Chapter 2

Female Bodies, Contraception and Reproductive Norms

On a cold and humid January morning, while I was attending daily consultations in the family planning unit of Hospital T, a woman in her late thirties came into the room and asked a midwife to remove a hormonal implant (*gheraset*, or *'urf*) that she had being wearing for nine months because 'it was bothering her' (*yataqal-laqni*), (fieldnotes, 7 January 2014). When the midwife asked her to explain in more detail how the implant had affected her health, the woman complained about 'pain in her arm, her hip and even in her scalp'.[1] She also added that she had 'frequent spotting and therefore was seldom "clean"' (*nadhifa*). The midwife asked the woman if she had taken the vitamins that had been prescribed for her and explained that at least six months must pass before 'the body acquires a regular rhythm'. The midwife also added that the implant modifies hormonal production so that the woman would not have her monthly period. She stressed that this does not mean that the woman is pregnant. To clarify the effects of the implant's hormones, the midwife showed the woman two colour images from a booklet on her desk.

These images are meant to help patients understand the biomedical model of the body; they show a stylised female body in which the brain, ovaries and uterus are the only visible parts, as well as graphics that indicate the hormone levels related to the three mentioned organs. These illustrations are designed to show the effects that hormonal contraceptive methods have on the physiology of the brain, ovaries and endometrium. The midwife

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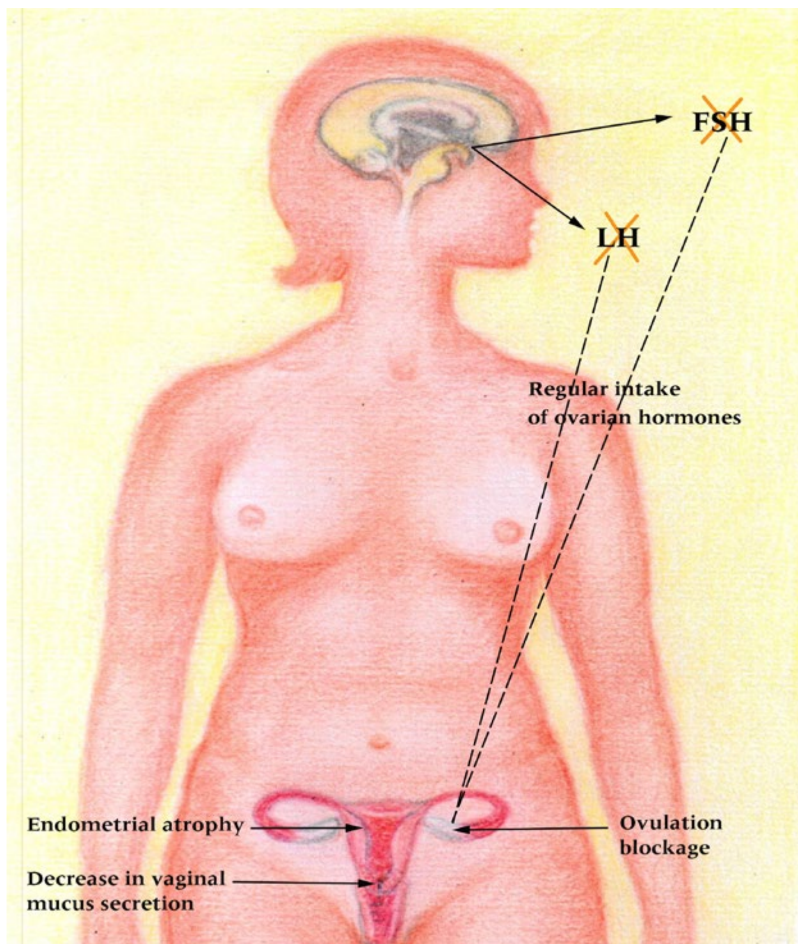

FIGURE 2.1 Image from a booklet used to explain the effects of hormonal contraception. Drawing by Marina Centonze, labelled by the author.

had good intentions, but I found that, in most situations, her patients did not understand these images, in large part because the majority of them had little education; some were even illiterate. My impression was that, for many women, looking at these drawings was like reading text in an unknown language. Based on the patients' reactions, most women (including contraception users) did not understand what the midwife was saying – despite her well-meaning efforts.

After listening to the midwife, the woman insisted on having her implant removed because she also felt pain in her heart. The

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midwife argued that the implant has no effects whatsoever on the heart and asked the woman to describe the quality and quantity of her periodic bleeding. At this point, the woman removed her trousers and underwear and showed the midwife a small piece of cloth with traces of blood. Instead of recognising the patient's complaints and accepting her request, the midwife argued that the problem was not with the implant but with the woman's endometrium. The midwife went on to say that she wanted to have a clear idea of the frequency and quantity of bleeding before continuing; she then handed the woman a menstrual calendar to complete during the following months. Because the midwife did not seem convinced of the necessity of removing the implant, the woman added that her husband 'was very unhappy' and was afraid of having sexual intercourse while she was bleeding because of the religious prohibition on sex during the menstrual period. The midwife replied humorously, saying that the woman should tell her husband that, if he does not want to make love, she would say *bislema* (goodbye); the provider also suggested that the woman and her husband should make love with only a *veilleuse* (night light) so that he cannot see the traces of blood. Anyway, the midwife decided to prescribe the patient a month-long treatment of Microval[2] (a progestin-only pill) to 'see what would happen'. At the end of the consultation, the practitioner also suggested that the woman have a third child (as she was already in her late thirties), but the patient vigorously rejected that idea, claiming that her personal situation did not allow her to have another child.

Conceptions of the Body

This ethnographic fragment concerns several considerations about contraceptive practices in Tunisia. One aspect is related to the model of female physiology that many Tunisian women I met – especially those who were poor and or had little education – shared. After a few months of research, I noticed that many of the public clinic users were suspicious of biomedical contraceptive methods and complained about recurrent symptoms while using them. An experienced midwife patiently explained to me that many Tunisian women conceive of the body in a way that differs from the biomedical model. She said that women consider menstrual blood to be a dirty fluid (*wasakh*) that the body has to regularly get rid of because retaining it can supposedly cause cancer or infectious disease (Maffi

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and Affes 2017). Many of these women had a somatic condition that had caused interruptions in their menstrual cycles, and they described this condition in terms of filth from menstrual blood accumulating in their bodies, leading to swelling and a build-up of toxic substances. They also described sensations of exhaustion and suffocation. These women justified their requests to end their contraception (e.g. have their implants removed, stop taking pills or end the administration of injectable medications) by saying that they needed 'to breathe' or 'to rest'.

In Tunisia, most of the women and healthcare providers whom I met in public clinics emphasised the hygienic aspect rather than the ritual and legal nature of menstrual blood. Although the ritual aspect is not absent (as shown in the consultation described above), the usual language for speaking about blood coming out of a woman's uterus is permeated with images of uncleanliness, accumulation and poisonous substances, as compared to the cleanliness and discharge of a healthy and uncontaminated body. In Tunisia, menstruation (*dawra*) is also called *ghassala*, a word that derives from the Arabic root *gh-s-l* (to wash, to clean), which is also the root of the term *ghusl* (the major ritual ablution); this term clearly alludes to the cathartic nature of menstrual blood. The suffocation metaphors that women commonly used are extremely interesting in that they are reminiscent of a pathological condition from ancient Greek medicine called 'suffocation of the matrix', which refers to the retention of menstrual blood within the uterus; this concept remained current in European medicine until modern times (Van de Walle and Renne 2001). A midwife also told me that many of her patients view their uterus as a bag that retains whatever enters into it and thus needs to be regularly cleaned and emptied.[3]

Many women's representation of female physiology is related to old Arab-Islamic medical theories, which, in turn, are based on ancient Greek medicine. Ibn Sina and Ibn Rushd creatively incorporated the Hippocratic and Galenic traditions together with Aristotle's theories about human conception (Inhorn 1994); in addition, Al-Suyyuti, the author of *The Medicine of the Prophet*, placed those theories at the origin of prophetic medicine (Del Vecchio Good 1980). In particular, 'the idea of menstruation as cleansing' that 'dominates the Hippocratic tradition' (Van de Walle and Renne 2001: xix) was very much alive in the representations and bodily experiences of many of the clinic users I observed. In pre-modern and modern Europe and in the Arab region, amenorrhea without pregnancy was deemed to be caused by an excess of blood in the

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body; this pathological state was called *plethora* in Latin. In fact, for many centuries, two interpretations, based on humoral medicine, coexisted: the first sees excess blood in a woman's body as pathological (the plethoric model), and the second considers such accumulated blood to contain toxic substances that cause female disorders (the cathartic model; Stolberg 2005). Van de Walle and Renne stress the longstanding influence of these conceptions in the Western medical tradition, noting that 'any book on official or home medicine for treating women's diseases written in Europe between the fifth century B.C. and the beginning of the twentieth century discusses the retention of menses as a pathology' (2001: xxi).

Researchers have proven the diffusion and persistence of this model of female physiology in the Arab-Islamic world via ethnographic works conducted in Iran (Del Vecchio Good 1980), Turkey (Delaney 1991), Egypt (Abu Lughod 1989; Ali 2002; Inhorn 1994, 1996) and Morocco (Mateo Dieste 2013). In these countries, menstrual blood is described as a ritual and physical pollutant; a danger for plants, animals and (especially) men; a contaminant; and a source of shame (Delaney 1991; Dwyer 1978; Saadawi 1980). In the Turkish village where Delaney (1991) conducted her research, menstruation was considered an illness and as a reminder of a woman's physical imperfection; it was commonly designated with a term that means soiled, blemished or canonically unclean. Among the Awlad Ali (Abu Lughod 1989), menstruation contributed to a culture in which women were seen as lacking self-control and independence[4] (two of the most cherished values in that society). Both the Turkish peasants depicted by Delaney and the Awlad Ali Bedouins studied by Abu Lughod considered menstruation to constitute a punishment that was inflicted on Eve (and thus all women) after she disobeyed one of God's orders. Among the Awlad Ali, menstruation was deemed to make women permanently less pure and less pious than men, even before menarche and after menopause. In contemporary Morocco, menstruation generates very negative feelings and representations among both women and men; according to Mateo Dieste (2013: 144), it can even engender fear and horror and cause women to be seen as contaminated. In rural areas of Morocco, mothers present the menstrual cycle to their daughters as a curse and describe menstrual blood as dangerous. This interpretation is extreme, as it characterises a woman as religiously impure (just like other fluids and excreta of the human body). Surah 2:222 of the Quran explicitly prohibits

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sexual intercourse during menstruation: 'The question thee (O Muhammad) concerning menstruation. Say: It is an illness, so let women alone at such times and go not unto them till they are cleansed' (quoted in Delaney 1991: 94). According to the legal Islamic tradition, menstrual blood is a major impurity (*janaba*) in a category with lochia and sperm, but the other bodily products are only minor impurities (*h'adath*) (Bouhdiba 1986: 61).[5]

Bouhdiba (1986) examines in detail the hygienic and ritually defined practices that Muslims have to follow if they want to be religiously pure. All excreta – semen, milk, post-partum discharges, urine, faecal matter, blood, pus and so on – create a state of defilement that has to be overcome via specific rituals in order to re-establish religious or legal purity. Because menstruation, lochia and the products of sexual intercourse (sperm and the female humours) are major impurities, Muslims must practise *ghusl* (major purification) to eliminate them. *Ghusl* consists of washing the whole body (including the hair) to remove the state of ritual impurity.

Menstruation in Popular Culture and in Sunni Islam

Bouhdiba stresses that, although menstruation is considered particularly repellent in popular culture (1986: 68), the Sunni Islamic legal tradition does not confer on women a permanent status of impurity. During the menstrual period, women have to avoid praying, touching the Quran or other sacred texts, and entering mosques or saints' tombs; they also cannot fast during Ramadhan and cannot go to Mecca for pilgrimage during this time.[6] As mentioned above, women and men both must abstain from sexual intercourse during the menstrual period and during the first forty days of the legally defined post-partum period (*couches légales*) (Bouhdiba 1986: 69). These restrictions are removed once women recover their legal and ritual purity.[7] It is important to distinguish between the popular conception of menstruation – which emphasises menstrual blood's filth and ostensibly dangerous qualities (Abu Lughod 1989; Delaney 1991; Dwyer 1978; Inhorn 1994) related to hygiene (*nadhafa*) – from the legal and religious definition of menstrual blood as a major impurity (*janaba*) (Mateo Dieste 2013). The view of menstrual blood[8] as shameful, filthy and defiling (thus making the female body impure) still permeates the mind set of Tunisian teenagers, as the sociologists Dorra Mahfoudh Draoui and Imed Melliti documented (2006: 116–20). This research forms a striking continuity with the past, as Lilia Labidi [9] showed in a study on women's sexuality during the 1980s:

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> Men's disgust about women's blood and every smell that their body emanates induce female subjects to experience their own body according to the male view, which means that it is apprehended as flawed, "stinking", a harmful malediction, an object of defilement and subordination, hardly mastered by women in the critical moments of their existence: defloration and childbirth . . . (1989: 199).

It is no coincidence that many women I met in ONFP clinics defined themselves as sick (*maridha*) when they were menstruating. Local culture defines menstruation as a sickness, and these women have been told from a young age that because their menstrual blood is impure and dirty it must be hidden from other people. They experience their bodies through categories dominated by men's perceptions and concerns that nonetheless define collective and individual affective states, symbols, spaces and behaviours related to menstruation or other female bodily functions. Thus, the Tunisian women I met manifested 'somatic modes of attention' that are 'culturally elaborated ways of attending to and with one's body' rather than 'biologically determined' perceptions (Csordas 1993: 140).[10] The perception of menstrual blood as dirty and shameful produces specific modes of attention in Tunisian women, thus eliciting culturally specific perceptions and experiences. Moreover, these modes of attention related to menstruation (or lack thereof) are also class-related, as Delanoë et al. (2012) demonstrate in a study on menopause among Tunisian and French women. Ambivalence in the semantics of menstruation – which is also present in other contexts, including in Brazil (Sanabria 2016), the United States (Martin 1987) and France (Delanoë 2007) – exists in Tunisia. There, despite its negative associations, menstrual blood is also a symbol of fertility. Having a menstrual cycle is associated with procreation, sexual desirability, youth, beauty and social value, as the feminine identity is strongly connected with maternity and fertility (Delanoë et al. 2012). This side of the semantic networks related to menstruation is illustrated by a short story that a doctor at an ONFP clinic once told me. A relative of hers had undergone a hysterectomy and had decided to hide it from her husband out of fear that he would neglect her and look for another woman, even though they already had children.[11] She told her husband that the operation she underwent was meant to remove a uterine fibroid; every month, she simulated the menstrual cycle by buying and throwing away pads as if she had used them (fieldnotes, 24 January 2014). The woman performed this mimicry to keep her feminine identity in the eyes of her husband, as fertility is central to that identity.

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Popular and Biomedical Semantic Networks

The metaphors described above are related to the popular Tunisian model of physiology and are present in the language of not just patients but also health providers, who refer to these images to help patients understand concepts. Although biomedical literature has been translated into Arabic and although technical expressions exist to describe every condition, anatomical part and physiological process, the latter are seldom used in favour of more popular and understandable terms. There is thus disparity between healthcare providers' biomedical representations of the female body and the language that they use with less educated patients (which is based on a different physiology). This difference is reinforced by the providers' use of French terms to define medical conditions, diagnoses and therapies (personnel are trained in French). An example can help clarify the coexistence of these two systems, a coexistence that is present in other contexts of the Middle East as the works of Mary-Jo Del Vecchio Good (1980) in Iran and Marcia Inhorn (1994, 1996) in Egypt reveal. Women who undergo medical abortions sometimes do not expel all the material within the uterus; in French, this condition is known as *rétention partielle* (partial retention)[12] and corresponds to the biomedical model of it. If there is partial retention, then the midwife or doctor usually informs the woman that the abortion was incomplete and that she will require further treatment. If a patient is not well educated, the provider does not use the word 'retention' and instead says that 'there is still filth' (*famma wasakh*). It is clear that the French biomedical term is conceptually and symbolically very distant from the Arabic expression. The two terms are part of different semantic networks (Good 1977) in that they not only refer to different medical models but also belong to different 'domains of meaning associated with core symbols and symptoms . . ., domains which reflect and provokes forms of experience and social relations . . .' (Good 1994: 54).

The coexistence of the biomedical and popular semantic networks allows for a better understanding of why patients often misunderstand (or are uninterested in understanding) health providers' attempts to explain the effects of hormonal contraception. The articulation of these two models generally follows educational, linguistic and socio-economic lines; those who belong to the middle or upper class and who have secondary or university education generally use the biomedical discourse, but poor and undereducated people generally adhere to the popular physiology of the female body. Despite their

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use of the biomedical model, upper-class women can also be hostile to (or at least suspicious of) hormonal contraceptives; several times I heard educated women, including doctors, say that they favoured 'natural methods' (such as periodical abstinence or retreat) over biomedical contraceptives. Their reasons included the belief that hormonal contraception interferes with ordinary physiology and that it can have harmful effects.[13] However, those same healthcare providers, including those who work in ONFP clinics, considered natural or traditional methods to be unreliable. They often scolded patients who used such methods and urged them to adopt more reliable methods. These providers believed that, as most of their patients are poor and have primary or no education, both the difficulties of ordinary life and their specific understanding of female physiology can be obstacles to the correct use of biomedical contraception.

Contraceptive and Reproductive Norms

Women's and providers' attitudes towards contraception constitute the second aspect of this investigation, as introduced in the ethnographic fragment at the beginning of this chapter. Firstly, it is necessary to describe the contraceptive methods that are freely available to women via local dispensaries, regional hospitals and ONFP clinics. In these three types of facilities, women can (at least theoretically) access the various biomedical contraceptive methods that the Tunisian government makes available for free: condoms, oral contraceptives (Microval and Microgynon), copper intrauterine devices (IUDs), injectable contraceptives (Depo-Provera), implants (Implanon) and (more recently) female condoms[14] and emergency contraceptive pills (NorLevo; *Manuel de références en Santé Sexuelle et Reproductive* 2013).

As in other national contexts, women are officially free to choose whichever contraceptive method they prefer, but this is often not the case in practice; their marital status, education, social class, economic situation and parity also contribute to which method they choose or are allowed to adopt (see, for example, Ventola 2016). Firstly, their choices[15] are limited by the available methods and the possibility of purchasing them: poor women usually adopt one of the contraceptive technologies offered in government clinics because other methods can be obtained only through the private sector. For example, due to cost concerns, a poor woman cannot use a hormonal IUD (Mirena)[16] or any of the contraceptive pills other than the two types offered in ONFP clinics. Though many users of public

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SRH clinics did not seem aware that in the private sector there are contraceptive methods with fewer side effects than those provided in government facilities, I often heard women ask the provider whether they could get an IUD made of silver or gold instead of the ordinary IUD made of copper. I think that the popular belief in the existence of medical devices made of more precious metals – which are not offered to government clinic users – reveals unprivileged women's consciousness about the possibility of receiving better care.

Secondly, practitioners tended to impose upon women the method they considered suitable for them. Each health provider had a medically based preference for specific methods, but all practitioners also had shared unwritten social and moral norms that they attached to certain types of contraceptive as well as the patient's socio-economic situation, age and marital status. Medical considerations are thus only one aspect that practitioners evaluate when they prescribe specific contraceptive methods, as I illustrate below.

Following Nathalie Bajos and Michèle Ferrand's terminology, these unwritten norms can be called 'contraceptive and reproductive norms' (2006). They are related to social habits, moral representations, state policies and medical logics. Although in the discourses and practices of healthcare providers these norms are conflated, they refer to two different orders of meaning. The reproductive norm refers to the desirable and socially legitimate conditions in which a child should come into the world; this includes the age of procreation for the mother and father, the family size, the relationship between the parents, their professions, the family's educational and economic situation, the family's housing and so on.

The contraceptive norm, on the other hand, refers to: 'the duty to use contraception if one does not want to have a child (dissociating sexuality and reproduction) and the necessity to adapt one's contraception to the phase of the life cycle . . .' (Bajos and Ferrand 2006: 91).

These two norms are not only related to each other but also strongly associated with the biomedical model because that model defines contracepted parental bodies as good and has a monopoly on contraceptive technologies. The superposition of these three orders of meaning – health providers' personal preferences, contraceptive and reproductive norms – is patent in the discourses of most of the healthcare providers I have met who did not limit themselves to contraceptive counselling and clinical acts and who thus transmitted many other messages. Their tasks included teaching poor and undereducated women about 'bodily regimes' (Ong 1995: 1250) with the aim of transforming them into modern and disciplined

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citizens who will take care of themselves and their families in appropriate ways.

The Reproductive Norm

To unpack these norms, I now describe each configuration of meaning, beginning with an examination of Tunisian reproductive norms as I have understood them from the consultations I attended in SRH facilities and the conversations with women and healthcare providers.

Contemporary reproductive norms include families having no more than three children – a standard that emerged more than thirty years ago. Since the 1980s, the Tunisian government has promoted small families[17] with the aim of reaching a replacement level at which the national population is stable and stops significantly increasing or decreasing. The family planning programme that the independent Tunisian government has promoted is but one element of the dramatic demographic decrease that the country has witnessed since the last decades of the twentieth century; important social and economic transformations have also played a determinant role (Vallin and Locoh 2001). Hence, within the past few decades, the total fertility rate (TFR) has dramatically decreased, reaching 2.4 in 1997 and remaining more or less stable since.[18]

The basic unit of the reproductive norm is the married couple: children are socially legitimate and welcome only within marriage. Despite this, Tunisian law – an exception within the Arab-Islamic countries – allows for the name of the mother's descent group to be given to a child born outside of wedlock, thus granting that child legitimate social status (Le Bris 2009).[19] However, unmarried mothers very often abandon their children, either because having a child compromises their possibility of marrying in the future or

Table 2.1 Evolution of the total fertility rate in Tunisia.

Year	**Total fertility rate**
1966	7.2
1975	5.8
1984	4.7
1994	2.9
1997	2.4
2000	2.0
2008	2.0
2016	2.3

Source: Evolution of the total fertility rate in Tunisia (Sandron et Gastineau (2000); Gastineau (2012); Institut National de la Statistique (2016)).

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because they are unable to take care of children without their family's help.

The ideal age at which to have a child is usually determined by both local nuptial practices and the medical model of the reproductive female body. For Tunisia in the mid-2000s, the average age of marriage was 32.9 for men and 29.2 for women (Ben Brahim 2006: 302); many women began their reproductive careers in their late twenties or early thirties. Biomedical discourses, for their part, consider that the best age for a woman to have children is between twenty-five and thirty-five years. During my fieldwork, I never heard health practitioners discuss the minimum age for which it is acceptable to have a child, but I heard innumerable people speak about the desire to 'complete the family' before the age of forty (for women). A few ethnographic snippets illustrate the kind of arguments that both the personnel of family planning clinics and patients use to justify their attitudes.

A 30-year-old woman came to the ONFP clinic where I was doing participant observation and stated that she would like to start using the IUD. The midwife took a look at the patient's medical file and realised that 'she only had one child' and therefore tried to convince her to have another one because 'she is already thirty' (fieldnotes, 27 March 2014). For a few minutes, the woman stubbornly requested the IUD, justifying her choice with the same vague argument that many patients use when looking for an abortion: *dhuruf* (which literally means 'circumstances'). This word can hint at wildly varying situations, and women usually do not go into detail unless their providers manifest a personal concern for their case.

Another woman in her early thirties came to the family planning unit of Hospital T because she wanted to get an abortion. She was not veiled, seemed to be well educated (as she spoke French with the midwife), and looked very calm. She explained that after many years of trying to conceive a baby with her husband she had gotten pregnant but now did not want to keep the baby because she was seeking a divorce. The midwife insisted that the woman wait before making such an important decision because this might be her only chance to have a child, but the woman was adamant and apparently very serene about her choice. She wanted to sever all ties to her husband, and a child would constitute a bond between them that would disrupt her attempt at complete separation. The woman eventually got the abortion that she desired.

I conversed with another woman in her early thirties in the waiting room of Hospital T; she told me that she was officially

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engaged and that she already knew her stepfamily well. She had engaged in a regular sexual relationship with her future husband and had unintentionally become pregnant. Although she was educated and economically independent, she did not want to keep the child because she was afraid of what her partner's family would say about a hastily planned wedding party that would be necessary to keep up appearances. She had not told her future husband that she was pregnant and intended to get an abortion because he would have opted to organise a quick wedding instead. She also wanted to be sure that if, in the future, something went wrong between them nobody would be able to reproach her for having married too hurriedly because of the pregnancy. She was also afraid of losing her job at the call centre where she had been working for five months, as a pregnancy would have jeopardised a regular work contract.

In ONFP clinics, women's and couples' economic and educational situations were rarely discussed because many patients belonged to the lower social classes, had only primary education or were illiterate, and were unemployed or had irregular jobs.[20] In the eyes of healthcare providers, the most desirable condition for the birth of a child was to be married and not have a large family (one with more than three children). As I discuss below, the patients' marital status and hence the legitimacy of their sexual behaviours played a crucial role in shaping the discourses and implicit norms that health practitioners applied. However, the patients' economic situations as well as their relationships with their partners and family members were very important; women tried to adapt their reproductive trajectories according to those factors. Some women needed to work – especially if their husbands were unemployed or had an irregular income; others had a desire to complete their education. Having to take care of a sick or disabled relative was also a good reason to postpone children for a few years or indefinitely. The emphasis on women's employment and education varies from one social milieu to another, and in Tunisia, most women continue to play the traditional role of mothers, wives and caregivers (Mahfoudh Draoui 2007); the maternal identity continues to be central in the definition of their social status and role.[21] Childless women are therefore stigmatised or considered to be failures, although a higher socio-economic position can reduce social blame, especially if they have built a socially recognised professional career.

During my time at the ONFP clinics, I happened to attend a few consultations in which recently married women in their late thirties had come to seek hormonal treatments to enhance their

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chances of getting pregnant. Interestingly, in some cases, these women did not think to involve their husbands in the medical consultations, despite the fact that part of the purpose was to verify whether the husbands were infertile. This attitude is understandable in light of the common and gendered representation according to which women hold the responsibility for procreation, including its failure (Inhorn 1994; Jansen 2000). More generally, as mentioned above, few men attend ONFP clinics,[22] and they are typically absent when their wives or partners consult providers on whether to adopt or change contraceptive methods (see also Chapters 1, 3 and 4 on the exclusion of men from SRH clinics). The contraceptive responsibility lies entirely with women, and healthcare providers do not mention men except in very specific cases such as when a woman has an infection that requires both her and her partner to undergo medical treatment or to adopt condoms as an additional contraceptive method.

Even when men do accompany their wives or partners to the clinics, providers often see them as intruders and try to keep them away. This happens for several reasons. Firstly, reproduction has traditionally been seen as a woman's domain that is best managed by female family members and female healers (Foster 2001; Gherissi 1992). Secondly, biomedical contraceptive technologies have strongly reinforced the feminisation of reproductive responsibility insofar as 'women are perceived and perceive themselves as the "guardians of the temple of sexual and reproductive health"' (Beltzer and Bajos 2008: 442).

Contraceptive technologies have thus far applied almost exclusively to female bodies (Oudshoorn 1994, 2003), and modern states have promoted frequent and regular access to gynaecological care for women across their life spans (Ruault 2015). These are all crucial components of the different roles that men and women play in reproduction. The large majority of Tunisian women resort to hormonal and mechanical contraceptives during their lives, and sterilisation has never been practised on men because it threatens their masculinity, which is defined by intact sexual and reproductive strength (see, for example, Inhorn 1996, 2012).

Women, Men and the Reproductive Responsibility

The feminisation of reproductive and sexual responsibility brought about by biomedical contraception was confirmed in a recent study of unmarried young men and women in Tunisia; the results show that only a small fraction of men think that they should

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take responsibility for the consequences of their sexual relationships (Gherissi and Tinsa 2017).

This confirms what I observed during my own research: the recurrent critical remarks of health providers to women who did not use contraception or who used it in what the providers saw as the wrong way are significant. I witnessed several midwives rebuke women coming to the SRH clinics for repeated abortions; they told the women that they had to use contraception (*tasbir*) and take responsibility for their careless behaviour by becoming more disciplined. However, I never heard a health practitioner mention a husband's or partner's responsibility for a woman's unwanted pregnancy. In these discourses, the husbands and partners were either absent or considered unwelcome parts of the women's decisions about contraception. One of the midwives whom I worked with had an explicit discussion with a patient who had refused to use an implant because her husband was hostile to the idea. The woman stated that a doctor with whom her husband was acquainted had told him that the *gheraset* (implant) makes women nervous and causes other side effects. The midwife was irritated and treated the intrusion of the woman's husband as illegitimate and undesirable because 'the choice of contraception should be only hers' (see also Chapter 4). She continued, saying that many doctors are ignorant about contraception and that she 'hated men meddling in their wives' affairs' for the sake of 'controlling and dominating every aspect of their lives' (fieldnotes, 7 April 2014). I also witnessed health providers reprimand women for refusing to use a biomedical contraceptive method instead of periodical abstinence (*calendrier*; literally, 'calendar method') or coitus interruptus, or for seeking to change their contraceptive method after only a few months of use. Although, especially in the first case, the male partner was clearly involved in the contraceptive practice, the midwives and doctors never mentioned them.

Whether modern contraceptive technologies are empowering or (on the contrary) oppressive devices for women cannot be determined without considering the local context and the specific situations in which they are prescribed. Each category of actor can use technologies in ways that were originally unforeseen. Indeed, users of a technical object play a crucial role in its definition and diffusion: they define the object's quality in relation to their environment, develop a practical knowledge of it that allows for its use to be made routine, and create a network to further circulate it (Akrich 2006). There is thus a 'reciprocal adjustment between the technical object

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and its environment' (Akrich 1992: 207). In the case of biomedical contraception, healthcare providers and patients can be considered two categories of users;they both use contraceptive methods but in different ways: providers apply them on women's bodies, women apply them to their own bodies. Health practitioners possess technical and scientific knowledge that patients lack but are committed to 'achieving high continuation rates' (Hardon 1992: 762); therefore, they downplay the side effects of contraceptive technologies as not important, whereas women are often more concerned about avoiding those effects as they can interfere with their ordinary lives.

The primary intention of a technical object cannot entirely determine its social use, as can be illustrated using the example of the contraceptive pill. Originally conceived of as 'foolproof birth control that would help stem population growth in underdeveloped parts of the world' (Tone 1997: 378), both doctors and population experts ended up considering it as a technology that 'only middle-class women, presumed to be white, educated, and responsible, could be "trusted" to swallow' every day for twenty-one days per month (ibid.: 380). On the contrary, the IUD was conceived as a technology under the exclusive control of healthcare providers; it was (and still is, in countries within the Global South) promoted for use among women who are deemed unwilling or unable to control their fertility (Dugdale 2000) as well as among marginalised and poor groups in the Global North (Corea 1977, Hartmann 1995, Takeshita 2010). However, in the Global North, the IUD is today used by middle-class women (Takeshita 2010) and is even recommended for young nulliparous women who do not want to take hormonal contraceptives (Lohr, Lyus and Praeger 2017).

Although they disagree,[23] several European and North American feminist scholars have criticised the effects that the introduction of biomedical contraception has had on women's lives, in that they reinforce women's social and moral responsibility in the domain of sexuality and reproduction (Bajos and Ferrand 2004; Giami and Spencer 2004; Krasnow 2007; Oudshoorn 2007 quoted in Ventola 2014). These methods can also cause somatic troubles, psychic constraints and social abuse (Hardon 1992, 1997; Hartmann 1995). Despite the 'biotechnological inequality' of modern contraception (Fennell 2011: 515), some Tunisian activists have argued that, in North African societies, biomedical contraception offers women control of their own bodies independently of their partners, thus granting women the possibility to make reproductive decisions without male interference (Maffi, Delanoë and Hajri 2017). This

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position can be interpreted in light of studies whose results indicate that

> responsibility for contraceptive decision making is so firmly masculinized in many developing countries that the theme of "covert contraceptive use" has emerged among researchers to refer to the frequent phenomenon of women in these societies using contraceptive methods deliberately without telling their partners. (Fennell 2011: 498)

I do not share the assumption made by the researchers in these studies – according to which, women in developing countries are oppressed but those in developed countries are not. However, I do believe that states' coercive family planning policies – as well as institutional practices, legal and social inequalities, patriarchal norms, insufficient medical facilities and economic vulnerability – place a greater burden on women living in the Global South (Dudgeon and Inhorn 2004) than on those in the Global North. If men play a very important (and often ignored role) in women's reproductive decisions, other family members, and specifically mothers-in-law, are also crucial actors in women's ability to exercise their agency, as shown, for example, in Marcia Inhorn's works on infertility in Egypt (1994, 1996), Emma Varley's research on Islamic family planning in Pakistan (2012) and my own study on childbirth practices in Jordan (Maffi 2012).

Hence, the forms of agency that biomedical reproductive technologies can generate need to be examined within specific political, social, cultural and economic arrangements that determine the ways in which actors use them. An ethnographic fragment helps to illustrate this complexity.

A woman in her early thirties and a mother of one came to Hospital T to get an abortion. During the medical interview with a midwife, she started crying and said that she would like to keep the pregnancy but that her husband did not want to have another child at that time. The woman had tried to persuade him to keep the child, but he was adamant. She was afraid that, if she did not end the pregnancy, it would affect her marriage or even induce her husband to leave her. The midwife asked whether he would be willing to come to the hospital to discuss it, but she said that he was unwavering. Eventually, the midwife advised the woman to accept her husband's decision but to change her discourse in order to make the abortion appear to be her own decision. She suggested that the woman tell her husband that she had realised that she did

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not want to have another child and that the abortion was her decision. Although forced to accept her husband's will, the woman thus resorted to a trick to reaffirm her autonomy, at least in front of him.

In this case, abortion technologies – which are liberating for women who do not want to have (more) children – have become an instrument of oppression. The ambivalence of abortion and contraceptive technologies is clear in certain cases; as already noted, in Tunisia, these methods were introduced to limit population growth rather than to empower women, and health practitioners have often used them coercively. Forms of coercion that contradict the rhetoric of sexual and reproductive rights are still present in the country,[24] as I observed in ordinary interactions between health practitioners and women at the clinics. However, this coercion was probably less violent than it was in earlier periods and was reserved mainly for poor and undereducated women who cannot access the private sector. Ridha Gataa, an official and previous president of ONFP, noted that staff youth-friendly clinics continue to deal with young women according to traditional views of sexual conduct; as a consequence, patients at ONFP clinics are confronted with 'a lot of external control and a lack of freedom' (Gataa 2008 quoted in Hassairi 2009: 19; see also Ksontini 2017). Getting an abortion in the private sector is very easy for women who can afford it; moreover, users of private-sector clinics are not subject to moralising and stigmatising discourses. This category of women also has a wider choice of contraceptive methods, including options that are available only in pharmacies or from private gynaecologists.

The Contraceptive Norm

I now turn to the contraceptive norm that emerged during the consultations in ONFP clinics. A clear distinction is to be made between the contraceptive norm that is applied to married and unmarried women. Although this distinction can also be observed in countries such as France and the United States (Bajos and Ferrand 2004; Takeshita 2010; Thomé 2016), the logics behind it are different because, in Tunisia, they include a strong moral and religious stigmatisation of unmarried women that is absent (or less present) in the other mentioned countries. I begin with the investigation of the contraceptive norm for married women whose sexuality in particular is socially, legally[25] and religiously legitimate. After marriage, couples do not generally adopt a contraceptive method because they are expected to procreate as soon as possible to prove that they are fertile.[26] Social and family pressure to quickly procreate is still

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very strong, although today a minority of young married couples, especially of the middle and upper class, wait some months or a few years before procreating. However, unless they have infertility problems, most women I met in ONFP clinics had their first child within one year after marrying, as I could easily verify in their medical records. Once they have their first child women are usually offered the pill, the IUD or, more rarely, the implant or injectable. A considerable number of midwives discouraged women from using the IUD before the birth of their second child, perpetuating the idea – that was internationally consolidated in the 1980s – that this method can cause sterility. The origin of this idea is probably related to the tragic affair of the Dalkon Shield, which occurred in the United States in the 1970s and 1980s and caused the almost complete withdrawal of the IUD as a contraceptive method (Hartmann 1995, Takeshita 2010).[27] Although not all practitioners shared the idea that the IUD should not be used before the birth of the second child, it was regularly communicated to patients by several health providers. On the contrary, after two or more children have been born, the contraceptive norm that most midwives seemed to recommend is the IUD because artificial hormones were often considered to have harmful side effects. Only a few midwives I met encouraged the use of hormonal contraceptives, especially the implant, because it is effective for three years and releases hormones daily and in small doses, contrary to the injectable, which has to be renewed every three months and contains a high dose of hormones administered in one shot. Health providers often considered the implant and IUD to be more reliable, especially if their patients were impoverished and not well educated, because their use is not dependent on the latter's will. Most women I met in ONFP clinics or at Hospital T either agreed with the providers' choice of contraceptive or had a very difficult time negotiating their preferred means or a change of contraception. For example, once a woman had adopted a type of contraceptive that was suggested and controlled by the health practitioner, it was extremely difficult to convince him/her to remove it. The various side effects of each contraceptive method were the main reasons women gave when they asked to change it. Despite women's complaints, the personnel often downplayed their discourses by arguing that women were imagining and exaggerating side effects or were unwilling to accept the small drawbacks that came with contraception as illustrated at the beginning of this chapter.[28] The incompatibility of the popular physiological model described above and the biomedical paradigm shared by health practitioners played a

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major role in the miscommunication between them and clinic users. For example, I once heard a midwife scold a woman because she was complaining about the side effects of the implant and wanted it to be removed. The woman said that her legs and hands were swollen, that she had gained weight and had stopped menstruating. The health provider said, using an emphatic tone, 'you want everything: to avoid pregnancy and the side effects of contraception!' (fieldnotes, 14 April 2014). The woman insisted that her blood was suffocating her body as it could not be replenished each month and that she needed to rest (*tartahu*) because 'the implant (*gheraset*) made her tired'. The midwife emphasised that her ovaries and uterus 'rest' when she is under the effects of the implant rather than when she does not use contraception. The woman did not accept this explanation, but her implant was not removed; instead, she was prescribed a pill to take for the next three months in order to provoke an artificial menstrual cycle (withdrawal bleeding).

Other women wanted the IUD removed because of backache, long and heavy menstrual periods or because their husband was bothered by the rope during sexual intercourse.[29] These arguments were usually rejected by the ONFP clinics' staff members and considered as pretexts. Their resistance to abide by the women's desire to have the IUD removed and adopt another means, usually the pill, was even stronger when the woman had already had one or more abortions. The personnel believed that some women were unable to correctly use the pill and thus exerted pressure on them to use a technology that they did not directly control.

Despite the contraceptive norm that health providers in the public sector promoted for married women, recent ONFP statistics (Annual Report 2016) indicate that the pill is the most used biomedical method of contraception, followed by condoms and the IUD; implants and injectable medications are far less frequently chosen (Institut National de la Statistique 2016).[30] Until the 1990s, the IUD was the most used biomedical contraceptive method, followed by tubal ligation, which was largely employed from the mid-1970s through the mid-1990s.[31] An important change took place in contraceptive practices among married women during the 2000s.[32] The IUD – which was still the most-used method in 2006 – was abandoned by almost half of its users (from 46% to 25.3%), whereas the pill was used by 19 per cent of married women (MICS 2013). Tubal ligation is no longer available in ONFP clinics: in 2006, almost 10 per cent of women were still using it, but in 2012 that number had dropped to only 3 per cent (ibid.).

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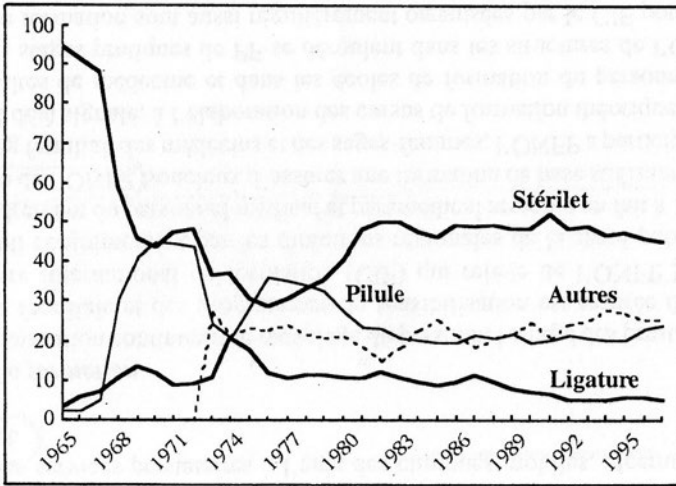

FIGURE 2.2 Evolution of contraceptive use by type. Scan of a figure from the book *Population et Développement en Tunisie: La métamorphose*, edited by J. Vallin and T. Locoh (Cérès Editions, 2001), published with permission. Translation: Pilule: Pill; Stérilet: IUD; Ligature: Tubal ligation; Autres: Others.

I believe that the recent and rapid evolution of contraceptive practices must be seen in relation to the already mentioned laissez-faire attitude of the Tunisian state, which, in the late 1990s, strongly reduced its commitment to population policies after the demographic transition took place in the country. By the end of the 1990s, the reproductive behaviours of Tunisian citizens significantly corresponded to what the independent state had planned and struggled to attain since the mid-1960s. As unanimously affirmed by the Tunisian health providers with whom I spoke, over the last fifteen years family planning policies have ceased to be a national priority. At the same time, international and foreign aid agencies such as the WHO, the World Bank and USAID, which have played a major role in the past, have stopped funding local programmes in the domain of reproductive health (Paulet and Gachem 2001).[33] The necessity of controlling the natality rate had pushed the Tunisian state to adopt contraceptive practices that aimed less to allow its citizens to freely plan the size of their family than to authoritatively limit it in order to trigger the socio-economic development of the country (see Introduction). Therefore, these factors lost their importance; more freedom was left to Tunisian citizens to take autonomous reproductive decisions that were, however, determined by a family model and

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lifestyle that had significantly changed. Thus, it became less important to impose contraceptive methods that only health providers could control (such as the IUD) or that were definitive (such as tubal ligation) for women. Tubal ligation has become impossible to obtain because the operation is a burden for the impoverished and under pressure public health system. Many times I attended consultations in which women asked to have a tubal ligation because they could not tolerate the side effects of regular contraception but were denied it.

Premarital Sexuality

To understand the contraceptive norm for unmarried women, it is necessary to describe the local moral and social rules that apply to premarital sex.

First of all, it has to be said that sexual relationships outside of wedlock are socially and religiously condemned. However, it is not punished by law if the individuals concerned have reached the age of consent[34] and it does not happen in public places (Hrairi 2017; Voorhoeve 2017). Stigmatisation and moral condemnation was palpable in the attitudes, gaze, voice and words of many health professionals working in ONFP clinics, including the personnel in charge of the youth-friendly clinics (*fadha sadiq li-al-shebab*), who are officially trained to offer services to unmarried individuals 'without judgment and lessons of morality, despite their age and even if they are very young' (*Manuel de référence en santé sexuelle et reproductive* 2013: 18).[35] It must also be stressed that the moral condemnation of unmarried individuals visiting the family-planning clinic was particularly strong because they are mostly women. Indeed, if Islamic moral precepts condemn both men and women who have sexual relationships outside of marriage (Bouhdiba 1986), the patriarchal moral regime (Morgan and Roberts 2012) dominating Tunisian society only stigmatises women's sexuality (Ben Dridi and Maffi 2018; Labidi 1989; Mahfoudh and Melliti 2006). Dominant social codes prescribe that a woman be a virgin and inexperienced and a man be sexually active and mature when the time of marriage comes. In this field, social norms do not seem to have significantly changed since the promulgation of the CPS, as emphasised in several socio-anthropological studies.[36] Nedra Ben Smaïl, a Tunisian psychoanalyst who has investigated the contemporary sexual life of Tunisian women, argues that 'the norm of virginity perpetuates itself despite the social transformation of Tunisian society' (2012: 35)[37] because, even if virginity is not

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regulated by the state, according to the law several types of sexual relationships such as those that involve concubinage and adultery are crimes.[38]

Thus, young unmarried women who have a sexual life before marriage are not considered in the same way as men: lack of sexual experience, ignorance and innocence are appreciated in unmarried women, and as a midwife in her late fifties declared during a conference I attended on sexuality,[39] when she married, she did not know anything about sexuality and was afraid of it. She argued that she had learned all about sexuality from her husband, whom she considered her teacher (fieldnotes, 30 May 2014). This asymmetric position in sexual matters has thus been internalised by several women I met, at least among the older generations. Today, sexual relationships are much more common among young unmarried people, not only because the age of marriage has risen but also because sexual habits have changed. In the early 2000s, Foster remarked that there was a 'consensus among health service providers that the average age of women's first sexual experience is decreasing and that the percentage of girls engaging in premarital intercourse is increasing' (2002: 99). Although not much is known about the sexual practices of young people in Tunisia, as very few studies have been conducted on this subject [40] due to social and religious taboos that have led institutions and researchers to see it as 'a forbidden and unspeakable domain' (Hamza and Chaabouni 2006: 409), the ONFP conducted research on family health in the mid-2000s (PAPFAM). This included a chapter on the sexual health of unmarried individuals (15 to 29 years old). The results of this research indicate that unmarried people primarily have occasional sexual relationships with different partners and only rarely use contraceptive methods to avoid conception and sexually transmitted infections. According to the ONFP survey, 50 to 60 per cent of men and 12 to 18 per cent of women have sexual relationships before marriage – although it is very probable that the percentage of women is underestimated. First sexual relationships, in 2002, were found to happen at either sixteen or seventeen years for both men and women (ONFP 2002: 216).

If sexual relationships have become ordinary, moral norms have not changed at the same pace and virginity continues to be a necessary physical, if not moral, condition for most women to get married (see Foster 2002; Hassairi 2009; Hrairi 2017). The flourishing surgical industry in Tunisia that pertains to hymen reconstruction and the preoccupation with it as expressed by many young women

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I met in ONFP clinics is but one consequence of the social norm of female virginity. Ben Dridi argues that hymen reconstruction has become so common in Tunisia that some people say that 'it has become part of the bride's trousseau' (2017a: 155). Meryem Sellami's research on Tunisian teenagers belonging to different social classes shows that differential and unequal norms regulate men's and women's sexuality despite the state's efforts to achieve modernisation. Thus, 'the boys interviewed claim their "legitimate virile desire" and the possibility of expressing it through sexual acts (*errajel rajel*; literally, 'the man is a man'), while girls consider their sexuality as a dangerous practice for their body, their reputation and their "purity"' (Sellami 2017: 103). Sameh Hrairi (2017) confirmed this in a survey of 735 high school students in various regions of Tunisia. The results of Hrairi's work show that the large majority of the young generation place immense value on female virginity. However, most of them revealed that they had already had a boyfriend or girlfriend, and all the young people who were interviewed seemed to talk much more easily about sexuality, expressing curiosity and asking questions, than their biology professors, 95 of whom were also interviewed. Being in charge of teaching human anatomy and physiology, including of the sexual organs, Hrairi examined how they interpreted and performed their role as educators in the sexuality domain. Most Tunisian professors were embarrassed and declared their discomfort when they had to listen to their students and answer their questions on the topic of sexuality (Hrairi 2017: 411).

As I detail in Chapter 3, healthcare providers in ONFP clinics were accustomed to asking unmarried women seeking abortion care if they were *sbiyya* (a virgin), a question that initially puzzled me. Talking to healthcare providers, I realised that many unmarried women have superficial sexual relationships (without penetration) in order to keep their hymen intact.[41] Indeed, according to Radhouan Fakhfakh (2010: 63), two thirds of young Tunisians (12 to 24 year olds) do not know that superficial sex can cause a pregnancy – a fact also confirmed in other socio-anthropological studies (Ben Dridi 2010; Hrairi 2017). Moreover, the persistence of a specific ritual called *tasfiḥ*,[42] which is designed to preserve a girl's virginity until her wedding day, was documented by Ben Dridi (2004) in south Tunisia in the early 2000s; she showed that several young women thought that they could not lose their hymen and become pregnant if they were under the effect of *tasfiḥ*, despite the fact that they had sexual intercourse.

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The Imposed Contraceptive Norm

To return to the contraceptive norm in Tunisia, the ONFP clinics where I conducted fieldwork included a separate youth-friendly clinic, although one of them was only partially accessible because the clinic had been devastated during the revolution.

These clinics play a paradoxical role because, on the one hand, they reinforce the idea that unmarried women – who also include divorced women or widows, who are not necessarily very young – are a separate category of citizens that requires specific treatment and classification; on the other hand, they offer a setting that can be experienced as protecting the users from the not always benevolent gaze of married women. This is especially important for young women, who usually want to conceal their sexual life from family members, acquaintances, neighbours or colleagues. While, as I show below, the youth-friendly clinics do not protect their users from the gaze and discourses of healthcare providers and the control of the state, they generally do allow them to get the service they have come for without making it known in their circle. This is at least the case for unmarried women who live in large cities, where anonymity is easier to keep, but women who live in smaller cities will often travel to clinics in larger cities in order to avoid being recognised (Ben Dridi 2017b; Gherissi and Tinsa 2017).

The contraceptive norm that ONFP personnel communicated to unmarried women, especially if they were young, varied according to their education and sexual practices. Generally, the pill, injectable and implant were considered the best methods as they are reversible and can be used for short periods of time without compromising the woman's fertility. The preference for the methods controlled by health professionals was clear in cases in which the woman had little education and/or was suspected of having many partners or engaging in prostitution, whereas the pill was more readily proposed to women with secondary or higher education and those with only one partner.

If women sought an abortion more than once or twice, they were suspected of engaging in prostitution or at least of being irresponsible. Thus, health practitioners tried to impose methods that patients were unable to directly control, such as Depo-Provera or the implant. They sometimes required it as a condition of having an abortion; however, women could refuse to come back to the clinic after the medical abortion was over, which obviously made it much more difficult for the medical personnel to force them

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to accept contraception. Until the end of the 1990s, doctors were allowed, during surgical abortion, to insert an IUD or an implant or to perform a tubal ligation while a patient was under general anaesthesia; however, the medical abortion procedure has changed the terms of the negotiation between healthcare providers and women. It is possible to say that, if they can get an abortion, women have more power to autonomously decide whether they want to go back to adopt a contraceptive method.

Although medical abortion can open up new spaces for negotiations about contraception, the asymmetric relationships between health practitioners and women has not been subverted as clinic users can be denied an abortion altogether. This primarily happened with women coming for repeated abortions, who were usually designated as 'recidivists' – a label that has very negative connotations, as it alludes to individuals who continue to repeat crimes after punishment (see Chapter 3).

Whereas many health providers did not seem to understand why young unmarried women fail to use contraception and treated them as irresponsible and immature, the latter had their own logic, which revealed a contraceptive norm that differs from the one the state and SRH institutions promote. Firstly, as mentioned above, they often avoided vaginal penetration and thus thought that they could not get pregnant. The pregnancy could come as a surprise that is discovered quite late; inexperienced women thought that conception was impossible if the hymen is intact (Ben Dridi 2004). They attributed the absence of menstruation and other possible symptoms of pregnancy to stress, fatigue or already existing troubles with the menstrual cycle. Another reason why unmarried women did not continuously use a contraceptive method lies in the fact that many of them affirmed they had irregular sexual intercourse (see also ONFP 2006). Hence, they did not wish to regularly take the pill or use other methods that interfere with their ordinary life, either because of their side effects or because they involve constraints, such as going to the clinic or remembering to take a tablet every day. Secondly, they thought that hormonal contraceptives could compromise their fertility and preferred to get an abortion rather than use medical technologies that can be harmful. As already stated when describing married women's attitudes, mistrust of hormonal methods is widespread in the Tunisian population and unmarried women are not an exception to it. Even some health practitioners share this opinion, as I realised while talking to midwives, nurses and doctors in family planning clinics and at Hospital T. Thirdly,

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young women who would like to use contraception were afraid of its side effects, even when they did not think that hormones could compromise their fertility. They believed, for example, that they could gain weight or become nervous. They were also afraid that their mother or sisters might discover that they use contraception. Several young women I interviewed expressed fear that, because their mothers regularly inspected their rooms and bags in an attempt to control them, their mothers or other family members would find their pills or see their implants under their skin. These anxieties are meaningful in that they reveal the existence of strong social control over unmarried women's behaviours; control that can take different forms. Labidi (1989) illustrated the way in which this control was exerted from an early age upon the women she interviewed in the 1980s. She explains that education for girls and boys was already clearly differentiated by the time they reached the age of six or seven: their rights, duties, responsibilities and tasks were defined as belonging to two different symbolic and material domains (Labidi 1989: 55). The completion of domestic chores and providing care was reserved for girls, whose movements in the public space were limited from infancy and strictly controlled by their mothers and female relatives. A main part of girls' education focused on the inculcation of bodily habits that were intimately related to female virtues: 'restraint in desires and passions, continence, resignation, detachment, discretion and finally patience and the acceptation of good and evil' (ibid.: 67). Girls' and women's gestures, bodily posture and voice had to translate these virtues into visible traits. Girls had to learn to move slowly, speak in a low voice, avoid looking into men's eyes and cover their body to avoid shameful behaviour.

More recently, researchers have indicated that girls' sex education continues to be a maternal responsibility. It is still oriented toward the suppression of female sexual desire, ignorance of one's own body, preservation of virginity and mistrust of men (Ben Smaïl 2012; Mahfoudh Draoui and Melliti 2006; Sellami 2014, 2017; see also Chapter 4).[43] Anne-Emmanuelle Hassairi (2009), who carried out a study on attitudes toward sexuality of a group of women from various generations active within the ATFD and thus claiming a feminist stance, shows that even the most progressive actors are caught up in a conservative ideology when it comes to sexuality. Several of her interlocutors affirmed, for example, that sex is a natural need for men but a pleasure for women. However, others have argued that it is both a need and a pleasure for men and women (Hassairi 2009: 45). They also agreed that boys are educated

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to take the sexual initiative and learn about sexuality from infancy, whereas women are 'educated to sexual frustration and have to repress their sexual desires until marriage' (ibid.: 39).

The case of Salwa, an unmarried woman in her late twenties with a university education and a good job, illustrates some effects of this education on female sexuality and the culpability feelings it can generate when it comes to sexual penetration. Although Salwa has had several partners and a few stable relationships, she was still a virgin when I met her. She told me that, although she 'had done everything' (alluding to various non-penetrative sexual practices), she could not perform vaginal intercourse and did not even want to engage in that act (Tunis, 11 March 2014). Her mother, like the majority of Tunisian women, taught Salwa that she has to preserve her virginity for her future husband. Her maternal aunt once taught her a Tunisian adage reminding women that, before marriage, they can do whatever they want except 'that' (meaning vaginal intercourse). The hymen is a sacred membrane that must be preserved as a precious gift or a good to be offered to the future husband: it entails the honour of the girl and her family and is also a kind of public and familial good (Sellami 2017; Zemmour 2002).

Although this kind of education is pervasive, even among the middle and upper classes, as explained by the psychanalyst Nedra Ben Smaïl (2012), many young women are able to step back and have a fulfilling sexual life before marriage (Ben Dridi 2017a). Such was the case of Hanan, an unmarried and well-educated woman in her late twenties, who told me that she had avoided vaginal penetration until the day she realised that society had imposed the norm of virginity upon her. She did not recognise the value of this norm and felt that it exists to preserve men's power over women. Hanan synthesised her idea about the unjust and gendered nature of the norm of virginity, stating that 'Tunisian men like to plant a flag on the body of their wife' (fieldnotes, 25 March 2014), as if the female body was a territory for the male partner to conquer (on this, see Young 2005: 80).

The Practised Contraceptive Norm

To return to unmarried women's sexual practices, the contraceptive norm followed by those I met in ONFP clinics and at Hospital T differs from the one promoted by healthcare providers, although both are affected by the moral and social condemnation of female premarital sexuality. The norm that unmarried women followed

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entails either no contraception at all before marriage or a limited use of contraception because of the anxieties surrounding the effects of hormonal biomedical technologies, the desire to avoid effects on their somatic or psychic well-being or the fear of being discovered. The dissonance between the puritanical education (Boufraioua 2017: 12) that most Tunisian women receive and their sexual practices is also translated into the refusal to use contraceptives, as if not using them would indicate that they do not breach the rules. Interestingly, young women who practise premarital sex often feel themselves to be in a liminal state, which can provoke a severe existential crisis. They experience their body as a territory that can be contaminated, soiled and made impure by sexual contact with men through sex outside of the legitimate framework of marriage, thus causing feelings of culpability that can bring women to engage in self-mutilation practices or to resort to various purification rituals (Ben Dridi 2017b; Sellami 2017). The defilement is to be removed from the body but also from the moral person, as the contamination coming from illegitimate sexual acts affects the spiritual aspect of the woman. Purification rituals, as well as surgical repairs of the hymen, can produce moral reform for a woman, who, for example, will begin to wear the headscarf to signify her interior transformation (Ben Dridi 2017b; Ben Dridi and Maffi 2018).

Notes

1. The implant is usually inserted under the skin in the upper inner part of a woman's arm.
2. Microval and Microgynon (a combined pill containing oestrogen and progestogen) are the only two pills that Tunisian family planning clinics, dispensaries and hospitals provide for free. Other types of pills are available from pharmacies for those who can afford to pay for them.
3. This is one potential reason why women who are not virgins can be designated as rotten (Sellami 2014); in this view, a man's sperm remains in the uterus and deteriorates.
4. Héritier (2002) and Mateo Dieste (2013) also mention that women's subordination originates from a lack of control over 'blood spilling'.
5. Classical Islamic texts distinguished between menstrual blood that flows every month (*damm al-hayd*), blood outside the regular cycle, and blood that flows after childbirth (*damm al-nifas*; Mateo Dieste 2013: 76).
6. The same is true for men 'who do not practice the ghusl after ejaculation' (Dwyer 1978: 169).

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7. For a comparison between the conception and treatment of menstruation in these three religions, see Jodelet (2007).
8. On the conception of blood in the Arab tradition, Edouard Compte remarks that blood (*damm*) is an ambivalent substance because it has a feminine origin and 'appears either as the substance nurturing the fœtus or as a defilement (*hayd*). Spilled blood is also ambivalent because it is sometimes the medium of sacrifice, sometimes a stain on the collective honour of its (male) guardians. Blood that runs through the veins is for its part considered as the seat of individuality, soul and humour' (2001: 67).
9. A similar attitude is still present in Euro-American societies, as Martin (1987), Lee and Sasser-Cohen (1998), Young (2005) and many others have shown.
10. For a brilliant example of how women's perceptions of their bodily functions are culturally constructed, see Lock's (1993) study on the conceptualisation, treatment and perception of menopause in the North America and Japan.
11. A sterile wife is considered a valid justification for a man to divorce and remarry.
12. I use the French term because the Tunisian providers always use French when they speak about medical conditions.
13. Scholars have recently shown that a significant number of women with tertiary education prefer the 'traditional methods'. According to Jalila Attafi (2015), 19% of women with university education (as compared to 6% of women with primary education) use non-biomedical contraception.
14. During my fieldwork, I never met a woman who used this method or a provider who suggested it. I only discovered that it was available in SRH government clinics by reading the ONFP's (2013) *Manuel de référence en santé sexuelle et reproductive*.
15. On the notion of choice, see Chapter 3.
16. In 2013/2014, Mirena cost 250 Tunisian Dinars (85 euros), which is a very high sum compared to local salaries.
17. The ideal family size according to the Tunisian government has decreased over time, as demonstrated in the evolution of the country's labour, fiscal and family laws. In the 1980s, tax relief was passed for families with two or three children; in this law, 'child allowances were limited to the first three children while over the 1960s and 1970s, legislation, discourses and the mass media were allowed to inscribe in "the unconscious of Tunisian families" four children as the ideal number' (Gastineau and Sandron 2000: 21). In addition, the number of months of paid maternity leave per woman has been reduced to three from four.
18. According to the latest national census from 2014, the average size of a Tunisian family is 4.05, down from 5.15 in 1994.

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19. For Morocco, see Bargach (2002) and Capelli (2016); for Algeria, see Rahou (2006); for the Maghreb region, see Barraud (2011).
20. The World Bank (2015) indicated that, in Tunisia, 72% of the female population is literate. Retrieved 14 August 2017 from https://donnees.banquemondiale.org/indicator/SE.ADT.LITR.FE.ZS?view=chart.
21. This is not specific to Tunisia; in contemporary France, the female identity is still defined by maternity (Bajos and Ferrand 2004).
22. According to ONFP statistics, fewer men than women have visited its clinics; the number of male visitors has also decreased significantly since the revolution. In 2010, 341,617 males attended but only 56,774 in 2013 and 64,446 in 2014. By contrast, 977,406 females attended clinics in 2010 and 872,128 in 2014 (Institut National de la Statistique 2016).
23. For the various positions that feminists from the Global North and South hold on this issue, see Rozario (1999).
24. On the coexistence of logics based on neo-Malthusianism and reproductive rights in contemporary societies, see De Zordo (2012).
25. As I explain below, Tunisian law does not directly sanction premarital sex and restricts it in various ways. Nédra Ben Smaïl (2012) cites the case of a 2004 state-promoted campaign during which 'more than seven hundred young women and men were arrested for "offending public decency"' (ibid.: 35) because they had, for instance, held hands while walking in the streets. Another law forbids hoteliers from hosting unmarried Tunisian couples (Ben Smaïl 2012).
26. In Tunisia, the henna ceremony is still widely practised at marriage; in this ritual, parts of the bride's body are coloured with henna; the intent is for her to get pregnant or even give birth to a child before it fades away.
27. The Dalkon Shield was a 'particularly poorly designed' IUD that caused 'sterilizing injuries to numerous women and killed several users who suffered overwhelming infections' (Takeshita 2010: 43).
28. Other researchers have shown that health professionals tend to dismiss women's complaints about the side effects of biomedical contraception (see, for example, De Zordo 2012; Hardon 1992, 1997; Van Kammen and Oudshoorn 2002; Watkins 2010). This attitude seems to be intimately related to the logic of medical knowledge, as well as to the neo-Malthusian policies of population control that institutions and states have implemented based on concerns related to efficacy rather than acceptability.
29. Interestingly, in the ONFP's (2013) *Manuel de référence en santé sexuelle et reproductive*, the husband's discomfort because of the rope is mentioned as a legitimate complaint that can justify the insertion of a new IUD (p. 100).
30. However, according to Dimassi et al. (2017), the IUD is still the most-used biomedical contraceptive method in Tunisia.
31. Interestingly, the women I met at the ONFP clinics or at Hospital T who wanted to undergo tubal ligation were denied that procedure

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for various reasons. One was that, today, there are reliable long-term methods that allow for control of one's fertility without resorting to surgical intervention; another was that health providers have other priorities and no longer perform tubal ligations unless doing so is strictly necessary for health reasons. The ONFP (2013), in its *Manuel de référence en santé sexuelle et reproductive*, no longer includes tubal ligation on the list of available contraceptive methods.

32. With few exceptions, the research on Tunisian women's reproductive and family health has only considered married women because implicit moral rules have affected local research (see also Dimassi et al. 2017). When I asked some ONFP researchers about the absence of studies on unmarried women (and men), they told me that the various ministries involved in the organisation of such surveys would not accept unmarried people's inclusion in research plans. This attitude is not unique to Tunisia; for instance, sexuality – and especially extramarital sex – was taboo until the 1970s in Euro-American anthropology on the Middle East, as Nikki Keddie (1979) emphasised.
33. At the turn of the century, Paulet and Gachem wrote, 'Having reached a relatively high level of development, cooperation agencies no longer consider Tunisia as a country in need of important support' (2001: 564).
34. The age of consent in Tunisia was 18 for men and 20 for women until the promulgation of a new comprehensive law on violence against women (July 2017), which stipulates 18 for both men and women.
35. In 2000, the ONFP introduced specific training modules for personnel who worked in youth-friendly clinics to help them deal with unmarried patients in the best way. In a 2010 booklet, the Directorate of School Medicine, the ONFP, the Ministry of Health and UNFPA discuss the main aspects of this training.
36. See Ben Dridi (2010, 2017b), Hrairi (2017), Mahfoudh Draoui and Melliti (2006), Sellami (2014) and Voorhoeve (2017).
37. Several legal dispositions limit and criminalise sexual relationships outside of wedlock: Article 236 of the Penal Code punishes adultery; Article 226 of the same code punishes those who 'infringe public morality through words and gestures'; Article 18 of the CPS punishes all forms of union that differ from the state-recognised monogamous marriage – including not just polygamous marriage but also cohabitation. Article 226 of the Penal Code potentially allows punishment for premarital relationships, although there is no specific article regulating this matter. On this topic, see Voorhoeve (2014, 2017).
38. See Ben Smaïl (2012: 35), Article 236 of the Penal Code and Article 18 of the CPS.
39. The one-day conference was hosted by the Union des sages-femmes de Tunisie du Nord on 30 March 2014. The speakers included a few well-known Tunisian sexologists.

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40. On this topic, see Capelli (2017) and Tremanye (2004).
41. On this topic, see Ben Dridi (2010, 2017a, 2017b).
42. Literally, the term *tasfih* indicates the actions of armouring, sealing and shoeing a horse (Ben Dridi 2004: 16). 'This protection is the subject of a first ritual phase, which takes place before the puberty of young girls (between 6 and 10 years old) and is based on two precautions affecting both women and men: under its action, the girl becomes impenetrable and any man approaching her loses his sexual power. Pre-marital sexual intercourse, voluntary or forced, is therefore no longer theoretically possible. On the eve of the wedding, a second ritual phase allows everyone to regain their sexual abilities. Thus the ritual succeeds one another with a time of "closure" and a time of "opening" of sexuality' (Ben Dridi 2010: 100).
43. For similar considerations regarding sex education in Morocco see, for example, Dialmy (1985) and Guessous Naamane (1988).

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