Islamic revival, structural violence and women’s right to abortion in Tunisia after the revolution

Tunisia is a pioneering state in the domain of abortion and contraception policies in the Arab region (Dabash & Roudi-Fahimi, 2008).

Abortion was introduced first in 1965 for married women who already had 5 living children and for therapeutic reasons until the third month – it is unclear if of gestation or amenorrhea. Husband’s consent was necessary as well as a doctor’s recommendation (Lee Bowen, 1997).

Some years later, the Tunisian Women’s Union was able to persuade the parliament to change the law showing that, because of legal restrictions on abortion, “hundreds of women arrive at the hospital every year suffering from haemorrhage after trying to abort in insanitary conditions” and 55 women committed suicide in 1972 because of “non legitimate pregnancy” (Asman, 2004, p. 85).

In 1973 the right to abortion was extended to married and unmarried women despite the number of children and without the husband’s consent. Abortion after the third month is possible to preserve the physical and mental health of the mother or for foetal impairment.

While until the early 1990s, state reproductive policies were aimed at reducing the total fertility rate – that dropped from 7.2 children per woman (1966) to 4.7 (1984) and 2.4 in 2014 (Bouattan, 2002) – later on efforts were put into expanding services to cover the recently introduced notion of reproductive health (Guillaume & Klat, 2004). The Office national de la famille et de la population (ONFP), the Tunisian agency in charge of family planning services since 1973,
established 24 clinics, one in each administrative district, in order to freely offer contraception, abortion, and more recently reproductive health services. During the first decades of birth control policies, women were often forced to accept contraception and even sterilization in return for abortion. Social pressure, blackmail, and stigmatization were common in government clinics and the creation in 1974 of the Bourguiba prize for the more virtuous governorates, i.e. for those that had been able to mostly reduce birth rates, is very significant (Sandron, 2000; Gastineau, 2002). Over the 1990s, the situation changed radically. Birth control policies gradually lost their importance and the concept of reproductive health was introduced in ONFP clinics expanding the previous family planning and maternity health concepts in order to include cancer, STI, infertility, menopause (Foster, 2001). In the 2000s, ONFP created in each of its clinics a special section for unmarried women and men called “al-fadha al-sadiq lil-shabab” (space young people friendly), meant to provide reproductive and sexual health services to this category of citizens. By the mid-2000 religious conservatism (Kerrou, 2010; Najar, 2012) emerged in Tunisia affecting also the domain of reproductive and sexual health. Already in the years 2007-2010 several midwives and obstetricians-gynaecologists working in the public sector adopted a religious discourse and began to discriminate against women coming to get an abortion in their clinics. In several reproductive health clinics, the abortion service did not work during the month of Ramadan and physicians started to use conscientious objection to refuse women abortion. At that time, the term “recidivist” entered the health professionals’ vocabulary to designate those women coming for repeated abortions (Association tunisienne des femmes démocrates, 2013). In 2011, the collapse of the previous regime’s apparatus of control and the electoral victory of the Islamist party Ennahda determined a situation of political, social and cultural uncertainty. Physicians supporting the new religious and conservative movement used medical reasons to justify the decrease in abortion services. For example, in 2010 two articles against medical
abortion were published in local newspapers in which the authors argue that the risk of haemorrhage is too high to let women practice it at home and that the latter should be hospitalized until expulsion of the pregnancy. The conservative medical lobby succeeded in affecting public policies and a ministerial circular was adopted that prescribes hospitalisation for all women using medical abortion. This became a pretext for refusing women medical abortion as there are not enough beds in the regional hospitals, while ONFP clinics offers only outpatient hospitalisation (ibid).

The strong economic crisis—that was one of the main factors at the origin of the evolution (El Khawas, 2012)—contributed also to the decrease of abortion services. According to ONFP’s statistics, between 2011 and 2012, there was a decrease of more than 55% of abortions in public hospitals and 2% in ONFP clinics. In fact, already in 2005 the ONFP had closed down the operation theatre in 10 of its clinics because of financial restrictions at a time when surgical abortion was still the main common technique. Medical abortion has been introduced in Tunisia in 2002 (Hajri, 2004) and until the Summer 2016 the method used by 75% of women in the public sector (Hajri, 2016). Little is known on the number of abortions in the private sector because no data are available.

In light of the above considerations, when in January 2013 the Ennahda deputy Nabila Berioul questioned the right to abortion during the works of the Constituent Assembly claiming the foetus’s right to be born, it came as no surprise. While Tunisian civil society and feminist associations fought to defend les acquis (acquired rights) in many social and political domains, reproductive rights did not become a main issue of their mobilizations. Some exceptions are the Association tunisienne des femmes démocrates, one of the Tunisian main non-governmental feminist associations (Labidi 2007), the Groupe Tawhida Ben Cheikh, an NGO created immediately after the revolution whose main aim is the defence of sexual and reproductive
rights, and the *Association tunisienne de santé reproductive*, a local association supported by the International Planned Parenthood Federation (IPPF).

Since autumn 2014 when the first post-revolutionary parliament and president were elected, more secular and progressive forces came to power than those that dominated the political arena during the first three years after the revolution. ONFP’s role, which was significantly weakened during Ennahda’s political rule, was slowly coming back to previous efficiency thanks to its general director and many members of its medical and paramedical staff working in the regional clinics. However, since the Summer 2016, the situation has again become very difficult: chronic funding shortage has drastically reduced the possibility for ONFP of buying the medicaments used for medical abortion making it impossible or very difficult for poor women to get an abortion for free. Moreover, the family planning unit of the Tunisian largest maternity hospital that offered abortion care to women from all regions of the country will be closing in a few months when the current head of the department will retire. The prospective candidate is hostile to abortion and plans to shut down the family planning unit suppressing a place where women with very difficult socioeconomic and family situations come to get abortion care.

**Dissention, freedom or what?**

In the Summer 2013 several health professionals working in the domain of RSH told me that at least 10 ONFP clinics out of 24 had stopped providing abortions for different reasons. Surprisingly, one of these clinics was not situated in a rural region of inner Tunisia -like many of those that had stopped providing abortions (Lahbib, 2015)- but in a central area of the capital. The official reason why after the revolution it had stopped to provide abortion care was that the operation theatre did not respect sanitary norms. While in 2013 the clinic had begun to offer medical abortions again, in June 2014 surgical abortions were still not available. As suggested by several of my interlocutors, the operation theatre had nothing wrong but the clinic's
responsible was afraid of possible attacks against the building and the personnel by Salafist groups. After the revolution several educational, cultural sanitary institutions had indeed been attacked and even devastated by extremist groups in the name of Islamic values or sometimes simply as symbols of the previous regime. Another clinic where I did participant observation had been heavily damaged and medical equipment stolen during the riots of 2011. This clinic had to stop working for a while and surgical abortion was not available anymore since the two anaesthesiologists working there had either left the job or retired. Despite the attempts of the clinic's director and head-midwife to employ a new anaesthesiologist, in Summer 2014 surgical abortions were still impossible. Bureaucratic procedures and lack of administrative control contributed to the weakening of abortion services in the government sector especially after 2011. Moreover, after the revolution, in this and in another ONFP clinics in which I worked not all midwives agreed about continuing to offer abortion care. The head-midwife of one of these clinics told me that she had to make pressure on two of her colleagues in order to provide women with abortion care. At the time I did fieldwork only one midwife out of the three in charge of RSH services for married women practiced medical abortions, while the two others refused to do it. According to the head-midwife, the youngest midwife had tried to persuade women not to get an abortion reading in front of them verses of the Koran that she kept on her desk. Another experienced midwife who trains student midwives told me in February 2014 that two of her students were shocked after having attended a very similar situation in another ONFP clinic in Tunis. The attitude of antiabortionist midwives was particularly disturbing in her opinion, since they not only try to persuade women that abortion is haram (forbidden by religion) and suggest that they commit sin, but they also turn the patients away without addressing them to another institution. A recently published study examine the trajectories of Tunisian women who are turned away showing the complicated therapeutic itineraries they have to follow if they want to get an abortion and the emotional and somatic distress they have
to face (Hajri, Raifman, Gerdts, & Foster, 2015). During a workshop organized by a Tunisian NGO in February 2014 two physicians responsible for two Tunisian ONFP clinics, one in the southern area of the capital and the other in eastern Tunisia made clear that several members of their staff -midwives and doctors- expressed antiabortionist positions and refused to accept women coming for pregnancy termination. According to an officer working in the ONFP headquarters, these attitudes were widespread also because of lack of supervision by the ONFP itself and the obstacles Tunisian women seeking abortion services were more and more important. As noted by some participants in the workshop, social class, economic resources, social networks and geographic location were crucial: a poor woman living in a rural area situated far from the coastal cities had almost no possibility of getting an abortion, while for women living in the main urban centres and with some social and economic capital it was easier to either get one in the ONFP clinics or in the private sector.

While antiabortionist behaviours have become more and more common in the post-revolutionary period, they are not new because already in the mid-2000 similar episodes happened to some of my acquaintances or their friends and relatives. If the ideological environment and the RSH practices had changed already in the pre-revolutionary period, they became much more widespread and publicly displayed after 2011. The religious revival and social conservatism promoted by Ennahda legitimated behaviours and discourses previously silenced or more discretely displayed putting into question years of contraceptive and abortion practices in the public sector. If it is true that in many ways these practices allowed certain categories of women -mostly middle class, educated, urban- to freely get an abortion and use contraception, they represented an oppressive and coercive form of biopower for many other Tunisian citizens belonging to underprivileged, uneducated and often rural strata of the population. To cite a Tunisian experienced gynaecologist, until the mid-1990, anti-natalist policies were less an instrument allowing women to dispose of their own bodies than a "war
machine" imposed on the Tunisian population whose targets were women's bodies. Disciplining female reproductive bodies justified what some called the 2 in 1 package (Association tunisienne des femmes démocrates, 2013), which meant that women were often forced to accept tubal ligation or an IUD or implant insertion -according to their age and parity- if they wanted to get an abortion. Surgical abortions were done under general anaesthesia, many times without the women being informed that they were going to undergo at the same time tubal ligation or IUD or implant insertion.

Back to the post-revolutionary period, economic restrictions and pressure on government hospitals and clinics worsened the situation of the previous years: most regional hospitals stopped offering abortion care as the structures were already overcrowded and the personnel unable to face the situation. In fact, abortion services in the government sector were among the first services to be suppressed because apprehended as unnecessary, even in the specialized health care structures such as the ONFP clinics. Hence, women from different areas of Tunisia who were unable to get an abortion in their place of origin came to seek abortion in the RSH unit in the hospital where I did fieldwork. In this hospital, one of the largest in Tunisia, only one midwife is in charge of abortions in her department. If she is sick or on holiday, the service is not offered and, despite the heavy workload, she alone allows about 1000 women per year to get voluntary abortion (Personal communication, January 2014). During 2013 and 2014 she also had to offer abortion care to women coming from ONFP clinics and regional hospitals that had turned them away with various pretexts. In many cases they had been turned away because of medical contraindications that were not conform to official clinical protocols or because they simply did not offer anymore the required service. Although referral letters are needed when a woman is sent to a third level hospital, most of the time, women were not given letters and could only orally communicate the reasons why they had been turned away. Many women seeking an abortion had to go to two or three local government clinics before ending up in this
hospital where they usually were able to get an abortion unless their pregnancy went beyond three months. If this was the case, different options were still available according to the woman's marital status, economic and social situation. Indeed, in my experience, the hospital staff facilitate the access to second trimester abortion to certain categories of women while they turn away others. Referring to the clause of article 214 of the Penal code that allows the termination of pregnancy after three months if the mother's psychological well-being is endangered, unmarried, homeless, very poor, very young, (often unmarried) detained women or women victims of violence were "helped" to get a certificate from a psychiatrist allowing abortion at later stages of pregnancy.

Women coming from other regions of Tunisia had to face very important obstacles to come to the hospital in Tunis: they had to pay for transportation, to find a place to stay in the capital, to justify their trip in front of their families and to wait several days before having an abortion. Indeed, in the public sector several days are needed to get an abortion not only because usually there are only a few clinics where it is available, but also because more than 70 per cent of abortions are medical and subject to a specific protocol that, if respected, lasts about two weeks. According to the typical itinerary, when no obstacles are present, women have first to make an appointment with the clinic -which can take some days-, to undergo a blood test, an ultrasound and finally spend two more days in which they will be administered first mifepristone and later misoprostol. If expulsion does not happen in the first three days, they have to go back to the clinic for a control after one week and, even if abortion is successful, they should go back after two weeks for a control and to adopt a contraceptive method. It is not surprising that, in the Symposium on medical abortion mentioned above, two midwives in charge of RSH clinics indicated that in the period 2014-2015 between 30 and 60 per cent of women did not come back for the control after abortion and to adopt a biomedical contraceptive method (Affès, 2016; Ghorbel 2016).
References


ONFP. (2010). *Le célibat choisi ou subi?* [Chosen or suffered celibacy?] Tunis, CEDAP.


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1 This expression did not exist in Arabic until very recently and it is usually not used by those who in the Euro-American countries are defined as objectors.

2 While, as already mentioned, it is unclear how many abortions take place in the private sector, it is probable that they have increased since the access to the government clinics is more and more difficult. The price for an abortion can vary according to the place, the clinic and the woman's situation -whether she is married or not, and the weeks of pregnancy (less or more than three months).

3 The stigmatization of certain categories of women such as unmarried women who seek abortion was already present in the 1980s and 1990s. Despite stigmatization, health professionals tried to help them more than married women in order to protect them from social stigma. See for example Labidi, 1989; Hamzaoui, 2001.