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Upcoming Spring for Reproductive Rights and Health in Tunisia and Egypt?

A Comparative Analysis of Reproductive Rights and Health Before and After the 2011 Arab Spring

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Abstract

This thesis attempts to deepen the understanding of changes and trends in reproductive health and rights after the occurrence of political turmoil in the region of the Middle East and Northern Africa in 2011. Using the *right based model of reproductive health* it explores the effects of economic development, social development, gender equality, democracy, abortion rights and religiosity on reproductive health in the politically diverse countries of Tunisia and Egypt. In the course of the thesis, the influence of these determinants and variables are accessed through literature review, scientific researches and statistical analysis. The aftermath of the Arab Spring suggests a great importance of the variables democracy, economic development, and religiosity, making them the most consequential contributors of change in reproductive health in Tunisia and Egypt.

Keywords: women's rights, reproductive rights, abortion, Egypt, Tunisia, reproductive health, contraception, Arab Spring

Abstrato

Esta tese tenta aprofundar a compreensão das mudanças e tendências da saúde reprodutiva e direitos após a ocorrência das turbulências políticas na região do Oriente Médio e Norte da África em 2011. Usando o modelo baseado em os direitos de saúde reprodutiva, a explora os efeitos do desenvolvimento econômico , desenvolvimento social, igualdade de gênero, democracia, direitos ao aborto e religiosidade na saúde reprodutiva nos países politicamente diversos da Tunísia e do Egito. No decorrer da tese, a influência desses determinantes e variáveis é acessada por meio de revisão bibliográfica, pesquisas científicas e análises estatísticas. O rescaldo da Primavera Árabe sugere uma grande importância das variáveis democracia, desenvolvimento econômico e religiosidade, tornando-as as contribuições mais importantes da mudança na saúde reprodutiva na Tunísia e no Egito.

Palavras- chave : direitos das mulheres, direitos reprodutivos, aborto, Egito, Tunísia, saúde reprodutiva, contracepção, Arab Spring

Content

List of Abbreviations

ATFD - Tunisia Associations of the Democratic Women

CEDAW - Convention on the Elimination of All Forms of Discrimination Against Women

DI - Democracy Index

FGM - Female Genital Mutilation

GDP - Gross Domestic Product

GII - Gender Inequality Index

HDI - Human Development Index

ICPD - International Conference on Population and Development

IUD - Intrauterine contraceptive device

MENA - Middle East and Northern Africa

NGO - Non-governmental organization

ONFP - The National Family Planning and Population Board

SCAF - Supreme Council of the Armed Forces

TFR - Total Fertility Rate

UN - United Nations

UNDP - United Nations Development Programme

UNFPA - United Nations Fund for Population Activities

UNICP - United Nations Informal Consultative Process

USAID - United States Agency for International Development

WHO - World Health Organization

MDG - Millennium development goals

SDG - Sustainable Development Goals

UNRISD - United Nations Research Institute for Social Development

UGTT- Tunisian General Labor Union

MOPH - The Ministry of Health and Population

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1) Introduction

For the past fifty years, accessible family planning has been a key method to control population growth, unwanted pregnancies and sexually transmitted diseases (Faúndes and Shah, 2015). Affecting mostly women and their children, two-thirds of the world's population has suffered negative repercussions from insufficient reproductive health policies, hindering economic and social development. Such impediments result in lack of education, worsened quality of life, increased health costs, social injustice and diminished productivity (Aoyama 2001, 20-22). The Middle East and Northern Africa in all its diversity is a region where a variety of religious discourses, patriarchal traditions, and economic development has dictated women's reproductive health. But has the politically turbulent and revolutionary era of the so-called 'Arab Spring' changed perceptions of contraception, abortion and other reproductive health indicators in Egypt and Tunisia?

The research question guiding this dissertation will be *How did the political turmoil influence reproductive health in Egypt and Tunisia*? This thesis enquires into reproductive health and reproductive rights focusing particularly on modern forms of contraceptives and abortion, examining predominant determinants that affect it and exploring how Jasmine Revolution and 2011 Revolution in Egypt changed reproductive rights and consequently the health of women in a before-mentioned historical moment. This work also examines the occurrence of abortion in legal and illegal settings as well as it seeks to explore the role of religiosity within this issue.

The thesis starts by defining reproductive rights and reproductive health within the international domain and continues by seeing the issue of reproductive health through human right approach. Reproductive health will be in chapter three analyzed through a rights-based model of reproductive rights followed by outlining and defining these latent constructs and variables. Next, reproductive health will be analyzed within the MENA region, Tunisia and Egypt providing us with available statistic data to comprehend the complexity of the issue. The fifth chapter separately examines the Jasmine Revolution and Egyptian Revolution of 2011, women's role in the political turmoil, and explores reproductive health and rights before and after the revolution by reviewing the literature. Last two chapters are dedicated to discussion, conclusion, and limitations of the study.

2) Reproductive health and reproductive rights

Reproductive health is a predisposition and one of the most important aspects of public health. It affects mostly women and it has been the second most important factor leading to disease, disability or death in the poorest countries worldwide (WHO 2009, 19). Although modern technology and development have provided us with affordable and accessible methods to control reproductive health diseases, limit unplanned pregnancies and make abortion safe, developed and particularly developing countries still struggle with an aforementioned issue. Unmet need in family planning is reflected in an estimating 56 million induced abortions[1] that occur worldwide every year (Sedgh G, Bearak J, Singh S, et al. 2016, 260), with 4.7% – 13.2% of maternal deaths which can be assigned to unsafe abortion.

Terms reproductive health and reproductive rights were officially endorsed for the first time in 1994 by the international community at Cairo International Conference on Population and Development (ICPD). The definition is now adopted by international health organizations, such as the World Health Organization (WHO), and has not changed since:

"*Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and wellbeing by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases."(UNICP 1994, 43).*

[1] Termination of pregnancy before the fetus is viable and able to survive outside uterus by itself.

Reproductive rights, fairly new term was put forward on International Meeting on Women and Health in 1984 but became fully recognized only after Beijing Fourth World Conference on Women in 1995 (Vijakan and Gupta 2011; 2), where the attention was brought to a positive correlation between reproductive health and reproductive rights. Several authors showed how an increased level of women's reproductive rights contributes to improving reproductive health in form of low maternal mortality, bigger contraception prevalence and a higher level of attended births by professionals (Vijakan and Gupta 2011; Nowicka Wanda 2011; Amroussia et al. 2016). Reproductive rights are therefore predisposition for adequate reproductive health, which can be obtained only with the presence of a wide spectrum of legal protection and are defined by:

"*certain human rights that are already recognized in national laws, international human rights documents and other relevant United Nations consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right of all to make decisions concerning reproduction free of discrimination, coercion and violence as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community*" *(UNICP 1994, 43).*

2.1. Reproductive health as a human right?

Reproductive health is a prerequisite for social, economic and human development. Providing the highest achievable level of health generates and contributes to civil, fiscal and personal development. Efforts of the first Millennium development goals (MDG) and now Sustainable Development Goals (SDG) have been focusing on reaching universal sexual and reproductive health. Nonetheless, due to legislative and cultural differences[2], unification and implementation of a universal policy is still a challenging project.

The adoption of the Universal Declaration of Human Rights in 1948 by the General Assembly of the United Nations has agreed that human rights belong to all individuals and all nations. On the other hand, the principle of universalism has been questioned by scholars with

[2] One of many concerning factors is the protection of nations' cultural, social and traditional heritage, which is one of the reasons why conservative and more traditional countries refuse to ratifying some of the international protocols protecting women's rights.

a critical stance, stating it is a construct of Western imperialism and the product of European enlightenment (Nowicka 2011, 126).

Fusion of Western culture and Islamic customs have been particularly challenging: such as in the debates dealing with Western secularisation and the involvement of Islam in constitution or jurisprudence, as well as women's rights in the Occident versus restrictions of women's freedom in the Orient etc. Human rights have been therefore considered in the eyes of Islamic believers in terms of "*universalizing rights discourse implies a sovereign and discrete individual, which is blasphemous from the perspective of the Koran*" (Ignatieff, 2001, 111.). Diverse societies have led to controversies within the international arena, including the endorsement of resolutions by Human Rights Council and the UN General Assembly, concerning the universality of reproductive rights. The Human Rights Council's Resolution 7/19 (2005), "*Combating defamation of religions*", has been one of the first conceptual motions that see religion and the necessity of its protection through the human rights discourse. Article 10 emphasizes "*that, as stipulated in international human rights law, everyone has the right to freedom of expression, and that the exercise of this right carries with it special duties and responsibilities, and may, therefore, be subject to that, as stipulated in international human rights law, everyone has the right to freedom of expression, and that the exercise of this right carries with it special duties and responsibilities, and may, therefore, be subject to certain restrictions, but only those provided by law and necessary for the respect of the rights or reputations of others, or for the protection of national security or of public order, or of public health or mo*rals".

Contradictory perspectives that allow both freedoms of expression and foist the boundaries on its execution are generating irreversible oppositions. The second crucial document is Resolution 12/21 (2010) claiming that the promotion of human rights and freedom should be seen through a better understanding of traditional values of humankind. What has made this resolution so contentious is the predisposition that all traditional practices, which are protected by law, are positive in nature. Yet this is not the case when it comes to harmful practices such as female genital mutilation, child marriage, preference of a son, etc. Protecting these conventions have a deep impact on women's rights, predominantly in strictly patriarchal oriented societies, where their effects harm and discriminate gender equality.

Together with Universal Declaration of Human Rights, set of international acts are protecting women's right to secure their reproductive rights, family planning methods and spacings of

children, internationally most important CEDAW and regionally The Maputo Protocol. The Convention on the Elimination of All Forms of Discrimination Against Women or more know as CEDAW is one of the most important international legal instruments, signed and ratified by both of our analyzed countries. All participant countries are by signing compelled to "*take all appropriate measures to eliminate discrimination against women in the field of healthcare in order to ensure...access to health care services, including those related to family planning*" (UN 1979). Tunisia accepted CEDAW without any reservations in 1980. Egypt has as well signed in the same year however it ratified CEDAW with reservations, as some articles[3] did not comply with the Islamic Sharia.

The African Charter on Human and Peoples Rights, also known as the Maputo Protocol, is praised to be one of the most progressive women's human rights instruments providing a legal framework covering political, social and economic rights of African women and girls. Article 14 obligates "*states parties (to) ensure that the right to health of women, including sexual and reproductive health is respected and promoted*" (Union A. 2003, 15). Egypt is together with Botswana and Morocco the only African countries which did neither sign nor ratify the Protocol, while Tunisia has signed it yet not ratified.

3) Research method and design

Reproductive health is a complex aggregate consisting of various factors influencing women's proactive sexual lifespan. Theoretic approach used for the analysis of the research question is a rights-based model of reproductive rights adopted by Vijayan K. Pillai and Rashmi Gupta in their research titled *Reproductive rights approach to reproductive health in developing countries*, which has been mildly modified by adding the factor "religiosity" to explore its effect on abortion rights as well (2011, 3). The model segmented reproductive health and right into subcategories, which helped us understand the magnitude of changes within the determinant. The aim is to explore possible changes in pre- and post-revolutionary Tunisia and Egypt, and its effect on reproductive rights and health of women.

[3] Articles 2, 9:2, 16, and 29

In order to analyze changes in reproductive health before and after the Arab Spring we need to closely observe and compare: (1) economic development; (2) gender equality; (3) democracy; (4) social development; (5) abortion rights and (6) religiosity, that work within the abortion determinant. There are four latent constructs (2-4) together with reproductive rights and three variables - abortion rights, economic development, and religiosity. Economic development, social development, and democracy are dependent and work in a positive relationship with each other (look figure 1).

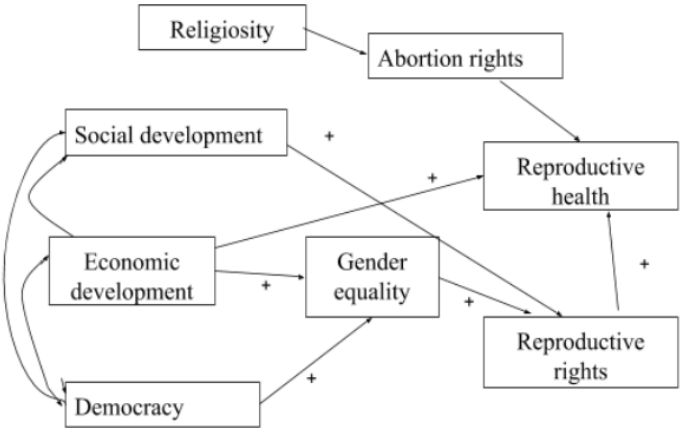


Figure 1: Right-based model of reproductive rights

3.1. Economic development

While economic growth can be easily measured and possesses quantified measures, economic development is far harder to comprehend. Sen (1999) in *Development as freedom* sees it as a substantive autonomy and freedom strengthener, that allows individuals to fully engage in economic life. Sen never provided an explicit definition for economic development. Feldman et al., inspired by his work, interpreted it "*as the expansion of capacities that contribute to the advancement of society through the realization of individuals', firms', and communities' potential*" (2016, 8).

Women's economic, educational and empowerment status play an important role in maternal health and mortality. Modernism and industrialization are two movements that contributed to economic development and raised the quality of life and health in many developing countries (Richey 2004, 931). It has been substantiated that reproductive health and economic development are in a positive correlation due to the improvement of public health. Consequently, women's lives are being positively affected by countries welfare upswing, but, on the other hand, this has contributed to inequalities among the ones that suffer from a deficiency of it.

Even though universal access to reproductive health was indeed accepted by 179 countries at the International Conference on Population and Development (ICPD) in Cairo in 1994, when put into action, the reality of person's income, ethnicity, nationality, level of education and other related features come to place. The poorest women have the least access to sexual and reproductive health, are less able to exercise their reproductive rights, and are most likely to be unemployed or underemployed. Andersen has even suggested that the number of unplanned births would be reduced by 82% in developing countries if the modern contraceptives services would be accessible to all 200 million women that are dealing with the unmet need for family planning (Andersen, 2014).

Ahmed S. et al. analyzed maternal health service in developing countries from three perspectives, namely women's economic, educational and empowerment status. Findings in Saifuddin Ahmed's research et. al. titled *Economic Status, Education and Empowerment: Implications for Maternal Health Service Utilization in Developing Countries* affirm that the likelihood of women situated in the poorest wealth quintile to be attended by a skilled professional at delivery is 94% lower than for women who are situated in the highest economic quintile. Same situation in relation to the access of modern contraceptive methods and antenatal visits, which are highly influenced by economic status. 74% and 84% of women, who are located in the 20% of the poorest compared to the richest group, have less chance of obtaining such mentioned services, respectively. As a result, the number of unwanted pregnancies is higher among the poorer population (2010, 2). To a greater extent these undesirable pregnancies, in several different ways, plunge into poverty even more females. If avoided, there is lower child/mother dependency ratio, current family members are elevated by receiving, directly or indirectly, a bigger share of the income and additionally women can generate a professional career and create a stable income.

Another study by Ann M. Starrs et al. have in their paper *Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission* researched the combination of both effects which have shown that elimination of all unwanted pregnancies could elevate the income of poor people by 10 or 20%. In the occurrence of extreme poverty, results show even higher magnitude, boosting the income for more than 20% (2018, 14). Advantages of women from higher socioeconomic backgrounds include reduction of a child, infant, and mother mortality, greater nutritious health of children and mother, lower fertility rates, participation and empowerment of women in working force, lessen ratio of women affected by sexual related violence etc (2018, 16). As fertility declines,

a participation of women in labor, their overall empowerment and their social inclusion increase. Reproductive rights, therefore, do not only protect women's lives and increase their quality, but they also create a high return from a social point of view, seen in the countries' general development, active labor force and consequently economic growth. Economic development in relation to health will be measured with health expenditure (% of GDP), which expresses the percentage of gross domestic product into healthcare goods and services during each year (WHO database 2018).

3.2. Gender equality

CEDAW represents gender equality as "*equality between men and women, entails the concept that all human beings, both men and women, are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles, and prejudices*" (2010, 22). Unequal power distribution in different spectrums of society often outcomes as gender inequality. Collective empowerment of women results in stronger bargaining power on social and personal level, which can be seen as increased career opportunities, political participation, economic independence and, in general, ability to make attainable choices at personal and social level. Active participation in the reproductive health agenda results in improved women's rights and consequently reproductive rights as well (Buvinic 1999, 569.) As the gender gap shrinks and gender inequality weakens the number of power women possess is likely to increase, resulting in an opportunity to make special and personal choices including reproductive health decisions (Buvinic 1999, 571; Pillai and Gupta 2011, 4).

Inequalities in sexual and reproductive health and rights are intertwined with gender inequality, meaning pregnancy and childrearing can contribute to the exclusion from the labor force or promote lower earnings. Correlation between economic inequalities and availability to sexual and reproductive health is problematic for the reason that "*impedes trust and social cohesion, threatens public health, and marginalizes the political influence of the poor and middle class*" (Worlds Apart 2017, 62). While educated and financially more stable urban women have the opportunity and easier access to modern contraceptive methods, family planning is difficult to be reached by those who are living in rural, undeveloped areas. Women's empowerment is considered to be a pivotal element influencing family planning and reproductive health which results in lower fertility, maternal mortality and access to modern contraceptives (Cleland et al., 2006).

Prata et al. in the study *Women's empowerment and family planning: A review of the literature* (2017, 714) introduce various authors confirming the positive correlation between women's empowerment and reproductive health behavior with various results. However, their study of 46 reviewed articles sees empowerment positively linked with ever use of contraception while associations between empowerment and current contraceptive are seen as inconsistent (2017, 725). Gender equality will be measured with gender inequality index (GII) which focuses on three main aspects of social development - health, empowerment and labor market, all split into multiple subcategories. With raising GII value the gender disparities increase. Data was gathered from UNDP (UNDP 2018).

3.3. Democracy

Democratic systems are expected to maintain citizens' human rights and dignities and provide such mechanisms and the environment by which their rights are actualized (Safaei 2009). Pathway through which democracy is conditioning women's health is direct or/and indirect.

Direct pathway mechanisms help them actualizing their rights, consist of laws straightening reproductive rights and education, freedom of speech and a free flow of information. For that reason, democracies have reduced women's rights violations by rules and regulations applied by the government. Less strict regulations in non-democratic countries make transgressions of such kind more common (Safaei 2009). For women, adequate policies make the process of agency development easier resulting in increased equity and equality within the country. Not only they are more likely to develop agency but they are protected by law as well. Democratic institutions are highly associated with economic development, where a system is more likely include women to freely express their opinion in political arenas and in the public sphere (Pillai and Gupta 2011, 4). With that, women gain political power, are politically active and with time consequently achieve gender equality at the institutional level (Inglehart in Pillai and Gupta 2011,4). Statson makes a clear connection linking democratic regime and states' attentiveness to the public interest (2001, 8). The sole reason of country being democratic doesn't always mean it represents women's best interest. She continues that advancing abortion right is an indicator that demonstrates democracy's interest in women's ability in policy-making (2001,10).

Indirectly, democracies exert influences on women's health through socioeconomic determinants of health seen as a systematic arrangement of ownership of economic resources,

distribution of income and affluence, employment opportunities, social security provisions and socioeconomic mobility (Safaei 2009). Definition of democracy is due to its variety in the academic world still inconsistent. Democracy as a system has four vital elements which are a (1) political system based on free and fair elections; (2) active political participation of citizens; (3) protection of the citizens with human rights and law and which are (4) equal for all citizens. The Economist Intelligence Unit (EIU) with its democracy index interprets democracies fundamental features which "*include government based on majority rule and the consent of the governed; the existence of free and fair elections; the protection of minority rights; and respect for basic human rights. Democracy presupposes equality before the law, due process and political pluralism*" (EIU 2017, 61). As democracy index will be a part of my research, the following interpretation will be adopted as a definition. This democracy index consists five major categories: electoral process and pluralism; civil liberties; the functioning of government; political participation; and political culture (EIU 2017, 2) and is measured in scale from zero to ten meaning: (0-4) authoritarian regime; (4-6) hybrid regime; (6-8) flawed democracy and (8-10) full democracy.

3.4. Social development

Social development, defined as the "*processes of change that lead to improvements in human well-being, social relations, and social institutions, and that are equitable, sustainable, and compatible with principles of democratic governance and social justice*" (UNRISD 2011, 2) is measured with the Human Development Index (HDI). It gives us insight into the crucial dimensions of human development: duration and life stability, education and a decent standard of living.

Social changes have witnessed a sudden increase in development in recent decades, seen through various aspect of development, including human and economic one. While Midgley (1995) saw social development as a "*process of planned social change designed to promote the well-being of the population as a whole in conjunction with a dynamic process of economic developmen*t", Amartya Sen, one of the first academics that challenged how we grasp and measure development, understood development as a "*removal of various types of unfreedoms that leave people with little choice and little opportunity of exercising their reasoned agency*" (Sen 1999, 12). From a broader perspective, human development contributes to society in favor of political freedom, free speech, and press, and promotes people's agency while on individual level intends to promote quality of life and social

security. A higher level of social development offers people access to universal social resources elevating their range of personal decisions making.

Talking about reproductive health and rights gives women not only the opportunity to make their own decisions but as well having the resources to do so. Education as a human capital is considered to be closely and positively linked with reproductive health and fertility (Prata et al. 2017, 714). Contrasting, low levels of human development and women's socio-economic standings are associated with fewer reproductive rights and lessened options in the decision making processes such as intercourse, contraception, and gestation (Pillai and Gupta 2011, 3). Data was gathered from UNDP (UNDP 2018).

3.5. Abortion rights

Abortion is known to be the second most common reason for maternal death according to various authors (Say et al. 2014; WHO 2008; Kassebaum NJ et al. 2014). At the same time studies have proven us that liberal rights to induced abortion substantially improve outcomes in maternal well-being (WHO 2008, 25). Abortion right is defined as "*the legal restrictions that establish the circumstances under which a woman can legally terminate a pregnancy"* (CRLP 2000).

Available and accessible reproductive health is a predisposition for minimization of unwanted pregnancies and consequently abortions, which would ideally completely prevent this fairly safe, yet, in many ways, controversial procedure. Nearly 98% of all unsafe and less safe abortions occur in developing countries, contributing to 13% of all deaths related to pregnancy and childbirth (WHO 2007, 1). In 2017, 43% of all pregnancies in developing countries were unplanned, a larger part of them occurs among rural, poor and uneducated women. This translates into 89 million unintended pregnancies and 48 million abortions, respectively (Guttmacher Institute, 2017).

When abortion is performed in environments where service is legal, reachable and safe, complications are uncommon (Faundes 2015, 57). On the contrary, complications do occur due to further factors. Restrictive law, poor availability of service, financial burden of the abortion, stigmatization, conscientious objection of health-care providers and unnecessary requirements such as mandatory waiting period, mandatory counseling, provision of misleading information or third-party authorization, force women to seek illegal, unsafe abortion outside specialized medical institutions (Lale Say et al. 2014, 331). Abortion rights

and unsafe abortion are still considered one of the most neglected public health challenges in the MENA region, where one in four pregnancies is not planned or intended (Daulaire 2000, 3). Pressing issue of unsafe abortion is the outcome of primary legal restrictions and greater contraceptive use and secondary social, economic, political and religious barriers. Some of the lowest abortion rates can be found in countries where the procedure is legalized (Western Europe), on the contrary, the highest where is not (Latin America). Rates of unsafe abortions are highly linked with the degree of restrictiveness - the more restricted the laws are, the more common unsafe abortion will be (Dailard C. 1999). For example, abortion-related mortality in Sweden lessened for 99.9% within 40 years period due to abortion legalization (Högberg U and Wall S. 1990, 378), on the other hand criminalization of the procedure became accounted for 87% of all maternal deaths during prohibition time in Romania (Hord C et al. 1991, 238). Data continually points out an association between maternal deaths attributed to restrictive laws - a median rate of unsafe abortions in countries with most restrictive abortion laws is 23/1000 women compared with 2/1000 in countries where abortions are allowed. Same goes for deaths related to unsafe abortion where there are 34/100.000 maternal death in countries with restricted laws compared to fewer than 1/100,000 maternal death in countries with less restrictive laws (Grimes et al. 2006; WHO 2007).

Dr. Bela Ganatra et al. showed a direct link between countries economic standing and abortion safety. Most of the safe abortion happened in upper-middle-income (67,1%) and high-income countries (82,2%), compared to the 21,8 % in low-income and 42,3% in lower-middle-income countries. Countries' economic standings have great importance as well when compared to developing and developed countries with similar restrictive abortion laws, where there were 31,3% least safe abortions compared to 0,3%, respectively (2017, 2377). There are five possible degrees of restrictiveness: (1) Abortion is permitted without restriction as to rea-son; (2) Abortion is permitted on socioeconomic grounds; (3) Abortion is permitted to protect a woman's mental health, as well as her life and physical health; (4) Abortion is permitted to protect a woman's life and physical health (5) Abortion is permitted only to save a woman's life, or the procedure is banned entirely (CRLP 2000).

3.6. Religiosity

Religion and religiosity are both constructs and fundamental parts of every culture. They define the core belief system of society and depending on liberal, traditional or conservative

stance intend to steer devotees decision making in various matters, even reproductive health. Religiosity consists of three fundamental components: affiliation, activity (attendance or participation in religious activities) and corresponding beliefs (Mathur 2012, 85). Islamic worship, as well as followings of other religions, considerably shape people's sexual and reproductive health together with health-related behaviors.

And when a majority of people such as 97% in Egypt and 93% in Tunisia find religion as an important day of their life, faith becomes a crucial element of public health determinant (Crabtree, S. 2010). Health status is not only influenced by families wellbeing, women's status, financial standing, level of education, women's power of decision making and political participation but additionally depends on the interpretation of the holy book Quran and individuals' religious devotedness. As population in the MENA region with predominantly Muslim population[4] roughly increased from 105 million in 1960 to 436 million in 2016 (The World Bank 2018), accessible and socially accepted modern contraception are particularly crucial.

Religiously speaking, family planning along with abortion have a long existence in Islamic thought. Early religious leaders approved contraception as a form of family planning upon agreement of both partners, as Quran or the Prophet's tradition (Sunnah) do not condemn birth control in any form (Shaikh et al. 2013, 67-72). On account of religious and cultural reasons, modern contraceptive methods need to be fully accessible and supported not only by the government to help them to produce stable socio-economic environments and control the population growth, but also by Islamic jurists who shape lives of believers. Adopting national plans in order to control the population growth is, together with education, one of the main effective ways for family planning methods. In 1930, during the time of Grand Mufti[5], one of the most authoritative thinkers of Islamic law, Egypt successfully implemented a religious decree by permitting contraception and initiated public attainable hospitals with birth control clinics. Later on, in 1964, this was even more encouraged due to the changing demand of the Muslim population (Kats 1983, 43-44). Since then, government bodies and religious leaders appeared as pivotal educational actors advocating for public acceptability of modern family

[4] With the exception of Cyprus and Israel, Islam is the most practiced religion in all of the countries.
[5] According to him, contraception was practices and permitted by the Prophet.

planning methods from a religious stance and made the concern of population growth as a major component in the Egyptian educational system[6].

When we talk about abortion in Islam the major conundrum lies between the religious imperative of potential human life itself and the welfare of the Muslim community. Taking care of the individual and the community essentializes long-term Islamic jurisprudence. As Bowen (2003, 61) states, "*Muslims treat respect for life as basic to religion, but not as the supreme ethical principle to which all others give away*". There are four basic sources in Islam, which lay down the fundamental perception on Islamic ethics view. Especially when we deal with delicate questions such as abortion, Islamic religious values converge with the ethical ones and serve as a moral compass when a believer is trying to determine important life choices. By descending order, the first source of ethical guidance is the Quran, which serves as a foundation for all inquiries. Together with the Holy Book, the second primary source in Islamic theology and law is the Sunna, verbally channeled record of lessons called Hadiths, deeds and proverbs, consents and disapprovals of the Islamic prophet Muhammad. The third source is the Fatwa, which provides interpretations of the Quran as a non-binding but authoritative legal opinion of qualified jurists or muftis and it serves as a moral source of everyday guidance for the untrained general public. Muslims are in general not obliged to follow and act in compliance with fatwas but in case they do, they bound themselves to the scholar and act accordingly to his beliefs. The essential difference between common-law opinions and fatwas is that the latter is not universally mandatory, and they do not carry such a weight as that of secular common-law opinion. The last source is the opinion of exemplary scholars, which may be a foundation for Islamic law but is strictly reviewed, particularly regarding the person who gives the decision (Elif 2016, 885-887). Although today Sharia is not wholly practiced in most Islamic countries, Muslims still consider it as an ideal law (Anderson V: Munh, 1998, 30). Throughout the colonial history, the Islamic world and thus Islamic law were not isolated from the contact with the European culture and hence with European law, which still have a major impact on the mentality of many Muslims. These different considerations left great footprints in the Islamic law practice and execution of it.

[6] Among others they have developed a program called "Ishraq" which is particularly aiming at young girls coming from deprived rural towns to educate them about health and diet necessities.

4) Reproductive health and abortion issues in the MENA region

Historically, the MENA region has suffered from many instabilities that have affected people's lives and consequently the quality of it. Needless to say, it is not the only region in the world suffering from gender inequalities but it is, however, the geographical area where the gap between rights of male and female population significantly differs (Nazir 2005, 14). The aspiration for more stable democratic settings and independence led to many conflicts, followed by humanitarian crises that have especially affected lives of already marginalized people, in many cases women. Nowadays, reproductive health is seen not only as a maternal and child health concern but as a promotion for "*broader objectives of social and economic development and stability*" (Aoyama 2001, 4). Although in the region there are significant contrasts and socio-economic asymmetries that have provided diversified progress in reproductive and abortion rights, they do share homogeneous cultural constraints, which limit the progress of health reforms and continue to endanger women's welfare. Reproductive health is monitored by a standardized set of indicators, which were decided in Cairo's ICPD conference in 1994 and are still in effect: (1) percentage of women using modern contraceptives, (2) maternal mortality ratio[7] and (3) percentage of women who gave birth supervised by trained personnel.

Contraceptive prevalence[8] in the region is little above the world average, but it has shown a dramatic increase from the 1990s - while the world's average usage of modern contraceptive methods has actually dropped from 53.5 in 1990 to 50% in 2013, the MENA region has displayed substantial gains. In such a time frame the prevalence of modern contraceptives has increased for 16% (The World Bank 2018), which can be assigned to more accessible information and education about family planning, assertive family planning policies and, overall, acceptability due to all the causes mentioned above.

Maternal mortality in the MENA region is compared to global trend decent. Latest World Development Indicators show a decrease in maternal mortality from 166.0 and 385.0 in 1990 to 81.0 and 216.0 in 2015. It varies from country to country, with Kuwait's 6.0 to Yemen's 385.0 maternal deaths per 100.000 live births. Causes are closely linked to women's rights,

[7] Number of maternal deaths per 100.000 live births.

[8] Contraceptive prevalence rate is the percentage of women who are practicing, or whose sexual partners are practicing, at least one modern method of contraception. It is usually measured for women ages 15-49 who are married or in union. Modern methods of contraception include female and male sterilization, oral hormonal pills, the intrauterine device (IUD), the male condom, injectables, the implant (including Norplant), vaginal barrier methods, the female condom and emergency contraception (The World Bank 2018).

which are based on countries' gender inequalities, public health expenditures, poor socioeconomic and development indicators, low levels of literacy and secure governance. The lowest maternal mortality is found in countries with the highest levels of health spending per capita and the smallest gap in education (Singh 2012, 124; WHO 2008, 3).

In the work *Women's Reproductive Health in The Middle East And North Africa* Farzaneh Roudi-Fahimi gathered data from various reports and projected reproductive health through statistical analysis of Middle Eastern and North African countries (Farzaneh Roudi-Fahimi 2003, 4-5). The last indicator defining reproductive health is the percentage of all births attended by skilled health staff[9] (3). An influential factor is the geographical area of delivery - if the total percentage of all deliveries attended by skilled personnel in the MENA region is 70%, only 54% of rural women compared to 88% of urban women do get appropriate care. Globally, compared to the addressed region, attended births heighten from 62.8 and 78.6 in 2000 to 78.5 and 88.1 in 2013, respectively (Farzaneh Roudi-Fahimi 2003, 6-8; The World Bank 2018).

Abortion on request during the first trimester is legal only in two countries of the region - Turkey and Tunisia, while in the 79% of the region abortion is restricted in some way. 55% of people lives in countries[10] where termination of pregnancy is prohibited with the exception of saving woman's life, and 24% in countries[11] where abortion is permitted exclusively to preserve woman's physical and mental health (Elif Ekmekci et al. 2016, 889). Even with recent advances and efforts recommended by the international community that permit easier access to safe abortion in developing countries, less safe and the least safe abortion are almost as common as secure ones. Infections, complications during and after the procedure or even maternal death follow as an additional financial burden which substantially influences women's and families lives and additionally worsens women's health care.

In a global, regional, and subregional classification of abortions by safety between 2010 and 2014, estimated on a Bayesian hierarchical model, significant research estimated that approximately 55,7 million abortions occurred within the researched time spread, among which 54,9% were marked as safe (2017, 2377). In North Africa, there were performed

[9] Births attended by skilled health staff are the percentage of deliveries attended by personnel trained to give the necessary supervision, care, and advice to women during pregnancy, labor, and the postpartum period; to conduct deliveries on their own; and to care for newborns (The World Bank 2018).
[10] Following countries are Egypt, Iran, Iraq, Lebanon, Libya, Oman, Palestinian Territory, Syria, United Arab Emirates, and Yemen.
[11] These countries are Algeria, Bahrain, Jordan, Kuwait, Morocco, Qatar, and Saudi Arabia.

1.920.000 abortions on a yearly basis. According to the results, only 29,0% of all abortions in the region are safe, meaning they occur under the supervision of health-care workers and are made by procedures recommended by WHO. The other 71% are marked as unsafe, with 29,0% less and 44,4% least safe. Ganatra et al. show noticeable differences between developed and developing countries, where 87.5% compared to 50.5% of abortions were safe (2017, 2377). The most important factor influencing feticide safety is its lawful status - while in 57 countries where the procedure is legal and available on request only 12,6% was marked as less [12] and the least safe[13] compared to the 74,8 % in 62 analyzed countries where laws completely ban or allow abortion only to save woman's life or to preserve her physical health (Ganatra et al. 2017, 2377).

4.1. Reproductive health in Tunisia

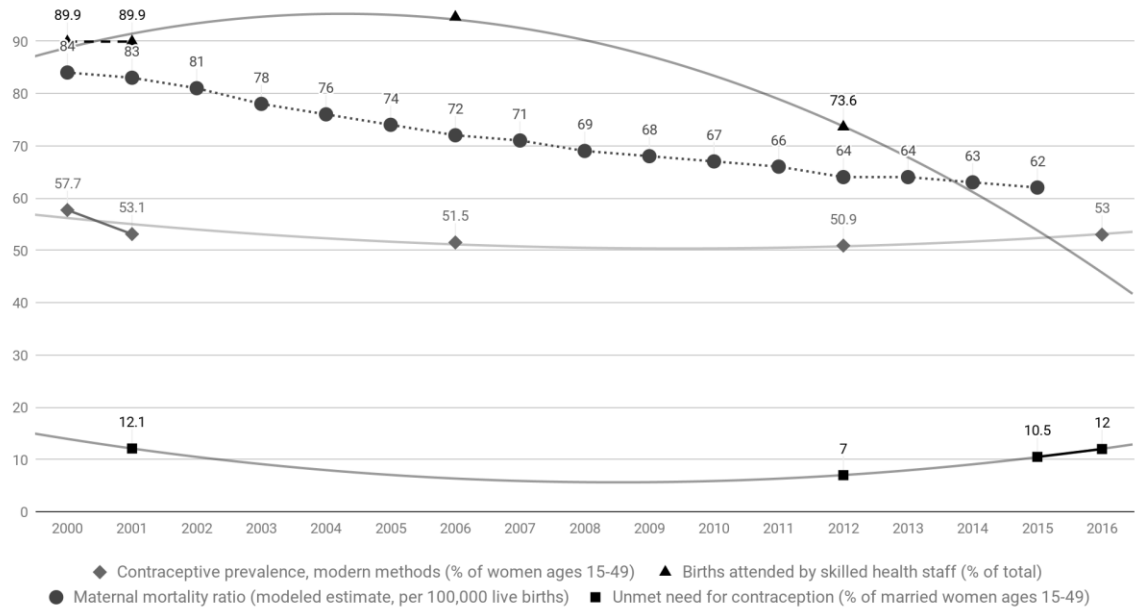
Tunisia, a so-called pioneer in women's rights and status in the MENA region, has been since its independence in 1956 (Warren G. et al. 1968, 620) advanced when it comes to reproductive and sexual rights. It has always incorporated women in the development/political agenda, in particular reflecting on women's reproductive health in the long term. Among such benefits, the choice in family planning which has consequently lowered fertility rates and has lengthened the average life expectancy has improved social inclusion of women (Gataa, 2011). Since 1994 Tunisia has shown improvements in reproductive health, although CEDAW shadow report manifested some of the still existing issues such as discrimination against unmarried women, criminalization of homosexuality and virginity testing (ATFD 2010, 20-25).

As defined before, reproductive health is measured by three components that determine the quality of women's reproductive health care. In relation to this, usage of modern contraceptives (1) in Tunisia has been rising since the first statistic analysis in 1988, when only 35.5% of all women used modern methods of contraception. Prevalence of it was as of 2012 measured as 50.9 %, with its highest measured value over the past 34 years in 2000 (57.7%) and lowest 24.7% in 1978. Interestingly and in contradiction with global trends, the percentage of women using modern contraceptives reached its peak in 2000 and since then it has been in a constant decline[14] (The World Bank 2018).

[12] Less-safe abortion, defined by WHO, is done by trained providers using non-recommended methods or using a safe method (eg, misoprostol) but without adequate information or support from a trained individual.
[13] The least safe abortion, defined by WHO, is done by untrained people using dangerous, invasive methods.
[14] Values as followed: 53.1% in 2001, 51.5% in 2006, 50.9% in 2012

Maternal deaths (2) have been steadily and constantly, with a minor upswing in 1997, decreasing. This lower middle-income country has reached its lowest rate in 2015[15], but it is still far behind developed countries[16] and the majority of MENA countries as well. Births attended by professional staff (3) have been rising till 2006 when they have reached a peak at 94%. Next and final measured value was in 2012 where the value dropped by more than 20% (73.6%), almost reaching the value in 1988 (69%).

Graph 1: Reproductive health indicators in Tunisia



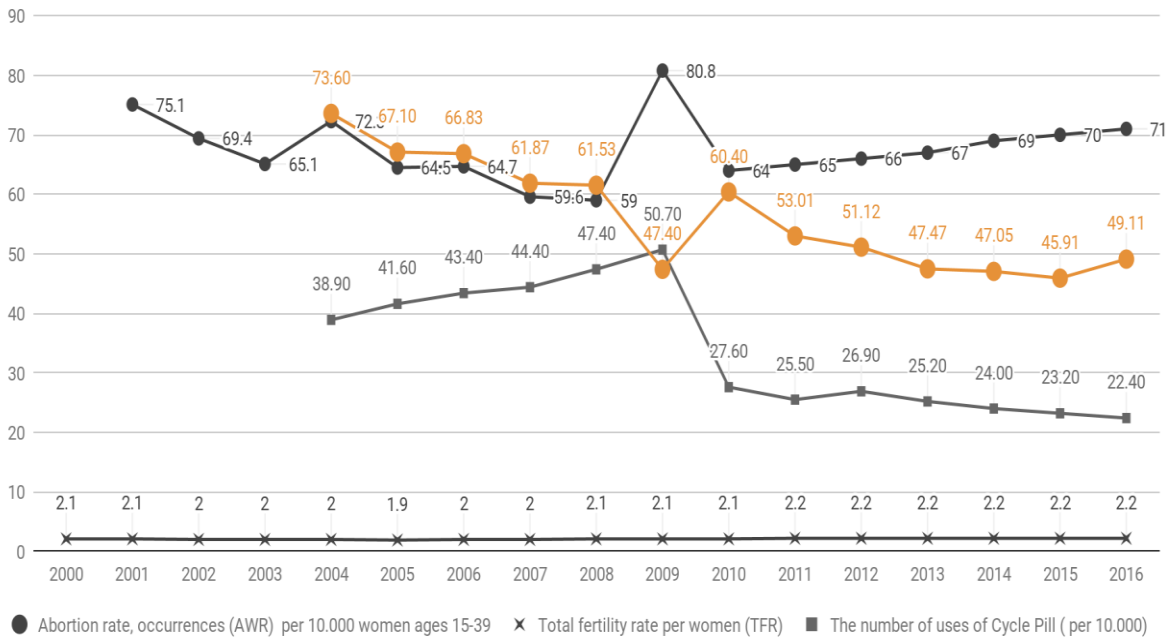
In 2015, IUD was still the most common use of modern contraceptive (27%), followed by pills (20,3%) (Trends in Contraceptive Use Worldwide 2015, 25). The same trend continues in 2017 when the first is used by 27% of all 53% of women who are using contraception and the second by 20% (UNDP 2017). In 2009 there have been more than 506.000 number of uses of cycle pill while there has been a significant almost 50% lessening in 2010. The number of females using the pill has been dropping ever since and is now valued at approximately 224.00 women (Tunisian data portal 2018). The share of IUD users has been dropping on a yearly basis up until 2009 (from 73000 to 47 000) when they have to contrast with pills gained in its utilization. Short term gain continued in a steady drop with value in 2016 similar to the one before the uprise in 2010 (49,000). The only method that has been consistently gaining in its consumption are condoms, which pharmacists often described as

[15] 62 deaths per 100 000 live births.
[16] 12 deaths per 100 000 live births.

financially more difficult to obtain but as well the only option in the time of contraceptive shortage that occurred in 2017 (France 24, 2018).

In Tunisia abortion is allowed and legalized since 1973 and is permitted without restriction as to rea-son. It is very interesting to observe the attitudes of contraception regarding abortion. In 2009, there have been noticed a fall in contraception usage among women in their reproductive age, as the level of abortion jumped from 5.9 to little more than 8 abortions per 1000 women. In other respect, abortion rates have been pretty constant and are operating within 5.9 and 7.5 abortions per 1000 women ages 15-39. The total fertility rate has been persistent over the last 20 years, moving from 1.9 to 2.2 children per women, with overall higher values in the last decade.

Graph 2: Contraceptives, abortion rate and fertility in Tunisia

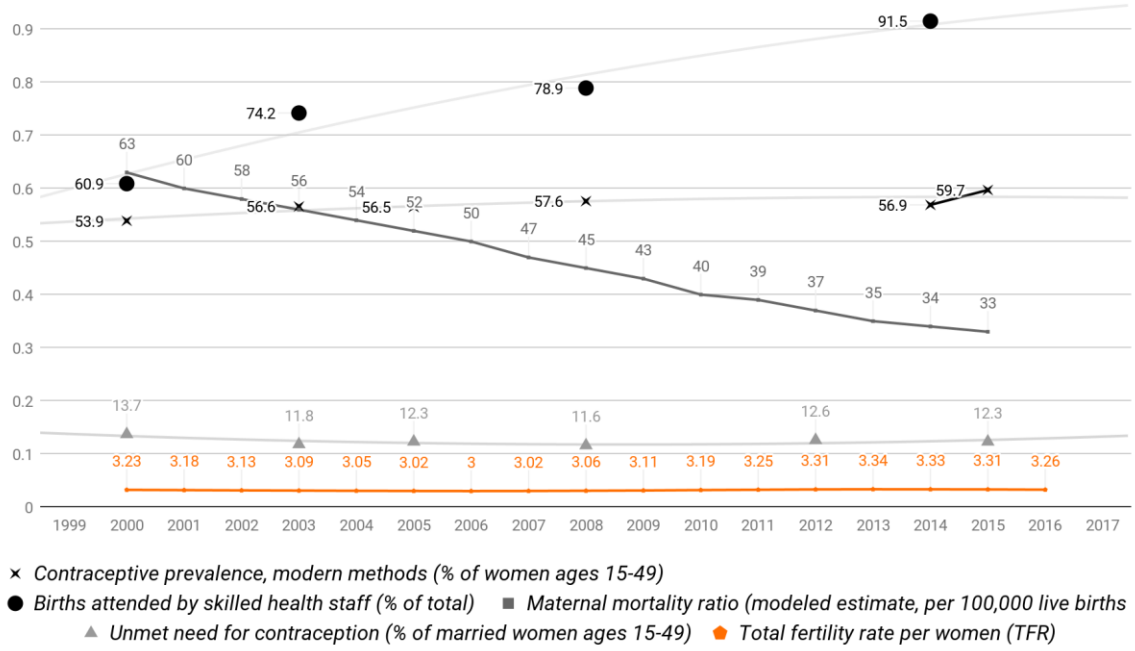


4.2. Reproductive health in Egypt

Existing within the well-established framework of family planning, reproductive health in Egypt is not yet well developed and understood. Contraceptives and birth control clinics have been available in Egypt since 1930, supported by the most authoritative interpreter of Islamic law, the Grand Mufti. Religious leaders have accepted birth control in the eyes of Islam as the need for population control has arisen (Babar 2013, 69).

Recent changes of socio-economic decrease in usage of modern contraceptive (1) have influenced Egyptian fertility rankings which are now at the same level as 16 years ago (The World Bank 2018). Egyptian fertility rates have dropped on yearly basis up to 2006 (3.0%) when the curve changed its course and in 2014 equalized with the value in 1998 (3.5%) (World Bank 2018).

Graph 3: Reproductive health Indicators in Egypt



Contraception prevalence (1) among women aged 15-49 years reached its peak with 57,6% in 2008 and slightly declined over the next six years (56,9%). The unmet need of contraceptive[17]for married women has been in constant decrease until 2008 when it reached the minimal value (11,6%). Interestingly, in 2012, the value raised for additional percent, leaving 12,6% of women with an unmet need for methods of family planning. Constantly decreasing maternal deaths (2) reached its lowest rate in 2015, with 33 deaths per 100,000 live births and are compared with MENA and as well global rate above average. Birth attended by professional personal (3) has been increasing since the addressed year till the latest statistic analysis in 2015. 56.9% growth - from 34.6% in 1988 to 91.5% in 2015 - has

[17] Unmet need for contraception is the percentage of fertile, married women of reproductive age who do not want to become pregnant and are not using contraception.

overcome the global average for approximately 10% but it is still behind the highest Tunisian ranking from 2006, measured value 94,6%. Total fertility has been increasing since 2006 (value 3.0) and reached its maximum value in 2013 with 3.34. In the last three years, we can see a trend of reduction.

5) Arab Spring and its effect on reproductive rights in Tunisia and Egypt

5.1. Jasmine revolution in Tunisia

In early 2011, all across the Middle East and Northern Africa, people gathered at the forefront as demand for freedom, dignity, and change arose. The long-lasting despotic regime of Tunisian president Zine El-Abidine Ben Ali repressed human rights activists, Islamist, opposition politicians and civil society in general. As a result, the oppressed people became unified by the struggles against the dictatorship and became stronger as they gathered their forces. Secular political parties working together with Islamists in 2005 by carrying out a hunger strike have already shown that political constructivism could exist in Tunisian society (Boubakri 2015, 72). The so-called Jasmine revolution arose from authoritarian characteristics of the ruler, long-lasting social and political exclusion of marginalized people but it has as well symbolized the revival of civil society (Boubakri 2015, 73). In December 2010 a street vendor Mohamed Bouazizi took his own life after being refused to talk to the governor's office who confiscated his wares. He carried out political self-immolation which was a breaking and starting point for the Tunisian revolution. Years of strikes, protests, inspiring social movements and bloggers beforehand and during played a specifically crucial part in the revolution (Mullin 2015, 89).

Women particularly played a vital role standing side by side to male counterparts - including working and professional women, journalists, bloggers, activists, female lawyers working at Tunisian General Labor Union (UGTT) and even rural women outside Tunis who participated in the uprising across the Tunisian countryside. They all experienced a lot of hardship and violence that the government crackdown had forced them to undergo (Khalil 2015, 287) and were often victims of sexual, physical assault and even rape (Sahin 2014, 162). In relation to this, a persistent Western perception of Muslim women seen as "*victims, (being) oppressed, (and) having little agency*" (Joseph 2012, 10) was challenged by women's active participation in political transition.

Regional lone success story after Jasmine spring changed de facto one-party state to multi-party democracy with the first free election in the history of Tunisia electing Ennahda party. Center-right and moderately Islamist Ennahda, inspired by Muslim Brotherhood and Iranian revolution won 37% of the vote by having no real opposition (NDI 2011, 13), almost winning the complete majority. In December 2011 the assembly elected human rights activist Moncef Marzouki as a president and Hamadi Jebali, Ennahda's leader, sworn as prime minister. In 2014 Tunisia held first free regular legislative elections since independence in 1956 that were won by secularist Nidaa Tounes party. Mohamed Beji Caid Essebsi, party leader, became the president later in the same year.

5.1.1 Reproductive rights and abortion in Tunisia before and after the Arab Spring

Tunisia is an economically lower middle-income country with a population of 11,3 million people where nearly 98% of the population is Muslim. Since 1956 Tunisia has been acknowledged as an independent state in Northern Africa. This semi-presidential representative democratic republic hold its first democratic election in October 2011, after the Tunisian Jasmine revolution which symbolized the country with dramatic political changes. Its legislative system is based on mixed civil law, French civil code and Islamic law (Freedom House 2010, 1). Until the Jasmine revolution, Tunisia was ruled by two presidents who were both focused on the modernization of the country where women were included as a part of the strategy. Habib Bourguiba (1957-1987) and Bin Ali (1887-2011) considered women's empowerment as a part of countries pursuit of modernization to reach economic growth (Grami, 2008), but they have never genuinely aspired to reach gender equality. While the first president used this as a mechanism for boosting countries economic power and women's labor, the second saw it as an opportunity to co-opt regime critics and satisfy domestic and foreign donors (Grami, 2008).

In Tunisia, women's rights are defined by state policy combined with religious ideology, which underwent a major transition after the independence. In 1956 it was the first country in the Middle East and Northern Africa to promulgate the Personal Status Code. The law provided female citizens with unprecedented rights such as abolishing polygamy and repudiation, establishing the minimum age for marriage to 17 for women and 20 for men, jabr (right to compulsion), the matrimonial guardian, and instituting legal divorce (Ben Achour 2001, 415). It has as well furthered itself from a pro-natalist policy established by French where contraceptives sells were prohibited (Warren G. et al. 1968, 620). The curb of the

population restraining became a national issue in 1960. Mufties, Islamic scholars, gathered in several meetings discussing the issue which would essentially control the population growth, decrease poverty and overall improve human development. Following issues led to the implementation of the first family planning program, which was inaugurated in 1966 in order to achieve countries ambition of modernization and development (Eltigani 2009, 215). It's important to acknowledge that legislation and fiscal measures were taken almost simultaneously with the program which contributed to the success of national family policy (Gueddana 1995 in Eltigani 2009, 220). At that time, thirty-nine centers focusing on family planning were allocated across the country in various hospitals, clinics and even mobile units, to reach the most inaccessible areas (Lapham 1970, 243).

In 1965 the abortion was made legal for women with five or more living children (Warren G. et al. 1968, 621), but due to too restrictive policies it was soon rewritten and the new abortion law, which is still in use nowadays, was legislated in 1973 (Hessini 2008, 21). The new law permitted abortion within the first three months provided in a suitable facility free of charge if women were eligible for free healthcare (Eltigani 2009, 220). After Tunisian Women's Union generated public and government pressure caused by multiple suicides due to pregnancies outside marriage, abortion became not only allowed among all, married and unmarried women, but publicly accepted in order to control population and boost socio-economic development (Amroussia, 2016, 182). Performed and available only within the first three-month frame[18], abortion became free of charge upon request and legal agreement of a personal medical practitioner. In 1969 women obtained the right to use contraceptives and after a few years, it was even noted that "*women were often forced to accept contraception and even sterilization in return for abortion*" (Maffi 2014, 682). Tunisian women underwent vast "*social pressure, blackmail, and stigmatization (that) were common in government clinics and the creation in 1974 of the Bourguiba prize for the governorates that had been able to mostly reduce birth rates is very significant*" (Sandron, 2000; Gastineau, 2002 in Maffi 2014, 682). Same year as abortion became legalized (1973), the National Family and Population Board (ONFP) was created with the purpose to "*manage concurrently a priority population program and a maternal health program stressing demographic balance; target group attention such as to rural populations, mothers and children, women, and young people generally; and the family*" (Clarke 1969, 47). It was until 1994 ICPD in Cairo that

[18] Before the ensoulment of the fetus according to the Islamic view.

family planning shifted in its purpose. Before solely considered as a way of population control, it underwent a transformation in its paradigm and shifted from a demographic concern to responsibility of protecting women's reproductive health (Amroussia 2016, 184). Due to that, ICPD is still considered as one of the most comprehensive legal agreements concerning reproductive and sexual rights, with the aim of redirecting the discourse in the human rights frame of reference (Nadakavukaren, 2000).

In the particular case of Tunisia, shifts in reproductive and sexual rights started showing off in the beginning of mid-2000. The religious discourse was an important element of the process of democratization and re-Islamization that aimed to replace national westernized mores (Maffi 2014, 681). Before the election, the Ennahda party made various commitments and promises towards protection of women's rights and civil liberties, but just after, several members started questioning some aspects of women's rights (Sahin 2012, 165). They have even suggested a clause in the draft of the new constitution describing women as "*complementary to men"* and for the *"first time, on the possibility of giving way to the principle of 'complementarity', rather than supporting the founding pillars of 'equality*'" (Daniele 2014, 20) followed by deafening demonstrations against the proposal (Sahin 2012,166). Irregularities in women's liberties, together with the potential involvement of Tunisian violent group known as Salafi, questioned their influence on women's rights, sexuality, family and education (Sahin 2012,167; Maffi 2014, 662).

Nonetheless, at the beginning of the 21st century, the National Office for Family and Population which was working within the Ministry of Public Health (ONFP) introduced clinics broadened in its purpose and started providing not only medical but also educational and counseling services for married and unmarried males and females. Irene Maffi in *Abortion in Tunisia after the revolution: Bringing a new morality into the old reproductive order* acknowledged that while the ONFP project was implemented in compliance with internationally accepted women's rights, state-sponsored clinics did not always agree with its "moral" ideology, specifically abortion, which due to religious and social dissimilarities sometimes opposed. Maffi continues by providing a notable statement from an experienced physician, who stated "*after the revolution, people are afraid to mention sexual and reproductive rights, although they have been officially recognized by the state*" (Maffi 2014, 684). Discriminatory attitudes of reproductive health providers were shown as abortion service became more difficult to acquire and budget, intended for family planning and reproductive health, decreased due to economic crisis (Khawas 2012, 12). Rejection of

abortion due to physicians personal beliefs and cancellation of procedure on days of Ramadan placed patients between their legal rights and unprofessional individuals, who were, even before the official change, victims of the new after-revolutionary political system (Maffi 2014, 685). Abortion was sometimes denied even when the legal condition for abortion was met. According to the ONFP, between 2011 and 2012 there has been a reduction of more than 55% of abortions in public hospitals and 2% in clinics managed by ONFP (Maffi 2014, 686). As stated in Maffi's research, in 2013 at least 10 out of 24 clinics providing abortion services, located in urban and rural areas, closed their doors due to various reasons such as unsanitary operation rooms, lack of physicians and anesthesiologists. Complicated bureaucracy and lack of governmental control over public hospitals contributed to a decrease in abortion services, especially after Ennahda came into ruling (Maffi 2014, 691).

Another important research led by full name Gerdts C. et al. and analysing *Abortion in legal settings* came to a conclusion that in 2012 in Tunis, 26% of women didn't receive the abortion they sought - 7% of women were turned away due to gestational age, 4% were required "*to have an ultrasound scan prior to the procedure or were referred to other providers*" and 15% of women due to medical tests not required by the law to undergo abortion and other reasons such as being single, unmarried and not being accompanied by a spouse (2014, 162).

Selma Hajri et al. (2015) have as well taken a closer look to seek reasons for denial of abortion in legal settings. Qualitative research was conducted on thirteen women having various gestational ages at the ultrasound, marital statuses, previous children and pregnancy outcomes. After being denied due to legal or medical reasons, researchers came to the conclusion and provided three main reasons: (1) gestational age, (2) health conditions, and (3) logistical barriers. Coming to the public hospital either too late or too early (1), one of the women reported that the doctor provided her with inaccurately reading of the ultrasound. At the first medical appointment, she rejected her due to the too small fetus and a month after for too advanced gestational age of the embryo. After confronting her, the doctor's response was: "*He's developed, it's a sin*" (Hajri 2015, 7). Other women were rejected because they had a history of diabetes, asthma or taking medications for blood clotting (2). Multiple times women sought abortion because of the health conditions they had, but clinics took those defects as a reason to deny them from the procedure. The last reason was represented by bureaucratic delays (3) including long waiting periods which forced women, at least the ones

that were financially able to, to continue with the procedure at private clinics (Hajri 2015, 6-9).

Tunisia has suffered a great deficit in contraceptives in the last year, caused by a recall of substandard stock, while pharmacists explain that deeply in debt state pharmaceutical company made it difficult to pay the drug makers (France24, 2018). The shortage in contraception forces more women proceeding abortion and even though abortion is legal since 1973, social stigmas still condemn women who carry on with the procedure as abortion is "haram". Emna Hassairi, midwife and activist (ATFD) explains that "*right now the state doesn't have the will to invest in women's sexual rights. Contraceptives have been out of stalk, which is unheard of since Tunisia ensured the right for contraception. There have been months and months without IUD in Tunisi*a". In relation to this, Maffi says that since the revolution "*social class, education, geographic origin, and professional status have determined women's possibility of taking a decision about their reproductive life. New, democratic Tunisia has compelled women to travel within the country and overcome economic, social and ideological obstacles in order to find a clinic or hospital where they can get abortion care and family planning*" (2014, 691).

5.2. Egyptian Revolution of 2011

Egypt was the second country after Tunisia that was hit by the uprisings of unsatisfied and change demanding nation. Economic, social, political and military factors encouraged active participation and resilience towards political domination of Mubarak's family. Right before the revolution, in 2010, Hosni Mubarak made a constitutional amendment which would authorize his son to succeed his presidency (Abdulsattar 2015, 69). The possibility of having no real modern democratic state after the end of Mubarak era generated protests which were boosted by the events in Tunisia and after Ben Ali's resignation, exceeding in its dimension and turning into revolution. Inspired Egyptian people started their own revolt in Tahrir Square on 25th January 2011 accompanied by the slogan "*bread, freedom, and dignity*", facilitated by social media and by having no real leaders. Some authors argue the uprising can be considered as "*one of the most important socio-political events of modern times*" (Fatuma and Macharia 20113, 359-360). Predominantly women and male, regardless of social, political or economic status gathered, challenging status quo, demanding presidents Mubarak's resignation after almost 30 years of ruling and demonstrating rare moments of equality (Malmström 2012, 7).

In the revolution women were primarily not pushing for women's rights agenda but as Malmström stated they have been maintaining the liveliness of the revolution and nursing injured (2012, 8). Egyptian women's movement has a deeply-rooted history of resistance, striver for equality in the public sphere and as well domestic domain. Women supported a national movement for independence against the British occupiers in 1919, founded the Egyptian Feminist Union, being the first feminist organization in 1923 and years later in 2011 became the epicenter of a revolutionary movement to overthrow Mubarak's regime (Kamal 2016, 5). Demonstrations were characterized by numberless physical and sexual harassments, terrorizing and discouraging acts as women protested on the streets. One of them stated: "*and while pushing me inside they were trying to pull off my clothes and sexually harassed me, one grabbed my breasts, another held my waist, and another grabbed my bottom. They grabbed the mobile from me, then threw me to the asphalt road. Despite the pain, I will go on protesting"* (Prince 2011, 320).

This was not the first or last time women were publicly sexually assaulted by men in civilian outfits protected by police. For the past decade occurrence of sexual harassments in public places grew in its frequency with little help from the government in order to confront the attacks (Kamal 2016, 14) which were in a way even supported, perhaps not directly, by apathetic state. Later, under Morsi's government, senior figures and members of Shura Council[19] let the safety factor into the hands of peoples themselves declaring protesting women "*cause rape upon themselves through putting themselves in a position which makes them subject to rape*" (Egypt Independent 2013). Harassment in form of inappropriate physical contact, rape, beating and stripping clothes of women's body and virginity tests were carried out by state security and used as a political tool of repression, protected by law (Amar 2011, 300; Malmström 2012, 7; Kamal 2016, 15).

Revolution finished when achieving its aim, the resignation of Hosni Mubarak on February 15th, 2011 after 18 days of the uprising. The transition towards democratic settings in Egypt wouldn't be possible without women. Yet once again they found themselves as a crucial part of the fight just to be forgotten in the aftermath. Surprisingly, even though women's political participation on the streets and as voters contributed to the political change, female representation in parliament shrunk. Cultural, structural and election specific factors after the revolution hinder women's involvement in parliament (Baradei et al. 43, 2013). The end of the revolution was the beginning of the Egyptian crisis, far away from the desired democratic

[19] In that time the upper house of the previous bicameral Parliament of Egypt.

outcome. After Mubarak's fall, the Supreme Council of the Armed Forces (SCAF) took the control and at the end of 2011 Egypt recognized one of its first fair elections in modern history with a strong victory of the Muslim Brotherhood's Freedom and Justice Party. Following presidential elections held in June 2012, won by a small percentage by Mohamed Morsi, pristine member of Muslim Brotherhood, ended the SCAF ruling. In November 2012, after granting himself the power to prevent the court from overturning his rulings, Islamist and their opponents clashed in a violent protest. The events of bloody 2013 Egyptian coup d'état revoked Morsi's presidential position in one of the biggest protests in Egypt's history (Saleh; Fayed 2013). In January 2014, after gaining people's popularity, General Abdel Fattah el-Sisi won 96.9% of the vote and was now reelected in March 2018. He was the first president that openly condemned sexual violence against women (Sanghani 2015). The new law enactment in 2014 threatened the liberty and independence of civil organizations and NGOs which made it complicated for charitable institutions to deliver their services. In 2017 he signed a law restricting operations of more than 47,000 Egyptian NGOs and as well prohibits domestic and foreign associations to engage in right work which could possibly harm anything national security, public order, public morals or public health (Najjar 2017).

5.2.1. Reproductive policies in Egypt before and after 2011

The Arab Republic of Egypt, being declared independent from the United Kingdom protectorate status on the 28 February 1922, is a lower middle-income country which was one of the first states that signed an agreement with UNFPA to control population activities (Oraby 2015, 147; A. Ragab 9, 2010). The Ministry of Health and Population (MOPH) is the biggest public health care provider, together with other non-governmental organizations (NGOs) and other private clinics and hospitals (Oraby 2015, 147). In the last five decades, the population has almost tripled from 32,5 million people in 1967 to 97,5 million in 217, (World Bank 2018) which can be linked with slow fertility decline, high adolescent fertility rate and unmet need of contraception (A. Ragab 4, 2010). Abortion is permitted only to save a woman's life, as the sections 260-264 of the Egyptian Penal Code of 1937 prohibit the procedure. Therefore Egypt is a country with the highest degree of abortion restrictiveness. Husband's consent must be acquired unless doctor believes the operation is needed, with an additional requirement that consists of confirmation from three physicians as a validation for the necessity of the procedure. Induced abortion is punished by imprisonment, even if it is performed by the pregnant women herself.

The Egyptian nation was after 1952 Revolution freed from British presence, which was after a coup declared a Republic[20], led by a short ruling of first President of the Republic General Muhammad Naguib. While he opposed introducing women's political rights as a part of a newly formed Republic, the second president Gamal Abdel Nasser Hussein, who was serving from 1954 until his passing in 1970, had interest in giving more political power to women in order to achieve the goal of liberalization of social factions and national development project (Sullivan 1986, 32; Kamal 2016, 10). In 1956 his interest was transmuted in the new Constitution and National Charter which recognized women's equal status as citizens and as well enabled women to participate in political domain (Sullivan 1986, 33; Kamal 2016, 11). Health service was expanded, contraceptives were distributed free of charge and family planning became a national policy promoting nuclear family model. These reforms were presented as secular discourse depending on modern values and simultaneously adopting modernized and reinterpreted discourse of women's rights in Islam in order to tackle with religious conservatism (Kamal 2016, 11).

Following Nasser's death, Muhammad Anwar el-Sadat as the third Egyptian President (1970-1981) replaced beforehand leftist framework with a religious one, which had serious implication for Egyptian females (Botman 1999, 79). Islamic Shari'a became a prime source of legislation, a homogenizing government with Islamic discourse, which religiously contradicted to the act in the Constitution written in 1956, equalizing men and women. Surprisingly, he enacted a new law by instating a quota for women in parliament, reserving 10 to 20% of the local council seats for women, which has successfully contributed to women's political participation in parliament reaching 9% in 1979 (Sulllivan 1986, 36). Sadat enacted laws and programs supporting women's rights such as the Personal Status Law of 1979 allowing women legal rights in marriage, polygamy, divorce and child custody (Al-Ali 2000, 74) and with reservations signed and ratified the CEDAW. Nonetheless, as Al-Ali claims, even with the effort and progressive laws made in 1979, "*the state lacked an overall programme to ensure women's rights and did not encourage independent feminist activism*" (2000, 74).

Hosni Mubarak's presidency (1981-2011) that was after assassination of President Sadat in 1981, tried to balance two opposing poles - Islamists, who demanded more conservative laws

[20] Egyptian modern legal system was modeled after French civil code system but was over the course of time modified and adapted to one known today. Their mixed legal system is based on Napoleonic civil and penal law, Islamic religious law with some traces of other colonial-era laws. The House of Representatives is the unicameral parliament of Egypt, with current presidential leader Abdel Fattah el-Sisi (IPU 2018).

affecting women and limiting women's political participation - and international donors, who offered financial aid and as well expected to obtain more democratic values, including women's' rights. Even though the regime wanted to be seen as progressive and advanced when it came to women's rights, it did in a way that women would stay away from political mainstream (Botman 1999, 92). By revising the Personal Status Law, women lost many of the rights they have already obtained in the previous version, but the pressure in 1985 Nairobi Conference restored some of the issues and started an open debate about contraception, reproductive rights and female genital mutilation (Al-Ali 2000, 75-76).

The language of reproductive rights was in Egypt introduced in 1994 after Egypt hosted the ICPD conference in Cairo. The concept of reproductive rights became discussed among scholars, activist, and women who confronted these concepts from the standpoint of religion and culture (Dawla 45). In practice, health services in Egypt, public or private institutions, have not done much more than supply women limited, in number and choice, contraception. Women have to be married not to become a victim of scrutiny and judgment (Aida Seif El Dawla 200, 49). While contraceptives are available without a prescription and supported by the Ministry of Health, they are rarely used among unmarried or single women. El-Zanaty et al. in the *Egyptian Health Issues Survey 2015* published an interesting study questioning attitudes towards family planning methods. While 90% of women and 87% of men considered using family planning methods after the birth of the first baby as appropriate, only 8% of women compared to 10% of men find it equally suitable to use it before the first pregnancy (82, 2015). Another interesting aspect revealed that 57,6% of women were using modern non-traditional methods of contraception, but 29% of women had discontinuity using them within the first year due to issues that could be solved simply by education (El-Zanaty & Ann 2009).

For these reasons, reproductive rights are rather a complex topic in Egypt, where accessibility to family planning methods is restricted not only by regulations but also due to cultural stigmas. Nevertheless, Egypt was the first Arab country to launch an official family planning program (El-Zanaty 2015, 81) which stayed inconsistently supported until 1980. Family planning programs received great support from Hosni Mubarak as he saw population growth as a socio-economic impediment (Eltigani 2009, 2015). The program received huge financial support from international donors, specifically from the U.S. Agency for International Development (USAID), which together with financial donations pushed for the embrace of their reproductive rights agenda (El-Zanaty 2015, 83). USAID financial withdrawal has

played a significant role in the Egyptian family planning agenda, now facing new challenges with Trump administration.

The ICPD in Mexico City in 1984 changed the future of many national and international NGOs in developing countries that were receiving U.S. support. The Helms Amendment, which passed in 1973, prohibited direct financing of abortion services within family programs provided by U.S. funds. Sandra D. Lane in *Buying safety: The economic of reproductive risk and abortion in Egypt* explains that prior the ICPD in New Mexico, in the 70s and 80s, many sorts of research exploring health consequences of induction abortion in Egypt were made. As a consequence, the fear of not receiving USAID caused a delay in further researches. As an Egyptian NGO spokesman explained: "*Since the Mexico City policy took place, all discussions of abortion and abortion-related issues have stopped. Those receiving aid funding are frightened of the policy and have thus turned their backs on a significant health issue [septic abortions] that is important in the context of female reproductive health*" (Blane and Friedman 1990, 25 in S. D. Lane et al. 1998, 1094). The policy was reversed with Clinton's office in 1993, then re-instituted with Bush in 2001, rescinded with the Democratic President Barack Obama in 2009, and it is now reinstated by Trump's administration in a considerably dangerous form. Previously, the rule was applied only to US bilateral family planning assistance (USAID) but to all global health assistance, cutting back from 575 million to 9.5 billion dollars in the fiscal year 2016 (Stars 2017, 485). U.S. is one of the largest international donors in family planning services (KFF, 2015), therefore discontinuation of the program could result in denial of family planning for thousands of women, clinic closures and service reduction (Stars 2017, 486). Additional researches made in Ghana and sub-Saharan Africa show that the effect of the global gag is conflicting with its initial aim, reduction of abortion. As results show, the global gag rule contributed to decrease in availability of modern contraceptives and consequently, increased abortion (Kalser 2017 and Bendavid 2011 in A.M. Starrs 2017, 485).

Since Egypt became a Republic in 1956, there have been seven variations of the Constitution which incorporated women's reproductive health to different degrees. The 2012 Egyptian Constitution, following the Provisional Constitution of the Arab Republic of Egypt that was adopted right after Mubarak's fall in 2011, was approved by the Constituent Assembly and signed by the President by law Mohamed Morsi. Female underrepresented writing committee failed to keep some of the already existing women's rights in the Constitution and this was seen as a major failure for Egyptian women (Kamal 2016,16). Surprisingly though, among

all, this Constitution was the only one that gave women the right to maternal health services without financial charges. As article 10 states: "*the state shall ensure maternal and child health services free of charge, and enable the reconciliation between the duties of a woman toward her family and her work* ". The article in the current Constitution, which was adopted in 2014 after the removal of the Islamist President Morsi, was replaced with a more broader perspective referring to maternal health with article 11 which promulgates that: "*the state ensures care and protection and care for motherhood and childhood*", withdrawing women's entitlement to free health services (Egyptian Constitution 2014). Regardless, new constitutional amendments under al-Sisi regime granted women rights in several of its articles (Kamal 2016,16) by highlighting the commitment of the state to ensure gender equality and women's participation in state institutions.

Since the occurrence of mass protests in Cairo, the total fertility rate increased to 3.4 which shows a 0.4 increase from a historically lowest level in 2008. The fertility growth "*is widely believed to be linked to post-revolution social and political upheaval, potentially due to disruptions in family planning services or an increasing proportion of young women married in response to safety concerns - a factor that has been observed during periods of conflict in other Middle Eastern countries*" (Radovich E. et al 2018, 2). At the beginning of 2016, there was a shortage of imported contraception pills which reached its peak in early 2017. Flotation of the national currency and low prices of medicines that hadn't changed since 1955, when the government fixed the price, let the majority of women without adequate family planning methods (Egyptian Streets 2017). This was later reflected in the demand for abortion pills on the black market (Hilal Rania, 2017) as the prices skyrocketed. Additionally, according to an Egyptian pharmacist, the scarcity was seen in all birth controls methods, not only the pills. Even with the Health Ministries guarantee that pills are available in governmental medical centers and hospitals, pills could only be bought on the black market until they ceased to be acquired (The Economist, 2017).

Egypt is one of the 50 countries worldwide where abortion is allowed only if the procedure protects the life or health of the mother (Labna, 1987; UN 2014,15). Due to cultural, religious sensitivity and legal constraints, reproductive health issues with an emphasis on abortion still are a relatively unexplored area of Egyptian healthcare issues. In Egypt, as in most of developing countries, social class and wealth regulate the type and consequently the safety of abortion performed, while countries' legal regulations effect on the safety of abortion. The result of the research titled *Incidence and socioeconomic determinants of abortion in rural*

Upper Egypt indicated that unsafe abortion is a serious health problem in Egypt. Among 1025 women that were a part of the analysis 40,6% had aborted at least once in their lifetime and not more then 20% of them seek for medical care due to various reasons, such as most common lack of knowledge (48,8%) and economic factor (34,8%) (Yassini 220, 2000). Religion was not one of the most significant barriers for women to seek medical care after abortion (Yassini 272, 2000).

Another research made by Sandra D. Lane et al. in 1998 titled *Buying safety: The economics of reproductive risk and abortion in Egypt* showed that the cost of the least costly biomedical abortion ends up being more than per capita monthly Egyptian salary (1998, 1094). Two women, interviewed in the study, sold their golden jewelry, which is a traditional way of saving, in order to perform the procedure. Women who can't afford the cheapest biomedical procedure have to seek indigenous abortion methods, which are more likely to cause additional post-procedure complications (Sandra D. Lane et al. 1998, 1095). Even though the interviewed women overall preferred biomedical abortion, more than half of them utilized indigenous methods (80% ended up having additional complications). While abortion for a wealthy woman, performed by their own gynecologist is considered safe, financially limited women cannot even afford minimum safety (Sandra D. Lane et al. 1998, 1098). Labna (1987) states that even with legal restrictions, clandestine abortions are fairly widely available and safe but at the same time costly (Labna 1987). This limits its usage only to families who are financially capable to cover the cost of the procedure, while poorer families often proceed with indigenous methods.

As already confirmed by many authors illegal abortion is thus more likely to be unsafe, but not necessarily. Millar, M. I., & Lane, S. D come to a conclusion that in Egypt there are at least seven potential reasons which influence on the safety of illegal abortion, among them there is the lack of training. As stated by an Egyptian physician, even though abortion is allowed in some cases, throughout his 15-year medicine career as a professor, 95% of his students never performed an abortion on any level. The same happens with students specializing in gynecology - the majority of them were never taught how to perform a safe abortion (1998, 1095).

6) Discussion

Economic determinant (graph 3) has played a significant role in both countries as described by the current literature (Quadeer 2005; Dyches 1993; Pillai and Gupta 2011). Throughout the last few authoritarian ruling Hosni Mubarak's years, there was a shortage of assets allowing the Ministry of Health to purchase a sufficient amount of family planning commodities. This resulted in contraception deficit and the rise of fertility, which grew for 0.3 TFR in only a few years. Fertility rates reached the lowest value right before the revolution in 2011 and have been raising ever since with a slight decline in the past two years (look graph 2). There are two additional causes for increased TRF and drop of contraception.
USAID has played a significant role as international donor in terms of contraception supplier but since 2004 they started shifting their responsibility for contraceptive supply to the Egyptian government, having to take full responsibility by 2007 (USAID 2011). Another reason is the flotation of the national currency in 2016/2017 that first prevented securing modern contraceptives and, after, with increased prices of contraceptives (from 1.6 USD to 3.7 USD), financially burdened families using modern planning methods (Hilal Rania 2017). As this is a fairly new issue, predicted consequences will be seen in few years as increased TRF and in an illegal number of abortion.

Same as in Egypt, in 2018 Tunisia has underwent a dramatic drug shortage that hasn't been seen since 1969 (Emna Hassairi ATFD, France24) due to a recall of substandard stock. There was indeed noted a slight fall in total health expenditure dropping for 0,11% of total Tunisia GDP (World Bank 2018). It is widely known that the development of democratic establishments is correlated with an increased level of economic development. The political turmoil that affected both countries divergently can be thus as well seen through their health expenditure, which consequently has influenced women's reproductive rights.

There has been also a link between reproductive health and religiosity, where religion is hindering the development process of reproductive health. Muslim Brotherhood's increasing power not only influenced reproductive rights of women through the Constitution but greatly influenced their safety in the streets as well. A leading Egyptian professor on fertility and family planning, Gamal Serour, claims that "*after the revolution, and when the Muslim Brotherhood got in office, there was a serious setback in many issues of reproductive and sexual health, including family planning and FGM*" (Barbara Crossette in PassBlue 2016).

Both of the analyzed countries are predominantly Muslim, although the level of religiosity differs. When asked about the importance of religion in Egypt the rates were considerably higher compared to Tunisia. Level of religiosity was in 2011 in Egypt rated as 97% and 94% in 2012 (World Values Surveys 2012). Same survey from 2012 marked level of religious people in Tunisia as 75% and 65% in 2014.

In Tunisia, religiosity played the most significant role when talking about abortion rights, even though the procedure is legalized. After the Jasmine revolution, Ennahda majorly influenced reproductive and sexual health through religious discourse that aimed to replace national westernized mores (Maffi 2014, 681). Abortion denied within the legal setting or during holy Ramadan, women being denied of procedure because of personal physicians beliefs and issues due to too complicated bureaucracy were common cases in the time of Ennahda Movement Party (Maffi 2014; Selma Hajri et al. 2015). Level of abortion thus after the Arab Spring reduced; this doesn't come as a surprise as religiosity is strongly associated with less progressive abortion laws (Hyne Jessica 2015, 19).

In the time of increased popularity of Muslim Brotherhood in Egypt, women started having more children as a result of a higher religiosity and overall conservative stance (Al Zalak & Goujon 2017, 1021). Religiosity has a major influence on contraceptive prevalence as the results of the *Egyptian Health Issues Survey 2015* show that only 8% of women finds suitable to use modern protection before the first pregnancy (82, 2015). Abortion, barred by the religious Egyptian establishment, forbidden by Sharia law and discouraged by Fatwas, is still fairly common. As mentioned before, Yassini's (220, 2000) research showed that more than 40% of women aborted at least once in their lifetime, risking their lives due to cultural, social and religious barriers.

Democratic index (graph 4) is a determinant which encountered a dramatic change in both countries within the examined time frame. The revolt momentum offered a unique opportunity to escape authoritarian systems, to gain a voice in the public domain and by economic and social development to improve reproductive health. Even though Egypt and Tunisia had similar authoritarian regimes they transitioned in different directions. Before Jasmine revolution, under Zine El-Abidine Ben Ali's despotic regime, Tunisian democracy index was labeled as authoritarian, but due to the successful aftermath, democracy index reached its highest value in 2015 labeled as a flawed democracy. The Egyptian regime was prior 2010 considered more democratic, however nowadays rankings are similar to the ones

before the January 25 Revolution (3.36), meaning Egypt is still contemplated in terms of authoritarian regime.

In the first elections after the Arab Spring, in late 2011, only 10 out of 508 parliamentary seats got appointed to female politicians, which equals only 1,97% (IPU, 2018). Surprisingly, the percentage of women in Parliament under Mubarak's regime arose well above Arab states average at 12% (Fadel & Hassieb, 2012). However, due to unconstitutional elections the Parliament was dissolved by the Supreme Court six months after, as now stands at 14,93% (IPU, 2018). Even if women became more politically active after the revolution (Baradei et al. 57, 2013), they were excluded from the Constitutional Committee and women's quota system was abolished causing a drastic fall of women's participation in the lower house. In democratic settings, women are more likely to gain political power, be politically active and secure their own interest.

Freedom of speech is one of the direct pathways to democracy, which was in the time of the revolution highly violated. Sexual and physical assaults, specifically on the Egyptian side, disabled women to freely participate in demonstrations. Tunisia, known as a pioneer in women's rights in the MENA region, has gained in the proportion of seats held by women in the national Parliament which increased dramatically from 11.5% to 31.3% (IPU 2018). There have been some improvements in women's political participation, such as greater gender variety in 2014 committee, removal of the controversial Article 28 that referred to women as "complementary" to men and some other important legislative changes, but the level of democracy didn't directly impact reproductive health or rights in Tunisia.

2011 Revolution in Egypt or Jasmine revolution didn't bring any significant changes in reproductive right policies, but de facto Tunisian and Egyptian Constitution, both implemented in 2014, explicitly protect the right to health and outline the state's obligation to implement women's rights. Advancing reproductive health is the government's liability that should be conceptualized and seen in a wider framework connecting social fairness to human rights. Indirectly, higher democracy index influences gender equality which has a positive and significant effect on reproductive rights (Pillai and Gupta 2011,5). As they state, "*democracy is one of the most important preconditions for the growth of gender equality*" (2011, 9).

Gender inequality index (graph 5) in Tunisia is pretty consistent, with no visible changes before or after the revolution even with democratic changes (graph 4). Egypt's lack of GII

data prevented us to conclude any correlated trends with reproductive health, but the value in 2012 is equal to the one in 2005, which is an abnormality, and suggests an increased value of inequality right after the revolution. Even though gender inequality in relation to reproductive health has been validated on theoretical and policy level, the sole event of the Arab Spring didn't contribute to any GII changes till now. Analysed tectonic political shifts translate into gender equality over long-lasting time span without causing any immediate increases or decreases. Thus graph 5 till now shows no abnormalities. Both countries have a long feminist history which has consequently empowered female citizens.

Surprisingly, Baradei et al. research on the effect of culture on women political empowerment shows that Egyptian culture is the most significant barrier (54,09%) preventing women winning parliamentary seats, followed by the lack of qualifications and experiences (24,55%) and third the Islamic dominance or rule (20%) (Baradei et al. 55, 2013). The most important factor seen as an advantage was "*experience and knowledge of the political sphere*".

Human development index is, same as GII, gradually and steadily rising with no significant deviations. Social development (graph 6) has been proven to have a significant positive effect on reproductive rights (Pillai and Gupta 2011, 7). In contradiction to the latter study where "*social development plays a prominent role in promoting reproductive rights*" (2011, 6) this study found no correlation applied in the specific time frame of the Arab Spring, which was relatively short. Social development is a determinant that is measured by three indicators: education, GNI index, and life expectancy.

Education as one of the crucial determinants broadens knowledge and disregards all the uncertainties regarding family planning. Lack of knowledge is recognized as one of the biggest limitations and reasons for discontinuation of contraception among married women, associating contraceptives with unjustified health concerns and side effects. Iman Bibars, head of the *Association for the Development and Enhancement of Women in Egypt* claims that only education about modern contraceptives and reproductive health, in general, will reduce illegal abortion practices. There are no NGOs in Egypt specifically dealing with the abortion issue, as Bibars says it would be impossible as "*you would be terrorized by everyone and probably shut down in the end*" (Cristopher Walker, 2014). While at the beginning of 21st-century education about sexual and reproductive health was offered by Tunisia ONFP, after the revolution many discussions about sexual and reproductive rights were silenced with Ennahda's overwhelmingly religious discourse (Maffi 2014, 684).

Granted the pivotal role of knowledge, HII determinants have to be seen as acquired human capital that influences the long-term development and doesn't have an immediate effect. It impacts only current people's life choices and behavior which will be seen after a longer time frame and not in a shorter period such as the case of the Arab Spring. We can draw a parallel with stagnation or slow increase in HII and GII through Amartya Sen's Social choice theory, as acutely repressed freedom and rights within a region will be conveyed into stagnated human development and socio-economic progress (Sen 1977).

7) Conclusion and study limitations

One of the major setbacks in this research was data accessibility. As abortion in Egypt is prohibited, there are no national statistics concerning this issue nor researches have been conducted at the national level. Gaps in data have been seen in other determinants such as GII, contraceptive prevalence and unmet need of modern contraceptives which disrupted parts of analysis and may influence on the accuracy of research.

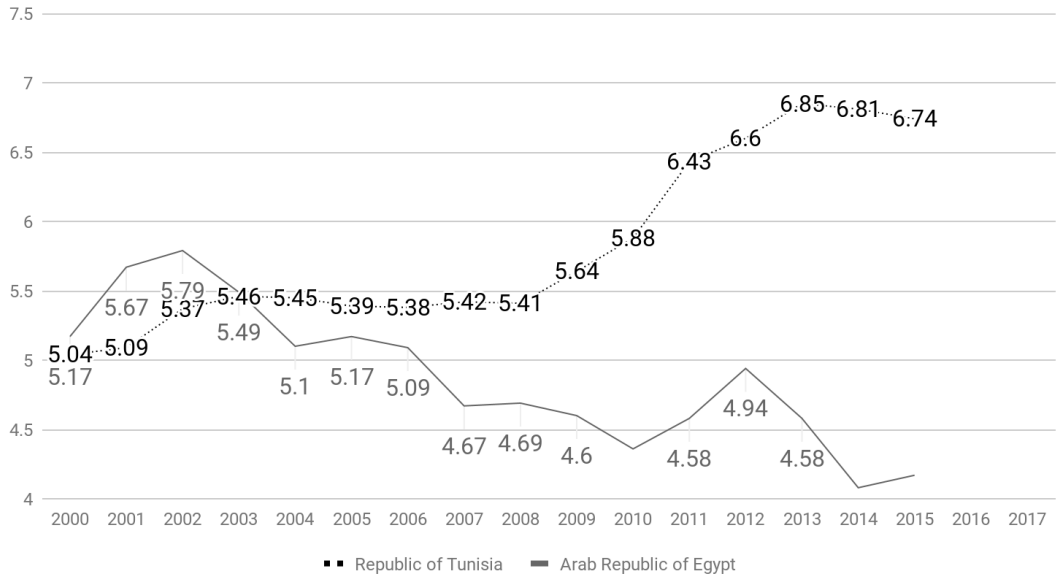
Having said that, his thesis reveals a series of interesting patterns affecting reproductive rights and health before and after the Arab Spring revolts in Egypt and Tunisia, which differ with findings of Vijayan and Gupta (2011). It demonstrates that the most important factors affecting the reproductive health of Egyptian and Tunisian women have been state of democracy, economic expenditure in health and religiosity, especially pronounced in ruling time of Islamist Ennahda and Muslim Brotherhood. At that time women were deprived of many, sometimes even state implemented, rights. Possible progress in reproductive health and reproductive rights has been till now repressed due to regime changes in order to reach political, economic and social stability. For these reasons, such changes have negatively influenced reproductive health in Tunisia and Egypt, as economic circumstances have deprived the possibility of evolution or even caused stagnation.

Women have been discriminated in relation to their marital status seeking for contraception or abortion. Egypt, a country with one of the highest fertility levels worldwide, should set aside cultural conservatism that is strengthened by religious ideology in order to control population growth. Most importantly, it should guarantee women's rights to control their family planning and guarantee adequate family plan that would contribute to overpopulation. On the other hand, Tunisia has already included the issue of reproductive rights in the reproductive health agenda, but there are still lacking in transforming this adoption into actions. Right-based

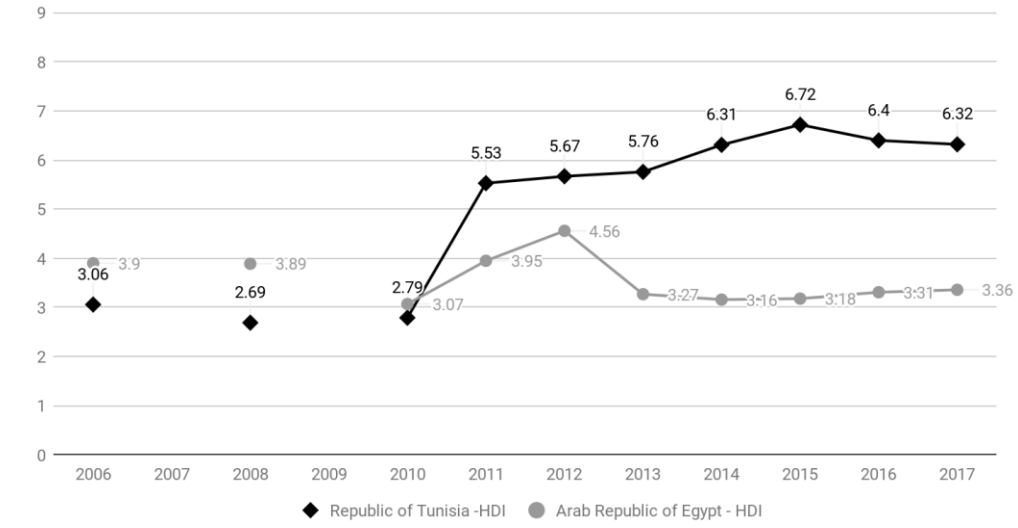
model of reproductive rights sees the issue of reproductive health through a human rights perspective, which is essential for liberalization of discriminatory reproductive rights policies. Deeply culturally and religiously embedded issues, such as abortion denial, should be seen and considered as a human right violation. It has been widely acknowledged that restrictive abortion rights don't prevent women from seeking the termination of pregnancy but forcing them to do it in illegal settings. Therefore legalization of such practices would guide women to conduct proceedings in a safe environment and, what is more necessary, it would become accessible to women from all social and economic backgrounds.

8) Graphs

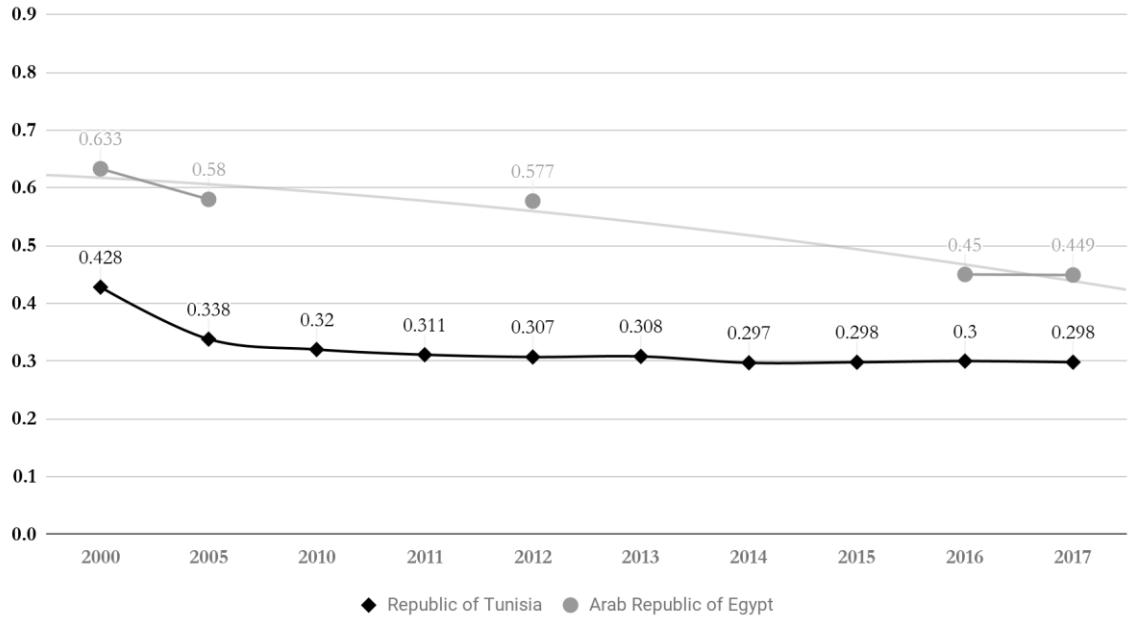
Graph 4: Current health expenditure (% of GDP)



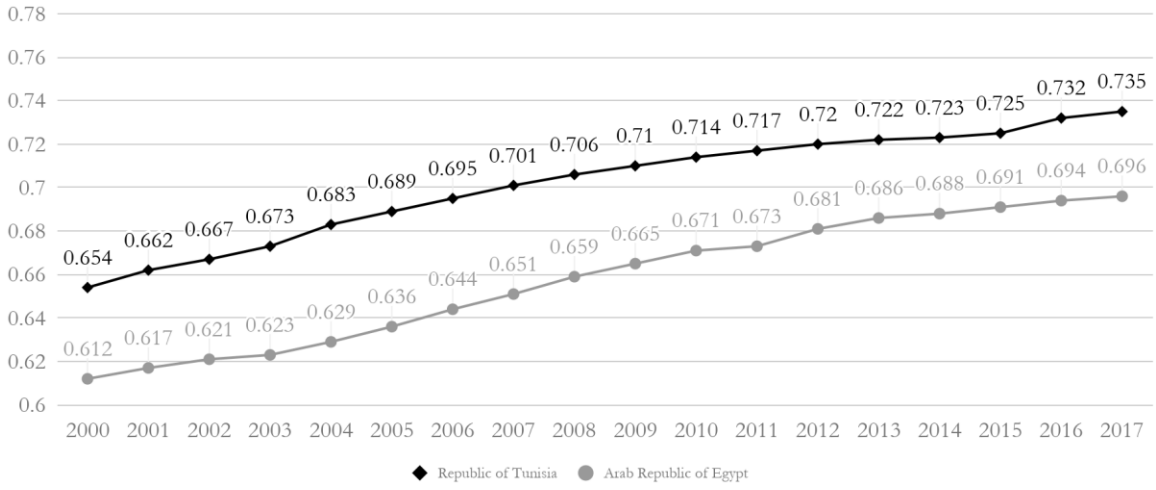
Graph 5: Democracy index (DI)



Graph 6: Gender Inequality Index (GII)



Graph 7: Human Development Index (HDI)



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