

Migrant women's experiences of pregnancy, childbirth and motherhood

An interpretative phenomenological study in Tunis, Tunisia

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Abstract

Bearing a child and giving birth are often considered as a life-changing event in the life of a woman and her family, a source of joy and fulfillment. But in spite of the progress achieved in the last century, every two minutes one woman still dies from pregnancy or childbirth related causes (WHO 2018). All too often, becoming a mother can be associated with pain, suffering and even distress, disability or death. Recent research has shown that women in situation of migration count among the most vulnerable - notably facing consequent barriers to health services including maternal care - and are exposed to health risks that in most cases can be prevented. This study addresses the perceptions of migrant women living in Tunisia on their experiences of pregnancy, childbirth and postpartum care. Via a qualitative, interpretative phenomenological study design, a sample of 13 pregnant women or women who recently gave birth, has been interviewed in Tunis in parallel with 10 health professionals. The aim was to explore their perceptions of maternal health as well as to collect some insights on their patient care experiences in order to ensure the quality and continuity of care for all and to prevent any woman from experiencing giving birth abroad as one more trauma.

The results indicate that according to migrant women and health professionals; migrant women's experiences of pregnancy, childbirth, motherhood and care are affected by many struggles – cultural, displacement and human rights related – at the individual, social environment, living and working as well as at the socio-cultural and health system levels. Understanding these difficulties constitutive of migrant women vulnerabilities and implementing appropriate relational and operational changes could improve maternal health experiences for both the women and the health care providers.

Further research on maternal health in Tunisia is needed to gain a broader understanding of migrant women's experiences at the national level as well as in other MENA countries, to improve the maternal health experiences of this particularly vulnerable population.

Key words: migrant women, health professionals, maternal health care, Tunisia, interpretative phenomenological study

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List of acronyms

DoW: Doctors of the World
GII: Gender Inequality Index
HDI: Human Development Index
IOs: International Organizations
IPA: Interpretative Phenomenological Analysis
MDG: Millennium Development Goals
MENA: Middle East and North Africa (region)
SRH: Sexual and Reproductive Health
SRHR: Sexual and Reproductive Health and Rights
UN: United Nations
UNFPA: United Nations Population Fund
VAP: Violence Associated with Pregnancy
WHO: World Health Organization

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1 Introduction

Women around the world are not equal in terms of access to care, anxiety associated with the prospect of giving birth, pain during delivery or distress when confronted to the new reality of motherhood. Their maternal health encompasses their well-being during the pregnancy (or intrapartum), childbirth and postpartum stages; and is ensured through fundamental steps in terms of care. Health providers and experts in academia and International Organizations (IOs) usually recommend expectant mothers to receive at least some form of prenatal care (antenatal visits with monitoring of and counselling for the pregnant woman), skilled birth attendance (i.e. trained health workers in a safe environment with emergency back up in case of complications), and postnatal care to prevent any disorders that can arise after the birth and decrease the vulnerability of the woman and her baby. However, when they are not provided with appropriate medical care and follow up, expectant mothers are very vulnerable to infections, hemorrhages, high blood pressure and complications - especially when exposed to unsafe abortions or obstructed labor - which compose the major causes of maternal ill-health and mortality (WHO 2018 ; UNFPA 2018). These complications usually affect the most impoverished communities, considering that 99% of all maternal deaths reported happened in developing countries (WHO 2018) and more generally women in precarious conditions or facing threatening, straining situations.

These indicators of vulnerability are often attributed to migrant women, taken here as a wide category encompassing refugees, asylum seekers, economic or educational migrants, illegal migrants, transient etc. Experiences of migration are heterogeneous and unique, but for pregnant women any can turn out to be particularly challenging and of great influence on the health and the future of the mother and the infant. Despite their different backgrounds and motivations, these pregnant women all share the reality of being a newcomer needing to adapt to the ins and outs of a new country and seeking some form of health support to carry their pregnancy to full term and give birth to a healthy baby. This is described below by Balaam, Haith-Cooper and colleagues in their concept analysis of the term "migrant women in the context of pregnancy" developed under three main takeaways points: " Firstly, women entering a new country as migrants are located within and subject to a range of socio-legal-cultural-economic discourses and practices different to those applied to women deemed to be native to/nonmigrant. Secondly, that these women are forced to seek ways to adapt to their new situation as pregnant women in "the new country". Thirdly, that these women will be involved in the healthcare system of their host country because of their pregnancy" (Balaam et al 2017:7).

Due to many structural forces worldwide – such as globalization and economic inequalities, wars and political conflicts, scarcity of resources and natural disasters, etc - many individuals chose to migrate abandoning the known for the unknown with hope of life improvements. In these conditions, the perspective of a positive experience of pregnancy, especially in developing countries, can seem difficult to achieve or even imperiled, and very little is known on the issue.

1.1 Research question

For this reason, this research project focuses on the situations of migrant pregnant women or who recently gave birth in Tunis, Tunisia by raising the following question:

How are migrant women perceiving pregnancy, childbirth and postpartum care experiences in Tunis?

The purpose of this research is to provide insights on the struggles migrant women in intrapartum, childbirth and postpartum situations face today in the capital city of Tunisia.

This research project positions itself as a humble step toward the improvements of migrants' living conditions and health professionals' working conditions worldwide. Indeed, the potential number of women migrating and needing maternal care around the world is very high. In 2015, the UN reported that 3.3 % of the world population could be considered as international migrants, meaning that 244 million individuals were in movement. Simultaneously, three times more individuals were migrating within their countries (i.e. 740 million internal migrants in 2009), a total of 40.3 million were displaced and the world counted in 2016 more than 22.5 million refugees (IOM 2017:2). Migrant women represented about half of all migrants in 2005 according to an estimate of the IOM (IOM 2012:2) and last year, in 2017, 48% of international migrants were female, including about 70% at working and childbearing age (IOM 2017:17), a phenomenon coined in the scientific literature as "the feminization of migration" (Lourdes 2012:2).

Understanding the background, the experiences and the habitus of these women along with their perceptions and feelings is fundamental to identify their needs, comprehend their responses and behaviors during the unique process of becoming a mother and is thus key to provide them with adequate care and support to cope with the challenges they face (Balaam et al 2017;2). In fact, in light of such insights, health providers and policy makers will be better informed on the adequate provision of care when services face these types of vulnerabilities and may ultimately reduce mortality and morbidity rates for the mother and the

infant as well as prevent migrant women from experiencing giving birth abroad as one more trauma. With this perspective in mind, this research project investigates in the perceptions and lived-experiences of migrant women who sought maternal health assistance in Tunis.

1.2 Significance of research

Now that the research question, its scope and goal have been established, we can fully grasp the significance of the research project, both in the human rights field and the academic sphere. First, this research is enshrined in the continuity of international laws, treaties, recommendations and projects aiming to ensure health care as a basic right, accessible, equitable and of quality regardless of status or other social markers. In this regard, it informs the public debate on the situation in Tunisia and the improvements still required in terms of migrant maternal health. Secondly, it identifies a gap in the scientific literature and makes a plea for extensive research on the subject. These two aspects will be developed now.

1.2.1 Sexual and Reproductive Health and Rights goals

Maternal health is a core element of Sexual and Reproductive Health and Rights (SRHR). The official definition of SRHR was adopted in Cairo in 1994 during the 4th International Conference on Population and Development (ICPD) and specifies it as a “...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 they have the capability to reproduce and the freedom to decide if, when and how often to do so” (UN 1995). In this regard, the Sexual and Reproductive Health (SRH) field encompasses many health areas ranging from contraception to abortion and including diseases, sexually transmitted infections, infertility, violence against women as well as maternal and perinatal health among others. Since this convention’s call in 1994, the goal was set to secure the universal access to quality Sexual and Reproductive Health services and Rights, in order to protect the neglected and the most vulnerable, ensuring a better health for all.

Today, Sexual and Reproductive Health (SRH) both in terms of education or care is considered as essential to the attainment of the 2030 Sustainable Development Agenda’s rights and goals, agreed upon in 2015 and to which many countries and organizations are committed. The plea was then made to “leave no one behind”. Migrant women’s adequate SRH care falls under multiple categories of objectives such as “good health and well-being” (3), “quality education” (4) or “gender equality” (5) among others (UN 2015) and are hoped to be attained in the next decade now. These goals have also been reaffirmed for migrants and

refugees in 2016 by the United Nations through the New York Declaration for Refugee and Migrants (as individuals moving within countries and across borders), especially under the following article 31:

We will ensure that our responses to large movements of refugees and migrants mainstream a gender perspective, promote gender equality and the empowerment of all women and girls and fully respect and protect the human rights of women and girls. We will combat sexual and gender-based violence to the greatest extent possible. We will provide access to sexual and reproductive health-care services. We will tackle the multiple and intersecting forms of discrimination against refugee and migrant women and girls. At the same time, recognizing the significant contribution and leadership of women in refugee and migrant communities, we will work to ensure their full, equal and meaningful participation in the development of local solutions and opportunities. We will take into consideration the different needs, vulnerabilities and capacities of women, girls, boys and men.

(UN 2016:7)

If many countries are committed to the MDGs and other international treaties, there are great variations in the obstacles they have to overcome and emerging challenges they need to face. Despite real progress, Tunisia belongs to the category of countries where several consequent improvements are needed in the provision of accessible, equitable and quality maternal health care (Amroussia et al 2016, Boutayeb & Helmert 2011). In the same way, demographics on the profile of migrants are lacking in the country – and more generally in the region – notably in terms of health status and on their relation to health structures, as we will see in the upcoming chapter dedicated to the background information.

1.2.2 Contributing to existing knowledge in academia

In the last decades, researchers have produced evidence that contemporary migration induces many health risks (Almeida et al 2013; Bollini et al 2009; Filippi et al 2006 among others) leading to the growth of the migration health field, to which this research contributes. It has been defined by the IOM as “all aspects of migration and mobility that may affect human health” (IOM 2012:2).

At the nexus of migration, SRH and gender issues, this research contributes to the growing body of knowledge informing on migrant women maternal health. In this regard, it intends to bridge a research gap by analyzing the experiences of women in Tunis the capital city of Tunisia - where no similar research is yet available – and offers a new perspective on the existing theoretical dialogue by using the Interpretative Phenomenological Analysis approach as developed by Smith, Flowers and Larkin (Smith et al 2009). Closely related to other research areas such as psychology, biology or management in care organizations, this study could also better inform future interdisciplinary research projects.

1.3 Outline of the thesis

The present thesis is divided into seven sections, or chapters. Among them, this introductory part embodied the first chapter. The second chapter presents the background section. Its purpose is to provide the reader with key information regarding the Tunisian political system and society - as they seem relevant for the understanding of migrant women's situations, that is with a focus on health, migration and the civil society - synthesized to prepare the discussion held in the next section. The third chapter contains the theoretical framework section. In this section, the theories composing the current body of knowledge trying to address migrant women's maternal health – and especially their perceptions of it as raised in the present research question - are exposed and then analyzed through the theoretical lens of the Interpretative Phenomenological Analysis approach. The chapter four contains the methodology section which explains the data gathering process and the analysis strategy chosen to best answer the research question.

Following the theoretical part of the thesis, the chapter five exposes the main findings retrieved from the in-depth analysis of the fieldwork data, organized in a synthetic manner and ready to be discussed in the next section. The chapter six then discusses the results and put them in perspective with the theoretical part of the research project (background section and theoretical framework). It also concludes the research project by offering some last opening comments and suggestions for further research. Finally, the last sections (seven and eight) display the list of references and appendices.

2 Background

In this section, a contextual analysis of Tunisia is offered. The objective here is to provide to the reader with key information regarding the state of the country and its advancements on gender, migration and health issues as they may be relevant to the maternal health experiences of migrant women. Indeed, these information about the situation of the host country, its positioning toward migration, the structure of its health system and the role played by support organizations will shed light on the environment in which migrant women are evolving and enlighten the perceptions of pregnancy, childbirth and motherhood that may result from it.

2.1 Understanding Tunisia as a host country, geopolitical considerations

2.1.1 Democratic transition and a reformist identity

To this day, Tunisia is often referred to as a "successful" post-Arab spring democratic laboratory in the Arabic countries (Winter 2016) and still presents a strong reformist identity (Hibou 2009), which confers it a special place on the international scene and a unique profile as a destination area for migrants. The North African and Middle East regions experienced many political and socio-economical changes for the past two decades, especially since 2011 when the Arabic countries were agitated by uprisings, protests movements and revolutions. Ben Achour & Ben Achour describe a multiform reality for these countries with heterogeneous experiences. For them, the Tunisian experience is characterized by a strong revolution movement and a "complete rupture of constitutionality" with a clear separation from the past as opposed to the formulation of a new constitutionality enshrined in the continuity of the former (case of Morocco), or to the modifications of the existing constitution (like in Jordan or Mauritania) - (Ben Achour & Ben Achour 2012:716).

If the form of government and constitution radically changed, the "reformist DNA" of the Tunisian culture lasts. In her historico-sociological analysis, Hibou offers an in-depth analysis of this identity that she conceives as more than just an alternative solution between heritage, tradition and modernity but a complex phenomenon bearer of social cohesion under an imaginary, a myth also hiding past ambiguities in the conception and expression of liberty, constant in the

history of the country and under various forms of governments (Hibou 2009:39). Therefore, Tunisia as a developing country demonstrates many progress as measured on the Human Development Index (HDI) and the Gender Inequality Index (GII) (UNDP 2016). According to the 2015 data, the country belongs to the High Human Development Group, positioned 97 out of 188, with an increase in the HDI value of 27.3% between 1990 to 2015. If under the average in this category, it is above the average among Arab States. Moreover its GII rank, including reproductive health measures, is of 58 out of 159 countries in 2015 (UNDP 2016:2-5, tables reported in Appendix A). This is coherent with the fact regarding women rights, Tunisia is perceived as a pioneer country in the region of Middle East and North Africa (MENA), which prioritized SRH as early as 1994 (Amroussia et al 2016:184). For the purpose of our research questioning the perceptions of migrant women regarding their maternal health experiences, the next subsections will now briefly look at the question of migration in the country, its health system and civil society.

2.1.2 The question of migration in the country

In the MENA region, Tunisia often presented as an emigration country is also undoubtedly a transit area, especially acknowledged since the migration wave in 2015 and the risings of 2011 whereas it counted an existing but silent migration corridor from Sub-Saharan Africa even before that. Indeed, the region of North-Africa presents numerous and considerable migration corridors as well as an increasing number of migrants. It is primarily a transit area (Boubakri & Mazella 2015:152) but may become in the near future a destination area, if it is not already. The violence in the sub-regions partly explains this evolution. The migratory movements in Tunisia may not seem as impressive as those observables in its neighboring countries but here too, the numbers are growing.

The migratory context in Tunisia has mutated since the 1990s when Sub-Saharan migrants started to come looking for economic opportunities, better living conditions and maybe a path toward Europe. To this was added the migration flow coming from Arab Countries, especially Libyan – whose integration were quite facilitated due to the cultural and geographic proximity - and Syrian because of the agitations in these country, in addition to the migration flows from other Northern African countries (Boubakri 2015:17). The reception conditions along with the integration process however reveal to be very difficult for migrants due to a rigid legislation (Boubakri & Mazella 2015:164, Boubakri 2015:18). Last year, most of the migrants in transit in Tunisia aimed for Italy and Europe through the Central Mediterranean Route (IOM 2017:47,50). The last population census of the country achieved by the National Institute of Statistics in 2014 for the period from 2009 to 2014 and published in 2017, reports a number of 53000 foreign nationals in the country against 35194 in 2004, a number almost stable since 1975 (NIS - RGPH 2017:18). Unfortunately, these numbers are not up to date and have been assessed as underreported with data lower than in reality by

counting only declared migrants (Boubakri 2015:26). International Organizations however seem to observe substantial increases from a heterogeneous group of migrants, with different status, vulnerabilities and reasons to migrate, as we will see in the subsection dedicated to the civil society after addressing the national health system.

2.2 Health and society in modern Tunisia

2.2.1 Healthcare system and disparities in the country

In order to comprehensively make sense of migrant women patient care experiences and how these can shape their perceptions of pregnancy, childbirth and motherhood, the present subsection intends to portray the health system in which they try to evolve. The Tunisian's Health Care system has been funded by the government and is therefore free for Tunisians since 1956. Since 1982, a primary line of care was put in place through a network of primary health care centers which led to significant improvement for the next three decades in terms of coverage (including deliveries, immunization, pre and post-natal care), (Kouni Chahed & Arfa 2014:1). In terms of Sexual and Reproductive Health, it was the first country in the region to legalize abortion and to create a National Board for Family and Population both in 1973, a board who later put in place a family program acknowledged as successful (Amroussia et al 2016:184).

However, akin to other North-African countries, the HDI achievements presented earlier (in health, standard of living and education) were not shared equally among the population considering visible discrepancies between regions, urban/rural areas and socio-economic groups (Boutayeb & Helmert 2011:1). The main disparities Tunisia still faces relates to wealth groups and geographic area, with a low access and provision of care in the Western part of the country (shortage in trained staff, drug availability and appropriate infrastructures) compared to the coastal areas (Kouni Chahed & Arfa 2014:1, Boutayeb & Helmert 2011:7). The literature reports that household's out-of-pocket expenditures for health-purposes in 2010 had risen to 45% of the total health expenditures because of an incomplete insurance scheme (about one million individuals not covered in 2014) and ineffective public medical health scheme, leaving the poorest parts of the population exposed (Abu-Zaineh et al 2014 :434, Kouni Chahed & Arfa 2014:2). The Tunisian health care situation seems to show the symptoms of a system with health inequities – i.e. avoidable inequalities – according to the definition of the WHO: "... avoidable inequalities in health between groups of people within countries and between countries. These inequities arise from inequalities within and between societies. Social and economic conditions and their effects on people's lives determine their risk of illness and the actions taken to prevent them becoming ill or treat illness when it

occurs.” (WHO 2008). According to Amroussia and colleagues, these health inequities are apparently also to be found in the Sexual and Reproductive Health services in terms of availability and accessibility to SRH services for many Tunisian women, discriminatory practices at least toward single mothers and low quality of maternal health services reported in several studies (Amroussia et al 2016:192). These disparities and inequities in the Tunisian society, affecting the Tunisians but also the migrants settled there, might explain or legitimate the active role of the civil society in Tunisia.

2.2.2 The civil society in Tunisia, assisting migrants in Tunis

Numerous and consequent efforts have been made in Tunisia to help the country in its democratic transition in diverse areas. Since the revolution, many civil society organizations have emerged and are strengthening the participatory approach taken by the government as written in the 2014 Constitution and citizens are more and more consulted and implicated (OECD 2016:16). Furthermore, this trend revitalizes the wishes of international aid donors to invest in the Tunisian society (Hibou 2009:14) in order to complement the national efforts launched toward social progress.

It is the case notably in the big Tunis where a strong partner network have been established since 2015 to accompany the migrants present in the capital city of Tunisia. At least 16 organizations are involved in this network to provide medical, psychological, social, legal assistance in addition to help for departure and economic insertion (Doctors of the World Belgium-Tunisia 2017, see framework in Appendix A). These organizations have also helped in the identification of certain patterns in the migration dynamics in the city, notably the following estimates: among the migrants seeking medical assistance in the network between September 2015 and mid-April 2018, about 88% are from Sub-Saharan Africa, 8% from Middle-East and 4% from Maghreb. These findings are consistent with several organizations of the network in other areas of assistance. Among them, 34% were men and 64% women including 34 % who consulted for a pregnancy desired or not. (Doctors of the World Belgium-Tunisia 2018). Now that key information on Tunisia and its migrant population have been laid out, the upcoming chapter will provide the reader with the theoretical framework necessary to answer the research question of how migrant women are perceiving pregnancy, childbirth and postpartum care experiences in Tunis.

3 Theoretical framework

The objective of the present chapter is twofold. First, it will theoretically inform the research by reviewing the scientific literature on the topic of migration and maternal health – including health access and outcomes for migrants as well as their social constructions of pregnancy, childbirth and motherhood as reported in the literature. Secondly, by assessing the body of knowledge it will provide a theoretical framework for this research project using the phenomenological, hermeneutical and idiographical theories forming the Interpretative Phenomenological Analysis (IPA), considered as the best way to answer the research question.

3.1 Previous research on migration and maternal health

When reviewing the literature on migration and maternal health, one can identify three research areas. The first two, addressing the health access for migrants and their health outcomes, indirectly speak to the research question as they account for empirics on the physical aspect of maternal health and are synthesized in the first subsection. The last one, emphasizing the perceptions and experiences of migrant women, directly correlates with the research question by looking at lived-experiences and is extensively discussed in the second subsection.

3.1.1 Health access and outcomes for migrants

On the global level, access to health services for the neglected populations remains an issue and is visible through the adverse health outcomes reported. The multiple types of barriers vulnerable populations may face when trying to access health services are often investigated by International Organizations in national settings. The mostly used framework is Tanahashi's ladder toward effective coverage, a model usually used to evaluate health services coverage (Tanahashi 1978:301) reporting the different stages of availability of services, accessibility, acceptability, contact and effective coverage of the target population. Altogether with the WHO's conceptual framework to study the Social Determinants to Health – that are social environment and conditions with which individuals evolve (WHO 2003:8) – the countries are encouraged by IOs to assess the performance of their health system and remedy its pitfalls. Ultimately, health structures

composing the welfare system of the country should demonstrate a certain continuity of care. This goal is described below by Reid and colleagues, whose definition assesses the perspectives of the different stakeholders and stands as a point of reference for quality care in health services:

1. Continuity is the result of a combination of adequate access to care for patients, good interpersonal skills, good information flow and uptake between providers and organizations, and good care coordination between providers to maintain consistency.
2. For patients, it is the experience of care as connected and coherent over time.
3. For providers, it is the experience of having sufficient information and knowledge about a patient to best apply their professional competence and the confidence that their care is recognized and pursued by other providers.

(Extract of Reid et al 2002:7)

Overall scholars reported numerous barriers hampering migrants' access to health, from structural barriers (paperwork control, cost...) to individual barriers (language, culture...) at least (Gil-Gonzalez et al 2015:539). Recently in 2017, the WHO reported that in persisting barriers to maternal health services: mainly socio-economic constraints (1), demographic and jurisdictional constraints (2), political and institutional constraints (3), knowledge and education constraints (4), social norms (5) and physical constraints (6). Most of the research focused on the United States and the research design revealed to be mostly quantitative (WHO 2017:15). The list of barriers in maternal health was similar to the cross-sectors analysis. Thus, although these findings inform the public debate on the major obstacles to health, they appear limited by the geographic area and the type of research methodology used. Research on the topic needs to be extended to developing countries with increasing flows of migration, placing the voice of the most vulnerable at the center of the analysis.

Regarding health outcomes of migrants, many papers have hypothesized what have been called the "healthy migrant effect" to explain the fact that some migrants were proven to have better health than host populations, possibly because only the healthiest seem capable for (or accepted after) migrating. However, this theory does not relate to the actual figures on migrant women maternal health and has been many times refuted (Akker & Roosmalen 2016:33). To assess maternal health outcomes and the potential complications induced by the act of migrating, researchers look at indices of maternal mortality (death within 42 days after childbirth and caused by the pregnancy) and morbidity (severe maternal outcomes) for physical evidences (Akker & Roosmalen 2016) as well as signs of mental health shifts and/or fragilities for psychological ones (Firth & Haith-Cooper 2018). Indeed, additional research has shown that migrant women are often confronted to poorer pregnancy outcomes in the host-country compared to the ones of the host population (Balaam et al 2017:7). Among the migrant population, higher rates of complications, preterm births and low birthweights are often reported (Balaam et al 2013:1927). Most of the findings on the topic come from comparing migrant groups with host-population in high-income countries, demonstrating higher risks of maternal mortality and severe morbidity (or "maternal near miss") among migrants unevenly prevalent between

their different groups (Akker & Roosmalen 2016:27). Besides the profile of the migrant, with health risks induced by inappropriate or lack of care in the country left behind or during the journey, Akker & Roosmalen in their meta-analysis report the recurring hypothesis of suboptimal care in host countries more often reported in migrant women group than in host-population group (Akker & Roosmalen 2013:33). Moreover, going to full term of pregnancy and delivering a healthy baby are not the only markers of a good maternal health. Mental health state and patient experience matter as much and unfortunately the latter is too often far from positive (Nothemba Simelela 2018:1). Alongside high mortality and morbidity risks, evidence demonstrate higher rates of mental health issues such as psychological distress and postnatal depression among migrant women, often directly linked to the migration process (Firth & Haith-Cooper 2018:78). It is possible that after having experienced a trauma or certain types of violence, these women show sign of posttraumatic stress disorders as well. These complications can be explained due to the increased vulnerability of the migrant women, as they face multiple discriminations at once, for being women, for being foreigners, and for being in a situation of migration (Adanau & Johnson 2009:180). Considering migrant women patient care experiences, some researchers addressed their perceptions of pregnancy, childbirth and motherhood for multiple populations in different host countries. This section of the literature directly speaks to the research question and is investigated below.

3.1.2 Migrant women's social constructions of pregnancy, childbirth, motherhood

In this regard, the scope of the literature reviewed included theories ranging from maternal health coverage, use, access, needs and experiences. The articles were recent (going back up to twenty years ago maximum) or exceptions when the approaches were used recently. In the last decade some systematic reviews of the literature appeared (Balaam et al 2013; Almeida et al 2013; Benza & Liamputtong 2014; Almeida et al 2014) examining a majority of qualitative or ethnographic studies but only in the context of western countries as host countries. Before, sporadic articles in different areas of the globe were published. Mirroring the international literature, the following review is thematically synthesized. Indeed, when assessing scholars' theories on migrant women's social constructions of pregnancy, childbirth and postpartum period, three major themes were identified: cultural struggles (1), displacement-related struggles (2), human rights struggles (3). Each appeared more-or-less significant during the three phases assessed (pregnancy, childbirth and postpartum).

Based on the literature, cultural struggles (1) are often the first identified, first because the use of maternal health care services greatly varies in consideration of patients cultural and ethnic diversity (Say & Raine 2007:815), which similarly influence the women's perceptions on pregnancy, childbirth and by extension motherhood too. Culture in this context can be understood as "a pattern of learned but dynamic values and beliefs that gives meaning to experience and influences

the thoughts and actions of individuals of an ethnic group”, a definition developed by Wikberg & Eriksson and often referred to in health-related journals (Wikberg & Eriksson 2008:485). In this regard, the concept of cultural struggles encompasses migrant women’s social constructs on pregnancy, childbirth and postpartum care based on their culture, traditions and habits valued in their home country. The studies often report strong cultural clashes, confusion and conflicts with beliefs, with consequences disruptive for the mother or mother-to-be (Balaam et al 2013; Almeida et al 2013; Benza & Liamputtong 2014; Almeida et al 2014). Markers of cultural struggles are observed throughout the maternity process – i.e. from pre to post-partum periods – but are particularly emphasized during childbirth in terms of medical practices (birthing positions, refusal of caesarean section, painkillers and deinfibulation when the woman is circumcised) and attitudes of the mother (asking questions or remaining silent, environment and lack of privacy, accepting the presence of the husband or not, preferences on the gender of the health provider etc). Among the difficulties linked to cultural differences in antenatal care experiences and perceptions, scholars discussed the underrecognition of antenatal care, the difficulty of preserving traditional practices (diets and lifestyles), the loss of rituals and meanings and the fears related to female genital mutilation. In terms of postpartum experiences, cultural struggles focused mainly on postpartum traditional practices (such as confinement) and childrearing perspectives. Overall, it seems that the main source of distress lies in the misunderstanding and disconnection between health care professionals and migrant women. Although all cultures aim in valuing the process of motherhood alongside the safe health and well-being of the mother and the child (Benza & Liamputtong 2014:576), unique intercultural care relationships – beyond the universal expectations – are needed to achieve these goals (Wikberg & Bondas 2010:2). The increase of cultural and ethnic diversity often represents a challenge for health services, usually non-adapted. In order to achieve equity and quality maternal health care, culturally sensitive maternal health services need to be enhanced (Lyberg et al 2012:294, Balaam et al 2013:1926) along with the cultural competency of its health providers (Benza & Liamputtong 2014:583).

The second category is the one of the displacement-related struggles (2). The migration process, regardless of the motivations to migrate, is almost always marked by a transition period, sometimes a brutal shift, resulting in feelings of unrootedness, isolation (missing former ties and loved ones) and unsettlement for the migrant. These struggles linked to displacement and migration challenges can be understood as emotional burden influencing the perceptions and experiences of migrant women. Displacement-related struggles are particularly distinguishable during the pregnancy and postpartum phases. Indeed, the antenatal care perceptions and experiences of migrant women in the literature reveal their priority toward resettlement over maternity needs, with concerns encompassing financial needs, work and family responsibilities, lack of support and communication problems (Balaam et al 2013; Almeida et al 2013; Benza & Liamputtong 2014; Almeida et al 2014). These issues are often recurring during the postpartum phase, with consequent strivings to cope and manage without kinship and support, which may lead to increased vulnerability and depression

(Firth & Haith-Cooper 2018:78). In this regard, the literature provides some evidence of relevant theories and strategies to cope with these issues. For instance, Balaam et al emphasize the importance of psychosocial resources, the emotional intelligence and resilience strategies of the migrant (Balaam et al 2013:1926). Indeed, the ability of the migrant women to adjust and manifest resilience cumulated to the support of key individuals, organizations or the community could considerably improve the situation of migrant women and their feelings of displacement and unsettlement (Gagnon et al 2010:566; Balaam et al 2013:1926). Several support and empowerment mechanisms were developed in the literature such as health promotion and community participation (Filippi et al 2006:1536; Akker & Roosmalen 2016:34). It has been defined as a way for the community to support the empowerment process, achieving it by inducing positive outcomes on maternal, newborn and child health when integrated to primary care (Rosato et al 2008:963). Integration policies also plays a vital role and are addressed further below.

Finally, migrant women face human rights struggles (3). Beyond the feelings of inadequacy related to newcomer strangeness and cultural differences, the category of human rights struggles includes perceptions of negative treatments, judgements, discrimination and experiences of failed continuity of care when entitled. These perceptions can arise during the pregnancy, childbirth and postpartum or even continuously during the entire process, and can originate from individual actions (stereotypical judgments, stigma and taboos) or from systemic factors (difficulty of navigating health services, negation of rights regarding practices such as abortion, treatments such as HIV treatment or insurance for instance). Often these types of situations induce in the migrant a feeling of unfairness and abandonment when confronted to these kinds of barriers and struggles (Benza & Liamputtong 2014:580). Bollini et al reported that in Europe strong integration policy toward migrants reduced the consequent disadvantages and health risks migrant women were facing compared to the national population. In this case, integration policy globally defined as “a multidimensional social policy that increases protection, economic integration and participation in social life” (Wanner 2004) can be understood as health policies designed to “increase access to and effective utilization of health care by the immigrants’ communities, minimising language, financial and administrative barriers” (Bollini et al 2009:454). Such commitments from the government appear indeed necessary to help bridging the gap between rights and reality. This relates to the necessity to adapt and implement a rights-based approach to health care delivery to the new challenges of migration, the complexity of the migratory process and its inherent multistage and cumulative health risks (Zimmerman et al 2011:1) in general as well as pregnancy-related illnesses, their social determinants and consequences in this particular situation (Filippi et al 2006:1537).

3.2 Adding an Interpretative Phenomenological Analysis (IPA) perspective: gaps of and contributions to the body of knowledge

Over the last decades, a new approach to qualitative research was assembled in order to answer the demand of psychologist first than public health specialists on the understanding of events, actions and their meanings for the patient with the objective of improving their care. Thus, Interpretative Phenomenological Analysis (IPA) allows for in-depth exploration of individuals “lived experiences” and according to Alase, is one of the most, if not the most participant-oriented approach to study the perceptions of major phenomena in the lives of individuals (Alase 2017:10). With its strong theoretical foundations and its accessible methodology for topics that still require to be explored, particularly when few or no research is available on complex and sensitive topic involving pain for example, the use of IPA has been particularly relevant and helpful (Pringle et al 2011:20). Indeed, patient-centered care requires health providers to listen, show empathy toward their patient if they want to comprehend the full impact of the illness, which can be very difficult when neither the provider nor the patient share any cultural perspectives or values. This is what Pringle reveals in its analysis of the approach, using Biggerstaff and Thompson’s words: “This may be of relevance in healthcare research, if the views of groups that are difficult to reach are being sought or where beliefs and expectations may be ‘outside the perceptual field’ of healthcare professionals (Biggerstaff and Thompson 2008).” (Pringle et al 2011:22). Therefore, it seems relevant here to process the three major theoretical underpinnings of IPA - phenomenology, hermeneutics, idiography – in the light of our research question and confront these theories to the actual body of knowledge so as to contribute efficiently to the research discussion on the subject.

3.2.1 Patient care experience and phenomenology theories

In a recent declaration, the obstetrician, academic and Assistant Director-General for Family, Women, Children and Adolescents at the WHO reminded that “a good birth goes beyond having a healthy baby” and that “high quality care should encompass both service delivery and the woman’s experience” (Dr Nothemba Simelela 2018). We therefore need to look at what and how is constituted a woman’s experience as a patient needing care.

The review of the previous research is focused on the experiences of migrant women in needs of pre, inter and post-partum care. By patient care experience, health professionals usually imply the perception of the continuum of care in the eye of the patient. Here, Wolf et al provided a more comprehensive definition, involving the following elements:

1. The patient experience reflects occurrences and events that happen independently and collectively across the continuum of care

2. Embedded within patient experience is a focus on individualized care and tailoring of services to meet patient needs and engage them as partners in their care.
3. The patient experience is strongly tied to patients' expectations and whether they were positively realized (beyond clinical outcomes or health status).
4. Finally, the patient experience is integrally tied to the principles and practice of patient- and family- centered care.

(Extract of Wolf et al 2014:7)

Being phenomenological is intentionally having a moment of self-reflection on something that has happened or is happening (Smith et al 2009:13). Here, IPA encourages researcher participant to have a reflexive attitude and consciously reflect on the appearance of the phenomenon of pregnancy, childbirth and postpartum as an experience to share with the researcher. As Merleau-Ponty depicted human-beings, we are holistic and subjective individuals. (Smith et al 2009:19). Our social constructs never leave us and work constantly as interpretive filters in our daily lives (Parsons 2010:80). It is also the case for migrants through their journeys, and their constructed ideas, identities, beliefs accumulated along the way affect their perceptions of reality and their behaviors in their new country.

It is on this idea that are based phenomenology theories, as they deal with human life and especially their meaningful lived experiences upon which our social world is constructed (Smith et al 2009:11). By acknowledging that while looking at the struggles perceived by migrant women, we can understand the importance of attitudes such as a birth position or tradition like confinement after birth and the necessity of extended communication with health providers to provide as much comfort as care itself. This process is not always the natural response when strangeness appears between two human beings, but quality communication starts with the understanding of how the world and its different features like activities, relationships or languages become or are rendered meaningful to human beings who are constantly contextualized and intertwined with what composes the world (Heidegger in Smith et al 2009: 18). In the experience, the absence of expected things also matters and has been theorized by Sartre under the term "nothingness". It matters because the experience constitutes with other experiences the being itself, the essence of the individual. (Smith et al 2009: 20). This relates to the confusion and depression migrant women can feel even when assisted, because they are not surrounded by their familiar environment or loved ones.

3.2.2 The processes of making sense and hermeneutics theories

Hermeneutics theories compose as a whole the theory of interpretation and questions the difference between appearances and hidden meanings. In this regard, talking about the phenomenon, discussing it, can help in making sense of it (Smith et al 2009:25). Indeed, the conscious or unconscious meaning attached behind social constructions when disrupted by difficult situations can be stressful or traumatic. Therefore, IPA appears as a "Double hermeneutics" (Smith et al 2009) or "two-stage interpretation processes" (Pringle et al 2011) where the

researcher tries to analyze the self-interpretation of the phenomenon by the interviewee.

It is through this process of trying to make sense that we encountered many reflections on the self and coping mechanisms in the theoretical review of migrant women perceptions of their struggles. Social psychology's concepts such as self-integrity and resilience theories put in perspective the perception themes and struggles and enlighten the main findings of the current state of knowledge. The self-integrity theory relates to what is felt to oneself; while the resilience theory relates on how to cope with these feelings. More precisely, integrity within health care experiences in the eye of the patient can be understood as the conservation of the self, dignity toward the health provider and confidence between health provider and patient (Widang et al 2007:543-545). A perceived threat to self-integrity could therefore explain a lot concerning women's perceptions of their pregnancy, the moment of the birth and even the sense of motherhood. Closely related, the concept of resilience according to the definition of Caldeira & Timmins in the concluding section of their thorough concept analysis could be grasp as "the ability to recover from perceived adverse or changing situations, through a dynamic process of adaptation, influenced by personal characteristics, family and social resources, and manifested by positive coping, control and integration" (Caldeira & Timmins 2016:194). Considering the migrant women's vulnerabilities identified in the previous sections, it seems that migrant women are likely to demonstrate forms of resilience while trying to make sense of their experience as a soon-to-be mother or a mother already. This can be particularly relevant if they have encountered forms of significant violence such as violence associated with pregnancy (VAP) according to Gagnon & Stewart who, among other findings, highlighted that migrant women often draw their resilience from their own coping resources, the environment surrounding them and finally from system factors as well (Gagnon & Stewart 2014:303).

3.2.3 Country-specific practices and idiography theory

The main limitation of the body of knowledge lies in the fact that most studies were conducted in the framework of Western countries, mostly in Europe, Australia, and United States. Although they can still shed light on the main issues under review, their potential on informing MENA situations are limited. Moreover, due to the difficulty of the MENA region, Tunisia especially, to implement rights-based Sexual and Reproductive Health policies and the increasing migration dynamics reaching the country, it appears critical to address the patient care experiences of the most vulnerable in these particular conditions.

The theory of idiography opposes to usual trend for nomothetic inquiries where the data while treated are progressively detached from the individuals who provided them in the first place, by being generalized at the level of averages or laws of populations' behaviors (Smith et al 2009:29). On the contrary, idiography focuses on the particular context of the phenomenon studied, and how information regarding this phenomenon is processed by a particular group of people.

When it comes to migrant women's perceptions on their pregnancies and new-motherhood situations, the understanding of the former country as well as new country's practices seems crucial, and with an IPA lens must be addressed in the interview process as well as discussed in the analysis. Considering the host country, Tunisia, the background section has covered the main elements of an introductory contextual analysis at the national level. Here, the idiography theory invites us to look closely at the cultural practices in the country. For instance, it seems relevant to know that Tunisia abolished the practice of polygamy as soon as the 1950s and culturally envisions sexual relationships as acceptable only in the frame of wedlock, while homosexuality is criminalized in the country (Amroussia et al 2016:184). Finally, even though Tunisian women are becoming more and more aware of their Sexual and Reproductive Rights and more generally empowered in the society, the human rights-based analysis of Amroussia and colleagues reported the presence of patriarchal norms in the society hampering gender equality and women empowerment in the country in 2016 (Amroussia et al 2016:191).

4 Methodology

This chapter aims at explaining which data will be gathered and how they are analyzed to answer the research question. Following a reflection on the global approach and the research design of the study, this chapter presents the best method of data collection as in-depth semi-structured interviews, retrieved from small purposeful emerging sampling, conducted and analyzed through the particular approach of IPA. The three steps taken in the data analysis process include triangulation with health professionals' interviews, organization of the data collected via inductive coding in a software and completion with additional material. To conclude the chapter, the last section considers the ethics and limitations of the methodology.

4.1 Methodological considerations

4.1.1 Interpretative Phenomenological Analysis (IPA)

So as to address the very question of migrant women's perception of pregnancy, childbirth and postpartum care experiences in Tunisia and generate empirics that speaks to the debate of vulnerable population's maternal health worldwide, solid and detailed qualitative data need to be retrieved. Here, the research question requires to dig into personal lived experiences of specific individuals and their relatedness to the different stages of maternal health, by exploring the sense-making process of their lifeworlds (Smith et al 2009:40). It is a detailed examination, which includes the participants concerns and claims.

Many qualitative methodological approaches alternative to IPA could offer relevant ways to tackle the question at stake. One can think of grounded theory (systematic and inductive analysis for theoretical-level outcomes), discourse analysis (examination of language and practices with a performative focus) and narrative analysis (exploration of participants' stories, their structure and link to other texts), all approaches closely related to IPA (Smith et al 2009:43). Choosing Interpretative Phenomenological Analysis however is choosing a method allowing the retrieving of meanings surrounding a phenomenon that took place in a specific context and the sense-making process the constructs underwent for participants sharing the experience. In this way, the method is consistent with the epistemological standpoint on which the research question is grounded.

In an IPA setting, the actors involved in the research are positioned at the different levels of interpretation in the hermeneutics circle. The participating woman accounts for the first layer as she engages in the telling and sense-making activity upon her experience. The researcher here does not have an “insider” status but engages in a close participant-researcher relationship as he actively listens and embodies the second level of interpretation. Finally, both need to be aware of the third hermeneutic level by considering the place of the reader (Smith et al 2009:41&64). This general methodological perspective leads us now to look at the specifics of the research design.

4.1.2 Research design

The fieldwork for the research was set up in Tunis where 23 interviews were conducted in the time frame of two weeks with the practical support of an NGO. The research field, the area of Tunis, is distinctive by the fact that as it is the capital city of Tunisia it is also a migration platform, concentrating a large number of immigrants looking forward to settling in Tunisia and emigrants willing to cross the Mediterranean Sea to reach Europe (NIS - RGPH 2017:19-21). It is the largest city of Tunisia and has spread beyond the Tunis Governorate to neighboring Governorates of Ben Arous, Ariana and Manouba forming the “Big Tunis”.

The study explores and examines the cases of 13 migrant women in Tunis, 5 being pregnant and 8 who recently gave birth, with the idea that these particular cases analyzed in relation with each other and contrasted with the insights from health providers (10 interviews) along with written materials’ data will shed light on more general assumptions in maternal health. This strategy of the particular informing on the universal echoes a quote from Goethe who stated, “The particular eternally underlies the general; the general eternally has to comply with the particular” (Goethe quoted in Smith et al 2009:31).

The fieldwork period lasted for two weeks early April 2018. The partnering NGO Doctors of the World acted as a gatekeeper and provided some support related to the practicalities of the researching activities. The two weeks consisted in observation and interviews, reasons for why notes were taken continuously, and brief memos were written before and after each interview. The researcher was closely engaged with the setting, participating and observing at the reception room of the NGO where the migrants were met and visiting health structures to interview the health professionals. In this regard, the adopted strategies in terms of collection and analysis are developed below.

4.2 Interviews

4.2.1 Semi-structured in-depth interviews

Because of the sensitivity of the topic and the aim of reflecting upon it, the participant needs to be able to talk openly, at length, with her own pace and words. Thus, semi-structured in-depth interviews appeared to be the best method to collect the type of data identified previously, suiting both requirements in terms of methodological consideration and organizational constraint. Indeed, this interviewing strategy provides the time for the respondent, within a comfortable interaction, to freely tell her story and make sense of the experience with some guidance but without pressure. This is a process aligned with the idiography theory (particular event in a specific context) requiring depth in the analysis, detailed and thorough exploration (Smith et al 2009:29).

The themes of the questions asked are reported under the format of the topic guide in present at the end under the section Appendix B. Depending on the interviewee, between 10 and 20 questions were formulated along with possible prompts, as recommended by Smith and colleagues (Smith et al 2009:60). In the topic guides designed for the interviews with migrant women, the topic areas investigated account for the research streams of: background and migration (1), pregnancy and childbirth experiences in the home country and in Tunis – depending on the mother's current stage (2), motherhood and childrearing perspectives (3), future prospects and ideas for change (4) and finally conclusive questions. Concerning the interview questions for the health professionals, the main themes investigated are background and general practice (1), interactions with migrant women (2), the health system in Tunisia (3) and conclusion. The questions are made open and broad to give the participant the leeway to disclose in her own way and time.

4.2.2 Selecting interviewees

The selection strategy accounts for a small purposeful emerging sampling. Traditionally, samples in phenomenological research include between 2 and 25 participants (Alase 2017:13). In IPA, selecting small number of individual cases is usually preferable as the approach focuses on in depth experiences of complex phenomena. In this way, a small sample offers the opportunity of discovering the richness of the cases and the complexity of the phenomenon analyzed, by making quality prevailing over quantity (Smith et al 2009:51). Restraining the study to a small number of cases also allows to pursue good quality research with the limits of organizational constraints.

The sampling strategy was also labelled as emergent, or sometimes called opportunistic, because it was driven by the fieldwork and the opportunities which

occurred (Patton 2002:240). Indeed, this choice was made because of the constraints linked to the population analyzed. This type of participant group involved in the research – migrant women - is usually difficult to reach and required here the help of an NGO for accessing the field and contacts of their closest health providers within a short timeframe (see triangulation section 4.3.1. for more information on the interviews and demographics of the health professionals). Additionally, it is preferable to adopt a purposeful sampling strategy in order to keep a certain homogeneity in the participants’ pool and thus provide extensive insights on the analyzed experience (Alase 2017, Cresswell 2012, Smith et al 2009). The homogeneity insures the internal validity of the study (partly) but still preserves the uniqueness and variability of the participants’ profiles and perceptions.

The sample is divided in two between women still in the situation of pregnancy and women who already gave birth. This division will provide two sets of perspectives at two different time-points (key moments of the phenomenon investigated) for the purpose of gradually obtaining the bigger picture. It is a way of enriching the IPA process and strengthening the validity of the results (Smith et al 2009:52). Key information on the participants such as country of origin and pregnancy stage for the migrant women are illustrated below.

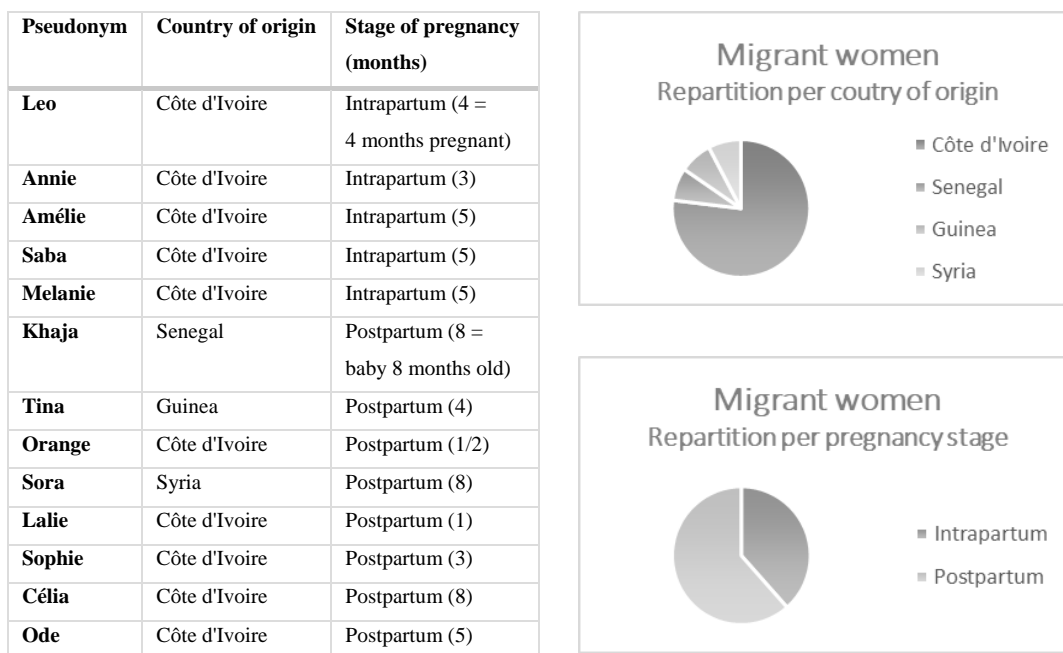


Figure 1: country of origin and pregnancy stage of the interviewed migrant women

4.2.3 Conduction of interviews

The methodological underpinnings of IPA such as the hermeneutic circle (described above) and the inductive principles of phenomenological research that will be fully described here, motivate the researcher for a certain interviewing style. The phenomenological method, as encouraged by Husserl, is the process of

“bracketing” oneself -i.e. putting our preconceptions and own ideas aside – to analyze the ones of others. (Smith 2009:13). The objective is then to render oneself capable of grasping the essence of one lived experience of the phenomenon by reducing assumptions and preconceptions to get the sense of the participant’s perceptual experience (Smith 2009:14). Indeed, for Husserl it is the duty of the researcher to open up the lifeworld – i.e. everyday life composed of taken for granted facts – with scientific insights (Husserl 1970:128). By applying this method of interview conduction to the integrality of the individual cases considered while respecting the hermeneutic circle, the internal validity of the study in accordance with the IPA approach should be secured at this stage of the research.

With this method in mind, the interviews lasted from 15 min to 45min for the migrant women – 11 fully conclusive and 2 too short, only partially conclusive - and between 30 to 90 min for the health professionals, all in an environment comfortable to the interviewee. It is also important to add here that the interviewing process also includes the monitoring of the interviewee through the observation and reporting of the silences and hesitations, the non-verbal behavior / body language.

4.3 Approaches to data analysis

4.3.1 Triangulation: health professionals’ interviews

In order to complement the interviews of migrant women the choice was made to also interview some of their closest health professionals. This choice of multi-perspectival study (Clare 2002) – a study enriched by the analysis of two sets of points of views at least - was motivated by the ambition of getting a bigger picture of migrant women patient care experiences by contrasting their perceptions with the one of health providers. Indeed, these health professionals from diverse background possess an interesting and rich perspective on their patients’ maternal health and attitudes toward it. For Smith and colleagues, this variance of IPA study provides a “detailed and multifaceted account of the phenomenon (Smith et al 2009:52), here the phenomenon being the pregnancy as well as the perceptions on childbirth and motherhood closely related.

For these interviews, the same interviewing procedure in accordance with IPA methodological underpinnings as detailed above has been followed. The only difference lies within the use of a different topic guide, specifically designed for this interviewee group (themes reported in the interview section). Additionally, some of the health professionals’ interviews lasted a bit longer due to the increased easiness to talk about sensitive medical topics and the level of education and language, compared to migrant women who had sometimes more difficulties

to discuss. There was a total of 10 interviews of professionals with diverse specialties as reported below.

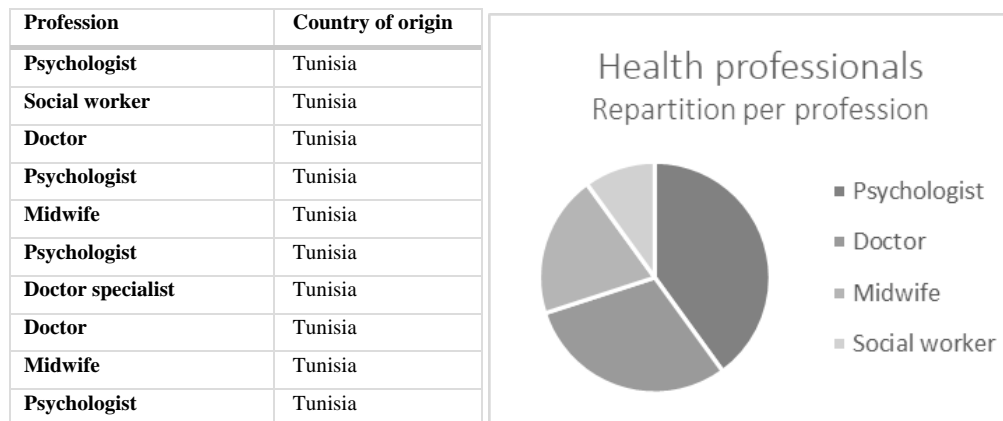


Figure 2: repartition per profession of the interviewed health care providers

4.3.2 Additional material

In addition to the data generated from the interviewing process, more information were accumulated from “semi-participant” observation and pertinent written documents collected. If the research was fully engaged into participant-observation, this technique was unfortunately only partial, hence the label “semi-participant” observation, for two reasons. The first one is that the time spent on the field was quite limited and more information could have been retrieved if the time-frame was not restricted by practical factors. The second stands in the languages spoken, as the researcher was only able to speak one of the two possible languages, French and not Arabic. Nevertheless, French was the most commonly used among migrant women and all health professionals were fluent in this language.

Beyond these limits, the status of the researcher was not hidden, and she was presented to the interviewees as working with the gatekeeping NGO as an independent researcher. The data retrieved from participant observation were observations in situ through an ongoing note-taking activity. Some items were observed systematically, namely the interactions between migrant women and health providers when possible, interactions between the members of the NGO and interactions between the NGO and external health professionals or partners. These specific notes added to the general background of the research and to the final discussion. A self-analysis of the research was conducted continuously in

order to improve the quality of the general inquiry and the interviews in particular, as well as to serve the ulterior analysis.

Written materials were also collected during the entire fieldwork period. These includes medical tools (such as health booklet, administrative forms and health passport designed to facilitate the circulation of the migrant among the health structures), advocacy tools (flyers, notes on video materials and advocacy report) and research supports (one on migrants' mental health in Tunisia and one on young migrants needs in sexual and reproductive health care in Tunis).

4.3.3 Data organization

According to Smith and colleagues, the transcriptions of the interviews represent "meaningful snapshots" of the participants lived-experiences and therefore need to be analyzed with care and rigor (Smith et al 2009:66). This organization and analysis process is detailed here.

After the transcription, the interviews were sorted by categories of interviewees (migrant women as patients and health professionals). Preliminary comments of descriptive, analytical and conceptual natures were made before the transcripts were uploaded in a Qualitative Data Analysis Software Nvivo11. Similarly, the way of coding was inductive in order to witness the emergence of major themes associated with migrant women perceptions of pregnancy, childbirth, postpartum care experiences. Patterns, contradictions and juxtapositions within and among the interviews were assessed. This list of themes – or codebook – is available in the appendix section under appendix C. Finally, in light of the additional materials, the results of the analysis were confronted to the theoretical framework in the discussion section, which resulted in 10 main findings. Before reaching the analysis section, a few ethical considerations and thoughts on the limitations of this study are highlighted in the upcoming section.

4.4 Ethics and limitations

4.4.1 Ethical considerations

For the conduction of the interviews, some ethical principles were established beforehand and followed. At the beginning of each interview, the researcher presented herself, precisising the general theme of the research and the time commitment necessary from the participant. Often, the precision was made that the researcher was interested in their own, subjective experience which implicated no right nor wrong answers. The role of the researcher was therefore the one of an active listener, as advised by Smith and colleagues (Smith et al 2009:53).

Before asking the consent of the participant, the researcher informed him or her of the anonymity in the process and the probable outcomes / uses of the research. Participants were also asked if audio recording was permitted and most of them (one exception) agreed. Finally; when sensitive topics came up during the discussions accompanied sometimes with emotional outburst, time and space were given to the participants before they resumed their stories.

4.4.2 Limitations of the study

Akin to other research projects, this study presents several limitations that need to be addressed here. The first limitation has, in fact, already been mentioned previously and concerns the participant or rather semi-participant observation, constrained by practical matters (timeframe and financial resources) and language. Fortunately for the second, only one interviewee could only speak Arabic and a translator was appointed to translate thoroughly by the NGO. The other participants could all speak a language for which the researcher was fluent.

The second limitation concerns the sampling strategy defined as purposeful emerging sampling strategy. Other strategies could have been very relevant to use, such as purposeful random strategy or purposeful completely homogeneous sampling strategy. However, the emerging one appeared to be the best suited to the situation because of the exploratory nature of the research and the difficult access to the participant population. Nevertheless, it provided a particular sample mainly constituted with Ivorian testimonies and did not allow for in-depth comparison with Arab migrants. The one and unique interview of a Syrian woman served more as a point of reference.

The last and maybe the most important limitation to consider lies in the external validity of the research design itself. Because of the phenomenological interpretative and especially idiographic aspects of the research, its design cannot be generalized, even if the particular informs on the general. Nevertheless, this limitation is alleviated by the theoretical transferability of the study through its well documented theory section and thorough analysis (Smith et al 2008; Pringle et al 2011). These limitations conclude the methodology section and give way to the upcoming chapter dedicated to the analysis.

5 Analysis

When asked about their maternal health care experiences, migrant women reported that many aspects of their lifeworlds shaped their lived-experiences of pregnancy, childbirth and motherhood, and this at their micro, meso and macro levels. Indeed, emerging themes in the discussions concerned the individual herself but also her social environment, working and living conditions, and the socio-cultural structure of the society alongside the health system. To a certain extent, health professionals similarly referred to many external factors in the social world of the migrant women, outside their medical field and sometimes outside their perceptual fields too, influencing the patient care experiences. These perceptions and expectations of pregnancy, childbirth and motherhood as well as the aspects of their lifeworlds shaping them, are altogether composing migrant women’s maternal health lived-experiences. For the purpose of this in-depth analysis, I looked at each of these emerging themes – i.e. life aspects of migrant women surrounding and challenging each stages of their maternal health – alike a deconstructed puzzle as represented below.

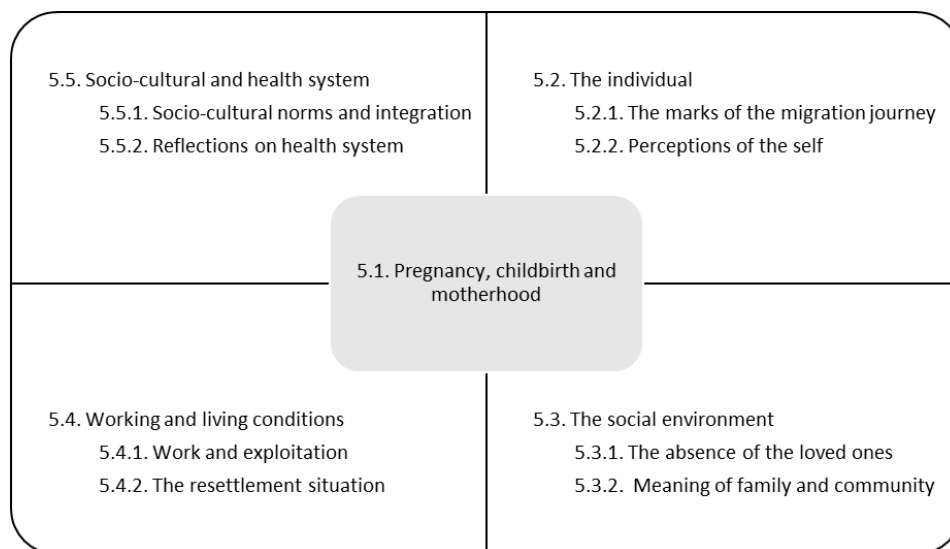


Figure 3: Migrant women’s maternal health lived-experiences, from their own perspective and the one of health professionals

Therefore, to fully comprehend the maternal health lived experiences of migrant women, the multi perspectives of pregnant migrant women, women who recently gave birth and health professionals are simultaneously analyzed, confronted and interpreted here, in light of the additional material. In this regard, the first sub-section emphasizes the social constructs of pregnancy, childbirth and motherhood stemming from the sense-making efforts of the interviewees. Subsequently, the following sections focus on the perceived struggles migrant

women face affecting their well-being and hampering their maternal health care experiences. In the discussion section, these results are confronted to the academic literature.

5.1 Migrant women's social construction of pregnancy, childbirth, motherhood

Migrant women maternal health experiences are characterized by the perception of pregnancy as an occurrence incurred by the woman as opposed to the result of a choice and a well-planned project, the fear of the caesarean section during childbirth and the representations of motherhood as a source of hope, strength and fulfilment.

5.1.1 Pregnancy as an occurrence not a well-planned project

Overall, interviewed migrant women perceived the pregnancy as an occurrence, ordinary in the life of a woman, which results for them in the choice of keeping the baby or aborting. In occidental countries – a context where the number of children per woman decreases – women are more likely to envision the prospect of pregnancy and motherhood as a well-planned project. For these women however, the question of the willingness and the readiness to have a baby does not appear as an upstream decision when thinking about contraception or stability (financial, social etc). A pregnancy is perceived as an event, the result of a physical act, that will arise sometime in life according to God's will. In contrast the choice is downstream: it is the choice of keeping the baby or not.

So uhm I got pregnant, his father told me oh really it is very difficult this situation, what do we do are you going to keep it or remove...? I said no, I will keep it because... I told myself it is God who gave me that child.

(Celia, Ivorian, Tunis 2018)

In this regard, aborting represents a possibility, an alternative often dismissed. Many health professionals interpreted their higher number of children as a consequence of the fact that they were not knowledgeable about the right for a legal and free abortion in Tunis. I did not encounter this unawareness as many of my respondents described their choice of keeping the baby. One explaining factor can be that the interviewed women have already been informed and oriented by Doctors of the World in the past. Nevertheless, this reason appears consistent with the status of abortion in their home country, not always legal. Indeed, it is prohibited in Senegal, in Syria and Côte d'Ivoire with the only exception of saving the woman's life, tolerated to preserve the health of the woman in Guinea and permitted in Tunisia (CFRR 2018).

This decision however, is rarely understood by the health providers for two reasons: one economical and one social. The economical reason might seem more

obvious and is due to the precarious state of migrant women, who usually do not have enough support and economical needs to support themselves. The social reason is usually the first mentioned as this behavior diverges a lot from the social norms regulating the Tunisian society. Indeed, most Sub-Saharan migrant women are single mothers while raising a child out of wedlock in Tunisia is not really well perceived. In this situation, Tunisian women often hide their pregnancy as illustrated below or give birth at the hospital anonymously where the child is placed in the care of state structures.

They live really, really well their pregnancy their childbirth! They are quite fulfilled...; there is not this relation like for us for example for these women who conceive out of wedlock are all a bit in the embarrassment... it is a bit... a bit... trying to hide their pregnancy (...) this is civilizational in fact well (...) the North-African remain in uhm in a paternalistic civilization per excellence... so even if they are very free (...) we choose our husband, we choose our partner, but we do not have children out of wedlock. (...) And if they want to keep her, the child she can but then... there is also the civilizational issue, will the family acknowledge her? or completely take her off the familial dictionary?

(Doctor in public hospital, Tunisian, Tunis 2018)

Finally, it seems important to highlight the facts that keeping the baby might not always be their own individual choice, and might not be consensual among all migrants either, even coming from Sub-Saharan countries with shared cultural aspects and religion. When present, the family can also consequently weight in the abortion decision.

Finally I was not really happy in my skin... because when I look I was not good... a moment I said I will abort it... it is then that... my husband refused and said to leave it and ok... because I am not really at ease in my skin I feel all weird besides I have pains and fatigues... that's it and everyday I vomit, I can't eat... (...) it's complicated... aborting that's what I wanted... otherwise I will keep the baby that's all... well hooked that is what is in my head... well hooked that's all.. (...) it means that I pray God that everything will go well, everything will go well...

(Annie, Ivorian, Tunis 2018)

Other situational factors, such as the city where the migrant woman is settled and her future prospects, seem to matter too as it would explain why migrant women in the city of Sfax (platform area toward Europe) seek more abortions than in Tunis, which was interpreted by one of the psychologists.

5.1.2 Childbirth marked by the fear of the caesarean section

Included in the portrayal made on pregnancy, the moment of the birth takes a considerable place in the thoughts of migrant women. Interestingly, most of the comments on the topic were significantly about the fears associated with the way of giving birth and more specifically the caesarean section. In addition to the “traditional” fears associated with childbirth, migrant women dread the possibility of a caesarean section perceived as an institutionalized norm or at least common practice compared to their home country. Not understanding it, not knowing about

it but just hearing the experiences of other migrants make them fear the moment of the birth and the assistance they will receive at the hospital.

Well... I am only afraid of the day of the birth... it's all only how I will be treated... how I will give birth in what conditions... that's all... else for the moment I am not afraid but often when it comes in my head the day of the birth what will happen at the hospital how they will treat me at the hospital... that's all!"

(Leo, Ivorian, Tunis 2018)

"uhm... that... I pray God... it can only come the right way... the part I'm afraid it is the part of the uhm caesarean... it is the part... I am afraid... a bit... I want it to happen a normal birth... yes... that I pray God for that... it is the part of the caesarean that that worries me a lot..."

(Saba, Ivorian, Tunis 2018)

"Well here well... it is inevitably a caesarean section... at least it is what they told me... here, it is inevitably a caesarean and in fact it is what I am a bit afraid of... that's it..."

(Amélie, Ivorian, Tunis 2018)

This perception of the caesarean section procedure resembling the one of a norm can contrast with some health professionals' perspectives, who sometimes perceive it as a request from the patients.

And uhm in the hospital we don't we don't operate per caesarean section only when it is needed. So they come with the perception that the caesarean section is the solution to all their sufferings and uhm it is the forbidden fruit... Because she is in pain and we, we don't relieve her sufferings uhm by operating and and it creates the disarray and uhm the tension increases (...) well uhm if she had been informed uhm it would have helped her to get through the situation..."

(Doctor, formerly intern in a maternal health unit, Tunisian, Tunis 2018)

On this matter, a midwife I interviewed explained to me the trend for excessive caesarean section in Tunisia, calling it "abusive", and the need for more training to prevent them. This is consistent with the 2012 UNICEF data reporting an average of 26,7% of total births (UNICEF 2012) whereas the international scientific community recommend an ideal number between 10 to 15% (WHO 2014).

To a lesser extent, another issue was mentioned during the interviews and concerned the allowance of the injection to alleviate the pain during the labor phase. Its use might be refused unless the woman chose to undergo the surgery.

And besides what is not good here, they say when you are going to give birth even if you are in pain they, they don't do the injection to calm the pain! So you have to give birth or they send you to the operating room to operate there they give you the injection to calm the pain.

(Orange, Ivorian, Tunis 2018)

But, in that regard, I think that it is really primordial to offer to the patients at least the choice to get the right to the epidural, it is her who chooses if she wants to endure it or she doesn't... Now no it is not systematic

(Doctor, formerly intern in a maternal health unit, Tunisian, Tunis 2018)

These findings are consistent among mothers in intrapartum as fearful expectations and mothers in postpartum when making sense of their memories.

5.1.3 Drawing from motherhood hopes, strength and fulfillment

Overall, looking at the results at a global level, motherhood and childrearing perspectives in the eye of the migrant women from the sample are perceived as a source of joy and fulfillment, of responsibility and legacy and/or of strength compensating for the suffering. For some women a new sense of motherhood emerged and for others they associated motherhood with representations of the future of the baby.

Indeed, expressions of joy were present in almost all, if not all, the women's statements on motherhood, despite the difficulty or precarity surrounding their situations. The doctor in the quotation below makes sense of Sub-Saharan women's perceptions by analyzing the pregnancy as the fulfillment of a woman's life, the ultimate accomplishment:

Uhm the pregnancy they live it very well! The sub-Saharan women have uhm a lived-experience very particular with the pregnancy, the pregnancy is the fulfillment itself of a woman for them. (...) as soon as she becomes a mother, there it is, it is over, she has done everything, she has accomplished everything.

(Doctor in public hospital, Tunisian, Tunis 2018)

This sense of fulfillment however is usually accompanied with other feelings, mainly the one of responsibility and legacy, but this responsibility devolved sometimes to very young migrant women, such Sora who is Syrian, 19 years old, has two kids from four pregnancies:

Uhm well there are girls who lived some situations well more uhm difficult than me and uhm a child is a responsibility. It is when you start uhm the journey you need to be responsible and to commit and to be deeply involved in the thing.

(Sora, Syrian, Tunis 2018)

More than a responsibility and the risk of vulnerability, having a child embodies an investment in the future, a social and economic security for their future in the Ivorian culture and in other Sub-Saharan countries. It is another view of the generational cycle where grown-up child will take care of the old mother:

I am very happy ooh it is a joy for me yeah for us in the family having a child it is very important when you don't have children in your life mmmh I know I see! Often in my family some aunts who don't have children I know what sorts of insults they endure... (...) we are not married we have children we are pregnant at home it's okay like that... it's only at church they defend it but it is very important for a person especially when you get old (...) because our parents they tell us....: all the work you do and the money you seek, the house you build, you will leave it for whom? When you have a child you are where you should be... your name is not forgotten... because when you don't have a child you are soon forgotten!

(Leo, Ivorian, Tunis 2018)

Through the pregnancy they also regain confidence by finding in the motherhood a source of strength compensating for the suffering they experienced in their former country, on the migratory road or even here in Tunis as it is the case for Celia who was a victim of human trafficking:

He is tiring me **talking of her son and laughs**... I tell myself still he gives me some joy! The joy to have the strength to pursue to fight, fight for him and his sister...

(Celia, Ivorian, Tunis 2018)

Another interesting theme which emerged from the interviews describes the renewed or even complete new sense of motherhood that some of the migrant women from Sub-Saharan countries were feeling. Because in their home country the responsibility of the education of a child is shared in the community (see perceptions of the family for details) they did not have the same relationship with their previous children. Here in Tunis, being alone also means that they have a chance to really gain a full experience of motherhood and have a close relationship with the baby and are as close to him as they never were before with the others.

So it is now that maybe I can say I will have an experience of mother, **she insists on the word mother** because now, I will be the only one to take care of my child (...). No in all cases it pleases me because I tell myself maybe this time here maybe I will really feel like a mom... I will take care of my child from the first day until he will grow up...

(Amelie, Ivorian, Tunis 2018)

The last theme mentioned by the participants was the imaginary around the baby. They shared their hopes about the gender of the baby or the wishes concerning his future. Most of the time, wishes relate to education, leading to a form of financial security, wishing that they will not have to face the same difficulties as their mothers.

Pursue their studies... because myself I speak French that I learnt that in my street... It is the French of the street because myself I did not attend **school**... so it should not be that my kids be the same as me! Them they must be more than me because children have to go to school... until... that at least they will have a job to do... but if it is not big but just a little for tomorrow if I become old they can buy water, food to give me so that I can eat... I need to fight for that, I need to fight, that for my kids, I cannot get beaten...

(Lalie, Ivorian, Tunis 2018)

Some mothers also hope for the Tunisian nationality for her baby but the right of soil, of birthplace does not exist in Tunisia.

5.2 The role of the individual herself in the maternal health experience

Beyond the individual physical factors – such as body changes – the maternal health experience of the migrant woman is frequently linked to her background and self-assessment.

5.2.1 Migration journey: remaining motivations, hopes and memories

Migration in itself is acknowledged internationally as a social determinant of health influencing many aspects of the self (IOM 2018). Here the motivations, hopes and events before undertaking and during the migration journey weight in migrant women's perceptions of pregnancy, childbirth and motherhood and on their care experiences.

Most migrant women interviewed came to Tunisia looking for life improvements and new opportunities, often using the expressions of “finding oneself” and “get through”.

Uhm it's okay, as always, I am here I think... because I left my country to come here just to find myself a bit... to take care of my children in Côte d'Ivoire...

(Lalie, Ivorian, Tunis 2018)

No I am Ivorian but I went to Togo when the crisis arrived, I went there then I came back. Well, I try to uhm start an activity, but it didn't work out. Considering the problems, I didn't know where to stay, it is what made me come to Tunisia here to try to find some work and try to get through a bit.

(Celia, Ivorian, Tunis 2018)

Often, other reasons were coupled with searching new economic opportunities such as escaping violence or looking for someone. Indeed, among the nationalities in the interviewee sample, Syria is a country in war and Côte d'Ivoire has a complicated political situation.

Until the election of 2011 came completely dividing the country, divide the population...Put resentment in their heart...put the war in the heart of the people... scorn... so it makes that we don't get along. Even you see your brother you hate them... It is what you see that the party makes that you hate them you want to kill them... it is what is happening now...

(Leo, Ivorian, Tunis 2018)

After the crisis it became a difficult country because during the crisis we... we lived lots, lots, lots of things really... that made us... that made us to come here in Tunisia because there... there is no security anymore! (...) After the crisis it became the war between ethnicities so... things that we lost... myself my sisters were raped and killed in front of me so after that we decided to leave!

(Sophie, Ivorian, Tunis 2018)

She really wanted to be with her husband, she refused to be separated and refused to have a kid without, without a dad. So she started to look for how coming to Tunisia **from Turkey** (...) her brother-in-law advised her to go to Algeria (...) so that they deal with their administrative documents and come back together to Tunisia. (...) She bought her plane ticket while she was going to give birth in the upcoming three days. She started to get contractions in the plane”

(Extract of the simultaneous translation of Sora's story; Syrian, Tunis 2018)

Besides, the choice of Tunisia as a country of destination or transit is motivated by the fact that there usually is a connection between the departure and host countries, if not cultural – i.e. Arabic countries - at least economic as it is the case for the Côte d'Ivoire.

5.2.2 Perceptions of the self

When asked about their state of minds, migrant women directly expressed or indirectly demonstrated different types of feelings. As an overall estimate, about 15% of the references concerned the feeling of resignation, 18% the outsider feeling, 29% the discouragement and 38% resilience. Of course, in the frame of this qualitative research these numbers only reflect subjective estimates but give some indications on the most encountered perceptions of the self in the interviews of migrant women.

The resigned or silent self was not the most encountered attitude during the interviews but was mostly used during the descriptions of work environment or health structures. It is also consistent with the perceptions of the health professionals about migrant women when recalling their interactions. In this way the silent or resigned self means a person quite quiet, barely engaged in a conversation, with very “fatalistic” views.

“That is to say uhm working, staying quiet that is all... no worries in the head, a lot of thoughts... work and stay calm.”

(Khaja, Senegalese, Tunis 2018)

Furthermore, many migrants explicitly reported feeling as an outsider in the Tunisian society, using the semantic field associated with powerlessness. Most of these feelings were reported in relation with the resettlement experiences explained further below. However, this state of mind if persisting will, by influencing every aspect of the woman’s life, also impact her perceptions of pregnancy, motherhood and her care.

Very difficult... first to enter here it is difficult and then to adapt here it is difficult... like that... you are not at home so we cannot take you as if you are at home so you cannot be at ease like it is at home... It is different... No I will not do that and and we are in a foreign country and it is a bit difficult... Here it is an Islamic country it is a bit difficult... so no. We adapt to that and we are compelled to accept that... to stay at our place and until when you pray the all-powerful God it’s all right...

(Leo, Ivorian, Tunis 2018)

Similarly, but to various degrees, migrant women reported feeling lost, feeling discouraged. Some of them associated this discouragement with a momentary distressing situation but for others they were the symptoms of a more chronic desperation. In the example below the mental health state influenced the perceptions of the migrant woman regarding her pregnancy and childbirth (she was scheduled for a caesarean section because she was not strong enough for the natural process) and she called her son Dieudonné, literally “God given” who “could have killed” her but instead saved her life by helping her through depression.

No no it’s the stress... it is because you are a woman you are pregnant and you are abandoned, your money is stolen too so it’s like that the thoughts... because there is nothing you can do about it, you don’t work anymore... you cry... you can’t do anything... (...) But when you are sitting there and then you think a lot a lot, from day to day you wither you start to melt... Some ask you what do you have you are

sick? No I am not sick but they ask me why do you lose weight? No there is nothing no (...) it is like even I had even the myself in front of me I told myself what... and if I died it was good and if I died it was good why did I not die so you see... because when you cry that you are there that God hurts you.. you say and God why didn't you...? If I die it is good time instead of living that... because you, you do the suffering... and you don't have you father next to you your mother your sisters next to you, you are alone and it is not your country... it is like it is another... it is you came on an adventure and then now it failed do you say but why all happen to me... I am not in my country and all that happens to me God I want to die!

(Lalie, Ivorian, Tunis 2018)

Fortunately, Lalie recovered with the help of several health professionals and NGOs, and as most of the migrants she showed signs and expressed feelings of resilience, as illustrated by the examples below.

No it is not the same... it is not the same you know where you are born you came on an adventure it is not the same hum (...) Yes... when you come on an adventure, you need to be strong in your head, no it is not easy (...) hum... you need to be strong in the head because here if you are sick you are alone, you need to stand up, go seek for food, clean the house to do the housemaid, you are compelled to do it all alone...

(Saba, Ivorian, Tunis 2018)

No. **very firmly, saying no with her head**. You need to do on the front not go backward!

(Khaja, Senegalese, Tunis 2018)

However, according to the few psychologists interviewed, these strong abilities to cope with distressing situations differ from one population to another. Based on a study they conducted on migrants' mental health in Tunisia, they found that the state of resilience for Sub-Saharan population was stronger than the one of migrants from the MENA region or the Middle East. The main hypothesis formed to explain this phenomenon would be cultural:

I explain that by the fact that uhm the sub-Saharan culture is a uhm and the living conditions in the sub-Saharan countries are too harsh. And so they are used to since their childhood to a difficult way of life, complicated uhm they are used to the culture of risk too. They are all the time in the risks, being natural disasters or risks of civil wars or I don't know diseases...uhm severe uhm so they are all the time ready to cope because they don't have the choice, if they don't do it they can't survive. It is a bit the system of natural selection. And so when they come to Tunisia despite the difficult living conditions uhm legal, economical, the living conditions in Tunisia remain a lot, let's say of better quality than in their home country

(Psychologist, Tunisian, Tunis 2018)

By contrast, migrants from the MENA region and the Middle East are to a lesser extent used to difficult living conditions, especially if they had a good socio-economic condition before migrating. These findings also echoed their observations in terms of responses to offered psychological care:

The Arabic refugees or migrants ask to see a psychologist contrarily to the sub-Saharan population... because as I said the problem is not stated. We do not need a psychologist to listen to us because they react in concrete terms. I need this or that pill to feel better. I manage well my struggles, so I don't see the necessity or benefice euh to ask for a psychologist... (...) The remission or recovery is faster for

them than for the Arabic population or uhm from the MENA region even if the diagnosis or the disorders are severe!

(Psychologist, Tunisian, Tunis 2018)

5.3 The influence of the social environment

Encompassing the previous responses on the individual level, the state of isolation of migrant women was striking. The two factors of missing former bonds and lacking real support were overwhelmingly expressed in migrant women responses and in the testimonies of health professionals as struggles marking their maternal health experiences.

5.3.1 The absence of the loved ones: emptiness and concerns

During the interviews, migrant women disclosed their perceived feeling of increased vulnerability due to the absence of their loved ones around them especially during the intrapartum, childbirth, and postpartum periods. Beyond their maternal health care, the concerns and the responsibilities toward the family weaken them on both psychological and economical levels.

Indeed, experiences of pregnancy and childbirth mainly were strongly influenced by the regret of and absence of the family and particularly of an older kin to take care of the newborn and advise the new mother. From the information retrieved in the interviews, it seems preferable when the supportive kin is a woman, a practice particularly cherished by women raised in Sub-Saharan countries notably.

Well uhm I just have my husband and my brother. That's it. For others it is only friends, just friends. But parents it is I don't have them here. And because it is a man well! Otherwise if it has been a woman it was good (...) if it was my sister she could help me with the first moments well! Do a lot of things but it is a man we will do with it uhm (...) for others well the man can live after he can travel, leave her with the pregnancy and travel, when it is like that it is not easy. (...) In any case, in our home country when you give birth, there is always somebody to take care of the child because one can think that you can't wash your baby, he is newborn you can't take good care of him, you need an older person... (...) then you have the time to take care of yourself that is to say for us a pregnant woman, no a woman who gave birth should not touch anything... she should not work that's it. So we cook food for her, it is to give, nurse the baby, eating, resting... that's it just for you. After three months then there you can now do your job and you can take care of the child.

(Amelie, Ivorian, Tunis 2018)

This perception of the role of the family is recurring in many interviews of migrant women.

The family left behind in the home country can also influence the feelings and attitudes of the migrant women on the economical level, which can lead to further psychological fragilities. The financial expectations of the family toward the migrant who is perceived and feels responsible for them can also become an

additional source of anxiety. Sometimes anxiety even transforms in profound suffering when they forbid themselves to come back home without the means expected to come from them. The situation can worsen when migrants are aware of the precarity and emotional distress of their loved ones left behind:

It is that which is very difficult for me... because now they tell me I have penalties and I need to wait for them to be cancelled and then after that I will see my mother again...because right now she is going through a very difficult period...**she cries**... she is going through a very difficult period I lost my little brother... in the water! He was in Algeria and then he followed his friends to Libya to go to cross because of the suffering! Unfortunately, he remained in the water... His friends made it but not him...! So now that affects my mother everyday even yesterday I talked to her I tried to cheer her up... she has withered! She is not the same...and me it makes me suffer! **she talks and cry simultaneously** I try to be strong, but I suffer in the inside... (...) It is true that I have nothing... what I thought I would have here I didn't have! But I had a child and... I know that the fact of seeing us both will alleviate her pain...

Celia, Ivorian, Tunis 2018

5.3.2 Social constructions of the family

From the perspective of the health providers, there is a difficult differentiation between family and community for migrants coming from Sub-Saharan countries, when they try to provide them with the appropriate care. Indeed, migrants often attest to their lack of familial and even amical support when asked by health professionals, which are therefore often surprised knowing that migrants live in communities of fellow citizen and often call themselves brothers and sisters. This is the result of contrasting visions, social constructs of the family, nuclear on the one hand and extended, community upbringing on the other hand.

Yes, uhm I have noticed uhm some very different perceptions of the family and the children uhm in the Sub Saharan population in comparison with our population, well I will compare with the Arabic populations. (...) Us, we are in the affiliation, that is when it is a mother or a father it will really be a mother or a father who protects who is there who, who, who is there all the time and always have the mental load of her children despite the traumas she lives despite an unfavorable socio-economic situation and all (...) so when she comes she speaks with us not about herself but she speaks about the situation with her children (...) and she neglects herself. However, with Sub-Saharan women it is different. Uhm the children it is normal if I, I give birth a child and I leave him to work in another country and that I leave, and I don't see him for years and years it is normal. Why? Because they explain it to me, it is not only the mother who raises the child it is the grandparents, the community uhm the neighbors it is everybody who educates the child.

Psychologist, Tunisian, Tunis 2018

This perspective of the family requires the Sub-Saharan migrant to receive the care and the information adapted to the life in the community, which results sometimes in different approaches and advocacy strategies from health providers, as some of them emphasized below:

There are all uhm in union they are not all uhm they are couples, couples uhm boyfriends uhm cohabiting unions not weddings, no united family, this child from this boyfriend, this one from the other (...) There is no sense of family here... and

sometimes the couples they are... they change the spouses well... heterogenous... that's it.. They change themselves their couple... yes that is why here we take great care uhm we are always vigilant (...) uhm for the HIV tests especially serological checks we are always cautious. And we make sure they are safe and sound that's it.
(Midwife, Tunisian, Tunis 2018)

It is there the challenge to be able to mobilize people **among migrants within their community to raise awareness** really uhm... who see the interest behind and who see the importance of education, of the community of the community investment...
(Doctor, Tunisian, Tunis 2018)

Therefore, the family and the community themselves as well as the perceptions of health providers about them will influence and shape the maternal health experience of the migrant woman. Some of them will be able to find great support in the community (for instance I met two young migrants among which him offered her marriage to continue to support her and her baby even if they are not in love) but others prefer to keep some distance.

I did not make friends... because uhm when you have friends you see enough stories some blab la bla uhm you said that! She said that!... no it sends stories among the persons in the group so when it is like that I came my work to home, home to work...

(Lalie, Ivorian, Tunis 2018)

5.4 Working and living conditions

The migrant women's working and living conditions account for one of the most recurring reported struggle affecting their maternal health experiences, by inducing risks and emotional distress.

5.4.1 Abusive working conditions and exploitation

Many of the women interviewed have been or were victims of human trafficking, an old phenomenon finally acknowledged and punished by law since 2017. Indeed, if the migration flow from Côte d'Ivoire and Tunisia (mainly Côte d'Ivoire but also other countries from Sub-Saharan Africa) has existed for a long time, there used to be a certain silence on the matter.

There are a lot of people who say that uhm the thematic of migration is new in Tunisia whereas no it is not true, the thematic of migration is not new. But it was hidden, before we did not talk about it. In fact we did not disclosed that, human trafficking for example (...) the jurisdiction starts really to be operational in 2017... it is a long period of time for finally realizing ah uhm well we have a lot of human trafficking (...) whereas we had this issue of human trafficking before but nobody talked about it... in fact the government buried his head a little bit about that...

(Psychologist, expertise on legal assistance and asylum right, Tunisian, Tunis 2018)

Thus, many migrant women when discussing their perceptions of pregnancy childbirth and motherhood, also tell a story of exploitation and violence. The

usual scenario is that she was approached by a fellow citizen in her country and offered a contract for a job in her area of interest in Tunis in exchange of a certain amount of money supposedly to cover the expenses of the visa and the plane ticket. They find themselves locked, usually working as a housemaid in a Tunisian home with their passport taken and sometimes with no money at all. The contract is supposed to be for about five months but after three, the visa for Ivorian expires and they start receiving penalties every day, penalties they cannot pay.

Well so really... I don't have a good experience... I did not expect... it is not... what I expected. That's it... no at that moment I was put in a contract for 5 months... thank God I did 4 months, I did not have the right to go out my limit was the door... I open for my employer, get in, close. I worked from 6am to midnight / 1am no really it was painful for me.

(Celia, Ivorian, Tunis 2018)

Some of them had to continue working in these very difficult conditions until the end or a very advanced stage of the pregnancy. Most stops in the middle of the pregnancy and often find themselves in precarious economic situations.

The pregnancy... I worked... until the very last day I went to the hospital I gave birth through caesarean section... (...) I did that I worked slowly, slowly and all because I can't stay at home without working. I can't I need to work to get a bit to bring. Just necessary to live. Pay the rent etc...

(Khaja, Senegalese, Tunis 2018)

Furthermore, the issue of combining work and with motherhood continue in the postpartum period and after. Migrant women struggle to find a way to get the financial means to support themselves and to take care of the newborn. Usually, if they can rely on someone they stop working but when they cannot, they try to find alternative solutions or try to go back to their home country. Thus, in addition to probably influencing the development of the pregnancy at a physical level, it can add various degrees of stress, tension and financial insecurity to the migrant women, affecting her motherhood perceptions.

5.4.2 The influence of the resettlement situation

Overall, even if their experience of living in Tunisia was different from what they imagined when leaving their home country, most asked migrant women appreciated living in Tunis despite their complicated resettlement situation. For migrants coming to Tunisia, the resettlement situation as mentioned briefly in the previous subsections is characterized by an economic precariousness and the need to live up to the expectations placed in them by their family. To that, migrant women who get pregnant cumulate the expenses related to the resettlement and to the birth of the baby.

For the caesarean they tell us to pay 400 dinars, all all 400 but there is a woman at the payment desk she saw me she asks do you have the money I said no here is all I have she said ok give... I could not pay the 400 dinars...

(Orange, Ivorian, Tunis 2018)

Often, they rely on NGOs such as Doctors of the World assisting them with the pregnancy follow up and other associations of the network, or on the goodwill of their community. Finally, the financial penalties the Ivorian population has to face because of their illegal presence on the Tunisian territory are also recurrently reported and increase the vulnerability of the migrant.

The resettlement situation for migrant women also includes housing instability. This theme occurred at different occasions but not always during the interviews. There are however some cases where it completely conditioned the lived experience of the pregnancy for the migrant women as related below.

So I will stay at the hospital... she said no the hospital is for those who are sick. But as it is okay with you we free you, you go back to your home! Now you say you want to stay here... with the beds made for the sick ones... you, you are cured it is okay with you the health... it is not totally good but it is good... so you must go back home. I said no madam I can't go back. Because I don't know where to go! With the pregnancy I don't know where to go! If I say yes, I say yes I accept, I will find myself in the street because I don't know where I could stay...! The homeowner he will not say no it is fine your husband left you you can stay in the house no! the homeowner will not tell me that only the month he wants his money... well if I don't work anymore... with the belly... no I don't know where to go...

(Lalie, Ivorian, Tunis 2018)

For those women, there are really few women's shelter, maybe two to three in Tunis; and they are usually required to access it for a temporary moment until they are assisted to go back voluntarily in their home country.

It is also important to emphasize that despite reported situations of verbal or physical violence, migrant women declare feeling safe in Tunis. According to the interviews of the present research, the cases of insults and stones depicted below are not isolated unfortunately.

So we cannot really, really say safety because too often you can find yourself in a place where... there are young ones who insult you... or they stone you... so I can't really say safety in itself... that's it but it depends also of the area...

Amelie, Ivorian, Tunis 2018

One health providers shared the fact that she met several migrant women who never left their community neighborhood for years and that many of them still leave in fears. To conclude this subsection, it is interesting to add here the fact that the majority of interviewed migrant women wants to leave the country and return home.

5.5 Structural level: socio-cultural norms and the health system

At a further level, norms and habitus in the host country rendered the maternal health experience difficult for migrant women, engendering painful memories often disclosed during the interviews.

5.5.1 Socio-cultural norms and integration in the host country

The former layers have demonstrated a profound isolation and a certain outsider feeling among migrant women. All migrants are not equals in terms of integration and did not experience the same treatment, at and since, their arrival. Indeed, Sub-Saharan migrant women have integration issues mainly due to systemic factors and perceived discrimination by individuals. On the one hand, they have difficulties to find a decent job while often facing painful working conditions because of their irregularity status. The regulation procedures are not favorable to the working category, only the students, and they continue to live in the fear of being arrested. On the other hand, they encounter discouraging human interactions, but also emphasize the necessity of avoiding unnecessary generalization to the whole Tunisian population.

Very difficult... first to enter here it is difficult and then to adapt here it is difficult... (...) You can fall on good people who like you and treat you well... you can fall on bad people who don't like you and mistreat you... and that there is a lot here... a lot of our sisters are mistreated... we are a lot insulted, pointed out...

Leo, Ivorian, Tunis 2018

They usually meet Tunisians in the frame of work, and for them the resulting relationship is a matter of chance. Some migrant women therefore emphasized the need to behave well.

We are not at home here, we came in a foreign country it is to behave well then... walk, smile, walk in a way we should walk, make decisions and that is all. We should walk as everybody because we are not a home here we came in a foreign country... we should behave well...

Annie, Ivorian, Tunis 2018

For migrants coming from Arab countries, the overall integration in the population seem to be slightly better, likely due to the similarity of culture. But there too there are disparities, for instance the population from the neighboring country Libya is usually well received and can settle more easily than for Syrians.

We don't give certificate of refugee status for the Syrians it is a policy in Tunisia we give them uhm the paper of asylum seeker... for the Libyans however well they come uhm they are welcomed in Tunisia so we don't give them the refugee card but they can uhm even have goods etc so "refugee themselves" if you want... having the asylum in Tunisia without having effectively the paper that say so...

(Psychologist, expertise on legal assistance and asylum right, Tunisian, Tunis 2018)

These facts do not prevent very bad experiences to occur.

They told her uhm if you entered Tunisia we will know about it how did you do to come here? * *Authorities**. She said uhm she said she came in an irregular way. And how did it happen they asked uhm... she was afraid (...) she said she managed by herself alone to come here (...) they spent the day to beat her uhm to mistreat her uhm for her to speak. To get some information from her they separated her from her baby, they put him just in front of her she can see him but not touch him and uhm he started to cry. They told her if he is starving it is your fault you can stop it if you want speak and then you can nurse him and have him in your arms and uhm she insisted it was the truth and uhm she did not want to speak and uhm they beat her they pushed her head against the wall uhm she had some head injuries and still she

held up to not say but uhm they did all of that knowing that she was a minor non accompanied in Tunisia and that she had a baby they used him to manipulate her and torture her to get information.

(Extract of the simultaneous translation of Sora's story; Syrian, Tunis 2018)

5.5.2 Reflections on the health system

During the interviews, migrant women as much as health professionals extensively discussed their experiences and their perceptions of the health system in Tunisia and the maternal health continuum in particular. Regarding the perspectives of migrant women, the comparison of the host with the home country first allowed to emphasize the value of the increased pregnancy follow up (yet looking similar for some migrants) but also the difficulty with the decentralization of care.

Here the care is more, we can say more thorough compared to Côte d'Ivoire. Here when you are pregnant they do all the exams to see if there is not a hidden disease or to not have the child affected by the disease we do all those exams. In Côte d'Ivoire they don't do it. It is they do exams, your blood test and that's all. They don't take care of you like here with the echographs 2 or 3 times, you do the blood test other exams... there no...

(Leo, Ivorian, Tunis 2018)

Beyond this general assessment, migrant women pointed out the patients' reception especially at the hospital as disrespectful and problematic, often perceived as discriminatory.

She said that she, she does not like to go to hospitals (...) the behavior there is not really correct uhm there are behaviors that bother me (...) the fact that in Tunisia they don't accept uhm they don't give me the title of married woman until I have a wedding contract in Tunisia they look at me with a look uhm full of judgements in the way that I am a single mother and I have a child and uhm I reoffend with uhm a second one or uhm they, they, they make derogatory remarks uhm in the way that I did not feel way when they took care of me.

(Extract of the simultaneous translation of Sora's story; Syrian, Tunis 2018)

Others did not even receive, apparently, the compulsory prenatal consultations.

But at the level of the hospital, but us we go for a consultation but uhm it is a problem (...) They make us they ask us always the analysis but if you take my health booklet there is no consultation inside... When you go you want to get a consultation they say no we do the exams, you have to do all what you are asked but... we don't know why they are like that with us...

(Orange, Ivorian, Tunis 2018)

Due to this fact, some of the migrant women associated childbirth with a strongly negative memory. Sometimes this is due to a caesarean section unplanned and very expensive for the mother, in other cases it is the care before and after the birth.

After the birth he left *the gynecologist** but they uhm they did not clean me they left me there in my blood. All dirty. They told me no man could get in and that the father of my child could not come in. (...) And then they left me there, uhm

undressed (...) there I was compelled to leave the child on the bed because I did not have any kin with me. I went to the bathroom to try to clean up myself (...) really uhm it was uhm I did not recover I wondered in fact in what situation I was really in what situation did I put myself in? And well... after I tried the loincloth hat I had on me but I tried it but it was full of blood so uhm I tried to clean the loincloth too... but then when I was trying to clean it, I felt weak... I could not breathe and all, everything became dark in front of me... I had to struggle against the bathroom and the bedroom where I was put in and arrived there I felt (...) one of the patient saw me and called (...) there is a woman dying here!

(Celia, Ivorian, Tunis 2018)

For health professionals on another note, the general perception is that the pitfalls in the patient care experiences are not due to the profile of the population but related to the perceived difficulties within the health system, aspects requiring improvements.

It is not the skill uhm of the health professionals, health providers medical or paramedical it is rather the question of the structuring of the system itself, the adaptation of strategies in terms of the means we have. It is very frustrating to see uhm there are the competences and that finally the service provided was rather maladapted to the reality because uhm there are a lot of people uhm they shove uhm there is no health coverage, we don't touch to certain issues that are neglected we look at the body as being an object of medicine uhm not a full person in her environment, even if there was the wish to do it (...) well... what is striking at the hospital that there is a certain lack of means in terms of anesthesia in terms of, of comfort all that is uhm... the things of comfort for the person and, and participate to the wellbeing that is to say the epidural uhm alleviate the woman uhm give her maximum intimacy, allow her husband to be there in the labor room, all, all that do not exist... thus you really need to have a big mental strength to confront such a situation.

(Doctor, former intern in a maternal health section of a public hospital, Tunisian, Tunis 2018)

According to the health professionals they provide a homogeneous care for all, with no particular approach specific to migrants. Nevertheless, among other difficulties reported by health professionals, beyond the general unawareness of the care circuit among the migrants, we find also the overcrowding of certain services from migrants who heard positive feedback and wish to consult despite their geographical area (there are requirements in terms of sectorization), as stated by a midwife. Concerning the specifics of the health provider – migrant patient interactions, sometimes the care can be more complicated due to the language barrier but also the fear of migrants to disclose personal information thinking that they may be deported, as explained by a doctor precisizing that it does not happen. The care provision in the health system is depicted by the professionals as person-dependent in certain aspects as opposed to institutionalized and this fact hampers its functioning sometimes, such as here in the case of the HIV prevention of transmission treatment:

Uhm for the pregnancies, for pregnant women it is complicated... because the system is in fact it depends on the persons... we try to lay down a system, but it is the system of one's resourcefulness that works.

(Doctor, public hospital, Tunisian, Tunis 2018)

There are several consequences resulting from these difficulties. First, the reluctance of the patient to come to the health structures might increase, which can lead to serious risks for her, and the baby in the case of the pregnancy. Another consequence lies in the fact that many women, especially in the Tunisian population, turn to the private sector for longer waiting time and better reception even though it is more expensive and that the professionals might not be as qualified as in the public sector (a consensual opinion among the interviewed health professionals).

5.6 Interviewees’ suggestions for improving maternal health experiences in Tunis

To conclude this chapter dedicated to the analysis, both migrant women and health professionals shared key improvement areas that they perceived essential to progress toward more positive maternal health care experiences, as illustrated below.

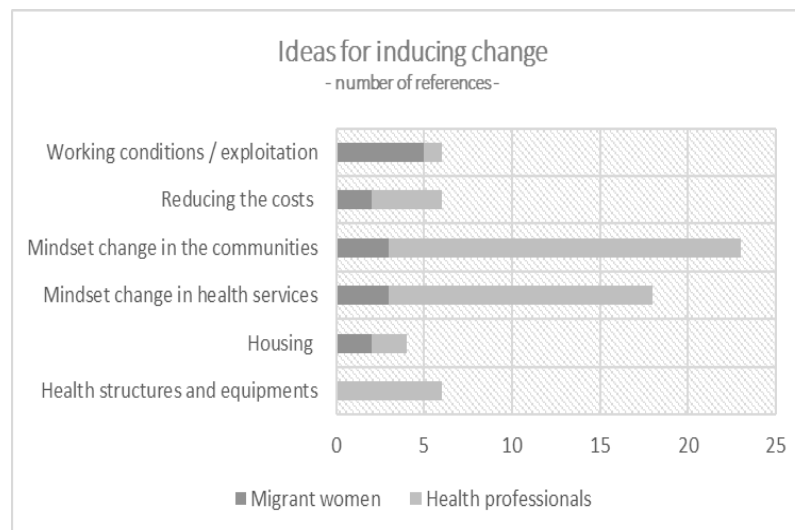


Figure 4: Interviewees’ ideas for inducing better maternal health experiences for both migrant women and health professionals

Most of the identified areas of improvements relate to mindset changes both in the communities and in the health services. Within the communities it is primarily a joint wish of the health providers and migrants to educate and raise awareness on certain SRH topics (especially HIV, STDs, legal abortion etc). Among health services, the will is to improve the overall system for all, especially in terms of patient reception and care, and to inform on certain aspects of migrant’s vulnerabilities – notably the absence of guidance and support from the family and the resettlement difficulties. In both environments, it as matter of more

communication, patience and empathy that is required. In the other areas, both migrants and health professionals would like to witness a decrease of prices for many services, especially tests and exams. Health professionals also insist on the general health structures improvements and equipment provision. Finally, several voices in both groups mentioned further efforts in the shutdown of human trafficking channels.

The discussion on the betterment of the actual situation for migrant women and health providers also addressed the role of the network of partnering associations. Usually, it was really valued by the interviewees. Migrant women often expressed their gratitude toward Doctors of the World and health professionals on many occasions underlined the efforts made by the civil society. Nevertheless, some questions on the future and the sustainability of this complementary system remain as NGOs can only strengthen the national system to a certain point. This section concludes the analysis of the qualitative data retrieved from the fieldwork. The next chapter is dedicated to the discussion of the results in light of the insights provided in the theoretical section.

6 Discussion and conclusion

As depicted in the literature, migrant women worldwide face simultaneously numerous difficulties which affect their maternal health and general well-being. Through an IPA perspective, this research project explored their perceptions of pregnancy, childbirth and postpartum care experiences in Tunis in order to inform both the academic sphere and in the operational sphere of health providers and political decision makers. In this regard, the intent of this chapter is therefore to discuss the findings in light of the reviewed literature. It will also conclude the research by suggesting few ideas for further research in the area of migrant maternal health.

6.1 Reflections on the maternal health-related struggles faced by migrant women in Tunis

This research process allowed the exploration of migrant women maternal health experiences by highlighting and sharing their own social constructions of pregnancy, abortion, childbirth, motherhood and the family as accurately as the hermeneutics stages allow it, and how they are intertwined with several other aspects of their lifeworlds in the specific context of Tunis. Overall the discussions with migrant women proved to be very rich and insightful considering the difficulty in reaching them, their ability to speak, to disclose and the sensitivity of the topic. The cross-perspective approach of interviewing on the one hand pregnant women and on the other, women who already gave birth allowed to discuss both expectations and memories often coherent, providing therefore a more comprehensive and consistent analysis of their maternal health experiences to confront to the literature. Similarly, the secondary set of interviews with the health professionals offered interesting insights on their sense making activity of migrant women lived-experiences and their opinions resulting from it. As one can expect, these findings are closely linked to the categories of struggles identified in the literature and reviewed in the theoretical section, but to a certain extent. Indeed, in the previous review of the literature, three main categories of struggles faced by migrant women were identified and are coherent with the situation in Tunis. Namely, these three categories correspond to cultural struggles, displacement-related struggles and human rights struggles.

In Tunis, the cultural struggles faced by the migrant women in their maternal health care experiences correlate with those presented in the literature. In fact, it is probably the most significant category. The previous analysis chapter recurrently presented the confusion of migrant women and health providers regarding

culturally different practices, attitudes and even contrasting conceptions of fundamental concepts such as family or motherhood. These differences had an impact at all maternal health stages – from intra to postpartum – but were also similarly striking at the moment of childbirth with the fear of the caesarean section less practiced in their home country, the wish of having kinship with them or even the use of the epidural anesthesia. However, if the struggles around childbirth theorized in the literature have been verified to a certain extent in this particular Tunisian case, the under-recognition of antenatal care often pointed out in the literature can be moderated here. If the under-recognition is coherent to some responses of the interviewees, the reason as it seems does not lie in the lack of value given to the follow-up for the migrant but rather in the practical difficulties of pursuing it. Nevertheless, according to some testimonies in the sample and observations on the ground, this absence or lack in the follow-up procedure seems in decline in Tunis. This fact can be explained for two reasons: 1) it can be a positive outcome of the intervention of Doctors of the World raising awareness on the issue – 2) or it can embody a false assumption due to the fact that the sample is not large enough to draw any conclusions on this point and that the interviewees were accessed by Doctors of the World as a gatekeeper. Finally, the major struggle witnessed on the field also belongs to this category and correlates with the misunderstanding and disconnection between healthcare providers and migrant women theorized in the literature. If this disconnection between health providers and patients might be extended to the host population too in Tunis due to the developing state of the country (as opposed to some occidental situations depicted in the literature), it is increased for migrant women. In this regard, migrant women need to better understand the maternal health continuum and gain SRH knowledge, whereas the healthcare providers could benefit from an increased awareness of migrant women's perceptions and vulnerabilities. Thus, to improve the continuity of care for both the health professional and the patient, a more culturally sensitive approach to maternal health care could be envisioned where the migrant woman is not only the patient but the partner in her care, empowered and fully aware of her Sexual and Reproductive Health and Rights.

Several displacement-related struggles were also observed in Tunis. The isolation of the migrant for instance, closely linked to the cultural category, was omnipresent. Housing and economic difficulties were also reported, therefore matching the literature. The theorized question of the resettlement needs prioritized over maternity needs is asked. Despite their increasing efforts for following the intrapartum follow up, it seems that resettlement remains a priority to migrant women in Tunis due to their precarious state, financially notably, their lack of support and their often abusive working conditions.

In this regard, the last category concerns the human rights struggles. Although the findings of this research account for subjective perceptions or reality, the issue of discrimination and sometimes even lack of integrity were very present, continuously, during the maternal health process and the life of the migrant in Tunis. Some of them were reported in the health services nevertheless, they do not seem to be systemic but rather individual-based. Many barriers to health

belonging to the category of human rights struggles reported in the literature have been alleviated, such as the systematic denial of access to health in some structures for example, but this somehow feeling / perception of discrimination is still there, directly maybe but also indirectly under the form of fears and expectations and is not mended by some forms of communication, which are lacking. Finally, one particularity of migrant women's struggles in Tunis is the ongoing issue of human trafficking leading to the exploitation of many migrant women, especially from Côte d'Ivoire. This issue affects migrant women, their integrity and their well-being, beyond maternal health. Because there are intertwined few or no progress can be made in terms of maternal health if human trafficking and other abusive situations linked to migration are not ceased.

6.2 Conclusion and suggestions for further research

This investigation of a qualitative nature allowed us to explore the perceptions of migrant women in Tunisia on fundamental concepts and their associated care experiences constitutive of their maternal health and well-being. Overall, many efforts have been made in Tunisia, especially due to the commitment of several associations, to improve the maternal health access and outcomes for migrants. Nevertheless, the results indicate that their experiences of pregnancy, childbirth, motherhood and care are affected by many struggles – cultural, displacement and human rights related – at several levels in their lives, namely at the individual, social environment, living and working and cultural and systemic levels. Understanding these difficulties constitutive of migrant women vulnerabilities and implementing appropriate changes, relational and operational, could improve maternal health experiences for both the women and the health care providers.

As emphasized in the methodology section, this research presents many limitations and its phenomenological, hermeneutic and idiographic grounds provided a rich account for a specific sample of individuals only, preventing generalization to other migrant women even from the same region or to other geographical areas. For this reason, further research could intent to replicate this research design in other cities in Tunisia; such as Sfax or Médenine, to provide the perspectives of other groups in other settings and cross-analyze them to generate findings at the national level. Another interesting qualitative inquiry could be to compare the perceptions of migrant women in Tunisia to Tunisian women themselves and provide an in-depth exploration on their cultural differences. Finally, mixing the qualitative method of data collection to a quantitative one on the pregnancy outcomes between host population and migrants could offer a better understanding of maternal health experiences and their determinants in Tunisia.

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8 Appendix

8.1 Appendix A: data supporting the background section

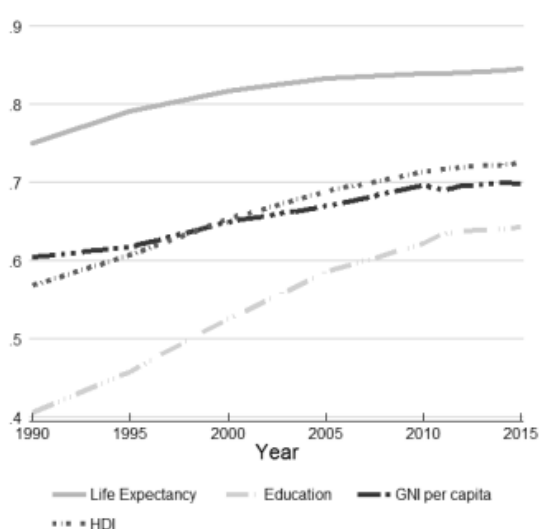


Figure 1: Evolution of the main components forming Tunisia's HDI

(source: UNDP 2016)

Table E: Tunisia's GII for 2015 relative to selected countries and groups

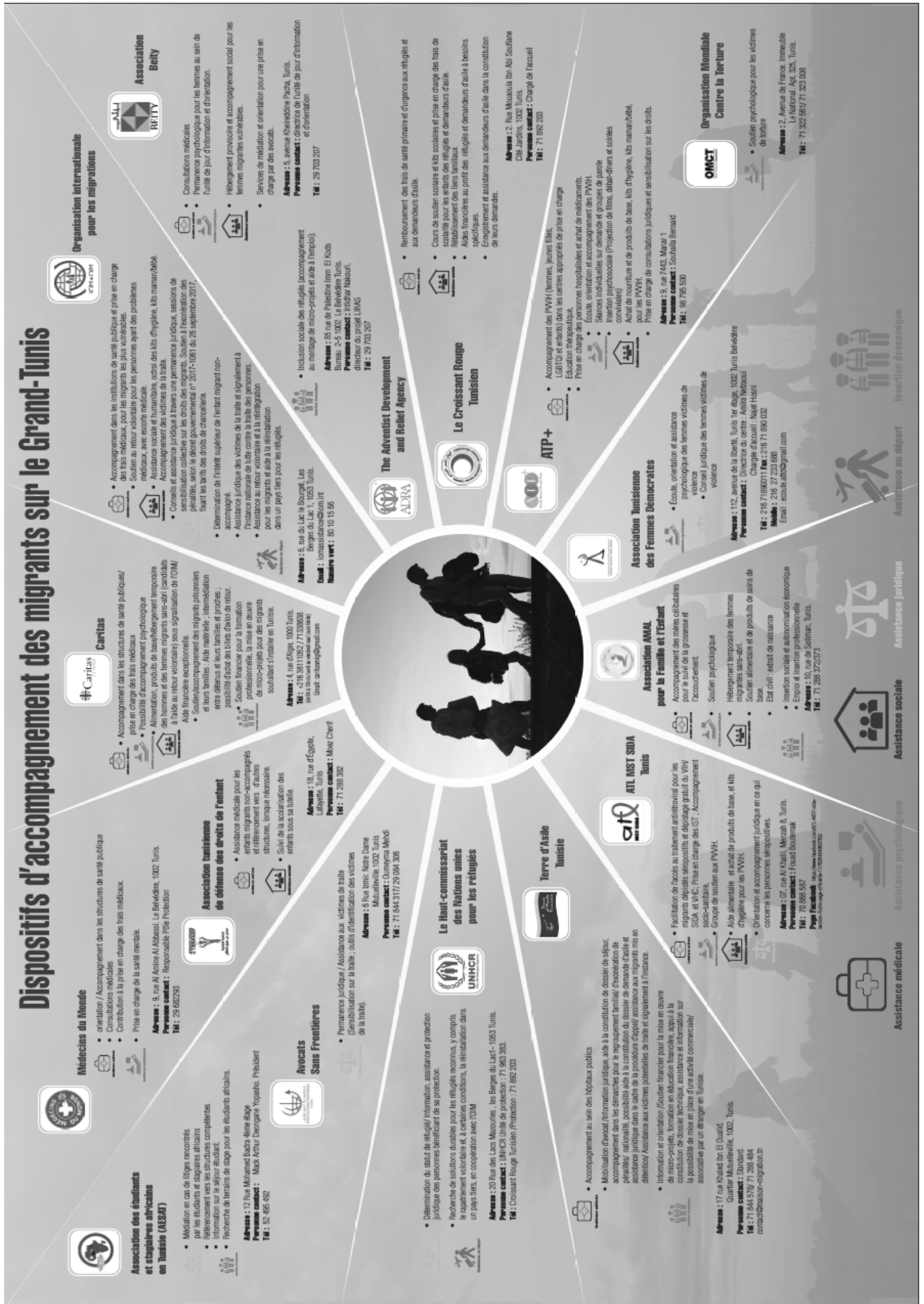
	GII value	GII Rank	Maternal mortality ratio	Adolescent birth rate	Female seats in parliament (%)	Population with at least some secondary education (%)		Labour force participation rate (%)	
						Female	Male	Female	Male
Tunisia	0.289	58	62	6.8	31.3	37.5	49.9	25.1	71.3
Libya	0.167	38	9	6.2	16.0	65.7	44.2	27.8	78.7
Morocco	0.494	113	121	31.7	15.7	25.7	33.2	25.3	74.3
Arab States	0.535	—	142	47.7	15.5	41.6	52.3	22.3	75.1
High HDI	0.291	—	36	27.4	21.6	66.9	74.0	56.5	77.1

Maternal mortality ratio is expressed in number of deaths per 100,000 live births and adolescent birth rate is expressed in number of births per 1,000 women ages 15-19.

Figure 2: Compared analysis of Tunisia's GII in 2015

(source: UNDP 2016)

Figure 3: partner network of associations supporting migrants in Tunis (source: DoW 2018)



8.2 Appendix B: topic guides

8.2.1 For migrant women

Background, migration

- Would you like to start by introducing yourself?
Age / nationality / work / place of residence
- Can you tell me your story?
- Can you tell me about your home country?
How was it like? / how was your daily life there?
- Why did you decide to come to Tunisia?
Share the reasons to leave your country? Why Tunisia in particular?
- How was the resettlement phase here?
How were the first few months? How did you feel moving to Tunis?
- Does it look like what you expected when leaving your home country – why?
What is similar or different? What pleases you or doesn't?
- How do you feel now?
Physically? Psychologically?

Pregnancy & childbirth

a) In the home country

- How is it going with the pregnancy? / How went the pregnancy?
How would you describe it? How do you feel about it?
- About the pregnancy, how does it work in your home country?
What does a woman do when pregnant? How is the follow up?
- What happens when the moment of childbirth come?
How is it? Can you share with me your past experiences on that if you have some?

b) In Tunis

- How is / was the pregnancy here?
How would you describe it with your own words and feelings? / What is similar or different?
- What do you think about the care you receive(d)?
How did you look for medical assistance? / How was the reception in the health structures?
- About childbirth here, what do/did you expect or imagine?
Can you share with me your thoughts? Share your experience?
- How is it going in your community, how did people react when you told them?
Family / friends, maybe other pregnant women? What do you discuss together, how is it going for them?

Motherhood and childrearing perspectives

- What does this pregnancy mean to you?
What is it for you? Thoughts or feelings related to it? How would you describe this experience?

- How do you represent yourself the fact of being/becoming a mother?
What is being a mother for you? Thoughts and feelings? How would you describe it?
 - How will it go when the baby will be there / is it going now that the baby is there?
What do you imagine / how would you describe it? What is working well, what is difficult?
 - What about your family, would you like to talk about them?
Who are they? How is a family for you? Anybody to support you here?
- Future prospects, advice & ideas for change**
- How do you picture the next few years?
Evolution of the situation: child / children, job, family / stay in Tunisia, going back to home country?
 - What would you say about your experience of living in Tunis?
What would you share? How is/was Tunisia? How did you feel here in terms of safety?
 - What would you say, what advice would give to any other woman in a similar situation, soon-to-be mother in a new country?
What will help her according to you? Any difficulties you encountered she should think about?
 - How do you think we can improve the situation for you and other women in a similar situation?
Any changes you would like to see happening? Support from other associations? Wishes? About the care, the resettlement, your experience of pregnancy or maternity...
- Conclusion**
- Is there anything you would like to add?
Anything important for you we forgot to discuss?

8.2.2 For health professionals

Background & general practice

- Would you like to start by introducing yourself?

Profession / expertise / years of experience

- Generally speaking, how are going the consultations?

Position in the continuum of care? Specifics for women in pre or postpartum?

- Do you often receive women patients with a migration background in your consultation?

Evolution in time? If they are “specialists”: how did you start focusing on the thematic?

Interactions with migrant women

- How does the migratory profile influence your care?

Your approach to care? Did you feel the need to adapt it? Differences / similarities?

- Did you identify any contrasts in terms of needs / attitudes / reactions to treatment or care depending on the home country?

Between regions of origins? Specifics about the Tunisian population/ other populations?

- Could you share with me some patient cases when the patient was a migrant woman, which felt special for you?

Why is it special? Why does it differ from other experiences? What was the challenge?

- How do you think these women perceive their pregnancy and their maternity?

How do you think they live the pregnancy? Motherhood perspectives? Feel or think about the follow up in Tunis?

The health system in Tunisia

- As a health professional, what do you think about the health system in Tunisia?

Key strengths? Axes of progression? Specificities for migrants' care?

- What kind of changes would you like to see implemented?

At a general level? Specifically, to facilitate your practice? Toward the migrant population?

- What do you think about the partnership network and of its functioning?

Difficulties encountered? Key strengths? Thoughts for improvements? Tools?

Conclusion

- Is there anything you would like to add?

Anything important, relevant in your opinion, that we forgot to discuss?

8.3 Appendix C: codebook

Domain	Sub-domains	Example quotes
Context	Patients' profiles	"Before I was in my country in Côte d'Ivoire. Well there I was pregnant I had two kids before coming here I was pregnant at home" (Melanie, Ivorian, Tunis 2018)
	Professional experience	"Well I am a clinical psychologist, uhm I have been practicing in psychology for seven years, I have a background a neuropsychology (...)" (Psychologist, Tunisian, Tunis 2018)
Perceptions of pregnancy	Conceptual: as an occurrence not a project	« Because so many people told me that I should remove the pregnancy many people told me but I said no. It's the first time I'm taking pregnancy from a man so then I would keep it by myself! » (Tina, Guinean, Tunis 2018)
	Physical: physical changes due to pregnancy	"It is tiring me in my back and all... someday it is not okay somedays it is all right" (Saba, Ivorian, Tunis 2018)
	Fears and memories associated with childbirth	"Childbirth is in the hand of God... I can say... I hope it will go well... easy" (Saba, Ivorian, Tunis 2018)
Perceptions of motherhood and childrearing	A source of joy and fulfillment	"In all cases I am so very happy" (Melanie, Ivorian, Tunis 2018)
	A source of responsibility, legacy	"Yes very very important. To see children you see yourself in life. I am a mother, I am responsible. It is pleasant" (Khaja, Senegalese, Tunis 2018)
	A source of strength, compensating for the suffering	"I gave birth and I said his name will be "Godgiven", because God did this for me, he touched all these Tunisian women who came for help (...) to say thank you" (Lalie, Ivorian, Tunis 2018)
	A new sense of motherhood	"So it is now I can say I will have a real experience of mother" (Amélie, Ivorian, Tunis 2018)
	Imaginary around the baby	"Yes here there are good educations... because I want to give birth here so that my child grow up here" (Annie, Ivorian, Tunis 2018)
The migration journey	Escaping violence	"She fled the war at the age of 12 in Syria and uhm they lived with her family in Turkey, it is where at the age of 14 she met her husband who is Tunisian (...)" (Translator for Sora, Syrian, Tunis 2018)
	Looking for new opportunities	"I came here to make my life... to work here... that is why I came here... like that..." (Khaja, Senegalese, Tunis 2018)
	Reach someone	"I came here because my husband came to Tunis. Now he did two years. I stayed with my parents but I felt so alone... I decided to come to be with him" (Saba, Ivorian, Tunis 2018)
	Choosing Tunisia	"There are a lot if Tunisians in Côte d'Ivoire, they have hotels and restaurants, we found easier to come to their country since they are in ours (...)" (Leo, Ivorian, Tunis 2018)

		2018)
Perceptions of the self	The lost, discouraged self	"I was discouraged, really, I wanted to go back, I wanted to go back" (Amélie, Ivorian, Tunis 2018)
	The resilient self	"Yes when you come for an adventure, you need to be strong in the head" (Saba, Ivorian, Tunis 2018)
	The self as an outsider	"Here we are foreigners... so you feel good only at home" (Khaja, Senegalese, Tunis 2018)
	The silent, resigned self	"They would see me I thought they would have pity... but in was not the case... like that" (Sophie, Ivorian, Tunis 2018)
Perceptions of the family	During the pregnancy	"If I was in Côte d'Ivoire I would not come here alone, I would have come with one of my sisters or sisters in law, they would accompany me to the hospital and we would go back together" (Saba, Ivorian, Tunis 2018)
	At the moment of childbirth	"I was alone, I had to leave the baby on the bed because I didn't have any kin close to me" (Celia, Ivorian, Tunis 2018)
	Family left behind	"I have two children in Côte d'Ivoire, in addition to this one it is three! And the charge is on me!" (Lalie, Ivorian, Tunis 2018)
	Meaning of family	"Well generally they are single, without the partner or the biological father" (Social Worker, Tunisian, Tunis 2018)
	The community	"They live in small communities, they don't mix with the others, they are in closed communities so it is difficult to understand, to grasp" (Doctor, Tunisian, Tunis 2018)
Work and or exploitation	Combining pregnancy & work	"The work here is very tedious, the work is not easy so then you have to be very cautious on the baby otherwise you can lose it" (Leo, Ivorian, Tunis 2018)
	Combining work & kids	"When you don't have somebody to take care of the child how do you pay for the house?!" (Orange, Ivorian, Tunis 2018)
	Work experiences	"We come here to suffer that is all, they make us come to work, to put us on a contract to work at some people's house like slaves!" (Orange, Ivorian, Tunis 2018)
Resettlement	Economic matters	"The salary is too little! They pay me 400 dinars, the house is 400 dinars... it is too little!" (Saba, Ivorian, Tunis 2018)
	Feeling of safety	"Personally when I have to go out I am afraid, even if it is not everybody" (Sophie, Ivorian, Tunis 2018)
	Housing	"I said no I cannot go back, I don't know where to go! With the pregnancy I don't know where to go, if I say yes I leave I will find myself in the streets" (Lalie, Ivorian, Tunis 2018)
	Integration	"No here I did not really make friends" (Celia, Ivorian, Tunis 2018)
	Tunisia as a host country	"The life in Tunisia is really agreeable but the procedure to get papers for short term or refuge it is very hard" (Sora, Syrian, Tunis 2018)
	Future prospects	"I want to go back it is not easy... I have a problem of penalties" (Orange, Ivorian, Tunis 2018)
Reflecting on the health system	Patient care experiences in Tunis	"They say no even the nurses in the childbirth room they see you suffer but they don't take care of you" (Leo, Ivorian, Tunis 2018)
	Patient care experiences in home country	If there was more health centers, more doctors it would be easier" (Khaja, Senegalese, Tunis 2018)
	Pregnancy follow up	"We feel like they want to do the follow up, see?" (Psychologist, Tunis 2018)
	Professionals' description of healthcare circuit	"Uhm for the pregnancies, for pregnant women it is complicated... because the system is in fact it depends on the persons... we try to lay down a system, but it is the system of one's resourcefulness that works." (Doctor, public hospital, Tunisian, Tunis 2018)
	Professionals on care experiences in Tunis	"Because of the word of mouth, some Ivorians come from other neighborhood and that, that for us is a problem" (Midwife, Tunisian, Tunis 2018)
Inducing change	Health structures & equipment	"We have huge lack in hospitals, lack of staff, lack of equipment..." (Psychologist, Tunisian, Tunis 2018)
	Housing	"If we can act on the shelters that would be already something" (Doctor, Tunisian, Tunis 2018)
	Mindset change in health services	"Really try to see at the public hospitals, for some women to be a bit more indulgent... we come here without our family, our parents... we are alone facing fate! And a woman giving birth is between life and death" (Celia, Ivorian, Tunis 2018)
	Mindset change in the communities	"Trying to tell our sisters you can go on adventures *with men* but to be careful because of infections" (Orange, Ivorian, Tunis 2018)
	Reducing the costs	"She cried she did not have the money. Money is the biggest problem" (Midwife, Tunisian, Tunis 2018)
	Working conditions / exploitation	"We have catch these persons because what they are doing is horrible!" *talking about human trafficking* (Celia, Ivorian, Tunis 2018)
	DoW & the network of NGOs	"We say thank you to Doctors of the World because without them there are things we can't do... we can't do..." (Orange, Ivorian, Tunis 2018)

8.4 Appendix D: original citations in French

Corresponding section 5.1.1. Pregnancy as an occurrence not a well-planned project
<p>« Donc euh comme je suis tombée enceinte son père m'a dit ah vraiment c'est difficile la situation puis on fait quoi tu vas garder tu vas enlever... J'ai dit non je vais garder parce que... et je me dis que c'est Dieu qui m'a donné cet enfant là »</p> <p style="text-align: right;">(Celia, Ivorian, Tunis 2018)</p>
<p>« Elles vivent très, très bien leur grossesse leur accouchement ! elles sont tout à fait épanouies.; y a pas cette relation comme chez nous par exemple pour ces femmes qui conçoivent hors mariage sont tout un petit peu dans la gêne c'est un peu... c'est un peu...; en train de cacher leur grossesse, (...) ça ça c'est civilisationnel en fait un bon(...) les nord-africaines restent euh dans un dans une civilisation paternaliste, par excellence... donc même si elles sont très libres, (...) on choisit un mari on choisit son partenaire mais on fait pas d'enfant hors mariage. (...) Et si elle veut garder sa son enfant elle peut le garder mais là.. y a aussi le problème civilisationnel, est-ce que la famille va la reconnaître ou complètement l'enlever euh du dictionnaire familial.. ? »</p> <p style="text-align: right;">(Doctor in public hospital, Tunisian, Tunis 2018)</p>
<p>« Un peu... finalement j'étais pas trop contente dans ma peau... parce que quand je regarde j'étais pas bien... un moment j'ai dit je vais l'avorter... c'est là où... mon mari a refusé il dit de laisser et ok... parce que je suis pas trop à l'aise dans ma peau je me sens tout bizarre en plus j'ai des douleurs des fatigues... voilà chaque jour je vomis, je n'arrive pas à manger... (...) C'est compliqué... Avorter c'est ça je voulais... sinon je vais garder le bébé... c'est tout... bien accroché c'est ça qui a dans ma tête... bien accroché c'est tout... (...) ça veut dire je prie Dieu que tout se passe bien... tout se passe bien... »</p> <p style="text-align: right;">(Annie, Ivorian, Tunis 2018)</p>
<p>« Bon... j'ai seulement peur du jour de mon accouchement... c'est tout seulement comme je serai traitée... comment je vais accoucher dans quelles conditions... c'est tout... sinon pour le moment je n'ai pas peur mais souvent quand ça me vient dans la tête le jour de mon accouchement qu'est-ce qui va se passer à l'hôpital comment il va me traiter à l'hôpital... c'est tout! »</p> <p style="text-align: right;">(Leo, Ivorian, Tunis 2018)</p>
<p>« aah... ça .. je prie Dieu... il n'a qu'à venir à la bonne voie.. la partie j'ai peur c'est la partie de euh césarienne... c'est la partie... j'ai peur ... un peu... je veux que ça se passe à accouchement normal... oui ... ça je prie Dieu pour ça... c'est la partie de césarienne ça ça m'inquiète beaucoup... »</p> <p style="text-align: right;">(Saba, Ivorian, Tunis 2018)</p>
<p>« Autant ici bon... non c'est forcément une césarienne... En tous cas c'est ce qu'on m'a dit... voilà c'est forcément une césarienne et en fait c'est ce qui me fait un peu peur... voilà... »</p> <p style="text-align: right;">(Amélie, Ivorian, Tunis 2018)</p>
<p>« Et euh dans l'hôpital on ne ne n'opère par césarienne que lorsqu'il le faut. Du coup elles viennent avec la perception que la césarienne c'est la solution à toutes leurs souffrances et euh c'est le fruit interdit... Parce qu'elle est en train de souffrir et que nous on soulage pas ses peines euh en l'opérant et c'est ça crée le désarroi et euh la tension monte (...) euh si elle avait été informé euh ça l'aurait aidé à surmonter la situation...»</p> <p style="text-align: right;">(Doctor, formerly intern in a maternal health unit, Tunisian, Tunis 2018)</p>
<p>« Et euh en plus ce qui n'est pas bien ici, ils disent quand tu vas accoucher même si tu as mal eux ils te font pas injection pour calmer la douleur! que tu dois accoucher soit on t'envoie au bloc pour opérer là on te fait injection pour calmer la douleur »</p> <p style="text-align: right;">(Orange, Ivorian, Tunis 2018)</p>
<p>« Mais déjà je trouve qu'il est vraiment primordial d'offrir au moins le choix aux patientes d'avoir le droit à la péridurale, c'est elle qui choisit elle veut elle veut subir ça ou elle veut pas... (...) Non c'est pas systématique. »</p> <p style="text-align: right;">(Doctor, formerly intern in a maternal health unit, Tunisian, Tunis 2018)</p>
<p>« Ah la grossesse elles la vivent très bien! les subsahariennes ont un, uhm ont un vécu très particulier avec la grossesse, la grossesse c'est l'épanouissement même de la femme chez eux. (...) Et dès qu'elle est maman ça y est c'est fini, elle a tout fait elle a tout accompli.»</p> <p style="text-align: right;">(Doctor in public hospital, Tunisian, Tunis 2018)</p>
<p>« Euh bon euh il y a des filles qui ont vécues des situations beaucoup plus euh difficiles que moi et euh un enfant c'est une responsabilité. C'est quand tu commences euh le parcours il faut que tu sois responsable et que tu t'engages et que tu sois à fond dans le truc. »</p> <p style="text-align: right;">(Sora, Syrian, Tunis 2018)</p>
<p>« Je suis très contente oohh c'est une joie pour moi ouais chez nous dans la famille avoir un enfant c'est très important quand tu n'as pas d'enfants dans ta vie mmmh je connais je vois! souvent dans ma famille des tantes qui n'ont pas d'enfant je sais quelles sortes d'injures elles subissent... (...) on est pas mariée on a des enfants on est enceinte chez nous ça se fait... c'est que à l'église on défend mais c'est très important pour une personne surtout quand tu prends de l'âge (...) parce que nos parents nous disent...; tout le travail que tu fais l'argent que tu</p>

<p>cherches, la maison que tu construis tu laisseras à qui? quand tu as un enfant même quand tu l'as cet enfant t'es en place... ton nom ne s'oublie pas... parce que quand tu n'as pas d'enfant on t'oublie très vite ! »</p> <p style="text-align: right;">(Leo, Ivorian, Tunis 2018)</p>
<p>« Il me fatigue mais *elle parle de son fils et en rit* ... me dis mais quand même il me donne de la joie! la joie d'avoir la force de continuer à lutter, à lutter pour lui pour sa soeur... »</p> <p style="text-align: right;">(Celia, Ivorian, Tunis 2018)</p>
<p>« donc c'est maintenant que peut être je peux dire j'aurais une expérience de mère.. *elle insiste sur le mot mère* parce que là je serai seule à m'occuper de mon enfant... (...). Non en tous cas ça me plaît parce que je me dis que peut être cette fois ci peut être je vais me sentir vraiment maman... je vais m'occuper de mon enfant depuis le premier jour jusqu'à ce qu'il grandisse... »</p> <p style="text-align: right;">(Amelie, Ivorian, Tunis 2018)</p>
<p>« (...) pour m'occuper de mes enfants... et puis poursuivre aussi les études... parce que moi même je parle le français ça j'ai appris ça dans ma rue... c'est le français de la rue parce que moi même je n'ai pas fréquenté... donc il faudrait pas que mes enfants soient la même chose que moi! (...) eux ils doivent être plus que moi plus élevés que moi parce que les enfants doivent aller à l'école ... jusque a... que au moins ils vont avoir un boulot à faire.. mais si c'est pas le grand boulot mais juste un peu pour que demain si je demain vieille ils vont pouvoir acheter l'eau, la nourriture pour me donner pour que je mange... je dois lutter ça je dois lutter ça pour mes enfants je dois pas me laisser battre... »</p> <p style="text-align: right;">(Lalie, Ivorian, Tunis 2018)</p>
<p>5.2.1. The marks of the migration journey: remaining motivations, hopes and memories</p>
<p>« uhm ça va mais comme souvent je suis là je pense... parce que j'ai quitté mon pays pour venir ici juste pour me chercher un peu... pour pouvoir m'occuper de mes enfants en Côte d'Ivoire... »</p> <p style="text-align: right;">(Lalie, Ivorian, Tunis 2018)</p>
<p>« Non je suis Ivoirienne mais je suis partie au Togo quand la crise est tombée je suis venue et après je suis rentrée. Bon j'ai essayé de euh faire une activité mais ça n'a pas marché. Vu les problèmes, je savais pas où rester c'est ce qui a fait que je suis venue en Tunisie ici. Pour essayer de trouver du travail et de m'en sortir un peu. »</p> <p style="text-align: right;">(Celia, Ivorian, Tunis 2018)</p>
<p>« Jusqu'à l'élection de 2011 venie vraiment diviser le pays, diviser les habitants... mettre des rancunes mettre la guerre dans le coeur des gens... le mépris... donc ça fait que on ne s'entend pas. Même tu vois ton frère tu les hais... C'est que tu vois sa parti fait que tu les hais tu as envie de les tuer... c'est ce qui se passe actuellement... »</p> <p style="text-align: right;">(Leo, Ivorian, Tunis 2018)</p>
<p>« après la crise c'est devenu un pays difficile parce que pendant la crise on... on a vécu beaucoup beaucoup beaucoup beaucoup de choses vraiment... qui nous ont... en tous cas ce qui nous a poussé de venir en Tunisie parce que là bas il n'y a plus de sécurité! (...) après la crise c'était devenu la guerre entre les ethnies donc... chose qu'on a perdue beaucoup moi même mes soeurs ont été violées, tuées devant moi donc après ça on a décidé de quitter! »</p> <p style="text-align: right;">(Sophie, Ivorian, Tunis 2018)</p>
<p>« elle voulait vraiment être avec son mari, euh refusait qu'ils soient séparés et refusait d'avoir un gamin sans sans père sur place et elle voulait que son fils ait le passeport tunisien. Donc elle a commencé à se renseigner comment venir en Tunisie (...) son beau frère lui a conseillé de partir en Algérie (...) pour qu'ils règlent leurs papiers et rentrent ensemble en Tunisie. (...) Elle a pris son billet d'avion alors qu'elle euh allait accoucher dans les trois jours qui qui venaient. Elle a commencé à avoir ses contractions dans l'avion »</p> <p style="text-align: right;">(Extract of the simultaneous translation of Sora's story; Syrian, Tunis 2018)</p>
<p>5.2.2 Perceptions of the self</p>
<p>« C'est à dire euh travailler rester tranquille c'est tout... pas de souci dans la tête, beaucoup de pensées... travail et tu restes calmes. »</p> <p style="text-align: right;">(Khaja, Senegalese, Tunis 2018)</p>
<p>« Très difficile... d'abord pour rentre ici c'est difficile et puis pour s'adapter ici c'est difficile... comme ça... tu n'es pas chez toi donc on peut pas te prendre comme si tu es chez toi donc tu peux pas être à l'aise comme si c'est chez toi... C'est différent... Non je vais pas faire ça et et... nous sommes à l'étranger... et c'est un peu difficile... ici c'est un pays islamique c'est un peu difficile... donc non. On s'adapte à ça on est obligé de se contenter de ça... reste à nos places jusqu'à ce que bon on prie le Dieu tout puissant ça va... »</p> <p style="text-align: right;">(Leo, Ivorian, Tunis 2018)</p>
<p>« Non non c'est le stress... c'est tout c'est parce que t'es une femme t'es enceinte et puis tu es abandonné on te vole ton argent aussi donc quand c'est comme ça les pensées... les pleurs.. parce que tu ne peux rien faire encore... je ne travaille plus... je ne fais rien... (...) Mais quand tu es assis là et puis tu penses beaucoup beaucoup de jours en jours u dépérit tu commences à fondre... on te demande mais tu as quoi tu es malade? non je suis pas malade on me dit pourquoi tu maigris? non y a rien non... (...) c'est comme si même j'avais même la moi même en face de moi même je me disais quoi... et si je mourrais c'était bien et si je mourais c'était bien pourquoi je suis pas morte donc tu vois.. parce que quand tu pleurs que tu es là que Dieu te fait mal tu dis et Dieu pourquoi tu m'as pas.. ?. si je meurs c'est bon temps au lieu de vivre ça... parce que tu tu fais la souffrance... et puis tu n'as pas ton père à côté ta mère à côté tes soeurs à côté t'es tout seul et puis c'est pas dans ton pays... c'est comme si c'est un autre .. c'est tu es venue à l'aventure et puis maintenant ça a échoué donc tu dis mais pourquoi tout m'arrive... je suis pas dans mon pays et puis tout ça m'arrive Dieu je veux mourir ! »</p>

	(Lalie, Ivorian, Tunis 2018)
« Non c'est pas pareil...c'est pas pareil tu sais où tu es né et puis tu es venue à l'aventure c'est pas pareil hein (...) Oui... quand tu viens à l'aventure, il faut être fort dans la tête... il faut être fort dans la tête, non c'est pas facile...(...) hum... faut être forte dans la tête parce que tu es ici tu es malade tu es seule, tu es obligée de te lever, chercher à manger, nettoyer la maison, pour faire le ménage, tout tu es obligé de faire seule...»	(Saba, Ivorian, Tunis 2018)
« Non. *très fermement en faisant non de la tête* il faut faire devant pas aller arrière »	(Khaja, Senegalese, Tunis 2018)
J'explique ça euh par le fait que euh la culture subsaharienne est une euh et les conditions de vie dans les pays subsahariens sont trop dures. Et donc ils sont habitués depuis leur enfance à un mode de vie difficile, compliqué euh ils sont habitués à la culture du risque aussi. Ils sont tout le temps dans le risque que ce soit le risque des catastrophes naturelles que ce soit le risque des guerres civiles que ce soit je sais pas euh le risque de maladies... euh graves euh.. donc euh ils sont tout le temps prêts à faire face parce qu'ils n'ont pas le choix s'ils ne font pas face à « ça ils ne vont pas pouvoir survivre. C'est un peu le système de la sélection naturelle. Et donc quand ils viennent en Tunisie, malgré euh les conditions difficiles euh économiques, juridiques les conditions de vie en Tunisie restent beaucoup... disons de meilleure qualité que euh chez eux »	(Psychologist, Tunisian, Tunis 2018)
« (...) les réfugiés ou les migrants arabes demandent de voir un psy contrairement à la population subsaharienne... parce euh comme j'ai déjà dit que le problème ne se pose pas. On n'a pas besoin d'un psychologue pour nous écouter parce qu'ils réagissent en termes concrets. J'ai besoin de tel ou tel médicament pour me sentir bien. Je gère bien mes conflits et mes problèmes donc je vois pas la nécessité ou le bénéfice euh d'avoir recours à un psychologue... (...) La rémission ou la « guérison » est plus rapide chez eux qu'avec les personnes arabophones ou euh ou euh de la région MENA même si les diagnostics ou les troubles qu'ils présentent sont lourds! »	(Psychologist, Tunisian, Tunis 2018)
5.3.1. The absence of the loved ones: emptiness and concerns	
« Bon euh j'ai juste mon mari et mon frère voila. Pour les autres c'est les amis, juste les amis. Mais les parents c'est je n'ai pas ici. Puis comme c'est un homme bon! Sinon si c'était une femme c'était bon... (...) si c'était ma soeur elle pouvait m'aider les premiers moments bon! faire beaucoup de choses mais c'est un homme on va faire avec hein...(...) pour les autres bon... l'homme peut partir après il peut voyager, la laisser avec une grossesse et puis voyager quand c'est comme ça c'est pas facile. (...)en tous cas chez nous quand tu, tu accouches, il y a toujours quelqu'un pour s'occuper de l'enfant parce qu'on se dit que tu peux pas laver l'enfant, il est nouveau né tu peux pas bien t'occuper, il faut une personne âgée... voilà donc chez nous il faut forcément une personne âgée pour s'occuper de ton enfant... là toi tu as le temps de s'occuper de toi c'est à dire pour nous une femme enceinte, non une femme qui a accouché ne doit rien toucher... ne doit pas travailler voilà.. donc on lui fait à manger elle, s'est pour donner, allaiter l'enfant, manger se reposer... voilà juste à toi... après trois mois maintenant là, tu peux maintenant faire ton boulot et là tu peux t'occuper de l'enfant... (...)»	(Amelie, Ivorian, Tunis 2018)
« C'est ça qui est beaucoup difficile pour moi... parce que là on me dit que à cause des pénalités, il faut que j'attende que ça soit annulé et après ça je vais revoir ma maman... parce que en ce moment elle traverse une période difficile *les larmes se mettent à monter et à couler sur ses joues* elle traverse une période difficile j'ai perdu mon petit frère... dans l'eau! Il était en Algérie et puis il a suivi ses amis en Libye pour aller traverser l'eau à cause de la souffrance! Malheureusement il est resté dans l'eau... Ses amis sont arrivés mais pas lui....! Donc actuellement ça agit sur ma maman tous les jours même hier j'ai parlé avec elle j'ai essayé de lui remonter le moral... elle a déperé! Elle n'est plus la même... et moi ça me fait souffrir! *elle continue de parler en pleurant* j'essaye d'être forte mais ça me fait souffrir à l'intérieur (...) c'est vrai que je n'ai rien... ce que je pensais avoir ici, je n'ai pas eu! Mais j'ai eu un enfant et... je sais que le fait de nous voir nous deux, ça va la soulager... »	(Celia, Ivorian, Tunis 2018)
5.3.2. Contrasting conceptions of the family, nuclear vs community upbringing	
« Oui euh j'ai euh remarqué euh des une euh perceptions très différentes euh de la famille et des enfants euh chez les subsahariens en comparaison avec notre population. Je comparerai bon euh les populations d'origine arabe, (...). Nous on est dans l'affiliation, c'est à dire quand il s'agit de maman ou de papa, c'est vraiment une maman ou un papa qui protège qui est là qui qui est tout le temps euh qui a tout le temps la charge mentale de ses enfants malgré les traumatismes qu'elle vit malgré la situation socio économique défavorable et tout, (...) Donc quand elle vient elle nous parle pas d'elle même elle nous parle de la situation avec ses enfants. (...) et elle se néglige. Par contre avec les subsahariennes c'est autre chose. Euh les enfants euh c'est normal si je je met au monde un enfant et que je le laisse et que pars travailler dans un autre pays et que je pars et que je le vois pas pendant des années des années c'est normal. Pourquoi parce que et elles me l'expliquent, parce que c'est pas seulement la maman qui éduque, c'est les grand parents, c'est le quartier euh c'est les voisins c'est tout le monde qui éduque l'enfant. »	(Psychologist, Tunisian, Tunis 2018)

<p>« Elles sont tous euh des unions elles sont tous euhm elles ont des couples des couples euh des copains pas de, des unions libres euh pas de mariage, pas de une famille unie, cet enfant de ce copain là l'autre (...) Y a pas le sens de la famille ici... et parfois des couples qui sont... Ils changent les conjoints quoi...hétérogènes...voilà...Ils se changent de couples... voilà c'est pour cela ici on prend beaucoup de euhm on est toujours vigilantes (...) euh pour les tests VIH pour les bilans surtout sérologiques on prend toujours notre précaution. Et on s'assure qu'elles sont saines et sauves voila. »</p> <p style="text-align: right;">(Midwife, Tunisian, Tunis 2018)</p>
<p>« Donc c'est là le challenge arriver à mobiliser des personnes vraiment euh... qui voient l'intérêt derrière et qui voient euh l'importance de l'éducation, de la communauté de l'investissement communautaire... »</p> <p style="text-align: right;">(Doctor, Tunisian, Tunis 2018)</p>
<p>« je me suis pas fait des amis... parce que quand euh tu as des amis tu vois assez d'histoire des bla bla euh tu as dit ça ! elle a dit ça ! non !... non ça envoie des histoires parmi nous le groupe donc quand c'est comme ça je suis venue mon travail à la maison à la maison le travail... »</p> <p style="text-align: right;">(Lalie, Ivorian, Tunis 2018)</p>
<p>5.4.1. Abusive working conditions and exploitation</p>
<p>« Beaucoup de monde qui qui parle qui disent que euh la thématique de la migration est nouvelle en Tunisie alors que non c'est pas vrai, la thématique de la migration n'est pas nouvelle. Mais elle était cachée avant on ne parlait pas de ça. En fait on ne euh on ne divulguait pas ça, la traite par exemple (...) l'instance elle commence réellement à fonctionner en 2017.. ça fait énormément de temps pour qu'on puisse enfin se dire ah et bin on a énormément de euh on a la traite on a la question de la traite alors que avant oui y avait la question de la traite mais personne n'en parlait réellement .. en fait le gouvernement se voilait la face un tout petit peu par rapport à ça »</p> <p style="text-align: right;">(Psychologist, expertise on legal assistance and asylum right, Tunisian, Tunis 2018)</p>
<p>« Voila donc vraiment ttt... j'ai pas j'ai pas une bonne expérience... je me attendais... c'est pas.. c'est pas ce à quoi je m'attendais. Voila... non à ce moment j'ai été mise dans un contrat où j'ai été enfermée pendant 5 mois... Dieu merci j'ai fait 4 mois, je n'avais pas le droit de sortir ma limite c'était à la porte... j'ouvre la porte ma patronne rentre et je referme. Je travaillais de 6h jusqu'à minuit / 1h du matin non vraiment ça a été pénible pour moi... »</p> <p style="text-align: right;">(Celia, Ivorian, Tunis 2018)</p>
<p>« La grossesse... j'ai travaillé... jusqu'à le dernier jour je suis partie à l'hôpital j'ai accouché par césarienne. (...) Comme ça j'ai travaillé doucement doucement tout ça parce que je ne peux pas rester à la maison sans travailler. Je ne peux pas il faut que je travaille pour avoir un peu à ramener. Juste quoi vivre. Payer mon loyer etc... »</p> <p style="text-align: right;">(Khaja, Senegalese, Tunis 2018)</p>
<p>5.4.2. The influence of the resettlement situation</p>
<p>« Pour la césarienne on nous dit au pays 400 dinars, tout tout 400 dinars mais y a une dame à la caisse elle m'a vue elle m'a demandé tu as l'argent je lui ai dit voilà tout ce que j'ai elle m'a dit ok donne... je n'ai pas pu payer les 400 dinars... »</p> <p style="text-align: right;">(Orange, Ivorian, Tunis 2018)</p>
<p>« Donc je vais rester à l'hôpital... elle m'a dit non à l'hôpital c'est pour ceux qui sont malades. Mais comme ça va chez toi on te libère tu rentres en fam... tu rentres chez toi! Maintenant toi tu dis que tu veux rester ici... avec les lits c'est fait pour les malades... toi tu es guéri, ça va chez toi ta santé ça va... c'est pas ça va totalement mais ça va... donc tu dois rentrer. J'ai dit non madame je ne peux pas rentrer. Parce que je sais pas où aller! avec la grossesse je sais pas où aller! je te diis je te dis oui j'accepte, je vais me retrouver dans la rue parce que je sais pas où je vais rester...! le bailleur il va pas me dire bon comme ton mari t'a quitté tu restes dans la maison non! le bailleur va pas me dire ça lui seulement le mois il veut son argent... alors si aussi je ne travaille plus ... avec le ventre... non je sais plus où aller... »</p> <p style="text-align: right;">(Lalie, Ivorian, Tunis 2018)</p>
<p>« Bon on peut pas dire trop trop sécurité parce que souvent tu peux passer d'un endroit où... y a des jeunes qui insultent... ou bien qui te lapident... voilà donc je peux pas dire sécurité en tant que tel voilà parce que ça dépend aussi des quartiers... »</p> <p style="text-align: right;">(Amelie, Ivorian, Tunis 2018)</p>
<p>5.5.1. Socio-cultural norms and integration in the host country</p>
<p>« Très difficile... d'abord pour rentrer ici c'est difficile et puis pour s'adapter ici c'est difficile... (...) Tu peux tomber sur des gens qui sont biens qui t'aiment qui te prennent bien... tu peux tomber sur des gens aussi qui t'aiment pas qui te maltraitent... et ça y en a plein ici... beaucoup de nos soeurs sont maltraitées... on est beaucoup insulté on est beaucoup montré du doigt... »</p> <p style="text-align: right;">(Leo, Ivorian, Tunis 2018)</p>
<p>« on est pas chez nous... on est venue en étranger c'est pour se comporter bien quoi... marcher, sourire, marcher d'une façon qu'on doit marcher, prendre les décisions c'est tout.On doit marcher comme tout le monde parce qu'on est pas chez nous on est venue en étranger donc... on doit se comporter bien... »</p> <p style="text-align: right;">(Annie, Ivorian, Tunis 2018)</p>

<p>« On ne donne pas d'attestation de réfugiés pour les syriens c'est une politique en Tunisie on leur donne euh le papier de demandeur d'asile... pour les libyens par contre ba ils viennent euh et ils sont les bienvenus en Tunisie donc on leur donne pas de carte de réfugiés mais ils peuvent et ils peuvent même avoir des biens etc etc ... donc euh se réfugier entre guillemets.. donc euh avoir l'asile en Tunisie sans avoir effectivement le papier qui dit voila... »</p> <p style="text-align: right;">(Psychologist, expertise on legal assistance and asylum right, Tunisian, Tunis 2018)</p>
<p>« ils lui ont dit euh si tu es tu es entrée en Tunisie euh on aurait été au courant comment tu as fait pour venir ici? *les autorités* Elle a dit euh elle leur a dit euh je suis venue d'une façon irrégulière. Euh ils lui ont dit comment ça s'est passé, ils lui ont dit euh... elle a eut peur elle (...) elle a dit je me suis débrouillée toute seule euh pour arriver. (...) ils ont euh ont passés la journée à la tabasser euh à la malmenier maltraiter euh pour qu'elle parle. Pour lui soutirer les infirmations et ils l'ont séparés de son gosse, ils l'ont mis juste devant le euh la chambre là où elle voit mais elle ne peut pas euh euh le toucher et il commençait à pleurer. Ils lui ont dit si ton fils est affamé c'est à cause de toi tu peux pas si tu veux, parles et tu pourras l'allaiter et l'avoir dans tes bras et elle euh insistait que c'était la vérité elle n'a pas du tout voulu euh parler et euh du coup ils l'ont frappé ils lui ont euh poussés la tête contre le mur euh elle a eut des plaies à la tête et quand même euh elle a tenue bon pour ne rien dire. Mais euh... ils ont fait tout ça euh en connaissance de cause qu'elle était mineure non accompagnée en Tunisie et euh alors qu'elle avait un gosse ils l'ont utilisé pour euh la manipuler et la torturer pour avoir des informations. »</p> <p style="text-align: right;">(Extract of the simultaneous translation of Sora's story; Syrian, Tunis 2018)</p>
<p>5.5.2. Reflections on the health system</p>
<p>« Ici les soins sont plus, on peut dire approfondis par rapport à la Côte d'Ivoire. Ici quand tu es enceinte on te fait tous les examens pour voir s'il n'y a pas une maladie cachée pour ne pas que l'enfant soit atteint de cette maladie on te fait tous ces examens. En Côte d'Ivoire on les fait pas. C'est il te fait les examens, ton groupe sanguin c'est fini. Ils s'occupent pas de toi comme ici tu fais l'échographie 2 à 3 fois, tu fais les prises de sang des examens... là bas non... »</p> <p style="text-align: right;">(Leo, Ivorian, Tunis 2018)</p>
<p>« Elle a dit que elle elle aime pas aller dans les hôpitaux (...) le comportement n'est pas très correcte euh c'est qu'i y a des comportements qui me dérangent (...) le fait qu'en Tunisie on n'accepte pas euh on ne me donne on ne m'accorde pas le titre de femme mariée tant que je n'ai pas un contrat de mariage en Tunisie on me regarde d'un regard euh plein de jugements dans le sens où je suis une mère célibataire et euh déjà j'ai un enfant et je récidive avec euh un deuxième euh c'est qu'on me lançait des regards qui me montaient, euh qui me mettaient mal à l'aise ou bien on me me me me faisait des remarques euh désobligeantes euh dans le sens où je me sentais pas bien quand on prenait soin de moi. »</p> <p style="text-align: right;">(Extract of the simultaneous translation of Sora's story; Syrian, Tunis 2018)</p>
<p>« Mais au niveau de l'hôpital mais nous on va pour faire consultation mais c'est un problème (...) Il nous fait, ils nous demandent toujours des analyses même si tu prends mon carnet il y a pas de consultation dedans... Quand tu vas tu veux faire consultation on dit non on fait examens faut faire tout ce qu'on nous demande on sait pas pourquoi ils sont comme ça avec nous... »</p> <p style="text-align: right;">(Orange, Ivorian, Tunis 2018)</p>
<p>« Après l'accouchement il est parti *le gynécologue* mais elles ne m'ont elles m'ont pas nettoyées elles m'ont laissées comme ça dans mon sang. Toute sale. Elles ont dit que aucun homme ne devait rentrer et que le père de mon enfant n'avait pas le droit de rentrer. (...) Et là elles m'ont laissées toute sale, euh pas habillée (...) là j'étais obligée de laisser l'enfant sur le lit, parce que je n'avais pas de parents auprès de moi. Je suis allée dans les toilettes pour essayer de me nettoyer moi même... (...) vraiment... uhm... c'était c'est ... euh je me remettais pas je me demandais en fait où je me trouvais au juste, dans quelle, dans quelle situation je me suis mise? Et bon... après j'ai essayé le pagne qui était sur moi. J'ai essayé de la passer mais c'était rempli de sang donc euh j'ai essayé de laver le pagne.. mais après pendant que je lavais, je me suis sentie faible... je ne pouvais plus respirer et puis tout est devenu noir devant moi... donc j'ai du lutter contre les toilettes et la chambre où les gens m'avait mise. Arrivée là je suis tombée (...) l'une des patientes qui m'a vu et puis elle elle a appelé (...) il y a la dame qui est en train de mourir ici! venez! »</p> <p style="text-align: right;">(Celia, Ivorian, Tunis 2018)</p>
<p>« ce n'est pas la compétence euh des du professionnels du personnel médical ou paramédical plutôt c'est une question de structuration du système, d'adaptation des stratégies en fonction des moyens qu'on a. C'était assez euh frustrant de voir que euh y avait les compétences et que finalement le service fourni était assez inadapté à la réalité parce euh il y a trop de monde ça se bouscule il n'y a pas de couverture de santé on ne touche pas à certains problèmes qui sont négligés on regarde le corps comme étant un objet de médecine euh et non pas une personne entière dans dans dans son environnement.. même s'il y avait la volonté de le faire. (...) Bon... ce qui est assez marquant à l'hôpital c'est qu'il y a un certain manque de moyens en termes d'anesthésie en termes de de de confort tout ce qui est euh... les choses qui font le confort de la personne et et participe au bien être c'est à dire euh faire la la la péridurale euh soulager la femme euh lui permettre un maximum d'intimité, permettre à son mari d'être là dans la salle de travail, tout ça ça n'existe pas... du coup il faut vraiment une grande force mentale pour confronter une situation pareille. »</p> <p style="text-align: right;">(Doctor, former intern in a maternal health section of a public hospital, Tunisian, Tunis 2018)</p>

