Dualities between Tunisian provider beliefs and actions in abortion care

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Abstract: Despite Tunisia’s historically progressive reproductive health policies, Tunisian women now face significant challenges accessing legal abortion. Through in-depth interviews with providers at six facilities, we explored factors influencing provider attitudes about abortion and provider perspectives about abortion morality, safety, and legality. We found that gatekeepers (counsellors and front office staff) generally believed abortion was immoral, while obstetricians and gynecologists were more likely to support an individual’s right to access abortion. However, providers’ actions do not necessarily align with their stated beliefs regarding abortion; some providers who said they support abortion access generally held personal beliefs about when and for whom abortion is appropriate which influenced their provision of care. System-level barriers to abortion provision, such as a lack of resources, hinder some providers who may otherwise be willing to provide the service. These system-level barriers may also account for inconsistencies between providers’ beliefs and actions related to abortion. Illuminating the complexity in provider beliefs and attitudes about abortion can help us to better understand whether and why abortion care is provided, as well as the factors that ultimately determine whether a woman can obtain an abortion. DOI: 10.1080/09688080.2018.1472486

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Background

Tunisia has long been a leader in providing access to reproductive health services for women. Tunisia was the first Muslim country to legalise abortion, the first country in the Arab world to register a dedicated emergency contraceptive pill, and the first African country to legalise mifepristone for medical abortion.1,2 These policies, including improved access to and use of contraceptives in the country,3 likely contributed to the dramatic decline in both fertility and maternal mortality in the 20-year period from 1990 to 2010.4,5 Recent events, including the 2008 global financial crisis, the Arab Spring of 2010–2011, and the ensuing increase in political conservatism, have raised concern about the availability of reproductive health services, including abortion, in Tunisia.6–10

Legally, elective first trimester abortion is available to women in Tunisia at no cost when prescribed by a physician and performed by a physician or midwife at authorised public facilities or in private clinics.11 After the first trimester, abortion is permitted in cases of physical or mental health risks to the pregnant woman, or foetal anomaly. Despite a relatively liberal law, women in Tunisia face increasingly significant challenges accessing legal abortion services.10,12 A lack of data on abortion in both public and private settings makes it difficult to evaluate recent changes in abortion access since 2011. Anecdotal accounts suggest that budget cuts have led to a reduced number of facilities offering abortion services in the country.5,10 Further, advocates report that some Tunisian physicians are invoking a conscience clause, referring to the International Federation of Gynecology and Obstetrics’ 2006 Resolution on Conscientious Objection in lieu of a national medical conscience clause. Refusal for religious reasons has become more common since the 2010–2011 revolution.
Qualitative interviews with women denied abortion services at legal facilities in and around Tunis in 2013 suggested that providers may lack training on comprehensive abortion care, they object to providing abortion care within the law, or both. Women reported that they were referred between facilities unnecessarily, denied services on the basis of irrelevant conditions (such as asthma or diabetes), and treated poorly by public medical staff. Many women said that the abortion-seeking process was frustrating, and some were concerned about their ability to obtain an abortion within the legal gestational age limits due to service delays. Little is known about Tunisian provider attitudes and practices around abortion. A recent article discusses the newfound freedom of Tunisian health professionals in the post-revolutionary period to express their opinion and adjust their behaviour according to their political and religious convictions, particularly with regard to abortion. Yet, providers are not officially able to object to providing abortion services, given the lack of a legal medical conscience clause in Tunisia.

In the international literature, providers qualified to offer abortion care are often categorised as abortion providers or objectors. This binary categorisation ignores the nuanced approach of many providers in responding to their patients’ needs. Provider abortion practices are not only nuanced but also evolving. Harris et al in Colombia developed a conceptual model of conscientious objection to abortion provision, which posits three domains of conscientious objection: beliefs about abortion and conscientious objection, actions related to conscientious objection and abortion, and self-identification as a conscientious objector. The conceptual framework includes full consideration of a provider’s actions (related to counselling, provision, denial, and referral), as well as stated beliefs (on morality, safety, and legality of abortion), both of which influence patient care experiences. Harris et al also acknowledge the influence of context on provider approaches to abortion care, arguing that both provider beliefs and actions are influenced by economic, social, and political pressures. It is essential to understand the factors that influence provider attitudes about abortion. Provider objection, in whatever form, can limit and delay access to legal abortion services for women and further stigmatise patients, ultimately leading to greater morbidity from unsafe abortion.

In this paper, we applied Harris et al’s conceptual framework to assess conscientious objection among Tunisian providers. Specifically, we explored provider beliefs about abortion, abortion safety and legality, and contraception, and whether these beliefs correspond to their actions with respect to abortion counselling, provision, denial, and referral. We hypothesised that assessing provider actions as separate from beliefs, rather than assuming their alignment, would enable us to gain a more nuanced understanding of abortion provision in Tunisia.

Methods

We conducted in-depth qualitative interviews with a range of providers at six facilities in and around Tunis, Tunisia, including one maternity hospital and five family planning clinics. More than 25% of the population lives in Tunis and those living in other regions of the country are typically referred to Tunis for care. Providers were eligible to participate in the study if they worked at a facility authorised to provide abortion services and were involved in serving abortion patients in some capacity, including as a physician, nurse, midwife, reception staff member, or counsellor. A Tunisian non-governmental research and advocacy organisation, Groupe Tawhida, familiar with providers working at abortion facilities, recruited participants. Recruiters aimed to enlist up to three nurses or midwives, two physicians, and one registration or counselling staff member (referred to here as “gatekeepers”) from each facility, in acknowledgement that most women encounter a range of personnel during clinic visits.

Potential participants were contacted initially by telephone, at which point recruiters described the study and asked to interview the participant. Interviews were conducted face-to-face in a private room at each facility. Informed consent for interviewing and audio-recording was requested at the time of the interview. Three interviewers, trained in qualitative methods, used a semi-structured interview guide, which included questions about participants’ role and position; training; background; medical experience; attitude to abortion provision; experiences treating abortion clients; knowledge of the law; and their suggested changes to abortion law or policy in Tunisia. Interviews were conducted in Tunisian Arabic and/or French, depending on participant preference,
then transcribed and translated to English for analysis by a local translator.

One researcher (SR), based at University of California San Francisco and trained in qualitative analysis, developed, finalised, and applied a code structure to the English transcripts using a thematic content analysis approach in ATLAS.ti. Interviewers completed all interviews before the researcher began analysis. Initial categories for analysing data were drawn from the interview guide and additional themes emerged after reviewing the data. Key themes included patient demographic factors that determined provider comfort in providing abortion, such as marital status, age, and number of previous abortions; provider counselling tactics related to influencing a patient’s decision about abortion; provider perceptions of abortion safety; and other factors influencing providers’ decision to provide care (or not), such as indication. These themes were applied to a subset of the transcripts, after which a codebook was developed and reviewed by the research team. After revising and finalising the codebook, the codes were applied to the rest of the interview transcripts. We classified participants in to three main categories for analysis according to Domain 1 of Harris et al’s model: beliefs about abortion and conscientious objection. Actions related to conscientious objection and abortion (Domain 2) were reviewed for each of the Domain 1 categories in order to assess whether Domains 1 and 2 were aligned. Domain 3 of Harris et al’s model was not included in the scope of this study’s analysis.

Ethical approval was granted by Le Comité d’Ethique du Service A du CMNT in Tunis as well as the Committee on Human Research at the University of California, San Francisco. Authorisation of the Family Planning National Ofﬁce (ONFP) was obtained according to a partnership agreement between Groupe Tawhida and the ONFP. Participants were assured that they would not be identiﬁed by name, facility, or any other identiﬁer in all forms of dissemination, including publications and at meetings.

Results

Twenty-nine providers were recruited to participate in the study and 25 agreed to participate. Three providers who were recruited but did not participate declined after learning more about the study and one was called for an emergency and unable to return for an interview. Of the 25 participants who consented to participation, 23 completed interviews, including 7 physicians, 10 midwives, 2 nurses, and 4 gatekeepers. The other two were unable to complete interviews due to scheduling conﬂicts. Participants were on average 44 years old (range: 27–59, SD = 9.44), with 20 years of medical experience (range: 6–35, SD = 10.11).

We classified providers into three broad categories with respect to the first domain of Harris et al’s model (beliefs about abortion and conscientious objection): (1) those who believe abortion is a moral and legal right and personal decision for all women; (2) those who are morally opposed to abortion and believe it should be legally restricted; and (3) those who support legal access to abortion but do not support it for some women on moral grounds depending on the circumstances. Throughout the rest of the paper, physicians (primarily obstetricians and gynecologists) are referred to as “P”, nurses are referred to as “N”, midwives are referred to as “M”, and gatekeepers are referred to as “G”.

Providers who believe abortion is a moral and legal right

Nine providers believed that abortion access should be a legal right, regardless of the reason, including four physicians, four nurses or midwives, and one gatekeeper. These providers reported that their personal views on abortion were irrelevant. One physician explained:

“So, let’s keep abortion within the medical context. It is a woman’s right, that’s all. And it’s up to her to choose. That’s the way it should work in my opinion”. (P4)

Another physician said:

“…these women have personal reasons for doing this… it is not my worry, if she wants to abort two or three times, that’s possible… No added interpretations. I am really careful with this… I do not give any political opinions”. (P1)

When asked about her views, a young midwife said:

“I don’t say to myself that if I see this woman again I am going to be alarmed, that I am going to hate her or love her, do you see? There are no feelings. It is all routine… routine… neutral”. (M7)
When asked about the law on abortion access, providers in this category replied that it should remain the same or that it should be changed to further improve access. One physician said that the number of abortions provided is too low:

“For me it is insufficient. We are not meeting needs. We are not fixing patient problems 100%. Just the fact that we transfer them ... We should stop changing the law and provide more support on the medical level. That’s all that I am requesting.” (P1)

Another physician said the law should merely be tweaked to reflect the fact that medical abortion can be provided safely in outpatient settings (P7). And finally, one called for legal protection for abortion providers:

“In the end, there is no law which protects those who prescribe abortion and this is a truth that must be told. On a scientific level you can do it but when there are issues you also have to have clear structures in place ... The policy has to change in the direction of prevention, of making laws that protect both patient and the medical and paramedical profession”. (P6)

Counselling

The providers in this category said that their role was to provide counselling and information and to support the patient through the decision-making process, again without imposing their own assumptions or judgements. One gatekeeper said:

“... We have to listen to her, and to gain her trust to soothe her fears, because as I told you the women only come here because they are convinced of the necessity to have an abortion. In fact, no one can know what a woman is feeling when she comes here, so I have no right to discuss with her the reasons of her decision”. (G4)

Another physician agreed that inserting one’s personal opinion either way should not be part of the provider role:

“We are not required to ask why. She wants an abortion? The conditions are all there. We are health care providers ready to respond to your needs ... If a woman, or a couple, has decided to terminate a pregnancy, we shouldn’t have to convince them to do otherwise, to keep the pregnancy. The name says it all; it is a voluntary termination of pregnancy”. (P7)

One midwife said:

“I don’t think that a woman should be forced to keep a child against her will or that she should be forced to have an abortion ... in my opinion we are here to provide women with correct information, because many times, they receive wrong information ... “. (M9)

Another midwife said:

“You cannot harass a woman to keep a pregnancy and destroy her life! The choice is hers alone”. (M2)

Safety

The majority of providers who believed abortion is a legal and moral right said that the risks of abortion are minimal, similar to other routine medical procedures. One explained the risks of abortion with respect to childbirth:

“If there is a contra-indication for an abortion this means that there is an even greater contra-indication to the pregnancy itself, and that is when you end up with abortions for medical reasons”. (P7)

When asked whether abortion is dangerous, one nurse answered:

“In an assisted setting? In a setting like ours, at the clinic? No!! But there are abortions that take place in the office of private practitioners or others, which are really very dangerous”. (N1)

Another midwife shared a similar impression:

“... when abortions are performed at establishments like [a national family planning clinic], they are not dangerous. If her abortion takes place with an established medical record, according to the rules, and with correct data, she has nothing to worry about”. (M9)

Denial

Providers who support legal and moral access to abortion identified provider shortages as a common reason for denial. One OBGYN explained:

“We are working beyond capacity in an exceptional manner and our medical teams are much reduced. We are unable to make ends meet, as the saying goes ... because our staffing is reduced and our activity is constantly increasing. ... To carry out adequate Family Planning services, you have to listen to patients. It takes a lot of time. You need people who are totally dedicated to Family Planning, and in this respect we have a total lack of staff to enable us to carry out good quality Family Planning for our patients”. (P7)
At another clinic, a midwife explained:

“Normally, abortion has to be monitored by a doctor. Someone who has medical training, not even a midwife. We did not have a doctor and so we could not receive [abortion patients]… We found ourselves obliged to turn them away to… The women had to travel all the way to Tunis, all the way to Nabeul”.

(M8)

Providers who are morally opposed to abortion and believe it should be legally restricted

Four providers (three gatekeepers and one midwife) said they believe abortion is sinful and that it is a woman’s duty to bear children. Three out of four of the gatekeepers who participated in this study fell in to this category. One elaborated on a personal belief:

“Personally, I am against [abortion]. As a woman … it is impossible for me to eliminate [a pregnancy], unless it is an interrupted pregnancy (with fetal death), in which case this would be the will of God. But if it was sent to my belly, I cannot eliminate it. It is awful. This is a child that God is sending, and it is a sin to prevent him from living in the world. There are ways of preventing pregnancy”.

(G1)

On the gestational age limit, this same respondent argued that:

“three months is too much. The baby is just about ready to move in her belly!”

(G1)

Another gatekeeper said:

“For me a woman really feels like a woman once she has delivered a baby. Woman, mother, in brief, femininity. We try to inform, to always raise awareness … because when she becomes a repeat offender, it displeases us, it annoys us. When abortion becomes a means of contraception, it vexes us immensely. She comes to abort every two days, every month, it is dangerous. … For me, to get rid of the best thing that God gave us, is not a positive experience”.

(G2)

Only one midwife expressed sentiments aligned with this category:

“For me a human being is a gift from God. … And that women are created to produce children. Being a mother is a beautiful thing. As for abortion, it is no, no, no. I can see that it is a failure. The failure of contraception, the failure of sexual life, of everything, everything, it is a failure. Termination. This is the right term. You are stopping something”.

(M1)

When asked about abortion legality, a third gatekeeper said that the number of abortions per woman should be limited, particularly for women who have only one child or no children:

“When a woman has two abortions or three abortions per year and the law is on her side, it is not a good thing at all … for example, if an abortion costs 300, why waste it on women who have two or three abortions per year when you could allocate this money to obtain medication for women who are in need? If the number of abortions were limited during the lifespan of a woman or per year … women would become more aware. She would have a better understanding of her limits. She would be convinced that she has to have a contraceptive method”.

(G3)

Counselling

Providers who were against abortion on moral grounds explained that they have overtly or covertly attempted to persuade patients not to have an abortion. One gatekeeper said she often attempts to influence young clients in particular:

“I told her: ‘You can finish your studies and keep the baby. Does your husband help you or not?’ She answered that he did. ‘So, how is it that your studies are an obstacle?’ She said: ‘No, I am convinced. I do not want to keep it. I want to continue studying.’ I told her: ‘Please, honey, I am just going to register you on a form. Go to your consultation, think about it and come back.’ She left to talk about it with her husband in the waiting room. Her husband came back. He asked [my colleague]: ‘Where is the woman who spoke to my wife? Why did she tell her not to have an abortion? My wife is crying.’ My colleague explained to him that we do not favor abortion as a way, at first. She has to be aware of what she is doing. He told her: ‘My wife is very nervous. She has to have an abortion.’ My colleague explained the risks of a curettage with zero children. … And despite this, she had an abortion … She was not turned away … I wanted to convince her to keep it’.

(G3)

Similarly, a midwife, who had said she does not support abortion access, explained:

“We have a thorough consultation with her, and we tell her everything. If we can convince her, we convince her and we tell her that it is not worth it to have an abortion. Sometimes, with the insistence of a psychologist from time to time …”.

(M1)
Safety
Unsurprisingly, these providers generally believed that abortion is unsafe physically and psychologically for the patient. Four respondents said that it can cause sterility in women, especially for women who do not have any other children or who have had multiple abortions. One gatekeeper said:

“The idea, that we have, is that if a woman without children has an abortion, she will not be able to have any more children”. (G1)

Another explained:

“They have three or four curettages. In those cases, secondary sterility could occur and she would not be able to become pregnant”. (G2)

A third gatekeeper said:

“Psychologically, she may regret the abortion that was performed. … It becomes dangerous for her personal life and her life as a couple. The abortion can wreck her life”. (G3)

Denial
The providers who were against abortion reported that they deny abortion services to clients primarily for medical contraindications and advanced gestational age, as well as for lacking appropriate paperwork, or being young or unmarried. One provider said:

“We turn women away when they do not bring a letter, because now we require a letter, and the decision is up to the doctor. We have nothing to do with the decision. … We turn them away if they do not bring their marriage contract or their national ID cards, where it is specified ‘wife of …’, because we are afraid there may be social cases”. (G1)

Providers who support legal abortion access for some women, depending on the circumstances
The final category of providers, those that indicated they support abortion rights but only under certain conditions, included five midwives and two physicians. The following factors determined whether providers approved of a patient’s access to abortion: marital status, number of children, husband’s income and employment status, number of previous abortions, and patient’s health status. One midwife explained:

“When I am dealing with a diabetic woman, taking insulin, sick, tired, and the possibility that her pregnancy becomes a risk to her health, in this case … abortion is appropriate”. (M6)

On the other hand, she said she is uncomfortable with non-medical reasons for abortion, such as financial reasons or marital conflict:

“These sorts of reasons … get on my nerves … it bothers me, because these are not medical reasons”. (M6)

Some of the providers in this category said they were more likely to approve abortion care for young single women, who would likely be ostracised from their communities if they continued the pregnancy (“I am in favor of helping them to avoid creating another victim”, M5). These providers seemed to lack empathy for married women, particularly those with no children or one child, unless they also had a debilitating health condition. Many providers said that they do not support “repeat abortions”. Some of these providers still provided abortions in these scenarios despite their personal beliefs.

“She has one, then she repeats having an abortion twice … three … four times. That is, where is she going like this? … there should be a limit on the number of abortions per woman … so that she would have to take contraception”. (P3)

Another provider said:

“If you want my personal opinion, yes [the number of abortions should be limited] … because we have for example a few women who have repeat abortions. That is, they might have 4 curettages per year”. (M3)

When asked about training on abortion, several providers in this category said they had not received trained explicitly on abortion provision but would welcome it. A family physician in charge of reproductive health at a public facility said:

“In 2015, they cut down on the abortion training. Personally I have done very little training at the Central Office. We are always wanting more training”. (P3)

An obstetrician/gynecologist said she never received training on abortion or family planning:

“Quite the contrary, we would like to have this training. … If I ever found a Complementary Education Course in this sense, I would register, really!” (P2)

One midwife in a rural area explained:
it is a catastrophe for a credentialed midwife to find herself [in rural areas] with such limited, such inadequate and such insufficient training, facing women, who have not sinned, who have not done anything wrong, except find themselves [in rural areas], and who do not have someone who is well trained to care for them, and to handle their cases. (M5)

Counselling

The providers in this category said that any attempt to convince women not to have abortions depended on the circumstances of the case. One midwife said:

“I am very strict with women who request abortions … almost that I turn people away. That is, that I am more inclined to convince them [not to have an abortion] … and sometimes, I am successful. I am very successful especially when she has a plan for another baby. She says ‘I am waiting for another year, before I will get pregnant again’… So then, she carries on with her pregnancy, pretending that this is next year and she brings it to term, that’s all. This is to avoid all the risks for her, especially for the mother, the risks of abortion”. (M4)

Safety

Providers who supported access to abortion only under certain circumstances, did not agree on beliefs about abortion safety. Two midwives reported concern about the physical health risks of abortion. One said:

“When a woman has an abortion, she puts her life on the line, especially when the pregnancy includes some pathology, such as diabetes, hypertension, anemia, thrombopenia … ”. (M4)

Another said:

“For me, an abortion equals ten deliveries, considering the trauma to a woman’s uterus and body”. (M5)

A physician in this category said that complications do happen, but are rare and you can “count them on one hand” (P2). Another midwife explained a divided position on the safety of abortion:

“It is dangerous and not dangerous. Dangerous when it is performed with a non-qualified person. And it is not dangerous because all of our staff are very informed, and at an establishment you will find an anesthesiologist and all of the equipment. That is, when the right methods are used, it is not dangerous at all”. (M3)

Denial

Providers who supported abortion services only in some cases explained that they might deny abortion care to women for reasons such as gestational age and limited resources. In some cases, providers explained that their personal views influenced their willingness to provide care and their decision to deny abortion care. For example, one midwife explained:

“We refuse women the second time. We open a case and we see that she has aborted two months ago and she is coming back for another abortion”. (M4)

Another midwife explained:

“Beyond 12 weeks of pregnancy, the woman is categorically turned away, except when there is a therapeutic reason to terminate the pregnancy. We are very clear in this regard. This is legally binding”. (M5)

Most providers who supported abortion access only in certain circumstances discussed resource limitations as reasons for denial of abortion care. One midwife explained that a lack of providers and physical space could lead to denial of services:

“Unfortunately, due to the lack of space we do not admit her. We do it on an ambulatory basis. We have to because we do not have enough beds to keep women who come for abortions. When there are many patients, and staffing is low, and the salaries are low … it results in not very elegant behavior. It results in offenses. It results in brutality”. (M5)

Another provider explained the impact of shortages of medical abortion pills on service delivery:

“Before we used to give them the choice. Now we give them choice but with not much freedom. Because, if we give a choice, thinking that we will have more Mifegyne soon … but sometimes we stay 2 and 3 weeks, even one month waiting for Mifegyne”. (P3)

One midwife at a family planning clinic explained:

“Before we used to have many more [abortions] … Now supplies have decreased … If she comes at the end of the month [for medical abortion] and there are no supplies, she will then come back at the beginning of the month when we have received a new supply”. (M3)
Contraception
Provider beliefs about contraception were not necessarily aligned with their moral and legal views about abortion. Some of those who supported access to legal elective abortion care also blamed women for their failure to use contraception, while some of those who were against abortion access still acknowledged that women were not solely to blame for getting pregnant. Almost all providers agreed that contraceptive use among their patient populations is lower than ideal, but they held a range of different actors responsible for this low contraceptive prevalence rate. Some attributed low contraceptive use to women’s lack of knowledge about contraception and the trivialisation of abortion. One physician, who supported abortion in certain cases, explained:

“Contraception is a big problem, really a big problem… we see that women are lacking a lot of awareness”. (P3)

A midwife, who also supported access to abortion in certain situations, said:

“They do not know how to take the pill. When she has sexual relations, she takes a pill. When she does not have sexual relations, she does not take the pill”. (NM7)

A physician agreed:

“… I have heard women say: “I have my period. I am taking [a birth control pill]. It stops my period, so I stopped taking the medication.” This means that they do not understand why they are using it, nor how to use it”. (P2)

Many providers shared the view that contraception should be promoted in an effort to decrease “repeat abortion”. One physician, who had advocated for improved access to abortion with outpatient medical abortion, said:

“The majority of Tunisian women think that it is an easy solution. … it is true that [abortion] exists, and that this is a legal right, but it is not really contraception, it is not a contraceptive method of last recourse”. (P7)

An gatekeeper who did not support abortion on moral grounds said there is no excuse for unintended pregnancy:

“Let me tell you that there are responsibilities to assume in life! Ok? If you do not use contraception and you do not understand it, then you will have to assume the responsibility, dear friend!” (G1)

Other providers argued that contraceptive use is low in part because their peers need to improve their contraceptive counseling for women. One physician said:

“This is not [the patients’] fault. There is a problem with service delivery. … Our problem is that even our interns are not properly trained in this sense. They do not know how to convey information, how to explain. … there is a problem with patient health education”. (P2)

A midwife, who did not support access to abortion, nevertheless advocated for non-judgemental reproductive health care:

“It is an art to consult with a patient. You have to feel for the woman. You have to put yourself in her shoes, feel for her, understand her problems, never judge or lecture her, as it is useless. … Unfortunately this spirit does not exist for all people. … Sometimes, even a professor in medicine does not know how to consult with a patient. He can shock her. He can confuse her. He can humiliate her. He can say something offensive”. (M5)

Some providers avoid investing time in counselling because they think that a patient’s peers will ultimately have greater influence on her behaviour. One midwife explained:

“These are women who have heard a lot. So, you have nothing to add. Because what is said in the family and in their circles is stronger than what the doctor or a midwife says. ‘Take the opinion of an experienced person. This is better than a doctor.’ That is a proverb from where I come”. (M2)

Another midwife said:

“… Even if you explain to them, they do not accept the information because they already have so many false ideas received from the outside, or they know women wearing an IUD, who nonetheless became pregnant. So, it is useless”. (M7)

Finally, some providers credited the failure to prevent unintended pregnancy to structural factors, such as limited resources, lack of autonomy, and gender inequality, all of which make it difficult for women to access preferred contraceptive methods. One physician who supported the right to abortion access said that:
“...[Contraception] should simply be brought back to the level of poorer people, to the level of the disadvantaged, so that even women without means can benefit from the best contraceptive methods available on the market". (P7)

Two providers, despite having sentiments against abortion, highlighted gender inequality and lack of autonomy as barriers to contraceptive use, acknowledging that unintended pregnancy is not the fault of the woman alone. One gatekeeper questioned:

"Why doesn’t he himself use contraception? In my opinion, this is a woman who is a victim of violence. I pity her". (G2)

A midwife said:

"The husband refuses, at least that is what I think. Contraception is for women. It is not for men. Even if, in cases of STDs, we request the use of a condom during sexual relations, he refuses. He even refuses the treatment. When she comes back and you ask her if she asked her husband. She responds ‘No, he didn’t want to’". (M1)

Discussion

The results presented in this paper shed light on provider attitudes about abortion in Tunisia. The providers interviewed for this study demonstrated a wide array of beliefs about abortion, ranging from support of the right to choose for all women, to support of abortion access only in limited circumstances, to complete opposition to elective abortion access. Those who held the most progressive ideas about abortion access were predominantly physicians who had been trained more extensively on the subject of abortion. On the whole, gatekeepers appeared particularly unsupportive of clients’ requests for abortion from a moral perspective and were misinformed about the evidence base for clinical indications and contraindications of abortion. Those who supported abortion access only in certain circumstances were less informed about the safety of abortion, relative to those who supported the patient’s right to choose. They were also more likely to attribute denial of abortion care to structural or resource limitations. These providers may therefore be less likely to deny patients if they were better equipped with resources and training on abortion.

Many providers exhibited dualities in their beliefs and actions related to abortion and contraception. Some providers stated they supported the right to choose but simultaneously stated their willingness to deny abortion services in certain cases, such as if a woman had previously had an abortion or for nulliparous women. On the other hand, there were also providers who were committed to providing services despite their personal objections to abortion. In addition, provider views on contraception did not necessarily align with their views on abortion; some who believed in the right to choose attributed low rates of contraceptive use to a perception that women “trivialised” abortion. Those who believed abortion was immoral often blamed poor provider counselling for the low contraceptive use rate. Contradictions between and dualities among providers’ beliefs and actions make it difficult to categorise them as abortion providers or conscientious objectors and to predict their likelihood of denying services to a patient. Our results indicate that there is a complex relationship between a provider’s beliefs and actions regarding abortion provision, which supports the conclusions drawn in Harris et al.15,16

These data are unique in that they are the first to discuss provider attitudes about abortion in Tunisia, and that they include the perspectives not only of clinically trained staff associated with abortion care, but also the perspectives of gatekeepers who are often the first point of contact for women seeking abortions. Most conversations about provider attitudes and conscientious objection do not include gatekeepers, often because in many countries they are not legally eligible to conscientiously object. Our results indicate that gatekeeper beliefs and actions may be an important barrier for women, supporting previous findings.12 Investigation and discussion about the influence of gatekeepers is needed within conversations about conscientious objection.

As anticipated with an exploratory qualitative study, the sample is not representative of all providers in Tunisia. Given that providers were sampled from Tunis and the surrounding area, they are more likely to be urban and more educated than the staff employed at clinics elsewhere in Tunisia. The providers in our sample also may encounter more women seeking abortion care than the average provider in Tunisia, which could influence their attitudes and actions with respect to abortion care. These data present information from only the provider perspective, so patient experiences are
not represented here. However, a previous study provides insight on women’s perspectives on denial of abortion in Tunisia. We also did not ask providers about their religion, gender, or self-identification as an abortion provider or conscientious objector, which may influence attitudes about abortion.

**Conclusion**

There is variation in how providers treat patients seeking abortion in Tunisia. Further research on the various aspects of provider attitudes, including their beliefs as well as their actions, may help to better illuminate and improve the quality of abortion care. Understanding when and how abortion providers treat certain patients differently than others, even when they believe all women should have access to abortion, would be critical in identifying and preventing implicit bias and reducing barriers to abortion care for women.

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Résumé
Malgré les politiques de santé reproductive traditionnellement progressistes de la Tunisie, les Tunisiennes rencontrent maintenant des obstacles de taille pour avoir accès à un avortement légal. Au cours d’entretiens approfondis avec des prestataires dans six centres, nous avons étudié les facteurs qui influencent les attitudes des prestataires sur l’avortement et les perspectives des prestataires sur la moralité, la sécurité et la légalité de l’avortement. Nous avons constaté que les « contrôleurs d’accès » (conseillers et personnel du bureau d’accueil) pensaient en général que l’avortement était immoral, alors que les obstétriciens et les gynécologues avaient plus de probabilités de soutenir le droit reproductif d’un individu. Néanmoins, les actions des prestataires ne sont pas nécessairement alignées sur les convictions déclarées concernant l’avortement ; certains prestataires qui affirmaient soutenir l’accès à l’avortement avaient en général des avis personnels sur le moment où l’avortement était approprié et pour qui, des avis qui influençaient leur prestation de soins. Les obstacles à l’avortement au niveau du système, comme le manque de ressources, freinent certains prestataires qui seraient autrement prêts à assurer ce service. Ces obstacles au niveau du système peuvent aussi expliquer les incohérences entre les convictions des prestataires et leurs actions relatives à l’avortement. En mettant en lumière la complexité des croyances et des attitudes des prestataires sur l’avortement, nous pouvons mieux comprendre si les avortements sont pratiqués et pourquoi, ainsi que les facteurs qui déterminent en dernier ressort si une femme peut obtenir un avortement.

Resumen
A pesar de las políticas históricamente progresistas de Túnez relativas a la salud reproductiva, las mujeres tunecinas ahora enfrentan retos significativos para acceder a los servicios de aborto legal. Por medio de entrevistas a profundidad con prestadores de servicios en seis unidades de salud, examinamos dos factores que influyen en las actitudes de los prestadores de servicios respecto al aborto y sus perspectivas sobre la moralidad, seguridad y legalidad del aborto. Encontramos que los guardianes (consejeros y personal de la recepción) generalmente creían que el aborto era inmoral, mientras que los gineco-obstetras eran más propensos a apoyar el derecho reproductivo de cada persona. Sin embargo, las acciones de los prestadores de servicios no necesariamente coinciden con sus creencias declaradas respecto al aborto; algunos prestadores de servicios que dijeron que apoyan el acceso a los servicios de aborto generalmente tenían creencias personales sobre cuándo y para quién el aborto es adecuado, que influían en su prestación de los servicios. Las barreras del sistema para prestar servicios de aborto, como falta de recursos, obstaculizan a algunos prestadores de servicios que, de lo contrario, estarían dispuestos a proporcionar el servicio. Estas barreras también podrían causar que las creencias de los prestadores de servicios no coincidan con sus acciones relacionadas con el aborto. Iluminar la complejidad de las creencias y actitudes de los prestadores de servicios respecto al aborto, podría ayudarnos a entender mejor si y por qué se proporcionan servicios de aborto, así como los factores que en última instancia determinan si una mujer puede obtener un aborto.