Faculty of Social Sciences

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On the quest for “medical home”: diasporic healthcare arrangements of Tunisians residing abroad

Carole Wenger

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Thèse dirigée par:

Jean-Michel Lafleur (FRS-FNRS et Université de Liège)

Membres du jury:

Elsa Mescoli (Université de Liège) Présidente de Jury

Jean-Michel Lafleur (FRS-FNRS et Université de Liège) Secrétaire de Jury

Meghann Ormond (Wageningen University)

Irene Maffi (Université de Lausanne)

Karel Arnaut (KU Leuven)

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Abstract

This thesis explores how transnational healthcare arrangements and diasporic networks shape the transnational healthcare strategies of Tunisian migrants. It unpacks the multiple strategies that migrants employ to navigate healthcare systems across borders, emphasising the interplay between formal and informal mechanisms, the impact of socio-economic disparities, and the importance of social networks and emotional ties.

Drawing on the literature on diasporic medical mobilities and a combination of sociological, geographical and anthropological work at the interplay of studies of health, migration and space, the thesis explores how diasporic ties are built and maintained through healthcare consumption. In doing so, this thesis examines the interactions between immigration, health and transnational medical mobilities in order to improve our understanding about how migrants' presence in transnational social fields influences their healthcare practices.

The main research goal of this thesis is to explore how transnational healthcare strategies unfold and are refashioned through the variety of healthcare resources at the disposal of migrants, both in countries of residence and of emigration. More specifically, this study addresses the following research questions: what are the transnational strategies that migrants mobilise to meet their healthcare needs and expectations, and what does it say of their agency in the pursuit of healthcare?

The findings draw on a multi-sited ethnography in Tunisia, France and Belgium, which was carried out between 2019 and 2022 to investigate therapeutic mobilities taking place from, to, and between these different places. Research participants included Tunisian migrants (primarily first generation) and their families, Tunisian associations, public and private healthcare providers, and civil servants in the field of healthcare policies.

Moving across spaces, fields and disciplines, the thesis presents a comprehensive understanding of the relation between health, migration and transnational spaces, with the ambition that its multi-sited observations and conceptual proposals add to the emerging scholarship on the subject. In addition to examining the moral economy of healthcare and migration, this thesis proposes original concepts, such as the notion of "diasporic healthcare arrangements", the transnational healthcare strategies "from below" and "from above" formulated within diasporic space; the notion of "diasporic therapeutic network" to qualify the therapeutic strategies deployed by and within the Tunisian diasporic network, using instances observed in the wake

of the Covid-19 pandemic; and the concept of "medical home", bridging literature on therapeutic landscape, diasporic medical travel and literature on the concept of home.

The general proposal of this thesis advances the argument that the quest for a "medical home" gives shape to a variety of transnational healthcare practices, mobilising diasporic therapeutic networks and resources, and shaping diasporic healthcare arrangements. The observation of such transnational healthcare practices invites us to rethink the limitations of a nation-state scale for provision and contribution to healthcare systems and social protection in general, and explore the all-encompassing relationships between health, migration and citizenship.

Résumé

Cette thèse explore la manière dont les arrangements transnationaux en matière de soins de santé et les réseaux diasporiques façonnent les stratégies de soins de santé des migrants tunisiens. En mettant l'accent sur l'interaction entre les mécanismes formels et informels, l'impact des disparités socio-économiques et l'importance des réseaux sociaux et des liens émotionnels, elle examine les multiples stratégies employées par les migrants pour naviguer dans les systèmes de santé par-delà les frontières.

En s'appuyant sur la littérature sur les mobilités médicales diasporiques, au prisme de travaux sociologiques, géographiques et anthropologiques sur la santé, les migrations et l'espace, la thèse explore comment les liens diasporiques se construisent et se maintiennent à travers la consommation de soins de santé. Ce faisant, cette recherche examine les interactions entre l'immigration, la santé et les mobilités médicales transnationales pour permettre de mieux saisir la manière dont la présence des migrants dans les champs sociaux transnationaux influence leurs pratiques en matière de soins de santé.

L'objectif principal de cette thèse est ainsi d'explorer comment les stratégies transnationales de santé se déploient et sont remodelées à travers la variété des ressources à la disposition des migrants, tant dans les pays de résidence que dans les pays d'émigration. Plus précisément, cette étude aborde les questions de recherche suivantes : quelles sont les stratégies transnationales que les migrants mobilisent pour répondre à leurs besoins et attentes en matière de soins de santé, et qu'est-ce que cela dit de leur capacité d'action dans la poursuite de ces soins ?

Les résultats s'appuient sur une ethnographie multi-située en Tunisie, en France et en Belgique, menée entre 2019 et 2022, pour étudier les mobilités thérapeutiques depuis, vers et entre ces différents lieux. Ce travail de terrain ethnographique se fonde notamment sur des observations et entretiens avec des migrants tunisiens (principalement de première génération) et leurs familles, des associations tunisiennes, des prestataires de soins de santé publics et privés et des fonctionnaires dans le domaine des politiques de santé dans les pays de résidence et d'émigration.

Traversant différents espaces, domaines et disciplines, la thèse propose une vision globale de la relation entre santé, migration et espaces transnationaux, avec l'ambition que ses observations multi-situées et ses propositions conceptuelles contribuent au champ de recherche émergent sur le sujet. En plus d'examiner l'économie morale des soins de santé et des migrations, cette thèse développe des concepts originaux, tels que la notion de *diasporic healthcare arrangements* (ou

arrangements diasporiques en matière de soins de santé), qui désigne les stratégies de soins transnationales « par le bas » et « par le haut » formulées au sein de l'espace diasporique ; la notion de *diasporic therapeutic network* (ou réseau thérapeutique diasporique) pour qualifier les stratégies thérapeutiques déployées par et au sein du réseau diasporique tunisien, à partir des exemples observés dans le sillage de la pandémie de Covid-19 ; et le concept de *medical home* (ou chez-soi médical), faisant le lien entre la littérature sur le paysage thérapeutique, les voyages médicaux diasporiques et le concept de « chez-soi ».

La proposition générale de cette thèse est que la quête d'un *medical home* donne forme à une variété de pratiques de soins transnationales, mobilisant des réseaux et des ressources thérapeutiques, façonnant les arrangements de soins diasporiques. L'observation de ces pratiques de santé transnationales nous permet de reconsidérer les limites de l'échelle nationale pour la prise en charge et la délivrance de soins de santé, ainsi que la protection sociale en général, en nous invitant à explorer les relations globales entre santé, migration et citoyenneté.

TABLE OF CONTENTS

List of abbreviations *11*

General introduction *13*

1. Research context and questions. 14
2. Analytical lenses and concepts 17
3. Thesis roadmap 19

Chapter 1: State of the art - The interplay of health, migration and transnationalism *23*

Introduction **23**

I. Health in the study of migration **24**

1. The figure of the "foreign disease body" 24
2. Discussing the "healthy migrant effect" 25
3. Health and migrants' acculturation 29
4. Social determinants of migrants' health 30
5. Intersectional approach in the study of migrants' health 31
6. Cross-national perspectives 33

II. Situating health in space **35**

1. Medical geography: the geography of disease and healthcare 35
2. Health geography: reconsidering health, place and space 36

III. Transnationalism in the study of health and migration **43**

1. The "transnational turn" in migration studies 43
2. Transnationalism, health and migrants 46

Chapter 2: Methodological choices, fieldwork sites and ethical considerations *59*

Introduction **59**

I. Multi-sited ethnography: fieldwork continuities and disruptions **60**

1. Fieldwork choices 61
2. Fieldwork in Belgium 64
4. Fieldwork in Tunisia 71
5. Virtual fieldwork space: online ethnography before and during the pandemic 80
6. Fieldwork in France 85
7. Overview of the main categories of actors of the research 90

II. Ethics "on paper" vs ethics "in practice" **95**

1. "Ethics ready" … on paper 95

2. "Ethics ready" …in practice 96
3. The principle of "doing no harm" during the pandemic 100
4. Ensuring reciprocity 101

Chapter 3: Diasporic healthcare arrangements: Tunisian migrants' strategies to meet healthcare needs and expectations. 103

Introduction 103

I. Gaining access to healthcare through informal social protection strategies 107

1. Social networks as healthcare resources in migrants' country of residence 107
2. Intra-diaspora medical solidarities 115
3. Tunisian migrant women's experiences of sexual and reproductive health provision in the country of residence 121

II. Reversing disparities: circumventing healthcare barriers through therapeutic mobilities ..136

1. Formal transnational social protection mechanisms: usage of bilateral social security agreements 138
2. Thriving on medical tourism: the growth of the private healthcare landscape in Tunisia 143
3. Holiday visits to Tunisia as the annual therapy 148

Conclusion 166

Chapter 4: Accessing private and culturally adapted healthcare services at "home": the "reproductive returns" of Tunisian living abroad 169

Introduction 169

I. The globalisation of assisted reproductive technologies and the increase of reproductive mobilities. 172

1. Tunisia as a "reprohub": ARTs development in Tunisia 176
2. Intimate Journeys: the emotional character of reproductive mobilities 182
3. Virtual spaces on ARTs and "biosociality" 187

II. "Home" to Procreate: "Reproductive Returns" of Tunisians Living Abroad 190

1. Comfort consultations. 191
2. Family Network as Healthcare support? 197
3. Quest for "cultural intimacy" in patients-doctors relationship 204
4. Rethinking temporality in a context of transnational care 209
5. Variations in medical protocols 212
6. Religious Preferences and fear of discrimination 215

Conclusion 221

Chapter 5: Diasporic networks as therapeutic networks: mobilisation of the Tunisian diaspora in Europe during the Covid-19 pandemic 223

Introduction 223

I. Diaspora in crisis 227

1. The concomitant healthcare and political crisis in Tunisia 228
2. The Tunisian collectives abroad against Covid-19 232

II. The reconfiguration of diaspora-homeland relationships along biomedical narratives 237

1. Questioning the moral economy of the relationship between diaspora and country of emigration. 237
2. Strengthening of the moral absence through exclusionary measures 242

III. Diaspora engagement in Tunisia during the pandemic: negotiating its membership to the emotional community. 251

1. Diaspora as agent of development 252
2. The Tunisian medical diaspora during the pandemic 256
3. Diasporic network as therapeutic network: an act of moral authority? 257

Conclusion 272

General Conclusion: 276

1. Thesis Overview 276
2. Rethinking diasporic medical mobilities through a moral economy approach 279
3. Conceptual contributions and way forward 282

References 285

List of figures 322

Appendix I : Biographical presentation of the research actors, in their order of appearance. 323

List of abbreviations

AEMNA	*Association des étudiants musulmans nord-africains*
AIDS	Acquired immunodeficiency syndrome
AME	State medical aid
AMTN	Association of Tunisian Doctors in the World
AMU	Arab Maghreb Union
ART	Assisted reproductive technology
ASA	Association of Social Anthropology
ASSEM	Association of Support to Children
ATE.COVID19	Tunisians' Associations abroad against Covid-19
ATUGE	Association of Tunisians from higher education
AWSA	Arab Women's Solidarity Association
BIM	Beneficiary of the increased intervention
BSSA	Bilateral Social Security Agreement
CAIT	Coordination of Tunisian Immigration
CBRC	Cross-border reproductive care
CNAM	National Health Insurance Fund
CNPRS	National Pension and Social Security Fund
CNSS	National Social Security Fund
CPAP	Continuous Positive Airway Pressure
ERC	European Research Council
EU	European Union
FTCR	*Fédération tunisienne pour une citoyenneté des deux rives*
GDP	Gross Domestic Product
HISB	Health information–seeking behaviour
HPV	Human papillomavirus
ICMPD	International centre for Migration Policy Development
ICSI	Intracytoplasmic sperm injection

IFFS	International Federation of Fertility Societies
IOM	International Organisation for Migration
IT	Information technology
IVF	In vitro fertilisation
MiTSoPro	Migration and transnational social protection in (post) crisis Europe
MRI	Magnetic Resonance Imaging
NGO	Non-governmental organisation
NHS	National Health Service
ODSE	Observatoire du Droit à la Santé des Étrangers
OTE	Office for Tunisians Abroad
PCR	Polymerase Chain Reaction
PSD	*Parti Socialiste Destourien*
SEMTE	Secretary of State for Migration and Tunisians Abroad
TRA	Tunisians residing abroad
TSP	Transnational social protection
US	United States
UGET	*Union générale des étudiants de Tunisie*
UK	United Kingdom
UN	United Nations
UTIT	*Union des travailleurs immigrés tunisiens*
UTSS	Tunisian Union for Social Solidarity
WHO	World Health Organisation

General introduction

There is a fish shop close to my neighbourhood in Brussels called "Poissonnerie d'Agadir."[1] The owner is Moroccan. I go there every now and then when I want to get some fresh fish. One day I was waiting in line. The person before me seemed to be a regular costumer as he was having a friendly discussion with the fishmonger behind the counter.

> *"How is your sister?"* asked the fishmonger.
> *"She is very well hamdullha, she is pregnant"* replied the consumer.
> *"I am so happy for her, finally."*
> *"Yes, they went to see a doctor 'au bled'*[2] *and thanks be to god she got pregnant."*
> *"Ah for sure, there is nothing best than doctors 'du bled'."*

Overhearing that conversation six months into my thesis I suddenly realized that I had heard similar discourses during my preliminary fieldwork, as I was tentatively exploring healthcare practices of Tunisian migrants in Belgium and their transnational circulation. While I had envisioned the topic through the circulation of ideas and practices around health and the body, I had never really paid much attention to the circulation of people themselves to their country of emigration for medical purposes. Was this in fact a common practice among diaspora groups? I took out my phone and wrote down the conversation, followed by a note: "*to explore for my thesis"*.

This movement of return could appear counter-intuitive at first, as the general discussions on health and migration tend to emphasise the pull factor of receiving countries' health services for migrants. However, my preliminary findings on migrants' access to basic healthcare services in countries of destination, which highlighted the obstacles some may face, combined with my prior knowledge of the high quality of Tunisia's medical care, gradually reinforced my intuition that medical returns from the receiving country to Tunisia were worth exploring further.

A few months later, during summer 2019, I went to Tunisia to explore the medical practices of Tunisians residing abroad during their holiday visits. There, I followed several of my Belgian participants, whom I had met previously in Brussels. For some, these medical visits in Tunisia

[1] Agadir is a town on the southern Atlantic coast of Morocco.
[2] *Bled* refers in colloquial Arabic to the home in the country of origin.

meant a visit to the family doctor in order to "keep him/her informed "or "because it's better to keep going to the doctor who has all your medical history" (Interview Slim, Tunis, August 2019). For some, this meant annual check-ups with the gynaecologist because they "haven't found a doctor they trust in Belgium yet" (Interview Cyrine, Brussels, April 2019). And for others, it meant a visit to the dentist to take advantage of low prices and for treatments that were not covered by their health insurance in Belgium.

Those first considerations became the stepping stones of a four-year multi-sited ethnography in Tunisia, Belgium and France, investigating diasporic healthcare arrangements of Tunisians residing abroad. Through this research I have looked at Tunisian migrants' health practices and how they navigate the healthcare system in the receiving countries, while making use of healthcare resources in Tunisia. I came to explore the multiple forms of transnational healthcare practices between those fieldwork spaces and grounded my thesis in the field of therapeutic mobilities (encompassing patients, medical knowledge and material), along with a combination of sociological, geographical and anthropological work at the interplay of studies of health, migration and space, which I introduce briefly in the next section.

1. Research context and questions

Gaining access to social rights and health care rights is an important concern for any internationally mobile person settling in a new destination country. If healthcare systems have traditionally been bounded within the limits of nation-states (Ormond and Lunt, 2019), however, in the context of the globalisation of healthcare governance, state and non-state actors are increasingly acting beyond national health systems. Meanwhile, debates around the inclusion and/or exclusion of migrants[3] from healthcare entitlements have become increasingly controversial at the societal and political levels.

Existing literature on health and migration has been largely concerned with the impact of migration on the health of immigrants, while studies on transnational medical mobilities have, on the other hand, looked at the process by which people seek different health services across borders. The division between these two fields of study is neither simple nor rigid. In fact, both phenomena are embedded in complex dynamics, such as the increase of international mobility, the globalisation of healthcare governance and societal and political debates around the

[3] In this research, I use the term emigrant when taking the perspective of the country of emigration, immigrant with the one of the countries of residence and migrant as a more generic term.

inclusion and/or exclusion of migrants from healthcare entitlements. The globalisation of healthcare and the development of a transnational healthcare offer both impact healthcare practices and the provision of healthcare (Johnson and Garman, 2010).

This thesis examines the particular case of Tunisian migrants' transnational healthcare arrangements and the barriers and opportunities in accessing healthcare in both their countries of emigration and of residence[4]. It unpacks how Tunisian migrants meet their healthcare needs through the mobilisation of transnational and diasporic resources. Drawing on the literature on diasporic medical mobilities, the thesis explores how diasporic ties are built and maintained through healthcare consumption. I wish to explore the interplay between immigration, health and transnational medical mobilities in order to improve our understanding of how the presence of immigrants in transnational social fields (Faist 2006) influences migrants' health practices.

The main research objective is to explore how transnational healthcare strategies unfold and are refashioned by migrants who turn to the variety of healthcare resources at their disposal, depending on their needs, medical preferences, and perception of healthcare services as well as accessibility of healthcare in both countries of residence and of emigration. I namely explore how migrants' ability and chances to circumvent healthcare challenges can be a function of social variables, such as their level of education, gender, and social capital. Drawing on data collected through observations and interviews with Tunisian migrants and their families, Tunisian associations, public and private healthcare providers, and civil servants in the field of healthcare policies, the research seeks to map out healthcare circulations while also discussing the drivers of such practices.

In carrying out this research, I will explore the following empirical research questions: What are the transnational strategies that migrants can mobilise to meet their healthcare needs and expectations, and what does it say of their agency in the pursuit of healthcare? How and why do migrants return to their country of emigration for healthcare? What are the factors of decisions to undertake therapeutic journeys to their country of emigration? How does the relationship between diaspora groups and their country of emigration affect healthcare, and what do transnational healthcare practices reveal about one's attachment to and engagement with a place?

[4] In this thesis, I use country of emigration and country of residence. This choice of terminology is justified by the fact that when looking at aspects of transnational social protection, being formally resident of a specific country opens up a number of social protection entitlements, including healthcare.

This thesis is part of a larger research project entitled *"Migration and transnational social protection in (post) crisis Europe"* (MiTSoPro[5]) hosted at the university of Liège between 2017 and 2023. This project combines quantitative and qualitative approaches to the study of policies and strategies that enable migrants and mobile European citizens to access social protection. The research project departs from the observation that high unemployment rates in Europe since the start of the 2008 financial crisis, coupled with changing migration patterns, have led large numbers of European and non-European migrants to seek social protection. In this context of crisis, governments across the EU have also considered reducing immigrants' access to this assistance, despite the fact that they are increasingly at risk of poverty and exclusion. Migrants' strategies to cope with health, unemployment, old age and other social risks are at the heart of this project. Ranging from rights in host and origin countries to informal family and community practices, the project investigates "transnational social protection" defined as "migrants' cross-border strategies to cope with social risks in areas such as health, long-term care, pensions or unemployment, that combine entitlements to host and home state-based public welfare policies and market-, family- and community-based practices".

My PhD thesis has therefore been built within and around the research themes of the MiTSoPro project. In line with the MiTSoPro project's aim of examining the construction of transnational social protection networks between different intra- and extra-European countries, I have selected, in coordination with the research team, two European countries - Belgium and France - as well as one extra European country, Tunisia (more details are provided on the fieldwork choices in the methodology).

My thesis is thus embedded in different fieldwork spaces within different geographical locations (Tunisia, France and Belgium), exploring, through multi-sited ethnography, therapeutic mobilities taking place from, to and between these different places. Each fieldwork site allowed me to examine a different dimension of therapeutic mobilities, thus bringing different perspectives to transnational healthcare practices which I detail below.

In Belgium, I conducted fieldwork intermittently between 2019 and 2022, where I explored questions around interculturality in healthcare as well as Tunisian migrants' perceptions of the Belgian healthcare system. My fieldwork in Tunisia, which took place during the summer of 2019 and from May to September 2021, allowed me to observe the medical practices of Tunisians residing abroad during their holiday visits back home as well as "holiday returns" as

[5] http://labos.ulg.ac.be/socialprotection/

a therapeutic framework for my participants. Through an online ethnography, I explored the use of communication means and technologies in building transnational ties and transnational healthcare practices but also as an instrument of mobilisation during the COVID-19 crisis. Finally, from October 2021 to January 2022, I conducted two short fieldwork stays in Paris which complemented the online data collection I had undertaken during the pandemic as well as my data collection in Tunisia regarding diaspora mobilisation during the pandemic.

2. Analytical lenses and concepts

Moving across fields and disciplines, the thesis intends to present a comprehensive understanding of the relation between health, migration and transnational spaces, with the ambition that its multi-sited observations and conceptual proposals add to the emerging scholarship on the subject. In this section, I briefly present the key concepts and analytical lenses from which this thesis derives its conclusions and contributions to the scholarship.

First, drawing on the body of literature on transnational social protection, this research explores the transnational healthcare practices deployed by migrants and their families, and how they navigate among different social protection mechanisms, involving various actors, such as the state, associations or the private sector.

Studies on transnationalism and health have looked at how migrants address their health concerns and needs *transnationally*. The concept of transnationality "refers to the deep and permanent embeddedness of migrants and their offspring, and non-migrant relatives in the countries of emigration, in cross-border social formations such as fields of contact, kinship groups, networks, organizations, and diaspora communities" (Amelina *et al.* 2012: 8).

In the case of healthcare, social protection strategies may be mobilised in a transnational way to overcome barriers and to meet healthcare needs and expectations. To study the combination of formal and informal social protection strategies which migrants may use, this thesis mobilises the notion of transnational healthcare arrangements (Lafleur and Romero 2018), which itself draws on earlier work on "assemblages of social protection" (Faist 2013, Bilecen and Barglowski 2015) and "social protection arrangements" (Kilkey and Merla 2014; Vivas-Romero 2017).

In this research, I aim to show how transnational healthcare arrangements mobilising family and diasporic networks are a demonstration of "migrants' transnationality". Following this

perspective, in conjunction with the scholarship on diasporic medical mobilities and transnational social protection, I propose in this thesis the notion of **"diasporic healthcare arrangements"**, which I define as the transnational healthcare strategies "from below" and "from above" formulated within the diasporic space. Indeed, I argue that "diasporic healthcare arrangements" can be seen as the expression of individuals' transnationality as the "social practices of agents – individuals, groups, communities and the organizations – across the border of the nation-states" (Faist *et al.* 2015: 195).

As will be further developed in Chapter 3, I use this conceptual approach to study the particular case of transnational healthcare practices of Tunisian migrants and explore the use of diverse transnational healthcare strategies. In doing so, I examine, through the different chapters of the thesis, the interplay between different forms of formal and informal transnational social protection strategies.

Transnational therapeutic mobilities include the circulation of patients as well as all health-related goods and knowledge, and also often involve relatives in the country of emigration. Transnational ties maintained by emigrants and the circulation of material and emotional support with the family and the community back home are said to shape their health and that of their family and community (Acevedo-Garcia *et al.* 2012). Following this approach, Krause developed the concept of "transnational therapy networks" as "interlaced situational, formal and informal contacts between people, which become meaningful in the event of sickness, providing financial and practical support and help in finding the right treatment" (Krause 2008: 236). Social linkages can be understood as a resource mobilised in the event of sickness, demonstrating "the social fabric of health" (Janzen 1992).

By observing the circulation of (health) care across borders, the thesis examines how diasporic ties, networks, and flows are mobilised to meet healthcare needs. In particular, I propose the notion of **"diasporic therapeutic network"** to qualify the therapeutic strategies deployed by and within the Tunisian diasporic network, using instances observed in the wake of the Covid-19 pandemic.

Finally, in this research I propose to create a bridge between literature on therapeutic landscape and on diasporic medical travel and the literature on the concept of home, which leads me to articulate the concept of **"medical home".** This concept, further unpacked in Chapter 3, will allow me to explore further the relationship of the actors in my research to their country of emigration – Tunisia - as a place to heal and that heals. By combining the literature on the geography of health, transnationalism and diasporas as well as the concept of "home", I explore

the role played by the family in the intimacy of the medical journeys of migrants, and their quest for cultural intimacy in their relationship with doctors. As will be developed further in the thesis, the concept of "medical home" is of great help qualifying the affective relationship as well as the familiarity that migrant patients maintain with the healthcare ecosystem in the country of emigration.

As a common thread through the thesis, I mobilise the concept of moral economy to explore the role of values, norms and emotions in defining relationships between Tunisian emigrants and their relatives, as well as with authorities in Tunisia. The concept of moral economy explores how social norms, values, and obligations regulate economic exchanges. Originally developed by Thompson (1971) and Scott (1976), this approach goes beyond material aspects, emphasising the role of justice, reciprocity, and emotions in maintaining the relationship between authority and individuals. In migration studies, scholars including Fassin (2009) and Lacroix (2019) have analysed how moral expectations shape interactions between migrants and non-migrants. Solari's idea of "transnational moral economies" (2019) highlights the fluid and negotiated nature of these exchanges across borders, involving both emotional and material support.

3. Thesis roadmap

The following section introduces the main chapters of the thesis, in their order of appearance in the manuscript.

Chapter 1 presents the theoretical framework of the thesis and shows how it results from a combination of sociological, geographical and anthropological work at the interplay of studies of health, migration and space. In the first part of this chapter, I present the literature on health in the study of migration and migrant populations, drawing on the rich sociological scholarship in this field. I then draw on the various works on the social determinants of migrants' health, which justifies the intersectional focus of the thesis, and I then briefly present the literature on cross-national frameworks in studying migrants' health. In the second part, I observe how health has been investigated from the perspective of health geography and anthropology. Looking at the recent evolutions of the scholarship on health and "spaces", I emphasise important evolutions in health geography in redefining key concepts and methodological approaches, such as the emergence of the notion of therapeutic landscapes. In the third part of this chapter, I

present the literature on transnationalism in the study of health and migration, drawing on sociological and anthropological perspectives. I propose a brief genealogy of this concept and present the typologies which have emerged across various fields of research. This leads me to unravel important concepts that I mobilise in this thesis in relation to the literature on transnationalism, such as remittances, diasporic medical travel and transnational social protection arrangements.

After presenting the thesis' theoretical framework, ***Chapter 2*** explores the methodological approach and challenges faced during the thesis' fieldwork, as part of the different fieldwork spaces covered throughout this ethnography. In the first section of this chapter, I start by discussing the methodological approach of my multi-sited ethnography, the fieldwork continuities and disruptions, and the impact of the Covid-19 pandemic for my fieldwork development. Then, I present my different fieldwork "spaces" in Belgium, Tunisia, France and "online", zooming in on the different fieldwork spaces I navigated in each of these locations. While discussing my own positionality in the field, I also propose a reflection on the ethical approach of my research and its confrontation with the ethical requirements of the broader research project in which this thesis also originates.

Chapter 3 opens the empirical part of the thesis. This chapter explores Tunisian migrants' strategies to meet their healthcare needs and expectations between Tunisia and their country of residence in Europe. I draw on the notion of transnational healthcare arrangement (Lafleur and Romero 2018) to emphasise the agency of migrants in addressing their healthcare needs, across borders, using formal and informal resources. The first part of the chapter explores the healthcare experiences of Tunisian migrants in the country of residence and examines their access to healthcare and perceptions about healthcare delivery. Identifying challenges and disparities, I document the important role played by interpersonal and social networks of migrants, and I study how their individual strategies are partly a response to the evolutions of domestic healthcare systems, driven by patterns of marketisation and self-responsibilisation of patients. I also argue that these strategies are direct evidence of how migration implies a relative downgrading in migrants' access to healthcare. The second part of the chapter moves from the country of residence to the country of emigration. It focuses on the use of medical resources in the country of emigration, looking specifically at diasporic medical returns. I underline in this section how transnational medical spaces are shaped both by individuals' agency and therapeutic opportunity structures (Zanini *et al.* 2013) and suggest that, through their "diasporic

healthcare arrangements", Tunisian migrants demonstrate their agency in the pursuit of healthcare.

In ***Chapter 4***, I discuss the medical mobilities of the Tunisians residing abroad for assisted reproductive technologies (ART) in Tunisia and examine the factors behind couples' decisions to undertake therapeutic journeys in their country of emigration. Based on fieldwork in a private fertility clinic as well as in a gynaecological practice, I explore the relationship(s) that these individuals have with the health systems in the country of emigration and in the country of residence. In the first part of the chapter, I present the recent globalisation of ART, the resulting growth of reproductive mobilities over past decades. and the diverse realities that this process has generated. I describe the development of Tunisia as a "reprohub" in the wake of the ART industry's growth during the past twenty years. I show how the development of the ART industry appeared mainly driven by the private sector and was facilitated by a national law, giving rise to a new moral economy around these technologies. In the second part of the chapter, focusing specifically on the returns of TRA to Tunisia for the purpose of reproduction or reproductive returns of TRA. Reproductive mobilities are presented as not being only geographical, but also consisting of intimate and emotional journeys. I argue that the nature of the care provided in reproductive health and its interlinkage with intimate issues invite us to rethink transnational medical strategies through the prism of the intimate. Through the discourses of couples and health professionals around reproductive returns of TRA (Tunisians residing abroad) collected during my fieldwork stays in a fertility centre and gynaecological practice, I expose the different drivers of these reproductive returns and discuss dynamics of "medical patriotism" (Inhorn 2011), notions of "medical culture" (Horton and, Cole 2011), as well as the role of structuring factors (legal framework, coverage and cost of healthcare). I articulate the concept of "medical home" in order to explore the relationship of the actors in my research to healthcare consumption in Tunisia.

In ***Chapter 5***, I discuss the forms of mobilisation and (dis)engagement from the diaspora and Tunisian authorities in the management of the Covid-19 crisis. I argue that this time of rupture offers a particular perspective on the relationship between diaspora groups and their country of emigration. In the first section of the chapter, I start by discussing the rupture created by the Covid-19 pandemic, the interruption of my fieldwork research and the resulting immersion into online ethnography. Then the chapter describes how this episode, which led to the stigmatisation of TRA, considered as vectors of the virus, materialised a moment of rupture in the moral economy of diaspora-homeland relationships. Looking at the mobilisation of the Tunisian

diaspora in Europe, I argue that the state of crisis brought on by the Covid-19 pandemic became a catalyst for pre-existing tensions characterising relations between Tunisians from "outside" and "from inside". The third section of the chapter explores how the Tunisian diaspora continuously navigates the ambivalence around its membership to the national community, notably from an emotional perspective. To illustrate this dimension, I use the case of diaspora groups active in the medical sector, which directly supported Tunisia during the pandemic. I propose the notion of diasporic therapeutic network to analyse the circulation of healthcare material and knowledge across borders through diasporic network.

In the ***Concluding chapter***, I will then summarise the main findings and conceptual innovations from the thesis. This section will show also the relevance of a moral economy approach in understanding diaspora-State relations, where values, emotions, and norms play crucial roles in shaping interactions and expectations. Finally, I will identify new research questions which have emerged from my research, representing promising avenues for future research and conceptual developments.

Chapter 1: State of the art - The interplay of health, migration and transnationalism

Introduction

This first chapter presents the theoretical framework of the thesis, which draws on a combination of sociological, geographical and anthropological works at the interplay of studies of health, migration and space. Each of the three parts structuring this chapter is introduced by a brief overview of the trajectory of the academic fields under study, followed by an extended presentation of the concepts which are mobilised in this thesis.

In the first part, I cover the literature on health in the study of migration and migrant populations, drawing on the dense sociological scholarship on migrants' health. This allows me to reflect on the traditional framing of the migrant as a "foreign disease body" in host countries, and its sociological counterpoint known as the "healthy migrant effect" and how it still affects migrants' health and healthcare delivery to migrants today. I then draw on the various works on the social determinants of migrants' health, while laying an emphasis on the need to adopt an intersectional perspective. This will be mobilised in particular in Chapter 3 when examining examples of Tunisian migrant women's experiences of sexual and reproductive health provision in the country of residence. Finally, I briefly present the literature on the cross-national frameworks in studying migrants' health. This notion of 'cross-national' is further explored in the second part, which looks at spaces and places in the study of health.

In the second part, I look at how health has been investigated by scholars in human geography, namely from the perspective of health geography, and anthropology. After considering the recent evolutions of the scholarship on health and "spaces", drawing on the work in medical geography and the study of diseases for instance, I present the importance of the more recent works in health geography in redefining key concepts and methodological approaches. I focus

in particular on the emergence of the notion of therapeutic landscapes, a concept which I mobilise in the thesis and build on to articulate my conceptual contributions.

In the third part, I present the literature on transnationalism in the study of health and migration, drawing on sociological and anthropological perspectives. I start by briefly presenting the genealogy of this concept and the various typologies which have emerged across various fields of research. I then cover the most relevant sections of the literature on transnationalism to pinpoint key concepts for my thesis, namely, medical remittances, diasporic medical travel and transnational social protection arrangements.

I draw on the body of literature on transnational social protection in order to explore the transnational healthcare practices deployed by migrants and their families, navigating between different social protection mechanisms involving diverse actors such as the associative network, states and the private sector. This allows me to demonstrate in Chapters 3, 4 and 5 how different transnational social protection mechanisms are mobilised by the actors of my research.

Moving across fields and disciplines, the thesis intends to present an encompassing understanding of the relation between health, migration and transnational spaces, with an ambition that its multi-sited observations and conceptual proposals add to the emerging scholarship presented in this chapter.

I. Health in the study of migration

The scholarship in sociology on migration and migrant populations has long focused on the issue of the health of migrant populations, primarily through the attitudes of host country authorities and population towards the "foreigner and his diseases".

1. The figure of the "foreign disease body"

The relation between migration and health was first approached from the perspective of the epidemic risk that migrants could pose to the population in the country of destination (Prothero 1977; Kraut 1994; Markel 1997).

Koch (2011) shows that, as long ago as 1690, there was fear that migrant populations would spread the plague, as indicated in maps illustrating the borders of Bari in Italy. Ever since then, public health authorities have developed policies to control infectious diseases to safeguard their population's health and welfare, from the historical practices of quarantine (Gensini *et al.* 2004) to contemporary border control and immigration medical screening measures (Gushulak and MacPherson 2011; Klinkenberg *et al.* 2009; Arshad 2010).

Markel and Stern (2002) illustrated the way immigration policy in the United States has been informed and framed by medical language and medical categories. The 'new' immigrant was depicted as a threat to the nation's health (Higham 1988), as infectious risks and the control of the spread of virus translated into exclusionary policies (Markel and Stern 2002). The 1924 National Origins Act later marked a turn from medicalised rationales for containing immigration to the rhetoric of the biological hierarchy of races. Greater potential for assimilation into mainstream society was associated with immigrants who most closely resembled, physically, the majority of white Americans (ibid.).

The use of medical labels of exclusion and their "biological metaphor" (Markel and Stern 2002: 758) contributed to anchoring the link between unrestricted immigration and increased risks to the nation's social health (Markel and Stern 2002). However, the creation and application of categories of medical exclusion and its social perception have always outweighed the actual presence of disease among immigrants. Categories of medical exclusion kept moving over time to include an ever-increasing array of medical conditions. The shift from acute and ephemeral illnesses (typhoid and cholera) to chronic, mental, or moral conditions (feeble-mindedness, psychopathic inferiority) turned immigrants into a potential economic and social burden, a "public charge" on the nation (Markel and Stern 1999). This history still resonates in research conducted today (Darlington-Pollock *et al.* 2018) and on immigration policies that still draw on the figure of "the foreign disease body" (Harper and Raman 2008).

Contrasting with the attitudes of host countries' authorities and individuals towards migrants, the literature on migrants' health has for decades observed patterns known as the "healthy migrant effect".

2. Discussing the "healthy migrant effect"

Early studies in the epidemiological and demographic literature on immigrants' health in the 1980s focused primarily on the use of the healthcare system by immigrants and on their access

to care after arrival in the destination country (Brahimi 1980; Marmot *et al.* 1984). In their study on immigrants' mortality, Marmot *et al.* (1984) argue that lower male mortality among immigrant groups suggests the selective nature of migration, as disease patterns of migrants do not reflect the ones in the country of emigration. Migration is not random and, they argue, its selective nature influences health and disease risks (ibid.). Commonly referred to in the literature as 'the healthy migrant effect', studies suggest that immigrants tend to be healthier than individuals in the country of destination even though a majority of immigrants come from developing countries with worse morbidity indicators than in the developed countries to which they migrate (Fennelly 2007; Mackenbach *et al.* 2005; Kennedy *et al.* 2006; Farré 2016).

The "healthy migrant effect" has been attributed to different factors. Firstly, the health screening (the exclusion of migrants with certain health issues) by immigration officers in the destination country could explain the relatively better health of migrants after arrival in the destination country (Kennedy *et al.* 2006). Some studies have, however, contested that explanation as it does not explain the mortality gap between immigrants and native-born (Laroche 2000, Uitenbroek and Verhoeff 2002). Secondly, it has been associated with the fact that 'candidates' for migration are often healthier individuals prior to departure. Pre-migration lifestyle of individuals living in developing countries such as high levels of activity and low-fat and low-calorie diets are conducive to good health. Immigrants from developing countries migrating to developed countries benefit from both the healthy habits in the country of emigration and the efficiency of the health care system in the country of destination (Powles 1990; Khlat and Darmon 2003). The early work of Marmot and Syme (1976) on Japanese immigrants in the US shows a correlation between healthy behaviour before migration and adherence to the Japanese culture after migration with better health status in the country of destination. This explanation later led to acculturation theories and the protective effects of culture and norms in the country of emigration, as well as within the communities in the country of destination. Thirdly, migration acts as a 'selective process' whereby migrant groups are composed of resilient working individuals (generally composed of young men) able to respond and adapt to the healthcare risks of migration (Organista, Organista, and Kurasaki 2003). They are therefore considered to be physically and mentally better equipped to face the healthcare hazards of migration. Moreover, migration has a cost and only the wealthiest, and thus healthiest, individuals in the country of emigration are those who have the necessary means to migrate, and are believed to do so. This is based on the postulate that there is a positive relationship between income and health (Kennedy *et al.* 2006). Jasso *et al.* (2004) note, however, that to

validate this theory, immigrants should be compared to native-born individuals with similar backgrounds rather than to the overall population.

A second selection process, called the 'salmon bias', is also presented in the literature to explain the differences in mortality rates between migrants and non-migrants. As aging immigrants return to their country of emigration for retirement, when they are ill and toward the end of their lives, the immigrant population remains healthier as it is mainly composed of young individuals (Abraido-Lanza *et al.* 1999). In many cases, the effect of the salmon bias on immigrants' mortality was considered negligible or even invalid (ibid.). However, an 'unhealthy remigration effect' (or 'return effect') characterised by the return of less healthy individuals to the country of emigration could explain some results (Razum *et al.* 1998; Kohls 2008).

A considerable proportion of the literature on the selective health of migration has been written with regard to Hispanic communities in the US. Research analysing what is called the "Hispanic paradox" or "Hispanic mortality paradox" sought to explain their mortality advantage in comparison to the native-born population (Palloni A, Morenoff 2001; Franzini *et al.* 2001). The "salmon bias hypothesis" and "healthy migrant hypothesis" were the two main theories used to explain this difference. The work of Abraido-Lanza *et al.* (1999) was one of the first studies to reject both theories and to call for the integration of cultural factors in research on immigrant health.

In Europe, migration started to gain growing attention at the political and societal levels in the 1970s and 1980s. Debates were raised around family reunification, unemployment, social security, and healthcare as migrant guest workers who immigrated after the Second World War started to settle permanently in the county of immigration. Before that, policy development in migration and health had mainly been addressed through border control for epidemiological reasons but also and foremost for the selection of healthy guest workers after World War II and the Fordist industrialisation of Europe (Cattacin and Chimienti 2007). Some studies, therefore, talk about the 'healthy worker effect' rather than the 'healthy migrant effect' (Razum, Zeeb, Akgun, and Yilmaz 1998).

The European literature on migrants' mortality has been more limited (Bouchardy *et al.* 1995; Bouchardy *et al.* 1996; Brahimi 1980; Darmon and Khlat 2001; Khlat and Courbage, 1995; Mejean *et al.* 2007) and considered the cause of death for migrants from specific countries of birth. Khlat and Courbage (1995) examined, for instance, the mortality rates of Moroccan immigrants in France and argued that the omission of Moroccan immigrants' deaths from the French civil registry could be explained by the return of immigrants with poor health conditions.

By cross-referencing the data from the French civil registry with the data of a survey conducted in Morocco, they observed that disease was an important factor in the return of these migrants. They further argue that the phenomenon could have a more significant on men, older individuals, and on isolated individuals with limited financial resources concerned about their burial in the country of emigration and the respect of their religious funeral rites. The European literature refers, however, more commonly to "mobility bias" rather than "salmon bias" as they considered the influence of the geographical proximity between the Mediterranean countries of Southern Europe and North Africa allowing migrants to return for short or long periods, independently of their health status (Khlat and Darmon 2001).

These theories have been critiqued, with critics raising methodological and analytical issues, such as the availability and comparison of mortality estimates between countries and regions with differences in health care. Moreover, some questions remained unanswered such as the persistence of the health selection effect on mortality with time and on the potential factors underlying migrants' health advantage (ibid.). The migrant population is not homogenous and a number of factors, such as the reason for migration, the country of birth, the duration of stay may influence the selective effect on mortality (Boulogne *et al.* 2012).

Further studies on immigrant health trajectories postulated that the healthy migrant effect is expected to decrease with the length of the stay in the country of destination and to translate into health disparities (Trovato, 2003). Landale *et al.* (2000), in their study on infant death among Puerto Ricans in the US, observed that the risk of infant mortality increased with increasing length of migrant mothers' residence, suggesting that the health advantage resulting from the selectiveness of migration was then lost with life exposure in the US. The deterioration of immigrants' health over time has been attributed to different causes. Immigration itself can be considered to be a process impacting the health of migrants, as it may bring a new set of health risks (Trimble, 2003). It can be stressful and involve lifestyle changes and adjustments. Finally, immigrants can face persistent barriers to access health services.

This relationship between migrants' health and their country of destination has been further explored in scholarship looking at the acculturation of migrants to healthcare systems and practices.

3. Health and migrants' acculturation

The process of acculturation, defined as the gradual adoption by immigrants of 'Western habits' and lifestyle, is observed to contribute to closing the health gap between migrants and non-migrants. The very large body of literature in health research among immigrant groups in the US postulates that culturally-based behaviours change over time as a result of acculturation (Salant and Lauderdale 2003; Arcia *et al.* 2001; Lee *et al.* 2000). According to some, health behaviours are presumably deteriorating with acculturation and with the adoption of unhealthy behaviours from the country of destination. McDonald and Kennedy (2005) for instance, observe that the probability for immigrants in Canada of being overweight is lower (in comparison to native-born) upon arrival and increases as years go by, even exceeding native-born levels after 20 to 30 years spent in Canada. Arcia *et al.* (2001) note in their review of the literature on acculturation and health behaviours among Latino immigrants in the US that there are two different sets of findings that contradict one another. If health indicators of Latinos with low acculturation tend to be better than the ones of Latinos with high acculturation, studies based on self-reported health, however, come to the opposite conclusion. Studies using disease prevalence rates show that the foreign-born have much lower rates of chronic conditions than the native-born. On the contrary, studies using health index and self-reported health highlight that foreign-born are in either fair or poor health compared to the native-born (Jasso *et al.* 2004). Cultural differences in health perception should also be considered in that regard and literature shows that cultural differences tend to affect not only healthcare use, but also the perceived quality of the services provided (Jasso *et al.* 2004).

The literature has not agreed on a common model of acculturation to explain why and how it affects health. Different disciplines (physical health studies, psychological studies, etc.) have developed different models of acculturation and have based their analysis on data of different nature (qualitative and quantitative, national health survey data, disease prevalence rates, self-reported health, etc.). However, they all acknowledged that acculturation (taken in its broad understanding) influences health outcomes to some extent (Salant and Lauderdale 2003). Several limitations of the acculturation models have been pointed out in the literature such as their application to very diverse and heterogeneous populations and the use of a static definition of culture essentialising ethnic and immigrant groups (Hunt *et al.* 2004). As noted by Viruell-Fuentes *et al.* (2012), a universal theory explaining the health of immigrants should not be the core objective of research in that domain. On the contrary, research should develop various

theories mirroring the diversities of immigrants' health experiences. Another main criticism toward acculturation models is that they overlook the socio-historical contexts of migration and the racialisation of contemporary immigrants (ibid.). Also, Fox *et al.* suggest that "a fundamental aspect of the way cultural exposure, acculturation, and health interact is that these constructs are embedded within a sociocultural context, which modifies the relationships of interest" (Fox *et al.* 2017: 3).

If culture plays a role in immigrant health outcomes, it ignores the effects of social inequalities and social determinants on health outcomes, which are unpacked in the following sub-section.

4. Social determinants of migrants' health

The literature identifies a large number of determinants shaping health inequities, namely their living conditions and endemic diseases in immigrants' home countries, social, political, and environmental conditions surrounding the immigration process, social isolation, cultural conflicts, poor social integration and assimilation, role changes and identity crises, low socioeconomic status, and racial discrimination (Dunn and Dyck 2000; Koh *et al.* 2011).

Immigrants generally experience more precarious socioeconomic conditions in the host countries. They tend to have more difficult working conditions and are often more at risk of work-related injuries (Schenker 2008), have lower levels of remuneration, and higher unemployment rates (Ahone *et al.* 2007). Housing conditions and residential segregation also have implications in health outcomes in a variety of ways. Poorer housing conditions can be responsible for accidents, physical illnesses and can impact health indirectly through barriers to receiving services (access to healthful foods, parks, and recreation centres) (Fennelly 2005; Acevedo-García 2000; Boëldieu and Thave 2000).

The concentration of poverty coupled with higher exposure to environmental risks and lack of resources can affect mental and physical health as well as access to care (Acevedo-García *et al.* 2003, Williams and Collins 2001, Pickett and Pearl 2001, Kirby and Kaneda 2005). In addition, they are more often subject to isolation and loss of their social network, factors known to be associated with a deterioration in health status. Immigrants can face difficulties in accessing health care services and make less use of the healthcare system due to language and cultural barriers, lack of knowledge of health systems, and difficulties in accessing health coverage (Cognet *et al.* 2012; Rechel *et al.* 2013; Couillet 2009; Dourgnon *et al.* 2009). Moreover,

administrative insecurity (Baudet-Caille and Mony 2010) accentuates the difficulties of access to care.

Discrimination and xenophobia against foreigners in the host countries (Viruell-Fuentes 2007), including when using health services, can again affect their health (Nazroo 2003; Williams *et al.* 2003). As argued by Link and Phelan (1995), racism produces and reproduces social and economic inequities along racial and ethnic lines, and is in and of itself a fundamental cause of disease. Daily experiences of racism and discrimination impact health in multiple ways (Gee *et al.* 2009; Williams and Mohammed, 2009; William *et al.* 2003). Bernstein *et al.* (2011), for instance, show the association between experience of discrimination and the appearance of symptoms of depression among Korean immigrants in New York City. Studies conducted among different immigrant groups in the US have demonstrated that perceived discrimination correlates with lower physical and mental health, lack or reduced access to health care, and unfavourable health behaviours (Perez *et al.* 2009; Finch *et al.* 2000; Ryan *et al.* 2006; Gee *et al.* 2008). In Chapters 3 and 4, I examine in particular how negative perception of healthcare delivery in the country of residence and experiences within healthcare services impact access to healthcare.

Another determining factor influencing the health trajectories of immigrants is immigration policies (Viruell-Fuentes *et al.* 2012). Viruell-Fuentes *et al.* (2012) note that, outside of their well-documented effect on access to health care, policies shape access to life opportunities such as education (and higher education) and employment, which play a fundamental role in health and wellbeing (for undocumented migrants and their families in particular).

One of the criticisms toward the social determinant approach suggests that "social determinants" are too often equated to "socioeconomic determinants" (Ingleby 2012). If they uncontestably play a central role in health inequities, factors such as gender, age, ethnicity, disability, and geography should not be left out of the analysis (ibid.). Viruell-Fuentes *et al.* (2012) call in this regard for an intersectional approach considering the power dimensions of race, class, gender, and immigrant status hierarchies in shaping migrants' health trajectories.

5. Intersectional approach in the study of migrants' health

As important as the socio-economic causes may be, they do not necessarily exhaust the health gaps between groups that result from multiple forms of social inequalities and discrimination

(Aïach, 2010; Aïach and Fassin 2004; Fassin, 1998, 1999). It is, therefore, necessary to examine more closely the possible links between health conditions and sexist and racist discrimination (Cognet *et al.* 2012). Feng *et al.* (2005) argue that women are doubly disadvantaged as women and migrants. Im and Yang (2006) review the classical theories on immigrants' health and apply them to four case studies of Korean immigrant women's experiences in the US and show that their health experience differs from men's. The selective theory on migration discussed above stipulates that healthier migrants tend to migrate. However, as many immigrant women immigrate in the context of family reunification, even if their husbands are supposedly healthier men, the same conclusion cannot automatically be made about women (Im and Yang 2006). Im and Yang argue that immigration and health are taken as defined categories without considering the gender differences in the meaning, process, and outcome of immigration nor the gender differences in stress, physical overload, and other physiological or psychological characteristics. Differences in health, health perspectives, and health care experiences can significantly vary by gender (Llácer *et al.* 2007). Cognet *et al.* (2012) note that women are more likely than men to report poor general health, which can be partly explained by their higher involvement in the medical sphere through reproductive health. Better familiarity with medical criteria may also result in higher health expectations.

The effects of migration on women's health are impacted by several factors: the conditions of migration, the time spent and integration in the country of destination, their social status in the home and host society, and the health conditions in the country of destination (Adanu and Johnson 2009; Iglesias *et al.* 2003). When migrating from lower-income countries to higher-income countries, women might benefit from improved healthcare systems resulting in better health status. However, employed women who speak the language of the country of destination will more likely benefit from the health system (Bollini *et al.* 2007).

Recent research on women's sexual and reproductive health and rights in Europe (Council of Europe 2017) shows that several gender stereotypes and stigma as well as laws, policies, and practices in Europe still affect women's sexual and reproductive health. This is particularly exacerbated among marginalised groups such as women living in poverty and migrant women (ibid.). They have poorer pregnancy outcomes, higher infant and maternal mortality rates, less access to family planning and contraception as well as gynaecological healthcare (Keygnaert *et al.* 2014). Studies on migrant women's sexual and reproductive health in Europe have primarily looked at vulnerable migrant women with irregular status and poor access to healthcare services and insurances (Sauvegrain 2012; Marsicano *et al.* 2011), maternal health and HIV/AIDS and,

sexual violence and prostitution in the context of migration (Platt *et al.* 2013; Jacquemyn *et al.* 2012). As I expose in my methodological chapter, several of my research actors have recently immigrated to Belgium or France for their studies or for work. Their trajectories and experience of migration therefore puts them in a comparably privileged position and their experience of sexual and reproductive healthcare cannot be associated to the one of vulnerable migrant women. In Chapter 3, I however suggest how gender, in interaction with other social variables, affects the quality of access to healthcare in the country of residence.

While intersectionality brings an important lens to unpack migrants' health, the last sub-section of this first part insists also on the need for cross-national frameworks on migration and health. It draws on the fact that the large majority of research in migration and health has focused on healthcare determinants in the country of destination and has relatively recently paid attention to the role of the migration process in itself (Rechel *et al.* 2013).

6. Cross-national perspectives

As pointed out by Zimmerman *et al.* (2011), migration and health policy development has worked in sector silos and lack of effectiveness as they separately address the different phases of the migration process: pre-departure, travel phase (sometimes called transit phase), destination phase (or post-migration phase) and return phase. With the intensification and complexification of migratory movements, the migration process cannot be read as a linear movement but as a complex phenomenon involving several phases and sometimes cyclical (ibid.).

In that perspective, the social determinants in the country of emigration and the pre-departure phase should be considered to understand individuals' health outcomes both in the country of emigration and the country of destination (Gushulak and MacPherson 2011; Acevedo-Garcia *et al.* 2012). Factors such as individual characteristics, the prevalence of chronic diseases or infectious diseases, environmental, social, cultural, and political factors, as well as healthcare access in the country of emigration influence healthcare trajectories of migrants long after migration. The travel phase corresponds to the migration process itself. Health consequences of the transit phase are related to conditions and circumstances of travel, in particular for undocumented migrants. The journey itself can be an important impacting factor on migrants' health and can expose migrants to a number of healthcare risks (e.g., gender-based violence,

human trafficking). The destination phase has been widely covered in the literature investigating the migrant healthy effect, the effect of acculturation on health among different ethnic groups (Zimmerman *et al.* 2011; Acevedo-Garcia *et al.* 2012). Finally, the return phase considers individuals who go back temporarily or indefinitely to their country of emigration and the implications it might have on their health and the health of the population in the emigration context. Some studies suggest that immigrants may have learned and engaged in certain high-risk behaviours following migration. Over time, return migration may result in high-risk behaviour and transmission from immigrants to the non-immigrant population in sending communities (Magis-Rodríguez *et al.* 2009; Sanchez *et al.* 2004). Older migrants returning to lower-income countries with healthcare conditions may face difficulties in accessing quality healthcare in the country of emigration. However, returning labour migrants may be able to afford a healthier lifestyle upon their return and afford better health care for themselves and their families. Bilateral agreements and portability of health care benefits play an important role when migrants return to retire, with potentially higher healthcare needs due to old age, after having contributed to the welfare system in the country of destination (Zimmerman *et al.* 2011; Davis *et al.* 2011).

The cross-national framework proposed by Acevedo-Garcia *et al.* (2012) considers the influences on health outcomes that derive from immigrants' sending and receiving contexts and from the immigration process (Acevedo-Garcia *et al.* 2012). They also underline the importance of the life-course perspective (Poulton *et al.* 2002; Gong *et al.* 2011) on immigrants' health as socioeconomic conditions, infectious or environmental exposures in countries of emigration and age at migration may influence the health of adult immigrants and the development of active disease in destination countries. Furthermore, their cross-national framework intersects with theories on transnationalism which considers the role of transnational ties in shaping the health of migrants and their families. They, however, distinguish the cross-national perspective from the transnational one as the first does not account for influences on health that result from exchanges (exchanges of information, resources) and migrant's agency but rather refer to factors occurring at different points in time without agency on the part of immigrants (Acevedo-Garcia *et al.* 2012), a point which is central for the analysis of my empirical material.

The cross-national perspective emphasises the role of various spaces for migrants and their health. To further unpack this notion of space, the next part presents the literature situating health in space, from the perspectives of human geography and anthropology.

II. Situating health in space

The second part of this theoretical framework explores the geographical and anthropological perspective on health, looking at health and healthcare behaviour through the perspective of space, place, and their interaction with migrants. In order to later discuss the contemporary understandings of the relationship between health and place, I first present the different paradigms that have marked the discipline and the evolutions it undertook, reflecting transformations in the discipline of geography.

1. Medical geography: the geography of disease and healthcare

The relationship between health and place has been acknowledged for centuries and studied by geography, sociology, epidemiology, and other disciplines. The recognition of the interconnection between the two goes back as early as Hippocrates writing on Airs, Waters and Places (400 BC) that already acknowledged "the causal influence of place (water, food, climate and seasons) on health and well-being" (Crooks *et al.* 2018: 1). During the 19th century, social reformers in Great Britain looked at the impact of the industrialisation of British cities on the health of their inhabitants. They noted important differences across different urban areas and identified the living conditions that explain these inequalities (Pearce 2014). Similarly, pioneer works in public health looking at traditional medicine (such as the work of Nightingale in 1859 on nursing) investigated the connection between the local environments and the opportunities for health and well-being (Barrett 2000).

Initially named "medical geography", this sub-discipline of human geography was focusing mainly on the ecological perspectives of disease, its environmental determinants, and the spatial distribution of health services (Andrews 2002; Crooks *et al.* 2018). In terms of methodology, medical geography has been characterised by a “quantitative revolution” taking place in the 1960s (Kearns 1993: 140) often using census data and large population datasets.

In this sub-discipline the local environment and its characteristics were recognised to have an impact on individuals' health. This positivist approach to health examined the causal interconnections between diseases and the particular characteristics of places (Kearns and Moon 2002). The environment was mainly framed as a set of attributes responsible for causing

particular diseases among people living in particular locations. The work of Stamp (1964) for instance, considered the relation between climate and health in specific locations.

Medical geography was involved in two main fields of study: the "disease ecology framework" (geography of disease) which involved mapping and modelling disease distributions and diffusions and, the "spatial study of health services provision" (geography of healthcare) focusing on location, access and utilisation of health services (Mayer 1982; Jones and Moon 1987; Rosenberg 1998; Andrews 2002). This "unproblematized geometrical conception of disease and space" (Andrews 2002: 224) was mainly concerned with "giving geographical expression to various epidemiological models of infectious disease and mapping disease diffusion" (ibid.).

Studies have later evolved to take into consideration environmental factors, risk exposure as well as the association between poverty and vulnerability in the developing world in particular (Borroto 1998; Brightmer and Fantato 1998; Kalipeni 2000). Research on non-infectious and common diseases were merely focusing on spatial patterns that could explain the frequency of the disease (Rosenberg 1998, McNally *et al.* 1998) while studies on rare diseases focused on geographical characteristics determining the prevalence of particular disease in specific localities (Johnson 1981; Zeiger *et al.* 1983; Gould 1990). Some studies considered, for instance, public health risks of areas that underwent rapid industrial growth and experienced high levels of pollution (Eyles *et al.* 1993; Eyles 1997).

During the same period, another area of research developed, looking at the spatial study of health services and distributive equity in service provision (Joseph and Phillips 1984; Mohan 2000). Among the themes that were being explored were the distribution, access, and use of health services by older people, children, women, and immigrants.

2. Health geography: reconsidering health, place and space

Moving from the approach of medical geography, the "cultural turn" in human geography marked the shift from a biomedical model of health to a standpoint that considers its economic, political, social, and cultural components. In 1946, the adoption of a wider definition of health by the World Health Organization initiated the progressive development of this new analytical framework going beyond the biomedical model. From that point onward, health was not only defined as the absence of disease but as encompassing physical and social environment. Health

involves "physical, mental and social well-being" rather than just "the absence of disease or infirmity" (World Health Organization 2014:1).

The intellectual transformation in sociocultural geography interrogated medical categories and called "for more nuanced accounts of the contextual shaping of health and illness" (Dyck 1999: 244). Since the 1990s, new debates have emerged regarding the role of place in shaping individuals' health experiences and on the importance of individuals and/or place characteristics (Eliott 2017). At the time, geographers were increasingly concerned with the importance of place in the definition of people's everyday health practices. Kearns (1993) was among the first to call for repositioning of the discipline and the incorporation of social theories moving towards post-medical geography focusing on health and wellness, away from concerns on disease and disease services (Kearns and Moon 2002). He suggested that more attention should be paid to the meaning of places in healthcare delivery rather than merely on the location of healthcare services.

The shift away from medical geography was also marked by a change of methodological tools, suggesting alternative ways of understanding health concerns, from the quantitative and positivist approaches to more qualitative approaches.

2.1 Methodological approach

The literature on health geography has been primarily driven by qualitative approaches which “recognizes individual situated experience as a valid way of knowing” (Eliott 2017: 207). Kearns argued that experience of medicine is also dependent on the different settings of healthcare delivery (hospitals, clinics, home) and that geographers should be situated into place to observe individuals' experience of health and place. The sub-discipline adopted qualitative methods in order to grasp how people experience health, illness, and healthcare and the impact of larger political and social structures on individuals (Dyck 1999). Health had become a social science (Wilkinson 1996) and the sub-discipline was renamed “health geography”. This change of paradigm was concomitant with the rise of the population health perspective which took into consideration the broader determinants of health (Evans *et al.* 1994). These alternative health frameworks (Lalonde 1974) gave less attention to biomedicine and formal healthcare system in the analysis of health and illness "while the importance of socioenvironmental factors and their interaction with individual-level biological and behavioural variables took on increasing importance" (Elliott 2017: 207).

The change from medical geography to health geography also implied a redefinition of the understanding of space, place, and health.

2.2 Redefining key concepts

In a discussion on the distinction between concepts of space and place and their interactions, Kearns and Joseph suggest that space can be both "the medium and outcome of social relations" that "guides and records individual and collective behaviour within a landscape of places" (Kearns and Joseph 1993: 712). One should differentiate the geometric space that is concerned with location and distance from the social space as the site of social interactions. According to Gesler (1991), "space" is composed of quantifiable attributes and patterns, while "place" is imbued by meanings.

Researchers thus started to investigate individuals' experience of place and the meaning people attribute to it. They are socially constructed and the result of both structural components and individuals' agency. The concept of "sense of place" (Tuan 1974; Elyes 1985) describes "the consciousness people have of places holding a special significance for them" (Kearns 1993:140). In a nutshell, "place can be a specific location, fixed set of geographic coordinates or politically defined space, or it can be a social and cultural phenomenon, one that is performed, sensed, felt and imbued with meaning and identity" (Crooks *et al.* 2018: 3). This definition is relevant here, since my research includes reference to the relationship that actors in my research maintain with Tunisia, both as a location and politically defined space, as well as to the subjective meanings or "sense of place" they attach to it. I therefore propose to explore how a "sense of place" impacts their experience of healthcare in Tunisia and in their country of residence.

Indeed, health and illness are understood to be socially constructed in place and by place (Dyck 1999 and Wilton 1999). Studies adopted a holistic understating of health redefined as being the result of the interconnections between emotional, social, environmental, physical, and spiritual factors (William 2002). Health constitutes a resource that individuals can mobilise to manage and cope with their environment (World Health Organization 1986). Therefore, geographers investigated how the character of places and health mutually affect each other (Andrews 2003; Gastaldo *et al.* 2010). The place individuals occupy in the world and their experience of place influence their experience of health (Elliott and Gillie 1998). This is further discussed in the following section on therapeutic landscapes.

2.3 The emergence of the notion of therapeutic landscape

The notion of 'landscape' has been an important development in geography of health and "brought an enhanced awareness of the cultural importance of place and the intersection of the cultural and the politico-economic in the development of place-specific landscapes of health care and health promotion" (Kearns and Moon 2002: 610). The concept of "therapeutic landscape" (Gesler 1992, 1993) was first introduced by Gesler who described it as places or situations that support physical, mental, and spiritual healing. Under this approach, places are viewed as a "symbolic system of healing" (Andrews 2002) and studies explored how healing landscapes are created through the interaction between individual, social, cultural, environmental and structural factors (Gesler 1992; Chakrabarti 2010; Milligan and Wiles 2010). Attachment and connection that individuals build within places is a central concern of the humanist approach which looks at "individuals' and groups' attitudes and feelings toward the environments they inhabit, suggesting that intimate personal and emotional relationships between self and place could impact one's health and well-being" (Finlay 2018:116). Certain environments possess a 'healing sense of place' through a juxtaposition of the physical and built environment, social conditions, and human perceptions that promote healing. The subjective ways in which individuals interpret these landscapes, as well as their specific social and physical health-promoting qualities, participate in the fabric of these therapeutic landscapes: "these landscapes are not mere containers of people's health outcomes but are produced through the mundane and not-so-mundane experiences and wilful action of those who make them" (Sothern and Reid 2018: 97).

Early works looked at therapeutic landscape as particular places with special healing qualities such as sacred pilgrimage sites, groves, and hot springs (Gesler 1998). In his studies on Lourdes in France (1996), the Asclepin sanctuary in Epidauros in Greece (1993), and Bath, England (1998), Gesler explored the historical reputation of the sites for their healing qualities and the attributes that produce this sense of place. Another field of studies looking at the healing qualities of particular places investigated therapeutic landscapes in institutional settings such as clinics, hospitals, and health centres. Attention was given to their architecture and as well as to the type of comfort and technology that they provide (Smyth 2005). William (1999) later expanded the concept of therapeutic landscape from extraordinary locations to investigate the "therapeutic value of everyday spaces" (Bell *et al.* 2018). These "everyday healing landscapes" (English *et al.* 2008; Andrews 2002) possess both aesthetic qualities and social networks

suggesting a sense of security and inclusion (Smyth 2005; Wakefield and McMullan 2005). Andrews (2004) noted, however, that the understanding of physical space as a structuring feature remained too restrictive and that a larger conceptualisation of landscapes should be considered to include non-physical space in the study of therapeutic landscape (Andrews 2004; Milligan and Wiles 2010). Following this idea, Gastaldo *et al.* (2004) have extended the concept to "therapeutic landscape of the mind" to "explore, in particular, the personalized mental strategies that individuals enact to enhance their mental health and promote their well-being in times of change" (Gastaldo *et al.* 2004: 157). These "mental landscapes" are relational images experienced alone or shared with others that represent "what generates a sense of well-being for ourselves or others" (Gastaldo *et al.* 2004: 160).

Some studies also looked at individuals' agency to pursue health by making use of healing landscapes (English *et al.* 2008; Sampson and Gifford 2010; Wood *et al.* 2015). Sampson and Gifford (2010) for instance, looked at active processes of place-making among young refugees after resettlement in Melbourne, Australia. These studies highlight how individuals experience the places around them and shape them through the meaning they attribute to them, and how, in return, these places shape their self and experience of health (Sothern and Reid 2018: 97). Finlay (2018) notes, however, that if spaces are not intrinsically therapeutic and if their healing qualities depend on how they are viewed by people, "what may be therapeutic for one person may be harmful to another" (Finlay 2018: 118) or "anti-therapeutic" (Gastaldo *et al.* 2004: 172). Moreover, individuals' perception of places as well as their embodied identity - their race, ethnicity, gender - influence their experience of places.

2.4 Health and the social aspects of places

Geographers have also been concerned with the social aspects of places, their impact on health and healthcare opportunities. As we have seen previously, local market dynamics, local resources, urban segregation, social capital and networks, the presence of green areas such as parks and access to healthy food constitute social determinants that influence health and well-being and that are inscribed in spaces.

These determinants have spatial and geographical components (Crooks *et al.* 2018: 2) and act as "opportunity structures" that may or may not promote health through the opportunities (or the lack of opportunities) that they provide (Macintyre *et al.* 2002). Bambra suggests that "places mediate the way in which individuals experience social, economic and physical

processes on their health: places can be salutogenic (health-promoting) or pathogenic (health-damaging) environments – places act as a health ecosystem" (Bambra 2018: 29). Following this logic, "poor places lead to poor health" (ibid.). This contextual approach of health, therefore, suggests that it is the attributes of certain places that define the health of the individuals. Conversely, the compositional approach of health stipulates that it is the individuals (who live here) that inhabit certain places that define health. This understanding of the relationship between health and place is central to my analysis of the healthcare experience of participants, as linked to my research in the country of emigration.

Health behaviours such as smoking, alcohol consumption and dietary habits as well as individuals' socioeconomic position (income, education, type of employment) living in specific places determine healthcare outcomes. Accordingly, "poor people make poor health" (ibid.). Indeed, a lower socio-economic background is often associated with worse health outcomes (Marmot *et al.* 1991) and the level of income plays an important role in determining health status. The "social gradient" in health corresponds to the positive association between social position and health (Adler *et al.* 1994; Pinxten and Lievens 2014) and "implies that each improvement or worsening of someone's social position is associated with a similar change in health" (Pinxten and Lievens 2014: 2). Many studies on health-seeking behaviour have therefore demonstrated the relation between the level of income and decision to seek treatment, where (within which facilities), and how (Ferland and Paquet 1995; Kunst and Houweling 2001). Moreover, social inequalities in health are not only apparent in the material disadvantage related to lower socioeconomic status but also as a psychosocial pathway associated with social positions (Wilkinson and Marmot 2003; Uphoff *et al.* 2013).

Collective social functioning is another social aspect of places that influence health. High levels of social cohesion and social capital within a community are beneficial for health. In its broad understanding, social capital "involves resources obtained through social relationships and the nonmonetary power and influence, with the central idea being that membership and participation in groups may have positive consequences for the individual and/or the community" (Pearson and Sadler 2018). Putnam defines social capital as social networks within which norms and trust facilitate action and cooperation for mutual benefit (Putnam, 1993, 2007). Trust, norms, and networks are social mechanisms "through which place mediates the relationship between individual socioeconomic status and health outcome" (ibid). The literature demonstrates that social networks constitute a fundamental health resource, and it is recognised that social relationships have effects on physical and mental health (Cassel 1976; Berkman and

Glass 2000; Menjívar 2000; Hawe and Shiell 2000). We do see that places with a high level of community trust are observed to have lower mortality rates, better mental health, or healthier behaviour. The attachment individuals carry to a place can promote their health and, on the contrary, marginalised and stigmatised places can result in ill health or psychosocial stress (Bambra 2018).

The role of social networks also appears in the study of migration and health. Smyth (2005) readapted the concept of social networks to the study of migrants' health and suggested the term "therapeutic network" to better capture the use of informal networks operating in parallel with formal medical care. These "networks of support" can take place within the community, the home, or through the care provided by alternative medicine. As immigrants are observed to often face issues in accessing (formal) healthcare services, they, therefore, rely more heavily on such informal networks taking place on different levels - from the household to local and international levels. In her works on south Asian migrant women in Canada, Dyck (1995, 2006) analyses how healthy spaces are created and experienced by immigrant women with chronic illness through the channel of social networks and the distribution of non-medical resources. She argues that "the social, cultural and geographic connections of local social networks, shaped by shared experiences of migration and settlement in immigrant and ethnic landscapes, are important resources for maintaining health" (Dyck 2006: 14). Her study was also concerned about the way social constructs such as race and gender "contribute to women's experience of their illness and their use of a variety of health care resources" (Dyck 1995: 247). The gendered and culturally oriented construction of places also needs to be considered. Dyck (1995, 2006) highlights in her studies on South Asian and Chinese immigrant women how relationships to places such as the home, the neighbourhood, the workplace, are intertwined with the maintenance of their health and that of their family. She, therefore, highlights women's agency in the creation of healthy homes and places. Furthermore, Dyck also observes in a later study that "healthy space is not simply locally constituted but involves relationships and materialities stretched over space" and that "the home country remained an anchor point in the women's interpretation and practice of health" (Dyck 2007: 699-700). Through everyday health practices, the maintenance of regular contacts with relatives back home, use of remedies from the home country, and traditional cooking, women build a "transnational sense of home" (Dyck 2007: 697).

In Chapter 3, I examine how actors in my research mobilise their social capital and networks in order to facilitate or gain better access to healthcare in their country of residence and emigration.

I also demonstrate how social capital is sometimes mobilised transnationally. The observation and analysis of such transnational ties are at the heart of this research. Thus, the last part of this theoretical chapter reviews the dense literature on transnationalism, migration and health, and identifies a series of key "transnational" concepts that are mobilised throughout the thesis.

III. Transnationalism in the study of health and migration

In the previous parts of this chapter, I have presented how acculturation and assimilation theories have been used to describe the process through which individuals, when migrating to another country, adopt parts of the cultural values of the dominant culture in the country of destination and sometimes fully integrate to the point of losing their former cultural heritage (Mitchell 1997). The Chicago School assimilation theory and its inability to conceptualise immigrants' maintenance culture of origin as non-pathological (Dunn, 1998) became increasingly hard to apply to contemporary life (Glick Schiller *et al.* 1992). The transnational approach, on the other hand, acknowledged the multiple and continuous ties that immigrants maintain across nation-states (Vertovec 1999) offering a response to the criticisms of the unidirectional and linear approach of the assimilation and acculturation models. The literature on migration and transnationalism has proposed several definitions and readings of the phenomenon. The scope of the literature is too large to be fully detailed in this review and this section mainly seeks to uncover the use of transnationalism in the study of health and how it has contributed to the understanding of migrants' health practices and behaviours. However, some of the main developments of the research on transnationalism should be presented here in order to understand their later application in the study of health.

1. The "transnational turn" in migration studies

While Bourne was one of the first to refer to the concept of transnationalism in 1910 in his work on immigrants entering America, and he talked about "trans-national America" (Bourne 1916), what is described as the "transnational turn" in migration studies only took place in the 1990s, raising strong debates within the discipline.

Basch, Glick-Schiller, and Blanc's work *Nations Unbound: Transnational Projects, Postcolonial Predicaments, and De-territorialized Nation States* (1994) is considered to be the first groundbreaking publication on transnationalism that went beyond the description of what was until then mainly considered as a structural-economic phenomenon (globalisation of production). In their definition of transnationalism, human practices and agency are at the centre of their conceptualisation, which considers the way "immigrants build social fields that link together their country of emigration and their country of residence" (1994: 1). Moreover, the concept of transnationalism offered an alternative to the nation-state as the primary unit of analysis (Schiller 2007a) and aimed at describing more than just "patterns of living across borders" but to rethink "the spatial and cultural interconnectedness of people, cultural forms and objects as well as economic processes" (De Jong and Dannecker 2018).

Transnational migrants are simultaneously engaging socially, culturally, economically and politically with both countries of emigration and destination (Levitt and Schiller 2004). As a result of these transnational practices, a sense of belonging and places, aspirations, citizenship and nationality, imaginaries, and everyday life decisions are being transformed and shape individuals' dual identity (Tedeschi *et al.* 2020). According to Schiller *et al.* (1992b) 'transmigrants' develop and maintain ties across borders through family, social, economic, religious, and political practices which affect their sense of belonging to places and, consequently, their citizenship and nationality. Their dual or plural identities are built as a result of their simultaneous connections between two or more societies. They "take actions, make decisions, feel concerned, and develop identities within social networks that connect them to two or more societies simultaneously" (Schiller *et al.* 1992b: 1-2). These 'transnational social fields' are created through migrants' transnational practices (Schiller *et al.* 1992; Pries 1999), operating a 'deterritorialisation' of the world beyond the control and borders of nation-states. Transnationalism offered in this regard an alternative to the methodological nationalism adopted until then by the positivist approach of migration studies (Levitt 2012; Barglowski *et al.* 2014).

In an attempt to better define and narrow down the phenomenon of transnationalism, several categorisations, as well as typologies, have been suggested to discuss different expressions of transnationalism. Smith and Guarnizo (1998) suggested that transnationalism is "from below" when it is led by people who make use of the political and economic opportunities deployed by globalisation (Al-Ali *et al.* 2001; Tedeschi *et al.* 2022). Also, "transnationalism from below" describes the frequent cross-border practices, activities, and exchanges between individuals and

civil society highlighting individuals' agency in the production of transnational social fields (Smith and Guarnizo 1998). Munro notes, however, that this "positive spin" which perceives "transnational migrants as actors exploiting the resources available to them to make informed choices about the ways in which they carry out their lives across the territories of two or more nation-states" risk "restricting the transnational space to those labour or economic migrants who are seen to be making empowered decisions and capitalizing on the opportunities afforded by globalization" (Munro 2015: 5). It overlooks those who have not migrated voluntarily and who do not have a positive experience of transnationalism.

Vertovec provided a broader definition of transnationalism as the "multiple ties or interactions linking people or institutions across the borders of nation-states" (Vertovec 1999: 447). According to him, transnationalism is evidenced as "social morphology (social networks spanning borders), type of consciousness (multiple identities and sense of belonging), mode of cultural reproduction (hybridization of various cultural phenomena), avenue of capital (activities of transnational corporations), site of political engagement (cross-border public participation and political organization through technologies), and (re)construction of 'place' or locality (creation of new social spaces across countries)" (Vertovec; 2003). The activities and cross-border relationships that individuals engage in affect their sense of belonging, their loyalty, and their sense of attachment (Vertovec 2003). Their meaning, relevance, consistency, and diffusion, through the mobility of people and ideas, is important enough to provoke societal structural transformations and reshape localities (Rizvi 2019).

Other categorisations have emphasised dimensions of identity and citizenship. Also, Ip *et al.* (1997), proposed a distinction between relational, experimental, and legal transnationalism. Relational included movements between one or more countries to visit relatives, for holidays or business, as well as communication. Experimental concerns sense of identity and belonging, immigrants' incorporation into national spaces (Soysal 2000), as well as imaginaries about the 'homeland' and perception of the new 'home' (Westwood and Phizacklea 2001). Finally, legal transnationalism refers to the 'formal' attachment (citizenship, dual citizenship) that individuals have to one or more countries. Dunn (2005) explains in his review that debates were raised among scholars around the complexity of citizenship in the transnational field (Castles and Davidson 2000; Faist 2000; Ip *et al.* 1997; Soysal 2000) and on the impact of discrimination and racism on individuals' sense of belonging and attachment (Dunn and McDonald 2001; Vasta and Castles 1996).

The study of transnationalism now encompasses several fields of studies that are too broad to be fully detailed here. Among them are entrepreneurialism (Sommer 2020) and economic interactions - including remittances, economic activities taking place across borders going from small businesses to transnational corporations - (Portes 1996; Guarnizo 2003; Sana 2005; Djelić and Quack 2010), political engagements - such as activism from abroad, bilateral agreements between nation-states and international NGOs - (Nye and Keohane 1972; Ostergaard-Nielsen 2002; Bauböck 2003; Guarnizo *et al.* 2003; Bordes-Benayoun 2010; Lafleur 2013), cultural and social bonds (Appadurai 1996; Hannerz 1996; Kennedy and Roudometof 2002; Jackson, Crang and Dwyer 2004; Koundoura 2012) and everyday practices (Innes 2019). Moreover, several sub-themes have been explored such as global/cross-national diaspora or community networks (Van Hear 1998; Brettell 2006; Bauböck and Faist 2010), gender (Pessar and Mahler 2003; Erel and Lutz 2012; Oso and Ribas-Mateos 2013; Yeoh and Ramdas 2014), and transnational family care and parenthood (Salih 2003; Skrbiš 2008; Carling *et al.* 2012; Baldassar and Merla 2014).

2. Transnationalism, health and migrants

Looking at the field of study on migration and health, the adoption of the "transnational lens" "scaled up" the analysis of health and space from the local to the global. The focus shifted from understanding local determinants of health and healthcare behaviour allowing (or not) the creation of healthy spaces or therapeutic landscapes to an investigation of its transnational determinants, ties and practices.

In this sub-section, I focus in particular on five key concepts that I mobilise throughout the thesis and which derive from this dense literature on transnationalism. The first concept revolves around diasporas and the study of "transnational therapeutic networks".

2.1 Diasporas and transnational therapeutic networks

The concept of diaspora was originally related to the condition of exile suffered by the Jews (Cohen 1997). Later, the concept of diaspora stretched to other religious and ethnic groups. Over time, the concept has come to be defined in a multiplicity of ways in different disciplines and on different theoretical grounds. Its various definitions and fields of application constitute both its strength and its weakness as the term is often considered as too general and all-

embracing. As noted by Ragazzi, "Diaspora need not necessarily be specifically defined because it is, in fact, all of these things" (2012: 108).

Vertovec described the notion of diaspora as a state of mind and a sense of identity (1999). Continuous processes of identity negotiations shape the definition and the limits of what constitutes a diaspora. Clifford (1994) highlighted the point that diasporic identities are not fixed, but are instead marked by hybridity and continuous transformation. This view challenges the notion of fixed diasporic identities and instead sees it as a dynamic process. Moreover, diasporas are not composed of a homogenous group of people who nourish the same relationship with their country of emigration. As pointed out by Brubaker, "diaspora can be seen as an alternative to the essentialisation of belonging, but it can also represent a non-territorial form of essentialised belonging" (Brubaker 2005: 12). One must consider individuals who indeed wish to maintain connections with their country of emigration as well as with other co-nationals abroad as members of a diaspora.

The transnational lens allows us to understand members of diasporas as parts of wider communities, regardless of their geographical locations. Bruneau (2010) argues that:

> "a community diaspora first comes into being and then lives on owing to whatsoever in a given place forges a bond between those who want to group together and maintain, from afar, relations with other groups which, although settled elsewhere, invoke a common identity" (Bruneau 2010).

Faist pointed to the "ubiquitous politicization" (2010:18) of the term 'diaspora' and its reappropriation by state actors and also in the field of development. This is a point that I discuss in Chapter 5 where I describe the instrumentalisation of diasporas by States as well as by international organisations sometimes described as the "diaspora turn" in policy discourses and practices (Aguinas 2009; Ragazzi 2014). However, I also demonstrate how this categorisation is also reused and reappropriated by "diaspora actors" themselves, in particular by Tunisian civil society abroad, as a legitimate socio-political category.

To overcome the limitations around the usage of the term diaspora, Brubaker suggested looking at diaspora as "a category of practice (rather than as a category of analysis) used to make claims, to articulate projects, to formulate expectations, to mobilise energies, and to appeal to loyalties" (2005: 12). From the same perspective, the utilisation of the term "diasporic" highlights the constructivist approach toward diaspora as a social practice (Ragazzi 2012), as something being produced and reproduced across time and generations, as well as being the result of socio-

political processes (Mathieu 2019). This terminological shift emphasises the ongoing and dynamic nature of diasporic experiences.

Discussing the links and commonalities among different Black communities, Campt (2006) proposes to understand diaspora as a formation of dynamics of differences rather than as relations of unity and similarity. She further conceptualises diaspora as:

> "Space in which the relations, definitions, and identifications within and between communities come to materialize and to matter as "real" in ways that are strategically useful; these phenomena in turn "hail" and thus interpellate us in important political, symbolic, and often quite material forms" (ibid: 209).

Following the definitions from Brubaker and Campt, both the terms "diaspora" and "diasporic" are employed in this thesis to discuss the transnational healthcare practices of TRA. While I am aware of the critiques concerning the potential for essentialising groups, "diaspora" remains a valuable conceptual tool for several reasons. Firstly, it captures the complex and fluid nature of migrant identities and experiences, which are central to my study. Secondly, the term allows for an examination of the diverse and dynamic social networks that span across national borders. Finally, I use "diaspora" in a way that acknowledges and emphasises its internal diversity.

In the context of health, diasporas can build and rely on therapeutic networks, which are characterised by their transnationality. As discussed in the state of the art on geography of health, social networks have long been identified as powerful promotors of health. The notion of 'therapeutic network' (Smyth 2005), which derives from social network theories and is applied to the study of health, examined the role of these networks in promoting the health of individuals. Studies on reproductive health, for instance, show that these informal networks and the circulation of tangible and intangible care across borders contribute to positive birth outcomes among certain immigrant groups by creating a healthy environment for pregnant women (Viruell-Fuentes 2007; Zambrana *et al.*1997). The role of the family in pregnancy care, including advice and goods, in improving the health of the mother and the newborn has been explored in literature on migrant women's health. Communication means and technologies play an important role in building transnational ties (Levitt and Jaworsky 2007) and this virtual co-presence (Baldassar and Merla 2014) is essential to the construction and reproduction of transnational life trajectories. Virtual co-presence (ibid) allows women to access therapeutic resources and knowledge in migrant and diasporic spaces (Dyck and Dossa 2007). In his work on pregnant Bengali women in New York, Chakrabarti (2010) shows how daily phone conversations and communication with relatives back home provided women with a supportive

setting during their pregnancy and operated as "transnational social therapeutic networks of pregnancy care" (Chakrabarti 2010: 367). Healthcare advice and emotional support during pregnancy are provided through these transnational therapeutic networks, helping women to have a healthy pregnancy (Andrews 2004).

Through her concept of "transnational therapy networks", Krause (2008) describes the medical and spiritual knowledge circulation between Europe and Africa, highlighting the transnational dimension of health. Money, medication and prayers are circulating across borders within a transnational therapy network, providing financial and practical support for migrants in search of the right treatment.

The transnational ties that immigrants maintain, including the circulation of material and emotional support from the family and the community back home, shape their health and that of their family and community (Acevedo-Garcia *et al.* 2012). "Family members as sources of financial, emotional, moral and practical support across geographical distance and national borders" (Baldassar *et al.* 2006: 6) play an important role in the promotion of good health. According to the transnational family approach (Bryceson and Vuorela 2002), "non-migrants who stay behind in the home country and have kin across national borders also think and act in transnational ways" (Baldassar *et al.* 2006: 14). If they are not themselves moving, they are, however, not passive actors in building transnational ties and are, on the contrary, actively taking part in the circulation of care practices, both as recipients and as senders.

The literature on transnationalism, health and migration has placed a great focus on remittances, as an important transnational practice. In the following sub-section, we look at how this relates to health, and how this has been applied to the study of healthcare behaviours among immigrants and their families in the country of emigration.

2.2. (Medical) remittances as transnational practices

Remittances to migrants' countries of emigration have been largely explored in the literature and have also caught the attention of the political and economic sphere as a powerful vector of development (De Haas 2007). In addition to money transfers, Levitt suggests in her book *The Transnational Villagers* (2001) that migrants also export ideas and behaviours back to their sending communities - what she defines as social remittances. Levitt differentiates four types of social remittances: norms, practices, identities and social capital. Return migration or return visits to the country of emigration, the visits of non-migrants to the family in the country of

destination, and the continuous exchanges and communications through phone calls, videos, or social media are the media through which these social remittances circulate within the transnational social field (Levitt and Lamba-Nieves 2011).

The impact of migration on health has raised significant attention, and immigrants' strategies to respond to health care needs through remittances have been explored in the literature (De Haas 2007; United Nations Development Programme 2009). Other studies have also examined the relationship between remittances and healthcare outcomes and healthcare behaviour in certain places. Frank (2005) found that Mexican women whose partners are living abroad have lower rates of smoking, exercise more, and lived healthier pregnancies than Mexican women whose partner remained in Mexico. As postulated by Levitt (2001), remittances also influence norms and practices. Fargues (2006) examined fertility and reproduction and found a positive correlation between birth rate and migrant remittances in Morocco, Turkey, and Egypt. He observed that birthrates were decreasing among the families of migrants who went to Europe and increased for those who went to the Gulf countries. These differences are explained, according to him, by the influence of European values, including the practice of smaller family size, compared to family values, with larger families, in the Gulf countries.

While the focus on remittances highlights the role of migrants as "senders", there is also an important literature looking at return migration and transnational ties. Moreover, when looking at transnational practices such as remittances, it is important to consider the norms and values guiding them.

2.3.A moral economy approach to transnational healthcare practices

Beyond their economic function, studies have highlighted how remittances are regulated by norms, values and moral and social obligations underlying the relationship between migrants and their relatives in the country of emigration as well as between the diaspora and the authorities in the country of emigration. Initiated by Thompson (1971) and developed by Scott (1976), the moral economy approach suggests no longer studying economic activities solely from a material perspective but considering the social norms and obligations accompanying the economic functions occupied by a community. As its application to the most diverse social and geographical contexts shows, the use of the concept of moral economy in the field of socio-anthropology has been very fruitful. Its development has allowed for the consideration of the role of values (such as justice) in the resistance practices of marginalised populations.

According to Thompson (1971) and Scott (1976), "'moral economy' implies a relational conception of legitimation that invites us to think together about contestation and paternalism, patronage and rumour, deference to authorities and the injunction to behave like 'good authorities'" (Siméant-Germanos 2010: 145). It "refers to the conception of exchange based on norms of reciprocity" (ibid: 144), balancing the relations between authority and individuals. Siméant-Germanos (in Fillieule *et al.* 2020: 208) observes, however, that the use of the notion of moral economy has been loosening and underlines the interest of the concept to "think about the vertical link between elites and the governed, the transformations and crises of this link" (Siméant-Germanos 2010: 157). Fassin (2009) defines moral economy as "the production, distribution, circulation, and use of moral feelings, emotions and values, norms and obligations in the social space" (2009: 1257). Indeed, the sociology of emotions (Kemper 1978; Hochschild 1979; Goodwin *et al.* 2001; Traïni 2009) takes emotions into account in order "to consider their role in the processes of mobilization, militant socialization, maintenance of loyalty but also disengagement" (Sommier, in Fillieule *et al.* 2020: 222).

In the field of study of migration, Fassin (2005) also suggests that the moral economy approach allows for the analysis of the norms and values by which migration is framed and regulated. More recently, Lacroix (2019), following Carling (2008), argued that the transnational spaces in which migrants move are perceived by migration actors in terms of moral centrality and periphery and that, as a result, "these representations associated with space of migration feed a moral economy between migrants and those who have stayed" (Lacroix 2019: 3). The moral economy of migration is constantly in a state of flux as diaspora actors mobilise their financial resources and virtual capital acquired in their country of residence. To take into account the transnational dimension of the moral economy at play with social remittances, Solari proposes to talk about "transnational moral economies" (2019: 773). He argues that transnational moral economies are constructed and negotiated both by emigrants and their relatives in the country of emigration. Beyond purely utilitarian approaches to diaspora policies, the perspective of moral economy invites us to consider the role of values, norms, and emotions, in defining the relationship between emigrants and their relatives in the country of emigration as well as between home governments and their diasporas.

Through these different understandings of the concept of moral economy, I therefore intend to consider the role played by norms and emotions on two different scales: on a larger scale, between diaspora and country of emigration as well as on the interpersonal level, between migrants and their relatives in the country of emigration.

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3. Transnational medical mobilities

This section explores the literature on medical mobilities and how diverse mobile agents engage in what Langwick *et al.* called "transnational configurations of medicine and health" (Langwick *et al.* 2012: 15).

Following Appadurai's conceptualisation of scapes (1990), Hörbst and Wolf formulated the concept of "medicoscape" in order to encompass the practices, policies, individuals, and institutions that together shape the globalisation of healthcare. They defined it as:

> "landscapes of individuals as well as national, transnational, and international organisations and institutions, and heterogeneous practices, artefacts and things, that are connected to different policies and regimes of medical knowledge, treatments, and healing all around the world. While concentrated in certain localities, medicoscapes connect locations, persons, and institutions via multiple and partially contradicting aims, practices and policies" (Hörbst and Wolf 2014: 4).

The new 'mobility paradigm' (Sheller and Urry 2006) replaced mobility at the centre of the analysis of health, which was until then, largely approached through specific (national) medical systems and geographic locales (Dilger *et al.* 2012). Under the health-mobility nexus, mobility becomes "a means, an instrument, a strategy to facilitate therapeutic impacts or to unfold therapeutic powers" (Kaspar *et al.* 2019: 4). This conceptual lens acknowledges the importance of the interactions between health, medicine, and mobility in contemporary life and the context of the transnationalisation of healthcare. Studies on therapeutic mobilities, therefore, aim to explore how health mobilities shape and are shaped by individual and collective practices as well as by socio-material structures. Kaspar *et al.* defined therapeutic mobilities as follows:

> "Therapeutic mobilities consist of multiple movements of health-related things and beings, including, though not limited to, nurses, doctors, patients, narratives, information, gifts, and pharmaceuticals. These beings and things are made mobile through the work of multiple assemblages (including states, markets, non-markets)

> creating an infrastructure with the potential to unfold, develop and/or expand the therapeutic capacities of these inputs. Mobility can enhance, magnify, distort or intensify the therapeutic effects and powers of these inputs in motion. Mobility thus transforms the practice and product that is being moved" (Kaspar *et al.* 2019: 1-2).

The phenomenon of patients traveling abroad for treatment is not new. In studies of "therapeutic mobilities", health is an ethnographic entry point for studying mobility and transnationalism (Bell *et al.* 2015; Ormond and Lunt 2019). While it is generally assumed that patients prefer to seek care locally, the literature on transnational patient mobilities (Glinos *et al.* 2010; Sakoyan 2012; Musso *et al.* 2012) demonstrates that some conversely choose to travel abroad for care. By comparing health services in the country of residence with those abroad, patients thus decide where to seek care (Brouwer *et al.* 2003). Some medical care may be unavailable or difficult to access due to legislation, medical skills, or cost, and thus motivate the search for medical solutions abroad (Hottois and Missa 2001; Le Borgne 2007). The transnationalisation of healthcare consumption and provision challenges the dominant national imaginaries of health as a public good.

Looking at medical tourism, a significant amount of the literature on transnational medical travel has focused on the movement of wealthy individuals from higher income countries seeking care in the Global South (Ackerman 2010; Aizura 2010; Bergmann 2011; Mazzaschi 2011; Ramirez de Arellano 2011). In particular, the deployment of medical supplies in some Southern countries has encouraged North-South mobilities (Lautier 2013). Media images of medical tourism influenced the perception of these mobilities as being mainly the work of middle-class Western patients moving from the North to the South for cosmetic surgery, in particular (Connell 2016). However, the increase in the number of medical destinations as well as the diversification of patients' countries of emigration has indicated that there are new forms of medical mobility and practices as well as new models of health delivery (Lunt *et al.* n.d.).

Several criticisms have been made toward the "narrow" perception of medical tourism which overlooks the complexity and diversity of patients' profiles, type of healthcare, and determinants of medical mobilities. As pointed out by Rouland and Jarraya (2020), the study of medical tourism and medical travel have largely ignored its complexity and the "array of statuses, networks, economic resources, types of care, duration of the journey, and conditions of payment (e.g. private, subsidized or bilateral agreements) shaping health mobilities and patient profiles" (Rouland and Jarraya 2020: 2).

Subsequent studies on medical travel have challenged this perception and explored South-North mobilities where relatively wealthy patients from the Global South move in search of better healthcare facilities (Kangas 2007, 2010, 2011), as well as lower-income residents engaging in cross-border healthcare mobility (Dalstrom 2012). As outlined by Ormond and Lunt (2019), the establishment of appropriate terminology to define the phenomenon of individuals moving across borders for healthcare has raised strong debates. Several appellations have been suggested such as medical migration and medical exile (Ormond 2013). Broadly defined, transnational medical travel consists of "the temporary movement by patients across national borders in order to address medical concerns abroad that are (considered to be) unable to be sufficiently met within their countries of residence" (Ormond and Lunt 2019: 2). Moreover, one should also pay attention to the profile of these "mobile patients". Indeed, migrants and non-migrants alike are taking part in transnational travels. However, as stipulated by Ormond and Lunt (2019), people with migration backgrounds have long included transnational medical travel in their therapeutic coping toolboxes.

3.2.Diasporic medical mobilities

Transnational migrants make use of their multiple identities and involvements in both countries of emigration and country of residence, to creatively respond to their healthcare needs and the ones of their family. Villa-Torres *et al.* (2017) argue that "some transnational migrants create an ethnic identity flexible enough to be able to navigate multiple health systems and resources from different cultures". They further argue that "by embracing this flexible identity, these migrants take discretional advantage of their resources at hand, locally and/or transnationally" (Villa-Torres *et al.* 2017: 72).

Studies on diasporic medical mobilities, to which my thesis contributes, examine in particular the healthcare behaviour of diaspora members toward their country of emigration and explore how transnational connections can be created through the consumption of medical care (Horton 2013; Ormond 2014; Hanefeld *et al.* 2015; Mathijsen 2019; Şekercan *et al.* 2014, 2018). "While transnational community bonds are forged in multiple ways between people and their places of emigration, diasporic medical mobilities explore how bonds can be generated through healthcare" (Ormond 2014:1). Maintaining medical visits "at home" thus becomes an expression of the relationship migrants keep with their country of emigration, "a demonstration of identity, attachment, and commitment" (ibid). Motivations to seek healthcare in the country of emigration are multifactorial. These include the proximity to family, familiarity with the

healthcare system, trust in the 'culture of medicine', perception of quality of services, and dissatisfaction with the health system in the country of destination. Medical culture corresponds to the affinity between the culture of the patient and healthcare providers. It combines a country-specific medical culture, familiarity with the system, and the form of attention that is given to the patient (Wallace *et al.* 2009; Mathijsen and Mathijsen 2020). Wallace *et al.*'s (2009) work on Mexican immigrants in the US receiving care in Mexico shows that mobilities are partly driven by patients' perception of technical and interpersonal quality of healthcare providers. Conversely, perceived cultural distance from the healthcare system in the country of destination entails a lack of trust toward the system, while the feeling of being misunderstood or even discriminated against motivates the utilisation of healthcare in the country of emigration (Şekercan *et al.* 2014). Horsfall (2019) shows in his study on Polish migrants residing in the UK that multiple informal barriers, such as language and lack of knowledge on healthcare access to access formal entitlements to National Health Service (NHS), push them to seek healthcare in their home country. However, when they do seek healthcare in the UK, his respondents were generally dissatisfied with service delivery, primarily due to perceptions of under-medicalisation. Health services at home were conversely perceived as more familiar and more appropriate to their healthcare needs. The healthcare system in the home context is thus not only therapeutic in terms of the medical treatments it offers, but also in its emotional dimension through patients' trust in the medical culture, surrounded by familiar people and places (Lee *et al.* 2010). Lee *et al.* stress that the "analysis of experienced consumption spaces is informed by the perspectives of emotional geographies" (Lee *et al.* 2010:108) as people seek effective and affective medical experiences (ibid.). Their analysis of first-generation Korean immigrants to New Zealand seeking care in their homeland shows that Korean hospitals were emotionally 'therapeutic' as patients trusted the hospitals and "felt included and experienced a sense of comfort" (ibid: 114).

The pursuit of care in the home context is thus consistent with Gesler's (1992, 1993) concept of a "therapeutic landscape" as a place associated with healing. The comfort of being "at home" for treatment, surrounded by one's family and in places that one considers pleasant, participates in the therapeutic process. "Affective medical care" (Lee *et al.* 2010) signifies familiarity with the healthcare system and the search for a certain "culture of medicine" (Ormond 2014:3) perceived as 'more authentic' and placing trust in the competencies of 'their people' (Horton and Cole 2011). Mathijsen (2019) note that for certain types of healthcare, such as that

surrounding childbearing, the cultural dimension and having one's family around one might play a particularly important role as psychological support.

3.3. Transnational healthcare arrangements as transnational social protection practices

As described in the introduction of this thesis, the MitSoPro project, in which my research work is embedded, investigates transnational forms of social protection strategies put in place by migrants, their families and associative networks, states and private actors. Social protection, as a tool to reduce risks and vulnerabilities, has protective, preventive, promotional and transformative functions (Devereux and Sabates-Wheeler 2004; Loewe and Schüring 2021). It is intended to cover a specific set of risks including life-cycle risks, health risks and job loss/unemployment. Devereux and Sabates-Wheeler (2004) defined social protection as the combination of social insurance, social assistance and labour market policies. It can be divided into two categories: contributory, such as unemployment and pension, and non-contributory social benefits, such as family benefits, minimum income and healthcare. Many authors have considered the state as the main provider of social protection (Harvey *et al.* 2007; Neubourg *et al.* 2021) and examined it only in the framework of government programmes, while all other forms of risk management are thus considered as just "protection" (Loewe and Schüring 2021).

In the context of migration, scholars have been paying attention to specific needs that migrants may face in terms of social protection. As argued by Sabates-Wheeler *et al.*, "migrants move between countries and hence between distinctively regulated labour markets and social security systems, which creates specific vulnerabilities" (2011: 91). Indeed, social protection mechanisms were initially thought to accommodate the needs of a non-mobile population and are therefore ill-adapted to new mobility patterns. In addition, the economic crisis in 2008 and the Covid-19 crisis in 2020 are examples of sensitive times that have brought immigrants' access to social protection to the forefront of political debates questioning their legitimacy and deservingness to access social protection rights. Migrants are redefining social protection practices across borders. As argued by Sabates-Wheeler and Feldman:

> "Migrants often live and gain a living outside the parameters of the state. At times they strategically choose how to interact with state provisioning and negotiate other regimes of provisions that may be transnational, cross-border, charity-based or non-formal" (2011: 20).

The transnational turn in migration studies (Basch *et al.* 1994; Vertovec 1999) encouraged scholars to look at social protection needs in countries of emigration and residence. Studies have investigated the circulation of material and moral support through family and kinship ties (Hochschild 2000; Parreñas 2001; Yeates 2009; Kilkey and Merla 2014). Following this perspective, other forms of risk management through family and community have started to be considered as falling under social protection. In this regard, migration constitutes a safety net for transnational families, conceptualised by Yeates (2008) as "transnational social welfare".

Using the typology proposed by Smith and Guarnizo (1998) of transnationalism from above and from below presented earlier in the chapter, Lafleur (2019) identifies two types of transnational social protection (TSP) strategies: TSP "from above" and "from below". In doing so, he extends the understanding of social protection mechanisms from instruments that emanate from states to alternative instruments put in place by migrants themselves or by the private market. TSP "from above" refers to the formal strategies pursued by home country authorities to meet the social protection needs of citizens abroad through various policies and programs such as the International Treaty or Convention, the Bilateral Social Security Agreement (BSSA), and diaspora policies. However, several challenges impede the effective implementation of such policies. As questioned by Holzmann: "do bilateral social security agreements deliver on the portability of pensions and health care benefits?" (2016). In a pioneering work looking at the portability of pension benefits and healthcare benefits between the USA, France, Austria, Germany, Morocco, Mexico, the Philippines and Turkey, Holzmann, Koettl and Chernetsky (2005) had already demonstrated that in practice, several obstacles prevent migrants from accessing these benefits. They suggest that further research is needed to understand the limits of such mechanisms and enable their development. Following this call, I examine in Chapter 3 the case of Tunisia regarding healthcare benefits, and present ethnographic material on the use (or lack thereof) of BSSAs by TRA (Tunisians residing abroad).

Secondly, TSP "from below" refers to the strategies pursued by migrants using market, community or family resources across borders to meet their social protection needs (2019: 582). This is particularly relevant when state mechanisms are absent or ineffective or when institutional access is challenging. Indeed, when access to social protection is limited or insufficient in both the country of residence and of emigration, families, associative networks and the private market can constitute alternative forms of social protection. It extends the understanding of social protection beyond the realm of public policy. As demonstrated in the

literature on social protection and migration, these mechanisms are often used in a complementary way. Concepts such as “assemblages of social protection” (Faist 2013; Bilecen and Barglowski 2015) and “social protection arrangements” (Kilkey and Merla 2014; Vivas-Romero 2017) translate into transnational social protection practices of migrants that combine mechanisms defined as “formal” and “informal”. Indeed, the opposition between formal and informal is often not that clear cut, since informal mechanisms can be used to access formal mechanisms as actors combine social security benefits from countries of residence and emigration, use of the private sector, family practices and the associative network.

In my thesis, I apply this definition of transnational social protection to the case of transnational healthcare practices of Tunisian migrants and explore the use of diverse transnational healthcare strategies “from below” and “from above”. I discuss, through the different chapters of the thesis, the interplay between different forms of formal and informal transnational social protection strategies.

On the basis of this presentation of the state of the art, and after having detailed the theoretical frameworks on which this thesis is based, my conceptual contributions will be developed in my empirical chapters. My conceptual developments will revolve around the three following concepts: diasporic therapeutic arrangement, diasporic therapeutic network and medical home.

Chapter 2: Methodological choices, fieldwork sites and ethical considerations

Introduction

Ethnographic fieldwork is a challenging endeavour paved with unforeseen events, time constraints as well as many methodological and ethical questions that the researcher has to navigate to complete his/her research. Fieldwork is also a learning process and a form of "rite of passage" (Gennep 1909 [1981]) as its performance allows you to prove that you belong to the community of researchers. Those who already went through it share their experiences and recommendations, they warn you about mistakes to avoid and precautions to take. Some give you personal advice such as how not to let fieldwork impact your personal life and your mental health, giving you sometimes worrying prospects of the experience to come. All of them seemed, however, satisfied with the work they had done and enriched by the multitude of encounters they had had. In my mind, fieldwork seemed like a storm you had to walk through to find recognition on the other side. This is how I entered fieldwork: determined and ready to battle, wanting to move fast and be efficient, yet not allowing the fieldwork to put my personal life on hold. Being on the other side now, I can say that I was sometimes too impatient and sometimes too patient, too optimistic at times and too pessimistic at others. I do feel enriched by the encounters I had and filled with new knowledge and perspectives. I can also point out the mistakes I made and the intuitions I successfully followed. In this chapter, I, therefore, wish to reflect on my fieldwork trajectory by going through the methodological choices I made and the difficulties I encountered in the different fieldwork spaces of which this thesis is composed.

My thesis is embedded in different fieldwork spaces within different geographical locations, exploring therapeutic mobilities taking place from, to and between these different places. I adopted a different perspective on transnational healthcare practices, each time and, thus, each fieldwork site allowed me to examine a different dimension of therapeutic mobilities. Drawing

on data collected with Tunisian migrants and their families, Tunisian associations, Tunisian, Belgian and French public and private healthcare providers, and Tunisian, Belgian and French civil servants in the field of healthcare policies, I wish to map out, in this research, healthcare circulations and the various drivers of such practices.

In Belgium, I conducted fieldwork intermittently between 2019 and 2022, where I explored questions around interculturality in healthcare as well as Tunisian migrants' perceptions of the Belgian healthcare system. My fieldwork in Tunisia during the summer of 2019 and from May to September 2021 allowed me to observe the medical practices of Tunisians residing abroad (TRA) during their holiday visits back home as well as "holiday returns" as a therapeutic framework for my participants. Through an online ethnography, I explored the use of communication means and technologies in building transnational ties and transnational healthcare practices, but also as an instrument of mobilisation during the Covid-19 crisis. In November and December 2021, I conducted two short fieldwork stays in Paris which complemented the online data collection I had undertaken during the pandemic as well as my data collection in Tunisia regarding diaspora mobilisation during the pandemic.

Finally, I have also completed an extensive secondary data review: a critical discourse analysis of the policy context and the legal framework on social protection in Belgium, France and Tunisia to understand how this framework constrains or guides transnational healthcare practices.

In the first section of this chapter, I start by discussing the methodological approach of the multi-sited ethnography and the fieldwork continuities and disruptions that it created. I also discuss the impact of the Covid-19 pandemic on my fieldwork development as both disruptive and helpful. Secondly, I present my different fieldwork "spaces" in Belgium, Tunisia, France and "online", zooming in on the different fieldwork spaces I navigated in each of these locations. Throughout the chapter, the different sections also discuss my positionality. Finally, I also propose a reflection on the ethical approach of my research and its confrontation with the ethical requirements of the ERC project of which my thesis is part.

I. Multi-sited ethnography: fieldwork continuities and disruptions

My thesis is part of the MiTSoPro research project detailed in the introduction of the thesis. The larger project aimed to analyse strategies deployed by migrants and their families to access

social protection across borders and between their place of residence and their country of emigration. Starting from this postulate, I decided to conduct a multi-sited ethnography situated between Belgium, France and Tunisia.

Breaking with the tradition of classic ethnography rooting fieldwork in particular locales, Marcus suggested making ethnography mobile (1995) by following research objects. Following transnational practices in a migratory context involves incorporating "mobility" in the methodological approach as part of the research object under analysis. To understand how individuals, ideas, identities, narratives, conflicts, representations, etc. circulate, the researcher ought to follow them in the different spaces that compose the transnational social field (Levitt and Schiller 2004).

1. Fieldwork choices

My French fieldwork was a natural choice as it is home to most of the Tunisian diaspora and because the immigration history between these two countries is closely intertwined. France has the largest population of Tunisians residing abroad (Boubakri 2009; Kriaa *et al.* 2011). The colonial ties between France and Tunisia played an important role in migration flows between the two countries. The history of Tunisian emigration is closely intertwined with Europe as the primary destination of consecutive migration waves from Tunisia starting in the mid-1900s. The first migration wave to Western Europe was encouraged by a significant need for low-skilled workers to support the post-war reconstruction of the European economy. France was the main destination, and emigrants were primarily male temporary guest workers (Mensard 2004). Historically, Tunisian immigration to France was concentrated primarily around Marseille-Lyon-Paris and secondarily between Marseille-Toulon-Nice. Marseille served as an entry point rather than a point of attachment (Simon 1976). Until today, the largest proportion of the Tunisian diaspora in France lives in the Ile-de-France region (Paris, Val de Marne, Seine-Saint-Denis), with Provence-Alpes-Côte d'Azur ranking second and Auvergne-Rhône-Alpes third.

From the 1960s to the mid-1970s, a second migration wave of temporary workers was encouraged by Tunisia's signature of bilateral agreements with several European countries such as France in 1963, followed by Germany in 1965 and Belgium in 1969, which sought to regulate migration flows. In 1974, the beginning of the oil crisis marked a turning point, putting an end to guest workers' agreements and introducing visa regimes. These new regulations aimed at

encouraging temporary migrant workers to return to their country of emigration, but, instead, new policies of family reunification led emigrants to bring their families and to settle down in the destination country (Pouessel 2017). This marked the third migration wave, from the mid-1970s to the early 1980s. Finally, the migration wave from the mid-1980s to the mid-2000s was characterised by a skilled migrants pushed out of Tunisia by high unemployment rates among university graduates, along with immigration policies in Europe which encouraged the migration of high-skilled workers. Student migration to France, Germany and other European countries has also increased significantly (Natteur 2015). As emphasised by Pouessel (2017), there is also a small but historically important number of Tunisian emigrants who are political exiles under the Bourguiba and Ben Ali regimes (a point to which I will return below). A variety of profiles characterise Tunisian emigration to Europe today, with resident citizens composed of former exiles, student migration, migrant workers, dual nationals and irregular migrants.

In Belgium, the Tunisian diaspora is much smaller, accounting for approximately 35,000 individuals, according to the Tunisian consulate in Brussels. The significant difference of size of the Tunisian diaspora between France and Belgium as well as the limited number of studies conducted in Belgium offered an interesting contrast. Most studies on the Tunisian diaspora have indeed been conducted in France and Italy, which host the two largest Tunisian diasporas in Europe. The majority of the Tunisian population lives in Brussels, Liège, Gand and Renaix. This dispersion can be explained by the small numbers of Tunisians as well as by the diversity of migratory experiences and the significant number of mixed marriages which was common among Tunisian students coming to Belgium starting in the 1960s. In 1960, with the implementation of bilateral agreements, Tunisian immigration to Belgium was primarily low-skilled workers (Kriaa *et al.* 2013). As was the case in other European countries, the bilateral agreements favoured the settlement of Tunisians in Belgium, allowing family reunification after three months (Gsir and Mescoli 2015). With the oil crisis in 1974, a new influx of Tunisian migrants (mainly women) came to Belgium, primarily through family reunification (Gabrielli 2015). At the same time, irregular flows started to develop, in response to restrictions in recruitment. After 1970, Tunisian immigration to Belgium was mainly education-related (ibid.).

Finally, fieldwork in Tunisia allowed me to examine how transnational social protection strategies are constructed across borders and to examine the role played by the country of emigration, considering emigration and immigration contexts as two faces of the same coin (Sayad 1999). As mentioned in the introduction, the Tunisian case study had been determined

in collaboration with the MiTSoPro research team as one of the 12 non-European countries under investigation.

In the initial research design, the fieldwork was planned to place between cities as places where immigrants access social protection policies in the country of destination and diaspora social protection policies (through embassies, consulates and other emigration-related institutions). For my research, I had decided to focus on the cities of Marseille and Brussels, allowing comparison between a northern European city and a Mediterranean one, with the Tunisian community having different settlement patterns in the two cities.[6] As the fieldwork progressed, the "city component" diluted for several reasons. Firstly, most of the participants with whom I was in touch were often navigating between different cities in the same country or even in different countries. As described above, the settlement of the Tunisian community in Belgium, for instance, is spread between different cities with important concentrations in secondary cities like Renaix. After a promising exploratory fieldwork phase in Marseille in March 2019, the pandemic limited the possibilities to conduct further research there. Although very short, the exploratory fieldwork in Marseille at the beginning of the research was decisive in building my research approach and brought important dimensions to the thesis. The pandemic also imposed a reconfiguration of the subject under analysis and the French fieldwork therefore largely transformed into a virtual ethnography with associations and participants based in different cities in France.

As I describe in detail below, applying the methodological approach of multi-sited ethnography, I followed therapeutic mobilities within the transnational social space in between and across my different fieldwork locations. The multi-sited approach, did, however, run the risk of remaining superficial, due to restricted time shared between the different fieldwork spaces (Mazzucato 2016). As a matter of fact, the ethnographic requirement of an in-depth approach and long fieldwork in a given site (Malinowski 1963 [1922]) can hardly be met with a multi-sited approach. Multi-sited ethnography "assumes that researchers must trace social practices along their geographical paths of mobility in order to understand complex social phenomena in a globalized world" (Amelina *et al.* 2012: 6). Furthermore, following individuals or practices inevitably implies leaving spaces of interactions, even if only temporarily (Mazzucato 2016).

[6] The Tunisian settlement in Brussels and Marseille contrasts in terms of physical expression and presence within the city landscape. Walking through the city in Marseille, the Tunisian presence is indeed visible and has marked the urban landscape in some areas such as Noailles and Belsunce with a concentration in some streets of several Tunisian restaurants such as "Le Carthage", "La Goulette", "Le Sfaxien". In Brussels, the Tunisian population seems to be spread in different locations in the city and there is no noticeable "Tunisian centrality".

Also, throughout my research, immersion in one fieldwork site implied a partial exit from others. Moreover, returning to one fieldwork site after a long absence implied renegotiating the position I had gained before leaving.

This constituted one of the main challenges of the multi-sited nature of my research as maintaining contacts with the different fieldwork sites simultaneously required creativity but also important logistics. The use of social media played an important role in that regard, an aspect to which I will come back later in the chapter. Yet, choices constantly had to be made and I would often be pulled between my different fieldwork spaces. In Belgium, this was often further complicated by the fact that I was also splitting my fieldwork time with university obligations in Liège and my personal life in Brussels. As Marcus phrased it:

> "in conducting multi-sited research, one finds oneself with all sorts of cross cutting and contradictory personal commitments" (Marcus 1995: 113).

The researcher has to renegotiate identities in different sites. The pandemic would only further intensify this problem. This time however, fieldwork discontinuities were imposed by the lockdown, the difficulty or even impossibility of meeting participants in their private homes or in cafes, as well as by travel restrictions.

2. Fieldwork in Belgium

2.1. Entering the Tunisian social spheres in Belgium

In March 2019, I was starting my explorative fieldwork in Belgium. At the time, the research objectives of the thesis were still rather blurry and although I had the general framework in mind, I was open for it to change. The fieldwork started in Liège, as I met the sister of a friend and ex-colleague of mine from Tunis with her Tunisian friends living in Liège. Indeed, I lived and worked in Tunis between 2014 and 2017. I moved there to complete an internship with the International Organization for Migration (IOM) and ended up working for the Tunis office for some time.

The years that I had spent in Tunisia played a central role in my fieldwork. It not only allowed me to build on previous contacts in Tunisia but also on shared experiences of the place as a country that I had also inhabited for some time. In fact, in the relationship building with the actors of my research this turned out to be a key element, a commonality which created bonds. In their eyes, this seemed to give "credit" to my endeavour. On many occasions, when

participants were questioning me about my research choices, my previous life in Tunisia and the fact that it is where I met the person who would later become my husband, seemed to provide a better explanation as to why I had decided to work on Tunisia than any other scientific explanations I could provide. They would often react to that anecdote laughing: “you owe something to Tunisia, that’s why”. This was an interpretation which was partly true and partly wrong. As I mentioned above, the Tunisian case study had been determined by the research project MiTSoPro as one of the 12 non-European countries under investigation.

On a personal level however, I was indeed particularly interested to work on the Tunisian case as I had myself built a connection with the country while living there. I also nourish an emotional attachment to it as it has been my home for a little bit less than 3 years, a place where I grew as an adult and met some of my closest friends. Moreover, without necessarily being aware of it at the time, working and leaving in Tunis was satisfying a curiosity I had had since childhood - to get to know the Maghreb region where I have family origins, and to try to learn some Arabic. My mother was born and raised in Morocco by Jewish Moroccan parents and left for France and then to Switzerland to pursue higher education when she turned 19. The whole family eventually moved to France in the 70s and has been living in Paris since then. My mother met my Swiss father and remained in Switzerland. I therefore grew up receiving a mixed education and I am a descendant of a Judeo-Arabic culture. If I am writing this here, it is because I believe that this also played a role at times in my relationship with some of my participants. I personally felt that on many occasions I could strongly relate to the understandings of some of my participants of family relationships and obligations, for instance. On the side of some participants, this also seemed to provide a common ground: “we have the same mothers” (Ons, Brussels, February 2020).

Finally, since the beginning of the thesis I have been taking classes in Tunisian Arabic dialect. This also contributed to facilitating exchanges with participants and in situations of participant observation where participants were discussing in Tunisian dialect. Moreover, the Tunisian dialect presents the particularity of being largely mixed with French terminology (in particular when spoken by people coming from the region of Tunis) which once again, facilitated my understanding and my ability to engage in conversations. It should be said, however, that the majority of my participants spoke fluent French and most of my exchanges were in French.

2.2.Tunisian associations

Coming back to my access to fieldwork in Belgium, in order to diversify my fieldwork entry points, I approached several Tunisian associations in Brussels, Liège and Renaix. Since the Tunisian community is rather small in Belgium and quite dispersed between different cities and different neighbourhoods, I could not access fieldwork through Tunisian "immigrant centralities" (Battegay 2003). Therefore, I reached out to several Tunisian diaspora associations. To find relevant community associations, I first carried out a systematic search on the internet and social media pages using keywords. I also followed activities and discussions on social media, looking at events dedicated to the Tunisian community in Belgium.

The majority of the Tunisian associations that I have been following in Belgium are cultural associations that were created after the revolution in 2011. They aim to promote Tunisian cultural heritage and create ties within the Tunisian community. Also, the majority of the events that they organise are connected to cultural or religious celebrations where members of the community gather and have the chance to meet each other. Several associations are, for example, very active during the period of Ramadan where they organise gatherings for *"Iftar"* (end of the fast). They also regularly organise events, such as concerts, dance performances, food festivals, handicrafts exhibitions, etc. Other associations have political activities and were therefore particularly active during elections, organising political debates and conferences around the presidential and legislative elections. Participant observation at these events allowed me to get in touch with people revolving around the associations, active as well as passive members. Moreover, key actors within these associations often helped me get in touch with the people in their network by directly introducing me to other members of the associations but also family members and friends. Attending these events allowed me to keep regular contact with association members and also to meet new people from the Tunisian community. Those first participants facilitated the identification of further contacts within the community through the well-known 'snowball effect' by which initial contacts with whom trust is built facilitate the expansion of the sample thanks to the recommendation of participants (Bradshaw and Stratford 2005).

Participants I met through the associations were very diverse, belonging to different age groups, different social classes and from the first and second generations. The associations were usually led by people who had been living in Belgium for a very long time (20-30 years). Some of them are even led by members of the second generation (in the city of Renaix in particular). In the

first phase of the fieldwork, I did not try to restrict myself to one category of person in particular, as these interactions also allowed me to familiarise myself with the composition of the Tunisian diaspora in Belgium and to understand the dynamics at play. In the particular trajectories that I later decided to follow individually, I then narrowed down my sample of participants. I will come back to that point below.

Participating in these events, although not directly related to questions on healthcare, allowed me to understand the different types of transnational practices in which people were involved. Moreover, I would soon realise that discussions on healthcare were often emerging in such contexts, through discussions regarding their relatives back in Tunisia, conversations between women about their children's health issues, pregnant women discussing the arrival of their mothers in anticipation of their delivery, bringing with them a different type of "traditional" medicine from Tunisia. When this was the case, I would often contact the person afterwards to discuss the matter in more detail and in a more private environment. Catching on elements of conversations during these events allowed me to explore with my participants practices that they would often not have thought of presenting me otherwise. After some time, my presence had become natural if not expected to some of these events, and people were aware of my position of researcher.

2.3. "Let's meet in Belgium": networking events.

Living in Brussels, I had the opportunity to slowly familiarise myself with the Tunisian diaspora[7] landscape in Belgium "online" and "offline". Since the beginning of the thesis, I have been following the Facebook pages of Tunisian consulates and associations as well as public groups for Tunisians in Belgium. Those social media pages allowed me to get a sense of the type of events that were organised by the different associations and to get in touch with people by attending those events myself. Over the course of the two first years of the thesis, I met important actors involved in the diaspora in different Belgian cities. Some of them had been easy to identify through their regular posts on the different Tunisian Facebook groups in Belgium. They were indeed playing the role of "facilitators" or "intermediaries" and shared on social media platforms news of important events taking place in Tunisia, communications made

[7] If I choose to talk about "diaspora", it is because the concept encompasses different elements that I discuss in this thesis. A detailed discussion on diaspora is provided in Chapter 1. Diaspora includes, in my understanding, individuals, associations as well as politically engaged civil society actors who engage in multiple exchanges as well as symbolic and objective solidarities. The concept of diaspora also refers to a common identity, an emotional bond to the country of origin and expressions of solidarity (Schnapper 2001; Bordes and Schnapper 2006).

by the consulate regarding administrative procedures and cultural and social events organised by different associations. I would quickly meet them in person in many of the cultural events organised by associations and have remained in close contact with several of them throughout the thesis.

As a point of entry, I therefore identified persons particularly active on the administrations of Facebook pages of Tunisians in Belgium to identify key actors from the Tunisian community. On some occasions, such as for booking special events, community dinners, etc., I got a first contact with participants over the phone, through social media, or by email. This sometimes gave the opportunity for a fortuitous encounter. Once, as I was coming back from Liège (where my university is based) to Brussels (where I live) I contacted an event organiser on Facebook to try to get a ticket to an event celebrating the Tunisian Independence Day in Brussels. The event was announced as full, but I wanted to see if there were other possibilities to get a ticket. I contacted him on Facebook, and we started to exchange briefly on my research. As we were chatting on Messenger, we soon realised we had friends in common from Tunis, through Facebook indications of "common friends". We kept writing to each other and eventually realised that we were sitting on the same train to Brussels. We therefore decided to meet at the train station upon arrival. This is how I met Ramzi who would later become one of my key participants and also a resource person, as he was very active in the Tunisian community in Belgium. On that day, for instance, he was on his way to a networking event in Brussels taking place every week and suggested I go with him. I spontaneously followed him to the event which turned out to be one of my key fieldwork spaces in Brussels.

These events aimed to put young professionals from diverse origins and professional spheres in contact with each other. As the organisers of these events are Tunisian, it was also a place for Tunisian young professionals and students to socialise with other Brussels-based Tunisian workers but also professionals from other nationalities. As Ramzi explained to me, the idea behind these events is to encourage Tunisian professionals to mix with other nationalities to favour their integration but also to create work opportunities. Ramzi had successful examples in mind of Tunisian young professionals who found their current jobs through these networking events. They also seemed to be (even more) successful at bringing couples together. Through this fieldwork space, I therefore got in touch with several participants. Most of them were quite young, between 20 and 40 and had been in Belgium for less than 5 years. As some of them had "just landed" in Brussels, it was also an opportunity for me to follow their journey in Belgium almost from its beginning. Some of them were in Belgium with long career prospects but others

only for a short period of time. I met people working in IT, international commerce, engineering, dentistry as well as medical students, paramedics, etc. but also people in irregular situations or with refugee status in Belgium. This space offered a different perspective from the association landscape, which is generally composed of individuals who have been living in Belgium for a longer period of time, from a different generation who left Tunisia before the revolution. Despite the official aim of the event, they were also a moment of socialisation with other Tunisians in Brussels. Also, as I discuss in Chapter 3, these spaces of socialisation were also places of informal exchanges, allowing me to explore mechanisms of so-called social protection "from below" (Lafleur 2019), based on social network and community ties.

From there I then "followed" some participants in particular, those with whom I had created a privileged bond. I met regularly in Brussels in coffee places, in their house, taking part in activities with them, and meeting their relatives if they were also living in Belgium.

Over the months I had consolidated my relationship with some of my participants. After having preferred open discussion or non-structured interviews for the first part of the fieldwork, it was necessary to come back to certain subjects that we had touched upon. When conducting semi-structured interviews with participants that I had known for a long time, I would usually record the conversation with their agreement. I also prepared an interview guide with key questions to guide the conversation. I also conducted semi-structured interviews with the Tunisian embassy and the consular representation in Brussels.

2.4. Women's and reproductive rights associations

My initial thesis proposal was focusing mainly on sexual and reproductive healthcare. During the first part of my fieldwork in Brussels, I therefore explored different avenues in relation to female migrants' sexual health. I started by following activities from several associations in Brussels that are dedicated to migrant women and who organise several awareness-raising events on sexual and reproductive health. I also took part in some of their activities such as movie screenings, sewing and cooking workshops. This event aimed at offering a space of socialisation and of conversation for migrant women. They were indeed rich spaces and discussion would quickly shift to issues around healthcare access, pregnancy and maternity. The image below (Figure 1) is a painting that was made by a woman attending a painting workshop and which was on display at the association.

Figure 1: Painting on the wall of a women's association in Brussels

Source: picture taken by the author, March 2019.

However, Tunisian women were rarely present in these associations, or only in very small numbers. The "absence" of Tunisian women from these associations was explained to me, on many occasions, as being a byproduct of Tunisian women's advanced access (compared to Morocco, Egypt or Algeria) to sexual and reproductive rights in Tunisia, a point that I analyse in detail in Chapter 3. The data collected through participant observation in those events and through semi-structured interviews with representatives of the women's associations were very useful to better understand the debates over sexual and reproductive rights. I nonetheless had to reconsider the role of these associations in my fieldwork. In addition, after my return from my first fieldwork stay in Tunisia, during summer 2019, I decided to expand my observations to expand beyond sexual and reproductive health, including with a more general exploration of people's attitudes toward healthcare in Belgium and in relation to the home country. This fieldwork space allowed me to understand the role of feminist associations (focusing more specifically on the Arab world) in promoting sexual and reproductive wellbeing and rights as well as access to sexual and reproductive healthcare for migrant women in Europe. It provided me with insight into discourses around sexuality, motherhood, marriage, sexual and

reproductive rights for migrant women from the "Arab world". Reflections emerged from this fieldwork on interculturality in healthcare, as well as the gendered and racialised perceptions of patients' needs by healthcare professionals and, finally, on how healthcare systems adapt (or not) to the needs of an increasingly culturally diverse population. From that perspective, I have analysed pedagogic tools designed by these associations for healthcare practitioners on the management of cultural diversity in a medical situation, and, in particular, with regards to sexual and reproductive health of women migrants from the "Arab world". Furthermore, this fieldwork led me to one gynaecologist/sexologist in particular who is based in Brussels and very active in the feminist associative landscape. She is of Tunisian origin and was herself born and raised in France before moving to Belgium for work. Through her medical practice and activism, she aims to bridge the gap between misconceptions on sexuality of women from Arab Muslim backgrounds and to raise awareness on sexual and reproductive health. With her guidance, I started following medical doctors/ activists online which I detail later in this chapter.

4. Fieldwork in Tunisia

During summer 2019, I visited Tunisia for a first fieldwork stay for a little bit less than 2 months. Two years had already passed since the last time I had visited Tunisia for the wedding of a close friend of mine. I was excited to be back, to revisit familiar places in Tunis. I decided to stay with one of my friends. Entry into the Tunisian fieldwork was therefore rather smooth. No need to find my ways through the city or to familiarise myself with it. I was back in an environment I already knew how to navigate. A first step in fieldwork is always dedicated to familiarising yourself with the geography of the place where you are conducting research, understanding its structures and hierarchies. In that regard, Tunis was a place I knew a lot better than Brussels, where I had only settled in November 2018, a month after starting my thesis.

I went to Tunis with the intention of conducting exploratory fieldwork and to identify different avenues I would follow. One was meeting some of the participants I had met in Belgium and who were on holiday Tunisia. I was considering holidays returns as a decisive time/space for the circulation of practices across borders (Baldassar *et al.* 2006). I had coordinated with some individuals to be sure that I would be in Tunisia around the same = time as their holidays. I also paid attention to the dates of the *Eid el Kebir* celebration that was taking place in August that year. I therefore knew that several TRA would be travelling back to Tunisia during that time. Moreover, the summer in Tunisia is a period of the year where large numbers of TRA return

from Europe to visit their relatives, making it an excellent time for the observation of transnational healthcare practices. I took the plane from the Brussels airport with one of my key participants. We did not really plan it, but we happened to be booked on the same flight. Sharing the anticipation and preparation for the trip was insightful in many aspects. On many occasions, when participants were preparing for their trip, I would accompany them in Brussels, shopping for their relatives back home.

4.1.Following participants through their therapeutic journey

When in Tunisia, meeting with my participants in their family context, meeting their relatives, and also taking part in some of their holiday activities brought great insight into their family relationships, their relation to the place itself, and their use of their time in Tunisia as a source of wellbeing. This fieldwork helped me to reflect on the holidays in the country of emigration as "resourceful". I accompanied participants on several activities such as walks by the sea, spent time with them at the beach and swimming, went for lunches or dinners at restaurants they wanted to go to during their stay or ate specific food they wanted to eat during their stay. I visited their apartments in Tunis, in cases where they had one, and they showed me around their neighbourhood. I also stayed with the families of my participants.

Moreover, following participants allowed me to understand the type of administrative procedures that people undertake while on holidays in Tunisia, sometimes in relation to social protection (such as seeking information regarding pensions rights, etc.). On this occasion, I could also observe that, among my participants, some of them were also using their time in Tunisia to pursue healthcare (annual check-up, visit to the family doctor, gynaecologist, dentist, ophthalmologist etc.). This observation was the trigger for me to start exploring different forms of healthcare practices in the country of emigration.

In order to have the perspective of healthcare professionals on the medical returns of TRA, I conducted semi-structured interviews with a number of medical doctors from different specialties: gynaecologists, psychologists, dentists, and aesthetic surgeons, as well as several healthcare professionals and entrepreneurs such as midwifes, medical secretaries, clinic directors and medical tourism companies, and civil servants in the field of healthcare policies. I conducted interviews with other representatives of state institutions such as the National health insurance fund, the National social security fund, and the office of Tunisians living abroad.

My second fieldwork stay in Tunisia took place from early May 2021 to the end of September 2021. The economic crisis that the country had been experiencing over the past few years was only worsened by the pandemic. When I landed in Tunis on 1 May, almost 2 years after my first fieldwork stay, we were just 10 days before *Eid el-Fitr* which marks the end of the period of Ramadan. The pandemic played a role also: I had to move my departure date up by a few days, as the Tunisian authorities announced at the end of April that they were going to impose, once again, compulsory quarantine for 7 to 10 days in state-appointed hotels. I quickly changed my tickets and left a few days earlier to be able to quarantine in private accommodation upon arrival, rather than in an expensive hotel room. Once again, I was travelling with one of my participants, who also decided to leave earlier. The announcement of these measures was met with discontent among the diaspora, as many were planning to visit their family for the end of the Ramadan and had to cancel their trip at the last minute. Moreover, this was also another hard blow for the tourism industry. We were just a few people walking out of the airport, and the line of taxis waiting clearly exceeded the number of passengers coming out of the airport. The taxi pick-up outside the airport was always a bit chaotic, a scene with which I was very familiar from the many back and forth journeys I had done between Tunisia and Switzerland while I was living here. This time however, things felt different, and I had never seen taxi drivers battling so much for the customers - to the point that a fight started, and the police intervened to dissipate the crowd that had formed. I finally got into a taxi and asked the driver about the incident. He explained that people were frustrated because everything had been closed for months and people were not using taxi services as much as usual. With authorities imposing travel restrictions again, passengers would not be allowed outside the airport anymore, and would be taken by shuttles directly to their hotels. Many taxi drivers counted on the TRA returning for the end of Ramadan to make a little bit of money. Ramadan is usually a joyful time and there is a special atmosphere in the evening: at the time of *iftar*, the streets get quiet as people eat in their home or inside restaurants. Once dinner is over, people usually go out for walks and tea, and there is a festive mood with music and food stands everywhere. Not this time. The restaurants and the coffee places were closed due to Covid-19 and streets remained empty.

This second stay therefore was marked by Covid-19 which restricted fieldwork possibilities. Travelling within the country was difficult for most of the fieldwork as cities were put in lockdown. At some point in time, travel restrictions were even imposed within the city of Tunis, prohibiting movements in between neighbourhoods. Partial lockdown was imposed during most

of my stay. As a result of the upsurge of Covid-19 cases, many TRA cancelled their trips to Tunisia, including some of my participants in Belgium and France, which posed some challenges for my fieldwork. Moreover, even when participants were in Tunisia, it was sometimes difficult to meet, with the Covid-19 restrictions. Many of them were also concerned about the health of their relatives and therefore decided to avoid gatherings or bringing people into their homes as much as possible. For my part, I was also very concerned about the possibility of potentially contaminating participants, knowing that many of their relatives had not been vaccinated and that the healthcare system was constantly saturated, a point to which I come back in the section on research ethics.

Another dimension that I explored during this second period of fieldwork was the mobilisation of the Tunisian diaspora during the pandemic. At the beginning of the pandemic, while I was stuck in my Brussels apartment, I followed different Facebook groups of Tunisians living in Belgium and France and checked pages of Tunisian associations, as well as paying pay attention to the ways in which the Tunisian diaspora was mobilising in order to support their country of emigration. I was already following mobilisation through an online ethnography that I detail later in this chapter. Since the Covid-19 crisis hit Tunisia badly during the summer of 2021, I therefore tried to follow the mobilisation of the diaspora from Tunisia. I met with some of the participants I had been in touch with during the first lockdown through online meetings and phone interviews at the time. In summer 2021, who were in Tunisia during the summer coordinating the sending of medical and sanitary equipment. I also conducted interviews with a representative of the Ministry of Health responsible for the management of donations from TRA.

4.2. *Fieldwork in Fertility clinics in Tunis*

My early fieldwork had already revealed the emotional dimension of seeking care in the country of emigration. After reading several studies on reproductive mobility and on the specificities of the emotional burden that accompanies it, it seemed relevant to me to explore this medical practice during my fieldwork in Tunisia. Before my arrival, I had identified several main clinics with fertility centres in Tunis and made a first survey of the information available online. Some of them have a strong internet presence, with pages on social networks and hotlines to ask questions. From Belgium, I wrote to several of them by email, Facebook Messenger and via their platform. The clinics were quite responsive and quickly confirmed their availability in August by offering me medical forms to fill in remotely, with information on I was looking for and the medical interventions I wanted to do during my stay. I also consulted a large number of

forums where Internet users, mainly women, exchange advice on the best gynaecologists-obstetricians and fertility centres, and share their therapeutic experiences in Tunisia.

Upon my arrival in Tunis, I visited several clinics that have fertility centres. In order to facilitate this first contact with the clinics and to respect the ethical procedures imposed in the framework of my research project, I wrote a brief document presenting my research by adding my contact information, the name of my research director and by placing the logo of my university at the top of the page in order to formalise the document. Hospitals are institutionalised and hierarchical spaces and, without prior contacts, it seemed to me to be the best approach to use the same institutional language to access the field. Moreover, most of the clinic directors and gynaecologists I would meet during those first encounters were men and I, as a woman, was not always taken very seriously. Using the institutions behind my thesis helped me negotiate power relations in the ethnographic situation.

On the same day, I went to five different clinics. The same scenario was repeated: I presented myself at the reception desk with my document and briefly explained my request to the medical secretary. They did not seem particularly surprised by the request, and I was kept waiting in the waiting room.[8] I conducted a first round of interviews with gynaecologists working within the clinics and discussed informally with medical secretaries.

I then identified one clinic in particular which was particularly responsive to my request and who was ready to let me conduct my research within their walls. In agreement with the management of the clinic, I went to the fertility centre every day to follow the activities and to discuss with the patients and the medical staff. The consultations started early in the morning until 2 or 3 pm in the afternoon. I spent hours observing interactions within the fertility centres, registration of couples at the reception, dynamics in waiting rooms, the constant back and forth of the midwife coordinator and the brief appearance of gynaecologists.

The midwife coordinator, who was familiar with the follow-up of patients' files, was an essential resource person in the conduct of my fieldwork by helping me identify Tunisian patients from abroad, many of whom were from Algeria, in addition to those from Europe. I also conducted in-depth interviews with her, going into detail about cases of TRA who had come to the clinic since she started working there.

[8] It is possible that, in some of the centres, the recent visit of the research team of the project "Cross-Border Reproductive Care in the Maghreb (CBRC): an emerging reproscape?" contributed to "normalizing" my request.

When I returned to Tunis in May 2021, I started the fieldwork by getting back in touch with the fertility centre with whom I had already been conducting fieldwork during my last visit in 2019. Getting in contact with the doctors and the clinic was relatively easy, as I had remained in touch since the last fieldwork. The situation had, however, changed since the last time, as the midwife coordinator with whom I had been working was no longer part of the team. Moreover, after a year and a half of difficult conditions due to Covid-19, the place had quite another atmosphere as several patients from abroad, including Algeria, were not allowed to travel to Tunisia at this stage. As a result, the clinic was rather calm, and waiting rooms were not as full as during the first fieldwork period. Discussions with the staff and doctors in the clinic regarding these changes were in a climate of great uncertainty. If the centre had managed to get through this first year of Covid-19, they were counting on patients being able to return to make up for the losses. I nevertheless was able to get in touch with several couples by engaging with them in the waiting rooms. The couples this time were, for the most part\, local patients. Conversations were easier than during the last period of fieldwork at the centre, as my Tunisian Arabic had improved and I could introduce myself and my research in Tunisian. Indeed, I had trained with my language teacher and had learned a vocabulary related to my topic that would help me discuss with participants. This helped to facilitate discussion, even if, most of the time they went on to speak in a mixture of Tunisian and French.

When the pandemic started to worsen towards the end of June 2021, fieldwork within the waiting rooms was not appropriate anymore and the number of people inside the clinic was also limited. Next to the main reception of the clinic at the entrance of the building, bottles of oxygen were stored for the Covid-19 patients, as the clinic had located a Covid-19 section in the emergency room. On the side of the clinic, a refrigerated truck was parked and a tent was installed. The atmosphere in the fertility centre suddenly changed and Covid-19 added an extra layer of distrust in a fieldwork setting which was already difficult to navigate. Creating intimacy with the couples while wearing masks and respecting (as much as possible) distancing measures was difficult. I therefore decided to change my fieldwork plans and started conducting fieldwork within the medical office of one of the gynaecologists working with the fertility centre.[9] In fact, even if some couples get in touch with the clinic itself, most of them go through the gynaecologists' offices. In coordination with the gynaecologist (who I refer to as Dr. Khalil in Chapter 4) and with the midwife of his medical office, I was introduced to couples of TRA

[9] Fertility centres are indeed co-owned by several gynaecologists who also have their private practice outside of the clinic.

coming for their consultations. On many occasions, the gynaecologist would also contact the couples before their appointment to ask them if they would be willing to discuss with me. I was then able to conduct interviews with the couples or with the woman if she came to the consultation alone. The doctor had given me access to an empty office space where I could conduct my interviews. I was also put in touch with some couples who were still abroad and were in the process of planning their journey to Tunisia, and I could conduct interviews over the phone. I also met some of these couples face to face at the time of their first medical visit to Tunis. In three cases, I also met with the patients on the day of their procedures and met them in their hospital rooms. This was very useful for observing interactions with the hospital staff before and after their procedures. When I was not interviewing patients, I would engage in observation in the waiting room of the medical office as well as discussing extensively with the midwife and secretary, looking at how patients were monitored from abroad before arrival and how their medical follow-up was planned once they arrived.

Finally, during this second fieldwork phase within the clinic, I also conducted interviews with the director of the clinic, medical director, director of strategy and innovation as well as with the departments of accreditations and communication.

The atmosphere in the centre was always quite heavy. People were in general sitting in waiting rooms in silence and during the first days of fieldwork, I was very uncomfortable coming up to them and introducing myself. The waiting area was composed of small waiting rooms in which you could fit around four people when seated. They had doors that you could close in order to maintain intimacy. However, at times, the clinic was overcrowded, and people were standing in the waiting rooms. On the walls they had hung images of flowers that subtly suggested the female anatomy. Other pictures were representing newborn babies coming out of flowers. Having these pictures on the walls made sense yet also felt violent to me. As a fertility clinic, these represented the hope of all the couples sitting in these waiting rooms. All of these contributed to building a particularly difficult atmosphere.

Getting used to the atmosphere of the clinic took some time. I was going from one waiting room to another, talking with patients as they came in. When I was engaging in conversation, I would start by introducing myself and presenting the purpose of my research. At this stage I was not limiting myself to couples that I could identify as TRA, and discussed with couples from different countries[10] as well as “local couples”. When they gave me their consent to ask them a

[10] I talked with couples from Algeria, Mali, Gabon, Ivory coast.

few questions, I would take a seat in the waiting rooms and engage in conversation. The length of our exchanges would vary according to the waiting times. I was not recording and would simply take notes of the conversation. In fact, recording in this context was not appropriate as people could walk in the waiting rooms at any time. Moreover, asking to record the conversation was taking the risk of further formalising an atmosphere that I was trying to lighten. If some couples seemed rather happy to share a moment in my presence, stressing that it helped them relax while waiting, others were anxious and would cut the conversation short. Whenever I was sensed fatigue on their part, I would end the conversation and leave the waiting room. Sometimes, they would be called into consultation and the conversation would end there.

As pointed out in a collective paper with my colleagues Betty Rouland and Irène Maffi (2023), moving around within the fertility centre required an adapted methodology, concerned with preserving the privacy of infertile couples. Collecting data on such sensitive subjects in fact requires the researchers to respect an ethnographic "moral pact" (Fassin 2008) to protect patients. The fieldwork highlighted the role of “politics of patronage” (Inhorn 2004) in accessing data and meeting couples in the fertility centre. A primary agreement with the clinic management as well as the managers of the fertility centre enabled access to the field, but also helped to establish a relationship of trust between the hospital staff, the infertile couples and the researchers. We thus found ourselves practicing an intimate ethnography caught up in social relationships characterised by strong physical and/or emotional closeness involving the spheres of the body, sexuality and care (Waterstone and Rylko-Bauer 2006; Constable 2009).

Exchanges between the patients and the researchers take place in spatio-temporal configurations specific to the field of investigation: while waiting for an appointment, a diagnosis or medical check-ups. Non-verbal language, crying and silences, were therefore an integral part of the biographical narrative and symptomatic of the emotional experience lived by patients who resort to ART. For the researchers, the space of the clinic and the time of the interview involved temporarily entering into the couple's intimacy. On many occasions, couples welcomed the opportunity to discuss their journey and did not hesitate to share their experience. Indeed, these moments of exchange often took on a cathartic dimension. I was in fact regularly asked by couples to pass on a message: "it's good if you talk about this in your work, because mentalities don't evolve and that's unfortunate" (Amir, July 2021, Tunis).

Due to the sensitivity of the topic, two elements of methodology that I had planned to set up did not succeed. I had planned to follow patients into consultation and had obtained the authorisation from the clinic to do so. We had agreed that the midwife would be asking patients

for their authorisation for me to join the consultation. Most of the times, however, they refused. Although we only tried with a small number of patients, only two women agreed that I join their consultation. The second element was to try to keep contact with patients outside of the clinic. One day as I walked out of the clinic, I bumped into a couple I had just discussed with earlier during the day. I smiled at them and asked them if everything went well but I could tell that they felt embarrassed and despite the very informal conversation that we had had the same morning, our exchange sounded very formal, and they cut the conversation short. The walls of the waiting rooms and the "time waiting" created ephemeral intimacy, which vanished completely once we stepped out, even just to the reception area of the fertility centre. To avoid meeting them in the reception area, and to avoid this discomfort to the participants, I later waited a sufficient time before walking out of the centre.

4.3. "Do you want children too?": positionality on a sensitive research topic.

Being a woman of "reproductive age" played an important role in my research positionality. As I briefly mentioned before, I was not ready for what I would come across within the walls of the clinic. ART was something new to me and I had only a vague idea of the journey couples go through. The taboo that still surrounds infertility makes one rather ignorant about what it really involves and, most importantly, the psychological impact it has on many couples: "it feels like someone pressed pause, and your life is on hold, you are just waiting and waiting" (Sahar, Tunis, August 2021). When you are questioning people about such intimate subjects, one can only expect to be questioned in return. "And you, love, do you want to have children?"; "How old are you? Are you married? How long have you been together? If you know you want to have children together, then why are you waiting?". These are all the questions couples, and women in particular, would often ask me. While I was trying to provide an answer to those questions by responding that we were waiting for the right time or that I wanted to be further ahead professionally, my arguments fell flat most of the time. A participant once ended the conversation, adding: "I was also like you, I thought something like that could never happen to me" (Aïda, Tunis, August 2021). My identification with my participants and the identification of my participants with me was overwhelming at times.

During the first fieldwork phase in 2019 at the clinic, I was discussing with the midwife coordinator (with whom I had become quite close over the weeks) about how working on ART changed her perception of pregnancy. She explained that, after some time working at the fertility centre, she decided to undergo some examinations to learn if she had any fertility issues. As we

were talking, she suggested I take some examinations while in Tunisia: “don’t you want to know, too?”. Being in Tunisia, I could undertake medical examinations that I would not be able to access so easily in Belgium, making me shift from the position of researcher to the one of patient.

In that regard, the fieldwork definitely impacted my perception of pregnancy. Fertility centres are filled with couples who encountered fertility problems, but also with couples who sometimes experienced traumatic pregnancy experiences. Immersing myself into these stories almost inevitably made me consider a future pregnancy differently, having in mind the many things that could go wrong, the gamble that becoming pregnant in fact is, and, most importantly, it changed my perception of time.

5. Virtual fieldwork space: online ethnography before and during the pandemic

Multi-sited ethnography imposes, as I described above, interruption and discontinuities in between fieldwork stays. Online ethnography was, in that regard, a useful way to maintain contact with each fieldwork site at all times. Following participants online, through social media on Instagram and Facebook and keeping in touch through WhatsApp allowed me to maintain virtual presence in fields from which I was physically absent. The literature on migration and transnationalism has abundantly illustrated the technological shift and its use allowing migrants to be “co-present” (Baldassar and Merla 2014) by maintaining contacts with their relatives in the home country (Levitt and Jaworsky 2007). The use of technologies is indeed embedded in our everyday practices and individuals are simultaneously present physically and virtually. Migrants’ digital everyday life constitutes an important source of material, and an ethnographic analysis of its utilisation is important to understand migrants’ transnational practices (Leurs and Prabhakar 2018). In her work, Miller (2011, 2016) takes a dual approach by contextualising her "online" fieldwork in the "offline" world and analysing how her stakeholders use Facebook in their daily lives. According to Bluteau (2019), the place occupied by these "digital landscapes" in the daily lives of individuals is such that one can even question whether it is possible to conduct ethnographic fieldwork without taking these digital spaces into account. He thus proposes to think in terms of a "post-digital era, in the sense that it is no longer appropriate to consider digital technologies as separate entities" but as "embedded in everyday practices" and as part of a single fieldwork requiring the researcher's co-presence (Bluteau 2019: 2).

I have therefore used online ethnography as part of my research methodology in different instances. I already described above my regular consultation of social media pages of Tunisian groups in Belgium to stay informed about associations' events and also to get in touch with active members regularly posting information online. Moreover, the numerous groups of Tunisians in Belgium were also an inexhaustible source of data on the role that social networks play in health-seeking strategies, as people were regularly seeking healthcare advice or support online.

5.1. Virtual community of patients

Concerning ART, the numerous blogs where patients exchange advice and recommendations on clinics, medical offices, and doctors were an important source of information to understand how couples prepare their therapeutic journey. In the field of healthcare in general, and infertility in particular, the internet has become an important source of information for patients (Fox and Fallows 2003; Spink *et al.* 2004). Over the course of the fieldwork, participants have also shared with me Facebook groups for ART in Tunisia on which patients (the vast majority of whom were women) exchange medical results, tips and recommendations and provide each other with emotional and mental support by addressing prayers and encouragements. As noted by Maffi *et al.* (2023), this virtual space constitutes spaces of socialisation for the virtual community of patients. Composed by regular users (Akrich and Médael 2009), these virtual communities animate discussion threads, giving rise to the construction of social sphere within these digital spaces. Studying these virtual spaces is therefore essential to understanding behaviour in terms of health practices.

As part of my data collection around interculturality in healthcare and adaptation of the healthcare offer to the needs of a culturally diverse migrant population, I have followed medical doctors (gynaecologists, sexologists, psychologists) on social media (Facebook, Instagram) who adopt an intersectional approach in their medical practice so as to be more inclusive to the needs of a population from Arab-Muslim background. These doctors regularly take part in discussions and online debates (live Instagram for instance) to reach a larger population, often in collaboration with associations that promote the integration of migrants, access to healthcare, etc. Their use of social media offers rich ground to analyse new tools to raise awareness on certain healthcare issues. It is also a tool of healthcare activism defending an integrated intersectional approach to medical practices. Finally, I followed online training organised by

associations promoting migrants' access to healthcare, also designed for healthcare practitioners (for instance, training from the association *Migration et Santé,* in France). Online fieldwork allowed me to take part in "events" taking place in different locations.

5.2.Covid-19 and fieldwork rupture: entering virtual ethnography.

Just before the pandemic started, I was preparing my departure for my fieldwork stay in Marseille and in Tunis. I was getting ready to live abroad for the next six to seven months and was feeling both excited and apprehensive. My annual thesis committee took place on 13 March 2020, and I remember announcing my fieldwork plans, knowing that they would most probably fall through. A few days later, universities, schools, shops, and borders closed. It was like someone had switched off the power. I did not imagine at the time that what was happening would change my plans not only for the coming months but that it would change our lives so drastically for the coming years.

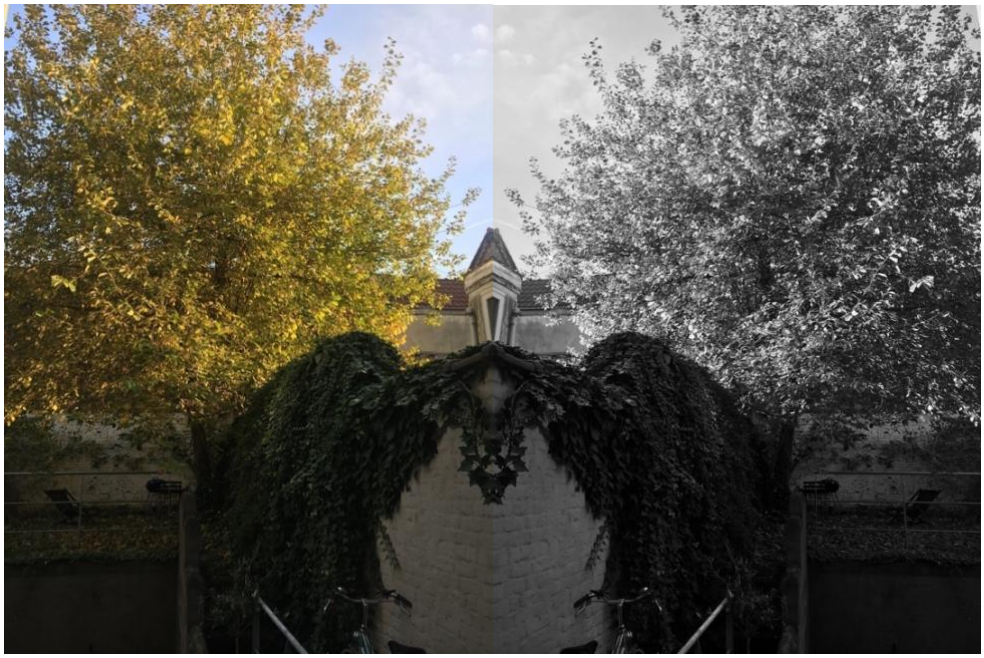

Figure 2: Lockdown view

Source: picture taken by the author

My daily landscape retreated to the tree outside my window (Figure 2), the paintings on my walls and the walks around my neighbourhood. I felt this pressing need to be in contact with

my family and friends over the phone several times a day. For at least two weeks after entering the first lockdown, I spent most of my time sitting in my living room, reading the news online, nervously scrolling down my Facebook feed.

We started teleworking and Skype got quickly outdated by more "interactive" platforms. I installed Zoom, Lifesize, Teams and doubled my consumption of internet data every month.

Internet and social media became the only space of socialisation that was still accessible and I found myself spending hours and hours online in need of interactions and seeking responses on what people were going through outside of my doorstep. Like most people of my generation, social media have been part of my daily life for a long time and have partly shaped the way I interact with others and the way I get informed. Integration of online ethnography to my research methodology therefore came "naturally". Virtual fieldwork had, however, not been a large part of my research until Covid-19 imposed it on the thesis. The spark of the pandemic gave a central role to my "netnography" (Kozinets 2019) which went from following information on social media and as a means to stay in touch with participants to an in-depth analysis of the interactions taking place on those platforms. Like many researchers who had to rethink their strategy for collecting empirical material during the pandemic, virtual ethnography was a real methodological challenge. Indeed, my research methodology – initially based on in situ participant observation and face-to-face semi-directed interviews - had to be rethought to adapt to this new reality. Since fieldwork opportunities were sporadic and dependent on the constant changes of the healthcare situation, it was also an alternative way to remain in touch with fieldwork and to observe the emergence of new paths to explore in relation to my thesis subject.

During the first weeks of the lockdown, posts on the different Facebook pages and groups of Tunisians living in France and Belgium, of Tunisian associations and consulates, attracted my attention to the different form of mobilisation taking place within the diaspora. From there I started to follow initiatives that were taken by Tunisian associations to support vulnerable members of the community as well as to support the capacities of the healthcare system in Tunisia. Over the course of the next weeks, I identified the networks of these initiatives and campaigns through regular conversations with my participants. Furthermore, participants I had already been in touch with since the beginning of my research introduced me to different virtual spaces in which the mobilisation was taking shape. In the same way that I had to adapt my research methodology, participants and associations that I had been following for some time also had to find alternative modes of interaction and mobilisation online. I was added to

Facebook groups where active diaspora members were discussing their initiatives, and I was also invited, from April to July 2020, to join virtual meetings of a collective of associations from the diaspora who were coordinating their action and their claims towards the Tunisian government during the pandemic. The person who invited me to join the collective was one of my participants in Belgium. Prior to joining the virtual meetings, he had sent an email to the collective and discussed the matter in one of their meetings. The first time I joined the event, I started by introducing myself, as well as the purpose of my research. I also shared my contact details and the information sheet of the project in the chat function of the online meeting.

I was added to the mailing list of the collective and therefore received all the documentation and exchange of information. Here again, I circulated an email with details on my research to make sure that potential people who were not present in the meeting would be aware of my "presence" in the mailing list. I was then able to easily contact members of the collective through the mailing list. These members were, for the most part, active members within the diaspora or civil society representatives. Participant observation of these virtual meetings taking place twice a week for two to three hours allowed me to get in touch with a very large network of actors, across different European countries (but mainly in France) and also to follow the evolution of their campaigns as they were progressing.

Furthermore, I participated in several online conferences, and debates organised by associations on the mobilisation of the Tunisian diaspora and the healthcare situation in Tunisia. I collected documentary material including press releases, resolutions, photographs, videos, publications, and Facebook comments. Finally, I conducted semi-structured interviews with representatives of Tunisian associations from the diaspora, and members of the Tunisian community in Belgium and France, both on the different dimensions of the diaspora mobilisation and the Tunisian state responses during the pandemic.

Online ethnography imposed a different work pattern. If fieldwork becomes accessible at all times on your phone or on your computer, the amount of information that I suddenly had access to simultaneously sometimes made my head spin. The virtual fieldwork also posed some logistical questions such as how to store the material collected online. It also raised ethical concerns, as material gathered on social media such as posts on public Facebook groups or pages is collected without virtual participants being aware of it.

Conducting online interviews also brought new perspectives. I was initially worried that conversation over the phone or through Skype or Zoom would tend to put a distance between the participants and me. For the first interviews I conducted online, I asked my participants if

they would agree to turn their camera on so that we could also have visual contact allowing the observation of facial expressions and body language. In some cases, however, and in particular during the lockdown, participants often did not spontaneously turn on their cameras. Most of the time, they were using their phones for communication, and not their computers. Turning on the camera and holding the phone in their hands in front of them was less comfortable.

When meeting participants in person during my fieldwork, I would usually let them decide where to meet and when. Following the same logic as with my online "meetings", I also let them decide on which online platform they wanted to "meet" and whether or not we would turn the camera on. Interviews lasted longer than I had expected, and the distancing of online interactions seemed to untie tongues. This may be explained by the fact that people had more time during the lockdown and that participants often missed social interactions. Moreover, since people were comfortably sitting in a "safe space" in their living room, this also become a time in which them talked more transparently about certain topics.

6. Fieldwork in France

When I started my virtual fieldwork, I was less familiar with the diasporic landscape in France, as I had only spent very little time conducting preliminary fieldwork in Marseille in 2019. My knowledge of it derived mainly from my past work experience working at IOM in Tunis and also through the Tunisian diaspora literature that focuses considerably more on the French case due to the high number of Tunisians residing in France, as well as the historical importance of the relationship between the two countries (Mabrouk 2010; Geisser 2012; Boularès 2015). As discussed in Chapter 5, the engagement of diasporas in the socio-economic development of their country of emigration has been invested importantly by intergovernmental institutions and international cooperation (Agunias and Newland 2012) and in particular after the 2011 revolution in Tunisia (Boubakri 2011). While working in Tunis, I therefore came to learn about the major diaspora associations and leaders in France as important stakeholders for IOM. From the beginning of the thesis, I started to follow several associations in order to slowly familiarise myself with the civil society landscape in France. I could also make bridges between my observations and the consequent history of Tunisian civil society in France which I detail in the following section, in order to provide a few elements of context on the development of Tunisian civil society landscape in France and Belgium.

6.1. Historical overview of the transnational political engagement of the Tunisian civil society in France

Several of the Tunisian associations that I followed throughout my fieldwork have a long history of transnational engagement. The beginning of Tunisian activism in France is closely intertwined with students' movements, which at the time were composed not only of an elite, but by middle class students coming from the coastal area in Tunisia and who benefited from state scholarships to pursue their education in France. They established the Association of Muslim North-African students (*Association des étudiants musulmans nord-africains-AEMNA*) in 1927. The determination and strong sense of organisation demonstrated by Tunisians students made AEMNA a founding school of thought and initiatives against Maghrebi nationalism (Dhifallah 2004). In the continuity of the "contestation knowhow" born with AEMNA, the first student union (UGET) was established in 1952. If they at first supported the nationalist movement and the political figure of Bourguiba, they distanced themselves from the new regime soon after independence and initiated a new cycle of political activism in France. The student union – UGET – in Paris (which was initially composed of students sympathetic to different political currents) was quickly dominated by leftwing opponents to the regime who established the Socialist group of study and action in Tunisia[11] in the early 1960s and created the journal "*Groupe Perspectives*" printed in France and clandestinely circulated in Tunisia. The *Perspectivistes* later published in Tunisian dialect in order to raise the revolutionary cause among immigrant workers from the lower class. They formed a fertile ground for contestation of the regime in Tunisia, defended the cause of the political exiles in France and focused on the rights of immigrant workers in France. This is the case of the Union of Tunisian immigrant workers (UTIT), established in 1974, which defended the interests of irregular migrants in France. They later become the Tunisian Federation for Citizenship of Both Shores (*Fédération tunisienne pour une citoyenneté des deux rives*-FTCR) which was among the associations involved during the pandemic. FTCR still advocates today for immigrants' right, namely in terms of access to social protection (healthcare in particular).

This transnational contestation that first took place on the left of the political spectrum later appeared in the Islamic movement (Abdessamad 2017). On the Islamic side, the growth of opposition followed different paths that reflect the distinct history of the settlement of Muslims exiled in France following the three main waves of repression in Tunisia under the Bourguiba

[11] Also called the *"Perspectivistes"*, referring to the title of the journal.

regime and the Ben Ali regime (Ayari 2008). A number of them (coming from various socio-economic backgrounds) immigrated irregularly to France in the 1990s and some to the UK (among them the future leader of the Islamist party *Ennahda,* Rached Ghannouchi, after being refused the right to remain in France).[12]

The dualism between these two ideological and political currents largely shaped the fabric of Tunisian associations in France until 2011 (Dot-Pouillard 2013). Before the revolution, transnational engagement (mainly carried out by left-wing activist figures) was rather discreet as they were closely watched by the Tunisian regime through its *Amicaliste* network. The "*Amicales*" were associations implemented by the Tunisian State in the countries of Tunisian emigration and closely connected to the consulates, which aimed at maintaining bonds of allegiance of the Tunisian diaspora through philanthropic events and services towards the TRA (Zederman 2018). Allegiance to the country of emigration was combined with allegiance to the regime in power and the single party (Geisser 2012: 160). The *Amicales* were under the command of the Destourian Socialist Party (Parti Socialiste Destourien – PSD) and their objectives were therefore to entertain the myth of return, to encourage remittances from Tunisian workers abroad and to prevent external political influence, considered to be working against the national interests of the single party (Geisser and Limam 2018; Zederman 2018). As Kenza, a consular official in Brussels, explained to me, the State adopted a number of social initiatives that responded to a "dual need" to "control" TRA and to encourage them to "bring in currencies" (Kenza, consular official, Brussels, 31 March 2021).

Under the Ben Ali presidency (which started with the political coup in 1987), the *Amicales* maintained their cultural objectives and further enforced their control and security agenda (Zederman 2018). Between 1990 and 2000, with the reinforcement of surveillance, activists had to abandon (at least in the public sphere) their engagement in the socio-political debate in Tunisia and invested themselves in the civil society landscape in France for the rights of immigrant workers, in local politics as well as on transnational human rights initiatives such as the Palestinian cause. This involvement in the country of residence can be thought of as a resistance to a "double absence" from the political sphere in both countries of emigration and immigration, in particular in the French context, where the political tradition is not open to the expression of cultural particularity (Schnapper 2001). According to Lotfi, activist engagement with the Human Rights League served as an "umbrella" against the Ben Ali regime: "they could

[12] Islamic supporters were also controlled by the French authorities.

reach out to socialists, communists and so on but someone who was under the label of Human rights was more complicated to reach for the regime" (Lotfi, online interview, October 2020).

Leftist, Islamist, and *amicaliste* networks have punctuated and shaped the history of association mobilisations of Tunisian immigration in France (Ayari 2017; GRDR 2021). The fall of Ben Ali's regime in 2011 revealed a "revolutionary Tunisianity" (Geisser 2012) which, in addition to the feeling of regained dignity, acted as a common ground for the post-revolutionary associative effervescence as well as the multiplication of initiatives in the direction of the country of emigration (GRDR 2021). Unlike mobilisations in the past decades, the protests in Paris in January 2011, after the departure of the President Ben Ali, gathered together diaspora members with different political affiliations (far left, human rights associations and Islamists). The mobilisations even went beyond "the professional opponents" (Geisser 2012: 156) who had been taking part in the revolutionary process for several decades, even if at times "underwater". In 2011, Tunisians who had never voiced their opinion and had remained publicly silent about the Ben Ali regime came out and joined the protest supporting the political changes in Tunisia.[13] The second-generation population who until then, had not expressed interest in the Tunisian socio-political debates but rather had an "exotic" (ibid.) and seasonal relationship with the country of their parents as a summer holiday destination, made the revolution their own. The mobilisations were intergenerational and interclass-based. The "professional opponents" had accumulated "opposition capital" (*capital contestataire*) (Geisser[14] 2012: 157) over time, understood as the experience and engagement of opposition against the regime which was able to fully and promptly unfold after the revolution.

The revolution acted in that regard as a moment of "unanimity" (ibid: 170), of consensus binding together the diaspora as a whole. In the following months after the revolution, their engagement would revolve around the "Tunisian cause", temporarily leaving aside their association initiatives and, independently of their traditional political affinity, putting forward a "diasporic patriotism" (Geisser and Kelfaoui 2001). Once the "moment" of the revolution had passed, the renewal of the association landscape soon became fertile ground for the reemergence of the "old" cleavages (Geisser and Limam 2018).

If what I have described above was drawn from literature focusing specifically on the Tunisian diaspora in France, part of these observations, I believe, can be applied to the Belgian context.

[13] Geisser underlines that the revolution also revealed the incapacity of social sciences to grasp the multiple forms of engagement before the revolution (taking place within family sphere etc.). The silence of some of the actors within the diaspora was wrongly interpreted as a lack of interest in political causes in Tunisia.
[14] The works of Vincent Geisser on the Tunisian diaspora are key references in this field.

Although the relation between the two countries (Belgium-Tunisia) and the importance of the Tunisian diaspora in Belgium cannot be compared to the one in France, within the association network, the Left/Islamist cleavage has been largely reproduced and shapes intra-diasporic dynamics. Moreover, both the Leftist and Islamist networks are connected to the one in France. This is probably due to its proximity with France, and Paris in particular, which, as described above, remains the "association headquarters" for the Tunisian diaspora. Also, the Tunisian associative landscape in Belgium, at least in terms of political affiliations, is very much aligned with the one in France.

Similarly to the case of France, many students were involved in the opposition and continued their engagement in Belgium, through student associations, such as the International Students' Association of the University of Liège, or within local sections of international NGOs, such as the League of Human Rights (Gsir and Mescoli 2015). The dispersion of the diaspora as well as the important number of mixed marriages, however, favoured the integration of former Tunisian students in the association landscape of the Belgian civil society (Hamzaoui and Caprioli 2021).

6.2. Complementing "online" fieldwork with "offline" fieldwork in Paris

In November and December 2021, I conducted a short fieldwork visit to Paris to visit some of the Tunisian civil society organisation that were particularly active during the pandemic. I had followed their initiatives throughout the pandemic and therefore wanted to meet face to face with some of the members and visit their association. After a first phase of online data collection, gathering heated reactions in the middle of the pandemic, this second phase allowed me to explore other dimensions, with some distance from what had happened in the past year and a half.

Before going to Paris, I contacted several of the participants I had been in touch with virtually since the beginning of the pandemic. On my first day in Paris, I was received by the coordinator of one association and, although we had never met each other in person before, it felt familiar, as we had talked on the phone and exchanged messages on several occasions over the past year. I had planned to spend the day with this association in particular and they took the initiative to circulate an email to its members. Several of them joined at the association on that day so that we could meet and discuss. In just a few days, I was able to meet with a lot of people and things were going faster than expected. The "online" fieldwork had in fact replaced the entry phase

necessary in any fieldwork and I was therefore able to directly dig into specific subjects. Moreover, I knew I had little time, and I therefore concentrated my efforts in exploring specific subjects that had already emerged during the online fieldwork.

As I discuss in Chapter 5, I visited the Tunisian Federation for Citizenship of Both Shores (FTCR) and met with several civil society representatives as well as also former activists against the Regime. After having read about the fascinating history of FTCR, its pioneering role in the resistance to the Ben Ali regime and the hardship that was imposed on some of its members, I felt a certain emotion to be located in their company in the very building within which their initiatives took shape. We retraced the long history of the diasporic transnational political engagement in Tunisia, central to the understanding of the mobilisation of the Tunisian diaspora during the pandemic.

Several associations had restarted organising events and I had the chance to attend some of their activities and be introduced to other active members in Paris. It was recommended to me to meet and I was put in contact with individuals who had been particularly active during the mobilisation. I also followed two days of social assistance in one of the associations that work primarily with irregular Tunisian migrants and support them in their procedures for obtaining emergency medical assistance. Finally getting to see, with my own eyes, the neighbourhood where these associations are located, the type of people coming to their activities and the different people surrounding the associations provided me with insight into the landscape of the Tunisian community in Paris and in France more generally.

Although many new and interesting paths emerged from these short stays, my fieldwork time was coming to an end, and I refrained from opening new doors in order to negotiate my exit from the field.

7. Overview of the main categories of actors of the research

As I have detailed in the different sections above, actors in my research are a diverse group. This diversity of actors was partly imposed by the multi-sited ethnography which, in my case, involved following some of my participants in between two of the fieldwork spaces, but also involved looking at different actors in each fieldwork spaces. After a first fieldwork phase where I encountered a large diversity of actors, I later narrowed down my sample of participants. In this sub-section, I provide an overview of the main categories of actors in my

research that are at the centre of my analysis in my empirical chapters which are composed of: Tunisians residing in Belgium, healthcare professionals and entrepreneurs in Tunisia, couples of TRA in fertility clinics, representatives of Tunisian civil society abroad, Tunisian medical diaspora and Tunisian State authorities. These categories are, however, not mutually exclusive, and some participants belong to several of these categories. Furthermore, other actors took part in the research, such as members of women's association in Brussels, staff of family planning offices in Belgium and France, couples from different nationalities within the fertility clinic (Tunisians living in Tunisia, couples from Gabon, Ivory Coast, Mali, Algeria) and staff of a health insurance company in Belgium.

I propose to classify participants in my research engaging in diasporic medical mobilities as resulting from what Whittaker and Leng conceptualised as "flexible bio-citizenship" defined as "transnational mobilities for the accumulation of biovalue" (2016: 292). Their category of "bio-citizens" encompasses actors belonging to different classes and different economic statuses as well as geography, but who share common "cultural logics of transnationality through which their claims for care are satisfied" (ibid:293). The profiles of the diasporic medical travellers in my research are consistent with the one of flexible bio-citizens as actors who have the ability to travel legally, are neither excluded from their state nor dispossessed, and who possess the necessary means to mobilise social and/or economic capital (ibid.).

In total, I conducted 82 semi-structured interviews and 32 non-structured interviews among the three fieldwork sites and between 2019 and 2022. As I have detailed in each sub-section of my different fieldwork spaces above, I have also collected important material through informal conversations and observation such as during association events and in particular during my fieldwork in the fertility clinic in Tunis.

In the annexes, I provide a table with the participants' pseudonyms that I present in the thesis, with information on their profiles.

7.1. Tunisians residing in Belgium.

In Chapter 3, where my thesis looks at Tunisians residing in Belgium, and follows their therapeutic journey while visiting Tunisia, most of my participants were first-generation immigrants who had settled in Belgium in the last 20 years. The majority of the people that I followed came to Belgium through work permits in the IT sector as computer engineers or in medical sector with doctors from different specialties. We can therefore talk about so-called

"highly skilled migrants" who immigrated for work opportunities. As I discuss in Chapter 3, growing restrictions on immigration imposed a competitive selection for those seeking work opportunities in Europe. Others came through family reunification or as students. The majority of the actors in my research had completed higher education and belonged to the middle class. They therefore enjoyed a certain level of mobility with an immigration status that allowed them to go back and forth between their country of emigration and their country of residence. They also had access to social protection benefits in Belgium and, among those who were in Belgium for more than five years, all had dual citizenship. Although I have also discussed with a few second-generation individuals born and raised in Belgium, I decided not to incorporate this material in the thesis as this would have opened other directions in my analysis. In Tunisia, a number of my participants were therefore some of the same people I was following from Belgium. I conducted 21 interviews with this category of actors and followed the therapeutic journey of 6 of them while visiting in Tunisia.

7.2. Healthcare professionals and entrepreneurs in Tunisia

A large number of participants in my research were healthcare professionals in Tunisia. By "healthcare professionals", I mean a large array of actors that are connected to the medical industry and are part of the healthcare ecosystem in Tunisia. This includes medical doctors from different specialisations (gynaecologists, dentists, aesthetic surgeons, psychologists, general practitioners), midwives, medical secretaries, clinic directors and clinics' administrative staff as well as staff from medical tourism agencies. I have grouped healthcare professionals and healthcare entrepreneurs, as many participants wore both hats. For instance, the gynaecologists in the fertility clinics are also healthcare entrepreneurs as they own shares of the fertility centres which are private lucrative enterprises. I have discussed with 46 healthcare professionals and entrepreneurs in Tunisia.

7.3. Couples of TRA in fertility clinics

The couples of TRA I met at the fertility clinics had relatively similar profiles. They were, for the most part, first generation emigrants who had left Tunisia for work opportunities in different European countries and in the Gulf countries. Many of them were working abroad as computer engineers or were doctors from different specialties. They therefore belonged to the middle

class. As I have described on the above section on the fieldwork within the fertility clinic, I sometimes met couples and sometimes met only with the women when they came alone to the appointment. I therefore exchanged with more women than men in the context of this fieldwork and a large part of my data therefore focuses on women's experiences. I also discussed with some couples over the phone while they were still in the country of residence before or on their way to their medical visit to Tunisia. There is also a selective bias, as couples of TRA I met at the fertility clinics had all (de facto) chosen to return to Tunisia for all or part of their reproductive journey. They therefore often had in common a negative experience during their reproductive journeys in their countries of residence. I discussed with a total of 28 TRA couples.

7.4. Representatives of Tunisian civil society abroad

Representatives of Tunisian civil society abroad are another important category of actors in my thesis. I identify as civil society the Tunisian associations in the countries of residence and in particular associations that are invested politically in the countries of residence and emigration. I have detailed above the long history of Tunisian civil society abroad and its engagement in political life in the countries of residence and emigration before and after the revolution. This category of actors will be at the centre of my analysis in Chapter 5 in particular, where I look at their transnational engagement during the Covid-19 pandemic. I conducted 18 interviews with this category of actors.

7.5. Tunisian medical diaspora

I have mentioned earlier that, among the participants in my research in Belgium and France, several were working in the healthcare sector, as it is one of the high demand sectors in several European countries. In Chapter 4 in particular, among the couples of TRA, some were working as medical doctors, cardiologists, but also emergency physicians. As I suggest in the chapter, their professional background impacted their perception and therapeutic experiences in both their country of residence and emigration. Similarly, for the fieldwork in France, participants included representatives of Tunisian civil society abroad. Among them were healthcare professionals who constitute a specific category of actors that I define as "medical diaspora". This medical diaspora has formed through years of consistent emigration of Tunisian doctors to Europe, a professional sector with high demand for workers. If the high demand of workers

in the medical sector in certain European countries has acted as a pull factor, the degradation of the public healthcare sector in Tunisia also largely explains this emigration pattern.

A study analysing immigration projects among young doctors in Tunisia addressed the interrelation between the shortage of doctors and emigration. The study shows the intention of doctors to emigrate after their studies. Among the main variables put forward: marital status, resident status, surgical specialty, personal dissatisfaction, underpayment, workload and difficult work conditions, lack of appropriate training, financial crisis and economic instability, lack of a clear strategy for the healthcare system and the impression by the model of other doctors who left Tunisia (Ajmi *et al.* 2022). The degradation of the public healthcare sector in Tunisia pushes doctors to leave the country for better work opportunities abroad. Doctors working in the public sector encounter many difficulties due to poor working conditions characterised mainly by an overload of hospital services (emergency, consultations and hospitalisation), the lack or obsolescence of medical equipment, lack of medical and paramedical staff as well as insecurity, with staff regularly experiencing violence and aggressive behaviour from patients or people who accompany them (Belhaj 2020). Over the past years, several scandals regarding deleterious working conditions – bad salary, poor infrastructure, long working hours but also insecurity for medical staff – made the headlines in Tunisia (Blaise 2020; La Presse 2022). These cases raised attention regarding mistreatment of medical staff. The Tunisian Organization of Young Doctors denounced what they considered one of the greatest challenges of Tunisia's healthcare sector (La Presse 2021): doctors being pushed out of the country and nothing being done by the state to impede it. A recent report from the National Statistical Institute and the National Observatory of Migration identified 3300 departures of doctors between 2015 and 2020 (INS, OIM, 2021). In 2017, the Board of Physicians reported that 45% of young physicians had left the country (Belhaj 2020). These numbers only account for doctors, leaving aside the important number of paramedics and nurses leaving the country every year. As discussed in Chapter 5, this departure of a growing number of medical practitioners from Tunisia has consequently transformed the medical landscape in Tunisia (Ajmi *et al.* 2022). I have discussed with 8 participants belonging to this category.

7.6. Tunisian State authorities

Finally, the State, in particular the Tunisian State, is the last privileged actor in my research. As I described in the general introduction of the thesis, the MiTSoPro research project studies at

migrants' TSP "from below" and "from above", looking both at mechanisms deployed by the state in terms of transnational social protection as well as the strategies put in place by migrants themselves. In order to investigate TSP from above, such as BSSA, as well as diaspora policies, I met with representatives of the Ministry of Health, representatives of the National Health Insurance Fund (CNAM), National Social Security Fund (CNSS), National Pension and Social Security Fund (CNRPS) and Office for Tunisians Abroad (OTE), as well as representatives of the Tunisian consular authorities and Embassy in Belgium. State actors were particularly central to my analysis in Chapter 5, and I conducted 11 interviews with this category of actors.

II. Ethics "on paper" vs ethics "in practice"

In this sub-section, I discuss the ethical considerations emerging from fieldwork as well as questions that arose from the application of ethical requirements imposed by the ERC ethical committee to my research. As I present here, the mismatch that arose between "ethics on paper" and "ethic in practice" led to collective reflection with other members of the research team as well as a member of the ethical committee at the University of Liège. The majority of what is discussed below has been developed as part of a collaborative paper discussing the application of ERC ethical requirements to ethnographic fieldwork (Caeymaex *et al.* 2023).[15]

1. "Ethics ready" … on paper

The increasing ethical expectations of academic institutions and funding agencies result from a long-term evolution within European research policies. The 2005 European Charter for Researchers, which reflects the prioritisation of research ethics, has been adopted by most national agencies and universities across the EU,[16] including the European Research Council (hereafter ERC), which was created in 2007. In this context, research ethics became a precondition of research excellence[17] and the EU provided tools to reinforce the implementation of ethical guidelines. At the university level, this process fostered the development of specialised ethics boards and procedures designed to address EU research policies. In line with

[15] The co-authors have expressed their agreement for the re-utilisation of the material in my thesis.
[16] Euraxess (n.d.). The European Charter and Code for Researchers. https://euraxess.ec.europa.eu/jobs/charter
[17] European Commission (n.d.). Horizon 2020 Programme, Guidance, How to Complete your Ethics Self Assessment step by step https://ec.europa.eu/info/funding-tenders/opportunities/docs/2021-2027/common/guidance/how-to-complete-your-ethics-self-assessment_en.pdf

this trend of formalising ethical clearance processes, the European Commission itself, as well as the ERC, started to regularly issue detailed documentation to guide researchers in completing their ethics self-assessment. Each project funded by the European Research Council goes through an ethical check before they consider the research project "ethics ready" or compliant with disciplinary ethical standards and the large body of ethical guidelines produced by the ERC.

For MiTSoPro to be considered "ethics ready" and to meet the ethical guidelines of the ERC, several steps had to be taken by the principal investigator. This included ensuring anonymity and taking precautions against predictable misinterpretations and misuse of data falling under the researcher's ethical obligations of "doing no harm". The ERC was particularly concerned about how informed consent would be obtained from participants and, after a series of communications between the ethical board and the project team, an agreement was made to provide participants with a project information sheet and to ask for written consent from all participants. Verbal consent was also possible in the case that participants were uncomfortable with written consent, in which case they would be asked to confirm consent at several points in times during the interview. During the duration of the project fieldwork, I shared with participants information about the project, its goals, funding sources, how I would use the information they shared, how it would be analysed, cited and stored. Based on this information, potential participants were able to make a voluntary and informed decision about their participation in the research. Moreover, care was taken to safely store all the recorded material and fieldwork notes on a secured server of the university. In addition, names of participants have been changed and a file containing the actual names of participants was stored separately on the server of the university. Recordings are also saved on the university server and files were deleted from the recorder immediately after being saved on the server.

2. "Ethics ready" …in practice

When I started conducting fieldwork, however, it became clear that being "ethics ready" from a bureaucratic standpoint did not immediately translate into being ethics ready in the field. If ethics have historically been a central tenet of social science methodology, the recent formalisation of ethical clearance procedure by large funders such as the European Union introduces new pressure on researchers to adjust their professional practices. Drawing from a biomedical science approach, ethical committees have therefore been presented challenges with

guidelines that have been inadequately adapted to the social sciences (Haggerty 2004). Ethnographers (Bosk and de Vries 2004; Lederman 2006; Librett and Perrone 2010) specifically addressed the problematic imposition of bureaucratic procedures such as informed consent. As shown by Murphy and Dingwall (2007), consent in ethnographic practices has long been debated in Social Sciences and Humanities research but "informed consent in ethnography is neither achievable nor demonstrable in the terms set by anticipatory regulatory regimes that take clinical research or biomedical experimentation as their paradigm cases" (Murphy and Dingwall 2007: 2225). The paradigmatic informed consent of biomedical ethics and law indeed come under what the authors call "anticipatory regulatory regimes". Such settings, in principle, allow prior and informed consent via written procedures. All these characteristics "led to the legalistic, contractual approach" (ibid.) and to "bureaucratic practices" (ibid.:2224) that prevail today.

These settings contrast strongly, however, with the ones established by ethnographic practices and what Fassin defines as "ethnographic consent" (Fassin 2008). Ethnographers are often better described as guests who spend a great deal of time in a particular environment, with research participants who can be considered as hosts. Becoming a guest takes time and creates implicit and explicit "expectations of proper behaviour" (Murphy and Dingwall 2007:2225). Trust is therefore needed and the process remains fragile throughout the ethnography.

At many points, trying to apply the ethics procedure to my fieldwork context felt counterintuitive. For instance, when I visited a participant's family in Tunisia who had invited me to the Eid celebration, following the pre-approved guidelines highlighted these challenges. Why sign a document that protects each other in case of litigation while in a family and trusting atmosphere? In a context of immersion into family life for the Eid celebration, reducing the relationship to one of researcher-participant by asking to record a verbal consent or by signing a consent form would have obviously been socially and emotionally inappropriate as well as methodologically inadequate. Out of politeness and respect for the code of conduct within such a family or a religious setting, the relationship should not be diminished as a mere functional access to fieldwork. Both research and social ethical codes of conducts are fundamental. In this sense "it is difficult to separate good behaviour as a researcher from good behaviour as a person. Ethical practice in social research is about being a 'good' researcher at the same time as being a 'good' human being" (Iphofen 2009: 3). The contractual approach of the consent form procedure changes the nature of the interaction. In fact, a contract is a truncated image of human

relationships and, as such, therefore breaks a precondition for the continuation of ethnographic work.

Asking for explicit consent when mutual trust has supposedly already been given does indeed change the register of the interaction and distance the researcher from the relationship, he or she is supposed to be part of. The rigid procedure is at odds with the informal process of negotiation essential to ethnographic fieldwork (Yuill 2018:38) and can provoke reactions of misunderstanding, deception or even fear. Gaining participants' trust to discuss sensitive or intimate topics is possible only through modalities more nuanced and subtle than the actual act of signing or recording an audio consent. Moreover, this materialisation of consent is in fact enforcing consent rather than really negotiating it. "[Such quasi-contractual rituals may sign away participants' rightful claims to knowledge shared with researchers" (Pels *et al.* 2018: 394). Bringing a consent form to the field with the alleged intention of ensuring the protection of our participants actually hinders the participants' ability to withdraw or renegotiate their consent, making them more vulnerable, rather than less. Therefore, ethics becomes a long-term task requiring sensitivity, responsiveness and learning processes in the field itself. The code of conduct of the Association of Social Anthropology (ASA) places the researcher's self-governance, reflexivity, strong training and moral obligations at the centre of ethical practice (Yuill 2018). The very essence of ethnographic fieldwork entails the need to continuously renegotiate consent and the researcher's presence in the field. As a matter of fact, "in anthropology, informed consent is gained, sometimes verbally, and then negotiated and renegotiated as fieldwork progresses and evolves" (Yuill 2018: 37). Moreover, obtaining fully informed consent from participants is challenged by the evolving nature of ethnographic fieldwork. The research settings are not known in advance and the knowledge about them depends heavily on the nature and quality of relationship both parties are able to build. This, in turn, may influence the design of the research itself.

One fieldwork scene was particularly revealing in that matter. One day, at the beginning of my fieldwork in Tunis in 2019, I was conducting participant observation in the waiting room of the fertility centre, a woman walked in and we engaged in conversation. After I explained the purpose of my research and informed her about the research project setting, the conversation went on. I wanted to make sure to respect part of the ERC procedure and thus carried on to present the consent form explaining to her once again the research project and the principle of confidentiality and anonymity. At this moment, the attitude of the patient suddenly changed and she became suspicious. I did not insist and suggested she could take the document home to read

it in a quieter time. But the participant refused as she did not want any proof of her visit to the clinic. Giving her name, signing the document or even just going back home with it was perceived as potentially harmful and only the intimacy and the anonymity of the waiting room got her to "consent" to talk to the me.

Following that incident, which I felt had created unnecessary harm to a participant who already found herself in a difficult emotional situation, coming to the fertility centre while having to keep it secret from her family in Tunis, I chose not to present the information sheet and the consent form in this specific fieldwork site and only present details of my research verbally. I only handed over the documents if participants spontaneously asked for written information on my research or if they showed signs, in my interpretation, that a written document would be reassuring. For some of them, their professional background also greatly impacted their perceptions of my work and of my position as a researcher.

The consent forms represent a "symbol of bureaucracy and governmentality" (Yuill 2018: 37) and can, thus, change the dynamic of an exchange, induce formality or even provoke mistrust and discomfort. In several contexts, these symbols of bureaucracy and "governmentality" can be perceived as threatening rather than protective. Moreover, the consent form requiring a participant's signature in fact provides an "absolute documentation of the subject's identity" (Bradburd 2006: 493) which appears to be in contradiction with the aim of the consent procedures.

In certain fieldwork situations, embodying the "quasi-contractual" and institutional modus operandi requested by the ERC would, however, facilitate access to certain fieldwork spaces. In most centres, presenting myself at the reception with the consent form played in my favour as this backed up my request with credentials. However, in one clinic, I handed the document in at the reception and was later called to an office by the secretary. The document had been well read with some sections highlighted and some words underlined. "Your document says 'healthcare practices' and not just 'medically assisted procreation'. You need to go back down to the first floor to get the authorization of the general director of the clinic" (The secretary, quotation by memory, Tunis, 2019). Also, in some cases, "playing the game" of the institution would slow the process, going up and down the stairs in a metaphor for the verticality of the hierarchical functioning of such an institution. The contractual and legalistic value of the form induced suspicion in some cases and activated a 'procedural' response in return. When I was reaching out to government representatives, public administrations or consulates and the

Embassy, presenting myself with the documents from the project would often be understood as a sign of seriousness and professionalism.

3. The principle of "doing no harm" during the pandemic

With the start of the pandemic, ethical considerations took on another form. Strict healthcare rules were imposed to impede the spread of the Covid-19 virus which posed several challenges to my research fieldwork. In Belgium (where I was at the time of the start of the pandemic), cafes, restaurants and shops (except grocery shops) were closed. Private gatherings were also forbidden and social distancing was enforced in public spaces.

In that context, it became very difficult to continue meeting participants face to face. Indeed, the enforcement of restrictions on social contacts outside of the family circle often "pushed me away" from the actors of my research. If many were themselves reluctant to maintain social contact with an "outsider" like me, some, on the contrary, sought contact, and non-compliance with the government's restrictions was not an issue for them. This situation put me in a challenging position, raising ethical considerations. Firstly, at the beginning of the pandemic, when we still knew nothing about the virus and its related risks, I was personally complying strictly with the restrictions imposed. I was preoccupied with preserving my own health and I also perceived myself as potentially harmful to my participants. Although many of them were rather young, I knew that some of them had regular contact with friends or family members who were in at-risk categories. Once, as we had already been in lockdown for several weeks, I decided to meet a participant at her place despite the restrictions. She had told me over the phone that she would be alone at home with her daughter. However, later in the night, her mother and father eventually joined us along with her sister. I felt very uncomfortable as I knew that her father was suffering from several health issues. My professional aim of progressing with my PhD research and continuing to collect the data that I needed could not come before the absolute necessity of preserving the health of my participants and that of their relatives.

My position regarding research ethics in the context of Covid-19 was made even stronger during my second fieldwork period in Tunisia, as I knew I was in contact with people who had not yet been vaccinated in a country where the healthcare system was completely overwhelmed. As I describe in Chapter 5, the healthcare crisis in Tunisia during the summer of 2021 was at its worst. Cities were put into lockdown and hospitals were full and running out of oxygen

supplies. I therefore felt an important responsibility not to put anyone around me at risk, even if that meant refraining from certain fieldwork opportunities. At times, even when participants were willing to meet, I sometimes decided not to. I also undertook Covid tests on a very regular basis and always before a visit to a family.

As a fully vaccinated person, my privileged position was not always easy to navigate. I knew that most of the staff at the fertility clinic where I was conducting fieldwork, aside from the gynaecologists, had not yet been vaccinated.

4. Ensuring reciprocity

Participants in my research dedicated time and energy and, on many occasions, they opened their house, cooked meals, and shared their stories and their experiences without being promised anything in return. Ensuring reciprocity was therefore a commitment I could make only in principle as they brought more to me and my research than vice versa. However, I tried to acknowledge their engagement and to express my gratitude by offering meals and drinks, especially when meetings with participants occurred around lunch or dinner time. Some participants were involved in association events and I was often invited to attend. Joining the events and offering to help with the preparation for events was also a way to demonstrate interest and gratitude. Moreover, attending events and supporting the association by buying and consuming food and drinks, or buying handicrafts during the events was also a way to support the activities of the associations.

I also regularly offered help in different situations such as proofreading and translation of association material in English or French (especially during the pandemic), carrying goods for relatives when travelling back and forth between Tunisia and Belgium for fieldwork, helping some participants with job applications or dissertations for university or professional schools.

When visiting or staying with participants' families, I would always bring presents for the family and participate in the daily tasks of the household as a way to compensate for my presence. On two occasions, I also hosted participants in the place I was renting in Tunis as I was staying in the area of La Goulette from which the boats to Europe depart. Some of my participants who had visited families in their hometowns outside of Tunis needed a place to stay in the middle of their trip.

If my fieldwork periods in Tunisia and France had come to a close "naturally" with my return to Belgium, I continued going to association events and to visit participants in Belgium long after the end of my fieldwork and data collection. As I had been participating in association events since the beginning of my fieldwork in 2019, my presence was somehow expected and I was also caught in a "gift and counter-gift" dynamic. Exiting fieldwork is indeed a delicate process that has to be negotiated in the same way as entering fieldwork and it requires time. Over the months, I participated less and less in events and gatherings, and it was the beginning of my pregnancy that put a final end to the fieldwork.

After having reviewed the methodological approach of the thesis, the next chapter opens its empirical part.

Chapter 3: Diasporic healthcare arrangements: Tunisian migrants' strategies to meet healthcare needs and expectations.

Introduction

This chapter explores Tunisian migrants' strategies to meet their healthcare needs and expectations between Tunisia and their country of residence in Europe. I draw on the notion of transnational healthcare arrangement (Lafleur and Romero 2018) to emphasise the agency of migrants in addressing their healthcare needs across borders using formal and informal resources. Looking at the case of Tunisian migrants living in Belgium and France, I first investigate how Tunisian migrants make use of formal and informal social protection strategies to navigate the healthcare system in their country of residence. Moving from the country of residence to the country of emigration, I study diasporic medical returns, exploring the use of mobility to navigate healthcare barriers and opportunities.

Studies on migrants' access to healthcare have demonstrated the recurrence of health inequalities between migrants and nationals. This often translates into lower health status and access to health services. This has been explained by the structure of health systems which were created to meet the healthcare needs of a particular population and have not been updated to accommodate migrants in particular (Mladovsky *et al.* 2012; Rechel *et al.* 2013). According to Padilla (2013), difficulties in accessing healthcare can be the result of external, internal or self-excluding barriers. They also depend on formal and informal factors. Legal status, for instance, is a determining formal factor in healthcare entitlements, while language difficulties, socio-

cultural factors, and what Phillimore *et al.* (2016) designate as "newness" could be considered informal factors. Furthermore, disparities in healthcare access are also the result of social variables such as gender or social class. These together shape healthcare disparities and inequalities between migrants and nationals.

However, inequalities also exist in transnational contexts (Dunn 2010). As argued by Faist *et al.* "certain forms of cross-border social protection may constitute an adaptive response to social risks and related inequalities but, at the same time, may perpetuate old inequalities and create new ones" (Faist *et al.* 2015: 194). The simultaneous presence of migrants in stratification systems both in the country of emigration and in the country of residence "creates alternative, non-national stratifications orders" (Amelina 2010: 4). Amelina (ibid) suggests in that regard that migrants' pluri-local way of living influences their everyday social practices and that their positioning within these different locales may vary: they "move between stratification orders in both the emigration and immigration countries" (ibid: 6). Migration is therefore not only a determinant revaluing social inequality within the country of immigration but also within the country of emigration.

Migrants are not passive actors in this process and, when encountering barriers and/or opportunities, they might respond by activating a number of personal strategies to meet their healthcare needs. From that perspective, the literature on migrants' access to social protection demonstrates how migrants combine formal and informal social protection mechanisms in order to respond to their social protection needs (Bilecen and Barglowski 2015). The dimensions cannot be strictly separated and the boundary between formal and informal is often blurred (ibid.).

Following Smith and Guarnizo's (1998) typology of transnationalism from below and from above, Lafleur (2019) proposes the concept of transnational social protection from below and from above and shows that access to social protection results from the combination of welfare policies in the receiving state, diaspora policies in the country of emigration and the formal and informal strategies that migrants develop using market, community and family resources to respond to their social protection needs (Lafleur 2019).

In the case of healthcare, social protection strategies may be mobilised transnationally to overcome barriers and meet healthcare needs and expectations. This chapter thus mobilises the notion of transnational healthcare arrangements (Lafleur and Romero 2018), which draws on earlier work on "assemblages of social protection" (Faist 2013; Bilecen and Barglowski 2015) and "social protection arrangements" (Kilkey and Merla 2014; Vivas-Romero 2017) to

highlight the combination of formal and informal social protection strategies. Lafleur and Romero argue that the notion of arrangements better emphasises "individuals' agency in adopting certain strategies over others" (Lafleur and Romero 2018: 2).

Studies on transnationalism and health have looked at how migrants address their health concerns and needs in a transnational way, by activating (or not) their transnational ties to get any form of health-related good, including information, medication, or healthcare (Villa-Torres *et al.* 2017). The concept of transnationality "refers to the deep and permanent embeddedness of migrants and their offspring, and non-migrant relatives in the countries of emigration and immigration, in cross-border social formations such as fields of contact, kinship groups, networks, organisations, and diaspora communities" (Amelina *et al.* 2012: 8). From this perspective, transnational healthcare practices, mobilising family and diasporic networks are a demonstration of "migrants' transnationality".

Following this perspective, and combining the scholarship on diasporic medical mobilities and transnational social protection, I therefore propose the notion of "diasporic healthcare arrangements" which I define as transnational healthcare strategies "from below" and "from above" formulated within the diasporic space. These strategies not only reflect a transnational nature but also embody diasporic logic and activate diasporic networks that span across borders. Through the fieldwork examples presented below, this chapter wishes to demonstrate how transnational social protection strategies unfold and are refashioned by actors who turn to the variety of healthcare resources at their disposal within the diasporic space, depending on their needs, medical preferences, perception of healthcare services and the accessibility of healthcare in both places of residence and of emigration. I suggest that, through their diasporic healthcare arrangements, Tunisian migrants demonstrate their agency in the pursuit of healthcare. I analyse diasporic healthcare arrangements as an expression of individuals' transnationality as the "social practices of agents – individuals, groups, communities and the organizations – across the border of the nation-states" (Faist *et al.* 2015: 195). The renegotiation and reinvention of healthcare practices or "'healthcare bricolage" (Phillimore *et al.* 2018) in the diasporic space is at the heart of my analysis in this chapter.

The first part of the chapter explores the healthcare experiences of Tunisian migrants in the country of residence (Belgium in particular) and examines their access to healthcare and perceptions about healthcare delivery. Identifying challenges and disparities, I document the important role played by interpersonal and social networks of migrants, which prove to be one of their main resources in the country of residence in navigating the national healthcare system.

These individual strategies are partly a response to the evolution of domestic healthcare systems, driven by patterns of marketisation and self-responsibilisation of patients. As a consequence, what I define as healthcare capital needs to be built through migrants' interpersonal networks, which my fieldwork shows to be the first entry point into the formal healthcare system for many Tunisians arriving in Belgium. This situation underlines the overlapping of informal and formal strategies, their complementarity and how their "assemblage" may secure access to social protection.

I also argue that these strategies are a direct outcome of the ways in which migration implies a relative downgrading in migrants' access to healthcare. Multiple factors come into play, starting with their newness and lack of familiarity with the way the healthcare system works in the country of destination, or the inadequate delivery of health services within the national healthcare system. As will be shown, their ability and chances to circumvent these challenges are a function of social variables such as their level of education, gender, and social capital. This is illustrated in my fieldwork by the case of Tunisian migrant women's experiences of sexual and reproductive health provision in the country of residence. In particular, I show how the role of gender, in interaction with other markers, affects the quality of access to healthcare in the country of residence.

Such inequalities have led diaspora associations to develop ways to respond to migrants' social protection needs. Taking the collective of Tunisian doctors in France against Covid-19 as a case in point, my fieldwork explores the response by civil society, and the mobilisation of diasporic networks and knowledge across the different silos of the healthcare system to support vulnerable migrants. While the Covid-19 pandemic further revealed inequalities and disparities in access to healthcare for the immigrant population, this collective developed initiatives in providing direct medical help as well as support in navigating the healthcare structure in France. This example further illustrates the concept of "arrangements" in which formal and informal are intertwined to provide the social protection needed.

The second part of the chapter moves from the country of residence to the country of emigration. It focuses on the use of medical resources in the country of emigration, looking specifically at diasporic medical returns. Indeed, barriers and obstacles experienced or anticipated in the country of residence can lead some percentage of the Tunisian diaspora to actively turn towards their country of emigration when looking for healthcare. I underline here how transnational medical spaces are shaped both by individuals' agency and by therapeutic opportunity structures (Zanini *et al.* 2013). Indeed, the pattern of transnationalisation of health has led to changes in

the interplay of national healthcare and social protection systems, in which States' rules and policies have gradually taken into account. Yet, my fieldwork shows that, bilateral social security agreements (BSSAs) are still far from addressing the reality of transnational health practices of the Tunisian diaspora. After pinpointing the inherent limits of these formal mechanisms, I describe the concomitant growth of the private medical offerings in Tunisia, a particularly well-suited context to further explore the notion of diasporic medical mobilities. As part of my fieldwork, I accompanied participants from Belgium and France on their holiday activities in Tunisia and observed how they moved between both healthcare systems, to circumvent healthcare barriers in the country of residence.

I. Gaining access to healthcare through informal social protection strategies

1. Social networks as healthcare resources in migrants' country of residence

On a Friday night, I went back to the networking event organised by Jamil in the centre of Brussels.[18] *The "usual suspects" were there for the Friday night routine along with some people I had never met before. I met Ramez for the first time that night. He is an assistant nurse and is currently in the process of opening a paramedical policlinic in Anderlecht. He had come 10 years ago as part of an immigration convention that facilitated the recruitment of paramedics in Belgium. He has slowly built a network of patients all around the city. Some time ago, he and a Tunisian friend also living and working in Brussels as a paramedic decided to launch their own small company. That night, Ramez was here to discuss the possibility of collaboration with other people present at the party.*

Skander was there too. He is a young intern currently completing his traineeship in a hospital in Brussels specialising in cardiology. Later in the night, Fedh joined the party. Fedh had moved to Belgium with his wife and two kids for about a year ago. They live in the city centre of Brussels and Fedh's parents were in Brussels for an extended stay. His father has Parkinson's and heart problems. His health had been declining

[18] Jamil works for a telecommunication company in Liège and had been in Belgium for four years at the time. For several years, he had been organizing networking events in Tunis and had now replicated the same type of events in Brussels. The idea behind those networking events was to put in touch members of the Tunisian community with the international community living in Brussels.

significantly in the past months. His brother, who lives in Germany, and he are considering having them settled permanently in Europe to be able to take better care of them. That night, Fedh drew on people present and working in the healthcare sector to get medical advice and contacts. Skander knows a cardiologist at the hospital where he did his traineeship - he is Tunisian and recommended that Fedh contact him, mentioning Skander's name. As we are talking, we are laughing about the fact that so many of their recommendations are for other Tunisian doctors. "They are so many of them in the hospital here! And in France, it is even more! We have everything: dentists, general practitioners, cardiologists, anaesthesiologist, … All those who are missing in Tunisia, they are here!" (Fieldnotes from interaction at the networking event, February 2019, Brussels).

Throughout my fieldwork in Belgium, this type of informal medical advice would often take place spontaneously at events that gathered together actors of the Tunisian community. For individuals like Fedh, this search for medical advice among his group of friends can be explained by his recent arrival in Belgium. As he had just been settled there for about a year, he was still rather unfamiliar with the healthcare structure and doctors in Brussels. The "newness" is introduced by Phillimore *et al.* (2016) as an element of disparity of access to healthcare between migrants and nationals. The lack of familiarity with the functioning of the healthcare system can indeed affect access to health services and professionals. Inadequate access is a primary barrier to effective healthcare delivery (Ingleby *et al.* 2005).

As discussed in Chapter 1, some studies have argued that, with time, migrants' health behaviour tends to resemble the one of non-migrants (Haenzel 1968) while other studies suggest that it is a matter of acculturation (Van der Sytuft *et al.* 1989; Stronks *et al.* 2011). Following that perspective, migrants and non-migrants should therefore, after a certain length of time, have equal access to health care and information and should present the same health risk factors as non-migrants. However, as noted by Ingleby *et al.* (2005: 102), it is not only migrants' task to familiarise themselves with the healthcare system of the country of destination, but healthcare systems also have to adapt to the needs and expectations of diverse users.

Debates around "access" to healthcare can sometimes be ambivalent as they do not deconstruct the different layers on which "access" to healthcare can be impacted for different groups of migrants. As noted by Ingleby *et al.*:

> "The first component of 'access' concerns the question of whether an individual has the right to help (legal rights, financial ability). A second component has to do with whether an individual can come in contact with the caregiver. Many factors will affect this, some related to the person seeking care and others related to the service provider. A third component concerns the question, when an individual has reached the caregiver, of whether they can access their helping and healing powers: in other words, is the help given effective for them?" (Ingleby *et al.* 2005:111).

The question of accessing doctors came up regularly in the course of fieldwork in Brussels. Research actors often complained about the difficulties of finding a general practitioner who would accept their request. As we shall see in the second part of the chapter, the lack of availability was sometimes a trigger for consultations in the country of emigration when access to a doctor was considered too complicated or too slow.

The actors presented above are highly skilled migrants who came to Belgium from Tunisia through a work permit and therefore have access to healthcare rights and insurance like any Belgian resident. As detailed in the methodology, a large number of the participants in my research in Belgium were first-generation Tunisian immigrants who had recently settled in Belgium through work visas. Immigration restrictions to most European countries have made access to work permits more difficult to obtain, often limiting access to skilled or highly skilled individuals in work sectors with a high demand for workers. Some of my participants also came through family reunification. They had access to social protection in Belgium, giving them access to health insurance. They were, in that regard, highly privileged when compared to irregular migrants. Although they certainly did not share the same challenges that irregular migrants have with accessing healthcare (they only access to emergency medical aid, and a limited amount of other health services), this still did not protect them from certain difficulties. In Belgium, the health system is based on a universal protection model to which everyone contributes. Based on compulsory insurance, it also relies on various means to support its accessibility, such as third-party payment, maximum billing, and the status of the beneficiary of increased intervention (BIM)[19]. Learning a new system with its codes, procedures, and way it works, in order to be able to benefit from social and health rights can be a slow process (Focus santé 2019). It can often be difficult to understand how the healthcare system works and to

[19] In Belgium BIM status (bénéficiaire d'intervention majorée - beneficiary of enhanced benefits) allows people with low income to benefit from greater reimbursement of healthcare and medication by their mutual insurance company.

become familiar with it. In Belgium, for instance, the social security-approved doctors, the reimbursement mechanisms, the mutual insurance companies, the role of general practitioners, and the ways the hospital and emergency room work are complex and difficult to navigate.

According to Viruell-Fuentes *et al.* (2016), the evolution of domestic healthcare systems has been accompanied by increasing healthcare marketisation and patient self-responsibilisation. The development of a more "individualized health culture" (Parr 2002: 77) puts the responsibility in the hands of the patients, who are expected to become "experts in their own health" (Ormond and Sothern 2012: 935). Massé (2001) notes the injunction for individuals to manage their health as a healthcare and moral duty.

Individuals may therefore rely more heavily on their social, cultural, and economic capital as well as networks to respond to their healthcare needs. These forms of capital (Bourdieu 1985; Portes 1998) of an individual all constitute resources mobilised to acquire and/or maintain good health (Hawe and Shiell 2000; Uphoff *et al.* 2013; Pinxten and Lievens 2014). Social position remains an important determinant of health, and studies have clearly demonstrated the association between levels of economic capital and health outcomes, as well as between social capital and health behaviours (Ahnquist *et al.* 2012). Social capital can be defined as resources embedded in individuals' social networks (Lin 2001; Li 2015). With regard to healthcare, studies have demonstrated that high social capital is associated with better health (Song and Lin 2009). Cultural capital interacts with social and economic capital and can be broadly defined as people's symbolic and informational resources for action or all culture-based resources (operational skills, linguistic styles, values, and norms) that are available to people to act in favour of their health (Abel 2008). Furthermore, social, cultural, and economic capital are also influenced by class, age, level of education and gender.

As a result, the ability to move within the healthcare system depends on the patient's ability to mobilise his/her economic, social, and cultural capital (Fleuret and Séchet 2004). The use of formal and informal channels to get access to healthcare has been identified by different fields of literature. The concept of "health information–seeking behavior" (HISB) (Cutilli 2010; Lambert and Loiselle 2007) or "personal health information-seeking behavior" (Stavri 2001) in the field of health policy looks at patients' strategies and actions in order to obtain healthcare information. Put differently, individuals may rely on informal channels to get access or find their way within the formal healthcare system. As expressed by Jamil:

> "after four years in Belgium, they indeed make some efforts for your social integration but there are lots of social benefits that you won't hear about. If you don't know about

them, they don't inform you. You have to hear about it from someone or go ask yourself" (Jamil, October 2019, Brussels).

Social media has become a source of information where individuals seek healthcare advice and share recommendations. On Tunisian Facebook groups such as *Tunisians in Belgium*, and *Tunisians in Paris*, members regularly exchanging doctors' contacts or advice on administrative procedures regarding healthcare.

"A good gynaecologist to recommend in Paris, thank you".

Figure 3: Medical information online

Source: Image taken from the Facebook group Tunisiens à Paris, 3 août 2021.

"Hello, I am looking for a Tunisian dentist in Brussels".

Figure 4: Medical information online

Source: Image Taken from the Facebook group Tunisiens (nes) de Belgique.20 mars 2022.

Individuals might use several sources of healthcare information such as healthcare professionals, friends, family, co-workers, newspapers and magazines, TV, and internet. They might use one or several of these sources, sometimes to supplement the information obtained from healthcare professionals or other sources (Cutilli 2010). The images above (Figures 3 and 4) taken from Facebook groups of Tunisians in Paris and in Belgium illustrate the use of this social network as a resource to seek recommendations on doctors in a specific location.

Furthermore, seeking healthcare information is influenced by social variables such as gender, access to technology, education, and level of healthcare literacy (Kutner *et al.* 2006; Wathen and Harris 2007). Some studies looked at the role of social networks to understand how health information is acquired. Following Granovetter's theory on "weak and strong ties" (1973), Baker and Pettigrew (1999) have observed that weak ties, composed of distant friends or

acquaintances, tend to provide more relevant or helpful information than strong ties – composed of family and close friends. Social networks function as nodes enabling the circulation of resources and support (Collyer 2005). Migrants' informal and personal social networks can, in that regard, constitute a social support system and facilitate their integration into the country of destination (Hernández-Plaza *et al.* 2006). The use of informal social networks to gain support might replace or be more "efficient" than formal resources offered by states. The circulation of information through social networks regarding healthcare (such as recommendations of doctors, medical centres, or information on certain illnesses) is found to be central to promoting health and well-being (Kim *et al.* 2015). Social networks constitute, in that perspective, a form of social capital, and individuals make healthcare choices in part based on word of mouth, following friends' advice on where to seek what type of healthcare (Bochaton 2015). Social capital provides individuals with opportunities to use other forms of capital (Burt 1992).

In the fieldwork example above, Fedh is receiving recommendations for several doctors in Brussels who happened to be Tunisian (first or second generation). As developed in Chapter 2, a significant number of health professionals migrate from Tunisia to Europe every year. The degradation of the healthcare infrastructure and the poor working conditions in Tunisia push many to look for work opportunities abroad, a majority in Europe (Belhaj 2020). As a result, this has led to the creation of a "medical diaspora" with the presence of doctors coming from Tunisia in healthcare infrastructures in France and Belgium. I suggest that contacts, through interpersonal networks, with doctors in the Tunisian community in Brussels also serve as an entry point to the formal healthcare system in Belgium. Indeed, the assembly (Faist 2013) of informal recommendations of Tunisian doctors, who are themselves embedded in the formal healthcare system, together shape the therapeutic itineraries of Tunisian migrants.

1.1 Transforming social capital into healthcare capital:

When Jamil had a health issue in the spring of 2019, he went to the hospital in Liège as his regular doctor was in Brussels, where he had previously lived. He first tried to book an appointment with a doctor in Liège but was unable to find one who was accepting new patients, so he decided to go to the emergency room. For a few days, he had been experiencing intense pain in his ears and was hearing noises, something that the doctor

first thought was tinnitus.[20] *He underwent several tests, but they did not find anything wrong with his ears. He was sent home with some* medication *to reduce the pain. Jamil was left with great anxiety, as the doctor at the hospital had told him that the symptoms could be a sign of a brain tumour and that if they did not disappear in the coming days or weeks, he should undergo a scan. Since he felt that the visit to the hospital was not conclusive, he made an appointment with his doctor in Brussels: "I went back to the doctor I already know and usually go to. She is young and reliable, I like her" (Jamil, interview October 2019, Brussels). His doctor in Brussels was rather surprised by the diagnosis he had been given in Liège but decided to order a MRI to rule out the most dangerous diagnosis. Jamil was only given an appointment at the hospital in Brussels in November, four months later. For Jamil, this waiting time did not make sense when considering the potential gravity of the diagnosis: "if they think that it is potentially a brain tumour, they should look into all the hospitals in Brussels, maybe even in Belgium, if there is not an earlier appointment! It does not make sense to tell me that I maybe have a brain tumour and then to tell me to wait for four months!". For Jamil this seemed to be a contradiction with the perception he had about the efficiency of the healthcare system in Belgium: "In Tunisia, these things indeed exist, and I can understand because there are maybe only two scanners. After all, there are no means and all the people who need a scan have to go through the same two machines… but here? How do they give you an appointment in November when you are in June?" He started looking for an earlier appointment by himself. Through the networking events that he used to organise in Tunisia and the event that he organises now in Brussels, Jamil has lots of contact with people working at the European Commission: "all my Italian friends that I know from Tunis, they work for the Commission. I asked them if they had recommendations for doctors or hospitals and my friends gave me a list of the hospitals they had been given upon starting their job at the Commission. I thought that recommendations from the Commission would be reliable, which is why I had this idea". He then called every hospital and ended up finding an appointment for a scan two days later: "I called and said that I had the list from the Commission, and I didn't specify if I was working with them or not. In any case, they are not going to check that once you come to the hospital. If I go through my friends at the Commission, it's better, I go through like a VIP, it is the same thing everywhere, in Tunisia, in Italy… They say it is a democracy, we respect the*

[20] Ringing or buzzing in the ears.

law but if you get recommended by someone it works better." Jamil also mentioned that the hospital he went to was more expensive but that, thanks the private health insurance from his company, he did not have to pay a lot.

Jamil's account of how he responded to what he considered to be an insufficient response to his health problems illustrates the type of arrangements developed by individuals to respond to their healthcare needs by mobilising their interpersonal networks. In the case of Jamil, the social capital accumulated in the country of emigration is here transferred and reactivated in the country of residence. He was able to build a large social network in the country of emigration through his network of friends from his IT training program as well as through his extra-professional activities with the organisation of networking events which included so-called "expats" living in Tunis. Once in Belgium, he met again with some of those from the training program as well as with some of the people he had encountered at the networking events and who had themselves moved to Belgium (some of whom came to work for the European Commission). Transnational social capital is turned into local social capital (Andersson *et al.* 2017). In this particular case, the connection of Jamil with individuals working for the Commission, an elite institution composed of relatively well-paid international staff, is being used to get access to health information that he did not have and that had not been delivered to him. Moreover, following social network theories, Jamil here gets access to information through friends who are embedded in other socio-economic networks in Belgium. The networking events organised both in Brussels and Tunis put him in touch with a more distant social network, opening up new healthcare opportunities. He then transformed his social capital into a healthcare resource or healthcare capital.

When, unlike the case of Jamil, social capital in the country of emigration cannot be transferred to the country of residence, the migrant may experience the loss of an information source. Unequal access to social capital influences disparities in healthcare access.

The exchange of information on healthcare can be understood as an informal social protection strategy (Faist *et al.* 2015). As briefly discussed in the introduction, informal social protection strategies are defined as a "set of risk-reducing practices in the area of human reproduction such as financial protection, child rearing, healthcare, elderly care and the exchange of various kinds of information about such issues as employment, education, health, laws, and social activities" (Amelina *et al.* 2012: 3). It is a "fundamental feature of dealing with and overcoming social risks" (Bilecen and Barglowski 2014: 204). Here, we see the overlap at times of informal and

formal strategies, their complementarity and how their arrangements enable, at last, access to social protection.

Inequalities in social and healthcare capital have led diaspora associations to develop ways to respond to migrants' social protection needs, which I explore in the following section.

2. Intra-diaspora medical solidarities

Migrant associations or diaspora associations are places where migrants can turn that provide support and bureaucratic assistance, helping their members to understand the way the social protection system works in the country of destination and its administrative complexities. Such associations are both vectors and expressions of transnationality connecting transnational spaces. They play an important role as a resource (Levitt *et al.* 2015) available to migrants to respond to their social protection needs. They often are an important source of information and play the role of intermediaries between migrant communities and State institutions in the country of destination. They often target members of the community that are most vulnerable such as people with low incomes, irregular migrants, and refugees. In Phillimore *et al.*'s discussion on the role of health providers as bricoleurs, the role played by civil society actors in "addressing gaps and cracks in provision" (2018:1) is underlined. In their understanding, healthcare systems are composed of a mixed economy of welfare which involves a multiplicity of stakeholders and providers that interact with patients as well as the socio-economic environment (Lee *et al.* 2013). The healthcare "ecosystem" is composed of public, private, and civil society providers and their interconnections. This ecosystem is even more relevant in protectionist contexts where a certain marginal group of the population is perceived as undeserving "because they do not belong or have not contributed sufficiently" (Phillimore *et al.* 2018:4). These informal networks of welfare provision are critical in ensuring access to services to the most vulnerable such as irregular migrants.

In Paris, this is the case of the Tunisian Federation for a Citizenship of Both Shores (FTCR) association. The association has a long history of advocating for immigrants' rights, in particular regarding access to social protection and healthcare. They accompany primarily Tunisian migrants, but also support migrants from other Maghrebi countries as well as sub-Saharan migrants. They have pursued a long-term engagement in supporting migrants in need of healthcare assistance, in particular for accessing State medical aid (AME) for irregular

migrants, but also regarding HIV prevention and treatment access. They take part in monthly meetings with the Observatory of the Right to Health of Foreigners,[21] a group of associations that intend to promote the "right to health" of foreigners. During my fieldwork in Paris in October and November 2021, I took part in a few events organised by FTCR, and also made observations during the time set aside for social and legal support. This was the occasion to understand the role of the association in advising migrants regarding their rights in France. Many came looking for assistance in accessing State medical aid and urgent care, which is not automatically granted to irregular migrants but is granted upon request. The procedure can take some time, during which individuals are not protected in case of healthcare emergencies. The confusion around the administrative procedure and to which institution one should turn has been identified as one of the factors impeding its access (Gabarro 2022).[22]

On the day of my observation at the FTCR, Mohamed, one of the social service counselling staff members, was gathering information and papers and filling in online requests for AME. Among the documents that need to be gathered to enter a request for AME are a passport showing the date of entry into France; an identity card; a translated birth certificate (by a sworn translator); a translated family record book (by a sworn translator) and a copy of a residence permit that is no longer valid as well as proof of one's residence exceeding 3 months.[23] In addition, there needs to be at least one more document proving the identity of the person: for example, a driver's license; professional card(s) from the country of emigration; student identity card(s) a document with the individual's name from the Ministry of Foreign Affairs, etc. Providing all this documentation constitutes, by itself, a significant obstacle for many irregular migrants and can be an exclusionary measure (Gabarro 2022). When emergency healthcare has been provided to a migrant who had not requested and received the AME, healthcare expenditure is technically not covered by the State. Many individuals end up at FTCR for legal support as they are asked to pay for healthcare bills that they cannot afford. This is the case of Mina, an irregular Tunisian woman migrant who arrived in France just a few weeks before the delivery of her baby. Uninformed about the necessity to apply for the AME, she did not request it in time for delivery. She was taken in by a public hospital in Paris which at the time of my fieldwork asked her to pay a bill of 8000 Euros for the delivery and the additional medical treatment she underwent during her hospitalisation. She was received at the duty lawyer service

[21] ODSE - Observatoire du Droit à la Santé des Étrangers.
[22] Gabarro, C. « Obtenir l'AME: un parcours du combattant », in: Betty Rouland (dir.), Dossier « L'aide médicale d'État, la fabrique d'un faux problème », De facto [En ligne], 31 | Février 2022, mis en ligne le 28 février 2022. URL: https://www.icmigrations.cnrs.fr/2022/02/09/defacto-031–01/
[23] https://www.ameli.fr/assure/droits-demarches/situations-particulieres/situation-irreguliere-ame

by a pro bono lawyer. Although she had then completed the procedure to ask for the AME, it did not work retroactively. The lawyer was therefore planning to engage in a legal procedure to exempt her from the medical expenses she was far from able to afford.

The example illustrated above demonstrates the response given by civil society, and the mobilisation of diasporic networks and knowledge across the different silos of the healthcare system to support vulnerable Tunisian migrants. As providers in the economy of welfare, they take part in the healthcare ecosystem by helping individuals navigate bureaucratic difficulties. The "flexibility" of their response is generated by the withdrawal or inflexibility of the State (Phillimore *et al.* 2018). The diasporic medical solidarity unfolding during the pandemic also illustrates the moral economy at play, with Tunisian civil society stepping in as welfare providers "from below" to support fellow Tunisians abroad in dealing with bureaucratic hurdles and accessing healthcare services in their countries of residence. Their involvement became especially significant when public healthcare systems, strained by the pandemic, were unable to meet their moral commitments and responsibilities.

After having looked at the mobilisation of Tunisian diasporic network and knowledge across the different silos of the healthcare system to support vulnerable migrants, I now take the collective of Tunisian doctors in France against Covid-19 as a case in point.

2.1 The collective of Tunisian doctors in France against Covid-19

With the outbreak of the pandemic, the Tunisian diaspora was quick to activate its network of solidarity in order to respond to the needs of precarious diaspora members. As I discuss in detail in Chapter 5, the Tunisian diaspora and its network of associations have mobilised to support other members of the diaspora most in need during the pandemic, such as low-income households, students who had lost their jobs, and irregular migrants with no access to social protection. Moreover, the Tunisian diaspora promptly responded to humanitarian needs in the country of emigration. Indeed, if diaspora actors are known to mobilise for their country of emigration in times of crisis, the response from home authorities to the needs of their nationals abroad in a similar context seems more volatile (Vintila and Konstantinidou 2022), as aid is often based on a principle of diasporic solidarity.

In the case of the Tunisian State, the consulates usually provide little assistance to their nationals abroad in case of hardship (Pouessel 2020). If during the pandemic the consulates were very active in assisting Tunisian residents stranded abroad and engaged in important repatriation

efforts, most initiatives to support Tunisians residing in Europe were taken by the Tunisian diaspora association or, as we shall see below, by collectives of individuals that formed during the pandemic. As stated by a Tunisian consulate official in Brussels:

> "It is not the mandate of the consulate and we do not have the necessary means to respond to such needs. They are on Belgian territory, and they should turn to associations that are specialised in supporting irregular migrants if they are irregular or to the dedicated services in the country if they are residents" (Kenza, interview March 2021, Brussels).

Indeed, migrant associations from different diaspora groups often mobilize to support their co-nationals in the country of immigration in times of hardship. There are countless examples of diaspora initiatives. However, home authorities' responses are more variable. In terms of healthcare support, the example of the *Ventanillas de Salud* or "Health Windows"- a culturally sensitive outreach program providing information and healthcare navigation support to underserved and uninsured Mexican immigrants (Gaitán-Rossi *et al.* 2023) - within Mexican consulates in the United States are an interesting example of home authorities' initiative (Alonso 2018).

The pandemic highlighted inequalities and disparities in access to healthcare for the immigrant population. Moreover, healthcare structures were quickly overwhelmed by the urgent healthcare needs and non-urgent interventions and consultations. This situation left many people with difficulty in finding the right information regarding Covid-19 measures and in case they were confronted with other medical issues. A collective of Tunisian doctors in France against Covid-19 formed a medical advice and guidance unit for Tunisians living in France and, in particular, those with limited access to healthcare services. I found out about the initiative while scrolling down my Facebook feed. Sofia is an ex-colleague who was working as a doctor for IOM in Tunis. She is now working in Paris as an emergency room doctor as part of the process of validation in France of her medical diplomas. She is what we a "highly skilled migrant" and has been travelling back and forth to Tunisia for work opportunities in international cooperation. She has, however, always remained connected to the medical landscape in Tunisia and has long had an interest in the development of the national healthcare system there. She is engaged with several health-related associations back in Tunisia, such as around sexual and reproductive rights and access to healthcare information for deaf people and maintains a transnational engagement. She is part of the "medical diaspora" defined in Chapter

2. In the context of the pandemic, she mobilised her personal and professional network to build a collective together with other volunteer doctors from Tunisia.

This collective of doctors set up a hotline in Tunisian dialect and also collaborated with the Tunisian Embassy in Paris to share the information effectively. People could call and access different options depending on their needs: food, accommodation, and medical assistance. People were directed to the collective of doctors through that channel. I interviewed Sofia and she explained:

> "Services were shut down and dedicated exclusively to Covid-19. Any other consultations such as diabetes checkups or prescription renewals and so on have been cancelled and people no longer had access to (health) services. Alternatively, they [doctors] set up telemedicine. But for the Tunisian community, they didn't know how to use it, especially since you need to have social security to access telemedicine, and therefore vulnerable people - students who didn't have their social security yet, people stranded in France, people who had difficulties expressing themselves in French and all those who simply have no clue about how the (health) system functions in France - they were confused. The system is in fact very complicated … It is not easy when you are not familiar with the system and people are talking to you as if it is basic. ... They were people who were in distress and did not know how to orient themselves in the French system" (Sofia, Telephone interview, October 2020).

Previously existing inequalities of access to healthcare services were exacerbated by the confusion brought about by the pandemic. As stated by the collective:

> "Some Tunisians residing in France may encounter specific problems: difficulties in accessing a doctor, difficult access to information due to the language barrier. We, Tunisian Doctors in France, are aware of the difficulties some of our fellow citizens experience in finding their way around the healthcare system in France, finding adequate care for chronic diseases, and finding answers to their questions about Covid-19" (Collective of Tunisian doctors in France, 16 April 2020).

Factors such as poor language skills in French, lack of computer literacy and isolation have been well documented in the literature as determinants of health and migration, as discussed in the theoretical chapter. The pandemic also highlighted disparities in social, cultural, and economic capital (Bourdieu 1985; Portes 1998) as resources were mobilised to acquire and/or maintain good health (Uphoff *et al.* 2013; Pinxten and Lievens 2014). A large part of the support

provided by the collective of Tunisian doctors was therefore in terms of guidance and in providing information on where to go within the healthcare structure in France, depending on the location and medical needs. They also provided medical advice online and offered consultations within the medical offices of volunteer doctors.

The collective involved the Embassy, as some of the volunteer doctors had not yet had their qualifications recognised; they were still in the process of having their Tunisian diplomas certified and being at the Order of French Doctors. To avoid any legal issues, Sofia explained:

> "We agreed on a way to work and to always redirect people to the French healthcare system. We had to work within the French structures to avoid any problems. Many people called me for medical issues, and I would tell them: "come to see me directly in the emergency room at the hospital where I work", so I could respond to their needs in a legal framework ... For instance, those calling for a prescription renewal came to the hospital and registered, went through the French legal framework first and then we did what was necessary. Other doctors were doing the same so that we made sure that this would not be considered as an informal parallel medical practice. It was really an orientation group to the French health system" (Sofia, Interview over the phone, October 2020).

We see here the ways in which informal support mechanisms provided by the collective are embedded within the formal public healthcare structures in France. This example illustrates diasporic healthcare arrangements where formal and informal strategies are intertwined and together provide the social protection needed to other members of the diaspora. Furthermore, connecting the Tunisian Embassy to their initiative was a way to ensure that their action would be considered legitimate in the eyes of the French State. Although the Tunisian Embassy, along with its consulate offices, did not consider such initiatives as part of their mandate and had no financial resources available for it, they however welcomed the initiative of the collective strengthening the interconnections between the different providers. These arrangements are diasporic as they take shape thanks to diasporic networks which derive from the long history of Tunisian emigration and the engagement that these actors wish to maintain with the country of emigration as well as with other diaspora members.

Here, I discussed the role of civil society and of the mobilisation of the Tunisian diasporic network in responding to the disparities of healthcare access, in particular in the context of the pandemic, The next sub-section explores the interwoven nature of different social variables and

their impact on transnational healthcare practices through the case of at Tunisian women migrants' experiences of sexual and reproductive health in their country of residence.

3. Tunisian migrant women's experiences of sexual and reproductive health provision in their country of residence

As we have seen earlier in the chapter, navigating the healthcare system in a country where one has recently settled can indeed be uncertain, and it is sometimes confusing to understand where to get the right information and what type of treatment is needed. The "newness" in a country can also result in a person having difficulties finding a referring doctor and other specialists, such as in the case of women migrants finding a gynaecologist. For several of the participants in my research, they had rarely seen a gynaecologist while still living in Tunisia and their first contact ever with a gynaecologist took place in the new residence country. Consultations with the gynaecologist would only occur in case of specific needs or in the context of reproduction. The perception of gynaecological care seems to be centred around reproduction (Gherissi and Tinsa 2017). Also, non-married women and women in their early twenties would often be surprised when asked about gynaecological visits, bringing up the concern about virginity. The norm of virginity impacts perceptions of women's gynaecological care before pregnancy (Skandrani *et al.* 2010). Why would they go to a gynaecologist if they were not married (and thus not sexually active) and/or pregnant? Discussing further their perception of gynaecological care, they would explain that while living in Tunisia, visiting a gynaecologist could lead to misunderstandings, letting people around them think that they were sexually active. Enquiring about gynaecological care was a source of embarrassment and, they explained that, as they were never told by their doctor or their mother to visit a gynaecologist, they did not take the initiative to go. After arriving in Europe, they did not change their healthcare habits and continued not to go to gynaecological exams. During my fieldwork on assisted reproduction in Tunis, women would often explain to me that they had no gynaecologist in their countries of residence until they had to consult for their infertility issues. Although, as I describe later in the chapter, Tunisia had a pioneering role among Arab countries with regard to sexual and reproductive health, Ben dridi and Maffi (2018) emphasize that its access and use was, and still is, conditioned by a moral economy of sexual and reproductive behaviours. This is a religious moral economy that perceives sexuality as legitimate, as long as it is practiced for procreative purposes and within the framework of marriage, but also a patriarchal moral economy, as this rule does not apply in the same way to men's sexuality prior to marriage (ibid.). Looking at the case of single mothers

in Tunisia, Le Bris (2009) highlights the fact that premarital sexuality remains socially and politically taboo. Pregnancy outside marriage and pregnancy within marriage do not have the same moral status. As a result, single women often suffer from a lack of care during pregnancy. These different moral registers influence the practices, discourses and perceptions of women and medical professionals as well as society on the topics of sexuality and reproduction (Ben dridi and Maffi 2018). This informs us about the age at which gynaecologists are consulted, but also about stigmas in certain sections of society that may be associated with a visit to the gynaecologist. These normative moral codes are embodied and embedded in habitus (Massé 2009).

Some mentioned, on the other hand, that they started visiting a gynaecologist after arriving in Europe. They mentioned being advised by their general practitioner to make an annual visit to the gynaecologist or receiving reminders from their health insurance on preventive care which encouraged them to go. The description of their gynaecological visits also reveals the difference in medical protocols between the country of destination and the country of emigration, which requires that both healthcare professionals and patients adapt.

Zeineb told me about her first gynaecological visit in Belgium and described the different steps of the visit. She had decided to visit a female gynaecologist as she felt uncomfortable seeing a male gynaecologist. She explained that the doctor started the check-up and as the doctor was about to proceed to the pap smear and insert the speculum, she asked her doctor to stop. In Zeineb's opinion, she didn't need to proceed to the pap smear as she was still a virgin. However, the doctor explained that past a certain age (21 years old), she would still recommend proceeding to the control. Zeineb refused as she was concerned about the impact that the "invasiveness" of the control could have on her virginity. She also refused to proceed to the vaginal touch. The doctor then simply proceeded to the external touch and the breast exam. She recalled:

> "I know that the pap smear is not compulsory. How can they use a speculum if the girl is a virgin? It was very embarrassing... I just thought, 'I am not going to lose my virginity over a gynaecological exam!' (She says laughing)" (Zeineb, 3 May 2019, Brussels).

If medical discussion over the necessity to proceed to a pap smear before being sexually active is also a topic of debate in Europe (Baldauf *et al.* 2011),[24] in Tunisia the test is usually not

[24] The necessity of pap smear screening at a young age are indeed debated in the medical sphere and several studies demonstrate that there is no scientific proof of the effectiveness of such control. For more information on this, see Baldauf *et al.*,

practiced before a woman's first sexual relationship and is still not systematically practiced after the first experience of sexual intercourse (Hsairi *et al.* 2007). Also, this example demonstrates the arrangement that Zeineb developed between following the advice and recommendation from her Belgian doctor regarding the gynaecological exam and the medical practices she had been informed about and used while still living in Tunisia.

Similarly, Nour's experience after childbirth demonstrates the type of arrangement made by women themselves as well as the adaptations from healthcare professionals to interculturality in healthcare.

> *Nour had been in Europe for about a year when she gave birth. Three weeks or one month after childbirth, she recalled going to the Office of Birth and Childhood for the first paediatric consultation. The paediatrician that received her on that day was of Moroccan origin and advised her to come directly to him for further consultations. She recalled him telling her: "I saw that you were not feeling comfortable in the waiting room, and I understood you are not a Belgian mother! I don't think a Belgian paediatrician would understand you well. I know the habits and the tradition and how you live this period" (Nour, 10 April 2019, Liège). Nour stopped going to the free consultations from the Office of Birth and Childhood and preferred going directly to the Moroccan paediatrician, even if consultations were only partially reimbursed. She explains that because he was from Morocco, she felt he was more "flexible" regarding what she could do or not with the child as he was aware of childcare habits in Tunisia: "Once he told me: "if you want to give him herbal tea just do it! It is not going to hurt him even if they don't recommend it here". He knew we are used to that in Tunisia. ... Or, you are normally not supposed to sleep with the baby. Whenever I saw a Belgian paediatrician, they would always tell me that I was not supposed to do it, but he (Moroccan paediatrician) never bothered me because I was sleeping with my baby" (Nour, 10 April 2019, Liège).*

The discussion with Nour highlights the notion of cultural competence and its role in the provision of healthcare. Its promotion among healthcare services and health professionals is one of the strategies put forward to improve the adaptation of health services to "migration-driven diversity" (Phillimore *et al.* 2016: 12). From that perspective, improved attention to

2011, "Is early cervical cancer screening justified?", *Gynécologie Obstétrique et Fertilité,* Volume 39, Issue 6, pp.358-363.

cultural differences, variations in health beliefs, as well as particular health behaviour related to cultural habits, allow the adoption of culturally appropriate strategies and reduce certain disparities in healthcare access (Balcazar *et al.* 2010; Hernandez-Plaza and Padilla 2014). As illustrated by the case of Nour, one adaptation put forward by some public health researchers is the "matching" of patients with health professionals of similar cultural backgrounds, which is believed to help alleviate cultural and linguistic barriers, prevent racial discrimination and the consequent lack of trust between the patient and the healthcare professionals (Saha *et al.* 1999). This approach has, however, been criticised by several scholars who argue that the notion of cultural competence encourages a deterministic understanding of a patient's culture rather than a socially constructed one (Ingleby 2012). Moreover, an application of the concept is not feasible in super-diverse environments. Finally, Hernandez-Plaza and Padilla argue that disparities in healthcare access should be read through the lens of social inequality and power asymmetry rather than giving too much importance to the cultural dimension of diversity, which considers ethnicity and culture of origin as the main cause of disparities (Hernandez-Plaza and Padilla 2014).

In the case of Nour, however, pursuing her consultations with the Moroccan paediatrician seemed to answer her concerns which had first arisen by her discontent with the health advice she was given while at the hospital after giving birth:

> "I felt very, very lonely while at the hospital and I was very anxious. I was in a shared room so my husband was not able to stay with me at night and Anis was crying a lot and I would, of course, take him in my arms and often I was falling asleep with him. Every time a nurse was walking in, she would argue with me and make me feel like I was doing something very wrong. For me, I understand that you have to be careful when you sleep with a baby, but you can't let him cry like this every time you put him down and it's not like we have a lot of accidents in Tunisia" (Nour, April 2019, Liège).

Indeed, healthcare arrangements are often deployed as a response to disappointing healthcare (Bradby *et al.* 2020). When healthcare needs are perceived as not fully met, individuals may search for alternatives such as looking for another doctor, for alternative advice or treatment, and in certain cases, might withdraw from treatment (ibid.).

3.1 The role of the healthcare sector: (lack of) responsiveness to heterogeneous healthcare needs

"Transnationality interacts with other heterogeneities such as gender, legal status, ethnicity, and educational and occupational status" (Faist *et al.* 2015: 194). The intersection of gender with other social variables influences the quality of access to healthcare (Phillimore 2015). It is therefore necessary to interrogate how gender, class or education influence one's power to make decisions about one's own health. Indeed, gender relations can have a decisive impact on the way we treat and receive care. Under the impetus of the North American feminist movement, social science studies have demonstrated that social representations linked to gender influence patient behaviour, medical practices and research. Hence the need to adopt a gender perspective in healthcare (Kuhlmann and Annandale 2015; Iyer *et al.* 2008). Research started to question the type of attention men and women give to their own health and illness and what factors constrain or facilitate their use of health services (Travis *et al.* 2010). Gender influences our relationship with our bodies, our perception of symptoms, our use of healthcare services, and also the interpretation of clinical signs and management of pathologies by healthcare professionals (Vida 2019). Differences may arise from social factors external to health services as well as to factors dependent on the operation of health services. Although they are medically monitored throughout their lives, women benefit from poorer medical care than men. They suffer from illnesses that are under-diagnosed or diagnosed at a later stage (ibid.).

Therefore, mobilising the concept of intersectionality is relevant for understanding women migrants' health and the (re)production of inequalities. "Bringing gender in[to]" (Pessar and Mahler 2003) the analysis of transnational migration is essential as "gender operates simultaneously on multiple spatial and social scales (e.g., the body, the family, the state) across transnational terrains" (ibid: 815). Existing studies on gender and transnationalism often set emigration and immigration contexts in binary opposition. Research on the impact of migration on women migrants has often equated emigration and emancipation and has neglected the transformations taking place in the often rapidly changing emigration context (Moujoud 2008) as well as the discrimination taking place within the immigration context. Migrant women are indeed at risk to be doubly discriminated against - as women and as migrants.

The experience of Nesrine when having an abortion in Belgium reveals the role of gender as well as its intersection with other factors in the quality of access to healthcare services:

> *Nesrine had only been in Belgium for three weeks when we met. She would become one of the main participants in my research and we have built close ties since then. Her*

journey to come work in Belgium involved a great deal of struggle after months of visa uncertainties, but she finally got to Brussels. When she moved, many things started to change in her lifestyle. Being alone here, she made great efforts to meet new people, despite having a rather reserved personality. Nesrine is quite religious and comes from a rather conservative family with a relatively privileged background, one we could identify as middle class. Being in Belgium and trying to experience relationships was not always easy, forcing her to question some of her religious beliefs, around sexuality in particular. Maybe two years after we had first met, she started dating someone. Nesrine is a believer and practitioner and, in her thirties, she was sexually active for the first time while in a relationship. After two months of dating, she got pregnant. She didn't talk to me about it when it happened as she felt ashamed of the situation. It was only months later that she would opened up about what had happened and recalled her abortion journey. When she realised she was pregnant, she didn't know where to go to get an abortion. After having taken a pregnancy test, she went to the pharmacy to ask for guidance. The pharmacist at the counter advised her on a few medical centres she could go to such as the family planning. She made an appointment and went in the following day. When telling me about her experience, she stressed the inadequate guidance she received from the doctor at the family planning. Nesrine was rather surprised by the "test" she was put through despite the fact that she had absolutely no doubt about wanting to get an abortion. She had been dating her boyfriend for less than two months when it happened. Not only did it seem impossible for her to keep the child of someone she had just met but it was also something that would probably shock her entire family. Indeed, virginity before marriage was something that her family had taught her and something that she initially wished to respect in accordance with her religious practice. Opening up about the issue with the doctor at the family planning centre, the doctor seemed to understand that the abortion was maybe more because of her family than her own will not to pursue the pregnancy. Nesrine recalls: "she went on and on telling me about my freedom of choice and that an abortion was an intimate and a personal decision and that what my family could think about me getting pregnant should not stop me from keeping the child if I wanted to. I was there sitting in front of her, and I just wanted her to leave me alone with her theories. I was trying to tell her that it was just impossible. I could not have a child with a man I met just weeks ago …. but she was blocked by the fact that I had mentioned my family. She was giving me a speech as if I am just submitted to my family and their religious morals. That bothered

me! For her she saw I was Maghrebi and so that was it: I wanted to get an abortion because of my family because I am not free to choose. My religion and my family are one thing but not wanting a child from someone you have been dating for two months is also legitimate".

The experience of Nesrine's abortion within a family planning centre in Brussels raises several points of discussion and crystallises a number of debates around the patient-doctor relationship, interculturality in the provision of healthcare as well as the importance given to cultural determinants in the analysis of healthcare behaviour. Firstly, as Nesrine was confronted with her pregnancy when taking a home test, she did not know where to go to seek abortion advice and therefore went to the pharmacy to get advice. It is not the first time that Nesrine used the pharmacy as a source of information to help her navigate the healthcare system in Belgium. A few months before, she had also sought advice at the pharmacy regarding access to contraception. The pharmacist at the time explained to her that she needed to get a prescription from a gynaecologist and helped her look for one in her neighbourhood. As she learned about her pregnancy during the weekend and the office of her gynaecologist was closed, she decided to return to the pharmacy. This time she was oriented to family planning. Seeking information from the pharmacy, a private healthcare actor, is a well-known phenomenon in the study of personal health information-seeking strategies (Phillimore 2015, Phillimore *et al.* 2018). The intervention of a private actor in the orientation of individuals within the national healthcare system demonstrates once again the interwoven nature of the different healthcare providers that are required for health service to be provided (Phillimore *et al.* 2018). This also resonates with the notion of "healthcare bricolage" (ibid.) which results from "tactics of utilizing available resources to address health issues" (Bradby *et al.*: 2) as well as the concept of "social protection arrangement" (Kilkey and Merla 2014; Vivas-Romero 2017) where formal and informal strategies mingle for social protection needs to be answered.

Furthermore, in the case of Nesrine, several of her family members work in the healthcare sector. On many occasions, Nesrine would seek advice from them when she had a health issue while living in Belgium. A few months ahead, she had a constant pain in her breast that lasted for several days/weeks. She sought advice from one of her relatives, who gave her advice over the phone on what to do and also told her to come for a medical visit upon her holiday visit in Tunisia just a few weeks later. Using her network of doctors within the family in Tunisia was therefore part of her toolbox to deal with healthcare issues and she still has no general practitioner in Belgium. However, when she started to be sexually active, she stopped seeking

advice from her extended family and also stopped going for ad hoc gynaecological consultation in Tunisia as she feared that they could find out about her loss of virginity. She was also reluctant to visit another gynaecologist in her hometown in Tunisia as she believed that her family knew almost all of them personally. She therefore lost an important healthcare resource. Moreover, the sensitivity of the medical issue kept her from asking help within her small social network in Belgium. Even though she had been talking to me very openly about sexuality, religion and moral questioning regarding her sexual life, she did not turn to me to ask for advice about where to go for an abortion. In this case the pharmacy represented a neutral and anonymous space where she could seek help. Indeed, Nesrine neither had access to a large social network in Belgium nor in Tunisia. When analysing her social network in Belgium, it seems that it more or less reflects the one she had in Tunisia. I believe that her religious family background and the associated gendered behaviour that accompanies it partly explain the restrained social network that she had built. Comparing the case of Jamil and the case of Nesrine, I believe that gender, as well as the nature of the healthcare intervention that they required, was a determining factor in analysing how they could rely (or not) on their social capital to navigate the healthcare system in Belgium. Here, I suggest that Nesrine's healthcare arrangements are diasporic, as the diasporic space somehow framed the healthcare resources she could or could not have recourse to in this particular healthcare situation.

Secondly, Nesrine's experience within family planning is a telling illustration of the problem around explaining healthcare behaviour through the prism of cultural determinants. Doctors' assumptions regarding migrant patients can result in prejudiced behaviour (Paternotte *et al.* 2015). As outlined earlier, while adaptation of the healthcare structure and training of medical staff awareness to be aware of different cultural dimensions of healthcare and culturally oriented needs is essential, there is a risk of essentialising certain behaviour. Women's access or lack of access to sexual healthcare is embedded in socio-economic and cultural factors (Zaouaq 2017). Here, the representations of women's sexuality impact their access to sexual healthcare, pointing to how social variables condition access to healthcare. Sexual health entails physical, emotional, social, and intimate well-being and "should be analysed within the context of the social and cultural construction of gender and the experience of social change" (Dawson and Gifford 2003, p.41). Power relations in the doctor-patient relationship are influenced by the respective genders of the actors involved. Moreover, gender stereotypes also influence how healthcare professionals interpret symptoms and manage illnesses (Ben Dridi and Maffi 2018). The representations and "orientalist" (Saïd 1980) imaginary about Arab women's sexuality play

a role in women's approach to their own sexual and reproductive health, but also in how their sexual and reproductive healthcare needs are being addressed within social and political public structures (Fortier and Monqid 2017).

Nesrine seemed to reject this association and the cultural explanation that was "applied" to her by the doctor at the family planning centre. Her association with the category of "the Maghrebi" and the "inappropriate assumptions of sameness" (Kaplan 2007: 187) made by the healthcare professional was something that she rejected. The case of Nesrine demonstrates the reproduction of gendered inequalities and cultural stereotypes as a woman migrant coming from the "Arab world".

3.2 A Tunisian particularism? Building otherness

Among the actors of my research in Belgium, the will to distinguish themselves from the Moroccan community, in particular, was an attitude that emerged regularly regarding different subjects. People often claimed that the Tunisians in Belgium were not as "communitarian" as the Moroccans, that they wanted to integrate and mix with the rest of the Belgian population. In their discourse, they, revealed the reproduction of certain stereotypes and stigmatising perceptions.

When I discussed the matter with Sofia (the young Tunisian doctor introduced earlier who was part of the collective of Tunisian doctors during the pandemic) she reflected:

> "Regarding migrant communities, from the point of view of the host society, it's always everyone in the same bag. The "Arab" community, the "Maghrebi" community… They assume that Algerian, Moroccan and Tunisian, it's the same needs, but it's not like that" (Sofia, Interview over the phone, October 2020).

According to her, the particular history of the development of sexual and reproductive health services in Tunisia was an element of response to understanding the different healthcare behaviour of Tunisian migrant women.

Tunisia has had a pioneering role in Arab and Muslim countries with regard to the promotion of men's and women's equality. In 1956, the creation of the Personal Status Code established a number of laws that redefined the position of women in Tunisian society and led to the abolition of polygamy and the right to divorce (Fortier 2010; Sadiqi 2008; Ben Achour 2007). The implementation of this State feminism (Ben Achour 2001) and of this new "biopolitics" (Kilani 2018) also had an impact on the development of sexual and reproductive rights in Tunisia. In

1966, a national program of family planning was launched and implemented throughout the country encouraging women's use of contraception (Gastineau and Sandron 2000). With this, we saw the emergence of a dualism between the development of a "State-modernism" and State's control over women's bodies, coupled with the perseverance of cultural and religious barriers, as well as social control over women's bodies (Gastineau 2012; Sadiqi F. 2008). Tunisia became the first Arab country to legalise abortion in 1973, before the Veil law in France in 1975 (Sadiqi 2008; Maffi and Affes 2017; Hajri *et al.* 2015). However, this Tunisian particularism was motivated at the time by the necessity to control demographic growth and reduce the birth rate. The introduction and legalisation of contraception and abortion were therefore part of family planning measures, aiming at achieving ambitious socio-economic development goals, and not the result of the State's willingness to emancipate women (Gastineau and Sandron 2000; Gastineau 2012; Mahfoudh and Mahfoudh 2014). The State resolution to reduce the population prevailed over the moralisation regarding women's sexual behaviour up until the 1990's (Ben Dridi and Maffi 2018). After that point and under the Ben Ali regime, the State's measures regarding family planning declined. After the 2011 revolution, the re-Islamisation of Tunisian society and politics after the election of the conservative party Ennahdha, further degraded access to sexual and reproductive health (ibid.). The significant economic crisis impacting investment in the healthcare sector and the availability of medication also played a role. In these different socio-political contexts, abortion (although legal) remained controversial. If women can legally access free abortion, in practice the law granting her access is not always effectively implemented. As a consequence, women lack adequate information about the availability of legal services and informal abortion continues to be practised (Maffi and Affes 2017; Hajri *et al.* 2015).

Maffi *et al.* (2017) remind us that the notion of sexual and reproductive health was first formulated in the context of international organisations in the 1970s and that the terminology of "sexual and reproductive rights" was first mobilised by feminist organisations. After the 1994 Cairo conference on population and development, sexual and reproductive health and rights was on the agenda of UN organisations and cooperation agencies. In the Maghreb countries, states are therefore pushed to integrate these notions into their development programmes in order to receive funding to implement local health services. Compared with Sub-Saharan countries, the Maghreb countries led the way in adopting population policies, with a strong emphasis on promoting family planning initiatives (Gastineau and Adjamagbo 2014).

Although more successful in Tunisia due to the strong political leadership of Bourguiba, family planning programmes were also put in place in other countries in the region.

In Morrocco, family planning programmes have taken shape since 1966 and expanded in the 1970s and 1980s. At the beginning of the 1970s, measures were taken to disseminate family planning throughout the country, even in isolated rural areas. Significant efforts were conducted to increase access and adherence to contraception. Development plans also included economic and social measures such as education (of girls in particular) and women's employment (Gastineau and Adjamagbo 2014). In 1998, an action plan for the integration of women in development was presented by a feminist collective and, despite being supported by the government of the socialist Prime Minister Abderrahmane Youssoufi, did not succeed due to a strong conservative opposition. Several important reforms have taken place since then, such as the establishment in 2004 of the new Personal Status Code (or *Moudawana,* first established in 1956), and the revision in 2007 of the law on nationality, which enabled children of Moroccan women to obtain their mother's nationality (Zaouaq 2017).

In Algeria, in 1966, the women's organisation UNFA urged the Algerian government to promote contraceptive use for the health of mothers and children. Despite efforts by secular leaders to improve women's rights in education, healthcare, and employment, these changes faced resistance. During President Boumediene's rule (1965-79), his stance on family planning shifted. Initially, he supported family planning as a means to abolish polygamy and improve women's health, but in 1969, he opposed it, due to the need to compromise with other political forces. Nonetheless, family planning initiatives progressed. The first birth-spacing centre opened in Algiers in 1967, and by 1980, there were 260 maternal and child health centres nationwide offering free contraception and healthcare services (Esseghairi 2003*)*. Family planning was incorporated into Mother and Child Health services, but the distribution of contraceptives faced important shortages of supplies. In 1983, there were 346 centres providing contraception, which increased to 2,054 by 1990. However, not all contraceptive methods were available at every centre (ibid).

Both in Morrocco and Algeria, abortion is considered illegal unless medically necessary to preserve the woman's life or health. Unsafe abortions are therefore a public health issue (Hessini 2007).

The explanation based on the specificities of Tunisian history was regularly given to me by Tunisian migrant women themselves as well as by members of associations in Brussels working on the promotion of women's rights and access to sexual and reproductive health. The

association AWSA - Arab Women's Solidarity Association - is a feminist, secular association that promotes the rights of women from the Arab world in their countries of emigration and of destination. It is a continuing education association, organising workshops with different groups (schools, youth centres, health professionals etc.) aiming to deconstruct stereotypes regarding Arab women and their sexuality. For Katia, an association member and social worker at the Saint-Pierre hospital in Brussels working on sexual and reproductive health (HIV-AIDS in particular), the difference between Tunisian women migrants and Algerians or Moroccans could also be explained by the different historical trajectory regarding sexual health in Tunisia:

> "As a result of this, they at least perceive themselves as different from the Moroccans… so it might be that even if they are facing similar difficulties, they won't come to these places because in their mind they feel superior to the others. That is how I understand it. … It can be that they are better educated than the Moroccan and Algerian women that we receive. They might come to us for specific needs, but they don't take part in women's associations. … They don't mix with the others" (Katia, association member and social worker, online interview, October 2020).

The argument of the historical trajectory of sexual and reproductive rights in Tunisia of course has to be nuanced, as there have been and still are important disparities in access to sexual and reproductive health in Tunisia between rural and urban areas, as well as across socio-economic classes (Maffi and Affes 2017).[25] In the case of Nesrine and of several of the participants in my research, this also reflects similarities in terms of class and level of education. Nesrine herself comes from a relatively privileged family background with, as I detailed above, easy access to doctors within the family. This also reflects different patterns of regular immigration, where the most recently arrived are often highly skilled or came to Belgium through family reunification after their husbands immigrated thanks to their highly skilled profile. Their positioning and experience of access to sexual and reproductive health in Tunisia do not reflect the experience of less privileged women. Moreover, the positioning of women in Tunisian society and its political history was perceived as an important component of their "Tunisianity" and was often flagged to me as a determining element of their Tunisian identity. This is part of what is sometimes described as the "Tunisian particularism" where Tunisia distinguishes itself from other Arab countries by its improved access to education, abortion rights and its political transition resulting from the Arab Spring.

[25] Moreover, backtracking attempts by the political party Ennahda in 2012 showed that gains in women's rights remain fragile (Fortier and Monqid 2017; Kilani 2018).

3.3 Social construction of cultural identities and health disparities.

In 2019, I met Dounia, a gynaecologist and sex therapist who has a medical office in Molenbeek in Brussels. She is a second-generation Tunisian and grew up in Paris. She initially came to Brussels for her medical training and remained in the country since then. For many years, Dounia had been very active both as a health specialist and as an advocate for sexual and reproductive health. Aside from her medical practice, she has developed several initiatives in collaboration with civil society organisations in Belgium such as AWSA (introduced earlier). Over the years, she had encountered several examples of women who have been the victim of stigmatising representation which, according to her, can lead to ineffective healthcare provision or even mistreatment:

> "I have always found it shocking when colleagues in the medical sector do not know anything about the culture of their patients and consider for instance that an Arab woman with vaginismus[26] is normal and doesn't provide the necessary care. They are not advised to go to a sex therapist because they assume that sexuality is too taboo or that sexuality doesn't matter to them anyway. It's obstetrical and cultural violence ... we are in a two-speed medicine ... they judge through the cultural prism. Because the patient belongs to the Arab culture, the doctor undermines the importance of offering them a cure to their sexual health issues" (Dounia, Brussels, 2019).

Misconceptions and stereotypes about the patient's culture and healthcare behaviour can indeed lead to ineffective treatment. If the examples above took place in Belgium, others are reported in the literature on migrant women in France (Sauvegrain 2012; Marsicano *et al*. 2011) and did emerge during my short fieldwork stay in Marseille. During my last visit in June 2021, I met a participant with whom I had been in touch since my first stay in Marseille in March 2019. Due to Covid-19, I never had the chance to return to complete a longer period of fieldwork, but the encounters I had during my short visits brought some interesting insights to my research. I met Rym during my first visit and we talked at the time about her experience of reproductive health after her first pregnancy and the type of medical arrangements she made after the birth of her child following both her mother's advice and instructions from her paediatrician in Marseille. We have remained in contact since then. When I went to Marseille for a conference in 2021, I used this opportunity to pay her a visit. I met her second daughter, who was born one year

[26] The involuntary tensing or contracting of muscles around the vagina.

earlier, for the first time. We discussed Rym's experience of delivery in a hospital in Marseille. She recalled:

> "I cannot say that the staff there did not take good care of me. Of course, they did everything that was needed for me and the baby. But the difficult thing for me came from the impression that when expressing the pain, the staff seemed to believe that I was overreacting. As if I was exaggerating my pain but that it was not as bad as I was letting them think. Do you see what I mean? As if I was acting like a drama queen" (Rym, June 2021, Marseille).

During my fieldwork, taking advantage of the lockdown period during the pandemic, I followed a series of online trainings that aimed to raise awareness among health professionals, civil society actors as well as social assistants on the issue of interculturality in healthcare. During a training given by the association *Migration Santé,*[27] based in France, the participants were warned about what trainers called the "Mediterranean syndrome", a widespread belief that patients coming from Mediterranean countries tend to be more expansive in their expression of their pain (Lévy 2013, Baertschi 2019). These stereotypes lead to cognitive biases and the complaints of the patients are not taken seriously because of their national origin. As noted by Baertschi, if taking into consideration the ethnic origin of patients is important, as some diseases are more prevalent in certain groups and social classes, this should not lead to what is defined as "differentiated care"[28] (Baertschi 2019). The treatment of the female body in the medical sector is revelatory of "systems of norms" in the social body (Fassin and Eideliman 2012).

According to Dounia, this is due to insufficient training of medical staff. She believes that professionals like her, who develop a medical practice that is particularly sensitive to these issues, can play a role in filing a gap in healthcare provision:

> "I realised that the women that came to me did it because I looked like them. The Arab Muslim side was answering some of their issues. That is when I realised that there were very few Arab Muslim sex therapists. That is how I decided to complete training in clinical sexology and that I started to work as a mid-wife, and sex clinician and to facilitate workshops for men, women, and teenagers" (Dounia, Interview in Brussels, October 2019).

[27] The purpose of the association is to promote the health of migrant populations and their families, favour their access to health services, rights and care. https://migrationsante.org/

I kept following the activities of Dounia on social media after we met in 2019. She has indeed been very active on social media through Instagram posts and live sessions, trying to make medical knowledge more accessible to her community of patients. Through Dounia, I got to learn about the existence of other healthcare specialists (gynaecologists, general practitioners) with similar profiles and aspirations who, as second-generation immigrants, advocate for a better understanding of migrants' medical needs.

As argued by Phillimore (2011, 2015), the diversification of medical needs, due to an increasingly diversified populations within national boundaries, imposes change on a healthcare system initially designed for more homogenous populations (Phillimore *et al.* 2016). Yet, "the use of static definitions of culture in public health research risks essentializing and homogenizing entire ethnic and/or immigrant groups and perpetuating racial/ethnic stereotypes" (Viruell-Fuentes 2012: 2100). A culturalist approach obscures the reproduction of inequalities by structural factors and its impact on immigrant health outcomes. The social construction of marked cultural identities, and institutional patterns of unequal treatment, contribute to health disparities.

As we have seen in the first part of this chapter, for the actors of my research, migration implies a relative downgrading in their access to healthcare. It is due either to their newness and lack of familiarity with the way the healthcare system works in the country of destination or because of the inadequate delivery of health services within the national healthcare system. Their ability and chances to circumvent these challenges are a function of a multitude of factors, such as their level of education, residency status, gender and social capital. In the second part of this chapter, I explore how these resulting inequalities lead segments of the Tunisian diaspora to actively turn towards their country of emigration when looking for healthcare.

II. Reversing disparities: circumventing healthcare barriers through therapeutic mobilities

Shifting the focus from the country of residence to the country of emigration, I now explore how Tunisian migrants circumvent healthcare barriers they encounter using mobility as a mechanism to bridge disparities.

Looking at how social, cultural, and economic capital theories on health inequalities apply transnationally, Bochaton (2015) notes that individuals' medical journeys depend on the healthcare facilities available, as well as on their capacity to use them. Economic, social, and cultural capital influence patients' ability to take advantage of different offers within and between healthcare systems. The unequal distribution of different forms of capital affects patterns of transnational medical mobilities (Bochaton 2015; Fleuret and Séchet 2004). Spatial resources, or spatial capital, defined as the ability to gain experiences within space through mobility, also influence the development of medical mobilities (Fournier and Raoulx 2003). Spatial capital diminishes physical distance as individuals have better experiences of places and know how to use and combine different means of transportation (Bochaton 2015).

The opportunities and restrictions associated with medical mobilities result from global economic stratification and divergent legal frameworks and regulations across States (Zanini *et al.* 2013). National borders and regulations play, in this case, a determining role in patients' therapeutic itineraries. Some health care may not be affordable in one national context and become affordable in another. Similarly, what is illegal in one country may be legal elsewhere. In examining how people take advantage of different regulations and procedures in different national settings, Zanini *et al.* propose to think in terms of "therapeutic opportunity structures" and "transnational medical structures of agentivity" (Zanini *et al.* 2013: 23). Transnational medical spaces are therefore shaped by individuals' agency and therapeutic opportunity structures. However, to make use of these therapeutic opportunities, people need to be aware of the options at their disposal in the different national contexts and be exposed to "global therapeutic knowledge" (ibid:12). According to Zanini *et al.*, "actors and social groups are differently positioned and therefore have unequal control and access in relation to flows and interconnections" (2013:27). Spatial analysis of medical mobilities allows us to examine

existing power structures, regulations, and moralities that create new forms of exclusion and agency for individuals.

For patients seeking healthcare, it is then a matter of weighing these different elements in determining where to pursue their treatment. Studies on diasporic medical mobilities focus on the healthcare behaviour of diaspora members toward their country of emigration. Their transnational lifestyle trajectories embed them in different healthcare systems, allowing them to draw from the different medical opportunities available for them and their families in order to meet their healthcare needs in ways they consider most appropriate. As formulated by Ormond, authors have raised attention to "migrants' agency in (re)fashioning healthy lifestyles and wellbeing practices for themselves and their families in ways that expand the horizons of care pursuit by acknowledging that migrants' health practices are often transnational composites, generated through the use of health system and practices in both place of settlement and of emigration" (Ormond 2013:152). In the second part of this chapter, I demonstrate through different fieldwork examples how diasporic healthcare arrangements are formulated by research participants through diasporic medical return.

The transnationalisation of health is a phenomenon fuelled by migration flows and their inherent transnational dimensions, but also indirectly by the limits of States' own national healthcare systems, turning individuals towards more hospitable destinations. In Europe, this pattern of transnationalisation has given rise to profound adaptations in the interplay of national healthcare and social protection systems, providing more flexibility and expanded health coverage.[29] This does not always apply, however, to the links established between European and non-European countries. Currently, bilateral social security agreements (BSSAs) are the main instrument at the disposal of States to facilitate this transnational dimension (Konstantinidou 2022). In the following section, I discuss one of the instruments of the BSSAs in relation to the therapeutic mobilities of TRA between their country of residence and emigration. As I illustrate below, their approach is far from encompassing the transnational health practices of the diaspora. After the presentation of this formal mechanism and its inherent limits, we will look at the parallel growth of the private medical offer in Tunisia, which is an instrumental context to further explore the notion of diasporic medical mobilities and what they reveal on healthcare disparities.

[29] An important example is the supranational agreement between EU Member States.

1. Formal transnational social protection mechanisms: usage of bilateral social security agreements

I discussed in the introduction to this chapter the broad distinctions between formal and informal transnational social protection mechanisms and transnational social protection from below and from above (Lafleur 2019). Transnational social protection from above corresponds to mechanisms put in place by States to provide access to social protection to their nationals and/or residents. BSSAs are international agreements signed by two countries to regulate their reciprocity in the field of social security for their nationals. They are mechanisms that emanate from States and can be understood as such as formal social protection or social protection from "above". They constitute, in a way, an institutionalisation of migrants' transnationalism. They resolve conflicts of law and coordinate legislation in order to facilitate the free movement of insured persons and to protect their social security rights. BSSAs between the two States allow for the portability and transfer of certain social protection rights of the nationals of the two signatory countries. According to Holzmann, "portability is defined as the ability to preserve, maintain, and transfer social insurance rights vested or on disbursement, independent of nationality and country of residence" (2016:4). Another essential foundation of the BSSAs is the application of reciprocity and equal treatment of nationals of both signatory countries. BSSAs usually include a non-discriminatory principle between nationals and migrants as well as rules of cooperation between the social security institutions of the signatory countries. These rules coordinate the aggregation of migrants' social security/tax contribution periods in both countries as well as the transfer and payment of acquired social security rights. Each BSSA has its own specificities and can differ significantly in what it covers between the different agreements. They can cover different types of social security benefits - on a contributory basis (e.g. pension scheme or unemployment benefits) or on a non-contributory basis (e.g. health care, guaranteed minimum income, and family benefits). Some BSSAs are limited to basic contributory benefits such as old age pension, while other agreements cover most areas of social protection including healthcare, family benefit, survivor pension, etc. (such as in the case of France and Belgium).

Since its independence (1956), Tunisia has signed BSSAs with 14 European and North African countries[30] including France and Belgium (Gelb and Marouani 2020). BSSAs have been signed with the main countries of emigration of the workforce as well as with neighbouring countries

[30] France, Belgium, Italy, Switzerland, Germany, The Netherlands, Luxembourg, Austria, Spain, Portugal, Morocco, Libya, Egypt, Algeria.

(Maddouri 2011). As my multi-sited ethnography took place between France, Belgium, and Tunisia, I only focus on the BSSAs between France and Tunisia as well as Belgium and Tunisia. The BSSAs between France and Tunisia were signed in 1963, just a few years after Tunisia gained its independence. Since 1960, one of the main objectives of the Tunisian emigration policy has been to encourage remittances of migrant workers living in Europe spontaneously or via bilateral agreements (Mabrouk 2010). In France, the establishment of the BSSA (in the 1950s) took place in the framework of the reconstruction of the country after World War II, and aimed at encouraging the immigration of foreign workers to the French areas most in need of workforce (de Lary 2004). The BSSA between France and Tunisia is "the most complete and most generous" compared to BSSAs Tunisia has with other countries (representative of the National Social Security Fund- CNSS, August 2021, Tunis). This can be explained because of the strength of colonial ties, the migration history between the two countries and the large number of Tunisian emigrants living in France (the primary country of emigration).

Tunisia signed a BSSA with Belgium in 1969 (Kriaa 2013), motivated by the economic crisis in Tunisia and Tunisian workers' needs in Belgium. The agreement allowed for the recruitment of low-skilled Tunisian workers in various employment sectors in Belgium (Gsir and Mescoli 2015).

Pensions (old age, disability, survivors) and health care benefits are the primary (sometimes only) benefits that BSSAs between European and non-European countries generally cover (Holzmann 2016). Healthcare coverage is often included in a limited form (Spiegel 2010), however, its operationalisation is more complex in comparison to pensions.

Focusing here only on the case of healthcare, BSSAs broadly allow for the portability of certain healthcare benefits.[31] Taking the example of France and Belgium with Tunisia, in both case, the BSSAs provide emergency healthcare coverage for workers during temporary stays in Tunisia: "benefits in kind in the event of a temporary stay in the territory of the other contracting state".[32] In practice, this means for instance, that a Tunisian national working in Belgium and travelling to Tunisia for a period not exceeding three months can benefit from healthcare coverage in case of emergency - a dimension I wished to explore during my fieldwork as a relevant transnational

[31] For more information on the healthcare benefits planned by the agreements with France: https://www.cleiss.fr/docs/textes/conv_tunisie.html; For Belgium: https://www.socialsecurity.be/CMS/fr/coming_to_belgium/files/cc73d96153bbd5448a56f19d925d05b1379c7f21/10c4aaf8d029aa7b20222124b7bf0ede2d8c1c2d/BE-TUN-verdrag-FR_PDF.pdf

[32] Administrative Arrangement relating to the Application of the Convention on social security between the Kingdom of Belgium and the Republic of Tunisia- Article 7.

healthcare resource that individuals could potentially use during their visits in Tunisia. Healthcare emergencies include medical consultations that cannot wait until the person returns to his/her country of residence. In such scenarios, the Tunisian national can get reimbursed by the National Health Insurance Fund in the country of residence (France) or the country of emigration (Tunisia). In Tunisia, health-related benefits are managed by CNAM. Regarding healthcare, administrative arrangements are therefore made between the CNAM in Tunisia and the National Health Insurance Fund in the country of residence to cover healthcare expenditures during the temporary stay. Both funds communicate through liaison forms and go through a verification system to ensure that the person is indeed entitled to coverage for the healthcare delivered. As summarised by a representative of the CNAM in Tunisia:

> "Every country has their own liaison forms and there are different types of liaison forms depending on the type of medical intervention and on the status of the person who perceived healthcare in Tunisia - if the person is retired, or a worker; if the person has a chronic disease, if it was an accident that necessitated a hospitalization, or was a simple consultation with a doctor or paediatrician. The procedure is not the same. The principle is that the liaison forms are the medium through which National Health Insurance Funds of both countries communicate and exchange information about the beneficiaries and establish the responsibilities of each fund" (Representative of CNAM Tunisia in charge of bilateral agreements, August 2021, Tunis).

Moreover, certain conditions have to be fulfilled for the healthcare expenditure to be covered. One is that the person travelling has to inform his/her health insurance about the length of his/her stay prior to departure, and obtain a form from his/her health insurance:[33] "This is how we make sure that the person has not exceeded the given period under which he/she can benefit from the coverage foreseen by the BSSA in the case of temporary stays" (ibid). The form has to be presented and filled in by the treating doctor, who details the type of medical intervention

[33] In order to receive benefits in kind under Articles 13 and 15 of the Convention, the person concerned must submit a certificate to the relevant authorities in the country of stay showing entitlement to those benefits. This certificate shall be issued by the competent institution at the request of the person concerned before he/she departs from the territory of the contracting State in which he/she resides. If the person concerned does not present the required certificate, the institution of the place of stay shall contact the competent institution to obtain it. The certificate issued shall indicate in particular the maximum duration benefits in kind, as provided for by the legislation of the legislation of the competent State. (Article 7, Administrative Arrangement relating to the Application of the Convention on social security between the Kingdom of Belgium and the Republic of Tunisia- https://www.socialsecurity.be/CMS/fr/coming_to_belgium/files/cc73d96153bbd5448a56f19d925d05b1379c7f21/007338b5bcbf2568c3a2c13251206911477874bd/BE-TUN-Administrative%20arrangm-FR_PDF.pdf

and certifies its emergency nature: “if the person travels intending to get healthcare in Tunisia, this is considered medical tourism and the conventions do not apply” (ibid).

When asked participants whether they used BSSA, the majority seemed to be unaware of its existence, in particular that they could get emergency medical consultations reimbursed. When I asked them if they sometimes made use of it, they would often look surprised: “Is that so?” They asked me to provide them with the details. I asked the representative of CNAM Tunisia in charge of bilateral agreements about the communication (or lack of) on the matter and if there were any initiatives taken to inform people regarding their rights:

> “It’s true that people often don’t know about it. Unlike pensions for instance, where people are well aware of the existence of BSSA. For healthcare, it is often when people have particular health conditions or older people who are more attentive to possible health concerns they might encounter when moving between their country of residence and emigration. We don’t have a communication strategy as such. For TRA coming on holidays, they are under the charge of the health insurer in their country of residence, so we can consider that it is the responsibility of that health insurer to inform their beneficiaries” (Representative of CNAM Tunisia in charge of bilateral agreements, August 2021, Tunis).

I did meet some who were aware of the mechanism, and they often explained that they learned about it after many years living abroad:

> “I heard about it maybe more than 10 years after I arrived in France. It is my cousin, who is a doctor in Djerba, who told me once that she often filled in forms for TRA so that they could get a reimbursement. I then looked it up and asked around and only learned about it then” (Ali, online interview, January 2021).

Reimbursement can be received in Tunisia through one of the local offices of the CNAM or upon return through the beneficiary's health insurance. However, beneficiaries are discouraged from asking for reimbursement upon their return, having to prove that they were unable to claim their refund locally. As explained to me by the representative of the CNAM, when the person submits his/her documents to the health insurance organisation in the country of residence, the health insurers need to communicate for the validation of medical records, and the procedure can take several months. The insurer in the country of residence asks the insurer in Tunisia to proceed with verifications and to validate the amounts etc. The central office of the CNAM in Tunis forwards the request to the closest regional office in the area where the person perceived

healthcare and medical records are checked by a medical advisor. After verifications, the regional office sends the medical records back to the central office in Tunis, which then sends them to the insurer in the country of residence. The lack of digitalisation significantly impedes procedures and makes the process burdensome. Looking around in the office of the representative in charge of bilateral agreements, the accumulation of paper files in cabinets and on his desk testify to the obsolescence of the administrative process.

Confusion about where to get reimbursement was therefore pointed out as a discouraging factor. As in the case of Nour (from Liège in Belgium), some people thought they could only submit their documents to the CNAM in Tunisia:

> "The administration in Tunisia is just a nightmare. When I am here only for relatively short holidays, I don't want to bother going to the closest CNAM office, waiting in line, and taking the risk that I have to come again because a document is missing. For maybe 20 or 30 euros, it's not worth it, so I never ask for reimbursement" (Fieldnotes from interaction with Nour, August 2021, Tunis)

For those who were aware of the possibility to submit their medical bills to their health insurance providers upon return, they would often argue that the administrations in Tunisia were not really accessible in practice, especially during the summer during which time administrations are only open for half days:

> "When you go to the closest CNAM office and say that you are a TRA and that you are coming for your reimbursement, they don't receive you at the main counter, but you have to see the person who is in charge of such procedure. Every other day, the person is not in her/his office or is not in on that day. Now I don't even try, I just wait until I return, and I save myself some time. Unless the amount is very large and I cannot wait until I return" (Fieldnotes from interaction with Seifeddine, July 2021, Tunis).

Visiting myself one of the CNAM offices in the area of la Goulette in Tunis (Figure 5), I experienced what Seifeddine told me. Arriving at the general counter, I was redirected to the first floor of the same building, "third office on the left at the end of the corridor" (CNAM official, September 2021, Tunis). I knocked on the door, but no one responded. I looked in the corridors to find someone who I could ask for help. I found an open door and asked the women sitting behind the office if she knew where I could find the person responsible for the BSSAs. She looked at her watch and told me to wait in the hallway. After about fifteen minutes, a woman came to me, and we went into the office I was first directed to.

Figure 5: CNAM Office, La Goulette,

Source: picture taken by the author, July 2021

If, on paper, BSSAs are an innovative initiative enabling States to work beyond the borders of their nation-states, implementing them effectively poses considerable administrative challenges. In practice, this sometimes results in the disinvestment of individuals from such transnational instruments. The concept of moral economy discussed in detail in Chapter 5 further evidence the discrepancy between states' transnational social protection infrastructures and the practices that emanate from them. As expressed by Slim, a diaspora expert that I will introduce in the next section of the chapter, "diasporas are by nature transnational, but ecosystems are not. They have been thought of to block or even cut bridges, making them more hermetic" (Slim, diaspora entrepreneur and expert, October 2020, online).

The constraints faced for mobilising bilateral social protection instruments and resources, coupled with the inherent limitations of the Tunisian public healthcare system, need to be understood in the broader context of the growth of Tunisia's private medical landscape.

2. Thriving on medical tourism: the growth of the private healthcare landscape in Tunisia

Over the past twenty years, the medical tourism sector has developed significantly in Tunisia. According to Lautier (2013), the country is the main care exporting country in North Africa and

experienced one of the highest growth rates worldwide in the sector of medical tourism. With the development of its medical sector, Tunisia today possesses medical resources equivalent to the ones of developed countries in terms of medical infrastructure and materials, qualification of healthcare professionals and standardisation of therapeutic protocols (Rouland and Jarraya 2016). The number and level of medical schools across the country ensure a new cohort of competent local manpower every year (ibid.). The growing number of foreign patients means a significant inflow of currencies. These patients not only consume medical services, but also other expenses related to their stays in Tunisia (Meinvielle 2012). According to estimates from the African Development Bank, total exports of health services reached 205 million US dollars in 2010 and, when including additional expenditures, this brought the total foreign exchange revenue generated by health services exports to 389 million dollars in 2010 (Lautier 2013). If, for European patients in particular, Tunisia has developed a reputation in aesthetic surgeries, wellness and comfort care services (Boumedienne 2012), a large proportion of patients come from neighbouring countries such as Libya and Algeria as well as sub-Saharan countries. According to Rouland *et al.* (2016), the development of the private healthcare sector in Tunisia is related to the degradation of its public healthcare sector under the Ben Ali presidency which encouraged the privatisation of several state services. This has resulted in the transfer of patients from the public to the private sector, which has, over the years, further exacerbated the degradation of the public sector and, as a result, impoverished households have had to spend more of their budget on health (Abu-Zaineh *et al.* 2013; Megdiche *et al.* 2021)[34]. As told to me by a representative of the Tunisian Ministry of Health:

> "Patients who can afford private healthcare services have made the shift from the public to the private for certain types of interventions. As a result of this, the remaining patients in the public sector are the poorer fringe of the population, some of whom (the most vulnerable) are sponsored by the State. These patients alone do not allow public hospitals to generate funds to maintain their infrastructures" (Interview, June 2021, Tunis).

Moreover, the transformation of the healthcare landscape in medical travel hubs like Tunisia deepens inequalities between local patients and "foreign" patients with unequal purchasing power "competing" to access the same medical services, facilities and equipment (Ormond *et al.* 2014).

[34] This has led to the reform of the National Social Security Fund in 2007 who mainly aimed at lowering direct household expenditures through the extension of insurance to private health care providers.

An economy has developed around the medical tourism industry with medical tourism agencies that are in charge of travel arrangements of patients, such as *Medespoir* or *Carthago Med*, which recruit patients in Europe, Africa, North America, and the Gulf countries. I met the director of a medical tourism agency in their main office at the end of August 2021. The office is situated in an area of Tunis that is paved with private clinics, radiology centres, and medical analysis laboratories. Indeed, the presence of medical tourism has grown to such an extent that it has changed the landscape of the city in certain areas of Tunis such as in *Mutuelleville*, *Lac 2*, and *Centre Urbain Nord*. The pictures below (Figure 6), showing signs of laboratory and medical centres in the area of Mutuelleville, illustrate the impact of the presence of medical infrastructures on the urban landscape.

Figure 6: Signs of laboratories and medical centres in Mutuelleville,

Source: picture taken by the author, July 2021

Beyond the new clinics that have emerged from the bottom up, many services benefit from this market and have created a "healthcare ecosystem...composed of complex networks or interconnected systems operating within a dynamic neighbourhood ...to include the mixed economy of healthcare provision" (Phillimore *et al.* 2018: 3). Medical tourism agencies are part of this healthcare ecosystem and play the role of intermediaries between the clinics and the patients, depending on their needs. They are in charge of handling the patients on every step of their medical journey, from the booking of their trip, the transportation from the airport, and the reservation of the hotel stays, etc:

> "the patients are taken care of from A to Z by the agency. Our role is to make sure that the patients' stay goes as smoothly as possible. We also select the best clinics and make sure we work with partners that are ethically irreproachable" (Director medical tourism agency, August 2021, Tunis).

With the growth of the sector, there has been significant diversification in patients' countries of origin emigration as well as their socio-economic backgrounds. Holliday *et al.*'s research in South Korea, Thailand and Tunisia challenges the dominant view of medical tourists as "footloose global elites" (2019: 29). They describe the patients they met in Tunisia as "ordinary people, not jet-setting elites" who "were shocked by the conditions that surrounded their stay and by the situation they had landed in" and were "unaware of the geopolitical context, or even of basic geography" (ibid: 83-84).

Medical tourism agencies have therefore developed offers that accommodate very diverse patients' needs and financial capacities, playing the role of intermediaries, facilitators and coordinators (Holliday *et al.* 2019). Some of them are specialised in certain geographical regions of origin of the patients. I met another tourism agency specialising in patients coming from Europe. According to him, most of the patients that they handle are people that have never stepped foot in Tunisia and sometimes have never even left Europe. Discussing the profile of their patient-clients, he explained:

> "The type of patients that come to Tunisia are people who cannot afford their treatment in Europe. For the large majority of our clients, we are not talking about "wealthy people", contrary to what we often imagine about these patients. So very often we handle people that are not used to travelling, don't know anything about the country and need to be assisted 100%" (Communication manager medical tourism agency, Tunis, September 2021).

These "new" patterns of healthcare mobilities are symptomatic of the transformation that has been occurring in the provision of healthcare. Historically, travelling abroad for health-related purposes was reserved for individuals from the upper classes who were seeking benefits from the Mediterranean climate, spas, mineral baths, and new therapies to improve their health (Hutson and Poland 2008). These "elite medical facilities" (Turner 2007: 307) were attracting international patients. Since the beginning of the 21st century, medical tourism patterns have changed and it is more often middle-class individuals who travel from developed countries to developing countries to access healthcare at better costs and avoid treatment delays for elective and even lifesaving surgeries (Gray and Poland 2008). Medical services offered by local

medical centres remain unaffordable for many North American and European patients (Turner 2007). Moreover, the reduction of healthcare benefits covered by states and employers pushes people to develop new healthcare strategies and to seek affordable medical care in a global market of privatised, commercial healthcare delivery (ibid.).

To understand the general landscape of the medical tourism industry in Tunisia, I conducted a small number of interviews with cosmetic surgeons asking about the profile of their patients coming from abroad and about the evolution of the market in Tunisia. Aesthetic surgery is indeed the main service sought by medical tourists coming from Europe to Tunisia. However, the terminology of "aesthetic" can be misleading, as it suggests that they are somehow superficial medical interventions or unnecessary. As explained by one aesthetic surgeon, who has his medical office in the posh Northern suburb of Tunis, la Marsa:

> "Aesthetic surgeries do not mean that they are not necessary or life-changing for the patients. They are not vital, meaning that the person could live without undertaking such surgery. But it is a lot more diverse than the nose job or the breast surgery because the person wants bigger or smaller breasts. We do a lot of reconstructions for instance if the person has a malformation, if a person experienced an accident or has breast cancer and had to have a removal. Not all health insurance providers in Europe reimburse reconstruction. Another common example is bariatric surgery, which is a very important sector in Tunisia. Many people do not fulfil the criteria fixed by health insurance providers to benefit from coverage. Moreover, people who undertake bariatric surgeries, once they have lost weight, usually need to undertake another surgery for excess skin removal. Again, this is often not reimbursed by health insurance but is essential for the person to carry on with his/her life. For the patients that we receive and that are often from the lower middle class, it is a way to democratise access to these surgeries that are affordable only by wealthier people in Europe" (Aesthetic Surgeon, la Marsa, September 2021).

Patients from Algeria, Libya, and sub-Saharan countries represent the majority of the patients coming from abroad and they come for all types of healthcare services, including medical interventions to address life-threatening concerns, whether illness or injury, as these types of medical care can often not be provided in the country where they reside (Rouland *et al.* 2016). For these patients, the private medical sector and medical tourism agencies, therefore, have different offers than for European patients. In their chapter on British medical tourists in Tunisia, Holliday *et al.* (2019) depict the random encounter of European patients coming for

aesthetic surgeries with Libyan patients injured during the civil war, turning these private clinics into sites of “cosmopolitan beginnings” (Yeoh and Huang 2015).

3. Holiday visits to Tunisia as the annual therapy

The summer is a time of the year when many TRA return, sometimes for a relatively long stay. The holidays in the country of emigration play a key role in maintaining social ties and serve a more complex function than mere entertainment and leisure, including fulfilling certain social obligations (Huang *et al.* 2017). Several of the participants in my research travelled to Tunisia for an extended period to visit family and enjoy the Tunisian weather and the sea. For parents, summer was often highlighted as a good time to familiarise children with their home culture, bond with family in Tunisia, and practice the Tunisian dialect. The geographical proximity of the Tunisian diaspora, which lives mainly in Europe (the majority of which is in France), as well as the significant means of connection, allow for relatively frequent returns, nourishing the feeling of belonging to a continuous transnational network (Clifford 1994). Some have invested in a house in their hometown or a vacation apartment close to the family, others own property inherited from their parents. Indeed, TRA represent a significant proportion of the "tourists" during the summer season and constitute a significant market and a substantial annual cash inflow for the country. In 2019, 1,444,533 TRA, or 15.3% of the total number of tourists, visited Tunisia. Thus, the summer vacation period constitutes a privileged time space for observing the transnational practices of these "diaspora tourists" (Wagner 2008, Li *et al.* 2019; Pearce 2014).

Figure 7: "I don't need therapy, I just need to go to Tunisia"

Source: Image taken from the Facebook page Tunisians in Belgium, May 2021

I downloaded this image (Figure 7) from the Facebook group of *Tunisians in Belgium*. The idea of holidays in Tunisia as therapy resonates with the concept of therapeutic landscape in health geography (Gesler 1992, 1993) that I detailed in Chapter 1. To study the relationship between health and place, geographers have taken a broader view of health, going beyond illness and the provision of health services (Gastaldo *et al.* 2010). The concept of "therapeutic landscape" (Gesler 1992, 1993) describes "settings or situations that encompass physical, psychological, and social environments associated with healing" (Gesler 1992 in Gastaldo *et al.* 2010). For the participants in my research, Tunisia is both a geographical and a relational place with which they have built meaningful ties.

I explained in Chapter 2 that part of my fieldwork in Tunisia was dedicated to spending time with participants from Belgium and France and accompanying them in their holiday activities. Some would express to me: "it makes me feel good to be here, I reconnect with myself" (Mayssa, quotation by memory, July 2021, Tunis), "I need to come every few months to Tunisia, if I spend too much time away, I feel too nostalgic and depressed". In August 2021, despite the Covid crisis that was hitting Tunisia, several of my participants came to visit their families as some of them had already cancelled their visit the previous summer and as trips had been made difficult with travel restrictions. One Sunday afternoon, I met Nour, a participant from Belgium

I introduced earlier in the chapter. She and her husband have an apartment in Tunis, and they usually come several times a year. She was here with her husband and her son, and she invited me to join them in a hotel by the sea in the Northern suburb of the city of Tunis. They had made a reservation at the pool of the hotel for the day. During the afternoon, I noticed that Nour was reading a book in Arabic. Nour explained that she only read in Arabic when on holiday in Tunisia. It is one of the things that she liked the most when she returned, going to the bookstore and buying some books to read during the holidays. Reading in Arabic, eating Tunisian food, and seeing the family brought her peace of mind and a sense of well-being.

Similarly, when visiting the family of Nesrine in Sousse in July 2021, we went for a swim very early in the morning before the beach got crowded. This is something that Nesrine loves doing with her cousins while on holiday in the summer: “the sea is curative to me, when I am here by the sea, I always reflect on myself better and it frees up my mind” (Nesrine, July 2021, Sousse). Several months later when visiting her in her apartment in Belgium, she had hung a picture of the sea view of one of her favourite beaches in Sousse: “when I am nostalgic or stressed out, I look at it and it helps me calm down instantly” (Nesrine, November 2022, Mons). In the words of Nesrine, the view of the sea is somehow therapeutic. For Nour, it is the personal and social practices she undertakes while in Tunisia that provide her with a therapeutic feeling. Places are "therapeutic symbolic systems" (Andrews 2002) and the intimate personal and emotional relationship between an individual and a particular place influences well-being and health (Finlay 2018).

If transnational bonds between migrants and their country of emigration can be forged in different ways, “diasporic medical mobilities explore how bonds can be generated through healthcare” (Ormond 2013: 150). Maintaining medical visits in the country of emigration thus becomes an expression of the relationship migrants keep with their country of emigration, “a demonstration of identity, attachment and commitment” (ibid).

3.1. Diasporic medical mobilities to Tunisia

Although there are not any statistics to date on the number of TRA among patients in Tunisia, they probably represent a small proportion of medical tourists in Tunisia compared to the large inflow of patients from Algeria and Libya. However, as I demonstrate below, and as already outlined by case studies looking at diasporic medical tourism in other countries, these patients

might represent a higher proportion than expected. Indeed, TRA are often hard to identify among patients as they are hard to differentiate from the "local patients" (Connell 2015).

When discussing the matter with doctors, clinic directors and healthcare entrepreneurs in Tunisia, they were always well aware of the presence of TRA among their patients. However, TRA were not perceived as a market worth investing in. As pointed out by Slim, a diaspora entrepreneur and expert who has mainly been active in the healthcare domain, "there are no real state strategies to take advantage of the market that TRA could represent for the medical tourism industry in Tunisia" (Slim, October 2020, online). Aside from his Tunisian start-up, Slim works in other African countries as an expert on the involvement of the diaspora in the development of countries of emigration. In 2018, he launched a project with his start-up *Allobledi*. The startup created a platform to connect TRA with healthcare professionals and services in Tunisia. I contacted him when I came across the platform online.

"Because we are far from our parents and we are concerned about not being able to look after them as we do with our own children, because I want to take advantage of my stay in Tunisia to rebuild my health (check-ups, dental implants, cosmetic surgery) ... Allolabes is for Tunisians abroad, inform them professionally and puts them in touch with the best health professionals in Tunisia" (taken from Allolabes website, August 2019*)*

Figure 8: Hello, how are you? Dad and mum first!

Source: Image taken from the website Allobledi.tn, year

The platform is called 'Hello, how are you? Dad and mum first!' They offer to monitor the health of Tunisians abroad and the health of their parents from a distance and to connect them with professionals for medical visits during the holidays. The advertisement for the service (Figure 8) puts forward the moral obligations of the children to take care of their parents back in their home country. According to Slim, medical visits during the holidays have become a growing practice and could constitute a fruitful market for the medical tourism industry in Tunisia:

> "It's like a ritual during the holidays… Refocusing a little on oneself, that's what vacations are all about. You take care of yourself, of the family…you take your parents to the doctor… you fulfil your moral obligations" (Slim, diaspora expert and entrepreneur, October 2020, online).

By sending money for medical expenses or through the direct payment of consultations for members of the family during their visit, TRA contribute to the health of their relatives in Tunisia through medical remittances (Zanini *et al.* 2013, Schühle 2020). The sending of medication from the country of residence is another example of medical remittances where the migrants represent a healthcare resource for the family back in the country of emigration. Emigrants have a moral obligation to care for the health of those who remain in the country of emigration, thereby establishing a moral economy between migrants and their families. This also echoes the concept of "transnational moral economy" between migrants and their relatives back in the country of emigration, defined as a "set of social norms which governs…economic and social practices in both sending and receiving sites" (Solari 2019: 760). Moreover, the moral obligation to take care of relatives, especially of the parents in later life, is particularly pregnant in Tunisia. Indeed, in the majority of Arab countries, the family serves as the primary source of support in old age. Intergenerational support within families is based on principles of kinship and paternal lineage (Charrad 2001; Yount and Sibai 2009). In many Islamic societies, family responsibility is a deeply held value, especially when it comes to the duty of children to care for their parents (Albertini and Mantovani 2022).

When I spoke with one of my participants in Brussels, he explained that, for him, supporting his family's medical costs in Tunisia is part of his obligations when he goes home*:*

> "I am not here for several months during the year. Even if I send money regularly because I am living and working in Belgium, I make more money than my brother and sisters in Tunisia, but bringing my mother to the doctor myself is a way to pay respect, to really take care of her. I also discuss with the doctor so I am still following what is going on and I have updated information about her health. Sometimes my mother just tells me that everything is fine because she doesn't want me to spend too much money, so when I go myself, I am a bit more in control of what is really going on" (Hédi, discussion in Brussels, December 2020).

Hédi is 56 years old and arrived in Belgium more than 30 years ago to complete his education as a computer engineer. He now has a small IT company that is based in Brussels and often recruits engineers from Tunisia. We met through his association in Brussels situated across the street from the Tunisian cultural centre in Porte de Namur. The association used to organise Tunisian dialect courses for adults and children, and I took classes for three months.

As illustrated by the example of Hédi, through medical remittances, migrants maintain their moral influence over their non-migrant relatives, thus exercising a transnational moral authority

(Lacroix 2019). As developed in detail in Chapter 5, migrants' transnationality makes them "doubly present" (Dufoix 2010), in their country of emigration and in their country of residence. If they are absent physically from their home country, they negotiate their moral presence by engaging in family care practices from a distance.

Transnational therapeutic mobilities includes the circulation of patients as well as all health-related goods and knowledge and often involves relatives in the country of emigration. Acevedo-Garcia *et al.* (2012) argue that the transnational ties that immigrants maintain and the circulation of material and emotional support with the family and the community back home shape their health and that of their family and community. Social linkages become a resource mobilised in the event of sickness, thus underlining 'the social fabric of health' (Janzen 1992).

On Facebook, publications on Tunisian groups have often highlighted the circulation of medication through the family network. For several years, the central pharmacy in Tunisia (the governmental organisation that imports all medication from abroad into Tunisia) has experienced a significant shortage of stock due to late payments to international pharmaceutical companies, making access to certain medication (including medication for chronic diseases) difficult.[35] Family members living abroad, therefore, become an indispensable healthcare resource.

[35] https://news.gnet.tn/crise-medicaments/ https://information.tv5monde.com/afrique/tunisie-pourquoi-le-pays-connait-il-une-penurie-de-medicaments-229847

Figure 9: Sending medication to Tunisia 1

Source: Image taken from the Facebook page Tunisians in France, 13 April 2020

Figure 10: Sending medication to Tunisia 2

Source: Image taken from the Facebook page Tunisians in Paris, 28 August 2021

As illustrated in Figures 9 and 10 above, this became particularly significant during the pandemic, when people could not travel back to Tunisia and provide their relatives with their treatment.

Conversely, several of my participants would often bring back medication from Tunisia because they felt more comfortable taking a specific medication hey had been taking several years before migrating. Zanini *et al.* (2013) note, regarding medication coming from the home context, that the emotional attachment to it is a form of expression of feelings of belonging in

the same way as cooking (Zanini *et al*. 2013:18). Some medication (antibiotics, in particular) may also be more easily accessible without a prescription and less costly:

> "In France, they don't want to give you strong drugs, anti-inflammatory, corticoid but in Tunisia they give it. Doctors are a little light-handed in France with the medicines" (Sawsen, August 2021, Tunis).

Representations of doctors not prescribing enough, or strong enough, medication recurred frequently in the conversations I had with participants. The position of certain doctors in Europe to reduce prescriptions of medication and to reduce antibiotics reveals diverging perceptions of efficient/inefficient healthcare. This was particularly well expressed by Hassine, residing in Germany:

> "General practitioners in Germany, they always tell you to drink water, drink tea whatever the health condition. I don't go to the doctor to be told to drink water!" (Hassine, August 2021, Tunis).

Although the TRA are not really considered by the medical tourism industry as a profitable market, some clinics took the initiative to offer treatment package during the summer. In August 2021, I met with a representative of the group *Amen santé* in Tunis (Lac 2). This is the clinic I myself used to go to while I was living in Tunis and they have a good reputation for the quality of their services and of their infrastructure. They opened their first clinic in Tunis in 1994 and have now a total of six clinics in different cities in Tunisia.

> "During the summer, the Bizertins who live in France come back, do check-ups, dental care, ophthalmic control, visits for children, for everyone, and generally, they pay for the parents because they are people who do not have so much money. The category of people from Bizerte who are abroad are not doctors or engineers, they are people with small salaries, they come to Tunisia and take care of the mother, the father... We know that there are TRA starting from June, and we communicate on packages for example, for circumcision, check-ups, a mammogram, electrocardiogram, and lung scans. We offer general check-ups and a global assessment. They [TRA] do all this before returning to France (Amen group representative, Tunis, August 2022).

This example illustrates how the private sector participates in this transnational moral economy of healthcare and migration by creating services tailored to the emotional and moral responsibilities of emigrants. These offerings appeal to emigrants' need to care for the health of their relatives back home as a way of compensating for their absence. This case highlights a

key aspect of the moral economy, where goods and services are exchanged within a framework of moral obligations (Fassin 2009).

According to Slim, the consumption of healthcare services in Tunisia by TRA is due to the particular relationship that Tunisians maintain with doctors in the country and the positive opinion of their medical skills. Although people in Tunisia, and some of the TRA, often question the ethics of private clinics that are perceived to be driven only by profit, the skills of doctors are almost always praised. For Slim:

> "This is something that we particularly find in Tunisia – a little less in Morocco – because this relationship of real esteem with doctors is very typical of Tunisia. It is a relationship of esteem because these are perhaps the professions that embody the most Bourguibism, with the teachers and education. So, these remained as icons of Bourguibism and the emancipation of Tunisia for the first generation of emigrants. We see this relationship of esteem and affection with doctors which is very, very clear with the first generation of Tunisian migrants … so there is something that has remained in the imagination of migrants ... and it is not just imagination because they [doctors] are indeed good. So, there was really a tradition that was perpetuated with doctors in Tunisia" (Diaspora expert and entrepreneur, October 2020).

I earlier introduced the impact of the Bourguiba presidency on the development of sexual and reproductive health in Tunisia. Bourguiba defended the idea of a secular state and was in favour of the development of the country through decentralisation and the establishment of schools and health centres across the territory. He supported the creation of health centres with universal access and established basic health centres and district hospitals in small localities as well as developing mobile medical teams that circulated between very remote areas. Regional hospitals as well as university hospitals (Tunis, Sousse, Sfax and Monastir) were also established under his presidency.[36] It is interesting to think about the association of Tunisian doctors with the idealised representations[37] of the Bourguiba presidency established as a "national hero in the Tunisian national novel" (Alcaraz 2021: 139). Also, according to Slim, imaginaries around the skills of Tunisian doctors have remained, despite the current decline of the public healthcare system. Beyond the valorisation of the competencies of Tunisian doctors, I believe that this also transforms place attachment to the country of emigration into medical patriotism (Inhorn 2011).

[36] https://www.maisonmedicale.org/tunisie-vers-une-medecine-communautaire/

[37] I am talking here about idealized representations as, Bourguiba's name, often referred to as the father of the Nation, is associated with some of the Tunisian state's greatest achievements. The Bourguiba presidency was nonetheless an authoritarian regime who exercised considerable political repression.

As argued by Beck, medical mobilities "do relations" (Beck 2012: 357) through health-seeking strategies spanning borders and within therapeutic networks, but also question political subjectivity and belonging (Zanini *et al*. 2013: 27). Individuals' subjective healthcare experience is forged by their translocal identities (Gilmartin 2008). Medical mobilities are a result of place attachment, but also forge place attachment (Ormond and Kaspar 2018). Coming "home" for healthcare reveals an additional dimension, compared to other forms of medical mobiliy, as they are also mediated by a sense of belonging to the national community in their country of emigration. These healthcare arrangements are diasporic, as these patients from the diaspora strengthening ties to Tunisia through their healthcare consumption and by evoking territorialised and non-territorialised belonging and attachments. Through these diasporic healthcare arrangements, Tunisia becomes a place located nationally, regionally and locally as well as a relational place formed from the multiple ties and interactions individuals have built within it (Holliday *et al.* 2019: 84).

For TRA, the move from Europe to Tunisia is characterised by a shift from the public to the private health system. As we have discussed earlier, a large proportion of the population in Tunisia makes use of the private sector, having stepped away from the public system. Several actors in my research are individuals who frequently drew on the private healthcare sector in Tunisia before their move to Europe. When arriving in Europe, they were more like to perceive waiting times, in particular, negatively, which may contribute to their dissatisfaction with health services.

> "When Tunisians who are resident abroad return to Tunisia for medical care it is to the private sector. Because the public sector is degraded. On the other hand, in the private sector, you find quality and if you have a salary from abroad you can afford it … There is disease and disease. If I have something serious in Tunisia, then I come back here [Belgium] because in Europe the hospitals are more at the forefront. In the private sector, it can also be dangerous because it's business, the doctor sees you as a bank. They can add things to increase the bill - they make you stay one night when you don't really need it, etc. - and then you end up paying a lot of money. So, the person who lives abroad has to be a bit clever and know when he/she needs the European doctor and when he/she needs the doctor in Tunisia. It is not about the competence of the doctor, we have very good doctors, but about the bill" (Selima, Brussels, February 2020).

The increased purchasing power of TRA when they return to Tunisia facilitates their access to private healthcare services that offer alternate healthcare opportunities to the public sector ones accessible in the country of residence. This shows how migrants' social variables, in this case, their social class, produce different effects in the country of emigration and residence, and how they "may actively design their social protection strategies to counterbalance the less advantageous position they have in one space with a more privileged position they have in the other" (Lafleur and Romero 2018: 2).

The asymmetry of supply (private/public), legislation, medical protocols and costs changes the experience of healthcare and influences the perception of the quality of the care provided. Depending on their medical needs and expectations, diaspora patients make use of both the public sector in their country of residence and the private sector in their country of emigration. From that perspective, they move from the status of "patient" to the one of "patient-consumer". The positioning and identity of the patient in public healthcare can be differentiated from the one of patient-consumer in the private sector as it implies new logics of choice and consumerism (Mol 2008). Ormond and Lunt (2019) stressed the complex nature of transnational medical travel:

> "patients are increasingly embedded in complex, messy transnational fields of contention comprising diverse, multiple and overlapping familial, community, private-sector and state resources regimes that together shape these patients' ties and identities relative to – and differently privilege or disadvantage them within – the different countries involved" (2019: 4).

Transnational spaces therefore become spaces of comparison where individuals ponder their social position and consequent life chances across borders sometimes acting "as brokers of ideas" (Faist *et al.* 2015: 1999) between different health systems.

3.2. Mobility as a source of agency: negotiating structures of therapeutic opportunities.

In the first part of the chapter, I described the case of Jamil, a 36-year-old Tunisian working and living in Belgium, and the healthcare issues he had to face in Belgium as well as the strategy he deployed – reaching out to friends working at the European Commission in Brussels – to get quicker access to a scan. The following summer, just a few weeks after his experience of therapeutic wandering in Brussels, he returned to Tunis during the summer vacation. I was also in Tunis during the same period as I was completing my first fieldwork stay in August 2019.

We met in a coffee shop in the area of Lac 1. When enquiring about the evolution of his health issues, Jamil informed me that he had just visited his family doctor a few days ago to get a second opinion and had him go through his medical file:

> "When I am here during the summer … I go to my family doctor and the dentist. Always. My doctor, it is like visiting someone from the family. I always pay him a visit; he has known me and all my family since I was little … Because he knows my family, he knows my history, the case of my father who had two heart attacks, blood vessel problems…This year, because I had all these health issues, I brought all my documents and the medical analysis I did in Belgium and showed him the prescriptions from my doctor. He said that the treatment they gave me was fine but prescribed me complementary medication. As soon as I started that medication, it started to get better" (Jamil, August 2019, Tunis).

Jamil's doctor also prescribed him a blood test to check his cholesterol level as well as potential vitamin deficiencies. His doctor noticed the abnormally high rate of cholesterol as well as important deficiencies in vitamins D, B, and O:

> "My Belgian doctor never told me that when you are not used to the climate in Belgium, you could have important deficiencies. Now I take it and every time I meet someone who just settled in Brussels, I tell him/her to take vitamin D".

Finally, his health issues seemed to be related to his high rate of cholesterol and a decrease in his immune system. Concluding his explanation, Jamil added:

> "In the end, my mother was right from the beginning, better than the doctors. When I told her about the pain in my ears and the noises, she told me straight that it was cholesterol. So now I also do some tricks that she gave me, like adding turmeric in my tea in the morning and eating raw onions at lunch and dinner time" (Jamil, August 2019, Tunis).

The transnational therapeutic journey of Jamil illustrates the form of "medical pluralism" (Leslie 1974), following advice from doctors, friends, and family, using medication and traditional remedies to satisfy medical needs. Coming back to the concept of "healthcare bricolage" (Phillimore *et al.* 2018) which is often either triggered by resource-poor environments or as a tool to turn challenges into opportunities "re-assembling and re-using resources to 'make do'" (Phillimore *et al.* 2018: n.p.). If it is sometimes a response to resource-poor environments, it can also be a creative strategy which differs from the usual approach and

achieves a better outcome. Moreover, Jamil's narrative also highlights some specificities of diasporic medical mobilities compared to other forms of medical mobilities. Jamil went to his family doctor in Tunis after experiencing some difficulties in finding the right treatment while in Belgium. Although he found a way to get his medical analysis in due time and was eventually prescribed treatment by his Belgian doctor, his medical expectations were still unmet, and he wanted to receive a second opinion from his family doctor in Tunis.

Dissatisfaction with the health systems in their countries of residence is one of the key drivers of medical mobilities, and migrants have therefore integrated it as part of their "therapeutic coping toolboxes" (Ormond and Lunt 2019). The perceived quality of the healthcare delivered may depend on the quality of the medical equipment and infrastructures as well as doctors' availability and the relationship with healthcare professionals (Glinos *et al.* 2010). Mobility occurs because of what cannot be obtained in the country of residence. From that perspective, the case of Slim highlights the possibility, in his opinion, of being "better served" within the private healthcare system in Tunisia. If the patient-consumer therapeutic itinerary is partly driven by a logic of choice, the effectiveness of health interventions is often influenced by how familiar and connected patients feel with health systems, the cultural and linguistic competence of both patients and medical professionals, and the presence of extended family support networks (Ormond and Lunt 2019:7).

The case of Sawssen presented below illustrates the embeddedness of diaspora patients in between two healthcare systems and the potential to circumvent healthcare barriers by moving between both systems, and negotiating structures of therapeutic opportunities:

> *Sawssen has lived in the agglomeration of Paris since 2014 and works for a tourist transport company. In September 2021, I got in touch with her by phone from Tunis. I had had an interview with her gynaecologist in Tunis a few days before. The gynaecologist told me about her medical case[38] as she had just undergone a conization (the surgical removal of a portion of the cervix) in July due to suspicion of cancer cells.*
>
> *She agreed to get in touch with me[39] about her medical journey and her motivations to come to Tunis to undergo her surgery. We got in touch by phone. She explained to me that she underwent a gynaecological check-up in France and that her doctor found out*

[38] When doctors were sharing medical information about their patients, it was always anonymously.

[39] As mentioned in the methodology, the doctor would first ask their patients their consent to be put in contact with me. I was put in touch with patients and was provided with their phone number (without their name) only after the patient had explicitly agreed.

she had Human papillomavirus (HPV).[40] *She underwent a biopsy in May 2021 and was informed that the lesions were at stage 2 and that she had to undergo a conization. Her gynaecologist was, however, not available to do the procedure in the coming months and recommended her to a colleague. He was himself not available and sent her to another gynaecologist, who made an appointment to plan the surgery in September. Because the date seemed rather far off to Sawssen, she called different places to find an earlier appointment. The earliest appointment she found was with a gynaecologist in the private sector in August. She asked for a quote and the total came up to 1000 euros, of which she could get 100 euros reimbursed by her health insurance. As she was planning on travelling to Tunis for the summer, she contacted her gynaecologist in Tunis and asked him for a quote, which came up to 500-600 euros: "I sent him the biopsy I had had in France so that he could assess the situation. He told me that I could come whenever I was ready to travel, and he would give me an appointment. I decided to advance my trip and came in early July …. In the public sector in France, it's going to be cheaper, for sure, but I looked for appointments and couldn't find any. The first appointment was at the end of August or the beginning of September in the private sector. In Tunisia, I come, I get the appointment directly and I pay less. There, I wait and it's expensive!" (Sawssen, August 2021, over the phone). When she underwent her surgery, the lesions were already at stage 3: "either the biopsy I had in France was wrong, or the virus progressed very rapidly. In both cases, I was right to insist to get the surgery as quickly as possible and to come to Tunis. Since that experience, this has further reinforced my lack of trust in doctors in France" (ibid.). Since 2014, she underwent several journeys back to Tunis for medical purposes. In 2018 for instance, she had to undergo an abortion and flew back to Tunis: "for the abortion, it was because I wanted to be with my family. In Paris, I didn't know anyone yet and I didn't want to experience that alone" (ibid).*

The return to Tunis for her surgery allowed Sawssen to bypass long waiting times in France. As discussed above, doctors' availability as well as long waiting times are often given as arguments to seek healthcare abroad. After searching for an appointment for some time, she considered returning to Tunis for her surgery, where she already knew a gynaecologist who had already treated her and who she knew she could trust. Since she was being pushed to the French private

[40] HPV is a group of viruses. For most people, they do not cause any problems. However, for some women, they can lead to lesions called dysplasia in the lining of the cervix. These are known as potentially malignant or pre-cancerous lesions and have to be removed.

sector because of long waiting times, the less expensive cost of the procedure in Tunisia also weighed in the balance when comparing both options. However, beyond availability and cost, finding a doctor she felt confrontable with and could trust was even more important:

> “I don't go to just any doctor, I look at the opinions, if the opinions are not good, I won't go to him even if there are availabilities. It's my health, it's not something you choose by default. I think about my safety. For me, it's more important than money. I've had too many bad experiences in France with doctors I didn't know and with things they didn't treat well and each time, I ended up going back to Tunisia" (ibid).

As my fieldwork progressed, I soon realised that many of the actors in my research would either regularly or, at least, occasionally make medical visits during their stays. The most common one was to go to the dentist for teeth cleaning. In the literature on medical tourism, dental care or “dental tourism” is identified as one of the main medical procedures pursued by medical travellers (Deloitte 2008; Mathijsen 2019; Mathijsen and Dziedzic 2022). In their study on the Polish diaspora (which constitutes one of the largest migrant populations in Europe) in Belgium, the Netherlands, and Luxembourg, Mathijsen and Dziedzic (2022) show that the healthcare service most frequently sought in the country of emigration was dental care (63.6% of their participants). Indeed, on top of the difficulties that were reported to me in finding availabilities with a dentist, many of my participants had not subscribed to complementary insurance for dental care:

> "When I had to do my insurance here [Belgium] and register with the insurance company, they offered me different options for teeth and other specialties like psychologists, osteopaths and all that. There is an insurance just for teeth. I thought about it, I said to myself, it's not worth it to pay every month for that when I can go to Tunisia if I need something. I pay once and that's it. Anyway, I'm going to go there several times a year, at least once a year, I already pay for the trip. Even if one day I have to do something more than just cleaning, it is never too expensive in Tunisia. I've been here for five years, and I've never found a dentist in Wetteren who accepts new patients - they have a ceiling. Once I had an emergency, and I was in pain, I took a plane and went back to Tunisia to see my dentist. And even if I find contracted[41] doctors and all, it is more expensive than the private one in Tunisia, therefore I prefer to take a plane

[41] Doctors in Belgium may be “contracted” or not. The contracted doctors are restricted to a certain maximum fee, arrived at by consultations between doctors’ associations and insurance companies. Non-contracted doctors may charge higher fees.

and then I also do other dental care, luxury care such as whitening etc. If I don't find a solution here, it's normal that I have to look for alternatives and find another solution in Tunisia" (Selima, Brussels, February 2020).

Patient physical mobility is sometimes a tool used to access care that is only partially or poorly covered by their health insurance in the country of residence, such as dental care. In these cases, these diasporic healthcare arrangements are a way to circumvent medical costs that become more accessible financially in the country of emigration, thus opening the way to therapeutic alternatives. Affordability of treatment is therefore another element identified by Glinos *et al.* (2010) in their typology of cross-border patient mobility. In the case of dental care, the economic argument plays a predominant role as well as being able, in the case of certain people residing in Belgium in particular, to not sign up for dental insurance.

Similarly, psychological consultations are another example of healthcare that is not always well covered by health insurance. Some TRA take advantage of their stay in Tunisia to consult a psychologist. Sometimes, some start a set of follow-up appointments in Tunisia and continue at a distance, through teleconsultation. For those who were already in therapy before moving abroad, it allows them to maintain therapeutic continuity with the same psychologist. While telemedicine also uses digital platforms that are not specifically designed for teleconsultation, such as Skype, WhatsApp, etc., some start-ups are developing telemedicine platforms that allow patients and healthcare professionals to get in touch wherever they are, participate in the consultation and its payment. In Tunisia, for example, this is the case of the start-up *Tobba.tn,*[42] which was created in 2019 and is representative of the development of telemedicine, in particular after the pandemic. Moreover, teleconsultations also enable migrant-patients to use healthcare services in their country of emigration without physically travelling to Tunisia, thus removing a potential barrier for those unable to travel due to financial restrictions or legal status. A psychologist I interviewed in La Marsa in Tunis had one patient who was a Tunisian living irregularly in the US:

> “He was a friend of an old patient. He contacted me to do teleconsultations from the US. At first, I thought that it would be too complicated with the time difference and so on. And usually, I prefer to alternate between teleconsultation and in-person consultations when people come on holidays. But I was touched by his situation. He was in

[42] https://www.tobba.tn/

> psychological distress and really needed someone to talk to in Tunisian dialect" (Psychologist 1, La Marsa, Interview August 2021).

Indeed, as emphasised by Glinos *et al.* "feeling at ease with a system, trusting its providers and being able to speak one's language is important in situations of illness and vulnerability" (Glinos *et al.* 2010: 1147). In the context of psychological consultations, the importance of language and cultural references shared with the psychologist seemed to play an important role. I conducted a series of interviews with psychologists in Tunis who all emphasised the importance of language for their patients from the diaspora:

> "When you are feeling unwell, we are in a 'regressive' position. We go towards what we know, what reassures us. … Language carries a whole world. It's not only words" (Psychologist 2, Lac 2, interview September 2021).

In addition to language, their patients often felt reassured by sharing common cultural references:

> "A few months ago, I had a patient coming from Paris. I wanted to recommend a colleague in Paris to her but she insisted on doing the consultations with me, saying that 'when I talk to you about my conservative father, or when I tell you about my region of emigration, you'll have an idea of what I am talking about'. Personally, I don't know her region of emigration and I don't come from a conservative background at all, quite the contrary. But because I understand some of the complexities of the Tunisian society and some religious referents, this might help me understand what she is telling me. If someone from the countryside refers to evil spirits or witchcraft, I won't send him/her to the psychiatric hospital because I know such beliefs exist in Tunisia" (Warda, Psychologist 1, La Marsa, Interview August 2021).

As underlined by Warda, the psychologist in La Marsa, the idea of a "shared 'Tunisianity' is partially imagined but gives the patient a sense of being understood. The affinity between the culture of the patient and the healthcare providers brings us back to the discussion in the first part of the chapter. This search for cultural proximity and affect is the focus of the following chapter.

Conclusion

This chapter explored how transnational social protection strategies are defined and evolve depending on actors' needs, medical preferences, perception of healthcare services, and the accessibility of healthcare in both countries of residence and emigration.

The first part of the chapter looked at the healthcare experiences of Tunisian migrants in the country of residence and examined access to healthcare, interculturality in healthcare provision, and perceptions of healthcare delivery. Looking at how Tunisian migrants can gain access to healthcare through informal social protection strategies, I emphasised the role of social networks and interpersonal networks as healthcare resources in migrants' country of residence, and how healthcare capital can derive from interpersonal networks. My fieldwork looked at Tunisian civil society abroad as part of the healthcare ecosystem, and as vectors of transnational solidarities, critical in ensuring access to healthcare for migrants, which I illustrated by their mobilisation in the context of the Covid-19 pandemic. This example clearly revealed the role of the civil society network and of the mobilisation of the diaspora in responding to disparities in healthcare access. These disparities develop in part because of imbalances of social, cultural and economic capital, and reflect the heterogeneities of migrants' trajectories and background. Illustrating the interlocking nature of different layers of heterogeneities and the impact on transnational healthcare practices, the chapter drew on the example of Tunisian women migrants' experiences of sexual and reproductive health to reflect on the lack of responsiveness to heterogeneous healthcare needs in their country of residence. This case put forward the relevance of an intersectional approach in understanding inequalities. Finally, the first part of the chapter underlined how the responsibility for accessing appropriate services is moved from "collective and professional bodies to individuals' initiative, without regard for how well equipped that person is to take on such work. This tension between individual and collective responsibility for health care is part of what is at stake in considering how patients respond to disappointing health care" (Bradby *et al.* 2020: 14).

The inadequate delivery of health services within the national healthcare system and migrants' lack of familiarity with the way the healthcare system works in the country of residence can limit their access to healthcare. The second part of the chapter thus addressed the use of medical resources in the country of emigration, looking at diasporic transnational arrangements. I explored, in particular, the role of States, both in the country of residence and the country of emigration, with respect to migrants' use of a specific provision of BSSAs. These formal transnational social protection mechanisms were associated with several constraints, adding to

the structural insufficiencies of Tunisian public healthcare system. This part also explored the role of the private sector in responding (or not) to the evolving needs of increasingly mobile individuals. The growth of the private health landscape in Tunisia is driven by the new economy of medical tourism. In this context, therapeutic mobilities appear as tools mobilised by my participants to circumvent healthcare barriers they may face in their country of residence, and to benefit from more favourable opportunity structures in the country of emigration. Coming back to the categorisation of "flexible bio-citizens" (Whittaker and Leng 2016) which I introduced in the methodology, my research actors:

> "act pragmatically and flexibly to take advantage of opportunities available in other states' medical systems to avail themselves of the services unavailable or restricted … By acting beyond their state's jurisdiction, such citizens remove themselves from their state's regulatory reach and protections and will travel to whichever jurisdiction allows them access to the services they want" (Whittaker and Leng 2016: 295).

Though they are only a small proportion of the "medical tourists" in Tunisia, the case of TRA offers interesting glimpses into how the move from Europe to Tunisia often means a shift from the public to the private health system. Participants' stories expressed how they can consciously navigate between two healthcare systems, deploying original diasporic healthcare arrangements. Their therapeutic journey is often triggered by their varying level of disaffection towards the health system in their country of residence.

Diasporic healthcare arrangements thus become an expression of these individuals' agency, negotiating therapeutic opportunity structures between countries of residence and emigration (Zanini *et al.* 2013). From this perspective, transnational ties are a useful resource for addressing healthcare needs and circumventing barriers to care in the country of residence. These mobilities can be understood through the concept of transnational social protection "from below" (Lafleur 2019), as strategies put in place by the actors themselves. They certainly demonstrate migrants' social protection arrangements who fluidly move between 'formal' and 'informal' social protection mechanisms.

While they have the power to circumvent inequalities of healthcare access in the country of residence, these therapeutic mobilities do create and reveal new patterns of healthcare inequalities in the country of emigration. For many of my participants, they experienced the feeling of "downgrading" in accessing healthcare in the country of residence, while they found that seeking care in Tunisia allowed a form of "upgrading". This situation illustrates Amelina's (2010) argument regarding individual differential positioning within stratification orders in the

country of residence and in the country of emigration. Their therapeutic mobilities are intertwined with their social mobility, which opens up access to alternative healthcare opportunities in the private sector in Tunisia.

Chapter 4: Accessing private and culturally adapted healthcare services at “home”: the "reproductive returns" of Tunisians living abroad[43]

Introduction

“The idea that you're going to be better cared for in France, that's over!" (Nour, August 2019, Tunis). Nour and her husband live in the Paris metropolitan area and came to spend the Aïd[44] holidays with their family in Tunisia. They had been trying to have a child for some time without success. They had already consulted a specialist in France, but the prospect of carrying out their reproductive journey there did not meet their expectations. Nour enquired about private clinics in Tunisia and did some research on the Internet. Seeing pictures of modern clinics in Tunis and comments from patients about the good reputation of the doctors on blogs about assisted reproductive technologies (ART), the couple decided to schedule their first appointment during their summer vacation. For this couple, the advantages of a medical follow-up in Tunisia were numerous, such as avoiding a medical protocol in France that they considered too slow.

Many infertile couples are forced to travel from one country to another to have children. These mobilities, also called “reproductive travels” (Moll *et al.* 2022), usually take place within countries but also across borders, sometimes with relatively long distances. Reproductive mobilities have become a globalised phenomenon and are a clear illustration of a transformation

[43] Some of the developments presented here are a continuation of two publications on assisted reproduction in Tunisia. One is a personal work on reproductive returns of Tunisians residing abroad. For more information see: Wenger Carole, 2024 , « “Chez — soi” pour procréer: l’exemple des “retours reproductifs” des tunisiens résidents à l’étranger », in Betty Rouland et Irene Maffi (dir.), Soins transfrontaliers en santé reproductive au Maghreb: Un paysage reproductif en devenir? Karthala, Paris. The second is a collective work on reproductive travels to Tunisia. For more information see: Irene Maffi, Betty Rouland, Carole Wenger (2023) « Les voyages reproductifs vers la Tunisie: l’intime au prisme des pratiques de l’assistance médicale à la procréation », *L’année du Maghreb*. The co-authors have expressed their agreement for the re-utilization of the material in my thesis.

[44] Aïd el-Adha in Arabic, or Aïd-el-Kebir ("the great feast") is a commemoration of the episode of the sacrifice made by Abraham reported in the Koran.

in healthcare provision. Infertile couples participate in the transforming "medicoscapes" and "reproscapes", two concepts which, respectively, refer to the globalisation of the healthcare landscape in general, and of reproductive health in particular (Inhorn and Shrivastav 2010; Hörbst and Wolf 2014). The "reproscape" is characterised by the circulation of people, know-how, biomedical technologies, funds, ideas, gametes, etc., and is structured by neoliberal market logic.

As we have seen in the previous chapter, diasporic medical mobilities are not a new phenomenon. They are part of migrants' strategies both to access healthcare needs that may not be accessible in their country of residence and to access healthcare that better meets their expectations. The usage of the healthcare system in the country of emigration is thus part of migrants' "therapeutic coping toolboxes" (Ormond and Lunt 2019). In the case of TRA, I have also demonstrated the influence of the growth of the private medical sector in Tunisia and the diversification of its healthcare offer. As individuals who are likely to travel regularly to Tunisia to visit their family and friends, TRA are, from that perspective, a "natural market" (Ormond 2013) for the private medical industry. This became particularly visible during the Covid-19 pandemic when many foreign patients who usually travelled to Tunisia from neighbouring countries (Algeria, Libya) were not allowed to travel due to travel medical visas being temporarily suspended, highlighting the presence of TRA within the fertility clinics where I conducted my research.

In this chapter, I discuss the medical mobilities of the TRA for ART in Tunisia and examine the factors behind couples' decisions to undertake therapeutic journeys in their country of emigration. Based on data collected during my fieldwork in 2019 and 2021 in a private fertility clinic in Tunis as well as in a gynaecological practice specialised in fertility, I explore the relationship(s) that these individuals have with the health systems in the country of emigration and in the country of residence. As I have argued in the preceding chapter, medical mobilities sometimes uncover particular emotional dimensions. According to Zanini *et al.* (2013), one must consider "the form of emotional dimension created by and driving therapeutic trajectories interrogating where people feel cared for and under what regimes of control" (ibid:28). The affective dimension behind the desire to procreate, and the moral and social suffering in the face of its impossibility, put emotions at the centre of these reproductive journeys. The materiality of the reproductive itineraries deployed (medical structures, technologies, means of transport and communication, etc.) is intertwined with its immaterial dimension driven by individuals' affect (Maffi *et al.* 2023).

In the first part of the chapter, I present the recent globalisation of ART, the resulting growth of reproductive mobilities over past decades. and the diverse realities that this process has generated. Diasporic reproductive returns remain, however, an understudied population, with a few exceptions, such as Inhorn's work on "return reproductive tourism" (2011). Contributing to this field in exploring the development of ART in the Maghreb region, I describe the development of Tunisia as a "reprohub" in the wake of the Tunisian ART industry's growth during the past 20 years. I show how the development of the ART's industry appeared mainly driven by the private sector and how it was facilitated by a national law in 2001 embedding religious norms and giving rise to a new moral economy around these technologies. My fieldwork in fertility clinics and with gynaecologists specialised in infertility in Tunisia between 2021 and 2022 highlights that, if geographic proximity is a key driver for reproductive mobilities, cultural factors (and Tunisia's particular "in-betweenness") also play an important role.

In the second part of the chapter, focusing specifically on the reproductive returns of TRA, I analyze my fieldwork stays in a fertility centre and gynaecological practice in Tunis. Reproductive mobilities are indeed far from only geographical, but also consist of intimate and emotional journeys. The nature of the care provided in reproductive health and its interwovenness with intimate issues invite us to rethink transnational medical strategies through the prism of the intimate. Through the discourses of couples and health professionals around reproductive returns of TRA, I discuss the different drivers of these reproductive returns and discuss dynamics of "medical patriotism" (Inhorn 2011) and notions of "medical culture" (Horton and Cole 2011), as well as the role of structuring factors (legal framework, coverage and cost of healthcare). While these discourses were at times collected *in situ*, for some in the waiting rooms of fertility clinics, in conversations with couples awaiting their appointments, I also observed the virtual "spaces" in which patient communities seek advice, offer support and share personal stories with each other. Such spaces give rise to new forms of biosociality and biosolidarity, which I refer to as environments in which patients seek support along an affective journey (Solomon 2011) that is usually characterised by patterns of isolation and invisibilisation.

Looking at the case of TRA returning to Tunisia to procreate, I propose the concept of "medical home" to qualify the affective relationship as well as the familiarity that migrant patients maintain with the health system in the country of emigration. The notion of "medical patriotism" proposed by Inhorn (2011) qualifies the relationship of pride and trust in the medical

competencies in the country of emigration but does not delve into the affective character of these diasporic reproductive returns by considering the “home country” as symbolically therapeutic. Combining the literatures on the geography of health, transnationalism and diasporas as well as the concept of "home", I first observe the role played by the family in the intimacy of the reproductive journey of infertile couples. I then explore the quest for cultural intimacy of patients in their relationship with doctors. Praise for the benevolence of doctors in Tunisia indeed reflected the struggles of couples in the diaspora in their reproductive journey in their country of residence, and their quest for forms of intimacy, or respect for their religious values. I argue that these returns to Tunisia for reproduction can be seen as a demonstration by TRA of their attachment to "home". Accounts from the fieldwork in fertility clinics also show the importance of time as justification for these reproductive mobilities, and the various medical opportunities arising from the transnational strategies of patients, thus emphasising their relative agency through their therapeutic journeys.

I. The globalisation of assisted reproductive technologies and the increase of reproductive mobilities.

Although infertility[45] is considered a worldwide public health issue by the World Health Organization (WHO) and estimates show that 186 million people around the world are affected by infertility issues, it remains a neglected reproductive health issue (Inhorn and Patrizio 2015; Rutstein and Shah 2004). Ombelet (2011) notes that it is rarely acknowledged as a key reproductive health priority. If in the Global North (where infertility is mainly age-related) ART have been made available to infertile couples, however cost and legal barriers still restrict its access to a majority of individuals. The Global South experiences the highest rates of infection-induced infertility and has the smallest proportion of ART medical infrastructure (Whittaker *et al.* 2019). The lack of accessibility of ART has therefore triggered reproductive mobilities beyond national borders, from/to the Global South as well as from and to the Global North. This has led to the increasing collaboration between two globalised industries, namely tourism and in vitro fertilisation (IVF) (Nahman 2016), which enabled the development of ART on a

[45] Defined as the failure to achieve pregnancy after 12 months or more of regular unprotected sex.

global scale. The main technologies used include artificial insemination,[46] in vitro fertilisation[47] (IVF), intracytoplasmic sperm injection[48] and donation (gametes, eggs).

In a world characterised by flows of individuals, communication and technologies, the globalised space of reproduction, conceptualised by the term "*reproscape*" (Inhorn 2011), is materialised through the circulation of practices, technologies and individuals as well as through the diversification of spaces and offers of reproductive health care (Beck *et al*. 2012). Inhorn, following Appadurai's conceptualisation on globalisation, argues that the scope of the global flow of patients, technologies, knowledge, professionals, and biomedical material has turned reproductive tourism into a kind of "meta-scape" (Inhorn 2011a). This has forged the de-territorialisation of assisted reproduction, which has shifted to new spaces (Whittaker *et al.* 2019) or "reprohubs". The movement of individuals across "national, jurisdictional, cultural and socio-economic boundaries in their quests to conceive a biologically related child" has, as a result, raised "a range of social, ethical and clinical challenges" (ibid.: 3).

The globalisation of ART has evolved in parallel with the development of a new "consumer culture" in health (Slater 1999; Hudson *et al*. 2011), "producing new subjectivities and mobilities" (Nahman 2016 :424). While some factors are common to medical travel as a whole, they nevertheless cover very different realities depending on the geographical context and medical care sought. It is also important to note that medical travel for cosmetic surgery, for non-urgent care, for life-saving treatments or for ART are not motivated by the same issues.

By examining the complex and multiple power relations at stake in transnational reproduction, anthropologists have moved beyond power/resistance dualism and global/local dyads to theorise "global assemblages" (Ong and Collier 2005). These "global assemblages" open up new possibilities and create new social and cultural imaginaries, but also new constraints (Whittaker and Speier 2010). The unequal distribution of ART services in different countries is representative of the global disparities in healthcare access (Connell 2016). As a result, the absence of ART clinics in some countries acts as a driver of "reprotravels" (Inhorn 2015; Inhorn and Patrizio 2009). Whittaker *et al.* point out that "socio-economic, gendered, racialized and

[46] Artificial insemination is the deliberate introduction of sperm into a female's cervix or uterine cavity for the purpose of achieving a pregnancy through in vivo fertilization by means other than sexual intercourse.
[47] In vitro fertilization (IVF) is a process of fertilization where an egg is combined with sperm in vitro ("in glass"). The process involves monitoring and stimulating a female's ovulatory process, removing an ovum or ova (egg or eggs) from their ovaries and letting sperm fertilize them in a culture medium in a laboratory. After the fertilized egg (zygote) undergoes embryo culture for 2–6 days, it is transferred by catheter into the uterus, with the intention of establishing a successful pregnancy.
[48] Intracytoplasmic sperm injection is an in vitro fertilization (IVF) procedure in which a single sperm cell is injected directly into the cytoplasm of an egg. This technique is commonly used in case of male infertility.

nationalized differentials structure people's capacities to undertake assisted reproduction resulting in 'stratified forms of reproduction' (Colen 2009) that both drive transnational movements and are essential to the industry" (Whittaker *et al.* 2019: 9). Data from the International Federation of Fertility Societies (IFFS) from 2016 testify to these disparities, with a total of 5000-5500 ART clinics worldwide, of which 1000 are located in India, 587 in Japan, 410 in the US, 350 in Italy, 371 in Spain and 358 in China. While some areas of the world see the emergence of "reprohubs", such as in Brazil and Turkey, other areas remain largely deprived of ART services, such as Sub-Saharan countries.

Studies on reproductive travels or "reprotravels" (Inhorn 2015) have used different terms to translate the heterogeneity of their motivations and causes. The term "reproductive tourism" was first used to describe the movement of people from one place to another in search of medically assisted reproduction treatment. But the concept of "tourism been has been criticised for a number of reasons, including its connotations of leisure, ease to travel, and individual choice. Several scholars came together to argue that it does not convey the complex journeys of these reproductive mobilities, the physical and emotional hardships they represent, or the underlying power relations at play (Culley and Hudson 2009; Inhorn and Patrizio 2009; Matorras, 2005; Pennings 2005, 2006). According to Nahman, "the term minimizes the pain and dilemmas experienced by those who seek to have children abroad and serves as a weak shorthand for the internal debates that prospective parents face" (Nahman 2016: 426). Studies on "reproductive exile" (Inhorn and Patrizio 2009; Matorras 2005) thus highlight the "forced" medical mobility of some couples to access appropriate health services when they are not available locally. The notion of exile strengthens the focus on the arduousness of these therapeutic journeys as well as on the lack of choice. The many names given to these mobilities testify to the diversity of the medical realities they cover. They are also referred to as "repro-migration" (Nahman 2016) or "infertility journeys" (Speier 2011). The more general term "reproductive journey" encompasses many of these, as well as the term "cross-border reproductive care" (CBRC) in the anglophone literature, although the concept of "care" also encompasses other dimensions (Gürtin and Inhorn 2011; Nahman 2016). The notion of "tourism", however, appears useful when studies seek to adopt a critical stance toward the fertility industry (Nahman 2013). The role of the private sector and its attempt to profit from growing infertility needs to be deconstructed, as it also responds to medical needs in the absence of public services in several countries.

The disinterest of many African states and international organisations in recognising infertility as a public health issue (Duchesne and Bonnet 2016), can be explained by fertility rates being considered too high. Similar to the case of Tunisia, several countries in the Global South have focused their attention on measures to reduce the demographic growth rate. In that framework, fertility issues remained a secondary issue, thus ignoring the difficulties faced by individuals suffering from infertility. Moreover, the relative newness of fertility treatment (which appeared in the 1980s) as well as the social taboo surrounding infertility further invisibilises the issue and limit debates in the public sphere (Maffi *et al.* 2023).

This chapter feeds into the field of studies on reproductive mobilities of diasporas, which represent an even smaller portion of the studies on ART. Some studies have observed that a large number of people living outside of their country choose to travel to countries with culturally and linguistically familiar ART services as well as in search of phenotypically similar gamete donations (Inhorn 2011; Whittaker 2009). An article in the French newspaper *Le Monde*[49] from 2023 discussed the growth of the ART sector in several countries in Africa, such as Senegal, and suggested that a growing number of patients were members of the diasporas, namely due to growing restrictions regarding family reunification, making it difficult for husband and wife to reunite in the country of residence and engage in an ART journey.

In her original work on "return reproductive tourism", Inhorn (2011) observed that a significant number of Egyptians living abroad return to Egypt for ART during the summer months, preferring "the comfort of being at home" for this type of care. According to her, these reproductive mobilities were already taking place long before the term “reproductive tourism” was coined, at the turn of the new millennium and since the arrival of ART in the Middle Eastern region in the late 1980s. She suggests that the desire to return home for assisted reproduction is related to “a constellation of features that are cultural and psychosocial in nature, so far rarely mentioned in the literature as factors underlying reproductive tourism” (Inhorn 2011: 583). By deliberately retaining the term "tourism", Inhorn defines the space-time of the return holiday to the country of emigration as a privileged period for medically assisted reproduction “Thus, these visits to Egypt were, in a sense, ‘IVF vacation’ in that they combined the dimensions of seeking treatment with pleasure and relaxation” (Inhorn 2011: 586). She emphasises the specificity of these reproductive returns, which combine both the pursuit of specific healthcare in a familiar context with visits to the family for cultural, moral and psychological reasons.

[49] https://www.lemonde.fr/afrique/article/2023/04/19/la-pma-progresse-en-afrique-continent-le-plus-touche-par-l-infertilite_6170096_3212.html

According to Inhorn, this confidence in medical skills "at home" can be described as an expression of a form of "medical patriotism". Also, for these diaspora patients, the comfort of being surrounded by family, speaking their mother tongue, being in a place that they perceive as pleasant, and with doctors that they consider more competent, contribute to creating a psychological mindset that is beneficial for their assisted reproduction to succeed.

Although Inhorn's findings suggest that similar patterns of reproductive mobilities take place in countries such as Lebanon and Iran, people engaging in diasporic reproductive returns remain an understudied population. Moreover, they may not always be counted as reproductive travellers if nationality, rather than residence, is used to define "foreign patients" (Whittaker 2009).

1. Tunisia as a "reprohub": ART development in Tunisia

Very few studies have explored the development of ART in the Maghreb region. In the Middle East, the substantial contribution of Inhorn (1994, 2006, 2011, 2012, 2015) has observed the growth of the ART industry in the region and the important social transformations in relation to fertility treatment. Her studies have not, however, looked at the Maghreb region. In this regard, the research program *"Cross Border Reproductive Care in the Maghreb (CRBC): an emerging reproscape?*" (2018-2020) conducted by Irène Maffi and Betty Rouland[50] constitutes a pioneering work in the region, and in Tunisia in particular.

The ART industry in Tunisia has experienced important growth during the past 20 years and more importantly between 2010 and 2020, placing Tunisia on the list of emerging "reprohubs". According to evidence collected by Maffi (2024), Tunisia only possessed two public fertility centres in 2010 (one in Tunis established in 1990 and one in Sousse in 1991) and two private fertility clinics. Within less than a decade, the number of fertility clinics went up to 12, a majority of which are located in Tunis and Sfax. ART constitutes a profitable market for the private medical sector in Tunisia, which benefits from its reputation in neighbouring Algeria and Libya as well as in several Sub-Saharan countries (Rouland 2021). The implementation and growth of the sector in Tunisia is originally related to the mobility of gynaecologists, who went abroad in the 1980s (mainly to France) in the framework of official agreements with French

[50] Project funded by the "Seed Money for Cooperation with Mediterranean countries" and by the High School for Health of Western Switzerland (HES-SO) as the Leading House (LH) for the Middle East and North Africa (MENA) https://cbrcma.hypotheses.org.

hospitals to train in reproductive technologies. They established the first ART clinics after their return (Maffi, 2024). This growth has emerged and been in part because of the decline of the public healthcare system in Tunisia, which was increasingly abandoned by health professionals for the private sector (Camau *et al.* 1990). The implementation of a 1989 law obliged doctors practicing in the public sector to abandon their private practices, which resulted in many doctors choosing to abandon the public sector in favour of their private practice (Maffi, 2024). As I have already outlined in Chapter 3, the degradation of the working conditions, incomes and infrastructure in the public sector only exacerbated the phenomenon, creating a significant quality gap between the private medical offer and the public one. Fertility clinics in the private sector present better success rates as well as shorter waiting times (ibid.).

Similarly to other African countries, infertility was not considered by the Tunisian State to be a public health issue, especially since Tunisia was one of the first Arab countries to develop a comprehensive birth control policy since the 1960s. I presented some elements of this policy in the last chapter on the State's introduction and legalisation of contraception as well as abortion as part of family planning measures, aiming at reducing demographic growth rates in order to achieve socio-economic development goals (Gastineau and Sandron 2000; Gastineau 2012; Mahfoudh and Mahfoudh 2014). The lack of interest in fertility issues explains the absence of national legislation regarding ART until 2001. Tunisia became one of the first Arab countries to regulate ART services, followed by Algeria in 2005 and Morocco in 2019.

IVF was introduced in Alegria in the early 1990s but the civil war put a stop to its development until early 2000. Until 2005, there was no legislation on ART. The law stipulates that ART is designated to remedy a couple's infertility and that the cause of the infertility must be medically diagnosed nature of the infertility must be medically diagnosed.

In Morocco, the first child conceived through IVF was born in 1991 in Casablanca. Several private fertility centres have developed since the 90s and it is only quite recently that public centres have developed, such as the university hospital in Rabat established in 2016, and one established in Marrakech in 2017. In his work on Morocco, Gruénais (2024) noted that gynaecological and medical associations were already calling for a legislation on ART, but that it was only in 2015 that authorities started to take interest in the issue. The 2019 law lays down the conditions for the practice of ART and opened the door for health insurance funds to partially cover the costs of medications and the use of certain available techniques. Any infraction of the law can be investigated by the judicial police and infraction of the law can be punished by a prison sentence of between 10 and 20 years and a fine of between €50,000 and

€100,000. According to Gruénais (ibid.), the strength of the sanctions provided for by law are telling about the sensitive nature of ART in Moroccan society. Similarly to Tunisia, egg and sperm donation is prohibited and considered an act of adultery both in Algeria and Morocco (Benabed 2024; Gruénais 2024).

In Tunisia, Maffi (2024) notes that despite the absence of healthcare norms on ART, even after it had been established by the state for a decade, the first private clinics were ethically and medically rather cautious and adopted techniques that were compliant with local religious values. They took advice from the Mufti of the Republic and were cautious in not introducing techniques (such as egg and sperm donations) that could break with religious values and compromise their activity in the long term. The 2001 law was prepared by a committee composed of doctors, legal experts and religious actors. The development of the ART industry in Tunisia took place based on initiatives from the private sector with little intervention from the Ministry of Health. If not proactive in supporting the development of ART services directly, the Ministry however showed some flexibility, allowing for a wide range of action in the private sector.

It is interesting to note that the architecture of the 2001 law combines both a "religious moral regime" (Morgan and Roberts 2016: 243) and a biomedical moral regime, giving rise to a new moral economy (Ben Dridi and Maffi 2018). Indeed, religious norms, directly and indirectly, defined the boundaries of medical practices and policies around ART in Tunisia. In addition, the development of the law shows how the private sector built in their legitimacy through the internalisation of religious norms within their practices and policy demands while being a central actor in shaping the State's legislation on ART. Looking at the case of medical tourism in Malaysia, Ormond shows how the Malay Muslim population's religious identity is strategically used to attract foreign patients from Muslim countries, turning "cultural competence" into a business strategy (Ormond 2013).

As discussed in more detail in the second part of this chapter, ART services are restricted to married heterosexual couples and strictly forbid the recourse to sperm and egg donation. The 2001 law indeed meets the Islamic standards of family and sexuality (ibid.). Contrary to Catholicism, sexuality and procreation can be dissociated in Islam because sexuality can be thought of outside of its procreative aim for its hedonistic objective (Fortier 2010). The law indirectly designates heterosexual married couples as individuals authorised to build a family. It is interesting to note that Islamic religious authorities in different Arab countries have been relatively open to ART, allowing its practice within the limits of Islamic values (Inhorn et

Tremayne 2016) as it is considered to serve a higher purpose, namely procreation (Fortier 2013). Genealogy plays an important role in Muslim societies, and procreation is a religious duty in Islam. This partly explains the openness of Muslim countries to ART (Fortier 2010). Interest in ART is all the more important since adoption is prohibited, as it is considered to blur the child genealogy. The preservation of the *nasab* (genealogy, kinship, lineage) is considered "a moral imperative for the constitution of legitimate personhood" (Inhorn *et al*. 2017: 44). Adoption is therefore considered unjust for the child and its prohibition is intended to prevent future incestuous marriages (Dabbou Ben Ayed 2010; Inhorn *et al.* 2017). In that regard, the Tunisian law permitting adoption is one of only three in the region (Abdellatif 2021), along with Turkey and Iran (which, unlike Tunisia and Turkey, is a Shia majority country).. The Tunisian family law provides two different types of family substitutes for the child: *kafala* (guardianship) and adoption, both introduced in 1958 (Ben Achour 2019). The *kafala* is derived from Islamic law and does not legally create a relationship of filiation between the child and the *kafil* (the persons in charge of the child). The child maintains his/her filiation with his or her family of origin. With adoption, the adopted child is assimilated as the child born to the adopter (ibid). Although adoption is legally possible, Inhorn *et al.* (2017) suggest that it remains an unpopular way to create a family, turning many infertile couples away from this alternative to access parenthood. The negative representations around adoption have reinforced the role of ART in many Middle Eastern countries which, in turn, host some of the strongest ART industries in the world, performing the highest number of IVF cycles per capita (ibid.).

1.1. ART services in Tunisia: at the crossroad between Sub-Saharan Africa and Europe.

On the first day of fieldwork on ART during my stay in 2019, I visited several fertility centres in Tunis. The gynaecologists I met during this first round of interviews in five different fertility clinics gave me more or less the same description of the motivations and profiles of foreign couples using ART services in Tunisia. According to them, infertile couples coming from abroad were attracted by the quality of care available, the reputation of some gynaecologists, as well as the competitive cost of ART in Tunisia on an international scale.

According to the gynaecologists I interviewed, the geographical position of Tunisia, with its proximity to Europe as well as to sub-Saharan countries, is a strong asset for the medical tourism industry in general and for ART services in particular. Private fertility clinics in Tunisia attract

patients from the Maghreb region (Algeria, Libya, Mauritania) as well as from the West African region (Rouland 2022). The lower quality of ART services in Algeria (Benayache 2019) and Libya sent patients (from the 1990s onward) to Tunisia, which benefited from the good reputation of its medical services (Rouland and Jarraya 2020). These clinics also receive small numbers of couples from Europe (France, Switzerland) and from North America (US, Canada). The motivations to seek ART services in Tunisia of course vary depending on the country of emigration of the couples. For those coming from Algeria and Libya, it seems that one of the main drivers is related to the quality of the ART services and the technologies available. The free movement agreements in the Maghreb (AMU agreements signed in 1989) as well as the visa exemption for several West African countries is another factor encouraging the mobility of patients to Tunisia. Moreover, the language facility, with the possibility of speaking either Arabic or French is another comparative advantage, compared to other destinations such as Turkey. For couples coming from Europe, the geographic proximity of Tunisia – less than a two-hour flight from most European countries – is a considerable advantage.

The coverage of ART by health insurance is also taken into account. In France, for example, the national social security system covers a certain number of attempts depending on the technique used and, once couples "have used all their cards" (gynaecologist 1, August 2019, Tunis), they must take care of the additional attempts themselves: "if you have to pay out of pocket, it becomes worthwhile to come to Tunisia"[51] (ibid). While some private clinics in France accept patients of older ages, it remains rarer than in Tunisia:

> “Private clinics in France lose their accreditation if they do not have a good enough success rate. So, in practice, they still do not accept women considered too old to have children, because it does not go their way. Success rates are necessarily better with a younger patient. Here it is more flexible, if you really want to, some clinics accept you. You pay, so you decide” (ibid).

According to the same gynaecologist, the legal age limit for using ART also plays a decisive role. In France, the age limit for using ART is 42, while it seems flexible in Tunisia: "if you really want, you can even go up to 45" (ibid). Thus, some couples go to Tunisia because they can no longer use ART in France: "their insurance no longer covers procedures after this age"

[51] In France, artificial insemination is supported by social security up to one attempt per menstrual cycle with a maximum of 6 attempts. IVF is supported for a maximum 4 attempts per pregnancy project and a successful pregnancy resets the coverage counter. Additional attempts are therefore the responsibility of the couples. Some complementary health insurance covers non-reimbursed IVF (over 43 years of age or over 4 attempts), *cf.* Mutualité française, 2019.

(gynaecologist 2, August 2019, Tunis). When I enquired more about the age limit in Tunisia during a discussion with Dr. Khalil in 2021, he explained that the law in Tunisia specifies that ART is allowed "until a natural age of procreation. Normally the age limit is 43 years old, but this can be extended until 45 years old if the women is still producing oocytes" (Dr. Khalil, August 2021, Tunis).

It is worthwhile emphasising that the concerns around the age limit for procreation are only applied to women's ages and not to men's. The law translates in that regard the gendered social perception around procreation. Indeed, it is commonly believed that men's age does not impact their fertility. Yet, medical studies have demonstrated that men's age also impacts fertility significantly (Dunson *et al.* 2004, Agarwal *et al.* 2021), and that advanced paternal age is associated with higher maternal, infant and childhood risks (Phillips *et al.* 2019). From the age of 40, the quality of the sperm can decrease, resulting in higher risks of miscarriage and medical complications for the mother (such as intra-uterine growth retardation, premature births), and increased risk of genetic disease (Sharma *et al.* 2015).

If geographic proximity and the ease of circulation are key drivers of these mobilities, gynaecologists often suggested that "cultural proximity" also played an important role. As stated by one of the gynaecologists I worked with during my fieldwork in 2021, "in Tunisia we are at the doors of Africa and at the doors of Europe" (Dr. Khalil August 2021, Tunis). He explained that doctors in Tunisia have an advantage compared to other medical destinations as they are "culturally in-between" (ibid.), they can therefore "speak both languages". With a foot in Africa and at the same time close connections with Europe, and "cultural proximity" with France in particular, they can adjust to different expectations in terms of the patient-doctor relationship. Moreover, they adapt their way of interacting with the patients depending on their habits and what makes them more comfortable and confident: "you need to know how to adapt to different social codes". He suggested that communication means therefore vary depending on the patients' place of residence: "Europeans want to use emails, Algerians often use Facebook, while sub-Saharans use WhatsApp".

ART services in Tunisia are thus at the crossroads between Sub-Saharan Africa and Europe, implying physical mobilities and journeys for their patients and users. These journeys are, however, far from only geographical, but also intimate and emotional.

2. Intimate Journeys: the emotional character of reproductive mobilities

The nature of the care provided in reproductive health and its interwovenness with intimate issues give it a particular emotional dimension. Medical treatments for infertility are physically and psychologically very demanding for the woman and her spouse. They require daily hormone treatments, repeated blood sampling, close ultrasound monitoring of ovulation, ovarian punctures[52] and embryo transfer. In the words of one research participant, "it's an emotional topic... psychological, mental" (Taoufik, from France, July 2021, over the phone). Furthermore, reproductive treatments often involve long therapeutic journeys that are paved with periods of uncertainties that can be psychologically exhausting. Studies in the field of public health have explored the psychological impact of the reproductive journey on men and women (Laffont and Edelmann 1994; Eugster and Vingerhoets 1999; Goëb *et al.* 2006; Girard *et al.* 2017). Most reported higher levels of stress and anxiety than in the general population, but also indices of depression (sadness, hopelessness, low self-esteem), anger, relational and social difficulties as well as stress-related physical distress. The repetition of the procedures, and coping with the long wait to have a baby are a great source of anxiety and tension. As expressed by one Tunisian woman residing in France regarding her reproductive journey between France and Tunisia:

> "Assisted reproduction is quite delicate, because we are not sick, but we are in hope, in expectation and it is very abstract. Because it is not an exact science, we don't have results right away, they don't explain much to us, there are protocols that we follow and that's all… reproduction is not like other medical procedures, it's quite long. As far as I'm concerned, I spent three years like that, and it became heavy. We are fragile sentimentally, you become sensitive, and everything is interpreted, everything has importance" (Nadia, interview over the phone, August 2021).

According to Laplantine (2020), the emotional nature of health invites us to rethink transnational medical strategies through the prism of the intimate. The burgeoning literature on transnational reproductive mobilities demonstrates the intrinsic link between these mobilities and questions of affect as a defining dimension in the strategies developed by patients seeking reproductive healthcare abroad (Inhorn and Gürtin 2011; Inhorn *et al.* 2012; Bonnet et Duchesne 2016; Rouland and Maffi 2024). Due to its interwovenness with intimate issues such as the couples' sexuality, and sexual performances but also social representations regarding

[52] Ovarian puncture is a medical act performed to extract the oocyte that form during ovulation.

“femininity” and “masculinity”, reproductive medicine is often perceived as “delicate”, if not” taboo”. The inability to conceive children questions social identities and family order and is considered in many sociocultural contexts as shameful, and can become a source of discrimination (Inhorn and Van Balen 2002). Affect and emotions are therefore a central dimension of these particular therapeutic journeys. Maffi *et al.* (2023) observe the resulting invisibilisation of these transnational therapeutic journeys, which are sometimes kept secret from the couples’ surroundings. Indeed, although the concept of “intimacy” can be defined in various ways, it, however, implies “a sphere where words and actions have no social consequences” (Laé 2003: 141). The issues at stake within that sphere have to be kept secret and, if exposed to community scrutiny, would be subject to sanctions (Lovell 2007). The issues of intimacy, linked to secrecy and the need for discretion, are very often at the heart of their discourses. Moreover, medical follow-up in reproductive health necessarily implies medical screenings that can be experienced as intrusive, such as the medical examination of sexual organs, the evaluation of their body performance and the monitoring of their sexuality. The respect (or lack of respect) of intimacy in the therapeutic process, therefore, plays a major role in patients' trust in medical care and their perceptions regarding its quality. As noted by Maffi *et al.* (2023), these relationships appear to be at the heart of what defines the intimate insofar as "they give shape to individuals' perceptions of themselves, their feelings, attachments, and identifications" (Sehlikoglu and Zengin 2015: 22).

If the decision to conceive a child is only a private individual matter, the progress of reproductive technologies has made it pass, to a certain extent, into the field of public debate (Goëb *et al.* 2006). Moreover, any assisted reproductive journeys, even when making use only of intra-marital techniques, necessarily implies the intervention of a third party: the medical body (Linconstant 2019). The couples’ intimacy is therefore invaded by medical experts that participate in the act of procreation. The couples have to let go part of their intimacy and spontaneity with the control of ovulation periods, the programming of sexual relations or even the dispossession from the actual act of fecundation with inseminations, IVF and ICSI. Procreation becomes a “collective action” (Théry 2010) and the medical body “participates in the production of kinship relationships” (Linconstant 2019: n.p). The medical body, by entering the intimacy of the couple, becomes a depositor of their secret, giving a particular significance to their relationship. I discuss in Section 2 how the quality of the relationship with the doctors during the reproductive journey was a particular element of consideration for the TRA couples.

2.1 Intimate ethnography: conducting research in a fertility clinic.

I conducted two fieldwork periods in Tunisia during the summers 2019 and 2021. Part of my fieldwork was dedicated to assisted reproduction, for which I approached fertility clinics and gynaecologist specialised in infertility. In 2019, I decided to undertake my fieldwork with the clinic which was the most cooperative regarding my presence in the field, and which seemed to receive a larger number of TRA. I was allowed to do my research there, to talk to patients in the waiting room and join in the consultations. During this first fieldwork period, the coordinating midwife played an important role in guiding me in the clinic and in providing me with details regarding patients and the functioning of the fertility clinic. Since she was the point of contact for many of the couples at the clinic, she knew several examples of TRA who had chosen Tunis for their reproductive journey. Apart from TRA, I also discussed in the waiting rooms with couples from different countries (Algeria, Libya, Guinea, Mali, etc.) as well as local patients (Tunisians in Tunisia) during both of my fieldwork periods.

When I came back to Tunis for my second fieldwork stay in 2021, I returned to the same fertility clinic. As I explained in my methodological chapter, my fieldwork plans had been postponed due to the pandemic, and this also impacted part my research methodology. Also, the choice of returning to the same clinic was a way to facilitate my re-entry into fieldwork during a period that was not favourable for conducting research within a medical structure. In 2021, the fertility clinic was a lot less busy than in Summer 2019. Covid-19 travel restrictions were still in place and many patients were therefore not able to travel to Tunisia for their medical follow-up. One morning at the clinic I bumped into one of the gynaecologists of the fertility clinic that I name Dr. Khalil. He recognised me and we took a moment to talk in the corridors about my fieldwork plans. We also discussed the changes that had been taking place due to Covid-19 but also the economic situation in Tunisia and how this impacted the fertility clinic. According to him, the presence of foreign and local patients had decreased, causing some financial difficulties to the fertility clinic. Due to Covid-19, some couples had decided to postpone their treatment, as some of them were worried that potential lockdowns and travel restrictions would occur in the middle of their therapeutic journey. Moreover, a number of local patients (Tunisians living in Tunisia) was no longer able to afford ART in private clinics and redirected themselves to the public sector. Since 2019, the economic situation in Tunisia was characterised by a reduction of purchasing power and a general impoverishment of the population.[53] According to Dr. Khalil, this partly explains the redirection to the public sector of Tunisians living in Tunisia. Also, some

[53] https://lapresse.tn/119300/retrospective-2021-de-leconomie-tunisienne-une-annee-eprouvante/

patients could not travel because of border restrictions, including patients from Algeria. This highlighted the persisting presence of TRA who, despite having faced difficulties in relation to Covid-19, were still able to travel back and forth between Tunisia and their country of residence and could still afford medical costs at the fertility clinic.

We agreed on that day that I would come to his gynaecological practice, and he agreed to help me get in touch with some of his patients. Indeed, the majority of the patients at the fertility clinic had their first contact with one of the gynaecologists of the group, through their private practice, and then came to the fertility clinic for part of their medical follow-up as well as all the medical procedures requiring medical equipment from the fertility clinic (sperm collection, ovarian puncture, insemination, IVF, etc.). The clinic also had a dedicated department for the "recruitment" of patients, and some couples would go through that channel rather than through a gynaecologist. They would be first received at the clinic and then meet one of the gynaecologists of the group, depending on the day of their appointment and medical needs. For these patients, it was usually the reputation of the clinic itself and the quality of the services and infrastructure that attracted them. As several of the gynaecologists of the clinic had a good reputation, this signalled a guarantee of quality. According to Dr. Khalil and to one other gynaecologist with whom I spoke with during my fieldwork, TRA usually go through the private practice first. This can be explained by the social capital of TRA in Tunisia who often hear about a particular doctor through family and friends.

During fieldwork, my position as a researcher required particular attention to the preservation of couples' intimacy. As I have discussed in the methodology, the collection of data on such sensitive subjects requires the researcher to respect an ethnographic "moral pact" (Fassin 2008). Establishing a relationship of trust with the medical staff, the fertility clinic and the couples, was essential for the completion of the fieldwork. I thus found myself participating in "intimate ethnography", caught up in social relations characterised by a strong bond of physical and/or emotional proximity involving the spheres of the body, sexuality, and care (Waterstone and Rylko-Bauer 2006; Constable 2009). The moments of discussion took place in peculiar spatiotemporal configurations in the waiting rooms while couples were waiting for their appointment and a diagnosis, in the bedrooms after a medical procedure, or in the consultation room. In the fertility clinic, the architecture of the centre was designed specifically to meet the need for intimacy sought by couples. The waiting area is composed of small private rooms (see Figure 11), separated from each other and able to hold four people seated. The small waiting rooms have doors, which couples can choose to close in order to further preserve their intimacy.

Figure 11: Waiting boxes at the clinic.

Source: picture taken by the author, August 2019

The time of the interview implied temporarily entering the sphere of the couple's intimacy and offering them a space to express what they were going through. The nonverbal language, crying and silences, were thus an integral part of the biographical narrative symptomatic of the emotional experience lived by couples during their reproductive journey. These moments of discussion through the interview often took on a cathartic dimension.

Among the couples I have discussed with during both of my fieldwork stays in 2019 and 2021, most shared a common profile. As with most of the participants in my research, they were first-generation immigrants, belonged to the middle class and had emigrated abroad for work. As I discuss in the example below, many worked abroad in the IT sector as well as in the healthcare sector. Both IT specialists and doctors are among high-demand professional sectors abroad. I have described in the methodology the large number of doctors emigrating abroad every year and its impact on the healthcare sector in Tunisia.

As emphasised in the methodology chapter, the social class of my participants as well as their immigration status are important determinants for the understanding of their transnational healthcare practices as these determine both the participants' possibility of moving back and

forth between their country of residence and Tunisia and the frequency of travel. Most of them travelled back to Tunisia at least once a year. In addition, the financial capital accumulated while working abroad provides them with a higher purchasing power upon return to Tunisia, opening access to the private healthcare sector. Only one couple were second-generation Tunisians living in France and belonged to the lower middle class, which, as we shall see, impacted their reproductive journey in Tunisia.

Furthermore, in the case of individuals who were themselves doctors, their profession has to be taken into account when analysing their reproductive journey and their experience of it. As illustrated in some of the examples in this chapter, this gave them greater access to the medical offers in Tunisia, as they could count on the personal social network that they had built during their medical studies. The social capital accumulated during their years of study in Tunisia helped them navigate their reproductive journey by providing gynaecologist contacts in Tunisia.

3. Virtual spaces on ART and "biosociality"

Internet and digital technologies play a decisive role for the promotion as well as facilitation of reproductive travels (Millbank 2018; Speier 2011, 2016; Whittaker 2018). As I have already discussed in Chapter 3, the use of the Internet for getting information about health issues has been highlighted by scholars since the beginning of the century (Fox and Fallows 2003; Spink *et al.* 2004). By pointing to gaps in the literature and underlying challenges for scholars investigating cross-border reproductive care, Inhorn and Gürtin reflect on a possible future research agenda taking into consideration 'novel spaces', such as the internet, discussion forums and blogs of patients (Inhorn and Gürtin 2011). In the field of (in)fertility, the internet became a main source of information for patients to select their fertility centres, as well as a very important tool for private clinics to advertise their services (Shenfield *et al.* 2010; Hudson and Culley 2011). Internet-based communication enables infertile couples to gain medical knowledge on available treatments and medical destinations. Infertile couples seeking treatments outside of their country of residence and ART service providers therefore get in contact through these virtual spaces.

They are gendered spaces, as almost only women make use of them, and they also obey class logics as they require individuals to have a sufficient level of education to write as well as an economic situation that allows them to have a computer and access to the internet. For most of the couples that I met at the clinic, women were generally the ones who researched the most

about ART on the internet. Studies conducted in the Maghreb, West and South Africa also show the importance of those virtual spaces and communities in the "South", given the context of stigmatisation of infertility (Lamine-Benayache 2019, Rouland and Maffi 2024). The anonymity offered by the internet enables them to communicate freely, and express suffering without fear of being stigmatised.

These online spaces, beyond the information that they provide, also constitute "a meeting place" for the virtual patient communities, allowing them to seek advice, to offer support and to share personal stories with each other (Inhorn and Gürtin 2011; Simonnot 2016; Simon 2016). In that regard, they constitute new spaces of sociability. Individuals discuss about treatments, share their therapeutic experiences and share their opinion and recommendations on gynaecologists and fertility clinics on various platforms such as blogs or Facebook groups. Beyond their informational aim, individuals also seek moral support. Concepts such as "biosociality" (Rabinow 1996) or "biosolidarity" (Bradley 2021) have been used to refer to the social networks formed by people sharing common biomedical conditions as well as the type of group identities forming around biological knowledge. Furthermore, "'Biosociality' attempts to account for novel alliances between patients, scientists, politicians, doctors and biotech companies that give rise to new kinds of socialites formed around genetic knowledge" (Lemke 2015: 2). Most of the research work on biosociality has emphasised "processes of subjectivation 'from below'" (ibid: 5), as it results from the practices of self-help groups which play a role in the appropriation of genetic and biomedical knowledge.

Figure 12: Photo of the Facebook group "IVF and insemination in Tunisia, hope is here".

Source: Facebook group: "IVF and insemination in Tunisia, there is hope", August 2021

In Tunisia, Facebook groups such as "IVF and insemination in Tunisia, there is hope" (see Figure 12) gather more than 40,000 subscribers, exclusively women, who exchange daily prayers, fears, and good and bad news. In the picture above, a man and a woman's hands are turned in the direction of the sky in the same way hands are positioned to pray in Islam. The feet of a newborn in between their hands seem to symbolise the content of their prayer. Subscribers also share their test results (blacking out their names from medical files), names of specialists and advice on the steps to take. They also highlight the long therapeutic wanderings and the isolation of these couples and constitute places to give and seek support. Facebook posts reveal the distress and suffering felt by many couples as the following message attests:

> "I'll tell you, my little one, about the cold house, the sad mornings, the empty hugs, the missing dishes on the table, the long wait and the tears that came to my eyes. You will come, and then there will never be a sad morning again, with the help of God. Pray for me so that God blesses me (Asma, from Tunisia publication on the page "Facebook IVF and insemination in Tunisia… there is hope", December 13, 2022).

These virtual "safe spaces" composed of individuals facing the same hardship and seeking caring exchanges illustrate forms of bio-solidarities. If the concept is usually applied to patient groups and associations that come together to advocate for their biomedical conditions, here I refer to it as an environment within which patients seek support along a journey that is characterised, as we have seen, by isolation and invisibilisation.

Beyond blogs, Facebook pages and discussion fora, teleconsultation is another virtual space of these transnational medical practices, playing the role of a bridge between different places. Health professionals remotely advise and monitor (via email, via WhatsApp, by phone or on video communication platforms) patients who undergo part of their medical analysis in their country of residence, before planning their trip to Tunisia. As we shall see in the following section, for many couples coming from abroad, it is common to do part of the medical follow-up via teleconsultation from the country of residence.

II. "Home" to Procreate: "Reproductive Returns" of Tunisians Living Abroad

For my first fieldwork in August 2019, I arrived in Tunisia two weeks before *Eid-el-Kebir*, a holiday for which many TRA travel to Tunisia every year. Before my arrival, I had identified the main fertility clinics in Tunis and done a first overview of the information available online. Some have a strong presence on the Internet, including social media pages with hotlines to ask questions. From Belgium, I wrote to several of them by email, Facebook and *via* their platform. The clinics were reacted and quickly confirmed that they were open in August. I also consulted a large number of online forums and clinic websites. Upon my arrival in Tunis, I started by visiting some of the main fertility clinics in Tunis as I was trying to find an entry point to my fieldwork on ART as well as an understanding of the reproductive landscape in Tunisia. In the first fertility clinic, I was received by one of the gynaecologists and enquired about the presence of TRA. He told me that TRA represent a sizeable proportion of their patients at this time of the year:

> "In summer, Tunisians abroad represent about half of our patients. For example, if I take the list of patients today, 9 of the 20 procedures I have performed are with Tunisians from abroad. You came at the right time of year because it is the holiday period and many Tunisians abroad are there [Tunisia] right now" (gynaecologist 3, Tunis, August 2019).

He recounted that the summer was indeed used by many to take advantage of their visit to the family to plan their consultations or their procedure (when they had started their medical follow-up remotely). In that perspective, my observations are consistent with those of Inhorn and the idea of "IVF Holidays" (2011). Being on holiday also removed some stress in already stressful circumstances. As expressed by Anissa, coming from France, "because we don't have to work during the treatment, we are more relaxed, and more serene" (August 2021, Tunis). In 2021, some couples also took advantage of the generalisation of teleworking to plan longer stays in Tunisia for their medical follow-up.

In another fertility clinic, the observation was not as clear and if they indeed acknowledged the presence of TRA among their patients, they were still a minority compared to the large number of Algerian, Libyan and Sub-Saharan patients. Moreover, as pointed out by the director of one of the clinics, it is often difficult for doctors to distinguish between TRA and Tunisians in

Tunisia: "people present themselves with their Tunisian papers, but it is possible that, among them, some are from abroad" (Clinic director, Tunis, August 2019). Connell (2015) highlights, in that regard, the difficulty of identifying patients of the diaspora and to distinguish them from "local" patients. I was therefore advised to discuss it directly with the midwives who do all the follow-up of the couples as well as the medical secretaries who are sometimes better informed about the back and forth of couples coming from abroad.

1. Comfort consultations

The following week, I spent Eïd near Sousse where I was welcomed by Nesrine, a participant from Belgium who came to celebrate the holiday with her family. Sousse is the third-largest city in the country in terms of population, and one of the major seaside cities, receiving tourists every year from tour operators in large hotels facing the sea. Private medical services have also developed with the creation of new clinics adjacent to the city's tourist district. I went to one of the clinics that also had a fertility centre. The clinic was under construction and a sign announced its upcoming expansion (see Figure 13).

Figure 13. Poster announcing the expansion of the Clinic in Sousse.

Source: picture taken by the author, August 2019

I spoke with a gynaecologist at the ART centre about TRA:

> They come to consult, but they are rather consultations that I would call - [he hesitates] of "comfort", I would say. It reassures them to seek the advice of a doctor here. Someone in their family has recommended this or that person, or knows the daughter of such and such a person who became pregnant on her way to see such and such a doctor. But beware, there is also sometimes family pressure if they have possibly already done tests in France that did not work. Then, the mother tells them "try to go see this doctor, the daughter of a friend got pregnant" (gynaecologist 4, male, Sousse, August 2019).

The notion of "comfort consultations" here refers to the emotional dimension in the search for medical solutions within care space that meets their expectations from a medical and emotional point of view. Research on diaspora medical mobilities has often emphasized the affective character of these practices, which refer to the emotional dimensions of health (Horton and Cole 2011, Mathijsen 2019). For these authors, it is a search for medical care in an environment considered "familiar" and carrying an affective meaning. Patients are not only seeking medical care that is "efficient and productive but also affective and culturally comfortable" (Lee et al. 2010: 110). This sense of comfort felt by patients thus makes their medical experience "emotionally therapeutic" (Ibid:114). The healthcare system in the context of the home country is thus not only therapeutic through the medical treatments it offers, but also, or more importantly, through its emotional dimension through the patients' trust in the "medical culture" (Ormond 2013). From this same perspective, we can think of the notion of "therapeutic" as "an aspiration, a potentiality ... an orientation towards the future, a future imbued with hope and therefore with an affective/emotional texture" (Kaspar *et al.* 2019: 4). As stated by Holliday *et al.* “the clinic is a site of hope and of promise – and the networks of information that brought the patients there carried along with them particular messages, constructing Tunisia and the clinic as hopeful” (Holliday *et al.* 2019: p.84). Tunisia as a relational place becomes meaningful along their therapeutic wandering.

The gynaecologist’s words also suggest that the family plays a role (not always "positive") in the identification of a doctor. Indeed, word of mouth and personal recommendations are often more important for diaspora patients than visibility and formal accreditation (Connell 2015). Almost all the couples of TRA I came across during my fieldwork had heard about a particular doctor through friends and family. This was information that they could then confirm by looking online for recommendations. This highlights once again the use of social capital in the country of emigration in order to gain access to healthcare (cf. Chapter 3). As we shall see in some of

the examples below, the possibility to better navigate the healthcare system with facilitated access to the most renowned healthcare specialists through contacts or personal knowledge contributes to a feeling of having more control over the therapeutic journey rather than being subjected to it. This illustrates processes of "reverse social remittances" (Mazzucato 2011) as the family and relatives in the country of emigration enable those who have migrated to access healthcare.

This first tour of clinics gave me an overview of the reproductive landscape in Tunisia and of the use made of it by TRA during their visit to their country of emigration. Couples of TRA navigate between medical offers "here and there", between the public health sector in the country of residence, and the private sector in the country of emigration. Indeed, the shift from Europe to Tunisia is characterised by the transition from the public health system to the private sector, creating an asymmetry of supply (private/public), legislation, medical protocols and costs well described by the scientific literature (Martin 2009; Matorras 2005; Gürtin 2011; Nahman 2016). For patients in search of medical care, it is then a question of weighing these different elements against each other to determine the place of continuation of their treatment.

TRA come from different regions of the world. According to Khalil, their motivations to seek treatment in Tunisia have certain commonalities, yet some elements vary depending on their country of residence:

> "Those coming from the Gulf countries come for cost reasons as well as because of the lower level of competence of the physicians where they live. For Tunisians residing in France or Canada, it is because of the complexity of the medical protocols and the fact that the healthcare system is laborious and too slow. Those coming from the US are motivated mainly by cost reasons. All of them are driven to Tunisia rather than another medical tourism destination because of trust" (Khalil, gynaecologist, July 2021. at his medical practice).

Although cost was mentioned by several of the couples I discussed with, it was presented as a "plus", but not as the main driver of their mobility. Indeed, for most of them, the cost was a sacrifice they were ready to make to increase their chances to conceive: "We can spend the money of a lifetime to have a child" (Naïm, Tunisian residing in France, August 2021, over the phone). This had to be nuanced however by the fact that all the couples I met were, de facto, financially able to afford ART since they were present at the clinic. Moreover, as I have detailed above, the TRA couples I met at the fertility clinic belonged to the middle class. Some did mention that the cost of ART services "imposed on them" the need to remain abroad for work:

> "If we were working here [in Tunisia], we could not afford all of this. In Riadh [Saudi Arabia], I do overtime to save as much money as possible and come to Tunis twice a year for this. For years now, I have dedicated all my holidays and extra money for this. That is why it is so depressing when you are not obtaining any results. You live only for that and everything else is on hold" (Marwa, from Saudi Arabia, August 2021, Tunis).

Among all the couples of TRA I met during both of my fieldwork, only two of them mentioned struggling to afford their fertility treatment in Tunisia. This was the case of Anissa (36), a second-generation Tunisian from Nice in France. With her husband (38 - also second-generation Tunisian), they already had undertaken a long reproductive journey in France before coming to Tunisia. She worked as an assistant nurse in a hospital and her husband was a crane operator. Discussing with her in a separate room at Dr. Khalil's office (Figure 14), I could sense her exhaustion and resignation after years of unsuccessful treatments. She confessed that her husband insisted on trying again in Tunisia but that, if it had only been up to her, she would not have undertaken this therapeutic journey:

> "I have no more expectations. I have accepted by now that I may never have children and that this is what God has decided for us. It was God's will to put this ordeal on our path" (Anissa, from France, August 2021, Tunis).

After six IVF trials in France since they started their reproductive journey, they had decided to try again in Tunisia. Anissa explained that at times, they stopped the treatment for several years before trying again. It was sometimes by necessity, to let the body rest and other times because they could not mentally bear other failures. Psychological distress is indeed an important and frequent cause of drop-out during the reproductive journey (Girard *et al.* 2017). Contrary to most of the couples I met who were coming to Tunisia once to twice a year (sometimes even more), Anissa and her husband travelled only every other year. They also had to take some time to save enough money to undertake the additional trials that were no longer covered by their health insurance policy. To afford the trip and the stay as well as the fertility treatment, they had to anticipate and save the necessary money.

Figure 14. Painting on the wall in the clinic

Source: picture taken by the author, August 2021

Some of my discussions with Tunisian couples living in Tunisia during my fieldwork revealed the disparities between them and their co-nationals living abroad. Discussing with Soraya and Toumi in the waiting room before their appointment, they explained that the cost of treatment, although still accessible, required them to put some money aside for several months. After a first IVF trial a year ago, it took them another year to collect the necessary funds for a second trial. They already had a little girl (also conceived through IVF), and Soraya was a stay-at-home mum while Toumi worked for the national gendarmerie in Tunis. According to them, because they already have a child, their health insurance in Tunisia does not cover any costs of the treatment for a second child, requiring them to secure more money.

Soraya has a sister living in Italy who also had to go through ART and is still trying to have a child. They therefore discussed on their respective journeys. Soraya explained that the process had been much slower for her sister in Italy, and she tried to convince her sister to come to Tunisia to speed up the process: “For me, they are losing valuable time” (Soraya). Over the years, Soraya seemed to have built up expertise in ART and she was very well informed on the available treatments in France, Italy, Belgium, Turkey: “I have internet on my face,” she said laughing. They never considered going abroad as their financial capacity would not allow them to do so:

> "My sister can come to Tunis if she wants, but we can't go to Italy or another country in Europe. Between the visa, the travel expenses and the treatment there, it's not possible" (Soraya, July 2021, Tunis).

This illustrates, within the same family, the disparities of access to healthcare opportunities related to economic disparities as well as unequal access to transnational mobility (Neumayer 2006). It also reflects other forms of disparities. Soraya and Toumi explained that they have never told either of their respective parents about their difficulties in procreating. Their respective families do not know that their first daughter was conceived through IVF as it seemed impossible at the time to open up about it. When Soraya's sister living in Italy openly shared her experience with the family, Soraya decided to talk to her about what they had been through, but kept it secret from the rest of the family:

> "For my sister, because she is away, even if she talks about it, it is not going to impact her in her daily life. I think also people in Italy, they don't have the same mentality maybe. Here we see each other all the time and the family would want to interfere" (Soraya, July 2021, Tunis).

Seeing the ease with which her sister shared what she was going through, they are now considering telling her parents about the second child that they are trying to conceive. For Toumi, however, he prefers to keep his family out of it. This example illustrates the circulation of ideas regarding healthcare in the context of migration and transnational families, potentially impacting individuals' healthcare behaviour both in the country of residence and in the country of emigration. From that perspective, Levitt's concept of social remittances (1998) looks at how migrants export ideas and behaviours back to their home country in addition to other forms of remittances (financial, political, etc). In the literature on social remittances, individuals diffuse ideas and practices transnationally and interpersonally through their role within a family or a community and may contribute to reshaping these ideas and practices (Levitt 2015).

Furthermore, the situation of these two sisters highlights different moral economies of ART within the same family. In Fassin's understanding, moral economy refers to "the production, distribution, circulation, and use of moral feelings, emotions and values, norms and obligations in the social space" (2009: 1257). In this case, I suggest that those moral economies "regulate" intra familial relationships differently as a result of geographical and social distance.

However, if that example seems to suggest that there can be differences within the same family network between those living in Tunisia and those living abroad around infertility, I discuss in

the next section the role played by the family, which is sometimes included in the intimacy of the reproductive journey of the infertile couples, sometimes left aside.

2. Family Network as Healthcare support?

Amira (31), the first patient from the diaspora who I met at the fertility clinic in 2019, lives in Dubai. She allowed me to follow her in consultation with the midwife. At the time of our meeting, she was already quite advanced in her medical follow-up for IVF and had to perform her ovarian puncture and embryo transfer in the following weeks.[54] After the consultation, we took a moment to discuss alone about her choice to undergo IVF in Tunisia. She had been working in Dubai for several years in the human resources department of a large company. When she was speaking to me, she would switch from French to English and place Tunisian words here and there. Her husband was based a good part of the time in Tunis, and the couple had been making frequent trips back and forth between Tunis and Dubai during the past years. During the consultation, I noticed that it was partly her husband's insurance in Tunisia that would cover the cost of medication. In their case, cost was a determining factor in choosing Tunisia for their therapeutic journey. In Dubai, IVF would be too expensive: "why pay so much if I have the best doctors in my country?" (Amira, August 2019, Tunis). For this couple, who seem to have a certain financial ease allowing them to regularly go back and forth between the two countries, a similar treatment in Dubai would have been difficult to afford.[55] Paying high prices in Dubai therefore does not seem to be a rational choice in terms of value for money.

Amira's words also highlight the skills of doctors in Tunisia: "the best", according to her. As suggested by Inhorn (2011), these reproductive returns are indeed an expression of a form of "medical patriotism" where diaspora members associate feeling of national belonging with praises for medical skills of doctors in the country of emigration. This was unequivocally expressed by Hassine when questioned about the decision to return to Tunisia for ART: "it's nationalism, it's patriotism" (Hassine, August 2021, Tunis).

But price and medical skills are not everything. It is a set of considerations that are taken into account in this therapeutic itinerary:

[54] IVF (fertilization) *in vitro*) takes place in several stages: ovarian stimulation, egg retrievals, the culture phase and embryo transfers then the freezing phase of the surplus embryos.
[55] The different websites show a fairly variable price scale, active from 5,000 to 20,000 euros.

> It's not just the cost of treatment. Other than that, when you're here, you can also enjoy. There is the sea, you are at home with your mother who makes you food... You have your habits. Still, the hormones and the treatment, you feel them. You're tired, your mood can change, and you're stressed ... sometimes I'm like hysterical. So, before that, when you are at home (in Tunisia) you can go for a massage, go to the hammam, it doesn't cost a lot here. Even being able to go to the hairdresser to feel good... You have to count all of this into the total cost (Amira).

ART involves medical follow-up and treatment that represent a significant emotional burden for couples who wish to have a child. It is a slow and difficult process. As Amira pointed out, having her "habits", being at "home" with the presence of her mother are elements that contribute to her well-being during her therapeutic journey. This comfort of being "at home" to heal oneself, surrounded by family and in places that are considered pleasant, thus participates in the therapeutic process.

It, therefore, seems relevant to return to the definition of the concept of "home" in the literature on migration studies. Studies on the concept of "home" argue that it must not be understood only as a physical space, but also and above all in its symbolic and affective dimensions. It should be understood as a symbolic support, impregnated with social meaning but not necessarily rooted in space (Agier 1999: 54). This affective appropriation of space transpires through unnoticed, conscious and unconscious behaviours. Easthope (2004) describes a sense of security, attachment, belonging and identification. The feeling of being "at home" therefore implies:

> "This experiential sense of being at home involves bodily, spatial, kinaesthetic, sensual, emotional, ...qualities that combines speakable and unspeakable explicit and tacit, ... ways of experiencing" (Märtsin and Mahmoud 2012: 731-732).

I argue that the search for healthcare "at home", in the context of the country of emigration, is part of the therapeutic process of these (trans)migrant patients. It constitutes a "therapeutic landscape" in the sense developed by Gesler (1992, 1993) in health geography, as "frameworks or ... situations that encompass physical, psychological and social environments associated with healing" (Gesler 1992, in Gastaldo *et al.* 2010). According to this approach, places are considered as "therapeutic symbolic systems" (Andrews 2002). The consumption of medical care in the context of the country of emigration becomes thus inherently therapeutic. The notion of "medical home" that I propose here reflects this transnational care space (Rouland and Jarraya 2019) sensitive to the specific needs of these (trans)migrant patients. By evolving in a

therapeutic landscape that meets their medical and emotional expectations, within which they navigate easily, they feel confident and comfortable with the social norms that unfold there.

If the notion of medical home here means seeking care in a place imbued with emotional meaning, it also suggests the possibility of combining treatment with relaxing activities such as going to the sea or to the hairdresser. This validates the idea that these returns home allow some diaspora patients to combine medical care with the consumption of goods and entertainment as well as "wellness tourism" while benefiting from proximity to the family. Amira's case highlights the juxtaposition of factors that determine therapeutic choices. While cost is an important factor, it is also associated with the couple's transnational lifestyle between Tunis and Dubai and the possibility of combining treatment with family stays.

Like many patients coming from abroad, Amira does part of her medical follow-up remotely, from Dubai, where she carried out her hormonal assessment. Indeed, for these patients, if they do not remain in Tunisia for the duration of the treatment, the medical follow-up is partly done remotely. Contact with the midwife in Tunis takes place via WhatsApp messaging, phone or email. In order to build the medical file of the patient, certain medical examinations are undergone in the country of residence, prior to return to Tunisia. This usually allows the couple to save some time once they arrive in Tunisia. Amira, who often comes to Tunisia to see her husband, makes sure to travel at the appropriate time for her follow-up. During the summer, she usually returns to Tunisia for a long time, because it is very hot in Dubai, and she can get her employer to let her work remotely. It is therefore during the summer that she scheduled her procedure. Her husband was not present at the clinic the day we met. She explained that, as she started her medical monitoring from Dubai and that she is often alone there, her husband is involved "only for things that concern him" (Amira). She seems to have taken charge of the management of their reproductive journey and she approaches it as a personal project more than a couple project. She had also decided that she would give birth in Canada, so that her future child can access good universities, and she had already started to save money for several months:

> "I am already thinking about the future. In Tunisia and Dubai, there are no good universities and, if you do not have your papers in Canada, the university is not affordable, so you have to anticipate".

Amira's therapeutic journey is thus part of a project that she has thought about alone and over the long term. But it is important to analyse the role of the husbands in therapeutic trajectories. Some studies have highlighted the place of husbands "in the background" (Rouland and Maffi

2024). Although my fieldwork does not allow me to provide a detailed analysis of gender relations in couples' therapeutic itineraries, it nevertheless highlighted certain dynamics and, in particular, the fact that women seem to take most of the logistics in charge, from enquiring about specialists to consulting clinic websites to planning appointments. Indeed, Ventola (2014) underlines the assignment of contraceptive and reproductive responsibility to women. The gender analysis of Davidová and Pechová in their paper on infertility and ART illustrates how women tend to undertake the role of "manager" while men describe their participation as "passive bystander" (2014: 368). Indeed, as also shown in my fieldwork, women are more active than their spouses when it comes to researching treatment options and locations. As we have seen earlier, the predominantly female presence on blogs and Facebook pages on ART illustrates well the gendered dynamics behind such reproductive work or "intimate labor" (Boris and Salazar Parreñas 2010: 3). Like care and domestic work, reproduction came to be naturalised as part of women's contribution to the intimate relationship (Marre *et al.* 2017). Furthermore, as emphasised by Fortier (2013), from a medical point of view, women still endure most of the treatments (even when the husband is the "cause" of infertility). Nadia, whom I introduce below, explained that the greater impact that fertility treatments have on women's body implies that they are most in charge of the reproductive journey. She expressed in that regard:

> "It's the women, unfortunately for us, who are suffering the most during the journey, even if it's not our fault or that we are not responsible for the failure of the natural process. But since I am suffering more than my husband, since I am the one going to the appointments, undertaking ultrasounds and injections, ... so he doesn't want to upset me and he understands completely when I say that I am more comfortable in Tunisia" Nadia, August 2021, Tunis).

I noticed that husbands I interviewed during my fieldwork often emphasised the well-being of their wives. This seemed to be a result of their awareness of the greater burden on women's bodies caused by fertility treatments. They followed their wives' preferences in terms of place of treatments, choice of doctor etc. As already emphasised above, this also unveiled the gendered dynamics behind reproduction and it was clear from the interviews that women often decided on the place of treatments after having done most of the research themselves.

As we have seen, in the case of Amira, the closeness with the mother in particular was presented to me as a reassuring element and participating in her comfort. From the same perspective, Nadia felt that the proximity of her family in Tunisia could constitute a moral and emotional

support for her. She, however, did specify that she did not think of the family as a support for sharing the details regarding her reproductive journey as she did not want "to add burden on their shoulders" (Nadia) but to be surrounded outside of her medical follow-up:

> "For example, if I do an [embryo] transfer and then I go home and I find my mother, my sister and that we are all together with my husband…we talk about something else, I am in a good atmosphere, in a more intimate environment and I wouldn't be thinking about my reproductive journey all the time. I think that it would benefit me morally, I would feel as if I was on holiday" (Nadia, interview over the phone, August 2021).

The family is therefore an indirect support for dealing with the anxiety generated by the treatment but is not automatically involved in the details of the therapeutic journey. However, it is necessary to understand the place of the family in a nuanced way, as it sometimes plays the role of support and can, conversely, sometimes generate additional stress and conflicts. As expressed by Marwa who has come twice a year from Riadh since 2017 and dedicated all her holidays to her reproductive journey:

> "The worst for me is having to deal with the disappointment and sadness in the eyes of my parents. I involve them as little as possible. If I could, I wouldn't even tell them and would prefer dealing with this on my own" (Marwa, August 2021, Tunis).

In several of the cases encountered, the couple's families were left out. This was often presented to me as a deliberate choice, in order to avoid possible tensions, in particular between the wife and her in-laws. This is the case of Amir (38 years old) and Leila (39 years old) whom I met in July 2021 in Tunis. They have been living in Saudi Arabia, in Al Bahah, for more than 5 years and both work in the computer industry. When I met them at the fertility clinic, they had just carried out an ovarian puncture that would be preserved until their next stay in Tunisia to proceed to the embryo transfer. I met them in their room at the clinic. It was my first time meeting a couple in the private rooms of the clinics. During my last fieldwork stay in 2019, I only met couples within the waiting area and a few in consultations but had not "followed" couples beyond that point.

Arriving in the room area of the fertility centre, I was guided by a nurse to the room of Leila and Amir. When I entered their room, Leila was lying on the bed and Amir was working on his computer on an armchair. Their one-year-old daughter was playing on the ground with some toys. She was conceived through IVF in the same clinic in 2019. After some time talking, the nurse came back into the room and offered to take the little one for a walk down the hallway as

she was a bit agitated. The nurse put her hand in Leila's hair and told her in Tunisian dialect "Don't worry my dear, you rest a little bit, I am taking care of her". When the door closed Leila continued the conversation about their experience of assisted reproduction in Tunis and explained: "You see that, for example, you cannot have this contact with people in a hospital anywhere else than in Tunisia". This gesture and these kind words illustrate the emotional experience sought by this couple. If their little girl is with them in the hospital, it is because Leila and Amir came from Sfax pretending that they were going to visit friends in Tunis. On both sides, they did not share their experience with their relatives who "would not be of any help" (Leila). They also explained their silence by fear that "people would be talking nonsense" (Amir) and that their families and friends would not believe them. According to Amir, assisted reproduction is a subject that can lead families to push for divorce, but also to behave in a hostile way towards the wife:

> "for the family and in the traditional culture, if you like, it is more serious if the problem comes from the husband, it means that the man lacks masculinity or something like that. In the case of women, it's more accepted, but they put all the burden on her. So even if we tell them that it's also a problem on my side, they'll say that I'm saying that to protect my wife. They would repeat that it is her fault" (Amir, July 2021, Tunis).

Studies on ART observed that women often carry the social burden of childlessness (Bonnet and Duchesne 2016, Rozée and Unisa 2016) and they are most affected by the consequences of infertility. In certain contexts, infertility can be a reason for divorce and women are undertaking the risk of family and social isolation (Inhorn 1996). Moreover, women's identity has historically been depicted as intertwined with maternity (Inhorn et Van Balen 2002) and femininity is associated with fertility. The loss of their reproductive power is therefore perceived as a loss of social value. Masculine infertility can also have important social and personal impacts on me as studies have shown that it is perceived as one of the most stigmatizing male health conditions (Becker 2000, 2002; Greil 1991; Inhorn 2003a). Imaginaries around masculinity and virility are often associated with the capacity to procreate (Inhorn 2012a). The incapacity to procreate, perceived as a form of sexual impotence, thus threatens men's identity (Fortier 2013). ART has, in this instance, introduced greater gender equality as ART allows for the diagnosis of both men's and women's infertility (Inhorn 2012a). Indeed, in one-third of cases, infertility involves men only, another third involves women only, and around 25% of cases are caused by both the men and the woman. For the remaining 10%, no underlying cause can be identified (Boivin *et al.* 2011; Harvard 2009; WHO 2013; Davidová

and Pechová 2014). Although ART opened up new perspectives, the practices and representations linked to it can also maintain and even accentuate the dominant social norms of procreation, parenthood and gender (Rozée and Mazuy 2012). While many studies on ART often focus on women's experiences, Inhorn's work (2002; 2003a; 2003b; 2004) on infertility in the Middle East provides an original perspective on men's experience of infertility. Her studies demonstrate well the taboo around male infertility in Egypt, which is associated with manhood. She describes that the embarrassment around male infertility result in a "cult of silence ... which usually meant that women shouldered the blame for the infertility in public" (Inhorn 2004: 170). However, in her more recent work on Lebanon, Inhorn shows that with the development of new ART technologies such as IVF and ICSI male infertility has come to be more and more normalised with an increasing openness on the subject. The democratisation of infertility treatment in the country contributed to the evolution of the representations of male infertility as a medical condition that does not put manhood into question (Inhorn 2004). In her book*, The New Arab Man: Emergent Masculinities, Technologies, and Islam in the Middle East* (2012b). Inhorn further examined what she describes as ''emergent masculinities" or the new notions of manhood in the Middles East, defying patriarchy and breaking with long lasting Western stereotypes of the Middle Eastern Muslim men portrayed as "as terrorists, religious zealots, and brutal oppressors of women" (Inhorn 2013: 51).

In the context of my fieldwork in the clinic, men who were "responsible" for the infertility of the couple seemed to have no issues admitting their infertility to me. They would often jump in early in the conversation to clarify that they were "the one with the problem" (Amir, July 2021, Tunis). However, as illustrated by the case of Amir and Leila, their discourses seemed to be different outside of the clinic and with their families in particular.

Why take the risk to return to Tunisia when a procedure in Saudi Arabia would allow them to easily preserve their privacy? If the attempt to maintain the secrecy around their journey has indeed pushed them to consult in Tunis rather than Sfax, the instability of their professional situation and their residence permit in Saudi Arabia as well as their ties with their country of emigration have brought them back to Tunisia. As explained by Amir:

> "In the end, we are dependent on our work contracts. These are one-year contracts, we can't really know if we'll be able to stay. The problem is that if we freeze [eggs] in Saudi Arabia ..., how are we going to leave with it? It's not possible ... Here we have everything, our families, our ties and we can always come back to Tunisia ... It's our country, that's all, do you choose your mother?" (Amir, July 2021, Tunis).

In Amir's speech, the association of Tunisia with motherhood as an image of a "nest" is representative of the emotional dimension of health and subjectivity that guides the therapeutic itineraries of these TRA couples. The stigma surrounding ART then reduces the couples to silence and invisibilises therapeutic paths marked by numerous doubts and disappointments, without being able to express these sufferings outside the intimacy of the couple.

3. Quest for “cultural intimacy” in patient-doctor relationships

The kindness of a doctor and a good relationship with a doctor in Tunisia were often valued by TRA couples, reflecting certain struggles in their reproductive journey in their country of residence and the quest for a form of intimacy. As argued by Maffi *et al.* (2023), these intimacies fall under the umbrella of "cultural intimacy" (Herzfeld 2007). This term refers to an unofficial perspective of the world that members of a national community share and from which individuals who are not part of that community are excluded. This invisibilisation, both suffered and sought, is considered by health professionals who assimilate it into their practice. As stated by one doctor:

> "We know that we have an important role to play on the psychological level. ART can be a very exhausting experience mentally and the weight of the family and the pressure to have a child adds up difficulties for them. We need to be particularly attentive" (Dr. Khalil, gynaecologist, July 2021, Tunis).

In their work on medical facilitation companies, Whittaker and Speier (2010) suggest that owners are involved in what they define as “affective labor”, reinserting care and nurturing within the reproductive experience, dismissing the commodification of reproduction and reasserting the emotional relationship.

Figure 15. Gift to Dr. Khalil "Thank God, Thanks to you".

Source: picture taken by the author, August 2021

Many of the couples I met mentioned the quality of the relationship with the doctor in Tunisia compared to what they had experienced in their country of residence. Qualifying terms such as "too cold", "acting like a robot", and "treating patients like numbers" were used to describe the impressions they had of their gynaecologist in their country of residence. Some even suspected that their doctors were "only interested in money", which seems paradoxical as a reason to push them to consult for-profit private medical businesses in Tunisia. Conversely, they praised "human contact" with doctors in Tunisia and other medical staff who they said were "caring" and "considerate" (Figure 15). Moreover, many have stressed that they appreciated the staff using expressions in Tunisian dialect such as "it is in the hands of God" or "with the help of God".

Couples' discourses about their therapeutic experience in both locations sometimes sounded stereotypical, with their therapeutic experience in the country of residence and in Tunisia in binary opposition. It is important to question what might explain these dual perspectives. I should first emphasize that the couples in my sample shared a similar journey, since almost all of them (except for three) had started their reproductive journey in their country of residence and travelled to Tunisia because they could not obtain something in their country of residence or because their reproductive journey had not yet been successful. This necessarily implied that my sample shares a common ground: a negative experience in some way, repetitive failure of treatments, and accumulated fatigue with the emotional and psychological stress that it represents. In this context, their return to Tunisia was "imbued with hope" (Kaspar *et al.* 2019: 4) and the couples' "affective journey" (Solomon 2011) was driven by the quest of a successful

treatment, by their desire to become parents. They also came with certain expectations and representations of what a treatment in Tunisia could achieve for them and of what they did not want to find. As stated earlier, the fertility clinic and, by extension, Tunisia represented a site of hope and promises (Holliday *et al.* 2019).

Nadia (39) works as a surgeon, and has been living in Paris for 10 years. Her husband (37) is Italian, and they have been trying to have a child for the past 3 years through ART. She is one of Dr. Khalil's patients, who put me in touch with put me in touch with her[56] while she was still in France. According to Nadia, assisted reproduction is quite specific when it comes to the relationship with the doctor because couples are not only followed by the gynaecologist but meet a number of health professionals along their therapeutic journey:

> "We go to see the doctor, he gives us a protocol and from that point you see midwives and interns, but you are not in a very direct doctor-patient environment. It's a doctor-midwife-intern-nurse environment … there is not a very intense relationship with the doctor" (Nadia, from France, August 2021, Over the phone).

They have started their medical follow-up in France and after several unsuccessful attempts, they are now considering returning to Tunisia and have already had a few teleconsultations with Dr. Khalil. With time, she had felt the need to seek medical advice elsewhere and sought for a more privileged relationship with a gynaecologist than the one she experienced in France:

> "It's pretty impersonal, I think. I only see my gynaecologist on the day of the [ovarian] puncture. Afterwards, the biologist calls me back to give me the results of the [ovarian] puncture, even if it's bad news, it's the biologist who informs me. … I handled it well at the beginning but when I had consecutive failures, the last one, I was emotionally not well, I felt in need of social care, in addition to medical care. That is to say, I wanted to have someone who would follow me more closely, who would check on me more closely, someone I could see immediately if there was a failure. Even if he wasn't going to do anything about it, but he would be there to explain things to me and talk to me, etc. … After my last embryo transfer in July [in France], I was given a prescription on which they had written: "if beta HCG test[57] negative, stop medication and make a new appointment for the 27th of August", and that is it. I have not talked to anyone since then

[56] As mentioned in the methodology, the doctor would first ask their patients their consent to be put in contact with me. I was put in touch with patients and was provided with their phone number (without their name) only after the patient had explicitly agreed.
[57] A beta HCG test is a blood test used to diagnose pregnancy.

> and it is very hard. Maybe because I had deeper expectations, a more important hope and I was dumbfounded … So that's what I was lacking in France … It was a very personal frustration… emotional exhaustion. … It's mainly because I felt a bit isolated from my family and social environment. Maybe if I had my family in France, if I had always lived in France, maybe I wouldn't have even thought about going elsewhere" (Nadia, from France, August 2021, Over the phone).

Without blaming the skills of her doctors in France, she explained her wish to come to Tunis because of the different medical culture which, as she said, changes the relationship that patients can expect to have with health professionals. Although Nadia mentioned the absence of her family as a potential factor accentuating her feeling of isolation, as we had already seen above, she did not wish to involve her family in the details of treatments. She expressed missing "social care" alongside "medical care" and, throughout the years, her dissatisfaction intensified. As a doctor herself, she could compare her own practice in Tunisia and in France. She felt that it was a question of "culture" rather than of medical skill. She explained the difference between France and Tunisia:

> "it's culturally different because a doctor in France is there to do his job as a doctor and that's all … No one goes outside this framework, and everyone stays in their own professional field. In Tunisia, culturally, it's different, a doctor can be led to talk with a patient, to spend more time in the patient's room, to stay at the patient's bedside to talk with him about his private life if the patient wishes. As someone who practiced in Tunisia and now practices in France, I don't have the same attitude I had in Tunisia. In France, there is a social barrier between people, it is quite cultural I would say … In Tunisia, it is easier to approach people and to enter their intimacy if they wish … we also consider the psychological and moral aspect of the patient, … we do not put up a barrier with the patient. There is always respect, a little distance, but also the ease of communicating in both directions" (Nadia, from France, August 2021, Over the phone).

Nadia also mentioned the impossibility of building more direct contact with her gynaecologist in France who "kept using the formal form of address" (Nadia) and kept using email as a means of communication: "In three years, she never shared her number" (Nadia). After the failure of her last embryo transfer, she could not manage to discuss it directly with her gynaecologist, who had already left on holiday. Trying to reach her to get more information about the potential reasons for the failure of her embryo transfer, she had a very hard time, and simply received automatic messages that her gynaecologist was on vacation. When I talked to her over the phone

in August, she still had not talked to her gynaecologist and had to wait until her next appointment at the end of the month. Although Nadia understood the position of her doctor and the necessity to maintain some barriers, a certain flexibility regarding the contact with the patients is something that she was trying to maintain in her own medical practice and that she expected from her doctors as a patient:

> "it's true that when I am on holiday and a patient calls me, it bothers me, and I would prefer to disconnect completely but I think about the difference that it makes for the person over the phone. It's five minutes of my time but this can maybe change that person's day, week or even month. It can change that person's life" (from France, August 2021, Over the phone).

Also, after starting her medical follow-up with Dr. Khalil remotely from France, Nadia felt relieved by the proximity of their exchanges through WhatsApp. This indeed reflected my observations within the fertility clinic and with some gynaecologists. The coordinating midwife at the fertility clinic was constantly reaching out to patients on WhatsApp and answering questions over the phone or through text messages. The midwife at Dr. Khalil's medical practice was also connected to patients through WhatsApp. Similarly, Dr. Khalil would often interrupt our discussions to respond to patients' phone calls.

This would contrast with how TRA perceive their experience in the country of residence. Some expressed difficulties in communicating with their doctor in the country of residence as they were not familiar with the medical jargon. It was the case of Neila, a Tunisian residing in Paris, and working in the IT sector. Although she could express herself fluently in French, she, however, encountered difficulties understanding the diagnosis:

> "In Tunis, Dr. Khalil explains things clearly to me. It slready makes a huge difference for me if I manage to understand and receive the information correctly. The gynaecologist that was following me in France was explaining things that were too complex for me… She was using complex scientific terms and was not trying to help me understand. She was always in a hurry and did not take the time to explain what were the reasons, the next steps… I was not reassured, and I never knew where we were heading to" (Neila, from France, August 2021, over the phone).

Several studies regarding access to healthcare for migrants in the country of residence have long highlighted the language barrier as an element depreciating the quality of the healthcare delivered. Similarly, with the consultation with the psychologist that I discussed in Chapter 3,

in the context of healthcare, language goes beyond words. Patients often come to the consultation in a position of vulnerability, as they are apprehensive of the information that is going to be delivered to them by the doctor. Language can be considered constitutive of cultural intimacy.

Instances of this quest for “cultural intimacy” in patient-doctor relationships also reveal another determining factor for these mobilities, their temporality.

4. Rethinking temporality in a context of transnational care

One morning at the fertility clinic, I engaged in conversation with a couple in the waiting room. I understood that they came from France when the woman spontaneously explained to me the differences between medical protocol "here" (in Tunisia) and "there" (in France). She works in the medical sector, and he works in IT. For both of them, Tunisia seemed to be the best place to undertake their reproductive journey:

> "I know the medical system in France very well, I work in a hospital as an emergency room doctor. That's why I know how it's going to work. If I go there already, they would make me wait for months before I can have a first appointment. You're going to wait when we can't wait any longer, I mean, we've already waited too long" (Nour, from France, Tunis, August 2019).

Nour’s words reveal a determining factor in the reproductive journey: its temporality. Nour is 35 years old, and, for her, it is about saving time. By making the journey from France to Tunisia and moving from the public medical sector to the private sector, they avoid waiting lists and waiting times that would otherwise be "imposed" on them in France. The literature has indeed regularly highlighted the importance of temporality and waiting times, which, when considered excessive, trigger reproductive mobility (Pennings 2004, 2006, 2009; Mladovsky 2006; Ferraretti *et al*. 2010).

This time constraint then becomes more important than other factors, such as cost, which in the private sector in Tunisia is the responsibility of couples:

> “I know that in France I have the right to get everything covered by my health insurance, but that's not what matters. What matters is the result, that's all. We can't say ‘we’ll try

> in France first and then we'll see'. It's already late" (Nour, from France, Tunis, August 2019).

In addition, the couple expressed some dissatisfaction with the medical system in France that "imposes waiting times" or "forces you to follow their protocol". Nour's knowledge of the medical community seemed to discourage her from pursuing her reproductive journey in France. According to her, the idea that French healthcare provision would be of better quality no longer corresponds to the reality. Also, for this couple, this return reflects a mistrust vis-à-vis the public medical system and, conversely, a certain confidence in the medical skills of the private sector in Tunisia.

Similarly, Taoufik, a Tunisian residing in France, also explained to me the difficulties his wife and he faced in finding availabilities when they started their reproductive journey. I was put in touch with him through Dr. Khalil who had just carried out a teleconsultation with the couple who was still in France at the time. We talked over the phone for the first time at the end of July (2021) and I would later meet him and his wife at Dr. Khalil's office when they finally came to Tunisia. Taoufik explained that at the beginning of their journey, they were directly confronted with a long wait for their first appointment with a gynaecologist in a public hospital in the Parisian metropolitan area:

> "We tried to consult other doctors, but we did not succeed, they told us that we had to wait 6 months or even more. When I call the secretary, they tell me 'you have to send an email, you have to call, you have to call back, you have to wait, you have to, you have to', but France is complicated … administratively is complicated … so we thought that by the time we undertake exams and start a treatment, we would lose too much time" (Taoufik, from France, July 2021, over the phone).

In order to gain some time, they looked for earlier appointments in a private hospital. In their case, since they had the financial means to afford consultations in the private sector in France, the return to Tunisia was not the first strategy to which they had recourse. As we shall see later, the primary motivation for a move to Tunisia was their dissatisfaction with the medical protocol suggested by their doctor.

When I discussed the issue of temporality with the coordinating midwife at the fertility clinic, she explained the possibility to accelerate the reproductive process in Tunisia by using a type of ART with a better success rate (such as IVF instead of intrauterine insemination) even when the medical exams from the couple do not justify an immediate move to what is considered

"more invasive" technologies, in the sense of greater interference of medical technologies in the reproductive process.

> "In Europe, if the woman's age is, let's say, over 35, if she has been married for less than two years, they would say 'go ahead, go home, we'll wait for 6 to 12 months'... Whereas 35 is already a little bit too old. And then she would have three to six [she emphasised] intrauterine inseminations, and then [she emphasised], if ever after the inseminations, there is no pregnancy, they would do IVF. If the patient has been married for more than two years, they would not wait, but they would do between 3 and 6 cycles of intrauterine inseminations. If it doesn't work, they would go on to IVF. Between the ages of 35 and 38, and if the patient has been married for more than a year, then they do 3 cycles of intrauterine insemination, if it doesn't work, IVF. If the woman's age is over 38, they would do at least 2 intrauterine inseminations and then IVF... so it's not just money, it's not just injections, it's not just medication, it's exhaustion, it's disappointment every time, when there is no pregnancy. You have to take the psychological condition of the woman into account, and the pressure she has from her family, her friends, and everything...Why so many steps if you can go through IVF with, let's say, "better" results? It would be better to do IVF at 35 years old with a good success rate, better than waiting I don't know how long and doing it at 40 years old, when the chances of success are low" (coordinating midwife, Tunis, September 2019).

Indeed, one can easily imagine that in the public sector in many European countries, unless the medical exams of the couples reveal conditions that necessitate immediately using particular technologies, medical protocol sometimes implies a different temporality. In that case, less invasive technologies would first be prioritised over more invasive ones that have better success rates. Once again, the shift from the public to the private sector plays an important role in addition to bioethical positioning towards ART. If IVF treatments have higher success rates than inseminations, they are also more costly, and their use therefore needs to be medically justified when not paid out of pocket by the patients. The perspective from the coordinating midwife, however, cannot be taken as absolute, since regulations and protocols vary significantly from one European country to another and specialists also have a certain level of autonomy when deciding on treatments.

Some couples mentioned wanting to be able to choose freely between one reproductive technology over another if that would give them better chances to achieve pregnancy in a shorter time period. Taoufik and his wife mentioned wanting to "bypass the normal circuit and do

something personalised" (Taoufik, July 2021, over the phone). Similarly, a Tunisian coming from Qatar explained that she requested to jump straight to IVF even though she had no medical indications that inseminations would not be sufficient. For her, the psychological stress of undertaking treatment with a lower success rate justified using more efficient technologies, questioning in this instance understandings of "invasiveness".

Discussing the issue with Dr. Khalil, he confirmed that when establishing the protocol for a couple, they take into account their will and state of mind. Moreover, when patients are coming from abroad (whether they are TRA, Algerian, sub-Saharan, etc.), they also consider the effort that it represents for the person to be here: "we know that people have invested time and money to be here". These considerations can indeed lead them to direct the couples towards technologies with higher success rates. This is an interesting element as once again, "bypassing" certain treatment steps that are not medically justified (such as proceeding straight to an IVF without starting with insemination), would not be possible in certain medical contexts, in particular, in the public sector.

5. Variations in medical protocols

Coming back to the story of Taoufik (41) and his wife (35) who started their reproductive journey in France and tried to consult in the private sector in France in order to gain some time. After making the move to the private sector and getting their first appointment, they went through three trials of IVF without success. After two years of treatment, they were starting to feel discouraged about the succession of failures and they began to research alternative treatments. Their difficulty to procreate seemed to be related to embryo implantation defaults, possibly related to a uterine deformity. Taoufik is a computer engineer, and his wife is a doctor and researcher in medical sciences. Taoufik told me they had an "intellectual level that allowed [them] to do the research and to establish a general assessment of the existing treatments and possibilities". They felt that their gynaecologist in France was not being sufficiently proactive in exploring alternatives and carried on repeating the same medical protocol despite the failures:

> "My wife's gynaecologist was just repeating the same protocol without changing any of the parameters. Based on our research, there are some parameters to adapt in order to explore the causes of implantation defaults. That is when we contacted our relatives in Tunisia who recommended that we contact Dr. Khalil, because he is very renowned in this domain. He had a broader perspective. In France, I have already noticed that doctors,

> once they start their practice, they don't go back to readings and keeping current on medical innovations. They are not up to date. ... Doctors here [in France] gave us the impression that they didn't want to do explorations. In Tunisia, Dr. Khalil ... already opens up new paths" (Taoufik, from France, July 2021, over the phone).

The idea that protocols were somehow more flexible or could be better adapted to the couple's specific diagnosis was a point that was regularly raised and that motivated the return to Tunisia. Once again, the discourse has to be questioned in light of their medical situation and the different contexts within which both experiences are taking place. Many elements can explain the different medical protocols offered to them by their gynaecologist in France and the one in Tunisia, and they may have little to do with the doctor's willingness to respond to their medical needs. Offering new, cutting-edge ART is part of the commercial strategy of the private fertility clinic in Tunis. Moreover, ART regulations differ between both countries, potentially impacting the type of treatment that can be offered to them in France and in Tunisia. Finally, the couple is comparing their experience within the public sector in one place, and the private sector in the other. This transition is, however, central to understanding their perception of the quality of the healthcare delivered as well as their position, once as a patient (in the public sector) and once as patient-consumer (in the private sector) with underlying logics of choice (Mol 2008).

Similarly, Jihen (35), a Tunisian who had been living in Germany for 10 years expressed to me:

> "In Germany, they are following protocols in a robotic way ... they don't have this sense of experimentation. Here they don't give up so easily. They push more, they explore different methods and solutions" (Jihen, from Germany, July 2021, Tunis).

When I asked Dr. Khalil about the perception of some couples regarding the greater flexibility in Tunisia, he clarified that being in the private sector, indeed, allows doctors greater flexibility compared to gynaecologists in the public sector in Europe, who are bound by certain directives, although they do have some margin of action. He, however, underlined the constraints faced by gynaecologists in Tunisia regarding the law which forbids sperm and egg donations. According to Dr. Khalil, "inventions in science occur when faced with constraints" (August 2021, Tunis). Also, the impossibility to use certain ART procedures pushes them to envisage alternative techniques and be more experimental. We see here how the religious morals are internalised within the medical protocols and how it shapes a form of "religious moral economy" (Ben Dridi and Maffi 2018) between patients and doctors.

My discussions with the coordinating midwife also made me understand the negative perceptions sometimes attributed to medical practices in patients' countries of emigration. During my fieldwork, a training session for practitioners from different sub-Saharan African countries was held in the clinic. When I read through the training document and discussed the content with the midwife, I noticed that the differences in medical protocols were highlighted as an element that would allow for a quicker and more efficient response to the needs of the patients. The ability of the private sector to provide patients with "tailored" care is part of the marketing of these private medical businesses. She recalled the case of a Belgian woman married to a Tunisian who came to Tunisia to check the medical diagnoses she received in Europe and ask for a second opinion. She had a thyroid disorder that affected her fertility. However, there was a discrepancy in the reading of the rates of her dysregulation between Tunisia and Belgium:

> "A level of 4.9, something must be done immediately to lower it and to start an IVF cycle. ..., I had sent a detailed letter [to the doctors in Belgium], [saying] that we could not under any circumstances start stimulation with a TSH[58] of 4, so 4.9! But for them, no, before 6 or, maybe, 5, they don't treat. …. They're waiting until, I don't know, something comes up that they'll treat. To me, they don't anticipate. Here, we anticipate a little too much, and there, not at all! (Coordinating midwife, August 2019, Tunis).

After the back and forth between the doctors in Tunisia and in Belgium, the Belgian-Tunisian couple decided to undertake their fertility treatment in Tunisia and settled there for the entire time of their follow-up. They had been living there for several months when I met them at the clinic. The example of this binational couple clearly shows how these patients living between two different health systems can explore the opportunities and alternatives available to them to determine their treatment choices. In this case, knowing the medical environment in Tunisia, but also the differences in protocols that, according to them, would better meet their needs, motivated this temporary return. By circulating between different spaces, these patient-migrants have access to medical opportunities that may address different needs along their reproductive trajectory (Zanini *et al*. 2013). The increasing commercialisation of healthcare and patient self-empowerment (Viruell-Fuentes *et al.* 2016) have contributed to the development of a "more individualized culture of health" (Parr 2002: 77). Responsibility is placed in the hands of patients who become (or must become) "experts in their own health" (Ormond and Sothern

[58] Thyroid Stimulating Hormone. Hormone that is secreted by the anterior pituitary gland. Its role is to stimulate the thyroid in its function of secretion of thyroid hormones.

2012: 935). By better controlling the different medical offers (laws, medical protocols, prices, etc.) patients have capital that can be mobilised for their therapeutic choices. Zanini *et al.* (2013) suggest in that regard that, although structured by inequalities, transnational spaces still allow new forms of agency to emerge.

Variations in medical and legal norms surrounding the practice of ART as well as the positioning of private actors in these issues constitute structuring factors influencing the transnational strategies of these mobile patients. Switching to the private sector, once in Tunisia, allows patients to benefit from an "à la carte" medical offer, with greater flexibility in terms of the temporality of the follow-up and the consideration of their cultural and religious preferences.

6. Religious Preferences and fear of discrimination

As I have already illustrated, the mistrust of the health system in the country of residence came up regularly in interviews. In addition to the slowness of the procedures, the fear of being discriminated against was also evoked by some couples:

> "You see my wife, with her veil and everything [she wears a niqab[59]]. Already in Tunisia, people think she is Libyan.[60] Imagine France! The doctor, he's going to see her come into his office like that... you already know what he thinks (Karim, from France, male, 34 years old, Tunis, August 2019).

Medhi was born in Paris while Amal was born and raised in Zarzis, Tunisia. Since their wedding two years ago, they have been going back and forth between Tunisia and France. At the moment, Medhi was unemployed, and he explained to me that this allowed him to come to Tunisia whenever needed. He was mainly the one speaking and answering my questions. In the case of Medhi and Amal, accessing ART in a country where the law is aligned with religious prescriptions played an important role in their therapeutic choices:

> "Besides, here they do things by the book, you might say. In France if we ask to have a female doctor for the procedure [ovarian puncture and embryo transfer], they wouldn't leave us the choice. You can't decide. … You always find the money and you know you can do as you want. They've got the bracelet system, the photo, they check it out

[59] The *niqab* fully covers the face except the eyes.
[60] The Libyans in Tunisia are often discriminated against, and there are many prejudices against them.

carefully... You can trust them because they understand why you are afraid. That's what's important, the rest can always be arranged". (Medhi, from France, Tunis, August 2019).

Fertility clinics have very strict tracing systems. In the clinic in Tunis, I went behind the reception counter and the secretary explained the registration process to me. Couples are registered upon arrival and must prove that they are indeed married. They photograph the couple so that the different staff members (gynaecologist, biologist, midwife) can verify their identity at each step. In addition, each couple is provided with bracelets with a barcode which is used for labelling the samples. In addition, patients can choose freely whether they wish to be cared for by a female practitioner during the embryo transfer in order to respect the patient's privacy. In the image below (Figure 16), an explanation of how access to the laboratory and freezing room are controlled within the centre is provided in a training document from the clinic.

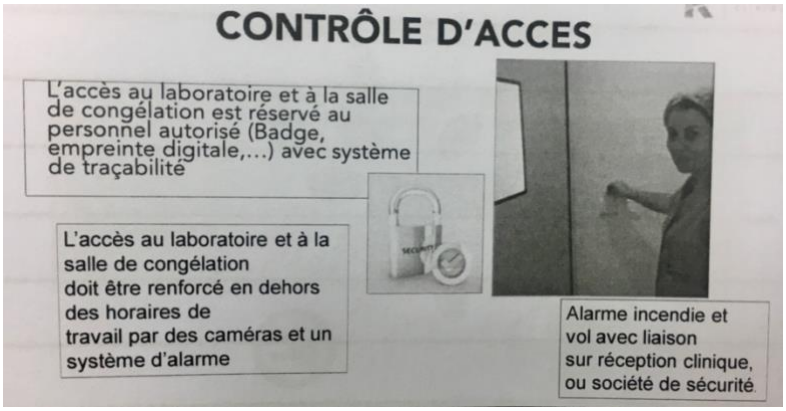

Figure 16. Access control

Source: Training document at the clinic explaining the security system to access the laboratory and the freezing room, August 2019

Inhorn (2011) points out "moral and religious trustworthiness" as an element put forward by couples who feel more reassured and that their fears are understood in a fertility clinic where doctors and biologists share the same religion. In these patients' perception, special attention is paid to sample labelling, handling and transfer to avoid any risk of mixing:

"The reasons have less to do with a sense of Muslim moral superiority than with the belief that a Muslim co-religionist understands the particular Islamic bioethical considerations surrounding assisted reproduction technology" (Inhorn 2011: 588).

The primary moral concern is therefore to ensure that there are no errors due to medical negligence or intentional misconduct. In fact, attention to labelling and strict protocols regarding handling of samples does not have to do with Islam as it is important in any religious or ART context. Yet, being followed in a clinic where gamete donations are never made, and in which the medical staff is well aware of these religious prescriptions is perceived by these couples as a reassuring factor (Inhorn and Tremayne 2016). It is therefore essential that doctors understand the religious beliefs of couples looking for solutions to their infertility problems so that they can meet their medical needs while respecting their beliefs as much as possible (Schenker 2000). As I show later in the chapter, for some TRA couples, the impossibility to recourse to egg and sperm donation for religious purposes was also a barrier in pursuing assisted reproduction in countries of residence, where the practice is allowed and recommended to couples presenting specific infertility pathologies.

Schenker (2000, 2005) stresses in this regard the importance of the different monotheistic religious perspectives (Islam, Judaism, Christianism and their different branches) related to reproductive health, and their influence on civil authorities in the field of reproduction. In Islam, there are important differences between Sunni and Shia. Sperm and egg donation are allowed by Shia religious authorities while they are prohibited for Sunnis (Inhorn 2006, Inhorn and Tremayne 2016). The Sunni position on ART (expressed by the University of al-Azhar in Cairo), is to authorise any medical technique for procreation carried out within the conjugal framework. It prohibits the use of gametes from a third party, which is associated with adultery, incest and genealogical confusion (Fortier 2007, 2010, 2013; Inhorn *et al.* 2017). Any form of procreation involving a third party, whether sperm or egg donation or a surrogate mother) is seen as akin to adultery and a child born through the use of these reproductive technologies would therefore be considered illegitimate. In Muslim law, the fact that the child is born from the father's sperm is a determining factor in the representation of filiation (Adhoum 2010). Moreover, the father is presumed to be the husband of the child's mother. Both elements determine biological and social filiation (matrimonial union of the father with the mother). As a result, sperm donation implies a mixed filiation, and the dissociation between social and biological paternity is not accepted in Sunni Islam. Social paternity can only be envisaged if it corresponds to biological paternity. Conversely, biological paternity implies social paternity since Sunni Islam does not accept that the sperm donor can be considered the father as he is not the husband of the child's mother (ibid.). In short, the prohibition of third-party assistance in ART in Sunni Islam is related to the importance of the preservation of the *Nasab* (genealogy,

kinship, lineage) as a moral imperative of legitimate filiation (Inhorn *et al*. 2017). Third party donation, therefore, implies a mixing of the genealogical relations (ibid.).

If third-party assisted reproduction is not practised in IVF clinics in Sunni-dominant Muslim countries, there are yet important differences in terms of how ART is regulated within the Middle East. In Jordan for instance, there are no specific laws or regulations dedicated specifically to ART (Kooli 2020), resulting in rather liberal practices of ART such as preimplantation sex selection for non-medical reasons (Mehboob 2023), which is forbidden under the Tunisian ART law for instance. Moreover, as mentioned above, third-party donation is not equally regulated in Shia and Sunni Islam. In Iran, a Shia-majority country, all forms of assisted reproduction (donation of eggs, sperm and embryos, as well as surrogacy) are authorised and practiced. For several reasons, third-party reproductive assistance was legitimised by leading Shia jurists through processes of *ijtihad,* the independent interpretations of the Islamic scriptures, including their relevance for contemporary social life and was even approved in the late 1990s by Ayatollah Khamenei, Iran's leading cleric (Inhorn *et al*. 2017).

These variations also question stereotypes of what part of the world may be more "conservative" or "progressive" towards ART. Indeed, Islam and Judaism, unlike Catholicism, both share a common positive attitude toward childbearing as well as a belief in the positive contribution of science and medicine to control and facilitate fertility (Inhorn 2003; 2012). As a result, they encourage medical technologies that enable married couples to have children in order to preserve the marriage. The Italian law on ART translates the Catholic religious attitude toward reproductive technologies with one of the most conservative ART practices in Europe at a time when many countries are moving towards greater liberalisation of ART (Robertson 2004; Penasa 2012). Belgium however is one of the countries in Europe where ART is considered most common and where the largest number of ART cycles are initiated (just behind Denmark in first position) (Präg and Mills 2017). According to Präg and Mills (2017), Denmark and Belgium are the most liberal countries in Europe when it comes to ARTs as the costs are largely covered by the public healthcare schemes. Moreover, in Belgium surrogate motherhood is not prohibited although there is no legal framework to this day[61]. Belgium also authorized single women and lesbian couples to access ARTs since 2007 while in France, the law was only recently revised in 2023. For many years, this difference in legislation between France and

[61] Commercial surrogacy is however not legal unlike in the US.

Belgium has given rise to a cross-border reproductive mobility of French Lesbian couples traveling to Belgium (van Hoof *et al*. 2015).

Dr. Khalil informed me in advance about a Tunisian couple residing in Germany who had booked an appointment with him. He had talked to them over the phone already as the couple started their follow-up through teleconsultation, and they had already shared with him the results of medical exams undergone in Germany. I met the wife at Khalil's office. After being introduced to her by the medical secretary, we sat in the waiting room that was almost empty that morning and we started discussing. She explained that after several exams their German gynaecologist had referred them to egg donation, an unthinkable option for them. Faced with a lack of alternatives, they turned to Tunisia. Safia explained:

> "You felt that the doctor could not understand our refusal of donation. ... he didn't try to offer us alternatives. Basically, it was our problem if we didn't want it and that was that. Whereas here, the doctor understands why you can't do that, even for him, it's forbidden, and he also knows why in a Tunisian family having children is... even more important than in Europe for example. That is to say that he really tries to fight for us and to try everything so that we have a child. If it doesn't work... we know that we have tried everything" (Safia, from Germany, 38 years old, August 2021, Tunis).

Several of the couples I met were under the impression that their doctors in Europe were not understanding how serious the issue of childlessness was for them. In their perception, having children was seen as somehow less important in Europe than it is in Tunisia.

Regarding religious preferences, the coordinating midwife explained to me that the medical staff of the clinic often adapt to the requests of the patients, in particular when the women do not wish to undergo certain medical examinations, which they feel would be an invasion of privacy. The midwife told me that medical care in private clinics in Tunisia is more "flexible" and better adapted to the particular situations of patients. It is also a "difference in mentality", or perhaps a difference "in the training of doctors" (Coordinating midwife, August 2019, Tunis). The midwife mentioned one case in particular, that of a Tunisian woman living in Germany who discovered that she had cancer. In order to preserve her eggs, before starting chemotherapy, an ovarian puncture had to be performed. In addition, the patient was to be married soon and wanted to preserve her virginity and requested a transvesical puncture.[62] However, doctors in

[62] This is a technique of follicular puncture under ultrasound guidance, which consists of placing a metal probe in the ureter, then introducing the puncture needle through the urethral catheter.

Germany refused to do this specific procedure, so she decided to travel to Tunisia for this procedure:

> "It is perhaps a little less reliable than an intravaginal puncture, and there can sometimes be risks of infection, but the patient really wants to get married ..., and she wants to keep her virginity, so she keeps it! We are going to do what we have to do with the means we have, and that's all. ... You have to be more or less flexible. We treat people, they are not rags where we can decide everything ourselves ..., it's a person and, for me, a person has the right to choose his or her treatment method. ... This is not an emergency case, no one is going to die if there is a transvesical puncture and not an intravaginal one. ... It's a cultural issue that we accept very naturally. On the other hand, if we are in Europe, the question of virginity does not really arise, so they don't care if she is a virgin or not. So, I don't know if it's a kind of misunderstanding, or they are not empathetic enough, or they are less trained, or it's a little bit of racism, I don't know. ... The patient said to me: 'If I were German, I don't think I would be treated the same way'. ... So, I think it was a mix of the three: racism, a lack of empathy, and the doctor was looking for the easy way out" (coordinating midwife, Tunis, September 2019).

In the case of Medhi and Amal, as well as for the patients from Germany, respect for religious preferences, the possibility to choose a practitioner or the mode of procedure are ways of reaffirming their agency in their therapeutic trajectory. The interviews also revealed a mistrust, sometimes even a clear dissatisfaction, with the public health system and the medical protocols in the country of residence (Ormond and Lunt 2019). "Cultural insensitivities" (Mathijsen and Mathijsen 2020: 8) lead to a lack of trust and give rise to the feeling of being misunderstood or even discriminated against, which motivates the decision to seek care in the country of emigration (Şekercan *et al.* 2015; Messias 2002). Inhorn (2011) already emphasised in her study that discrimination was one of the reasons mentioned by Middle Eastern couples to justify their return to the home country. Not being "at home" becomes a source of discomfort and can lead to a sense of mistrust. These medical returns can thus also betray a medical system perceived as inadequate in the country of residence, as it does not adapt (or only inadequately adapts) to the healthcare needs of these migrant patients (Elliot and Gillie 1998).

Conclusion

Although considered to be a public health issue, ART services have developed unequally around the world, giving rise to transnational reproductive mobilities and developing reprohubs. In recent years, Tunisia has emerged as a regional hub for reproductive care in the Maghreb. ART services occupy a strategic commercial position in the region, producing a plurality of new reproductive mobilities. If some observations made regarding reproductive mobilities are comparable with the globalisation of healthcare in general, and the resulting growth of healthcare mobilities, they however involve other issues. Their close involvement with intimacy gives reproductive mobilities a particular "affective/emotional texture" (Kaspar *et al.* 2019: 4). The globalisation of ART can be seen in a multitude of spaces, including virtual spaces. The intimacy and anonymity provided by virtual spaces are constitutive of new patterns of "biosociality" (Rabinow 1996) and "biosolidarity". composed of online communities of patients.

The purpose of this chapter was to discuss the reproductive returns of TRA to Tunisia. In particular, I have examined the place of the country of emigration in the therapeutic pathways of these couples and their relationship with the healthcare system in the place of residence. As already noted by Inhorn (2011), these reproductive returns of diaspora members respond to specific dynamics that are not usually discussed by studies in reproductive mobilities in general. The specificity of these patients from the diaspora lies in the particular relationship that they entertain with their country of emigration, and the role that this relationship plays in their experience and perception of ART services. We have seen that the time of treatment coincides with the time of holidays, during which they consume other touristic goods, helping them create favourable conditions for receiving medical care. Therefore, if the association of the term "reproductive tourism" does not do justice to the physical and emotional difficulties experienced by the couples, it does translate the concomitant consumption of touristic and ART services. These returns for reproduction are also a demonstration of the attachment to "home". I have thus thought of these medical mobilities in relation to the concept of "home" and defined the medical in the country of emigration by the notion of "medical home". Conversely, not being "at home" becomes a source of discomfort and can lead to a sense of mistrust, reflecting instances of "cultural insensitivities" (Mathijsen and Mathijsen 2020: 8), motivating the decision to seek care in the country of emigration (Şekercan *et al.* 2014; Messias 2002). Looking at the motivations behind these reproductive returns informs us about the healthcare experiences of these migrant patients in their country of residence. Moreover, the mobility of

patients seeking healthcare is influenced by the varying levels of access to healthcare in their countries of residence. In turn, this mobility may impact their relationships with these states. They might develop a diminished sense of trust towards the healthcare system in the country of residence, leading to a sense of disconnection or dissatisfaction with the state governance and policies in terms of healthcare.

The field examples cited identified a number of factors "here" and "there", between the country of residence and the country of emigration, that influence therapeutic trajectories and motivate these returns to procreation. Couples take advantage of the interstices created by economic inequalities and regulatory specificities and oscillate between different degrees of trust given to practitioners (Zanini *et al.* 2013: 17). They also alternate between accessing medical care in the public sector on the one hand, and in the private sector on the other, allowing for a more individualised healthcare offer. Similarly to the conclusions drawn in Chapter 3, the couples' comments reveal a feeling of "downgrading" in terms of access to care in their country of residence and, conversely, of "upgrading" once they returned to Tunisia. The social mobility acquired through their emigration abroad is now opening new therapeutic opportunities in their country of emigration. These therapeutic mobilities are the expression of their social mobility.

Finally, these transnational reproductive journeys stem from the transnational lifestyle of these diaspora patients. These couples do not participate in either system but are simultaneously implanted in the health systems of the countries of emigration and residence, thus creatively employing the different medical resources at their disposal. This dual location allows them to compare therapeutic opportunities and to reaffirm their agency in their therapeutic choices.

Chapter 5: Diasporic networks as therapeutic networks: mobilisation of the Tunisian diaspora in Europe during the Covid-19 pandemic

Introduction

In a declaration from the Collective ATE.COVID19 (Tunisians' Associations Abroad against Covid-19) on March 2020, members of a number of Tunisian associations across Europe (a majority of which were in France) stated their intention to support Tunisia during the crisis and called on the Tunisian authorities "to implement mechanisms … that allow TRA (Tunisians residing abroad) to fulfil their duty of solidarity with their country [as well as] to collect the appropriate financial and material contributions to take part in the national effort in this fight against the virus". They also strongly "refute[d] and condemn[ed] the hateful allegations against TRA returning to Tunisia, accused of importing and disseminating the virus in their country" (ibid). They concluded their statement by affirming "with force their determination to mobilise, in particular with the European authorities and international organisations, and to carry out initiatives in order to help [their] country to face this crisis" and underlined their intention "to take [their] full place … to act usefully and sustainably as citizens … and by engaging in various concrete acts of solidarity" (Press release, Collective ATE.Covid-19, 22 March 2020).

At the beginning of the Covid-19 pandemic, most countries around the world, including Tunisia, shut their borders in an attempt to contain the spread of the virus. Most countries decided to restrict the access to the country to non-residents, including their expatriate population. A line was therefore drawn between residents and non-residents, as well as between mobilities that were considered "risky" and "unnecessary" from those considered "necessary" and "legitimate" (Scheel 2020). As a result, this reactivated tensions and sensitivities around the status of

expatriates, sometimes included as fully-fledged citizens, sometimes excluded as second-class citizens.

At the same time, Tunisian authorities called for commitments from the diaspora[63] in supporting their country of emigration, which would soon be weakened by the health and subsequent economic crisis provoked by the pandemic, at a time when the country was already facing important social, and political instabilities (Tamburini 2023). Tunisian authorities expressed expectations of solidarity and loyalty from the diaspora towards the country of emigration, expectations at the core of State-diaspora relationships since the 1970s. Meanwhile, the media in Tunisia shared the many initiatives that the diaspora was undertaking for the country, praising its members for their solidarity (Karim Ben Said, La Presse, 20 April 2020). This paradox between the rejection and engagement of the diaspora placed many into a moral dilemma. As I discuss later in this chapter, Tunisian authorities and the Tunisian diaspora have indeed historically entertained ambiguous, sometimes even conflictual relationships. The Covid-19 pandemic was another moment of tension that created dissonance between the Tunisian government and the Tunisian diaspora in particular among civil society actors.

In this chapter, I discuss the ways in which the diaspora mobilised and the (dis)engagement between the diaspora and Tunisian authorities in the management of the Covid-19 crisis. This rift triggered a renegotiation of the "double presence" (Dufoix 2010) of emigrants in a “double space” (Quiminal 1991; Basch *et al.* 1994) and offers a privileged perspective on the relationship between diaspora groups and their country of emigration (in particular, its public authorities). To discuss this perspective, I refer to the concept of moral economy (Thompson 1971; Fassin 2005; Lacroix 2019), paying attention to an often-neglected dimension - the role of norms, values, and emotions that guide the initiatives of diasporas in their relations with the country of emigration. Moreover, by observing the circulation of (health) care across borders, the chapter examines how transnational ties, networks, and flows were mobilised to meet healthcare needs. I propose the notion of “diasporic therapeutic network” to describe the therapeutic strategies deployed by and within the Tunisian diasporic network in the context of the Covid-19 pandemic. Through this concept, I examine how, in the event of the healthcare

[63] If I choose to talk about “diaspora”, it is because the concept encompasses different elements that I discuss in this chapter. The theoretical chapter provides a detailed discussion of the concept. Diaspora includes, in my understanding, individuals and associations as well as politically engaged civil society actors who engage in multiple exchanges as well as symbolic and objective solidarities. The concept of diaspora also refers to a common identity, an emotional bond to the country of origin and expressions of solidarity (Schnapper 2001; Bordes and Schnapper 2006). Moreover, the terminology is used in official documents from Tunisian institutions together with the category of “Tunisian residing abroad” (TRA).

crisis, the Tunisian diasporic network was mobilised as a therapeutic network to improve the healthcare and the well-being of their co-nationals in the country of emigration.

In the first section of the chapter, I start by discussing the rift created by the Covid-19 pandemic, the interruption of my fieldwork research and the resulting immersion into online ethnography. Between March 2020 to January 2022, I conducted an in-depth online ethnography and collected material to document the virtual landscape of the Tunisian mobilisation during the pandemic. This was complemented by "offline" fieldwork in Tunisia in 2021, as well as several intermittent stays in Paris between 2021 and 2022 and semi-structured interviews conducted in Belgium. This diversity of approaches and sites allowed me to observe the diverse categories of diaspora actors who became active in supporting their country from the first lockdown in 2020, via different channels.

In recent years, a succession of important shifts has reshaped the political and social landscape in Tunisia. The time of the Covid-19 pandemic was a significant one for Tunisia. The acceleration of Covid-19 cases and deaths in 2021 and the ensuing political instability including the dissolution of the national Parliament by Kais Saïd, was in parallel to a critical economic situation. Once the poster child of the Arab Spring revolutions in the 2010s, Tunisia became a country where the health crisis served as a justification for increasingly authoritarian measures. The incapacity of the state to provide for the health of their citizens resulted in lost legitimacy. Indeed, healthcare is part of the fundamental responsibility of States (Rabinow and Rose 2006). They regulate through public and/or private means and national health systems; "the ability to provide health care became symbolic of a government's claim to legitimacy" (Whittaker and Leng 2016: 289).

Looking at the mobilisation of the Tunisian diaspora in Europe, I argue that the crisis brought on by the Covid-19 pandemic became a catalyst for pre-existing tensions between Tunisians from "outside" and "from inside" to intensify. The history of the transnational political engagement of the diaspora reveals the permanence of strong cleavages between diaspora groups, with State authorities, as a result of political, ideological and religious divisions, which echo the complex political history of Tunisia. While the revolution of 2011 led to a short moment of unanimity, the civil society landscape saw the reemergence of those cleavages.

It is in this complex context that Tunisian collectives emerged abroad during the Covid-19 pandemic, which, I argue, revived the consensus experienced by the diaspora during the revolution. Observing the initiatives of these collectives, I show how they became powerful tools to unify the claims made by the diaspora during the pandemic, notably in relation to the

public discourse in Tunisia which depicted “non-resident nationals” as potential health threats for the country.

This chapter describes how this episode, which led to the stigmatisation of TRA, considered as vectors of the virus, materialised a moment of rupture in the moral economy of diaspora-homeland relationships. A case in point was the decision of Tunisian authorities to stop body repatriations of TRA, coupled with the interruption of flights, and the following introduction of compulsory quarantines. This accelerated the mobilisation of the Tunisian diaspora to defend their right to travel back to their country of emigration in response to the healthcare restrictions put in place by Tunisian authorities. In parallel to what were considered discriminatory measures, I then show how the mobilisation of the Tunisian diaspora towards their country of emigration during the pandemic marked a strong moment of visibilisation of the moral economy that underlies the ambiguous relationship between the Tunisian state and its diaspora.

The third section of the chapter explores how the Tunisian diaspora continuously navigates the ambivalence around its membership in the national community, particularly from an emotional perspective. To illustrate this dimension, I draw on the case of diaspora groups active in the medical sector, which directly supported Tunisia during the pandemic. In particular I discuss how medical remittances, taking the form of transfers of medical and healthcare equipment, medical expertise, and advocacy, transformed the biomedical landscape in Tunisia during the pandemic, illustrating the transformative agency of the diaspora in the management of the healthcare crisis. These diasporic networks, acting as therapeutic networks, positioned themselves as a moral authority during the Covid-19 crisis, in front of what was presented as a failing response from Tunisian public authorities. The use of emotions and the reference to values were a crucial element of their strategies of mobilisation. The resulting disdain from the Tunisian authorities and the lack of recognition for the effort made by the collectives of TRA against Covid-19 indicate the fragility of the moral economy between the State and the diaspora.

While demonstrating the “moral” obligations of TRA and the evolving nature of their expectations in the context of a pandemic, the Covid-19 crisis also highlighted healthcare disparities and inequalities between Tunisians residing abroad and in Tunisia. To conclude, I argue that this context reactivated tensions around the inequalities at play and forms of rejection of TRA, underlining the role of "crises" and of the place of emotions and values in safeguarding the fragile balance of the "emotional community" in state-diaspora relations.

I. Diaspora in crisis

In March 2020 within a week after the start of the lockdown, my attention was caught by the calls for help posted on Facebook pages of the Tunisian consulates and associations as well as Tunisian Facebook groups. People were asking for food, money to pay for their rent, medication, and for advice on where to seek help. Several students were presenting their stories - having lost their part-time jobs, they were left with no financial resources to sustain themselves. It also brought to light the large number of irregular Tunisian migrants who were left with no jobs and no access to social protection. When discussing the issue with Ahmed, an association member whom I met in Paris when I visited in October 2021, he explained that as these concerns were generalised for most migrants' communities, migrants' associations had been overwhelmed by demands, facing a shortage of staff, equipment, and infrastructure. Some of the messages posted on social media were hard to bear, as some of them recounted not having eaten for a few days and were begging for help. Tunisian associations and individual members of the diaspora almost instantly reacted to these calls, and I saw the chain of solidarity unfolding on social media that was implemented in the following days and weeks.

The material that I am using in this chapter was collected during the period of March 2020 to January 2022. As described in the methodological chapter (Chapter 2), with the Covid-19 outbreak I started conducting an in-depth online ethnography and collected documentary material including news releases, photographs, videos, Facebook publications and comments, providing a snapshot into the living experiences of members of the Tunisian diaspora during this time. The data retrieved from Facebook were all content that was shared on public groups and public pages. Information that was shared by actors on their private Facebook pages also informed my understanding of the phenomenon. However, this material is neither presented nor quoted in this chapter. The selected material and images that I am using in this chapter in order to illustrate the virtual landscape of the Tunisian mobilisation during the pandemic were retrieved from public Facebook pages and groups.

Diverse categories of diaspora actors became involved during the first lockdown. First were associations (from smaller cultural and local associations to larger associative networks) almost all turned their activities towards providing emergency response to members of the community. Second were some diaspora “leaders”, as they are sometimes called, including “influential” individuals such as artists, writers, successful businessmen and women and, in the context of

the pandemic, healthcare professionals. I introduce these later in the chapter as "medical diaspora actors". Lastly, the solidarity also came from individuals within the diaspora who promptly responded to associations' call to donate money, food and to volunteer (see Figure 17). There were many initiatives such as food distribution, collection of funds, and sponsorship mechanisms connecting people in need with individuals that were ready to support them financially or through donations of food and other goods.

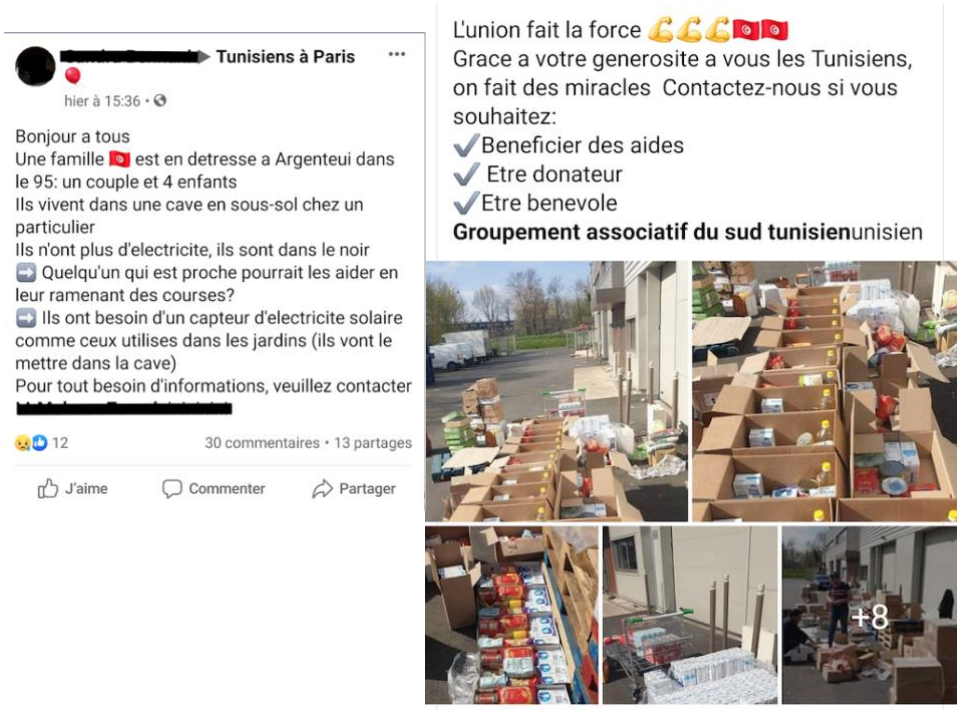

Figure 17: Instances of calls for generosity on Facebook.

Source: Retrieved from the Facebook group "Tunisiens à Paris"

As I discuss in the following section, concerns started to be raised about the impact that the crisis could have in Tunisia, in a country which was already economically and politically fragile.

1. The concomitant healthcare and political crisis in Tunisia

The pandemic in Europe was always a few weeks ahead of Tunisia, and the diaspora associations tried to anticipate the potential needs in Tunisia: "We Tunisians living abroad, we owe our country and our people to assume our share of the burden imposed by this health crisis"

(Collective ATE Covid 19, 22 March 2020). On social media, people were expressing their concern about their home country and the impact that the crisis could have on a country with a fragile healthcare infrastructure and with little resources to react to it. The chronology of the pandemic did differ in Tunisia, compared to Europe. After closing its borders throughout and implementing a full lockdown, Tunisia seemed reasonably spared from the first wave of Covid-19 that had shaken Europe for a few months. It was only in September-October 2020 that the numbers started to rise significantly, and that the healthcare system became overwhelmed. The highest peak of the pandemic in Tunisia took place in the spring and summer of 2021 when the number of Covid-19 contagions and deaths became uncontrollable and intervention from the international community was eventually required. By July 22, 2021, Tunisia reported 563,930 total coronavirus cases and 317 new deaths.[64] The healthcare crisis in Tunisia made the headlines in Europe.[65] The public health situation had been deteriorating for a few months, with insufficient state measures to counter the rising numbers. For months, the State had the difficult challenge of juggling economic needs and public health measures (Ben Ayed 2022). Indeed, the Covid-19 pandemic was accompanied by political and economic instabilities in Tunisia. Throughout 2020, the fragmentation and divergence between political forces had created a chaotic atmosphere in the legislative chamber, impeding its capacity for action (Elleuch 2020). Moreover, the Covid-19 pandemic came at a time where economic indicators were already critical and further aggravated the situation, which led to an 8.6% decline in GDP during the first wave (spring 2020), the largest in the Maghreb (excluding Libya) (Gobe 2021). Despite a first wave that had been relatively well controlled, the political disputes led to the resignation of the head of the government Elyes Fakhfakh, which triggered another period of political instability (Tamburini 2022). During the second half of the year, the GDP further declined by 19% and the restrictive measures taken by authorities and the new prime minister in the course of October 2020 to control the pandemic hindered economic recovery. The state, however, refused to return to a full lockdown, as in spring 2020, and adopted a strategy of coexistence with the virus in order to mitigate the economic impact of this second wave. The growing dissatisfaction among the population triggered significant protests and a wave of urban riots early 2021 which were violently repressed by the police (Gobe 2021).

[64] As of 30 December 2021, Tunisia had lost 25,548 lives to COVID-19 (Africa's worst death toll after South Africa, according to data from the World Health Organization).

[65] https://www.lemonde.fr/afrique/article/2021/07/14/tunisie-la-diaspora-se-mobilise-face-a-une-situation-sanitaire-catastrophique_6088278_3212.html
https://www.lemonde.fr/afrique/article/2021/06/22/en-tunisie-la-crise-sur-tous-les-fronts_6085241_3212.html

Furthermore, the vaccination campaign had considerable delays and in June 2021, less than 5 percent of the population had been vaccinated. When I met with a civil servant of the Ministry of Health in mid-June 2021 in Tunis, he confessed:

> "At the moment, we have around 80,000 vaccine doses in stock. These represent just a few days of vaccination in metropolitan Tunis alone" (Montassar, Interview Tunis, June 2021)

The preoccupation was palpable, and it seemed as if the crisis that was coming to a head was now inevitable despite lockdown measures, entire cities that had been put on red alert, there were strict travel restrictions, and even mobility restrictions within certain parts of the city in Tunis. Being in Tunis myself during this time, I still recall the shift that took place at some point in June 2021. People started to wear their masks more routinely, shops had installed plastic protection at their counters, people were queuing to enter shops, and queues were forming in front of pharmacies. By mid-July, Health Minister Faouzi Mehdi had organised the temporary opening of vaccination to all Tunisians over 18 years of age for two days during the Eid holidays, but the success of the call for vaccination, the lack of organisation and the rapid exhaustion of doses available caused scenes of chaos and jostling outside the vaccination centres where people had been queuing for endless hours under very high temperatures.[66] The health minister was dismissed by the head of the government, Hichem Mechichi, following the incident. Towards the end of July 2021, the crisis was truly at its worst, hospitals beds were full, oxygen stocks had run out and the country was simultaneously being shaken by a significant political crisis which reached a paroxysm when President Kais Saïd led a coup on the 25th of July 2021 (on the day of the commemoration of the birth of the Tunisian republic).

On that day, I was traveling back from Sousse where I had spent the Eid celebration at a participant's house. I left with a carshare from Sousse early morning, and it took us almost 5 hours and around 15 police roadblocks to reach Tunis. On the way down from Tunis, police processions accompanied convoys carrying oxygen tanks. Arriving in Tunis, access to the city was completely blocked by the police and we spent another hour and a half driving around the city to find a way to reach the centre and could get through, after multiple refusals, only because the driver was a student with the national police forces. Later that night, as I was having tea

[66] https://www.lemonde.fr/afrique/article/2021/07/20/en-tunisie-la-vaccination-sera-ouverte-a-tous-les-adultes-pendant-deux-jours_6088902_3212.html

with my neighbour, we suddenly heard applause and sounds of crowds relaxing in the street (Figure 18).

Figure 18: People in the streets of La Goulette, Tunis, 25th of July 2021.

Source: author's own photograph.

Kais Saïd had just dissolved the parliament and dismissed the prime minster, invoking the deleterious health situation and the high dissatisfaction of the Tunisian population as a reason to activate Article 80 of the constitution due to "imminent danger" threatening the stability of the State. Article 80 indeed stipulates that "the President of the Republic, in a state of imminent danger threatening the integrity of the country and the country's security and independence, is entitled to take the measures necessitated by this exceptional situation, after consulting the Prime Minister and the Speaker of the Cabinet". It does not. However, authorise the president to dissolve the parliament, and Saïd made an extensive reinterpretation of the article galvanised by his strong popular support (Desrues and Gobe 2023; Tamburini 2023). Indeed, in general opinion, the Islamic party was accused of being responsible for governmental inefficiency, political chaos, high unemployment rates and corruption, as well as the incapacity to manage the out-of-control Covid-19 virus wave (Tamburini 2023). As argued by Tamburini, Kais Said's speech declaring that the parliament was a danger to the State resembled Bourguiba's declaration jn which he stated that elections were "periods of fevers that are conducive to the

proliferation of microbes that are dangerous for the health of the country" (Borsali 2008: 132 in Tamburini 2023). The threat to the health of the nation served as the justification for authoritarian measures. It is in this complex political context that Tunisian collectives abroad against Covid-19 emerged.

2. The Tunisian collectives abroad against Covid-19

The gravity of the crisis which was unfolding provoked waves of emotions within the diaspora. It acted as a moment of "moral shock" (Jasper 1998), triggering the mobilisation and reorganisation of the Tunisian diasporic networks and its federation around a common cause. The globality, singularity, and suddenness of the crisis encouraged alliances between different categories of actors, as well as between associations that do not necessarily cooperate otherwise and are sometimes based in different countries. Several collectives such as *Solidarité Tunisie, ATE.COVID19 (Tunisians' Asscociations Abroad against Covid-19), Rassurez-Moi ("Reassure me"), the collective of Tunisian civil society associations abroad*, took shape to coordinate their initiatives. Emotions in that context became a mobilising force (Sommier 2020), providing a common motivation and goal which, I argue, revived the consensus experienced by the diaspora during the 2011 revolution.

The parallel between the time of the revolution and the pandemic was often expressed to me: "We all have our families over there and we are all connected to them through our hearts. The sea separates us, but we are together like in the Spring Revolution" (Amina, Facebook post on the group Jaw Tounsi). The emotion that traversed the diaspora revived for many a sense of responsibility towards their country of emigration and a sense of power to influence what is happening there through transnational engagement. Jasper suggests in that regard that social movements are both affected by "context-specific emotions, usually reactions to information and events" as well as by "more stable affective bonds and loyalties" (Jasper 1998: 397). As one of my interlocutors framed it:

> "Tunisians I think are in love with their country. I am convinced that if tomorrow there is a war in Tunisia, all the diaspora that lives comfortably in Europe, Canada, would return to wage war ... Probably because we had a revolution in 2011 that we all went through together … this social phenomenon where there was a spontaneous human rebellion… it was huge! ... Even if, one day, dictatorship returns to Tunisia, there is a

feeling that connected us and that the rest of the world cannot understand" (Zied, January 2022).

Moreover, the Tunisian civil society abroad had already gained experience and created diasporic networks during the revolution. This was emphasised by Nadia, a civil society actor who used to live in France and returned to Tunisia a few years after the revolution. She explained that many of these diasporic networks formed at the time of the revolution and after, to play a role in supervising the electoral process. Already at the time, social media had played an important role in connecting actors and it was thus "quite easy to reactivate these networks during the pandemic" (Nadia, Interview, Tunis, August 2021).

It was through Fakher, a civil society representative in Belgium with whom I had been in contact since the beginning of the thesis, that I was introduced to one of the collectives that formed at the beginning of the pandemic - the Collective of Tunisians abroad against Covid-19 (*ATE.COVID19).* Fakher is himself involved in an association based in Belgium and created after the revolution which is in the continuity of the leftist association movement in France. They advocate for human rights and promote democratic processes. They regularly organise conferences to discuss political evolutions in Tunisia and I myself attended several of their events in Brussels and in Liège. Being in close contact with associations in Paris but also throughout Europe, they integrated several collectives in March 2020 and carried their messages to the diaspora in Belgium but also voiced to the Tunisian authorities some of the demands emanating from the Tunisian diaspora in Belgium. When Fakher offered that I could join the meetings of *ATE. Covid19* I of course jumped at the opportunity. After confirming with the rest of the collective that I could join[67], I therefore followed their meetings taking place twice a week online (over Skype or Zoom) from early April 2020 to early July 2020 and was also added to the mailing list of the collective.

Members of the collective, being themselves in lockdown and restricted in their movements, had to rethink their mode of mobilisation and adapt to this new virtual mode of coordination.

[67] In the methodological chapter, I detail how I made sure that people in the meeting were aware of my presence and of the purpose of my research by introducing myself on the chat during the first meeting as well by sending an email providing all necessary information through the mailing list of the collective.

Figure 19: Logo of ATE.Covid-19

Source: Taken from the collective website.

The collective ATE. COVID 19 (Figure 19) reunited many associations in Italy, Belgium, Switzerland and France, which had already been gathered under the umbrella association Coordination of Tunisian Immigration (*Coordination des assises de l'immigration tunisienne*-CAIT) created in 2013. The objective of CAIT, two years after the revolution, which had seen the proliferation of associations within the diaspora, was to join forces and improve the visibility of diaspora associations who wanted to actively contribute to the reconstruction of the country and advocate for their inclusion into homeland affairs.

The creation of a virtual space of mobilisation during the pandemic enlarged the networks of these associations, connecting actors based in different cities and countries, sometimes even different continents, thus paradoxically bringing the existing "diasporic network" even closer together. Bruneau suggests that diasporas "preserve and develop among themselves and with the society of origin … multiple exchange relations (people, goods of various natures, information, etc.) organised through networks" (Bruneau 2010: 37). The continuity between the country of emigration and the diaspora is built through the creation of "diasporic networks" that are multilateral and span several national boundaries outside the homeland. This transnational coordination acted as a powerful advocacy tool by centralising claims formulated by the diaspora during the pandemic to defend the legitimacy of their demands and initiatives. They also became involved simultaneously in the country of residence and Tunisia, affirming and claiming their belonging to both socio-political spaces.

Over the course of the lockdown, the Tunisian civil society representatives based in different cities in France, Italy, Belgium and Switzerland provided feedback on the initiatives taken by their associations, and together, they discussed the issues they wanted to raise with the Tunisian authorities. As we shall see later in the chapter, several claims were formulated by the collectives in relation to measures that were taken by the Tunisian authorities. These ranged

from the assistance of authorities for non-resident Tunisians stranded in Europe, the question of the closure of borders and access to the country for TRA, embargo on body repatriations, customs facilitation for the shipment of medical donations and materials etc. Part of each meeting was therefore dedicated to the preparation of open letters to the Tunisian government and of news releases. There were numerous points they wanted to raise with the authorities, reflecting the concerns and needs of the Tunisian diaspora but also regarding the management of the healthcare crisis in Tunisia. Moreover, they also addressed authorities in Europe, namely for the assistance of irregular Tunisian migrants. ATE.Covid-19 only maintained their activity until summer 2020 and they dissolved the collective after that. In proportion to its size, the collective ATE.Covid-19 collected a very small amount of money (500 Euros) during the first lockdown. This seemed surprising as other collections that had been spontaneously organised through platforms such as Leechi or Helloasso had collected much larger amounts. The collective played, however, an important advocacy role and mobilised their political network and its contacts within the Tunisian political spheres.

Several other collectives took shape around the same period. In Belgium, the collective *Tammanni 3lik (*Reassure me) was also created in March/April 2020 and once again reunited different associations in Belgium that did not collaborate otherwise and were from different sides of the political spectrum. While discussing with Wajdi, one of the civil society representatives of the collective, he explained that it was indeed rare that they worked with leftist associations but "this time the issue goes far beyond political disagreements" (Interview Brussels, 10 October 2020). He recalled that the last time they really joined forces was in fact after the revolution: "we were all in front of *dar tounsi*[68] and we forced the doors to let Tunisians who had recently arrived sleep inside the building" reflecting the communion of the diaspora during the revolution. The size and scope of this collective was of course a lot smaller than the collective in France and they collected only a small amount of money during the overall period of the pandemic, mainly providing assistance to precarious Tunisian students and families living in Brussels.

Finally, the collective *Solidarité Tunisie* was the largest collective, composed of 70 associations. It served as an umbrella structure and even included most associations who were part of other collectives (such as CAIT associations mentioned above which formed the collective ATE.

[68] OTE created the Dar El-tounsi ("House of the Tunisian") network of socio-cultural spaces in 2000 to support the activities of the Tunisian community, to design and implement social mentoring programs for the diaspora, and to enable youth to engage in cultural and educational activities.

COVID19). In addition, some newer associations– formed during the 2011 revolution – and active in the humanitarian sector in Tunisia became active during the pandemic. These included some of the largest diaspora associations in France such as T2Riv (The Tunisian association of citizenship of both shores created in 2011), ASSEM[69] (The Association of Support to Children) which was already active in healthcare cooperation since 2010, but also ATUGE[70] (Association of Tunisian from higher education) which is itself a transnational association with branches in the UK and the US. They also involved private companies in France and in Tunisia such as the large supermarket chain Franprix or the relatively recent Tunisian start up *Tobba*[71] (Doctor), a healthcare platform for teleconsultation and healthcare monitoring. Their approach was therefore quite different, and they also involved the Tunisian embassy in France and the Tunisian consulates in Paris and Pantin. They collected a much larger amount (around 150,000 Euros) in comparison to other collectives. As I examine in detail in Section III, the association collectives surrounded themselves with medical experts within the diaspora, asking them to join the Covid-19 taskforce they had established, and receiving their guidance as to what medical material and knowledge needed to be remitted.

In the following section, I demonstrate how the collectives served as a powerful tool to strengthen and unify the revindications made by the diaspora during the pandemic.

[69] The Association of Support to Children (ASSEN) was created in 2010 by young Tunisian students in Paris. These young students wanted to bring their help to Tunisian children, especially in favour of the orphans of the SOS Mahres centre. This impulse of solidarity was accentuated by the Tunisian revolution which revealed the precarity in remote areas. They are active in different development projects in education, social and local economy as well as access to healthcare for precarious families.

[70] The objective of ATUGE, which was created in 1990, is to provide a collective space to support its members during their journey in higher education and facilitate their integration in the professional world. They wish to strengthen cooperation between Tunisia and Europe and be a force in proposing new approaches in economic thinking in France and Tunisia. They are also a networking platform between economic actors, recruiters, associations and public institutions and offer to their members the possibility of developing their personal and professional networks by organizing meetings and debates as well as recreational activities.

[71]The startup was created in 2019: https://www.tobba.tn

II. The reconfiguration of diaspora-homeland relationships along biomedical narratives[72]

1. Questioning the moral economy of the relationship between diaspora and country of emigration

As briefly outlined in the introduction, at the beginning of the pandemic, TRA were accused of importing the Covid-19 virus to Tunisia and were portrayed as an "external threat", challenging the ability of the State, with its limited resources, to cope with the crisis. Therefore, those who wished to return to their country of emigration during that time were pointed to as those responsible for the deterioration of the health situation in the country. The count of so-called "imported cases" put the stigma on returning emigrants as carrying a threat to their country and as a vector for the spread of Covid-19. By defending their "right to return", TRA became "bad citizens", and the State put in place measures making it difficult for them to travel to the country of emigration.

As many countries around the world decided to restrict access to residents only (excluding non-resident nationals), the pandemic called into question the consensus between states and diasporas. It provoked a rupture of the "system of symbolic exchange" (Triaud and Villalón 2009: 36) guaranteeing the social order and offering an opportunity to observe the values that govern the relations between the diaspora and their country of emigration (in particular, their public authorities). Conflictual emotions were common among the Tunisian diaspora. On the one hand, they were worried about their families and felt a renewed sense of belonging and attachment to their country of emigration. On the other hand, they felt resentment towards the Tunisian authorities and their co-nationals who were driving them out of the country.

In several of the letters sent to the Tunisian authorities by the different collectives of TRA against Covid-19, they denounced "a hostile climate being perceived as a source of contamination and circulation of the epidemic, … sidelined and stigmatised by compatriots and

[72] Some of the developments presented here are a continuation of the collective work on the mobilisation for the "right" for body repatriation during the pandemic, a comparative paper on the Tunisian and Senegalese cases. For more information see: de Heusch, Wenger and Lafleur, 2022, "États et diasporas face à la mort en migration: une analyse comparée des cas sénégalais et tunisien avant et pendant la pandémie de la COVID-19", *Revue Européenne des Migrations Internationales*, 38 (1 and 2), pp. 37-62. The co-authors have expressed their agreement for the re-utilization of the material in my thesis.

by some officials" (Collective Solidarity Tunisia, Letter to the President of the Tunisian Republic, 22nd June 2020). People also expressed their indignation on social media (Figure 20): “Please do not blame the political failures of the last 64 years on Tunisians abroad. There is no local or imported coronavirus. This is a vile racist categorization” (Facebook post, *Jaw Tounsi*, 27 April 2020).

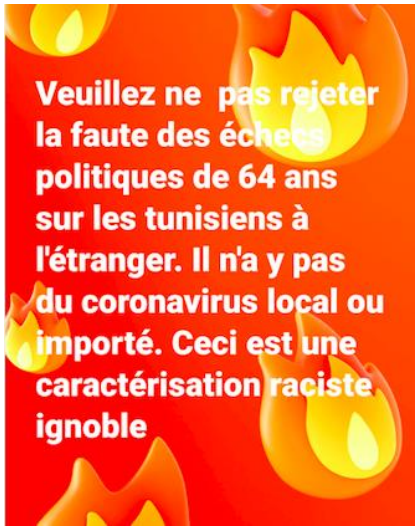

Figure 20: Comments on Covid-19 cases in Tunisia

Source: Taken from Facebook group Jaw Tounsi, 27 April 2020

The ban on returning to the country of emigration and the rejection of bodies as potential carriers of disease revived the historical association between migration and the circulation of disease (Prothero 1977; Markel 1997). The "foreign body" is then perceived as endangering the health of the nation (Higham 1988; Markel and Stern 2002) and pushes states to implement exclusionary policies. These bio-policies (Foucault 1976) excluding migrant bodies perceived as biologically threatening (Ormond 2021: 119) have fuelled negative representations of migration. It is interesting to underline how boundaries of who is labelled as “foreign” and who is not are fluid. In the context of the pandemic, emigrants were incorporated into the category of the “foreign”. This shift took place in Tunisia but was also documented in other emigration countries. In his paper on Senegal, Onoma (2021) shows the “scapegoating” of return migrants during the pandemic. The “foreigner” was not associated with the precarious migrant but with the emigrant, the “expatriate”. Similarly, in the case of the Philippines, Filipino migrant workers overseas had long been hailed as “bagong bayani (modern-day heroes) for keeping the Philippine economy afloat through remittances” (Fernandez *et al.* 2020: n.p). With the pandemic, and the resulting loss of income, many were stranded in receiving countries, pushing

the State to organise repatriation programs. The repatriation of these stranded migrants was met with opposition from local communities, afraid that they could help spread the virus in their home provinces.

In response to Facebook posts of Tunisians abroad denouncing the attitude towards TRA, I could read comments (Figure 21) such as “profiteers and whiners from both sides of the Mediterranean”. As one of my interlocutors expressed to me: “they were talking like Marine Le Pen ‘stay in your country’, but Tunisia is also our country, we have both nationalities” (Fakher, June 2020).

Figure 21: Facebook comments under a publication denouncing the accusations against TRA

Taken from the Facebook group “Tunisians in Paris”, March 2020

Moreover, TRA deplored the lack of coordination and consultation from the authorities and the lack of acknowledgment of the difficulties "at a time where Tunisians abroad had been rendered fragile by the pandemic and had suffered from the separation from their families in Tunisia" (Collective Solidarity Tunisia, Letter to the President of the Tunisian Republic, 22nd June 2020).

In this regard, the Covid-19 pandemic marked a period of tensions between diasporas and their countries of emigration, triggering a renegotiation of the place of emigrants: those "from outside" (Timera 2014) "absent" and kept away from the state of emigration. At times, the "nation-state creates an arbitrary limit between the networks inside it and those that are outside (Bruneau 2010: 48). Dufoix suggested that:

> "in a growing number of cases, the place of emigrants and their descendants in the space of the nation is being negotiated within a genuine trans-state national space, where actors from the national political sphere (institutions, politicians, parties) and actors from the community space outside the country (newspapers, associations, intellectuals…), all these actors being in struggle with each other for the imposition of the legitimate definition of the nation and for the delimitation of the institutional, legal, economic, social and symbolic frameworks of the presence of those who are absent. (Lacroix 2019: 37).

In his famous work, Sayad (1999) invited us to think of the immigrant as "doubly absent", in the place of emigration and in the place of arrival". The absence of the immigrant is "in fact a double absence, since if immigration is obviously a matter of presence ... it is also... a moral absence, one might say, a form of absence in the presence, an absence in spite of the presence" (Sayad 2000: 10). This "tragic" framework (Timera 2014) can nevertheless be rethought from the perspective of transnationalism, highlighting the simultaneous presence of the migrant in the country of emigration and the country of immigration, and the creation of a transnational social field (Levitt and Schiller 2004) through cultural, social, family, economic and political practices (Basch *et al.* 1993). Emigrants are therefore inhabiting a "double space" (Quiminal 1991; Basch *et al.* 1993) and are "doubly present" (Dufoix 2010). Sayad also suggests that immigration and emigration should be conceived as "two inseparable sides of the same reality; they cannot be explained without each other" (Sayad 1999: 15). "Double presence" and "double absence" are thus in tension and continuously renegotiated.

As argued by Timera, absence "durably structures the relationship" (2014: 41) between the country of emigration and emigrants, forcing the latter to reaffirm their membership to the "emotional community" by defending the legitimacy of their presence, especially in times of

crisis. The notion of "emotional community" was initially used by Weber (1976) to refer to the charismatic power founded by the affective and emotional bond forged between a leader and his partisans (Kalberg 2012: 489). Schnapper (1994) mobilised the concept later on, as a tool to build a "community of citizens". Moreover, the use of the concept was also made popular in other disciplines such as medieval history (Rosenwein 2006), emphasising the transformative capacity of emotions. Finally, for Boquet (2013: 6) while "emotional community" was first defined as a set of goals and values shared by its members, it also constituted "an environment adapted to accommodate performative approaches to emotion, in their intrinsic capacity to transform situations".

From a conceptual point of view, this time of a rift mobilising registers of pain and emotions (Stierl 2016) invites us to consider the concept of moral economy. As discussed in the theoretical chapter of the thesis, the literature on moral economy in migration studies highlights the relation between migrants' economic practices and the moral values, norms and emotions that govern them (Thompson 1971; Scott 1976; Fassin 2005; Carling 2008). For instance, migrants often engage in remittance-sending not solely as an economic obligation but as a moral duty to support their families back in the country of emigration. These remittances can be seen as part of a "transnational moral economy" (Solari 2019) where familial and community obligations and expectations dictate economic behaviour. In this regard, the moral economy approach allows us to examine how financial and emotional investments can intertwine. Fassin defined moral economy as "the production, distribution, circulation, and use of moral feelings, emotions and values, norms and obligations in the social space" (2009: 1257). Moral economy defines and regulates a society and the commitments and exchanges of its members, influences judgements and actions, and delineates what can be done and what cannot (ibid.).

Furthermore, in the Tunisian context, in an exploration of moral economy, as I do in this thesis, it is relevant to consider the influence of Islamic values. Indeed, as briefly mentioned in Chapter 3, family solidarity and responsibility are fundamental values in Islam. Albertini and Mantovani (2022) note in that regard that in the Quran "the most beloved man in sight of Allah is that who is most helpful to his family" (In al-Magribi, 1347: 128 in Albertini and Mantovani 2022). The individual can only exist in the community (Khaldun 1980: 322). Kinship and group solidarity in Islam are at the basis for the notion of brotherhood and Muslim Unity (Khairulyadi *et al*. 2021)

Also, religious values have to be considered in order to understand the moral economy shaping the relationship between Tunisian migrants and their non-migrant relatives, as well as between the Tunisian diaspora and Tunisians in Tunisia.

2. Strengthening of the moral absence through exclusionary measures

The closure of borders to non-resident nationals and the interruption of flights reinforced the absence of TRA from their country of emigration. This was further exacerbated by several measures taken by Tunisian authorities such as the closure of borders and compulsory quarantine. A decisive turning point that played a central role in the tensions that crystallised between the Tunisian diaspora and the Tunisian authorities at the start of the pandemic was the interruption of body repatriation (de Heusch *et al.* 2022). Indeed, in March 2020, Tunisian authorities prohibited the body repatriation of TRA, breaking with one cornerstone in the representation of the migratory experience of TRA, a point that is worth detailing here. The elements presented in this section allow us to understand the attitude of the Tunisian diaspora towards Tunisia during the pandemic and how this has framed their mobilisation.

2.1. "The State must assume its responsibility": mobilisation of the Tunisian diaspora for the respect of the "right" to body repatriation

The "right"[73] for body repatriation was initiated under the paternalistic regime of Bourguiba (early 1970s) who "authoritatively made the decision that any Tunisian must be repatriated" (Interview conducted online with Adnen, member of the Tunisian association in France, on 11 December 2020) thus acting as a transnational moral authority (Lacroix 2019) regarding the place of burial of its citizens. The choice of the country of emigration as the place of burial is based on a moral imperative to avoid the risk of a "bad death" in the country of immigration. According to Kenza, a consular official in Brussels, the possibility of respecting the Islamic ritual for burial, the presence or not of Muslim plots as well as the duration of the concessions in cemeteries in Europe were all elements that fuelled concerns about the "fate" of those who were buried abroad. Moreover, the "right" for body repatriation was part of the agenda of the Tunisian authorities to maintain allegiance to the State, to nourish the myth of return and to encourage remittances (Geisser 2012; Zederman 2018). It is therefore perceived as a "non-

[73] A decree from the early 1970s gave the task to consular authorities to repatriate the remains of any person of Tunisian nationality, regardless of their place of birth.

negotiable" and "acquired right" (Interview conducted online with Oussama, former official of the *Office des Tunisiens à l' Étranger*, 24 October 2020). that has “always existed” (Interview conducted online with Karim, member of a Tunisian association in France, 07/03/2021). In the imagination of many TRA, body repatriation to the country of emigration has thus been established both as a way of responding to religious prescriptions and as an essential value governing the relationship with the authorities of the state of emigration; the latter ensures body repatriation in exchange for the maintenance of loyalty and remittances of TRA to their country of emigration. Its questioning in the context of the Covid-19 pandemic nevertheless marked a moment of tension, of emotional crisis between the Tunisian authorities and the diaspora. These tensions are symptomatic of the changing moral economy between the Tunisian authorities and the diaspora over time, particularly since the revolution of 2011. On March 18, 2020, the Tunisian government closed its borders to non-residents and interrupted air and sea connections, preventing the return of both the living and the dead. In Tunisia, the burial of residents that passed away due to Covid-19 in local cemeteries provoked strong reactions from residents in some localities (Lachheb 2020). The fear of the circulation of virus through "Covid bodies" coming from abroad followed the same logic: "people were afraid of being attacked by these bodies” (Interview conducted online with Karim, 07 March 2021).

Families who were unable to repatriate their relatives to Tunisia had to accept that they would be buried in Europe. But, as stated by Karim, some families "did not have a budget for death" and could not alone assume burial costs in Europe. On social media, images coming from Italy, showing bodies of Tunisians who had died in hospitals and were waiting to be buried, provoked TRA’s emotions and fear. One could read in the comments under these images: "what is the Tunisian consulate doing?" (Facebook comment from Amal 22 March 2020), "associations must file a complaint against the consulate " (Facebook comment from Amal 23 March 2020). But for the consulates, without being otherwise instructed, their role is clear, and their intervention only concerns the transportation of the body back to Tunisia: “the directives only specify the transportation from point A to B and does not include any support for burial expenses (Interview conducted in Brussels with Kenza, consular official, on 31 March 2021).

Karim, a member of a Tunisian association in France, explained that "at the beginning there was a rumour" (Interview conducted online with Karim, 7 March 2021). In the hospitals, the places in the morgues were limited and the bodies could not be kept for long while waiting for a solution for their repatriation. There were "rumours" that if the bodies were not taken care of, they would be cremated, thus solidifying the fear of a "bad death" characterising the double

rejection of the "foreign body", from the country of residence and from the country of emigration:

> "You either take care of the body with a funeral company, or the body will be burned! ... When we heard this, we decided to sue the consulate and the Tunisian State for not assuming their responsibility and burring their patriots. Just in case we needed to take care of the body ourselves, we collected funds. In forty-five minutes, we collected 16,000 Euros… people were touched by the cause ... We are not used to that... If the Tunisian state did not take [this] in charge, we would have insurance ... but usually the state takes care of everything. But it is paid for with citizens' money, the state does not have the money, it is our money ... That is why we said that the Tunisian state must assume its responsibilities." (Interview conducted online with Karim, 07 March 2021).

In the perspective of many TRA, Tunisian authorities did not respect and honour the terms of the decree and were, in a sense, liable to the families of the deceased. Breaking with one of the founding values of the moral economy between the Tunisian State and the Tunisian diaspora, the State exposed itself to harsh criticism. In Belgium, as well, TRA were moved by the fate of those bodies and called on the Tunisian authorities:

> "Should they bury them temporarily here in the country where the death took place, leaving them in the morgues until better days, or should the Tunisian state find an exceptional way to repatriate the remains? ... Who could take care of them and pay the costs? ... We must act and give a response quickly to the families who are left in unbearable distress" (Press release of the Committee of Vigilance for Democracy in Tunisia-CVDT, 22 March 2020)

The Tunisian Ministry of Foreign Affairs quickly instructed the consulates to take on the costs of burial in Europe. For those who did not die from Covid-19, the associations, in collaboration with the consulates, also found an alternative and, until the return of commercial flights, repatriated the remains with cargo planes. Finally, it was not until November 2020, when the concerns of TRA in relation to the "crisis" seemed to have shifted to other issues, that arrangements were made to repatriate the "Covid bodies" to Tunisia.

The management of the repatriation of the remains of Tunisians who died abroad during the pandemic and its symbolic and emotional impact had greatly affected the relationship between these two actors at the beginning of the pandemic. Body repatriations being the expression of the "ultimate return" (Petit 2002) of the migrant, it is through this practice that the fragile

balance between "double presence" and "double absence" is disputed to ensure the continuity of the group: not only the transnational family and diasporic networks, but also the nation state. The COVID-19 "crisis" questioned traditional representations of the role of the state towards its diaspora. By suspending the repatriation of bodies, in contradiction to the expectations of the diaspora, the state did not fulfil its commitment made by the decree. Caught between the demands of the TRA and public health, the authorities negotiated the terms of the moral economy around body repatriation. The measures that followed, taken by the Tunisian authorities, accumulated, strengthening the resentment of the TRA towards their country of emigration.

2.2. "They want to make money off our backs": Compulsory quarantine and increase of consular fees

The Tunisian authorities communicated their decision in May 2020 to impose a compulsory quarantine of 14 days in hotels they would designate (Figure 22). Although it was not formulated that way, the measures targeted TRA in particular, as tourists traveling through tour operators could choose their hotel, and were not subject to the same quarantine measures upon arrival. This decision was taken in an attempt to preserve the tourism industry but, for TRA, this was at their expense: "they want to make money off our backs by making us pay for expensive hotel stays" (Facebook post, *Jaw Tounsi*, 7 May 2021). Another post: "our country takes us for cash cows, only good for sending money without ever receiving anything in return" (Aymen, post on the Facebook group *Jaw Tounsi,* 14 May 2021) reflected the frustration felt by many. As discussed above, the feeling of being considered second-class citizens was revived by these measures which many perceived to be unjustified. The authorities implemented this measure off and on throughout the pandemic and around every holiday such as for Eid celebrations or the summer, triggering the anger of TRA each time, as they had to cancel their family visits at the last minute or spend large sums on hotel quarantines. The Tunisian government was not the only country to adopt strict healthcare measures towards incoming individuals nor was it the only country to feel the consequences of the spread of the virus in the healthcare system. Nonetheless, TRA felt discriminated against, rejected, and infantilised by authorities who did not trust them to isolate in their private homes and still respect the measures. It is true that TRA might have interactions with a large network of people through family and friends during their visit, and that they had the potential to be super-spreaders. They contested

the measures taken by the authorities, saying that, if they had agreed that they would play their part to avoid worsening the public health situation, they would respect those measures:

> "This is nonsense. We all have houses in Tunisia. We are responsible enough to stay in our houses for a few days. We agree that those who do not respect the measures can even have their passport taken away" (Fakher, June 2020).

Communiqué

L'Ambassade de la République Tunisienne à Paris informe les membres de la communauté tunisienne en France que le Gouvernement Tunisien a pris les nouvelles mesures suivantes concernant le confinement sanitaire obligatoire des Tunisiens arrivant au territoire national de l'étranger :

1- **Principes généraux :** obligation de se soumettre au confinement sanitaire, pendant une semaine et à la charge des revenants, dans l'un des hôtels réservés à ce sujet. Le reste de la période du confinement obligatoire dépendra des résultats des tests médicaux qui seront effectués gratuitement par les services du Ministère de la Santé.

2- **Choix des hôtels de la part des revenants :** une liste nominative des hôtels qui serviront de centres de confinement obligatoire, a été arrêtée. Ces hôtels, répertoriés en catégories 3, 4 et 5 étoiles, appliqueront les tarifs suivants par personne (pension complète + frais de transport de l'aéroport à l'hôtel) :

- Hôtels de catégorie 3 étoiles : 60 dinars en hors taxes.
- Hôtels de catégorie 4 étoiles : 80 dinars en hors taxes.
- Hôtels de catégorie 5 étoiles : 100 dinars en hors taxes.

Les personnes intéressées trouveront ci-après la liste des hôtels réservés au confinement obligatoire et qui sera actualisée régulièrement si nécessaire. **A souligner que ces personnes doivent obligatoirement choisir l'un des hôtels figurant exclusivement dans cette liste, procéder préalablement au règlement de leurs frais de séjour et présenter le justificatif de ce règlement lors de l'opération d'enregistrement aux vols retour vers la Tunisie.**

Figure 22: Press release detailing the quarantine measures in hotels designated by the Authorities.

Source: Taken from the Facebook page of the Tunisian Embassy in Paris, 10 June 2020.

They felt sidelined even though they had promptly responded to the calls of authorities to support Tunisia during the pandemic or at any point in time when Tunisia experienced difficulties. They reminded the authorities of their obligation to treat all citizens equally as well as of the economic contributions made by TRA:

> "We remind you that Tunisians living abroad no longer need to prove their engagement in times of crisis. How are they rewarded? By depriving them of their constitutional right of access to their country like the rest of the citizens ... We insist on the principle of equity between all Tunisians and members of their families for the return to Tunisia and not to make this return almost impossible by opting for such discriminatory

measures" (Open letter to the President of the Republic and the President of the Government, signed by forty associations of the diaspora, February 1st, 2021)

Finally, in June 2020, the Ministry of Foreign Affairs announced a significant change in fees for consular services. Although the authorities said that the rise was not meant to discourage Tunisians abroad from returning during the summer of 2020, the decision to implement these changes at this particular time was perceived by Tunisians abroad as an additional provocation and a lack of attention and lack of recognition of the hardship experienced by TRA during the pandemic. The confrontation went on for weeks, and protests were organised in front of consulates in Brussels, Paris, Marseille and other European cities. The subject was also debated in the media in Tunisia, where association representatives expressed their disagreement loud and clear on national radio programmes. However, it seemed that, if TRA wanted to be considered full-fledged citizens, they also had to honour the obligations that derive from that right, including financial obligations. The role of the diaspora was debated in a media exchange between a journalist in Tunisia and diaspora representatives:

> "Just like the locals who put their hand in their pocket to help the State, Tunisians abroad must put their hand in their pocket and help this same State, since they are not less patriotic than the locals. They can have all the rights like the locals, but they must have the same obligations" (Business news, by Nizar Bhaloul, Les Tunisiens de l'étranger ont une « *richa* »[74] sur la tête, 28 May 2020).

The obligations are therefore both moral and economic. TRA not contributing financially to the national effort become disengaged from the moral economy and risk being stigmatised. This echoes the work of Lacroix showing how, if migrants were to fail to fulfil their obligations, they "would be accused of being selfish ... The moral economy is an economy of shame" (2019: n.p.).

2.3. From "admired" emigrant to "threatening" emigrant

Geisser and Limamn's (2018: 431) account of the ways dual nationals have been portrayed in Tunisia at different points in time shows that they have regularly been the object of accusations of "double allegiance" or even "patriotic betrayal," with the "purity" of their identity

[74] Literally translated, the term *richa* means 'feather'. Having a feather on the head is used to refer to people who are seen or perceived as being affluent or privileged. The expression is commonly used to denigrate and devalue a person or a category of people who are perceived as affluent.

questioned.[75] They emphasise in that regard that "the category of binational remains a precarious political resource here and there" (ibid.). Schnapper taught us that this negative representation of the diaspora takes its roots at the time of the triumph of the nation-state when national citizenship was posed as a founding value of state solidarities (Schnapper 2001). "The very idea of diaspora challenges the principle of modern political organization" (ibid: 11) and thus, diaspora took on a negative value, questioning national allegiance and creating social spaces beyond the control of the political order. Diaspora members were therefore accused of being "strangers within the gates" (ibid:13), the "paradigmatic Other of the nation-state" (Tölölyan 1991:3). In the case of the Tunisian diaspora, Pouessel (2017) reminds us that they have always been considered as a "somewhat different element of the community, as people leading split lives" (Pouessel 2017: 205). She further suggests that their involvement after 2011 in the reconstruction of the country could be perceived as an "intrusion from outsiders" (ibid.) The contested "purity" of TRA and its xenophobic undertone brings us back to migrants' representation as the "foreign diseased body" (Haper and Raman 2008).

Diaspora representatives reacted by reiterating the contributions made by TRA through various forms of remittances. In a Facebook Live feed, a well-known activist responded:

> "What is important to note and to remember is that there are two main types of expenditure [made by TRA to Tunisia]. One-third of the money flow is allocated to health expenditures - to pay for medication, consultations, and transportation, knowing that we get robbed by private clinics when we are the ones paying. There are practices back in the *bled* that are scandalous. We should be considered full-fledged Tunisians, but we are considered cash cows, even as a state logic. The second most important flow [of remittances] is for education… It is important to remind everyone that where he [TRA] invests, is where the state is failing to provide. Money from TRA could be used to invest for the creation of employment if we didn't have to cover for the state failures" (Video extract from Nadia Chaabane[76], association advocate, feminist activist and Tunisian politician, 31 May 2020).

[75] Tunisia adopted the principle of dual citizenship in 1975, recognising that Tunisians in Europe would probably not return to Tunisia but would settle permanently in Europe (Brand 2006).

[76] Nadia Chaabane is an activist involved in the General Union of Students of Tunisia, the Association of Tunisians in France and the National Collective for Women's Rights. She completed her studies in France and returned after the revolution to engage herself in politics, was elected in the French constituency for the *Pôle démocratique moderniste*, and later joined la *Voie démocratique et sociale,* both on the left of the political spectrum.

The tensions highlighted the perception that TRA have of their role and economic weight as "saviors of their community and the national economy" (Onoma 2021:659). They clearly stated their representation of their role as substitutes for the State, having to take on their shoulders the responsibilities that authorities are failing to fulfil. Schühle (2020) stresses in that regard that, "remittances - be they economic, social or medical - often fill voids created by absent state services" (Schühle 2020: 304). We see here the confrontation between different representations of moral authority. The diaspora, given its economic weight, does not accept the dismissal of its moral authority. Geisser and Liman (2018: 431-432) note that, suspicions formulated against TRA in 2013-2014 for being "bad citizens" resulted in disillusionment among the diaspora and a re-evaluation of their engagement with their country of emigration. They no longer accepted being sidelined in the public life of the Tunisian State and adopted a critical posture.

As already mentioned in Chapter 3, taking care of relatives' health back home is part of the moral obligations of emigrants, thus defining a moral economy between migrants and non-migrants. However, as expressed through their revindications and following an implicit logic of "gift"/ "counter gift" (Mauss 1923), these financial resources must bring in return symbolic and moral resources, which Gowricharn (2004) labels "moral capital".

Negotiations were engaged in every time the authorities implemented what TRA considered "discriminatory measures". Arguments on social media reflected the power struggles at play, with Facebook posts of TRA threatening to stop sending money back home or to stop coming on holidays and thereby taking money away from the tourism industry. Indeed, Tunisians from the diaspora return every summer in very big numbers and make a significant contribution to the tourism industry every year. Comments such as: "let them close the borders and we shall see how long they would survive without us" (Facebook post, Tunisian in France, 12 May 2020) were provocatively posted on social media, once again expressing their resentment towards Tunisian authorities.

Although they partially succeeded in making their voices heard, as the State provided a response for body repatriation, reopened their borders without restrictions to non-resident nationals before summer 2020 and also lowered the consulate fees early 2021, a certain feeling of disappointment prevailed. Also, when the collective ATE COVID 19 circulated their assessment report to all its members before putting an end to their activities, they wrote: "It should be noted that this period has accentuated the impression that TRA do not matter to the Tunisian government" (Moral assessment report ATE.Covid 19, 15 June 2020). In an editorial published

on the platform *Tunisie numérique* titled "TRA, come home, if you dare?", a journalist and founder of the journal of the Maghrebi diaspora, *Maghrébins du Monde*, wrote:

> "Tunisia has chosen to commit identity suicide by dividing its children and driving out a fringe of the population that is reputed to be faithful to and invested in its homeland, and by attacking the economic and social spearhead, the TRA ..." (Tunisie numérique, by Haythem Frioui, *TRE, rentrez chez vous, si vous osez?* 25 June 2020).

Relations between the diaspora and the authorities of the country of emigration are also based on representations assimilated by the diaspora itself regarding the expectations that the authorities of the country of emigration have of it. The Tunisian diaspora perceives - without necessarily accepting - that it is historically expected from them to be loyal to the government in place in the country of emigration. Thus, if many actively contest the politics of the government in place, they are nonetheless concerned about improving the living conditions of their relatives in Tunisia and "their aspirations are clarified by a moral feeling of commitment and loyalty towards Tunisia" (Delahaye and Tejada 2019). This ambivalence highlights sometimes conflictual loyalties: family loyalty versus national loyalty (Gouirir 2018). They thus demarcate allegiance to the country of emigration and allegiance to politics, which have long been juxtaposed in the history of the Tunisian diaspora's relationship with its country of emigration. It is indeed a redefinition of the moral economy that is at stake here.

When digging into press releases from the Coordination of Tunisian Immigration (CAIT) in 2014, after the establishment of the new constitution following the revolution, it is interesting to observe that the same tensions and the feeling of disdain from diaspora associations from the Tunisian authorities return in a cyclical way albeit on different issues. At the time, Tunisian associations from the diaspora had already deplored the lack of consideration from Tunisian authorities:

> "We note that the last Tunisian government, like the previous one, preferred to voluntarily dismiss us from the debate and consultations in order to minimize the role we are able to play in the organization of the affairs of Tunisian immigration and participation in development on the economic, cultural, social and civic level ... Tunisia belongs to all its citizens from inside and outside, the fight for our rights here and that

continues whatever the government in place." (News release, CAIT, MILAN Declaration February 1st, 2014)[77].

The Tunisian state, not fulfilling its part of the contract, questioned, once again, the moral economy that underlies the relationship with their diaspora, which triggered a reaction from its members. Through their thorough mobilisation against stigmatising discourses and actions formulated against them, TRA reminded the authorities that they were not "passive actors of their national destiny" (Geisser 2016:10) and reclaimed their bi-national belonging not "as a disembodied identity but as a creative alchemy" (ibid.). This ambivalent position, between "double presence" and "double absence", provokes a need to reaffirm their presence among the diaspora: "It translates into a feeling among dual nationals that they are no longer subject to the policies of their country of emigration, but that they contribute to making them, offering multiple horizons of action, aiming to re-found the bases of their citizenship here and there" (Geisser and Limam 208: 418).

In the following section, I attempt to demonstrate how the mobilisation of the Tunisian diaspora towards their country of emigration during the pandemic marked a strong moment of rendering explicit the moral economy that underlies the relationship between the Tunisian state and the Tunisian diaspora. Indeed, this moment highlighted the representations and expectations of these two groups of actors concerning their expected roles and responsibilities towards one another. In expressing these representations, values, expectations, and emotions, emigrants are, as we shall see, reminded of their ambiguous position in the country of emigration: if they are courted for their remittances, their skills, or their electoral support, they must also fight against negative representations of the emigrants as a foreign body to the nation.

III. Diaspora engagement in Tunisia during the pandemic: negotiating its membership to the emotional community

This section of the chapter explores how the Tunisian diaspora continuously navigates the ambiguity of its membership in the national community. Often considered an agent of development, several diaspora groups organised campaigns during Covid-19 to address the

[77]https://www.leconomistemaghrebin.com/wp-content/uploads/2014/02/Coordination-CAIT-Milan-Corrigé-1.pdf

medical needs observed in the country, thus constantly interrogating the relationship between the diaspora and the State.

1. Diaspora as agent of development

From the beginning of the pandemic, Tunisian authorities expressed on different occasions their expectation of loyalty from the Tunisian diaspora. Tunisian authorities created a diaspora fund as early as during the first months of the pandemic (Spring 2020) and invoked the responsibility of their nationals abroad to support Tunisia.

> The Embassy of Tunisia in France urges Tunisians living in France ... to actively contribute to the support of health institutions in Tunisia through donations in kind - medical and paramedical equipment and materials - or in monetary form ... The Embassy will work to coordinate the collection of donations in France, its facilitation and ensure its delivery, as soon as possible, to Tunisia... The Tunisian civil society in France... has always been present alongside the Tunisians. (Facebook page, Tunisian Embassy in Paris, 11 July 2021).

Emigration states often reach out to their diaspora "as a key resource -mobilisation actor whose philanthropy can sustain the post-disaster recovery process" (Vintila and Konstantinidou 2022) and diasporas often respond by supporting relief programs (Esnard and Sapat 2016; Sewordor *et al.* 2018; Koinova 2018; Shivakoti 2019). The role of the diaspora towards their country of emigration in times of crisis has often been studied from a developmental perspective. In that logic, diasporas are portrayed in the grey literature as powerful actors able to promptly mobilise to respond to the needs of the country of emigration when a crisis occurs. In a recent ICMPD report on diaspora mobilisation during the Covid-19 crisis, the diaspora is defined in this context as "a group of persons … [that] have contributed, or are interested in contributing, to humanitarian relief efforts" (ICMPD 2021), meaning that, according to ICMPD, concrete support to the country of emigration is a precondition to be considered a diaspora. In the discourse of development institutions, policies should therefore be put in place to favour the involvement of the diaspora in support of the emigration country. Diaspora is here considered through a utilitarian perspective (Ionescu 2006) as a resource whereby "the ultimate defining indicator is whether the actors engage in development policy" (Weinar 2010: 78) in the home country.

Diaspora as "agents of development" contribute economically through investment, transnational entrepreneurship and transfer of skills (social remittances) as well as politically through their participation in elections and the promotion of the interests of their country of emigration (political remittances) (de Haas 2006). As a result, they have raised governments' interest as important actors in the international political sphere (Vertovec 2005). To foster the links with their emigrant population, states of emigration have implemented, political representations, investment programs and cultural and symbolic initiatives institutions in charge of emigrants. The literature on diaspora policies has abundantly illustrated the emergence of diasporas as a specific category demanding government intervention, including in terms of social protection (Agunias and Newland 2012; Collyer 2013; Ragazzi 2014; Délano Alonso 2018; Gamlen 2019; Lafleur and Vintila 2020; Dufoix 2008). This literature has identified a range of economic (e.g., capturing savings remittances and returning high-skilled workers), political (e.g., adjusting to neoliberal forms of governance, see Ragazzi 2014), or electoral (e.g., capturing diaspora votes, see Lafleur 2013) factors justifying the adoption of such policies and programs.

The economic role of the Tunisian diaspora, as I have demonstrated earlier, is anchored in the historical construction of diaspora-home authorities' relations and defines the moral economy between these two actors. While Tunisia, at the time of its independence, initially opposed labour emigration, it did, however, develop controlled labour emigration in the mid-1960s, and signed bilateral emigration agreements with the main countries of residence (1965 with France and 1969 with Belgium) in order to reduce pressures on the Tunisian labour market and encourage remittances (Jaulin 2014; Kriaa 2013; Gsir and Mescoli 2015). From the 1960s onwards, one of the main objectives of Tunisian emigration policy was to encourage remittances from its workers who left for Europe (Mabrouk 2010). In addition to the repatriation of bodies presented earlier, the Tunisian state set up a number of diaspora policies to foster their bonds with their homeland and to boost remittances. Ben Ali attempted to further reinforce allegiance of TRA and implemented several populist social protection mechanisms (Harrigan and El-Saïd 2014), establishing "a clientelist relationship" (Zederman 2018) between the diaspora and the authorities of their country of emigration. As stated by a consular official in Brussels during an interview: "we were in a win-win situation: we get you rights… you bring in foreign currency" (Kenza, consular official, interview Brussels, 31 March 2021). As Abed - former activist against the Ben Ali regime - pointed out, many of these initiatives constituted social gains that still exist today and "one cannot ... deny the social initiatives they [successive Tunisian governments]

have taken ... even if the purpose may be questionable" (Civil society representative, online, 19 October 2020). The Office of Tunisians Abroad (*Office des Tunisiens à l'étranger-OTE*) under the Ministry of Social Affairs was established in 1988 and was in charge of social, administrative and cultural support to TRA. The social *attachés* designated by the OTE in Tunis were sent within consulate structures and embodied the dialectic of assistance and control (Zederman 2018) envisioned by the authoritarian State. The OTE and its social attaché still exist today and continued their mandate of social assistance toward TRA but, since the revolution, has no longer been a surveillance instrument of the Tunisian State. The role of the social attaché continued to affect, long after the revolution, representations of state institutions in the eyes of TRA, who distanced themselves from their administrations and consular services (Martin 2013).

After the 2011 elections, the new government recognised the potential contributions of the Tunisian diaspora to national development efforts and deployed a "contact policy" (Dufoix 2010) by creating a specific migration department within the Ministry of Social Affairs. The creation of the Secretary of State for Migration and Tunisians Abroad (SEMTE) in 2011 demonstrated the government's willingness to involve its diaspora in national development strategy (Delahaye and Tejada 2018). Moreover, TRA gained political rights and in 2014, the country ratified a law making it possible for TRA to become representatives in the Assembly as well as making it possible for dual citizens to become President (Pouessel 2017). The national development plan (2016-2020) further reinforced measures to engage diaspora in development through the creation of new opportunities for promoting trade and business links, entrepreneurial activities and for the transfer of skills and experience, particularly in terms of technology transfer and diaspora investment as well as academic and scientific exchanges (Delahaye and Tejada 2019).

The Tunisian diaspora has therefore always taken part in efforts to improve the economic situation in Tunisia by remitting money for education, health, consumption (including spending in the tourism industry when they return for the holidays), as well as real estate expenses (Bouchoucha *et al.* 2011). Remittances play an important role in preserving the financial balance of the state as well as for the implementation of regional development policy, regional investment and the functioning of local economies (Kriaa *et al* 2011).

The Tunisian diaspora has also long been involved in humanitarian initiatives in Tunisia through their civil society network, undertaking several initiatives every year to support families in need. For instance, every year in August and September, several associations across the diaspora

collect money to buy school material for children coming from poor families. They also mobilise to collect medical equipment such as wheelchairs sent from Europe to Tunisia.

As soon as the pandemic started, a large number of fundraisers were instantly launched using participatory financing platforms such as Leechi, Helloasso and circulated on social media (Figure 23). Some of them were carried out together by diaspora actors and local actors in Tunisia.

Figure 23: Fundraising for the hospital in Zarsis

Source: Image taken from the Facebook Group, Tunisians in Paris.

This engagement of the diaspora and its contribution was regularly praised in Tunisia. During the pandemic and from my living room in Brussels, I read the news in Tunisia daily and listened to radio program where the solidarity of the diaspora was praised. On the 9th of June 2020, the radio station Express FM in collaboration with the ATUGE (the Tunisian Association of High Schools) organised a "Tunisian diaspora special day" featuring diaspora representatives from all around the world to explain the initiatives that they had been taking to support medical effort in Tunisia and to safeguard its economy. Representatives from North America, France, and the UK talked one after the other in a mix of French and Tunisian Arabic, each of them presenting the many successful initiatives taken by the diaspora throughout the first wave of Covid-19. Newspaper articles such as an article in La Presse in April 2020 titled: "*Solidarity: a diaspora as we like it*"[78] praised the diaspora:

> "Young doctors who have left to practice elsewhere, especially in Germany, have sometimes been called deserters, accused of having shirked their responsibilities. …

[78] https://lapresse.tn/59127/solidarite-une-diaspora-comme-on-aime/

> However, during crises, such as the one we are currently experiencing, the Tunisian diaspora always reminds us that it never really left the country and that patriotism is much more than a pale flag" (Karim Ben Said, La Presse, 20 April 2020).

This media portrayal of the diaspora also reflects a background level of suspicion of the diaspora, inherited from the hegemonic past of nation-states and lyricism as a symbol/ mascot of modernity (Schnapper 2001). The diaspora is also reminded of the moral obligation to support their co-nationals and prove their belonging to the national community.

2. The Tunisian medical diaspora during the pandemic

Several doctors and healthcare professionals were among the active members of the collectives trying to support Tunisia during the pandemic. As already outlined in Chapter 2, Tunisia experiences massive departures in certain professions such as doctors and engineers who leave the country for work opportunities abroad (Belhaj 2020). As a consequence, Tunisia is experiencing a shortage of doctors in certain medical specialisations.

As pointed out by Hassan, a medical doctor based in Paris who has been particularly engaged during the pandemic, "they offer on a gold platter the most competent doctors trained by Tunisia to European countries" (Hassan, November 2021). When Hassan left Tunisia in the late 1970s, debates on brain drain and the exodus of doctors were not at the point they are today, this was still a point with which he was confronted all along his career. He even expressed that for him it has become "a moral dilemma" to receive Tunisian interns in his hospital department in France, knowing that most of them would then try to remain in France or would return to Tunisia, but in the private sector. If for him there is no doubt that doctors have fair reasons to leave and that the working conditions in Tunisia have become unbearable, he still hopes that the Tunisian state will implement measures to avoid this "haemorrhage". Through his contact at the Tunisian Ministry of Health and the University of Sousse, he formulated several propositions to the State and once again deplored the inaction of the authorities:

> "If it continues that way, Tunisia will end up with an inexistent public healthcare sector. Only the middle and upper class who can afford private clinics will have access to healthcare. This has already started" (Hassan, December 2021).

Over the years, these doctors from the diaspora have built networks that span Tunisia and Europe as well as other places and have come to form a "medical diaspora". They play a role as intermediaries/brokers and as a source of transformation for the biomedical landscape in Tunisia.

The migration of health professionals to complete part of their education abroad or for work opportunities feeds "multigenerational diasporic networks of skilled health workers" (Ormond 2015: 7) that can benefit, in turn, their countries' of emigration health systems. As we shall see through the examples below, during the pandemic, these networks were useful to the healthcare needs in Tunisia.

3. Diasporic network as therapeutic network: an act of moral authority?

In Chapter 1, I discussed how the literature on therapeutic mobilities (Whittaker *et al.* 2010; Kangas 2010; Ormond 2013; Bell *et al.* 2015; Ormond and Lunt 2019; Kaspar *et al.* 2019) demonstrates how biomedical materials and knowledge circulate across borders through what has been defined as a "transnational therapy network" (Krause 2008). The circulation of medication, medical advice, knowledge and technologies take place through these networks and are triggered by healthcare inequalities and disparities in access to healthcare opportunities (Zanini *et al.* 2013) and make up what Hörbst and Wolf have defined as a "medicoscape" (2014).[79] Following Krause's concept, I propose the notion of diasporic therapeutic network to encapsulate the circulation of healthcare material and knowledge across borders through a diasporic network. Similarly to the reflection on diasporic healthcare arrangements (in Chapter 3), these therapeutic networks respond to diasporic logics and dynamics. They build on the historically constructed transnational engagement of the Tunisian civil society abroad and on diasporic representations of emotional ties, obligations and loyalty toward the country of emigration. The diasporic therapeutic network, as I will detail below, enables the circulation of various forms of medical remittances.

[79] According to Hörbst and Wolf, "Medicoscapes constitute worldwide dispersed landscapes of individuals; national, transnational and international organizations and institutions as well as heterogeneous practices, artifacts and things, which are connected to different policies, power relations and regimes of medical knowledge, treatments and healing" (2014: 184). Moreover, persons and institutions are distinctly – and unevenly – positioned in hierarchical 'power topographies' (Massey 1994, 148).

Expanding further on the notion of medical remittances first used by Zanini *et al.* (2013: 15) to describe the circulation of medication within personal networks, Schühle's definition of the term encompasses "the mobility of *materia medica*, biomedical knowledge, and biomedical services, both within close-knit individual networks … and within broader social networks" (Schühle 2020: 26). She expands the notion by "looking at medical remittances that comprise practices, knowledge, and ideas that are aimed at transfiguring entire biomedical processes or even health care system; to change health care provision not only for specific relatives or friends, but for entire patient groups in one's home country" (ibid: 304). Looking at the case of Nigerian doctors' endeavours to "give back" through medical missions and sending of medical material to Nigeria, she demonstrates the "transformative agency" of diaspora (ibid: 289) and their potential in shaping the biomedical landscape from abroad through "collectively transmitted medical remittances" (ibid: 304). According to Connell (2011), both the mobility of patients and health workers are interconnected phenomena that can impact "people, places and health systems involved" (Ormond 2015: 6). Similarly, in their study on the contribution of the Sudanese medical diaspora to the healthcare delivery system in Sudan, the authors argue that it has the potential to reverse the effects of brain drain (Abdalla *et al.* 2016). Furthermore, diasporic communities are often mobilised to fill the gaps in public healthcare (Kane 2012: 203) and by doing so "broaden the medical landscape that is normally available for their relatives back home" (Schühle 2020: 257-258).

Following Schühle (2020), it is in that perspective that I refer to the notion of medical remittances, looking at the impact of the engagement of the Tunisian diaspora during the pandemic through the sending of medical equipment, healthcare advocacy through skills transfer, and in pressuring the State to take appropriate actions. Through the narratives of two doctors from the diaspora, Zied and Hassan, I try to outline the therapeutic circulations taking place between Tunisia and Europe and the power struggle between the Tunisian diaspora and their authority during the Covid-19 pandemic. Both Zied and Hassan expressed that their engagement back in Tunisia was a way to demonstrate solidarity despite having chosen to leave the country. Their engagement through their associations (Schühle 2020) was a way to remain connected and maintain a role in the biomedical landscape in Tunisia as well as to fulfil their moral obligation. Remittances are an expression of the moral presence of the emigrant despite his/her absence from the country of emigration. In the context of this chapter, we have moved from the individual level - the emigrant towards his/her family - to the collective level of the diaspora towards the country of emigration. Emigrants' accounts of the initiatives that were

taken by the associations and collectives in which they were involved encapsulate the ambiguous position of the diaspora, its instrumentalisation (at times) by States of emigration and resistance of the diaspora caught between patriotic sentiment vis-à- vis their country of emigration and a refusal to obey its authorities. The process of redefinition of the moral economy is expressed here through economic, moral, symbolic, associative and political practices and representations underlying the management of the healthcare crisis. This moral economy implies the circulation of practices, resources, values, norms and emotions across borders.

In the sub-sections below, I describe, through the story of Zied and Hassan, the role played by healthcare professionals who have been mobilised to advise collectives and have sometimes taken a leading role in their initiatives.

3.1 The story of Zied on how the diaspora "avoided a humanitarian crisis in Tunisia"

> "When the pandemic broke out, we knew that the Tunisian health system - especially in terms of human resources, because there are many doctors who have left Tunisia since 2010 - could not cope with such a pandemic" (Zied, November 2021).

Zied is a young healthcare professional working as an anaesthesiologist in a hospital in the South of France. He moved to France as a medical intern in 2017 and has remained since then. Zied is an active member of the Association of Tunisian Doctors in the World (AMTM), a professional diasporic organisation which aims at creating a network for mutual aid, exchange, and collaboration between Tunisian doctors practicing in France and the world, but also seeks to broaden their career perspectives and facilitate employment opportunities in France and throughout the world. They also wish to promote access to healthcare in the poorest regions of Tunisia and the world through the organisation of fundraising and donations as well as encouraging and supporting any activity of general interest for the benefit of Tunisia. Frehywot *et al.* (2019) observed in that regard that the willingness to improve medical resources in countries of emigration is a common attribute of medical diaspora organisations. In doing so, they maintain professional ties and networks in both the place of residence and country of emigration. As the spokesperson for the association, Zied is regularly active on social media and also works in health journalism, publishing articles in newspapers providing analysis on the healthcare system in Tunisia, new medical technologies and also organises webinars that attract viewers from the healthcare sector in Tunisia and among the diaspora.

When discussing the position of the diaspora with Zied, he explained: “We were not going to stand still watching the entire country crumble without taking any action" (Zied, January 2022).

One of the first initiatives taken by AMTM was to establish an exhaustive inventory of the medical infrastructure in Tunisia. The initiative felt that the government lacked the foundations for a plan of action, and so aimed to provide civil society abroad and the government with a foundation on which the government could act:

> “It is unfortunate to say but in Tunisia, we have ministers who do not know their files, who do not know their figures … Their work and decisions are made without taking the time to collect the necessary evidence. The result of this is inappropriate measures. It saddens me to say so, but they are incompetent … For example, in 2020, when the crisis started, we did not know the exact number of respirators in Tunisia.” (Zied, November 2021).

Zied expresses here the legitimacy of diaspora associations to act in place of what they perceive as a faltering state. This highlights the rupture of the moral economy and the positioning of diaspora actors as a moral authority.

They started by inventorying the number of intensive care beds in Tunisia and later proceeded to an inventory of respirators and other medical equipment. Zied explained that the idea came from the thesis of a friend, which had as its focus the number of intensive care beds in Tunisia. He therefore decided to update the study and later extended it to other medical equipment. Moreover, his contacts from his medical school allowed him to easily reach out to anaesthetiologists/intensive care doctors in the hospitals in Tunisia. To establish the inventory, AMTM members mobilised their personal and professional networks back in Tunisia:

> "Most of us know at least one person with whom we have studied or worked in Tunisia or we know someone who knows someone in that hospital … so that we could always get in touch with one person in each hospital and get the right information” (Zied, November 2021).

Beyond the involvement of the diasporic network, this illustrates the use of informal ties through friendship networks to connect with medical practitioners back in Tunisia and establish knowledge transfer transnationally (Bilecen and Faist 2015). Here knowledge transmission takes place from Tunisia to the diaspora and back to Tunisia. As we have already discussed in Chapter 3, for knowledge to be transferred through informal networks, Bilecen and Faist

underline the importance of trust, reciprocity and solidarity are underlying social conditions in networks among friends (ibid.):

> "From April 2020 when I started the data collection, to November 2020, almost all the heads of hospital services who were taking care of the Covid patients contacted me to give me their needs. […] This is the "expertise sharing" component of our action, which was really essential, and which was well accepted, given the quality of the Tunisian diaspora, which has a fairly respectable intellectual level and they [stakeholders in Tunisia] respect people who are experts" (Zied, November 2021).

In addition to remittances and the transfer of material resources, migrants' skills, knowledge and social capital also constitute resources that can be beneficial in the country of emigration (Faist 2008). In order to compensate for what is often referred to as "brain drain", some scholars argue that that medical knowledge transferred from diaspora actors can benefit, in turn, healthcare systems in the countries of emigration (Opiniano and Castro 2006; Abdalla *et al.* 2016; Frehywot *et al.* 2019; Taslakian 2022).

Referring to the notion put forward by Williams of migrants as "distinctive knowledge bearers" (Williams 2007b: 366), Ormond argues that they have "the potential to access, interpret and refine information gleaned from reflection on the intersections of their own unique range of transnational experiences, relationships, networks and resources that may be of use to other social actors" (Ormond 2016: 3). The social networks of diasporas actors enable local and diasporic knowledge to converge. In the era of globalisation, "global links may be more important than the human capital 'stock' in a particular country" (Wescott 2005: 2) and professionals abroad can effectively engage from a distance.

Zied explained that they were in contact with the Ministry of Health which based some of their actions on their inventory. During the pandemic, no less than five different Ministers of Health succeeded one another, reflecting the political crisis that accompanied the healthcare crisis. AMTM invited four of them to participate in an online webinar organised by the Association to debate the appropriate actions to be taken in Tunisia, giving indication of the contacts that these diaspora actors have with the political sphere in Tunisia. Over the months, the webinars attracted an audience of health professionals in Tunisia working in different services and in different places, which facilitated the regular updating of the inventory as well as the assessment of medical needs.

Between the exchange with the Ministry of Health at the highest level as well as its contacts with the networks of healthcare practitioners in Tunisia, the role of AMTM can also be analysed through the concept of brokerage (Burt 1992, 2004). Brokers could be understood as facilitators for opportunities (Faist 2015), creating "bridges between otherwise unconnected people" (Bilecen and Faist 2015: 218). They convert their knowledge, ideas and opportunities into "creative benefits" (ibid). Skills, network and social capital developed abroad are deployed back in Tunisia.

Similarly, as part of the Covid-19 taskforce formed through the diaspora collective against Covid-19, AMTM together with other associations took several initiatives for sending medical material to Tunisia. Receiving advice from medical experts allowed the collectives to order the appropriate medical equipment and the appropriate quantities. In September 2020, when death rates were rising in Tunisia, they ordered Optiflu, a device used to manage the acute phase of Covid-19 before reaching intubation. To do so they went through Tunisians based in China and Turkey. In Turkey, for instance, they went through a Tunisian intermediary who took care of dealing with the company that produces the device in Turkey and had the material sent directly from Turkey to Tunisia:

> "There are Tunisians all around the world and I don't know exactly what they do and how it works but this person agreed to help us, and we got the material for a very good price. He probably earned something out of the deal, I don't care because for us it was very advantageous" (Zied, November 2021).

The taskforce was also active in remitting medical knowledge by providing medical counselling to the ministry of health acting here as "knowledge brokers". During the third wave of Covid-19 in January 2021, when the hospitals' capacities were getting saturated, they advised the development of hospitalisation at home (*Covid dar* initiative) and became "a leading country in the development of this specialty" (Zied, November 2021):

> "Since January [2021] we have directed the action, that was really 100% from the Tunisian diaspora. Everyone began to buy oxygen concentrators and went through us to direct them according to the inventory that we had established. So, by the end of June, we had bought about 1800 oxygen concentrators that were distributed to all governorates according to needs. Unfortunately, at a certain point in June 2021 Tunisia was the most affected country in the world but thanks to all this I think we saved at least 10 or 20,000 patients who could be taken care of at home with the oxygen concentrators. … thanks to us we avoided a humanitarian crisis in Tunisia" (Zied, November 2021).

For the sending of medical equipment (Figure 24), they collaborated with the Tunisian Union for Social Solidarity (UTSS), a state structure in Tunisia that has the mandate of centralising all the material donations coming from abroad and then dispatches them within the country. As my interlocutors explained to me, the UTSS seemed to be the only gateway through which medical equipment could go through without having to pay significant amounts of customs fees.

Figure 24: Boxes from the Initiatives « Tunisia breathes»

Source: Taken from the Facebook page of Association des médecins Tunisiens dans le monde, 22 August 2021.

For most of the people I talked to, the status of the UTSS was rather blurry. They did not know if it was an association or a public structure attached to a Ministry. UTSS is indeed a sub-structure of the Ministry of Social Affairs. For Zied however, this was not important as long as it was a way for them to get the material through customs. If I mention this here, it is because this lack of clarity on the role of such an important structure during the pandemic is symptomatic of what was perceived as a lack of transparency from the authorities:

> "There is a route called customs. The customs don't let anything enter over the border. That's it, that's how it is, it doesn't come in … The second solution is the magic solution, it is called UTSS, Tunisian Union of Social Solidarity. I still don't understand what it is. If it is a non-profit association, if it is something attached to the Ministry … I do not know but this UTSS has the right to collect everything it wants from the border. … It is a little bit strange and one day it is probably going to explode. This is how civic work functions in Tunisia: it lacks transparency, and unfortunately, there is big lobbying within this work. There are lots of question marks. Why is there just one association that has such privilege, and no other association will ever be able to gain it? … If tomorrow I want to bring equipment to Tunisia, I would not have the authorisation and would be blocked because of customs. That's how it is" (Zied, November 2021).

As we shall see in the example below, this created tensions and power struggles between several associations that did not trust the Tunisian authorities to handle the distribution of the material in Tunisia and tried to circumvent them. The moral economy is here redefined around the granting, control and access to economic, political, symbolic and moral resources. The diasporic civil society network affirms its moral authority and position itself as a legitimate actor in the management of the healthcare crisis in Tunisia, discrediting the legitimacy of the other actors involved, that of the state in particular.

3.2 The story of Hassan on the power struggles between TRA and the Tunisian State

I met Hassan in Paris in November 2021 after having followed his activities online over the course of the pandemic. I came across his name through other interviews in Paris and was advised to get in touch with him, as he led several initiatives. I was warned by people: "You will see, he doesn't mince his words" (Quotation by memory, civil society representative, October 2021). Hassan is a renowned doctor who has been active in medical cooperation for more than twenty years. He agreed to meet me at a medical congress in Paris where he was presenting his latest book. Hassan comes from a poor family and left Tunisia for France for his studies after receiving a scholarship from the Tunisian state. Thanks to that scholarship, he was able to complete his degrees in France and has remained since then. When he started to invest time in medical cooperation it was, he said, "a simple return of debt towards my country" (Hassan, December 2021). According to Hage (2002), the moral implications of departure place migrants in a guilt-inducing process within a moral economy of social belonging. Following Hage, Carling argued that "migrants are not driven into a transnational existence by a feeling

of guilt, but repaying the gift of communality is a central element in the moral framework of transnationalism" (Carling 2008: 1458) and is constitutive of a moral economy between migrant and non-migrants. In that perspective, migrants are indeed in debt towards non-migrants. As argued by Lacroix, "in cases where the authority over individuals is particularly strong, the contribution of migrants is perceived as dues by non-migrants.

The association Hassan created organises medical missions in the south of Tunisia every summer. He goes with other volunteer doctors and visits patients with special medical needs identified beforehand by fellow doctors in Tunisia. As he pointed out, cooperation with experts on the ground is essential for the smooth running of these missions as it is a fertile ground for tensions and conflicts with political and professional stakeholders (Oyeni 2017). As argued by Schühle (2020), it means working closely within the frame of local politics, which can be both helpful and disruptive (Brada 2011). For a long time, Hassan has also been in close contact with the Ministries of Health and Higher Education in Tunisia, as he also teaches at the university in Sousse and has set up an inter-university diploma in his specialty. Since he is well known in Tunisia and among the diaspora for his successful career as well as for his engagement back in Tunisia, he was involved in the taskforce as well as in the initiatives of some associations. He worked in particular with the Tunisian Association of Both Shores (T2Riv), one of the major Tunisian associations in France which has a foot in France and a foot in Tunisia, with active members on both sides. Many collaborations took place with AMTM as well as with other associations in France but also in Germany, Austria, Italy, and other countries. Together they formed a new collective named "Tunisian civil society associations abroad". They were very engaged throughout the pandemic and collected an impressive amount of funds and quantities of medical equipment for Tunisia. The amount of funds collected and the volume of equipment sent to Tunisia through these associations says a lot about the size of their networks and their ramifications. These collectives, created through social media during the pandemic and the collective sending of medical remittances, are also an occasion for their members to socialise and expand their network while reaffirming their connection to their country of emigration (Schühle 2020).

One of the initiatives they undertook was to purchase two thousand CPAP (Continuous Positive Airway Pressure) Boussignac machines (Figure 25), a type of ventilator that maintains positive pressure in the airways during the entire respiratory cycle and was used to treat Covid-19 patients in respiratory failure. Once again, the consultation of medical experts was important as it allowed the Association to purchase the appropriate medical material. Through this example,

I wish to illustrate the mobilisation of interpersonal networks for the supply of the equipment. The therapy network in which they are embedded spans several continents and corresponds to their professional and social networks (Schülhe 2020: 31). Hassan explained in that regard:

> "We agreed that we should order Boussignac CPAPs to be sent to Tunisia. So, I happen to be a friend of Mister Boussignac, who created the device. I used to work with him in the past so I knew very well the advantages of using this device. In one device, six different elements need to be put together and it comes down at a cheaper price if you order each piece separately and you put them together yourself. One of the pieces had to come from Taiwan and, here again, I happen to be a friend of the ambassador of Taiwan in Paris and we could go through him to order the pieces and facilitate its transport from there" (Hassan, December 2021).

Here, the interconnections of the diaspora actor, his accumulated networks and multi-sited paths enables efficient access to knowledge, resources and information. The literature on brokerage demonstrates that the broker's multiple ties and affiliations to several group (Simmel 1995) give him the capacity to bridge "structural holes" (Burt 1992) by connecting alters that are not linked to other alters (Bilecen and Faist 2014). Furthermore, the broker's capacity to activate his contacts at any time gives him a strategic advantage. Hassan was able to mobilise past professional networks and informal ones, giving him better access to the medical equipment.

They gathered all the different pieces in Paris and mobilised a team of volunteers to assemble the devices before they were sent to Tunisia. They an agreement with the Tunisian Ministry of Health to assist them in the transportation of the material to Tunisia through a military flight. They collaborated with the authorities but complained about their lack of engagement and having to push for things to fall into place. Hassan recalls for instance that when the volunteers came to assemble the device, the association had invited the Ambassador in Paris to come and thank the volunteers for their work but the lack of acknowledgment for their contribution left them with a bitter taste:

> "You have to imagine that it was an immense effort what we did. Getting the pieces from different countries, assembling them with all the volunteers, and preparing each set to be packed and sent to Tunisia. We invited the ambassador to come and just say "thank you". They didn't come and they never even responded to say why they were not coming. It tells you the disdain they have for our work. We even let them take credit for our initiatives when, really, they did nothing but transport the material we had paid for." (Hassan, December 2021).

Figure 25: Respiratory kit

Source: taken from Facebook page T2Riv, July 2021.

The disdain from the Tunisian authorities and the lack of recognition for the effort made by the collectives of TRA against Covid-19 are another indicator of the fragility of the moral economy between the State and the diaspora.

The cooperation with the authorities did, however, go quite smoothly for this initiative. T2Riv had signed an agreement with the Ministry of Health so that medical donations can be exempt from customs taxes. The donation was addressed to the UTSS, who was put in charge of getting the equipment through customs. That was in April 2021. A couple of months later, the summer wave of Covid-19 was already starting and all the signals were turning red. The political climate was also deteriorating and a certain panic could be felt in Tunisia and among the diaspora who were accelerating their initiatives while the State was absent. As early as May, a collective of dual nationals published a piece in the newspaper *Le Monde*[80] asking for the intervention of the international community before the official visit of the Prime Minister, Jean Castex, in Tunisia in early June 2021. On the 8th of July another petition was written and circulated:

> "The extreme gravity of the health situation in Tunisia is treated with indifference. While the epidemic of Covid-19 ravages Tunisia, while civil society abroad tries to help

[80] https://www.lemonde.fr/afrique/article/2021/05/18/tunisie-les-acquis-democratiques-pourraient-s-effondrer-du-fait-de-la-crise-provoquee-par-le-covid-19_6080591_3212.html

> the victims, our President of the Republic is in his bubble. Mr. President of the Republic, Mr. Head of Government, Mr. Deputies, Tunisia must be declared a disaster area and must ask for international assistance. Our difficulties go beyond our borders**"** (Amicale de Médecins d'origine Maghrébine de France, Société civile Tunisienne à L'étranger, Compétences Tunisiennes à l'étranger).

These diaspora actors were once again, playing the role of brokers or "intermediaries" between the authorities in their country of emigration and the authorities of their country of residence, illustrating their embeddedness in both political spaces as multinational citizens. In their reflection on the concept of diaspora in a transnational world, Schnapper (2001) emphasised that diaspora have indeed often played the role of intermediary and fulfilled the social function of organising exchanges between the country of settlement and the country of emigration. Diaspora was in fact referred to in scientific literature as the "intermediate minority" (Bonanich 1973; Raulin 1991) stressing the role played by these actors in the country of settlement. Regarding the Tunisian diaspora specifically, Geisser and Limamn demonstrate their role as "mediators and connectors of political spaces between countries of emigration, countries of residence and Europe" (2018: 423). This was a position some collectives openly stated when they announced their intention to make the bridge between authorities in Tunisia and authorities in the European Union at the beginning of the pandemic:

> "The democratic associations and actors of the Tunisian civil society in Europe affirm with force their determination to mobilise in particular with the European authorities and international organisations, and to carry out initiatives in order to help our country … to face this crisis. At the same time, we intend to take our place in our countries of residence to act usefully and sustainably as citizens in the actions of prevention, monitoring, information and communication and by engaging in various concrete acts of solidarity" (News release Collective ATE.COVID19, 22 March 2020).

It is hard to estimate the impact of these initiatives on the responses from authorities both in Tunisia and in Europe. According to the actors with whom I have discussed the matter, the position of some of the diaspora "leaders" involved in the political scene in France and Belgium accelerated donations of vaccine shots. In Belgium, for instance, a Tunisian scholar working in a Belgian university (and a close friend of Hassan) advocated for the Tunisian cause together with a politician, himself a second-generation Tunisian in Belgium, which according to Hassan,

resulted in the sending of 150,000 vaccine shots.[81] Moreover, the intervention of the international community was indeed partly triggered by the initiative #Save_Tunisie, #Vaccine_For_Tunisia launched by civil society actors in Tunisia and abroad who circulated a petition demanding the intervention of the international community, which went viral on social media.

Already a few weeks ahead the Covid-19 peak, T2Riv launched another fundraiser to purchase oxygen concentrators. Different initiatives were taken over the weeks. Among them were *"Oxygen for Tunisia*", "*Kairouan breath*", and "*Tunisia breath*", which all aimed at collecting oxygen concentrators and other health equipment such as masks and antigen tests. Faced with the urgency of the situation, they wanted to move faster by transporting and making the equipment go through customs without mobilising the UTSS and thus avoid administrative slowdowns. They also wanted to reassure donors, as many voiced reservations regarding the use of the donations. On Facebook, individuals were discussing ways of travelling with oxygen concentrators for their families: "What if each of us brings a concentrator back home?" (Facebook post, Tunisians in France, 6th of July 2021). The comments under the post once again demonstrate the negative perception of state institutions: "It is not going to pass through customs! Knowing them [customs], they will confiscate them and sell them". Moreover, donors also wanted the equipment to go to certain regions in Tunisia and did not want the Ministry of Health to decide where they would reallocate the donations. Here again, suspicion of the State favouring certain regions at the expense of others was part of the association's argument to not hand the equipment to the Ministry of Health.

When discussing with Montassar, an officer from the Ministry of Health, in June 2021 about the way they organised the collection and distribution of medical equipment, he explained that, before anything else, the material has to go through a quality screening before being distributed, which of course takes some time. Secondly, he pointed to a misunderstanding with a fringe of the diaspora as people expressed their discontent with the State wanting to centralise all the medical equipment donated and then distribute it throughout Tunisia, starting with the most affected area: "people want the equipment to go where they have their families, but we have to respond to other priorities" (Montassar, civil servant from the Ministry of Health, Interview Tunis, June 2021).

[81]https://www.levif.be/belgique/la-belgique-envoie-une-aide-durgence-a-la-tunisie/#Echobox=1626941919

The suspicion of corruption since the beginning of the pandemic had contributed to discrediting authorities. As mentioned earlier, at the beginning of the pandemic, the Ministry of Health created a fund. It communicated a list of certified medical and sanitary equipment along with a list of suppliers from which associations could order the material they wished to donate. The Fund 1818 has been at the centre of a controversy when part of the money was reallocated to expenditures that were not initially planned by the Ministry of Health. This created a certain mistrust, and authorities were pinpointed for their lack of transparency on how the money had been used and accused of corruption. Tunisian associations abroad clearly expressed their disagreement and threatened that they would no longer send funds if they had suspicions of corruption: “before asking us to help Tunisia again to fight against Covid-19, we want an audit of the Fund 1818” (Facebook post, Tunisians in Belgium, 30 June 2021). According to Montassar, as the healthcare crisis lasted longer than they had initially expected, they indeed allocated some of the funds to expenditures that were not planned at the beginning of the pandemic (such as transportation for the medical material to be distributed in the regions) but he of course refuted accusations of corruption.

According to Ayoub (former leftwing activist, founder of the *Perspectivistes* movement in France) the controversy around the Fund 1818 is indicative of "the change of interest of Tunisians with public ‘things’" (Interview in Paris, October 2021). The revolution transformed the relationship with the State. While before there was a form of fatalism, submission, now they are “head-to-head". He further argued that "the state had failed in its responsibility to protect its citizens", notably with regard to vaccination, and, in doing so, they opened the floor for criticism, contestations, and interference in the management of the healthcare crisis. This weakening of the position of the Tunisian state vis-à-vis its diaspora is indicative of the rift that emerged at the time of the revolution, transforming their power relationship and calling into question the requirement of loyalty to the Tunisian authorities. Summarising the change in values underlying the relationship between the Tunisian state and the diaspora, Kenza, a consular official in Brussels, explained that the perception of governance had completely changed:

> "I vote, I pay taxes, so I have the right to know where my money is spent. Today, there is almost a lack of trust. With Covid-19, we are in a state of mistrust." (Interview conducted in Brussels with Kenza, consular official, on 31 March 2021).

Therefore, it came “naturally” that, in light of the State disengagement during the pandemic, the Tunisian diaspora was within its rights in voicing its opinion and seeking to be involved in

the management of the crisis. Bruneau (2010) suggested in that regard that, if “lobbying in favour of their origin society is not uncommon among diasporas, … neither is resistance against instrumentalization by the homeland” (Bruneau 2010:37). In the same perspective, Geisser and Limamn argued that expressions of distant nationalism from the Tunisian diaspora was always the result of “subjective reconstructions, critical or even dissident reappropriation” even at the time of authoritarian and paternalistic politics of allegiance - the result of a “diasporic subjectivity” (2018: 417) As formulated by Hassan:

> "The revolution has had a beneficial and unifying effect on Tunisians abroad. Why? Because before, people were afraid of each other. They were afraid of their institutions because they thought that anyway the embassy are all cops who make their reports. Then you could say things without fearing anything, whereas before if you say something, you are arrested at the airport. So, this has given confidence to the Tunisian civil society abroad - confidence in themselves and confidence in their country and its institutions in the sense that they were no longer afraid to contest them (Hassan, November 2021).

This show of strength between the authorities and the associations resulted in the medical equipment being blocked at customs for weeks, sometimes months. Furthermore, in the meantime, President Kais Saïd led a coup on the 25th of July 2021 which transformed the power dynamics. Hassan explained that “the first time [they] went through easily through contacts, but after the 25th of July everything changed and [they] didn't know who to contact anymore”. After much wrangling, they had to pay customs fees (14,000 USD) for part of the material and they agreed to hand the rest of the medical equipment to the UTSS, as they could not afford the customs fees that they were asked to pay (24,000 USD) for the rest of the equipment to go through. It still took a few weeks after they had agreed and finalised the administrative formalities for the material to be distributed by the UTSS. In the context of the public health disaster that the country was going through, the inflexibility of the State in reacting to the emergency and to adapt its procedure in the context of the crisis was the ultimate proof of the State's incapacities:

> “They ask for help, you do everything you can to help them and they ask you to pay … They coldly let people literally suffocate while oxygen concentrators were stored at customs. This is more than incompetent leadership, it is criminal leadership. It is unbearable … They did not move. They are guilty.” (Hassan, December 2021)

Through the conflicts and collaboration in the management of the healthcare crisis in Tunisia, this case illustrates how State and diaspora actors construct and negotiate the moral economy shaping their relationship. This case thus allows us to identify the tensions stemming from the formal role played by the actors as well as their moral obligations, and the evolving nature of their expectations in a context of a health crisis.

Conclusion

When thinking about the tensions crystallised by the Covid-19 crisis between the Tunisian diaspora and their country of emigration, it is interesting to question where these tensions come from, and how they are shaped by long-standing social dynamics (Onoma 2021:659). According to Onoma, “in many areas of the Global South, migrants are at once celebrated and vilified, embraced and distanced, and they simultaneously provoke envy and repulsion” (ibid). From the same perspective, Lacroix (2019) suggested that emigrants are simultaneously the object of great interest and great injustice while Kleist argued that “diaspora belonging is simultaneously emphasized, celebrated, and objectified” (2013: 287). If they are praised for their economic success abroad, they are also perceived as “socially disruptive”. This long-lasting ambivalence in diaspora-homeland relationships has also contributed to the strength with which emigrants were rejected at the beginning of the pandemic and held responsible for the spread of the virus (Onoma 2021).

According to Hassan, this distancing between Tunisians in Tunisia and "those from outside" exists historically because the emigration was primarily economic and therefore emigrants’ economic success created a gap between what used to be called “the Tunisians workers abroad” and their families in Tunisia. Then with social media and communication, they started to see how “Tunisians from Aulnay-sous-Bois are living in misery and Tunisians living abroad were both admired and pitied” (Hassan, December 2021). Later on, emigration became an emigration of competencies, which, according to him, created a hole in Tunisia, explaining a certain resentment from those who have no other choice than to stay and who chose to stay. He further argued that TRA are sometimes perceived as presumptuous or even arrogant because they have become used to living in "real democracies":

> “In Europe, when you have a right, you have it. So, the TRA, when he comes back to Tunisia after some time, he doesn’t accept these aberrant rules anymore, nor does he

> accept the humiliations from authorities. So, people think that we are presumptuous and arrogant. This misunderstanding exacerbates tensions." (Hassan, December 2021)

As we have seen in some of the arguments taking place between TRA and Tunisians in Tunisia, the pandemic highlighted the inequalities at stake between those who stayed and those who have left. The disparities in access to healthcare opportunities acted as a painful reminder of the social, economic, and political inequalities between TRA and Tunisians in Tunisia and, in particular, in the political context of summer 2021. In March 2020, Tunisian authorities declared that the number of intensive care beds in all public health facilities was less than 300, that 90% of the medical infrastructure was concentrated in four of the country's 24 governorates, and that most of the public facilities were not at all suitable to receive people infected with Covid-19. The public health care system, which had been deteriorating for decades, had to face shortages of multiple types of equipment (medical masks, sterilisation equipment, ambulances, medical oxygen cylinders, artificial respirators) as well as shortage of medical specialists (such as the insufficient numbers of intensive care anaesthetists) (Gobe 2021).

Inequalities became particularly evident on the point of access to vaccination. Tunisia was most affected when more than half of the population in most European countries had already been fully vaccinated. TRA had recovered their mobility through their vaccination pass, allowing them once again to travel back and forth between Tunisia and other countries with limited measures they had to respect (PCR test before flights etc.). On the other hand, in July 2021 in Tunisia, only 5% of the population had been fully vaccinated, and some of those had been vaccinated with vaccines that did not give access to the European health pass. Visas had already become even more difficult to obtain (in particular French visas, which became more restrictive in 2021), and the sanitary pass created another layer of isolation. As formulated by one of my interlocutors a few weeks after the coup enforced by the president Kaïs Saïd: "in Tunisia, despite all our willingness, we remain trapped by the political ambitions of some" (Ali, civil society representative in Tunis, August 2021).

The disparities in income, of access to medical materials and services, structure the relationship between the diaspora and the country of emigration. This led to a feeling of inequality that was expressed by Tunisians in Tunisia to their co-nationals abroad:

> "You decided to acquire another citizenship, it was your choice. Here we have nothing and we cannot escape to a country with better healthcare if we want to, so respect us and don't come to Tunisia" (Facebook comments, Facebook group Twenza in France, 26 March 2020).

Some Tunisians residing abroad decided to return to Tunisia at the beginning of the pandemic in order to escape the healthcare crisis which was intensifying in Europe. The fact that they still enjoyed the privilege of having a "safety-net" in the form of the possibility of moving back to their country of residence if the situation in Tunisia (in particular in terms of healthcare infrastructure) got out of control, reactivated tensions around the inequalities at play and led to rejection of TRA.

As I have shown, this ambivalent position between "double presence" and "double absence" led the diaspora to reaffirm its presence and led to an expression of a distant nationalism that is not imposed but chosen (Geisser and Limamn 2018). They thus reasserted the demarcation between allegiance to the country of emigration and allegiance to politics, which had long been juxtaposed in the history of the relations of the Tunisian diaspora with Tunisia. As illustrated by the involvement of associations in the search for solutions to the health situation in Tunisia, the position of the State had been once again weakened. In the face of the state disengagement in the management of the healthcare crisis, Tunisian civil society in Tunisia and abroad reclaimed their legitimacy as being a pillar supporting the well-being of their homeland, revealing "the way that moral sentiments have become generalized as a frame of reference in political life" (Fassin 2012a: 247). Fassin argued that humanitarian governments are formed out of two contradictory poles: the politics of compassion is both a politics of inequality and a politics of solidarity (Fassin 2012). For Schühle (2020), if this contradiction is the fact of the humanitarian domain in general, it is particularly salient when initiatives are led by diaspora actors and healthcare professionals in particular, as the encounter of two unequal biomedical landscapes (the one of healthcare professionals from the diaspora and the one of healthcare professionals in Tunisia) shed light on inequalities:

> "When medical services or skills are remitted by migrated health professionals, the dichotomy between "us" and "them" is blurred, and at the same time often entrenched" (Schühle 2020: 351).

As I discussed in Chapter 3, Faist and Bilecen define inequalities as "unequal access to material and symbolic resources, social status and power-that is the ability to enforce decisions and ways of thinking" (2015:193). In their paper, they consider the role of informal transnational social protection and its implication for social inequalities. They argue that, if cross-border social protection has the potential to respond to social risks and inequalities, it may simultaneously "perpetuate old inequalities and create new ones" (ibid: 194). From that perspective, medical remittances sent by the diaspora acted both as tool to respond to the healthcare risks of their

relatives and co-nationals in Tunisia and, at the same time, asserted inequalities of access to healthcare resources.

The engagement of the diaspora was triggered by the emotional character of the crisis while the fragmented political class in Tunisia impeded actions taken by authorities. The use of emotions and the reference to values guiding the diaspora as opposed to a state perceived as failing by the diaspora was a crucial element of the strategies of mobilisation. As expressed by Lotfi, a civil society representative based in Paris:

> "There are strong emotional ties that connect me with these people, which correspond to my political and personal commitment for a better life for these people" (Lotfi, October 2020, online interview).

When the state transgresses the values induced by the moral economy guiding its relations with the diaspora, the relationship between these two actors is immediately put under tension. As I have illustrated, the perception by the diaspora that they are being unilaterally challenged by the state pushes them to mobilise the register of values and emotions. By threatening to no longer behave in accordance with the expectations of the country of emigration, the diaspora hopes to remind the state of its obligations by raising fears of a loss of legitimacy.

The analysis of the mobilisation of the Tunisian diasporic therapeutic network during the Covid-19 crisis shows the relevance of a moral economy approach to understand the relations between diasporas and States of emigration. In so doing, this chapter illustrates the need to move beyond purely utilitarian frameworks of analysis of diaspora-home state relations that primarily identify the economic or political influence of the diaspora as an explanatory factor of state behaviour. On the contrary, this chapter calls for a better consideration in the study of state-diaspora relations of the role of "crises" and of the place of emotions, norms and values as explanatory variables of the evolution of these relations safeguarding the fragile balance of the "emotional community". Breaking with the values that underlie the moral economy governing diaspora-state relations implies jeopardising the consensus between home states and diaspora.

General Conclusion

1. Thesis Overview

In this thesis, I explored how transnational healthcare arrangements and diasporic networks shape health outcomes and the healthcare access of Tunisian migrants. The different chapters have examined, from different points of view, the multiple strategies that migrants employ to navigate healthcare systems across borders, emphasising the interplay between formal and informal mechanisms, the impact of socio-economic disparities, and the importance of social networks and emotional ties.

Looking at the specific case of Tunisians residing abroad, the thesis responded to the following overarching research questions:

1. What are the transnational strategies that migrants can mobilise to meet their healthcare needs and expectations, and what does it say of their agency in the pursuit of healthcare?
2. How and why do migrants return to their country of emigration for healthcare?
3. How does the relationship between diaspora groups and their country of emigration affect healthcare, and what do transnational healthcare practices reveal about one's attachment to and engagement with a place?

In this section I will now briefly summarise the main findings stemming from the empirical chapters of the thesis. When addressing the first research question in Chapter 3, I examined the healthcare experiences of Tunisian migrants in their countries of residence, focusing on their access to healthcare services and the role of interculturality in healthcare provision. I discussed how Tunisian migrants sometimes face barriers to accessing adequate healthcare, which are mitigated through informal social protection strategies. I have illustrated how these strategies rely on social and interpersonal networks, which act as healthcare resources. For instance, the diaspora associations played a critical role as a component of the healthcare ecosystem, mobilising resources and support during the Covid-19 pandemic. I illustrated the intersectionality of healthcare inequalities through the example of the experience of Tunisian women participants' experience with sexual and reproductive healthcare revealing a lack of responsiveness to their diverse needs in their countries of residence. This case underlined the relevance of an intersectional approach in understanding healthcare inequalities and demonstrated how multiple layers of heterogeneity impact transnational healthcare practices.

Additionally, it showed the shifting responsibility for accessing appropriate healthcare services from collective and professional bodies to individuals, which can lead to significant inequalities depending on the individual's social, economic and cultural capital. Furthermore, the inadequate delivery of health services within national healthcare systems and migrants' unfamiliarity with these systems can lead to a relative downgrading in their access to healthcare.

I also explored the use of medical resources in the country of emigration, highlighting the role of formal transnational social protection mechanisms, such as the BSSA. However, these mechanisms often come with constraints, resulting in individuals' disengagement from such mechanisms. I also examined the role of the private healthcare sector in responding to the evolving needs of migrant-patients. The structural insufficiencies of the Tunisian public healthcare system coupled with the deployment of a private healthcare offer enabled the growth of a medical tourism industry, redefining Tunisia as a "medical hub".

Different examples of therapeutic trajectories show how migrant-patients often engage in therapeutic mobilities to circumvent healthcare barriers in their countries of residence, seeking more favourable opportunities in their country of emigration. What I framed as "diasporic healthcare arrangements" thus become expressions of migrants' agency, as they negotiate therapeutic opportunity structures between their countries of residence and emigration. Their diasporic ties serve as valuable resources for addressing healthcare needs and overcoming access barriers. This phenomenon can be understood through the concept of transnational social protection "from below," where strategies are developed and implemented by the actors themselves. While these strategies can effectively address healthcare inequalities in the country of residence, they may simultaneously create new patterns of healthcare inequalities in the country of emigration. With migration, participants in my research experienced both a "downgrading" in healthcare access in the country of residence and an "upgrading" through their medical return to Tunisia, reflecting their differential positioning within stratification orders in both contexts. Their therapeutic mobilities are intertwined with social mobility, opening access to alternative healthcare opportunities in the Tunisian private healthcare sector.

In part to explore how and why migrants return to their country of emigration for healthcare, Chapter 4 then shifted focus to transnational reproductive mobilities, and particularly the return of diaspora members to Tunisia for assisted reproductive technologies (ART). The globalisation of ART services has indeed led to the emergence of Tunisia as a regional hub for reproductive care in the Maghreb, attracting diaspora members seeking reproductive assistance. I have shown how these reproductive returns result from different drivers and are influenced by economic

inequalities and regulatory specificities between the countries of residence and emigration. The use of virtual spaces has also become a significant aspect of these mobilities, providing anonymity and fostering online communities of patients. These virtual interactions contribute to new patterns of "biosociality" and "biosolidarity" (Rabinow 1996; Bradley 2021), where patients form supportive networks based on shared experiences.

I highlighted how these reproductive returns are not merely a response to inadequate healthcare in the country of residence, but are also a reflection of migrants' attachment to their country of emigration. I demonstrated how these reproductive mobilities were imbued with a particular "affective/emotional texture" as they involve intimate and personal dimensions. I proposed the notion of "medical home" to describe the comfort and trust migrants feel when receiving medical care in Tunisia. Conversely, the lack of familiarity and cultural insensitivity in the country of residence can lead to discomfort and mistrust, motivating the decision to seek care in Tunisia. Chapter 4 also underlined the economic and regulatory interstices that couples navigate to enhance their reproductive healthcare, moving between public and private sectors to access individualised care.

Both Chapters 3 and 4 illustrated the feeling of "downgrading" in healthcare access in the country of residence, contrasted with "upgrading" in Tunisia. Social mobility acquired through emigration opens new therapeutic opportunities in Tunisia, reflecting the interconnectedness of social and therapeutic mobilities. These transnational reproductive journeys exemplify the agency of diaspora patients, who creatively employ medical resources across borders and reaffirm their agency in therapeutic choices.

Moving to how the relationship between diaspora groups and their country of emigration affects healthcare, I addressed in Chapter 5 how the socio-political tensions between the Tunisian State and the Tunisian diaspora (in particular Tunisian civil society abroad) were exacerbated by the Covid-19. I explored the historical and socio-economic factors contributing to these tensions, noting the ambivalence in how migrants are perceived and treated by their country of emigration. Emigrants are often celebrated for their economic success abroad, yet vilified for perceived social disruptions. I discussed how the pandemic brought to the fore long-standing inequalities in healthcare access between those who remained in Tunisia and those who emigrated abroad. Disparities in income, access to medical resources, and healthcare services were made particularly evident during the pandemic. This situation fuelled feelings of resentment and reinforced social divides. This gap between emigrants and non-migrants in the country of emigration was also mirrored by the divide created by the pandemic between

privileged and disadvantaged residents. The engagement of the diaspora in supporting healthcare efforts was driven by emotional ties and a sense of moral obligation, highlighting the importance of values and norms in diaspora-State relations, and triggering the mobilisation of what I coin as "diasporic therapeutic networks".

As a result, I also examined the role of the State in managing the healthcare crisis and discussed the perceived failure of the Tunisian government in addressing the needs of its citizens, in turn resulting in its loss of legitimacy. The diaspora's mobilisation was seen as a response to the State's disengagement, with Tunisian civil society actors abroad stepping in to fill the gaps. In Chapter 5, as for the other empirical chapters, I emphasised the relevance of a moral economy approach in understanding diaspora-State relations, where values, emotions, and norms play crucial roles in shaping interactions and expectations, an analytical lens which will be further unpacked in the next section.

2. Rethinking diasporic medical mobilities through a moral economy approach

Healthcare as well as medicine is by nature a moral enterprise (Pellegrino and Thomasma 1993; Bartosch *et al.* 2024). Bartosch *et al.* (2024) emphasise in that regard that healthcare systems can be considered moral economies regulated by norms, values and ethics. Furthermore, Kehr *et al.* (2018) suggest that "societal values and meanings related to wellbeing and a good life shape illness experiences and health care, as well as economic, scientific and political thinking in relation to local, national and transnational health interventions" (2-3).

The case studies analysed in this thesis underline the intersection of macro processes of healthcare globalisation and individual, intimate, subjective bodily processes in the pursuit of health and well-being. Illness acts as a powerful reminder of our radical dependency on our bodies (Cameron 2001; Okoro 2024). From that perspective, and following Bartosch *et al.* (2024), I suggest that healthcare ecosystems are moral economies regulated by norms, values, ethics as well as emotions and affect.

In Chapter 3, I draw on the case of diasporic healthcare arrangements, and in particular diasporic medical solidarities during the pandemic, as other examples of the manifestation of a moral economy of healthcare and migration. Tunisian civil society, as providers "from below" in the economy of welfare, takes part in the healthcare ecosystem by helping Tunisian co-nationals navigate bureaucratic difficulties and the healthcare system in the country of residence. Their

role as healthcare providers was made particularly evident during the pandemic when national public healthcare systems were overloaded and could not fulfil their moral obligations and engagement.

The moral economy underlying the relationship between TRA and their relatives in Tunisia was also made particularly evident through the sending of medication, as part of what can be defined as medical remittances. Indeed, taking care of the health of the relatives back in the country of emigration is part of the moral obligations of emigrants, thus defining a moral economy between migrants and non-migrants. However, following an implicit logic of "gift"/ "counter gift" (Mauss 1950), these financial resources must bring, in return, symbolic and moral resources or "moral capital" (Gowricharn 2004).

I have also illustrated how the private sector engages in this transnational moral economy of healthcare and migration by designing offers that "speak" to the moral obligations and the emotional triggers of those who have left and must, in compensation for their absence, provide for the health of their relatives in the country of emigration. This example relates to one of the primary dimensions of moral economy as a system for exchanging goods and services (Fassin 2009).

The patient-doctor relationship experienced by the actors of my research also speaks to the concept of moral economy. As noted by Bartosch *et al.* (2024), doctors (and healthcare professionals) taking care of "the sick" act as moral agents "within the moral economy of care" (2024: 2). As moral agents, they subjectively judge patients' deservingness of certain care, deciding what to include or exclude in treatment plans (Higashi *et al.* 2013). The experiences of some female participants with sexual and reproductive healthcare are telling examples of the influence of doctors' subjective judgements in therapeutic monitoring. Applying the moral economy approach as defined by Thompson (1971) and Scott (1976), they are, however, bound by obligations arising from their position of power. If the patient must act as a "good" patient, the doctor should, in return, act as "good" doctor from which he/she draws his/her legitimacy. The doctor not fulfilling his/her role somehow breaks the implicit moral pact and loses his/her legitimacy in the eyes of the patients.

This was also made evident in Chapter 4 through the negative experiences of some TRA couples during their reproductive itineraries in their countries of residence. This negative experience prompted, in some cases, the decision to seek ART in Tunisia. The perceptions and discourses of these couples emphasise the central role played by emotions, norms and values in their reproductive journeys. The "better alignment" of their values with the values of healthcare

professionals in Tunisia constitutes a "therapeutic symbolic system" (Andrews 2002). Fassin (2009) suggested in that regard that the moral economy approach goes beyond the realm of norms and obligations, habits and customs but also encompasses the realm of values and affects, and the feeling of justice in particular. Analysing the ways in which neoliberal policies and practices shape the everyday experience of health and medicine, Kehr *et al.* (2024) argue that growing economic instability resulting in loss of public provision and transformation of intimate relationships put into question well-established values and principles. They further argue that "such affective economies influence how people conceive of, engage in and sustain social relations (family, community, nation) in different parts of the world, and fashion how care provision and the moral responsibility for it are unevenly distributed along lines of gender, race, class and education in neoliberal times" (Kehr *et al.* 2024: 9).

Regarding diaspora policies, I have suggested that, beyond purely utilitarian approaches, the perspective of moral economy invites us to consider the role of values, norms, and emotions in defining the relationship between home country governments and diasporas. The rift created by the Covid-19 pandemic between Tunisia and the Tunisian diaspora mobilised registers of pain and emotions (Stierl 2016). The engagement of the diaspora was triggered by the emotional character of the crisis. The use of emotions and the reference to values guiding the diaspora, as opposed to a state failing to fulfil its role of protection, was a crucial element of the strategies of mobilisation. The accounts of the initiatives that were taken by Tunisian civil society abroad encapsulated the ambiguous position of the diaspora, its instrumentalisation (at times) by the Tunisian State and its resistance, caught between patriotic sentiment vis-à-vis their country of emigration and a refusal to obey its authorities. The process of redefinition of the moral economy was expressed through economic, moral, symbolic, associative and political practices and representations underlying the management of the healthcare crisis.

For the actors of my research that I classified as being part of the Tunisian "medical diaspora", their engagement back in Tunisia was a way to demonstrate solidarity despite having chosen to live abroad. The moral implications of the departure place migrants in a guilt-inducing process within a moral economy of social belonging (Hage 2002). They are indebted and are driven by a feeling of guilt constitutive of a moral economy between migrants and non-migrants (Carling 2008; Lacroix 2019).

Overall, the concept of moral economy seems particularly relevant for a holistic approach to the different observations of this thesis. It allows me to highlight the complex and ambiguous logic behind the values, norms and emotions shaping the diverse forms of diasporic healthcare

mobilities under study and the "formal and informal regimes of care, medicine and social protection in different geographical regions" (Kehr *et al.* 2024: 10).

3. Conceptual contributions and way forward

In addition to examining the moral economy of healthcare and migration, this thesis also proposed original concepts, which are outlined briefly below. Drawing from the literature on transnational social protection, the empirical chapters explored how various transnational social protection mechanisms are employed by the research actors. For healthcare, transnational social protection strategies are used to overcome obstacles and fulfil healthcare needs and expectations. This thesis borrowed the notion of transnational healthcare arrangements (Lafleur and Romero 2018) to illustrate the mix of formal and informal social protection strategies utilised by migrants. Combining research on diasporic medical mobilities and transnational social protection, I introduced the concept of "diasporic healthcare arrangements," which I defined as the transnational healthcare strategies "from below" and "from above" formulated within diasporic spaces. If these strategies are transnational by nature, they also reflect diasporic logic and mobilise diasporic networks. Using this conceptual framework, the thesis examines the transnational healthcare practices of Tunisian migrants, exploring a variety of strategies employed both from the bottom-up and top-down perspectives. Throughout the chapters, the thesis demonstrates the interaction between different formal and informal transnational social protection strategies. It illustrates, for instance, how the mobilisation of family and diasporic networks in transnational healthcare practices showcases migrants' transnationality.

By analysing the movement of healthcare across borders, the thesis investigated how diasporic ties, networks, and flows are mobilised to address healthcare needs and meet healthcare expectations. In particular, I examined how diasporic networks turned into therapeutic networks. I introduced the notion of "diasporic therapeutic network" to describe the healthcare strategies employed within the Tunisian diasporic network during the Covid-19 pandemic. This notion allowed me to analyse how the historically built networks of the Tunisian civil society abroad were mobilised with the aim of improving the management of the healthcare crisis in Tunisia. The circulation of medication, medical advice, knowledge and technologies took place through these diasporic therapeutic networks and were triggered by healthcare inequalities and disparities.

Finally, I proposed the notion of “medical home” by bridging the literature on therapeutic mobilities (and diasporic medical mobilities in particular) and the scholarship on the concept of home. Through this notion, I examined the relationship maintained by actors in my research engaging in diasporic medical returns with their country of emigration; this is a relationship with the country as a healing place which meets their medical and emotional expectations and within which they navigate easily, feel confident and comfortable. The term "medical home" denotes the emotional bond and familiarity that migrant patients retain with their country of emigration through the “consumption” of medical care. Through healthcare, the migrant questions and redefines his/her relationship with the “home”. The notion of “medical home” that I proposed also translates into a transnational care space (Rouland and Jarraya 2019) sensitive to the specific needs of these (trans)migrant patients, and one which is a therapeutic landscape that contributes to improving health and well-being.

The notion of “medical home” summarises the general proposal of this thesis. What does it mean to return home to seek healthcare, to have a child? The emotional geography of these transnational (healthcare) practices is revealing about one’s attachment to and engagement with the country of emigration. As suggested by Whittaker and Leng (2016), “mobility for health care can change the ways in which people think about their citizenship, their sense of belonging and their sense of rights and responsibilities” (2016: 297). The quest for a “medical home” gives shape to a variety of transnational healthcare practices, mobilising diasporic therapeutic networks and resources, and shaping diasporic healthcare arrangements.

The thesis, through its original empirical contribution and its conceptual proposition, aimed to reinforce previous studies and contribute to the scholarship on diasporic medical mobilities. New research questions have also emerged from my research representing promising avenues for future research and conceptual developments.

The Covid-19 pandemic constituted a considerable challenge for my fieldwork. Although, as described in the methodology, it did open up new research opportunities and enlarge the number of participants in my research, it also profoundly transformed how I conducted research. Beyond its repercussions on data collection, the pandemic most significantly impacted and durably transformed the transnational healthcare practices under study. Further research on the long-term impacts of how the pandemic changed processes of transnationalisation of healthcare and individuals’ transnational healthcare practices would constitute an important avenue of research.

Secondly, I have defined my research participants as belonging to what Whittaker and Leng have defined as "flexible bio-citizens" (2016). My thesis has contributed to deconstructing categories of privileged "medical tourists" and, while highlighting their privileges compared to other migrant categories, it also showed the complex nature of these diasporic medical mobilities. Extending this research to other migratory profiles as well as to other countries would enable us to broaden our understanding of this phenomenon.

Finally, one important avenue of research could also lie in expanding the study on the practicalities of the implementation and usage of transnational social protection mechanisms such as BSSAs. Indeed, my observations on the administrative constraints of such mechanisms demonstrated the resulting disengagement of individuals from such mechanisms. There is an important mismatch between policies on paper and in practice. Furthermore, the transnational healthcare practices of the actors in my research are revealing with respect to the non-alignment between expectations as well as practices and regulations/systems. However, these conclusions remain limited in their capacity to contribute to rethinking such mechanisms, and call for further research.

The study of transnational healthcare mobilities highlights the conflation of health policies with immigration policies, as well as labour and social welfare policies (Faist *et al.* 2015; Baldassar and Merla 2014). As outlined at the beginning of the thesis, healthcare systems have traditionally been bounded within the limits of nation-states, which derive part of their legitimacy by ensuring the health and well-being of their citizens (Rabinow and Rose 2006). Entitlement to healthcare and the obligation to contribute to it are part of the "national membership package" (ibid). However, as individuals travel for medical care, "they invoke not territorialized notions of citizenship, but make new claims" (Whittaker and Leng 2016: 286). The observation of transnational healthcare practices thus invites us to rethink the limitations of a nation-state scale for provision and contribution to healthcare systems and social protection in general. More broadly, it invites us to explore the encompassing relationships between health, migration, citizenship and the State.

References

Abdalla, F. M., Omar, M. A., and Badr, E. E. (2016). Contribution of Sudanese medical diaspora to the healthcare delivery system in Sudan: exploring options and barriers. *Human resources for health*, *14*, 65-77.

Abdellatif, S. (2021). L'adoption au Maghreb : *quid* de « l'exception » tunisienne ?. Dans : Vincent Meyer éd., *Parentalité(s) et après* (pp. 299-312). Toulouse: Érès.

Abdessamad, H. (2017). La gauche et l'islam politique ou le conflit suspendu. Retour sur le mouvement du 18 octobre en Tunisie, Editions Nirvana.

Abel, T. (2008). Cultural capital and social inequality in health. *Journal of Epidemiology and Community Health*, *62*(7), e13-e13.

Abraido-Lanza, A. F., Dohrenwend, B. P., Ng-Mak, D. S., and Turner, J. B. (1999). The Latino mortality paradox: a test of the" salmon bias" and healthy migrant hypotheses. *American journal of public health*, *89*(10), 1543-1548.

Abraido-Lanza, A. F., Dohrenwend, B. P., Ng-Mak, D. S., and Turner, J. B. (1999). The Latino mortality paradox: a test of the" salmon bias" and healthy migrant hypotheses. *American journal of public health*, *89*(10), 1543-1548.

Abu-Zaineh, M., Romdhane, H. B., Ventelou, B., Moatti, J. P., and Chokri, A. (2013). Appraising financial protection in health: the case of Tunisia. *International journal of health care finance and economics*, *13*, 73-93.

Acevedo-Garcia, D. (2000). Residential segregation and the epidemiology of infectious diseases. *Social science and medicine*, *51*(8), 1143-1161.

Acevedo-Garcia, D., and Almeida, J. (2012). Special issue introduction: place, migration and health. *Social science and medicine (1982)*, *75*(12), 2055.

Acevedo-Garcia, D., Lochner, K. A., Osypuk, T. L., and Subramanian, S. V. (2003). Future directions in residential segregation and health research: a multilevel approach. *American journal of public health*, *93*(2), 215-221.

Acevedo-Garcia, D., Sanchez-Vaznaugh, E. V., Viruell-Fuentes, E. A., and Almeida, J. (2012). Integrating social epidemiology into immigrant health research: a cross-national framework. *Social science and medicine*, *75*(12), 2060-2068.

Ackerman, S. L. (2010). Plastic paradise: Transforming bodies and selves in Costa Rica's cosmetic surgery tourism industry. *Medical Anthropology*, *29*(4), 403-423.

Adanu, R. M., and Johnson, T. R. (2009). Migration and women's health. *International Journal of Gynecology and Obstetrics*, *106*(2), 179-181.

Adhoum, I. (2010). Éthique et religion dans la décision de recourir à l'assistance médicale à la procréation en Tunisie. *Revue Juridique de l'Ouest*, *23*(2), 129-155.

Adler, N.E., Boyce, T., Chesney, M.A., Cohen, S., *et al.* (1994) Socioeconomic status and health: the challenge of the gradient, *American Psychologist*, 49, 1, 15–24.

Agarwal, A., Baskaran, S., Parekh, N., Cho, C. L., Henkel, R., Vij, S., ... and Shah, R. (2021). Male infertility. *The Lancet*, *397*(10271), 319-333.

Agier, M. (1999). *L'invention de la ville: banlieues, townships, invasions et favelas*. Ed. des archives contemporaines.

Aguinas, D.R. (2009). « Institutionalizing Diaspora Engagement within Migrant-Origin Governements. In : Closing the Distance. How Governements Strenghten Ties with Their Diasporas, edited by D.R. Aguinas, Washington, DC : Migration Policy Institute, pp. 1-45.

Agunias, D. R., and Newland, K. (2012). *Comment associer les diasporas au développement: manuel à l'usage des decideurs et praticiens dans les pays d'origine et d'accueil*. Organisation internationale pour les migrations (OIM).

Agunias, D.R. and Newland, K. (2012), *Developing a Road Map for Engaging Diasporas in Development. A Handbook for Policymakers and Practitioners in Home and Host Countries*, Geneva and Washington. DC: International Organization for Migration and Migration Policy Institute.

Ahnquist J., Wamala S.P., Lindstrom M., (2012), Interaction effects of socioeconomic factors on health outcomes, *Social Science and Medicine*, 74 930e939.

Ahonen, E. Q., Benavides, F. G., and Benach, J. (2007). Immigrant populations, work and health—a systematic literature review. *Scandinavian journal of work, environment and health*, 96-104.

Aïach, P. (2010). Les inégalités sociales de santé. *Medecine/Sciences*, *26*, 540.

Aïach, P., and Fassin, D. (2004). L'origine et les fondements des inégalités sociales de santé. *La revue du praticien*, *54*(20), 2221-7.

Aizura, A. Z. (2010). Feminine transformations: Gender reassignment surgical tourism in Thailand. *Medical anthropology*, *29*(4), 424-443.

Ajmi, M., Kahloul, M., Kacem, I., Chouchane, A., Ben Mansour, S., Slama, Y., … Naija, W. (2022). Immigration projects among young doctors in Tunisia: Prevalence, destinations and causes. *European Psychiatry*, *65*(S1), S633–S634.

Akrich, M., and Méadel, C. (2009). Les échanges entre patients sur l'Internet. *La presse médicale*, *38*(10), 1484-1490.

Albertini, M., & Mantovani, D. (2022). Older parents and filial support obligations: A comparison of family solidarity norms between native and immigrant populations in Italy. *Ageing & Society*, 42(11), 2556-2587.

Alcaraz, E. (2021). Écrire la prison politique sous Bourguiba. Le cas des détenus de l'organisation d'extrême-gauche Perspectives et Al-'âmil al-tounsi. *Expressions maghrébines*, *20*(1), 139-158.

Alonso, A. D. (2018). *From Here and There: Diaspora Policies, Integration, and Social Rights beyond Borders*. Oxford University Press.

Amelina, A. (2010). Scaling inequalities? Some steps towards the social inequality analysis in migration research beyond the framework of the nation state.

Amelina, A., Bilecen, B., Barglowski, K., and Faist, T. (2012). Ties that protect? The significance of transnationality for the distribution of informal social protection in migrant networks.

Amelina, A., Nergiz, D. D., Faist, T., and Schiller, N. G. (Eds.). (2012). *Beyond methodological nationalism: Research methodologies for cross-border studies*. Routledge.

Andersson, A., Edling, C., & Rydgren, J. (2018). The intersection of class origin and immigration background in structuring social capital: the role of transnational ties. The British Journal of Sociology, 69(1), 99-123.

Andrews, G. J. (2002). Towards a more place-sensitive nursing research: an invitation to medical and health geography, *Nursing Inquiry,* 9(4): 221–238.

Andrews, G. J. (2004). (Re)thinking the dynamics between health care and place: therapeutic geographies in treatment and care practices. *Area*, 36(3), 307e318.

Appadurai, A. (1996). *Modernity at large: Cultural dimensions of globalization* (Vol. 1). U of Minnesota Press.

Arcia E., Skinner M., Bailey D., Correa V., (2001). Models of acculturation and health behaviors among Latino immigrants to the US, Social Science and Medicine, 53, pp. 41–53.

Arshad, S., Bavan, L., Gajari, K., Paget, S. N., and Baussano, I. (2010). Active screening at entry for tuberculosis among new immigrants: a systematic review and meta-analysis. *European Respiratory Journal*, *35*(6), 1336-1345.

Ayari, M. B. (2017). *Le prix de l'engagement en régime autoritaire. Gauchistes et islamistes dans la Tunisie indépendante (1963-2008)*, Paris/Tunis, IRMC-Karthala.

Ayari, M. B., (2008), Rester le même tout en devenant un autre : les "islamistes" tunisiens exilés en France, Maghreb-Machrek, no 194, 55–73.

Ayed, W. B. (2022). The Tunisian stock market before invoking Article 80 of the Constitution: the (in) direct impact of government interventions during the sanitary crisis. *Journal of Business and Socio-economic Development*, *4*(1), 20-36.

Baertschi, B. (2019). Stéréotypes et heuristiques: le problème des soins différenciés. *Revue française d'éthique appliquée*, *8*(2), 15-17.

Baker, L. M., and Pettigrew, K. E. (1999). Theories for practitioners: Two frameworks for studying consumer health information-seeking behavior. Bulletin of the Medical Library Association, 87(4), 444–450.

Balcazar, F. E., Suarez-Balcazar, Y., Willis, C., Alvarado, F. (2010). Cultural competence: A review of conceptual frameworks. In F. Alvarado, Y. Suarez-Balcazar, T. Taylor Ritzler, C. Keys (eds), Race, culture and disability: Rehabilitation science and practice. Boston, MA: Jones and Barlett.

Baldassar, L., and Merla, L., (2014). *Transnational Families, Migration and the Circulation of Care: Understanding Mobility and Absence in Family Life*. UK: Routledge.

Baldassar, L., Baldock, C. V., and Wilding, R. (2006). *Families caring across borders: Migration, ageing and transnational caregiving*. Springer.

Baldauf, J. J., Fender, M., Akladios, C. Y., & Velten, M. (2011). Is early cervical cancer screening justified?. *Gynecologie, Obstetrique & Fertilite*, *39*(6), 358-363.

Bambra C. (2018). Placing health inequalities: where you live can kill you, In: Crooks V.A., Andrews G.J. and Pearces J., Routledge Handbook of Health Geography, Routledge, New York.

Barglowski, K., Bilecen, B., and Amelina, A. (2015). Approaching transnational social protection: Methodological challenges and empirical applications. *Population, Space and Place*, *21*(3), 215-226.

Barrett, F. (2000). Disease and geography: the history of an idea. Toronto: Becker Associates.

Bartosch, P., Jaye, C., & Crampton, P. (2024). Moral economy and moral capital: A new approach to understanding health systems. *Social Science & Medicine*, *352*, 117016.

Basch, L. G., Glick Schiller, N. and Szanton Blanc, C. (1994). *Nations Unbound : Transnational Projects, Postcolonial Predicaments, and Deterritorialized Nation-states,* Amsterdam: Gordon and Breach.

Battegay, A. (2003). Les recompositions d'une centralité commerçante immigrée: la Place du Pont à Lyon. *Revue européenne des migrations internationales*, *19*(2), 9-22.

Bauböck, R. (2003). Towards a political theory of migrant transnationalism. *International migration review*, *37*(3), 700-723.

Bauböck, R., and Faist, T. (2010). *Diaspora and transnationalism: Concepts, theories and methods*. Amsterdam University Press.

Baudet-Caille, V., and Mony, P. (2010). Discriminations: quel impact sur la santé?. *Plein droit*, (3), 3-4.

Beck, S. (2012). Biomedical mobilities: Transnational lab-benches and other space-effects. *In* Reproductive Technologies as Global Form. Ethnographies of Knowledge, Practices, and Transnational Encounters, 357-374.

Becker, G. (2000). *The elusive embryo: How women and men approach new reproductive technologies.* Univ of California Press.

Becker, G. (2002). Deciding whether to tell children about donor insemination. *Infertility around the globe*, 119-133.

Belhaj, S. (2020), *Etude sur La Migration des Tunisiens Hautement Qualifiés*, IOM, ONM.

Bell, D., Holliday, R., Ormond, M., and Mainil, T. (2015). Transnational healthcare, cross-border perspectives. *Social science and medicine*, *124*, 284-289.

Bell, S. L., Foley, R., Houghton, F., Maddrell, A., and Williams, A. M. (2018). From therapeutic landscapes to healthy spaces, places and practices: A scoping review. *Social science and medicine*, *196*, 123-130.

Ben Achour, S. (2001). « Féminisme d'État: figure ou défiguration du féminisme ». In Mohamed Charfi (éd.), Les Mélanges en l'honneur de Mohamed Charfi (pp. 413-430). Université de Michigan : Centre de publication universitaire.

Ben Achour, S. (2007). Le Code tunisien du statut personnel, 50 ans après: les dimensions de l'ambivalence. *L'année du Maghreb*, (II), 55-70.

Ben Achour, S. (2019). Tunisia. In: Yassari, N., Möller, LM., Najm, MC. (eds) Filiation and the Protection of Parentless Children. T.M.C. Asser Press, The Hague.

Ben Dridi, I., and Maffi, I. (2018). De nouvelles économies morales des mœurs? Femmes, professionnels de santé et régimes discursifs en Tunisie. L'Année du Maghreb, (18), 71-91.

Benabed A., (2024). Le vécu des couples en quête d'enfants confrontés aux traitements de l'assistance médicale à la procréation en Algérie. In Rouland B. and Maffi I. (Eds*), Voyager pour procréer au Maghreb: Expériences d'une nouvelle industrie médicale.* IRMC- Karthala, p.275.

Benayache, M. L. (2019). *Les couples infertiles algériens dans un espace médico-commercial transnational*. Mémoire de master, Université Paris Nanterre/Université Paris Est Créteil.

Bergmann, S. (2011). Reproductive agency and projects: Germans searching for egg donation in Spain and the Czech Republic. *Reproductive BioMedicine Online*, *23*(5), 600-608.

Berkman L. F., and Glass T. (2000). "Social integration, social networks, social support and health". In L. F. Berkman, and I. Kawachi (Eds.), Social epidemiology (137- 173). New York: Oxford University Press.

Bernstein, K. S., Park, S. Y., Shin, J., Cho, S., and Park, Y. (2011). Acculturation, discrimination and depressive symptoms among Korean immigrants in New York City. *Community mental health journal*, *47*, 24-34.

Bilecen, B., and Barglowski, K. (2015). On the assemblages of informal and formal transnational social protection. *Population, Space and Place*, *21*(3), 203-214.

Bilecen, B., and Faist, T. (2015). International doctoral students as knowledge brokers: Reciprocity, trust and solidarity in transnational networks. *Global Networks*, *15*(2), 217-235.

Bischoff, A. (2006). Caring for migrant and minority patients in European hospitals: A review of effective interventions. SFM. University of Basel.

Blaise, L. (2020), En Tunisie, colère après la mort accidentelle d'un médecin à l'hôpital, Le Monde Afrique, December 4th.

Bluteau, J. M. (2019). Legitimising digital anthropology through immersive cohabitation: Becoming an observing participant in a blended digital landscape, Ethnography, 138 (1), pp. 1-19.

Boccagni, P. (2012). "Rethinking Transnational Studies: Transnational Ties and the Transnationalism of Everyday Life." European Journal of Social Theory 15 (1): 117–132.

Bochaton, A. (2015). Cross-border mobility and social networks: Laotians seeking medical treatment along the Thai border. *Social Science & Medicine*, *124*, 364-373.

Boeldieu, J., and Thave, S. (2000). Le logement des immigrés en 1996. *Insee première*, (730).

Boivin, J., Griffiths, E., and Venetis, A. C. (2011). Emotional distress in infertile women and failure of assisted reproductive technologies: meta-analysis of prospective psychosocial studies. *BMJ*, 342, 1-9.

Bollini, P., Stotzer, U., and Wanner, P. (2007). Pregnancy outcomes and migration in Switzerland: results from a focus group study. *International journal of public health*, *52*, 78-86.

Bonacich E., (1973). A theory of Middlemen minorities, *American Sociological Review*, 38, pp. 583-594.

Boquet, D. (2013) Le concept de communauté émotionnelle selon B. H. Rosenwein, *Bulletin du centre d'études médiévales d'Auxerre*, 5, pp. 1-8.

Bordes-Benayoun, C. (2010). Contemporary diasporas, nationalism, and transnationalism politics. In *The Call of the Homeland* (pp. 47-58). Brill.

Borroto, R. J. (1998). Global warming, rising sea level, and growing risk of cholera incidence: a review of the literature and evidence. *GeoJournal*, *44*(2), 111-120.

Borsali, N. (2008). *Bourguiba à l'épreuve de la démocratie (1956-1963)*. Sfax: Samed.

Bosk, C. L., and De Vries, R. G. (2004). "Bureaucracies of mass deception: Institutional review boards and the ethics of ethnographic research", *The Annals of the American Academy of Political and Social Science*, Vol. 595 No. 1, pp. 249-263.

Bouchardy, C., Parkin, D. M., Wanner, P., and Khlat, M. (1996). Cancer mortality among north African migrants in France. *International journal of epidemiology*, *25*(1), 5-13.

Bouchardy, C., Wanner, P., and Parkin, D. M. (1995). Cancer mortality among sub-Saharan African migrants in France. *Cancer Causes and Control*, *6*, 539-544.

Bouchoucha, I., Fourati, H., and Zekri, L. (2011). Quels liens les Tunisiens résidant en Europe gardent-ils avec le pays d'origine. *Tunis: Internationale Organisation für Migration*.

Boularès, H. (2012). Histoire de la Tunisie: Les grandes dates de la préhistoire à la révolution, Cérès Editions.

Boulogne, R., Jougla, E., Breem, Y., Kunst, A. E., and Rey, G. (2012). Mortality differences between the foreign-born and locally-born population in France (2004–2007). *Social science and medicine*, *74*(8), 1213-1223.

Boumedienne, L. (2012). Le tourisme médical: un enjeu stratégique pour la Tunisie. *Les journées de l'entreprise*.

Bourdieu, P. (1985). The forms of capital. In Handbook of Theory and Research for the Sociology of Education, ed. JG Richardson, pp. 241–58. New York: Greenwood.

Bourne, R. S. (1916). "Transnational America." The Atlantic Monthly, July, 86–97.

Brada, B. (2011). "Not Here": Making the Spaces and Subjects of "Global Health" in Botswana. Culture, Medicine and Psychiatry, 35(2), 285-312.

Bradburd, D. (2006). "Fuzzy boundaries and hard rules: unfunded research and the IRB", *American Ethnologist*, Vol. 33 No. 4, pp. 492-498.

Bradby, H., Lindenmeyer, A., Phillimore, J., Padilla, B., and Brand, T. (2020). 'If there were doctors who could understand our problems, I would already be better': dissatisfactory health care and marginalisation in superdiverse neighbourhoods. *Sociology of Health and Illness*, *42*(4), 739-757.

Bradley, B. (2021). From biosociality to biosolidarity: the looping effects of finding and forming social networks for body-focused repetitive behaviours. *Anthropology and Medicine*, *28*(4), 543-557.

Brahimi, M. (1980). La mortalité des étrangers en France. *Population (french edition)*, 603-622.

Brettell, C. (2006). Introduction: global spaces/local places: transnationalism, diaspora, and the meaning of home. *Identities: Global studies in culture and power*, *13*(3), 327-334.

Brightmer, M. I., and Fantato, M. G. (1998). Human and environmental factors in the increasing incidence of dengue fever: a case study from Venezuela. *GeoJournal*, *44*, 103-109.

Brubaker, R. (2005). 'The 'diaspora', *Ethnic and Racial Studies*, Vol. 28, No. 1 pp. 1-19.

Bruneau, M. (2010). Diasporas, transnational spaces and communities. *Diaspora and transnationalism: Concepts, theories and methods*, *3*(1), 35-50.

Bryceson, D., and Vuorela, U. (Eds.). (2020). *The transnational family: New European frontiers and global networks*. Routledge.

Burt, R. S. (1992). Structural holes: the social structure of competition, Cambridge, MA: Harvard University Press.

Burt, R. S. (2004). 'Structural holes and good ideas', American Journal of Sociology, 110 (2), 349–99.

Caeymaex, F., Wenger, C., De Heusch, F., and Lafleur, J. M. (2023). “Ethics Ready”? Governing Research Through Informed Consent Procedures. *International Journal of Qualitative Methods, 22*, 16094069231165718.

Camau, M., Zaiem, H., & Bahri, H. (1990). *État de santé: besoin médical et enjeux politiques en Tunisie*. Feni XX.

Cameron, NM de S. (2001). The New Medicine: Life and Death After Hippocrates. Chicago: Bioethics Press.

Campt, T. (2006). Diaspora Space, Ethnographic Space. *In :* K. M. Clarke and D. A. Thomas (Eds.), *Globalization and Race: Transformations in the Cultural Production of Blackness* (pp. 93–111).

Carling, J. R. (2008). The human dynamics of migrant transnationalism. *Ethnic and racial studies*, *31*(8), 1452-1477.

Carling, J., Menjívar, C., and Schmalzbauer, L. (2012). Central themes in the study of transnational parenthood. *Journal of Ethnic and Migration Studies*, *38*(2), 191-217.

Cassel, J. (1976). The contribution of the social environment to host-resistance. American Journal of Epidemiology. 104. 107–122.

Castles, S., and Davidson, A. (2000). Citizenship and Migration: Globalization and the Politics of Belonging.

Cattacin, S. and Chimienti, M. (2007). Difference Sensitivity in the Field of Migration and Health: National policies compared. University of Geneva. Working Paper 2007; 1.

Cattacin, S., and Chimienti, M. (2007). From control policies to health policies as a tool for inclusion. *International Journal of Public Health*, *52*(2), 73-74.

Chakrabarti, R. (2010). Therapeutic networks of pregnancy care: Bengali immigrant women in New York City. *Social Science and Medicine*, *71*(2), 362-369.

Charrad, M. (2001). *States and women's rights: The making of postcolonial Tunisia, Algeria, and Morocco*. Univ of California Press.

Clifford, J. (1994). ‘Diasporas’, *Cultural anthropology*, Vol. 9, No. 3, pp. 302-338.

Cognet, M., Hamel, C., and Moisy, M. (2012). Santé des migrants en France: l’effet des discriminations liées à l’origine et au sexe. *Revue européenne des migrations internationales*, *2*, 11-34.

Cohen, R. (1997). *Global Diasporas: an introduction,* UCL Press, London.

Collyer, M. (2005). When do social networks fail to explain migration? Accounting for the movement of Algerian asylum-seekers to the UK. Journal of Ethnic and Migration Studies, 31(4), 699-718.

Collyer, M. (2013) *Emigration Nations: Policies and Ideologies of Emigrant Engagement*. New York, Palgrave.

Connell, J. (2015). From medical tourism to transnational health care? An epilogue for the future. *Social Science and Medicine*, *124*, 398-401.

Connell, J. (2016). Reducing the scale? From global images to border crossings in medical tourism. *Global Networks*, *16*(4), 531-550.

Connell, R. (2016). Masculinities in global perspective: Hegemony, contestation, and changing structures of power. *Theory and Society*, *45*, 303-318.

Constable, N. (2009). The commodification of intimacy: Marriage, sex, and reproductive labor. *Annual review of anthropology*, *38*, 49-64.

Couillet, M. (2010). *Les Africains subsahariens vivant en France: Caractéristiques sociodémographiques et accès aux soins* (Doctoral dissertation, Centre Population et Développement).

Crooks V.A., Andrews G.J. and Pearces J. and Synder M., (2018), Introducing the Routledge handbook of health geography, in Crooks V.A., Andrews G.J. and Pearces J., Routledge Handbook of Health Geography, Routledge, New York.

Cuellar, I., Bastida, E., and Braccio, S. M. (2004). Residency in the United States, subjective well-being, and depression in an older Mexican-origin sample. *Journal of Aging and Health, 16*(4), 447–466.

Culley, L., and Hudson, N. (2010). Fertility tourists or global consumers? A sociological agenda for exploring cross-border reproductive travel, *Interdisciplinary Social Sciences*, vol. 4, n° 10, 139-150.

Cutilli, C. C. (2010). Seeking health information: what sources do your patients use?. *Orthopaedic nursing*, *29*(3), 214-219.

Dabbou Ben Ayed, S. (2010). Le rôle de la religion dans l'élaboration de la loi de 2001 sur l'Assistance Médicale à la Procréation. *Revue Juridique de l'Ouest*, *23*(2), 69-88.

Dahinden, J. (2010). The dynamics of migrants' transnational formations: Between mobility and locality. *Transnationalism and diaspora. Concept, theories and methods*, 51-72.

Dalstrom, M. D. (2012). Winter Texans and the re-creation of the American medical experience in Mexico. *Medical anthropology*, *31*(2), 162-177.

Darlington-Pollock, F., Norman, P., Exeter, D. J., and Shackleton, N. (2018). Researching migration and health: Perspectives and debates. In *Routledge handbook of health geography* (pp. 59-66). Routledge.

Darmon, N., and Khlat, M. (2001). An overview of the health status of migrants in France, in relation to their dietary practices. *Public health nutrition*, *4*(2), 163-172.

Davidová, K., and Pechová, O. (2014). Infertility and assisted reproduction technologies through a gender lens. *Human Affairs*, *24*(3), 363-375.

Davies, A. A., Borland, R. M., Blake, C., and West, H. E. (2011). The dynamics of health and return migration. *PLoS medicine*, *8*(6), e1001046.

de Haas, H. (2006). Engaging Diasporas: How Governments and Development Agencies can Support Diaspora Involvement in the Development of Origin Countries. Oxford.

de Heusch, F., Wenger, C., Lafleur, J. M., O'Neill, A. P., & Booth, K. (2022). States and diasporas facing death in migration: A comparative analysis of the cases of Senegal and Tunisia before and during the COVID-19 pandemic. *Revue européenne des migrations internationales*, *38*(1), 37-62.

De Jong, S., and Dannecker, P. (2018). Connecting and confronting transnationalism: Bridging concepts and moving critique. *Identities*, *25*(5), 493-506.

De Lary, H. (2004). "les accord bilatéraux en matière d'immigration conculues par la France", in OCDE, *Migration et emploi Les accords bilatéraux à la croisée des chemins.*

de Neubourg, C., Cebotari, V., and Karpati, J. (2021). Systematic approaches to social protection. In *Handbook on Social Protection Systems* (pp. 189-209). Edward Elgar Publishing.

Delahaye, S. G., and Tejada, G. (2019). Transnational investments of the Tunisian diaspora: Trajectories, skills accumulation and constraints. *Diaspora Networks in International Business: Perspectives for Understanding and Managing Diaspora Business and Resources*, 105-126.

Délano Alonso, A. (2018). *From here and there: diaspora policies, integration, and social rights beyond borders*. Oxford University Press.

Deloitte (2008). Medical tourism: Consumers in search of value. Deloitte Center for Health Solutions. Retrieved from https://www.deloitte.com/centerforhealthsolutions.

Desrues, T., and Gobe, E. (2023). 'We don't want to be governed like this anymore': protest democracy as an expression of a crisis of governmentality in post-revolution Tunisia. *British journal of middle eastern studies, 50*(3), 648-665.

Devereux, S. and Sabates-Wheeler, R. (2004). Transformative social protection. *Institute of Development Studies and partner* organisations.

Devereux, S., and Sabates-Wheeler, R. (2004). *Transformative social protection* (Vol. 232). Institute of Development Studies.

Djelic, M. L., and Quack, S. (Eds.). (2010). *Transnational communities: Shaping global economic governance*. Cambridge University Press.

Dobson, M., Jones, K., and Moon, G. (1989). Health, Disease and Society: An Introduction to Medical Geography. *Transactions of the Institute of British Geographers, 14*(2), 244.

Donato, K. (2008). 'Gender and the effects of migration on Mexican child health'. Amsterdam: University of Amsterdam, paper presented at the International Workshop on Researching Transnational Families, Children and the MigrationDevelopment Nexus.

Dot-Pouillard N., (2013). Tunisie : la révolution et ses passées, Paris, L'Harmattan, coll. « Cahiers de l'IREMMO ».

Dot-Pouillard, N. (2018). L'appel du Levant: les divisions entre mouvements islamistes et de gauche en Tunisie au miroir du monde arabe (2011-2017). *Tunisie: une démocratisation au-dessus de tout soupçon?*.

Dourgnon, P., Jusot, F., Sermet, C., and Silva, J. (2009). Le recours aux soins de ville des immigrés en France. *Questions d'économie de la santé,* (146), 1-6.

Duchesne, V., and Bonnet, D. (2016). Procréation médicale et mondialisation: expériences africaines, Paris, L'Harmattan, collection Anthropologies et Médecines.

Dufoix, S. (2008) *Diasporas*, Berkeley, University of California Press.

Dufoix, S. (2010) *Un pont par-dessus la porte. Extraterritorialisation et transétatisation des identifications nationales.* In : Dufoix Stéphane, Guerassimoff Carine et de Tinguy Anne (dir.) *Loin des yeux, près du cœur. Les États et leurs expatriés*, Paris, Presses de Sciences Po.

Dunn, J. R., and Dyck, I. (2000). Social determinants of health in Canada's immigrant population: results from the National Population Health Survey. *Social science and medicine, 51*(11), 1573-1593.

Dunson, D. B., Baird, D. D., and Colombo, B. (2004). Increased infertility with age in men and women. *Obstetrics and Gynecology, 103*(1), 51-56.

Dyck I. (2006). Travelling tales and migratory meanings: South Asian migrant women talk of place, health and healing, Social and Cultural Geography, Volume 7, 1-18.

Dyck I., and Dossa P., (2007). "Place, health and home: gender and migration in the constitution of healthy space". Health and Place, 13(3), 691-701.

Dyck, I. (1995). Putting Chronic Illness 'In Place'. Women Immigrants' Accounts of their Health, *Geoforum*, Vol. 26. No. 3. pp. 237-260.

Dyck, I. (1999). Using qualitative methods in medical geography: deconstructive moments in a subdiscipline? Prof. Geogr. 51, 243–253.

Elleuch, M. (2020). « Parlement et partis politiques au temps du coronavirus : une sacrée en trompe-l'œil » *in* Rédissi Hamadi (dir.), *La Tunisie à l'épreuve du Covid-19*, Tunis, OTT, Friedrich Ebert Stifung, p. 217-230.

Elliott S. J. (2018). 50 years of medical health geography(ies) of health and wellbeing, *Social Science and Medicine* 196 206–208.

Elliott, S., Gillie, J. (1998). Moving experiences: a qualitative analysis of health and migration. Health and Place 4 (4), 327–339.

Engler, N. (2009). The psychological impact of infertility and its treatment. *Harvard Mental Health Letter*, *25*(11), 1-3.

English J., Wilson K., and Keller-Olaman S. (2008). "Health, healing and recovery: therapeutic landscapes and the everyday lives of breast cancer survivors", Social Science and Medicine, 67(1), 68-78.

Erel, U., and H. Lutz. (2012). "Introduction: Gender and Transnationalism." European Journal of Women's Studies 19 (4): 409–412.

Esnard, A.-M. and Sapat, A. (2016). 'Transnationality and diaspora advocacy: lessons from disaster', *Journal of Civil Society*, 12(1), pp. 1–16.

Esseghairi, K. (2003). *Sustaining fertility control in Tunisia while addressing emerging reproductive health needs: a comparison with Algeria* (Doctoral dissertation, University of Southampton).

Eugster, A., and Vingerhoets, A. J. (1999). Psychological aspects of in vitro fertilization: a review. *Social science and medicine*, *48*(5), 575-589.

Euraxess (n.d.). The European Charter and Code for Researchers. https://euraxess.ec.europa.eu/jobs/charter

European Commission (n.d.). Horizon 2020 Programme, Guidance, How to Complete your Ethics Self-Assessment step by step. https://ec.europa.eu/programmes/horizon2020/en/h2020-section/ethics

Evans, R., Barer, M. and Marmor, T.R. (1994). Why Are Some People Healthy and Others Not?: the Determinants of Health of Populations. Aldine de Gruyter, New York.

Eyles J. (1997). Environmental health research: Setting an agenda by spinning our wheels or climbing the mountain. *Health and Place* 3: 1–13.

Eyles, J., Taylor, S.M., Johnson, N. and Baxter, J. (1993). Worrying about waste: living close to solid waste disposal facilities in southern Ontario. *Social Science and Medicine* 37, 805–12.

Faist, T. (2000). The Volume and Dynamics of International Migration and Transnational Social Spaces. Oxford: Oxford University Press.

Faist, T. (2006). The transnational social spaces of migration. (COMCAD Working Papers, 10). Bielefeld: Universität Bielefeld, Fak. für Soziologie, Centre on Migration, Citizenship and Development (COMCAD)

Faist, T. (2008). 'Migrants as transnational development agents: an inquiry into the newest round of the migration–development nexus', *Population, Space and Place*, 14(1), 21-42.

Faist, T. (2010). Diaspora and transnationalism: What kind of dance partners. In : *Diaspora and transnationalism: Concepts, theories and methods*, *11*, 9-34.

Faist, T. (2013). Transnational social protection. *COMCAD WP*, (113).

Faist, T., Bilecen, B., Barglowski, K., and Sienkiewicz, J. J. (2015). Transnational social protection: migrants' strategies and patterns of inequalities. *Population, Space and Place*, *21*(3), 193-202.

Fargues, P. (2006). *The demographic benefit of international migration: Hypothesis and application to Middle Eastern and North African contexts* (Vol. 4050). World Bank Publications.

Farré, L. (2016). New evidence on the healthy immigrant effect. *Journal of Population Economics*, 29(2), 365–94.

Fassin, D. (1999). Santé et immigration. Les vérités politiques du corps. *Cahiers de l'Urmis*, *5*, 69-76.

Fassin, D. (2005). Compassion and repression: The moral economy of immigration policies in France. *Cultural anthropology*, *20*(3), 362-387.

Fassin, D. (2008). L'éthique, au-delà de la règle: Réflexions autour d'une enquête ethnographique sur les pratiques de soins en Afrique du Sud. *Sociétés contemporaines*, (03), 117-135.

Fassin, D. (2009). Les économies morales revisitées. In *Annales. Histoire, sciences sociales* (Vol. 64, No. 6, pp. 1235-1266). Cambridge University Press.

Fassin, D. (2011). *Humanitarian reason: a moral history of the present*. Univ of California Press.

Fassin, D., and Eideliman, J. S. (2014). *Économies morales contemporaines*. La découverte.

Feng, W., Ren, P., Shaokang, Z., and Anan, S. (2005). Reproductive health status, knowledge, and access to health care among female migrants in Shanghai, China. *Journal of Biosocial Science*, *37*(5), 603.

Fennelly, K. (2005). *Immigration and poverty in the Northwest area states* (No. 65). Julian Samora Research Institute, Michigan State University.

Fennelly, K. (2007). The" healthy migrant" effect. *Minnesota medicine*, *90*(3), 51-53.

Ferland, M., Paquet, G. (1995). Liens entre le statut socio-economique et la santé. In: Santeé Québec. Et la sante, ca va en 1992e1993? Rapport de l'Enquête sociale et de santé 1992-1993, vol. 2, pp. 81-112.

Fernandez, I., Muyot, J., Pangilinan, A., & Quijano, N. (2020). A hero's welcome? Repatriated overseas Filipino workers and COVID-19. *LSE Southeast Asia Blog*, 8.

Ferraretti, A. P., Pennings, G., Gianaroli, L., Natali, F., and Magli, M. C. (2010). Cross-border reproductive care: a phenomenon expressing the controversial aspects of reproductive technologies. *Reproductive biomedicine online*, *20*(2), 261-266.

Finch, B. K., Kolody, B., and Vega, W. A. (2000). Perceived discrimination and depression among Mexican-origin adults in California. *Journal of health and social behavior*, 295-313.

Finlay, J. M. (2018). Therapeutic landscapes: From exceptional sites of healing to everyday assemblages of well-being. In *Routledge Handbook of Health Geography* (pp. 116-123). Routledge.

Fleuret, S. and Séchet, R. (2004). Géographie sociale et dimension sociale de la santé. Texte pour colloque ESO (Espaces géographiques et sociétés), p. 16.

Foner, N. (1997). What's new about transnationalism? New York immigrants today and at the turn of the century. *Diaspora: A Journal of Transnational Studies*, *6*(3), 355-375.

Fortier, C. (2007). Blood, sperm and the embryo in Sunni Islam and in Mauritania: Milk kinship, descent and medically assisted procreation. *Body and Society*, *13*(3), 15-36.

Fortier, C. (2013). « Genre, sexualité et techniques reproductives en islam », in Florence Rochefort et Maria Eleonora Sanna (sous dir.), Normes religieuses et genre. Mutations, Résistances et Reconfiguration XIXè-XXIè siècle. Paris, Armand Colin (Recherches): 173-187.

Fortier, C. and Monqid, S. (éds.) (2017). Corps des femmes et espaces genrés arabo-musulmans, Paris, Karthala.

Fortier, C., Kotobi, L., and Moulin, A. M. (2010). Se masturber pour les hommes, montrer son sexe pour les femmes: recueil de sperme et pratiques gynécologiques dans le cadre des Procréations Médicalement Assistées (Islam sunnite-Égypte-France). *Sociologie et santé*, *31*, 221-232.

Foucault, M. (1976) *Histoire de la sexualité*, vol. 1, La volonté de savoir, Paris.

Foucault, M. (1976). *Histoire de la sexualité*, vol. 1, La volonté de savoir, Paris

Fournier, J. M. and Raoulx, B. (2003). La géographie sociale, géographie des inégalités. *CRÉSO-Université de Caen, ESO-UMR6590, Travaux et documents*.

Fox, M., Thayer, Z. M., and Wadhwa, P. D. (2017). Acculturation and health: the moderating role of sociocultural context. *American anthropologist*, *119*(3), 405-421.

Fox, S., & Fallows, D. (2003). Internet health resources. *TPRC*.

Frank, R. (2005). International migration and infant health in Mexico. *Journal of immigrant health*, *7*, 11-22.

Frank, R. and Heuveline, P. (2005). A crossover in Mexican and Mexican-American fertility rates: Evidence of explanations for an emerging paradox. Demographic Research 124: 77-104.

Franzini, L., Ribble, J. C., and Keddie, A. M. (2001). Understanding the Hispanic paradox. *Ethnicity and disease*, *11*(3), 496-518.

Frehywot, S., Park, C., and Infanzon, A. (2019). Medical diaspora: an underused entity in low- and middle-income countries' health system development. *Human resources for health*, *17*, 1-16.

Gabarro, C. (2022). Obtaining the AME: an obstacle course. *De Facto-Institut Convergences Migrations*, (31).

Gabrielli, L. (2015). *Corridor Report on France The case of Turkish and Tunisian immigrants*. GRITIM–Universitat Pompeu Fabra, Barcelona.

Gaitán-Rossi, P., Vilar-Compte, M., & Bustamante, A. V. (2023). Adaptation of a community health outreach model during the COVID-19 pandemic: the case of the Mexican consulates in the United States of America. *International Journal for Equity in Health*, 22(1), 138.

Gamlen, A. (2006). Diaspora engagement policies: What are they and what kinds of states use them?. COMPAS, University of Oxford.

Gamlen, A. (2019) *Human Geopolitics*: *States*, *Emigrants*, and the *Rise* of *Diaspora Institutions*, Oxford, Oxford University Press.

Gastaldo, D., Andrews, G. J., and Khanlou, N. (2004). Therapeutic landscapes of the mind: Theorizing some intersections between health geography, health promotion and immigration studies. *Critical Public Health, 14*(2), 157-176.

Gastineau B. (2012). Transition de la fécondité, développement et droits des femmes en Tunisie, *Les Cahiers d'EMAM,* Vol.21

Gastineau, B., & Adjamagbo, A. (2014). Les droits individuels face aux politiques de population. Regard sur trois pays africains: Bénin, Madagascar, Maroc. *Autrepart*, 70(2), 125-142.

Gastineau, B., & Sandron, F. (2000). *La politique de planification familiale en Tunisie (1964-2000)* (No. 61). Centre français sur la population et le développement.

Gee, G. C., and Ford, C. L. (2011). Structural racism and health inequities: Old issues, New Directions1. *Du Bois review: social science research on race, 8*(1), 115-132.

Gee, G. C., Ro, A., Gavin, A., and Takeuchi, D. T. (2008). Disentangling the effects of racial and weight discrimination on body mass index and obesity among Asian Americans. *American journal of public health, 98*(3), 493-500.

Gee, G. C., Ro, A., Shariff-Marco, S., and Chae, D. (2009). Racial discrimination and health among Asian Americans: evidence, assessment, and directions for future research. Epidemiologic Reviews, 31(1), 130e151.

Geisser, V. (2012). Quelle révolution pour les binationaux ? Le rôle des Franco-Tunisiens dans la chute de la dictature et dans la transition politique, *Migrations Société*, N° 143, pp 155 à 178.

Geisser, V. (2016), Une controverse peut en cacher une autre : les binationaux suspects « ici et là-bas », Migrations et Société, N°163, pp.3-12.

Geisser, V. and Limamn, W. (2018), L'an prochain à Tunis? Les binationaux franco-tunisiens au prisme des héritages millitants et des subjectivités diasporiques, in Allal Amin and Geisser Vincent (eds.) Tunisie: une démocratisation au-dessus de tout soupçon?, CNRS Editions.

Geisser, V. et Kelfaoui, S. 2001. « Marseille 2001, la communauté réinventée par les politiques. Enjeux municipaux autour de la communauté musulmane ? », *Migration et société*, vol. 77, n° 3, p. 55-77.

Gelb, L., & Marouani, M. A. (2020). Access to social protection by immigrants, emigrants and resident nationals in Tunisia. *Migration and Social Protection in Europe and Beyond (Volume 3),* 363.

Gensini, G. F., Yacoub, M. H., and Conti, A. A. (2004). The concept of quarantine in history: from plague to SARS. *Journal of Infection, 49*(4), 257-261.

Gesler W. (1992). "Therapeutic landscapes: medical issues in the light of the new cultural geography". Social Science and Medicine, 34, 735–746.

Gesler W. (1993). “Therapeutic landscapes: theory and a case study of Epidauros, Greece. Environment and Planning D: Society and Space, 11, 171–189.

Gesler, W. (1996). Lourdes: healing in a place of pilgrimage. *Health and Place*, *2*(2), 95-105.

Gesler, W. (1998). Sacred Spaces, Sacred Places: The Geography of Pilgrimages.

Gherissi, A., & Tinsa, F. (2017). Les services de Santé Sexuelle et Reproductive en Tunisie. Résultats d’une recherche qualitative auprès des jeunes usagers. *L’Année du Maghreb*, (17), 133-150.

Gilmartin, M. (2008). Migration, Identity and Belonging, *Geography Compass* 2/6: 1837–1852.

Girard, D. E., Galani, V., Toma, S., and Streuli, M. (2017). Détresse psychologique des couples infertiles: une approche globale. *Rev Méd Suisse*, *13*(549), 371-374.

Glinos I.-A., Baeten R., Helbe M. and Maarse H., (2010). “A typology of cross-border patient mobility”, Health and place, 16 (6) : 1145-1155.

Gobe, E. (2021). La Tunisie en 2020 : les luttes politiques au temps du Covid-19, l’Année Maghreb, N°26, pp. 301-327.

Goëb, J. L., Férel, S., Guetta, J., Dutilh, P., Dulioust, E., Guibert, J., ... and Golse, B. (2006, November). Vécus psychologiques des démarches d'assistance médicale à la procréation. In *Annales Médico-psychologiques, revue psychiatrique* (Vol. 164, No. 9, pp. 781-788). Elsevier Masson.

Gong, F., Xu, J., Fujishiro, K., and Takeuchi, D. T. (2011). A life course perspective on migration and mental health among Asian immigrants: the role of human agency. Social Science and Medicine, 73, 1618e1626.

Goodwin, J., Jasper, J. M., and Polletta, F. (Eds.). (2001). *Passionate politics: Emotions and social movements*. University of Chicago Press.

Gouirir, M. (2018) « État, Politique et absence : le « statut » des Marocains Résidant à l’Étranger (MRE) », *Revue des mondes musulmans et de la Méditerranée, pp. 81-98*

Gould, P. R. (1990). *Fire in the rain*. Baltimore: Johns Hopkins University Press.

Gowricharn, R. (2004). Moral capital in Surinamese transnationalism. *Ethnic and Racial Studies*, *27*(4), 607-621.

Granovetter, M. S. (1973). The strength of weak ties. *American journal of sociology*, *78*(6), 1360-1380.

Gray, H. H., & Poland, S. C. (2008). Medical tourism: crossing borders to access health care. *Kennedy Institute of Ethics Journal*, *18*(2), 193-201.

GRDR (2021). Frise historique analytique des mobilisations collectives des Tunisien.ne.s en France, GRDR.

Greil, A. L. (1991) *Not Yet Pregnant: Infertile Couples in Contemporary America.* New Brunswick: Rutgers University Press.

Grineski, S.E. (2011). Why parents cross for children's health care: transnational cultural capital in the United States-Mexico border region. Soc. Theory and Health 9, 256-274.

Gruénais, M-E (2024). Au Maroc, l’accès à l’assistance médicale à la procréation devient une cause nationale. In Rouland B. and Maffi I. (Eds), *Voyager pour procréer au Maghreb: Expériences d’une nouvelle industrie médicale.* IRMC- Karthala, p.275.

Gsir, S., and Mescoli, E. (2015). Les pratiques citoyennes transnationales des Tunisiens et Tunisiennes de Belgique. In *Soirée de réflexion au sujet de l'engagement philanthropique de la diaspora Belgo-Tunisienne*.

Guarnizo, L. E., Portes, A., and Haller, W. (2003). Assimilation and transnationalism: Determinants of transnational political action among contemporary migrants. *American journal of sociology*, *108*(6), 1211-1248.

Gürtin, Z. B. (2011). Banning reproductive travel: Turkey's ART legislation and third-party assisted reproduction. *Reproductive BioMedicine Online*, *23*(5), 555-564.

Gushulak, B. D., and MacPherson, D. W. (2011). Health aspects of the pre-departure phase of migration. *PLoS medicine*, *8*(5), e1001035.

Haenzel, W. (1968). Mortality from cancer and other diseases among Japanese in the United States. *J Natl Cancer Inst*, *40*, 43-68.

Hage, G. (2002). 'The differential intensities of social reality: migration, participation and guilt', in Ghassan Hage (ed.), Arab Australians Today: Citizenship and Belonging, Melbourne: Melbourne University Press, pp. 192-205.

Haggerty, K. D. (2004), "Ethics creep: Governing social science research in the name of ethics", *Qualitative sociology*, Vol. 27 No. 4, pp. 391-414

Hajri, S., Raifman, S., Gerdts, C., Baum, S., and Foster, D. G. (2015). 'This is real misery': Experiences of women denied legal abortion in Tunisia. *PLoS One*, *10*(12), e0145338.

Hanefeld, J., Lunt, N., Smith, R., and Horsfall, D. (2015). Why do medical tourists travel to where they do? The role of networks in determining medical travel. *Social Science and Medicine*, *124*, 356-363.

Hannerz, U. (1996). *Transnational connections*. London: Routledge.

Harper, I., & Raman, P. (2008). Less than human? Diaspora, disease and the question of citizenship. *International Migration*, *46*(5), 3-26.

Harvey, P., Holmes, R., Slater, R., and Martin, E. (2007). Social protection in fragile states. *London: ODI*.

Hawe P. and Shiell A. (2000). Social capital and health promotion : a review Social Science and Medicine 51 871- 885.

Hernández Plaza, S., Padilla, B. (2014). Meeting the healthcare needs of culturally diverse populations: A psycho-sociopolitical approach to cultural competence in health professionals. Final Report Summary, Marie Curie Intra-European Fellowship, 7th European Community Framework Programme, No. Ref. 272976. Brussels: European Commission.

Hernández-Plaza, S., Alonso-Morillejo, E., and Pozo-Muñoz, C. (2006). Social support interventions in migrant populations. The British Journal of Social Work, 36(7), 1151-1169. http://www.jstor.org/stable/23721354

Herzfeld, M. (2007). L'intimité culturelle. *Poétique sociale dans l'État nation. Quebec: Les Presses de l'université Laval, coll."Intercultures*.

Hessini, L. (2007). Abortion and Islam: policies and practice in the Middle East and North Africa. *Reproductive health matters*, 15(29), 75-84.

Higashi, R. T., Tillack, A., Steinman, M. A., Johnston, C. B., and Harper, G. M. (2013). The 'worthy'patient: rethinking the 'hidden curriculum'in medical education. *Anthropology and medicine*, *20*(1), 13-23.

Higham, J. (1988). *Strangers in the Land: Patterns of American Nativism, 1860–1925.* New Brunswick, Rutgers University Press.

Hochschild, A. R. (1979). Emotion work, feeling rules, and social structure. *American journal of sociology*, *85*(3), 551-575.

Holliday, R., Jones, M., and Bell, D. (2019). Beautyscapes: Mapping cosmetic surgery tourism. In *Beautyscapes*. Manchester University Press.

Holzmann, R. (2016). Do bilateral social security agreements deliver on the portability of pensions and health care benefits? A summary policy paper on four migration corridors between EU and non-EU member states. IZA Journal of European Labor Studies, 5(1), 17.

Holzmann, R., Koettl, J., and Chernetsky, T. (2005). *Portability regimes of pension and health care benefits for international migrants: an analysis of issues and good practices* (Vol. 23). Geneva: Global Commission on International Migration.

Hörbst, V., and Wolf, A. (2014). ARVs and ARTs: medicoscapes and the unequal place-making for biomedical treatments in sub-Saharan Africa. *Medical Anthropology Quarterly*, *28*(2), 182-202.

Horsfall, D. (2019). Medical tourism from the UK to Poland: how the market masks migration. *Journal of Ethnic and Migration Studies*, *46*(20), 4211-4229.

Horton, S. B. (2013). Medical returns as class transformation: situating migrants' medical returns within a framework of transnationalism. *Medical Anthropology*, *32*(5), 417-432.

Horton, S., and Cole, S. (2011). Medical returns: seeking health care in Mexico. *Social science and medicine*, *72*(11), 1846-1852.

Hottois G., Missa J.N. (2001). Nouvelle encyclopédie de bioéthique, De Boeck Université, 831-832.

Hsairi, M., Gobrane, H. B., Alaya, N. B., Bellaaj, R., & Achour, N. (2007). Connaissances et attitudes des étudiants en fin d'études médicales vis-à-vis des dépistages des cancers du col utérin et du sein. *Santé publique*, (2), 119-132.

https://anthrosourcMassey, D.(1994). *Place, Space and Gender*. Cambridge: Polity Press.

Huang, W. J., King, B., & Suntikul, W. (2017). VFR tourism and the tourist gaze: Overseas migrant perceptions of home. *International Journal of Tourism Research*, *19*(4), 421-434.

Hudson, N., Culley, L., Blyth, E., Norton, W., Rapport, F., and Pacey, A. (2011). Cross-border reproductive care: a review of the literature. *Reproductive biomedicine online*, *22*(7), 673-685.

Hunt, L. M., Schneider, S., and Comer, B. (2004). Should "acculturation" be a variable in health research? A critical review of research on US Hispanics. *Social science and medicine*, *59*(5), 973-986.

ICMPD, EUDiF, Shabaka (2021) "Diaspora engagement in times of crisis", ICMPD, Brussels.

Iglesias, E., Robertson, E., Johansson, S. E., Engfeldt, P., and Sundquist, J. (2003). Women, international migration and self-reported health. A population-based study of women of reproductive age. *Social science and medicine*, *56*(1), 111-124.

Im, E. O., and Yang, K. (2006). Theories on immigrant women's health. *Health care for women international*, *27*(8), 666-681.

Ingleby, D. (2012). Ethnicity, migration and the 'social determinants of health' agenda. Psychosocial Intervention 21(3), 331–341.

Ingleby, D., Chimienti, M., Hatziprokopiou, P., Ormond, M., and De Freitas, C. (2005). The role of health in integration. *Social integration and mobility: education, housing and health. IMISCOE Cluster B5 State of the art report, Estudos para o Planeamento Regional e Urbano*, (67), 88-119.

Inhorn, M. C. (1994). *Quest for conception: gender, infertility and Egyptian medical traditions*. University of Pennsylvania Press.

Inhorn, M. C. (2002). Sexuality, Masculinity, and Infertility in Egypt: Potent Troubles in the Marital and Medical Encounters. *The Journal of Men's Studies* 10:343–359.

Inhorn, M. C. (2003a). *Local Babies, Global Science: Gender, Religion, and In Vitro Fertilization in Egypt.* New York: Routledge.

Inhorn, M. C. (2003b). "The Worms Are Weak": Male Infertility and Patriarchal Paradoxes in Egypt. *Men and Masculinities 5:236–256.*

Inhorn, M. C. (2006). Making Muslim babies: IVF and gamete donation in Sunni versus Shi'a Islam. *Culture, medicine and psychiatry*, *30*, 427-450.

Inhorn, M. C. (2011). Diasporic dreaming: return reproductive tourism to the Middle East. *Reproductive Biomedicine Online*, *23*(5), 582-591.

Inhorn, M. C. (2012a). *Local babies, global science: gender, religion and in vitro fertilization in Egypt*. Routledge.

Inhorn, M. C. (2012b). *The new Arab man: Emergent masculinities, technologies, and Islam in the Middle East*. New Jersey : Princeton University Press.

Inhorn, M. C. (2013). Why me? Male infertility and responsibility in the Middle East. *Men and Masculinities*, 16(1), 49-70.

Inhorn, M. C. (2015). *Cosmopolitan conceptions: IVF sojourns in global Dubai*. Duke University Press.

Inhorn, M. C., & Shrivastav, P. (2010). Globalization and reproductive tourism in the United Arab Emirates. *Asia Pacific Journal of Public Health*, *22*(3_suppl), 68S-74S.

Inhorn, M. C., & Van Balen, F. (Eds.). (2002). *Infertility around the globe: New thinking on childlessness, gender, and reproductive technologies*. Univ of California Press.

Inhorn, M. C., and Birenbaum-Carmeli, D. (2008). Assisted reproductive technologies and culture change. *Annual Review of Anthropology*, *37*, 177-196.

Inhorn, M. C., and Gürtin, Z. B. (2011). Cross-border reproductive care: a future research agenda. *Reproductive biomedicine online*, *23*(5), 665-676.

Inhorn, M. C., and Patrizio, P. (2009). Rethinking reproductive "tourism" as reproductive "exile". *Fertility and sterility*, *92*(3), 904-906.

Inhorn, M. C., and Tremayne, S. (2016). Islam, assisted reproduction, and the bioethical aftermath. *Journal of religion and health*, *55*, 422-430.

Inhorn, M. C., Birenbaum-Carmeli, D., Tremayne, S., and Gürtin, Z. B. (2017). Assisted reproduction and Middle East kinship: A regional and religious comparison. *Reproductive biomedicine and society online*, *4*, 41-51.

Inhorn, M. C., Shrivastav, P., and Patrizio, P. (2012). Assisted reproductive technologies and fertility "tourism": examples from global Dubai and the Ivy League. *Medical Anthropology*, *31*(3), 249-265.

Ionescu, D. (2006). Engaging Diasporas as Development Partners for Home and Destination Countries: Challenges for Policymakers. IOM Migration Research Series 26. Geneva: IOM.

Iphofen, R. (2009). *Ethical Decision Making. A Practical Guide*. Palgrave Macmillan.

Iyer A., Sen G. and Östlin P. (2008). The intersections of gender and class in health status and health care, Global Public Health, 3:sup1, 13-24.

Jackson, P., Crang, P., and Dwyer, C. (Eds.). (2004). *Transnational spaces*. London: Routledge.

Jacquemyn, Y., Benjahia, N., Martens, G., Yuksel, H., van Egmond, K., and Temmerman, M. (2012). Pregnancy outcome of Moroccan and Turkish women in Belgium. *Clinical and Experimental Obstetrics and Gynecology*, *39*(2), 181-185.

Janzen, J. M. (1992). Ngoma: discourses of healing in Central and Southern Africa (Vol. 34). Univ of California Press.

Jasper, J. M. (2014). Emotions, sociology, and protest. *Collective emotions*, 341-355.

Jasso, G., Massey, D., Rosenzweig, M.R., and Smith, J.P. (2004). Immigrant health: selectivity and acculturation. In N.B. Anderson, R.A. Bulatao, and B. Cohen (eds), *Critical Perspectives on Racial and Ethnic Differences in Health in Late Life* (227–66). Washington, D.C.: The National Academies Press.

Jaulin, T. (2014). Géographie du vote à distance : l'élection tunisienne de 2011 à l'étranger, *L'Espace Politique*, 23 (2), pp. 2-20.

Johnson C. J. (1981). Cancer incidence in an area contaminated with radionuclides near a nuclear installation. *Ambio* 10: 176–82.

Johnson, T. J., and Garman, A. N. (2010). Impact of medical travel on imports and exports of medical services. *Health Policy, 98*(2-3), 171-177.

Joseph, A. E., and Phillips, D. R. (1984). Accessibility and utilization: geographical perspectives on health care delivery. London: Harper and Row.

Kalberg, S. (2016). *The social thought of Max Weber*. Sage Publications.

Kalipeni E. (2000). Health and disease in southern Africa: A comparative and vulnerability perspective. *Social Science and Medicine* 50: 965–83.

Kane, A. (2012). Flows of medicine, healers, health professionals, and patients between home and host countries. In: H. Dilger, A. Kane, and S.A. Langwick, eds., Medicine, Mobility, and Power in Global Africa. Transnational Health and Healing. Bloomington: Indiana University Press.

Kangas, B. (2007). Hope from abroad in the international medical travel of Yemeni patients. *Anthropology and Medicine, 14*(3), 293-305.

Kangas, B. (2010) 'Traveling for Medical Care in a Global World', Medical Anthropology, 29: 4, 344-362.

Kaplan, C. (2007). Questions of Travel: Postmodern Discourses of Displacement, Durham: Duke University Press.

Kaspar, H., Walton-Roberts, M., and Bochaton, A. (2019). Therapeutic mobilities. *Mobilities*, *14*(1), 1-19.

Kearns, R. A., and Joseph, A. E. (1993). Space in its place: developing the link in medical geography. *Social science and medicine, 37*(6), 711-717.

Kearns, R., and Moon, G. (2002). From medical to health geography: novelty, place and theory after a decade of change. *Progress in human geography*, *26*(5), 605-625.

Kehr, J., Dilger, H., & van Eeuwijk, P. (2018). Transfigurations of Health and the Moral Economy of Medicine: Subjectivities, Materialities, Values. *Zeitschrift Für Ethnologie*, *143*(1), 1–20.

Kemper Theodore, D. (1978) *A social Interactional Theory of Emotions*, New York, Wiley.

Kennedy, P. T., and Roudometof, V. (Eds.). (2002). *Communities across borders*. Milton Park: Taylor and Francis Limited.

Kennedy, S., McDonald, J. T., and Biddle, N. (2006). The healthy immigrant effect and immigrant selection: evidence from four countries, Social and Economic Dimensions of an Aging Population", Research Papers 164. McMaster University.

Keohane, R. O., and Nye, Jr, J. S. (Eds.). (1972). *Transnational relations and world politics*. Harvard University Press.

Keygnaert, I., Guieu, A., Ooms, G., Vettenburg, N., Temmerman, M., and Roelens, K. (2014). Sexual and reproductive health of migrants: does the EU care?. *Health policy*, *114*(2-3), 215-225.

Khairulyadi, K., Bukhari, B., Masrizal, M., Triyanto, T., & Saputra, A. (2021). Asabiyah and Religious Solidarity (A Socio-Historical Analysis of Asabiyah's Ibn Khaldun in relation to the Concept of Muslim Unity). *Community: Pengawas Dinamika Sosial*, 7(1), 1-14.

Khaldun, I. (1980). *The Muqaddimah, An Introduction to History.* New Jersey: Princeton University Press.

Khlat, M., and Courbage, Y. (1995). La mortalité et les causes de décès des Marocains en France 1979e1991.I. La mortalité générale. Une confirmation de la sous- mortalité masculine malgré les problèmes de mesure. Population, 50, 7e34.

Khlat, M., and Darmon, N. (2003). Is there a Mediterranean migrants mortality paradox in Europe?. *International journal of epidemiology*, *32*(6), 1115-1118.

Kilani M. (2018). « Femmes, Révolution et nouveau gouvernement des corps en Tunisie ». Anthropologie et Sociétés, 42 (1), 57–80.

Kilkey, M., & Merla, L. (2014). Situating transnational families' care-giving arrangements: the role of institutional contexts. *Global Networks*, *14*(2), 210-229.

Kirby, J. B., and Kaneda, T. (2005). Neighborhood socioeconomic disadvantage and access to health care. *Journal of health and social behavior*, *46*(1), 15-31.

Kleist, N. (2013). Flexible Politics of Belonging: Diaspora Mobilisation in Ghana, African Studies, 72:2, 285-306.

Klinkenberg, E., Manissero, D., Semenza, J. C., and Verver, S. (2009). Migrant tuberculosis screening in the EU/EEA: yield, coverage and limitations. *European respiratory journal*, *34*(5), 1180-1189.

Knecht, M. (2012). *Reproductive technologies as global form: ethnographies of knowledge, practices, and transnational encounters* (Vol. 19). Campus Verlag.

Koch, T. (2011). *Disease maps: epidemics on the ground*. University of Chicago Press.

Koh, H. K., Piotrowski, J. J., Kumanyika, S., and Fielding, J. E. (2011). Healthy people: a 2020 vision for the social determinants approach. *Health Education and Behavior*, *38*(6), 551-557.

Kohls, M. (2008). Mortality of immigrants in Germany. In European population conference, Barcelona.

Kohls, M. (2010). Selection, social status or data artefact-what determines the mortality of migrants in Germany?. In *Demographic aspects of migration* (pp. 153-177). Wiesbaden: VS Verlag für Sozialwissenschaften.

Koinova, M. (2018). Diaspora mobilisation for conflict and post-conflict reconstruction: contextual and comparative dimensions, Journal of Ethnic and Migration Studies, 44:8, 1251-1269.

Konstantinidou, A. (2022). Unpacking the black box of Bilateral Social Security Agreements: Protecting EU Nationals in non-EU Countries. Migration and social protection in Europe and beyond: public policies and migrant practices, HEC Liège Ecole de gestion.

Kooli, C. (2020). Review of assisted reproduction techniques, laws, and regulations in Muslim countries. *Middle East Fertility Society Journal*, *24*, 1-15.

Koundoura, M. (2012). Transnational culture, transnational identity: The politics and ethics of global culture exchange.

Kozinets, R. (2019). Netnography: The essential guide to qualitative social media research.

Krause, K. (2008). Transnational therapy networks among Ghanaians in London. *Journal of ethnic and migration studies*, *34*(2), 235-251.

Kraut, A. M. (1995). *Silent travelers: Germs, genes, and the immigrant menace*. JHU Press.

Kraut, A. M. (2004). Foreign bodies: The perennial negotiation over health and culture in a nation of immigrants. *Journal of American Ethnic History*, 3-22.

Kreyenfeld, M., & Konietzka, D. (2017). *Childlessness in Europe: Contexts, causes, and consequences*. Springer Nature.

Kriaa, M. (2013). Etude de l'impact de la migration sur les familles de migrants présentes au pays. *La Revue Documentaire*, EMR consulting.

Kriaa, M., S. Driss and Z. Karray (2011). Inequality and Spatial Disparities in Tunisia"; Economic Research Forum (ERF), Working Paper (631), 2011.

Kuhlmann, E., and Annandale, E. (2015). Gender and healthcare policy. In *The Palgrave international handbook of healthcare policy and governance* (pp. 578-596). London: Palgrave Macmillan UK.

Kuhlmann, E., Blank, R. H., Bourgeault, I. L., and Wendt, C. (Eds.). (2015). *The Palgrave international handbook of healthcare policy and governance*. Basingstoke: Palgrave Macmillan.

Kunst, A. E., and Houweling, T. (2001). Panorama mondial des différences entre riches et pauvres dans l'utilisation des soins obstétricaux. *Réduire les risques de la maternité: stratégies et évidence scientifique*. Studies in Health Services Organisation and Policy, Bruxelles, p. 488.

Kuo, W. H., and Tsai, Y. (1986). Social networking, hardiness and immigrant's mental health. *Journal of Health and Social Behavior, 27*, 133–149.

Kutner, M., Greenberg, E., Jin, Y., and Paulsen, C. (2006). The health literacy of America's adults: Results from the 2003 national assessment of adult literacy. Washington, DC: National Center for Education Statistics. (NCES No. 2006-483)

La Presse (2021, July 23th) L'organisation tunisienne des jeunes médecins dénonce l'agression de deux médecins à l'hôpital El Yasminet de Ben Arous, La Presse.

La Presse (2022, February 25th) Le ministère de la santé condamne toutes les formes de violence contre le personnel médical et paramédical, La Presse.

Lachheb, M. (2020) Chroniques de confinement : regards de chercheurs depuis la Tunisie, in Oissila Saaida Dir., *Vivre au temps du COVID-19*, Tunis, Nirvana-IRMC, pp. 81-84.

Lacroix, T. (2019). Transferts migratoires, institutions sociales migrantes et territorialité morale transnationale, *L'Espace Politique,* 38 (2). pp. 1-16.

Laé, J. F. (2003). L'intimité: une histoire longue de la propriété de soi. *Sociologie et sociétés, 35*(2), 139-147.

Laffont, I., and Edelmann, R. J. (1994). Psychological aspects of in vitro fertilization: a gender comparison. *Journal of psychosomatic obstetrics and Gynecology*, *15*(2), 85-92.

Lafleur J. M. (2013). *Transnational politics and the state: The external voting rights of diasporas*. Routledge. New-York.

Lafleur, J. M., and Romero, M. V. (2018). Combining transnational and intersectional approaches to immigrants' social protection: The case of Andean families' access to health. *Comparative migration studies*, *6*, 1-17.

Lafleur, J.-M. (2019). Migration and State Concerns about the Emigration and Welfare of their Citizens. In C. Inglis, B. Khadria, and W. Li (Éds.), Sage Handbook of International Migration (Sage, p. 575-591).

Lalonde, M. (1974). The Health of Canadians. Health Canada, Ottawa, ON.

Lambert, S. D., and Loiselle, C. G. (2007). Health information—seeking behavior. *Qualitative health research*, *17*(8), 1006-1019.

Landale, N. S., Oropesa, R. S., and Gorman, B. K. (2000). Migration and infant death: Assimilation or selective migration among Puerto Ricans?. *American Sociological Review*, *65*(6), 888-909.

Langwick, S. A., H. Dilger, and A. Kane. 2012. "Introduction: Transnational Medicine, Mobile Experts." In Medicine, Mobility, and Power in Global Africa: Transnational Health and Healing, edited by H. Dilger, A. Kane, and S. A. Langwick, 1–27. Bloomington: Indiana University Press.

Laplantine, F. (2020). *Penser l'intime*. CNRS éditions.

Laroche, M. (2000). Health status and health services utilization of Canada's immigrant and non-immigrant populations. *Canadian Public Policy/Analyse de Politiques*, 51-75.

Lautier, M. (2005). Les exportations de service de santé des pays en développement: le cas tunisien. Agence française de développement.

Lautier, M. (2013). Le développement des échanges internationaux de service de santé: perspectives des exportations en Afrique du Nord, Banque Africaine de Développement.

Le Borgne C. (2007). "Le tourisme médical: une nouvelle façon de se soigner", Sève /2, n°15 :47.

Le Bris, A. (2009). La maternité interdite: être mère sans être épouse en Tunisie. Entre déni et «normification». *Recherches féministes*, *22*(2), 39-57.

Lederman, R. (2006), "The perils of working at home: IRB "mission creep" as context and content for an ethnography of disciplinary knowledges", *American Ethnologist*, Vol. 33 No. 4, pp. 482-491.

Lederman, R. and Richards-Rissetto, H. (2018), "Data management in anthropology: the next phase in ethics governance?". *Soc Anthropol*, Vol. 26 No. 3, pp. 391-413.

Lee, J. Y., Kearns, R. A., and Friesen, W. (2010). Seeking affective health care: Korean immigrants' use of homeland medical services. *Health and place*, *16*(1), 108-115.

Lee, S. K., Sobal, J., and Frongillo Jr, E. A. (2000). Acculturation and health in Korean Americans. *Social science and medicine*, *51*(2), 159-173.

Lemke, T. (2015). Patient Organizations as Biosocial Communities? Conceptual Clarifications and Critical remarks. In: Wehling, P., Viehöver, W. and Koenen, Sophia (eds.), The Public Shaping of Medical Research. Patient Associations, Health Movements and Biomedicine, London and New York: Routledge, 191-207.

Leslie, C. (1974). The modernization of Asian medical systems. In J. Poggie, Jr. and R. N. Lynch (Eds.), *Rethinking modernization* (pp. 69–107). Westport, CT: Greenwood Press.

Leslie, C., (1973). The professionalizing ideology of medical revivalism. In: Singer, M.B. (Ed.), Entrepreneurship and Modernization of Occupational Structures in South Asia. Duke University Press, Durham, NC, pp. 16–42.

Leurs K. and Prabhakar M. (2018). "Doing Digital Migration Studies: Methodological Considerations for an Emerging Research Focus" in Zapata- Barrero and Yalaz (ed) Qualitative Research in European Migration Studies, IMISCOE reserach serie, Springler Open.

Levitt, P. (1998). Social remittances: migration driven local-level forms of cultural diffusion. *International Migration Review*, 32(4), 926–48.

Levitt, P. (2001). The Transnational Villagers. Berkeley: University of California Press.

Levitt, P. (2012). What's wrong with migration scholarship? A critique and a way forward. *Identities*, *19*(4), 493-500.

Levitt, P. (2015). *Artifacts and allegiances: how museums put the nation and the world on display*. Oakland: University of California Press.

Levitt, P., and Jaworsky, B. N. (2007). Transnational migration studies: Past developments and future trends. *Annu. Rev. Sociol.*, *33*, 129-156.

Levitt, P., and Lamba-Nieves, D. (2011). Social remittances revisited. *Journal of ethnic and migration studies*, *37*(1), 1-22.

Levitt, P., and Schiller, N. G. (2004). Conceptualizing simultaneity: A transnational social field perspective on society. *International migration review*, *38*(3), 1002-1039.

Li, T. E., McKercher, B., & Chan, E. T. H. (2020). Towards a conceptual framework for diaspora tourism. *Current Issues in Tourism*, *23*(17), 2109-2126.

Li, Y. (2015). *Handbook of Research Methods and Applications in Social Capital*, Cheltenham: Edward Elgar.

Librett, M., and Perrone, D. (2010), "Apples and oranges: ethnography and the IRB", *Qualitative Research*, Vol. 10 No. 6, pp. 729-747.

Lin, N. (2001). *Social Capital: A Theory of Social Structure and Action*, Cambridge: Cambridge University Press.

Linconstant, L. (2019). Acquérir un statut de patient: une redéfinition nécessaire des frontières de l'intime au cours des parcours d'assistance médicale à la procréation (AMP) en Italie (Lombardie), *Enfances, Familles, Générations, N°34,*

Link, B. G., and Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of health and social behavior*, 80-94.

Llácer, A., Zunzunegui, M. V., Del Amo, J., Mazarrasa, L., and Bolůmar, F. (2007). The contribution of a gender perspective to the understanding of migrants' health. *Journal of Epidemiology and Community Health*, *61*(Suppl 2), ii4-ii10.

Loewe, M., and Schüring, E. (2021). Introduction to the handbook on social protection systems. In *Handbook on social protection systems* (pp. 1-35). Edward Elgar Publishing.

Lovell, A. (2007). « Secrecy and silence in the ethnographic encounter », *In* McLean, A., and Leibing, A. (dir.), *The Shadow Side of Fieldwork. Exploring the Blurred Borders between Ethnography and Life*, Oxford, Blackwell, p. 56-80.

Lu, Y. (2008). Test of the 'healthy migrant hypothesis': a longitudinal analysis of health selectivity of internal migration in Indonesia. *Social science and medicine*, *67*(8), 1331-1339.

Lunt, N. (2020). The United Kingdom's Somali populations as medical nomads. *Journal of Ethnic and Migration Studies*, *46*(20), 4193-4210.

Mabrouk, M. (2010). *Voiles et sel. Culture, foyers et organisation de la migration clandestine en Tunisie*. Tunis, Les Editions Sahar. pp. 276.

Macintyre, S., and Ellaway, A. (2000). Neighbourhood cohesion and health in socially contrasting neighbourhoods: implications for the social exclusion and public health agendas. Health Bulletin, 58(6), 450–456.

Macintyre, S., and Ellaway, A., Cummins S., (2002). Place effects on health: how can we conceptualise, operationalise and measure them?, Social Science and Medicine 55, 125–139.

Mackenbach JP., Bos V., Garssen MJ., Kunst AE. (2005). "Mortality among non-western migrants in The Netherlands", *Nederlands Tijdschrift Voor Geneeskunde*, 149:917–23.

Mackenbach, J. P., Martikainen, P., Looman, C. W., Dalstra, J. A., Kunst, A. E., and Lahelma, E. (2005). The shape of the relationship between income and self-assessed health: an international study. *International journal of epidemiology*, *34*(2), 286-293.

Maddouri K. (2011). *Protection sociale des travailleurs tunisiens migrants : examen critique des dispositifs nationaux et internationaux,* CARIM Research Reports.

Maffi I., (2024). "L'émergence des cliniques pour l'infertilité en Tunisie: entre entreprises commerciales et innovations médicales". In Rouland B. and Maffi I. (Eds), *Voyager pour procréer au Maghreb: Expérience au sein d'une nouvelle industrie médicale,* IRMC-Karthala, p.275.

Maffi, I. and Rouland, B. (dir.), (2024). *Les soins reproductifs transfrontaliers au Maghreb : Un paysage reproductif en devenir ?* Paris, Editions IRMC-Karthala.

Maffi, I., and Affes, M. (2017). La santé sexuelle et reproductive en Tunisie. Institutions médicales, lois et itinéraires thérapeutiques des femmes après la révolution. *L'Année du Maghreb*, (17), 151-168.

Maffi, I., Rouland, B., & Wenger, C. (2023). Les voyages reproductifs vers la Tunisie: l'intime au prisme des pratiques de l'assistance médicale à la procréation. *L'Année du Maghreb*, (29), 39-61.

Maffi, I., Delanoë, D., & Hajri, S. (2017). La santé sexuelle et reproductive, champ d'exercice et d'affrontement des dominations de genre et de classe. *L'Année du Maghreb*, (17), 9-19.

Magis-Rodriguez, C., Lemp, G., Hernandez, M. T., Sanchez, M. A., Estrada, F., and Bravo-Garcia, E. (2009). Going North: Mexican migrants and their vulnerability to HIV. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, *51*, S21-S25.

Mahieu, R. (2019). *Feeding the ties to" home": Moroccan diaspora policies for the next generation.* Doctoral dissertation, University of Antwerp.

Malinowski, B. (1922). Ethnology and the Study of Society. *Economica*, *6*, 208–219.

Malinowski, B. (1963). *Les argonautes du Pacifique occidental. (1922)*. Gallimard.

Marcus, G. E. (1995). Ethnography in/of the World System : The Emergence of Multi-Sited Ethnography. *Annual Review of Anthropology*, *24*, 95-117.

Markel, H. and Stern, A.M. (2002), The Foreignness of Germs: The Persistent Association of Immigrants and Disease in American Society, *The Milbank Quarterly*, Vol. 80, No. 4.

Markel, H. (1997). *Quarantine! East European Jewish Immigrants and the New York City Epidemics of 1892.* Baltimore: Johns Hopkins University Press.

Markel, H. (1999). When Germs Travel. *The American Scholar* 68:61–9.

Markel, H., and Stern, A. M. (1999). Which face? Whose nation? immigration, public health, and the construction of disease at America's ports and borders, 1891-1928. *American Behavioral Scientist*, *42*(9), 1314-1331.

Marmot, M. G., Adelstein, A. M., and Bulusu, L. (1984). Lessons from the study of immigrant mortality. Lancet, June 30, 1455-1457.

Marmot, M. G., and Syme, S. L. (1976). Acculturation and coronary heart disease in Japanese-Americans. *American journal of epidemiology*, *104*(3), 225-247.

Marmot, M. G., Smith, G. D., Stansfeld, S., Patel, C., North, F., Head, J., ... and Feeney, A. (2013). Health inequalities among British civil servants: the Whitehall II study. In *Stress and the Brain* (pp. 61-67). Routledge.

Marre, D., San Román, B., and Guerra, D. (2018). On reproductive work in Spain: transnational adoption, egg donation, surrogacy. *Medical anthropology*, *37*(2), 158-173.

Marsicano, E., Lydié, N., and Bajos, N. (2011). Genre et migration: l'entrée dans la sexualité des migrants d'Afrique subsaharienne en France. *Population*, *66*(2), 313-341.

Martin, L. J. (2009). Reproductive tourism in the age of globalization. *Globalizations*, *6*(2), 249-263.

Märtsin, M., and Mahmoud, H. W. (2012). Never "at-home"?: Migrants between societies. *in* J. Valsiner (ed.), *The Oxford handbook of culture and psychology*, Oxford, Oxford University Press, 730-745.

Massé, R. (2001). « La santé publique comme projet politique et projet individuel », in Hours Bernard, Systèmes et politiques de santé. De la santé publique à l'anthropologie, Paris, Karthala, p. 41-66.

Massé, R. (2009). « L'anthropologie face à la morale et à l'éthique », *Anthropologie et Sociétés,* vol. 33, n° 3, p. 7-19.

Mathijsen, A. (2019). Home, sweet home? Understanding diasporic medical tourism behaviour. Exploratory research of Polish immigrants in Belgium. *Tourism Management*, *72*, 373-385.

Mathijsen, A., and Dziedzic, E. B. (2022). Diasporic medical tourism: where tourism meets migration and healthcare. Understanding its antecedents, behavioural intention and potential.

Mathijsen, A., and Mathijsen, F. P. (2020). Diasporic medical tourism: a scoping review of quantitative and qualitative evidence. *Globalization and Health*, *16*, 1-15.

Matorras, R., 2005. Reproductive exile versus reproductive tourism. Hum. Reprod. 20, 3571.

Mauss, M., (1950: 1990). *The Gift*, Routledge, London and New York.

Mayer, J. D. (1982). Relations between two traditions of medical geography: health systems planning and geographical epidemiology. *Progress in Human Geography*, *6*(2), 216-230.

Mazzaschi, A. (2011). Surgeon and safari: Producing valuable bodies in Johannesburg. *Signs: Journal of Women in Culture and Society*, *36*(2), 303-312.

Mazzucato, V. (2016). Bridging Boundaries with a Transnational Research Approach: A Simultaneous Matched Sample Methodology 1. In Multi-sited ethnography (pp. 215-231). Routledge.

McDonald, J. T., and Kennedy, S. (2005). Is migration to Canada associated with unhealthy weight gain? Overweight and obesity among Canada's immigrants. Social science and medicine, 61(12), 2469-2481.

McDonald, J.T., and Kennedy, S. (2004). Insights into the 'healthy immigrant effect': health status and health service use of immigrants to Canada. *Social Science and Medicine*, 59(8), 1613–27.

Megdiche, M., Mansour, N. B., Zina, B. B., Lassoued, F., Amor, S. H., Rahay, H., and Hajer, A. S. (2021). Le chemin vers la Médecine de Famille en Tunisie. Analyse stratégique. *La Tunisie Médicale*, *99*(1), 80.

Mehboob, Y. (2023). Legal Framework about Preconception Sex Selection in Muslim and non-Muslim Jurisdictions. *Al-Wifaq*, *6*(2), 1-28.

Méjean, C., Traissac, P., Eymard-Duvernay, S., El Ati, J., Delpeuch, F., and Maire, B. (2007). Influence of socio-economic and lifestyle factors on overweight and nutrition-related diseases among Tunisian migrants versus non-migrant Tunisians and French. *BMC Public Health*, *7*, 1-11.

Menjívar C. (2000), *Fragmented Ties: Salvadoran Immigrant Networks in America*, University of California Press. 301pp.

Menvielle L., (2012). Tourisme médical : quelle place pour les développement ? Mondes développement, 1/12.

Menvielle, L. (2012). Tourisme médical: quelle place pour les pays en développement?. *Mondes en développement*, *157*(1), 81-96.

Mesnard, A. (2004). Temporary migration and self-employment: evidence from Tunisia. *Brussels Economic Review*, *47*(1), 119-138.

Messias, D. K. H., and Rubio, M. (2004). Immigration and health. *Annual review of nursing research*, *22*(1), 101-134.

Millbank, J. (2018). The role of professional facilitators in cross-border assisted reproduction. *Reproductive biomedicine & society online*, *6*, 60-71.

Miller, D. (2011). *Tales from facebook*. Polity.

Milligan, C., and Wiles, J. (2010). Landscapes of care. *Progress in Human Geography*, *34*(6), 736-754.

Mingot E.S., and Mazzucato V. (2018). "Providing social protection to mobile populations: symbiotic relationships between migrants and welfare institutions". Journal of Ethnic and Migration Studies, 1-17.

Mladovsky, P. (2006). «IVF and reproductive tourism", *European Observatory on Health Systems and Policies*, vol. 8, No. 4, 5-7.

Mladovsky, P., Rechel, B., Ingleby, D., and McKee, M. (2012). Responding to diversity: an exploratory study of migrant health policies in Europe. *Health policy*, *105*(1), 1-9.

Mohan, J. (2000). Medical geography. In *The dictionary of human geography*, eds RJ Johnson, D Gregory, G Pratt and M Watts, 494–6. Oxford: Blackwell.

Mol, A. (2008), *The Logic of Care Health and the Problem of Patient Choice*, Routledge.

Moll, T., Gerrits, T., Hammarberg, K., Manderson, L., & Whittaker, A. (2022). Reproductive travel to, from and within sub-Saharan Africa: a scoping review. *Reproductive Biomedicine & Society Online*, *14*, 271-288.

Morgan, L. M., and Roberts, E. F. (2016). Reproductive governance in latin america. In *Reproduction and Biopolitics* (pp. 105-118). Routledge.

Moujoud, N. (2008). Effets de la migration sur le femmes et sur les rapports sociaux de sexe. Au-delà des visions binaires. *Les cahiers du CEDREF. Centre d'enseignement, d'études et de recherches pour les études féministes*, (16), 57-79.

Muennig, P., and Fahs, M. C. (2002). Health status and hospital utilization of recent immigrants to New York City. *Preventive Medicine*, *35*(3), 225-231.

Murphy, E., Dingwall, R. (2007). "Informed consent, anticipatory regulation and ethnographic practice", *Social Science and Medicine*, Vol. 65, pp. 2223-2234.

Nahman, M. R. (2016). Reproductive tourism: Through the anthropological "reproscope". *Annual Review of Anthropology*, *45*, 417-432.

Natter, K. (2015). Revolution and political transition in Tunisia: A migration game changer?. *Migration information source*, *28*.

Natteur, K. (2015). Revolution and political transition in Tunisia: A migration game changer?, Migration Information Source. *the Online Journal of the Migration Policy Centre, May 28th.*

Nazroo, J. Y. (2003). The structuring of ethnic inequalities in health: economic position, racial discrimination, and racism. *American journal of public health*, *93*(2), 277-284.

Neumayer, E. (2006). Unequal access to foreign spaces: how states use visa restrictions to regulate mobility in a globalized world. *Transactions of the Institute of British Geographers*, *31*(1), 72-84.

Newbold, K. B., and Wilson, K. (2019). Introduction to A Research Agenda for Migration and Health. *A Research Agenda for Migration and Health*, 1-10.

Okoro, D. C. (2024). The practice of medicine as a moral enterprise: Current brain-drain, the Nigerian experience, and bioethical intervention. *International Journal of Medicine and Health Development*, *29*(1), 3-9.

Ombelet, W. (2011). Global access to infertility care in developing countries: a case of human rights, equity and social justice. *Facts, views & vision in ObGyn*, *3*(4), 257.

Ong, A., and Collier, S. (2005). Global assemblages. *Technology, Politics and Ethics as Anthropological Problems*, Londres, Blackwell.

Onoma, A. K. (2021). The allure of scapegoating return migrants during a pandemic. *Medical Anthropology*, *40*(7), 653-666.

ONS, ONM, ICMPD (2021). Enquête Nationale sur la Migration Internationale, ICMPD, pp. 1-89.

Opiniano, J. M., and Castro, T. A. (2006). Promoting knowledge transfer activities through diaspora networks: a pilot study on the Philippines. In Converting Migration Drains into Gains: Harnessing the Resources of Oversears Professionals (eds) Wescott C. and Brinkerhoff J., Asian Development Bank, pp. 154.

Organista, P. B., Organista, K. C., and Kurasaki, K. (2003). The relationship between acculturation and ethnic minority health. In K. M. Chun, P. B. Organista, and G. Marin (Eds.), *Acculturation: Advances in theory, measurement, and applied research* (pp. 139–161). Washington, DC: American Psychological Association.

Ormond, M, and Lunt N. (2019). "Transnational medical travel: patient mobility, shifting health system entitlements and attachments", *Journal of Ethnic and Migration Studies*, vol. 46, no. 20, 4179-4192.

Ormond, M. (2013). *Neoliberal governance and international medical travel in Malaysia*. Routledge.

Ormond, M. (2016) 'Knowledge transfer in the "medical tourism" industry: The role of transnational migrant patients and health workers', in F. Thomas (ed.), *Handbook on Migration and Health*, Edward Elgar.

Ormond, M. (2021). Managing internationally mobile bodies in a world on hold: Migration, tourism and biological citizenship in the context of COVID-19, in Andrews Gavin J, Crooks Valorie, Pearce Jamie and Messina Janey Eds., *COVID-19 and Similar Futures: Geographical perspectives, issues and agendas*, Cham, Springer.

Ormond, M., (2013), 'Harnessing "diasporic" medical mobilities', in F. Thomas and J. Gideon (eds) Migration, Health and Inequality, Zed Books, London. P. 152-162.

Ormond, M., and Kaspar, H. (2018). South–South medical tourism. In *Routledge handbook of south-south relations* (pp. 397-405). Routledge.

Ormond, M., Mun, W. K., and Khoon, C. C. (2014). Medical tourism in Malaysia: how can we better identify and manage its advantages and disadvantages?. *Global health action*, *7*(1), 25201.

Oso, L., and Ribas-Mateos, N. (Eds.). (2013). *The international handbook on gender, migration and transnationalism*. Edward Elgar Publishing.

Østergaard-Nielsen, E. (2003). The politics of migrants' transnational political practices. *International migration review*, *37*(3), 760-786.

Oyeni, B.A. (2017). From Brain-Drain to Brain-Gain. In T. Falola and C. Hoyer (Eds.), Global Africans: Race, Ethnicity and Shifting Identities. London; NewYork: Routledge Taylor and Francis Group, pp- 113-129.

Paerregaard, K. (2010). "Interrogating diaspora: Power and conflict in Peruvian migration ", in Diaspora and Transnationalism: Concepts, Theories and Methods Rainer Bauböck and Thomas Faist, IMISCOE Reserach, Amsterdam University Press.

Palloni, A., and Morenoff, J. D. (2001). Interpreting the paradoxical in the Hispanic paradox: demographic and epidemiologic approaches. *Annals of the New York Academy of Sciences*, *954*(1), 140-174.

Parr, H. (2002). New body-geographies: the embodied spaces of health and medical information on the Internet. *Environment and planning D: Society and space*, *20*(1), 73-95.

Parreñas, R. S. (2001). Mothering from a distance: Emotions, gender, and intergenerational relations in Filipino transnational families. *Feminist studies*, *27*(2), 361-390.

Parreñas, R. S., & Boris, E. (Eds.). (2020). *Intimate labors: Cultures, technologies, and the politics of care*. Stanford University Press.

Paternotte, E., van Dulmen, S., van der Lee, N., Scherpbier, A. J., and Scheele, F. (2015). Factors influencing intercultural doctor–patient communication: A realist review. *Patient education and counseling*, *98*(4), 420-445.

Pearce, J., (2014). Geographies of health inequality. In: W:C: Cockerham, R. Dingwal and S.R. Quah, eds., The Wiley-Backwell encyclopedia of health, illness, behavior, and society. Chichester: Wiley-Blackwell.

Pearson, A. L., and Sadler, R. C. (2018). Health geography's role in understanding social capital and its influence on health. In in Crooks V.A., Andrews G.J. and Pearces J., Routledge Handbook of Health Geography, Routledge, New York.

Pellegrino, E. and Thomasma D. (1993). *The virtues in clinical practice*. New York: Oxford University Press.

Pels, P., Boog, I., Florusbosch, J. H., Kripe, Z., Minter, T., Postma, M., ... and Richards-Rissetto, H. (2018). Data management in anthropology: the next phase in ethics governance?. *Social Anthropology/Anthropologie Sociale*, *26*(3), 391-413.

Penasa, S. (2012). The Italian Law on Assisted Reproductive Technologies n. 40 of 2004 Facing the European Court of Human Rights: The Case of Costa and Pavan v. Italy. Revista de Derecho y Genoma Humano/Law and the Human Genome Review, 37, 155-178.

Pennings, G. (2004). Legal harmonization and reproductive tourism in Europe. *Human reproduction*, *19*(12), 2689-2694.

Pennings, G. (2005). Reply: reproductive exile versus reproductive tourism. *Human Reproduction*, *20*(12), 3571-3572.

Pennings, G. (2006). "International parenthood via procreative tourism", *in* F. Shenfield, C. Elderberry (eds), *Contemporary Ethical Dilemmas in Assisted Reproduction*, London, CRC Press, 43-56.

Pennings, G. (2009). The green grass on the other side: looking at cross-border reproductive care. *Facts, Views and Vision in Obstetrics and Gynaecology*, *1*(1), 1-6.

Perez, D., Sribney, W. M., and Rodriguez, M. A. (2009). Perceived discrimination and self-reported quality of care among Latinos in the United States. Journal of General Internal Medicine, 24, 548-554.

Pessar, P. R., and Mahler, S. J. (2003). Transnational migration: Bringing gender in. *International migration review*, *37*(3), 812-846.

Petit, A. (2002). L'ultime retour des gens du fleuve Sénégal. *Hommes & migrations*, *1236*(1), 44-52.

Phillimore, J. (2015). 'Delivering Maternity Services in an Era of Superdiversity: The Challenges of Novelty and Newness', Ethnic and Racial Studies 38(4): 568–82.

Phillimore, J., Bradby, H., Doos, L., Padilla, B., and Samerski, S. (2019). Health providers as bricoleurs: An examination of the adaption of health ecosystems to superdiversity in Europe. *Journal of European Social Policy*, *29*(3), 361-375.

Phillimore, J., Bradby, H., Knecht, M., Padilla, B., and Pemberton, S. (2019). Bricolage as conceptual tool for understanding access to healthcare in superdiverse populations. *Social Theory and Health*, *17*, 231-252.

Phillimore, J., Humphries, R., Klaas, F., & Knecht, M. (2016). Bricolage: potential as a conceptual tool for understanding access to welfare in superdiverse neighbourhoods. *IRiS Working Paper Series, 14*.

Phillips, N., Taylor, L., and Bachmann, G. (2019). Maternal, infant and childhood risks associated with advanced paternal age: the need for comprehensive counseling for men. *Maturitas*, 125, 81-84.

Pickett, K. E., and Pearl, M. (2001). Multilevel analyses of neighbourhood socioeconomic context and health outcomes: a critical review. *Journal of Epidemiology and Community Health*, *55*(2), 111-122.

Pinxten, W., and Lievens, J. (2014). The importance of economic, social and cultural capital in understanding health inequalities: using a Bourdieu-based approach in research on physical and mental health perceptions. *Sociology of health and illness*, *36*(7), 1095-1110.

Piocos III, C. M., Vilog, R. B. T., and Bernadas, J. M. A. C. (2022). Interpersonal Ties and Health Care: Examining the Social Networks of Filipino Migrant Domestic Workers in Hong Kong. *Journal of Population and Social Studies*, *30*.

Platt, L., Grenfell, P., Fletcher, A., Sorhaindo, A., Jolley, E., Rhodes, T., and Bonell, C. (2013). Systematic review examining differences in HIV, sexually transmitted infections and health-related harms between migrant and non-migrant female sex workers. *Sexually transmitted infections*, *89*(4), 311-319.

Portes, A. (1998) 'Social capital: its origins and applications in modern sociology', Annual Review of Sociology, 24: 1-24.

Portes, A., Guarnizo, L. E., and Landolt, P. (1999). The study of transnationalism: pitfalls and promise of an emergent research field. *Ethnic and racial studies*, *22*(2), 217-237.

Pouessel, S. (2017), "Tunisia and Its Diaspora: Between Protection and Control", in Emigration and Diaspora Policies in the Age of Mobility, Global Migration Issues, Springer International Publishing, Cham.

Poulton, R., Caspi, A., Milne, B., Thomson, W., Taylor, A., Sears, M., *et al.* (2002). Association between children's experience of socioeconomic disadvantage and adult health: a life-course study. Lancet, 360, 1640e1645.

Powles, J. (1990) 'The best of both worlds: attempting to explain the persisting low mortality of Greek migrants to Australia', in J. Caldwell, S. Findlay, P Caldwell and G. Santow (eds.) *What we know about health transition: the cultural, social and behavioural determinants of Health*, Canberra: Health Transition Center.

Powles, J., Hage, B., and Cosgrove, M. (1990). Health-related expenditure patterns in selected migrant groups: data from the Australian Household Expenditure Survey, 1984. *Australian and New Zealand Journal of Public Health*, *14*(1), 1-7.

Präg, P., & Mills, M. C. (2017). Assisted reproductive technology in Europe: usage and regulation in the context of cross-border reproductive care. In : Kreyenfeld, M., & Konietzka, D. (2017). Childlessness in Europe: Contexts, causes, and consequences. Springer Nature, 289-309.

Prothero, R. M. (1977). Disease and mobility: a neglected factor in epidemiology. *International journal of epidemiology*, *6*(3), 259-267.

Putman, R., (1993). Making democracy work: civic traditions in modern Italy. Princeton, NJ: Princeton university Press.

Quiminal, C. (1991). *Gens d'ici, gens d'ailleurs : Migrations soninké et transformations villageoises*, Paris, Christian Bourgeois.

Rabinow, P. (1996). "Artificiality and Enlightenment: From Sociobiology to Biosociality." Politix 90 (2): 21–46.

Rabinow, P., and Rose, N. (2006). Biopower today. *BioSocieties*, *1*(2), 195-217.

Ragazzi, F. (2012). Diaspora: The politics of its meanings. *International Political Sociology*, *6*(1), 107-111.

Ragazzi, F. (2014). A comparative analysis of diaspora policies. *Political Geography*, *41*, 74-89.

Ramírez de Arellano, A. B. (2011). Medical tourism in the Caribbean. *Signs: Journal of women in culture and society*, *36*(2), 289-297.

Raulin, A. (1991). Minorités intermédiaires et diasporas. *Revue européenne des migrations internationales*, *7*(1), 163-169.

Razum, O., Zeeb, H., Akgün, H. S., and Yilmaz, S. (1998). Low overall mortality of Turkish residents in Germany persists and extends into a second generation: merely a healthy migrant effect?. *Tropical Medicine and International Health*, *3*(4), 297-303.

Rechel B, Mladovsky P, Deville W, Rijks B, Petrova- Benedict R, Mckee M, (2011), editors. Migration and health in the European Union. *Open University Press*; pp. 129–43.

Rechel, B., Mladovsky, P., Ingleby, D., Mackenbach, J. P., and McKee, M. (2013). Migration and health in an increasingly diverse Europe. *The Lancet*, *381*(9873), 1235-1245.

Rizvi, F. (2019). Global mobility, transnationalism and challenges for education. *Transnational perspectives on democracy, citizenship, human rights and peace education*, *27*, 27-50.

Robertson, J. A. (2004). Protecting embryos and burdening women: assisted reproduction in Italy. Human Reproduction, 19(8), 1693-1696.

Rose, N., and Novas, C. (2005). Biological citizenship. In: Ong A and Collier SJ (eds) *Global Assemblages: Technology, Politics and Ethics as Anthropological Problems*. Malden, MA: Blackwell, pp. 439–463.

Rosenberg M. W., (1998). Medical or Health Geography? Populations, Peoples and Places Int. J. Popul. Geogr. 4, 211- 226.

Rosenwein, B. H. (2006). *Emotional communities in the early middle ages*. Cornell University Press.

Ross, N. A., Rosenberg, M. W., and Pross, D. C. (1994). Siting a women's health facility: a location-allocation study of breast cancer screening services in Eastern Ontario. *Canadian Geographer/Le Géographe canadien*, *38*(2), 150-161.

Rouland, B. (2022). « Se faire soigner en Tunisie : du Maghreb à la rive sud du Sahara ». *Heinrich Böll Stiftung Tunisie*.

Rouland, B., and Jarraya, M. (2020). From medical tourism to regionalism from the bottom up: emerging transnational spaces of care between Libya and Tunisia. *Journal of Ethnic and Migration Studies*, *46*(20), 4248-4263.

Rouland, B., Jarraya, M and Fleuret, S. (2016). "From medical tourism to the establishment of a transnational care space. L'exemple des patients libyens à Sfax (Tunisie)", *Revue francophone sur la santé et les territoires*, 1-21.

Rozée, V., & Unisa, S. (Eds.). (2016). *Assisted reproductive technologies in the global south and north: issues, challenges and the future*. Routledge.

Rozée, V., and Mazuy, M. (2012). L'infertilité dans les couples hétérosexuels: genre et «gestion» de l'échec. *Sciences sociales et santé*, *30*(4), 5-30.

Ryan, A. M., Gee, G. C., and Laflamme, D. F. (2006). The association between self-reported discrimination, physical health and blood pressure: findings from African Americans, Black immigrants, and Latino immigrants in New Hampshire. *Journal of health care for the poor and underserved*, *17*(2), 116-132.

Sabates-Wheeler, R., Koettl, J., and Avato, J. (2011). Social security for migrants: A global overview of portability arrangements. *Migration and social protection: Claiming social rights beyond borders*, 91-116.

Sadiqi, F. (2008). Facing challenges and pioneering feminist and gender studies: women in post-colonial and today's Maghrib. *African and Asian Studies*, *7*(4), 447-470.

Safran, W. (2005). 'The Jewish Diaspora in a Comparative and Theoretical Perspective', *Israel Studies*, Vol. 10, No. 1, pp. 36-60.

Saha, S., Komaromy, M., Koepsell, T. D., and Bindman, A. B. (1999). Patient-physician racial concordance and the perceived quality and use of health care. *Archives of internal medicine*, *159*(9), 997-1004.

Salant, T., and Lauderdale, D. S. (2003). Measuring culture: a critical review of acculturation and health in Asian immigrant populations. *Social science and medicine*, *57*(1), 71-90.

Salih, R. (2003) *Gender in transnationalism: home, longing and belonging among Moroccan migrant women.* London and New York.

Sampson, R., and Gifford, S. M. (2010). Place-making, settlement and well-being: The therapeutic landscapes of recently arrived youth with refugee backgrounds. *Health and place*, *16*(1), 116-131.

Sana, M. (2005). Buying membership in the transnational community: migrant remittances, social status, and assimilation. *Population research and policy review*, *24*, 231-261.

Sarah L. Bell S. L., Foley R., Houghton F., Maddrell A., Williams A. M., (2018), Place-making, settlement and well-being: The therapeutic landscapes of recently arrived youth with refugee backgrounds, Social Science and Medicine 196, 123–130.

Sauvegrain, P. (2012). La santé maternelle des «Africaines» en Île-de-France: racisation des patientes et trajectoires de soins. *Revue européenne des migrations internationales*, *2*, 81-100.

Sayad, A. (1999) *La double absence : des illusions de l'émigré aux souffrances de l'immigré*, Paris, Seuil.

Scheel, S. (2020). The Corona-pandemic: from parasitic mobility to convenient crisis. *COMPAS.*

Schenker, J. G. (2000). Women's reproductive health: monotheistic religious perspectives. *International journal of gynecology and obstetrics*, *70*(1), 77-86.

Schenker, J. G. (2005). Assisted reproduction practice: religious perspectives. *Reproductive biomedicine online*, *10*(3), 310-319.

Schenker, M. (2008). Work-related injuries among immigrants: a growing global health disparity. *Occupational and Environmental Medicine*, *65*(11), 717-718.

Schiller, N. G. (2007). Beyond the nation-state and its units of analysis: Towards a new research agenda for migration studies. *Conceptsand Methods*, 39.

Schiller, N. G., Basch, L., and Blanc-Szanton, C. (1992). Transnationalism: A new analytic framework for understanding migration. *Annals of the New York academy of sciences*, *645*(1), 1-24.

Schnapper, D. (2001). De l'État-nation au monde transnational. Du sens et de l'utilité du concept de diaspora. *Revue européenne des migrations internationales*, *17*(2), 9-36.

Schühle, J. (2020). *Traversing Transnational Biomedical Landscapes: An Ethnography of the Experiences of Nigerian Trained Physicians Practicing in the US and UK,* Columbia university Press.

Scott, J. C. (1977). *The moral economy of the peasant: Rebellion and subsistence in Southeast Asia*. Yale University Press.

Sehlikoglu, S., and Zengin, A. (2015). Introduction: why revisit intimacy?. *The Cambridge Journal of Anthropology*, *33*(2), 20-25.

Şekercan, A., Lamkaddem, M., Snijder, M. B., Peters, R. J., & Essink-Bot, M. L. (2015). Healthcare consumption by ethnic minority people in their country of origin. *The European Journal of Public Health*, *25*(3), 384-390.

Şekercan, A., Lamkaddem, M., Snijder. M.B., Peters, R.J., and Essink-Bot, M.L. (2014). Healthcare consumption by ethnic minority people in their country of origin. European Journal of Public Health, 25(3), 384–390.

Şekercan, A., Woudstra, A.J., Peters, R.J.G., Lamkaddem, M., Akgün, S., and Essink-Bot, M.-L. (2018). Dutch citizens of Turkish origin who utilise healthcare services in Turkey: a qualitative study on motives and contextual factors. BMC Health Services Research, 18 (289), 1-10.

Sewordor, E. Esnard, A.-M., Sapat, A. and Schwartz, L. (2019) 'Challenges to mobilizing resources for disaster recovery and reconstruction: perspectives of the Haitian diaspora', *Disasters*, 43(2), pp. 336–354.

Sharma, R., Agarwal, A., Rohra, V. K., Assidi, M., Abu-Elmagd, M., and Turki, R. F. (2015). Effects of increased paternal age on sperm quality, reproductive outcome and associated epigenetic risks to offspring. Reproductive Biology and Endocrinology, 13, 1-20.

Sheller, M., and Urry, J. (2006). The new mobilities paradigm. *Environment and planning A*, *38*(2), 207-226.

Shenfield, F., De Mouzon, J., Pennings, G., Ferraretti, A. P., Nyboe Andersen, A., De Wert, G., ... & ESHRE Taskforce on Cross Border Reproductive Care. (2010). Cross border reproductive care in six European countries. *Human reproduction*, *25*(6), 1361-1368.

Shivakoti, R. (2019). 'When disaster hits home: diaspora engagement after disasters', *Migration and Development*, 8(3), pp. 338–354.

Siméant-Germanos, J. (2010). « Économie morale » et protestation – détours africains, *Genèses*, 4 (81), pp. 142-160.

Siméant-Germanos, J. (2020). *Économie morale* dans Olivier Fillieule éd., *Dictionnaire des mouvements sociaux. 2e édition mise à jour et augmentée*. Presses de Sciences Po, pp. 205-209.

Simmel, G. (1995) Soziologie: Untersuchungen über dir Formen der Vergesellschaftung. Band 11, Frankfurt am Main: Suhrkamp, first published 1908.

Simmonot, B. (2016). « Bloguer sur son infertilité : parcours de soins et espace d'expression de patients en Afrique du Sud », in Bonnet D. et Duchesne V. (dir.), *Procréations médicales et mondialisation. Expériences africaines*, Éditions L'Harmattan, p.109-119.

Simon, E. (2016). « Parcours en ligne d'internautes africaines francophones : une(bio)médicalisation de la reproduction ? », in Bonnet D. et Duchesne V. (dir.), *Procréations médicales et mondialisation. Expériences africaines*, Éditions L'Harmattan, p.91-108.

Simon, G. (1976). L'espace migratoire des Tunisiens en France. *L'Espace géographique*, 115-120.

Skandrani, S., Baubet, T., Taïeb, O., Rezzoug, D., & Moro, M. R. (2010). The rule of virginity among young women of Maghrebine origin in France. *Transcultural psychiatry*, *47*(2), 301-313.

Skrbiš, Z. (2008). Transnational families: Theorising migration, emotions and belonging. *Journal of intercultural studies*, *29*(3), 231-246.

Slater, D (1999). *Consumer Culture and Modernity*, Cambridge, Polity Press.

Smith, M. P., and Guarnizo, L. E. (Eds.). (1998). *Transnationalism from below* (Vol. 6). Transaction Publishers.

Smyth, F. (2005). Medical geography: therapeutic places, spaces and networks. *Progress in human geography*, *29*(4), 488-495.

Solari, C. D. (2019). Transnational moral economies: The value of monetary and social remittances in transnational families. Current Sociology, 67(5), 760-777.

Solomon, H. (2011). Affective journeys: the emotional structuring of medical tourism in India, *Anthropology and Medicine*, 18 (1), 105–118.

Sommer, E. (2020). *Social Capital as a Resource for Migrant Entrepreneurship*. Springer Fachmedien Wiesbaden.

Sommier, I. (2020). *Émotions. In* Fillieule *et al*. (eds) *Dictionnaire des mouvements sociaux.* Paris, Presses de Sciences Po. pp 217-225.

Song, L. and Lin, N. (2009). 'Social Capital and Health Inequality: Evidence from Taiwan', *Journal of Health and Social Behavior* 50(2): 149–63.

Sothern, M., and Reid, B. (2018). Humanism and health geography: Placing the human in health geography. In *Routledge Handbook of Health Geography* (pp. 94-100). Routledge.

Soysal, Y. N. (2000). Citizenship and identity: living in diasporas in post-war Europe?. *Ethnic and racial studies*, *23*(1), 1-15.

Speier, A. R. (2011). Brokers, consumers and the internet: how North American consumers navigate their infertility journeys. *Reproductive Biomedicine Online*, *23*(5), 592-599.

Spink, A., Koricich, A., Jansen, B. J., & Cole, C. (2004). Sexual information seeking on web search engines. *CyberPsychology & Behavior*, *7*(1), 65-72.

Stamp, D. (1964). Some Aspects of Medical Geography, London: Oxford.

Stavri, P. Z. (2001). Personal heath information-seeking: A qualitative review of the literature. Studies in Health Technology and Informatics, 84(pt. 2), 1484–1488.

Stierl, M. (2016) Contestations in death – the role of grief in migration struggles, *Citizenship Studies*, 20 (2), pp. 173-191.

Tamburini, F. (2023). 'How I Learned to Stop Worrying and Love Autocracy': Kais Saied's "Constitutional Self-Coup" in Tunisia. *Journal of Asian and African Studies*, *58*(6), 904-921.

Taslakian, E. N., Garber, K., and Shekherdimian, S. (2022). Diaspora engagement: a scoping review of diaspora involvement with strengthening health systems of their origin country. *Global Health Action*, *15*(1), 2009165.

Tedeschi, M., Vorobeva, E., and Jauhiainen, J. S. (2022). Transnationalism: current debates and new perspectives. *GeoJournal*, *87*(2), 603-619.

Théry, I. (2010). *Des humains comme les autres. Bioéthique, anonymat et genre du don*, Paris, EHESS.

Thomas, W. I., and Znaniecki, F. (1996). *The Polish peasant in Europe and America: A classic work in immigration history*. University of Illinois Press.

Thompson E. P. (1971). The moral economy of the English crowd in the eighteenth century. *Past and present*, (50), pp. 76-136.

Timera, M. (2014). Mots et maux de la migration. De l'anathème aux éloges. *Cahiers d'Etudes Africaines*, (213-214), pp. 27-47.

Tôlôlyan K. (1996). Rethinking Diaspora(s) : Stateless power in the transnational Moment, Diaspora, 5, 1pp. 3-36.

Tölölyan, K. (1991). The nation-state and its others: In lieu of a preface. *Diaspora: A Journal of Transnational Studies*, *1*(1), 3-7.

Traïni, C. (2009) *Émotions... Mobilisation !* Paris, Presses de Sciences Po.

Travis, C.B., Meltzer, A.L., Howerton, D.M. (2010). Gender and Health-Care Utilization. In: Chrisler, J., McCreary, D. (eds) Handbook of Gender Research in Psychology. Springer, New York, NY.

Triaud, J. L., and Villalón, L. (2009). Introduction thématique: L'islam subsaharien entre économie morale et économie de marché: contraintes du local et ressources du global. *Afrique contemporaine*, (3), 23-42.

Trimble, J. E. (2003). Introduction: social change and acculturation. In P. B. Organista and G. Marin (Eds.), *Acculturation: Advances in theory, measurement, and applied research* (pp. 3–13). Washington, DC: American Psychological Association.

Trovato, F. (2003). Migration and survival: the mortality experience of immigrants in Canada. *Prairie Centre for Research on Immigration and Integration (PCRII)*.

Turner, L. (2007). 'First world health care at third world prices': globalization, bioethics and medical tourism. *BioSocieties*, *2*(3), 303-325.

Uitenbroek, D. G., and Verhoeff, A. P. (2002). Life expectancy and mortality differences between migrant groups living in Amsterdam, the Netherlands. *Social science and medicine, 54*(9), 1379-1388.

Uphoff E.P., Pickett K. E. , Cabieses B., Small N. and Wright J. (2013). A systematic review of the relationships between social capital and socioeconomic inequalities in health: a contribution to understanding the psychosocial pathway of health inequalities, *International Journal for Equity in Health*, 12:54.

Van der Stuyft, P., A. De Muynck, L. Schillermans & C. Timmerman (1989), 'Migration, acculturation and utilization of primary health care', *Social Science and Medicine* 29 (1): 53-60.

Van Gennep, A. (1981). Les rites de passage.(1e édition 1909), A. et J. *Picard, Paris*.

Van Hear, N. (1998). New diasporas: the mass exodus, dispersal and regrouping of migrant communities. London and Seattle.

van Hoof, W., Pennings, G., & de Sutter, P. (2015). Cross-border reproductive care for law evasion. A qualitative study into the experiences and moral perspectives of French women who go to Belgium for treatment with donor sperm. *Social Science and Medicine*, 124, 391–397.

Vasta, E., and Castles, S. (1996). The teeth are smiling: The persistence of racism in multicultural Australia.

Ventola, C. (2014). Prescrire un contraceptif: le rôle de l'institution médicale dans la construction de catégories sexuées. *Genre, sexualité and société*, (12).

Vertovec, S. (1999). 'Conceiving and Researching Transnationalism', *Ethnic and Racial Studies*, 22, 447-63.

Vertovec, S. (1999). 'Three meanings of 'diaspora', exemplified among South Asian religions', *Diaspora,* Vol. 7, No. 2, pp. 1-37.

Vertovec, S. (2003). Migration and other modes of transnationalism: Towards conceptual cross-fertilization. *International Migration Review*, 37(3), 641–665.

Vertovec, S. (2005). The Political Importance of Diasporas (Working Paper No. WP-05- 13).

Vidal C. (2019). Biais de genre dans l'accès au soin: une préoccupation éthique, *Revue française d'éthique appliquée*, N°8, pages 12 à 14.

Villa-Torres, L., Gonzalez-Vazquez, T., Fleming, P. J., González-González, E. L., Infante-Xibille, C., Chavez, R., and Barrington, C. (2017). Transnationalism and health: a systematic literature review on the use of transnationalism in the study of the health practices and behaviors of migrants. *Social Science and Medicine, 183*, 70-79.

Vintila, C.-D., and Konstantinidou, A. (2022). *Crisis Management and the Protection of Citizens Abroad in Times of COVID-19: Evidence from Cyprus and Greece* [Paper presentation]. 2022 ECPR General Conference, Innsbruck, Austria.

Vintila, D., and Lafleur, J. M. (2020). The Immigration-Emigration Nexus in Non-EU Sending States: A Focus on Welfare Entitlements, Consular Services, and Diaspora Policies. *Migration and Social Protection in Europe and Beyond (Volume 3) A Focus on Non-EU Sending States*, 1-39.

Viruell-Fuentes, E. A. (2007). Beyond acculturation: immigration, discrimination, and health research among Mexicans in the United States. *Social science and medicine, 65*(7), 1524-1535.

Viruell-Fuentes, E. A., Miranda, P. Y., and Abdulrahim, S. (2012). More than culture: structural racism, intersectionality theory, and immigrant health. *Social science and medicine*, *75*(12), 2099-2106.

Vivas Romero M. (2017). *Who Cares for Those Who Cared? An Intersectional Ethnography of Global Social Protection Arrangements* (Doctoral dissertation, Université de Liège, Belgique).

Wagner, L. (2008). Diasporic visitor, Diasporic Tourist. Post-migrant generation Moroccans on holiday at 'home'in Morocco. *Civilisations. Revue internationale d'anthropologie et de sciences humaines*, (57), 191-205.

Wakefield, S., McMullan, C. (2005). Healing in places of decline: (re)imagining everyday landscapes in Hamilton, Ontario. Health and Place 11, 299–312.

Wallace, S. P., Mendez-Luck, C., and Castañeda, X. (2009). Heading south: why Mexican immigrants in California seek health services in Mexico. *Medical care*, *47*(6), 662-669.

Waterston, A., and Rylko-Bauer, B. (2006). Out of the shadows of history and memory: Personal family narratives in ethnographies of rediscovery. *American ethnologist*, *33*(3), 397-412.

Wathen, C. N., and Harris, R. M. (2007). "I try to take care of it myself," how rural women search for health information. Qualitative Health Research, 17(5), 639–651.

Weber, M. (1976). *Wirtschaft und Gesellschaft*, Tübingen, Johannes Winckelmann.

Weinar, A. (2010). Instrumentalising diasporas for development: International and European policy discourses. *Diaspora and transnationalism: In* Concepts, Theories and Methods, Rainer Bauböck and Thomas Faist, IMISCOE Reserach, Amsterdam University Press.

Weinar, A. (Ed.). (2017). *Emigration and diaspora policies in the age of mobility* (Vol. 9). Springer International Publishing.

Wescott, C. (2005). Promoting Knowledge Exchange through Diasporas, Asian Development Bank Prepared for G-20 workshop on 'Demographic Challenges and Migration", Sydney, 27-28 August.

Westwood, S., and Phizacklea, A. (2000). *Trans-nationalism and the Politics of Belonging*. Psychology Press.

Whittaker, A. (2009). Global technologies and transnational reproduction in Thailand. *Asian Studies Review*, *33*(3), 319-332.

Whittaker, A. (2010). Challenges of medical travel to global regulation: A case study of reproductive travel in Asia. *Global Social Policy*, *10*(3), 396-415.

Whittaker, A. M. (2011). Reproduction opportunists in the new global sex trade: PGD and non-medical sex selection. *Reproductive BioMedicine Online*, *23*(5), 609-617.

Whittaker, A., and Leng, C. H. (2016). 'Flexible bio-citizenship'and international medical travel: transnational mobilities for care in Asia. *International Sociology*, *31*(3), 286-304.

Whittaker, A., and Speier, A. (2010). "Cycling overseas": care, commodification, and stratification in cross-border reproductive travel. *Medical anthropology*, *29*(4), 363-383.

Whittaker, A., Inhorn, M. C., and Shenfield, F. (2019). Globalised quests for assisted conception: Reproductive travel for infertility and involuntary childlessness. *Global Public Health*, *14*(12), 1669-1688.

Whittaker, A., Manderson, L., and Cartwright, E. (2010). Patients without borders: understanding medical travel. *Medical Anthropology*, *29*(4), 336-343.

WHO. (2013). Sexual and reproductive health. WHO Regional Office for Europe.

Wilkinson R, Marmot, M. (eds), (2003), *Social determinants of health. The solid facts*. 2nd edition. Copenhagen: WHO Regional Office for Europe.

Williams A. (2002). Changing geographies of care: employing the concept of therapeutic landscapes as a framework in examining home space. Social Science and Medicine. 55(1): 141-54.

Williams A. (ed.) (1999). Therapeutic landscapes: the dynamic between wellness and place. Landham, MD: University Press of America.

Williams, D. R., and Collins, C. (2001). Racial residential segregation: a fundamental cause of racial disparities in health. *Public health reports*.

Williams, D. R., and Mohammed, S. A. (2009). Discrimination and racial disparities in health: evidence and needed research. *Journal of behavioral medicine*, *32*, 20-47.

Williams, D. R., Neighbors, H. W., and Jackson, J. S. (2003). Racial/ethnic discrimination and health: Findings from community studies. *American journal of public health*, *93*(2), 200-208.

Yeates, N. (2008). Global Migration Policy. In N. Yeates (Éd.), *Understanding Global Social Policy* (p. 229-252). Policy.

Yeates, N. (2009). *Globalizing care economies and migrant workers: Explorations in global care chains*. Basingstoke: Palgrave Macmillan.

Yeoh, B. and Huang, S. (2015) Cosmopolitan beginnings? Transnational healthcare workers and the politics of carework in Singapore, *Geographical Journal*, 181 (3), 249–258.

Yeoh, B. S., and Ramdas, K. (2014). Gender, migration, mobility and transnationalism. *Gender, Place and Culture*, *21*(10), 1197-1213.

Yount, K. M., & Sibai, A. M. (2009). Demography of aging in Arab countries. In *International handbook of population aging* (pp. 277-315). Dordrecht: Springer Netherlands.

Yuill, C. (2018), "Is Anthropology Legal? Anthropology and the EU General Data Protection Regulation", Anthropology in Action, Vol. 25 No. 2, pp. 36–41.

Zambrana, R. E., Scrimshaw, S. C., Collins, N., and Dunkel-Schetter, C. (1997). Prenatal health behaviors and psychosocial risk factors in pregnant women of Mexican origin: the role of acculturation. *American journal of public health*, *87*(6), 1022-1026.

Zanini G., Raffaetà R., Krause K., Alex G. (2013). Transnational medical spaces: Opportunities and restrictions, MMG Working Paper 13-16.

Zaouaq, K. (2017). Les femmes et l'accès aux soins de santé reproductive au Maroc. *L'Année du Maghreb*, (17), 169-183.

Zederman, M. C. (2018). *Trans-state spaces of mobilisation: Tunisian activism in France in the era of Ben Ali (1987-2011)* (Doctoral dissertation, SOAS University of London).

Zeiger, D. J., Johnson, J. H. and Brunn. S. D. (1983). *Technological hazards*. Washington DC: Association of American Geographers.

Zimmerman, C., Kiss, L., and Hossain, M. (2011). Migration and health: a framework for 21st century policy-making. *PLoS medicine*, *8*(5), e1001034.

List of figures

Figure 1: Painting on the wall of a women's association in Brussels ____ *70*
Figure 2: Lockdown view ____ *82*
Figure 3: Medical information online ____ *111*
Figure 4: Medical information online ____ *111*
Figure 5: CNAM Office, La Goulette, ____ *143*
Figure 6: Signs of laboratories and medical centres in Mutuelleville, ____ *145*
Figure 7: "I don't need therapy, I just need to go to Tunisia" ____ *149*
Figure 8: Hello, how are you? Dad and mum first! ____ *152*
Figure 9: Sending medication to Tunisia 1 ____ *155*
Figure 10: Sending medication to Tunisia 2 ____ *155*
Figure 11: Waiting boxes at the clinic. ____ *186*
Figure 12: Photo of the Facebook group "IVF and insemination in Tunisia, hope is here". ____ *188*
Figure 13. Poster announcing the expansion of the Clinic in Sousse. ____ *191*
Figure 14. Painting on the wall in the clinic ____ *195*
Figure 15. Gift to Dr. Khalil "Thank God, Thanks to you". ____ *205*
Figure 16. Access control ____ *216*
Figure 17: Instances of calls for generosity on Facebook. ____ *228*
Figure 18: People in the streets of La Goulette, Tunis, 25th of July 2021. ____ *231*
Figure 19: Logo of ATE.Covid-19 ____ *234*
Figure 20: Comments on Covid-19 cases in Tunisia ____ *238*
Figure 21: Facebook comments under a publication denouncing the accusations against TRA ____ *239*
Figure 22: Press release detailing the quarantine measures in hotels designated by the Authorities. *246*
Figure 23: Fundraising for the hospital in Zarsis ____ *255*
Figure 24: Boxes from the Initiatives « Tunisia breathes» ____ *263*
Figure 25: Respiratory kit ____ *267*

Appendix I: Biographical presentation of the research actors, in their order of appearance.

Chapter 3

Jamil	Jamil works for a telecommunication company in Liège and had arrived in Belgium four years ago at the time. For several years, he had been organizing networking events in Tunis and has now replicated the same type of events in Brussels, to put members of the Tunisian community in touch with the international community living in Brussels.
Ramez	A Tunisian residing in Brussels, he is an assistant nurse and is currently in the process of opening a paramedical medical clinic in Anderlecht. He had come 10 years ago as part of an immigration convention that facilitated the recruitment of paramedics in Belgium. He has never returned since then and has slowly built a network of patients all around the city.
Skander	From Tunisia, he is a young intern completing his traineeship in a hospital in Brussels specializing in cardiology.
Fedh	Fedh moved from Tunisia to Belgium with his wife and two children about a year before I met him. They live in the city centre of Brussels.
Mohamed	Mohamed is Tunisian. He lives in Paris and is one of the staff at the social service counselling of the association Tunisian Federation for a Citizenship of Both Shores (Fédération tunisienne pour une citoyenneté des deux rives-FTCR).
Mina	An irregular Tunisian woman migrant who arrived in France just a few weeks before the delivery of her baby.
Kenza	A Tunisian consulate official in Brussels.
Sofia	Formerly a doctor for the IOM in Tunis, Sofia works in Paris as an emergency room doctor as part of the validation of her medical diplomas in France. She was part of a collective of Tunisian doctors during the pandemic.
Zeineb	A Tunisian woman residing in Brussels, who had recently left Tunisia.

Nour	Nour is a Tunisian woman, who was in Europe for about a year when she gave birth in Belgium.
Nesrine	A Tunisian woman, who arrived in Belgium while I started the fieldwork. Nesrine comes from a relatively privileged family background in Tunisia, and moved to Belgium to follow a job opportunity.
Katia	A member of AWSA, Arab Women's Solidarity Association, and social worker at the Saint-Pierre hospital in Brussels working on sexual and reproductive health (HIV-AIDS in particular).
Dounia	Dounia is a gynaecologist and sex therapist who has a medical office in Molenbeek in Brussels. She is a second-generation Tunisian and grew up in Paris. She initially came to Brussels for her medical training and has remained in the country since then.
Rym	A Tunisian woman living in Marseille, who gave birth to her daughter there.
Representative of CNAM Tunisia	A representative of National Health Insurance Fund (CNAM) in Tunisia.
Ali	A Tunisian residing in France.
Seifeddine	A Tunisian residing abroad.
Slim	A Tunisian entrepreneur who created a startup to connect TRA with healthcare professionals and services in Tunisia. He also acts as an expert on the involvement of the diaspora in the development of countries of emigration.
Communication manager medical tourism agency	A communication manager in a medical tourism agency in Tunis.
Aesthetic Surgeon	An aesthetic surgeon who has his medical office in the Northern suburb of Tunis.

Mayssa	A Tunisian woman residing abroad.
Hédi	Hédi is 56 years old and arrived in Belgium from Tunisia more than 30 years ago to complete his education as a computer engineer. He now has a small IT company that is based in Brussels and often recruits engineers from Tunisia.
Sawsen	A Tunisian woman residing in France. Sawsen has lived in the agglomeration of Paris since 2014 and works for a touristic transport company
Hassine	A Tunisian man residing in Germany.
Amen group representative	A representative of the private clinic group Amen santé in Tunis (Lac 2). They opened their first clinic in Tunis in 1994 and now have a total of six clinics in different cities in Tunisia.
Selima	A Tunisian woman living in Wetteren, Belgium.
Psychologist 1	Warda, a Tunisian psychologist interviewed in La Marsa in Tunis.
Psychologist 2	A Tunisian psychologist interviewed in Lac 2 in Tunis.

Chapter 4

Gynaecologist 1	A Tunisian gynaecologist from a fertility centre in Tunis.
Gynaecologist 2	A Tunisian gynaecologist from a fertility centre in Tunis.
Dr. Khalil	A Tunisian gynaecologist from a fertility centre in Tunis.
Taoufik	A Tunisian residing in France. He is a computer engineer and his wife is a doctor and researcher in medical sciences.
Nadia	A Tunisian woman residing in France, who carried out a reproductive journey between France and Tunisia.

Gynaecologist 3	A Tunisian gynaecologist from a fertility centre in Tunis.
Gynaecologist 4	A Tunisian gynaecologist from a fertility centre in Sousse.
Naïm	A Tunisian residing in France.
Marwa	A Tunisian woman living in Saudi Arabia.
Anissa	A second-generation Tunisian, living in Nice. She works as an assistant nurse in a hospital and her husband is a crane operator.
Soraya	A Tunisian stay-at-home mum living in Tunisia. Her husband works for the national gendarmerie in Tunis. Soraya has a sister living in Italy who also had to go through ART.
Amira	Amira is Tunisian. She was first patient from the diaspora I met at the fertility clinic in 2019, and lives in Dubai.
Amir	A Tunisian man living in Saudi Arabia, in Al Bahah for more than 5 years, working in the computer industry. He is the husband of Leila.
Leila	A Tunisian woman living in Saudi Arabia, in Al Bahah for more than 5 years, working in the computer industry. She is the wife of Amir.
Neila	A Tunisian residing in Paris and working in the IT sector.
Coordinating midwife	A coordinating midwife at a fertility clinic in Tunis.
Jihen	A 35 years old Tunisian living in Germany for 10 years.
Medhi	A 34 year-old Tunisian living in France. Medhi was born in Paris. He was unemployed at the time of the interview. He is the husband of Amal.
Amal	Amal is a Tunisian woman living in France. She is the wife of Medhi.
Safia	A 38 year-old Tunisian woman living in Germany.

Chapter 5

Ahmed	A Tunisian association member, met in Paris.
Montassar	A civil servant of the Ministry of Health in Tunis.
Zied	A Tunisian doctor residing in France, he is a young healthcare professional working as an anaesthesiologist in a hospital in the South of France.
Fakher	A Tunisian man, member of the group ATE.Covid19.
Wajdi	A Tunisian man, and civil society representative of the collective Tammanni 3lik (Reassure me) in Belgium.
Adnen	A member of a Tunisian association in France.
Kenza	A consular official in Brussels.
Oussama	A former official of the Office des Tunisiens à l' Étranger.
Karim	A Tunisian man, he is member of a Tunisian association in France.
Hassan	A Tunisian medical doctor based in Paris.
Ayoub	A Tunisian residing in France, a former leftwing activist, and founder of the Perspectivistes movement in France.
Lofti	A Tunisian civil society representative based in Paris.