

# The Right to Abortion in Tunisia after the Revolution of 2011: Legal, Medical, and Social Arrangements as Seen through Seven Abortion Stories

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## Abstract

In this article, we explore the effects that Tunisia's post-revolutionary democratization process has had on the right to abortion, drawing on ethnographic material, interviews, and medical files that we collected between 2013 and 2017, as well as the professional experience of one of us. We show that despite the existence of a relatively liberal abortion law for more than 40 years, women in Tunisia have trouble getting abortion care for economic and organizational but also ideological and political reasons. The existence of the abortion law constitutes but one factor among many others that determine women's ability to access abortion services; medical practices and women's abortion itineraries are caught up within complex arrangements that entail multiple socioeconomic and cultural factors, political transformations, the variability of rules in medical and administrative institutions, and contradictory interpretations of the legal apparatus. Examining the abortion itineraries of seven women we met in a large hospital in Tunis, we argue that these abortion itineraries shed light on the ordinary constraints experienced by poor Tunisian women who cannot afford to turn to the private sector. We maintain that attitudes toward the right to abortion in post-revolutionary Tunisia are problematic and that the democratization of local society has brought about unexpected consequences that do not extend but rather reduce women's rights in the domain of sexual and reproductive health.

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## Introduction

This article explores the effects of the democratization process in post-revolutionary Tunisia, taking the domain of sexual and reproductive health as our field of study. In particular, we investigate the impact of larger social and political transformations on the right to abortion, drawing on ethnographic material that we collected from 2013 to 2017. We show that the existence of an abortion law is only one factor among many others affecting women's ability to access abortion services; medical practices and women's abortion itineraries are caught up within a complex configuration that entails multiple socioeconomic and cultural factors, political transformations, the variability of rules in medical and administrative institutions, and contradictory interpretations of the legal apparatus. Only by examining the interactions between all of these factors is it possible to understand why in Tunisia—where abortion has been legal for more than 40 years—many women experience physical and moral suffering when they want to abort, and many are forced to resort to illegal abortion.<sup>1</sup> In addition, because of the impossibility of accessing abortion services, more than 1,000 babies are abandoned every year by unmarried mothers.<sup>2</sup>

In the first part of the article, we give a brief overview of the history of abortion in postcolonial Tunisia, focusing on the transformations brought about by the revolution of 2011. We then examine the cases of seven women who sought abortion care in public facilities and the legal, administrative, sociocultural, and medical obstacles they had to face. We argue that their abortion itineraries shed light on the ordinary constraints experienced by poor Tunisian women who cannot afford to turn to the private sector. Their itineraries also show that attitudes toward the right to abortion are problematic in Tunisia and that the democratization of local society has brought about unexpected consequences that reduce—rather than extend—women's rights in the domain of sexual and reproductive health. In conclusion, we consider whether the democratization process that started in 2011 has improved women's access to abortion care or has instead made it more difficult.

## Historical overview

Tunisia is the only Arab country where abortion for social reasons has been legal for all categories of women since 1973. The law allows abortion in medical institutions under the authority of physicians until the end of the first trimester for married and unmarried women without marital consent. Minors, however, must obtain the consent of one of their parents or of a legal tutor in order to access abortion services at a public facility. Contraception and abortion care are provided for free in such facilities. Although the law applies to all medical institutions, in the private sector rules about accompaniment and permission for minors are not so strictly respected, and so most women who find themselves in “irregular situations” turn to private clinics or doctors if they can afford them. The decriminalization of abortion dates back to the mid-1960s when, influenced by the neo-Malthusian ideology circulating in the postwar period, the political elite of independent Tunisia considered the reduction of the high fertility rate a priority.<sup>3</sup> For several decades, Tunisian institutions promoted family planning and abortion as practices contributing to reducing the number of citizens and improving their educational and socioeconomic situations with the aim of engineering a modern society.<sup>4</sup> The legalization of abortion and promotion of family planning were the results of a political decision made by a modernist elite rather than the conquest of a women's movement, as in many European countries and North America. Thus, in Tunisia abortion was not introduced as a women's right but as an exception in the section of the Penal Code regulating “murder.” Despite the apparent secular character of Habib Bourguiba's rule, to justify the depenalization of abortion (as in other fields), he appealed to the religious tradition rather than to legal or medical arguments. National religious authorities drew on certain opinions within the main legal schools of Sunni Islam to state that abortion is religiously permitted until 120 days after conception.<sup>5</sup>

Precise demographic targets, the centralized and hierarchical structure of the family planning program, and aggressive public campaigns pro-

voked abuses and coercive practices that caused resistance and distrust among the population.<sup>6</sup> Paternalistic attitudes among medical personnel were widespread, and forced contraception and (female) sterilization were common in the early phases of the family planning program, which, above all, targeted uneducated, rural, and poor women.<sup>7</sup> After the demographic transition took place in the late 1990s, the family planning program lost its importance; local authorities and international agencies ceased to focus on it and funds were cut. The emergence of religious conservatism in the early 2000s and the deep political transformations Tunisia went through after the revolution of 2011 have contributed to redefining state policies in the domain of sexual and reproductive health. Although the abortion law has not been repealed in the wake of the revolution—despite the attempts of the Islamist party *Ennahdha* in early 2013—medical practices have changed over the last 15 years, showing that the legal aspect is only one element among many affecting women's access to abortion care. Social and religious conservatism has become more apparent, state control over medical institutions and personnel much weaker, and the freedom to act according to one's own moral convictions possible, despite the absence of a law regulating conscientious objection.

Even in 2014 the post-revolutionary Tunisian state dropped all reservations to the Convention on the Elimination of All Forms of Discrimination against Women and reaffirmed equality between men and women in the new constitution, women's access to abortion has become more difficult. Many of the health care practitioners we met did not consider abortion a human or woman's right and believed that offering abortion care is a controversial and morally problematic practice. Terms such as human rights and reproductive and sexual rights were generally absent from the discourses of the practitioners we talked to. This reflects more largely the absence of an international consensus on the definition of abortion as a human right: of all relevant international and regional instruments, only the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003) recognizes abortion as a human

right in specific circumstances. The then Tunisian president Beji Caïdi Essebsi signed the protocol in 2015, but the state ratified it only in 2018.<sup>8</sup>

Tunisia's recent and ongoing dramatic economic crisis has further impoverished the public health sector, in which staff, equipment, and medication were already insufficient before the revolution. According to several of the health professionals working in public facilities whom we interviewed, in the 1990s many regional hospitals, especially those located in western and southern Tunisia, were severely understaffed and most medicines were unavailable. Furthermore, Ibtissem Ben Dridi, who worked in the area of Gafsa in the early 2000s, writes that rural dispensaries were nearly abandoned and medical personnel were scarce during this time.<sup>9</sup> Saïd Ben Sedrine and Monji Amami also note that "since the 1990s, public health services have been undergoing a regression that is causing public health policy to lose its role as a social regulator in the face of disease risk."<sup>10</sup> The end of President Zine El Abidine Ben Ali's rule has also made illegal practices and corruption in medical institutions more frequent and uncontrolled. Cases of contracted doctors working in public medical facilities who redirect patients to their private offices to obtain services has become almost ordinary in the field of contraceptive and abortion care, as recounted to us by many women and health care providers.

As in other countries that have undergone dramatic political transformations, in Tunisia the revolution and the democratization of society have not meant the reinforcement of women's rights in the domain of sexual and reproductive health. In Russia, for example, the case of maternity care reforms after the collapse of the Soviet Union shows that the dissolution of the previous regime and the introduction of the "spirit of democracy" are not sufficient to grant women's rights unless the economic and political organization of health care is transformed.<sup>11</sup> While former regimes in both countries provided primary health services, including sexual and reproductive health services, the collapse of the system of power brought about new inequalities and made access to health

care more difficult. The (re)emergence of religious conservatism in post-revolutionary Tunisia and in post-Soviet Russia—and in several other Eastern European countries, such as Poland—is also a common feature.<sup>12</sup> In these countries, the questioning of women's reproductive and sexual rights has been fueled by political actors advocating religious arguments or by religious authorities themselves, such as the Catholic Church.

## Methodology

Before examining the abortion itineraries of seven women, we would like to stress that this article is the result of a research collaboration between Malika Affes, a midwife who has been working in Tunisian public facilities for more than 20 years, and Irene Maffi, a social anthropologist based in Switzerland studying reproductive and sexual health in the Arab world.<sup>13</sup> Our analysis draws on participant observation, the examination of medical files, interviews with women and health care providers, and the personal experience of Affes as a practitioner involved in abortion services.

Maffi conducted fieldwork between August 2013 and June 2014 and went on to collect ethnographic material until January 2018 by making short trips to Tunisia and reading the publications of local institutions and the media. Participant observation and interviews took place in one government hospital in Tunis and three public sexual and reproductive clinics in the area of Great Tunis, which includes four governorates. Affes has been in charge of the family planning unit of a large maternity hospital in the capital for 12 years. She has directly experienced the transformations of the national reproductive policies and the financial crisis of the government health sector. She has been an actor and a witness in the abortion itineraries we describe in the remainder of this article. To write the article, we combined Affes's medical, legal, and institutional expertise and Maffi's anthropological knowledge. We decided to base our analysis on a few selected cases that, in our opinion, are qualitatively representative of the abortion itineraries of many Tunisian women and give an accurate picture of

the public health care system in the region of Great Tunis. However, the ethnographic material we use does not allow for an overview of the abortion trajectories of women from other regions, especially those living in southern and western rural areas.

Permission to conduct research was obtained from the Ministry of Health and the Office National de la Famille et de la Population, the Tunisian agency in charge of sexual and reproductive health services. At the time of our research, no ethics committee existed at the University of Lausanne, and therefore we could not get an approval from this institution.

## Abortion itineraries

### *Lina*<sup>14</sup>

It was early March 2014 when Lina, a 16-year-old girl, came to the family planning unit of Hospital T, a large maternity hospital in Tunis, accompanied by two female guards of a detention center located in the capital. She had been arrested for illegal prostitution and was 13 weeks pregnant. She wanted to terminate the pregnancy, but her situation was extremely complicated because she was incarcerated, was a minor, and carried a late-first-trimester pregnancy. According to the law, Lina needed to obtain the consent of one of her parents or of a legal tutor to access an abortion. In her case, her parents were not involved in her life, and therefore the judge had to make the decision. The process took several weeks because when Lina first came to the hospital, the judge urged the head of the obstetrics and gynecology department to make the decision, refusing to take the responsibility for the decision himself. After a few weeks of uncertainty during which the doctor and the judge passed the buck to each other, Lina eventually obtained permission to terminate the pregnancy. However, her tribulations were not finished, because the social service department had refused to register her at the family planning unit. The opposition of the social workers was related to the fact that legally, Lina no longer had the right to get an abortion: at this point, she carried a second-trimester pregnancy. It was thus

necessary to resort to a psychiatrist, who wrote a medical certificate attesting that Lina's mental health was at risk and that she needed a therapeutic abortion. But because she was a minor and pregnant, there was yet another procedure that she had to undergo before getting abortion care. Tunisian law criminalizes sexual relationships with minor women even if they consent to it; if a girl under 18 is pregnant, the police must initiate a criminal investigation to identify the man responsible for the pregnancy. Therefore, Lina had to undergo an amniocentesis before getting abortion care so that the police could carry out a DNA exam, even if it was almost impossible to identify the offender.

Lina's case shows that social inequality and vulnerability, a lack of coordination between legal and medical public institutions, administrative rules, and the contradictory effects of various laws can generate bureaucratic violence and moral and physical suffering against young girls who seek abortion services. The interference of the actions of several individuals and institutions determined a specific management of time, shaping Lina's abortion itinerary and personal experience.

### *Dalenda*

Dalenda, a 17-year-old girl from Tunis, came to the hospital for the first time at the end of November 2013, accompanied by her father. She was 12 weeks pregnant and wanted an abortion. Her father gave his permission for the abortion, but Dalenda needed to meet a social worker first and undertake a few medical tests. Like Lina, she needed to undergo an amniocentesis to identify the DNA of the genitor of the embryo. But in Hospital T, women must wait until 14 weeks of pregnancy to undergo an amniocentesis. No other methods to collect the genetic material of the embryo (such as chorionic villus sampling) were available, meaning that Dalenda was forced to experience a long and excruciating waiting period and, subsequently, a painful medical abortion, as the fetus had become quite large. Indeed, at the time of her abortion, resident doctors did not want to resort to the technique of aspiration, which can typically be used during early pregnancy.

In Dalenda's case, the social service department did not request the intervention of the police, for reasons we will ignore. The midwife in charge of abortion asked Dalenda's father to quickly pay for the blood group test required before undergoing medical abortion so that his daughter would not exceed the three-month legal limit for abortion. The following day, Dalenda came accompanied by a woman in her fifties, probably a neighbor or a relative, as we learned that the girl's mother had died many years before when giving birth to her. Dalenda was hospitalized for the medical abortion because, according to local medical protocols, after nine weeks of pregnancy the procedure cannot take place at home. She was given tablets of misoprostol and had to stay in a room with several women who had recently given birth or were about to deliver their children. A few hours after her hospitalization, we went to visit her in the ward to see how she was doing: Dalenda was crying silently in one corner, alone, under the apparently indifferent gaze of the women sharing the room with her. A health provider approached her and tried to encourage and comfort her. The provider was moved by Dalenda's situation: as a child, the youngest of 10, Dalenda was neglected; when she became pregnant (allegedly after having sex with a much older man), her father drove her out of the house and she took refuge in one of her sisters' house.

Dalenda's fragmentary story shows how hospital organizations and administrative procedures can disregard the rights to privacy and protection to which a young girl is legally entitled: she was not offered a private room and could not have a companion, instead being forced to share a room with married mothers hospitalized for the birth of their children, whereas she was unmarried and subject to moral condemnation. As a provider once told an unmarried woman who had to be hospitalized to undergo medical abortion, "Do not look at the way people look at you, do not listen to what they tell you; ignore them! I am the person in charge of you and I respect you; I respect your freedom and your rights." These recommendations were motivated by the practitioner's awareness that many providers in the Tunisian public sector fail to show respect for

unmarried pregnant women because social norms proscribe premarital sexual activity.<sup>15</sup>

### *Ahlem*

In December 2016, several articles were published in the Tunisian newspapers reporting the case of a 13-year-old girl residing in a rural area in the north-east of the country who was going to marry her rapist, a 20-year-old relative. The girl was pregnant, and the families had tried to find an arrangement to preserve their reputations. Until 2017, article 227 bis of the Penal Code allowed rapists to avoid being incriminated if they married their victim, regardless of the victim's age. Before asking a judge to authorize the marriage, Ahlem's mother went to Hospital T because she wanted her daughter to abort and keep the event secret, as she feared that were the story to become public, it would ruin her personal reputation. She was ready to sacrifice Ahlem's right to bodily integrity to avoid social reprobaton and shame. When they arrived at the hospital, the girl's mother asked the health care personnel to provide an abortion without initiating the administrative and legal procedures required by law. She did not want to go through the social service department because it would report the case to the Brigade for the Protection of Minors. When the health provider received Ahlem and her mother, the girl kept playing with the door of the cupboard as if she were not concerned by the situation. Since the health provider refused to provide the abortion unless Ahlem followed the required procedures, the mother left the hospital with her daughter and never came back. Because it was socially shameful for the mother to file a complaint in court—an act the social service department of the hospital would demand—the mother and her family eventually decided to organize the marriage with the rapist and let her daughter keep the pregnancy.

Ahlem's story shows that sociocultural norms interact with the law in complex ways. The legal procedure that was required in Ahlem's case drove the mother and her family to accept the marriage instead of protecting the girl. Ahlem's mother's behavior can be understood when we consider that even in cases where the victim is not a minor, the

woman often gets an abortion and does not report the rape in order to avoid the scandal.

### *Sumaya and Maissa*

Sumaya, a woman from Ben Arous, was 25 years old and had married in February 2017, three months before coming to the hospital. Because she had signed the marriage contract, she was legally and religiously the wife of her spouse. However, in Tunisia, a marriage contract is not considered to be socially relevant until the wedding ceremony takes place. Thus, since Sumaya had not yet celebrated the wedding when she registered at the hospital reception desk, the employee refused to acknowledge her legal status and sent her to the social service department, where all unmarried women must undergo an interview about the circumstances of their pregnancies. Although an adult and married, Sumaya could not get abortion care without submitting to the specific procedures that the Tunisian state applies to unmarried women.

Like Sumaya, Maissa was from Ben Arous and came to Hospital T in May 2017. A 17-year-old high school student, she was already married but could not get abortion care without first going to the hospital's social service department. She had to undergo the procedures required of minor women even though, according to Tunisian law, she should legally be considered an adult. The social service department asked for the consent of Maissa's husband and of her mother before authorizing her to receive abortion care. This was a double infringement of Maissa's rights, for in Tunisia, women may receive an abortion without the husband's consent and, if married and an adult, do not need a legal guardian to take responsibility for this act. Also problematic was the fact that Maissa needed to end the pregnancy to complete her studies because the Ministry of Education does not allow students to attend school while pregnant. Maissa's rights to education and to reproductive freedom were thus in contradiction, a situation that forced her to make a decision that was not necessarily in accordance with her or her husband's wishes. These two cases show not only that the legal apparatus sometimes produces contradictory situations but also that

actors apply the law by adapting it to their moral and social interpretations of a woman's trajectory, violating the rights that legal norms are supposed to protect.

### *Sara*

Sara, a high school student from Melassine who was almost 18 years old, was hospitalized in Hospital L for a fever and cervical and inguinal lymphadenopathy in March 2017. Without requesting her legal guardian's consent, health providers decided to submit Sara to several tests for sexually transmitted infections, including HIV, and an etiologic investigation. They also performed a gynecological exam during which they detected a nine-week pregnancy. As written in the referral letter sent to the providers of Hospital T, her case was reported to the social service department and the Brigade for the Protection of Minors. She was transferred to Hospital T because Hospital L does not offer abortion services like most government hospitals in the country despite the law mandating them. When Sara met the practitioner in charge of abortion care, she claimed that she went to Hospital L for her health disorders rather than for abortion care. She did not understand why the providers at Hospital L wanted her to terminate the pregnancy when she had not requested it. She stated that she wanted to be free to make her own decisions and refused to follow the legal procedures required by the law in the case of a pregnant woman under 18. The health provider was surprised by Sara's story and shared her feelings of being caught up in a mechanism in which she was deprived of agency. Medical logic seemed less important than social logic in the way Hospital L's health care providers shaped Sara's therapeutic itinerary. Sara was supposed to come back to the hospital after several weeks to undergo the amniocentesis aimed at identifying the DNA of the genitor. Her father signed the consent for abortion, but she never came back. She had probably already planned an abortion in the private sector, where legal procedures never take place. Most private

clinics and doctors in Tunisia provide abortion care without investigating the circumstances of the woman's pregnancy, marital status, or age. This means that girls and women who can afford to turn to the private sector do not have to go through the same social and legal procedures and thus have more rights than women who cannot. Providers in the public and private sectors do not apply the law with the same rigor, generating discriminations that mark socioeconomic and regional divides. Other inequalities also exist between women from rural areas and from central and southern Tunisia and women living in the capital or in the major coastal cities. The former have to travel to the capital or the larger coastal cities if they want to get abortion care because this service is usually not available in the areas where they live. In some cases, even if abortion services are available, unmarried women who can afford it choose to travel to another city, as they are afraid to be seen by family members or acquaintances if they attend the government clinic of the city where they live.<sup>16</sup>

### *Fawziyya*

Fawziyya was a 30-year-old woman who lived in a small city located 200 kilometers from Tunis. She was married, did not have a job, and belonged to an underprivileged social milieu. In June 2015, she came to Hospital T to get an abortion, declaring that she was not married because, as she confessed, she thought that it was the only way to avoid involving her husband in the decision. Fawziyya was unaware that the law does not require a husband's consent for an abortion. The employees of Hospital T's social service department wanted to investigate why, at her age, she was not married and asked for her birth certificate, on which marital status is indicated. When they realized that Fawziyya was married, they immediately suspected that the pregnancy was the result of an extramarital relationship and that she was seeking an abortion out of fear that her husband would find out about the affair. Moreover, the social workers

of Hospital T required Fawziyya to pay out of pocket for a sonogram in a private doctor's office in order to date the pregnancy and be sure that she was not already beyond the legal term to receive abortion care. Fawziyya did not know that she was entitled to receive all medical services in the public hospital and that asking her to undergo an ultrasound in the private sector constituted a violation of her rights. Fawziyya's story is not uncommon in that most women are unaware of the law and accept abusive requests by health care providers or other categories of actors working in the public health sector such as social workers and secretaries. Social rules and moral judgments interfere with the law and hospital rules, pushing some employees of the public health sector to misinterpret the law and infringe on legal norms. Women who resort to public facilities usually lack the financial means to obtain an abortion in the private sector. There is thus a fundamental asymmetry between patients and health care providers in the public sector that allows the latter to exert a power that can seldom be opposed by the former if they want to obtain the desired services. Interference in women's lives can be very detrimental, as health practitioners can deny them abortions or make their abortion itineraries excruciating.<sup>17</sup>

## Conclusion

The abortion stories narrated above uncover several prevalent practices and attitudes among health professionals in Tunisia's public sector in the wake of the 2011 revolution. First, they show that despite the existence of a relatively liberal abortion law, women in Tunisia have trouble getting abortion care not only for economic and organizational reasons but also for ideological and political ones. The predicaments of the public health system that appeared as early as the mid-2000s have become more apparent in the aftermath of the revolution and the political and economic crisis that it has spurred.<sup>18</sup> Religious and moral attitudes requiring women

to follow tortuous abortion itineraries have become more common, refusal to offer abortion care has become a reality in many public hospitals, and travels to obtain abortion services have become necessary since many regional hospitals and family planning clinics no longer offer them.

Second, the decriminalization of abortion enacted by Tunisia's first president in an effort to achieve the desired demographic goals of the independent state was and remains an object of religious, moral, and social contention in medical settings.<sup>19</sup> In Tunisia, as in many European countries where abortion has been legal for decades, women's right to abortion is not unchallenged because pro-life groups, religious institutions, and nationalist pronatalist movements constantly threaten its legitimacy.<sup>20</sup> Although Tunisia's 1973 decriminalization of abortion drew on Islamic legal opinions that allow abortion until 120 days after conception, the Malekite tradition—which is dominant in the Maghreb—prohibits pregnancy termination, as do the other Islamic opinions that have begun to circulate in the country after the revolution of 2011. Many women and health care providers oppose abortion because they consider it *haram* (religiously illicit). Practitioners use religious or moral arguments to justify their refusal to offer abortion care, ignoring the law and the discourse of rights. Interestingly, however, when in January 2013 Najba Berioul, a deputy of the Islamist party Ennahdha, tried to re-criminalize abortion, she claimed the right of the fetus to be born, an argument typical of European and American anti-abortion movements rather than of the Malekite or other Islamic discursive traditions.

Third, the abortion stories we highlight show that strong social control is exerted on women who seek abortion care in the public health sector. Not only does the state impose specific devices to surveil and control women's sexual and reproductive behaviors, but the personnel of public hospitals and clinics interpret and bend legal rules in accordance with their



personal convictions. The idea that abortion is exceptional, morally despicable, and a transgression of ordinary feminine identity was expressed by many of the health practitioners we interviewed, who turned women who abort into pathological subjects. Therefore, women who are legal adults or married are often treated like minors or unmarried individuals, making their abortion itineraries longer and more painful. The pre-revolutionary legal apparatus that was still in use during our period of study (2013–2017) regulated the domain of sexuality and reproduction according to patriarchal principles under which the control of women's sexuality is much stricter than that of men's, especially as it concerns the conduct of unmarried and minor women. The relevance of these laws—which largely reflect existing social norms—affected the provision of abortion care in the public sector, such as with regard to the treatment of minors seeking abortion services. Even though a law was promulgated in 2010 lowering the age of majority for women from 21 to 18, many health providers at Hospital T, the regional delegate (*mandub jihawi*), and the Brigade for the Protection of Minors went on to apply the ancient law in the initial years after the revolution. Thus, women between the ages of 18 and 20 were forced to go through the procedures designed for minor women that, as mentioned, imply a stronger interference by the state and the family. Overall, it must be emphasized that because most women seeking abortion care in the public sector are unaware of their rights, they are unable to oppose health providers' refusal to offer them the required services.

Fourth, a lack of coordination between the police, the legal system, and the medical sector makes the abortion experiences of some groups of women—especially prisoners, minors, and the unmarried—very difficult. These women are subject to structural and institutional forms of violence that increases their social suffering.<sup>21</sup> Already marginalized and poor, and often with only primary education, prisoners and minors

in particular are abused by malfunctioning medical and legal systems that are paradoxically intended to protect them.

To sum up, the revolution has reinforced some attitudes and practices already present in the previous period on account of political instability, rising religious conservatism, a lack of financial resources (leading to shortages of health equipment and personnel), and a growing reluctance to offer abortion care in many public hospitals and family planning clinics. Class and regional divides have become more visible: women who live in the capital and coastal cities, as well as women from the middle and upper classes, enjoy a greater chance of their sexual and reproductive rights being respected compared to women who live in rural areas or in the cities of the interior. In addition, the private sector is gaining ground over the public sector, where abortion services are more and more difficult to get. This reflects a larger trend in which the public health care system is being increasingly neglected and the private sector is on the rise, thanks in part to the medical travels of patients coming to Tunisia from neighboring countries.<sup>22</sup>

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14. All names are pseudonyms.
15. See, for example, N. Amroussia, I. Goicolea, and A. Hernandez, "Reproductive health policy in Tunisia: Women's right to reproductive health and gender empowerment," *Health and Human Rights* 18/2 (2016), pp. 183-194; see also I. Maffi, D. Delanoë, and S. Hajri, "La santé sexuelle et reproductive, champ d'exercice et d'affrontement des dominations de genre et de classe," *L'Année du Maghreb* 17/2 (2017), pp. 9-19.
16. A. Gherissi and F. Tinsa, "Les services de Santé Sexuelle et Reproductive en Tunisie : Résultats d'une recherche qualitative auprès des jeunes usagers," *L'Année du Maghreb* 17/2 (2017), pp. 133-150.
17. Hajri et al. (see note 1); Raifman et al. (see note 1); Maffi, "L'interruption volontaire de grossesse" (see note 1); see also Ben Dridi and Maffi (see note 8).
18. Association Tunisienne des Femmes Démocrates (see note 7).
19. L. Labidi and L. Çabra Hachma, *Sexualité et tradition* (Tunis: Dar Annawras, 1989); I. Maffi, *A revolution for women? Sexual and reproductive health, dissention and moral dilemmas in democratic Tunisia* (New York: Berghahn Books, forthcoming).
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