

Introduction

SITUATING ABORTION

ISLAM, THE ARAB COUNTRIES AND THE TUNISIAN EXCEPTION

Abortion in Islam

The Quran does not contain any reference to abortion (*ijhadh*). Jurists and theologians have often referred to Surah 81 in which the Quran condemns *wa'd*, the pre-Islamic practice of burying female children alive, common among Arabian tribes, to justify their opposition to abortion (Bowen 1997: 163). Based on analogical reasoning (*qyas*), abortion – the suppression of the foetus – is equated with the killing of an already born child. The legal status of the foetus was an issue debated by jurists in the Middle Ages on the basis of the Quran, the Sunna and the hadiths (oral reports concerning the words and deeds of the prophet Muhammad). The foetus' relationships with her parents, her extended family, her community and God were important matters that were discussed well before the medical developments of the twentieth century.¹ Surah 23 of the Quran was (and still is) regarded as crucial:

We created man of a quintessence of clay. Then we placed him as semen in a firm receptacle. Then we formed the semen into a blood-clot; then we formed the clot into a lump of flesh; then we formed out of that lump bones and clothed the bones with flesh; Then we made him another creation. So blessed the God the best Creator. (Quoted in Musallam 1983: 53–54)

This passage concerns the theory of foetal development that has been central to the Islamic theological and juridical debate on abortion. Foetal development is supposed to entail four phases – *nutfa* (semen), *'alaqa* (blood-like clot) and *mudgha* (lump of flesh) – before the 'living being' in the womb of a woman becomes a human being (*insan*), which is when the soul enters the foetus' body ('the inbreathing of the spirit') (Katz 2003: 30). While the Quranic text does not provide any indication of the duration of each stage, a hadith specifies the following: 'The Prophet said: Each of you is constituted in your mother's womb for forty days as a *nutfa*, then it becomes a *'alaqa* for an equal period, then a *mudgha* for another equal period, then the angel is sent, and he breathes the soul into it' (Musallam 1983: 54). The legal status of the foetus evolves over time; it is characterised by a gradual process of humanisation that starts with conception and ends with the spirit entering the foetus. In the Islamic tradition, together with ensoulment, the progressive development of the 'recognizably human physical form' is also given great importance (Katz 2003: 34).

Muslim jurists refer particularly to Surah 23 and the cited hadith to justify their attitudes towards abortion. While abortion is never encouraged and generally prohibited, several Islamic legal traditions regard it as acceptable if it occurs before ensoulment and under specific conditions. The time of ensoulment varies according to the interpretations of the hadiths that describe foetal development. While the quote above indicates that ensoulment does not happen before 120 days, other hadiths 'give forty days as the total of the four stages' (Bowen 2003: 55). Hence, Islamic jurists consider abortion to be acceptable under specific circumstances, specifically before 120, 80 or 40 days after conception. The four legal schools of Sunni Islam – Hanafite, Shafiite, Malikite and Hanbalite – have divergent positions on abortion, and jurists can also express different opinions within each school (Bowen 2002, 2003; Katz 2003; Musallam 1983). The Maliki and Shafiite schools prohibit it altogether, whereas the Hanafis allow it before 120 days of conception even without what the juridical tradition regards as valid reasons. The other two schools locate themselves in an intermediate position. While the embryo is not already a human being before ensoulment, the 'potentiality' of becoming one cannot be ignored (Bowen 2003: 62). However, Islamic juridical traditions recognise several 'valid reasons' for abortion, such as to save the woman's life,² to preserve the woman's health, to preserve the health of a nursing child, to preserve the woman's beauty and to avoid the 'hardship resulting

from excessive offspring' (Katz 2003: 43). While it is beyond the scope of this chapter to go into the details of the Islamic discussions about abortion, it is necessary to emphasise their important theological, juridical, moral and social implications, as well as 'their high level of tolerance for ambiguity and complexity which avoids absolutist simplifications of the intricate moral issues raised by fetal life' (Katz 2003: 45). This flexibility and complexity is still present in the contemporary debate and has legitimised the adoption of different abortion laws by each Islamic country and even some changes in the regulations under different historical circumstances (Bowen 1997, Makhlouf Obermeyer 1994). For instance, Iran liberalised abortion in the years immediately before the Islamic Revolution (1979), then prohibited it altogether after Khomeini took power and again made it available after 1994 (Bowen 2003). Political, economic and demographic reasons have been at the origin of the changing Iranian reproductive policies, showing the plasticity of the religious discourse and the possibility of using it to justify very different laws. As emphasised by Carla Makhlouf Obermeyer, in Muslim countries as well as elsewhere, religion and morality are translated into politics in accordance with the political, social and economic interests of the group in power (1992, 1994).

The complexity of positions on abortion in Arab-Islamic countries also emerges in the reverse perspective, where, although officially prohibited, pregnancy terminations are very common and performed by healthcare professionals in generally safe conditions (Fathallah 2011; Gruénais 2017). In Lebanon, Zeina Fathallah interviewed a number of midwives and obstetricians-gynaecologists who belong to different religious communities that regularly perform abortions and do not seem particularly worried by the state laws criminalising it or by religious prohibitions (Fathallah 2011). In Morocco in 2010, Professor Chraïbi, a well-known obstetrician-gynaecologist and the founder of the AMLAC (Moroccan Association Against Clandestine Abortion), declared during a debate broadcast by the Moroccan TV Médiasat that 800 abortions were performed every day in his country, 600 of which were under medical supervision and 200 were outside medical settings (Gruénais 2017: 220).

I will now turn to the actual regulations of abortion in the Arab countries that show several similarities as well as the differences existing between the law of the state and the religious discourses.

Abortion in the Arab World

During the 1960s when several Muslim states were starting birth control policies, some international meetings between religious leaders, health professionals and other actors were organised to discuss Islamic positions on family planning and biomedical technologies (Hessini 2007). In 1971, a conference bringing together Muslim scholars to discuss Islam and family planning was held in Rabat. Modern contraception was approved in accordance with the 'right of families to look after themselves regarding procreation' and the freedom to choose the number of children they want to have (Lapham 1977: 18). While reproductive biomedical technologies were generally accepted, as they were not considered to infringe upon Islamic precepts, sterilisation and abortion were not allowed due to conflicting opinions among religious leaders. At the Rabat conference, it was decided that abortion 'is forbidden after the fourth month of gestation except for saving the life of the mother', although some scholars stated that it should be forbidden 'at any stage unless for extreme personal necessity to save the mother's life' (ibid.: 19). Among the Islamic countries of the MENA region, as already mentioned, Iran legalised abortion for social and economic reasons in 1976, and Turkey made it accessible on request in 1983³ (Dabash and Roudi-Fahimi 2008, Lapham 1977). The only Arab country that decriminalised abortion after independence was Tunisia; in 1973 it became accessible to all categories of women without the husband's consent and free of charge in family planning clinics. Recently, Bahrain has also made abortion available for social and economic reasons upon request (United Nations 2013).

By the end of the 1980s, abortion laws in the Arab countries were still very restrictive, and only Egypt, Jordan, Algeria, Morocco and Tunisia authorised it 'in the event of risk to the mother's physical or mental health' and 'in the case of danger of a deformed or congenitally abnormal birth' (Faour 1989: 259). The sanctions for health professionals who violate the law are severe, including imprisonment from six months to ten years and a fine and suspension from their professional activity. Women can also be punished with imprisonment and pecuniary sanctions (ibid.).

Overall, except for Turkey and Tunisia, the official statistical data on induced abortion rates in the countries of the MENA region are almost non-existent because legally performed abortions are very limited and abortion 'is largely a taboo subject' (Tabutin and

TABLE 0.1 Number of abortions and maternal mortality due to unsafe abortion in the MENA region for the period 1995–2000.

Country	Number of abortions	Deaths due to unsafe abortions
Algeria	718,670	1,076
Bahrain	25,754	16
Egypt	2,079,216	2,542
Iran	2,590,681	5,697
Iraq	893,285	908
Jordan	196,792	161
Kuwait	70,169	52
Lebanon	177,298	85
Libya	117,050	190
Mauritania	116,196	801
Morocco	699,692	1,084
Oman	80,642	105
Palestinian territories	98,135	141
Qatar	20,272	14
Saudi Arabia	699,405	927
Sudan	702,248	1,893
Syria	653,965	580
Tunisia	118,102	256
Turkey	2,301,955	1,536
United Arab Emirates	78,770	49
Yemen	606,339	842

Source: Leila Hessini (2007) in the journal *Reproductive Health Matters*, used with permission.

Schoumaker 2005: 652). However, induced abortion is illegally practised in most Arab countries, and in 1992 the Damascus Conference on Unsafe Abortion and Sexual Health in the Arab World recognised that unsafe abortion is a major health problem in almost all Arab countries (Hessini 2007). Sex education, revision of abortion laws, provision of family planning services and programmes designed to take care of women with post-abortion complications and to change healthcare providers' attitudes were discussed. Indeed, maternal mortality and morbidity related to unsafe abortions⁴ were and still are a major concern in the Arab countries where access to abortion is restricted.

It must also be noted that, as mentioned above, illegal abortions are safely performed in the private sector in several Arab countries, even though they are only accessible to those women who can afford to pay for them, excluding large groups of the population (Bowen 1997). In Jordan, where I previously conducted fieldwork,

I sometimes attended consultations in the private sector where a woman explicitly asked for abortion care and was referred to a practitioner who did perform pregnancy termination (Maffi 2012). This is also confirmed by the study of Lara Knudsen, who, however, stresses the fact that in the medical sector in Jordan ‘the cost of illegal abortion is exorbitant,’ and therefore ‘women who are unable to secure a doctor’s assistance may take certain medicines or insert traditional herbs into the vagina in an attempt to start bleeding’ (Knudsen 2006: 179).

A report by the World Health Organization (WHO) estimates the number of unsafe abortions in ‘Western Asia’⁵ to be 830,000 each year, causing about 600 maternal deaths, and 900,000 in Northern Africa (Maghreb), causing 1,500 maternal deaths (WHO 2008: 2).

In 1994, the United Nations International Conference on Population and Development (ICPD) held in Cairo ‘forged a global consensus on abortion’ (Dabash and Roudi-Fahimi 2008: 3). The *Programme of Action of the International Conference of Population and Development* established that abortion should ‘not be promoted as a contraceptive method’ but that it should be safe in the countries where it is not against the law; also, governments and nongovernmental organisations should ‘strengthen their commitment to women’s health, to deal with the health impact of unsafe abortion as a major public health concern’ (quoted in Dabash and Roudi-Fahimi 2008: 3). They should also ‘promptly’ offer post-abortion care, education, counselling and family planning services. Although the Cairo conference was a turning point because it focussed on the reproductive choice of individuals rather than families and female empowerment, as well as linked the issue of human rights to health and reproduction (Shalev 2000: 39), there was no recognition of a new international right to abortion (Bonnet and Guillaume 2004: 27).

In 2013, all countries of Northern Africa (Algeria, Egypt, Libya, Morocco, Sudan and Tunisia) permitted abortion to save a woman’s life, but only Algeria, Morocco and Tunisia also authorised it to preserve a woman’s mental health (United Nations 2014).⁶ Algeria no longer permits abortion in the case of rape and incest – as was still the case in the 1990s – whereas Morocco amended the Penal Code in 2016, allowing female victims of rape and incest to terminate the pregnancy. Sudan and Tunisia also allow abortion in the case of rape and incest. Foetal impairment is a legal ground for abortion in Morocco (since 2016), Tunisia and Sudan. In the ‘West Asia’ region, in 2013, all Arab countries allowed abortion to save a woman’s life,

TABLE 0.2 Legal grounds for abortion in the Arab states.

Risk to woman's life	All countries
Risk to mental health	Algeria, Bahrain, Jordan, Kuwait, Qatar, United Arab Emirates
Foetal impairment	Bahrain, Jordan, Kuwait, Morocco, Oman and Qatar
Rape and incest	Bahrain, Morocco, Tunisia, Sudan
Economic and social reasons	Bahrain, Tunisia
All grounds	Tunisia, Turkey

whereas only Jordan, Kuwait, Qatar and the United Arab Emirates (UAE) permitted it to preserve a woman's mental health (United Nations 2013). Rape and incest are a legal ground for abortion only in Bahrain, whereas foetal impairment is a legal reason to terminate the pregnancy in Bahrain, Jordan, Kuwait, Oman and Qatar.

Islamic Fatwas, Women's Rights and Abortion

Since the early discussions on family planning and abortion in the 1960s, religious leaders have been involved in the debate, and Islamic juridical traditions have been used to legitimate the laws of the state in the domain of reproduction (Hessini 2007). However, state legislations do not systematically reflect religious opinions, which can sometimes be more liberal than the law. Several examples can illustrate the gap existing between religious fatwas and state laws on abortion. In 1998 in Egypt, the Grand Mufti – the supreme religious leader – argued that 'rape victims should have access to abortions and to reconstructive hymen surgery to preserve female marriageability and virginity' (Hessini 2007: 78). His opinion notwithstanding, the Egyptian state did not change the law, which does not allow abortion on these grounds. In the same year, the Algerian Islamic Supreme Council issued a fatwa allowing abortion for women who had been raped by religious extremists during the civil war (1990–1998), but it was never transformed into law.

In other cases, religious opinions have contributed to the revision of a previously existing restrictive law, such as in Sudan and Saudi Arabia. In Sudan, abortion law was amended in 1991, shortly after the Islamists came to power, expanding the circumstances in which abortion can legally be performed (Tonnessen 2015). In

Saudi Arabia, Islamic jurisprudence also allowed for the expansion of indications in which an abortion can be performed (Hessini 2008). In other countries, religious opinions are more restrictive than the law, such as in Kuwait, where religious authorities do not consider rape as legitimate grounds for an abortion (Hessini 2007). Examining the abortion regulations in Arab countries, it is worth mentioning that existing restrictive laws mostly date back to colonial times, when pronatalist policies were enforced by British and French authorities.⁷

In the Arab countries where abortion has been partially decriminalised, it is usually not in the name of women's rights but to save the life of the mother, to protect the honour of the family, to ensure the marriageability of a woman, to avoid the birth of a sick child, to reduce population growth etc. Overall, the abortion debate in Arab countries is based on arguments that are different from those used in North America or in many European countries. Religious jurists are concerned for the women's life, the ensoulment of the foetus, the well-being and morality of society, the preservation of the greater good etc., rather than for the foetus' rights, although the pro-life Christian arguments have sometimes entered into the context of Islamic juridical traditions (Hessini 2008: 24).

While religious arguments are commonly used in Arab and Muslim countries to justify abortion laws and local cultural attitudes, international agencies such as the WHO, the United Nations Fund for Population and Development (UNFPA), the International Planned Parenthood Federation (IPPF) and some local NGOs promote the decriminalisation of abortion on the basis of a secular discourse based on concepts such as gender equality, health and human rights (Hessini 2008, Shapiro 2013).⁸

Abortion in Tunisia

In 2013, the feminist NGO Association tunisienne des femmes démocrates (Tunisian Association of Democratic Women, ATFD) published the booklet *Le droit à l'avortement en Tunisie –1973 à 2013* (*Abortion Rights in Tunisia – 1973 to 2013*), in which the authors outline the situation of abortion in the country, considering its legal, medical, social and religious aspects. Worried about the political and juridical questioning of the right to abortion and the dismantling of abortion services after the revolution of 2011, ATFD decided to take an active stance and reaffirm Tunisian women's right to abortion

care. The booklet denounces the fact that ‘Since 2011, we have witnessed a radical change: at the public sector level, the *omerta* (law of silence) allows the state to hide the impact of financial cuts and of religious conservatives’ actions who deny women abortion care without fearing legal sanctions’ (2013: 14).

Indeed, on 18 January 2013, during the debate on ‘rights and freedom’ of the constituent assembly – which was elected in October 2011 to write the new constitution – Deputy Najiba Berioul requested the criminalisation of abortion. Berioul, a member of *Ennahdha*, the Islamist party in power from October 2011 to February 2014, expressed the opinion of a section of the public who wished to deny women the right to abortion for non-medical reasons. In her speech, she recalled the ‘right of the foetus to be born’ and asked it to be included in the new constitution, abrogating Article 214 of the Penal Code that allows abortion. Interestingly, to justify her request, she employed an argument that comes from the North American pro-life movement, according to which the foetus is a person whose rights must be taken into consideration, and that can conflict with those of the mother. Mobilising the notion of rights does not refer to the terms of classic Islamic debates on abortion but is in some way attuned to the modern Euro-American representation of the foetus. Article 214 of the Penal Code decriminalises abortion in the section on ‘Wilful killing’, which is a derogation of the law insofar as, under certain circumstances, it permits the termination of pregnancy (i.e. the killing of a person). The derogation is inscribed in a code that was inherited from the French colonial state and that considers the foetus as a person and the abortionist as a criminal. To be legal, abortion must take place in a recognised medical facility under medical supervision until the end of the first trimester (fourteen weeks’ amenorrhoea). It can exceptionally take place after that period ‘if continuation of the pregnancy threatens the women’s physical or psychological health or if the foetus suffers from a serious illness and deformity’ (Foster 2001: 74).⁹

In 1965, only married women who had five living children were allowed to get an abortion with their husband’s consent; in 1973, the article was amended to allow all women, married and unmarried, with or without children, to access abortion services, including minors under the responsibility of an adult. The law was also changed thanks to the intervention of the Tunisian Women’s Union.¹⁰ Its representatives were able to persuade the parliament to change the law, showing them 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 that 55 women committed suicide in 1972 because of 'non legitimate pregnancy' (Asman 2004: 85). Since 1965, abortion care has been free of charge in government facilities. Although other administrative structures pre-existed it, in 1973 a specific state agency, the *Office national du planning familial et de la population* (ONFPF) – later to become the *Office national de la famille et de la population* (ONFP)¹¹ – was created in order to coordinate family planning policies. ONFPF had five main objectives: carry out research in the domains of demography, reproduction and health; implement state policies that 'enhance the equilibrium of families and the health of its members' (Gastineau and Sandron 2000: 16); provide all appropriate professionals with the means to reach the mentioned objective; offer training for healthcare professionals; and educate the population.

The legalisation of abortion was part of a larger project to control the demographic trends in Tunisia. Already in 1959, shortly after independence (1956), 'public authorities started to talk about the necessity of mastering procreation, first and above all to affirm the intention of reducing birth rates, ignorance, poverty and illness' (Gueddana 2001: 204). Demographic policies became a priority of the independent Tunisian government. Imbued with a neo-Malthusian and modernist view, the first Tunisian president, Habib Bourguiba, attributed crucial importance to containing 'the human tide relentlessly rising at a speed largely outreaching the increase of the means of subsistence' (Bourguiba in Gastineau and Sandron 2000: 11). Demographic policies were a main concern for postcolonial Tunisia and had already been inscribed as such in the development plans of the country since the mid-1960s, insofar as they were deemed necessary to ensure human progress (Foster 2001). The High Population Council (founded in 1974) oriented the action of ONFPF and coordinated the policies of different ministries under the supervision of the prime minister. Regional population councils were active in supervising and applying the national demographic policies designed to control reproductive practices.

Abortion was an integral part of the family planning policies, and for certain categories of women, it represented 'the only accessible and efficient method of birth control' (Gastineau 2012: 78). Some scholars even argue that in 1974 the Tunisian authorities thought that '40% of the targeted reduction in the birth rate would have to come from abortion with 60% from users of contraception' (Lapham 1977: 8).

Although, with a few exceptions, religious leaders cautioned the use of contraceptive methods and the promotion of family planning by the state (Brown 1981; Gueddana 2001), abortion was more controversial. It was religiously forbidden by Maliki legal tradition – the dominant legal tradition in the Maghreb – but was allowed by the more permissive Hanafi and Shafi schools, according to which the ensoulment¹² of the foetus does not happen before 120 days (three months). In this domain, as in many others, Bourguiba did not abandon the Islamic reference to legitimise his reforms, emphasising on the contrary that ‘we have made an effort (*ijtihad*) . . . we have used the reason inspired by the very principles of Islam’ (Bourguiba in Bessis and Belhassen 1992: 128). Bourguiba insisted that Tunisian reformers had ‘found inspiration in the *Shari’a* . . . and chose to open the doors of interpretation in order to rejuvenate the Islamic tradition’ (Charrad 2001: 222). The modernising rhetoric of Bourguiba notwithstanding, the religious reference maintained its legitimising function, in that it was used to justify the important social reforms promoted by the state in the first decades after independence. The same rhetoric was used to legitimise the Personal Status Code promulgated in 1956, which contributed to subvert previously existing power relations between men and women and the logics of patrilineal kinship solidarity (Charrad 2001).

As already mentioned, the introduction of family planning and abortion were part of a larger plan for the reform of Tunisian society in which women in particular were to be emancipated from previously existing traditions and constraints often designated as ‘backwards’, ‘archaic’ or ‘retrograde’ (Grami 2008: 353). However, ‘the family planning program was a function of the state, which aimed at furthering state goals. It was not about individual women or their needs’ (Foster 2001: 82). Precise demographic targets (Gueddana 2001), the centralised and hierarchical structure of the family planning programme and aggressive public campaigns provoked abuses and coercive practices that caused resistance and distrust among the population. Paternalistic attitudes among medical personnel were widespread and forced contraception, and (female) sterilisation was common in the early phases of the programme, targeting, above all, uneducated, rural and poor women. Disciplining female reproductive bodies justified what some called the two-in-one package (*Le droit à l’avortement en Tunisie – 1973 à 2013* 2013), which meant that women were often forced to accept tubal ligation or an Intrauterine device (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 would undergo tubal ligation, IUD or implant insertion at the same time.¹³ Economic incentives for health professionals performing specific acts and for women accepting to undergo tubal ligation (Foster 2001), as well as the creation of the Bourguiba prize in 1974 for the governorates that obtained better results in reducing birth rates, significantly show the nature of the programme.¹⁴ Although they also had beneficial consequences, the Tunisian family planning policies often took the form of ‘an unjustifiable intrusion of government power into the lives of its citizenry amounting in many cases to physical violence against women’s bodies’ (Hartmann 1995: XIII). Birth control became the priority rather than women’s health and the freedom to choose how many children they wanted. As effectively summed up by Nabih Gueddana, the main objective was the limitation of births in the 1960s, birth spacing in the 1970s, the integrated approach of mother–infant health in the 1980s, and reproductive health, which she considers to be synonymous with ‘family health’, in the 1990s¹⁵ (2001: 211). The words of one of the main actors of family planning in Tunisia – as she was president of ONFP from 1994 to 2011 – significantly identify the state’s goal as that of reducing birth rates and ensuring the health of the family. Women’s own health and individual agency were possibly a by-product of a development policy in which they were made to play the main characters. Men were late to be included, and then only marginally, in the family planning programme as secondary players. Women were and still are considered the main actors of the reproductive scene, although they are caught up in a social and cultural context where they rarely make individual decisions about procreation. Many studies published by the ONFP over the last thirty years have focussed on women’s reproductive behaviours in accordance with state reproductive policies, which have targeted them as if they were autonomous individuals making decisions independently of their family, sociocultural and economic contexts. The only systematically recognised relationship was that between the women and their children insofar as mothers were (and are) considered to be responsible for the physical and social well-being of their family. Gendered conceptions of women’s and men’s roles in society and within the family guided the conception of these studies and oriented government policies in the domain of reproduction. This is to be understood in relation to several local and transnational

representations that heavily affected the Tunisian family planning policies. As I will elaborate below, women were to become crucial actors in the modernising policies of the independent state, and therefore their role had to be transformed to make them allies of the elite in power. They were also easy to reach, as the family planning policies were based on the adoption of biomedical contraceptive technologies that were mostly applied to women's bodies (IUD, pill and later injectables and implants). Women's opinions could be influenced and their bodies manipulated in order to be at the service of the new demographic policies of the state when they consulted healthcare facilities. Because of the feminine nature of biomedical contraception, they were considered responsible for reproductive decisions. Moreover, the transnational paradigm of family planning policies considered women to be more responsible than men, as if they were endowed with specific universal, biological and moral qualities (see Chapter 2).

The Code of Personal Status and the Modernisation of Society

In order to enable women to be the triggers of the modernisation of postcolonial Tunisia, a few months after independence, Bourguiba promulgated the Code of Personal Status (CPS), which modified women's status and partially disrupted the patrilineal structure of the family.¹⁶ It provided female citizens with unprecedented rights: it abolished polygamy, repudiation, *jabr* (the right to compulsion) and the matrimonial guardian; instituted legal divorce; and made father and mother both responsible for a child (Ben Achour 2001; Charrad 2001). It also set the minimum age for marriage for men and women at fifteen for a woman and at eighteen for a man, which was modified in 1964 to seventeen and twenty, respectively. The principle of equality between men and women was explicitly recognised in the constitution (1959) and the labour code (1966), and measures to achieve universal schooling (1958) were taken. Moreover, the creation of the retirement fund, social security, disability pension and survivor pension in the event of a spouse's death contributed to the 'deregulation of the previously existing family system' (Sandron 1998: 42). These and other reforms¹⁷ were part of a modernisation process that had the effect of improving women's rights, promoting the nuclear family model and reinforcing matrimonial bonds (Charrad 2001). The construction of the nuclear

family was at the heart of the efforts of the legislators, who aimed to discard the logics of the patrilineal extended family that had dominated Tunisian society until independence, so as to build a new modern unit where conjugal and parental ties were central. Tunisia was a pioneer in the transformation of *ayla*, a relational and wide 'network of people who depend on each other' (Hasso 2011: 26) to survive, into *usra*, 'a nuclear family of parents and children in an architecturally bounded, private household' (ibid.). The new unit, modelled after the European modern family, represented modernity and progress within the teleological framework that colonisers presented first and that western international agencies presented later on. The creation of the *usra*, considered to be the basic unit of postcolonial society, was an effect of the governmentality characteristic of the new states of the Middle East and North Africa. The new family was conceived of as an entity that the state could shape and administer in contrast with the old *ayla* that represented a group competing with the modern state power logics. The creation of a new social unit, the *usra*, was thus necessary for the construction of a modern state where old tribal and family solidarities were excluded. Indeed, 'in liberal political theory the [nuclear] family is regarded as the natural basis for civil life' (Ali 2002: 123), and in addition, it is an economic productive unit that should adjust to state objectives. For instance, in Tunisia, land reform was enforced to abolish tribal collective property and to make each household responsible for its own survival. Although this was not the logic that postcolonial Morocco and Algeria adopted (Charrad 2001) after independence, Tunisia represented a model for future development in several other states of the region (Ali 2002; Hasso 2011).

Postcolonial state policies made the family a critical space of social and cultural change, where new values, practices and concerns could be created and transmitted to modernise Tunisian society. However, the transformation did not have to entirely subvert gender logics and power relations: the man was designated as the head of the family, and women were to give priority to family life and to their duties as mothers and wives. Although the constitution established men's and women's equality (1959), state institutions conveyed a very different message to families. Analysing various sources of the early 1960s, Ilhem Marzouki shows that a clear division of labour was explicitly proposed to married couples: the man's role was that of a breadwinner, whereas the woman had to be in charge of the domestic sphere, which included completing daily chores, managing the family budget, occasionally playing the role of secretary

for her husband and encouraging him to pursue his career. At the same time, the woman was supposed to avoid having the couple's life become a routine; rather, she had to make every day 'different and unexpected' (Marzouki 1993: 180). One of the main roles of women was the education of the children, who represented the new generation of Tunisian citizens. They had to play major roles in providing education, as the men were preoccupied with their work, with school playing only a secondary role for them. A differential education for girls and boys was recommended insofar as the former should develop 'feminine characteristics' and the latter should acquire a sense of responsibility and duty (ibid.: 181). Mothers were urged to conveniently prepare their daughters to become wives and mothers, which included learning how to manage the house and how to become modern women (Abu Lughod 1998).

Women's work outside of the home was represented as sometimes necessary for economic reasons but was always subordinated to domestic life, as their main roles were those of mothers and wives (ibid.: 181).

State Feminism, Grassroots Feminism and Abortion

Several authors have pointed out that postcolonial Tunisia was characterised by state or institutional feminism (Ben Achour 2007; Bessis 1999; Charrad 2001; Ferchiou 1996; Marzouki 1993), a political phenomenon that has significantly determined women's postcolonial history. As mentioned above, Bourguiba took the initiative of promulgating the CPS and reforming several social institutions, extending the rights of Tunisian women in an unprecedented way. The creation of the National Union of Tunisian Women (UNFT) in 1958 to supervise social reforms and to promote the new state policies in the domains of education, family, labour etc. was a crucial moment in the history of institutional feminism.¹⁸ The union was state sponsored and was very closely linked to Bourguiba and his entourage. Its members were subordinate to various ministries and never enjoyed autonomous political power (Marzouki 1993). The first phase of the union's activities was dedicated to the promotion of the modern family and to the new roles of women in it, whereas in the 1970s, the union began to focus on the role of women in the public sphere – employment, education, political and economic institutions. One of the stakes was the actual enforcement of women's rights, which were often violated in the economic, political and

social spheres. Despite the expansion of women's rights and the overall improvement of their life conditions (Bessis and Belhassen 1992; Omri 2009), institutional, economic and social inequalities were not eliminated (Bouraoui 2001; Marzouki 1993), and even after the revolution of 2011, women were under-represented in political and economic institutions (Mahfoudh and Mahfoudh 2014: 30). Regional disparities between the cities in coastal areas and in the interior of the country are important today, and the living standards of rural women are still very different from that of urban women: their access to education, health facilities, social services and employment is limited (Omri 2009). Social conservatism, ignorance about personal rights among illiterate or little-educated women and poverty contribute to the existence of substantial inequalities. Thus, class, geographic location and education constitute major obstacles to women's equality, in addition to Tunisian legislation that, despite the constitutional recognition of equal rights for women and men and the official withdrawal of reservations regarding the CEDAW¹⁹ (2014), entails differential treatments in various domains, such as with inheritances, where men are attributed shares twice as large as those of women.²⁰ Despite Bourguiba's pioneering reforms, discrimination against women is still present in Tunisia, where women's rights are often used as 'political commodities to be traded and exchanged between male leaders of various political groups' (Grami 2008: 359) rather than as principles orienting state policies.

Especially after 1987 – when Zine El Abidine Ben Ali²¹ took power – institutional feminism nurtured an official rhetoric about state modernism versus the Islamic obscurantism coming from the East (Mashrek), used as a political instrument to 'gain the support of still hesitant opponents particularly afraid of a hypothetical strong re-emergence of Islamism in the Tunisian political arena' (Geisser and Gobe 2007: 373).

Although the narrative of the state has long monopolised the history of Tunisian feminism, emphasising that women received their rights from above without having to fight for them,²² it must be remembered that women took part in the struggle for independence in the 1930s and 1940s (Bessis and Belhassen 1992; Grami 2008; Marzouki 1993) and that three women's autonomous associations were founded over these years that promoted women's education rather than emancipation because they were imbued with Islamic culture and originated in a religious environment (Marzouki 1993). It was not before the end of the 1970s that a postcolonial autonomous feminist movement emerged in the context of social and

economic instability, where social protest and unrest were common (Mahfoudh and Mahfoudh 2014). Their struggle was nurtured by feminist and democratic ideas because promoting women's equality and autonomy could not be separated from the larger objective of obtaining political freedom.

During the 1980s, two feminist associations were created by independent groups of women – mostly belonging to the urban intelligentsia – and both were based in Tunis: the already mentioned ATFD and the Tunisian Association for Research and Development (AFTURD) (Daniele 2014; Labidi 2007; Marzouki 1993). In the same period, other feminist groups were created within the local unions as well as the Tunisian League for Human Rights and the secular opposition parties.

Overall, during the 1990s and 2000s, the autonomous feminist movement engaged in a double combat against the rising Islamist movement threatening women's acquired rights and against monopolisation by the state of women's issues, insofar as its policies were ambivalent. The policies formally promoted equality but did not transform social practices, and they extended women's rights beyond what the CPS achieved in 1956²³ (Mahfoudh and Mahfoudh 2014).

After the revolution of 2011, several new feminist associations were created, often by militants, who were members of already existing associations. Many women's associations created after 2011 are close to the Islamist movement, although they represent a variety of positions ranging from the defence of acquired women's rights, but within an Arab-Islamic identity, to the promotion of men and women's complementarity²⁴ instead of equality, as well as the refusal of women's rights to employment and abortion.²⁵

Other associations are not explicitly feminist insofar as they consider the issue of women's rights and equality to be transversal to other questions, such as democracy, social justice etc. (Mahfoudh and Mahfoudh 2014). Hence, the landscape is extremely diversified and cannot be simplistically divided into two fields: Islamic feminism and secular feminism.

When a female deputy of Ennahdha questioned the depenalisation of abortion in early 2013, the ATFD reacted by organising internal meetings and by publishing the booklet mentioned above on the history of abortion in Tunisia. Among the historical feminist associations, the ATFD was the only one to publicly advocate the right to abortion. The UNFPA supported them as well as other NGOs working in the domain of women's health, such as the Tunisian

Association of Reproductive Health (ATSR) and the Groupe Tawhida Ben Cheikh, which has been extremely active in defending abortion and contraception rights since its creation in early 2012. Selma Hajri,²⁶ the president of this association and the physician who introduced medical abortion in Tunisia (Hajri 2004), explained during an interview with the Tunisian newspaper *La Presse* that,

by 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 were legitimised . . . Several ONFP clinics especially in the South: Tataouine, Gafsa, Sidi Bouzid, Siliana . . . stopped providing abortion care. Some clinics provided it again after 2013; others not yet. (Lahbib 2015)

The ATFD, Groupe Tawhida Ben Cheikh, ATSR, IPPF and UNFPA together with many anonymous healthcare providers – who daily worked on the frontline despite the unstable and sometimes hostile environments in which they had to practise – have played a major role in defending women’s right to abortion when it was openly put into question.

Conducting Ethnographic Research after the Revolution of 2011

When I arrived in Tunisia in August 2013, the constituent assembly elected in October 2011 was still working on the new constitution; the transitional government that was supposed to last only one year seemed endless (Gobe 2012), and a strong feeling of uncertainty and insecurity was common among the people I met. The strong economic crisis, the ideological divisions between Islamists and secular parties and the disappointment of a large section of the population after the end of Ben Ali’s regime were also very much present in the daily lives of Tunisian citizens. Taxi drivers, medical doctors, state officials, teachers etc. were all complaining about the situation of Tunisia, which they regarded as very negative. Narratives about the country’s previous order, security, cleanliness and well-being were common, and conspiracy theories about the revolution were widespread. Abortion was probably not the main issue for many of my interlocutors, but it was crucial for the women who wanted to terminate their pregnancies, as well as for many health professionals

working in ONFP clinics, government hospitals and various Tunisian NGOs and international organisations, such as the UNFPA and IPPF.

My research has focussed on government facilities offering abortion and contraception care in the area of Grand Tunis (Great Tunis), which includes four governorates: Tunis, Ariana, Ben Arous and Manouba, whose population is slightly more than 2.5 million inhabitants, according to the last national census completed in 2014.²⁷ I have carried out participant observation in three ONFP clinics offering sexual and reproductive health (SRH) services and abortion care, including the family planning unit of one of the largest maternity hospitals in Tunisia.²⁸ I have also become an active member of two Tunisian NGOs whose activities focus on women's health. I have collaborated with the UNFPA and ATSR on various occasions as well as with the ONFP. The ministry of health and the ONFP, respectively, gave me official authorisation to carry out research in reproductive health facilities. My collaboration with the other institutions was based on mutual agreement and common interests.

Although I have completed several formal interviews with healthcare professionals, university professors and personnel of health institutions, most of my ethnographic material derives from participant observation during consultations, informal conversations with the health professionals and the women using the government facilities where I conducted my fieldwork, and participation in workshops, conferences and meetings. I also collected various written, visual and digital materials produced by local and international institutions active in the domain of SRH in Tunisia.

This book focusses on the ambivalent attitudes of healthcare providers and women towards abortion and contraception during the period of August 2013 to July 2014, when Tunisia was still going through a period of political transition. The public arena was characterised by an ideological division between those willing to go back to an authentic Arab-Islamic identity that was allegedly lost or repressed after independence and those defending the modernising project that Bourguiba initiated. Although many nuances exist on both sides, this division was very much present in my interlocutors' discourses during my stay in Tunisia and affected the attitudes and ideas of healthcare providers working in clinics providing abortion care. Because the institutional supervision of public services at that time was weak due to the uncertainty of the political situation and the presence of recently appointed officials who were loyal to Ennahdha yet lacked qualified profiles and professional experience (see also Foster 2016), health professionals enjoyed a considerable

degree of autonomy. They were able to freely express their opinions and to act accordingly, which in some cases meant that they refused to provide abortion care to certain categories of women or to all of those seeking it. Negotiations, conflicts, even the harassment of some members of staff were not uncommon, and local arrangements were found at various moments to deal with abortion cases. These arrangements depended on the personnel's ethical and political positions in each institution, as well as on their national and local political circumstances, as I will show in the following chapters.

As for my work with NGOs, without having planned it, I started to collaborate more actively with two of them, and I took part in several workshops, organisational meetings and informal discussions that significantly helped me to enter the healthcare milieu in which I was interested. It was an unforeseen opportunity that expanded on what I had hoped to study. Becoming an active member of some NGOs allowed me to have reflexive discussions with providers about their moral and professional positions, experiences and feelings towards women's (and men's) sexuality, reproductive trajectories and conceptions of the family and of the ontological status of the foetus.

My reflections on the discourses and practices of abortion in post-revolutionary Tunisia are framed by the larger historical, political and cultural contexts in which a specific reproductive governance (Morgan and Roberts 2012), gender regime and social practices are inscribed. The language, actions and interactions of the local actors I describe must thus be interpreted in light of this context insofar as it shapes their forms of life and grammar to use a Wittgensteinian terminology.

Structure of the Book

The book is organised into four chapters that through the analysis of discourses and practices related to abortion and contraception investigate larger issues related to women's position and status in Tunisian society in the post-revolutionary period. I question the idea that there was a substantial change in clinicians' and women's practices and discourses related to the body, sexuality, reproduction and gender relationships after the revolution. I intend to show that although the revolution brought about some important changes it did not radically transform local values and norms in the medical domain I studied. Among the new phenomena I observed were the

possibility of publicly expressing one's opinion, the open political and social engagement of clinicians, the mobilisation of previously suppressed religious and moral registers in the clinical encounter, the health professionals' refusal to offer abortion and contraceptive care, the decreasing number of government facilities offering abortion services, the lack of state control over medical personnel, and the conservative turn witnessed by the personnel in the government sector in charge of sexual and reproductive care. However, practitioners' conservative attitudes and symbolic and physical violence against women using government clinics and hospitals were not new and showed that the change concerned the possibility for healthcare providers to publicly express opinions and act against the law or medical regulations rather than major transformations of social norms and values. As for the clinic users I met, when comparing their discourses and behaviours with the testimonies of women in the 1980s, collected by Lilia Labidi (1989), I found that the majority of them were less concerned by religious preoccupations and social norms about abortion and sexuality. They manifested very pragmatic attitudes and, in many cases, consciously took responsibility for their sexual and reproductive conduct.

The book also explores the complex moral world of healthcare providers working in government SRH facilities, as well as that of their users, who are mainly women belonging to the poorest strata of the population. Because of the methodological choices I made, I spent more time and had more opportunities to speak with healthcare providers than with women using government clinics. Although I observed the interactions between providers and patients and had frequent conversations with women seeking contraceptive and abortion care, I did not systematically interview them. As a result, I established more intimate relationships with clinicians than with their patients, and this explains why the former are given more space than the latter. Finally, the book offers an analysis of the 'arenas of constraint' (Inhorn 2011: 91) that shape the asymmetric relationships between clinicians and patients, as well as their impact on the contraceptive and abortive itineraries of Tunisian women who resort to reproductive and sexual health clinics in the public sector.

The first chapter examines the debates around women's role and rights in the political arena, focussing particularly on the discussions on the right to abortion that took place in the constituent assembly in early 2013. It considers the ideological struggles between Islamist and conservative forces, on the one hand, and the more secular and

progressive parties, on the other, that focus on the new constitution and their commitment to preserving women's acquired rights or to introducing new principles, such as that of the complementarity between women and men – which justifies openly discriminating policies. It also examines the activities of two local NGOs that are active in the domain of SRH to show how the political and social transformations that Tunisian society experienced in the first years after the revolution have affected the discourses and practices of health professionals and activists. I describe some training seminars that these two NGOs have organised for health providers and activists so as to unpack the various local moral regimes and the role of Tunisian and international actors in shaping discourses about women's conduct and social roles. In the second chapter, I set aside public debates and discourses that NGOs have promoted and enter into the clinics and into the hospital, where I completed participant observation and explored medical practices in the domain of SRH. I analyse the medical, social and moral norms that healthcare providers transmitted during consultations, as well as the attitudes of women using government facilities. I investigate the multiple representations of the physiology of the female body that clinicians and patients have and how they affect contraceptive practices. Each contraceptive method is perceived in various ways among professionals and patients, and their effects on women's bodies are framed according to a particular knowledge system. I also pay attention to how power relationships between healthcare providers and patients shape their interactions. A distinction is made between the contraceptive and reproductive norms that practitioners apply to married and unmarried women, as in their eyes, they belong to two separated moral and social categories of citizens and patients. I conclude with the analysis of healthcare professionals' representations of the sexual behaviours of unmarried women and how they affect their conduct towards this category of patients. Chapter 3 investigates the question of unwanted pregnancies and the attitudes of healthcare providers working in government facilities towards women seeking contraceptive and abortion care. It shows that most healthcare providers and clinic users have internalised the ideologies of modernisation and neoliberal rationalities, although other logics or practical impediments can prevent women from abiding by the norm of the 'willed pregnancy'. Reproductive and sexual health clinics are considered to be places where anatomo-political work is conducted on women's bodies and subjectivities. Biomedical, discursive and administrative devices are used to 'order' women's

bodies and regulate their moral and social lives in an attempt to subordinate them to the state's interests and to the patriarchal norms of society. Unplanned pregnancies are apprehended as the expression of a lack of discipline, order and responsibility of women who fail to incarnate the modern feminine subject in charge of ensuring the well-being of the family and consequently of the entire society. The treatment of pregnant unmarried women seeking abortion care in government reproductive and sexual health clinics is particularly significant in that together with sex workers they represent the most marginal figures of the locally conceived feminine identity. Youth-friendly units within sexual health clinics – which are meant for unmarried users – show the strict forms of the medical, social and moral surveillance that specific administrative practices ensure, as well as the informal behaviour of healthcare providers. Surveillance devices are often not just intended to perform pedagogic and disciplinary work but also imply various forms of symbolic violence that are examined in this chapter. Policing techniques designed to identify and control women's sexual and reproductive behaviours are part of the machinery that the medical authorities have set up and are specifically intended to control both unmarried women and married women manifesting undisciplined conduct. Particularly in this chapter, I draw on feminist literature on family planning and the imagination of the modern subject because it has significantly questioned the medical and demographic state-based rationalities dominating the work accomplished in government SRH clinics.

In Chapter 4, I describe how the biomedical visual culture has affected healthcare professionals' as well as their patients' representations of early pregnancy, the embryo-foetus and abortion. Ultrasound scans that have contributed to the transformation of the foetus in a patient and a new moral subject in the Global North do not seem to play an important role in shaping the perceptions of most users of government SRH clinics, whereas Tunisian healthcare providers have internalised technological images and the foetal development theories of biomedicine. As a result, various conceptions of the body and of the embryo-foetus coexist in the space of SRH clinics, generating different ontologies and moral configurations in relation to abortion. Popular representations of early pregnancy are examined in light of the local theory of the 'sleeping child' and the Islamic precept of ensoulment, conceived as the divine act transforming the product of conception into a person. The rest of the chapter is dedicated to the analysis of the discussions that took place during several training seminars that

a Tunisian NGO organised among health providers (and a few employees of the administration) working in SRH facilities. These discussions addressed abortion, contraception, sexuality, sex education of young people, sexual relationships and the experiences and attitudes of healthcare providers towards SRH. These exchanges were very rich and allowed me to evaluate the complexity of the postures of health providers caught up within various moral economies, rationalities, individual trajectories and material constraints. During these training seminars, which lasted two days and brought together several providers working in various facilities offering the same services, I had access to reflections, feelings and experiences that were rarely manifested in other circumstances. It is useful to think about the complexity and contradictions in which healthcare providers were caught up in light of the state rationalities examined in the previous chapters and the medical logics that frame their daily practices in the government clinics. Government SRH facilities abide by organisational, administrative and moral logics that are largely state-determined and thus play an important role in shaping clinicians' subjectivities.

In the conclusion, I consider the contradictory and paradoxical effects brought about by the democratisation of Tunisian society in the domain of SRH and on women's sexual and reproductive trajectories. I particularly emphasise the elements of continuity embedded in the new social practices and discourses I witnessed that, despite important changes, did not radically subvert the previous configurations of Tunisian society.

Notes

1. For more detailed discussions of abortion in the Islamic tradition see Brockopp (2003); Bowen (1997, 2002); Hessini (2007, 2008); Musallam (1983); Shapiro (2013).
2. 'Muslims universally agree that on all levels, whether the family, the community, or religious teaching, the primary concern must be for the life of the mother, and her welfare precedes any concern for the fetus' (Bowen 2003: 64). Today, all Islamic countries recognise this principle in the abortion legislation.
3. WHO defines abortion on request as follows: 'this legal ground recognizes the conditions for a woman's free choice. Most countries that allow abortion on request set limitations for this ground based on duration of pregnancy' (WHO 2012: 103). Abortion for social and economic

reasons is instead ‘interpreted by reference to whether continued pregnancy would affect the actual or foreseeable circumstances of the woman, including her achievement of the highest attainable standard of health.’ Some laws specify allowable reasons, such as pregnancy outside of marriage, failed contraception or intellectual disability affecting capacity to care for a child, while others only imply them. Laws may also require distress as a result of changed circumstance; for example, the distress of caring and providing for a child additional to existing family members (ibid.: 103).

4. Unsafe abortion is defined by the World Health Organization (WHO) as a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both (WHO 1993).
5. This geographic notion includes Bahrain, Iraq, Jordan, Kuwait, Lebanon, the State of Palestine, Oman, Qatar, Saudi Arabia, Syria, the United Arab Emirates, Yemen as well as Armenia, Azerbaijan, Georgia, Cyprus, Israel, and Turkey.
6. In this section I voluntarily adopt the terminology of the United Nations to designate the legal grounds for pregnancy termination.
7. On this point, see Bowen (1997: 173) and Hessini (2008: 20–22). These authors underline the European origin of abortion laws in Muslim-majority countries in Asia and Africa. For example, in colonial Tunisia abortion was forbidden and, even after independence, French doctors working in Tunisian hospitals refused to perform them (Foster 2001).
8. On the complex interaction between secular and Islamic discourses on family planning and abortion, see for example the study of Emma Varley (2012) on Pakistan.
9. The French text is the following: ‘Quiconque par aliments, breuvages, médicaments, ou par tout autre moyen aura procuré ou tenté de procurer l’avortement d’une femme enceinte ou supposée enceinte, qu’elle y ait consenti ou non, sera puni d’un emprisonnement de cinq ans et d’une amende de dix mille dinars ou de l’une de ces deux peines seulement. Sera punie d’un emprisonnement de deux ans et d’une amende de deux mille dinars ou de l’une de ces deux peines seulement, la femme qui se sera procurée l’avortement ou aura tenté de se le procurer, ou qui aura consenti à faire usage des moyens à elle indiqués ou administrés à cet effet. L’interruption artificielle de la grossesse est autorisée lorsqu’elle intervient dans les trois premiers mois dans un établissement hospitalier ou sanitaire ou dans une clinique autorisée, par un médecin exerçant légalement sa profession. Postérieurement aux trois mois, l’interruption de la grossesse peut aussi être pratiquée, lorsque la santé de la mère ou son équilibre psychique risquent d’être compromis par la continuation de la grossesse ou encore lorsque l’enfant à naître risquerait de souffrir d’une maladie ou d’une infirmité

- grave. Dans ce cas elle doit intervenir dans un établissement agréé à cet effet. L'interruption visée à l'alinéa précédent doit avoir lieu sur présentation d'un rapport du médecin traitant au médecin devant effectuer ladite interruption' (Penal Code, Art. 214).
10. Since the Tunisian Women's Union was created as 'a transmission belt in order to enforce the state politics of women's emancipation' (Marzouki 1993: 176), we can reasonably imagine that the liberalisation of abortion was a government strategy to increase the efficacy of its family planning policies as also argued by Lapham (1976).
 11. On the history of family planning in Tunisia: Brown (1981), Foster (2001), Gastineau and Sandron (2000), Gastineau (2012), Sandron and Gastineau (2000), Vallin and Locoh (2001).
 12. This term indicates the moment in which the soul is insufflated into the foetus.
 13. See for instance Gueddana (2001: 215).
 14. Precise numerical targets were established at different stages of the family planning programme. For example, in 1973 'The Minister of Health Mohamed Mzali launched a drive to carry out 500 female sterilization in Jendouba province [in the Northwest] within a four month period . . . Eager to please, local authorities managed to carry out 1200 sterilizations in the time period' (Jones quoted in Foster 2001: 86). Nabiha Gueddana, a former president of ONFP, explains also that 250,000 IUDs were to be inserted by midwives between 1966 and 1971 (2001: 212).
 15. On this concept and its effects on the Tunisian health programme for women in the 1980s see Foster (2001: 99ff.).
 16. Tahar Haddad and his book *Our Women in Shari'a and Society* (1930) anticipated these reforms, although the time was not ripe for accepting his ideas when he wrote it. Regarding Tahar Haddad, see, for example, Grami (2008); Sraieb (1999).
 17. For more details on the reforms that contributed to change in Tunisian society, see Charrad (2001, chapter 9).
 18. Women's organisations that existed during the colonial period were dissolved, and the UNFT was created to spread the good word of the president and of the party (Bessis and Belhassen 1992: 74). Bourguiba stated that the union was created 'to approach ordinary women, to investigate their way of life and to commit to improving it gradually' (quoted in Bessis and Belhassen 1992: 74).
 19. 'The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted in 1979 by the UN General Assembly, is often described as an international bill of rights for women. Consisting of a preamble and 30 articles, it defines what constitutes discrimination against women and sets up an agenda for national action to end such discrimination' (<http://www.un.org/womenwatch/daw/cedaw/>, consulted on 28 October 2016).

20. Regarding the reform of inheritance law, in postcolonial Tunisia, see the analysis of Charrad (2001: 228–31). Regarding disparities between rural and urban women, see Omri (2009: chapters 3 and 4). Regarding other legal inequalities, see Chekir (1996) and Bouraoui (1987).
21. Ben Ali removed Bourguiba from power in 1987 and became the second president of Tunisia. He fled the country in January 2011 during the revolution.
22. As Bourguiba stated in an interview, ‘Indeed, there was no feminist movement demanding the promulgation of a Code of Personal Status or the abolition of polygamy’ (quoted in Charrad 2001: 219). All historians in Tunisia recognise the absence of a grassroots feminist movement at the time of independence. See, for example: Bessis (2004); Charrad (2001); Marzouki (1993).
23. Several changes were made in the CPS after its promulgation aimed at improving women’s rights, but women’s legal status is still not equal to men’s (Ben Achour 2007, 2016).
24. The question of complementarity during the drafting of the new constitution caused a heated political debate and several public demonstrations. The engagement of feminist associations and the civil society was critical for reinscribing the principle of men’s and women’s equality in the new constitution (Mahfoudh and Mahfoudh 2014).
25. Regarding the post-revolutionary feminist movements in Tunisia, see the special issue of *Nouvelles Questions Féministes* dedicated to the topic ‘Féminisme au Maghreb’ (2014); Daniele (2014); Debuysere (2016); Khalil (2014); Labidi (2014); Tchaïcha and Arfaoui (2012); Zlitni and Touati (2012).
26. Selma Hajri is also a member of the ATFD and its internal Committee for Sexual and Bodily Rights.
27. In 2014, the total population, including foreigners, residing in the country for more than six months was 10,982,754, from the website of the Institut National de la Statistique <http://www.ins.tn/fr/resultats>. Retrieved 28 October 2016.
28. I conducted fieldwork for nine months in the hospital, eight months in two of the ONFP clinics and two months in the third one. The different duration of participant observation in every facility is related to access authorisation.