office National de la Famille and others (n 7); Institut national des statistiques & UNICEF (n 13).

18 Ministère de la santé and others *Stratégie nationale de la santé maternelle et infantile 2020-2024* (2019); Institut national des statistiques & UNICEF (n 13).

used without medical supervision, Misoprostol is quite safe for stopping a pregnancy and has contributed to reducing the severe consequences of unsafe abortions.[19] As a midwife who has been working in the public sector for 30 years indicated in 2018, women who live in areas where abortion care is unavailable can quite easily obtain Misoprostol.[20] This midwife had collected the testimonies of healthcare providers based in regions where abortion was not available in public facilities.

The availability of Misoprostol probably is the reason why unsafe abortions with tragic consequences are not reported in Tunisia. Many women know about Misoprostol because, in the early 2000s, Tunisia introduced medical abortion, a safe and cost-effective technology that largely replaced surgical abortion in government facilities.[21] However, the private sector continues to offer surgical abortions almost exclusively for various reasons. As the medications used for abortion have to be provided by the government central pharmacy, private clinics should make these available to private physicians using their technical facilities. This goes against the interests of private clinics and doctors for whom surgical abortions are much more lucrative and do not require a follow-up after two weeks.[22]

In this chapter we trace the history of abortion depenalisation by setting it in the larger history of the Tunisian state's demographic and public health policies from the colonial era to the present. We also show that access to abortion care in the public sector has progressively become more troublesome after the demographic transition took place at the end of the 1990s. The 2011 revolution and the pandemic have contributed to make the situation even more complex, although the law was not changed and, officially, government facilities should continue to offer free abortions to all Tunisian citizens. Moreover, 'in 2015, Beji Essebsi, then-President of Tunisia, signed the Maputo Protocol, but the Tunisian state did not ratify it until 2018'.[23] In 2021 laws had yet to be harmonised according to its principles, as the Alternative Report to the

19 Alan Guttmacher Institute *Abortion worldwide 2017: Uneven progress and unequal access* (2017), https://www.guttmacher.org/report/abortion-worldwide-2017 (accessed 4 January 2023).
20 Personal communication to Irene Maffi.
21 Office National de la Famille et de la Population (2016) (n 10); Hajri & Belhadj (n 12).
22 Maffi (n 16).
23 Maffi & Tonnessen (n 1).

seventh national report of the Tunisian state about the application of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in Tunisia clearly indicates.[24]

We begin by describing the rationale of demographic colonial policies and later examine the reforms that the independent political elite launched to modernise local society and favour the country's economic development. We also analyse the obstacles women attending government facilities must face in order to receive abortion care, especially after the 2011 revolution. We conclude with remarks on abortion care access since the beginning of the pandemic, which are based on two preliminary studies conducted in 2020 and 2021.

2 Historical background: Colonial and post-colonial time

As mentioned above, the legalisation of abortion in Tunisia dates back to the Bourguiba period, starting from the national independence in 1956, after having been strictly prohibited for decades.

2.1 During the colonial period (1881-1956): A moralising and repressive perspective

In Tunisia, the first Penal Code was promulgated by a July 1913 beylical decree, which became effective in January 1914.[25] In this Code, two articles clarify the prohibition of abortion.[26] Article 1 warns: 'shall be punished by imprisonment of six months to three years and a penalty of 100 to 3000 Francs, anyone who: either by speeches made in public places or meetings ... will have provoked a crime of abortion even though this provocation has not been followed by any effect'.

In the initial version of the Penal Code, article 214 states that abortion obtained in any way whatsoever, either by the woman or even with her consent, by a third party who does not fit into one of the categories of persons referred to in the following paragraph, shall be punishable by five years' imprisonment or 10 years of forced labour. The third party category includes the doctor, the surgeon, the pharmacist, the midwife,

24 Association tunisienne des femmes démocrates *Rapport Alternatif au 7e Rapport National de l'État tunisien sur l'application de la CEDAW en Tunisie* (2021).
25 A Guiraud *Histoire de la Tunisie: la Tunisie antique* (1937).
26 As above.

or the health officer convicted of having participated as the actor or accomplice in an obtained or attempted abortion.

In September 1920 a decree repressing the practice of abortion strengthened the established legal arsenal and even warned against advocating speech. In April 1940 the prohibition was confirmed by a decree related to the repression of abortion and morality outrage. These repressive measures reflected the law of the French metropole, where the authorities made efforts to promote natality, including in the colonial domains. Since the end of the nineteenth century, moral and medical, as well as military and economic, preoccupations pushed most European states to create new health and social services to reduce infant mortality and encourage natality.[27] They focused on women's and mothers' behaviours and bodies, as they were deemed the main actors of reproduction (or lack thereof). The states' aim was to have larger and healthier populations, a prerequisite to maintain and reinforce their power. Repressing abortion and contraception were part of the pronatalist policies that France and Great Britain promoted in Africa and other colonised areas.

2.2 In the post-colonial time: Women's emancipation and legalisation of abortion

The end of French colonisation constituted a turning point in the Tunisian state's demographic and social policies. The modernist political elite, which came to power in 1956, started a series of pioneering reforms to trigger the country's social and economic development.

2.2.1 A holistic and strategic context

Indeed, 1956 marks the launch of a series of liberal reforms that promoted Tunisian citizens, particularly Tunisian women, and in so doing set the environment for social emancipation. The most noteworthy of these reforms was the Personal Status Code (1956), which abolished polygamy and repudiation, set the legal age of marriage at 15 years for women and at 18 years for men (raised later to 17 and 20, respectively, in 1964).

27 F Cahen 'On the "effectiveness" of public policies: The fight against "criminal" abortion in France, 1890-1950' (2011) 58 *Revue d'histoire moderne et contemporaine* 90.

Moreover, free education was established for all children (1958), which was compulsory to the age of 15 years (1991).[28]

In 1959 the authorities launched a debate on the need to improve fertility control, reflecting the will to overcome fatalistic attitudes, ignorance, poverty and disease. Four years later, the population policy became one of the pillars of Tunisia's first exercise in economic and social planning. This policy, which aimed at mastering population growth, set a number of measures, including the legalisation of abortion and a post-abortion programme to link abortion to contraceptive use. However, the first family planning programme was not successful because only 27 000 intrauterine devices (IUDs) were inserted instead of the planned 120 000.[29] State officers' lack of motivation, organisational problems, contradictory messages of then President Habib Bourguiba, and the abuses of some healthcare providers were among the causes of this failure.[30]

In 1968, a new five-year national family planning programme was launched with the financial support of the United States Agency for International Development (USAID).[31] The Ministry of Health's reorganisation allowed for the creation of a special unit in charge of the family planning programme, which was not limited to the distribution of contraceptive means but included other services designed for women who attended clinics.

In 1973 the new five-year development plan strengthened the family planning programme.[32] In the same year, the *Office National du Planning Familial et de la Population* (National Board of Family Planning and Population) was created to conduct demographic studies, including economic, social and technical aspects; to collaborate with sanitary authorities in the private and public sectors; to train (para)medical personnel in the domain of family planning; to introduce training in universities and other institutions; and, finally, to inform and educate

28 Office National de la Famille et de la Population (1976); M Bchir & M Charfeddine 'L'avortement dans le programme de planning familial' (1976) 6 *Famille et Population. Bulletin mensuel* 5.
29 Gastineau & Sandron (n 3).
30 As above.
31 Foster (n 4).
32 As above.

the population about family planning.[33] Abortion was legalised in the framework of these programmes in two successive phases: the first in 1965 and the second in 1973.

2.2.2 1965: Legalisation of abortion under four strict conditions

A 1965 decree addressed social abortion and included it in a range of maternal healthcare services.[34] Abortion was authorised only if the pregnancy age was no more than three months; the couple had five living children; both spouses signed a consent; or if continuing the pregnancy might be life threatening for the woman.

The process gave rise to long debates in the national assembly, with some deputies expressing their fears that abortion would be used as a contraception method. Dr Tawhida Ben Cheikh, the Chairperson of the Tunisian Family Planning Association (founded in 1968) and the country's first woman gynaecologist, was the lead advocate for the legalisation of abortion to overcome this dramatic situation. The first legal abortions were performed in the association's pilot clinic in Tunis. The procedures were provided free of charge to make them affordable to all and to discourage women from resorting to illegal and risky abortions.[35] Thus, it was through medical and humanitarian considerations that the non-governmental organisation (NGO) advocated the legalisation of abortion.

A major advocacy operation was undertaken to promote the family planning programme by using political and medical arguments, such as the need to curb fertility, combat maternal deaths arising from abortion complications, reduce infanticide and the abandonment of babies, and ensure the psychological health of women and families.

A major debate also took place around Islam and abortion, and the Tunisian Family Planning Association facilitated a series of discussions targeting religious leaders as key actors in informing the population and raising its awareness on family planning issues. After an initial resistance,

33 N Gueddana 'L'expérience du programme tunisien de planification familiale (1956-1996)' in Office National de la Famille et de la Population Population et Développement (1998).

34 Gherissi and others *Responsible maternity and the 1973 law on legalisation of abortion in Tunisia: The results* (2002).

35 Bchir & Charfeddine (n 28); Gherissi and others (n 34).

the principle of abortion was accepted under the condition that it is performed before the *breath of life* entered the foetus, thus, before 12 weeks of pregnancy.[36] This argument refers to the verse of the Quran that describes the development of life *in utero* and that invokes the entry of the breath of life into the embryo after 120 days or gestation, from the twelfth week. Before this time, abortion does not transgress the religious principles of Islam.[37] If this is the opinion prevailing in the Hanafi and Shafi legal schools, it is important to note that the Maliki tradition, which is dominant in North Africa, forbids abortion from the time of conception. Bourguiba had to insist on the Islamic foundation of the legalisation of abortion in the first trimester of pregnancy to make it acceptable to the religious establishment and the population's groups that are more conservative.[38]

The National Union of Tunisian Women played an important role in legitimising abortion as a means to prevent women from suffering, dying or committing suicide.[39] It is important to mention that the creation of the National Union of Tunisian Women in 1958 to supervise social reforms and to promote the new state policies in the domains of education, family, labour, and so forth, was a crucial moment in the history of institutional and state feminism in Tunisia. These advocacy efforts resulted in the general acceptance of the new legislation and facilitated the transition to the second phase in the legalisation of abortion.

2.2.3 1973: Abortion legalised on demand

The second phase started with a 1973 decree by which abortion was henceforth made legal on demand and became a right for all women on a single condition, namely, that a qualified practitioner performed the abortion in a licensed facility during the first three months of pregnancy. Beyond this period, abortion could be performed if the pregnancy was life threatening for the mother, or if the foetus was likely to be born

36 A Omran *La planification familiale dans l'histoire de l'Islam* (Arabic version) (1994).
37 As above.
38 S Bessis & S Belhassen *Femmes du Maghreb: l'enjeu* (1992).
39 O Asman 'Abortion in Islamic countries – Legal and religious aspects' (2004) 23 *Medical Law International* 73.

disabled or with a serious illness. Thus, the conditions regarding the family dimension and the woman's marital status were eliminated.[40]

2.3 Late 1960s to the 1970s: Switching the rationale of the family planning programme from birth control to birth spacing

A broad social mobilisation campaign was undertaken in favour of the family planning programme, involving NGOs, religious leaders and the media as active partners.[41] The aim was to promote the use of modern contraceptives in such a way that women would adopt them out of personal conviction and by free choice.

Two NGOs played a determinant role. The Tunisian Association for Family Planning was the first NGO to promote family planning. It organised information campaigns through the creation of population clubs in primary and secondary schools to disseminate the population programme's main facet to teachers and pupils. On its part, the National Union of Tunisian Women became a leading advocate for family planning with decision makers and beneficiaries. The religious leaders expressed their interests early and lent their efforts to mobilising the community in favour of family planning.

The media played a key supporting role. The national television stations broadcast 620 programmes about family planning between 1974 and 1978. According to a survey, 79 per cent of the population attended a weekly programme on the same topic in 1980.[42]

Concerning the written press, the number of articles on family planning in the French-language press increased from ten in 1963 to 100 in 1973 to 1974. The themes included the programme's preparation, objectives and results. The television and radio channels invited the family planning programme's managers to talk about family planning in their cultural and social shows. From the early 1970s, some programme managers even had their own shows, which provided a forum to generate interest about contraception's impact on the health of women and families.

40 Office National de la Famille et de la Population (1976).
41 Gastineau & Sandron (n 3); Vallin & Locoh (n 2).
42 Salhi quoted in Gastineau & Sandron (n 3) 17.

With the enactment of the 1973 law related to abortion on demand, it became the duty of all family planning facilities to accommodate all women requesting an abortion if the pregnancy did not exceed three months. At least officially, no other questions should be asked of any candidate for abortion, and the abortion is performed free of charge because it is included in the range of preventive health services. Before leaving the facility, the woman is provided with post-abortion counselling as a preventive measure. However, the study Lilia Labidi conducted in the early 1980s in government family planning clinics showed that maltreatment, humiliation and symbolic and physical violence by healthcare practitioners were common, and that women often had to endure troublesome abortion itineraries.[43]

According to Labidi, unmarried women seeking abortion were treated as 'abnormal', 'asocial' and 'marginal' persons, as well as bad citizens.[44] Many providers introduced a 'non-institutional' interview – as the law did not require it – with these women 'based on the midwife's moral understanding of sexuality and dominant ideology'.[45] Labidi cited the shocking sentence of a physician who had to provide abortion care for a pregnant unmarried girl who was still a virgin: 'I will take her virginity with my scissors to give her a lesson.'[46] Despite the birth control policies of the time, healthcare professionals transformed some medical acts into 'dramatic events'[47] so that women would avoid the abortion experience in the future.[48]

2.4 1980s-1990s: First positive outcomes on contraceptive use and Integrated Maternal and Health Care and Family Planning adopted as a holistic approach of service delivery

Gueddana reported spectacular trends in contraceptive use by new family planning acceptors from 1965 to 1995. After 30 years, the IUD remained the method most frequently adopted, even if the percentage was cut down by half (from 94,5 per cent in 1965 to 47,4 per cent in

43 L Labidi Çabra Hachma. Sexualité et tradition (1989); see also Association Tunisienne des femmes démocrates (n 5).
44 Labidi (n 43) 102.
45 Labidi (n 43) 103.
46 Labidi (n 43) 102.
47 As above.
48 Maffi (n 4) 41.

1995). The use of pills increased from 2,5 per cent in 1965 to 20,5 per cent in 1995.[49]

According to the National Board for Family Planning (1999), the evolutive increase of contraceptive prevalence from 9 per cent in 1966 to 61,2 per cent in 1997 was followed by an evolutive decrease of the ratio of abortions per woman, which moved from 1,5 to 7,3 per cent, during the same period. Moreover, Gueddana[50] evaluated the contribution of the national family planning programme to the number of births avoided by contraception, which increased from 639 000 in 1966 to 1975 to 1 620 000 in 1985 to 1994. The contribution of abortion to the family planning programme evoluted from a percentage of 28 per cent of the number of births avoided in 1980 to 14 per cent in 1997.

The Primary Health Care Department of the Ministry of Health conducted a national survey on maternal mortality and morbidity in 1993 to 1994.[51] It revealed that the rate of post-abortion complications was at 3 per cent; 12 post-abortion deaths were identified, which equals 5,9 per 100 000 live births. The contribution of post-abortion mortality to overall maternal mortality is approximately 8,6 per cent, compared with 13 per cent in low- and middle-income countries. Those post-abortion deaths were mostly spontaneous (eight), therapeutic (two), and induced (one); the last one was not specified.[52] Henceforth, abortion was considered a failure of contraception, and the decision makers launched the integration of maternal and child healthcare with family planning services.

Since the United Nations (UN) International Conference of Population and Development in Cairo (ICPD) in 1994, reproductive health was promoted. It was integrated as part of the national policy for women's development and emancipation, including in the health policy and the strategic plans, in the framework of health services and the health education programmes. Already at the end of the 1980s, a National Programme of Safe Motherhood (PNP) was elaborated but was not fully implemented until the mid-1990s.[53] Its objectives were to

49 Gueddana (n 33).
50 As above.
51 Direction des Soins de Santé de Base *Résultats de l'enquête nationale sur la mortalité maternelle en Tunisie* (1993-1994).
52 As above.
53 Foster (n 4).

reduce infant and maternal morbidity and mortality. The programme mostly centred on women's reproductive life phases. The PNP 'divided women's health care into four stages: pre-marital, pre-natal, delivery, and post-natal'.[54] It also attempted to integrate reproductive health services with primary healthcare and defined the roles of the various healthcare practitioners in charge of each aspect to ensure better coordination.

The 1994 ICPD developed the idea that reproductive and sexual health was a larger concept than maternal or perinatal health or family planning. Thus, it concerned contraception, childbirth and post-partum care, as well as many other aspects of women's lives, such as infertility, sexually transmitted infections (STIs), HIV, breast and uterus cancer and menopause. Adolescents and unmarried individuals were also recognised as categories of citizens who needed reproductive and sexual healthcare services, whereas until the end of the 1990s, married women were the only targets of national programmes in this domain. Officially, men were also offered sexual and reproductive health (SRH) services, although in the public sector they underuse them, as official statistics of the *Office National de la Famille et de la Population* have shown.[55] In the early 2000s, special youth-friendly spaces were created in ONFP clinics to offer sexual and reproductive health services, including abortion, in a confidential and protected setting. The staff in these spaces received specific training, enabling them to offer a better quality of care and an attentive listening ear.

3 The 2000s: Introduction of medical abortion and first signs of ideological health professionals' reluctance towards abortion

After two conclusive experimental surveys among 850 women conducted under the umbrella of the World Health Organisation (WHO) and later the Population Council and the New York-based NGO Gynuity Health Project,[56] medical abortion was legally approved in Tunisia in 2000 through a marketing authorisation given by the Ministry of

54 Foster (n 4) 118.
55 Maffi (n 4) 92.
56 J Blum and others 'The medical abortion experiences of married and unmarried women in Tunis, Tunisia' (2004) 69 *Contraception* 63; S Hajri and others 'Expanding medical abortion in Tunisia: Women's experiences from a multi-site expansion study' (2004) 70 *Contraception* 487.

Public Health. Its implementation by the National Board for Family and Population was effective in 2002, and one year later, the institution recorded approximately 3 000 women who opted for medical abortion. In 2016, between 75 and 80 per cent of abortions in the public sector were performed using the pharmacological protocol.[57]

However, beyond these figures, a number of qualitative surveys noted the easy use and overuse of medical abortion mostly among young girls, reaching an average of three times a year.[58] This suggests that single young girls and women could use medical abortion as a contraceptive method for their irregular sexual activity. The same qualitative research highlighted another hidden explanation given by a 40 year-old woman. Highlighting her commitment for years with a married partner who was not ready to leave his wife, she guaranteed that she had no other choice than to remove her pregnancy, while noting, '[b]ut, at least, I know that I can procreate'.

In 2011 the abortion rate was estimated at 15 per cent.[59] In the early 1990s, the induced abortion rate was estimated at 8,6 per 1 000 women of reproductive age.[60]

Upon the introduction of medical abortion in Tunisia, a large number of clinicians, some jurists and many politicians opposed this technology. Doctors were afraid that it would deprive them of control over this act because paramedical personnel could easily supervise the procedure. Some jurists insisted that the law did not allow the use of medications to perform medical abortions or the possibility of women doing it at home (two features medical abortion includes) because the Penal Code stated that abortion could not be performed by administering 'beverages, medicines or any other means' (Penal Code, article 214) and shall take place in a licensed medical facility. Politicians were concerned by the possible freedom women could enjoy by using a less invasive and less medically controlled technology. This was a major ideological obstacle to

57 *Avortement médicamenteux 15 ans après* (n 9).
58 M Zaray *La demande d'avortement chez les jeunes filles porteuses d'une grossesse non désirée: connaissances, attitudes et pratiques en santé sexuelle et reproductive* (2005).
59 UNFPA & AECID *Projet de coopération UNFPA/AECID: Promotion de l'Equité de Genre et Prévention de la Violence à l'Egard des Femmes. Enquête nationale sur la violence à l'égard des femmes en Tunisie. Rapport principal* (2011).
60 Alan Guttmatcher Institute 'Sharing responsibility: Women society and abortion worldwide' (1999), https://www.guttmacher.org/sites/default/files/pdfs/pubs/sharing.pdf (accessed 4 January 2023).

the acceptance of medical abortion, as patriarchal rationalities, including control over women's bodies, are strong in Tunisian society.[61]

3.1 Abortion after the 2011 revolution

In 2015 Selma Hajri, the physician who introduced medication abortion in Tunisia[62] and a feminist militant for women's sexual and reproductive rights, stated during an interview with *La Presse*, a Francophone Tunisian newspaper:[63]

> [B]y the end of the 2000s, even before Ennahdha came to power, midwives and certain physicians began to manifest religious conservatism. This religious conservatism has affected the practices of healthcare providers ... and after the elections of 2011 these attitudes have been legitimised ... Several ONFP clinics especially in the South (Tataouine, Gafsa, Sidi Bouzid, Siliana ...) stopped to provide abortion care. Some clinics have provided it again since 2013, others not yet.

In 2013 the Association Tunisienne des Femmes Démocrates (ATFD), one of the main feminist associations, published the booklet *Le droit à l'avortement en Tunisie – 1973 à 2013*,[64] in which the authors reported the obstacles women had to face to receive abortion care and the conservative attitudes of many healthcare providers working in the government sector. These attitudes were not new but became much more visible after the 2011 revolution because the democratisation of Tunisian society created new spaces to express one's opinion and to act accordingly. During the previous decades under Ben Ali's rule, all behaviours going against the established order and all opinions criticising it were risky.[65] One could lose her job, be persecuted by the police, see her family members lose their jobs, and be harassed by the security forces. Even wearing the headscarf for a female employee of the public sector could be dangerous.

Several years of uncertainty and effervescence followed the revolution, a situation eliciting violence,[66] democratic debates and the

61 Maffi (n 16).
62 Hajri and others (n 56).
63 H Lahbib 'Après 2011, il y a eu une légitimation du rejet de l'avortement' *La Presse de Tunisie* 28 September 2015.
64 Association tunisienne des femmes démocrates (n 5).
65 B Hibou *La force de l'obéissance. Économie politique de la répression en Tunisie* (2006).
66 I Ben Dridi & I Maffi 'De nouvelles économies morales des mœurs? Femmes, professionnels de santé et régimes discursifs en Tunisie' (2018) 18 *L'Année du*

emergence of new political subjectivities.[67] The publication *Le droit à l'avortement en Tunisie – 1973 à 2013*[68] was also a reaction towards the attempt by a deputy of the Islamist party Ennahdha to change the law allowing abortion. On 18 January 2013, during the work of the Constituent Assembly in charge of drafting the new Constitution, Najiba Berioul intervened in the debate on the theme of 'rights and freedoms', invoking the criminalisation of abortion (*ijhâdh*). Berioul, a member of the Islamist party in power since the October 2011 elections, thus was the spokesperson for a part of public opinion that refuses to allow women to exercise their right to voluntary termination of pregnancy for non-medical reasons. In her speech, she invoked 'the right of the foetus to come into the world' and called for it to be included in the new constitutional text, effectively cancelling article 214 of the Penal Code, which authorises voluntary termination of pregnancy. Notably, the argument about fetal rights does not belong to the Islamic legal and religious traditions; rather, it reproduces a model coming from the anti-abortionist movements of North America and Europe. More generally, the mobilisation of the idiom of rights in the domain of sexuality and reproduction derives from the language of the international agencies based in the Global North, which are often considered as propagating Western, foreign and colonial values and ideas. The fact that a deputy of Ennahda, a party that promotes the return to the authentic Arab-Islamic identity of Tunisia, used the non-Islamic argument of fetal rights to cancel women's rights to abortion is quite paradoxical and simultaneously meaningful. It clearly shows the relevance of what Arjun Appadurai has called 'ideoscapes',[69] which are transnational discourses, ideologies and symbols circulating around the globe and being adopted and adapted by local actors in different contexts. This process of local adaptation, which some have called 'vernacularisation',[70] can produce

Maghreb 71; L Labidi 'Political, aesthetic, and ethical positions of Tunisian women artists, 2011-13'(2014) 19 *Journal of North African Studies* 157.

67 S Ben Achour *Violence à l'égard des femmes: les lois du genre* (2016); H Chekir 'Les droits des femmes en Tunisie: Acquis ou enjeux politiques ?' (2016) 160-161 *Herodotus* 365; D Gray 'Tunisia after the uprising: Islamist and secular quests for women's rights' (2012) 17 *Mediterranean Politics* 285.

68 Association tunisienne des femmes démocrates (n 5).

69 A Appadurai *Modernity at large: Cultural dimensions of globalisation* (1996).

70 P Leavitt & S Merry 'Vernacularisation on the ground: Local uses of global women's rights in Peru, China, India and the United States' (2009) 9 *Global Networks* 441.

paradoxes, in that it can assemble elements that seem contradictory, such as in the case of Najiba Berioul. In her discourse, the reference to the Arab-Islamic identity coexists with the idiom of rights. However, in the case of anti-abortionist movements, it is used to deny women's rights over their bodies.

More largely, women's rights and roles in society were a major topic of discussion during the work of the Constituent Assembly (2011-2014). In a moment of transformation of the previous order, in which there was a space to rethink and reorganise the society's social and political foundations, women's statuses and roles became a central topic in the public arena. The relevance of women's statuses in society has a long history, going back to the nineteenth century, when European colonisers considered colonised women an indicator of a society's level of modernisation or civilisation.[71] On the other hand, in many colonised societies, women became emblems of local authenticity, traditions and values in opposition to the foreign culture and norms brought about by colonisers.[72]

In 2011, after their active participation in the revolution, few women were involved in the post-revolutionary political institutions and decision-making processes. Instead, they became objects of discussion used to redefine the identity of post-revolutionary Tunisia, as had already happened in two previous transitional periods: in 1956, when Tunisia became independent from France, and in 1987, when Ben Ali deposed Bourguiba. In both situations, women's rights became a crucial concern for the state and civil society.[73] In 2011 the official position of Ennahdha was that the CPS had become part of the Tunisian heritage, although it was still possible to improve it.[74] Ennahdha was in power from October 2011 to January 2014 but was replaced by a national union government in the following months, until the parliamentary elections in October 2014. Islamist attempts to replace the principle of men's and women's equality with that of complementarity and to criminalise abortion did

71 L Abu Lughod 'Do Muslim women really need saving? Anthropological reflections on cultural relativism and its others' (2002) 104 *American Anthropologist* 783.
72 D Kandiyoti (ed) *Women, Islam and the state* (1991).
73 M Charrad 'From nationalism to feminism: Family law in Tunisia' in KM Yount & H Rachad (eds) *Family in the Middle East: Ideational change in Egypt, Iran and Tunisia* (2008). [111]
74 Gray (n 67).

not succeed because of the mobilisation of feminist groups, secular parties and other components of civil society. The complementarity issue, in particular, gave way to several demonstrations and protests, culminating on 13 August 2012 in the commemoration of the Code of Personal Status. After repeated discussions in the Constituent Assembly, articles 21 and 45 of the new Constitution promulgated in 2014 reaffirm women's and men's equality of rights and duties.

In short, after the revolution, women were once again at the centre of the Tunisian political and ideological debates opposing the advocates of modernist secular discourses and those of Arab-Islamic authenticity.

4 Abortion in the COVID-19 era

Based on an early 2020 online survey conducted among 126 midwives in Tunisia, Chekir and others[75] warned that the reorientation of public structures and resources during the COVID-19 pandemic has revealed structural and functional problems in the provision of sexual and reproductive healthcare services that affected healthcare workers, particularly midwives. In the population study, 21 per cent of midwives practised in healthcare facilities that offered medical abortion services. However, only 20 out of 26 of those healthcare facilities provided specific abortion drugs.[76]

A number of national organisations, including professional and scientific organisations, political figures and UN agencies conducted an advocacy to sensitise the public authorities. As a result, the Ministry of Health sent a letter urging regional health managers to re-establish first-line services, including antenatal and post-natal counselling, contraception and medical abortion. However, a follow-up online survey conducted among 161 midwives during the fourth quarter of the same

75 H Chekir and others 'Résultats d'une enquête en ligne sur la perception des sages-femmes de la continuité des services de santé sexuelle et reproductive et les besoins de protection durant l'épidémie Covid-19: Lettre à l'éditeur' (2020) 1 *Journal de Gynécologie et Obstétrique et Médecine Fœtale.*

76 H Chekir and others *Les sages-femmes et les activités de la santé sexuelle et reproductive durant l'épidémie Covid-19 en Tunisie: Résultats d'une enquête auprès de 126 sages-femmes* (Groupe Tawhida Ben Cheikh et l'Association Tunisienne des Sages-femmes, en collaboration avec UNFPA, Tunisie 2020).

year in Tunisia revealed a lack of preparedness and anticipation in the authorities' response to the second wave of COVID-19.[77]

5 Conclusion

In Tunisia, abortion was criminalised during the colonial era. French authorities wanted to increase the natality rate in a period during which colonial powers competed to reinforce their economies, political influence and international reputations. A large and healthy population was a crucial element to reach these goals. The first Tunisian Penal Code (1913), which was modelled after the French one, criminalised abortion and severely punished its perpetrators and the women who interrupted their pregnancies. Only after independence (1956) was abortion progressively de-penalised and made accessible to all categories of women. Habib Bourguiba, the first President of independent Tunisia, promoted a vast programme of social reforms aimed at modernising society and improving women's statuses. Inspired by a neo-Malthusian rationale and supported by international agencies, the first family planning programme was launched in the mid-1960s. Since this time, birth control policies became a pillar of the Tunisian state's social and economic plans, until the end of the 1990s when a demographic transition took place. Abortion was de-penalised as an instrument of demographic control rather than as the result of women's struggles to gain control over their own bodies – although some women's associations were active in promoting the procedure. The de-penalisation of abortion happened in two phases. In 1965 only married women with at least five living children were allowed to access it, whereas from 1973 to the present, all women, including unmarried women, have been able to access free abortion care in government facilities. From the mid-1990s, the concept of family planning was gradually replaced by the notion of reproductive health care because of ICPD 1994. Abortion and contraception were incorporated in a larger offer of reproductive and sexual health services. Despite the 1973 abortion law and the government policies aimed at providing all

77 H Belhadj and others 'Qualité de la préparation en vue de la deuxième vague de la covid-19 et continuité des services de santé sexuelle et de la reproduction: Résultats de l'enquête en ligne parmi les sages-femmes, menée par le groupe Tawhida Ben Cheikh. Faits et Arguments' (2021) 1 *Journal de Gynécologie et Obstétrique et Médecine Foetale* 41-48.

Tunisian women with the same sexual and reproductive health services, patriarchal social norms and moral and religious convictions have always made women's access to abortion care troublesome. Women have often been subject to humiliation, symbolic violence and infantilisation. The 2011 revolution made the situation even more difficult for women attending government-run sexual and reproductive healthcare facilities, as many facilities have stopped offering abortion care. Moreover, a large number of healthcare providers have begun to refuse abortion care without any legal basis, as there is no law on conscientious objection in Tunisia. Finally, the economic crisis and the subsequent pandemic have seriously affected the provision of abortion services in many Tunisian governorates. Although Tunisia is a progressive country in many ways – it is the only Arab-majority country and one of the few African countries to have de-penalised abortion – women who cannot afford to attend the private sector often have difficulties in accessing abortion care and are sometimes unable to do so. These women are usually law-income, little educated, and live in poor urban areas or in peripheral rural zones. Women attending government clinics have faced humiliating attitudes and mistreatment by some healthcare providers, who refuse to comply with the law in the name of personal convictions and social norms that should not interfere with their professional duties.

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