WOMEN'S COMPREHENSIVE HEALTH CARE IN CONTEMPORARY TUNISIA

by

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ABSTRACT

This dissertation explores the strengths and limitations of national health policy in Tunisia. The achievements of the Tunisian women's health program, as reflected in both statistical and elite-centered historical analyses, include an expansive health infrastructure, near universal primary health care coverage, and pioneering reproductive health initiatives. Yet the dominant historical narrative divorces women's health from the broader social, economic, and political context and largely excludes the experiences and perspectives of women from its analysis. Furthermore, research dedicated to women's health has historically concentrated almost exclusively on maternal and reproductive health, thereby precluding a sophisticated appreciation of other aspects of women's health and the full ramifications of health policy. This dissertation moves beyond this limited focus and instead incorporates a more comprehensive vision of women's health into the assessment of national health services. By approaching women's health as social history, this dissertation explores the contemporary lives, experiences, and needs of women in Tunisia and chronicles the involvement of women, individually and collectively, in the development, evolution, and implementation of the national women's health program. Highlighting three specific areas of women's health in Tunisia -traditional health services, domestic violence, and young women's health and sexuality- this research reveals both lacunae in the national program and arenas for future improvement.

To examine the history and development of the women's health program in Tunisia, identify limitations and strengths of the program, and consider a wide array of women's health issues, this dissertation combines qualitative and quantitative research methods. Based on fourteen months of fieldwork in Tunisia, this dissertation draws from the fields of medical anthropology, public health, and feminist studies. In using a variety of extractive and participatory techniques, this interdisciplinary approach yields a more complete and nuanced understanding of the history, evolution, and consequences of the Tunisian national women's health program and offers a framework by which to examine comprehensive women's health in other parts of the Middle East and North Africa region.

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It has been an honor and a privilege to learn from you.
Your stories, experiences, struggles, and accomplishments are an inspiration to us all.

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List of Acronyms, Abbreviations, & Foreign Terms

AIDS	Acquired Immune Deficiency Syndrome
animatrice	Community health worker
ATFD	Association Tunisienne des Femmes Democrates
ATPF	Association Tunisienne de Planning Familial
CERES	Centre d'Études et Recherches Economiques et Sociales
CREDIF	Centre d'Étude, de Recherche, de Documentation et d'Information sur la Femme
CREPF	Centre Regional d'Éducation et de Planification Familiale
CSP	Code du Statut Personnel
DDSB	Direction des Soins de Santé de Base
DMSU	Direction de Médecine Scolaire et Universitaire
hammâm	Public bath
HSP	Health Service Provider
IEC	Information, Education, and Communication
IPPF	International Planned Parenthood Federation
IPPP	Incapacité Permenante Personelle Partielle
IPPT	Incapacité Permenante Personelle Totale
ITTP	Incapacité Totale Temporaire Personelle
IUD	Intrauterine device
KAB	Knowledge, Attitudes, and Behaviors
khalti	Literally maternal aunt; also used as a term of respect for TBAs
MCH	Maternal-Child Health
MHC	Mobile Health Clinic
MHU	Mobile Health Unit
MENA	Middle East North Africa
MOPH	Ministry of Public Health
MSP	Ministère de la Santé Publique
NGO	Non-Governmental Organization
ONFP	Office National de la Famille et de la Population
ONPFP	Office National du Planning Familial et de la Population
PHC	Primary Health Care
PMI	Protection Maternelle et Infantile
PNP	Programme National de Périnatalité
PSD	Parti Socialiste Destourien
qâbla 'arabi	Traditional Birth Attendant
qâbla souri	Professional Midwife
quabla	Plural of *qâbla*
SAP	Structural Adjustment Program
SMI	Safe Motherhood Initiative
STD	Sexually Transmitted Disease
TBA	Traditional Birth Attendant
TND	Tunisian Dinar
UNFT	Union Nationale de la Femme Tunisienne
USAID	United States Agency for International Development
WHO	World Health Organization
WID	Women in Development

MAP OF TUNISIA



Map of Tunisia courtesy of *The World Factbook 2000*

CHAPTER 1: INTRODUCTION

If women are indeed to benefit from actions to improve their health, we in the health care community must first benefit from women's voices. To do this we must make listening and talking with women a fundamental organizing principle of women's health programs.[1]

--S. Brems and M. Griffiths, 1993

The institution of health fundamentally shapes women's lives; with physical, conceptual, biological, and social dimensions, health pervades personal and public spheres. Women's health and well-being help define the boundaries of self-actualization and empowerment, affecting participation in economic development and political processes, constructing identity and roles in the community, and influencing dynamics in the family. Health comprises an evolving combination of both universal elements and social constructions unique to particular contexts, and therefore any study of health benefits from a multi-faceted approach.

However, studies devoted to women's health in the Middle East remain limited in number. Although valuable contributions include work by medical anthropologists, demographers, and public health researchers, the increase in research on women in the Middle East during the last 15 years has centered largely on other aspects of social and economic development.[2] Research on and by Middle Eastern, Arab, and Muslim women has concentrated on several aspects of economic development and contemporary socio-economic history including women's participation in nationalist movements and state identity formation, formal and informal female networks, the impact of economic reforms on the family and gender

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[1] Brems, S. & M. Griffiths (1993), pg. 255.

[2] Works on both historical and contemporary women's health issues in the Middle East include Inhorn, M. (1994), Khattab, H. et. al. (1999) & Obermeyer, C. (Ed.) (1995).

roles, and women's participation in the formal and informal labor force.[3] Although issues relating to women's health intersect with research on feminism and gender identities, legal and institutional reforms, and the role and status of women, women's health in and of itself remains an under-explored field in Middle Eastern studies.

A review of the literature on women in the Middle East yields a substantial body of work dedicated to Egypt and Palestine, while Turkey, Morocco, Algeria, and Lebanon receive more modest attention. There is a dearth of literature and research dedicated to women in Tunisia in general and women's health in particular. The growing body of work devoted to political and economic liberalization largely excludes women from its analysis and focused efforts on women in Tunisia are concentrated on legislative reforms and the legal status of women.[4] Despite the rich history of women's health initiatives in Tunisia, Tunisia remains notably absent from most of the literature on women and development, women's health, and family planning.

Several factors make Tunisia a particularly compelling case study of women's health issues in the Middle East. Initiated in the wake of independence, the national women's health program accompanied improved legal and educational rights and opportunities for women. Explicitly integrated into national economic development efforts, public sector investments in health infrastructure and personnel resulted in near universal maternal and reproductive health coverage by the early 1990s. Tunisia's pioneering efforts in women's health programming received international

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[3] For example, see works by Chatty, D. & A. Rabo (Eds.) (1997), Hijab, N. (1988), Khoury, N. & V. Moghadam (Eds.) (1995), Macleod, A. (1991), Sabbagh, S. (Ed.) (1996), Singerman, D & H. Hoodfar (1996) & Singerman, D. (1995).

[4] There are several notable exceptions including the work of Laurie Brand that focuses on women and political liberalization. Brand, L. (1998).

acclaim and place it at the forefront of health policy formulation. In 1962, Tunisia initiated the first national family planning program in Africa and the Middle East, which by the mid-1980s had become one component of an integrated primary health care initiative.

Further, Tunisia's health indicators compare favorably with those of other Middle Eastern and Mediterranean countries (see Table 1.1). Notably, Tunisian indicators in almost all aspects of women's and children's health surpass those of Morocco and Egypt. This is particularly evident in such areas as infant and maternal mortality. Contraceptive prevalence in Tunisia is also comparatively high; the percentage of married women of reproductive age using contraception in 1999 was estimated at 60%. Tunisian health indicators also compare favorably to averages of MENA regional and lower-middle income groupings. Tunisia has managed to obtain these indicators with a physician base that is substantially lower, on a per capita basis, than those of Egypt, Italy, and Turkey. However, when compared to Italy (whose per capita GNP is nearly tenfold larger) Tunisia's health indicators show considerable room for improvement. The striking health statistics and Tunisia's pioneering role in women's health program development make the relative absence of studies and research dedicated to this field all the more surprising. These observations warrant a comprehensive examination of the health program in Tunisia.

Table 1.1: Comparative Health Indicators[5]

	Tunisia	Morocco	Egypt	Turkey	Italy	MENA*	LMI**
GNP per capita ($US)[a]	2,100	1,200	1,400	2,900	19,710	2,060	1,200
Health Expenditure (Public % GDP 1990-1998)[b]	2.2	1.2	1.8	2.9	5.6	2.3	2.3
Health Expenditure per capita ($US)[b]	108	49	48	177	1,701	126	62
Physicians/1000 People (1990-1998)[b]	0.7	0.4	1.6	1.2	5.9	1.0	0.9
Life Expectancy in years (Female/Male)[c]	71/68	69/65	68/65	72/67	81/75	68[b] overall	69[b] overall
Maternal Mortality[c]	70	230	170	130	7		
Infant Mortality (female/male)	29/32	46/56	47/53	39/51	7/7	44[b]	32[b]
Total Fertility Rate (1995-2000)[c]	2.6	3.1	3.4	2.5	1.2	3[b]	2[b]
Contraceptive Prevalence Rate[c]	60	50	47	63	--	52[b]	53[b]
% Assisted Deliveries (1996)[c]	90	40	46	76	--	--	--
% Prenatal Care (1996)[c]	71	45	53	62	--	--	--
Child Immunization Rate (%): Measles (1995-1999)[b]	93	93	96	76	55	91	87
Child Immunization Rate (%): DPT (1995-1999)[b]	100	94	95	74	70	92	87

* MENA = Middle East & North African Region

** LMI = Lower Middle Income Countries (Annual GNP/capita of $ 756 - $ 2,995)

a: World Bank (2001b). Statistics for 1999 unless otherwise noted.

b: World Bank (2001a). Statistics for 1999 unless otherwise noted.

c: UN Statistics Division (2001). Statistics for 1995-2000 unless otherwise noted.

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[5] The Maternal Mortality Rate is defined as the number of maternal deaths occurring during delivery or in the 42 days postpartum per 100,000 live births.
The Contraceptive Prevalence rate is defined as the percentage of married women of reproductive age currently using a method of contraception.
The % of Assisted Deliveries is defined as the percentage of deliveries attended by a skilled practitioner. Traditional birth attendants, regardless of training, are excluded.
The % Prenatal Care is defined as the percentage of women who received prenatal care by a skilled practitioner at least once during the pregnancy.
The Child Immunization Rate is defined as the percentage of children under the age of tweleve who have received the specified immunization.

To explore the factors underlying the relative success reflected in Tunisia's health statistics, this dissertation conducts a comprehensive analysis of the history of the women's health program in Tunisia from independence in 1956 to the present. However, aggregate statistics provide an incomplete depiction of the state of women's health, effects of national policy, and efficacy of service delivery systems. The goal of exploring more thoroughly what lies behind the numbers motivates two choices that have shaped the methodological approach of the dissertation. First, personal narratives detailing women's experiences as recipients and providers of health services are employed to inform a more profound understanding of the ramifications of national policy. Second, the discussion of national health policies is complemented by in-depth analyses of three specific areas of women's health: traditional health services, domestic violence, and young women's health and sexuality. The selection of these three areas for case studies reflects a view of women's health that transcends the reproductive life span, and approaches women in the context of comprehensive health and well-being.

SITUATING THE DISSERTATION IN THE LITERATURE

Research on women's health historically has been approached within a Western, biomedical, and curative model of health and disease. As noted by L. Doyal, "Within this model, the complex relationship between mind and body is rarely explored and individuals are separated from both the social and the cultural contexts

of their lives."[6] The detachment of health and disease from social, economic, and political factors has obstructed attempts to address the overlapping dimensions of women's health. Research and policy initiatives dedicated to women's health historically have been approached with a very narrow, almost exclusive, concentration on maternity and reproduction. As N. Lewis and E. Kieffer note, "Most discussions of women's health, especially with respect to developing countries, have referred only briefly, if at all, to health problems apart from reproduction or to post-menopause. This continues to have important implications for health policy and planning."[7] Further, the objectives of women's health programs have often centered on children's health, economic development, and population reduction, with individual women's health, rights, needs, and empowerment serving as secondary considerations.[8] This bias permeates the literature on women's health and has resulted in the neglect of health issues that transcend the reproductive life span or focus on areas outside the realm of procreation.[9]

The preamble to the Constitution of the WHO states, "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[10] Although this definition has only recently been applied

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[6] Doyal, L. (1995), pg. 15.
[7] Lewis, N. & E. Kieffer (1994), pg. 122.
[8] For further exploration of this dynamic in women's health policy formulation see Doyal, L. (1995), Hartmann, B. (1995) & Koblinsky, M. et. al. (Eds.) (1993).
[9] In recent years there has been a great deal of debate over the term "reproductive health". At the conclusion of the UNICPD conference in 1994, a comprehensive definition of reproductive health was adopted by consensus by the international community. This non-gender specific definition integrated physical, mental, and social well-being and incorporated a broad range of health issues and services into the concept of reproductive health. However, as is evident from the information presented in this dissertation, this has not historically been the operating defition of reproductive health in Tunisia or in international women's health research and policy development. Thus, throughout this dissertation the term "comprehensive women's health" is used. This term embraces the UNICPD definition of reproductive health as it applies to women and further incorportates areas of women's health that transcend the reporductive system and lifespan.
[10] Preamble to the Constitution of the World Health Organization.

directly toward women's health, the concept of women's health is evolving to become more comprehensive.[11] As maternal-child health scholar J. Stein wrote,

> Until recently, the health of these [third world] women was considered only in relation to the health of their children, and such programs as existed were restricted to reproductive health matters…Because of a confluence of factors-among them an increasing focus on women on the part of both the international health and development communities, an increasing demand from women for comprehensive and lifelong care, recognition that a child's health is determined in large part by a mother's preconceptual health…, a burgeoning of international women's movements, and a growing dependence on women to take care of the necessities of family and community life-a new emphasis is being given to women's health.[12]

This emerging comprehensive model of health recognizes women as whole and complex persons, whose health is influenced by biological, social, economic, and political factors. "Women's health...while recognizing the reality of women's reproductive and nurturing functions takes a broader view of women's lives and makes legitimate demands for services which meet the needs of the 'whole woman' irrespective of age or social status."[13] A comprehensive approach to women's health has significant implications for both policy and research, requiring researchers to adopt multi-disciplinary methods that address the myriad dimensions of health.

Comprehensive women's health is notably absent from the literature on women's health in Tunisia. Consistent with much of the work on women's health in the developing world, demographic objectives and the family planning program

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[11] In fact, the Constitution of the WHO states, "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." Gender is notably absent. Preamble to the Constitution of the World Health Organization.

[12] Stein, J. (1997), pg. 96.

[13] Orr, J. (1987), as reported in Koblinsky, M. et. al. (1993), pg. 35.

dominate the limited research agenda. Although several studies have focused on maternal health, children's health, and the history of medicine, contemporary exploration beyond the sphere of reproduction remains sparse.[14] Tunisia's success in family planning has often been credited to what demographer and anthropologist C. Obermeyer has described as the fateful triangle: as Islam is a weak political and cultural force in Tunisia, women have been empowered through formal political rights and this in turn has led to better women's health and, specifically, to lower fertility.[15] This essentialist analysis obscures the importance of health initiatives, health service providers, and individuals, and paints Islam as unequivocally inhibitory to improvements in women's health.[16]

This explanation for the achievements of the Tunisian women's health program influences the dominant historical narrative. Historical accounts of the development of the women's health program reflect elite-centered biases, citing individual politicians and health administrators for its success. In focusing on the legal reforms affecting the status of women, improvements in women's health, with the exception of family planning, are often presented as incidental. Dedicated almost exclusively to family planning, the dominant historical narrative fails to explore other components of women's health and the policies that influence outcomes, and neglects the role of women as agents of social change. Women are presented as passive

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[14] Several notable exceptions include works by Tunisian scholars Ben Miled, E. (1988), Ben Romdhane, H. (1992), Labidi, L. (1989) & Labidi, L. (Ed.) (1988).

[15] In this article, C. Obermeyer identifies the "fateful triangle" as a weak and overly-simplistic argument used by many authors looking at women's health in the Middle East. Obermeyer, C. (1992).

[16] A number of authors have explored the complex relationship between Islam and women's status. For nuanced reflections on this relationship see Kandyoti, D. (1991), Kandyoti, D. (Ed.) (1991) & Mernissi, F. (1987).

beneficiaries of centrally determined services and women's mobilization around health at the individual, health service provider, and community levels is ignored.

WOMEN'S HEALTH AS SOCIAL HISTORY

The importance of legal, political, and economic rights and reforms, direct government support and enthusiasm, the influence of individual political elites, and a strong family planning program should not be underestimated. However, crediting the achievements of the Tunisian women's health program exclusively to these factors appears overly simplistic and in conflict with the experiences of other countries in the developing world.[17] The causal gap between legislative action and outcomes as measured by health indicators remains a large one, and begs for deeper analysis of individuals and institutions that mediate change. Moreover, aggregate health indicators reflect only one type of efficacy, necessarily marginalizing the experiences of individuals and local communities. The exclusive focus on maternal health and fertility in conventional health indicators precludes an understanding of other aspects of women's health and the full ramifications of health policy. An alternative perspective, one that recognizes the efforts of the government, development agencies, local communities, and individuals, provides a better explanation for the success of health initiatives. As noted by S. Asthana,

> Community participation came to be seen as a central component of PHC [primary health care]: not only would active involvement of individuals and communities ensure that health programmes developed in response to locally felt needs; participation was also a way of raising political consciousness and of encouraging people to get involved in the wider development process.[18]

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[17] See, for example, Howard-Grabman, L. (1996) & Oranga, H. & E. Nordberg (1996).
[18] Asthana, S. (1994), pg. 183.

To explore the history and evolution of the Tunisian women's health program and identify factors underlying its strengths and weakness, this dissertation approaches the issues of women's health through the framework of social history.

> Social and economic historians also have sought to add women to history. Social and economic historians have easily moved, in their study of the lives of people, be they peasants, workers, merchants, or slaves, to include the women who formed the majority of past populations. These approaches have looked at women in the Middle East as economic actors and as members of communities, families, and classes. By constituting history as including the life patterns, thoughts, and activities of the ordinary person, social and economic history opened up a world of new dimensions far from the arenas of traditional political history.[19]

The analysis of Tunisian women's health history as social history demonstrates that women have been extensively involved, individually and collectively, in the development, evolution, and implementation of the women's health program. By moving away from the elite-centered narrative, it becomes apparent that the integration of women into the decision-making process, at the individual, health service provider, and community levels, has been a critical factor in the success of the national program. Chronicling and analyzing the experiences and perspectives of individual women provides a greater understanding not only of the history of the women's health program, but of women's mobilization, roles and status, empowerment, relationships, and everyday lives.

Situating women's health history in the context of social history is also consistent with examining comprehensive women's health. An investigation of

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[19] Meriwether, M. & J. Tucker (1999), pg. 6.

traditional health services, domestic violence, and young women's health and sexuality requires examination of a complex web of economic, social, cultural, religious, and political factors that influence health. Through an examination of three issues in women's health that move beyond the limits of reproduction and maternity, this research explores the contemporary lives, experiences, and needs of women in Tunisia.

THE STRUCTURE OF THE DISSERTATION

To examine the history and development of the women's health program in Tunisia, identify limitations and strengths of the program, and explore areas of women's health that move beyond maternity and reproduction, this dissertation employs a research approach that is both qualitative and quantitative. Chapter 2 presents a detailed overview of the research conducted during fourteen months of fieldwork in Tunisia. The qualitative component of the research included semi-structured interviews, in-depth interviews, group interviews, an oral history project, and community residence. Each of these techniques is explored in detail, with specific attention to reliability, validity, and ethical considerations. Chapter 2 then turns to the quantitative component of the research, comprising an open-ended, orally administered survey. Designed as a bi-directional project, the survey assesses knowledge, attitudes, and behaviors among seventy-five never-married female university students in Greater Tunis. This section of the chapter explores the importance of conducting participatory research. A discussion of the methods suggests an attempt to overcome the pervasive and somewhat artificial qualitative-quantitative methodological division, thereby combining the strengths and

contributions of both methodological approaches. Acknowledging that fieldwork is an inherently transformative and subjective process, Chapter 2 concludes by exploring the complex relationship between the researcher and the research.

Chapter 3 examines the history and evolution of the national women's health program. Relying on primary and secondary sources, interviews with health service providers, and the oral history project, Chapter 3 departs from the top-down historical narrative and instead integrates women's experiences and perspectives into the historical analysis. Shifts in philosophy, priorities, and decision-making differentiate the women's health program into three primary periods. From independence until the end of the 1970s, the women's health program was dedicated to furthering demographic and development objectives, reducing fertility through the establishment of a national family planning program, and expanding health infrastructure and personnel. Characterized by hierarchal and centralized decision-making, regional disparities, and poor service quality, the definition of women's health care during this period was limited to family planning.

However, beginning in the early 1980s, the national program began to devolve authority to health service providers and local communities. Influenced by a national reorientation toward integrated primary care, this second period in the women's health program is characterized by the peripheralization of decision-making and an increase in community participation in service determination. Largely inspired by innovative initiatives of individual health service providers, this second period saw improved service quality, greater community confidence in the health sector, and a broader scope of women's health services.

The Tunisian women's health program entered into a third phase in 1990. The transparency and accountability requirements of economic reform efforts influenced the development of the national perinatality program, a program designed to promote the standardization of services, primary health service integration, and the elimination of regional disparities.[20] However, the health reforms of the 1990s have again limited the scope of women's health, re-centralized the decision-making process, and reinforced physician-based hierarchies. Chapter 3 concludes by noting that the retreat in local community participation may limit the potential of the national women's health program.

With this historical context, the dissertation turns to three chapters dedicated to specific areas of women's health that are largely overlooked by the national program: traditional health services, domestic violence, and young women's health and sexuality. These three chapters show that the health reforms of the 1990s, and specifically the perinatality program, pose additional impediments to addressing these areas of women's health. Chapter 4 documents the contemporary work of traditional birth attendants and argues that TBAs continue to provide three principal socio-medical services in the Tunisian south: home deliveries, infertility treatment, and the legitimization of "sleeping children".[21] However, it is evident that the TBA continues to compensate for shortcomings in the national health program, shortcomings that include regional disparities, biases in treatment, and socio-cultural and linguistic

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[20] The medical community defines the perinatal period as the period beginning after the 28th week of pregnancy and ending 28 days after birth. However, the Tunisian perinatality program encompasses a wider array of women's health issues and includes pre-marital, pre-natal, and post-natal care. This is explored in detail in Chapter 3.

[21] The sleeping child is believed to be a child that is conceived but not born for a period of up to nine years. This phenomenon and its contemporary importance is explored in detail in Chapter 4.

barriers between the providers and the women who use their services. This chapter concludes that acknowledging and analyzing the work of the TBA allows for a critical examination of the national health system, offers an important mechanism for better identifying women's health needs, and has the potential to ultimately improve the quality of the national health program.

Chapter 5 moves beyond the maternal and reproductive aspects of women's health and explores the issue of domestic violence. This chapter argues that domestic violence, prevalent throughout Tunisian society, exerts a severely detrimental impact on women's physical and psychological health. After chronicling legal reforms affecting the status of abused women and the intersection between the legal and medical systems in identifying and documenting domestic abuse, it becomes apparent that the national health program is generally unresponsive to abused women's needs. Although women receive assistance from informal kinship networks and a number of non-governmental agencies, the health implications of domestic abuse demand explicit recognition and targeted reforms in the national health system.

Finally, Chapter 6 turns to the issue of unmarried women's health and sexuality. A controversial and sensitive issue within policy circles, young women's health and sexuality historically has been ignored, resulting in a dearth of information and services for young women. In the university context, the absence of services contributes to the proliferation of misinformation, resulting in high-risk behaviors with negative physical and psychological health outcomes. The knowledge, attitudes, and behaviors study conducted with never-married female university students demonstrated that there exists a great deal of interest and enthusiasm for recognizing the realities of young women's experiences and enacting health promotion programs.

The national health program has the potential to better address young women's health needs, but has yet to identify this area as a priority.

Chapter 7 concludes by exploring the significance of the interdisciplinary and social history approach employed in the dissertation. In situating women's health into a larger social, economic, and familial context, using a more holistic and comprehensive model of women's health, and combining qualitative and quantitative methods, this framework contributes to a more complete understanding of both the strengths and weakness of the Tunisian national women's health program. Chapter 7 argues that by moving beyond a maternal and reproductive health framework and broadening the scope of women's services, adopting participatory approaches to health promotion that involve local communities, and devolving authority to local communities and health service providers, the national health system has the potential to be more responsive to all women's health needs. The chapter concludes by noting that the framework developed in this dissertation offers important insights into the study of other aspects of health services and systems, both in Tunisia and other countries in the Middle East and North African region.

CHAPTER 2: METHODOLOGY

The human reality must be apprehended by a variety of viewpoints, not by one alone, because this very reality is always in part a construct, always in part an image, and only by encouraging difference in perspective and approach can one obtain the needed richness of imagery, and consequently, theory.[1]

--J. Bennett and G. Thaiss, 1967

INTRODUCTION

Historically, researchers have fallen into either quantitative or qualitative methodological camps. This constructed dichotomy has identified quantitative methods with positivism and empiricism and qualitative methods with documentary, phenomenological, and interpretive research.[2] However, the scholarship of the last twenty years has witnessed considerable movement toward recognizing the importance of integrating qualitative and quantitative approaches.[3] In order to better understand the history and development of women's health care in Tunisia, examine a broad range of women's health issues, and at the same time achieve a certain degree of representation, this dissertation embraces the integration of qualitative and quantitative methods. Drawing from the fields of medical anthropology, public health, and feminist studies, this research uses a variety of different methods and techniques, both extractive and participatory. This chapter is dedicated to the particulars of the fieldwork and the types of research conducted. After presenting a brief overview of the debate over methodological approaches, this chapter argues that a comprehensive examination of women's health is best served by a combined research effort. This discussion is followed by an outline of the qualitative components of this research, presenting in detail the methods employed and the

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[1] As cited in Warwick, D. (1998), pg. 275.
[2] Mikkelsen, B. (1995), pp. 224-225.
[3] See, for example, Bulmer, M. & D. Warwick (Eds.) (1998), de Koning, K. & M. Martin (Eds.) (1996) & Mikkelsen, B. (1995).

reliability of these methods and techniques. Particular emphasis is placed on the oral history project and the importance of relating and integrating women's experiences into research on women's health. The chapter then turns to the quantitative component of the research; a survey conducted with 75 never-married female university students living in Tunis. Each phase of the survey project will be examined and particular attention will be given to the trade-offs associated with implementing a participatory project. However, an exploration of the research conducted for this project demonstrates that the divisions between qualitative and quantitative approaches is somewhat artificial, the methods and techniques are integrated and overlapping. This chapter concludes with a consideration of reflexivity and situates the researcher in the research.

The assessment of public policy has largely depended on quantitative research. Quantitative research emphasizes measurable indicators of performance and change and is therefore integral to the design and assessment of policy initiatives. Focused on the aggregate and touted as "objective", representative, deductive, and vested with high reliability and validity, quantitative research has been credited for making the social sciences scientifically rigorous. However, quantitative research underemphasizes the individual and often ignores the experiences and perspectives of marginalized populations: women, minority groups, and the illiterate, to name but a few. Further, quantitative research does not generally integrate the participants into the process of knowledge production, provide a forum for empowerment, or successfully uncover or measure the influences of historical, socio-cultural, political, religious, or economic factors on the outcomes of interventions.

Qualitative techniques allow for a better understanding of what lies behind the numbers generated through quantitative approaches. Descriptive, interpretive, and

case-based, qualitative research explores behaviors, complex socio-cultural processes, and traditions through individuals and small communities. Generalizations are extrapolated from observing, recording, analyzing, and interpreting the lives, histories, actions, opinions, and explanations of individuals. Although qualitative research is still concerned with collecting valid, impartial data about the question under study, qualitative research recognizes the subjectivity of the research process, the power differentials between the researcher and informants, and the influences that these differences have on the interpretation and presentation of results. However, this orientation has resulted in criticisms related to reliability, summarized by W. Shaffir and R. Stebbins as "[the] belief that the undisciplined procedures in fieldwork enable researchers, to a greater degree than practitioners of other methodologies, to influence the very situations they are studying, thereby flagrantly violating the canons of scientific objectivity."[4] However, qualitative researchers embrace and acknowledge this subjectivity and challenge the premise that any type of research is truly "objective".[5]

To explore the different layers involved in women's health, to validate experiences, to empower women, and to analyze health interventions, researchers have increasingly turned to multi-disciplinary approaches, using a combination of qualitative and quantitative methods.[6] Indeed, C. Pope and N. Mays argue that in the field of medicine "qualitative work can reach aspects of complex behaviors, attitudes, and interactions which quantitative methods cannot."[7] Approaching women's health

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[4] Shaffir, W. & R. Stebbins (Eds.) (1991), pg. 15.
[5] See, for example, Davies, C. (1999) & Shaffir, W. & R. Stebbins (Eds.) (1991).
[6] The works of Inhorn M. (all), Khattab H. et. al. (1999) & Labidi L. (1989) are but a few examples of this trend toward employing both qualitative and quantitative methods in research on women's health.
[7] Pope, C. & N. Mays (1995), pg. 44.

from an interdisciplinary and participatory approach is particularly important. As R. Khanna wrote,

> Working with women's health involves exploring and understanding woman's experience of herself within society, her relationship to and control over her body. The layers of negation and devaluation need to be peeled off, so that women are empowered, their experiences are validated and they are enabled to develop their self-image within a context where they can exert control over their bodies and recognize their intrinsic strengths, both individually and collectively.[8]

Thus, to engage in "participatory" research, better understand the history and development of the national women's health program, and explore the experiences of individual women, I chose to use a combination of qualitative and quantitative methods and techniques. This chapter now turns to a detailed discussion of the fieldwork employed in this project.

FIELDWORK

LIBRARY-BASED RESEARCH

Primary and secondary literature and surveys form an essential part of the dissertation. Collection of these documents necessitated the consultation of libraries and research centers in the US, Britain, France, and Tunisia. Library-based research at universities in Britain and the United States yielded a wide range of English and French language sources, particularly in the general fields of medicine, Middle Eastern studies, and development studies.[9] However, the bulk of the library-based research was conducted in Paris, Aix en Provence, and Tunisia. The Tunisian libraries included the research center libraries of CEMAT and the IRMC as well as

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[8] Khanna, R. (1996), pg.64.

[9] These included various libraries at Stanford University, Portland State University, Oregon Health Sciences University, Harvard University, Oxford University, and the University of London.

the ONFP libraries in Tunis and Tataouine, Les Facultés de Médecine (Sousse and Tunis), IBLA, CERES and CREDIF. Of particular importance was access to Tunisian newspapers and journals (*RTSS*, *La Tunisie Médicale*, and *Famille et Population*) and unpublished theses. Documents were also collected from various international and non-governmental organizations and individuals. French is the dominant language in the health sector in Tunisia and thus most of the sources consulted (both published and unpublished) were in French.[10] The Arabic language materials consulted centered on health educational materials (for both community health workers and local communities), newspaper articles, and a small number of documents on the history of medicine and pharmacopoeia. Finally, during my fieldwork, I had the opportunity to attend several conferences and seminars and I have drawn from both the oral presentations and the unpublished papers (in English, French, and Arabic).

QUALITATIVE RESEARCH

More than fourteen months of fieldwork conducted in Tunisia in 1998 and 1999 form the basis for this dissertation.[11] Extensive qualitative research was conducted and involved a number of different methods, determined by the type of person from which information was to be solicited.[12] This chapter will now outline

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[10] A small number of sources were also available in bilingual translations (French & Arabic). In most cases, I consulted the French translation.

[11] Since embarking on the D.Phil. I have made four separate trips to Tunisia: Summer 1997 (preliminary fieldwork and language training), May 1998 to May 1999 (fieldwork), September-November 1999 (fieldwork), and April-May 2000 (post-doctoral research project). This dissertation was informed by experiences in all four periods. However, my time in Tunisia from May 1998-November 1999 was dedicated exclusively to fieldwork for this project and thus references made to "fieldwork" refer specifically to this period. From September 1, 1998 to May 31, 1999, I obtained research permit from the Tunisian Ministry of Higher Education. I have included a copy of this permit in Appendix I.

[12] For a more detailed discussion of qualitative research in different county contexts see: Asthana, S. (1994) & de Koning, K. & Martin, M. (Eds.), (1996) on qualitative and participatory research in general; Mensch, B., (1993) on direct observation of consultations;

briefly each technique and provide information on recruitment, reliability, validity, and language.[13]

Semi-Structured Interviews

Semi-structured interviews were conducted with more than 180 government representatives, academics, representatives from international, non-governmental, and women's organizations and health service professionals (HSPs). Representatives from more than 25 international, non-governmental, and women's organizations and government agencies were interviewed, often with more than one representative being interviewed from each organization.[14] In addition, a number of these organizations have regional offices or branches and thus representatives from several regions were often interviewed.[15] Informants were selected because of their affiliation with the organization and these interviews were arranged by referral or through an organization administrator. Many of the informants subsequently referred me to other representatives of the organization to gain a wider or different perspective or to obtain specific information.[16] The majority of these interviews took place at the office of the interviewee though a number of interviews were conducted in the home of the

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Brems, S. & M. Griffiths (1993) & Wallman, S. (1996) on group interviews; and El-Mouelhy, M. (1990), ENDA Inter-Arabe. (1996), Friedl, E. (1991), Inhorn, M. (all) & Wolf, D. (Ed.), (1996) on oral histories.

[13] Reliability and validity are concepts that are often misused, confused, and conflated. Reliability refers to the degree to which measurement of a particular phenomenon (stable), when repeated, yields similar results. Validity is defined as the extent to which the results of the measurement accurately correspond to the "true" state of the phenomenon being measured. For a comprehensive discussion of these terms, see Fletcher, R. et. al. (1996).

[14] These organizations include: ACT, AFTURD, ATFD, ATPF, CERES, CREDIF, ENDA, DSMU, DSSB, Les Facultés de Médecine (Tunis, Sousse and Sfax), JMSF, MSP, ONFP, RTT, UNFPA, UNPD, UNFT, UNESCO, UNICEF, and academics from several different disciplines.

[15] These organizations include: ATPF, ONFP, MSP, and UNFT.

[16] This was particularly the case with women's organizations (ATFD and AFTURD) where the different perspectives and experiences of individual members appear to be highly valued. At the ATFD alone I formally interviewed five different women and spoke with a number of others.

respondent, at her or his request. Nearly all of these interviews were conducted in French.[17]

Health service professionals were interviewed in fourteen of twenty-three Tunisian governorates. These regions are indicated on Figure 2.1, presented at the end of this chapter. Health service professionals (HSPs) from a variety of different fields and specialties were interviewed including physicians (both general practitioners and specialists), professional midwives, nurses, health aides, and community health workers. HSPs from public, private, and non-governmental health facilities and programs were interviewed. Interviews with physicians, midwives, and nurses were almost exclusively conducted in French but interviews with community health workers and health aides were generally conducted in Arabic. Interviews took place at the health center, on site (if a member of a mobile health team), at the home of the respondent, or in an outside venue, depending on the preference of the informant.

Health service professionals were selected for interviews through referral or recruitment. I was referred to many health service professionals by other HSPs, academics, and researchers as well as by patients and community residents. However, a significant number of HSPs were recruited on site. In visiting health centers I was often introduced to a health service provider by a health center administrator and through internal referrals I was often able to interview several HSPs in the same health service facility.

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[17] On approximately ten occasions the semi-structured interviews were conducted in English. Three of these informants were native English speakers. Further, several of these interviews were conducted in Arabic or in a combination of French and Arabic. The language(s) used in each interview is included at the end of the dissertation.

Questions for the semi-structured interviews were prepared in advance. However, the questions were tailored to the activities and responsibilities of the individual, the individual's responses to initial questions, and her/his experiences, expertise, and personality, thus the interviews were generally free-flowing.[18] Notes were taken during the interview in shorthand to obtain direct quotes.[19] All informants were aware that notes were being taken during the interview and all were informed that the interview was confidential.[20] On more than ten occasions follow-up interviews were conducted to either clarify or expand upon issues covered in the initial interview. The range in interview time varied significantly but averaged approximately ninety minutes per interview. When possible I attempted to independently confirm information revealed during these interviews through published sources, internal documents, available records, and/or other interviews.[21]

Direct Observation of Health Services

In addition to interviewing health service providers, throughout the fieldwork period I visited more than 45 health service sites in fourteen governorates. These sites included regional and local hospitals, family planning centers, maternal-child health centers, dispensaries, caravans, and private clinics. During these visits I toured the facilities and noted information about the layout, cleanliness, equipment, available

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[18] On a rare number of occasions I was given a pre-determined amount of time for the interview. Due to these time constraints, I would more closely adhere to the pre-prepared questions. Consequently, some interviews were more structured than others.

[19] These shorthand notes were generally expanded immediately after the interview in order to record details of the interview while recall was fresh.

[20] Even though some informants were pleased to have their names used in my research, I have chosen to refer to individual informants by name only if the statement was made in a public forum (i.e. conference, published or written document, etc.). However, the date and place of the interview, the organization represented and the position (if it is general enough to mask individual identity) have been supplied at the end of the dissertation.

[21] Of course, this type of independent confirmation is not always possible, especially when discussing highly sensitive or illegal acts.

medications, and waiting room structure. I was also able to note the types of health education information available (in the form of posters and pamphlets) and how and where patient records were kept. These tours were usually conducted by a health service provider and I was able to obtain information about the history of the facility, its hours of operation, the composition of the staff and, where applicable, the case histories of patients in residence.

In the majority of these health facilities I was permitted to observe consultations with patients. Direct observation of consultations was dependent on obtaining permission from administrators and health service providers at each site.[22] Throughout this period of direct observation I was able to examine patient records, listen to consultations and observe patient-health service provider interactions. Brief notes were taken at the time and more extensive notes were recorded after the patient left the consultation.[23] I did not actively participate in any part of the consultation nor did I intervene in the patient-health service provider relationship, even if I found that interaction to be problematic.[24] After the patient left the consultation I was often able to discuss the patient's history and treatment with the HSP.

In-Depth Interviewing

A different interviewing technique was employed when interviewing traditional birth attendants. In-depth open-ended interviews were conducted with 20

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[22] I was permitted to observe consultations in all but one private clinic. Although I obtained permission from health service providers, I did not obtain permission directly from all patients. In general, I was simply introduced by the health service provider as a colleague and the patient was asked if it I could stay, listen, and observe. None of the patients objected.

[23] My decision not to take extensive notes during the consultation was based on my desire not to alienate the patient as well as to fully concentrate on the consultation itself.

[24] However, when accompanying friends to health facilities I would advocate on their behalf. As my involvement as an advocate may have directly influenced the consultation, I have not included these visits as direct observation sessions.

traditional birth attendants (TBAs) in seven central and southern governorates. These governorates are marked on the map in Figure 2.1. These interviews were conducted in Arabic and nearly all of the interviews were recorded on tape. I was generally referred to these women by other women in the community. These interviews were conducted in the home of either the TBA or her neighbors.[25] Often other women from her family or the community were present during the interview, though men were nearly always excluded at the request of the TBA.[26] Interview time ranged from less than 30 minutes (1) to more than two hours (5). Though I had prepared a series of questions, these interviews usually began with an open-ended prompting question and then flowed from the TBA's response. In addition to TBAs, several other types of traditional healers were interviewed in the governorates of Tataouine, Gabes, and Tunis.

Most of the TBAs were extremely forthcoming about their work and provided detailed descriptions of treatments and even acted out physical positions. On one occasion when asked about when she had performed her last delivery, the TBA left the interview before answering the question. She returned several minutes later clutching the hand of a three-year-old girl, proof of her last healthy delivery. However, when TBAs were more hesitant in providing details, I emphasized that I had spoken with other TBAs and I then often related a small example of something I had heard, followed by a question.[27] By posing a "leading question" that indicated that other TBAs had spoken with me in detail I was able to establish a greater degree

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[25] The one exception was the interview that was held in a barn, at the request of the TBA.
[26] There was one exception in Douriet when a TBA spoke in front of her husband. She was specifically asked if she wanted to postpone the interview or change locations and she stated that her husband knew everything about her work. Indeed, on several occasions he reminded her of particular cases or treatments, serving to jog her memory rather than dominate.
[27] For example, "When I was in Kasserine I heard that the TBA sometimes puts *kohl* on the umbilical cord. Is that what happens here."

of trust with the TBA and with a single example the TBA would generally become more forthcoming.[28]

Group Interviews

More than two dozen informal and formal group interviews were held in El-Hamma, Médenine, Siliana, Tataouine, and Tunis. Group interviews involved facilitating a discussion around a variety of women's health issues largely dependent on the composition of the particular group. In the majority of group interviews the group was informal (familial, friends, co-workers). Prompting questions were used to facilitate discussion but the interviews were largely free-flowing. While several of these group interviews were taped, most were recorded as notes. As a facilitator I attempted to create a comfortable space for discussion and encouraged quieter members of the group to participate. At times I participated actively, sharing my experiences with women's health issues in the United States, Britain and other parts of the Middle East. The experiences often triggered significant debate and proved to be an effective method of creating a more open space for discussion.[29]

These group interviews need to be distinguished from two other types of group work used in this research: spontaneous group discussions and university student focus groups. Spontaneous group discussions frequently emerged during the process of interviewing TBAs or collecting oral narratives. When conducting interviews with TBAs and also when collecting oral narratives (see below) other women were often present. In these cases, although there was a primary interviewee/respondent other

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[28] I was somewhat fortunate in that the first TBA with whom I spoke was very open. This interview lasted well over two hours and though she had never met the other TBAs with whom I subsequently spoke, she was instrumental in my gaining the trust of many of them.

[29] In addition, on two occasions group discussions on the specific issue of domestic violence were conducted with pre-existing formal groups.

women often commented and participated. These spontaneous discussions were generally related to the interviewee's story and often women would add their opinions and contribute their experiences. This generally occurred at the end of the interview when an informal discussion would sometimes emerge between female relatives, friends, and neighbors who had been present. While I would sometimes encourage these discussions by asking trigger questions, these spontaneous discussions were not focused at the outset on particular health issues, nor was I functioning as a true facilitator. Indeed, I made a point of curtailing comments if they were interrupting the primary informant. These spontaneous discussions were often recorded on cassette (because the primary interview was being recorded on cassette) and many of these women were asked to participate in the oral history project. Both the group interviews and the spontaneous group discussions are distinct from the focus groups conducted with female university students, which are discussed later in this chapter.

Oral Histories

The use of life histories, oral narratives, and biographies has long been held as one of the most significant methodological components of anthropological and ethnographic research.[30] Historically, life histories have been collected and thematically analyzed to provide insights into social and cultural processes, collective identities, and cultural traditions. However, the life history also has the potential to give voice to historically marginalized populations through the representation of difference, diversity, and individuality. Feminist research, research by, about, and for

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[30] L. Watson and M. Watson-Franke define life histories as "any retrospective account by the individual of his life, in whole or in part, in written or oral form, that has been elicited or prompted by another person...We use the term 'autobiography,' by contrast, to refer to a person's self-initiated retrospective account of this life, which is usually but not always in written form." Watson, L. & M. Watson-Franke (1985), pg. 2.

women, has embraced oral histories as a technique for defying the tenets of positivism and objectivity and instead orienting research toward conscious partiality, consciousness-raising, empowerment, and advocacy. Emerging from these traditions, an oral history project was carried out and constitutes one of the most significant components of the fieldwork.[31]

Throughout the fieldwork period, I recorded over 120 oral narratives with women throughout the country, the distribution of which is indicated on Figure 2.1. The women who participated in the oral history project reflect the geographical, educational, socio-economic, age, marital status, parity, and health diversity present in Tunisia. Women were asked to speak about their experiences, throughout their lives, with health and illness. Although a vast array of issues were discussed, the most common subjects to emerge in the oral narratives were child bearing, family planning, infertility, menstruation and menopause, domestic violence, nutrition, and celebrations/rituals. Women also used this opportunity to speak about their experiences with health service professionals and traditional birth attendants and the health needs of women in the community. Some of the more educated participants chose to speak in French or English, but majority of the oral narratives were collected in Arabic.[32] The majority of the oral narratives were recorded on tape but numerous narratives were recorded through detailed note taking at the time of collection. The participants were all informed that the project was confidential and all names and

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[31] At the outset, a distinction needs to be made between the terms "oral narrative" and "oral history". An oral narrative is one step of the oral history process and refers specifically to the material recorded. In this case, oral narratives were collected through open-ended interviews. An oral history is a process and includes recording, transcribing, and representing the oral narrative. Thus, the oral history project that constituted one part of this research includes the entire body of oral histories. These definitions are adapted from Gluck, S. & D. Patai (Eds.) (1991).

[32] In approximately 25% of the oral narrative collections I was assisted by someone who would formulate my questions into proper Tunisian dialect from either French or English. However, as my confidence in my language skills increased I conducted the oral history project unassisted.

some locations have been changed in the dissertation. Women primarily chose to speak in their own homes, but others spoke in their offices or, on rare occasion, in my home. Some narratives were delivered in one sitting, others required multiple sessions. The oral narratives represent a wide range of time, with the shortest less than 45 minutes and the longest nearly 15 hours. However, the average narrative took approximately 1½ hours.

Women were recruited for the oral history project through both formal (flyers) and informal (referral) channels.[33] The majority of women participated after a referral from a TBA, a relative, a friend, or other women in the community. Snowball sampling was an important source for gaining participants.[34] Finally, some women participated after I specifically asked them to participate. Women who participated were able to choose who else was present during the narrative process. While many women chose to exclude other people from the room, some women, particularly in the central and southern regions of the country, opted to have friends and relatives present. Often these women volunteered to participate after hearing the first woman share her story. In general, I did not interject during the narrative process except to ask follow-up questions or suggest other topics for discussion.

Research is often extremely subjective. My invitation to participate in the project was based on a particularly positive interaction and intuitive feelings. By way of example, in Ancienne Matmata I collected an oral narrative from a woman living in

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[33] Eight women participated through formal recruiting. Several of these women went on to refer me to other participants.

[34] Snowball sampling has the potential to result in a biased sample as referrals are generally made to family members and friends, people of the same socio-economic, religious-cultural, and educational group (see, for example, Oppenheim, A. (1992)). However, if there are multiple snowballs samples, representing a diversity of initial participants, it is possible to mitigate this bias. This was indeed the case with this project.

an above ground dwelling.[35] At the conclusion of the narrative I asked her if there was anyone else she thought I should speak with. She immediately referred me to her friend and former neighbor, a woman whose 10 year-old daughter happened to be in the room. I arranged to meet the daughter the next day so that I could meet her mother and ask her to participate. Exhausted from a full day of work, I decided to drive to the outskirts of town to find a vantage point to watch the sunset. About a mile from the village center, an elderly woman leading a donkey came toward me on the dirt road. The donkey carried a woman who appeared to be in her early fifties. Dressed in traditional clothes of flamboyant colors, the woman's face and hands were covered with deep blue tattoos. With the sun setting behind her, I was immediately drawn to this woman. I got out of my car, introduced myself, explained my research, and asked if she would be willing to participate. The woman appeared delighted, immediately got into my car, and asked me to drive her to her house where she would be more comfortable. When we arrived at her house the 10 year-old girl with whom I had an appointment the next day was waiting on the stoop: the woman on the donkey was her mother, the elderly woman leading the donkey her grandmother. When the mother learned of the coincidence she laughed and stated that this was God's doing and that she was meant to speak with me. She was one of the first informants to report having had a sleeping child and from her referrals, I collected the oral narratives of three other women.[36]

As referrals constituted a significant method of recruitment for the oral history project, it is worth noting some of the issues that arise in their use. Referrals occur for

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[35] In three communities in the Ancienne Matmata area many families continue to reside in subterranean (pit) dwellings. The distinction between subterranean and above-ground dwellings has important socio-economic and identity implications in these communities and thus the type of residence has been included.

[36] April 6, 1999.

a number of reasons including, the hospitable and helpful nature of the participant, the enjoyment experienced by the participant during the process and the desire to share this enjoyment with others, the participant's support of the project itself, the participant's relationship to me specifically, and the belief that participation would be beneficial or "good for" the woman who is being referred.[37] Yet another common reason for a referral was the participant's belief that the woman being referred had an interesting or relevant experience to share. However, what it is deemed important to a relative or friend may not be important to the woman herself or she may not want to share that particular experience. In collecting oral narratives it is important that the woman's story is recorded and that the researcher not influence the telling of that story by depending on other women's perceptions of her experiences. This situation is perhaps best illustrated an oral narrative I collected in El-Hamma.

Nabila had been referred to me by numerous women in the community as someone that I "had" to speak with. She had given birth to four children and although both she and her husband have dark complexions and black hair, their youngest child, Zouhair, had been born blond and blue-eyed. Women in the community explained that Nabila had chosen to have her last child at home because she was afraid that the doctors at the hospital would steal her "beautiful baby." When I finally met Nabila, she enthusiastically agreed to participate in the project. However, when relating her birthing experiences, she focused not on the birth of Zouhair but on the birth of her second child whom she had delivered alone in a goat barn. Subsequently, she suffered a series of second trimester miscarriages resulting in many visits to the local public hospital. Because she already had two living children many of the staff were

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[37] This last reason for recruitment was particularly true with the university students because of the bi-directionality component of the survey.

unsympathetic to her desire to have more children and were often rude to her. The hostility was so great that even though her unassisted home delivery had been traumatic, Nabila chose to deliver her subsequent children at home, with the assistance of a traditional birth attendant. Although she spoke extensively about her fear of hospitals and being mistreated, she never expressed fear of having a child stolen. Several of the women who had referred me to her were present during the interview and prodded her to speak about her beautiful baby. Her response was simply, "How could I know what he would look like before he was born?" This anecdote simply emphasizes the importance of allowing the participant to direct the course and focus of the narrative.[38]

Throughout the oral history project women often discussed other people's experiences when sharing their own stories. The influence of the perceived experience is often important, regardless of the "truth" of the experience itself.[39] However, I have tried to independently confirm the stories involving third parties through talking to the person(s) involved, discussing particular cases with local health service professionals to ascertain if there is a record of the described event, and/or through triangulation of the details of the story. These latter approaches were particularly important when the experience described involved the death of a third person. Throughout the dissertation I refer to third party experiences as they relate to the behavior of the participant, if they have been verified, and/or if the participant has first hand knowledge of the event, which I cite accordingly.

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[38] November 16, 1998.

[39] A number of women spoke about how they refused to use an IUD because it had caused a neighbor or relative pain, discomfort, or to become infertile. This had an impact on these women's behavior, regardless of the 'truth' of the story.

Without question, oral narratives are subjective, selective, related in a specific social, political, and cultural context, and influenced by the audience/researcher.[40] Indeed, this can be said of almost any type of interview or social science research. However, as K. van Nieuwkerk and others have noted, one must distinguish between life as lived, life as experienced, and life as told.[41] When engaging in an oral history project, one can only represent lives as told. However, it is important to consider that when collecting oral narratives the "truth" of the experience is secondary to how one remembers and relates the experience, which is an inherently subjective process.[42] As anthropologist C. Davies argued, "When interviewing individuals about their life histories, it is important to bear in mind that what is being collected are remembered lives. Obviously there will be great individual variation in what is remembered, why certain things are remembered and how the memories are presented."[43] Though I have conducted extensive research outside of the oral history project, research that provides a larger context in which to view individual stories, I have not attempted to verify the details or the "truth" of each woman's oral narrative in the sense of consulting medical records or conferring with health service providers.[44] As K. van Nieuwkerk writes, "The narrative becomes more reliable by cross-checking and comparison but the life history method cannot be used to give a truthful account of real lives…This would assume that there exists objective knowledge of someone

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[40] These factors may both consciously and sub-consciously influence the telling of the narrative. As an example, a participant may consciously decide to omit certain experiences or she may simply not remember particular experiences at the time of the collection. In both cases the narrative is selective but only in the first case is it intentionally so.

[41] van Nieuwkerk, K. (1999).

[42] This is not in any way meant to suggest that these narratives or the experiences related in them are not "true". However, they are constructed by the individual participant, at a particular moment, for a particular audience.

[43] Davies, C. (1999), pg. 169.

[44] Indeed, I have consulted individual women's medical records, but only when asked to do so by the woman to either explain the content of the records or act as her health advocate.

else's social life."[45] Indeed, to a large degree this oral history project involves women's perceptions of their experiences, which are, of course, impossible to verify.

Creating an oral history from an oral narrative presents a series of challenges for the researcher. In recounting their lives, few women speak of events in chronological order, most skip from event to event and then "backtrack", and while some women speak with coherent structure, others let their consciousnesses stream. Women speak in different styles and express different degrees of emotion, they speak in different languages as well as different language levels, and they reflect different degrees of articulateness. Capturing this diversity presents a challenge in the translation and presentation process in that the researcher wants to at once reflect these differences but also allow for a structured and flowing oral history. In an attempt to reconcile the realities of oral narratives with the requirements for academic writing, I have chosen to present oral histories in italicized script. The italicization indicates that this is a presentation/representation of the oral narrative, not the woman's words exactly as they were uttered.[46] Throughout this process I have tried be true to language level and speech style but I have often chronologized the oral history by changing the order in which the events were related. Finally, given the length of the narratives and the arguments of the dissertation, I often present only excerpts from the oral narratives. This necessarily emphasizes certain experiences in the woman's life, experiences that she would perhaps not emphasize herself.

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[45] van Nieuwkerk, K. (1999), pg. 3.

[46] Obtaining direct quotes from oral histories can sometimes be very difficult. A woman may describe in detail the births of each of her four children but never explicitly state that she has four children, three boys and a girl. Direct quotes are indicated throughout the dissertation in the conventional format.

However, all of the events described were related in the oral narratives and are therefore, at least to some degree, important to the participants.[47]

There is a great deal of debate as to whether oral narratives are in fact participatory and empowering. For some women, the opportunity to disclose an event or experience to an "impartial" listener outside of their social network can be valuable and empowering. By way of example, in October 1999 I met Saida at her office in Tunis to collect her oral narrative. Although Saida's office was covered with pictures of her son and daughter, she appeared extremely reluctant to talk about them. During our conversation, Saida asked me about my own family and I explained that I have two foster brothers. At this, Saida began sobbing and disclosed that both of her children were adopted. Saida has only shared this secret with her immediate family and she lives in constant fear of discovery. Subsequently, Saida told me that she had volunteered to participate in the oral history project precisely because she had wanted to talk to someone about her experience; she needed to get it off her chest.[48]

Although relating an oral history may be empowering and even cathartic for some women, it is still an extractive research technique that benefits the researcher much more than the participant. As N. Naples wrote,

> [T]he research process always invites questions of power and control. No matter what kinds of participatory processes we employ in our work, the researcher still retains control over the decisions regarding who benefits from the research, who controls the dissemination of information, and who determines the particular processes chosen for the research. The more self-

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[47] It can be very difficult to evaluate what is "most important" or "emphasized" in the oral narrative. For example, is length of time spent discussing an event a good indicator of importance? Many women will recall in more detail recent events (the birth of the most recent child for example) and more detail often translates into more time. But does this necessarily mean that the event is more important or only that the event is more recent and therefore the details are more fresh? Indeed, perhaps recalling an event that occurred thirty years earlier, even if only briefly, is a better reflection of the importance the event had on the woman's life.

[48] October 9, 1999.

> reflective we are about the social structure of the research and our own position within that structure, the less we will fall prey to the false belief that we can be objective in our search.[49]

Cognizant of this dynamic, I did try to create an empowering environment for the women who chose to participate, to offer a space for women to express themselves, ask questions, and generate ideas for community action. The asymmetries between the researcher and the participant can never be entirely overcome, but I attempted to create egalitarian relationships built on respect and compassion. And I attempted to respond to women's immediate needs and concerns. I took these opportunities to answer basic health information questions, correct misinformation, and provide first aid materials. I encouraged women to seek appropriate medical treatment for ailments described in the narrative. I validated women's experiences and shared my insights on ways of responding to particular health care and social issues. I personally assisted and accompanied women, when asked to do so, in seeking either health or social services. I provided women with basic information about their legal rights and put women in contact with appropriate agencies, particularly in the cases of domestic abuse. In general, I did not pay informants, but I did attempt to contribute to their lives and health, if only in small ways.[50]

Community Residence

Health is a component of women's everyday lives and it is constant topic of conversation among Tunisian women. While living in Tunisia for over a year, I

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[49] Naples, N. (1996), pp. 147-148.

[50] Though I did not generally pay participants, I often offered small gifts (honey, scarves, meat etc.) at the end of the oral narrative collection. I also took photos of many women and their children, which I framed and sent to them. However, on a small number of occasions I did offer extremely poor women a small amount of money. On only one occasion was I asked for money by a prospective participant before the collection, and on this occasion I gave the woman a little money but did not collect her oral narrative.

participated in women's daily activities, celebrations, and hardships. I stayed with families in El-Hamma, Matmata, Médenine, Sidi Bouzid, Siliana, Tataouine and Tunis and from visiting circles to day trips, childbirths to weddings, hospital visits to circumcisions (male), exam periods to movies and discos, my interactions with people and my participation in everyday life constituted a part of my research. In the course of everyday interactions, I had the opportunity to casually speak with countless women about myriad issues, including health, well-being, and relationships. Although some issues about women's health are particularly sensitive, to either individual women or the larger community, many areas of women's health are discussed frequently and publicly. For example, several weeks into my fieldwork I was waiting to photocopy a document and began chatting with a woman in front of me in the photocopying line. When I explained that I was doing research on women's health in Tunisia, the woman began speaking about her health history. I learned that she had intended to have only two children and had an IUD inserted 40 days after her second child was born. However, the IUD caused her discomfort and upon its removal, she became pregnant with her third child. Now in the sixth month of her pregnancy, she was already considering which form of birth control she would next use, and although she did not want to have additional children, she was uncomfortable getting a tubal ligation because it seemed too permanent and conflicted with her religious beliefs. Our conversation was interrupted when she reached the front of the line.[51] These experiences, too many to enumerate and difficult to chronicle, contributed to my perception and understanding of women's experiences.

Throughout my time in Tunisia, I have grown personally close to numerous women and I have learned from them and shared in their experiences. Although all of

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[51] June 1998.

these experiences have invariably shaped my research and work, I have chosen not to relate the specific stories of friends if those experiences were related in confidence as a friend rather than in confidence as a researcher. However, the distinction between friend and researcher is often extremely blurry and poses a number of ethical dilemmas. For example, after living in Tunisia for over a year, I had grown extremely close to a woman named Rouqia. Rouqia and I talked frequently about our work, families, and lives and though she had been instrumental in introducing me to women who participated in the oral history project, I had never asked Rouqia to participate directly in the project. Indeed, throughout the fieldwork period, I was hesitant to ask close friends to participate in the oral history project or become directly involved in other aspects of my research; I was afraid friends might feel obligated to participate and I had not wanted to "abuse" our friendship or place my friends in awkward positions. One evening over coffee, her voice shaking, Rouqia quietly asked, "Why have you not asked me to participate? I have so much to say and I want to share this with you, are my experiences not interesting enough?" I was devastated: in my attempt to separate friend from participant, I had inadvertently hurt my friend's feelings. The next night I began collecting Rouqia's oral narrative, which she related to me nearly every evening for two weeks.[52]

The distinction between friend and researcher becomes even more complicated when the research involves sharing experiences that are often deeply personal. Indeed, after listening to a particularly intimate narrative, I was often accepted as a friend. By confiding in me, I had become a part of these women's lives. And although I too felt very close to many women after hearing their stories, this is distinct from friendship. The researcher-participant relationship contains power

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[52] October 1999.

inequities that make adhering to the social and cultural conventions of friendship difficult. This posed one of the most complicated ethical dilemmas I faced: how much about myself can or should I relate to participants? In asking women to share their experiences with me, I was in effect asking for their honesty and their confidence. I attempted to create a space where women would feel comfortable asking any and all questions. But I was not always able to be honest about my background, opinions, and relationship history, as relating certain kinds of personal information might be offensive, cause me to lose credibility, or influence the participants' behavior and reactions.[53] This was a negotiation, a compromise between honesty and privacy, and an intermediate between researcher and friend.

QUANTITATIVE RESEARCH

Surveying University Students

Having reviewed the more qualitative aspects of the fieldwork, this chapter will now turn to the most quantitative component of the research, specifically a knowledge, attitudes, and behaviors (KAB) survey conducted with never-married female university students living in Greater Tunis. In the course of interviewing a number of health service professionals and Ministry of Public Health representatives, it became clear that there was both interest in and a need for a better understanding of young women's health issues in Tunisia. Given my background in peer health education I proposed conducting a survey with female university students, a suggestion met with enthusiasm from health services providers. I then embarked on

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[53] As an example, several male friends visited me during my time in Tunisia. During their visits they stayed at my apartment and traveled with me around the country. As I was an engaged woman, many Tunisian women would find these relationships to be inappropriate; women in Tunisia do not often have platonic (male) friends. Thus, I often introduced my male friends as family members (cousins, brothers), which made my behavior and these relationships more socially acceptable.

the long process of creating the survey while in the field. In response to the support I received from the Ministry of Public Health, I agreed to provide the MOPH with a separate report of the findings of the survey including policy recommendations.[54]

Survey Design

In order to explore issues involving young women's health and sexuality it was determined that a knowledge, attitudes, and behaviors survey would be the most appropriate technique. To personalize the survey process, allow for follow-up probative questions, and create a bi-directional project (see below) it was decided that the survey would consist of an interview with open-ended or free-response questions. The survey was designed to be completed in 45 minutes, though many of the individual respondents spoke for hours. The survey was confidential and was conducted in dorm rooms, common rooms, the grounds outside of university building, and my apartment. The location of the survey interview was the choice of the student. Students were also able to determine who else was present during the interview.[55]

The survey was first written in English and piloted with fourth year university students studying English. The questionnaire was reformed in response to the pilot and translated into both French and Tunisian Arabic. The survey was then re-piloted with a number of students in subjects other than English. The French and Arabic forms of the survey were also shown to several health service professionals and their

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[54] For the Ministry of Public Health, the project is more comprehensive. The survey is currently being extended to never-married non-university educated women in Tunis and six other governorates. The analysis of this project will be completed by December 2001.

[55] While some students preferred to be interviewed individually and others with their close girlfriends present, men were always excluded from the interview. If men approached us during the interview, as sometimes happened in public areas outside of university departments, the interview was suspended.

feedback was incorporated into the final version of the survey.[56] This was a collaborative process and involved feedback from more than 20 people before the survey was launched. The initial pilots and the first survey interviews were recorded on tape. From these taped interviews it was possible to create a data collection sheet and by October 1999 all of the surveys were recorded on paper. [57]

The survey itself consists of a questionnaire, divided into several sections with different questioning techniques, addressing a number of young women's health issues.[58] The survey begins (Part A) with direct questions to gather demographic/biographic information about the student. Part B of the survey asks a series of questions about the students' desired future family structure. This section of the survey requires that students respond to short answer questions and then elaborate on the reason(s) for those responses. This section is the least "sensitive" section of the survey (aside from the demographic data component) and was placed first so as to ease the participant into responding to questions, to establish a rapport with the student, and to gain a certain degree of trust.[59]

Part C of the survey contains a series of questions designed to assess the knowledge levels of students on four different health issues, although not all of the issues covered in the survey are included in the dissertation.[60] These four issues were determined for both my research needs and in order to respond to the needs of the

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[56] Indeed, the HSPs suggested one of the most controversial subjects covered on the survey, out-of-wedlock pregnancy.

[57] As I was the only interviewer, for both the pilots and the sample, I was able to develop a consistent system of note-taking/field coding, thereby mitigating the impact of interviewer bias.

[58] The English version of the questionnaire (standardized interview questions) is included in Appendix II.

[59] A number of students seemed doubtful that my survey was actually on women's health and not on a highly controversial issue such as politics. However, after a few questions about desired future family structure students realized that my survey was exactly what I had explained it to be. For those students who initially appeared a bit tense, this section was instrumental in establishing a comfortable environment and gaining their trust.

[60] The four topics were HIV/AIDS, contraception, breast cancer, and domestic violence.

MOPH. These questions are straightforward and the majority have correct, partially correct, and incorrect answers.[61] I made a conscious effort to respond to correct and incorrect responses in exactly the same way so as not to influence student responses.

Part D of the survey presents the students with five different hypothetical situations, asks for an initial response and then asks a short series of follow-up questions. These situations were chosen with care to reflect situations that students might encounter. As a testimony to the relevance of the presented situations, in almost every interview the student responded at least once with "that happened to me/my friend/my aunt, etc." This questioning technique was chosen in order to discuss more sensitive issues (pre-marital intercourse, dating violence, and out-of-wedlock pregnancy) with the students.[62] This part of the survey also explores students' perceptions of both the expected and the actual behaviors of others. By asking questions about hypothetical situations respondents were able to respond without disclosing personal experiences. However, many students chose to disclose their own experiences or discuss how they had responded to a family member or friend in these situations. Detailed notes on these responses were taken.

The survey concludes (Part E) with a series of open-ended general questions about the health system and the health services available to young Tunisian women. The final question, perhaps the most important and revealing question of the survey, asks the student if she has any questions.

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[61] Several of the seventeen questions in this section call for students to express an opinion and thus these questions do not have a "correct" answer.

[62] This is not to suggest that these questions were sensitive to all of the participants. Indeed, many students found this part of the survey to be the most interesting and enjoyable.

Recruitment

Students were recruited for the survey through a variety of channels. Formal recruitment took place in the Fattouma Bourguiba Dormitory, Tunis (flyers, sign-up sheets) and through third year English classes at La Faculté des Lettres de Manouba (announcement in the classes). Snowball sampling widened the pool of students to include students at various faculties in Manouba, 9 Avril, La Conservatoire, l'Institut de Travail, IPSI, and their respective dormitories.[63]

Formal recruiting proved very useful in completing the pilot and the initial surveys and establishing initial student contacts. This principally took place at the Fattouma Bourguiba dormitory. However, bureaucratic obstacles prevented me from continuing to formally recruit participants in this dorm.[64] In October 1999, I returned to Tunisia to dedicate the better part of a month to the survey.[65] An American researcher/professor at the la Faculté de Manouba invited me to her four third year English classes to announce my project and recruit volunteers. A number of students volunteered to participate both out of interest in the survey and out of a desire to practice their English. Thus there is a bias in the survey in that English majors constitute a larger percentage of respondents than in the university student population as a whole.

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[63] The full names for these faculties are: La Faculté des Lettres et des Sciences Humaines de 9 Avril (9 Avril), l'Institut Superior de Musique (La Conservatoire), and l'Institut de Presse et des Sciences d'Information (IPSI).

[64] In spite of my official research permit from the Ministry of Higher Education and the support I had received from the Ministry of Public Health, the director of the residence hall continuously interfered with my ability to work in the dorm. Even after I had met with her on five separate occasions (each time with new letters and documents in hand) she continued to arbitrarily change rules (such as when I could enter the residence hall). Even though I had received significant student support for the project (more than fifty requests to participate), and although I was able to conduct both the pilot and a small number of initial interviews in the dorm (by sneaking into the dorm in the evenings), working in the dormitory ultimately became so difficult that I suspended my work there.

[65] October was chosen because, as it is in the very beginning of the school year, students do not have exams and generally have more free time.

However, snowball sampling constituted the primary route of recruitment for the survey. Once I had established contacts with students at Manouba I was able to gain access to the dormitories and conduct surveys with other students, the vast majority of whom were non-English majors. Further, throughout my fieldwork I had established relationships with students at La Faculté de 9 Avril, La Conservatoire, and l'Institut de Travail and these students were instrumental in introducing me to participants, both through entrance into their dorms and their faculties. Indeed, given the bi-directional aspect of the survey, many students brought their friends to me stating that this friend "had to do the survey" in order to provide them with the opportunity to ask questions to a health educator. Thus, even though there is a bias in the recruitment process, this sample represents a diverse population of students, as is explained in the following section.

Presentation of Basic Data

Although more than 100 students were surveyed in the course of this project the results of a sample of 75 will be presented in this dissertation.[66] At this time this chapter turns to a presentation of the basic demographic information of this sample (corresponding to the questions in Part A). The basic data indicates that the sample population reflects a great deal of the diversity represented in the university student population. Students from all regions of the country participated in this project with 27% hailing from Greater Tunis, 23% from the Northeast, 16% from Central governorates, 12% from the Sahel/Sfax, 12% from the Northwestern regions, and nearly 11% from the South. The majority of students (65%) lived in dorms at the

[66] Pilots, incomplete surveys, and "corrupted" surveys (i.e. respondents that were influenced by other participants) were eliminated for an ultimate sample of 75.

time of the survey while almost all of the remaining students lived with their families. Students ranged in age from 18 to 28 with a median age of 22. Only one student was an only child and while more that 50% of the surveyed students had three or fewer siblings, nearly one fourth had more than six siblings. Students from all years in the university participated, with 36% of their sample in their first year, 27% in their second year, 25% in their third year, and 11% in their forth year.[67] As was previously noted, because of the recruiting process and because of the way that the university system is divided by campuses, the vast majority of students were majoring in the humanities (79%). However, 13% were in the social sciences.[68] Finally, as was previously noted, a large percentage of the sample population (35%) chose to use the English version of the survey. Approximately 50% of the students were interviewed in French and nearly 15% of the students used the Arabic version of the survey. While the choice of language was left to the student, students who appeared to be having difficulty responding in a particular language were encouraged to use the Arabic version. Though many students used multiple languages throughout the interview, the recorded language was the language in which the majority of questions were asked.[69]

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[67] The year recorded is the year in which students are currently in, regardless of how many times they may have repeated that year.

[68] Natural and technical science students are not represented in this survey (one student). Although medical students and biology students were specifically excluded from participation, the absence of other natural and technical science majors is a result of the division of the faculties. In most cases, technical and natural science students are not on the same campuses as humanities and social science students. As I had access to the social science and humanities campuses and dorms I had little contact with students in the natural and technical sciences.

[69] For example, a number of students chose to participate in French but during the interview indicated that they did not understand a number of questions. The questions were then repeated in Arabic. However, in this situation, the language used in the survey was recorded as French because the majority of questions were asked in that language.

Constructing a Bi-directional Survey: Action-Oriented Research

> [Participatory Research] approaches have several advantages over the conventional survey research methodology. PR can help identify local community needs, people's perception of the health services and reasons for non-use of current programmes; it can also provide direction for improvement of the programmes, as well as help ensure participation at all stages of their implementation, thus empowering the community.[70]

This project was designed to be participatory and to benefit and empower the student participants. To this end, the survey was created as a bi-directional survey in that information would not only be extracted from the student but also extracted by the student. At the conclusion of the formal interview, misinformation expressed by the student was corrected and explained. These corrections focused on the knowledge assessment section, but also involved the follow-up questions to the hypothetical situations. Explanations were accompanied with diagrams, pictures, pamphlets and books. Students were also given information about organizations and services available in Tunis.

However, the most important component of the survey was the question and answer session at the end of the structured interview. Participants were encouraged to ask any and all questions they had about health issues. Indeed, correcting students' misinformation was often a springboard for open discussions and personal questions. This proved to be both revealing and informative. Questions about pregnancy and abortion, heterosexual intercourse and other sexual practices, menstruation and puberty, the hymen and its "reparation", STDs and available health services are just some of the most frequently occurring themes. The majority of students took advantage of this opportunity and often invited friends and dorm-mates to join in the

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[70] Mavalankar, D., Satia, J. & B. Sharma (1996), pg. 216.

discussions. While invited friends and colleagues were encouraged to ask questions and participate in the discussions, they were eliminated from participation in the survey, though some of these students were invited to participate in the oral history project.[71] Thus, in the process of the completing the survey I worked with over 300 students, many more than the number of survey respondents. At times these informal sessions spanned over several days. Indeed, while the survey interview was designed to be completed in 45 minutes, the average time spent with each participant was more than two hours and several of the sessions took more than 12 hours to complete.

In addition to the discussions held with students after the interview, focus groups were held with a number of students to more fully explore young women's health issues. These focus groups assembled four to eight women who knew and were comfortable with each other (often roommates). During these focus groups students exchanged ideas, opinions, and information on young women's health issues. In particular, students focused on ways the health system and services could be improved to better meet young women's health needs.[72] In these sessions information was provided on a variety of different health issues such that students would then be able to disseminate this information to other students.[73]

From these focus groups and informal discussions I prepared a separate report for the university students. The report is in French and provides a brief summary of the results of the survey as well as the correct answers to the knowledge assessment

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[71] These informal educational sessions included a great deal of information about issues covered in the survey. Thus while all students were encouraged to ask questions and participate in these sessions I felt that participating in the formal interview (survey) afterward would bias the survey results.

[72] The issues and suggestions that emerged in these focus groups will be included as part of the report given to the MOPH.

[73] Because of time and logistical constraints, it was not possible to implement a full peer health educator training program as I had originally intended. However, these sessions served as "mini-trainings" where basic information was explained in detail so that these students could help correct misinformation held by other students.

questions. However, the report also relates the answers to the most commonly asked questions or misunderstood aspects of health and sexuality, and includes diagrams and pictures. Copies of the report were sent to a number of students with the hope that it would then be distributed to others.[74]

There are trade-offs in conducting a bi-directional survey. As most of the participants had never had the opportunity to ask an informed person these types of questions, many of the sessions were extremely long. From a participatory standpoint this is a testimony to the success of the project. However, from the standpoint of a quantitative researcher this approach necessarily reduces the sample size. Further, given the social nature of dorm and university life, groups would assemble during both the structured interview and the question and answer sessions. Indeed, to explain material covered in the survey to a group of ten young women, only one of who had participated in the formal interview, meant that the other nine women would never be able to participate in the survey, resulting in more recruiting and a smaller sample. However, designing a participatory project aimed at arming students with better information about their health and sexuality was well worth this trade-off.

The detailed presentation of the research conducted for this dissertation shows that this project moves beyond the qualitative-quantitative dichotomy prevalent in the literature. Indeed, components of this project that have been traditionally defined as "qualitative", also serve as representative samples. The "quantitative" survey was constructed to integrate qualitative and subjective elements into the numerical data collection process. Thus, this fieldwork effort strives to overcome a pervasive and

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[74] Confidentiality was an important part of this project and thus names and contact information was not recorded. Consequently, the report cannot be sent to all of the participants. However, more than 30 of the participants volunteered their contact information after the survey. It is to these students that the report was sent.

somewhat artificial methodological division, and combines the strengths and contributions of both methodological approaches.

SITUATING THE RESEARCHER IN THE RESEARCH

> Reflexivity, broadly defined, means a turning back on oneself, a process of self-reference. In the context of social research, reflexivity at its most immediately obvious level refers to the ways in which the products of research are affected by the personnel and process of doing research. These effects are to be found in all phases of the research process from initial selection of topic to final reporting of results.[75]

Conducting fieldwork is an inherently subjective and transformative process. From the initial choice of subject to the manner in which the fieldwork is approached, from the assumptions underlining the project to the ability of the researcher to participate in community life, from the way in which the researcher is perceived by participants to the interpretation and presentation of the information gathered, the identity of the researcher influences every aspect of the research.[76] But identities are fluid, complex, and interpreted. Educational level, gender, sexual orientation, marital and childbearing status, age, socio-economic level, nationality, race and ethnicity, religion, and health status are but a few of the factors that define who we are, to ourselves and to others. The multi-faceted components of our identities may facilitate our relationships with others or they may create seemingly insurmountable divisions. And often, it is impossible to make an evaluation of how our identities affect our experiences, relationships, and perspectives: to what do we make the comparison?

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[75] Davies, C. (1999), pg. 4.

[76] In recent years, there has been increased discussion about the need for self-reference and reflection. A number of scholars have written on their personal experiences and the importance of explicitly exploring the relationship between the researcher and various components of the research. For further discussion, see Altorki, S. & C. El-Solh (Eds.) (1988), Caplan, P. (1988), Davies, C. (1999), Inhorn, M. (1994), Renzetti, C. & R. Lee (Eds.) (1993), Smith, C. & W. Kornblum (Eds.) (1996), Watson, C. (Ed.) (1999) & Wolf, D. (Ed.) (1996).

The academic and the personal are intertwined and inseparable. Formative experiences in the United States, Britain, and the Middle East, as a feminist-scholar, an activist, a development worker, and as a health educator, shaped my approach to this project. My decision to focus on domestic violence, young women's health and sexuality, and on empowerment and decision-making derived from my previous research and work experiences with international organizations, NGOs, academic institutions, and women's organizations. The decision to employ both qualitative and quantitative research methods was influenced by my own straddling of the disciplinary fence.

Reflections on the origins of the project are relatively straightforward. It is much more challenging to reflect on how my background affected my relationships with the women and men that I worked with. In professional and activist circles, my background in international development work in the Middle East, my status as a soon-to-be-matriculated medical student at Harvard, and my previous work as an activist, contributed to my legitimacy and credibility. To sit with a group of women from the ATFD and exchange experiences about working in the field of domestic violence, to share experiences in peer health education programming with a group of researchers at the IPPF, and to converse with a doctor about the differences between the medical education system in the United States and Tunisia opened avenues for collaboration and facilitated communication.

Being a relatively young, white, educated, American woman lacking complete fluency in Arabic undoubtedly erected some barriers between myself and the communities in which I lived and worked. Yet, many of these barriers can be overcome and some are even advantageous. For example, many of the differences between me and the traditional birth attendants with whom I worked fundamentally

influenced our perspectives, experiences, and values. However, our shared commitment to women's health transcended many of these differences. Indeed, that I, a young American woman, would take the time to learn from them, listen to them without condemnation, speak to them in (imperfect) Tunisian dialect, and show interest and respect, was both exciting and perplexing and perhaps compensated for some of my strangeness and difference.

But differences also have their advantages. Many, if not most, of the women who participated in the oral history project had never before met an American. Their curiosity about me and my background often fostered warm receptions and openness. As a foreigner, outside of Tunisian social and medical circles, many women had greater confidence that their stories and experiences would not be shared with their families and communities, a factor which contributed, perhaps, to greater openness. Indeed, as a foreigner trained in health education I was often perceived as having experience with issues of health and sexuality from both a personal and a professional perspective. For students and for participants in the oral history project this often created a space in which they felt comfortable asking intimate, personal questions. For students and young women, I was often perceived as a peer and a friend and my age was most certainly an important factor in establishing an open and comfortable rapport. Finally, as a foreigner, I was perhaps able to overcome some of the educational and socio-economic barriers prevalent within Tunisian society.

Thus, it is evident that the relationship between the researcher and the research is complex. Some elements of my background and experiences resonated with groups of people, as well as with individuals. Other elements created challenges that needed to be identified and overcome. Throughout my fieldwork period, I was conscious of the inequalities in power and the socio-cultural differences that existed between

myself and the participants and I worked diligently to minimize and break down these barriers. Indeed, one of the most rewarding aspects of the research was connecting with women and overcoming these differences.

Figure 2.1: Map of Tunisia, Fieldwork Sites[77]



Key

X Semi-Structured Interviews with Health Service Professionals and Organization Representatives

• Oral History Project

■ In-depth Interviews with Traditional Birth Attendants

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[77] In this map, the transliterations of the names of Tunisian governorates differ from those used throughout the dissertation. Further, it should be noted that interviews with health service professionals, interviews with organization representatives, and the oral history project were conducted throughout Greater Tunis (the governorates of Ben Arrous, Tunis, and Ariana).

CHAPTER 3: THE HISTORY & EVOLUTION OF THE NATIONAL WOMEN'S HEALTH PROGRAM
PHILOSOPHIES, PRIORITIES & DECISION-MAKING

INTRODUCTION

The national women's health program in Tunisia has a rich and complex history. Overcoming many of the limitations imposed during the colonial period, the women's health program has achieved considerable success in providing universal primary care and improving health indicators. After briefly examining the status of women's health in the pre-independence era, this chapter argues that there are three primary periods in the evolution of the women's health program: independence in 1956 to the end of the 1970s, the early 1980s to 1990, and the 1990s. Through an examination of primary and secondary sources, interviews with health service providers and government representatives, and the health histories of individual women, this chapter bases the periodization on shifts in the philosophy, approach, and implementation of the national program. Initiated in the wake of independence, the first period in the development of the women's health program centered on the expansion of health infrastructure and personnel and the establishment of the national family planning program. Largely founded on demographic and development objectives, this period was characterized by hierarchal and centralized decision-making, regional disparities and poor service quality. However, in the early 1980s the health program began to devolve authority to health service providers and local communities. This second period in the women's health program resulted in an expanded definition of women's health and better service integration. Finally, the chapter contends that through the creation of a national perinatality program, the most recent period in the women's health program promotes the standardization of services,

primary health service integration, and the elimination of regional disparities. However, this chapter concludes by positing that the re-centralization in decision-making and the retreat in local community participation may limit the potential of the national women's health program.

HEALTH SERVICES UNDER COLONIAL RULE

The French occupation of Tunisia in 1881 followed nearly a century of growing French influence and power in the region.[1] In contrast to other North African countries, French colonial rule in Tunisia was instrumental and characterized by Tunisian sociologist E. Hermassi as "a form of domination that is…exclusively economic but does not hesitate, when necessary, to intervene in other levels of the social structure."[2] French colonial rule was executed through a growing network of French civil bureaucrats who were able to overcome initial Tunisian resistance to the occupation and reinforced the existing centralized Tunisian administration, ultimately working in conjunction with Tunisian elites.[3] Although immediate resistance to colonial rule took place, political nationalist mobilization became prominent with the creation of the Destour party in 1920 and represented the first phase of a sustained nationalist movement.

Prior to the formalization of Tunisia's Protectorate status, French health policy toward the country had revolved around the twin goals of limiting the spread of infectious diseases and protecting the interests of Europeans living in Tunisia.[4] As trade between Tunisia and Europe increased, French interests in influencing health

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[1] Although France formally occupied Tunisia in 1881, Protectorate status was imposed in 1883.
[2] Hermassi, E. (1972), pg. 57.
[3] Hermassi, E. (1972), pp. 63-67.
[4] For a more thorough discussion of the impact of Europe on 19th century Tunisian medicine, see Gallagher, N. (1983).

policy intensified. Issues of health and medicine were used as a justification for increased European authority and ultimate colonization. Consequently, throughout the second half of the 19th century Muslim health service providers, including doctors and pharmacists, became increasingly regulated by Europeans. A few years after the establishment of the Protectorate, the decree of June 15, 1888 formally curtailed the work of indigenous practitioners by regulating medicine, surgery, and obstetrics. This decree required that all persons who had practiced medicine in Tunisia for five years or less prove completion of at least three years of medical school, a requirement that indigenous practitioners were unable to meet.[5] Indigenous practitioners who had received authorization from a bey and were at least sixty years of age or those who practiced in towns void of licensed practitioners were allowed to continue to practice but prohibited from performing surgery.[6] Although indigenous practitioners, including doctors, pharmacists, herbalists, and traditional birth attendants continued to provide health services for the majority of the population, the prohibition shaped health institutions throughout the country. As historian N. Gallagher wrote,

> There was now a dichotomy along ethnic lines: legal, European medicine, supported by the French colonial government; and semi-legal, Arabic medicine, utilized by most of the populace. At the time there were no European-trained Tunisian doctors and perhaps twenty European doctors, nearly all residing in Tunis. European medicine had become a first-class system associated with the wealthy ruling elite. Arabic medicine had become a second class-system patronized mostly by those outside the privileged sector.[7]

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[5] By 1914, there were only four European-trained Tunisian physicians in Tunisia. Zitouna, M. (1994), pg. 129.
[6] Gallagher, N. (1983), pg. 93. The term bey is an Ottoman military title that denoted "ruler" in Tunisia.
[7] Gallagher, N. (1983), pg. 100.

In addition to a bias toward European trained physicians, the colonial period also intensified regional disparities within the country. The colonial population in Tunisia was disproportionately located in Tunis. Research indicates that nearly 30,000 Europeans resided in Tunis in 1898, constituting over 18% of the population of the capital.[8] By 1921, the European population had increased to more than 150,000, the majority of whom were concentrated in the capital.[9] Thus, it is unsurprising that the colonial administration invested in health facilities in the capital, a network that included hospitals, research institutes, and a center for ophthalmology. Throughout this period of Tunisian history health infrastructure increased dramatically, yet by 1950, 78% of the available 4,000 hospital beds were located in Tunis.[10] Despite investments in health infrastructure, Muslims were often prohibited from using European health facilities or were allocated only a small number of beds.[11] In health facilities designated to serve the majority Muslim population, the staff, equipment, and services were often inadequate. Thus, throughout the colonial period, the health services available to the Tunisian population were limited because of a lack of service providers, regional disparities, and discriminatory policies.[12]

However, the colonial period also ushered in a new epoch in Tunisian medical research and scholarship, including the launching of several medical journals and training programs.[13] Further, a number of individual European physicians are credited for having taken an active interest and role in mentoring Tunisian physicians

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[8] However, as N. Gallagher notes, these population statistics should be looked at with caution. Gallagher, N. (1983), pg. 108.
[9] Hermassi, E. (1972), pg. 76.
[10] Daly, A. (1969a), pg. 12.
[11] Zitouna, M. & S. Haouet (1997), pg. 710. In fact, l'Hôpital Civil Français (the precursor to l'Hôpital Charles Nicolle) opened its doors in 1898 only to French patients. Zitouna, M. (1994), pg. 90.
[12] See, for example, the discussion of L'Hôpital de la Rabta which was established in 1897 in Zitouna, M. & S. Haouet (1998).
[13] These journals included several bulletins and, in 1903, the precursor to *La Tunisie Médicale*.

and encouraging bright students to pursue a career in medicine.[14] Programs to encourage the indigenization of medical and paramedical staff included the first school of nursing which was created in 1924 and offered training to both French and Muslim women, an institute of higher education established in Tunis in 1945 to academically prepare future medical students, and the first school of midwifery created in 1946 to train women in the area of obstetrics as well as in the fields of nutrition and pre-natal care.

Toward the end of French colonial rule, as the population of Tunisian physicians steadily increased, a growing number of Tunisian physicians and administrators gained posts and a limited degree of decision-making within the health system. In the ten years prior to independence, Tunisian administrators even gained limited autonomous control over public health.[15] The reorganization of the Ministry of Public Health (MOPH) in 1945 formalized the public health sector in colonial Tunisia. However, the MOPH focused its work almost exclusively on urban and heavily colonized areas and on epidemics and infectious diseases such as measles and tuberculosis. Work on infant mortality and hygiene was negligible.[16] Thus, the Tunisian health system was significantly influenced and shaped by French colonial rule. As Dr. M. Zitouna summarized,

> The French policy during this period was based on the medicalization of the conquered country, so as to dazzle the natives and facilitate the installation of the army and the colonists. The French doctors, who were of a very high scientific level, came to set up shop in Tunisia, not behaving as colonizers but as true "missionaries." Their coexistence with other foreign doctors, notably Italians, permitted [Tunisia entering its] second golden medical age,

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[14] See, for example, the references to Drs. Burnet, Nicolle, and Durand in Kazdaghli, H, (1993) & Zitouna, M. (1994).
[15] Ammar, S. (1998), pp. 297-298.
[16] Daly, A. (1969a), pg. 12.

> culminating with the 1928 Nobel Prize in Medicine, awarded to Charles Nicolle for his work conducted at the Pasteur Institute in Tunis.[17]

The health system under colonial administration marginalized indigenous practitioners, discriminated against the Muslim population and justified continued colonial rule and simultaneously encouraged research, the professionalization of health service providers, and the development of health infrastructure.

Although the first half of the 20th century witnessed a significant amount of growth in hospitals and infrastructural development, advances in women's health care during the colonial period were more limited. Throughout the period of French colonial rule the vast majority of women received health services through uncertified health service providers, specifically traditional birth attendants and traditional pharmacists. This was true for women outside of the capital as well as in Tunis.[18] Despite the 1888 decree restricting the obstetric activities of uncertified practitioners, few alternatives existed for Tunisian women. Home delivery was nearly universal in part due to both the lack of maternity wards and the lack of female or Tunisian service providers. Indeed, the dearth of female health service providers continued throughout the colonial period: the first female Tunisian physician was registered in 1936, in 1946 there were 104 midwives (of all nationalities), and 1952 witnessed the registration of the first certified female pharmacist.[19] From 1919 to 1924 only 70 births were recorded in the maternity ward of l'Hôpital Sadiki, a hospital in Tunis reserved for the Muslim population.[20] Moreover, the maternal and neo-natal mortality

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[17] Zitouna, M. (1994), pg. 223.
[18] Bakalti, S. (1996) & Binous, J. (1992).
[19] Bakalti, S. (1996), pg. 258.
[20] Bakalti, S. (1996), pg. 260.

rates involving hospital births remained high. The 70 deliveries which took place in l'Hôpital Sadiki in 1939 resulted in only 35 living children and 16 maternal deaths.[21]

However, toward the end of colonial rule women's primary and tertiary health services expanded considerably. Throughout the colonial period there was a pervasive attitude among both European and Tunisian physicians that the practices of traditional birth attendants, particularly in rural areas, were "primitive".[22] Consequently, general interest existed to promote the medicalization of childbirth through the expansion of maternity services and by 1949, there were three hospitals in Tunis that housed maternity wards and collectively held 220 beds. These wards also provided limited pre-natal and nutritional services. Also in 1949, l'Institut de la Mère et de l'Enfant opened in Tunis, a facility that included a maternity ward, provided gynecological and pediatric consultations, and was affiliated with the pediatric nursing school.[23] Toward the end of the colonial period, the number of women giving birth in Tunis hospitals increased significantly and the maternal mortality rates improved; of the 1,166 women who delivered in the maternity ward of l'Hôpital Sadiki in 1946, only 24 died in the process.[24] However, despite some increase in the primary health services in regions outside of the capital, including dispensaries and maternal-child health centers, the majority of health services for women continued to be concentrated in Tunis.

The influence of French colonial policy went beyond health infrastructure, health service personnel, and maternal health services. As in other parts of its colonial empire, the colonial administration shaped Tunisian law after the French

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[21] Blili, L. (1988), pg. 179.
[22] Labidi, L. (1989), pg. 404.
[23] Bakalti, S. (1996), pg. 256.
[24] Balkati, S. (1996), pg. 260.

model with French interests as the primary consideration.[25] Consistent with this general trend, Tunisian laws regarding issues of contraception and abortion were influenced by colonial pro-natalist laws. In 1913, Article 214 of the Tunisian penal code criminalized abortion. Inspired by the Napoleonic Code of 1804, Article 214 stated that any person performing an abortion, either the woman herself or a third party, faced a five-year prison sentence.[26] Contraception was also banned. Based directly on the French law of July 31, 1920, a Tunisian decree in September 1920 imposed sanctions against anyone who promoted anti-conception treatments, substances, or instruments. This was followed by a decree in July 1923 that prohibited the importation of contraceptive instruments or devices.[27] Yet, in spite of these laws, Tunisian women continued to use both contraception and abortion, often jeopardizing their health in the process.[28] Tawhida Ben Cheikh, Tunisia's first female physician, worked in the private sector in Tunis after her return from Paris in 1936 and commented on the impact of the pro-natalist policy on Tunisian women's health. "The repression did not eliminate abortion, it only rendered it clandestine and a woman who wanted to terminate her pregnancy was forced to call on unqualified people…often operating in unfavorable conditions, the majority of time without either anesthesia or antiseptic. For women, the risks were great."[29] Thus, the French legacy for Tunisian women's health included the marginalization of traditional service providers, the medicalization of childbirth, the expansion of hospital-based maternal health services in the capital, and the prohibition of abortion and contraception.

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[25] Hermassi, E. (1972), pp. 80-83.
[26] Ben Romdhane, H. (1992), pg. 127.
[27] Balkati, S. (1996), pg. 261.
[28] Interview (Former Health Aide), Tunis: October 10, 1999.
[29] Ben Romdhane, H. (1992), pg. 128.

PERIOD I: THE DEVELOPMENT OF A NATIONAL WOMEN'S HEALTH PROGRAM

Although resistance to colonization was active throughout the period of occupation, the creation of the Neo-Destour party in 1934 was a turning point in Tunisia's struggle for independence from France.[30] Men and women participated in the nationalist movement from the earliest formal demonstrations in the 1930s to continued vocal demonstrations after World War II. At the helm of the party was Habib Bourguiba, a charismatic leader who called for Tunisian independence, but who also was willing to compromise with the French administration and agree to a gradualist transition.[31] On March 20, 1956, Tunisia gained independence.[32]

The newly independent government dedicated itself to modernization, centralization, and stability. Noting the paucity of natural resources in Tunisia, the government turned to the agricultural sector and human resource development as strategic priorities. Further, Bourguiba was committed to consolidating power and establishing dominant control and decision-making over the new state. Commenting on the early actions of President Bourguiba, L. Brand wrote,

> The architect of the Tunisian state embarked...upon a path of political and social engineering, a transformative project initiated from above that required a careful management of institutions to preempt opposition from below. Bourguiba put in place a vast, centralized state apparatus: a bureaucracy, a

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[30] The Neo-Destour party evolved from the Destour party and the evolution reflected a change in both direction and leadership. Although both the Destour and the Neo-Destour parties were nationalist constitutionalist parties, the Destour party had been largely comprised of traditional Tunisian elites from Tunis. Members of the Neo-Destour party originated from the Sahel and Djerba, as well as Tunis, and served as full-time politicians. For a more comprehensive discussion of the differences between the Destour and Neo-Destour parties, see Green, A. (1994) & Hermassi, E. (1972). The Neo-Destour party was renamed the Parti Socialiste Destourien (PSD) in 1964.

[31] Green, A. (1994), pg. 16.

[32] Although Tunisia gained independence in 1956, a French military presence persisted in both the south and Bizerte. Despite Tunisian objections, France expanded its naval facilities in Bizerte in 1961 and ultimately overpowered Tunisian military resistance to occupy much of the city. Tunisia challenged this occupation before the United Nations but the bases in Bizerte were not turned over to the Tunisian navy until 1963, after Algeria had successfully gained independence.

> single party, and satellite organizations that were subordinate to it…A primary instrument used to effect change was legislation.[33]

When Tunisia gained independence in 1956, the government embarked on a series of legal and institutional reforms to enhance the social and economic development of the state. Of particular concern to Bourguiba were those aspects of Tunisian culture and society that he viewed as inhibiting development and progress. Consequently, social institutions, and specifically women's emancipation, became key areas of reform in the early post-independence era.[34] Although Bourguiba saw the improvement of women's educational and economic status as integral to Tunisian development, Bourguiba also viewed women's emancipation as a strategy for undermining "regressive" values, leaders, and institutions, enhancing relations with prospective European allies and donors, and strengthening his own leadership.[35] On August 13, 1956 Bourguiba ushered in the Code du Statut Personnel (CSP), a personal status code which secularized civil law and granted women full legal majority with all subsequent rights and duties. The CSP significantly reformed marital law through the prohibition of polygamy, the elimination of repudiation, the requirement that both the bride and the groom consent to the union, and the establishment of a minimum age of marriage,18 years for men and 15 years for women.[36] As sociologist S. Galal noted,

> The Tunisian Personal Status Code of 1956, amended in 1964, 1966, and 1981, is the most progressive in the Arab world. Divorce can only be granted in court. A divorced wife is housed until she remarries...Bigamous men and women are liable to imprisonment. Custody is determined by the best interests of the child. The Personal Code provides for equality in all fields;

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[33] Brand, L. (1998), pp. 178-179.
[34] Green, A. (1994), Hopwood, D. (1992), Vandewalle, D. (1988) & Vandewalle, D. (1980).
[35] See, for example, discussions in Brand, L. (1998), Chater, S. (1992) & Daly, A. (1969a).
[36] ONFP (1997), pg. 42.

> nevertheless, women still receive a smaller share of inheritance, and the man is deemed the head of the family.[37]

Educational rights also were extended to women in the early independence era and reforms in employment law entitled women to enter into contracts and work outside of the home.[38] Further, in 1957 women were granted full citizenry rights, including the right to vote and the right to run for public office. The Tunisian Constitution, formally ratified in 1959, defines all citizens, male and female, as equal.[39]

In 1956, L'Union Nationale des Femmes Tunisiennes (UNFT) was formed with the explicit goal of elevating the cultural, social, economic, and political status of Tunisian women.[40] As a women's auxiliary of the national party, the UNFT was primarily responsible for communicating, supporting, and implementing the Neo-Destour party's initiatives and policies.[41] Among the early initiatives of the UNFT were literacy and education campaigns and awareness raising programs about the personal status code and women's rights. The UNFT became a prominent organization in the years after independence, with nearly 14,000 members in 1960 and over 38,000 members in 1969.[42] And although the organization was largely subordinate to the Neo-Destour Party, individual women used the UNFT to advance their own political, social, and legal agendas.[43]

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[37] Galal, S. (1995), pp. 63-64.
[38] For a more detailed discussion of educational and employment law see Chtioui A. (1992) & Ministère des Affaires de la Femme et de la Famille (1995).
[39] The importance of the CSP, the improvement of women's status, and women's health will be discussed more comprehensively in Chapter 5.
[40] There is some debate about the date of the UNFT's creation. The UNFT resulted from the fusion of several precursor organizations, including the Union Musulmane des Femmes Tunisiennes which was established in 1936. Women's cells, which had been affiliated with the Neo-Destour party, also formed the new state-sponsored women's organization. Thus, while most of the literature states that the UNFT was created in 1956, the first congress was not held until 1958. Marzouki, I. (1993).
[41] Ferchiou, S. (1996).
[42] Brand, L. (1998), pg. 206.
[43] Chater, S. (1992).

The importance of these legal reforms should not be underestimated. However, as early as 1959 it was apparent that women's ability to take advantage of their political and social rights was influenced by women's health issues. The following account, related by M. Thorne and J. Montague, reveals a growing recognition of the impact of high fertility on women's education and political participation.

> [In 1959] a Tunisian teacher in Tunis led the first public discussions on the need for family planning. She had helped with organizing the queues of women voters in the first national elections and had found that virtually all of the women who came to vote were in the lines reserved for pregnant women and women with small children. After attempting to discuss the issues with them, she concluded that Tunisian women were unlikely to become politically interested or active until they were free from the tyranny of excessive fertility. In addition, as Director of a National Teacher Training School, she clearly saw that pressures on the school system from large yearly increases in school-age children would be a serious problem in the future.[44]

This teacher then brought her concerns to the UNFT in order to initiate a discussion on better addressing women's reproductive health needs. Thus, individual women were beginning to mobilize around family planning as early as 1959. However, the first reforms in the health sector focused on the development of infrastructure and the creation of a professional medical and paramedical staff.

Independent Tunisia inherited a health system that suffered from the regional concentration of services, a lack of both medical and paramedical personnel, and policies restricting the scope of women's health services. One of the most important reforms for women's health care was the establishment of primary health services for women via maternal-child health (MCH) facilities. In 1959, the first center of PMI (protection maternelle et infantile) was created in Tunis by the MOPH in

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[44] Thorne, M. & J. Montague (1976), pg. 202.

collaboration with the World Health Organization (WHO) and UNICEF. The PMI centers provided a variety of services for women and children, including pre and post-natal care, maternal and child vaccinations, pre-nuptial certificates, and health education seminars on hygiene, breastfeeding, and nutrition.[45] Three types of PMI facilities were constructed: large PMI centers in regional capitals which included maternity wards and were attached to regional hospitals, small PMI centers located in larger towns and villages and were attached to local hospitals, and autonomous PMI centers located in areas without hospitals or maternity wards.[46] By 1966, eighty-nine PMI centers, nineteen of which were autonomous, were distributed throughout Tunisia and provided the backbone of women's health services throughout the country.[47] Further, many of the midwives who worked at the PMI centers would visit women in their homes, thereby further extending maternal-child health coverage.

However, in order to take advantage of the expansion of health infrastructure, a concentrated effort to expand the population of health service providers was necessary. Tunisia's total population at the dawn of independence was 3.78 million with approximately one physician per 6,700 inhabitants.[48] Of the 548 physicians who worked in the country, the majority were foreign (359), male (546), and resided in Tunis (360).[49] By 1962, the number of physicians fell to 460 as a number of expatriate physicians left the country.[50] In 1956, the population of female medical personnel was comprised of two physicians and approximately sixty nurses,

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[45] Chamakh, D. (1969), pg. 59.
[46] Chamakh, D. (1969), pg. 58.
[47] Chamakh, D. (1969), pg. 58.
[48] Dahmani, B. (1988), pg. 17.
[49] Rossignol, G. (1969), pg. 32.
[50] Rossignol, G. (1969), pg. 32.

midwives, and social assistants.[51] The lack of female personnel was particularly important for women's health, as many women felt uncomfortable with unknown male practitioners.[52] Therefore, the government placed significant priority on training medical and paramedical personnel, both male and female. The MOPH established a number of scholarships for students to study medicine in Europe (primarily France and Belgium) and female students were actively encouraged to pursue careers in medicine.[53] Although Tunisian students continued to pursue medical degrees in Europe throughout the 1960s and 1970s, the first medical school in Tunisia, established in Tunis with bilateral assistance from the French government, admitted its first class of students in 1964. Nearly three quarters of these students were offered scholarships by the Tunisian government and female students represented slightly less than one fifth of incoming medical students.[54] The first class of 34 medical students from the Faculté de Médecine à Tunis graduated in 1970-1971.[55] The early 1970s saw notable growth in the physician population; between 1966 and 1976 the number of physicians grew 288% at a rate of nearly 11% each year. The period from 1976 to 1985 saw a further increase of 300% with an annual growth rate of 13%.[56] This growth was due, in large part, to the creation of new medical faculties in Sousse, Sfax, and Monastir, which began in1974. The number of female physicians also continued to rise. Although there were only two female physicians in 1956, by 1972 women constituted nearly 5% of the practicing physician population and by 1985 this

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[51] Bakalti, S. (1996), pg. 202. There is some disagreement in the published literature as to the number of female physicians registered at the time of independence. Dahmani, B. (1988) indicates that there was only one female physician in 1956.
[52] Interview (DSSB Representative), Tunis: October 27, 1998.
[53] Zitouna, M. (1994), pg. 129.
[54] Rossignol, G. (1969), pg. 38.
[55] Dahmani, B. (1988), pg. 18.
[56] Dahmani, B. (1988), pg. 19.

percentage had risen to over 21%.[57] However, despite the increase in the physician population, few Tunisian physicians practiced outside of Tunis and the Sahel.[58] Of the 188 Tunisian physicians practicing in 1968, 133 practiced in Tunis, 44 practiced in Bizerte, Nabeul, Sousse, and Sfax, and the 11 remaining physicians practiced in the southern and central governorates.[59]

The MOPH also invested in the training of paramedical personnel with the creation of three professional schools in 1956 and a training program for midwives, through the national school of public health, in 1957. Initially, the professional schools were located exclusively in Tunis and the Sahel, thus limiting access. As a nurse from Ancienne Matmata explained,

> I began my training in Tunis in 1963. I am from Médenine and there were no programs in the south at that time; nursing schools, one for boys and one for girls, were only located in the capital. The government expanded the program after I had finished my studies and it became much better, especially for women. Students could live at home with their families and the schools were able to better tailor their programs to regional needs. As a man, moving to Tunis was not too difficult, but it was very hard for some of the women. Most women from the south simply could not participate in the training.[60]

After 1966, additional professional schools were established in governorates outside of Tunis and the Sahel, thereby increasing the access to training.[61] The number of paramedical personnel tripled between 1956 and 1968, from 2,000 to over 6,000.[62] The training of midwives, nurses, and health aides was critical to the success of the new women's health program. As Habiba's story indicates, the introduction of

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[57] Dahmani, B. (1988), pg. 20.
[58] The Sahel is an Eastern coastal region containing the governorates of Sousse, Monastir, and Mahdia.
[59] Rossignol, G. (1969), pg. 43.
[60] Interview (Nurse), Ancienne Matmata: February 13, 1999.
[61] Dahmani, B. (1988), pg. 23.
[62] Daly, A. (1969a), pg. 14.

Tunisian female health aides helped to expand the provision of services, encourage consultations, and promote confidence in the health sector.

Habiba's Story

Habiba began working for the national health system in 1958 as a health aide. Habiba had always been interested in women's health and knew a great deal about traditional medicine. Thus, when she learned that the Tunisian government was looking to train women to become health aides, Habiba volunteered. Habiba participated in one of the first training classes in Tunis and though she was illiterate, Habiba learned the information quickly. A mother of three, Habiba accepted the night shift in order to be with her children during the day and she worked for several years in the maternity ward of a Tunis hospital. Although the Tunisian health system suffered from a shortage of staff in general, this problem was particularly pronounced during the night shift. Consequently, Habiba not only performed the duties of a health aide, but also worked as a midwife. On several occasions, trained professionals were unavailable to deliver babies and thus Habiba stepped in. On one occasion, in 1960, she delivered twins. Habiba would also impart her knowledge of traditional health and medicine to women using the hospital; she would close women up after their deliveries and prepare traditional postpartum meals and broths. Habiba also spoke with women about breastfeeding, infertility, and traditional contraception. Habiba started making home visits in 1959, even though this was not officially part of her job. But Habiba understood the community in which she lived and knew that many women would resist going to a hospital. Habiba believes that her work was very effective because she felt connected with the women she worked with and offered a combination of traditional and modern medicine and services.[63]

Habiba's experience was not unique. Many of the newly trained paramedical personnel used their positions within the newly emerging health structure to advise women on traditional methods of contraception and abortion.[64] Although a small number of Tunisian physicians provided contraceptive and abortion services through private clinics, these services remained inadequate for the needs of Tunisian women.[65] As a result, like Habiba, many health aides performed the work of physicians and midwives. As another former health aide from Tunis explained,

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[63] Interview (Former Health Aide), Tunis: October 10, 1999.
[64] Interview (Academic), Tunis: October 19, 1999.
[65] Tawhida Ben Cheikh, the first female Tunisian physician, opened a private practice after returning from Paris in 1936. Even though she was a general practitioner, she found that her practice was dominated by female patients. Ben Cheikh therefore provided gynecological services, including contraception and abortions, throughout her career. Kazdaghli, H, (1993).

I was working as a health aide in 1960, before abortion was legal. That is not to say that women did not have abortions, they just did it more secretly. One afternoon a neighbor came to my house because her daughter was bleeding. When I arrived, I knew immediately that the young woman was bleeding from an incomplete abortion. I knew that I needed to complete the abortion; I had never done this before and I was shaking. I stayed with the woman all night and the next day and when her fever went down I knew she would be okay. I later learned that the young woman was engaged and she had become pregnant with another man's baby. That is why she had to resort to abortion. She was lucky that she did not bleed to death.[66]

Although individual health service providers assisted women in limiting their fertility and terminating unwanted pregnancies, the French legacy continued to dominate Tunisian policy throughout the 1950s. Further, many of the French physicians who continued to work in Tunisian hospitals were opposed to family planning and refused to provide assistance or services to women seeking contraception. As Souad's experience illustrates, the colonial pro-natalist legacy and the consequent lack of family planning services in the years immediately following independence had a dramatic impact on women's health.

Souad's Story

Souad was fifteen when she married a man nearly twenty years her senior. Souad was not able to have a proper wedding because of the growing tensions in Tunis over French occupation. Souad became pregnant almost immediately and delivered her first child when she was sixteen years old, just a year before Tunisian independence. Though she was from Tunis, she was unable to deliver in a hospital; transportation to the facility was not available. Souad was concerned; she was less than seven months pregnant and knew that the delivery would be complicated. However, a traditional birth attendant, an older woman from the neighborhood experienced in delivering babies, assisted Souad both during and after the delivery of a healthy girl. Souad wanted to limit her fertility and the traditional birth attendant attempted to assist her by preparing a vaginal suppository and an herbal broth. However, Souad became pregnant with her second child within five months.

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[66] Interview (Former Health Aide), Tunis: October 11, 1999.

With the expansion of health services in Tunis after independence, Souad delivered her second child at a public hospital. However, two years after her marriage, Souad was beginning to feel desperate; she did not want to have any more children. She continued to take the herbal broth, but she decided to experiment with other contraceptive methods as well. Souad had heard that douching with alcohol would prevent a woman from conceiving and she carefully prepared an alcohol-based douche in her kitchen. However, this concoction caused a severe burning sensation in her womb as well as considerable pain and discomfort. As this made sexual intercourse with her husband exceptionally painful, she decided to discontinue its use; she had to perform her marital duties. Within a few months, she became pregnant for the third time. Souad was terrified of having another child and decided to swim in the sea every day in order to provoke a miscarriage. Though it was difficult for her to travel to the beach each day with her two children, she miscarried five months into the pregnancy. Yet, she fell pregnant within months of the miscarriage and this time her husband refused to allow her to leave the house. For the second time she delivered the baby in the hospital. She explained her situation to the French doctor, and though she begged him to help her avoid a fifth pregnancy, her pleas for assistance were ignored.

Thus, by the age of twenty Souad had three children and was in the midst of her fifth pregnancy. Souad prayed for a miscarriage and during the second trimester she lost the baby. Souad tried to resist having sexual relations with her husband and this resistance put a strain on their relationship. After seven years of marriage, Souad decided that she had to divorce her husband; she could not have additional children. But after initiating divorce proceedings, Souad discovered that she was pregnant for the sixth time in seven years. She tried to find a way to abort the fetus, but she was unsuccessful. Souad delivered her child at a public hospital and decided to give the child up for adoption, a rare but not unheard of action in 1962. Souad simply could not cope with another baby. Souad still thinks of the child daily; she knows that he was adopted by a Tunis-family, but she knows nothing else about her son. In 1966, when her eldest child was nearly eleven years old, Souad finally obtained the long awaited divorce and left Tunis. She suffered a mental breakdown and decided to leave her children with their grandmother. Souad did not return to Tunis for ten years, on the occasion of her eldest daughter's wedding. Souad never remarried; she did not want to have additional children and she never wanted to give another child up for adoption. Souad believes that the lack of options Tunisian women had at that time dramatically affected her life. She is certain that six pregnancies in seven years, most of them unwanted, had a significant impact on both her physical and psychological health. If she had been able to have access to contraception and abortion, she believes that her life would have been very different.[67]

In addition to the detrimental effects on women's psychological and physical health, the inability to effectively control fertility and space pregnancies in the early independence period prevented many women from accessing the opportunities

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[67] Interview, Tunis: October 9, 1999.

afforded through educational and employment reforms. A domestic servant and mother of two reflected on her experience in Tunis in 1960,

> One day, I noticed that I was pregnant again. At that time there were no birth control or abortions. I took a traditional remedy that was supposed to stop pregnancies. The result: I got inflamed ovaries and was in terrible pain. I went to the hospital immediately, where I spent 25 days. My neighbors took care of my daughter…After my sickness, I couldn't work the same as before. I got tired easily and could not do any of the hard physical cleaning.[68]

Although women through the UNFT and professional organizations had begun to mobilize around more comprehensive women's health services as an issue of women's emancipation, the creation of the family planning program in Tunisia was due primarily to demographic and development objectives. President Bourguiba saw improvement in women's status as an important component of development, but also viewed unrestrained population growth as an impediment to Tunisia's development efforts. As one of the architects of the family planning program, A. Daly, noted in 1969,

> Forming the basis of Tunisia's family-planning program are the wider concepts of the liberation of women and the improvement of society by education, health, and work. Family-planning constitutes one of the many aspects of a general plan for balanced economic and social development whose objectives are primary short term education for all and progressive elevation of the standard of living.[69]

To this end, the government instituted a law in December 1960, which limited family allowances to the first four children.[70] The first initiative directly affecting family

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[68] ENDA Inter-Arabe (1996), pg. 38.
[69] Daly, A. (1969b), pg. 103.
[70] This system is based on family allowances that decrease as a percentage of income as the number of children increases. Faour, M. (1989).

planning was the reversal of the anti-contraception laws with Law 61/7 of January 1961, which overturned the prohibition on the advertisement, importation, distribution, and sale of contraceptives.

The following year marked a watershed moment in family planning and women's health in Tunisia. In 1962, the national family planning program began with a sociological survey designed to identify population attitudes and contraceptive knowledge. Midwives conducted interviews with more than 2,175 married men and women, sampling couples in 12 clinics. The results of the survey indicated that there was a significant unmet need for contraception and determined that "[among] women who have at least four children and who represent 62 per cent of the group, 70 per cent want no more children and are inclined to practice contraception."[71] In response to the survey results, the Tunisian government launched an experimental family planning program in 12 urban and semi-rural clinics in 1964. The initial pilot program, sponsored by the Ford Foundation and supported by technical assistance from the Population Council, was targeted to last for two years, but within months the number of participating clinics tripled.[72] Enthusiasm from national and regional government authorities and national organizations, particularly the UNFT, provided additional support for the program. Because of the success of the program, by February 1965 all hospitals and maternal-child health clinics were providing contraceptive information and services free of charge. As A. Daly explained,

> In Tunisia it is believed that the maternal and child health center creates the ideal conditions for teaching contraception and for distributing contraceptive techniques. Women go there for the care of a child that is ill from lack of food or shelter. Women go there because they are tired of pregnancy. And women

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[71] Daly, A. (1969b), pg. 105.
[72] Ghachem, M. (1997), pp. 2-3.

> go there because they suspect an unwanted pregnancy. In Tunisia these centers constitute real "little clubs," where women come to gossip and at the same time consult the doctor or mid-wife.[73]

The MOPH administered a training program for physicians and midwives, who attended in waves at a Tunis hospital. The program included clinical training as well as the distribution of equipment and contraceptives.

The health program was accompanied by laws favoring family planning and women's health care. In 1964, the CSP was amended such that the age of marriage was raised to 20 for men and 17 for women.[74] Further, a law legalizing first trimester voluntary abortions for women with five or more children was enacted in 1965 and expanded to all women, regardless of family size, in 1973.[75] Thus by the mid-1960s, Tunisian law had been reformed such that family planning and abortion were no longer prohibited.

By the end of the experimental program in June 1966, more than 29,000 women had consulted a family planning center at least once and of these nearly 20,000 women accepted intrauterine devices (IUDs).[76] The family planning services, including consultations, contraceptives, and surgical procedures were free of charge. During the experimental phase, single use methods of contraception were available through mobile health units and small PMIs, but oral contraceptives and IUDs were only available through hospitals. Thus, the program was both integrated (with the

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[73] Daly, A. (1969b), pg. 106.
[74] Ministère des Affaires de la Femme et de la Famille (1995), pg. 34.
[75] Article 214 of the penal code was amended in 1965 such that an abortion performed by a licensed physician in an authorized hospital or clinic was permissible if a woman had five or more children or if the pregnancy endangered her health. In 1973, the law was further amended such that all women, regardless of the number of children, are able to obtain first trimester abortions for medical or social reasons. After the first trimester, abortions are permissible if continuation of the pregnancy threatens the women's physical or psychological health or if the fetus suffers from a serious illness or deformity. Tunisian abortion law remains unique in the MENA region. For more discussion on abortion law in Tunisia, see Bejaoui, F. (1988) & Bowen, D. (1997).
[76] Vallin, J. (1969), pg. 21.

hospitals) and autonomous (in clinics).[77] At the end of the experimental phase of the program, the Tunisian government adopted a five-year plan for a national family planning program. The five-year plan laid out specific demographic objectives, involving an anticipated decrease in the birth rate, the number of consultations, and the number of IUD acceptors. To meet these goals, the program was dedicated to training physicians and midwives on the importance, use, and prescription of contraceptives as well as expanding the service areas and frequency of the mobile health unit schedules. Further, an aggressive public education campaign extolling the importance of family planning was proposed.

However, after the publication of the 1966 census there was a period of declining support for the family planning program. The results of the census indicated that the demographic pressure was perhaps not as significant as once had been projected and Bourguiba delivered a speech revealing ambiguous support for national family planning efforts.[78] Funding for the family planning program remained at $124,000 per year and the growth in family planning personnel began to taper off. However, renewed national enthusiasm for family planning emerged by 1968. The annual family planning budget increased nearly eight fold through bilateral and multi-lateral funding and culminated in a $4.8 million loan from the International Bank for Reconstruction and Development.[79] Thus, by the end of the 1960s, family planning had become the base of the women's health program. As a Tunisian historian of medicine noted, "By the end of the 1960s the agenda for women's health had been

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[77] In 1968, a system of mobile health units was constructed to provide services to areas lacking stationary family planning clinics. Mobile Health Units (MHUs) expanded the geographic reach of services and will be discussed in more detail later in this chapter.

[78] Thorne, M. & J. Montague (1976).

[79] By 1972, some twenty-six international organizations were involved with the Tunisian family planning program. These organizations included USAID, Swedish SIDA, IPPF, and the IBRD. Thorne, M. & J. Montague (1976).

firmly established. Family planning would continue to dominate policy, services, training, and research for many years to come."[80]

The new enthusiasm brought reforms in the national family planning program. Family planning services became more integrated into maternal health services with the training of 35 nurse aides, who provided bedside education of women in maternity wards, a program executed in conjunction with the US Peace Corps. In addition, a full time health administrator was assigned to the post of Directorate of Family Planning and Maternal-Child Health.[81] A public education campaign, including posters and house visits, was conducted in the early 1970s and a community health-worker training program dedicated to information, education, and communication (IEC) was proposed, though only partially implemented. However, the family planning program also gained greater autonomy. Tawhida Ben Cheikh, who created a family planning service within the Charles Nicolle hospital in 1963, established the first autonomous family planning center in Tunis in 1970.[82] This effort was followed by the creation of more than 20 autonomous regional family planning centers throughout the mid 1970s.[83] Further, in 1973, the Office National du Planning Familial et de la Population (ONPFP) was created as a semi-autonomous body under the auspices of the MOPH and was designed to oversee and coordinate family planning activities.[84] Bourguiba reaffirmed his support of family planning in a speech

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[80] Interview (Historian), Tataouine: April 14, 1999.
[81] Tawhida Ben Cheikh was nominated for this position in 1970 but declined the position in favor of continuing to practice as a physician. Kazdaghli, H, (1993), pg. 28.
[82] Kazdaghli, H, (1993), pg. 28.
[83] These autonomous family planning centers are known as CREPFs (centre regional d'éducation et de planification familiale). CREPFs are distinct from other elements of the ONFP infrastructure. Fixed centers include PMIs and hospitals in which family planning services are provided through the staff. Mobile health units are comprised of a team of practitioners who provide services through non-family planning stationary facilities, such as PMI centers and health posts. ONFP (1997), pg. 46.
[84] In many English language publications, the ONPFP is cited as being under the auspices of the Ministry of Health. This appears to be a manipulation of the translation so as to reflect the comparable structures in the American and British governments. Throughout this document, the phrase Ministry of

given in Kairouan on the *maulid* (the Prophet's birthday) in 1973.[85] In this speech, Bourguiba emphasized the compatibility of Islam with family planning, including sterilization and abortion, and pronounced the government's continued support and encouragement of the family planning program.[86]

In the twenty years after Tunisia gained independence significant progress was made in a number of basic health indicators. Life expectancy, vaccination rates, and the percentage of medically assisted childbirths increased and infant and maternal mortality decreased.[87] But the most significant changes in women's health involved fertility. The first fifteen years of the family planning program were viewed as largely successful in meeting demographic objectives and improving a number of basic health indicators. The average age of first marriage for women increased from 19.4 years in 1956 to 22.5 years in 1975.[88] The total fertility rate decreased from 7.2 children per woman in 1962 to 5.8 children per woman in 1976.[89] Further, the contraceptive prevalence rate increased from 9.1% in 1966 to 31.4% in 1978.[90] Importantly, the program saw results for populations of both uneducated and educated women as well as urban and rural residents. Although many methods were available, the majority of Tunisian women used IUDs.[91] Oral contraceptives constituted the second most significant contraceptive method, and the majority of women using birth

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Public Health (MOPH) will be used, as this is the most accurate translation of Ministère de la santé publique (MSP). For more information on the relationship between the ONFP and the MOPH see Laâjimi, A. (1987).

[85] Bourguiba delivered this speech from Tunisia's holiest mosque, the 'Uqba bin Nafi'.

[86] As reported in Brown, K. (1981), pp. 69-70.

[87] ONFP (1998).

[88] ONFP (1997), pg. 310.

[89] ONFP (1998).

[90] ONFP (1997), pg. 82.

[91] Nearly 75% of modern contraceptive users from 1964-1969 used IUDs. ONFP (1997), pg. 58.

control pills procured them through private sector clinics.[92] For many individual women, particularly those in Tunis, the family planning program significantly impacted their psychological and physical health, opening opportunities and offering reproductive control, as Houda's story demonstrates.

Houda's Story

The youngest of four children, Houda was born in Tunis in 1936. Although Houda was born during a period when educational opportunities for girls were not readily available, Houda taught herself to read and write by borrowing her older brothers' schoolbooks. Houda was the only daughter and was expected to help her elderly and ailing mother with the cleaning and cooking. By the time Houda was ten years old she was responsible for maintaining the household.

Houda's father had died when she was a young child and thus her brothers served as her guardian. When Houda's cousin first proposed to her at the age of fifteen her family forbade the match; her unmarried brothers depended on her. Though Houda wanted to get married and start a family, she did not challenge her brothers' decision. Her cousin promptly married another woman and Houda feared that she would never get married. For over ten years men continuously asked for her hand in marriage and each time her brothers refused. When Houda was twenty-six her uncle intervened on her behalf and Houda was briefly engaged to an Egyptian man. However, when her fiancé refused to change his nationality, her brothers again forbade the marriage; they wanted Houda's children to carry Tunisian citizenship.[93] *Houda's cousin had never forgotten the woman he wanted to marry and when he learned that her brothers were finally permitting her to marry, he divorced his wife and proposed to Houda again. Her brothers conceded the engagement but delayed the marriage for years; Houda was needed not only to maintain the household but also to care for their mother. After a seven-year engagement Houda's mother and uncle insisted that she be permitted to marry her cousin. Begrudgingly, her brothers allowed her to marry for the first time at thirty-five years of age.*

Houda's husband wanted a large family and encouraged Houda to have children immediately and in rapid succession. She became pregnant for the first time within the first year of marriage and delivered her second child in 1973, less than a year after the birth of her daughter. Houda delivered both of her children at a private clinic where her uncle worked as a physician. Although she was embarrassed to have her children at her uncle's clinic, her uncle promised that he would not be present

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[92] The ONFP and the MOPH encouraged the private sector to provide family planning services, particularly the prescription of oral contraceptives. By 1983, nearly 6% of Tunisian women were using oral contraceptives and over half had obtained their prescription from a private sector physician. Coeytaux, F. et. al. (1987, July/August), pg. 230. For more discussion on the role of the private sector in the initial phase of the family planning program, see Aloui, T. (1985, dècembre) & Taamallah, L. (1984).

[93] Until 1993, Tunisian women who were married to foreign nationals could only pass Tunisian citizenship to their offspring if the children were born in Tunisia. This was not the case for men. Brand, L. (1998), pg. 210.

during her deliveries. When Houda returned home after the birth of her second child, she found the responsibilities overwhelming. Without sisters or other female relatives to assist her, Houda had difficulty caring for two infants. She was exhausted and depressed. Her husband offered no assistance and was extremely possessive; he did not want her to leave the house without him and he carefully monitored her behavior. Houda took to stealing small sums of money from him each night and hiding it the mattress so that she could purchase food and medicine for herself and her children. Her husband wanted Houda to continue to have children, but Houda knew that it would be too difficult for her. In the year after the birth of her second child Houda had two miscarriages, one was spontaneous and one was caused when she threw herself down a flight of stairs. Without discussing it with her husband, she went back to the private clinic and got a prescription for birth control pills. Houda secretly took the pills for five years until she reached menopause.[94]

Houda's experience illustrates the positive impact that access to family planning had on individual women. Indeed, many women, particularly those from Tunis born around the time of independence, credit the family planning program for their educational, professional, and political accomplishments and the overall improvement of women's status. The President of the UNFT's commission on health articulated this position.

> Tunisian women have many choices and opportunities and the health reforms helped make this possible…Women want to show that they are competent, that they can surpass whatever challenges they face, and even though it is sometimes difficult, women believe in themselves and their accomplishments. Women are able to excel and take advantage of their rights and opportunities. This would not have been possible without the ability to control our fertility.[95]

However, the first fifteen years of the family planning program were plagued with systemic problems. Poor service quality characterized the women's health program generally, and the family planning program specifically, from the 1960s to the early 1980s. Once the national family planning program was firmly established in 1966, family planning dominated the women's health agenda and other components

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[94] Interview, Tunis: October 5, 1998.
[95] Interview, (UNFT Representative), Tunis: January 28, 1999.

of women's health care were neglected. Indeed, the fourth development plan of 1973-1976 was the first plan to refer specifically to women's health and focused almost exclusively on family planning.[96] In spite of the coordination of PMI and family planning services, a lack of integration abounded, with family planning often taking precedence over all other women's health needs, thereby contributing to poor service quality.[97] Although individual women unquestionably benefited from the early reforms in the health sector, the philosophical underpinnings of the early family planning program centered on the promotion of demographic and development objectives, not on the empowerment of women or improvement of women's health *per se*. M. Jones argued,

> While some proponents saw family planning as a means to advance women's emancipation, the Tunisian government, like many others, justified family planning above all in the name of economic development and social progress. On several occasions, President Bourguiba defined rapid population growth as a serious restraint on the country's economic growth, and called for a reduction in the birth rate as a means of facilitating economic development.[98]

Many of the problems with the early family planning program were directly tied to the philosophy of the program, which placed primacy on demographic and national development objectives, rather than quality, health, or individual couple concerns. Throughout the 1960s and the 1970s, the orientation and construction of the family planning program contributed to a hierarchal decision-making structure which marginalized both female health service providers as well as individual women, coercive programs which were designed to inflate acceptor statistics, and systemic biases against rural, poor, and uneducated women. These factors contributed to the

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[96] Bakay, C. (1988), pp. 31-32.
[97] Interview (DSSB Representative), Tunis: January 26, 1999.
[98] Jones, M. (1983), pg. 132.

overall poor service quality, which hampered the family planning program's success and impacted numerous areas of women's health.

One of the most significant problems with the family planning program involved the hierarchal decision-making structure and the subsequent marginalization of both female health service providers and female patients.

> During the first phase of the women's health program, women were not integrated into the decision making process at all. Women's health was completely under the direction of the state. The ideology was based on national objectives and a belief that programs had to be "given" to women; women were perceived as being incapable of making decisions and articulating demands themselves.[99]

Indeed, the structure of decision-making among health service professionals had an important impact on patient care. Despite the growing number of paramedical personnel and the priority placed on training additional female health aides and midwives, physicians remained the dominant lobbying force within the MOPH. Physicians actively resisted the decentralization of authority and the autonomy of midwives, which had a significant impact on women's health and access to services. Of the forty-eight gynecologists practicing in Tunisia in 1972, sixteen of the eighteen Tunisian practitioners worked in Tunis.[100] Yet, largely due to the physician lobby within the MOPH, only gynecologists were legally permitted to insert IUDs until 1971. Further, community health workers were prohibited from distributing oral contraceptives, in spite of numerous pilot studies conducted by the ONPFP in the 1970s, which showed the effectiveness of this type of service.[101] "Despite these results, the government, under substantial pressure from a very conservative medical

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[99] Interview (CERES Researcher), Tunis: October 27, 1998.
[100] Thorne, M. & J. Montague (1976), pg. 208.
[101] Coeytaux, F. et. al. (1989), pg. 166.

community, was reluctant to distribute contraceptives through community workers on a nationwide basis."[102] Thus, deference to the medical lobby limited the access and quality of family planning services available to women, particularly in rural areas, and marginalized female paramedical personnel. This marginalization had a profound impact on patient care as foreign, foreign trained, and French language educated male physicians were often unable to overcome the language, gender, cultural, class, and educational barriers that existed between themselves and their patients. Thus, many Tunisian women were unable to communicate with or were uncomfortable voicing their concerns to their physicians, thereby impacting the quality of care.[103]

Yet, despite the dominance of the physician lobby, a shortage of administrators and health service providers persisted throughout the first fifteen years of the program. The continued dearth of trained gynecologists limited services and follow-up, and many women discontinued contraceptive use after the first year.[104] Thus, by minimizing the autonomy and authority of female health service providers, women who were perceived as being "more like" the women they serviced, the scope and acceptability of the program remained limited.

Hierarchal decision-making not only affected female health service providers; it also marginalized individual women through the physician-patient interaction. As a researcher at CERES noted, "During the first period of the women's health program the focus was entirely on mothers and motherhood. 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."[105] A paternalistic attitude was prominent within

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[102] Coeytaux, F. et. al. (1987), pg. 230.
[103] Interview (Former Health Aide), Ancienne Matmata: April 6, 1999.
[104] Daly, A. (1969b), pg. 112 & Sutton, K. (1980), pg. 45.
[105] Interview (CERES Researcher), Tunis: October 27, 1998.

the MOPH and often women's individual desires were ignored.[106] Indeed, there was a pervasive attitude that rural, uneducated, and poor women were unable to make their own choices and thus physicians were "required" to make contraceptive decisions on their behalf. Many health service providers were unresponsive to women's legitimate concerns about the health risks and side effects of using oral contraceptives and IUDs, and women's questions and concerns were often belittled and ignored.

> Mobile teams, short on staff, visited irregularly and made few attempts to follow up IUD users. Some medical personnel failed to warn women of normal side effects that might follow the insertion of an IUD. When pain or other symptoms appeared, some women panicked and tried to remove the devices themselves. Others simply complained to friends and relatives, starting rumors about the dangers of the device. With little or no follow up medical service available, such complaints helped discredit the programme in places.[107]

Thus, by the mid-1970s rumors abounded about the risks associated with IUDs, leading to widespread reservations about visiting family planning centers. However, public health administrators resisted acknowledging the legitimacy of women's concerns and individual needs. Indeed, former Minister of Health Fathi Zouhair blamed the women themselves and implied that problems relating to IUDs were not related to the program or the devices themselves, but to the women's lack of maturity.[108]

This belief in women's incapability of making their own decisions regarding health and fertility also led physicians and health service providers to select methods of contraceptives for women. [109] As F. Coeytaux et. al. noted,

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[106] Ben Romdhane, H. (1992), pg. 146
[107] Jones, M. (1983), pg. 132.
[108] Jones, M. (1983), pg. 132.
[109] Jones, M. (1983), pg. 133.

> As a result of the ONFP's policy to emphasize methods with high use-effectiveness, such as the IUD and tubal ligation, and in part due to the medical community's bias against oral contraceptives (based partly on a concern about medical contraindications and on the belief that Tunisian women, and rural women in particular, will not use the pill effectively), the use of oral contraceptives in Tunisia had been historically low.[110]

Many women were pressured into accepting IUDs or were offered only a limited number of contraceptive options, thereby marginalizing women from the decision-making process.

In addition, during the first phase of the family planning program, many women were stripped of control and power through the coercive insertion of IUDs and forced sterilizations. Although women in rural areas were particularly susceptible to the coercive and abusive actions of health service providers, these practices occurred in the capital as well.

Rouqia's Story

Rouqia met her husband when she was fifteen years old, after her husband had seen her at her cousin's wedding. A strong student from Tunis, Rouqia wanted to become a secondary school teacher and for the three years of their courtship, Rouqia continued her studies with the intention of passing her BAC and pursuing a university degree. However, at seventeen, Rouqia's family and her in-laws pressured the couple to marry. Within a month, Rouqia was pregnant with her first of three children and was required to leave school; pregnant women were prohibited from attending. After an uncomplicated pregnancy, Rouqia delivered a son in 1976 and Rouqia, her husband, and their families were delighted. However, when Rouqia became pregnant again within a year of the delivery, she decided to have an abortion; she felt that it was simply too soon to have a second child. Rouqia had been using birth control pills, but she had become pregnant due to method failure. The abortion was performed by a physician in a public hospital in Tunis and Rouqia felt uncomfortable throughout the procedure. Even though she was a bright and relatively well-educated woman, Rouqia felt she was being belittled because she was nineteen and already pregnant for the second time. After the abortion was performed, the physician inserted an IUD, without Rouqia's consent or permission. Over a year passed before Rouqia realized that the IUD was in her body. She was informed of the IUD during

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[110] Coeytaux, F. et. al. (1987), pp. 229-230.

an annual gynecological exam; she had wanted to renew her birth control pill prescription but the physician told her it was unnecessary because of the IUD. Although Rouqia was furious, she decided to leave the IUD in her body and discontinued her use of the pills.

Five years after the abortion, Rouqia again became pregnant. Her third pregnancy was diagnosed as an ectopic pregnancy after she experienced severe pain and blood loss in the sixth week.[111] *The IUD was immediately removed and she was required to undergo surgery to remove the fetus. Rouqia was terrified. Instead of returning to a public hospital, Rouqia insisted that her husband take her to a private clinic in Ariana; she did not want to repeat her first operation experience. After the surgery, a midwife spoke with Rouqia about her contraceptive options and Rouqia decided to again use birth control pills. However, after several months she discontinued their use because of the weight gain, nausea, and irregular bleeding she experienced. At first, she switched to the calendar method, but she found the required effort unreasonable and the method too risky. Nine months after the surgery, Rouqia returned to the IUD. However, the second insertion was different; the second time she made the decision to use the IUD herself. Rouqia continued to use the IUD until she reached menopause, having it removed only when she intended to get pregnant.*[112]

Although Rouqia's experience reveals extreme abuse by an individual practitioner, it is by no means unique: similar cases of coercion and abuse have been documented throughout the 1970s.[113] Thus, the hierarchal decision-making structure within the MOPH, one that gave priority to physicians, supported the marginalization of female health service providers and individual women, thereby shaping the quality of women's health services.

Coercive acts were not limited to individuals; the early family planning program also suffered from coercive programs geared at increasing the number of acceptors. The incentives embodied in the demographic and development objectives of the family planning program often worked at cross-purposes with the objective of

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[111] An ectopic pregnancy is defined as the implantation of the fertilized ovum outside the uterine cavity. In Rouqia's case, the ectopic pregnancy was a tubal pregnancy (with implantation occurring in the fallopian tube). Removal of the fetus and placenta is required. If rupture occurs without prompt treatment, the resulting hemorrhage and shock can be life threatening. Although IUDs reduce the overall rate of pregnancy, the risk of ectopic pregnancy increases significantly should a woman become pregnant while using an IUD. The relationship between ectopic pregnancy and IUD use also appears to depend on the type of IUD. For a more thorough discussion of the relationship between IUDs and ectopic pregnancy, see Roberts, J. & J. Hedges (1998) & Sivin, I. (1991).

[112] Interview, Tunis: October 1999.

[113] Interview (Former Health Aide), Ancienne Matmata: April 6-7, 1999.

improving women's health. Individual governorates faced significant pressure to increase the contraceptive prevalence rate, thus leading to a flurry of new initiatives in the 1970s. Incentive and disincentive programs took a number of different forms, including programs that tied employment and free milk to contraceptive use.[114] Although not commonly referred to in the literature, incentive programs also took the form of payment-for-sterilization campaigns conducted in the early 1970s in rural governorates. Researcher M. Jones reported,

> In mid-1973, then Minister of Health, Mohamed Mzali launched a drive to carry out 500 female sterilizations 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. It is not clear what they got for the effort. According to some accounts, the average age of women sterilised was 38, with reports of sixty-year old women volunteering for the operation in order to get the five dinar payment for 'lost time.' The fervour of the campaign and reported abuses (round-ups) tainted the name of the programme in some areas and led to resignations within the family planning services.[115]

The national program did not officially condone these regional initiatives. However, the Bourguiba Prize in family planning was created in 1974 to recognize individual governorates for successfully reducing births and the specific initiatives that led to the reduction were not evaluated.[116] As sterilization campaigns were often conducted in conjunction with forced sterilization, claims of coercion and abuse were numerous.[117] One woman from the Northwest recounted the experience of her aunt Sonia.

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[114] For a more comprehensive discussion on general incentive and disincentive programs in family planning, see Hartmann, B. (1995) & Ross, J. & S. Isaacs (1988, September/October). For further information on incentive and disincentive programs in Tunisia, see Jones, M. (1983).
[115] Jones, M. (1983), pg. 133.
[116] Jones, M. (1983), pg. 132.
[117] Interview (CERES researcher), Tunis: October 27, 1998.

> In my town there are a lot of women who do not know anything about their health. These women are poor and uneducated and easily influenced. For example, in Teboursouq they used to offer women money to get sterilized. Many women accepted because they were poor, not because they did not want to have more children…But sometimes they sterilized women without telling them. This happened to my aunt [in 1975]. My aunt, Sonia, had two boys and she wanted to have a girl. She tried for years to have another child and she was unable to get pregnant. Finally, she visited a doctor and learned that she had been sterilized. Apparently, after delivering her second son at the local hospital, the doctor decided to perform a tubal ligation on her without her permission. My aunt was devastated.[118]

These types of programs tainted the family planning program for years and led to widespread feelings in some communities that the program was authoritarian.[119] Thus, the coercive programs designed to increase contraceptive acceptors also affected the overall quality of services.

Finally, biases against rural, poor, and uneducated women abounded. This was not only true in the context of direct service provision, as Sonia's story reflected, but socioeconomic biases were also prevalent in the educational efforts. As M. Jones reported,

> Field workers questioned the usefulness of some posters in rural areas showing urban women in urban settings. In other cases, the message conveyed was not the message intended. Some people saw in the contrast of the orderly, well-off two child family with the disorderly, destitute large family, the joy of at least having children in poverty. Elsewhere, a woman reportedly complained that after several months of contraception, she still had no television, moped, or other luxuries which in her eyes had been 'promised' by family planning information.[120]

Thus, in the first phase of the family planning program, the hierarchal decision-making structure, coercive programs, and ingrained biases diminished the quality of

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[118] Interview, Tunis: October 25, 1999.
[119] Brown, K. (1981, January).
[120] Jones, M. (1983), pg. 133.

services and thereby hindered the effectiveness of the program and affected other areas of women's health. As demographic and development objectives remained paramount, issues of quality were considered a lower priority. As one professor of medicine noted,

> Most countries have very specific objectives early in their health programs. These objectives often revolve not around the health of women *per se*, but demographic and development goals. Limiting fertility is one way of furthering those goals. After a long enough period it becomes clear that deeper programs are needed to both truly meet needs as well as continue with those goals: the numbers can only be lowered so much by focusing on family planning. In my opinion, Tunisia entered this stage of expansion in the 1980s.[121]

PERIOD II: THE DEVOLUTION OF DECISION-MAKING AND THE BROADENING OF THE DEFINITION OF WOMEN'S HEALTH

Influenced by the aforementioned shortcomings and abuses, the 1980s witnessed a significant shift in the philosophy of the women's health program,. Derived in large part from a devolution of decision-making within the health administration, this shift resulted in a broader definition of women's health, better service articulation, and greater community participation and local input into program determination. The second phase of the national women's health program, largely inspired and implemented by female health service providers, reflected new innovation and creativity. By the beginning of the 1990s, reforms in the program had a profound impact on both women's health and women's empowerment.

For more than twenty years after Tunisian independence, the women's health program centered around the development of health infrastructure, the training of

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[121] Interview (Professor of Medicine), Tunis: January 13, 1999.

service providers, and the reduction in the population growth rate through family planning. An examination of the Tunisian national development plans reveals the evolution of this focus and the re-prioritization of other areas of women's health care. The first, second, and third national development plans (1962-1964, 1965-1968, and 1969-1972, respectively) outlined infrastructural, professional, and demographic goals and made few direct references to women's health.[122] The fourth development plan of 1973-1976 was the first that focused on women's health in any detail. Specific investment targets included construction of maternity wards and PMI centers and training of gynecologists. The development plan also identified maternal health and family planning as target areas of women's health. However, the fourth development plan contained no references to the development of paramedical personnel and continued to link all women's health issues to demographic objectives, which were outlined numerically in the text.[123] Maternal health and family planning programs were to serve as a vehicle for gaining new contraceptive acceptors and "in short, [in the fourth development plan] women's health was not addressed except through the lens of family planning."[124]

By the middle of the 1970s, there was growing consensus in both medical and policy circles that the women's health program was stagnating. Criticisms of the program, both in philosophy and application, had emerged, statistics represented national averages and obscured regional disparities, and improvements in many health indicators (including maternal and infant mortality, assisted births, and contraceptive

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[122] The direct references to women's health focused on two particular PMI projects in Tozeur and Médenine. Bakay, C. (1988), pp. 28-29.
[123] ONFP (1987), pg. 18.
[124] Bakay, C. (1988), pg. 30.

prevalence) had stalled.[125] Further, research, concentrated on a small number of regions and urban centers, remained insufficient, thereby limiting the potential for improving the program.[126] Within this context, the fifth development plan of 1977-1981 proposed to address some of these shortcomings and marked the first substantial shift in the orientation of the women's health program.

Dedicated explicitly to health, Chapter 20 of the fifth development plan addressed women's health through the frameworks of preventative medicine, family planning, nutrition, and health sector investment. By extending the network of primary care facilities (both PMI and family planning centers) and expanding the number of midwives, obstetric nurses, and gynecologists, the fifth development plan aimed to decrease regional disparities in pre and post-natal services, assisted births, and maternal-child health services. Further, for the first time, the fifth development plan outlined goals for improving the nutritional status of the population, particularly among vulnerable groups such as pregnant and lactating women. Finally, the 1977-1981 development plan called for the improvement of the newly articulated concept of "family health." In the spirit of promoting family health, the development plan proposed to focus on enhancing service articulation, expanding health education programs, and improving prevention activities in local dispensaries and clinics. Although the importance of population growth rate reduction, through the expansion of family planning services, continued to be a major theme, the fifth development plan moved away from simply viewing maternal health as a means of promoting demographic objectives. Instead, improvement in maternal health services aimed at

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[125] For information on the stagnation of health indicators during the 1972-1976 period, see Ayad, M & Y. Jemai (1978), Bchir, M. (1988) & Ben Romdhane, H. et. al. (1988b).
[126] Interview (ONFP Representative), Tataouine: April 12, 1999.

lowering maternal and infant mortality, reducing complications in pregnancy, and better integrating maternal-child health, family planning, and family health.

The new emphasis on midwifery training, preventative care, and health education resulted in significant changes within the health system. From 1977 to 1981, the population of professional midwives more than doubled, increasing from 240 to 650.[127] In 1980, the population of physicians had increased to 765, 94 of whom (12.3%) were female.[128] Infrastructural development had also continued and in 1982, the ONPFP had established 159 health centers and the mobile health units operated in 615 centers throughout the country.[129]

Yet, research conducted in the late 1970s and the beginning of the 1980s indicated that severe shortcomings in the women's health program remained. By the end of the fifth development plan research had revealed the persistence of tremendous regional disparities. By 1982, physicians remained disproportionately concentrated in Tunis and the Sahel, as Table 3.1 demonstrates.

Table 3.1: Distribution of the Tunisian Population & Physicians February 1982[130]

Regions	Percentage of Population	Percentage of Physicians	Gap
North East	33.9%	57.3%	+ 24.4%
North West	16.2%	8%	- 8.2%
Central East	20.8%	20.8	0
Central West	14.4%	5.2%	- 9.2%
South	14.7%	8.7%	- 6.0%

An examination of individual governorates reveals more profound disparities. The physician density in Tunis approached one physician per 1,450 inhabitants whereas

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[127] Bakay, C. (1988), pg. 31.
[128] Dahmani, B. (1988), pg. 20.
[129] ONFP (1987), pg. 22.
[130] Table adapted from Dahmani, B. (1988), pg. 27.

this ratio in the rural governorate of Siliana approximated 1 physician per 12,058 residents. Further, in 1982, the southern governorates of Tataouine and Médenine continued to lack a pediatrician and five central governorates contained only one pediatrician each.[131] Foreign physicians provided the bulk of services in rural and central governorates, with non-Tunisians constituting 96%, 85%, 82%, and 52% of the public sector physician population in Sidi Bouzid, Kasserine, Touzeur, and Siliana, respectively.[132] These disparities were also reflected in the distribution of paramedical personnel. In 1982, the density of nurses in Tunis and Sousse had reached one in 259 and one in 267 inhabitants respectively, in contrast to one in more than one thousand in governorates such as Sidi Bouzid, Kasserine, and Siliana.[133] And although the population of Tunis comprised approximately 17% of the Tunisian population, 40% of physicians, 46% of pharmacists, 53% of dentists, and 33% of the paramedical personnel were concentrated in the capital.[134] Finally, the distribution of health infrastructure paralleled the distribution of health service providers. By the end of the fifth development plan, the hospital bed density in Tunis was nearly ten fold greater than that in rural and central governorates, such as Touzeur and Siliana.[135]

The disparities in the distribution of personnel and infrastructure certainly contributed to the regional disparities in health indicators. A female child born in 1978 had a life expectancy of 70.8 years in Monastir, 66.3 years in Tunis, and 54.5 years in Sidi Bouzid.[136] In 1981, the maternal mortality rate in southern and central

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[131] Ben Ayed, A. (1984), pg. 88.
[132] Ben Ayed, A. (1984), pg. 87 & Fassin, D. (1983), pg. 300.
[133] Ben Ayed, A. (1984), pg. 87.
[134] Ben Ayed, A. (1984), pg. 86.
[135] In 1982, the hospital bed density had reached 48 per 10,000 inhabitants in Tunis, 5 per 10,000 in Tozeur, and 3 per 10,000 in Siliana. Ben Ayed, A. (1984), pg. 87.
[136] Bchir, M. (1988), pg. 56.

governorates was approximately double the maternal mortality rate in Tunis.[137] Further, the maternal mortality rate in hospitals in Tunis was significantly less than the maternal mortality rate in hospitals outside of the capital.[138] The rates of contraceptive prevalence, assisted childbirth, pre-natal consultations, and infant mortality differed significantly among regions and governorates, as well as within governorates, further reflecting urban-rural disparities.[139]

However, disparities in the distribution of personnel and infrastructure did not fully account for the disparities in health indicators. In spite of the fifth development plan's departure from previous development plans, the 1977-1981 development plan continued to situate women's health exclusively within the context of procreation, reproduction, and motherhood, thereby limiting the scope of services that were provided.[140] A study conducted in Siliana in the early 1980s found that poor service quality, a lack of service integration, and the limited authority of local practitioners to determine the types of service provision exacerbated systemic problems related to access and opportunity cost.[141] An evaluation of post-natal consultations at a PMI center in Zouhour concluded that post-natal services lacked an integration of maternal and pediatric services and reflected an absence of education on issues such as nutrition, hygiene, infant care, and family planning.[142] Rym's experience in Médenine in the 1970s illustrates the lack of service integration.

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[137] Ben Romdhane, H. et. al. (1988b), pg. 65.
[138] Ben Romdhane, H. et. al. (1988b), pg. 60.
[139] Both within and between governorates, rural to urban migration continued at a steady rate throughout the 1970s. By 1980, more than 50% of the Tunisian population resided in cities. Taamallah, M. (1986), pg. 380. However, the distribution of health services was not commensurate with this population distribution, with both facilities and personnel concentrated in urban areas. For examples of regional and rural-urban disparities in women's health indicators see Azlouk, Z. et. al. (1986), Bchir, M. (1988), Fassin, D. (1983), Gueddana, N. et. al. (1986), ONFP (1997) & ONFP (1998).
[140] Bakay, C. (1988), pg. 32.
[141] Fassin, D. (1983).
[142] Zouhour is a low-income area located in Greater Tunis. Kefi, Z. (1984).

Rym's Story

In 1972, at the age of twenty, Rym married a successful and handsome friend of the family. Prior to their marriage, Rym and her fiancé consulted a physician for a routine medical examination. The doctor conducted blood tests, discussed vaccination and pre-natal care schedules, and encouraged Rym to deliver her children in the hospital. However, Rym was given no information about family planning or contraception; it was assumed that she would want to have her first child as soon as possible. Rym became pregnant with her first child three months after her marriage and attended three pre-natal consultations throughout her pregnancy. During the prenatal consultations Rym was measured, examined, and given medication, but the mechanics of pregnancy and childbirth were never discussed. Thus, when it came time to deliver, Rym was terrified: she did not know from where the baby would emerge. Ashamed and embarrassed, Rym refused to remove her underwear and did not inform the midwife when she began to feel something hard between her legs. When the baby began to crown, Rym tried to push it back into her body with her hand. However, with the help of a competent and friendly midwife, Rym ultimately gave birth to a healthy girl.

After her delivery, Rym was not given any information about caring for herself or the newborn. The new mother returned home confused: she did not know how to breastfeed, clean, or care for the baby and she felt overwhelmed and exhausted. As her daughter was healthy, Rym did not return to the maternal-child health center until she became pregnant for the second time. Throughout the 1970s, Rym obtained regular pre-natal care and delivered her children at the hospital. Only in 1981, after her fifth delivery did a practitioner discuss breastfeeding, nutrition, child-care, and contraception with her.[143]

Experiences like Rym's were not unique and informed the growing call for reforms in the women's health program. Indeed, studies published in the early 1980s argued that improvements in women's health required greater service integration, the decentralization of both service determination and health service provider training, a broader realm of service activity, including more prevention and nutrition education, and the regularization of mobile health team schedules.[144] These researchers argued that the devolution of authority to local health centers and service providers would allow for better tailoring of services to the local population and would broaden the

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[143] Interview, Médenine: April 8, 1999.

[144] Dufriche, O., et. al. (1986, mai), Fassin, D. (1983), Kefi, Z. (1987) & Maguire, S., et. al. (1982, September).

scope of activities provided. This emerging body of research, which documented both direct and indirect impediments to access, informed the reforms present in the sixth national development plan.

Like its predecessors, the sixth development plan of 1982-1986 continued to place primacy on family planning and quantifiable demographic objectives and to promote prenatal, post-natal, and delivery care, with the goal of improving infant mortality and morbidity. Formal references to women's health continued to be limited to maternal health and reproduction. However, the sixth development plan formally introduced a new focus into the Tunisian national health system, that of primary health care. The reorientation to primary health care moved away from investment in health infrastructure and emphasized the need for improvement in care quality, promotion of preventative health services, and targeted investment in rural and underserved areas, including the construction of sixty new primary health facilities.

> This new orientation [toward primary health care] has already been retained by the sixth development plan…relying on a more equitable distribution of infrastructure, equipment, and personnel, according priority to the most vulnerable groups in the population, and sufficiently taking into account the problems of malnutrition and environmental degradation.[145]

On June 9, 1981, the reorientation resulted in the creation of the Direction des Soins de Santé de Base (DSSB). [146] Housed under the MOPH, the DSSB was established to

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[145] Ben Ayed, A. (1984), pg. 92.

[146] The DSSB was one of four departments created in 1981-1982. The other three departments included the Direction de la Médecine Scolaire et Universitaire (DSMU), Direction de l'Hygiène du Milieu et de la Protection de l'Environnement, and Direction de la Médecine de Travail. These four departments derived from the Direction de la Médecine Préventive et Sociale (created in 1974) and constituted the new orientation toward integrated primary health care.

promote primary health and the integration of curative and preventative services.[147] Although other organizations within the MOPH, including the ONPFP, continued to have significant autonomy, and although the goals of the primary health program were given in generalities, a national commitment to primary health care had been formalized.

The reorientation to primary health care was influenced by both the aforementioned domestic critiques and emerging international trends. In 1978, the International Conference on Primary Health Care was convened in the former Soviet Union in Alma-Ata. Sponsored by the World Health Organization (WHO), the conference resulted in the adoption of the global commitment to "health for all by the year 2000." Primary health care formed the backbone of this initiative. The Declaration of Alma-Ata provided the following definition,

> Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process.[148]

The Conference of Alma-Ata concluded with calls for national and international action to design and implement programs dedicated to primary care, the central elements of which included the integration of preventative and curative care, the

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[147] Gribaa, H. (1999), pg. 47.
[148] WHO (1978).

peripheralization of services, the integration of health and development strategies, and the participation of local communities in health promotion.[149]

The reorientation of the international community toward primary care had been building throughout the 1970s, reflected in the Tunisian context by a limited number of bi-lateral and multi-lateral funded projects. Although family planning programs and health infrastructure development dominated international assistance in Tunisia throughout the 1970s, the rural health project of 1977 and the health and population project of 1981 signaled the reorientation toward primary health care. In cooperation with USAID, the rural health project aimed to provide technical assistance and create forty-one integrated primary health facilities in Siliana and Sidi Bouzid. The World Bank sponsored a health and population project that focused on re-enforcing and extending the primary health system throughout eight governorates.[150] Thus, the reorientation of the sixth development plan represented, to a certain degree, a continuation of a trend that had been building throughout the fifth development plan, through both specific projects and the formulation of the concept of family health. As M. Camau et. al. wrote, "The existence of a trend favorable to integrated medicine predates [the sixth development plan]. But until then, [integrated medicine] lacked an important base of support among health service professionals and a favorable international environment capable of legitimizing its proposals."[151]

Women's health was not directly referred to in the context of primary health care in the sixth development plan. However, the reorientation toward primary health care was viewed by many as having the potential to address a number of the problems plaguing the women's health program. As C. Bakay noted,

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[149] Camau, M. et. al. (1990), pg. 225.
[150] Camau, M. et. al. (1990), pg. 228.
[151] Camau, M. et. al. (1990), pg. 229.

> The development of primary health centers close to the population (notably in rural areas) and offering women and children needed preventative and curative care will make a significant contribution to the woman and her child and will favor better health.[152]

One of the most significant changes affecting the women's health program was the devolution of decision-making within the health system. Following the sixth development plan, health service providers obtained a greater degree of autonomy in establishing services and programs to meet the needs of local populations. The shift to the peripheralization of authority benefited rural and underserved areas and created a space for the innovative actions of female health service providers. A Tunisian academic succinctly described this evolution in decision-making by stating, "After 1980 the women's health program began to change. Women had become more educated and realized that, to be effective, women's health had to be approached in a different way. These women, midwives, nutritionists, nurses, health aides, were finally in a position to effect change within their communities. It was a period of immense creativity and growth."[153] The experiences of individual health service providers illustrate this shift in authority.

Nadia's Story

When Nadia's family moved from Tunis to Gabes in the early 1970s, Nadia immediately noticed a difference in women's health services. At that time, women's health services in the south were extremely limited and reflected a shortage of service providers. This situation motivated Nadia to become a nurse. After completing her training in Gabes, Nadia began working at a PMI center in a small community south of city. However, due to the shortage of midwives and doctors in the south, the government initiated an obstetrics-training program for nurses. Thus in 1982, Nadia traveled to Sfax to complete a four-month training in obstetrics. After the training,

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[152] Bakay, C. (1988), pg. 33.
[153] Interview (Academic), Tunis: October 28, 1998.

Nadia relocated to Matmata where she began working as a delivery nurse in the maternity ward of the local hospital.

Upon her arrival, Nadia noted that postpartum care was negligible and breastfeeding was not routinely discussed, either in the pre-natal consultations or after the delivery. Nadia initiated a program in which women were given their babies immediately after the delivery and allowed to sleep with their newborns during overnight stays in the hospital. Nadia believed that this would both encourage breastfeeding and promote mother-child bonding. Nadia also used this opportunity to provide women, especially new mothers, with postpartum counseling, on feeding, bathing, and clothing the newborn, nutrition, and family planning. Nadia began to incorporate breastfeeding education into the pre-natal consultations and within a year, this had become the standard of care within the hospital. After four years in the maternity ward, Nadia began to hold weekly and bi-weekly education seminars focused on nutrition, breastfeeding, diabetes, and hypertension. Throughout the 1980s, Nadia kept herself informed of the legal changes affecting maternity leave, breast-feeding, women's health, and female employment and education and informed and counseled women on their rights during their consultations and in the seminars.[154] *Nadia believes that these programs were extremely successful in improving the quality of care in Matmata and empowering women. Although the work was difficult and demanding, Nadia found her work extremely rewarding.*[155]

Nadia's experience demonstrates that the actions of individual practitioners had a profound impact on women's health at the community level. The devolution of decision-making allowed for individual women to take the initiative of developing and tailoring programs to meet community needs. However, collective mobilization also was influencing the position and activities of female health service providers. By the early 1980s, midwives had established informal professional organizations in Tunis and Sousse and nutritionists had started to organize in the capital. These organizations served as a venue for health service practitioners to lobby for institutional reforms, implement in-service trainings, and share experiences in project

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[154] Employment law was reformed in the 1980s with far-reaching implications for working women. In 1983, Law 83/112 guaranteed paid maternity leave, legal reforms in the mid-1980s limited workloads and toxic exposures to pregnant and childbearing-aged women, and a circular in 1992 institutionalized breastfeeding breaks for women employed in the public sector. Further, in 1985 a decree required couples to obtain a medical certificate prior to marriage and in 1988 benefit payments to families were limited to the first three children. For more detailed discussion, see Abderrahim, S. (1996), Cochrane, S. & D. Guilkey (1992), Ministère des Affaires de la Femme et de la Famille (1995) & République Tunisienne (1995).

[155] Interview (Nurse), Nouvelle Matmata: February 3, 1999.

development.[156] The collective action of female health service providers influenced the devolution of authority and served as a means for translating successful local projects to the national level. Although politicians, ministerial bureaucrats, and physicians continued to have final authority over many components of funding, training, and policy, health service providers now directly influenced the implementation of the women's health program. As one physician from Tataouine remarked,

> Changes in the women's health program have resulted from service providers, not bureaucrats. Technicians have taken the initiative: we explain our desires, our efforts, and our projects to administrators at the ministerial level and then we press for reform. Sometimes the process is slow-it can take years to turn a successful local effort into a national program-but good ideas are eventually accepted. The technicians are responsible for the success of the women's health program.[157]

In conjunction with the national focus on primary health care, the shift toward the peripheralization of authority and the initiatives of health service providers resulted in a broader definition of women's health, better service integration, and greater community participation in service determination.

The devolution of decision-making catalyzed expansion of the scope of women's health services. From independence to the mid-1980s, women's health remained formally limited to reproduction and maternity. Primacy was generally not placed on the women themselves as women's health was largely viewed as a means for achieving other primary goals including demographic targets and better infant and child health. Limited to specific periods in women's reproductive lives, women's

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[156] Interview (Academic), Tunis: October 28, 1998
[157] Interview (Physician), Tataouine: April 14, 1999.

health was not generally situated within larger gender, social, or economic contexts.[158] However, the devolution of decision-making created a space for health service providers to establish programs outside of this framework and explore a broader array of women's health issues. In working with local communities to determine local needs, the scope of activities expanded throughout the 1980s to include mental health services, sexual health education, family and domestic violence counseling, nutrition and breast cancer education, infertility counseling, geriatric care, and adolescent health. Some of the programs that emerged were confined to individual health service centers, while others were eventually incorporated into national campaigns and policies. Thus, although the concept of women's health on the national level remained relatively stagnant, the work of health service providers came to include a wider spectrum of physical, psychological, and social health issues and began to span a greater period of women's lives. The breast health program initiated by a male physician in Kasserine illustrated this shift.

Adnan's Story

In 1987, Adnan arrived in Kasserine and became the first gynecologist to work permanently in the governorate. After completing his medical training in France, Adnan took a post in a large public hospital in Sfax with an eye toward working in academia. Adnan's family had played a prominent role in the early nationalist movement and Adnan had entered the field of medicine with the goal of improving the lives and living conditions of the Tunisian people. However, after two years Adnan became restless: he felt that his skills could be put to better use in an underserved area. The Ministry of Public Health soon transferred him to Kasserine.

When Adnan arrived at his new posting, he was shocked by the conditions. Many of the women who came to the regional hospital for routine gynecological care had only consulted a physician in the context of childbirth, abortion services, or trauma. Adnan soon realized that many of the women had misconceptions about their bodies and health. In response to routine questions about breast health, Adnan observed that women became deeply concerned. Taboos surrounding breast cancer were such that many women believed that by discussing cancer, Adnan would bring the condition to Kasserine. Consequently, Adnan decided to launch a breast cancer

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[158] Interview (CERES researcher), Tunis: October 27, 1998.

awareness initiative. Cognizant of the sensitivity required in such a campaign, Adnan began slowly. In conjunction with community health workers and midwives, Adnan began to discuss breast health issues with women in the context of pre-natal, post-natal and family planning services. Adnan and his co-workers encouraged women to come to the hospital for routine gynecological exams and Adnan used these opportunities to teach women how to perform self-exams and monitor breast health. Three years after Adnan arrived in Kasserine breast health had become an important component of the women's health program. Adnan proposed to expand this initiative to other regions of the country and several years later Adnan became involved in the national breast cancer awareness campaign.[159]

Many physicians, particularly those in rural and underserved areas, used the peripheralization of authority to establish programs broadening the scope of women's health services. As Adnan's story reveals, these programs often originated through reforms in direct service provision. Through consultations with individuals, practitioners were able to expand care and begin reshape the concept of women's health.

However, the scope of women's health care also was shifted through programs and activities designed to integrate women's health into the larger social and economic context. Through the expansion of personnel, the encouragement of home visits, and the establishment of rural health service centers, health service providers came into greater contact with the communities in which they served. This contact allowed health service providers to better understand the overlapping social, economic, and community issues affecting women's health and many practitioners established initiatives that addressed health through this framework.

Mounira's Story

In 1982, Mounira began her work as a maternity ward midwife in Ain Draham. Mounira's responsibilities included providing family planning services to women in the community. To that end, Mounira began making home visits soon after her arrival. She quickly realized that the health needs of the women she was servicing

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[159] Interview (Gynecologist), Tunis: November 10, 1998.

included more than family planning and assisted deliveries. For example, in the mountainous region of Ain Draham many women and their families suffered during the winter months from inadequate heat and scarce resources. An expert knitter, Mounira arranged weekly lessons for women at the hospital and the family planning center to teach mothers how to prepare proper clothing for themselves and their children. One of the women who attended the first session went on to become professional knitter and continues to sell her goods to this day. However, in the process of conducting the knitting seminars Mounira learned that women had many other health concerns. Mounira began to combine the knitting sessions with educational programs on food preparation and nutrition, breastfeeding, personal hygiene, diarrheal diseases, and clothing. By 1984, Mounira was spending two afternoons a week, without pay, holding seminars for women in the community. Themes expanded to include pre and post natal information, sexuality and reproductive health education, and family and domestic violence counseling. Over time, these sessions resulted in an increase in the number of consultations, for both pre-natal care and adult and child vaccinations, because women in the community knew and trusted her. By the end of the 1980s Mounira also created a "delivery without pain" program in which she taught women about exercise during pregnancy and breathing during delivery. This became one of her most popular programs and women would often travel great distances to have their consultations with Mounira at the local hospital in Ain Draham.[160]

The experiences of Adnan and Mounira show how the actions of individual health service providers helped to broaden the definition of women's health. By moving away from a model exclusively focused on maternity and reproduction, and more comprehensively and holistically approaching women's health, the women's health program began to encompass a wider spectrum of issues. This more expansive concept of women's health encouraged trust between health service providers and patients, improved the quality of care, and better addressed community needs.

Mounira's experience also illustrates that the devolution of decision-making furthered the goal of integrating women's health services. The sixth development plan's reorientation toward primary health care called for the integration of preventative and curative health services. However, there also was growing recognition within the medical community that improvements in women's health care

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[160] Interview (Midwife), Ain Draham: March 23, 1999.

required better integration of primary health services. The autonomy afforded to practitioners thus contributed to the design of experimental programs aimed at promoting this integration. One of the most successful of these initiatives was led by a group of physicians in Sfax.

In many parts of Tunisia, the fortieth day postpartum marks an important moment for the woman and her child. Historically, a woman returns to the *hammâm* (the public bath) for the first time forty days after giving birth. Accompanied by her newborn and female kin, the woman engages in a ceremonial cleansing denoting her reintroduction into the female social network and her ability to perform household responsibilities. This ritual bath was also made in preparation for the resumption of the conjugal relationship.[161] Recognizing the importance of caring for both the child and the mother in the postpartum period, a small group of physicians initiated a postpartum consultation program in Sfax. Capitalizing on this culturally significant tradition, the physicians, in conjunction with the ONFP, implemented a fortieth-day postpartum consultation program.[162] Women were encouraged to return to a health service center forty days after giving birth at which time pediatric, gynecological, and family planning services were offered. This integrated program achieved notable success.

> Between 1983 and 1987, the number of women returning for the fortieth-day consultation at the Maternal and Neonatal Hospital of Sfax had risen from 60 to 83 percent. Of the 7,686 women who returned for a postpartum visit, 55.6 percent accepted a contraceptive method during that visit.[163]

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[161] Interview (Midwife), Tabarka: March 24, 1999.
[162] The ONPFP changed its name to the ONFP in 1984. This will be discussed in more detail later in this chapter.
[163] Eschen, A. & M. Whittaker (1993), pg. 122.

By the beginning of the 1990s, this program served as a model for postpartum care throughout the country. The physician-initiated program received international acclaim for its success in providing much needed services through the integration of maternal-child health, family planning, and local traditions. A physician in Gabes credits the achievements of the women's health program to this type of integration.

> In my opinion, the success of the women's health program is due to the articulation between health service centers and the integration of different areas of women's health. In Tunisia, physicians have excellent training and are able to identify and address many different types of illnesses and conditions. Physicians work in many different fields, performing multiple tasks, but are also willing to refer patients to others if it is necessary. Local hospitals, regional hospitals, private clinics, we all collaborate with each other and with the local community.[164]

Efforts to formally enhance the integration of women's health services through structural reforms also took on new strength during the sixth development plan. Since the 1960s, women's primary health services centered on the network of PMI and ONPFP centers. In 1968, the ONPFP adopted an approach to family planning service delivery that revolved around mobile health units (MHUs). These teams, which included a midwife, a health aide, and a driver, traveled to rural areas lacking a stationary family planning center.[165] Operating out of PMI centers, dispensaries, and health posts, the mobile health units extended family planning coverage throughout the country. Although these MHUs were able to provide maternal-child health services and routine gynecological care, throughout the 1970s their efforts remained concentrated on increasing the number of contraceptive acceptors and providing

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[164] Interview (Physician), Gabes: August 21, 1998.

[165] Later these mobile health units also were staffed with community health workers. Trial programs with community health workers began in the 1970s but full implementation of the IEC worker program did not occur until the late 1980s.

family planning counseling.[166] Thus, experiences of individual women and community-based studies show that women's primary care often lacked coordination.

In concert with the reorientation toward primary health care, the ONPFP launched an initiative in 1982 to extend family planning services to rural and underserved populations. Modeled after the mobile health unit program, the ONPFP implemented a mobile health clinic (MHC) program, in which eight specially equipped vehicles provided services in areas where mobile health teams were unable to operate.[167] Staffed with a midwife, a health aide, a driver, and often a community health worker, mobile health clinics were designed to provide family planning services, including IUD insertion, pre and post-natal counseling, and gynecological care, to areas of the country lacking stationary facilities. The MHC program was introduced in conjunction with a community health worker training program in order to promote health education and outreach through an information, education, and communication (IEC) program. The combined efforts of the MHUs and the MHCs greatly increased women's access to family planning and primary care services. By 1989, 55 mobile teams serving 868 centers and eight mobile health clinics operated in 22 of the 23 Tunisian governorates.[168]

However, the mobile health program (both units and clinics) in the 1980s provided more comprehensive family planning services than the MHUs in the 1970s. In 1984, the ONPFP officially changed its name to the Office National de la Famille et de la Population (ONFP), reflecting its shift toward more integrated services.[169] Indeed, a study conducted in 1985 found that nearly 60% of visits to the mobile health

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[166] Interview (Former Nurse), Médenine: April 7, 1999.
[167] ONFP (1997), pg. 45.
[168] Coeytaux, F. et. al. (1989).
[169] Abderrahim, S. (1996) & Boukhris, M. (1993).

program were for contraceptive services (including information and follow-up), and the remaining 40% of visits were related to gynecological services and non-fertility related counseling and information.[170] Further, the services provided by the MHUs and MHCs differed between communities, indicating that services were tailored to local community needs. By extending health services to local communities and endowing service providers with a substantial degree of autonomy, health services became more comprehensive and better integrated. This is captured in Leila's story.

Leila's Story

At the age of twenty-nine, Leila had already given birth to six healthy boys. Although she desperately wanted a girl, Leila decided that she could not physically or emotionally accommodate additional children. Thus, in spite of her husband's initial objections, Leila elected to have a tubal ligation in 1974. Liberated by this decision, Leila decided to become a health service provider. Once all of her children had entered school, Leila trained to be a health aide. Self-educated, Leila was a quick learner and her teachers encouraged her to become a nurse. In 1982, at the age of thirty-seven, Leila graduated from nursing school and joined a mobile health team that worked throughout the governorates of Médenine, Tataouine, and Gabes.

Leila worked as both a family planning counselor and as an obstetric nurse. She found that many of the women she worked with were reluctant to use contraception or deliver in hospitals: rumors about the dangers of contraception abounded and many women were afraid of being ill-treated in the hospital. Leila began making home visits and shared her personal experiences with women in the community. Leila explained that her decision to have a tubal ligation affected her life profoundly and afforded her countless opportunities. She provided women with information on family planning, and encouraged women to think about the options. However, Leila never advocated a particular method or pressured women to accept contraceptives; she believed that women needed to make those decisions for themselves. Leila also assisted in deliveries, provided pre-natal and postpartum care, and counseled women on hygiene and nutrition. Through her home visits, Leila became close to many women in the community and listened to their struggles and experiences. She soon began to provide information on women's rights, social services, and literacy programs. Over time, Leila found that this approach led to an increase in contraceptive use, pre-natal consultations, and hospital births: the women trusted her and were comfortable with her because she was like them and understood their experiences.[171]

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[170] Coeytaux, F. et. al. (1989), pp. 160-161.
[171] Interview (Nurse), Médenine: April 7, 1999.

Due in large part to the work of women like Leila, women who were able to relate to the community in which they served and better able to identify and address women's health needs, the number of women obtaining family planning services and routine gynecological care through the mobile health program steadily increased throughout the 1980s. In 1985, the mobile health program accounted for twenty-five percent of the ONFP's operating budget and provided one third of all ONFP services.[172] By the end of the 1980s, the mobile health program had become an integral component of both family planning and the women's health initiative. The success of this more integrated approach to women's primary care prompted the ONFP to introduce prenatal and postnatal care into all ONFP centers in 1986.[173] By extending health services into rural areas and coupling that expansion with a devolution in decision-making, women's health services became better integrated and more responsive to community needs, ultimately resulting in greater use.

Indeed, the peripheralization of decision-making contributed to greater local participation in health service determination throughout the 1980s. A representative from the ATPF reflected on the importance of this shift noting that,

> In the beginning [of the women's health program], women were only viewed as service beneficiaries, they were not consulted about the development of the program or about what their needs were. In fact, the early family planning program was more like a population control program. This changed throughout the 1980s and the program evolved into one that was much more concerned with women's reproductive health and much more committed to meeting local needs.[174]

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[172] The direct costs associated with the mobile health program approached US$1.326 million in 1985. The total budget for the ONFP, including both governmental and donor contributions exceeded US$5.3 million. Thus, the mobile health program comprised 25% of the overall ONFP budget and over 40% of the ONFP budget allocated by the Tunisian government. Coeytaux, F. et. al. (1989), pg. 162.

[173] Boukhris, M. (1991), pg. 16.

[174] Interview (ATPF Representative), Tunis: September 22, 1998.

This integration of local communities into the determination of services occurred through diverse mechanisms. As some of the experiences of health service providers have shown, individual practitioners often created health programs through consultations with women, individually and collectively, to better understand community needs. Zeinab's experience exemplifies the importance of community participation.

Zeinab's Story

In October 1980, Zeinab took a position at a maternal child health center in Zouhour, a low-income community near Tunis. As a nutritionist, Zeinab was brought into the community to address the high rate of malnutrition among children. Initially, she approached her work through discussions with individual mothers, standard "well-baby" checks, and home visits. However, in listening to women in the community, Zeinab observed that the child's health status was a reflection of the mother's life, health status, attitude, and knowledge. She soon learned that malnutrition was intertwined with numerous social issues, including poverty, unemployment, illiteracy, depression, alcoholism, and family stability and Zeinab realized that addressing malnutrition in isolation would not be effective. Because of the link between the health of the mother and that of the child, Zeinab decided to approach nutrition through the creation of a program for mothers.

Zeinab began by organizing a weekly nutrition seminar. Each week, one woman would bring a recipe and lead the group through the preparation of a meal. Throughout the afternoon, Zeinab provided information on nutrition, breast-feeding, and postpartum and pre-natal care, hygiene, and food preparation. Women would then bring home to their families the meal they had prepared during the session. Through word of mouth, women in the community asked to become part of the program and within one year Zeinab was facilitating sessions three afternoons per week. Although meal preparation and nutrition continued to serve as the official objective of the program, women used these sessions to ask questions about other aspects of their health, from family violence and reproductive health, to family planning and depression. Zeinab functioned as a facilitator, encouraging participants to respond to each other's questions, and stepped in only to respond to incorrect information or technical questions. In response to the discussions that arose spontaneously in the nutrition sessions, Zeinab organized seminars on numerous women's health and social issues, including hygiene, respiratory infections, family planning, child rearing, and the legal status of women. Zeinab invited guest speakers from other health centers, local organizations and social service agencies and showed films and videos. As the program continued to grow, Zeinab and her colleagues arranged for day care services so that more women could attend the sessions.

The program continued for several years, much to the appreciation of the participants. Zeinab encouraged women in the community to facilitate the

discussions and organize special sessions. Over time, Zeinab noticed differences in the participants; they dressed up, prepared their hair, and took pride in their appearance. Zeinab observed that the women spoke with greater confidence, asked more challenging and probative questions, and took on greater leadership responsibilities within the group, all indicating increased self-esteem. For Zeinab, empowering the participants and providing women with a forum for self-actualization were the most rewarding aspects of the program.[175]

Zeinab's commitment to enhancing community participation and empowering women through health had a powerful impact on the success of her program. Women individually and collectively were able to provide input and take responsibility for the services that were provided. By the end of the 1980s, increasing numbers of female health service providers strongly believed that women's health was integrally tied to women's empowerment.[176]

Although local participation was often facilitated through the actions of individual health service providers, the community health worker program provides an example of a national project designed to increase community participation. When the ONPFP launched the MHC program in 1982, it also embarked on an information, education, and training (IEC) program. The objective of the IEC project was to extend family planning outreach and education in underserved areas through the use of community health workers (*animatrices*). By recruiting women from rural communities, the ONFP believed that the *animatrices* would be able to better understand the needs, concerns, and fears of women in the community. The *animatrices* were expected to conduct home visits and provide information on family

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[175] Interview (Nutritionist), Tunis: January 26, 1999.

[176] In 1995, H. Ben Romdhane conducted focus groups with health service providers (male and female physicians, midwives, and nurses) in order to investigate the relationship between the family planning program and the improvement of women's status. Midwives, in contrast to physicians, consistently argued that the family planning program revolutionalized Tunisian women's lives, in both rural and urban areas. The group of midwives also contended that the reforms that supported women's legal and political rights worked in tandem with reproductive control, a belief that influenced their approach to their work. Physicians, and in particular male physicians, were less convinced of the importance of this relationship. ONFP (1997).

planning, extend follow-up services, and identify and recruit contraceptive acceptors. In the initial year of the project, thirty-six women were recruited from rural communities and trained to become community health workers.[177]

The *animatrices* were tremendously successful in promoting the use of ONFP services and the community health worker program rapidly expanded.[178] By 1988 more than one hundred *animatrices* worked for the ONFP.[179] From the perspective of the ONFP, the primary objective of the *animatrices'* work was related to the promotion of family planning services.[180] However, the work of the *animatrices* encompassed a much broader array of health issues.

> *Animatrices* are from this community; they know what women's lives are like. They visit women in their homes and they see how they live. Yes, they provide family planning information, but they do much more. They listen to these women and hear about their struggles and their daily lives. The *animatrices* have the time to explain things in language that people understand. They provide women with information on nutrition, child-care, pre-natal care, and hygiene. In El-Hamma, because so many women were interested, the *animatrices* even became involved in a literacy campaign…The work that they do is invaluable.[181]

Much of the success of the community health worker program was due to the *animatrices'* ability to identify and address women's health needs and translate community needs back to the mobile health units and stationary clinics. Thus, the *animatrices* not only reflected community participation in and of themselves, they also served as a vehicle for local participation in the determination of services.

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[177] Coeytaux, F. et. al. (1987), pg. 230.
[178] In 1984, F. Coeytaux, et. al. conducted a controlled study of the efficacy of information, education and communications (IEC) workers in Mahdia. This study found that the addition of an outreach program through *animatrices* had a more positive impact on service output and resulted in more than twice as many new contraceptive acceptors than the addition of service sites alone. Coeytaux, F. et. al. (1987).
[179] Azouz, F. (1994 Juillet/Décembre), pg. 152.
[180] Boukhris, M. (1991), pp. 32-34.
[181] Interview (Midwife), El-Hamma: November 16, 1998.

By the end of the1980s, the MOPH and health service providers had started to address many of the shortcomings characteristic of the first twenty years of the women's health program. Through a reorientation toward primary care and the peripheralization of decision-making, the 1980s witnessed a broadening of the scope of women's health, better service integration, and greater community participation. Women's health indictors at the end of the decade reflected the improvements in the program. The demographic health survey conducted in 1988 found that 99% of currently married women knew a modern method of contraception and 61.7% of the sample had used a modern contraceptive method.[182] By 1992, the contraceptive prevalence rate exceeded 50% and the total fertility rate had fallen to 3.32 children per woman.[183] Abortion services had become widely accessible and in 1988 approximately 23,000 abortions were performed. Representing one per ten live births, abortion "is used primarily as a back-up for contraceptive failure rather than as a major method of family planning".[184] Pre and post-natal services had also expanded considerably; over 70% and nearly 40% of women sought the respective consultations in 1988. This same year, assisted births reached a national average of 72%, with an urban rate of 85% and a rural rate of 58.8%. Vaccination coverage had become nearly universal and in 1991, 90% of children were adhering to the immunization schedule.[185] In 1992, the infant mortality rate had decreased to 32‰ and a study in 1993-1994 found the national maternal mortality rate to be approximately 69 per

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[182] TDHS (1991), pg. 57.
[183] The overall CPR was reported at 54%, with the modern method CPR of 45%. Boukhris, M. (1993), pg. 69.
[184] Cochrane, S. & D. Guilkey (1992), pg. 5. In 1988, the ratio of abortion (number of abortions per 100 known pregnancies) in Tunisia was 9.8. This ratio compares to 18.6 in England and Wales (1987), 22.2 in Norway (1987), 32.7 in Singapore (1987), and 29.7 in the United States (1985). Henshaw, S. (1990), pg. 78. For more information on abortion in a global context see Henshaw, S. (1990) & Coeytaux, F. et. al. (1993).
[185] Further, ninety-nine percent of the population had received the BCG vaccine and over 90% had received the first of the measles series. République Tunisie (1995), pp. 50-52.

100,000 live births.[186] Midwives, paramedical personnel, and community health workers were responsible for much of this progress and had become the foundation of women's primary health services throughout the country. By 1991, health infrastructure had expanded considerably throughout the country and the number of midwives per 10,000 had reached 8.3.[187]

The reforms in the women's health program were not uniform and marked regional and urban-rural disparities persisted. Further, as much of the innovation that characterized the 1980s depended on the initiative of individual health service providers working at the local level, significant variation in both approach and services existed. However, the 1980s were a period of immense innovation and experimentation, resulting in renewed confidence and enthusiasm for the women's health program. Reflecting on this period of women's health care in Tunisia, one public health administrator at the DSSB said,

> The early 1980s was a unique period in Tunisian history. It was the real period of development; it was a time when people were experimenting...People in the early 1980s were very enthusiastic; they were open and creative. There was a broader definition of health developing, one that was more holistic. Being a leader meant something then, someone with people skills, someone who worked well with others. People used to be involved with health care because they wanted to be involved, it was a choice, a drive. People were there for the principles of aiding their communities and being agents of development. This is no longer the case. Now the climate has completely changed.[188]

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[186] Ministère des Affaires de la Femme et de la Famille (1995), pg. 32 & Ministère de la Santé Publique. (1994), pg. 4.

[187] In 1991, the health services network included 29 university hospital and institutes, 25 regional hospitals, 99 local hospitals, 130 peripheral maternity wards, 48 CREPFs and stationary ONFP clinics, and 1,572 primary health centers (dispensaries, health posts, and clinics). Abderrahim, S. (1996), pg. 71.

[188] Interview (DSSB Representative), Tunis: January 26, 1999.

The shift in the late 1980s and 1990s was a dramatic one for the women's health program. This period resulted in both a consolidation of the expanded definition of women's health care and a retreat in local participation and health service provider initiative.

PERIOD III: THE PERINATALITY PROGRAM
NATIONAL STANDARDS AND RE-CENTRALIZATION OF DECISION-MAKING

The changes in the 1980s occurred within the context of a period of ambitious political and economic reform in Tunisia. By the middle of the 1980s, Tunisia was suffering from significant economic, political, and social tensions and unrest. The physical and mental decline of President Bourguiba brought his and the PSD's legitimacy into question and contributed to widespread discontent and instability. The mounting economic crisis led to severe reductions in basic commodities subsidies and provoked popular demonstrations and riots in 1984.[189] Unemployment, socio-economic disparities, economic stagnation, and disillusionment with the regime fueled political opposition, including the Movement de la Tendence Islamique (MTI), which resulted in a harsh extra-judicial response from the government. [190] On November 7, 1987, Prime Minister Zine Labidine Ben Ali succeeded Habib Bourguiba through a "constitutional coup."[191]

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[189] As V. Daines and D. Seddon explain, "In Tunisia, when a wave of demonstrations broke out across the country in January 1984, in response to price increases in basic commodities, women in the southern towns where the demonstrations originated were reported to have supported the demonstrators by shouting and screaming from their houses. During these demonstrations, the security forces fired at the crowd and several people were killed. Many others, including women, were injured." Daines, V. & D. Seddon (1993), pg. 30.

[190] For more discussion on the MTI, see Entelis, J. (Ed.) (1997), Layachi, A. & A. Haireche (1992) & Waltz, S. (1986).

[191] Invoking Article 57 of the Tunisian constitution, on November 6, 1987 Ben Ali assembled seven doctors who certified Bourguiba's incapacity to govern. As Prime Minister, Ben Ali assumed the functions of the presidency until legislative elections were held in 1989. Ben Ali was then thrice elected to the presidency, in 1989, 1994, and 1999. For more information on Ben Ali's transition to

Faced with political and economic instability, Ben Ali assumed power with the promise of political and economic liberalization. As a result of growing debt and the need for economic restructuring, Tunisia embarked on its first round of structural adjustment in 1986.[192] Although economic liberalization pre-dates this agreement with the IMF, the degree of commitment to economic reform changed considerably in the mid-1980s and Ben Ali pledged to honor the commitment to reform. According to political scientist D. Vandewalle,

> The country's acute crisis in 1986 was due to a critical combination of structural and conjunctural factors. With external reserves almost depleted and a current account balance showing a persistent deficit, the government was unable to cope with the combination of a drastic reduction in oil income, bad harvests, and greater competition for exports within the European community; all of this served to reinforce the longstanding but growing imbalance between exports and imports.[193]

Although Tunisia's reforms were predicated primarily on currency devaluation, macroeconomic stability, debt repayment, and enhanced competitiveness, by the 1990s a stronger focus on privatization, decentralization, and controlled social spending emerged.[194] Both F. Zallio and T. Tachibana agree that the first round of structural adjustment (1986-1992) produced mixed results, including successes in

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power and contemporary Tunisian politics, see Entelis, J. (Ed.) 1997, Murphy, E. (1999), Vandewalle, D. (Ed.) (1996), Vandewalle, D. (1988), Ware, L. (1988) & Zartman, I. (Ed.) (1990).

[192] Structural Adjustment Programs (SAPs) developed in the late 1970s and early 1980s in response to the debt crisis in the developing world. Evolving from a shift in international agencies toward neo-liberalism, SAPs are a medium-term strategy for reforming inefficient macroeconomic policies. While not expected to serve as a long-term engine of economic growth, the SAP is intended to generate hard currency to pay off debt and enhance economic viability. Further, structural adjustment aims to encourage trade based on comparative advantage, stimulate foreign direct investment, and down-size parastatal enterprises and public expenditures. To these ends, the SAP usually consists of a series of macroeconomic reforms including devaluation (to increase the competitiveness of exports), deregulation, decentralization, and reduction of subsidies and public sector payroll outlays. Thus structural adjustment aims to rationalize resource allocation in the economy and create policies conducive to long-term sustainable growth.

[193] Vandewalle, D. (1988), pp. 610-611.

[194] For more detailed information on the SAP in Tunisia see Murphy, E. (1999), Vandewalle, D. (Ed.), (1996) & Zartman, I. (1990).

economic growth and public deficit reduction.[195] However, the structural adjustment program (SAP) exacerbated socioeconomic disparities and the social costs were considerable.[196] Thus the second round of structural adjustment, entered into in 1993, was designed to compensate for shortcomings in foreign direct investment, macroeconomic stabilization, and private sector growth as well as offset some of the negative social consequences of the SAP.

The health sector was not a direct target of the SAP. Indeed, the national health budget comprised approximately 3.9% of Tunisia's GDP in 1980 and steadily increased to 4.2% in 1985, 5.2% in 1990, and 5.9% in 1994. Per capita health expenditures also increased from 22 TND in 1980 to 108 TND in 1994.[197] However, as political economist E. Murphy shows, these statistics are somewhat misleading.

> At the twenty-third Maghrebi Medical Congress in May 1994, it became clear that while overall government spending on health services in Tunisia increased during the era of structural adjustment, in real terms it has fallen as a percentage of total public spending. The impact of structural adjustment on health provision has been to transfer an increasing burden of costs onto private individuals and away from the public sector.[198]

Further, foreign aid began to steadily decrease as a proportion of health sector financing. In the1970s, foreign aid constituted approximately 39% of the ONFP's budget, compared to less than 25% in the 1992-1996 period.[199]

The SAP also ushered in a new era of accountability and transparency in the public sector.[200] Although the health sector was not a specific target of public sector

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[195] Tachibana, T. (1995) & Zallio, F. (1995).
[196] S. Zaimeche states that "By 1985... 31 per cent of the rural and 16 per cent of the urban population [in Tunisia] were still living in poverty...By 1987, the situation had worsened and possibly another 5 per cent fell into poverty."
[197] Expressed in US dollars, the per capita expenditure increased from US$54 in 1980 to US$107 in 1994. République Tunisienne (1996), pg. 180.
[198] Murphy, E. (1999), pg. 158.
[199] Ghachem, M. (1997), pg. 15.

reforms, the SAP created an atmosphere of reform that permeated government health organizations. An administrator at the DSSB explained the impact that the SAP had on her working environment.

> I think the structural adjustment program has profoundly affected the health sector. For administrators, it is now more important that employees sign in at 8am and sign out at 5pm than what they do throughout the day. Accountability is about logging hours, not about the work. I have to get permission from my supervisor to go to the faculty of medicine to work in the library! Yes, we need to have greater efficiency and more transparency, but we also need human resource training. We need to encourage employees to maximize their potential and have the freedom to express themselves and implement ideas. That isn't happening anymore, we are constantly being questioned.[201]

Given this context then it is not surprising that by the end of the 1980s, enthusiasm for promoting greater coordination and standardization within the health sector had emerged.

Ben Ali assumed power in 1987 with a pledge to continue to promote the social programs and improvements in the status of women that characterized the Bourguiba period.[202] Thus in the first few years of the Ben Ali presidency the women's health program continued in the tradition set in previous decades. The seventh and eighth development plans (1987-1996) continued to set demographic goals and encouraged the expansion of family planning services, particularly by emphasizing greater birth spacing and delayed onset of marriage and childbearing. Further, the health strategy for the 1990s focused on promoting integrated women's health services, targeting underserved areas, and fusing health objectives with larger

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[200] Interview, (UNDP Representative), Tunis: February 8, 1999.
[201] Interview (DSSB Representative), Tunis: January 26, 1999.
[202] Boukhris, M. (1991).

development and social objectives.[203] Yet, health policy was also influenced by a desire to consolidate the women's health program through a strict delineation of responsibilities and the establishment and reform of national standards, standards that would be easy to adhere to and implement.[204] To this end, the Programme National de Périnatalité (PNP) was initiated.

Developed at the end of the 1980s, the principal goals of the PNP were to reduce maternal and infant morbidity and mortality through the increased integration of the primary health services network and the early identification of and response to high-risk pregnancies. Through the regular and systematic training of health service personnel, the expansion of maternity services, and the standardization of pre- and post-natal care, the PNP aimed to establish greater regional parity in health services and the overall improvement of maternal and child health.[205] After several years of program development, the PNP was first piloted in 1990 and achieved widespread implementation by the mid-1990s.[206]

The PNP formally divided women's health care into four stages: pre-marital, pre-natal, delivery, and post-natal. Within each component of the program, specific recommendations and guidelines were developed. The PNP outlined both the type and schedule of services and identified the member of the health team and the type of health facility responsible for these services. One of the architects of the PNP explained the new regulations.

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[203] Boukhris, M. (1991).
[204] Interview (Gynecologist), Tataouine: November 21, 1998.
[205] Tej Dellagi, R. et. al. (1997).
[206] By 1997, it was estimated that all midwives and at least one physician from each health facility had been trained on the new regulations. Interview, (Gynecologist), Tataouine: November 21, 1998 and Tej Dellagi, R. et. al. (1997).

Major changes in the Tunisian health system occurred in the 1990s and the most significant involves the standardization of pre-natal, post-natal, and delivery services. There are now four books, manuals really, that have been distributed to health service providers throughout the country. These manuals outline the procedures, the expectations for health service personnel, and the requirements for documentation. By systematizing the information that we record, we hope to have better statistics both nationally and regionally. We also hope that by providing national standards of care, women and children will receive more uniform, consistent services that will result in better health outcomes.[207]

The recommendations and requirements for each of the four components of the PNP were determined through a national committee, primarily composed of physicians and ministry representatives. Inspired by the national standards and programs of several Western European countries, the PNP guidelines were culturally tailored to address the needs and conditions of Tunisia.

> The perinatality program aims to coordinate and standardize women's health services. The first step in the process was to develop a series of norms, specific for Tunisia. For example, in the Tunisian context, what is the definition of a high-risk pregnancy? In France, a woman who has four or more children is considered high-risk. But in the south of Tunisia, there are many women who routinely have seven or eight children. How do we define risk based on multi-parity in Tunisia? Our [Tunisian national] statistics indicate that risk increases if a woman has five or more children, so we adopted that as our benchmark. Of course we were influenced by the programs in other countries, but we did not blindly apply them to Tunisia.[208]

Many of the guidelines for the services provided by each component of the PNP were derived from pre-existing programs in Tunisia. For example, although pre-nuptial certificates had been required in Tunisia since 1985, the program had not been widely available, accessible, standardized, or enforced until the development of the PNP. Thus, the pre-marital component of the PNP focused almost exclusively on pre-

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[207] Interview (UNICEF Representative), Tunis: January 13, 1999.
[208] Interview (Physician), Tataouine: November 21, 1998.

nuptial certification and outlined the requirements for blood and STD testing, genetic counseling, and family planning information.[209]

The PNP's guidelines for pre- and post-natal care also emphasized continuation and expansion of the integrated programs that had emerged during the 1980s. In addition to supporting the expansion of pre-and post-natal services to all health facilities within the primary care network, the PNP introduced a schedule for services that recommended four prenatal consultations (in the 3rd, 6th, 8th, and 9th months of the pregnancy) and two post-natal consultations (8 and 40 days postpartum).[210] The pre-natal services were to include monitoring of the pregnancy as well as information on immunization schedules, breastfeeding, and child-care. In the postpartum component, family planning was emphasized. To this end, there was a significant emphasis on expanding the network of *animatrices* and ensuring that all health facilities (including family planning centers, mobile units, DSSB centers, and hospitals) provide comprehensive pre- and post-natal care.[211] Through the use of standardized record keeping involving the mother-child health record booklet, integrated primary health services were monitored and communication between health service centers and providers was facilitated.[212] The improvement in service integration had a profound impact on many women, particularly in rural and underserved areas, as Emna's story demonstrates.

Emna's Story

Emna was married in 1991 at the age of nineteen. Prior to her marriage, Emna knew a great deal about sexuality and women's health; she had been discussing

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[209] The pre-nuptial certificate will be discussed in more detail in Chapter 6.
[210] The postpartum visit on day 8 depends on the baby and mother's condition. This is an optional well baby check unless there were complications in the delivery.
[211] CREDIF (1996).
[212] Njah, M., et. al. (1994).

these issues with friends and young relatives, though never with her mother, for years. Born and raised in Tataouine, Emna wanted to have her first child soon after her marriage in order to prove to her in-laws that she was fertile. She delivered her first child a year and half after her marriage and then delivered her second child a year and a half later. Emna regularly attended prenatal examinations during both of her pregnancies and through these consultations learned valuable information about breastfeeding, nutrition, and vaccinations. Although her mother delivered all of her children at home, Emna delivered both of her children at the local hospital in Tataouine; she felt that the hospital would be safer and more comfortable. She breastfed her daughter for nine months but discontinued when she realized she was pregnant with her second child. After her son was born, Emna closely followed the nutritional guidelines given to her by the midwife; she breastfed him for a year and a half and introduced broth, yogurt, vegetables, and meat at the recommended intervals.

Although Emna has never used traditional medicine or visited traditional healers, she looked forward to participating in the postpartum traditions. On the 7th day after the birth of her first child, Emna and her daughter participated in a traditional celebration; the child was bathed for the first time after leaving the hospital and relatives and friends visited the new mother at her home bringing with them special foods and sweets. On the 40th day after her first delivery, Emna went to the hammâm for the first time. Joined by her mother and in-laws for a ritual bath, the women wrapped Emna's stomach with scarves in order to close her uterus and promote future fertility. On the 40th day postpartum, Emna also visited the local PMI where she discussed family planning options with a midwife. The midwife encouraged her to use a method of contraception immediately, but Emna explained that she wanted to have another child as soon as possible. The midwife was supportive of this decision and discussed vaccination, nutrition, and child rearing with her.

After the birth of her son, Emna also celebrated on both the 7th and 40th days. The 7th day celebration for her son included the slaughter of a sheep and relatives brought gifts for both mother and child; the community celebrated the birth of a son more than the birth of a daughter. On the 40th day postpartum, Emna again visited both the hammâm and the PMI. However, on the visit to the PMI, after discussing her options with the midwife, Emna decided to accept an IUD. She felt that the IUD would be easier than pills, which she had heard caused headaches in young women, and the IUD was inserted during the same visit. Emna would ultimately like to have four or five children but she feels it is important to space their births, both for her own health and the health of her children.[213]

Thus, many of the PNP recommendations formalized and standardized efforts that had been initiated during the 1980s. However, the PNP also ushered in an era of strict role delineation, both for health service providers and health centers.

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[213] Interview, Tataouine: April 9, 1999.

The most significant reforms brought forth in the PNP involved maternity and delivery services. Since the beginning of the Tunisian women's health program, regional disparities in maternal health services and indicators persisted. In the 1990s, these regional disparities continued to influence both health outcomes and health behaviors as Salwa's experience reveals.

Salwa's Story

Salwa is a 43-year-old woman homemaker who originally hails from Gabes. Salwa's husband works for the national pharmaceutical company and Salwa became pregnant with their first child one month after their marriage, at the age of nineteen. After the birth of their first son, the family moved to a small rural area in the governorate of Kairouan, an area without running water or electricity. When Salwa became pregnant with her second child she decided it would be more prudent to travel to her mother's home and deliver her child in Gabes; the obstetric facilities in Kairouan were too dirty and dangerous. Salwa's two sons were born over three years a part, spacing resulting from both long-term breastfeeding and contraceptive suppositories. Her delivery was uncomplicated and she found the services to be excellent. Therefore when Salwa became pregnant four years later, after her family had relocated to a small town in the Cap Bon, she decided to return to Gabes to deliver her third child; Salwa wanted to both be with her mother and deliver in a reliable regional hospital. On the morning that her labor pains began Salwa traveled by bus from Nabeul to Gabes via Tunis. Her journey took all day and she arrived at the Gabes hospital fully dilated; she delivered her daughter within 15 minutes of her arrival.

After the delivery of her third child, Salwa decided not to have any more children, she was pleased with two boys and a girl. While her husband strongly supported her in this decision, Salwa's neighbors were shocked; they believed that it was unfair to her daughter to be raised without a sister and pressured Salwa to have another girl. At first, the pressure did not bother Salwa, but as the family became more comfortable financially she heeded the advice of her neighbors. In 1990, five years after the birth of her only daughter, Salwa discovered she was pregnant again. Although Salwa wanted to return to Gabes to deliver the baby, she decided to remain in the Cap Bon; her due date fell in the month of Ramadan and Salwa decided she could not leave her husband and children during that period. Salwa's labor pains began in the afternoon and she was promptly admitted to the hospital. However, just as Salwa started to deliver her baby she heard the sound of al-maghrib, the final call to prayer. As the baby's head began to emerge she called for the midwife, but the midwife and other staff members were breaking their fast and thus no one came to her aid. Salwa delivered her child alone. When the midwife came to her bed, she found Salwa cradling her newborn son. Salwa left the hospital the following day, and although both she and the newborn were healthy, she decided she would never return

to a health facility in the Cap Bon. Nine months later, the family moved to Ancienne Matmata so that Salwa could be closer to her family and reliable hospitals.[214]

Salwa's experiences with childbirth, both traveling by bus to Gabes and delivering her fourth child in the Cap Bon, carried significant risk. To reduce maternal and infant morbidity and mortality the PNP established formal standards in delivery care. The PNP standardized the forms used by maternal health facilities to facilitate accurate record keeping and promote service standardization. Equipment, medication, and personnel standards also were established for each type of health facility, and the types of deliveries each type of facility was expected to accommodate were outlined.[215] Women identified as having high-risk pregnancies were to be transferred to the appropriate type of facility.[216] The PNP recommended that identification of high-risk pregnancies occur in the course of pre-natal consultations or during presentation for delivery. The number of conditions requiring transfer is extensive and includes,

1. Women with co-existent conditions (such as anemia, diabetes, and hypertension);
2. Women with complicated obstetric histories (i.e. five or more offspring, infertility, or a previous delivery by cesarean section or requiring the use of forceps);

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[214] Interview, Ancienne Matmata: April 6, 1999.

[215] The Tunisian health system is divided into tiers. Primary health facilities and local hospitals constitute the base of the system and are distributed throughout the country. The second tier is comprised of regional hospitals, with at least one facility located in each governorate. The third tier includes the university, research, and specialist hospitals. For more information on the structure of the Tunisian Health System, see République Tunisienne (1996).

[216] High-risk pregnancies are evaluated and assigned a priority ranking. This ranking is based on whether particular services are expected to be necessary (an OBGYN only vs. an OBGYN, a pediatrician and a fully equipped operating theater). This ranking is then used to determine the appropriate transfer facility. Interview (Midwife), Douz: February 15, 1999.

3. Women presenting with difficult pregnancies (multiple, breech, large, small, or premature fetuses); and
4. Women with complicating physical conditions (small stature, obesity, physical disability, or older than 40).[217]

Requirements for transfer were precisely outlined and regional and national reporting was mandated.

In addition to defining the requirements for maternity facilities, the PNP also outlined the expectations and responsibilities of midwives. The midwife's role in documentation and record-keeping, high-risk pregnancy identification, and follow-up was clearly established. Further, with few exceptions, midwives were prohibited from performing high-risk deliveries.[218] Following the lead of the PNP, the MOPH issued an Order in November 1996, which reformed the approved perimeters of midwifery practice. As a national commission member explained, "The [PNP] reforms especially target midwives. Midwives are not physicians and they should not behave like them. Now [midwives'] responsibilities are delineated and limited, and once a problem is identified, the physician is in charge of the delivery."[219] Thus, the PNP proposed national standards for services and documentation, outlined the responsibilities and roles of both health service providers and health centers, and promoted integrated primary health services in four areas of women's health.

Consistent with the orientation of the PNP, other sections of the MOPH also launched programs promoting better primary health service integration and regional parity in service provision. By 1994, regionally focused research projects became the norm throughout the country and as national standards became more widely

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[217] Commission Nationale de Pérnatalité (1990).
[218] The exceptions are based on emergency circumstances, when transfer is not a viable option.
[219] Interview (Gynecologist), Tataouine: November 21, 1998.

implemented, region specific statistics became more accessible. For example, research conducted in 1994 found that contraceptive prevalence rates in the governorates of Kasserine and Tataouine (34%) lagged significantly behind the national average (60%).[220] The ONFP, working with both bilateral and international donor organizations, established initiatives in rural and underserved areas.[221] This included a stronger focus on extending the network of *animatrices*. A representative from the UNFPA described one of the cooperative projects.

> In 1997, the UNFPA initiated a project with both the ONFP and NGOs. The "reproductive health in underserved areas program" focused on training *animatrices*...These young women, many of them unmarried, are selected by either the local government authority or the NGOs. The women attend a training that is supervised by the NGO and focuses on a variety of health issues, including pre-natal care, family planning, hygiene, and sanitation. Many of the *animatrices* came to the project very timid and shy. Now they are much more assertive and excited about their responsibilities and their work. This increased confidence is good for other women in the community, role models if you will...Two hundred and fifty *animatrices* have been trained through our program with the mission of orienting communities to family planning and health issues. They work in 250 different communities and serve about 100 families each. The women work 4-5 hours each day and receive a symbolic salary of 75 TD/month. The project has been so successful that the ONFP will most likely extend the program. It may also be possible to have the program encompass other areas, such as educating women about their rights and democracy. This program has been successful because women come from the community and feel responsible for working toward the improvement of their community. They are dynamic agents of change and we are extremely proud of them.[222]

Government organizations dedicated to women, including CREDIF and the UNFT, continued to work in the field of women's health, primarily through educational

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[220] Interview (ONFP Representative), Tataouine: April 12, 1999.
[221] One of the most significant was an extensive rural family-health initiative supported by the World Bank. CREDIF (1996), pp. 120-121.
[222] Interview (UNFPA Representative), Tunis: January 11, 1999.

seminars, thematic conferences, and research.[223] These organizations also served as important links to the NGO community working in the field of women's health through direct service provision, training programs, educational campaigns, research, and financial investment in infrastructure and personnel.[224] These combined government-NGO efforts did much to address the needs of women in historically underserved communities, as Khadija's experience reveals.

Khadija's Story

From a Berber village near Tataouine, Khadija is in her early forties and has been married for over twenty years. Khadija and her husband have nine children: seven boys and two girls. Khadija was married just after her twentieth birthday and had her first child within a year. Although Khadija had intended to deliver her first child at home, prolonged labor concerned her mother who encouraged her to go to the local hospital. Khadija delivered her first son almost immediately after she entered the maternity ward. The midwife who delivered the baby spoke with Khadija about breastfeeding and showed her how to hold the baby and get him to suckle. She did not speak with Khadija about contraception or postpartum care and Khadija left the hospital the same day.

Khadija delivered her next two children at the local hospital and all of her deliveries were quick and pleasant; the nurses and midwives treated her well and her mother always accompanied her to the hospital. However, after the birth of her third child, Khadija did not visit a health service provider for over twelve years. At the end of her fourth pregnancy, Khadija decided it was simply more convenient to stay at home. Khadija's neighbor and several of her female relatives assisted Khadija through the delivery and with the postpartum period. As her home birth experience was comfortable and convenient, Khadija delivered the rest of her children at home as well.

Khadija's nine children were born with only a year between each pregnancy; Khadija would breastfeed each newborn until she became pregnant with her next child. Even though Khadija had only intended to have five children, Khadija never used contraception; no one had ever spoken to her about it and she never had the opportunity to obtain it. However, after the birth of her ninth child, an animatrice visited her at her home. The animatrice, who was from Douriet and knew Khadija well, spoke with Khadija and encouraged her to visit the family planning center in Tataouine. Khadija knew that she did not want an additional child and heeded the

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[223] CREDIF, the Centre d'Etude, de Recherche, de Documentation et d'Information sur la Femme, was created by government decree in 1990 to serve as a clearing house for research and information on women. CREDIF has sponsored several conferences on women's health issues, including mental health (1995), obesity (1997), and smoking (1997).

[224] NGOs working in the field of women's health include the ATPF (est. 1968), ATFD (est. 1989), and JMSF (est. 1993). International NGOs providing direct service provision include Swedish ACT and ENDA Inter-Arabe.

advice of the animatrice. After a warm and friendly reception by the midwife at the family planning center, Khadija opted for an IUD; she felt that birth control pills might exacerbate her headaches and she thought that single use methods carried too much risk of failure. Nearly three months after her visit to the family planning center, Khadija remains pleased with the IUD. Though she loves all of her children, she only wishes that she had learned of the device earlier.[225]

Although primary health care continued to be the principal focus of the PNP and the health reforms in the 1990s, the MOPH also initiated efforts to improve tertiary health services. University hospitals, specialized hospitals, and research institutes benefited from public sector investment in research, equipment, technologies, and personnel. Initiatives to explore the prevalence, detection, and treatment of breast cancer, uteral and ovarian cancer, infertility, and menopause were also supported through international organizations.[226]

> Tunisia is now entering a phase that focuses on a broader concept of reproductive health. Beginning in 1997 the UNFPA became involved with creating greater awareness about the new concept of comprehensive reproductive health and we now provide the government with information and support. This new phase includes a focus on new technologies, on cancer, menopause, and infertility and moves beyond primary health services.[227]

Although treatment and research centers remained concentrated in Tunis, Sousse, and Sfax, initiatives focusing on education, prevention, and early detection were also developed and extended to central and southern regions of the country.

The impact of the overall reforms in the 1990s, and the PNP specifically, have yet to be fully evaluated. However, preliminary assessments suggest that maternal and infant mortality and morbidity statistics have improved and progress toward

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[225] Interview, Douriet: April 10, 1999.
[226] Ben Ahméd, S. et. al. (1997), Farhat, K. et. al. (1996), Gorgob, K. et. al. (1993), Khrouf, M. (1993) & Mesedi, W. et. al. (1993)
[227] Interview (UNFPA Representative), Tunis: January 11, 1999.

greater regional parity has been made.[228] Although there is growing recognition that full implementation of the PNP will require additional training and formal evaluation, the PNP has been hailed as a resounding success both among physicians and within the Tunisian government.

Yet, preliminary examination of the PNP suggests several limitations. The underlying philosophy of the health reforms in the 1990s has resulted in a re-centralization of decision-making and threatens to undermine local participation. The erection of national standards, the streamlining of services, and the strict delineation of health service provider roles appears to have re-institutionalized physician based hierarchies, endorsed the medicalization of childbirth, and inhibited the creation of local programs and initiatives. A full assessment of the PNP remains premature, but with this precaution in mind, three areas of potential concern can be identified.

A prominent feature of the re-centralization of decision-making is the return to physician-based hierarchies. The architects of the PNP were predominately male physicians and during the development of the PNP there were few avenues designed for input from midwives and paramedical personnel.[229] This has most profoundly affected the area of obstetric care where control has largely been transferred from midwives to physicians. Further, due to the requirements of the transfer system, specialists are taking on increased responsibility within the health sector, being responsible for a large proportion of deliveries. As there continues to be a shortage of

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[228] However, these statistics should be approached with caution. Widespread confusion exists over the reporting requirements for women who are transferred during childbirth. Many health service providers are unclear as to which institution (the institution of origin or the institution of reception) is to report a maternal or neo-natal death. Due to lack of coordination and follow-up, it appears that mortality and morbidity is being under-reported under the new guidelines. Interview (Gynecologist), Tataouine: November 21, 1998, Interview (Hospital Administrator), El-Hamma: November 14, 1998, Interview (Health Administrator), Nouvelle Matmata: February 3, 1999, Interview (Hospital Administrator), Testour: March 22, 1999, & Interview (Midwife), Teboursouq: March 22, 1999 & Interview (ACT Representative), Sidi Bouzid: April 1, 1999.

[229] Interview (Gynecologist), Tataouine: November 21, 1998.

Tunisian specialists, the PNP has relied on increasing numbers of foreign physicians, particularly in rural areas.[230] Many of these foreign physicians are from Eastern Europe and Central Asia, resulting in significant cultural and language barriers. As one woman from El-Hamma explained,

> When I started to have the miscarriage I went to the local hospital [in El-Hamma] and then I was taken to the hospital in Gabes by ambulance…The doctor [in Gabes] was not Tunisian. I do not know where he was from, but he did not speak Arabic. I could not speak to him directly; we spoke only through an interpreter. The interpreter asked how many children I had, whether or not I was using a method of family planning, and whether or not I had previously miscarried. I told him that I had not had miscarriages and that I did not follow a family planning method. That was it, the interpreter left the room. He never explained what was happening to me. After the miscarriage, the doctor gave me an injection and I still do not understand what was wrong with me.[231]

The re-orientation toward physician-based delivery care has not only affected patients, but also has severely undermined the role of midwives. In addition to aiding in the collection of statistics and improving health outcomes, the national standards were designed to take responsibility away from local health service providers and administrators. The comprehensiveness of the transfer system has resulted in substantial transfer rates from local hospitals to hospitals in regional centers; in some regions, transfer rates approach nearly fifty percent.[232] This is not to suggest that the transfer guidelines are inappropriate. However, midwives with more than 20 years experience who have successfully handled hundreds of breech births, twins and other

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[230] There appear to be two primary reasons that foreign physicians are concentrated in rural areas: 1) many Tunisian specialists are disinclined to live in rural and impoverished areas devoid of research facilities, and 2) there is a greater need for specialists in central and southern governorates as a higher proportion of women are identified as high risk. Interview (ACT Representative), Sidi Bouzid: April 1, 1999 and Interview (Physician), Tabarka: March 24, 1999.

[231] Interview (Salima), El-Hamma: November 18, 1998.

[232] Interview (Midwife), Douz: February 15, 1999, Interview (Midwife), Ain Draham: March 23, 1999, Interview (Midwife), Teboursouq: March 22, 1999 & Interview (ACT Representative), Sidi Bouzid: April 1, 1999.

complicated deliveries now face reprimands for performing these deliveries at local hospitals. As was noted by a midwife in Teboursouk, "My job is simply not interesting anymore. To be in compliance, I have to transfer everyone."[233] There is considerable fear that failure to comply with transfer requirements will result in severe personal repercussions.

> In one of the areas of Sidi Bouzid that we work in, more than 40% of women are transferred. Service providers are scared. A couple of years ago there was an in-service training and a bigwig at the MOPH said that the goal was to completely eliminate maternal and neo-natal mortality in the region. The administrator explained that if there was a single maternal death "heads would roll." Not surprisingly, there have been some strange diagnoses when women die during or just after delivery. Women's deaths are being recorded as the result of rare conditions and illnesses. Retrospective inquiry into preventable deaths is not occurring and so improvements aren't really happening.[234]

Thus, there is a widespread feeling among midwives, and other paramedical personnel, that they have lost much of their autonomy and responsibility.

However, the aforementioned quote also demonstrates that national objectives have begun to take precedence over individual and local community needs. There appears to have been a movement away from an emphasis on individual needs toward a focus on standardized guidelines, which support routine medical and surgical interventions. Preliminary reports suggest that the rate of cesarean section deliveries has increased with the implementation of the PNP.[235] This is occurring in both rural and urban areas, as is illustrated by one woman's experience with childbirth at a main hospital in Tunis,

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[233] Interview, Teboursouk: March 22, 1999.
[234] Interview, (ACT Representative), Sidi Bouzid: April 1, 1999.
[235] Interview (Physician), Tunis: February 20, 1999, Interview (Physician), Interview (Physician), Tabarka: March 24, 1999 & Interview (MOPH Representative), Sidi Bouzid: April 2, 1999.

I delivered my fourth child in Tunis because I had gone to visit my mother. I had been in labor for a long time, longer than with my previous children. They [hospital staff] asked me if I wanted an operation [cesarean section] and I told them I did not...But then the nurses started to yell as me. They told me that I had to deliver or I would be forced to have an operation. Maybe they thought that by pressuring me I would deliver more quickly, but it just made me nervous...My labor pains were very severe and when I started to cry one of the nurses hit me. I will never give birth in Tunis again, even though this is where my mother lives. I prefer the hospital in Tataouine; people there are patient and nice.[236]

The role of individual health service providers' judgment, either in transferring a pregnant woman or in establishing a program in a local community, was minimized during the standardization process, thus inhibiting creativity and displacing responsibility at the local level. Influenced by the economic reforms in the late 1980s, the PNP also responded to a drive to eliminate perceived government waste and thus budget cuts made experimental health programs difficult to sustain.[237] Erosion of local authority curtailed the activities of midwives and health aides, and by the mid-1990s, the era of local programming had drawn to a close.[238]

The PNP has also dealt a blow to progress in the definition of women's health. Although the women's health program has evolved from one previously dedicated almost exclusively to family planning and the promotion of development and demographic objectives, the PNP continues to define women's health as primarily related to reproduction and motherhood. Although this was certainly the national orientation in the 1980s, the actions of health service providers and local communities led to a broadening of the definition of women's health at the local level. Rather than continuing in that vein, the government has again formally limited the definition of women's health.

[236] Interview, Tataouine: April 10, 1999.
[237] Interview (Physician), Tunis: February 8, 1999.
[238] Mounira's knitting sessions and Nadia's seminars were both curtailed in the early 1990s.

Women's health can be looked at as a series of levels or stages. The first is the family planning and contraceptive stage. The second is a movement toward more desired fertility and thus includes work on infertility. The third stage looks more generally at women's reproductive health and thus refocuses on sexuality and issues such as STDs. Tunisia has completed the first stage and with the perinatality program, we have formally entered the second stage. There has been a little progress on the third stage, but this will require a shift toward young people, premarital sexual relations, and the identification and early treatment of STDs. We aren't there yet and I don't anticipate that we will be for many years to come.[239]

By re-centralizing decision-making, reinforcing medical hierarchies prioritizing physicians over midwives, and moving away from local community input into service determination, the PNP risks ignoring several important areas of women's health care, areas that were, albeit on the local level, addressed in a wide variety of ways in the 1980s. It is within this context that the second part of this dissertation will explore three areas of women's health that are largely ignored by the health reforms of the 1990s: traditional women's health services, domestic violence, and young women's health and sexuality.

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[239] Interview (Gynecologist), Tunis: November 9, 1998.

CHAPTER 4: THE CONTINUED IMPORTANCE OF TRADITIONAL BIRTH ATTENDANTS IN THE TUNISIAN SOUTH

Salima's Story

Salima is 33 years old and from a medium size town near Gabes. Salima was 25 years old when she married her husband. Like most women in El-Hamma, Salima wanted to get pregnant right away and her first child was conceived during the first year of marriage. Although Salima's mother delivered four of her seven children at home, Salima decided to use the local hospital. She found the hospital facilities adequate, though somewhat unfriendly, and she opted to use a private physician for her pre-natal care. Though she wanted to have a second child, Salima did not become pregnant for four years, and this pregnancy resulted in a second trimester miscarriage. Her husband was informed that Salima's blood and the blood of the baby did not match, and because of this Rh incompatibility Salima was given an injection.[1] *However, another few months passed and she still did not become pregnant. Encouraged by her mother, Salima decided to go to a traditional birth attendant, a* qâbla arabi, *for help.*[2] *The traditional birth attendant (TBA) began by binding her breasts and upper chest with a cord in order to promote closure. Hospital births are believed to cause infertility because women lie on their backs, thus being exposed and open. However, when binding didn't lead to a pregnancy, the TBA gave Salima a lavender based lotion, which she spread over her breasts, knees and ankles. This lotion remained on her body for a week until it fell off naturally. She was also instructed to prepare a special meal of couscous with chickpeas, fenugreek, and rotten meat, which she both ate and sat on. However, neither of these treatments worked. At the advice of a neighbor, Salima decided to go to a traditional healer, a seer, for help. This elderly man told her to buy a goat of three colors; red, white and black. When she later returned with the goat she was instructed to lay on the ground, with the goat on top of her, for five minutes. The next month she became pregnant and ultimately delivered a healthy son. Salima believes that her infertility was caused by a lack of faith. This act with the goat demonstrated her belief and she was ultimately rewarded with a child.*[3]

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[1] Individuals are designated Rh+ or Rh- depending on the presence or absence of specific red blood cell surface antigens (Rh factor). Rh incompatibility occurs when an Rh- woman becomes sensitized by blood of an Rh+ fetus. During subsequent pregnancies, if the fetus is Rh+, the woman produces antibodies that may cross the placenta and destroy fetal cells, resulting in miscarriage. Although Salima was not familiar with the term Rh incompatibility or the biological explanation for the miscarriages, this appears to have been the cause.

[2] There is some debate about the transliteration of this word. قابلة or قابلة (depending on the region) is transliterated as qâbila in the H. Wehr dictionary, but I have also seen it transliterated as qaabila, qâbla, kâbla (French) and gâbla (regional). Throughout the dissertation, the qâbla transliteration will be used as this best represents the pronunciation of the term in Tunisian dialect.

[3] Interview (Salima), El-Hamma: November 18, 1998.

INTRODUCTION

Often an artificial dichotomy is created between users of "traditional" and "modern" health services.[4] As C. Obermeyer suggests in her work on Morocco and Tunisia, "The shift from traditional to modern health care is not necessarily a unidirectional process that results from the increasing enlightenment of potential clients. While many of the studies of health-care use are based on a dichotomy between users and nonusers of health services…this division may not correspond to the more fluid reality of health-care behavior."[5] Indeed, as exemplified in Salima's story, women in Tunisia often simultaneously use multiple types of services, combining traditional medicine with bio-medical services and visits to traditional healers with physician consultations. For women in the center and south of the country, the traditional birth attendant is the most significant of the traditional healers and continues to play an extremely active and important role in women's health.[6]

Drawing on both the limited body of research previously conducted on TBAs and primary research, this chapter discusses the continued activities of TBAs in the interior and south of Tunisia.[7] In her work on 18th and 19th century Tunisia, D. Larguèche explores issues of women's empowerment and marginalization, with specific reference to health and healing. Drawing from judicial archives, medical

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[4] The term "traditional" in reference to health is problematic. Alternative and complementary medicine are frequently used in the literature, but these terms necessarily are used in juxtaposition with biomedical medicine, which is implied as being the dominant form of medicine used. Ethnogynecological treatment has also been used, but this implies physical gynecological interventions. As the term in Tunisian Arabic is *dwâ arabi* (دوا عربي) the term "traditional medicine" appears the most appropriate.

[5] Obermeyer, C. (1993), pg. 362.

[6] For a discussion of the other types of traditional healers in Tunisia see Abdmouleh, R. (1993), Khaznaji, M. (1980), and Shabou, A. (1995).

[7] The Tunisian south and interior is an extremely diverse area and is comprised of ten governorates. This chapter is based on fieldwork conducted in six of these governorates: Kebili, Sidi Bouzid, Kasserine, Gabes, Médenine and Tataouine. The term "Tunisian south" also will be used to refer to these governorates.

reports, and literature on popular medicine, Larguèche eloquently reconstructs the activities of the TBA and other female healers in the colonial and pre-colonial eras. J. Binous has conducted research on TBAs in post-colonial Tunis. Drawing from interviews with the surviving daughters of a Tunis based *qâbla arabi*, Binous examines the work and changing role of the *qâbla arabi* in the early independence period. Finally, L. Labidi has conducted extensive research on women's health, and has written prolifically on the establishment of professional midwifery. In the 1980s, Labidi investigated the relationship between professional midwives and TBAs, and drew from several interviews with TBAs in the central governorates of El-Kef and Siliana as well as from public health surveys. This chapter expands on these authors' works by relying on a more extensive number of in-depth interviews with both TBAs and the recipients of their services in a broader geographic area, thereby exploring the previously unexamined contemporary work of TBAs.

Although the role of the TBA has decreased significantly in recent years, this chapter contends that TBAs remain important in three aspects of women's health care: home deliveries, infertility treatment, and "sleeping children". This chapter begins with an historical overview of the *qâbla arabi* in Tunisia and then turns to a specific discussion of the contemporary work of the TBA. Examination of the reasons for which women choose to use the services of traditional health service providers offers a forum for exploring a number of the shortcomings in the national health program and the PNP. Yet, despite the evident importance of the traditional birth attendant, she and her work remain marginalized. By continuing to ignore the role and importance of the traditional birth attendant, the national health program is missing a valuable opportunity to acknowledge and analyze its weaknesses. This chapter concludes with a discussion of the relationship between the national health program

and traditional women's health services and proposes that enhanced recognition and integration will promote better quality services and improved health outcomes.

THE HISTORY OF THE *QÂBLA ARABI* IN TUNISIA

Prior to Tunisia's independence, the TBA was the primary health service provider for virtually all women's health needs in Tunisia.[8] A respected member of the community with substantial power and legitimacy, the TBA was trusted to provide a variety of services and assist women with their most intimate problems. Though her most noted role was assisting in childbirth, the *qâbla arabi* also provided contraception and abortions, treated diseases and afflictions, including menstrual cycle irregularities and infertility, with herbal medicines and broths, offered relief from cramping and pain, and provided pre- and post-natal care.[9] Their skill and commitment, combined with the absence of accessible health facilities and professional practitioners, resulted in TBAs' domination of women's health services throughout the country.

However, the TBA served a role that extended beyond medicine and health; she also helped empower marginalized women. Historically, gender roles in Tunisia reflected a division between the private, domestic female sphere and the public male sphere.[10] Prior to Tunisian independence, women were relegated to the status of legal

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[8] Bakalti, S. (1996), pp. 202 & 260.
[9] Binous, J. (1992), Blili, L. (1988), and Larguèche, D. (Forthcoming).
[10] As is the case with nearly all societies, gender roles in Tunisia have reflected a public/private dichotomy related to economic power and procreative responsibility. "The history of women is invariably dominated by child-rearing…maternity, care-taking, domestic chores: roles and chores which were certainly valued because of their fundamental importance in the survival of humanity, but often served as pretexts for the exclusion of women." ONFP (1997), pg. 293. However, this is not to suggest that women have not played an active role in the public sphere. Throughout Tunisian history, as J. Binous and others have shown, women have worked outside of the home and participated in resisting French colonization thus indicating the complexity of the public/private dichotomy. Bakalti, S. (1996) & Binous, J. (1992).

minors and their value was largely related to their procreative ability. The financial, familial, and religious pressure to provide heirs and security through childbearing influenced both fertility and son preference.[11] A woman's conduct reflected on the honor of her extended family and thus women's chastity and fidelity were mandated and monitored.[12] Thus, femininity and femaleness were constructed around domesticity, maternity, and sexual legitimacy.

However, social realities did not always conform to societal expectations. The historical evidence suggests that individually and collectively women used "female spaces", the home, the *hammâm*, and saint's tombs, to achieve a considerable amount of autonomy and power in spite of social restrictions.[13] Due to the importance of maternity and chastity in both female identity and social respectability, it is not surprising that women's autonomous control over their bodies and fertility served as an arena of empowerment. In concert with traditional birth attendants, women were able to devise strategies that secured a degree of sexual and reproductive freedom. As Tunisian historian D. Larguèche notes, "The feminine medical art based on a vast knowledge of physiotherapy and magical practices, transmitted from woman to woman across generations and ages, gave to women the power to intervene in their bodies and also [some] autonomy and control."[14] Whether through herbal abortifacients and contraception, hymen restoration, infertility treatment, or the preparation of concoctions to cause impotency in abusive or adulterous men, TBAs provided women with the ability to negotiate their maternity and sexuality, a

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[11] Obermeyer, C. & R. Cardenas. (1997, September) & Obermeyer, C. (1994, January/February).
[12] Labidi, L. (1989).
[13] This is consistent with D. Kandiyoti's concept of patriarchal bargaining, a term "intended to indicate the existence of set rules and scripts regulating gender relations, to which both genders accommodate and acquiesce, yet which may nevertheless be contested, redefined, and renegotiated." Kandiyoti, D. (1991), pg. 40.
[14] Larguèche, D. (Forthcoming), pg. 17.

negotiation which allowed women to both side-step to societal expectations and preserve their femininity.[15] Thus, TBAs have served a critical role in meeting women's physical, emotional, and psychosocial health needs.

The activities of the *qâbla arabi* have evolved considerably in the last fifty years. Despite the evident importance of the TBAs, the colonial medical establishment disparaged their work and in 1888 instituted a decree that required TBAs to apply for authorization to practice. However, throughout the colonial period, the work of the TBA throughout Tunisia was largely unregulated, restrictive laws went un-enforced, and the *qâbla arabi* provided services in all areas of women's health care.[16]

Yet, it was with the establishment of professional midwifery in the years after independence that the role of the *qâbla arabi* began to substantially change. After independence, the Tunisian government instituted a policy to register and authorize the work of TBAs in Tunis. In 1957, a new nomenclature was developed to distinguish between medically trained midwives (les sages-femmes diplômées) and TBAs (les sages-femmes tolerées).[17] Those TBAs deemed competent were incorporated into the emerging health system and given certificates to practice.[18] A small number of younger TBAs were also recruited to enter the first classes of nursing and midwifery students at the newly created professional schools. TBAs deemed incompetent were discouraged from practicing altogether.[19] As the number of midwives and obstetric nurses increased throughout the 1960s and 1970s, the

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[15] Ben Miled, E. (1988), pg. 33.
[16] Bakalti, S. (1996), pg. 259.
[17] "Tolerated midwives" were those who did not have a certificate to practice but who were recognized as having long-standing professional experience.
[18] This certification process was executed by midwives, nurses, and physicians and involved an oral examination surrounding female anatomy, pregnancy, and hygiene. It was during this interview that successful TBAs were given stamps and told how to officially register births. Binous, J. (1992).
[19] Binous, J. (1992).

activities of the TBAs in Tunis and the Sahel became more regulated, laws became better enforced, and, fearful of punishment, many TBAs were driven underground.

Many professional midwives (*quabla souri*) also wanted to distinguish themselves from the uneducated TBAs, even those who were tolerated.[20] As L. Labidi argues, "Knowledge, mastery, technical ability, and diagnostic precision introduced a demarcation line between the *qâbla arabi* and the midwives. Rational and organized, the quabla souri were the actors of change, the introducers of new values, a new type of relationship to the body..."[21] Thus, in Greater Tunis and other urban areas, the activities of the TBAs, especially in the area of childbirth, were almost entirely replaced by the work of professionally trained medical personnel.[22]

However, in the south and interior of Tunisia, where, as discussed in Chapter 3, the development of modern health facilities and the increase in health service personnel lagged behind Greater Tunis and the Sahel, the *qâbla arabi* continued to provide the bulk of women's health services. TBAs often practiced with the tacit consent and even encouragement of the government.[23] A number of TBAs were recruited to work formally in the local hospitals, as Khalti Ahlam's 1980 experience illustrates.[24]

> It was when I helped a woman whose husband is a civil servant. He went to the hospital for the doctor when they asked him whether or not his wife

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[20] The term "souri" is used in opposition to "arabi". This term can be translated as French, western, or foreign depending on context. In Tunisian dialect, the term arabi is used to denote traditional, popular, indigenous and natural, as well as Arab. The *qâbla souri* was used to distinguish a professionally trained midwife from the *qâbla arabi*, even though the *qâbla souri* was often a Tunisian Arab. It should also be noted that the adjectives *arabi* and *souri* often do not conform to the grammatical conventions of noun-adjective gender agreement. Thus, *qâbla arabi* is the term used in Tunisian dialect.

[21] Labidi, L. (1988), pg. 84. The term "quabla" is the plural of "qâbla".

[22] Binous, J. (1992).

[23] Dahmani, B. (1988).

[24] The term "khalti" is literally translated as maternal aunt. "Khalti" is also commonly used as a term of affection and respect for a traditional birth attendant.

delivered her baby in the hospital. He answered that she gave birth at home with the help of an old woman in the neighborhood. They asked to see the woman and her identity card. I then went [to the hospital] and told them that I had gone to visit the woman and upon finding her in labor I helped her deliver her baby. [The doctors] told me to come back again and they would give me a certificate to work in the hospital. I asked for time to think and ask about it. They told me that they'd give me a box with medicines and equipment but I was not [allowed] to help women who suffer from diabetes or hypertension. Additionally, I was to be paid 16 dinars for each case. I then refused because there are those who can't afford it and I'd never [be able to] ask for the money.[25]

Unlike in Greater Tunis and the Sahel, NGOs and public sector health service providers in the south often worked with TBAs. Throughout the 1980s, integration and educational efforts occurred at both the local and the regional levels in order to promote maternal child health and Safe Motherhood Initiatives (SMI). A survey conducted by the ONFP in the early 1980s revealed that as many as 75% of women were delivering at home in certain southern and central regions of the country.[26] In response, the MOPH and several NGOs launched regional initiatives designed to improve the quality of delivery services provided by TBAs, including a SMI training program. TBAs were invited to participate in educational and professional training seminars dedicated to hygiene, sterile technique, basic pre-natal and neo-natal care, and the identification and transfer of high-risk pregnancies and complicated deliveries.[27] In conjunction with local public sector health service providers, the program envisioned establishing a network that fostered trust and collaboration.

Although these training programs were not widely implemented, a number of individual health service providers worked informally with TBAs to establish this same dynamic. Throughout the 1980s, individual midwives and nurses working in

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[25] Interview (TBA/Khalti Ahlam), Kasserine: March 14, 1999.
[26] ONFP (1988), pg. 2.
[27] ONFP (1988).

PMIs and maternity wards initiated educational programs targeting TBAs.[28] A number of health service providers recognized the importance of the TBA in the local community and forged personal relationships with TBAs in order to encourage open communication and collaboration. This appears to have been particularly important for health service professional who originated from southern and central regions and were personally familiar with the work and role of the TBA.

> When I was growing up, the women in my family only used the services of a *qâbla arabi*. I know how important these women are and how much influence they have within their communities. When I became a midwife and began working in Douz I decided to make contact with some of them, to let them know that I was here and would help them in any way that I could. I would sometimes give them supplies from the hospital; gloves, razors, iodine, gauze, thing like that. Some of my colleagues scoffed at me. But they don't understand that women here will always continue to [consult] the *quabla arabi*. Of course, I would prefer that all women deliver in the local hospital, but this isn't realistic. As long as the *quabla arabi* are here, we should work with them. If they know that we value them, they are more likely to transfer women in distress to us.[29]

Local and regional programs designed to provide training and supplies to TBAs appear to have been largely discontinued in the 1990s.[30] However, as recently as 1997, one TBA in Kasserine was offered certification by a midwife in the local hospital.

> They even called me to work as a qâbla in the hospital. They gave me a certificate and I'll tell you how. I was ill and I had to stay in the hospital for days when they brought a pregnant woman into the same room. They left her and went away. The woman was on the table in hard labor. I called another woman who was with me and I told her to help me. She held the woman's

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[28] Interview (Nurse), Nouvelle Matmata: February 3, 1999, Interview (Midwife), Douz: February 15, 1999, Interview (Nurse), Nouvelle Matmata: February 3, 1999, Interview (Midwife), Kasserine: March 12, 1999, & Interview (Midwife), Ain Draham: March 23, 1999.
[29] Interview (Midwife), Douz: February 15, 1999.
[30] Interview (ACT Representative), Sidi Bouzid: April 1, 1999.

arms and I helped her deliver her baby. Then the midwife came and was blaming me…[I explained] that it was urgent and there was too much risk to leave the woman alone, the baby might fall down on the floor, he might have been injured or even killed. I added that I was a qâbla like her except that she worked in the hospital and I worked on the outside…[Later] I was having lunch when she came to my table and asked me whether I wanted to do the job in the hospital. She said, "This is a certificate for you and you can do the same job without any problem, you have to work in the hospital and you'll be paid TND 80 at first." It was two years ago, but I firmly turned her down because it was out of the question that I would take off my traditional gown and put on their white costume and work outside my home…No, that's impossible. I'll stay in my house and if there is someone who asks for my help then I'll do it and I'll do it for free, only for God's grace.[31]

Even though TBAs in the south and center were more integrated into and tolerated by the national health program than in the north, their activities became progressively more limited. With the development of an extensive network of local and regional hospitals and primary health facilities, public health campaigns, and the increasing educational status of Tunisian women, much of the TBAs work in the center and south has been replaced by modern medicine and care. Thus while the TBA was once active in a broad range of women's health issues throughout the country, her activities are now more limited in scope and more geographically concentrated. Yet in certain areas of women's health care TBAs continue to provide essential services, often compensating for the shortcomings in the national health program.

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[31] Interview (TBA/Khalti Ahłam), Kasserine: March 12, 1999.

CHARACTERISTICS OF THE *QÂBLA ARABI*

Mabrouka's Story

Mabrouka has lived in Tataouine her entire life. Born in 1920, Mabrouka began working as a traditional birth attendant in her late thirties, after her marriage and giving birth to her children. Mabrouka received her skills directly from God and has spent over forty years working in his honor. Throughout her career, Mabrouka delivered more than 300 babies and has helped hundreds of women and their children. In addition to delivery services, Mabrouka provides women with infertility treatment, pre- and post-natal care, nutritional counseling, and herbal medicines for pain, discomfort, headaches, and menopause. Well known throughout the south, Mabrouka received patients from all over the region and once had a woman visit her from Tunis.

Now in her seventies, Mabrouka performed her last delivery in the fall of 1997. Seven days after the baby girl's birth, the child died. Until this last delivery, Mabrouka asserts that she had never been involved with the death of either a baby or a mother. Mabrouka took the death of the child as a sign from God, that she was too old and that she should stop delivering children, except in cases of extreme emergency. Indeed, when the mother of the deceased girl became pregnant again, she asked Mabrouka to deliver the baby and Mabrouka refused. However, Mabrouka continues to provide other services to women in her community. She also advises and supervises two younger women who live and work in her neighborhood. Mabrouka is pleased that the activities of traditional birth attendants will continue after she is no longer able to practice.[32]

There is a great deal of uniformity in the characteristics of TBAs in Tunisia, a uniformity that transcends geographic and ethnic boundaries. Mabrouka epitomizes the characteristics of a Tunisian traditional birth attendant. Consistent with the World Health Organization's definition of a traditional birth attendant, the *qâbla arabi* is a respected member of a small community, a village or a neighborhood of a larger town.[33] This respect comes not only from her abilities in medicine and healing but often from her personal experiences with childbirth and motherhood. As Tunisian anthropologist L. Labidi noted, "The qâbla [arabi] is imposing. She is a strong personality and a determined character that commands respect. They are, in the

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[32] Interview (TBA/Mabrouka), Tataouine: November 20, 1998.
[33] For a more comprehensive discussion of the definition and role of the TBA in other developing countries, see Leedam, E. (1985), Lewis, J., et. al. (1985), and Stanley, D. (1997).

majority of cases, energetic, full of initiative, and authoritative."[34] Most of the TBAs are older women, but of the 20 TBAs interviewed for this study, the average age was in the mid-sixties and their ages ranged from 40 to over 80.[35] Most continue to work through their seventies and often stop because of blindness, arthritis, or the death of a newborn.[36] The majority of TBAs have trained with another TBA, often their mother, aunt, or other female relative. As Khalti Ahlam noted,

> It's all from God, but I knew these matters from my own experiences in delivery. I also have an aunt who is a *qâbla*. I used to go with her and I saw how she helped women have their babies. I learned by myself and I knew how to do it: you shouldn't pull down too soon, you have to wait until [the baby] drops down, and then you pull. I began with a woman in the neighborhood; there was no one with us, just her and me. I helped her have a baby who is now a 35-year-old woman. The woman's husband came to me to tell me that his wife was in hard labor. I went and I asked her to push hard and when she did so I put my hand inside and pulled a female baby down and all was fine.[37]

Like Khalti Ahlam and Mabrouka, many of the TBAs interviewed began to work after the birth of their own children or being widowed. Nearly all of the TBAs stated that their healing powers come directly from God. The knowledge of their gift either came in the form of a dream, or in their response to an emergency. As Khalti Aisha explained, she realized she was able to birth children during her own pregnancy.

> It was given [to me] as a gift from God. The first time I delivered a baby I remember there was a woman in labor and she couldn't find anyone to help

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[34] Labidi, L. (1989), pg. 291.
[35] However, this age data is somewhat unreliable as many of the women are innumerate and unsure of their ages.
[36] Interview (TBA/Mabrouka), Tataouine: November 20, 1998, Interview (TBA), El-Jem: February 12, 1999, Interview (TBA), Sidi Bouzid: April 2, 1999, Interview (TBA), Nouvelle Matmata: April 7, 1999, & Interview (TBA), Médenine: April 8, 1999.
[37] Interview (TBA/Khalti Ahlam), Kasserine: March 14, 1999.

> her. Both of us were pregnant at the time. Her family brought my mother to her, but my mother was already very old and couldn't [deliver babies] anymore. My mother checked the woman and when she found that [the woman was dilated] she told me "Aisha, my daughter, come to see her because I can't do it." And when I came to her, the baby was emerging. I swear I gave birth only nine days later...From then on I started helping other women deliver their babies.[38]

Most of the TBAs work out of their own houses as well as performing home visits, some of which are of a substantial distance.[39] Finally, TBAs in Tunisia do not generally charge a specific fee for their services. Most are compensated in cash or kind at the discretion of the patient, though all of the TBAs noted that they enthusiastically perform their services for free if the patient is poor and unable to pay. Payments in kind range from valuable carpets and scarves to more modest chickens and couscous. Asked if she ever asked for money or presents, Khalti Ahlam responded,

> What, me? Never! But it's them who tell me that it's not good to refuse. They don't want me to leave empty handed. Once I helped a woman deliver a male baby and when I took off my gown to be washed she gave me another one to put on. She told me that I should take it for I helped her deliver her son. Another woman gave me a scarf, even some vegetables. Do you understand? It's not me who asks for anything, thank God. I'm not needy, all of my children work and I'm doing something that's for the sake of God's grace. And I never take anything from someone who is poor. I swear once I helped a poor woman give birth...her husband gave me 500 millimes and I refused to take it. On the following morning I went to visit her and I gave her some food that I cooked at home. I gave her some clothes to dress the baby in and some more money for she was really needy.[40]

Having described the traditional birth attendants, this chapter will now turn to their contemporary work in the Tunisian center and south.

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[38] Interview (TBA/Khalti Aisha), Kasserine: March 12, 1999.
[39] Interview (TBA), El-Jem: February 12, 1999.
[40] Interview (TBA/Khalti Ahlam), Kasserine: March 14, 1999.

THE CONTEMPORARY ACTIVITIES OF THE QÂBLA ARABI

HOME DELIVERIES

Home deliveries remain one of the most important functions of the *qâbla arabi* in Tunisia. Although accurate statistics are somewhat difficult to obtain, a 1994-1995 survey by the ONFP found that approximately 18% of women who have given birth in the last five years had delivered a child at home.[41] This survey found that women of all ages are continuing to deliver at home, with approximately 20% of women between 30 and 49 and 15% of women under the age of 30. Consistent with other studies, the ONFP survey found significant regional as well as urban/rural differences in home birthing rates (see Table 4.1). The ONFP survey also found that illiterate women and women with four or more children were nearly three times more likely to deliver at home than women with even some primary education and women with three or less children.

A 1988 survey of home birthing in Tunisia also noted significant regional differences. This survey found that nearly 70% of women surveyed in the governorates of Sidi Bouzid, Kasserine, Kebili, and Siliana and over 50% of women in Gafsa, Tataouine, and Médenine reported delivering at home, the majority with the assistance of a TBA.[42] However, less than 10% of women in the urban governorates of Tunis, Ariana, Monastir and Sousse reported home births and many who delivered at home used professional service providers. Overall, the 1988 survey found that approximately 32% of deliveries within the five previous years occurred at home.[43]

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[41] Of these women approximately 63% were aided by a traditional birth attendant. ONFP (1996), pp. 162 & 165.
[42] Hamza, A. (1994), pp. 38-57.
[43] Hamza, A. (1994), pg. 38.

Table 4.1: Place of Delivery for Births Recorded Between 1989-1994 (ETSME 1994-1995)[44]

Variables	*Public Health Care Facility (%)*	*Private Health Care Facility (%)*	*Home (%)*
<30 years	79.94	4.39	14.57
30-49 years	72.03	5.66	19.98
TYPE OF RESIDENCE			
Urban	84.47	9.05	5.55
Rural	65.07	0.45	31.69
REGION OF RESIDENCE			
North East	83.74	2.64	10.56
Greater Tunis	85.73	10.54	3.29
North West	67.98	3.04	25.82
Central West	62.90	1.21	34.33
Central East	84.17	10.29	4.23
South West	67.19	0.30	30.58
South East	71.33	3.62	23.79

However, as one physician in Sidi Bouzid noted, surveys on delivery sites are likely to underestimate home births due to embarrassment and fear of reporting.[45] This physician noted that recent statistics from Sidi Bouzid indicate that the percentage of home births in this governorate is still greater than 60%.[46] Thus, it is evident that although the trend toward hospital birthing continues, home birthing remains an important contemporary aspect of maternal health care in Tunisia.

As the statistics indicate, home birthing remains an important component of the TBAs' work and there is a great deal of consistency within Tunisia with respect to home births. While there are some regional differences with home birthing and though, of course, every woman's experience is unique, the 1991 experience of Hind of Médenine is particularly illustrative.

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[44] ONFP (1996), pg. 162.
[45] This is consistent with research in other developing countries. For a more comprehensive discussion of this issue see L. Doyal (1995), pg. 126.
[46] Interview (ACT Representative), Sidi Bouzid: April 1, 1999.

Hind's Story

Hind had been in labor several hours before her sister contacted the qâbla arabi. This elderly woman was a neighbor who had helped many of the women in the community give birth. Other relatives, including her mother, came to Hind's house to be with her. Hind's mother put some sand in a scarf and placed it on the ground to catch the baby's head when it emerged. The qâbla arabi *tied a second scarf to the window and Hind held onto the scarf in a squatting position over the sand. However, her labor continued. The* qâbla arabi *massaged oil and lavender onto Hind's belly and applied pressure to her abdomen with her bare feet. As the head began to emerge the* qâbla arabi *rubbed olive oil onto the baby's crown and onto Hind's vagina. When the baby was born, the* qâbla arabi *placed oil in the baby's mouth with her finger and kohl in the corner of her eyes. The* qâbla arabi *took a string and tied it around the baby's umbilical cord, at a distance of four fingers from the belly button for a girl and three fingers for a boy.*[47] *The cord was then cut with a razor and a mixture of honey, oil and kohl was applied. Taking the baby by the feet, the* qâbla arabi *shook the baby upside-down and splashed warm water over its body. After thirty minutes Hind had not expelled her placenta. The* qâbla arabi *instructed her to blow forcefully into her upper arm and the expelled placenta was then collected. The* qâbla arabi, *with permission from Hind, took this placenta to her home and dried it on the roof of her house so it could later be ground into a powder for infertility treatment.*

The qâbla arabi *stayed with Hind for several hours and helped her breastfeed the baby for the first time. Following the birth, the* qâbla arabi *wrapped Hind's abdomen, breasts, and ankles with scarves. The binding promotes closure and the scarves remain on the body for several days. Further, the* qâbla arabi *brought Hind a wool ball containing herbs, oil, and honey. This ball was used as a vaginal suppository, an absorbent, to remove excess water from the uterus to both cleanse the woman and promote future conceptions. A postpartum meal of eggs, fenugreek, and chickpeas was cooked for Hind. A few days later, the* qâbla arabi *returned to check on the mother and baby.*[48]

Hind's experience is representative of the home birth experience in Tunisia and raises questions as to the reasons for which women give birth at home. Interviews with women who have chosen to deliver at home suggest that there are three important factors influencing women's decisions regarding home-delivery: comfort, reception, and convenience.

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[47] This difference in length is due to the fact that girls will grow into women who will need to expand during pregnancy. Boys will neither get pregnant nor breastfeed and therefore do not need the additional space.

[48] Interview, Médenine: April 8, 1999.

The issue of comfort is one of the most important factors influencing women's decisions to deliver at home. As described by Hind, the traditional birthing position is a squat and the woman is stabilized by family members or tied scarves. The squatting position is believed to promote closure of the uterus because the mother is less exposed. In hospitals, women lie on their backs and this is not only embarrassing to many women who are exposed to unknown males, but it is also believed to cause infertility. As one TBA described,

> We close her up from her ankles or her feet to her breasts. It is said that her back is open after giving birth, especially if she gives birth in a hospital. Perhaps, with her back open, she will catch a cold and might remain open [and not be able to conceive other children] so we close her up.[49]

Thus for many women the squatting position is not only more physically comfortable but, in conjunction with postpartum closing and the vaginal suppositories, promotes future fertility.

Additionally, women who give birth at home claim to be more comfortable because they report being at greater ease. Indeed, in the 1994 ONFP survey, one fourth of women from all ages who gave birth at home in the preceding five years stated that familial ambiance was the most important factor in their choice.[50] With reference to the hospital birth and the medicalization of childbirth, L. Labidi wrote, "The new ideology imposes individualism on the act of childbirth which no longer concerns the group."[51] Assisted by their female relatives and neighbors, women who deliver at home are encouraged, supported, and aided by the group. As Mabrouka of

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[49] Interview (TBA), Douriet (Aziza): April 9, 1999.
[50] ONFP (1996), pg. 162.
[51] Labidi, L. (1987), pg. 34.

Tataouine stated, postpartum closing is an integral part of the home-birthing experience and involves other female family members.

> In our traditions, the woman is not to stop giving birth. You go to the woman, dress her, wash her and then two women go to her, one on each side. And they close her up…In the beginning we use our hands. We push hard so that all the pain will disappear. One woman is on each side and then we use a scarf or clothes. We heat this thing on a traditional pan (*hamas*) and then we wrap the woman up from her head to her feet so that the pains will dissipate. And also so that the remainder of the pregnancy will [be expelled]…I then cook her eggs, *ojja*, with cumin and oil. She is to eat four eggs and she has to eat bread, chickpeas, lentils, *tebeha*, and if she can afford it she should eat grilled meat on the seventh day…And on the seventh day she should be fine.[52]

With home deliveries women are also able to recover from the delivery in their home where they are cared for by family members and, as Mabrouka mentioned, fed traditional postpartum foods.

The reception of women by the traditional birth attendant is also an important factor in women's decision to deliver at home. The *qâbla arabi* is characterized as being patient and reassuring. She waits with the woman as she delivers and talks to her throughout the delivery. As a traditional birth attendant in Douz stated,

> [In the hospital] they often tear the woman or do operations to get the baby, but not me. I take the woman and in God's name I gently get the baby out. For example, I remember when Hachim's wife was in labor. He called me and was frightened and he asked me to take [his wife] to the hospital. But I assured him that she was fine and not to worry, and I helped give birth and everything was okay. Yes, in the past all women came to me.[53]

Many women also fear that they will not receive sufficient attention in the hospital because it is overcrowded and impersonal. As one woman in El-Hamma noted,

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[52] Interview (TBA), Tataouine: April 9, 1999.
[53] Interview (TBA), Douz: February 15, 1999.

It's better for me to give birth at home because the midwives in the hospital are bad, neglectful women. For example, this daughter could have fallen from the table. I was in labor and they were telling me to be quiet, to close my mouth, that this was not my time. They are accustomed to treating women in this way. They leave the woman alone and go. When I was afraid that she might fall down I called to them loudly, to rescue her, and when they came they found that her head was not on the table. That's why I told you it's better for me to have my children at home. They all cared for me here.[54]

Consistent with this woman's story, many women report feeling alienated from health service providers in the hospitals. Uneducated and illiterate women are often belittled, and women with many children are often teased and humiliated.[55] Nabila, another woman from El-Hamma, delivered her third child at the hospital, but the experience was so painful and humiliating that she chose to deliver her fourth and final child at home. As she explained,

> [Having a child in the hospital] is okay as long as the woman who goes there doesn't have many children. In the hospital they will blame and mistreat her if she has many children…I was frightened. I am afraid of doctors…and so I planned to have my [fourth] baby at home, I didn't want to repeat the horrible experience that I had in the hospital with my [third].[56]

The alienation women feel from professional health service providers also relates to the lack of communication between physicians and patients. TBAs talk with the woman throughout the delivery, keeping them abreast of changes in their condition as well as their interventions and treatments. Strong, powerful, and similar to the women with whom they work, TBAs engender respect and confidence. Many women report that physicians never properly explain complications in their pregnancies or

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[54] Interview, El-Hamma: November 16, 1998.
[55] Hôpital de Douz: February 15, 1999.
[56] Interview (Nabila), El-Hamma: November 16, 1999.

deliveries.[57] Exacerbated by language, cultural, educational, and gender barriers, women often feel marginalized and confused in their interactions with professional health service providers, and as Aisha's experience reveals, this often influences their decision to use the services of a traditional birth attendant.

Aisha's Story

Aisha married a man from a neighboring village when she was twenty years old. Now in her late 40s, Aisha has lived her entire life in a village near Tataouine. Aisha had always wanted a large family and she had intended to deliver all of her children at the hospital. Within months of her marriage, Aisha became pregnant for the first time and her family and her in-laws were delighted. However, Aisha's son died at the hospital, shortly after childbirth. Aisha was distraught over the death of her first son, depression that was compounded by the lack of information she was given; in spite of repeated inquiries, no one ever gave her a reason for her child's death. After this first traumatic experience, Aisha decided to deliver her future children at home. Aisha returned to the hospital only one other time during her life, when, after the delivery of her fourth child, she began to bleed profusely. Her family and the traditional birth attendant became worried and brought her to the hospital in Médenine. She stayed overnight in the hospital and returned to her village the next day. She delivered her following two children at home without complication. Since the delivery of her fourth child, Aisha has not returned to a physician.[58]

Thus for many women, the reception they receive at home with the *qâbla arabi* makes for an attractive alternative to giving birth in hospitals.

Finally, many women still give birth at home because of the conveniences associated with home birthing. In certain communities, transportation to the hospital is either not readily available or inhibited because of a lack of infrastructure or a great distance.[59] The ONFP survey found that 11% of women who gave birth at home from

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[57] Interview (Salima), El-Hamma: November 18, 1999, Interview, Médenine: April 8, 1999, Interview, Tataouine: April 9, 1999, & Interview, Tunis: October 9, 1999.
[58] Interview (Aisha), Douriet: April 10, 1999.
[59] Dufriche, O., et. al. (1986), Interview, Haddej: April 7, 1999, Interview, Douriet: April 9, 1999, & Interview, Douriet: April 10, 1999..

1989-1994 cited the non-availability of medical services as the primary factor in this decision.[60] As a woman from Haddej disclosed,

> There is one [child] who I delivered at home. I actually delivered in a rush at home and then I took him to the hospital…three days later. This was because they went to bring me a car when I was in labor, but I used to live far in the desert. By the time they returned I had started to deliver and the hospital was too far. One of our neighbors, an old woman, came to help and cut the umbilical cord.[61]

A woman from Douriet echoed this experience when she described the birth of her fourth child in 1992. Though she had wanted to deliver in the hospital there was not a car available to take her to Tataouine (approximately 20 kilometers). Her husband called a neighbor experienced in deliveries and her daughter was born without complication. In spite of her positive experience with home birthing, and though she found delivering in her home to be more comfortable, she delivered her next child in the hospital. For her, the safety and medicine available in the hospital was more important than the comfort and familial support associated with delivering at home.[62]

Finally, birthing in public facilities, and of course private clinics, remains prohibitively expensive for many lower income women.[63] The ONFP survey found

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[60] ONFP (1996), pg. 164.
[61] Interview, Haddej: April 7, 1999.
[62] Interview, Douriet (Zohra): April 10, 1999.
[63] The health insurance and financing system in Tunisia is complicated. The bulk of health service and financing occurs through the public sector. Health insurance for public and private sector employees is mandatory and involves one of several principal insurance schemes, depending on job type and retirement status: CNSS, CAVIS, CNRPS, and CREGT. The government also provides free or heavily subsidized health services to approximately 800,000 lower-income families through two additional schemes (AMG I and AMG II). Women's primary health services, including family planning, pre-and post-natal care, are free. The cost associated with childbirth is based on the insurance scheme (some have co-payments depending on the service site) and is free for most of the population. However, families enrolled in the AMG II scheme must pay an annual inscription fee. As the private health sector has grown in recent years there are an increasing number of patients who elect to enroll with private sector insurance plans or make direct out-of-pocket payments. For more information on the health insurance and financing system see Bekay, C. (1994), Ben Hamida, A. et. al. (1994), Boukhris, M. (1994) & Country Operations Division (1993).

that 18% of women reporting homebirths from 1989-1994 indicated that the high cost associated with a birth in a medical facility was the primary factor in this decision. Not surprisingly, women in rural areas and illiterate women were more likely to cite this issue than their urban and educated counterparts.[64] This is not simply the cost of delivery, but also the costs associated with transportation, food, and accompaniment of a loved one.[65] Thus it is evident that women choose to use the services of TBAs because of the comfort, reception, and convenience of home birthing. Although some women are obliged to deliver at home because of a lack of infrastructure or services, it is evident that many women are choosing to deliver at home because they prefer the experience of home birthing or dislike the services available at medical facilities.

Yet home birthing is not without significant risks. A study published by the DSSB in 1994 placed the maternal mortality rate at 69 per 100,000 live births.[66] Approximately 36% of these deaths occur during childbirth and home birthing is believed to significantly contribute to these maternal deaths.[67] Many of the TBAs interviewed in the course of this research spoke openly of their desire to transfer complicated deliveries to local or regional hospitals, if transportation is available. Indeed TBAs appear more prepared to involve local health professionals if they have established positive relationships with public sector midwives and health practitioners.[68] However, almost all of the interviewed TBAs indicated that they had

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[64] ONFP (1996), pg. 164.
[65] Interview, Kasserine: March 12, 1999.
[66] As per the international standard, the MMR is determined by the number of women who die in the course of a pregnancy, delivery or in the 42 days after its termination per 100,000 live births. Ministère de la Santé Publique (1994), pg. 12.
[67] This includes women who begin their deliveries at home and are subsequently transferred to local hospitals. Interview (UNICEF Representative), Tunis: January 13, 1999, Interview (ACT Representative), Sidi Bouzid: April 1, 1999, & MSP (1994), pg. 5.
[68] Interview (TBA), El-Hamma: November 16, 1998, Interview (Midwife), Douz: February 15, 1999, Interview (ACT Representative), Sidi Bouzid: April 1, 1999, Interview (TBA), Nouvelle Matmata: April 7, 1999, & Interview (TBA), Tataouine: April 9, 1999.

delivered twins, breech births, and the children of women defined by the PNP as high risk.[69] Many also revealed experiences with deliveries involving obstructed labor, retained placentas, and hemorrhaging, deliveries with increased risk of maternal morbidity and mortality.[70]

It is not only through the delivery experience that women using traditional health services face significant health risks. Postpartum deaths constitute nearly 34% of the MMR.[71] The vaginal suppositories used in the postpartum period carry considerable risk of infection, thereby increasing the risk of maternal morbidity and mortality. As one gynecologist noted,

> Another problem with health care in the south is the *qâbla arabi*. The *quabla* are not specifically trained and they cannot be controlled…The *quabla* often prescribe things that are dangerous and harmful. For example, vaginal suppositories with vinegar. I have consulted many women who complain of discomfort and who have infections after using [them]…It kills eggs, erodes part of the lining, and can upset the vaginal chemistry causing infections, discharge and odor.[72]

Further, there is a problem of hygiene and sterilization. While most of the TBAs insisted that they wash themselves before the delivery and use only new or sterilized razors, the delivery sites ranged from fairly clean to extremely dirty. The non-sterile conditions often associated with home births also contribute to postpartum infections.

Yet, in spite of these risks, many women continue to choose to use the services of the *qâbla arabi*. In her research on home-birthing in Morocco, C. Obermeyer wrote, "The reluctance of many women to deliver in health care-facilities is, in part, a

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[69] High risk in this case would include women suffering from hypertension, anemia, and diabetes in addition to those who are extremely short, over 40, or have delivered more than five times.
[70] But one example of this increased risk is the use of olive oil on the vagina to help ease or stimulate the birth. Introduction of the oil to the vagina carries a risk of infection. L. Doyal (1995), pg. 132.
[71] MSP (1994), pg. 5.
[72] Interview (Gynecologist), Tataouine: November 21, 1998.

function of their having neither grounds for dissatisfaction with the traditional custom of home birth nor compelling motives to seek treatment from a stranger in a hospital."[73] This also appears to hold true in Tunisia. Because of the comfort, reception, and conveniences associated with home birthing women continue to deliver at home in spite of the known risks.

INFERTILITY TREATMENT

TBAs also continue to play an important role in treating infertility. Global statistics indicate that about 10% of couples face the challenge of infertility problems at some point in their reproductive lives.[74] There is no evidence that Tunisia is any different in this regard.[75] Indeed reported infertility rates in Tunisia range from 6.5% to 7.8%.[76] However, one factor that may be different in Tunisia involves the popular definition of infertility. For many young married women infertility is socially defined as not conceiving a child within the first year after marriage or in any three consecutive years.[77] This places a great deal of pressure on couples to have a first child immediately and then space additional children. However, this social definition

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[73] Obermeyer, C. (1993), pg. 362.

[74] L. Doyal cites a World Health Organization study indicating that between 8% and 12% of all couples experience infertility for some period of their reproductive lives. Doyal, L. (1995), pg. 145.

[75] The Central African infertility belt has dominated the research on infertility in Africa and WHO surveys have indicated that as many as 50% of couples in this area experience infertility problems. Tunisia, located north of this region, has not been the focus of such surveys. However, in her work on infertility in Egypt, M. Inhorn (1994, pp. 13-14) reports infertility levels in Egypt to be documented at between 7% and 11% of couples. Though this probably represents an underestimate it is likely that this is similar to the infertility level in Tunisia.

[76] These survey results were reported in H. Fourati (1985), A. Ladjami et. al. (1988), and H. Rezigua et. al. (1994, pg. 682). However, it is likely that these results represent underestimates. In these surveys the infertility rate was determined by estimating the percentage of married women without children who are at the end of their reproductive lives (45-49 years). Therefore, this would significantly underestimate secondary infertility (infertility experienced by a couple after the birth of at least one child).

[77] Fourati, H. (1985), pg. 21.

of infertility also influences women to seek treatment early and many women begin their quest for conception with traditional treatments through the *qâbla arabi*.

The TBA uses a variety of different methods to induce a pregnancy. For women who deliver at home or women who deliver at the hospital and then visit the *qâbla arabi*, there are a number of treatments designed to promote future fertility. In addition to closing the woman up, many TBAs prepare vaginal suppositories for a woman who has recently delivered. These suppositories are designed to absorb remaining fluids (blood and water) thereby drying and purifying the uterus and preparing the woman for her next conception. This process was described by one *qâbla arabi* in El-Hamma.

> After the woman gives birth, we take a piece of cloth, put it in hot water, and we put it between the woman's legs, pushing hard. Then the woman has to lie on her back and sleep...On the seventh day we put some fenugreek in a small, sterilized ball and put it inside the woman for two days. The fenugreek is very effective in curing fever and all of the other problems of birth. All the rubbish [in the uterus] is sucked out by the small grains of fenugreek, which become bigger and bigger. The woman is supposed to both eat the fenugreek and put it inside of her, because it's very effective and good.[78]

There are a number of variations on this postpartum treatment. A *qâbla arabi* in Ancienne Matmata described the local purification tradition.

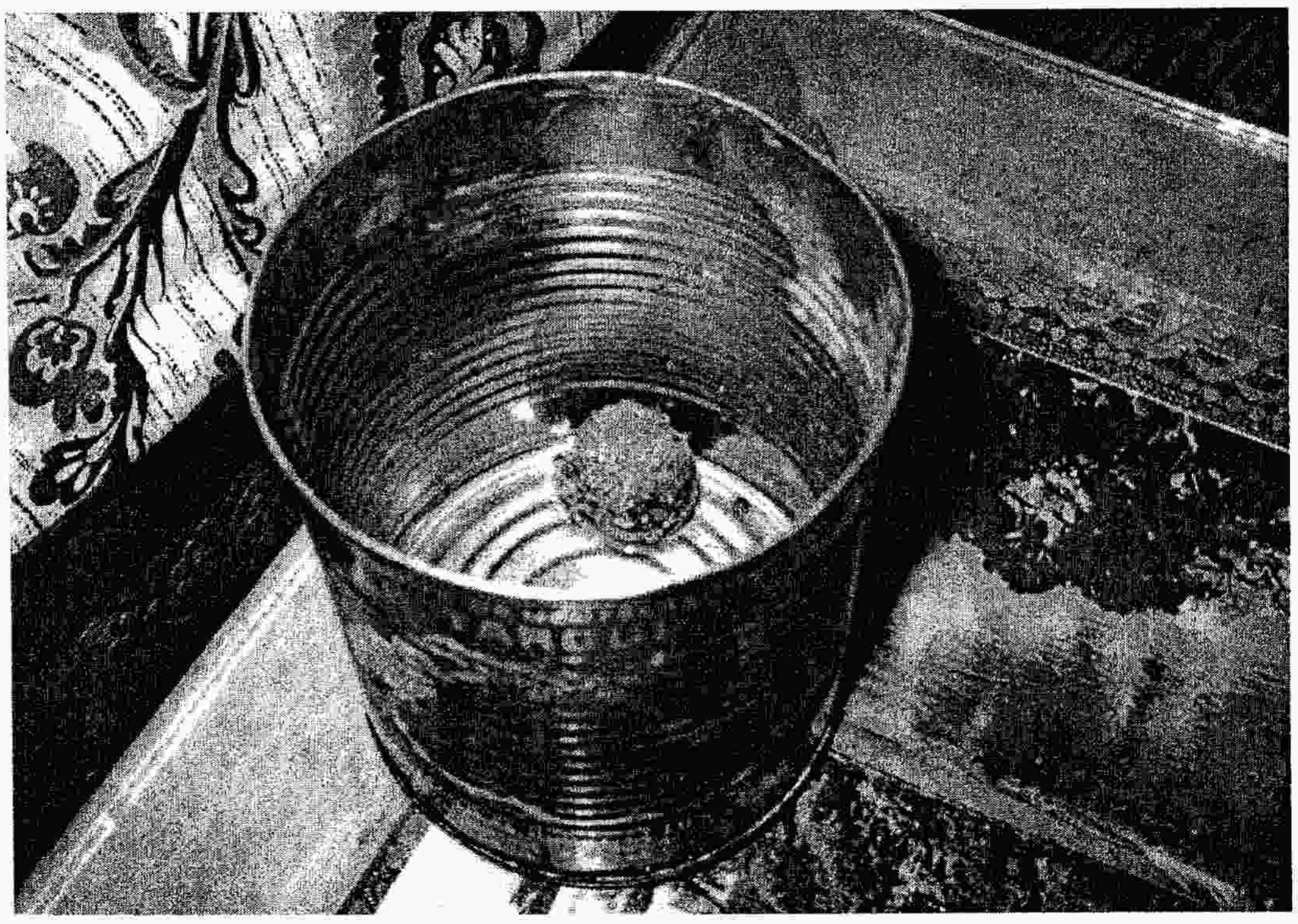
> We clean some herbs and put a woolen cloth in some olive oil. The woman is to [use] two balls. After three days the first ball will fall down with all the waste and blood. The thyme [in the ball] is supposed to suck it all out [of the uterus]. The woman has to wait until it falls down and then puts in another one. The second might stay in until the 40th day. Each day you check yourself by determining the degree of cleanliness of the ball. If you put in the wool ball with thyme and it falls down clean then you don't have to put in another one. Something else to add, if a woman carries a heavy load during this critical period she might bleed a lot and she should use a chickpea ball. You

[78] Interview (TBA), El-Hamma: November 16, 1998.

> put 8-12 peas in a ball and put it inside. The peas will grow and hurt you when inside but don't be afraid. Just leave them inside two or three or four days and if they don't fall down just put your fingers in and pull them down, then you make another ball, a ball of lavender. You make the lavender into a powder, clean it and put it in a ball, just like you've done with the thyme. The second ball is to be made once you've done the first ball. Once you know you are clean, you do the second ball to have a nice smell.[79]

This ritual is such an important part of the home birth experience that some women save the suppository as a memento. One such wool ball, preserved in olive oil, is presented in Figure 4.1

Figure 4.1: Postpartum Vaginal Suppository[80]



While TBAs promote fertility for women who have given birth, they also treat women who are believed to have difficulty conceiving. These treatments for

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[79] Interview (TBA), Ancienne Matmata: April 6, 1999.
[80] Photo taken by A. Foster in Ancienne Matmata: April 7, 1999.

infertility include combining olive oil, honey, mint, and lavender with other herbs and flowers. These combinations can be consumed as a drink, cooked through food, burned in a *kanoon* as incense, or distilled into a liquid to be used as a vaginal douche. As a traditional healer from Gabes reported,

> [For a woman who can not have children] we prepare for her some couscous with rotten meat, fenugreek, peppers, and all the farm's herbs. The woman has to wake up early in the morning and eat this couscous and then we tie her up closely and she should stay like that for days. Then she goes to the *hammâm* and washes her body and if there is not another problem, she'll fall pregnant right away.[81]

Vaginal suppositories are also made with the aforementioned ingredients. Made out of wool balls, these suppositories include such substances as ground placenta powder, vegetables, meat, and, as Halima mentioned, tobacco:

> Rejeb's wife was in France and they told her that she could not have children. Then she came to me…I made her the medicine and now she has five boys. For the medicine, I take some tobacco, some *afes* (dyeing grains), some *dhokkar*, and some *mehleb* (scented crystals). I make them into a powder and purify the mixture. Then the woman has to wash her body and head and take some of the mixture and put it inside her [in a wool ball]. Then she has to sleep with her husband. She has to do this as soon as she is finished with her period.[82]

These vaginal suppositories are left in the body for a period of time ranging from one day to two weeks. In Médenine, women attach the ball to a string, which they tie to

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[81] Interview (Traditional Healer), Gabes: February 13, 1999.
[82] Interview (TBA/Halima), Douz: February 15, 1999.

their thigh. This ensures that the ball is not lost and can be easily removed.[83] These treatments are consistent with treatments documented in other parts of North Africa.[84]

Infertility treatments by TBAs fill a significant gap in the bio-medical services. Clinical infertility services are only available in the regional and specialized hospitals of Tunis, Sousse, and Sfax. For many Tunisian couples, travel to a Northern urban center, let alone treatment, is financially prohibitive. As one gynecologist from Tataouine noted,

> What are we [doctors] supposed to do? In general, the services for infertile couples are prohibitively expensive. When I consult poor people, I tell them that there is nothing that can be done for them. In Tataouine there is nothing to be done, there are no laboratory facilities, there is only one gynecologist and no support staff, and there are no testing facilities. And even if they come up to Tunis for tests, it is too expensive: the couple has to get to Tunis, find someplace to stay, eat, and then pay for lab analyses and medicine.[85]

Indeed, the issue of fertility treatment, and its limitations in Tunisia, was one of the issues raised at the annual OBGYN conference in 1998.[86] Thus women will often use traditional treatments for several years before going to specialists. The decision to visit TBAs for infertility treatment is often due to social pressure and financial constraints. This is perhaps best illustrated by the experience of Faouzia.

Faouzia's Story

Faouzia is from Tataouine. She has been married for seven years and has yet to have a child. When she didn't become pregnant after 14 months she went to an herbalist who told her to drink a broth with oregano, rosemary, and cumin. When the broth didn't work, she went on a pilgrimage to a local saint's tomb, but in spite of the dancing, prayers, and incense burning she still did not become pregnant. As talk

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[83] Interview, Médenine: April 7, 1999.
[84] See, for example, the ethnogynecological treatments described by M. Inhorn in her work with infertile women in Alexandria, Egypt. Inhorn, M., all.
[85] Interview (Gynecologist), Tunis: November 28, 1998.
[86] VIII éme Congrés National de Gynecologie et Obstetrique. Tunis: November 27-29, 1998.

began to grow in the neighborhood, her mother-in-law took her to a qâbla arabi. *The* qâbla arabi *gave her other medicines, including douches and suppositories. But these treatments still did not produce a child. After several years she consulted with the physician in Tataouine. However, no infertility services are available in this part of the country and the doctor was not able to help her, he simply referred her to a special clinic in Tunis. For two years she and her husband saved so that she could travel to Tunis, all the while continuing to consult the* qâbla arabi. *After nearly six years of treatment, Faouzia will be going to Tunis with her brother next month. Her husband refuses to accompany her or get tested, because the problem is most certainly not his.*[87]

As Faouzia's story demonstrates, many women use the services of the *qâbla arabi* for infertility treatment because of the absence of affordable alternative services. Further, as both Salima's story at the beginning of this chapter and Faouzia's story reveal, many younger women use the services of TBAs with the encouragement of older female relatives and neighbors. Women who would not deliver at home with a *qâbla arabi* often use the services of TBAs when treating infertility.[88] Thus many younger women are continuing to use the services of TBAs because of her perceived legitimacy and availability. Indeed, some TBAs who believe themselves to be too old to deliver children continue to provide infertility treatments to women in the community.[89]

Additionally, as Faouzia's experience indicates, women remain primarily responsible for fertility and reproduction in the center and south of Tunisia.[90] Many men refuse to get tested or treated for infertility problems.[91] Within many families, communities, and couples, women are still held responsible for procreation and are

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[87] Interview, Tataouine: April 12, 1999.
[88] This is consistent with the student survey. While none of the surveyed students reported that they would deliver at home with a traditional birth attendant, over 10% would advise a female cousin suffering from infertility problems to seek traditional treatment.
[89] Interview (TBA/Mabrouka), Tataouine: November 20, 1998 & Interview (TBA), Nouvelle Matmata: April 7, 1999.
[90] Interview, Tunis (Physician): February 23, 1999.
[91] Indeed, one of the largest surveys on infertility in Tunisia found that of the couples presenting with probable infertility, one third of husbands were not tested because they refused or the clinician was negligent. (Rezigua, H., et. al., (1994), pg. 683.

consequently blamed if the couple is childless or has difficulty bearing additional children.[92]

Latifa's Story

Latifa was married in her early twenties and had two children, both daughters, in rapid succession. Exhausted from having to balance her professional and parenting responsibilities, Latifa decided to use an IUD. However, within months of the insertion Latifa experienced a considerable amount of pain. She returned to the family planning center in Gabes and was encouraged to have the IUD removed and then reinserted. After receiving the second IUD, she suffered from bleeding and infection. Unable to cope with the pain, Latifa had the second IUD removed. However, the pain continued. Although it has been five years since its removal, Latifa still experiences pain on intercourse and had not been able to have additional children.

Latifa fears that she is infertile. When she returned to the family planning center and discussed her concerns with the midwife she was met with an indifferent response. The midwife was unable to assist her and seemed unsympathetic to her problem. Latifa's husband blames her for having taken the IUD in the first place and is extremely disappointed in not being able to have a son. Latifa is depressed and frustrated. She feels that rural women are solely responsible for contraceptive and fertility decisions and blamed if there are complications. Latifa visited a traditional birth attendant for the first time last year and she has confidence that the treatments with eventually lead to a pregnancy. However, her husband is becoming increasingly impatient and has threatened to divorce her if she doesn't become pregnant soon.[93]

Thus, many women seek traditional treatments to avoid community and familial stigma.

Unfortunately, many of these treatments, in particular the douches and vaginal suppositories, may cause infertility. On a significant number of occasions women seek bio-medical treatment too late, with infertility that is the result of the traditional treatment, not a pre-existing condition.[94] However, the continued pressure on women to become pregnant within a year after marriage pushes women to seek traditional

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[92] Rezigua, H., et. al., (1994)
[93] Interview (Latifa), Tunis: September 10, 1998.
[94] Interview (Gynecologist), Tunis: November 10, 1998.

treatment.[95] Thus it is evident that the TBA's role in infertility treatment remains both important and socially acceptable.

THE SLEEPING CHILD

The third area in which the TBA remains important is that of the identification and treatment of the sleeping child. The sleeping child is not a concept unique to Tunisia, but has been documented in other North African and West African countries.[96] The belief of the sleeping child, *l'enfant endormi* or *sghiir yurqud*, refers to a child who is conceived but remains unborn for several years and this period of sleep appears to range from one to nine years. Typically during this period, the woman menstruates normally but cannot become pregnant. In Tunisia, it is with the assistance of the *qâbla arabi* that this phenomenon is identified and the birth is ultimately induced.

The sleeping child is believed to sleep after the mother experiences extreme happiness, desire, or shock. As one woman explained, "If a woman is pregnant with a three month old baby and she is shocked, she will have air in her uterus and her baby will sleep."[97] Reported shocks range from the death of a loved one to a barking dog.[98] It appears that a child can only sleep in the three to six months after its conception: fetuses younger than three months will be miscarried and fetuses older than 6 months continue to develop and are born normally. A woman knows that she is pregnant with a sleeping child because she experiences a "normal" first trimester pregnancy: her behavior and taste changes, she suffers morning sickness, nausea, and cramps, and she

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[95] Interview (Gynecologist), Tunis: November 28, 1998.
[96] For more on the sleeping child in other contexts see Slomka, J. (Morocco, 1986) and Bossaller, A. (personal communication, publication forthcoming).
[97] Interview, Douriet: April 10, 1999.
[98] Interview, Tataouine: November 20, 1998.

experiences amenorrhea. As a TBA from Kasserine explained, "We know because a woman's behavior changes during the first three or four months. Then she begins to bleed for many days and then after a month and two months there are no symptoms of a baby who is growing up. Then we know that [the baby] sleeps."[99] The sleeping child is differentiated from a miscarriage because it is believed that a woman cannot get pregnant after the child sleeps, because she is still pregnant.[100] Indeed, women who have had both miscarriages and sleeping children use different terms to describe the events.[101] The sleeping child will awake through a second similar shock or the intervention of a *qâbla arabi*. As was noted by a *qâbla arabi* in El-Hamma,

> I know what to do in these cases. I take a castor oil seed, cook it, and grind it into a powder with some herbs. I put the mixture into three [wool] balls. [The woman] is to put the first one inside in the morning and get rid of it at night before sleeping with her husband. She is to use the second ball the second day and the third one the third day. This is effective for waking the child. She might also drink castor oil boiled in water. It's strong and sour but it's good. My brother-in-law slept for nine years and then woke up this way and now he is fine and healthy.[102]

The sleeping child seems to serve three distinct functions in the contemporary Tunisian south. The sleeping child offers an explanation for early onset menopause, serves as a traditional means of contraception, and legitimizes children conceived through illicit sexual relationships. The first type of sleeping child involves the child who sleeps and causes the menstrual cycle to stop. Most women who have sleeping children continue to menstruate normally until the child is awoken by a shock or a *qâbla arabi*. However, for this type of sleeping child, the *qâbla arabi* is unable to

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[99] Interview, Kasserine: March 14, 1999.
[100] This is also not an issue of time. Women describe experiences of miscarriage through the second trimester of pregnancy.
[101] A miscarriage is referred to as رمو (*rmu*: abortion) whereas a sleeping child is صغيريرقد (*sghiir yurqud*: a child that sleeps).
[102] Interview (TBA), El-Hamma: November 16, 1998.

awake the child and the woman is thus unable to conceive additional children. In Tataouine and Kasserine, this appears to serve as an explanation for menopause.[103] This is particularly important for women who begin menopause at an early age, as Ahlam's story reveals.

Ahlam's Story

Ahlam is in her early seventies and is from an area near the town of Kasserine. Ahlam believes that she has been carrying a sleeping child for nearly forty years. Throughout her twenties and thirties Ahlam struggled to carry a pregnancy to term and experienced six miscarriages. However, by the age of thirty-two Ahlam had delivered two healthy sons. In the year following the delivery of her second child, Ahlam dreamt that she would only have two children and was thus very surprised when she became pregnant for the ninth time. However, four months into her ninth pregnancy Ahlam's father died and Ahlam believes that her child slept because of the shock. At first, Ahlam's family insisted that she wake the baby and her husband encouraged to her seek out a cure. But when Ahlam explained that the baby was sleeping because of the shock and that this was consistent with her dream, her family accepted this explanation and stopped pressuring her. Ahlam's period never resumed and her child continues to sleep to this day.[104]

In addition to the case of menopause, historian D. Larguéche found that this explanation has sometimes been given for women who are infertile or unable to conceive children with their husband.[105] By preserving the procreative identity of menopausal or infertile women, the sleeping child serves to preserve the femininity of these women. Through the preservation of their feminine and maternal characteristics these women are less subject to the community and familial pressure and stigma associated with infertility, as is demonstrated in Ahlam's story.

A second type of sleeping child is associated with contraception, as Amel's experience illustrates.

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[103] Interview (TBA), Tataouine: November 20, 1998.
[104] Interview, Kasserine: March 14, 1999.
[105] Interview (Academic), Tunis: October 19, 1999.

Amel's Story

Amel is a 54-year-old woman from Ancienne Matmata. She believes that contraception is forbidden and asserts that she has never taken anything to prevent conception or pregnancy. However, there was a period of nine years between Amel's fourth and her final child. During this period, Amel said that she was pregnant with a sleeping child. Two months after Amel finished breastfeeding her fourth child she still hadn't begun to menstruate, and thus she knew she was pregnant. However, she didn't want to have a child right away, she had her hands full with her existing children. Amel went to the qâbla arabi who gave her a pill to take once a year so that the child would go to sleep.[106] *Amel's menstruation resumed and the baby slept in her belly for eight years before Amel decided that it was time to birth the child. She returned to the qâbla arabi who gave her an herbal drink so that the infant would awake. The healthy child was born ten months later into the hands of the* qâbla arabi.[107]

Amel's experience is consistent with women's experiences in Tataouine, where the sleep-inducing act includes performing a series of somersaults and drinking an herbal broth.[108] Thus in the case of Amel, the sleeping child clearly serves as a way to legitimize her use of contraception. For Amel, she did not prevent a conception; she simply delayed the birth of an already conceived child. As has been previously discussed, contraception is widely available, accessible, and accepted in Tunisia and in 1995 the national contraceptive prevalence rate was slightly greater than 60%.[109] Only 9% of women use traditional methods of birth control, and these women are largely concentrated in central and southern governorates.[110] But even through only a small percentage of women use traditional methods of contraception, the sleeping child remains important for those women who have husbands or families opposed to contraception but themselves want to use. In these cases, the *qâbla arabi* not only assists in the distribution of traditional contraception, but identifies, legitimizes, and wakes the sleeping child when necessary.

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[106] This pill was a castor oil seed (*kharoua).* Interview, Tataouine: April 12, 1999.
[107] Interview, Ancienne Matmata: April 6, 1999.
[108] Interview, Tataouine: April 12, 1999.
[109] ONFP (1996).
[110] Ben Romdhane, H. (1992), pg, 139.

The third type of sleeping child has served to legitimize otherwise illegitimate pregnancies. For example, if a woman's husband dies during the early months of her pregnancy the fetus becomes scared and sleeps. Several years later the child is born and is, with the help of the *qâbla arabi*, identified as the child of the long since deceased husband.[111] The *qâbla arabi* will often "induce" the birth through a combination of rituals and herbal broths. Thus, even though the widow had never remarried, she and the child enjoy a fully legitimate status in the community.[112] Thus, the sleeping child serves as a socially acceptable and femininity-enhancing explanation for the fruits of an illicit sexual act. The legitimacy of the child is tied to the respect and credibility given to the *qâbla arabi*.

These types of sleeping children serve the same general function: they preserve the respectability, maternity, and femininity of women who might otherwise be marginalized. Tunisian women, with the assistance of the TBAs, use the sleeping child to negotiate their sexual and reproductive freedom while simultaneously adhering to societal expectations. Yet, the sleeping child is no longer universally or even widely accepted; it is less-educated women who continue to accept its existence. In the absence of a scientific or medical understanding of reproduction and pregnancy, the sleeping child may be plausible. Although the phenomenon of the sleeping child is currently concentrated in the interior and south of Tunisia, some women in greater Tunis continue to believe in its existence as well, as Lilia's story indicates.

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[111] Interview, El-Hamma: November 17, 1998.
[112] Interview (Former Health Aide), Ancienne Matmata: April 6, 1999 & Interview (TBA), Nouvelle Matmata: April 7, 1999.

Lilia's Story

In the fall of 1999 Lilia, a married illiterate woman in her early thirties, decided to attend a community health education program dedicated to basic women's health issues. From the outskirts of Greater Tunis, Lilia joined nearly thirty women each week in listening to a presentation by a female physician. At the end of a session on the female reproductive system and pregnancy Lilia asked the physician to explain how the sleeping child was able to remain in a woman's belly for such a long time. The physician laughed and ignored the question. However, Lilia persisted with her query and the physician explained that a sleeping child was medically impossible. Lilia entered into a heated debate with the doctor: her sister had only recently given birth to a sleeping child.[113]

The physician's response to Lilia and her question typifies the responses of medical professionals, educated women, and civil servants. Within these circles, the sleeping child is simply discounted as medical superstition or folklore and its believers characterized as foolish or stupid.[114] Indeed, there appears to be a pervasive attitude that belief in the sleeping child will soon disappear, as women become more educated and traditional birth attendants become more rare. However, it appears evident that the sleeping child should be seen as a phenomenon created and sustained by women to serve specific biological, medical, and social functions. The sleeping child represents an extremely resourceful way for women to enhance their social legitimacy and gain greater control over their reproductive and sexual lives. By maintaining their maternity, these women, often geographically, socio-economically, and educationally marginalized, are able to defend their feminine identity and respectability. And it is through the TBA that this sleeping child is supported and accepted.

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[113] Seminar, Ariana: October 22, 1999.

[114] Interview (Gynecologist), Tataouine: November 21, 1998, Interview (Physician), Tunis: January 14, 1999, Interview (Health Administrator), Nouvelle Matmata: February 3, 1999, Interview (Physician), Tunis: February 24, 1999, Interview (Midwife), Teboursouq: March 22, 1999, & Interview (Former Nurse/Lilia), Médenine: April 7, 1999.

Although the sleeping child as a phenomenon is decreasing, all of the TBAs interviewed in this research had been involved with sleeping children and most could cite a case of the sleeping child that had occurred in the last several years. Discounting the relationship between the sleeping child, social devaluation, and femininity ignores the real pressures and restrictions faced by Tunisian women. Further, the regional and educational distribution of the sleeping child reflects disparities in the acceptability and accessibility of alternative routes to female empowerment.

CONCLUSION

This chapter has demonstrated that the *qâbla arabi* continues to play a significant role in women's health care, particularly in the areas of home delivery, infertility treatment, and sleeping children. And while the rate of home births has decreased from 30% in 1988 to 18% in 1996, the importance of the *qâbla arabi* in infertility treatment does not appear to be in decline.[115] Yet, in spite of her continued importance, her role is generally overlooked and ignored. Many health service providers in the center and south of the country appear unaware of the contemporary work of the TBA.[116] Indeed, there seems to be a pervasive attitude or hope within the MOPH that the work of the *qâbla arabi* will become moot over time; the accessibility of health services will increase, the population will become more educated, and the

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[115] Interview, Tunis (Gynecologist): November 10, 1998.

[116] By way of example, on the morning of March 12, 1999 I interviewed a head nurse at the new local hospital in Kasserine who stated, "There really aren't any traditional healers in Kasserine, there are no traditional medicines like herbs or acupuncture. However, in the rural regions one can find old women who used to deliver children. But in town you can't find them." That afternoon I interviewed the first of two TBAs working in downtown Kasserine, less than a kilometer from the hospital.

older *quabla* will pass away.[117] Thus, time will erode both the supply of and the demand for the services of the *qâbla arabi*.

However, this attitude seems inconsistent with the realities of the TBA's contemporary work as presented in this chapter. Women are choosing to use the services of TBAs in spite of biomedical alternatives and some knowledge of the health risks. By ignoring the contemporary work of TBAs, the national health program is missing an opportunity to examine the reasons for which women continue to use traditional health services, reasons that often reflect shortcomings in the national program. In particular, women's legitimate concerns about their reception and treatment in health centers, the regional disparities in services, the high costs associated with specialized treatment, and the continued lack of understanding about sexuality and reproduction are all factors that necessitate the TBAs continued work.

It appears that many of the health reforms in the 1990s, and specifically the PNP, may contribute to the continuation, if not intensification, of the TBAs' work in the south and center of Tunisia. The reforms of the 1990s include no provisions for recognizing the work of TBAs or integrating them into any component of the national health system. There also appear to be no current efforts to train or educate traditional birth attendants. As a number of the traditional postpartum and infertility treatments appear carry significant health risks, the lack of acknowledgement on the part of the MOPH may contribute to negative health outcomes. Further, the re-centralization of decision-making and program determination poses an obstacle to individual health service providers who previously worked with TBAs in their local communities.[118]

By impeding the relationship between professional health service providers and

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[117] Open discussion with midwives, MOPH and ONFP representatives, Tunis: October 28, 1999.
[118] Interview (Midwife), Douz: February 15, 1999 & Interview (ACT Representative), Sidi Bouzid: April 1, 1999.

TBAs, it appears likely that TBAs will be more resistant to referring or transferring high risk cases to the national health system. Finally, the transferring requirements established by the PNP suggest that the conveniences associated with home-birthing may become more pronounced, as Monia's story reveals.

Monia's Story

Monia visited the PMI in Douz for the first time during the eighth month of her pregnancy. Monia had delivered six of her seven living children at home: she gave birth to her last child a public hospital after complications caused the qâbla arabi *to transfer her. During her consultation, the midwife and nurse lectured her: Monia was told that she had too many children, that she was too old to have additional children, and that her behavior is irresponsible. After fifteen minutes, Monia is informed that she will not be able to deliver the baby in Douz. Because of her obstetric history, Monia is labeled high risk and she will have to travel 45 minutes Northeast to Kebili in order to deliver at the regional hospital. Monia listened patiently and left the office on the verge of tears. After the rude treatment and the news that she would have to be transferred to a distant facility, Monia has decided to deliver her child at home.*[119]

Thus, it appears that the contemporary work of the TBA not only compensates for problems and shortcomings in the national health program, but the reforms which took place in the 1990s may exacerbate many of these problems and therefore increase the appeal of traditional health services.

The TBA's role has changed since the pre-independence era, but although she no longer provides the majority of women's health services, her function in Tunisian society remains largely the same: she continues to fill the void left by the national health program. Acknowledging and analyzing the work of the TBA allows for a critical examination of the national health system and offers and important mechanism of better identifying women's health needs and ultimately improving the quality of the national health program.

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[119] Participant observation of consultation, February 15, 1999.

CHAPTER 5: THE INTERSECTION OF LEGAL, MEDICAL & SOCIAL INSTITUTIONS
DOMESTIC VIOLENCE IN TUNISIA

Miriam's Story

Miriam is a Tunisian-French bi-national and after living in France for 13 years, she decided at age 24 to return to Tunisia, the country of her birth and heritage. Now in her mid-thirties, Miriam divorced her husband three years ago because he was physically and emotionally abusive, but she still lives in fear of him, for both herself and her child.

Miriam describes her courtship as magical and romantic. She found her future husband to be gentle and kind and, despite his modest background and lack of education, he seemed intent on bettering his position and that of his future family. Miriam and her family were delighted with the match. But immediately after their marriage, at which time Miriam and her husband moved down the street from his family, his behavior changed. It became clear to Miriam that her husband resented her education and her bi-nationalism, things he could never share with her. His family seemed to resent her as well and became cold and distant. She soon found herself isolated. Her husband became restrictive and limited her contact with other people. As he constantly insulted her, Miriam's self-esteem fell to an all time low. She contemplated suicide, but her daughter served as her lifeline. When the physical abuse escalated, Miriam decided that she had to divorce him; she did not want her daughter to grow up watching her mother being abused. Throughout their marriage, Miriam only disclosed her abuse to a Catholic relief organization in Tunis. She never reported the abuse or went to a hospital.

Miriam wanted to leave Tunisia immediately after the divorce, but she decided to remain for the sake of her daughter. However, in the years since her divorce Miriam's ex-husband has been using their daughter and his visitation rights as a way to pressure, humiliate, and threaten Miriam. Despite her divorce, Miriam still feels restricted and isolated. Over the last three years, she has become depressed and increasingly desperate. She has not been able to find work and divorced women still face substantial unofficial discrimination, even in Tunis.

In October 1998, Miriam decided to illegally take her daughter to France. At the end of January, with the assistance of the French embassy, Miriam risked a 20-year prison sentence and took her child out of Tunisia on Tunisian papers with a fraudulent French visa. Though her ex-husband has no right to impede her travel, it was illegal for her to take her daughter out of the country without his consent. In addition, her ex-husband has a high-ranking relative in the Ministry of the Interior and Miriam was afraid he would be able to stop her from leaving. Miriam now resides in a shelter in France with her daughter and is searching for work. Though she will not be able to return to Tunisia for twenty years without facing a prison sentence, she said that this was a choice between her parents and her daughter and her daughter had to come first.[1]

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[1] Interview (Miriam), Tunis & France: January-March 1999.

INTRODUCTION

Despite the growing body of research on domestic violence in the developing world, and the impact this violence has on women's health more generally, both qualitative and quantitative research on domestic violence remains muted. Not withstanding the accomplishments of the women's health program in Tunisia, the issue of domestic violence has been and continues to be marginalized. This chapter demonstrates that domestic violence has a substantial impact on women's physical and psychological health in Tunisia. Yet, in spite of the significant legal reforms affecting the status of abused women, and the importance of medical respondents in those reforms, the national women's health program remains generally unresponsive to abused women's needs. Although several women's organizations and NGOs have adopted programs to address issues of violence and better support abused women, this chapter demonstrates that these services are insufficient. Only by recognizing the importance of domestic violence as a women's health issues and by more conscientiously interacting with legal and social institutions will the national women's health program be better able to respond to these particular health needs of women.

DOMESTIC VIOLENCE AS A WOMEN'S HEALTH ISSUE

Domestic violence, typically the abuse of a woman by a husband or intimate male partner, is the most common form of violence against women worldwide.[2]

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[2] Although there are cases where the perpetrator is female, these cases are rare, and the violence is often in response to the abuse of the husband or partner. In almost every study on domestic violence, the male partner is the primary perpetrator. And although domestic violence does occur in same sex partnerships, the research on this issue in the developing world is extremely limited and this chapter will only focus on domestic violence in heterosexual relationships.

Domestic violence has been documented in almost every culture in which it has been researched.[3] As R. Carrillo noted, "Its manifestations may be culturally specific, but gender violence cuts across national boundaries, ideologies, classes, races, and ethnic groups."[4] Domestic violence can take many forms including physical, sexual, and psychological abuse, threats of abuse, humiliation, neglect, and deprivation.[5]

Globally, domestic violence also represents one of the most severe threats to women's health. The 1993 World Development Report estimated that 5% of the disease burden of women in developing countries and 19% in developed countries was the result of rape or domestic violence.[6] As there is overwhelming agreement that domestic violence is under-reported throughout the world, it is likely that the disease burden is even greater.[7] Case studies have demonstrated the enormous impact domestic violence has on female mortality and morbidity.[8] Indeed, studies from both developing and developed countries indicate that domestic violence is the leading cause of injury for women and constitutes the single largest reason for emergency

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[3] In his research on 90 peasant societies, D. Levinson identified 16 small, non-patriarchal, pre-industrial societies in which domestic/family violence was absent. Reported in Heise, L. (1993).

[4] Carrillo, R. (1993), pg. 102.

[5] Though physical, sexual, and psychological violence are intertwined and constitute domestic violence independently and collectively, this chapter limits its focus to physical violence. This is in no way meant to suggest that these other forms of domestic violence are less important than physical violence. However, as will be shown throughout this chapter, physical abuse, and more precisely wife beating, is legally, socially, and attitudinally differentiated from other forms of domestic violence in Tunisia and dominates the limited research agenda.

[6] The disease burden is measured in disability-adjusted life years (DALYs) and quantifies the number of years of healthy life lost because of a disease or condition. As the total disease burden in developing countries is much larger than in developed countries, domestic violence constitutes a smaller proportion of the disease burden in developing countries. However, it is estimated that the disease burden of domestic violence per capita in developing and developed countries is roughly equivalent. World Bank (1993), pg. 50.

[7] Under reporting occurs for a variety of reasons including, the shame and humiliation associated with the abuse, the lack of reporting mechanisms and/or laws sympathetic to abused women and the pressure on women to remain silent for fear of retaliation.

[8] In the US, several studies have shown that 28% to 30% of women have been physically abused by a man with whom they have had an intimate relationship. Heise, L. (1993). In Kenya, a survey of 733 women found that 42% were beaten regularly by their husbands. Fischbach, R. & B. Herbert (1997).

room consultations.[9] Physical violence includes hitting, punching, kicking, biting, coerced sexual activity, burning, and stabbing and abuse related physical injuries include bruises, broken bones, burns, concussions, miscarriages, increased risk of contracting an STD, loss of hearing or vision, partial or permanent disabilities, and death.

In addition to the impact of domestic violence on women's physical health, it is unquestionable that domestic violence has a significant impact on psychological morbidity. Indeed, for some women the psychological impact of the abuse is more profound than the physical impact.[10] Depression, low self-esteem, anxiety, fear, post-traumatic stress disorder, and fatigue are but a few of the most common psychological reactions to domestic violence.[11] Further, self-destructive behaviors, including substance abuse and suicide, have been well-documented reactions to domestic violence in both developed and developing countries.[12] Finally, the humiliation, embarrassment, and shame surrounding domestic violence have also been shown to exert a significant impact on women's mental health. "Most battering remains hidden, undisclosed to neighbors, relatives, clinicians, and researchers due to differing cultural constructs about its importance as well as the individual shame, guilt, fear of recrimination, and social taboos associated with victimization."[13] Thus, domestic violence poses a significant threat to women's physical and mental health worldwide.

In certain areas of Papua New Guinea nearly two-thirds of women have been beaten by a male partner. Heise, L. et. al. (1994).

[9] These surveys, as reported in Heise, L., et. al. (1994) & Doyal, L. (1995), include research conducted in the United States, Britain, Papua New Guinea, and Egypt.

[10] Heise, L., et. al. (1994).

[11] Fischerbach, R. & B. Herbert (1997), pg. 1168.

[12] Doyal, L. (1995), pg. 56.

[13] Fischbach, R. & B.Herbert (1997), pg. 1162.

THE PREVALENCE & CHARACTERISTICS OF DOMESTIC VIOLENCE IN TUNISIA

Having reviewed the prevalence of domestic violence globally and the impact of domestic violence on women's health, this chapter now turns to domestic violence specifically in the Tunisian context. Little research has been conducted on domestic violence in Tunisia, and that which has been conducted has almost exclusively focused on Greater Tunis, the Sahel, and Sfax. However, available statistics indicate that the prevalence of domestic violence in Tunisia is comparable to the prevalence of domestic violence in other countries in the developing world and poses a significant threat to women's physical and psychological health.

In 1998, the largest survey to date on the prevalence of domestic violence in Tunisia was conducted by Le Centre d'Etudes et Recherches Economiques et Sociales (CERES), a public research institute affiliated with the University of Tunis.[14] Approximately 950 ever-married women in the greater Tunis area were asked to participate in a survey about an acute episode of violence. Over 800 responded that they had experienced at least one incident of abuse.[15] Thus, over 80% of the women surveyed reported that they had experienced at least one incident of wife battering.[16] For the women who replied affirmatively, the survey consisted of a number of questions about the episode focusing on whether or not she sought medical attention, whether or not it was reported, her current relationship to the perpetrator (living together, separated,

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[14] This survey was under the direction of Tunisian medical anthropologist and psychologist Lilia Labidi and was enumerated by approximately 90 second-year psychology students.

[15] A small number of women indicated that the abuser was not the husband but the brother or father. No female abusers were reported.

[16] However, it is probable that this percentage is an overestimate. Many of the enumerators went first to their families and neighbors. While this undoubtedly enhanced the openness of the interview and provided more personal contact, inevitably the enumerators focused on women they knew to be victims of violence, because of their own personal observations or neighborhood rumor. Further, enumerators living in the dorms concentrated their efforts on the area hospitals (emergency rooms) and clinics, increasing the bias in the survey.

divorced), the proximate cause, and the nature of the injury. The woman was also asked to mark on an outline of the female body where she had been injured.

The preliminary results of the CERES survey indicate that there was a negligible rate of reporting and less than a third of women had received medical treatment.[17] Indeed, many women never spoke about the violent episode to anyone. Preliminary trends indicate that educated and employed women were more likely to have reported the event, sought medical treatment, and left their abusers. Illiterate women and women with many children were likely to have neither sought treatment nor separated from their abusive partners. Reasons for the violence were varied and many women spoke of several factors that contributed to the acute violent episode. Frustration, poverty and unemployment, alcohol, children, and jealousy were repeatedly identified as proximate causes for the violent episode. Infertility was also a significantly reported proximate cause of violence. The survey also found that head and arm injuries were the most common, and over one fifth of respondants indicated injuries to the genitals.[18]

The CERES study is largely consistent with several smaller studies conducted in the 1980s and early 1990s. In a 1986 survey, psychologist E. Ben Miled asked one hundred women from a wide age range living in Tunis to discuss issues of violence.[19] This survey population included an even number of urban and rural residents and the majority of women disclosed incidents of physical abuse.[20] A 1991 survey of 220 women

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[17] The results of this study are in the process of being published. Personal communication with the director and enumerators, Tunis: October-November, 1998 & February, 1999.

[18] The body was divided into eight zones: the back and the front of the head, the front and back of the upper body, the abdomen and genital region, the buttocks, legs, and arms.

[19] The informants ranged from 21 to 94 years of age and though the women lived in Greater Tunis at the time of the project, many originated from other governorates.

[20] E. Ben Miled found significant generational differences. Ben Miled argues that repudiation and polygamy, both outlawed in 1956, constitute forms of violence against women. She found that these forms of violence were replaced by physical violence, which was documented in more than half of her sample. Ben Miled, E. (1988).

by S. Hamzaoui found that 65% of urban residents and 15% of rural residents reported spousal abuse.[21] Consistent with the CERES study, infertility and jealousy were cited as important proximate causes of the violence. For rural residents, stress surrounding the emigration of the husband to Europe was also cited as an important contributing factor. Finally, a 1991 study by S. Rjeb focused on child abuse in Tunis and the Sahel.[22] In order to investigate cycles of violence, Rjeb asked 120 children under the age of 14 who were still living at home to report on spousal abuse. Twenty-five percent of the children in Mellassine, 15% in the Sahel area, and 5% in Menzah reported that their father battered their mother, though, as Rjeb herself acknowledges, these statistics are likely significant underestimates.[23]

These studies were consistent with the results of the oral history project, conducted as part of the fieldwork for this dissertation, which found that over one third of the ever-married participants related an incident of spousal abuse. This was true of women from all regions of the country and of all educational backgrounds. Though several of these women subsequently divorced their partners, the majority did not report the abuse or seek a divorce. As one woman explained,

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[21] S. Hamzaoui argues that rural residents are more likely than their urban counterparts to under-report violence because women in rural areas are more likely to tolerate domestic violence and see it as a normal part of the marital relationship. Hamzaoui, S. (1992), pp. 96 & 99-100.

[22] Rjeb, S. (1991).

[23] Young children living at home are likely to under-respond to a single direct question about domestic abuse in a survey conducted by an adult official for fear of parental or outside punishment. Further, and perhaps more significantly, young children are likely to define their "mother being beaten" differently than the women themselves. Indeed, many of the women in the CERES study described incidents in which they were slapped, pushed, or kicked and received only minor injuries. Other women indicated that they had only experienced one episode of spousal abuse, because the abuse was either never repeated or they left their husbands. This is not to suggest that these experiences are any less traumatic or painful then repeated beatings or beatings resulting in more severe injuries, only that young children are less likely to identify them as beatings in a survey.

> I have been married to my husband for more than thirty years and now that I have retired [from nursing] I am going to divorce him. All of my [six] children are grown and have good professions so I do not need to be married to him anymore. He has been abusive since the beginning of our marriage. Look at my finger! He broke several of my fingers about fifteen years ago by twisting my hand. I was too embarrassed to go to the hospital because that is where I worked so I set the bones myself. I did not do a very good job with this one and you see, this [finger] is still crooked.[24]

Further, of the never-married women who participated in the oral history project, nearly one fourth related an episode of dating violence.

Thus the limited number of studies on domestic violence indicate that physical abuse is highly prevalent but under-reported to both medical and legal institutions. These studies also show that domestic violence is not restricted to any particular socio-economic, regional, educational, or professional group but is prevalent throughout Tunisian society. Though the aforementioned studies indicate that the vast majority of Tunisian women do not divorce their abusive partners, for those women who do divorce their husbands, domestic violence does appear to be a significant cause.[25] In a research project involving 20 divorced women from Tunis, S. Rjeb found that the proximate cause for 35% of the divorces was wife beating.[26] In several cases, the violence was both sexual and physical. As one woman reported to Rjeb,

> [My husband] became very violent…I refused him...I refused him because he did not take my pleasure into account. I was an object for him to discharge himself in. His way of making love was humiliating. I was never satisfied with him…One evening he came into my room and I pushed him away. He exploded, he punched me twice in the face and once in the stomach, he used coarse language toward me, and he raped me.[27]

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[24] Interview, Médenine: April 7, 1999.
[25] The divorce rate in Tunisia in 1994-1995 was found to be 6.2% of all first marriages. In total, 1.9% of women are divorced at any given time. ONFP (1996), pp. 177 & 181.
[26] Rjeb, S. (1986), pg. 316.
[27] Rjeb, S. (1986), pg. 292.

Domestic violence has important health consequences for women in Tunisia. Though the body of research is limited, it is consistent with the global health statistics previously explored. Surveys from emergency rooms in Sousse, Monastir, and Sfax have all shown that domestic violence is the most prevalent form of intra-familial violence and represents the leading form of violence against women.[28] Indeed, a 1990 survey examining cases of intentional assault and battery at the emergency room of Farhat Hached hospital in Sousse found that domestic violence represented 17% of total cases and more than half of cases involving intra-familial violence.[29] Researcher J. Gnounou found that in over 90% of the cases the perpetrator of the violence was male and the victim was female. The majority of cases (74.5%) occurred in the marital home and nearly 15% of the violent episodes occurred in a public place. Over 97% of the women were married to their abuser at the time of the abuse, with the remaining three percent either divorced from or in the process of divorcing the abuser. The majority of cases were not reported to the police and no judicial action was taken.[30]

In a similar study conducted in Sfax, researcher N. El-Aoud found that domestic violence was the leading cause of injury to women visiting the emergency room (30.5% of all cases with women as victims).[31] Consistent with the survey in Sousse, men were the aggressor in more than 96% of the cases of domestic violence. Over 85% of the violent episodes occurred in or in front of the marital home. As with the study in Sousse, few women reported the abusive episode.

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[28] El-Aoud, N. (1994), Gnounou, J. (1992) & Zouhaeir, Y. (1995).
[29] Gnounou, J. (1992), pg. 96.
[30] Gnounou, J. (1992), pg. 97.
[31] El-Aoud, N. (1994), pg. 102.

These studies also shed light on the severity of the abuse. In Sousse, 65% of the cases of violence were perpetrated without a weapon or other object and resulted in a total of 1,419 days of temporary incapacity, with an average of 11.2 incapacity days per woman. In nearly half of the cases the incapacity was greater than ten days per woman. However, unlike the study in Sousse, in 62% of the cases in the Sfaxian study the aggressor used a blunt object.[32] Women suffered from bone fractures in 8.5% of cases and genital hemorrhaging in nearly 4% of cases. All of the cases resulted in more than 1 day of incapacity and in nearly 73% of the cases the incapacity lasted more than 10 days. Partial permanent incapacity occurred in 7.5% of cases, indicating severe physical violence.[33]

Evidence of the psychological impact of domestic violence on women in Tunisia is sparser. The Tunisian Mental Health Association found that Tunisian women, when compared to their male counterparts, suffer from higher rates of depression, anxiety, and suicidal tendencies, in large part due to familial stresses and conflicts.[34] Miriam's story at the beginning of this chapter is consistent with this finding. Indeed, a 1992 UNFT study found that abused women speak about the psychological injuries, depression, humiliation, and injustice more than they speak of physical injuries.[35] Further, S. Hamzaoui found that, "In the course of this study, 35% of women interviewed from the urban milieu were labeled as depressives, 45% of them consumed tranquilizers, with or without a medical prescription, and 6% admitted to having attempted suicide following spousal conflicts."[36] Finally, a study

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[32] El-Aoud, N. (1994), pp. 105-106.
[33] El-Aoud, N. (1994), pg. 102.
[34] Douki, S. et. al. (1998), pp. 1-2.
[35] UNFT (1992), pg. 10.
[36] Hamzaoui, S. (1992), pg. 111.

by J. Ben Abid found that the majority of women institutionalized at the Razi Psychiatric hospital suffered from psychiatric disorders related to domestic violence and family conflicts.[37] Thus it is apparent that, consistent with the global situation, domestic violence has a significant impact on women's physical and mental health in Tunisia.

Yet in spite of the relatively high prevalence of domestic violence in Tunisia, domestic violence is not an expected part of the marital relationship and is almost universally seen as morally and legally wrong. In 1992, the UNFT published the results of an attitudinal survey conducted with a sample of 1,000 Tunisians, 668 of which were women, from 42 locations. The UNFT survey found that 2.5% of female respondents believed domestic violence to be a normal and expected part of the marital relationship.[38] The majority of women from the south (79%), Tunis (61%), and the central west (60%) reported that domestic violence was unacceptable.[39] As one woman related, "Me, I was hit by my husband in the first month of my marriage. I said nothing but when he left for work I returned to my parents' home. He understood that violence would never be acceptable to me. Since then, he screams and gets angry, but he never dares to approach me or beat me."[40] Further, the majority of women characterized men who beat their wives as "brutal".[41] Though only a minority of women indicated that divorce was the only solution for an abusive marriage, condemnation of domestic abuse was found throughout the country and among all age groups.

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[37] Ben Abid, J. et. al. (1993), pg. 115.
[38] UNFT (1992), pg. 22.
[39] UNFT (1992), pg. 24.
[40] UNFT (1992), pg. 24.
[41] UNFT (1992), pg. 26.

The UNFT study found that, in comparison to women, men expressed a much greater tolerance of and support for domestic violence. Overall, 51% of men described domestic violence as unacceptable and nearly 50% described abusive men as "brutal". Men were more likely than women to condone domestic violence and state that it is a natural or expected part of the marital relationship (12.6%). However, it appears that approximately half of the men in the sample voiced opposition to domestic violence.[42]

The women who participated in the oral history project expressed opinions consistent with the UNFT survey. Women would condemn domestic violence as both morally and legally wrong, citing both the Quran and penal law as evidence.[43] Further, women throughout the country would describe abusive husbands as "not good" and stated that abusive men were weak and unmasculine. As one illiterate woman in her seventies stated, "A man who beats his wife, what kind of man is that? What does it prove if you beat a woman? If my sons did that to their wives I would feel ashamed, I would feel that I had not raised good children."[44] Thus it appears that though domestic violence is highly prevalent, women generally do not condone it or believe it to be acceptable and do not expect it to be a normal part of the marital relationship.

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[42] UNFT (1992), pp. 14-15.

[43] The relationship between domestic violence and Islam is complex. During the oral history project, women often cited the Quran as evidence of the immorality of domestic violence. However, the UNFT survey found that observant Muslim women (women who pray regularly and fast during Ramadan) were more likely that their less observant counterparts to excuse and legitimize spousal abuse, 18.5% and 3% respectively. Consistent with a growing body of feminist Islamic scholarship, the UNFT concludes that certain interpretations of Islam condone domestic violence. However, other interpretations of Islam find that domestic violence is completely incongruous with the egalitarian principles expressed in the Quran. As there appear to be differences between the Quran, the sunna, and the hadith with respect to the permissibility of domestic violence (and specifically wife-beating), individuals draw from different traditions to support or explain their views. For further discussion of the relationship between Islam and violence against women, see Beinin, J. & J. Stork (Eds.) (1997), Cherif, K. et. al. (Eds.) (1995) & El Saadawi, N. (1980).

[44] Interview, Tunis: September 10, 1998.

The student survey also indicated that young women overwhelmingly find domestic violence and dating violence to be unacceptable. Students were asked to respond to a situation in which a close friend is having problems with her boyfriend; he is extremely jealous, he sometimes yells at her, and he once pushed her very forcefully.[45] Over 60% of students stated that this behavior was completely unacceptable and that they would advise the friend to leave her partner, either immediately or after a discussion and trial period. Twelve percent suggested that the friend should modify her behavior (i.e. not speak to men) so as to not provoke her boyfriend. And although 5% of respondents stated that jealousy is a normal part of a relationship and that the friend should be flattered, the majority of women stated that this type of behavior was wholly unacceptable. As Bahia's experience illustrates, many of these young women have themselves chosen to leave abusive partners.

Bahia's Story

Bahia originally hails from El-Jem, a small town located in the governorate of Mahdia. She is now a third year student at the University of Tunis in the Labor Management program. When Bahia came to Tunis, she met the man she says she intended to marry. They were together for over a year and she had every intention of building a life with him. Bahia says that everything in their relationship was good because he knew everything about her and they had no secrets. However, one night, when he was jealous, he slapped her across the face. It was the first and only time because she left him. Though she says she still loves him very deeply, that she will always love him, she had to leave him. In spite of his evident remorse and apologies, Bahia believes she made the right decision: if he could do this to her now, what would he do to her after their marriage? Bahia remains deeply affected by the relationship. She feels isolated and depressed and does not understand why this happened to her.[46]

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[45] The question from the student survey reads: Scenario #4: A close friend tells you that she is having problems with her boyfriend. He is extremely jealous and does not want her to speak with other men. Sometimes when he is angry he yells at her and once he pushed her. How would you respond?

[46] Interview (Bahia), Tunis: February 25, 1999.

It is probable that the overwhelming condemnation of domestic violence has a significant impact on the mental and psychological health of women who are abused. Indeed, as Bahia's experience shows, feelings of isolation and depression are common amongst abused women and not unlinked to the belief that domestic violence is immoral and unacceptable.[47] Because domestic violence is perceived as unacceptable, there is an assumption that the rate is low, even when this is in contrast with women's personal experiences. In the oral history project, women and students who disclosed incidents of abuse or talked about the abuse of family, friends and neighbors, spoke about these events as exceptions. Indeed, many women were stunned upon hearing other women disclose their experiences of abuse.[48] Further, a number expressed shock at the similarities between their own experiences and those of others in the group.[49] Thus domestic violence, though widely condemned, remains prevalent in Tunisia and has serious health consequences for women.

DOMESTIC VIOLENCE LAW IN TUNISIA

Having examined the prevalence of domestic violence in Tunisia, this chapter now discusses Tunisian penal and civil law and the impact that legal institutions have

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[47] In her work on domestic violence in Mexico, K. Finkler (1997) argues that because domestic violence is generally perceived as being wrong and immoral, abused women carry a moral load which results in anger and illness.

[48]Interviews with a number of the enumerators of the CERES survey revealed that the young women were deeply shocked and affected by the results of the survey, both from their exposure to individual episodes of violence and from the realization that these episodes were not isolated. As a result of the project a number of the students have suffered from acute depression and one student was so traumatized by the episodes of abuse disclosed to her that she is questioning whether or not she should continue in psychology. The young women who spoke with members of their own families appear to have been particularly affected. Much of this depression coincided with the compilation of the data, when realizing that each enumerator's experience paralleled those of the others. Interviews, Tunis: October-November, 1998 & February, 1999.

[49] Group Discussions in Tunis, Tataouine, and Médenine: August 27 & October 28, 1998, November 20, 1998, and April 7-8, 1999.

on the status of abused women. The Tunisian penal code has evolved considerably since Tunisian independence. Prior to 1993, domestic violence was not explicitly illegal and the murder of a wife caught in the act of adultery by her husband was legally differentiated from other murders, carrying a penalty of only 5 years. This same exception was not accorded to a woman who found her husband in a similar compromising position.[50] Further, until 1981 a wife was criminally liable for adulterous behavior whereas a husband was not.

However, recent reforms in both the penal and civil codes significantly affected the legal status of abused women. In 1993, Article 207 of the Tunisian Penal Code was amended such that murder by a spouse was no longer differentiated from other murders. Under Article 218 a person who causes injury, hits, or otherwise assaults or attempts an assault on a spouse is punishable by up to 5 years imprisonment and a fine. Abuse of a spouse or descendent is now considered an aggravating factor and thus the penalties are more severe. Indeed, while the maximum period of imprisonment is 5 years for domestic violence it is only 3 years for premeditated non-spousal or non-descendent abuse. The threat of assault is punishable as well. However, unlike other crimes of violence, criminal proceedings in domestic violence cases can be halted at any time by the withdrawal of the victim's complaint.[51]

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[50] Daoud, Z. (1994), pg. 47.

[51] While this provision allows women to retain control over the criminal proceedings, L. Brand and others have persuasively argued that this provision can have detrimental affects on abused women as familial pressure can often force them to withdraw complaints against abusive partners. Brand, L. (1998), pg. 213. Further, the ATFD has found that when going before the judge in the presence of the husband, many women are intimidated and withdraw the complaint in fear. ATFD (1994a), pg. 56.

The penalty for abuse depends on the severity of the abuse and whether or not it is premeditated. Severity is determined by a medical exam and an assessment of the number of "incapacity days" with ten serving as the benchmark for severe violence. For non-severe abuse the punishment for a first time offender is 15 days in prison and a fine (Article 319). For severe, but non-premeditated domestic abuse, the sentence is two years (one year for non-spousal or non-descendent abuse). This is raised to five years if the abuse is premeditated. As the medical certificate is required for legal prosecution, the medical system is thus directly tied to domestic violence law.

Civil law is also important with respect to abused women.[52] In 1956, the first Code du Statut Personnel (CSP) was created. Revolutionary for its time, the CSP formally divorced civil law from Islamic law, though, as A. Mayer and others have argued, the laws themselves were construed in light of Islamic principles.[53] The CSP granted women full legal majority, established a minimum age for marriage, and required that both the bride and groom consent to a union. The CSP also abolished polygamy and repudiation, actions that in and of themselves, some have argued, constitute forms of violence against women.[54] Yet, perhaps most importantly, the CSP established equal rights in divorce, including the ability of women to initiate divorce proceedings for cause or for non-specified reasons.[55]

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[52] Although most of the discussion on domestic violence law revolves around criminal statutes, civil law is also important for abused women. Access to divorce, child custody, and financial autonomy have been consistently shown to enable women to more easily leave abusive partners.

[53] Mayer, A. (1995, Summer) and Tunisian jurist M. Jmour in ATFD (1994a).

[54] E. Ben Miled has noted that as domestic violence is essentially about power, both repudiation and polygamy are forms of violence. Indeed, the threat of these activities women caused women fear, anxiety, and psychological morbidity. Ben Miled, E. (1988).

[55] A divorce can also be granted under mutual consent.

In spite of the fact that the CSP was widely accepted as the most progressive civil code in the Arab world, there were significant limitations. Men were codified as the head of the household and differential obligations for spouses required that women obey their husbands.[56] Further, there were substantial problems in the application of the law in that women often faced a great deal of difficulty in initiating a divorce and retaining custody of the children. Indeed, only in 1981 were children's best interests considered when determining custody.

However, after considerable lobbying by women's organizations, the CSP was also further amended in 1993. The most profound changes affected divorce and included fortifying a woman's right to alimony and child support, including lifelong support for disabled children, and providing mothers with increased custody rights and influence over childrearing. Further, revisions to Article 12 granted women the right to pass Tunisian nationality to the child. Finally, while the husband legally remains the head of the family (Article 23), the obligations of marriage were changed to be reciprocal, though differential obligations toward contributing to family income remain.[57] Thus by enhancing the ability of women to divorce abusive partners, retain custody of their children, and attain a certain degree of economic self-sufficiency, the reforms to the CSP improved the legal status of abused women. The importance of divorce is evident from Zohra's experience.

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[56] A number of jurists have noted that the requirement that a woman obey her husband has influenced the perception of marital rape. As sexual relations are widely seen as a woman's marital duty, the requirement that she obey her husband eliminates the need for consent. UNFT (1992), pg. 52.

[57] While the husband is required to meet the maintenance needs of his spouse and children, the woman must contribute to family expenses only if she has property. Daoud, Z. (1994), pg. 39.

Zohra's Story

Zohra married her first husband when she was 25 years old. Her first husband was a "foreigner", a non-relative from outside of her small village near Tataouine. A few months after their marriage Zohra's mother-in-law moved into her home and immediately there was tension. Her mother-in-law constantly criticized her and was always insulting her. As Zohra had not become pregnant after six months of marriage her mother-in-law began to humiliate her in front of neighbors and relatives. Zohra's husband sided with his mother and began to blame Zohra as well. Zohra's husband wanted a divorce but he did not want to pay her alimony or return the things she brought with her to the marriage. Encouraged by his mother, Zohra's husband tried to drive her out: he hid all of her clothes, he refused to allow her to leave the house, and, after several months, he began to beat her. Zohra was determined not to be pushed out without that which was rightfully hers so in retaliation she refused to cook and clean for him. He responded by refusing to provide her with food. Zohra's mother was terrified that he would kill her and tried to convince Zohra to leave him. Zohra felt trapped and became physically and emotionally exhausted. But she was afraid that if she left the house her husband would claim that she deserted him and would win a divorce on those grounds. After nearly a year, Zohra's eldest brother saved enough money to provide her with a lawyer and she went before the court in Tataouine. She explained that her husband had abused her and she was granted a divorce, her property, and 15 TND per month in alimony. Several months after her divorce she married her second husband. She now has five children.[58]

However, significant shortcomings remain in Tunisian penal and civil law. In the criminal code, domestic violence is considered a form of assault and battery (with aggravating circumstances) and thus is limited to physical assault and physical injuries. Sexual violence is addressed separately through rape law. The penalty for rape can be severe depending on the age of the victim and the relationship between the victim and the perpetrator. Indeed, the use of a weapon during the rape and the rape of a child is punishable by death.[59] However, "Tunisian legislation does not recognize marital rape. This non recognition of marital rape explains the man's tightly held belief that marriage offers him total liberty to have his wife at his sexual

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[58] Interview, Douriet: April 10, 1999.
[59] Chtioui Aouij, E. (1992), pg. 28.

disposal."[60] Further, the CSP still contains several clauses that legally differentiate women from men and place women in a subordinate position to their husbands.[61]

Yet it is the application of the existing laws that appears to be the most significant problem for abused women. As one Tunisian lawyer who specializes in domestic violence cases noted,

> The legal system in Tunisia is very supportive of women and children. The CSP is strong, and weaknesses are in application not in theory. In theory, the civil and criminal law always assume that the man is at fault, it is not case specific. However, the problem lies in the application.[62]

Indeed, many family judges are disinclined to grant a divorce unless there has been a formal attempt at reconciliation, a reconciliation that can be both prolonged and require co-habitation.[63] Further, many women have found it difficult to obtain a divorce on the grounds of domestic violence.[64] For some women it is easier to obtain a divorce on other grounds, as Jamila's experiences illustrates.

Jamila's Story

Jamila is a 32 year-old secretary from Tunis. She and her husband were married for two years but were unable to have children. Under pressure from her in-laws and neighbors to become pregnant, Jamila visited a specialist and underwent a series of tests which determined that she was fertile. The physician encouraged her to bring her husband into the clinic for an examination. Jamila's husband was offended at the suggestion and beat her for the first time. For nearly a year he refused to consult

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[60] ATFD (1994b), pg. 5.

[61] Article 23 of the CSP declares that "the two spouses must fulfill their conjugal duties in conformity with usage and custom." While no longer declaring that a woman must obey her husband, issues such as sexual duties have a long cultural tradition of being different for men and women and this law continues to support this differentiation. As noted by one member of the ATFD, "Marital rape in Tunisia does not exist because it is considered an obligation…[that a] woman satisfy the needs and desires of her husband. If the woman refuses she will break her obligation and the husband will be considered a victim and will be able to divorce her with prejudice." ATFD (1994a), pg. 18.

[62] Interview (Lawyer), Tunis: September 21, 1998.

[63] In fact, co-habitation can even be a requirement of the divorce itself. ATFD (1994a), pg. 58.

[64] Interview (ATFD Representative and Lawyer), Tunis: October 15, 1999.

with a physician and blamed Jamila for not becoming pregnant. Jamila became extremely depressed and begged him to visit the clinic. Finally he went to the doctor and was told that he had a low sperm count. Jamila's husband became even angrier and the violence intensified. After 14 months of abusive behavior Jamila decided she could no longer remain with her husband: she returned to her mother's home and sued for a divorce. The divorce was granted, but because of her husband's infertility rather than the abuse. Although she wants to have children and start a family, over five years after her divorce she is still afraid to remarry. Jamila does not want to have a relationship with another violent man.[65]

Further, many women have found it difficult in practice to retain custody of their children after a divorce and are thus disinclined to formally separate from an abusive partner. As one professional woman commented,

> In Tunisia the woman is blamed if there is violence in the marriage. It is her fault...The judge and the police are supposed to protect abused women, but they generally do not do so. Many women stay with their abusive husbands because of the children. I know one woman who stayed with her abusive husband for years because she knew he had the money, power, and influence to gain custody of the children. It was terrible for her and people blamed her for staying with him, but what was she supposed to do. I know I could never leave my children.[66]

The vast majority of women do not seek redress through the courts. The Association Tunisienne des Femmes Democrates (ATFD), which operates a domestic violence center in Tunis, found that less than one third of women who visited the center took judicial action of any kind.[67] The lack of judicial action is in part due to the problems in application and the belief that due to misapplication the action would be futile.[68] However, the lack of legal redress is also due, in part, to the continued lack of knowledge among women about their legal rights with respect to domestic violence.

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[65] Interview, Tunis: October 5, 1998.
[66] Interview, Tunis: October 15, 1999.
[67] Saidi, F. (1998a), pg. 8.
[68] ATFD (1994b), pg. 19.

In spite of the awareness raising campaigns conducted by several women's organizations and NGOs, many women remain unaware of their rights and options.[69] Of course, this has an enormous impact on women's use of the judicial system.

Many Tunisian women prefer to utilize informal rather than formal intervention and instead rely on family and/or community networks. Familial, kinship and community networks constitute the basis for this type of informal intervention. By confiding in male relatives, seeking refuge with extended family members, and involving neighbors in domestic disputes, abused women often draw on these networks for sanctuary and assistance.[70] The UNFT survey found that more than 50% of their respondents would turn to familial assistance as their first recourse.[71] As explained by one woman from Tataouine,

> I once had a neighbor who would go into the street every time her husband beat her and she would yell and scream and tell everyone within hearing distance how he had wronged her. The whole community would get involved; the men would talk to the husband and tell him to change his behavior and she would go to a neighbor's house for a few days. Normally, a woman would go directly to her father's house but this woman's family did not live in the area so the neighbors had to help her.[72]

The use of informal networks appears to be tied to both region of origin and educational level, with less educated women and women from the south and rural

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[69] The results from the UNFT survey suggest that as many as 40% of women are unaware of their legal rights. UNFT (1992), pg. 58.

[70] The use of informal, kin-based networks in the context of domestic violence is not unique to Tunisia. For information on the use of informal and community based networks in other contexts see Finkler, K. (1997), Friedl, E. (1991a), Hegland, M. (1992) & Krauss, H. & B. Krauss (1995).

[71] UNFT (1992), pg. 37.

[72] Interview, Tataouine: April 11, 1999.

areas more inclined to depend on familial intervention. The UNFT survey found that while 55% of illiterate women cited familial intervention as the resource of first recourse, this was true of only 37% of the women with a post-secondary school education.[73] The survey conducted with university students found that students from the south and interior of the country were more than twice as likely to cite familial intervention as a resource for abused women than their urban counterparts. A teacher from Tunis who now works in Tataouine explained,

> Women rarely report domestic violence because a woman risks divorce if she reports the violence or goes to the police or the hospital for treatment. Families and neighbors provide an important support network for women with marital problems and intervene on her behalf. People get involved to try to change the situation. In my opinion, the situation is better here [Tataouine] than in Tunis where couples are separated from these kinds of networks and are isolated from family members and therefore do not have people who can support them.[74]

Through the direct intervention of family members and community leaders, an abused woman is often able to place pressure on her husband to modify his behavior. Male relatives are more likely to speak directly with the abusive husband than female relatives and neighbors, who are likely to act as a go-betweens with the husband's female relatives.[75] Further, violent behavior deemed excessive by the community results in social stigma and shame, factors that often motivate men to end to the abuse and attempt reconciliation.[76] As the first priority for many abused women is to stop

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[73] UNFT (1992), pg. 38.
[74] Interview (Public HS Teacher), Tataouine: November 21, 1998.
[75] Interview (AFTURD Representative), Tunis: October 1999.
[76] Systematic studies evaluating community definitions of excessive violence have not yet been conducted. However, it appears that different families, communities, and neighborhoods have different thresholds for "acceptable" violent behavior. Some communities appear relatively intolerant of violence and become involved with any known level of physical violence, other communities tolerate greater levels of violence before the abuser is stigmatized.

the violence, not necessarily to divorce or punish the abuser, informal intervention offers an appealing alternative to involving the police or the courts. Afef's story demonstrates the efficacy of familial intervention in assisting abused women.

Afef's Story

A married woman in her late forties, Afef comes from Zaghouan, southwest of Tunis. Afef had been married to her husband for nearly twenty-five years before he hit her for the first time. She did not understand why he began to beat her regularly, he had always been a gentle and agreeable man, and he had never previously been violent with either her or their children. Afef did not want a divorce, but she did want the abuse to stop. She left her home and moved back with her parents. She also went to the police and filed a report. The police talked with her husband and told him that if he hit her again he would go to prison. Afef also talked with her father, who then confronted her husband. Her husband begged for her forgiveness and after a week, Afef moved back with him. He has not been violent with her since she returned to their home, more than five years ago.[77]

Afef's experience reflects the importance of kin networks in addressing domestic violence. The involvement and mediation of an abused woman's male relatives can have considerable influence on spousal behavior, particularly if the community is small or the woman's family is prominent or well-connected. However, Afef's experience is also instructive as it demonstrates that some women chose to use both formal and informal mechanisms to induce changes in the marital relationship. The role of informal networks is so significant in rural and southern communities that it appears that many civil servants (police, health service providers, teachers, social workers, etc.) work with the kin-based networks to regulate or end the violence and reunite the couple.

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[77] Interview, Tunis: August 27, 1998.

Thus, even though there have been significant reforms in the laws affecting abused women in Tunisia, it appears that the majority of women do not avail themselves of these resources. The actual and perceived misapplication of the law, the lack of awareness of legal rights and options, and the desire to address the abuse through informal networks are all factors influencing the lack of reporting in Tunisia.

DOMESTIC VIOLENCE & THE HEALTH SYSTEM IN TUNISIA

The medical system bears an extremely important relationship to domestic violence. Not only is domestic violence a significant threat to women's health but the medical certificate required for prosecution of a criminal case directly ties the national health system to the legal proceedings. In order to pursue a criminal case, a woman must obtain a medical certificate within 15 days of the acute violence episode. In addition to basic information about the patient, this examination includes an interview with the victim and an assessment of the severity of the injuries. Severity is based on the ITTP (Incapacité Totale Temporaire Personelle) and reflects the number of days that a person is unable to perform daily functions (i.e. work). The extent of the injuries is also assessed and the IPPP/IPPT (Incapacité Permenante Personelle Partielle ou Totale) evaluates pain and suffering, scarring, and damage to quality of life. While not specifically required for a woman to obtain a divorce, a woman's ability to obtain a supportive judgment is greatly aided with this certificate as well.[78]

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[78] Interview (Lawyer), Tunis: September 21, 1998.

Aïda's story demonstrates that some women who seek medical care in emergency rooms are able to obtain medical certificates with relative ease.

Aïda's Story

Aïda is in her late thirties and lives in the Greater Tunis area with her three children. Throughout their fourteen-year marriage Aïda's husband was both physically and emotionally abusive. After the death of her father Aïda's brothers decided that it would be best for her to get married immediately so that she would have someone to take care of her. She agreed to marry a colleague of her brother and Aïda quit school to begin her life with her new husband. It was not long before he beat her for the first time. The abuse became more frequent when her husband lost his job in the factory and began to drink regularly. Aïda suffered in silence for years; she wanted to keep her family together. She was embarrassed and ashamed and so she decided not to go to her family or tell anyone else. One night in a drunken rage her husband stabbed her in the arm with a large kitchen knife. Aïda went immediately to the emergency room and remained in the hospital for weeks. Aïda received a medical certificate documenting her injuries and a social worker visited her during her hospitalization. She now suffers from partial paralysis and has to return to the hospital biweekly for physical therapy and treatment. Her husband was filled with guilt, fear, and remorse. Rather than face prison, divorce, and further shame his family, he committed suicide.[79]

Aïda's tragic story serves as an example of both the severe health consequences associated with domestic violence and an appropriate response by the medical system.

Although Aïda was able to successfully obtain a medical certificate, her experience appears to be the exception. Deeply flawed, the medical certification procedure requires that the woman prove the origin of the injuries, a burden too difficult for many women to meet. A representative of the ATFD noted,

> [There was a case] of a woman who was a victim of domestic violence, her husband burned her with cigarettes. She went to the police station to lodge a complaint and [after a long while] there was a hearing. Unfortunately, a medical certificate was required to prove that after a year and a half the burns marks were still there...The doctor said that the burns existed but he noted that

[79] Interview, Tunis: October 28, 1998.

> these burns could have come from the victim herself. He said, "Mme. X, who claims to have been a victim of violence, does not present the after-effects of violence attributable to a third party. There is no good reason to accept the IPPP."[80]

Women who do not work outside of the home are often disadvantaged in the medical certification process because they receive lower assessments of incapacity in the exam. One doctor from Rabat hospital in Tunis explained,

> [The] degree of importance of the physical damage afflicted on a battered woman and the number of [incapacity] days noted on the certificate must take into account the activity and the status of the woman. For example, if it is a matter of a teacher or a seamstress who was unable to work because of the assault, I give her a larger number of incapacity days than that which I certify for a housewife.[81]

However, the overall number of women seeking assistance in emergency rooms remains very low. The emergency room in Douz, which services a population of approximately 10,000, identifies and treats about three abused women each year.[82] From 1990 to 1995, only 45 domestic violence cases were subject to a medical-legal investigation at the main hospital in Monastir.[83] In 1990, 127 medical certificates were issued to female victims of domestic violence at the main hospital in Sousse, and in the same year 106 medicate certificates were issued to abused women in Sfax.[84] Part of the reason for the small rate of certificate issuance is that women are

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[80] ATFD (1994a), pg. 57.
[81] UNFT, (1992), pg. 48.
[82] One emergency room doctor who had worked at the hospital for more than 14 months had only been asked for a medical certificate on one occasion. Interview (Physician), Douz: February 15, 1999.
[83] Zouhaier, Y. (1995).
[84] Gnounou, J. (1992) & El-Aoud, N. (1992).

unaware of the requirement of the medical certificate. Further, as one representative of the ATFD noted,

> There is a significant problem with the medical certificate in that sometimes, after several days, there are no longer physical traces of the violence or the bruising etc. is very weak. I encourage women to take photos right after the event, but obviously, most women do not have cameras. Further, there are men who specifically hurt women in ways that will not leave marks or the marks will be placed [in such a way] that the woman is too embarrassed to show a doctor, especially if the doctor is male.[85]

Even if there is evidence of abuse such as slapping, pushing, or hair pulling, many physicians define this abuse as insignificant and refuse to issue a medical certificate.[86] A physician from Sfax remarked,

> There is a significant difference between a single violent episode and long-term abuse. Everyone becomes angry and frustrated and behaves badly at some point in their marriage. I am not proud of it, but I have pushed my wife on a couple of occasions. It is normal and I do not consider this abuse. I would never issue a medical certificate for these cases.[87]

Thus, despite both the significant physical health consequences of domestic violence and the legal importance of the medical certificate, the biases in the certification process prohibit women from effectively utilizing this system.

However, the weaknesses in the certification process extend beyond the assessment of physical injuries. Inherent biases in the examination exclude the assessment of the psychological impact of the violence. Regardless of the degree of physical injury, domestic violence often disrupts a woman's sense of well-being

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[85] Interview (ATFD Representative and Lawyer), Tunis: October 15, 1999.
[86] UNFT (1992), pg. 11.
[87] Interview (Physician), Tunis: February 24, 1999.

leading to depression, low self-esteem, anxiety, and distress. Even in the absence of physical injuries, psychiatric institutionalization, psychiatric consultations, and suicidal ideation and behavior have all been linked to domestic violence in Tunisia.[88] Although the psychological ramifications of the domestic violence may be incapacitating, mental health is not evaluated in the medical certification process.[89] Further, few counseling services are available to support abused women. Though a small number of psychologists are comfortable addressing issues of domestic violence, they are largely concentrated in the private sector in Tunis and can only be contacted by referral.[90] Thus, women's mental health needs are not being met by the health system.

Another shortcoming in the certification process involves the treatment of sexual violence. Marital rape is not widely recognized within medical circles and sexual violence is not evaluated during the certification process. Indeed, many physicians appear reluctant to accept that a woman can suffer sexual abuse at the hands of her husband, as is evident from the comments of this physician.

> As a gynecologist, I am the one who is involved in rape cases. I have never heard of marital rape and I do not think it exists here. Women often claim there was a rape, but there is no evidence to prove it. It is very difficult to prove rape in Tunisia. In actuality, rape is not common in Tunisia, but there are a lot of false accusations. Real rape victims are too scared to talk to a health practitioner and thus there is no intervention. Thus, a woman who comes to the hospital claiming rape is naturally suspect.[91]

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[88] Ben Abid, J. et. al. (1993), Douki, S. et. al. (1995) & Hamzaoui, S. (1992)
[89] Interview (ATFD Founding Member and Academic), Tunis: October 12, 1999.
[90] Interview, Tunis: February 8, 1999.
[91] Interview (Gynecologist), Tunis: November 10, 1998.

Thus, the medical certification process is severely problematic in that it only acknowledges limited types of domestic abuse and assesses only a narrow range of health implications. Many women are disadvantaged in both civil and criminal cases because of the manner of execution of the medical certification process.

Although the number of abused women seeking medical certificates is low, abused women frequently use the primary health services as a way of gaining support, intervention, and referrals.[92] One physician noted, "It is rare that a battered woman speaks [of the abuse] the first time...Plaintives are already known in our services [because] they return periodically."[93] In some communities, health service providers use their position within the community as a way of supporting abused women. As a nurse from Ancienne Matmata explained,

> Health service providers are first and foremost educators. To succeed in our duties we must gain the trust of both the individuals and the community. We must be trusted to keep secrets. So health service providers play a large role in domestic violence in Ancienne Matmata. It is not our job but it is our role. This takes a lot of tact, but we often talk to couples. Women aren't going through the courts, they are going through trusted third parties...These women need someone who will listen to them, someone they can talk to...We can do this because of the trust that we have earned.[94]

Many primary health service providers also work directly with informal networks and extended families in an attempt to intervene on behalf of the woman.[95]

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[92] It should be noted that the number of women treated for domestic violence related injuries at emergency rooms is probably significantly higher than the number of certificates issued. Women may be unlikely to disclose the origin of the injury to the ER physician and thus the domestic violence is not officially recorded. As physicians remain largely untrained in domestic violence, it is probable that they are failing to identify injuries related to domestic violence.

[93] UNFT (1992), pg. 10.

[94] Interview (Nurse), Ancienne Matmata: February 13, 1999.

[95] Interview (Community Health Worker), Gabes: August 21, 1998.

A number of individual health service providers have attempted to create safe spaces in which women can discuss issues surrounding domestic abused. As was explored in detail in Chapter 3, a number of the programs developed by local practitioners included information on women's status and rights, family and domestic violence counseling, and activities designed to empower women in the community. Mounira, the midwife from Ain Draham who created a women's knitting circle explained that, "[During the afternoon sessions] women would speak about everything and we would try, collectively, to find a solution to their problems. Domestic violence was a frequent topic of conversation and women would often relate their experiences. I would try to give advice and assistance, but often they just wanted a forum in which to speak."[96] Zeinab's nutrition initiative in Zouhour also included programs and services directly related to domestic violence.[97] Although these types of programs were often extremely successful, their impact was limited to local communities and the national health reforms in the 1990s largely curtailed their continuation.

One of the reasons for the continued marginalization of domestic violence in the health sector involves the dearth of training opportunities available to health service providers. A midwife in the Maternity Ward of El-Hamma asserted, "Women who complain of abuse are usually referred to social workers or the emergency room. Sometimes the staff will talk to them about their experiences, but they have not had any training on these sorts of issues."[98] Training on identification or reporting of

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[96] Interview (Midwife/Mounira), Ain Draham: March 23, 1999.
[97] Interview (Nutritionist/Zeinab), Tunis: January 26, 1999.
[98] Interview, El-Hamma: November 14, 1998.

domestic violence is completely absent in Tunisian medical education.[99] In spite of its documented impact on women's physical and mental health, domestic violence training is neither a part of the clinical training nor of residency programs. Further, the legal aspects of domestic violence, including the medical certification process, are not systematically addressed. As one medical student in Tunis noted, "Not once in four years has anyone mentioned domestic violence. I did a rotation in an emergency room and there was a woman who arrived in need of some sort of medical certificate. I had no idea what she was talking about and I still do not know how one is evaluated."[100] Domestic violence is also not included in the midwifery-training program.[101] This continued lack of training has a significant impact on women's health by contributing to the medical institutions' lack of responsiveness to abused women.

Interviews with medical personnel indicate the presence of a widespread belief that domestic violence is important and does occur, but that it is a social and legal problem, not a medical one. This attitude was perhaps best expressed by the President of the UNFT's Commission on Health, "We do not do anything about domestic violence: that is part of the judicial commission."[102] Thus, in spite of the documented physical and psychological consequences of domestic violence and the codified importance of the health system in the legal process, domestic violence is largely ignored by the health sector. Notwithstanding the efforts of individual health

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[99] Interview (Medical Student), Tunis: October 20, 1998, Interview (Professor of Medicine and Physician), Tunis: January 13, 1999, Interviews (Medical Students), Sousse: March 18, 1999, Interview (University Professor), Tunis: October 5, 1999 & Interview (Medical Student), Tunis: May 3, 2000

[100] Interview (Medical Student), Tunis: April 31, 2000.

[101] Interview (Midwifery Student), El-Hamma: November 14, 1998.

[102] Interview (UNFT Representative and Physician), Tunis: January 28, 1999.

service practitioners, the national health program appears to be neither sympathetic to abused women nor responsive to their needs.

DOMESTIC VIOLENCE & WOMEN'S ORGANIZATIONS

While intervention and support may be linked to families and communities, NGOs have also been instrumental in addressing the issue of domestic violence in Tunisia. Indeed, the direct and indirect services provided by women's organizations and NGOs are perhaps the most important health services provided by the non-governmental sector.[103] In order to better address abused women's needs, needs not currently being met by the national health program or legal institutions, a number of women's organizations and non-governmental organizations have created formal and informal services dedicated to domestic violence.

No organization in Tunisia had dedicated itself as much to the issue of domestic violence as the Association Tunisienne des Femmes Démocrates (ATFD). Formally created in 1989, the ATFD is an autonomous activist women's organization dedicated to the elimination of all forms of discrimination against women, the transformation of patriarchal attitudes, the defense of women's acquired rights, and the participation of women in all aspects of political and civil rights.[104] In the early 1990s, the ATFD conducted several educational campaigns around the issue of domestic violence and began to counsel and provide resource referrals to abused women on an ad hoc basis through their Tunis office. On International Women's Day 1993, in response to demand expressed during a national domestic violence

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[103] Interview, Tunis (Professor of Medicine and Physician): January 13, 1999.
[104] For a more detailed discussion of the philosophy and structure of the ATFD see Ben Romdhane, Y. et. al. (1994), Ghanmi, A. (1993) & Saidi, F. (1998b).

campaign, the ATFD opened the first domestic violence center in Tunisia, staffing both a listening center and a hotline.[105] "We wanted to see if there was interest, if there was a demand for such a center. The need was immediately apparent."[106] Before 1993, the ATFD had provided direct services to 55 women in Tunis. After a series of round table discussions and a training program, the center opened and between 1993 and May 1997 the ATFD had opened dossiers on 438 abused women.[107]

To provide women with a safe environment to discuss their situations, the ATFD created a listening center dedicated to validation, confidentiality, and empowerment. Although direct advocacy does occur, the majority of cases focus on listening and counseling.[108] However, the domestic violence center's staff also provides practical information on medical, legal, and social service institutions and support, including direct accompaniment. As many ATFD members are lawyers, physicians, and psychologists, abused women are often referred internally to women who work on a pro bono basis.[109] The center also works with a growing network of professionals sympathetic to issues of domestic violence.[110] The center does not

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[105] Le Centre d'Ecoute et d'Orientation des Femmes Victimes de Violences will be referred to throughout this chapter as the ATFD's domestic violence center. Although over 80% of the women seeking assistance from the ATFD are victims of spousal or partner abuse, the center responds to all forms of violence against women, as its name suggests. Interview (ATFD Representative and Academic), Tunis: October 11, 1999.

[106] Interview (ATFD Representative and Psychologist), Tunis: October 11, 1999.

[107] Saidi, F. (1998), pg. 3.

[108] Indeed, in nearly 60% of cases the representative from the center only listens and validates. Saidi, F. (1998a), pg. 6.

[109] Interview (ATFD Representative and Lawyer), Tunis: October 15, 1999.

[110] The UNFT found that a substantial bias against medical certificates obtained through private sector facilities and practitioners exists in Tunisia. Having been paid for, these certificates are often deemed suspect by the courts. Thus the ATFD, which often works with pro bono service providers in the private sector, faces additional obstacles in the referral process and thus with medical certification referrals the ATFD tries to work with people affiliated with public hospitals. UNFT (1992), pg. 48 and Interview (ATFD Representative and Lawyer), Tunis: October 15, 1999.

serve as a shelter, though individual members have housed abused women themselves.[111] "By the inauguration of the violence center and hotline in 1993 the ATFD was able to realize a real intervention…through a process of awareness-raising and by the reintegration of abused women into their [social] environment, in breaking the wall of isolation experienced by these women."[112]

In addition to the activities of the center, the ATFD has been active in promoting campaigns and raising awareness around issues of violence against women. From coordinating round-table discussions on violence, to educational seminars targeting physicians, lawyers, and judges, the ATFD has committed itself to addressing violence against women. The ATFD also works with other organizations, both governmental and non-governmental, to increase awareness about domestic violence and provide services to a larger sector of the population. Finally, the ATFD works on improving the legal status of women and sponsoring educational campaigns dedicated to women's rights in Tunisia.

With approximately 200 members, fifty of whom are active at any given time, the ATFD is limited in the amount that it can achieve. In 40% of cases the abused women return for at least one follow-up session.[113] Thus, the nearly 450 visits between 1993 and May 1997 represent more than 1,000 visits to a center which is open approximately 20 hours per week and has less than 15 volunteer counselors at any given time.[114] Mostly comprised of professional women in their 30s and 40s, the organization depends on the time and location constraints of its members, thus the

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[111] Interview (ATFD Representative and Academic), Tunis: October 11, 1999.
[112] Saidi, F. (1998b), pg. 28.
[113] Saidi, F. (1998a), pg. 6.

ATFD concentrates its work Tunis. Finally, the ATFD continues to face political opposition to its activities. Although the organization has an official legal status, its ability to advertise and publicize the center is severely constrained, thus increasing the difficulty of expanding the services. "We do what we can with our limited resources. But by word of mouth more and more women are learning of what we do and we will continue to assist abused women in whatever way we can."[115]

The activities of other organizations in Tunisia are less dedicated to direct service provision and assistance and remain more concentrated on awareness raising and education. Further, the programs sponsored by other organizations are generally more ad hoc and indirect than the work of the ATFD. The UNFT, as the largest women's organization in Tunisia, has been primarily dedicated to women's advocacy at the national level and the implementation of state sponsored programs.[116] Thus, much of the UNFT's work in domestic violence has involved lobbying for changes in the Code du Statut Personnel and offering educational programs and awareness campaigns on women's legal and political rights.[117] Although the UNFT sponsored an important study on domestic violence in 1992, little of its national programming has been dedicated specifically to issues of violence against women.[118] However, the UNFT has regional offices and regional delegates in each of Tunisia's 23 governorates and direct services to abused women are sometimes provided at the

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[114] The ATFD has two full time staff members who are available during business hours to welcome women to the center. However, the center is only staffed with a trained counselor approximately four hours per day Monday-Friday.

[115] Interview (ATFD Founding Member and Academic), Tunis: October 12, 1999.

[116] For a more comprehensive discussion of the UNFT and its relationship with the Tunisian ruling party see Brand, L. (1998).

[117] Interview (UNFT Representative), Tunis: January 24, 1999. The UNFT has also worked with the RTT (Radio et Television Tunisie) to provide information about women's legal rights on the morning radio program. Interview (RTT Representative), Tunis: February 27, 1999.

[118] Interview (CREDIF Representative and former UNFT Member), Tunis: October 21, 1998.

regional or local level. In Tunis, the UNFT does little direct service provision for abused women. "Here in Tunis the UNFT does not do anything practical, even though they have a lot of power. In fact, they send women to the ATFD because they know we have a good center. The UNFT has many other areas it concentrates on, so it is important to coordinate."[119]

However, outside Tunis the UNFT provides more direct services to abused women. In Ain Draham seminars for women are organized with physicians, social workers and lawyers so that women can ask questions relating to their personal situations. Often these sessions are dedicated to domestic violence.[120] The UNFT regional office in Gabes holds similar seminars. After determining that there was a need for more direct, individual assistance, the Gabes office decided to host a social worker three afternoons a week, who would be available to assist women specifically on the issue of domestic violence.[121] However, the services provided by the UNFT are neither standardized nor nationally orchestrated and are not based on the validation and empowerment model of the ATFD's services.[122]

Other NGOs unofficially work in the area of domestic violence. The ATPF (Association Tunisienne du Planning Familial), the Tunisian branch of the

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[119] Interview (ATFD Founding Member and Academic), Tunis: October 12, 1999.
[120] Interview (UNFT Representative), Ain Draham: March, 23, 1999.
[121] Interview (UNFT Representative and Teacher), Gabes: February 4, 1999.
[122] This difference in orientation is perhaps best reflected in a comment made by a UNFT representative in Gabes who was describing the domestic violence services provided by the social worker. "The social worker…tries to help the woman identify what the cause of the violence is and brainstorms ways in which the woman can resolve the problem and improve the situation. Often [domestic violence] involves the number of children that [the couple] have. For example, the husband comes home from work and gets angry about the noise or the behavior of the children. In addition, many women have nothing to do and annoy their husbands. The social worker might counsel these women to get a job or a hobby. She might suggest that the woman come to the [UNFT] center for training or further education. But sometimes the problem is specifically about money. The social worker can help the woman learn how to economize. The social agent tries to explain to the woman how to cut costs and how not to bother her husband." Interview (UNFT Representative), Gabes: February 4, 1999.

International Planned Parenthood Federation, holds regular seminars in its Tunis office that are attended by 30-40 women. In coordination with women's organizations, the ATPF invited a lawyer to come once a week and discuss women's legal and medical rights. Like the UNFT's programs in Gabes and Ain Draham, many participants used the opportunity to ask questions and obtain free legal advice regarding domestic violence.[123] In addition, several other organizations, including a number of the Catholic relief organizations, have developed de facto battered women's shelters under the guise of shelters for the homeless or the poor.[124]

Despite the organizational mobilization around the issue of domestic violence, which in the last ten years has taken the form of both lobbying for legal changes and direct service provision to abused women, both research and services remain limited in Tunisia. Further, services in Tunisia are largely concentrated in Greater Tunis and, to a lesser degree, the capital cities of other governorates. For example, El-Hamma, located approximately 30 kilometers from Gabes, does not have any women's organization or NGO representatives, and there are no services directly related to domestic violence.[125] As one physician from the south commented,

> In Tataouine there are no specific services for domestic violence nor are there women's organizations to fill the medical and legal gap. Doctors and other health service providers have had no special training on domestic violence or in responding to battered women. Not even those who work in the ER.[126]

Finally, the available services themselves are not widely publicized or well known. The student survey found that less than 10% of respondents were aware of the activities of

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[123] Interview, (ATPF Representative): Tunis, September 22, 1998.
[124] Interview, (Lawyer): Tunis, September 21, 1998.
[125] Interview (Nurse), El-Hamma: November 15, 1998.

women's organizations in the area of domestic violence. Further, interviews with the enumerators of the CERES survey revealed that only one had heard of the ATFD and its center.[127] Thus although the services provided by the non-governmental sector are laudable, they are inadequate for women's health needs.

CONCLUSION

Domestic violence remains a serious threat to women's health worldwide. Prevalent throughout Tunisian society, domestic violence affects women from all educational, regional, and socio-economic backgrounds. Although the physical and psychological mortality and morbidity related to domestic violence in Tunisia are considerable, the health implications of domestic violence have been largely neglected. The issue of domestic violence continues to be addressed almost exclusively within a legal framework, and though the importance of the legal reforms affecting abused women should not be underestimated, problems in both the definition of domestic violence and the application of civil and penal laws continue to limit the options available to abused women. These problems are compounded by the inadequacies of the medical certification process, a process that formalizes the relationship between the national health system and the legal system and highlights the importance of medical respondents in addressing violence against women. The absence of research on domestic violence, the dearth of formal training focused on domestic violence, and the lack of awareness among health service providers continues to hamper the national health system's ability to adequately and effectively

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[126] Interview (Gynecologist), Tataouine: November 21, 1998.
[127] Interviews, Tunis: October-November, 1998.

address abused women's health needs. Though the non-governmental sector has attempted to compensate for these shortcomings, this chapter has demonstrated that due to financial, personnel, and political constraints, the activities of women's organizations and NGOs are insufficient to meet abused women's health needs throughout the country.

Therefore, systemic improvement in the ability to meet women's health needs will require much greater cooperation between the government and the NGO community. By exchanging information and insights with organizations working on the issue of domestic violence, the national health system can benefit from the experiences of women's organizations and NGOs to correct deficiencies in its own programs, including training, program design, and research. With greater coordination between the government, NGOs, and women's organizations, services such as hotlines, counseling, home visits, and seminars can be more effectively provided throughout the country. The unparalleled reach of the national health system implies that incorporation of domestic violence into its mandate is needed to extend needed health services to women outside of major urban areas and governorate capitals. However, the health reforms of the 1990s make this transition toward incorporating domestic violence into the national health program more challenging. By re-centralizing decision-making and excluding domestic violence from the defined components of women's health care, the PNP poses obstacles to local initiatives and closes avenues for constructive collaboration with NGOs.

CHAPTER 6: YOUNG WOMEN'S HEALTH & SEXUALITY
FEAR, EXCITEMENT & MISINFORMATION

Hager's Story

Hager is a twenty-five year old university student in Tunis. For her, sexuality is a problematic issue in Tunisia. Hager notes that in the past girls married young and therefore enjoyed full sexual lives, in their late teens, with their husbands. Now many university students like Hager anticipate marrying in their late twenties or early thirties, after finishing their studies and perhaps beginning a career. For Hager, this is a long time to wait to experience sexual intimacy. Hager is torn: she believes strongly in the longstanding cultural and religious tradition of abstaining from sexual relations until marriage, but she has sexual needs that she wants to meet. Hager feels pressure, from her family, her fellow students, and society. She comes from what she calls a conservative family in Tunis, a family that expects women to preserve their virginity until marriage. But what if she never gets married? If she doesn't get married until her thirties, will she still be attractive? Will she still have sexual desires? Many of Hager's friends are sexually active and most will have their hymens repaired in a private clinic before their wedding nights. And though Hager believes that hymen reparation is one of the most important medical procedures to become accessible in Tunisia, she feels a great deal of familial and societal pressure to remain a virgin. This pressure became so extreme and her depression so severe that Hager sought counseling, a service not widely available to university students. The sessions were largely unhelpful, the psychologist didn't seem to understand or appreciate her dilemma. Feeling judged and humiliated Hager doesn't know whom else to talk with. Though she knows that many of her friends are suffering as well she doesn't feel comfortable openly discussing the problem of sexuality with them or anyone else. Hager feels very alone.[1]

INTRODUCTION

Despite the accomplishments of the Tunisian women's health program, issues surrounding young women's health and sexuality have been largely ignored. Though rarely discussed publicly, there is growing consensus among health service providers that the average age of a woman's first sexual experience in Tunisia is decreasing and that the percentage of girls engaging in pre-marital intercourse is increasing.[2] Thus unmarried women's health needs, particularly those relating to reproductive health and sexuality, are becoming increasingly significant. Yet, as Hager's story indicates,

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[1] Interview, Tunis: October 22, 1999.
[2] Interviews, Tunis: January 11, 1999, January 13, 1999 & February 23, 1999.

the subject of sexuality remains largely taboo. The lack of information and services specifically directed toward young women has helped to perpetuate a great deal of misinformation regarding sexuality and reproductive health. This misinformation contributes to behaviors that have negative physical and psychological health consequences for young women. Compounded with the continued social expectation of virginity until marriage, it appears that a significant number of young women in Tunisia are suffering from depression, anxiety, and fear related to sexual behavior, which have serious implications on their decision-making and health.

This chapter begins by examining the limited amount of research and literature on young women's health issues in Tunisia. Tracing the research and policy initiatives dedicated to young women's health provides a context in which to view health issues in the university setting. After establishing this foundation, this chapter presents the results of a survey conducted with 75 never-married female university students living in Greater Tunis.[3] The results of this knowledge, attitudes, and behaviors (KAB) survey shows that a great deal of misinformation remains within the university student population. The analysis of these results also reveals significant regional differences. In drawing from the survey, representative oral narratives, and group discussions with students, this chapter also discusses some of the high-risk behaviors associated with this misinformation, fear, and lack of services and concludes with some reflections on ways in which the national health program can better meet young women's health needs.

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[3] Greater Tunis in this context refers to the governorates of Tunis, Ariana, and Ben Arrous.

YOUNG WOMEN'S HEALTH IN TUNISIA: AN HISTORICAL OVERVIEW

As is evident from Chapter 3, a family planning and maternal health agenda has dominated the Tunisian women's health program since its inception. However, the early 1990s witnessed considerable movement toward a more comprehensive reproductive health program.[4] Inspired in part by the growing concern of health service practitioners and health policy makers over the threat of STDs/AIDS and the increasing number of out-of-wedlock pregnancies, several government health organizations began to explore the issue of young people's reproductive health.[5] Nébiha Gueddana, Director General of the ONFP, characterized this national shift in a speech in 1999.

> The 1990s [focused on] the concept of reproductive health. [This includes] raising the awareness of young people, increasing information and education, and providing training programs for medical and paramedical personnel. [The ONFP] will continue demographic research as well as study the behavior of women in Tunisia.[6]

This shift in focus was due in part to an international reorientation toward a broader definition of reproductive health.[7] Indeed, the United Nations Conferences in Cairo (1994) and Beijing (1995) provided an impetus for international organizations, NGOs and Tunisian government agencies to examine more extensively reproductive health issues in Tunisia.[8] In preparation for these conferences several surveys were

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[4] Interview (UNICEF Representative), Tunis: January 13, 1999.
[5] In 1974, adolescent girls (puberty through age 17) accounted for 0.43% of deliveries in Tunisia. In 1995, adolescents (puberty through age 18) accounted for 1.25% of deliveries in Tunis and Monastir. Triki, A. (April 3, 1999). Speech given at "La journée de la santé de la reproduction" conference, Gammarth, Tunisia.
[6] Gueddana, N. (April 3, 1999). Speech given at "La journée de la santé de la reproduction" conference, Gammarth, Tunisia.
[7] The definition of reproductive health adopted at the 1994 United Nations International Conference on Population and Development in Cairo incorporated issues such as sexuality and sexual health into a framework that included the psychological, social, and physical dimensions of reproductive health.
[8] Ghachem, M. (1997), pg. 11.

conducted with adolescents and young adults. These surveys revealed poor levels of knowledge regarding sexual and reproductive health issues. As a report issued by the ATPF noted,

> A study conducted in 1993 revealed that 78% of women in the sample had not received any information on sexual and genital life before adulthood and that their sexual life is largely influenced by taboos. In effect, two women in three perceive sexuality as an obligation (religious or legal).[9]

However, despite a small number of projects and programs developed in the late 1980s, often at the local level, young women's health needs remained largely unmet.

In response to a growing body of research revealing the importance of addressing reproductive health and this shifting domestic and international climate, a number of collaborative projects were initiated in the 1990s. The following statement from an UNFPA-Tunisia report perhaps best summarizes the goal of these initiatives,

> In the long term, the project aims, in part, to reinforce and complete information on the reproductive health of young people from both sexes, particularly those from social groups identified as vulnerable, thus permitting them to master their sexual health and reduce their risk to STD/AIDS exposure, unwanted pregnancies and the psychological disequilibria tied to adolescence. Additionally [this project aims] to facilitate young people's access to structures appropriate to their sexual health and reproductive needs.[10]

Of the projects and programs targeting young adults (aged 18-30) and adolescents (aged 12-18), this chapter concentrates on three initiatives: the pre-nuptial counseling and certification program, the establishment of health activity clubs by the Direction de Médecine Scolaire et Universitaire (DSMU), and curriculum reform which has added a reproductive health component to the natural science program in secondary

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[9] Abderrahim, S. (1996), pg. 89.
[10] FNUP-Tunisie. (1998), pg. 8.

schools. These programs represent the most collaborative, sustained, and extensive initiatives, reflecting a more comprehensive vision of reproductive health.

Throughout the late 1980s and early 1990s, a series of studies revealed that young women had an extremely low level of knowledge regarding sexual health and reproduction. A survey published in 1987 found that nearly two thirds of female secondary school students did not have a basic grasp of female reproductive anatomy.[11] Health service professionals assume that this level of knowledge would be even lower within the non-student population. Consequently, several programs were designed to target young women, both inside and outside of the educational system, including the pre-nuptial certification program, which dominates the component of the PNP dedicated to pre-marital women's health. A MOPH Order in December 1995 required that all couples obtain a pre-nuptial health certificate before marriage. As outlined in both the PNP guidelines and the 1995 law, couples must undergo a physical examination and testing in order to procure the certificate. The consultations are available through government health facilities as well as NGOs and private practitioners. Although pre-marital counseling and examinations had been available throughout the 1980s, the 1995 law standardized the examination and increased the availability of the service. During the physical examination the family, personal illness, and vaccination histories are collected, blood is typed and analyzed, and both partners are tested for Hepititis (B & C). Some physicians and centers require other exams as well, including sperm analysis, syphilis testing, and HIV testing.[12] Upon receiving the results of the exams, couples are counseled on genetic, infertility, and sexual health issues. This is particularly important with

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[11] Gueddana, N., et. al. (1987), pg. 51.
[12] Interview (ATPF Representative), Gabes: August 21, 1998.

consanguineous couples, as cousin marriages still exist, particularly in central and southern Tunisia. For these couples, pre-marital counseling includes information on the risks associated with intra-familial marriages, with an emphasis on genetic disorders.

Pre-marital sessions also serve as an opportunity to discuss issues of sexuality and fertility with the woman prior to her wedding night. As one physician in Tataouine noted,

> A large part of the program is education. Many women in Tunisia, especially in the South, are very uneducated on issues such as anatomy and sex. The wedding night is traumatic for many people; I see many cases of women hemorrhaging the next day. Obviously, this can have a long-term impact on a woman's marital life. The educational part [of the consultation] begins with an explanation of the male and female body and how sexual intercourse works. Thus women know more about what will happen on their wedding night and will be less nervous.[13]

Through the certification process, women may also receive information about pregnancy, contraception, and birth-spacing. Some health service providers use this opportunity to reassure women that they do not have to become pregnant immediately, or even in the first year after marriage.[14] After both the physical examination and the counseling session the couple receives a certificate.

However, the degree to which health service providers and patients follow this procedure varies widely. Although guidelines are set forth in the PNP regarding the testing and examination components of the certification process, the information and counseling components are not standardized and differ significantly between health service providers and health centers. Many physicians do not separate the couple,

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[13] Interview (Gynecologist), Tataouine: November 21, 1998.
[14] Toumi-Metz, L. (1993), pg. 8.

therefore eliminating the opportunity to discuss issues of sex and anatomy with the woman. Other health service providers dispense with the counseling component altogether. Further, many health service providers continue to encourage women to adopt family planning methods only after the birth of the first child, and consequently do not discuss family planning options with women during the session. As Rima's experience reveals, this can have a profound impact on women and their families.

Rima's Story

Rima was a doctoral student at the University of Tunis when she married her husband. A bright and dynamic woman in her mid-twenties, Rima decided that she wanted to delay having her first child until after finishing her studies. When Rima and her fiancé went to obtain the required pre-nuptial certificate, they were surprised at the lack of discussion about family planning options. Rima explained to the physician that she wanted to obtain a method of birth control before the marriage: she wanted to ensure that she would not become pregnant on their wedding night. The physician was visibly shocked and explained that he didn't usually prescribe contraception to unmarried women. Rima was then told to come back to the family planning center after the marriage and if she was still committed to accepting a method of birth control someone would assist her at that time.

Rima was extremely frustrated by this response. With the support of her fiancé, Rima visited a family planning center in Tunis the week before their wedding. The midwife was supportive of her choice and encouraged Rima to use birth control pills. Rima explained that she was worried about the side effects of taking hormonal contraception, her sisters had not responded well to oral contraceptives. When the midwife explained that there was no other option for a young unmarried woman, Rima conceded. Within six months, Rima discontinued her use of the pills; she felt they were affecting her skin and causing nausea and spotting. When she returned to the family planning center to discuss the side effects, the physician with whom she spoke was unsympathetic and suggested that she was exaggerating. Rima felt humiliated. Within weeks of giving up birth control pills, Rima became pregnant. Rima has had a great deal of difficulty bonding with her daughter; because of the ill-timed pregnancy, Rima gave up her Ph.D. and resents her daughter for it.[15]

Rima's difficulties in obtaining contraception as an unmarried, albeit engaged, woman, are not unique. The pre-marital component of the PNP is dedicated exclusively to women on the cusp of marriage and Rima's experience demonstrates

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[15] Interview (Rima), Tunis: October 1999.

both the shortcomings in this approach and the lack of standardization in the counseling and information component of the certification process.

However, many couples are choosing not to go through the pre-nuptial certification process at all. Indeed, in the capital, pre-nuptial certificates are relatively easy to purchase through the private sector. As one newly-wed stated,

> I didn't get the certificate because I'm not worried about anything. My husband has a friend who is a doctor and he procured a certificate for us. I don't know anyone who got one through an actual exam; there are a lot of men who refuse to be tested.[16]

For many couples, the pre-nuptial component is viewed as unnecessary and useless because it is not perceived as addressing relevant health needs. Thus, the pre-nuptial certification process offers an opportunity for reaching out to unmarried women, but to date the full potential of the program has not been realized.

Although some programs target young women both within and outside of the public educational system, more governmental effort has focused on students. The creation of the "clubs de santé" in 1990-1991 began as a strategy adopted by the DMSU to actively involve young people in health issues. By 1999, health activity clubs were present in almost all secondary schools throughout the country.[17] In addition to providing a forum to educate students on health issues, these clubs aim to increase student participation in and promotion of community health issues. To this end, the health activity clubs organize fieldtrips to health service sites and seminars with health service providers. Further, the clubs actively participate in international

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[16] Interview, Tunis: January 17, 1999.

[17] While the direct translation of "club de santé" is "health club", this translation is awkward because of the English connotation of fitness club. Therefore, I have chosen to translate the phrase as "health activity club" to convey a more accurate sense of the organization.

and national health education campaigns, such as World AIDS day. Participation in a club is an extra-curricular activity and thus it is hoped that those students who voluntarily participate will disseminate the information learned in the club, thereby serving as educators to their families and communities. Indeed, the DSMU states that one objective of the program is "…to instill in young people a "health culture" which will encourage them to adopt healthy behaviors themselves and then in turn relay this information to their circles of family and friends."[18]

The health activity clubs are not limited to sexual health and reproduction issues but also focus on nutrition, hygiene, sanitation, and most recently, smoking. However, reproductive health issues have been an important focus of the project since its inception. Indeed, part of the impetus behind the creation of the health activity clubs relates to the DSMU's desire to increase awareness of and education about HIV/AIDS. In October 1992, the third national health club day was dedicated to STDs and AIDS.[19] Further, the health clubs have served as a vehicle by which governmental and non-governmental organizations can address sexual health issues with young people. For example, a project co-sponsored by the JMSF, ONFP, UNFPA and the scouts reached approximately 16,000 youth through the health activity clubs between 1994 and 1999 and focused exclusively on reproductive health and STD/AIDS.[20] The health activity clubs have generated much enthusiasm among interested students, especially those who intend to pursue a career in medicine or the medical sciences. As one 7th year student in El-Hamma noted,

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[18] Masmoudi, M. (1996), appendix.
[19] In 1990, a joint circular issued by the Minister of Public Health and the Minister of Education and Science designated the third Friday in October as National Health Club Day (La Journée des Clubs de Santé). Each year a theme is chosen and individual clubs focus on this issue (though not exclusively) throughout the year. Masmoudi, M. (1996), appendix.
[20] Interview, Tunis (JSMF representative): January 14, 1999.

> I have been a part of the club for several years and I love it. Each year we focus on a different health issue. The teacher puts together handouts and we watch videos. Last year we went to the hospital and spoke with the midwife about maternal health and contraception. I learned a lot.[21]

Some NGOs and individual government health facilities also run health activity clubs and seminars for unmarried women in the community, thereby targeting non-students.[22] However, the programs are done on an ad hoc basis and not part of a larger national initiative.

Though the health activity clubs serve as an important component of the reproductive health program, their success is somewhat limited. Despite a national agenda set by the DSMU, the activities of the health clubs remain at least partially determined at the local and even school level. Consequently, issues deemed sensitive by educators or the community can be eliminated from discussion. In the case of Tataouine, resistance to a discussion about contraception and pregnancy has limited the utility of the clubs in conveying information about reproductive health issues.[23] The Regional Director of the ONFP Tataouine reflected on these regional differences.

> There is a temperament specific to Tataouine. Here there is a real lack of knowledge about sexuality, and contraception is still associated in people's minds with permissive behavior. Contraception is looked at as something that can liberate sexuality and people [men] are worried [that] if women use birth control it will reflect on them or their families…The national program doesn't deal with this real concern about sexuality. Thus, [in Tataouine] one can only get so far with the anti-sexuality message when our communities believe that the program has sexual ramifications.[24]

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[21] Interview, El-Hamma: November 14, 1998.
[22] For example, ENDA holds seminars on Friday evenings. Facilitated by a female physician these lectures are focused on reproductive and sexual health issues.
[23] Interview (Public HS Teacher), Tataouine: November 20, 1998.
[24] Interview (Regional Director of the ONFP), Tataouine: April 12, 1999.

Further, though there have been attempts to establish clubs at universities the groups have not been particularly successful. Even in the secondary school context, the vast majority of students are choosing not to participate in these clubs and are therefore not directly exposed to the information conveyed during meetings. Indeed the health activity clubs compete with other extra-curricular organizations (sports, music, culture) and as it is nearly impossible to participate in more than one activity club, few students are directly involved with the health clubs.[25]

The third program to be discussed in this chapter is that of curriculum reform. Throughout the 1980s and early 1990s studies indicating extremely poor levels of health knowledge came to the attention of government and non-government health representatives. An ONFP study published in 1994 found that although 75% of the young adults surveyed identified AIDS as a disease, over 50% believed that HIV could be transmitted via kissing and only 14% cited condoms as a method of preventing transmission of the virus.[26] The authors of this study, among others, called for major reform in the secondary school curriculum to better inform students about reproduction and sexual health issues. Throughout the early 1990s this curriculum reform was implemented.

A significant factor in the implementation of this program was the 1994 appointment of a pediatrician, Nébiha Gueddana, to the position of Director General of the ONFP. An established researcher with several books and published studies to her credit, Gueddana was determined to integrate children's and adolescent health

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[25] Focus group discussions, Tunis: August 1, 1998, March 15, 1999, & October 25, 1999.
[26] This survey consisted of a sample of over 2,600 single people between the ages of 17 and 24. Masmoudi, M. (1996).

issues into the ONFP's program.[27] To this end, the ONFP conducted or sponsored a series of studies with children and teens and supported wide-ranging curriculum reform, reform that Gueddana had been advocating since the 1980s. By 1995 reproductive health themes had been integrated into the official natural science curriculum through a joint effort by the Ministry of Education and Science and the ONFP. The initiative introduced reproductive health themes into the third year curriculum, thereby affecting all third year students (age 13-15), and into the seventh year curriculum, only affecting students in the experimental science track (age 17-21).[28] These themes include puberty, reproduction, contraception, and STDs. The student response to these educational reforms has been significant. One survey conducted by the ONFP found that "ninety-nine percent of educated young people affirm that the natural sciences are important and that actually tackling these themes in the official context of secondary education is extremely useful."[29] In fact, this same survey found that almost 75% of students preferred this component of the natural science curriculum to other sections (geology, zoology, botany, etc.)[30] Though students from the south were slightly less enthusiastic, there appears to be near universal student support for the program. This section of the curriculum is not just a public health program but also an academic program. Indeed, in 1998 the

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[27] For a more thorough discussion of Dr. Nébiha Gueddana's political, research and educational background see Curtiss, R. (1996) and Z.B. (1990).

[28] The Tunisian educational system is modeled after the French educational system. Third year students are generally between 13 and 15 years old and are roughly equivalent to freshman in US high schools. After the 6th year of secondary school, students are assigned a track (experimental sciences, humanities, economics, mathematics, or technical sciences). Through the 6th year, all students take the same courses. During the 7th year, students focus their coursework on the subjects covered in their track. For example, experimental science students will take advanced courses in biology and chemistry whereas humanities students will take courses in language and literature. At the end of the 7th year students sit the baccalauréat exam (BAC). The BAC is roughly equivalent to British A-Levels and serves as a university placement exam. All students must pass a number of required subjects as well as those subjects specific to their track. A passing grade on the BAC is required to both graduate from secondary school and continue one's formal education.

[29] Gueddana, N., et. al. (1996), pg. 49.

[30] Gueddana, N., et. al. (1996), pg. 50.

natural science question on the baccaluréat exam revolved around male reproductive physiology.[31]

It is perhaps this "academic" nature of the program that has limited its effectiveness. For some students the reproductive health sessions represent an opportunity to ask personal questions and have open discussions. A university student from Gafsa spoke of her experience in the third year natural science course.

> Fortunately, the teacher was female and we had two groups, a group of girls and a group of boys. And this was good because we were all girls so we weren't ashamed or embarrassed. We talked with her about all of these subjects [pregnancy, childbirth, menstruation] and she advised us to drink a mint or fennel broth when we had our periods. These are the kinds of things we talked about.[32]

However, many students had experiences that were much more restricted. Students in the 3rd year are often taught in large co-ed groups and thus many students, particularly girls, feel uncomfortable asking questions. As one student from Hammamet noted,

> We were all in one big group. I had so many questions about pregnancy and about how sex worked, but I couldn't ask. If I asked questions people would judge me. People would think that I wanted the information so I could do those things. So I only listened and it wasn't until I came to Tunis [for college] that I realized there were a lot of things I didn't know.[33]

Further, 3rd year students are generally between the ages of 13 and 15 and the vast majority of Tunisian girls are not sexually active at this age. Indeed, a 1996 study by the ONFP found that the average age of puberty for girls was nearly thirteen and a

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[31] Interview (UNFPA Representative), Tunis: January 11, 1999.
[32] Interview (Student # 11), Tunis: October 10, 1999.
[33] Interview (Student # 29), Tunis: October 26, 1999.

half and over fourteen and half for boys.[34] Only students who pursue the experimental science track or join a health activity club will receive additional information and opportunities for discussion when they are older and when the discussions are perhaps of more practical relevance. As one student from Monastir commented,

> When I was in the 3rd year I was too young to know what kind of questions to ask, I was still a child. It didn't occur to me to ask questions about hymen reparation or condoms or anal sex. But now that I want to know more about these things, where am I supposed to go? Who am I supposed to talk to?[35]

While it has been shown to be extremely effective to expose younger adolescents to reproductive health issues, the information is often forgotten without reinforcement of the messages. This was well summarized by one student from El-Kef,

> You ask me these questions about AIDS, contraception and infertility and I know I should know the answers, but I don't remember. The class was so long ago and now I study music, I don't learn about those things any more.[36]

Thus, though curriculum reform has been an important initiative in raising awareness and educating young people about sexual health issues, the impact of the program remains limited.

As is evident from this discussion, programs focusing on reproductive health issues have been largely oriented toward younger adolescents (aged 13-15). Those programs, such as the pre-nuptial certification program, dedicated to an older population are tied to marriage and provide information on reproduction and sexuality

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[34] Gueddana, N., et. al. (1996), pg. 50.
[35] Interview, Tunis: May 3, 1999.
[36] Interview (Student # 36), Tunis: October 27, 1999.

as it relates to marital life. While there has been overwhelming support for these programs within government, academic, and non-governmental circles, a much greater debate has arisen regarding the extension of reproductive health services and information to unmarried young women outside of the marital context. As one physician explained,

> Young women's health issues are gaining priority in Tunisia, in terms of both information and services. However, this movement is somewhat tentative because the subject is a delicate one. Some people feel that there are contradictions between sexual education for young people and the Quran. It's true; the Quran expressly prohibits pre-marital sex. However, many of us in health promotion feel that it is important to protect young people. But there are others who want to make sure that the program doesn't encourage young people to become promiscuous. But I think that a [young woman's health] program is very important...the curiosity about sexual issues is enormous among young people.[37]

Individual health service providers have made the decision to expand reproductive health services to unmarried women. A number of health service providers, in both the public and NGO sectors, have initiated programs addressing young people's health needs. Further, many health service providers provide services to young women through the private sector. However, the direct reproductive health services provided to unmarried women remains extremely limited, ad hoc in nature, and concentrated in urban areas. The resistance to working in the area of comprehensive reproductive health has also curtailed research efforts with young women.[38]

In response to this lack of information on young women's health issues, both in terms of research and services, a survey was conducted in 1998 and 1999 with 75 never-married female university students living in Tunis. These students, aged 18-28,

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[37] Interview (UNICEF Representative), Tunis: January 13, 1999.
[38] Interview, (MOPH Representative) Sidi Bouzid: April 18, 1999.

represent a group not currently being targeted by reproductive health initiatives.[39] However, the majority of these students were exposed to the reproductive health curriculum and a number participated in the health activity clubs while in secondary school.[40] This chapter now turns to a presentation of the results of this survey.[41] By providing information on the knowledge, attitudes, and behaviors of these students, the survey results, in conjunction with representative oral histories and information collected through focus groups, illustrate a number of these young women's health needs. Thus, the survey results also provide an indication of the efficacy of reproductive health initiatives with respect to the sample population.

SURVEYING NEVER-MARRIED UNIVERSITY STUDENTS

Desired Family Structure

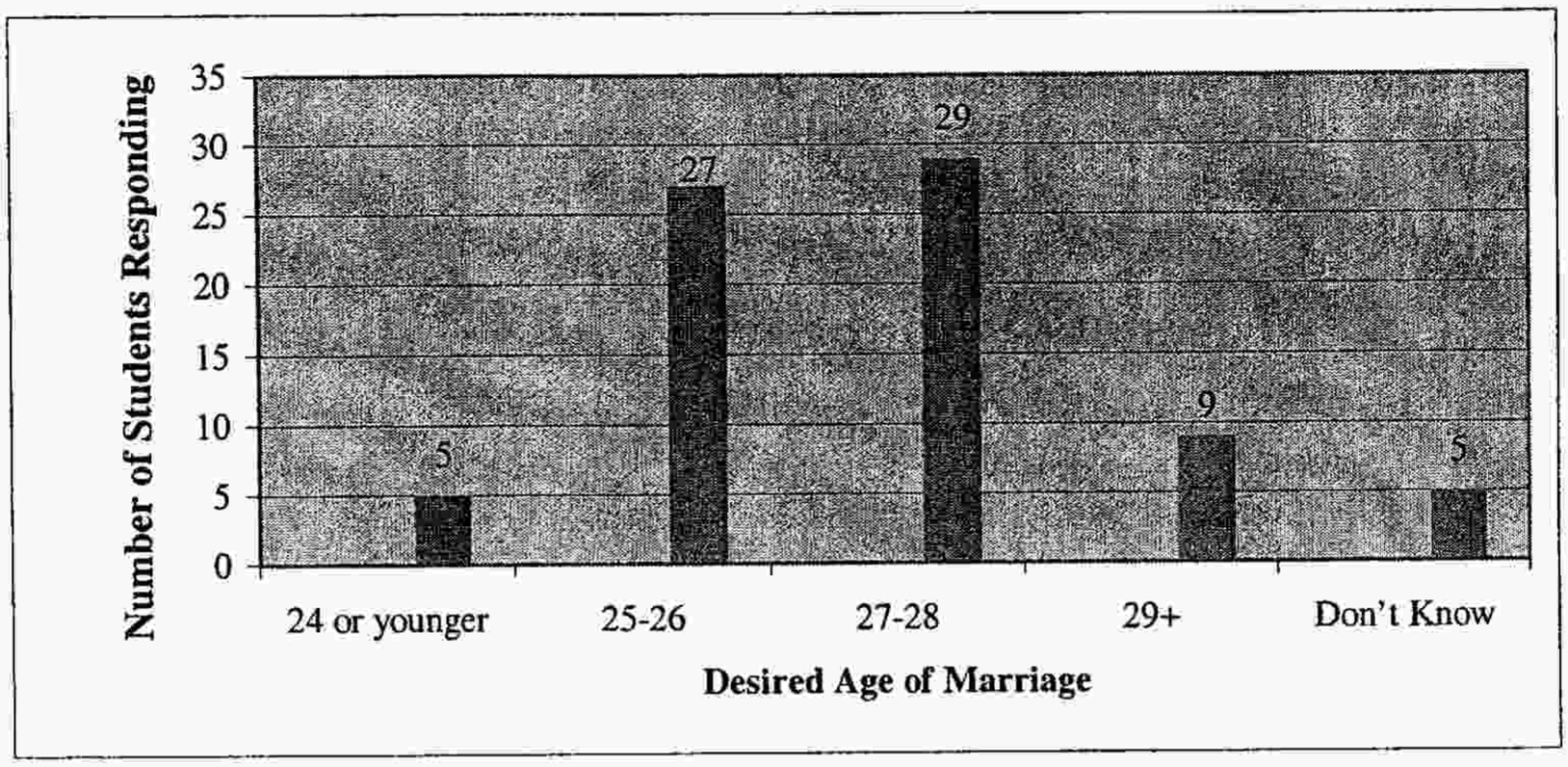
Students were asked to respond to a number of questions regarding the timing and structure of their desired future family. The educational and informational campaigns put forth by the ONFP have encouraged women to delay the onset of marriage and have few, well-spaced children. Results from the survey indicate that the desired family structure of university students is generally consistent with the structure recommended by the ONFP. Statistics gathered in 1994 indicate that the average age of marriage for women is 26.4 years, an increase of over two years from 1978.[42] Never-married students in this survey appear inclined to marry in their mid to late 20s. Desire for marriage is almost universal with all but one student (98.7%)

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[39] Interview (Gynecologist), Tunis: November 10, 1998.
[40] As the curriculum reforms were gradually introduced throughout the early 1990s nearly all of the students under 23 were exposed to reproductive health issues in secondary school. As was noted in Chapter 2, nearly 80% of the students were between the ages of 19 and 23.
[41] For a full discussion of the creation of the survey and the demographic profile of this sample, see Chapter 2. The survey questions are presented in English in Appendix II.
[42] ONFP (1996), pg. 175.

reporting a desire to marry at some point.[43] Of those wanting to marry, 75% of students would prefer to marry between the ages of 25 and 28. An additional 12% intend to marry when they are 29 or older. This information is presented in Figure 6.1.

Figure 6.1: Desired Age of Marriage



The most important factor in determining age at marriage was education, with the vast majority (90%) of students intending to complete their studies before getting married. As one woman from Jendouba noted, "I am the first in my family to attend university. It is very important to my family and to me; if I get married I will have to take care of my husband and I won't be able to finish [my studies]."[44] As reflected in this comment, many students (88%) fear that the demands of marriage will prevent them from pursuing their educational or professional goals and thus they intend to wait.

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[43] In the first question of this section of the survey, students were asked, "Would you like to get married in the future? Why or why not?" Although students were not explicitly asked about their sexual orientation, in response to this question one student identified herself as a lesbian. This student still intends to get married in order to have children and social legitimacy. The one student who stated that she did not intend to married said that she did not want to be restricted. She did not identify her sexual orientation.

[44] Interview (Student #2), Tunis: October 19, 1999.

However, within the same sample nearly 15% of the young women were already engaged. Almost all had become engaged before entering the university and the majority of the engaged students come from southern, central, or northwestern regions of the country. For two thirds of these students familial pressure was the determining factor in the engagement. As one engaged student explained,

> Many girls now get engaged before they leave for the university because their families think that it will be safer for them, they will be able to avoid problems. They think that if the girl is engaged she won't be able to go around with other men. However, this can be difficult for the couple because often the fiancé lives in her hometown and she is at school so they never see each other. At least I am fortunate; my fiancé lives in Tunis and I am able to see him on weekends.[45]

Indeed, these long distance courtships are often strained, especially when the engagement does not stem from a strong previous relationship. Imen, an engaged student from Jerba discussed this problem.

> I became engaged to my fiancé before I came to Tunis. He is my cousin and he works as a day laborer in France. My family wanted me to be engaged before coming to the university, they were afraid that I might meet someone here that they wouldn't approve of. However, it is very hard for us; I only see my fiancé on holidays when I go back to Jerba, maybe twice a year. When I do see him we are always around our family so we don't have privacy, we aren't able to express ourselves, and we are frustrated. We also often quarrel: he is jealous and he doesn't trust that I am not seeing anyone else. It is important to my family that I marry him, and I will after I finish my studies, but it is very hard. I want to be able to have a real boyfriend, someone to talk to, someone to be affectionate with.[46]

Due to the strain and pressure of this relationship, Imen sought counseling through a private therapist, which has proved extremely expensive and only somewhat effective.

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[45] Interview (Student # 16), Tunis: October 22, 1999.
[46] Interview, Tunis: October 21, 1999.

And although a number of engaged students intend to complete their studies before marrying, over half of the engaged students indicated that they would marry prior to graduation.

Kauther's Story

Kauther's family was delighted when she passed her BAC and was admitted to the university to study English. However, her family was concerned that her move to the capital would expose her to strange men and inappropriate situations. Thus, before she left for the university two years ago, Kauther's family arranged her engagement to an engineer from her hometown of Teboursouq. Kauther only spoke to her fiancé, a distant relative, once before their engagement. Their conversation was awkward, both of their families remained in the room the entire time. But, Kauther believed he was bright, attractive, and polite and consented to the engagement, much to the relief of her family.

Kauther's decision to become engaged was pragmatic: she knew that her family would resist her move to Tunis if she wasn't engaged. After a large and traditional engagement ceremony, Kauther came to the university. An ambitious woman with aspirations to become a professor, Kauther studied diligently and saw her fiancé on weekends. Over time, she grew to care about him and was excited about the prospect of marrying him. Kauther intended to delay her marriage for several years, at least until after her graduation. However, in the middle of her third year, Kauther was selected to travel to England for a language immersion program. Her family was insistent that she marry her fiancé before leaving the country. Rather than confront her family and risk not being able to go to England, Kauther conceded. She knows that it will be more difficult for her to excel in her studies after she's married, but life is about trade-offs: she knows that to pursue her educational and professional dreams she must balance her own desires with those of her family. Kauther plans to get married about three weeks before traveling to Britain. However, she is adamant that she will not have children until after she has completed her studies.[47]

Consistent with the national fertility trends, the majority of students in this survey expressed a desire to have two or less children (70%), with an average of 2.3 children per woman. These results are presented on Figure 6.2.

Also consistent with Tunisian national statistics, the student survey revealed regional disparities. Students from central and southern governorates were more likely to desire three or more children, while all but one of the students desiring no

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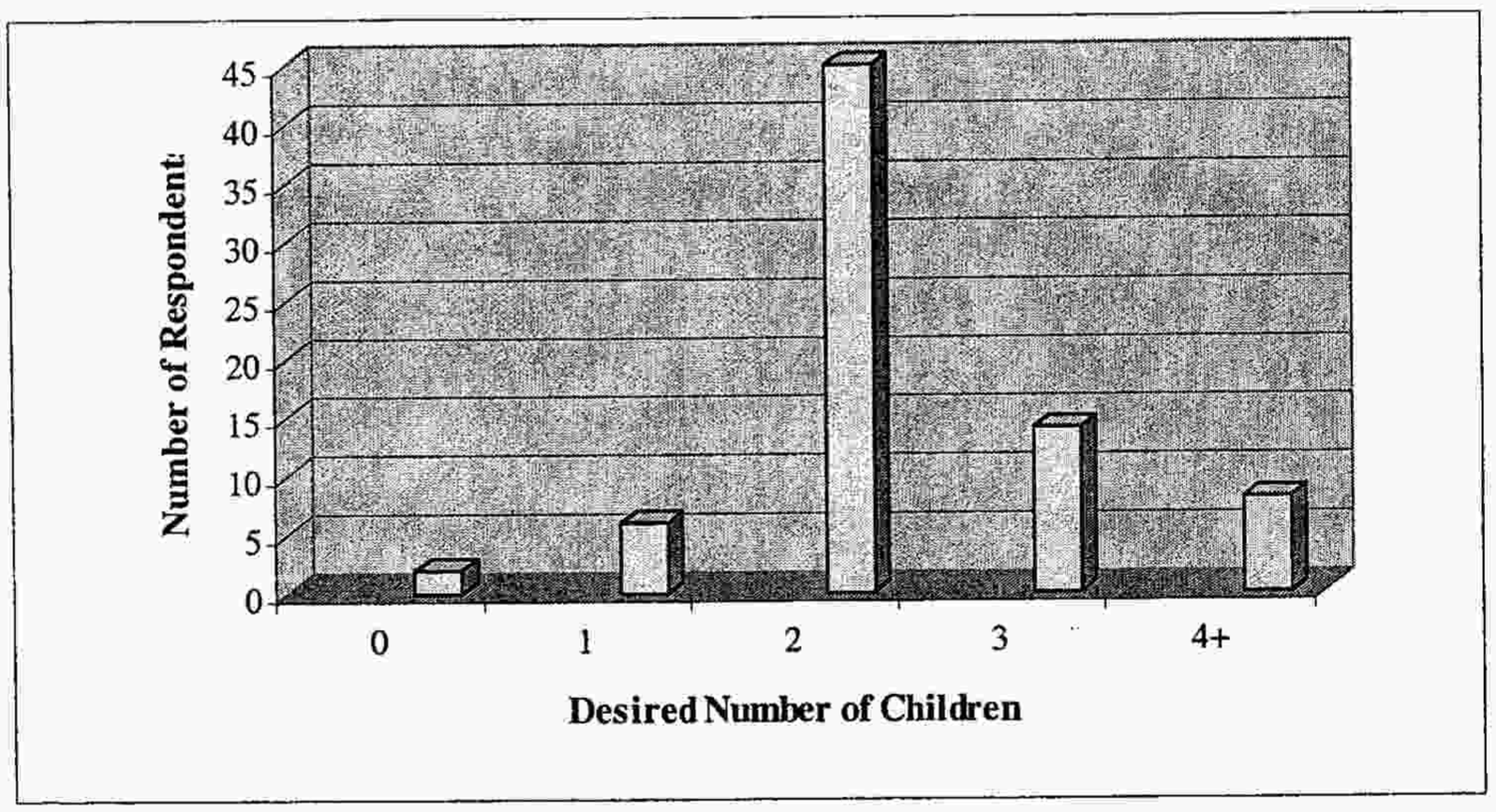
[47] Interview (Kauther), Tunis: October 22, 1999.

more than one child were from Tunis, the Sahel and the northeastern governorates of Nabeul and Bizerte. However, many students who stated that they desired two or fewer children noted that they would have more children if their finances permitted. As one student from Monastir stated,

> I love children and I want to have children desperately. If I married a man who was infertile I would divorce him. But I think I will only have one child: it is just too expensive. There are no jobs, not even for doctors, so it is very hard on families. I want to provide my children with everything. I would love to have more children, but I don't think I will be able to afford them.[48]

In fact, over 50% of students stated that cost of living was an important factor in determining their desired family size.

FIGURE 6.2: DESIRED NUMBER OF CHILDREN



There is a strong desire among students to have children soon after marriage. Thirty-five percent of students in this survey want to have their first (or only) child

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[48] Interview (Student #28), Tunis: October 29, 1999.

within a year after their marriage. And over 75% of students would like to have their first child within the first two years of their marriage. Students from the center and southern regions of Tunisia were more likely to desire that their first child be born within a year after their marriage. As one student noted, "In Tunisia, you have to have a child right away. If you don't, people will begin to question your fertility. There is still a big stigma attached to not having children immediately."[49] Overall, nearly 20% of students stated that they wanted to have their child immediately or soon after marriage because of their love for children or their belief that having children is the function of marriage. Thus, it appears that in spite of recent initiatives by the ONFP to encourage women to delay the birth of their first child, an overwhelming majority of students want to become pregnant within the first 15 months of their marriage.

Of the students desiring multiple children, over 10% reported wanting to have their second child within a year of the first, and 40% reported wanting to have their child within two years of the first. Approximately 50% stated that they would like to space their first and second child by three or more years. Forty percent of these students stated that maternal health influenced this decision. Issues of spacing are particularly important for women who want to have more than three children yet anticipate waiting until their late twenties to get married. As one student from Gafsa noted,

> I want to have four children but I probably won't be able to get married until I am nearly 30. I have to have them close together. I know it will be hard on my body, I know it is better for my health to space them more, but I want to

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[49] Interview (Student #33), Tunis: October 27, 1999.

> have a large family and this is the only way. My mother had 10 children and some of us are close together, so I know it can be done.[50]

The results of this survey reveal that a combination of educational goals, economic realities, and a greater awareness of maternal health issues has caused university students to embrace the concept of marrying later and having fewer, well-spaced children. Thus the family structure desired by university students is largely consistent with that recommended by the ONFP. Regional disparities are also evident within the student population, both in the desired number and desired timing of children. Finally, women hailing from the more distant governorates are more likely to be engaged as a consequence of familial intervention.

KNOWLEDGE ASSESSMENT

HIV/AIDS

Results from this survey suggest that the national health program has not been nearly as successful in transmitting other messages about women's health and sexual health as in delivering messages about family planning and birth spacing. An assessment of the level of knowledge of the issues of HIV/AIDS and contraception reveals that there is a great deal of misinformation within the university student population.

In response to a definitional question about AIDS all but one student correctly identified AIDS as an illness or disease, the majority emphasizing that AIDS is serious or deadly.[51] However, approximately 51% of students knew that AIDS was a

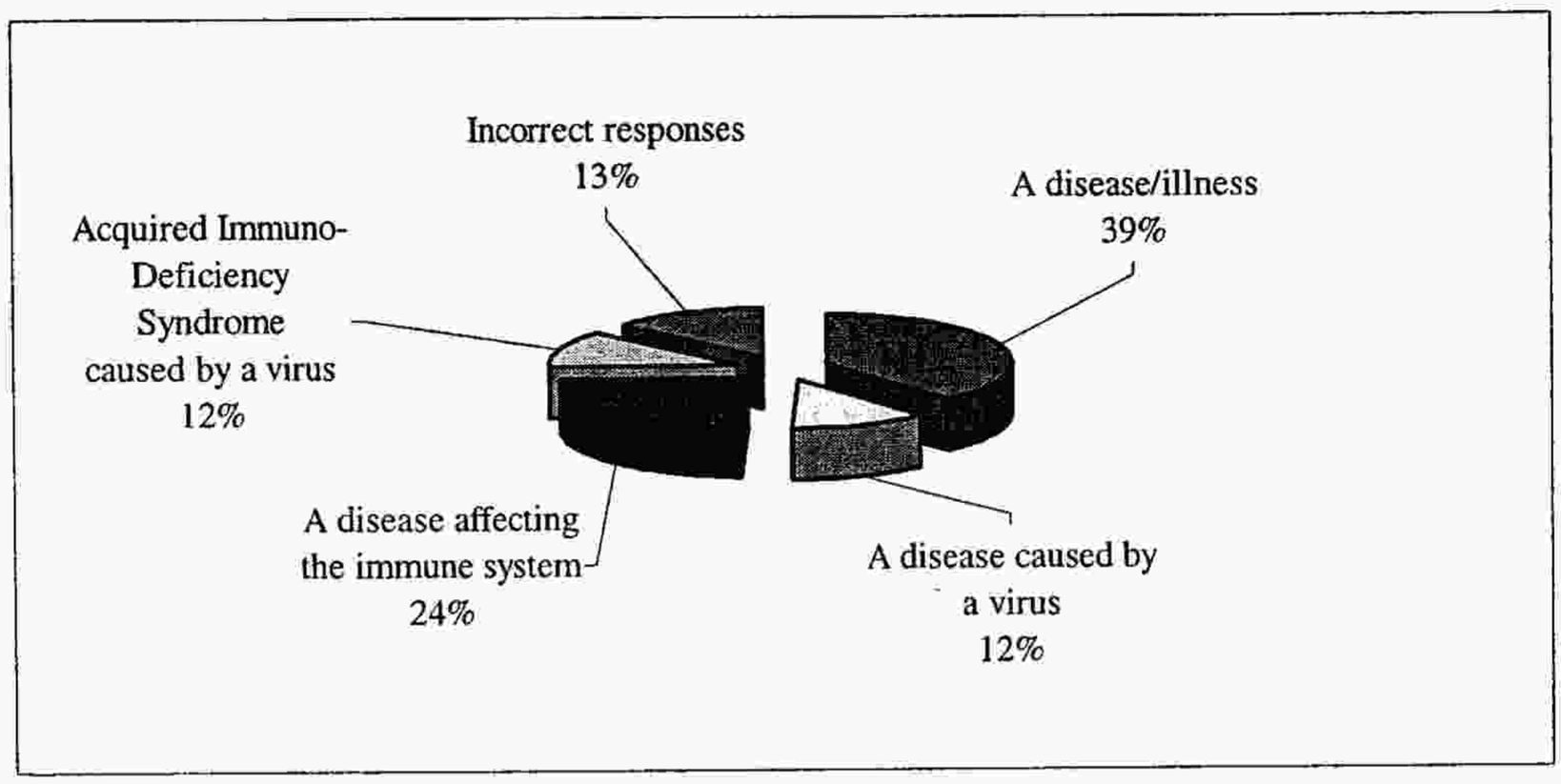
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[50] Interview (Student #75), Tunis: March 10, 1999.

[51] AIDS is not, in fact, a disease. AIDS is the final stage of infection of the HIV and this stage is generally defined by a combination of clinical conditions and a CD4+ T cell count of less than $200/mm^3$. However, responses that AIDS was a disease or illness were accepted as correct because

disease but nothing else. Indeed, 12% of students incorrectly described the nature or cause of the disease (i.e. genetic disease or cancer).[52] Slightly less that fifty percent of the students reported that AIDS was caused by a virus, affected the immune system, or stood for an acronym, which they were able to cite.[53] This information is related on Figure 6.3.[54]

FIGURE 6.3: RESPONSES TO "WHAT IS AIDS"



In spite of the relatively low level of knowledge regarding AIDS in general, students demonstrated a somewhat higher degree of knowledge of HIV transmission routes. One hundred percent of respondents correctly cited sexual fluids/relations as a

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these responses indicated knowledge that AIDS was a health issue and these responses are consistent with the messages conveyed in major media and educational campaigns. AIDS, rather than HIV, has been the phrase used in educational campaigns and it is often discussed in the context of sexually transmitted diseases. Indeed, most students who were aware of HIV used the phrase interchangeably with AIDS.

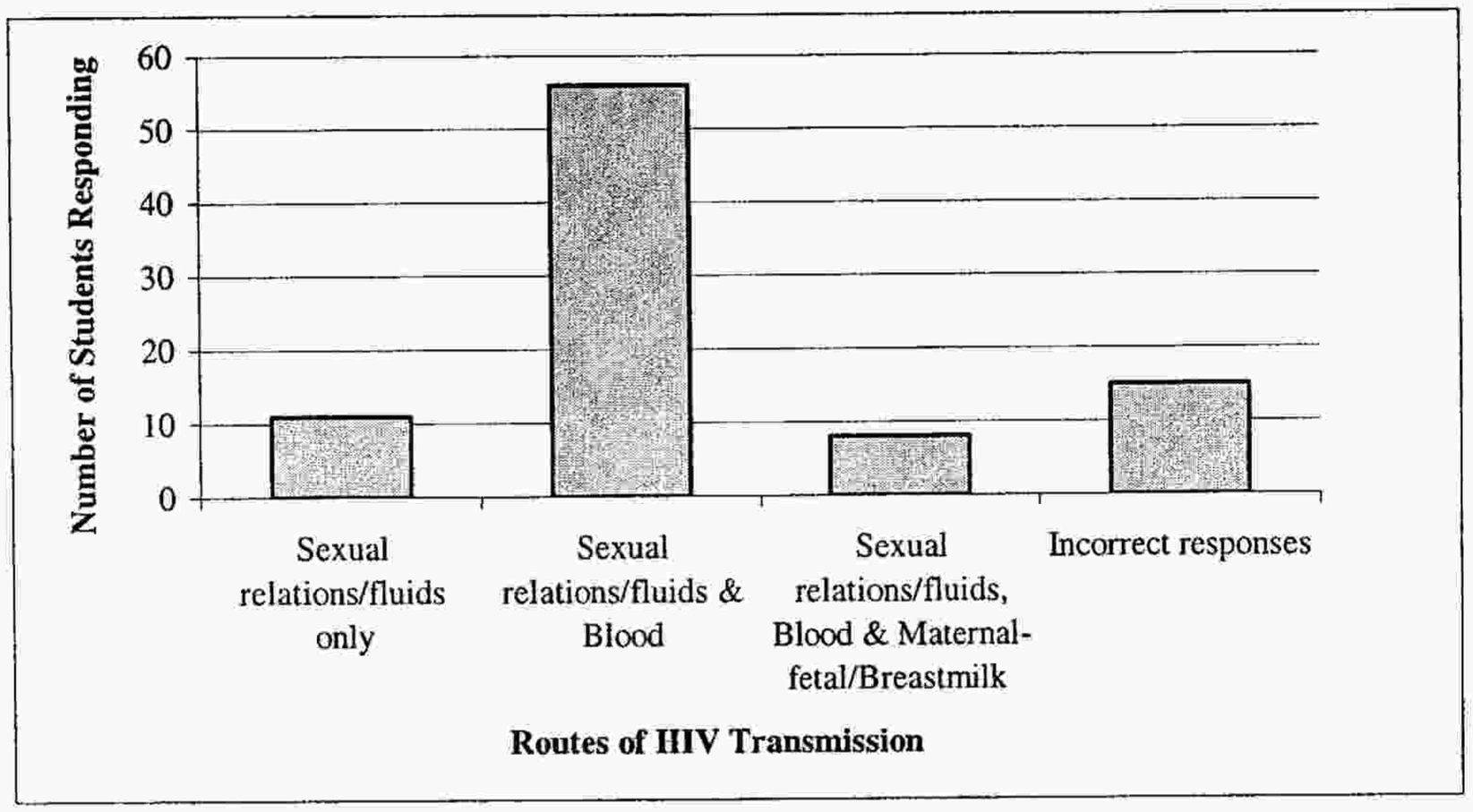
[52] After an initial response students were prompted further with questions such as "What is the nature of the disease?" "What is the cause of the disease?" and "What part or system of the body does AIDS affect?"

[53] While AIDS and SIDA are acronyms in English and French, SIDA is not an acronym in Arabic. Students responding in Arabic were counted as having cited the acronym if they were able to state the major components of the acronym in Arabic (acquired/contracted, affecting the immune system, a syndrome). Three students responding in Arabic met this criterion. All students citing the acronym also knew that AIDS is caused by a virus.

[54] This pie chart represents mutually exclusive responses.

transmission route for HIV and 85% cited infected blood or blood products. However, only 11% knew that HIV was transmitted via sexual fluids, infected blood, and breast milk.[55] Twenty percent of students cited incorrect routes of transmission including kissing, casual contact, and sharing objects (spoons and glasses) with infected persons. These results are outlined in Figure 6.4.

FIGURE 6.4: HIV TRANSMISSION: CITED ROUTES



Students from the center and the south were slightly more likely to offer incorrect routes of transmission (25%).

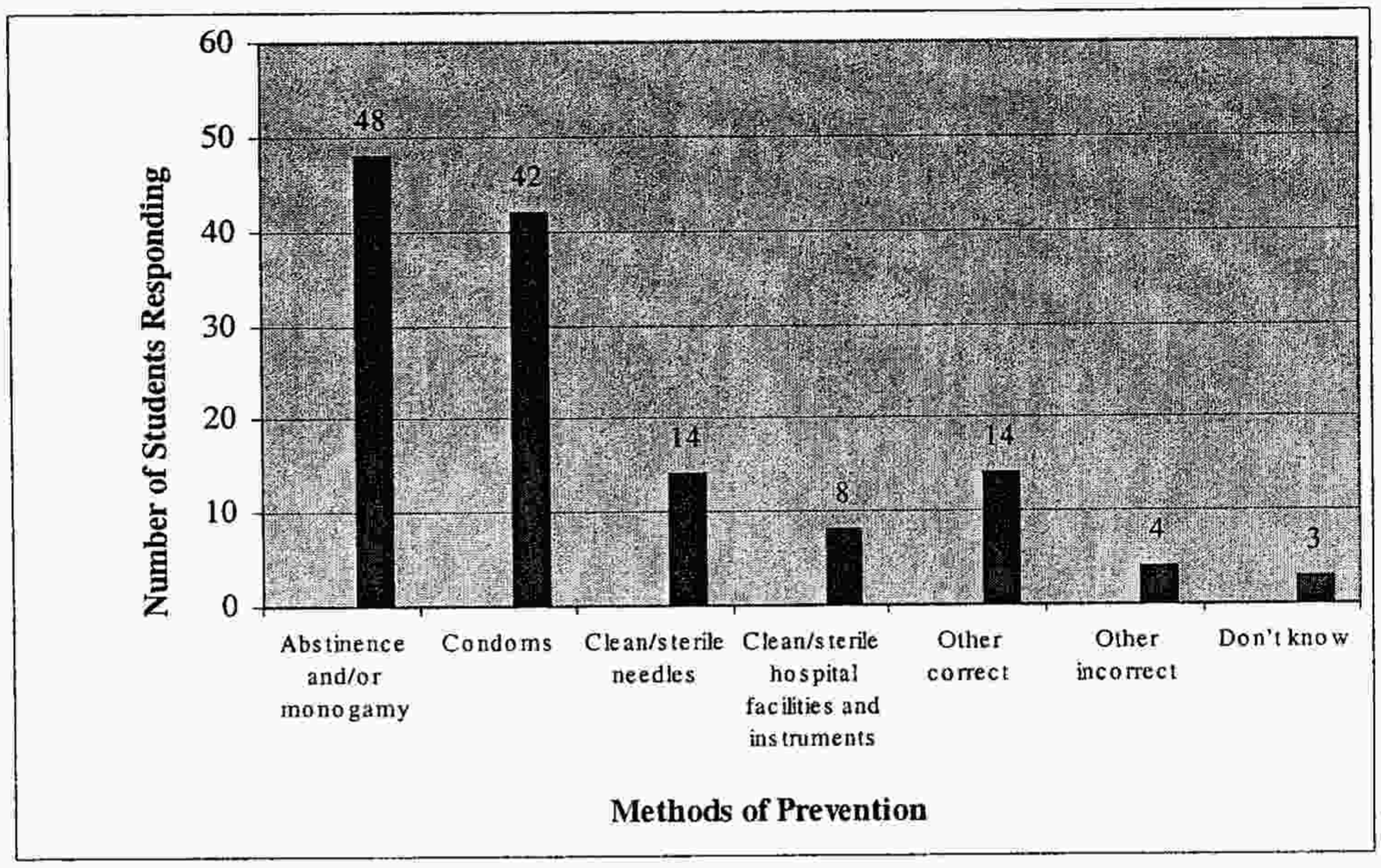
As to the prevention of the transmission of HIV, nearly 65% of students referred to abstinence or monogamy. Additionally, 56% of students referred to condoms and approximately 19% of students referred to using clean or sterile needles as a method of preventing transmission. As numerous students expressed fear that HIV could be transmitted in public hospitals through either blood transfusions or

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[55] Maternal-fetal transmission can occur through blood or breast milk. Students who offered the response "infected mother to fetus/child" or "breast milk" are included in this 11 percent.

equipment contaminated with infected blood, approximately 11% of students mentioned sterile, clean and/or controlled medical instruments and hospital facilities as a method of preventing the spread of HIV. This information is represented on Figure 6.5.[56]

Figure 6.5: HIV Transmission: Cited Prevention Methods



The final topic covered in the HIV/AIDS section of the survey was designed to assess knowledge levels of other STDs. When asked to name an STD other than HIV/AIDS only 13% of students were able to correctly identify a disease, with 80% of this group citing syphilis. Nearly 15% of students cited a non-sexually transmitted disease (including breast cancer) and over 73% of students stated that they did not know of one.[57]

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[56] Many students gave more than one response and thus the total number of responses in all categories exceeds the number of students in the survey.
[57] Several students also cited homosexuality as a sexually transmitted disease.

As was previously noted, the majority of students in this survey benefited from the curriculum reform and were therefore exposed to information about STDs in secondary school. Further, nearly all of the students who participated in this survey indicated that they had been exposed to information on HIV/AIDS through public health programs, including television and radio broadcasts. Yet these results indicate that university students' knowledge of STDs remains limited and a great deal of misinformation exists. Indeed, the results of this survey compare unfavorably to those of studies involving secondary school students. In a study under the direction of the ONFP, researchers found that 94.4% of surveyed secondary school students correctly identified infected blood/blood products as a route of HIV/AIDS transmission (compared to 85% of the university students in this survey).[58] In M. Masmoudi's 1995 survey, nearly 55% of students cited breast milk as a route of transmission and over 60% cited maternal fetal transmission (compared to a combined 11% in this study).[59] Further, both surveys revealed a higher rate of identification of condoms as an effective method of preventing transmission with 90% and 68% respectively (compared to 56% in this survey).

However, perhaps the most alarming result of this part of the survey is the university students' demonstrated lack of knowledge of STDs other than HIV/AIDS. Statistics on the prevalence of STDs in Tunisia are not widely available. Between1985 and 1992, 130 cases of AIDS and 250 cases of HIV were recorded.[60] Throughout the 1990s the number of reported cases rose steadily and 378 cases of HIV had been registered by July 1995.[61] In Tunisia, the 25-30 age group is most

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[58] Gueddana, N., et. al. (1996), pg. 62.
[59] Masmoudi, M. (1995), pg. 15.
[60] Fekih, Z. (1993), pg. 31.
[61] Masmoudi, M. (1995), pp. 3 & 6.

affected by HIV.[62] Though there is general agreement within the medical community that HIV/AIDS has been underreported there is also general consensus that other STDs are considerably more prevalent, particularly gonorrhea, herpes, and chlamydia.[63] However, in this survey only 13% of students were able to identify an STD other than HIV/AIDS. In the ONFP's survey, a greater percentage of students were able to identify an STD other than HIV/AIDS including nearly 5% of students who cited gonorrhea.[64] The disparity in knowledge levels of STDs between secondary school and university students suggests that university students no longer retain much of the information they were exposed to years earlier. These results suggest that a more comprehensive program on STDs is needed. As one gynecologist involved with health policy at the ministerial level noted,

> STDs are becoming a new focus in the health program. University students are particularly susceptible to contracting STDs and it is important that we educate them. They should be a target population: they are an easy population to find, they are all in one place, and they are vectors for getting information out to other people who are either not in school or who haven't received an education. But now, it's not happening.[65]

The lack of knowledge about STDs is particularly concerning as university students represent the most educated young women in Tunisia and would therefore be expected to have greater knowledge levels than their less educated counterparts.[66]

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[62] Gueddana, N., et. al. (1996), pg. 61.

[63] Interview (Gynecologist), Tunis: November 10, 1998. M. Abdessalem reports that in two studies of infertile women in Tunisia, STDs were found to be the cause of the infertility problem in 50% of the cases. Abdessalem, M. (1990), pg. 10.

[64] In the ONFP survey students were asked to identify any STD and the majority (80%) cited HIV/AIDS. However, 16% of students accurately cited other STDs. Gueddana, N. et. al. (1996), pg. 61.

[65] Interview (Gynecologist), Tunis: November 9, 1998.

[66] In an on-going project conducted in conjunction with the Tunisian Ministry of Public Health in Sidi Bouzid and the ONFP Tunis, this survey is being replicated with several other groups of never-married women. The survey has been completed with groups of never-university educated never-married

Contraception

University students appear to have a somewhat higher level of knowledge regarding contraception. Nearly 70% of students could name three or more types of contraception available in Tunisia. Birth control pills were cited the most often, followed by IUDs and condoms. Numerous students also referred to the calendar method of birth control, though several noted that this is not a reliable method. These responses are presented in Figure 6.6.

Regional disparities were found to be significant. Women from central, southern, and northwestern governorates reported fewer methods of contraception. Women from these regions were more likely to report the calendar method as an effective method of birth control and they were more likely to cite tubal ligation as an available method. Students from these regions were less likely to identify condoms or IUDs as available methods of birth control.[67] Figure 6.6 displays these comparative results as well.

However, a more profound understanding of the use of contraception was not as prevalent. Students were asked to choose a method of birth control and explain how it works and/or how it is used. Nearly 43% of students were able to accurately discuss their chosen method, with the majority selecting birth control pills. However, 32% of respondents incorrectly described the use of their chosen method.[68] The remaining 25% of students did not offer a response. Students living in dorms, and in

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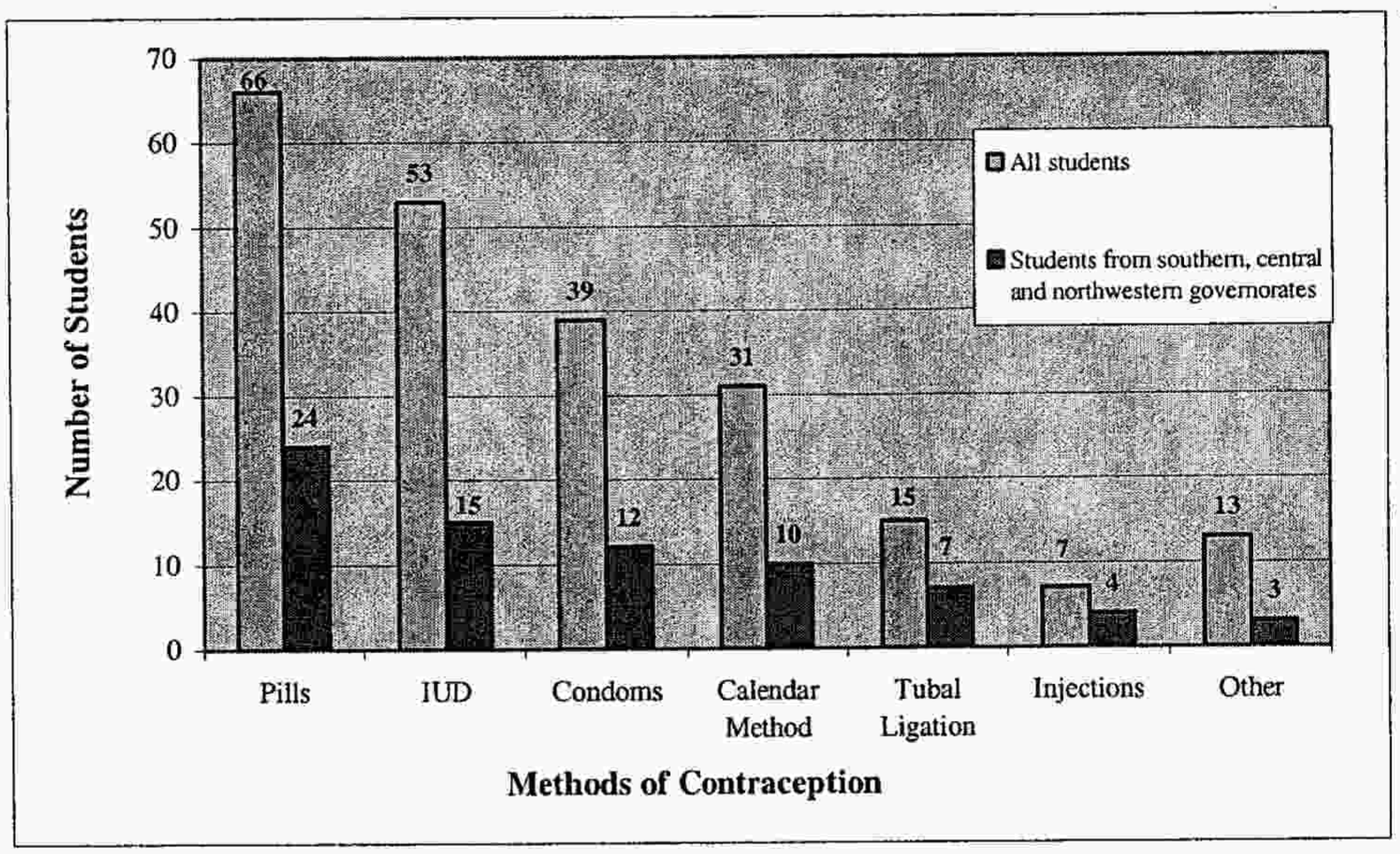
women in Tunis, Sidi Bouzid, Siliana, Béja, and Sfax and preliminary results indicate that knowledge levels are significantly lower in the never-university educated samples.

[67] Students from these three regions constituted 38% of the sample. This group constituted 100% of the students reporting zero methods of contraception and 80% of the students citing only one method. Women from these regions constituted 48%, 30%, and 28% of the students who cited tubal ligation, condoms and IUDs, respectively.

[68] An example of this incorrect description would include those students who stated that one birth control pill is to be taken after each act of sexual intercourse.

particular students from the center and south, were more likely to provide incorrect information or be unable to correctly provide details about a method of contraception. Students from the center and south were also more likely to choose the calendar method and explain how this method works. When asked to cite where a woman can obtain contraception 93% were able to name at least one correct location, with 25% citing two and an additional 25% citing three. Women cited private clinics, pharmacies, and public facilities in almost equal numbers.

FIGURE 6.6: REPORTED TYPES OF CONTRACEPTION AVAILABLE IN TUNISIA



Finally, students were asked if the situation vis-à-vis contraception was different for married women and young unmarried women. Nearly 60% of students responded that unmarried women were prohibited from obtaining contraception in Tunisia.[69] In contrast, approximately 13% of students correctly stated that unmarried

[69] Although there are significant barriers to access, unmarried women are not prohibited from obtaining many types of contraception, including single use methods (condoms, foams, sponges) and birth

women had access to certain types of contraception but not others (for example, never-married women would not be able to obtain an IUD or a tubal ligation but would be able to obtain condoms and birth control pills). Finally, 21% responded that all women have access to contraception, though many respondents noted that a young unmarried woman would need to go to a private physician to obtain services confidentially.

It is clear from these results that university students have a higher degree of knowledge of contraception than of STDs. These results compare favorably to surveys conducted with secondary school students. The 1996 ONFP survey found that nearly 93% of secondary school students could cite at least one method of contraception with over 90% citing birth control pills, 50% citing IUDs and nearly 34% citing condoms. This compares to 96%, 88%, 71%, and 52% in the university student survey. However, university students were also three times as likely to identify natural methods of birth control, specifically the calendar method, than their secondary school counter-parts.

The results of the survey indicate that although superficial knowledge about HIV/AIDS and contraception is high, more profound and practical knowledge is limited. The knowledge displayed by university students supports the argument that the educational programs and resources available to young people shy away from reproductive health issues in the non-marital context and do not provide practical information about issues such as contraceptive use and access. Of course, this practical information is of particular importance to sexually active students.

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control pills. Unmarried women can most easily obtain contraceptives from pharmacies (particularly condoms). However, most private sector facilities and some public sector facilities will provide contraceptives upon request.

Yet interest in discussing these topics and learning more about sexuality, sexual health, and sexual intimacy is widespread among university students. Thus, it comes as no surprise that young women are creating alternative channels by which to obtain information about sexual health issues. This survey revealed that for university students the exchange of information about sexuality and sexual health is primarily transmitted intra-generationally, taking place among friends and peers. Although this transfer of knowledge can involve relatives from the same generational cohort (cousins, sisters, and young aunts), most of this information is coming from outside of the family. Very few students are openly discussing issues of sexuality, sexual health, or women's health care with older women, particularly their mothers. As one woman from Gabes stated,

> In the dorm we talk a lot about women's health. Girls with girls. I speak with my mother a little bit, but not a lot. My mother speaks with her cousin and her sister, not with me. I speak with my mother only about the essentials, not about pregnancy or AIDS.[70]

Undoubtedly, this intra-generational exchange of information is more open and responsive than the forums currently provided through the national health and educational systems. However, this type of information exchange is also prone to the transmission of inaccurate information. This survey and focus group discussions revealed that some students are well informed and have the ability to disseminate accurate and practical information about sexual health issues. Many others, however, propagate myths and misinformation.[71]

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[70] Interview (Student # 71), Tunis: February 27, 1999.
[71] Focus group discussions, Tunis and Tataouine: November 20, 1998, February 26, 1999, March 15, 1999, & October-November 1999.

In addition to many of the inaccuracies previously discussed, focus group discussions centering on sexual behavior and pregnancy found a consistently high level of misinformation. A great deal of confusion exists regarding the mechanics of pregnancy and the risks associated with particular sexual behaviors. Popular inaccuracies include the belief that pregnancy or STD transmission requires full penetration or multiple liaisons, that the hymen serves as a barrier method to both pregnancy and STD transmission, and that oral and anal intercourse are risk-free alternative to penile-vaginal contact. Students repeatedly indicated that they had learned this information from peers, primarily through discussions with other students living in the university dorms.

A more profound level of knowledge is both desired and desirable for the university student population, particularly as an increasing number of female students are choosing to become sexually active. This desire and need are borne out by the third component of the survey, which specifically addressed student attitudes toward sexual behavior.

Responses to Hypothetical Situations

The third part of the survey examines the attitudes and perspectives of students with respect to several issues involving relationships, sexuality, and sexual health. As these topics are generally considered more sensitive, a different questioning technique was used. Students were presented with a hypothetical situation and in turn asked to respond to and reflect on the situation. This qualitative technique was then followed by a series of opinion soliciting questions. This section will examine student responses to two hypothetical situations, one addressing the issue of pre-marital sex

and one addressing the issue of out-of-wedlock pregnancy. The presentation of the results is followed by a more in-depth discussion of students' attitudes and behaviors.

Pre-marital Sex

When asked to assess the level of sexual activity within the female university student population, 73% of students stated that many students are having sex and an additional 12% of students reported that some students are sexually active. Only two students, both from the south, stated that there are virtually no sexually active students. Over half of the students believe that sexually active women at the university are using contraception. However, 44% of students stated that few to none of the sexually active students are using contraception due to misinformation, embarrassment, a partner's refusal, or lack of access. As Lamia's experience illustrates, the inaccessibility of contraception is a major determinant of behavior.

Lamia's Story

Lamia and her boyfriend have been involved for almost three years and have been sexually intimate for over two of them. Finding privacy is sometimes a challenge, as both Lamia and her partner live at home with their respective families. However, Lamia's boyfriend has many friends who have apartments and the couple often spend weekends outside of Tunis. Lamia feels extremely comfortable with the decisions that she has made regarding her relationship and she firmly believes that sex is part of the reason her relationship is healthy and fun.

When Lamia and her partner first decided to have sex, they opted to use condoms. Although they were not worried about STDs, neither of them had previously had an intimate relationship, the accessibility of condoms was extremely appealing. For Lamia, it was important that both she and her partner could buy condoms at the pharmacy and thus both take responsibility for contraception. However, within a few months of becoming intimate, Lamia discovered that she had an allergy to laytex, a condition that required that she discontinue the use of condoms. Although she debated about going directly to a pharmacy, after her painful experience with condoms Lamia decided to consult with a physician to determine if pills would suit her. For nearly six months, Lamia and her partner practiced the withdrawal method while Lamia searched for a physician who was willing to prescribe birth control pills to an unmarried woman. On two occasions, Lamia met with physicians who chastised her for her sexual behavior and refused to provide her

> *with contraceptive alternatives. However, Lamia persisted and eventually found a supportive private sector physician who, after a thorough gynecological exam, did not hesitate to prescribe her oral contraceptives. Lamia now refers all of her sexually active friends to this doctor: she never wants anyone else to have to go though what she went through to get birth control pills.*[72]

Lamia's difficulty in finding alternatives to condoms is not unique. Although there are numerous physicians in areas like Tunis that provide a variety of reproductive health services to unmarried women, many students do not know how to contact them.

In spite of the near consensus in the belief that a significant portion of university students is sexually active, students' attitudes toward pre-marital intercourse vary widely. Students were asked to respond to a situation in which a close friend was considering having sexual relations with her boyfriend before marriage. Forty percent of students stated that they would advise the friend not to engage in pre-marital sexual relations under any circumstance. As one student from Tunis stated,

> In our religion [pre-marital sex] is forbidden. I would tell her not to do it. Even if the man loves her, after she sleeps with him he will leave her. He won't marry her because he will judge her, he won't be able to trust her. No man deserves a woman's virginity-it is very precious. Now there are some girls who make themselves virgins before their wedding night. I think this is very bad, it's forbidden. If my friend decided to have sex I wouldn't speak with her, I would shun her.[73]

Approximately 45% of students stated that it would be acceptable for a friend to have sexual relations before marriage as long as she was prepared for the risks, both societal and medical. Half of these students went on to say that she should only

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[72] Interview (Lamia), Tunis: November 1, 1999.
[73] Interview (Student #10), Tunis: October 8, 1999.

engage in sexual relations with her boyfriend if she was confident that they were going to get married. As one woman from Béja explained,

> She has to be aware. She has to be sure that he loves her; she has to know that he will marry her. If they have sex and she gets pregnant, neither her family nor society will forgive her unless she marries this man. So if she knows this man well, if she trusts him, I think it's okay. But I would advise her to use protection. Condoms.[74]

Finally, 15% of students indicated that she could engage in sexual activity with her partner but must keep her hymen intact and thus preserve her virginity. As a student from Hammamet noted,

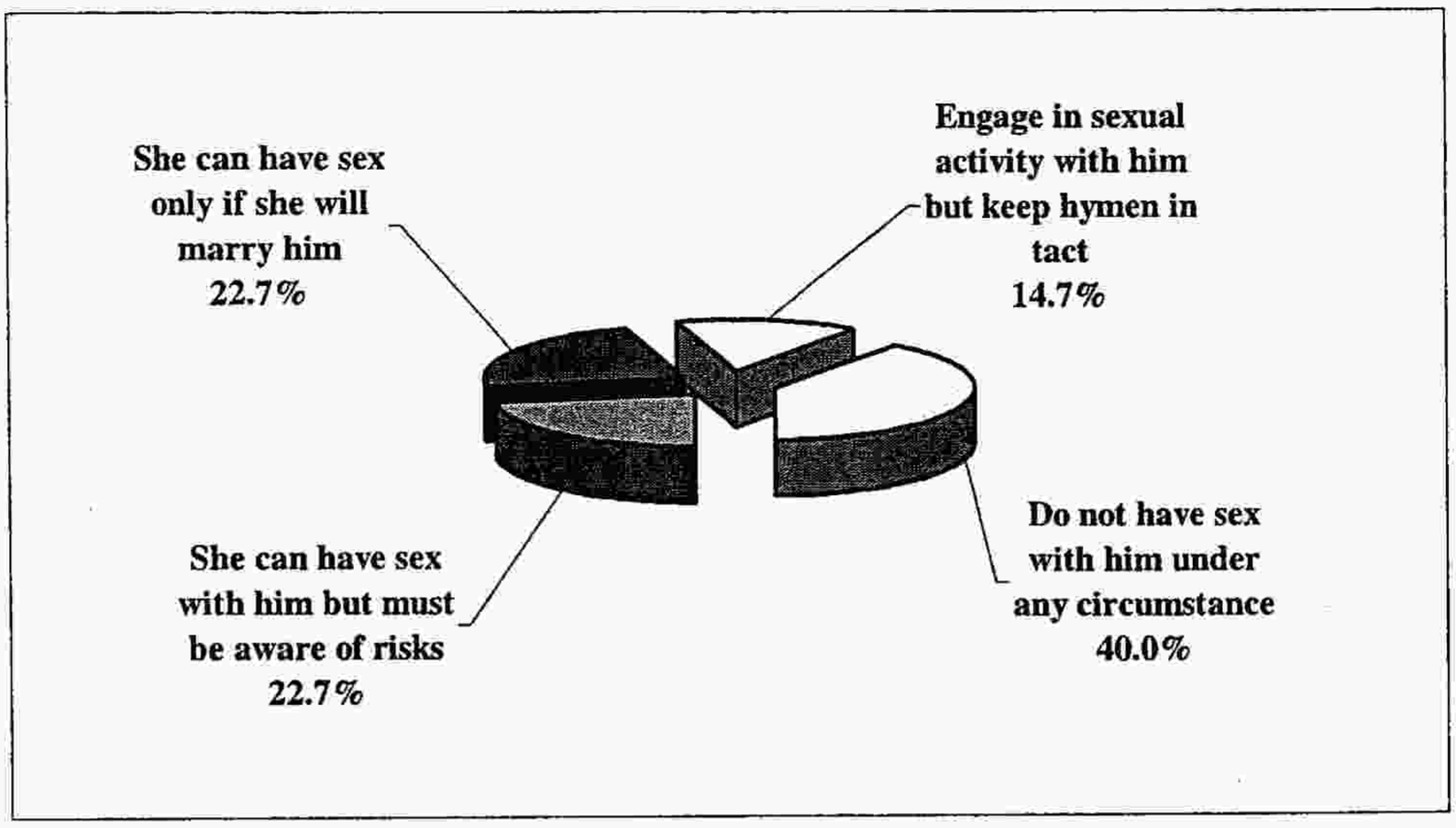
> Don't have sex. Even if you love him, even if you are sure that you are going to marry him, you must wait. What if he dies? What if something happens? What if you get pregnant? No, virginity is a gift to your husband and to your family. But, that's not to say you can't do other things. You can be sexual without losing your virginity. Don't let him penetrate you, sleep with him but don't lose your virginity. Or anal sex, my friend does this with her boyfriend. You can do that and still be a virgin.[75]

Students from central, southern and northwestern regions were more likely to state that the friend should not engage in sexual relations under any circumstances. These responses are represented on Figure 6.7.

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[74] Interview (Students #20), Tunis: October 25, 1999.
[75] Interview (Student #29), Tunis: October 26, 1999.

Figure 6.7: Responses to Hypothetical Situation on Pre-marital Sex



Students were then asked to further explore their attitudes toward pre-marital sex by describing how they would respond to a friend if she decided to engage in pre-marital sexual intercourse. Three quarters stated that her decision to have sexual relations with her boyfriend would have no impact on their friendship. Indeed over 60% of these students said that they would support their friend by giving her information on contraception and/or going with her to consult a private physician. However, 17% of students noted that this decision would impact their friendship, with nearly half of this group stating that they would sever relations with her completely. "I think pre-marital sex is wrong. If the man leaves her she won't be able to get married. If my friend did decide to [have sex] I would ignore her. She wouldn't be my friend anymore."[76] Students from the center and south of Tunisia were more likely to respond in this manner. Thus the survey results indicate that not only is there a perception among university students that female university students represent a

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[76] Interview (Student #43), Tunis: October 29, 1999.

highly sexually active population, but there appears to be a growing acceptance for and approval of pre-marital intercourse.

In spite of this perception of a high level of sexual activity amongst the female university student population, there remains overwhelming social pressure against pre-marital sexual intercourse. Researcher S. Laroussi-Zahar echoed this sentiment in 1994.

> Now in society, especially Tunisian society on account of the socio-cultural heritage, a great importance is accorded to the concept of virginity and she who loses hers finds herself devalued and rejected, not only by one's family but by the entire social body. Her chances of concluding a marriage are significantly reduced if not lost forever.[77]

Indeed, the attitudes and experiences of female students in Tunisia suggest a dissonance between the sexual realities and the societal expectations with regard to pre-marital sex. This dichotomy places significant pressure on many young women, both women who choose to abstain from sexual activity as well as those who engage in pre-marital sexual relations. As one student explained,

> Sex is a problem in Tunisia. It is a problem because of the dilemma that girls face. There are options, including hymen reparation, but this doesn't address the core problem. The core problem is the double standard that exists and the lack of open discussion about sexuality and women's sexual desires. There needs to be information, discussions, groups, and services to address this issue.[78]

As Hager's story at the beginning of this chapter illustrated, many women are torn between acting on their sexual desires and adhering to social expectations. Like Hager, some women who choose not to engage in sexual relations question their

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[77] Laroussi-Zahar, S. (1994, décembre), pg. 174.
[78] Interview (Imen), Tunis: October 22, 1999.

attractiveness and their femininity, thereby impacting their self-esteem and leading to depression. The results of the survey and focus group discussions indicated that this trend is more pronounced when women are in their mid and late twenties. Further, the familial and societal pressure on young women to remain virgins is often accompanied by pressure from men to be sexually active. As one student from Gafsa noted,

> Men want to date women who will have sex with them but they only want to marry virgins. Men break up with me because I won't sleep with them and it makes me feel awful. I feel ugly and sad. I can't concentrate on my studies. I failed my exams last year because of this. It's not fair. No one asks men if they are virgins before they get married, but for people in my town a woman's virginity is very important. I'm twenty-six years old and I'm still a virgin, but I don't want to be. I want to be able to express myself, but I can't. I think about my family and how they would respond and I just can't.[79]

The majority of participants in the focus groups commented on the societal double standard that holds different sexual expectation for men and women. Yet, in spite of the evident stress and depression many women are experiencing, there are almost no counseling services dedicated to young women. Further, young women perceive that, in general, health service providers are unsympathetic to this dilemma and many women continue to feel isolated.[80]

Social expectations also place a significant psychological burden on many of the young women who decide to engage in pre-marital sexual activity. Indeed, as members of the Tunisian Mental Health Association wrote, "The taboo of sexuality remains effective, above all, outside of the ties of marriage, evidenced by the too high frequency of suicidal conduct among female adolescents who "sinned" and lost their

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[79] Interview (Student # 75), Tunis: March 10, 1999.
[80] Focus groups, Tunis: February 26, 1999, February 27, 1999, March 15, 1999, & October-November 1999.

virginity."[81] The depression, anxiety, fear, and taboo associated with virginity loss are depicted in Noura's experience.

Noura's Story

Noura and her boyfriend began dating in secondary school. Though they were sexually intimate, they refrained from penetrative intercourse because Noura wanted to preserve her virginity. However, one evening he penetrated her and Noura was afraid that she had torn her hymen. Noura was terrified that her family would find out so she constructed a story about falling on the lip of a toilet bowl. Her family was supportive and suspected nothing but as a result of the incident her boyfriend broke up with her.

As Noura prepared to leave for the university her family began to pressure her to become engaged. Her parents had already chosen a suitable man, a distant relative, who was working in Tunis. However, his family required that Noura produce a certificate of virginity before the engagement. Noura was terrified and sank into a profound depression. She had no one to confide in and she was afraid her secret would be revealed. Her mother accompanied her to the gynecologist.

Noura's first visit to a gynecologist was traumatic. The doctor refused to examine her and told her that she should come back a week before her marriage. Only then would he examine her and repair her hymen, if necessary. Noura tried to explain that she had fallen, but the doctor refused to listen and sent them out of this office. Noura began to contemplate suicide.

Noura and her mother then went to a second gynecologist, a woman, who was much more understanding. Again Noura was accompanied into the examination room by her mother so she was unable to speak frankly with the doctor. Noura explained that she had fallen. The gynecologist examined her and pronounced that she was still a virgin. She explained that Noura's hymen had suffered a small tear but that it was self-repairing and completely consistent with the accident she had described. Noura felt an incredible sense of relief. The gynecologist issued Noura a medical certificate attesting to her virginity, which her mother promptly took and explained to Noura that she should return in the weeks before her wedding to make sure that her hymen had completely healed. If not, the doctor would be able to perform a reparation at that time. Noura became engaged later that year. Noura's not sure what she would have done if this doctor hadn't been so understanding.[82]

The pressure on Noura to obtain a certificate of virginity is not unique.

Indeed, there is often suspicion cast on young women when they leave their hometowns for the university and thus the number of university students demanding

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[81] Douki, S. et al.(1995), pg. 3.
[82] Interview (Noura), Tunis: October 26, 1999.

these certificates has been steadily increasing.[83] Further, the last ten years have witnessed an increase in the demand for hymen reparations.[84] A growing number of physicians in Tunis work in the public sector but provide hymen reparations through a private office, sometimes on a sliding fee scale.[85] One physician reflected on his work in this area. "Though I think it is a form of deception, I reconstruct women's hymens. I don't believe that a girl's life should be ruined because of an adventure. Tunisian mores are conservative and there is a double standard, so I don't feel any guilt about my work."[86]

As was revealed by the results of the survey, many young women in Tunisia seek a compromise between the desire to be sexually active and the societal expectation to remain a virgin. For many young women the solution is to refrain from sexual activity that would rupture the hymen. A 1993 on Tunisian couples concluded,

> In effect, virginity at marriage is still an important factor in Tunisian society, even if many young people deny it and even if many young people engage in premarital sexual relations. It is therefore necessary to consider that…all is done to respect the young woman's virginity. Sleep together, but respect the hymen. Get pregnant, but respect the hymen. Certain unmarried women abort, they arrive in the maternity wards still virgins, or they ask their gynecologist to repair their hymens.[87]

Students reported engaging in many different types of sexual activity to avoid hymen rupture, including mutual masturbation, incomplete penetration, oral sex, and anal intercourse. Obviously, significant risks accompany these last three types of sexual

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[83] Interview (University Professor), Tunis: October 5, 1999.
[84] It should be noted that "hymen reparation" is, in fact, a misnomer. Hymenoplasty is an outpatient surgery generally performed during the week prior to the wedding. The physician creates a small "membrane" from either the hymen remnants or the posterior vaginal wall with dissolvable sutures. Upon intercourse this approximated hymen can be ruptured resulting in bleeding.
[85] The reported cost of a hymen reparation ranges from 40-300 TND.
[86] Interview (Physician), Tunis: February 23, 1999.
[87] Toumi-Metz, L. (1993), pp. 6-7.

activity, notably the risk of pregnancy and STD transmission. And as Noura's experience illustrated, the risk of tearing the hymen during attempts at incomplete penetration is not insignificant.

However, most female university students in the social science and humanities appear unaware of these risks. Indeed, group discussions with students found that students were generally surprised by the fact that a woman could get pregnant without full penetration.[88] As a former Professor of Medicine at the University of Tunis confirmed,

> I found that there was a very high level of ignorance with respect to women's bodies and reproduction, especially among young women. Girls would come to me, pregnant, without knowing how they got that way because, technically, they were still virgins. Many young women just don't know how pregnancy works and they think that you must have complete penile penetration and ejaculation to become pregnant.[89]

Indeed, there appears to be a widespread belief that the hymen acts as barrier method of birth control. Therefore, many women engaging in this type of sexual activity do not use condoms or other types of contraception, which has led to the increasingly prevalent phenomenon of pregnant "technical virgins". As one student from the northwest explained,

> A good friend of mine became pregnant when she was still a virgin. She is from Gafsa and she had never learned about sexual intercourse or pregnancy. She thought that she couldn't get pregnant unless her hymen was broken. And she didn't understand that she needed to use contraception even though she

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[88] Focus groups, Tunis and Tataouine: November 20, 1998, February 26, 1999, February 27, 1999, March 15, 1999, & October-November, 1999.
[89] Interview (Gynecologist), Tunis: January 13, 1999.

> wasn't having full sex. She was so scared. I went with her to a private clinic to get an abortion. The doctor was very patient with her and explained how she became pregnant. I'm sure she will be more careful now, but it was awful.[90]

Although there are numerous physicians who try to use these consultations to communicate information about sexual health, the timing does not appear conducive to behavioral change. As one gynecologist who performs private sector hymen reparations and abortions noted,

> I find this aspect of my work [technical virgins] the most difficult. So many times educated girls have come into my office not knowing how their bodies work. I ask them who they have had intercourse with and when and they stare at me. They tell me that they haven't had sex, even though they are three months pregnant. I have to coax them into giving me the full story and many of them still don't know exactly what type of act led to the pregnancy. I try to use the consultation as a way of educating the young women, but when they are scared and under pressure they don't absorb a lot of this information. I doubt that it affects their behavior.[91]

Thus, it is clear that ignorance or misinformation, combined with the social pressure to remain virgins has led to an increase in high risk behaviors among young women.

High-risk behaviors and misinformation also appear to be tied to regional disparities. As was shown previously, women from southern and central governorates were found to have a lower degree of sexual health knowledge. While this population of students was more likely to express disapproval of pre-marital sexual intercourse, young women from the south and center, particularly those living in the dorms, are actually perceived as being more sexually active. As one student from Siliana stated,

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[90] Interview (Student #15), Tunis: October 21, 1999.
[91] Interview (Gynecologist), Tataouine: April 15, 1999.

> Many girls in the university are sexually active. This is especially true of girls from the center and south, from the more conservative places. They come from these other areas and they get a little out of control; they begin looking for boys, they start smoking, they go to discos, etc. Of course, one of the main problems is that these are also the girls who know the least about pregnancy and STDs and so are at the greatest risk.[92]

Indeed, many students who come from towns significantly distanced from Tunis are often divorced from the familial support and community expectations they are accustomed to. This separation appears to have a profound impact on many women's behavior. A student from Tataouine described her impressions.

> Before I came here, my father and mother told me not to go anywhere or speak to anyone, especially not with boys. But [in Tunis] I see that the majority of girls have boyfriends. Every night or every weekend they go out. They do everything…there is a big difference between girls who live in Tataouine and girls from Tataouine who live here. In Tataouine, girls are terrified of many things, even of speaking with people. [In the South,] you would never see a boy and a girl walking in the street holding hands or a boy putting his arm around a girl [in public]. Maybe there are some girls who have boyfriends, but it is secret, not public. But here it is not a problem. Their mother and father do not know. There is no authority of the family here.[93]

As is evident in the coming section on out-of-wedlock pregnancy, this regional divide has important health implications for young women.

Out-of-Wedlock Pregnancy

The social pressure to refrain form pre-marital sexual relations influences students' attitudes toward out-of-wedlock pregnancies. In the second hypothetical situation, students were asked how they would advise a friend who became pregnant when she was not married. Students overwhelmingly stated that they would

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[92] Interview (Student #13), Tunis: October 21, 1999.
[93] Interview (Student # 68), Tunis: May 1, 1999.

recommend that the friend have an abortion. Nearly seventy percent stated that she should abort the fetus under all circumstances and an additional 11% stated that she should have an abortion if the father refused to marry her.[94] As one young woman from Bizerte noted,

> As long as she is in her first trimester, she has to get an abortion. There is no question about this. Life in Tunisia would be too difficult as a single mother. Her boyfriend, her family, the society, no one will accept this. And it would be too difficult for the child. She has to have an abortion.[95]

Finally, fifteen percent of students would recommend that she carry the child to term. As one student explained, "She should have the baby. She took the risk and it is not the fault of the baby. The child could grow up to be a good person. I don't support the killing of babies."[96]

Students were well informed as to where an unmarried woman could obtain an abortion in Tunisia. Eighty percent cited private clinics, 23% cited public health facilities and 4% cited traditional healers. Only 8% of students were unable to name a place and/or believed that it was illegal for unmarried women to obtain an abortion in Tunisia. However, many of the students who cited private clinics noted that though it is possible for an unmarried woman to obtain an abortion at a public health facility, they would not recommend it because of the perception that unmarried women are

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[94] Approximately 80% of the student respondents would recommend that an unmarried pregnant friend have an abortion. Most of these students would advise the friend to have an abortion because of the social stigma associated with out-of-wedlock pregnancy. Students repeatedly mentioned that family, communities, society, friends, and future partners would not accept the woman or her child. Only one student suggested that the friend should have the abortion for fear of being killed by her family. In Tunisia, "honor crimes" have been explicitly outlawed since 1992. The last reported honor crime occurred several years prior to this legal change. Lecture at CEMAT, Lilia Labidi: November 1998.

[95] Interview (Student #50), Tunis: November 1, 1999.

[96] Interview (Student #69), Tunis: February 24, 1999.

mistreated, humiliated, and/or judged in public facilities. One woman spoke from personal experience.

> During my first year at university a close friend of mine became pregnant. Eight weeks into her pregnancy I went with her to get an abortion. The man was not going to marry her and she couldn't tell her family… She didn't have a lot of money so we went to a public hospital. It was terrible. The staff was rude to her-they embarrassed and humiliated her. They talked about her condition and her marital status in front of other patients and amongst themselves. My friend was humiliated. In the future, I would only advise a pregnant friend to go to a private clinic, even if I had to lend her the money. She would have been treated so much better.[97]

Many students also expressed their concern that services in public health facilities are not confidential and thus the family could learn of the abortion.

When asked their opinion about abortion in general, almost half of the women stated that although they were personally against abortion or thought it was immoral, abortion was sometimes necessary.

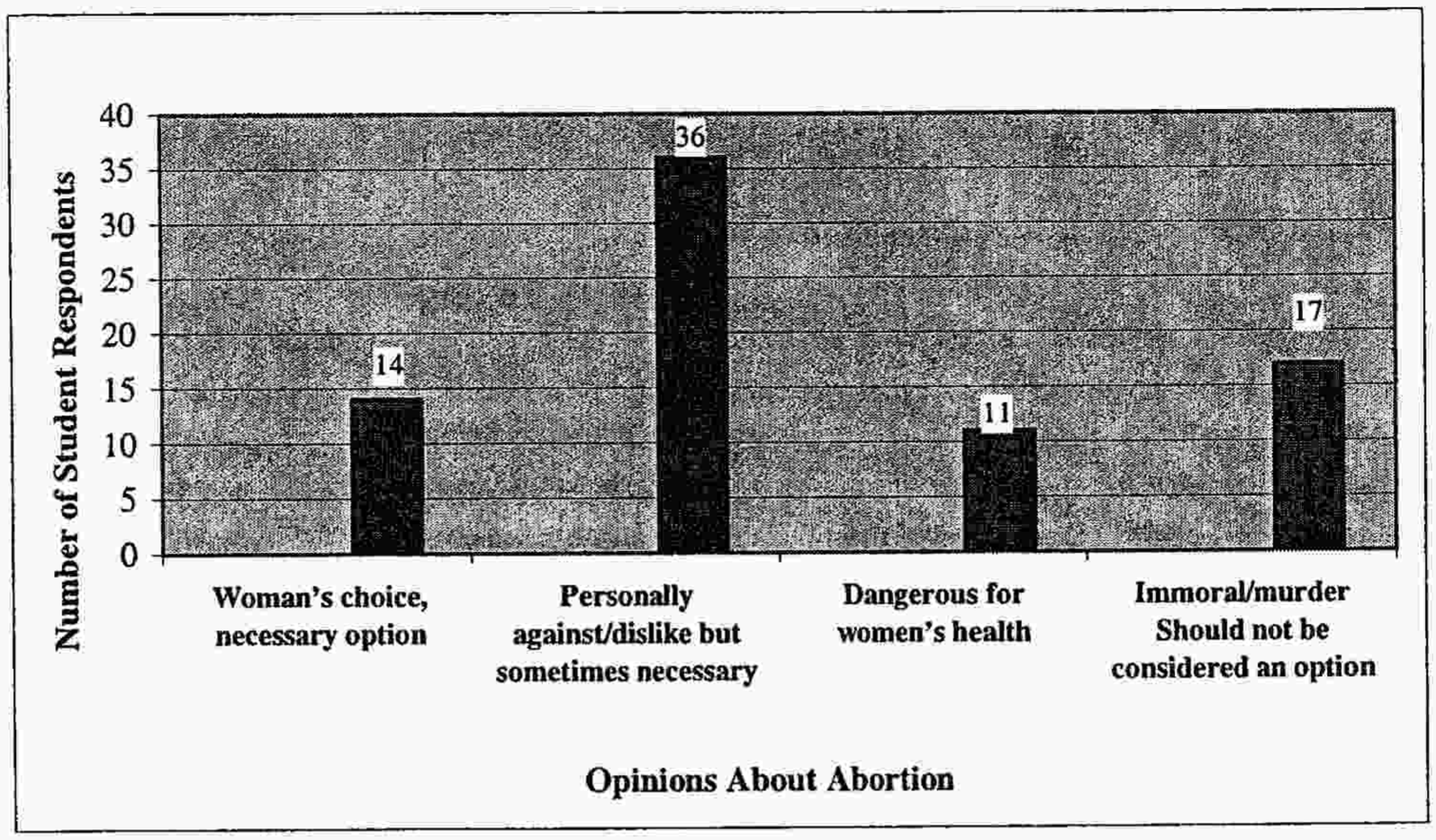
> If you get pregnant outside of marriage, you really don't have a choice. You have to get an abortion. Your parents won't accept the situation and you can't be a single mother in Tunisia. Though I am personally against abortion I would definitely advise my friend to have one.[98]

Approximately 20% believe that it is a necessary legal option for women and that it is the choice of each woman. Nearly 15% of students believe that abortion puts a woman's health at risk and 23% of students stated that abortion was immoral and/or murder and should not be an option. These results are presented in Figure 6.8.

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[97] Interview (Student # 15), Tunis: October 21, 1999.
[98] Interview (Student #8), Tunis: October 20, 1999.

FIGURE 6.8: STATED OPINIONS ABOUT ABORTION



Young women appear to be using the abortion services available to them. The overall rate of abortion in Tunisia as reported in 1995 was 96.2 abortions for 1000 live births. Statistics indicate that the vast majority of women seeking abortions are married and that women in the 30-34 age cohort have 35% of all abortions. This survey also found that approximately 5% of abortions occur within the 20-24 year old population, an age cohort largely comprised of unmarried women.[99] Current statistics indicate that approximately 1.4% of deliveries are by unmarried women with 31% of these by adolescents.[100] Yet, a survey published in 1985 found that 3.1% of abortions were performed on adolescents.[101] Thus while the national abortion rate is 9.6% of

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[99] Matsuda, T. (1996).
[100] Triki, A. (April 3, 1999). Speech given at "La journée de la santé de la reproduction" conference, Gammarth, Tunisia.
[101] Ben Romdhane, H. et. al. (1988), pg. 139.

live births, this rate appears roughly three times higher for unmarried women and adolescents.[102]

Young women's experiences with abortion indicate that there is a great deal of misinformation regarding pregnancy. Physicians and researchers have reported that because young women are unclear on the mechanics of pregnancy, they are unaware that they have become pregnant.[103] This appears to be particularly true if the woman has an intact hymen. In concert with shame and embarrassment, this confusion has led to women either being unable to obtain abortions or having to obtain late second trimester abortions. This has a significant impact on women's psychological and physical health as late second trimester abortions are less accessible, more expensive, and carry a greater risk of complications. As one woman described,

> I have a friend who didn't realize she was pregnant until she was in her sixth month. I guess she was in denial. It is almost impossible to find someone to perform an abortion in Tunisia this late in the pregnancy. I encouraged her to get money together and go to a private physician. Her family would never accept her if she had the baby. She was finally able to find someone to give her the abortion, but it was very expensive.[104]

Young women's personal experiences with abortion reveal a significant amount of confusion and fear, fear related to societal pressures about virginity and the taboo of single motherhood. Fatma's tragic story is but one example of the degree of desperation and fear some young women experience.

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[102] It is probable that the abortion rate of unmarried women is much higher as abortions performed in private sector facilities are undercounted in the statistics.

[103] Little research has been conducted on out-of-wedlock pregnancies and single motherhood in Tunisia. However, in her 1993 study with 20 single mothers, R. Ben Rejeb found that 16 came from the interior (center and south) of Tunisia and that 19 pregnancies resulted from consensual relationships without the use of contraception. Rejeb's study revealed that these women first consulted a physician during or after their fifth month of pregnancy, often because they were unaware that they were pregnant or were in denial of the pregnancy. In identifying their pregnancies in the second or third trimester, these adolescents had extremely limited access to abortion. Ben Rejeb, R. (1993).

[104] Interview (Student # 57), Tunis: November 1, 1999.

Fatma's Story

Fatma had never been to Tunis before she came there to study. When she arrived in Tunis she felt lost and conflicted. She had never left her southern governorate or her conservative family before. Fatma wore traditional dresses and a headscarf, a rare form of attire for young women in Tunis. She also started to see someone. After dating for a couple of months Fatma became pregnant. Her boyfriend would not take responsibility for the child and he refused to marry her. Fatma was desperate. She decided to get an abortion but she didn't have the money to go to a private clinic. And she couldn't go to a public hospital. Fatma was afraid that the services would not be confidential and that her family would be informed of her condition. So Fatma decided to abort the fetus herself.

Unlike some of the other students who self-induce abortions with plants, herbs or detergent, Fatma decided to use scissors. Fatma waited until the weekend because she knew that most of the women in the dorm, including her roommates, would be home with their families. Fatma performed the abortion in her dorm room. In the process of the abortion she punctured her uterus and began to hemorrhage. Another student found her body later that day, after she had bled to death.

Fatma's father was contacted and he came to Tunis to collect her body. However, when he arrived and was told the circumstances surrounding her death, he refused to identify her. He told the dorm administrators that he didn't have a daughter and that this girl was not related to him. Fatma had shamed him and her family. He returned to the south without her. [105]

Fatma's experience dramatically illustrates how fear and misinformation contribute to high-risk activities with serious health consequences. This experience had a profound impact on women studying at the university. As one student living in the dorm at that time noted,

> The dorm never acknowledged her death; it was as if she didn't exist. Girls in the dorm were scared and it was all we talked about for weeks. No one wanted to live in the same wing as the one in which Fatma had died, like there was a curse on that part of the dorm. And [the administrators] did not do anything, they did not even offer us counseling. I think this would have been a perfect opportunity to talk about sexuality and pregnancy. There are a lot of

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[105] Obviously this story was not collected from Fatma herself. Fatma's story was first revealed in an interview with a student from Béja on October 21, 1999. This student was Fatma's neighbor, worked in the administrative office of the dorm, and was present when Fatma's father came to collect the body. The basic elements of this story were later confirmed in three separate interviews.

> girls here who do not even know how pregnancy works. But the university chose to ignore it. I was disgusted by the way the situation was handled so I decided to live in a private dorm the following year. A number of other students did this as well.[106]

As this student's comment reveals, the lack of educational programs and counseling services available to university students contributes to significant misinformation.

Many students are aware of high levels of misinformation at the university and the impact this has on student behavior. Indeed, nearly half of the surveyed students suggested that young women's health could be improved through programs designed to communicate openly about sexual health issues and increase student awareness.

> There are a lot of things that aren't being discussed right now. I am a journalism student and I know how important it is to communicate with people directly. But with issues involving sexuality, people don't feel comfortable talking about this publicly. Many girls at the university are becoming pregnant and contracting STDs but we don't have programs that focus on this. I think we really need them.[107]

Efforts to increase information and services to the university population would be overwhelmingly welcomed by female university students. Almost half of the surveyed students suggested that young women's health could be improved by increasing the accessibility of health service providers, particularly counselors and psychologists. Students who are not residents of the dorms noted that health services should be available through the university rather than through the dorms themselves.

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[106] Interview (Student # 14), Tunis: October 21, 1999.
[107] Interview (Student #15), Tunis: October 21, 1999.

> We students lack support in Tunisia. We need more services to be directed toward us, particularly in the areas of mental and psychological health. A lot of girls feel isolated here, especially if you are outside of the dorm. There need to be more opportunities for us.[108]

Finally, one third of surveyed students suggested health activity clubs should be extended to or expanded within the university population. However, these students overwhelmingly proposed that the clubs focus their discussions on sexual health issues and contain a practical rather than academic orientation. Again, students living outside of the dorms suggested that these groups be open to all female university students rather than being dorm-based.

CONCLUSION

This survey revealed that university students have health needs that currently are not being met by the national health program. The lack of both direct health services and educational programs for unmarried women is contributing to considerable confusion, fear, and misinformation. Although the health reforms of the 1990s made significant strides toward increasing the health education opportunities for adolescents and soon-to-be married women, the national program excludes unmarried adult women and university students from its initiatives. Students compensate for these shortcomings by providing each other with information. However, this information is often inaccurate. This survey revealed that the misinformation and fear young women experience contributes to depression, stress and anxiety as well as behaviors that are detrimental to young women's physical health. Thus increasing accessibility to health service providers, establishing counseling services, facilitating open discussions on issues of sexuality through health

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[108] Interview (Hager), Tunis: October 22, 1999.

activity clubs or the dormitories are but a few of the reforms that might assist in improving young women's health.

Reform in the area of young women's health will continue to be a challenge. In spite of the growing number of health service providers who provide services to unmarried women through the private sector, there are many health service providers who are resistant to targeting services and information toward unmarried women. Indeed, many health service providers believe that increasing the information available to young women will encourage sexual experimentation and promiscuity. A midwife from El-Hamma explained this position.

> I do not think that there should be sexuality education for female university students, in the dorms for example. It is against Islam to engage in pre-marital sex and even if girls say that they just want to have the information, you know they will really do more. They will act with the knowledge.[109]

However, there is growing momentum in both medical and policy circles toward acknowledging the real health needs of unmarried women. As more information about young women's attitudes, behaviors, and needs becomes available, the need for reform becomes increasingly evident. As a physician working in health policy remarked,

> Students [female] are sexually active. Now the average age of marriage for Tunisian women is over 26 years old. What are these girls supposed to do between the ages of 15 and 26? Many of them are going to experiment. It isn't responsible for us to just close our eyes and hope that problem will go away. It won't.[110]

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[109] Interview (Midwife), El-Hamma: November 14, 1998.
[110] Interview (MOPH Representative), Tunis: January 11, 1999.

Thus, it is evident that until the national health program explores and accepts the reality of young women's sexual activity, young women's health needs will remain inadequately met.

CHAPTER 7: CONCLUSION

This dissertation explores the strengths and limitations of national health policy in Tunisia. By taking a comprehensive definition of women's health and grounding the analysis in social history, this research yields a more complete understanding of the history, evolution, and consequences of the Tunisian national women's health program than that provided by the dominant historical narrative. The achievements of the Tunisian women's health program, as reflected in statistical and traditional historical analyses, include an expansive health infrastructure, near universal primary health care coverage, and comprehensive reproductive health initiatives. However, a social history approach to women's health and a focus on three specific areas of women's health in Tunisia -traditional health services, domestic violence, and young women's health and sexuality- reveals continuing shortcomings in the national program and arenas for future improvement.

Assessments of aggregate health statistics and elite-centered historical approaches to studying women's health and policy formulation provide valuable information about the accomplishments of the national women's health program in Tunisia. However, these conclusions present an incomplete picture of women's health; they obscure disparities, divorce health from the larger social, political, and economic context, and overlook the experiences and perspectives of both health service providers and beneficiaries of services. As a consequence, these approaches tend to focus on a narrow range of women's health issues, emphasizing those aspects of health related to reproduction and maternity. In employing a social history approach to women's health, this dissertation moves beyond many of these

limitations, encompassing a more holistic understanding of women's health and placing health in a broader social and experiential context. A re-examination of the history of the women's health program through the lens of social history reveals greater depth and complexity in the evolution of the national program, highlighting both its achievements and the weaknesses.

An evaluation of the shifts in the philosophical underpinnings of the women's health program, the changes in health service provider autonomy, and individual, community, and health service provider input into service determination suggest a division of the history of the women's health program into three distinct periods. From the 1960s until the late 1970s, the focus of the women's health program remained limited to family planning and demographic and development objectives shaped the construction and implementation of the program. This period in women's health history emphasized physician-based hierarchies and limited the autonomy of female paramedical personnel. By the end of the 1970s, women's primary health indicators reflected improvement, but poor service quality, hierarchical decision-making, and narrowly focused services characterized the program.

This analysis shows that the 1980s represented a significant shift in the national program. Due to a reorientation toward primary health care and growing recognition of the need for better service integration, the MOPH began to devolve authority to local communities and the individual health service providers practicing in them. During the 1980s, the national program evolved to include a broader array of health issues. The peripheralization of decision-making produced an opportunity for individual health service providers and communities to create programs tailored to local needs. These initiatives resulted in increased service integration, greater community confidence in the health sector, and a broader scope of services. These ad

hoc programs resulted from the efforts of innovative individuals rather than centralized programs, but could not have happened without governmental willingness to devolve authority. Although significant regional disparities persisted, health indicators continued to improve and women gained a greater voice in service determination.

A social history approach to women's health demonstrates that health is intertwined with the larger economic and political context. The economic reforms of the late 1980s emphasized greater accountability and transparency within the public sector. This policy environment, coupled with the desire to improve health indicators and minimize regional disparities, strongly influenced health reforms in the early 1990s. Dividing women's health services into four areas (premarital, prenatal, delivery, postpartum), the national perinatality program (PNP) outlined national standards and strictly delineated health service provider responsibilities. The reforms of the 1990s curtailed the activities of both individual health service providers and communities, and re-instituted a narrowly constructed definition of women's health. The full impact of the program cannot yet be assessed. However, the re-centralization of decision-making, and the return to a focus on maternal and reproductive health, threaten to stifle the innovation and individual initiative that characterized the 1980s, thereby erecting barriers to meeting comprehensive women's health needs.

The achievements of the Tunisian national women's health program should not be underestimated. Tunisia has reached a state of near universal coverage in maternal care and family planning, recorded substantial improvements in primary health indicators, and ranks among the most successful countries with respect to women's health in the Middle East and North African (MENA) region. Yet, combining qualitative and quantitative methods to examine a broader range of health

issues reveals lacunae in the national health program. This dissertation demonstrates that traditional health services, domestic violence, and sexual health constitute important components of women's physical, psychological, and social health and well-being.

Traditional Health Services

The dominant historical narrative and aggregate health statistics obscure the contemporary importance of traditional birth attendants. However, an examination of women's experiences demonstrates that traditional birth attendants continue to play a vital medical and social role in the delivery of women's health care in the southern and central governorates of Tunisia. Despite both national and individual health service provider attempts to promote the articulation of national and traditional health services, there has not yet been a systematic effort to involve TBAs in the national health program. Indeed, the health reforms of the 1990s, including the transferring requirements of the PNP, pose additional challenges to policy initiatives aimed at integration.

However, experiences in other MENA and developing countries provide evidence of the potential value for enhancing coordination, collaboration, and integration between TBAs and government maternal health services.[1] Recognition of the role of the TBA and additional research efforts dedicated to understanding the scope and impact of her services would place the MOPH in a better position to work with TBAs to improve the quality of health services available to Tunisian women. With additional research into the knowledge, attitudes, and practices of TBAs and

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[1] For examples of initiatives in other countries, see Hyma, B. & A. Ramesh (1994), Leedam, E. (1985), Lewis, J. et. al. (1985), Okarfor, C. et. al. (1994) & Timyan, J. et. al. (1993).

participatory initiatives to assess the opinions and needs of both TBAs and professional health service providers, a tailored national program can be constructed.[2] Although it is beyond the scope of this research project to offer specific recommendations as to the type of program that should be established, the integration of traditional health service providers into the national health program has the potential to improve service quality, reduce maternal morbidity and mortality, promote trust between the national and traditional health systems, and gain greater community support and participation. Thus, a program designed to work toward integrated health services could make important inroads into addressing shortcomings in the national program.

Domestic Violence

In Tunisia, domestic violence continues to be viewed as a marginal component of women's health. In designating domestic violence as a legal and social issue, evaluations of both the prevalence of domestic violence and its impact on women's physical and psychological morbidity remain limited. However, in approaching women's health through a more holistic framework, this research reveals that domestic violence is a significant health issue in Tunisia. Further, an assessment of the national health program reveals a consistent failure to satisfactorily address the physical, mental, and psychosocial health needs of abused women. Indeed, the recent re-centralization of decision-making within the health sector, the formalization of a limited definition of women's health care, and the impediments to NGO-government collaboration, present challenges for comprehensively addressing domestic abuse. However, the shortcomings in the national health system are not insurmountable and the effort to promote national standards

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[2] Lewis, J. et. al. (1985).

provides a base for enhancing education and training, fostering research efforts, and establishing a national policy dedicated to domestic violence.

The national health program plays a pivotal role in the way in which domestic violence is perceived outside of the health system, particularly by the legal system. Since the medical certification process defines incapacity, the health system, in effect, has the ability to define domestic violence. To date this definition has been limited to physical violence and physical injuries. However, by recognizing the complex relationships between domestic violence and women's physical and psychological health and the importance of integrating health into its larger social and political context, the national health program can shape the manner in which the legal system defines and responds to domestic violence. Moving beyond the limited definition of women's health, recognizing the importance of psycho-social health, and working with and learning from the experiences of local service providers and the non-governmental sector will allow the national health system to better address all Tunisian women's health needs.

Young Women's Health and Sexuality

The needs of unmarried women have not factored into the development of the national health program. In combining qualitative and quantitative methods, the bi-directional survey results conclusively show that the lack of information and services directed toward never-married female university students is contributing to the perpetuation of misinformation, high-risk behaviors, and negative physical and psychological health outcomes. These finding demonstrate the importance of incorporating a broader array of health issues into an evaluation of women's health.

Further, this research illustrates the importance of moving beyond the

qualitative/quantitative dichotomy and approaching women's health through a more complex framework.

The PNP and the reforms of the 1990s make significant inroads into standardizing and improving married women's health services. These reforms can also serve a model for broadening the scope of women's health services to better meet unmarried women's health needs. The research with university students conducted for this dissertation demonstrates the importance of and desire for extending health services to unmarried women. Effective services can take a variety of forms, including direct gynecological services, counseling and mental health services, peer health education programs, and programs dedicated to health education. Yet, this research has shown that inclusion of the beneficiaries into the determination, construction, implementation, and assessment of health programs has greater potential for accurately identifying, targeting, and meeting women's health needs.

The three specific areas of women's health addressed in this dissertation differ considerably and affect women of different ages, marital statuses, regions of residence, and educational levels. However, the traditional health sector, domestic violence, and young women's health and sexuality share a general exclusion from the national health program, and warrant the formulation of policy initiatives to address each of these issues. As the most dynamic period in Tunisian health history took place during the 1980s, the peripheralization of decision-making and the participation of local communities into service determination during this period offer valuable lessons for better addressing comprehensive women's health needs.

FUTURE AREAS FOR RESEARCH

A definition of women's health must reflect the unique dimensions of our lives: The reproductive roles (childbirth), the biological reality (menstrual cycles), and the social context in which we live, work, and age. Each dimension impinges on our health and is in turn impacted by it.[3]

Historically, motherhood and reproduction have dominated the limited research agenda on women's health. This dissertation moves beyond this limited focus and has instead incorporated a more comprehensive vision of women's health into the assessment of national health services. Through an examination of traditional health services, domestic violence, and young women's health and sexuality, this research has investigated a range of overlapping health issues that move beyond the reproductive and maternal health of married women. This project examines women's health holistically, as it is influenced by women's social, economic, and familial contexts, and offers a framework for the evaluation of health policy as social history.

A comprehensive definition of women's health encompasses a wide array of issues, many of which were beyond the scope of this dissertation. Mental health, geriatric and adolescent care, occupational health, nutrition, and sexuality are but a few of the areas of women's health that have been historically excluded from analysis and merit further attention. In order to assess the needs of both communities and individuals, evaluate the national program, and better understand the complexities of Tunisian women's lives and health, further qualitative and quantitative research on comprehensive women's health is warranted. The methodological approach employed in this research project provides a base and a framework for future studies dedicated to women's health in Tunisia.

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[3] Koblinsky, M., et. al. (1993), pg. 54.

Specifically limited from the outset, this research also focuses exclusively on women's health, largely from the perspectives and experiences of women. Both the oral history project and the survey included only female participants. Yet, men play important direct and indirect roles in women's health. From reproductive decision-making to domestic violence, contraceptive use to the distribution of food within the household, from sexual harassment to the allocation of health resources within the family, men have a direct impact on women's health and well-being. However, men's influence over women's health is complex and takes indirect forms as well. As fathers, brothers, husbands, and sons, as community leaders, religious authorities, and professionals, men reinforce and institutionalize gender roles and inequalities, affect women's educational and professional opportunities, and shape legal reforms, thereby influencing women's health and health policy. Although men often serve as impediments to women's empowerment and access to health services, many also serve as agents of change. Thus, future research dedicated to the perceptions, opinions, knowledge, and experiences of men may provide useful insights into women's health in Tunisia.[4]

However, men do not simply serve as impediments to or promoters of women's health; the opinions, perspectives, and experiences of men are important in and of themselves. An exploration of the evolution of the national health program as it relates to men and men's needs may showcase other strengths and weakness in government health services and suggest additional avenues for reform. The approach employed in this research provides valuable insights for conducting this type of research with men as well. As women's health overlaps with children's health, family health, and men's health,

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[4] Recent work on men and masculinity in Egypt provides a model for exploring men's attitudes, perspectives, and experiences and their relationship to women's health and status. Wassef, N. & A. Mansour (1999).

focusing research efforts on these other areas of health services would also contribute to a better understanding of women's health.

This project was limited to an exploration of women's health issues in Tunisia. However, the recognition and understanding of the achievements in the women's health program may contribute to the development of more efficient and responsive health systems in other Arab and developing countries. Furthermore, approaching women's health through both qualitative and quantitative methods, integrating women's lives and stories into an historical analysis, engaging women's participation in evaluating the health system, and providing women a forum to voice their experiences and needs, serves as a possible framework for investigating women's health outside of the Tunisian context. In the Middle East, research in particular areas of women's health, including domestic violence and unmarried women's health and sexuality, remains sparse. Thus, further areas for research include efforts to assess comprehensive women's health in other countries in the region. While no country specific analysis should be employed as a template for a region, it does appear that the social history and interdisciplinary framework used in this dissertation may be successfully applied to other countries, thereby promoting a greater understanding of women's health throughout the Middle East and North Africa.

APPENDIX I: RESEARCH PERMIT

République Tunisienne
Ministère de l'Enseignement Supérieur
Direction Générale de la Recherche
Scientifique et Technique

AUTORISATION DE RECHERCHE SUR TERRAIN

N°. 14./98

Melle : FOSTER Angelina

Née le : 19 Décembre 1973 à Perth, Australia

Nationalité : Américaine

Passeport n° : Z 7042704 délivré le 27 Juillet 1993 aux U.S.A.

Qualité : Chercheur-doctorant

est autorisée à effectuer des recherches sur terrain :

Gouvernorats : Tunis, Beja et Gafsa

Période : un séjour du 1 Septembre 1998 au 31 Mai 1999

Institution(s) (s'il y a lieu) :

Nature des travaux de recherche: - Entretiens non-directifs avec des femmes;
- vivre et recueillir les histoires de vie de femme.

Objectifs des travaux de recherche : Explorer qualitativement des aspects de la santé des femmes par des études quantitatives.

Cadre des travaux recherche: Thèse de doctorat sur le thème : " L'Evolution de la santé des femmes en Tunisie".

Correspondant tunisien (s'il y a lieu): CEMAT

L'intéressée s'engage à respecter la nature et l'objet des travaux de recherche indiquées ci-dessus.

L'intéressée est tenue de présenter un rapport de fin de mission au Ministère de l'Enseignement Supérieur, dans un délai d'un mois. Elle est aussi tenue de présenter une copie du mémoire objet de cette autorisation dés sa réalisation.

Cette attestation est délivrée à l'intéressée pour lui faciliter l'accomplissement de sa mission de recherche auprés des autorités civiles, régionales et locales concernées.

Lu et approuvé
le chercheur
17 Aout 1998

1,000

Tunis, le 17 AOUT 1998
P/ Le Ministre de l'Enseignement Supérieur
Le Directeur Général de la Recherche Scientifique et Technique

Direction Générale de la Recherche Scientifique et Technique

APPENDIX II: STUDENT SURVEY

PART A: INTRODUCTION

I am doing my doctoral research on women's health care in Tunisia. I am specifically focusing on five areas of women's health: maternal health, nutrition, health education, family planning, and domestic violence. I am very interested in learning about Tunisian women's experiences. I would be very grateful if you would participate in this survey. Everything you say will be confidential. I will not use your name in my research- Is this okay? If at any point you would like to stop or take a break, please tell me. If you have any questions or if anything is unclear, please ask me at any time. Would you mind if we start with a few demographic questions?

1. Where are you from? Where do you live now?
2. How old are you?
3. Do you have any siblings? How many? How old are they?
4. What year are you in school?
5. What do you study?
6. What do your parents do?
7. Are your currently taking medicine?
8. Do you currently have any illnesses or health problems?

PART B: FUTURE

During this part of the survey I would like to ask you a series of questions about different health issues and your opinion on a number of health problems. Is that okay? I'd like to start by asking you a number of questions about what kind of family you would like to have in the future and why.

1. Would you like to get married in the future? Why or why not?
2. At what age would you like to get married? Why?
3. How many children, if any, would you like to have? Why or why not?
4. How long after your marriage would you like to have your first child? Why?
5. How much time would you like to have between children (if applicable)? Why?
6. Where would you like to deliver your children? Why?
7. Do you think that you will breast feed your children? Why or why not? For how long and why?
   The same amount of time for boys and girls? Why or why not?
8. Would you like to continue to work after you get married? Why or why not?
9. Would you like to continue to work after having your first child? Why or why not?

PART C: INFORMATION EVALUATION

I would now like to ask you a series of questions about four women's health issues. Reply if you can and if you have any questions, please ask me.

- **AIDS**

1. What is AIDS?
2. How is HIV/AIDS transmitted?
3. How is HIV/AIDS transmission prevented?
4. Can you tell me the name of another sexually transmitted disease?

- **Contraception**

5. What kinds of contraceptive devices are available in Tunisia?
6. Choose a method. How does one use this method? Is this method effective?
7. Where can a woman obtain contraceptives in Tunisia?
8. Is the situation the same for married and unmarried women?

- **Breast Cancer**

9. What can you tell me about breast cancer?
10. How can one detect breast cancer early?
11. What kind of treatments are available in Tunisia?
12. Where can one find these services?

- **Domestic Violence**

13. What constitutes domestic violence?
14. Is there a lot of domestic violence in Tunisia?
15. Is the situation today the same as in the past (Mother's generation? Grandmother's generation?)? Why or why not?
16. What services are available to abused women in Tunisia?
17. Are there informal services available in the community or in the family?

PART D: HYPOTHETICAL SITUATIONS

Now I would like to present you with hypothetical situations. I will read the situation to you and then I'd like you to respond to the questions. Is that okay?

Scenario #1: Your friend tells you that she is considering having sexual relations with her boyfriend before their marriage. She wants your opinion. How would you advise her? If she asked you for information about contraception how would you respond.?

1. Are many university women sexually active in Tunisia?
2. Is contraception used often? What do you think about this?

Scenario #2: Your unmarried friend is pregnant. She comes to you for advice. How would you advise her?

3. Where can an unmarried woman obtain an abortion in Tunisia?
4. What do you think about abortion in general?

Scenario #3: You have a friend who thinks that she is overweight. She feels depressed and has low self-esteem. She comes to you for advice. What would you suggest that she do?

5. In Tunisia, where do images of beauty come from?
6. What kind of (female) body type is ideal?
7. Is it a problem to be overweight in Tunisia?
8. How do girls in Tunisia stay thin?

Scenario #4: A close friend tells you that she is having problems with her boyfriend. He is extremely jealous and doesn't want her to speak with other men. Sometimes when is angry he yells at her and once he pushed her. Your friend comes to you for advice. How would you respond?

Scenario #5: Your cousin has been married for four years but she has no children. Her family and her inlaws are putting a lot of pressure on her to get pregnant. She wants a child and she wants your advice. How would you advise her?

9. How would one combat infertility in Tunisia?
10. In Tunisia, is it difficult to be infertile?
11. Is it more difficult for the woman or the man? Why?

PART E: GENERAL QUESTIONS

I only have a few more questions. Thank you for your patience!

1. Are there differences between the health situation now and that of your mother's generation? Can you give me an example?
2. What do you think about the health services in Tunisia? Are there big differences between the public services and private services?
3. What do you think about health education in Tunisia? Where do most young women get their information about health issues?
4. How can the services for young women be improved?
5. Do you have any questions for me?

THANK YOU!!!!

INTERVIEWS

Below is a list of the interviews conducted in Tunisia between August 1998 and May 2000. Each entry includes the date and place of the interview as well as the language in which it was conducted. If an individual was referred to by a pseudonym in the dissertation I have included that information as well. For health service providers and organization representatives I have also included the occupation and/or organization. Many individuals were interviewed more than once, some several times over a number of months. I have only listed the date of the first interview.

Health Service Providers

1. Interview (Physician), Gabes: August 21, 1998. (French)
2. Interview (Animatrice), Gabes: August 21, 1998. (French)
3. Interview (Community Health Worker), Gabes: August 21, 1998. (French)
4. Interview (Medical Student), Tunis: October 20, 1998. (French)
5. Interview (Gynecologist), Tunis: November 9, 1998. (French)
6. Interview (Gynecologist/Adnan), Tunis: November 10, 1998. (French)
7. Interview (Hospital Administrator), El-Hamma: November 14, 1998. (French)
8. Interview (ER Nurse), El-Hamma: November 14, 1998. (French)
9. Interview (Midwife), El-Hamma: November 14, 1998. (French)
10. Interview (Nurse), El-Hamma: November 14, 1998. (French)
11. Interview (Midwifery Student), El-Hamma: November 14, 1998 (French/Arabic)
12. Interview (PMI Midwife), El-Hamma: November 16, 1998. (French/Arabic)
13. Interview (Animatrice), El-Hamma: November 16, 1998. (Arabic)
14. Interview (Animatrice), El-Hamma: November 16, 1998. (Arabic)
15. Interview (Health Aide), El-Hamma: November 16, 1998. (Arabic)
16. Interview (ONFP Midwife), El-Hamma: November 16, 1998. (French)
17. Interview (Animatrice), Bouatouche: November 17, 1998. (French/Arabic)
18. Interview (Animatrice), Bouatouche: November 17, 1998. (French/Arabic)
19. Interview (Health Aide), Bouatouche: November 17, 1998. (French/Arabic)
20. Interview (Health Activities Club Teacher), Tataouine: November 20, 1998. (French)
21. Interview (Gynecologist), Tataouine: November 21, 1998. (French)
22. Interview (Gynecologist), Tunis: November 28, 1998. (French)
23. Interview (Physician), Tunis: January 11, 1999. (French)
24. Interview (Gynecologist), Tunis: January 13, 1999. (French)
25. Interview (Physician), Tunis: January 14, 1999. (French)
26. Interview (Nutritionist/Zeinab), Tunis: January 26, 1999. (French)
27. Interview (Nurse), Nouvelle Matmata: February 3, 1999. (French)
28. Interview (Midwife), Nouvelle Matmata: February 3, 1999. (French)
29. Interview (Health Administrator), Nouvelle Matmata: February 3, 1999. (French)
30. Interview (Physician), Nouvelle Matmata: February 3, 1999. (French)
31. Interview (Physician), Tunis: February 8, 1999. (French)
32. Interview (Nurse), Ancienne Matmata: February 13, 1999. (French/Arabic)
33. Interview (Midwife), Douz: February 15, 1999. (French)
34. Interview (Nurse), Douz: February 15, 1999. (French)
35. Interview (Midwife), Douz: February 15, 1999. (French/Arabic)
36. Interview (Physician), Douz: February 15, 1999. (French)
37. Interview (Nurse), Tunis: February 20, 1999. (French)
38. Interview (Physician), Tunis: February 20, 1999. (French)
39. Interview (Physician), Tunis: February 23, 1999. (French)
40. Interview (Medical Student), Tunis: February 23, 1999. (French)
41. Interview (Psychologist), Tunis: February 23, 1999. (French)
42. Interview (Physician), Tunis: February 24, 1999. (French)
43. Interview (Physician), Tunis: February 24, 1999. (French)
44. Interview (Nurse), Kasserine: March 12, 1999. (French)
45. Interview (Midwife), Kasserine: March 12, 1999. (French)
46. Interview (Physician), Kasserine: March 12, 1999. (French)
47. Interview (Physician), Kasserine: March 13, 1999. (French)
48. Interview (Psychologist), Sidi Bouzid: March 13, 1999. (English/French)
49. Interview (Medical Student), Sousse: March 18, 1999. (French)

50. Interview (Medical Student), Sousse: March 18, 1999. (French)
51. Interview (Medical Student), Sousse: March 18, 1999. (French)
52. Interview (Midwife), El-Jem: March 19, 1999. (French)
53. Interview (Midwife), El-Jem: March 19, 1999. (French)
54. Interview (Nutritionist), El-Jem: March 19, 1999. (French)
55. Interview (ER Physician), El-Jem: March 19, 1999. (French)
56. Interview (Midwife), El-Jem: March 19, 1999. (French)
57. Interview (Nurse), El-Jem: March 19, 1999. (French)
58. Interview (Nurse), El-Jem: March 19, 1999. (French)
59. Interview (Health Aide), El-Jem: March 19, 1999. (Arabic)
60. Interview (Hospital Administrator), Testour: March 22, 1999. (French)
61. Interview (Midwife), Testour: March 22, 1999. (French)
62. Interview (Nurse), Testour: March 22, 1999. (French)
63. Interview (Midwife), Teboursouq: March 22, 1999. (French)
64. Interview (ER Nurse), Teboursouq: March 22, 1999. (French)
65. Interview (Midwife), Ain Draham: March 23, 1999. (French)
66. Interview (Nurse), Ain Draham: March 23, 1999. (French)
67. Interview (Health Aide), Ain Draham: March 23, 1999. (French)
68. Interview (Midwife/Mounira), Ain Draham: March 23, 1999. (French)
69. Interview (Gynecologist), Ain Draham: March 23, 1999. (French)
70. Interview (Health Aide), Ain Draham: March 23, 1999. (Arabic).
71. Interview (Midwife), Tabarka: March 24, 1999. (French)
72. Interview (Midwife), Tabarka: March 24, 1999. (French)
73. Interview (Physician), Tabarka: March 24, 1999. (French)
74. Interview (Nurse), Tabarka: March 24, 1999. (French)
75. Interview (Nurse), Tabarka: March 24, 1999. (French)
76. Interview (Nurse), Sidi Bouzid: April 2, 1999. (French/English)
77. Interview (Former Health Aide), Ancienne Matmata: April 6, 1999. (Arabic)
78. Interview (Pharmacist), Ancienne Matmata: April 6, 1999. (Arabic)
79. Interview (Nurse), Mobile Heath Clinic, Haddej: April 7, 1999. (French/Arabic)
80. Interview (Health Aide), Mobile Heath Clinic, Haddej: April 7, 1999. (French/Arabic)
81. Interview (Former Nurse/Lilia), Médenine: April 7, 1999. (French/Arabic)
82. Interview (Animatrice), Tataouine: April 10, 1999. (Arabic)
83. Interview (Nurse), Tataouine: April 12, 1999. (French)
84. Interview (Midwife), Tataouine: April 12, 1999. (French)
85. Interview (Physician), Tataouine: April 14, 1999. (French)
86. Interview (Dentist), Tataouine: April 14, 1999. (French)
87. Interview (Gynecologist), Tataouine: April 15, 1999. (French)
88. Interview (Medical Student), Sousse: April 16, 1999. (French)
89. Interview (Medical Student), Sousse: April 16, 1999. (French)
90. Interview (Physician), Tunis: October 9, 1999. (French)
91. Interview (Nurse), Tunis: October 9, 1999. (French)
92. Interview (Former Health Aide/Habiba), Tunis: October 10, 1999. (French)
93. Interview (Nurse), Tunis: October 10, 1999. (French)
94. Interview (Former Health Aide), Tunis: October 11, 1999. (Arabic)
95. Interview (Physician), Tunis: October 15, 1999. (French)
96. Interview (Animatrice), Tunis: October 16, 1999. (Arabic)
97. Interview (Animatrice), Tunis: October 16, 1999. (French/Arabic)
98. Interview (Animatrice), Tunis: October 18, 1999. (French/Arabic)
99. Interview (Psychologist), Tunis: October 18, 1999. (French)
100. Interview (Physician), Tunis: October 20, 1999. (French)
101. Interview (Nurse), Tunis: October 20, 1999. (French)
102. Interview (Health Aide), Tunis: October 20, 1999. (French/Arabic)
103. Interview (Gynecologist), Tunis: October 22, 1999. (French)
104. Interview (Community Health Worker), Tunis: October 22, 1999. (French/Arabic)
105. Interview (Midwifery Student), Tunis: October 24, 1999. (French)
106. Interview (Physician), Tunis: October 30, 1999. (French)
107. Interview (Medical Student), Tunis: April 31, 2000. (French)

108. Interview (Medical Student), Tunis: May 3, 2000. (French)
109. Interview (Medical Student), Tunis: May 3, 2000. (French)
110. Interview (Medical Student), Tunis: May 3, 2000. (French)

Government, Non-Governmental Organization, and International Agency Representatives

1. Interview (Lawyer), Tunis: September 21, 1998. (French)
2. Interview (ATPF Representative), Gabes: August 21, 1998. (French)
3. Interview (Sociologist), Tunis: September 15, 1998. (French)
4. Interview (ONFP Representative), Tunis: September 17, 1998 (French)
5. Interview (ATPF Representative), Tunis: September 22, 1998. (French)
6. Interview (ONFP Researcher), Tunis: October 10, 1998. (French)
7. Interview (ONFP Researcher), Tunis: October 10, 1998. (French)
8. Interview (CREDIF Representative), Tunis: October 21, 1998. (French)
9. Interview (CREDIF Representative & Former UNFT Member), Tunis: October 21, 1998. (French)
10. Interview (CERES Researcher), Tunis: October 27, 1998. (English)
11. Interview (DSSB Representative), Tunis: October 27, 1998. (French)
12. Interview (Academic), Tunis: October 28, 1998. (French)
13. Interview (CERES Study Enumerator), Tunis: October 28, 1998. (French)
14. Interview (CERES Study Enumerator), Tunis: October 28, 1998. (French)
15. Interview (CERES Study Enumerator), Tunis: October 28, 1998. (French)
16. Interview (CERES Study Enumerator), Tunis: October 28, 1998. (French)
17. Interview (CERES Study Enumerator), Tunis: October 28, 1998. (French)
18. Interview (CERES Study Enumerator), Tunis: October 28, 1998. (French)
19. Interview (CERES Study Enumerator), Tunis: October 28, 1998. (French)
20. Interview (Community Leader), Haddej: October 30, 1998. (French/Arabic)
21. Interview (Journalist), Douz: November 2, 1998. (French)
22. Interview (Community Leader), El-Hamma: November 16, 1998. (French)
23. Interview (Public HS Teacher), Tataouine: November 19, 1998 (French/Arabic)
24. Interview (Public HS Teacher), Tataouine: November 20, 1998 (English)
25. Interview (Public HS Teacher), Tataouine: November 21, 1998 (French)
26. Interview (Public HS Teacher), Tataouine: November 21, 1998 (French)
27. Interview (CERES Study Enumerator), Tunis: November 25, 1998. (French)
28. Interview (CERES Study Enumerator), Tunis: November 25, 1998. (French)
29. Interview (Ministry of Economic Dev. Representative), Tunis: November 26, 1998. (French)
30. Interview (UNFPA Representative), Tunis: January 11, 1999. (French)
31. Interview (MOPH Representative), Tunis: January 11, 1999. (French)
32. Interview (UNESCO Representative), Tunis: January 13, 1999. (French)
33. Interview (UNICEF Representative), Tunis: January 13, 1999. (French)
34. Interview (Professor of Medicine and Physician), Tunis: January 13, 1999. (French)
35. Interview (JMSF Representative), Tunis: January 14, 1999. (French)
36. Interview (DSSB Representative), Tunis: January 26, 1999. (English)
37. Interview (Journalist), Tunis: January 27, 1999. (French)
38. Interview (Historian), Tunis: January 27, 1999. (French)
39. Interview (Academic), Tunis: January 28, 1999. (English)
40. Interview (UNFT Representative and Physician), Tunis: January 28, 1999. (French)
41. Interview (UNFT Representative), Tunis: January 28, 1999. (French)
42. Interview (Historian), Tunis: January 28, 1999. (French)
43. Interview (UNFT Representative), Gabes: February 4, 1999. (French)
44. Interview (UNFT Representative), Gabes: February 4, 1999. (French/Arabic)
45. Interview (UNFT Representative and Teacher), Gabes: February 4, 1999. (French)
46. Interview (UNDP Representative), Tunis: February 8, 1999. (English)
47. Interview (Lawyer), Tunis: February 23, 1999. (English)
48. Interview (CERES Representative), Tunis: February 24, 1999. (French)
49. Interview (Academic Researcher), Tunis: February 24, 1999. (English)
50. Interview (RTT Representative), Tunis: February 27, 1999. (French)
51. Interview (RTT Representative), Tunis: February 27, 1999. (French)
52. Interview (RTT Representative), Tunis: February 27, 1999. (French)

53. Interview (RTT Representative), Tunis: March 1, 1999. (French)
54. Interview (Professor of Law), Tunis: March 17, 1999. (French)
55. Interview (Professor of Medicine), Sousse: March 18, 1999. (French)
56. Interview (UNFT Representative), Ain Draham: March 23, 1999. (French)
57. Interview (MOPH Representative-Béja), Tunis: March 25, 1999. (French)
58. Interview (Academic), Tunis: March 30, 1999. (English)
59. Interview (Lawyer), Tunis: March 30, 1999. (French)
60. Interview (ACT Representative), Sidi Bouzid: April 1, 1999 (English)
61. Interview (MOPH Representative), Sidi Bouzid: April 2, 1999 (French)
62. Interview (Regional Director of the ONFP), Tataouine: April 12, 1999.
63. Interview (ONFP Representative), Tataouine: April 12, 1999. (French)
64. Interview (RTT Representative), Tataouine: April 13, 1999. (Arabic)
65. Interview (Historian), Tataouine: April 14, 1999. (French)
66. Interview (MOPH Representative), Sidi Bouzid: April 18, 1999. (French)
67. Interview (Researcher in Psychology), Tunis: May 3, 1999. (French)
68. Interview (University Professor), Tunis: May 5, 1999. (English)
69. Interview (AFTURD Representative), Tunis: October 1999. (French)
70. Interview (Academic), Tunis: October 1, 1999. (French)
71. Interview (ONFP Representative), Tunis: October 4, 1999. (French)
72. Interview (University Professor), Tunis: October 5, 1999. (French)
73. Interview (ATFD Representative and Academic), Tunis: October 11, 1999. (French)
74. Interview (ATFD Representative and Psychologist), Tunis: October 11, 1999. (French)
75. Interview (ATFD Founding Member and Academic), Tunis: October 12, 1999. (French)
76. Interview (ATFD Representative and Physician), Tunis: October 15, 1999. (French)
77. Interview (ATFD Representative and Lawyer), Tunis: October 15, 1999. (French)
78. Interview (ENDA Representative), Tunis: October 15, 1999. (English)
79. Interview (Academic), Tunis: October 18, 1999. (French)
80. Interview (Professor of Political Science), Tunis: October 19, 1999. (French)
81. Interview (Academic), Tunis: October 19, 1999. (French)
82. Interview (ONFP Representative), Tunis: October 21, 1999. (French)

Traditional Health Service Providers

1. Interview (TBA), El-Hamma: November 16, 1998. (Arabic)
2. Interview (TBA), El-Hamma: November 16, 1998. (Arabic)
3. Interview (TBA/Mabrouka), Tataouine: November 20, 1998. (Arabic)
4. Interview (TBA), El-Jem: February 12, 1999. (Arabic)
5. Interview (Traditional Healer), Gabes: February 13, 1999.
6. Interview (TBA), Douz: February 15, 1999. (Arabic)
7. Interview (TBA/Halima), Douz: February 15, 1999. (Arabic)
8. Interview (TBA), Kasserine: March 12, 1999. (Arabic)
9. Interview (TBA/Khalti Fatma), Kasserine: March 14, 1999. (Arabic)
10. Interview (TBA), Sidi Bouzid: April 2, 1999. (Arabic)
11. Interview (Traditional Healer), Ancienne Matmata: April 6, 1999. (Arabic)
12. Interview (TBA), Ancienne Matmata: April 6, 1999. (Arabic)
13. Interview (TBA), Haddej: April 7, 1999. (Arabic)
14. Interview (TBA), Haddej: April 7, 1999. (Arabic)
15. Interview (TBA), Nouvelle Matmata: April 7, 1999. (Arabic)
16. Interview (TBA), Médenine: April 7, 1999. (Arabic)
17. Interview (TBA), Médenine: April 8, 1999. (Arabic)
18. Interview (TBA/Azziza), Douriet: April 9, 1999. (Arabic)
19. Interview (TBA), Tataouine: April 9, 1999. (Arabic)
20. Interview (TBA), Douriet: April 10, 1999. (Arabic)
21. Interview (TBA/Aisha), Douriet: April 10, 1999. (Arabic)
22. Interview (Traditional Healer), Tataouine: April 12, 1999. (Arabic)
23. Interview (TBA), Tataouine: April 12, 1999. (Arabic)
24. Interview (Traditional Healer/Pharmacist), Tunis: October 7, 1999. (Arabic)
25. Interview (Traditional Healer/Pharmacist), Tunis: October 7, 1999. (Arabic)
26. Interview (Traditional Healer/Pharmacist), Tunis: October 7, 1999. (Arabic)

27. Interview (Traditional Healer/Pharmacist), Tunis: October 7, 1999. (Arabic)
28. Interview (Traditional Healer/Pharmacist), Tunis: October 7, 1999. (Arabic)

Oral History Project

1. Interview, Siliana: August 13, 1998. (English)
2. Interview, Siliana: August 15, 1998. (Arabic)
3. Interview, Siliana: August 17, 1998. (Arabic)
4. Interview (Afef), Tunis: August 27, 1998. (French)
5. Interview, Tunis: August 28, 1998. (French)
6. Interview, Tunis: September, 1998. (English)
7. Interview, Tunis: September, 1998. (Arabic)
8. Interview, Tunis: September 10, 1998. (Arabic)
9. Interview, Tunis: September 21, 1998. (Arabic)
10. Interview (Houda) Tunis: October 5, 1998. (Arabic)
11. Interview (Jamila), Tunis: October 5, 1998. (French)
12. Interview, Tunis: October 7, 1998. (French/Arabic)
13. Interview (Aida), Tunis: October 28, 1998. (French)
14. Interview, Tunis: October 28, 1998. (French)
15. Interview, Tunis: November 4, 1998. (English)
16. Interview, El-Hamma: November. (Arabic/French)
17. Interview, El-Hamma: November. (Arabic)
18. Interview, El-Hamma: November 14, 1998. (French)
19. Interview (High School Student), El-Hamma: November 14, 1998. (French)
20. Interview (Nabila), El-Hamma: November 16, 1999. (Arabic)
21. Interview, El-Hamma: November 16, 1999. (Arabic)
22. Interview, El-Hamma: November 17, 1998. (Arabic)
23. Interview (Salima), El-Hamma: November 18, 1998. (Arabic)
24. Interview, El-Hamma: November 18, 1998. (Arabic)
25. Interview, Tataouine: November 20, 1998. (French)
26. Interview, Tataouine: November 20, 1998. (Arabic)
27. Interview (Miriam), Tunis: January 1999. (French)
28. Interview, Tunis: January 9, 1999. (English)
29. Interview, Tunis: January 17, 1999. (Arabic)
30. Interview, Tunis: January 26, 1999. (English)
31. Interview, Tunis: January 27, 1999. (French)
32. Interview, El-Jem: February 12, 1999. (Arabic)
33. Interview, El-Jem: February 12, 1999. (Arabic)
34. Interview, Gabes: February 13, 1999. (Arabic)
35. Interview, Tunis: February 24, 1999. (French)
36. Interview (Bahia), Tunis: February 25, 1999. (French/Arabic)
37. Interview, Tunis: February 26, 1999. (French)
38. Interview, Tunis: February 26, 1999. (French)
39. Interview, Tunis: February 26, 1999. (French)
40. Interview, Tunis: February 26, 1999. (French)
41. Interview, Tunis: February 26, 1999. (French)
42. Interview, Tunis: February 27, 1999. (French/Arabic)
43. Interview, Tunis: February 27, 1999. (French/Arabic)
44. Interview, Tunis: February 27, 1999. (French)
45. Interview, Tunis: February 27, 1999. (French)
46. Interview, Tunis: February 27, 1999. (French)
47. Interview, Tunis: March, 1999. (English)
48. Interview, Tunis: March 10, 1999. (English)
49. Interview, Tunis: March 10, 1999. (English)
50. Interview, Kasserine: March 12, 1999. (Arabic)
51. Interview, Kasserine: March 12, 1999. (Arabic)
52. Interview (Ahlam), Kasserine: March 14, 1999. (Arabic)
53. Interview, Tunis: March 26, 1999. (French)
54. Interview, Tunis: March 27, 1999. (French/Arabic)

55. Interview, Tunis: March 30, 1999. (English)
56. Interview, Tunis: March 31, 1999. (English)
57. Interview, Tataouine: April, 1999. (Arabic)
58. Interview, Sidi Bouzid: April 1999. (French/Arabic)
59. Interview, Sidi Bouzid: April 2, 1999. (Arabic)
60. Interview, Sidi Bouzid: April 2, 1999. (Arabic)
61. Interview, Sidi Bouzid: April 3, 1999. (Arabic)
62. Interview (Salwa), Ancienne Matmata: April 6, 1999. (Arabic)
63. Interview (Amel), Ancienne Matmata: April 6, 1999. (Arabic)
64. Interview, Ancienne Matmata: April 6, 1999. (Arabic)
65. Interview, Ancienne Matmata: April 6, 1999. (Arabic)
66. Interview, Ancienne Matmata: April 6, 1999. (Arabic)
67. Interview, Ancienne Matmata: April 6, 1999. (Arabic)
68. Interview, Ancienne Matmata: April 6, 1999. (Arabic)
69. Interview, Ancienne Matmata: April 6, 1999. (Arabic)
70. Interview, Tamezret: April 6, 1999. (Arabic)
71. Interview, Haddej: April 7, 1999. (Arabic)
72. Interview, Haddej: April 7, 1999. (Arabic)
73. Interview, Haddej: April 7, 1999. (Arabic)
74. Interview, Haddej: April 7, 1999. (Arabic)
75. Interview, Haddej: April 7, 1999. (Arabic)
76. Interview, Médenine: April 7, 1999. (French)
77. Interview, Médenine: April 7, 1999. (Arabic)
78. Interview (Rym) Médenine: April 8, 1999. (Arabic/French)
79. Interview (Hind), Médenine: April 8, 1999. (Arabic)
80. Interview, Médenine: April 8, 1999. (Arabic)
81. Interview, Médenine: April 8, 1999. (Arabic)
82. Interview, Tataouine: April 9, 1999. (Arabic)
83. Interview, Tataouine: April 9, 1999. (Arabic)
84. Interview, Tataouine: April 9, 1999. (Arabic)
85. Interview (Emna), Tataouine: April 9, 1999. (Arabic)
86. Interview (Zohra), Douriet: April 10, 1999. (Arabic)
87. Interview (Aisha), Douriet: April 10, 1999. (Arabic)
88. Interview, Douriet: April 10, 1999.(Arabic)
89. Interview, Douriet: April 10, 1999.(Arabic)
90. Interview, Douriet: April 10, 1999.(Arabic)
91. Interview, Douriet: April 10, 1999.(Arabic)
92. Interview, Tataouine: April 11, 1999. (Arabic)
93. Interview (Faouzia), Tataouine: April 12, 1999. (Arabic)
94. Interview, Tataouine: April 12, 1999. (Arabic)
95. Interview, Douriet: April 12, 1999. (Arabic)
96. Interview, Tunis: May 1, 1999. (Arabic)
97. Interview, Tunis: May 1, 1999. (Arabic/English)
98. Interview, Tunis: May 3, 1999. (Arabic/French)
99. Interview (Rouqia) Tunis: October 1999. (English/French/Arabic)
100. Interview, Tunis: October 2, 1999. (English)
101. Interview, Tunis: October 8, 1999. (French)
102. Interview, Ben Arrous: October 8, 1999 (French)
103. Interview, Ben Arrous: October 8, 1999 (English)
104. Interview, Tunis: October 9, 1999. (Arabic)
105. Interview, Tunis: October 9, 1999. (Arabic)
106. Interview (Souad), Tunis: October 9, 1999. (French/Arabic)
107. Interview (Saida), Tunis: October 9, 1999. (French)
108. Interview, Tunis: October 10, 1999. (Arabic)
109. Interview, Tunis: October 10, 1999. (English)
110. Interview, Tunis: October 13, 1999. (Arabic/French)
111. Interview, Tunis: October 15, 1999. (French)
112. Interview, Tunis: October 16, 1999. (French)

113. Interview, Tunis: October 21, 1999. (Arabic)
114. Interview, Tunis: October 21, 1999. (French)
115. Interview, Tunis: October 21, 1999. (French)
116. Interview, Tunis: October 21, 1999. (French)
117. Interview, Tunis: October 21, 1999. (Arabic)
118. Interview (Kauther), Tunis: October 22, 1999. (English)
119. Interview, Tunis: October 22, 1999. (French)
120. Interview, Tunis: October 22, 1999. (French/Arabic)
121. Interview (Imen), Tunis: October 22, 1999. (English)
122. Interview, (Hager) Tunis: October 22, 1999. (English)
123. Interview, Tunis: October 25, 1999. (French)
124. Interview (Noura), Tunis: October 26, 1999. (Arabic)
125. Interview, Tunis: October 26, 1999. (French/Arabic)
126. Interview, Tunis: November 1, 1999. (French)
127. Interview (Lamia), Tunis: November 1, 1999. (French)

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