D'PASS | DROITS POUR L'ACCÈS À LA SANTÉ SEXUELLE ET REPRODUCTIVE

YOUTH MIXED MIGRATION PROJECT

MIGRATION DRIVERS AND NEEDS IN SEXUAL AND REPRODUCTIVE HEALTH SERVICES

About a quantitative and qualitative survey of young migrants in Greater Tunis 2017

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Association Tunisienne de la Santé de la Reproduction

Association Membre de IPPF International Planned Parenthood Federation

UNFPA

4M

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Dr Rym Fayala
Assistant representative

ABBREVIATIONS AND ACRONYMS

- **ARV** Antiretrovirals
- **ATSR** Tunisian Association of Reproductive Health
- **DRC** Danish Refugee Council
- **ESARO** UNFPA East and Southern Africa Regional Office
- **MdM** Doctors of the World
- **UN** United Nations
- **IOM** International Organization for Migrations
- **NGO** Non-Governmental Organization
- **PNLS** National AIDS Program
- **AIDS** Acquired Immunodeficiency Syndrome
- **SRH** Sexual and Reproductive Health
- **UNFPA** United Nations Population Fund
- **UNHCR** United Nations High Commissioner for Refugees
- **GBV** Gender-based Violence
- **HIV** Human Immunodeficiency Virus
- **D'PASS** Rights to access sexual and reproductive health

ABSTRACT

INTRODUCTION

In preparation for the 51st Session of the United Nations Commission on Population and Development for the period 9-13 April 2018 to discuss migration issues, UNFPA undertook a multicenter survey in four cities (Tunis, Beirut, Cairo and Nairobi) to generate knowledge on youth migration in this region of the world for advocacy and decision-making.

The survey is part of a global project entitled «Youth Mixed Migration Project» conducted by UNFPA in partnership with the Mixed Migration Monitoring Mechanism (DRC / 4Mi).

The project aims to:

- Describe the drivers of youth migration, including push and pull factors.
- Explore sexual and reproductive health (SRH) vulnerabilities and the knowledge and service needs of young migrants in urban centers.
- Generate real-time data on the experience of young migrants, particularly with regard to sexual and reproductive health of adolescents / youth, gender-based violence and socio-economic empowerment.
- Provide key actors and data planners with data to inform service delivery and advocacy efforts.

In Tunisia, UNFPA and ATSR collaborate for the implementation of this project

SAMPLING AND METHODS

This is a quantitative questionnaire survey administered to 311 young migrants between 18 and 29 years old living in Greater Tunis, conducted between 09 September and 13 October 2017. Sampling was based on a map of migrants in Greater Tunis that took into account the distribution of young migrants by locality and sometimes even by locality, time and meeting points of the population studied, nationalities and other specific information.

The data collection was done on a tablet through the Qualtrix application on which the validated questionnaire was downloaded. The interviewers received intense training and the survey was preceded by a pilot test.

The quantitative survey was supplemented by a qualitative survey conducted in November 2017 with four (4) groups of migrants living in Greater Tunis, one (1) group of key players and one (1) group of health professionals.

The ethical approval of all the work was obtained from the biomedical ethics committee of the Pasteur Institute.

RESULTS

1) DEMOGRAPHIC CHARACTERISTICS:

Of the 311 respondents, 56.6% were female (n = 176). The average age was 23 years for women and 24 years for men; 75.2% did not live in any form of conjugal relationship in Tunisia (not in a couple).

Ivorian nationality was predominant (29.5%) followed by Cameroonian and Malian nationalities (10.3% each) then Congolese (8.4%). Only 12 respondents were Syrian nationals, i.e. 3.9%.

2) MIGRATION DRIVERS:

Push factors:
More than 90% of migrants arrived in Tunisia after 2013. The factors that pushed them to migrate were mainly studies in 27% of cases, the economic factor in 25% of cases and security reasons in 7% cases.
Pull factors :
38% of migrants cited job opportunities and quality of life, 17% cited the economic opportunities associated with safety and third the opportunities to pursue studies (14%).
Expectations:
57% of women and 37% of men found the situation in Tunisia more difficult than they expected.

3) SEXUAL AND REPRODUCTIVE HEALTH:

Knowledge:
The age at which respondents began to learn about SRH was between 10 and 14 years old in 57.4% of cases and between 15 and 19 years old in 36.1% of cases. Women considered themselves well informed in SRH in 36.2% of cases compared to 44.2% of cases in men. Respondents thought that it is possible to cure AIDS in 18.9% of cases and did not know how to answer in 32.2% of cases. In addition, 62.7% of women and 65.9% of men said that a person can do a simple HIV test to find out if they are HIV positive. Regarding contraception, respondents spontaneously cited an average of three methods, but 26.6% of women versus 41.3% of men said that contraception makes women sterile.

Attitudes:
61.3% of women and 65.9% of men agreed that a girl and a boy who loves each other should have sex ($p = 0.4$). Only 4.9% disagreed with the idea that a boy sometimes has to force a girl to have sex if he likes her and only 6.5% of respondents disagreed with the idea that it is justified that a boy sometimes hits his girlfriend. Of the young migrants interviewed, 65% thought that their friends did not use condoms regularly.

Experiences:
69% of women interviewed and 76.1% of men reported having sex ($p < 0.02$) and 84.6% of respondents did not know where to access SRH services. The use of SRH services was found in 62 respondents, including 37 women, which is the fifth of the interviewees. Of these women, 26 gave birth in health facilities, of which 12 were dissatisfied with the service.

DISCUSSION

Young migrants are forced to leave their country of origin for economic reasons, studies and in third place to escape political insecurity as was the case of Ivorian or Arabic-speaking migrants (Syria and Libya).

Tunisia has attracted them to be a transit country because entry for certain nationalities does not require an entry visa, its proximity to Europe and the good reputation of its higher education diplomas.

In terms of SRH, the majority of migrants were sexually active, started to learn about sexuality early, but less than half of them thought they were well informed, false ideas were found in relation to contraception and HIV, and especially at the level of the HIV test.

Beside, we found liberal attitudes towards sexual relations but less clear opinions about the GBV. The focus groups have also highlighted different attitudes ranging from those rejecting the GBV to those who tolerate it.

The knowledge of contraceptive methods is satisfactory since respondents cited an average of three contraceptive methods, but condom use seems limited.

The qualitative survey showed a level of satisfaction with the quality of services in the private sector much better than in the public sector. Migrants complained mainly about the quality of reception and communication with nurses and reception officers in particular.

CONCLUSION AND RECOMMENDATIONS

young migrants to Tunisia are attracted by the proximity of this country of Europe which constitutes their final destination.

Because of their irregular situation, they live in socio-economic vulnerability. Their knowledge especially of HIV infection is quite low. They are sexually active but condom use is low. Those who have used SRH services are dissatisfied with the quality of services, especially in the public sector.

It is recommended to advocate for the creation of a social and health management unit for migrants within the Ministry of Social Affairs and to strengthen the networking between the various stakeholders.

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INTRODUCTION AND JUSTIFICATION

According to the United Nations Migration Report (2015), the world counted in 2014, 244 million international migrants, and an increase of 41% over 2000. This figure includes nearly 20 million refugees. The average age of migrants in low-income countries is 25 years old. In 2016, more than 5,000 people drowned while trying to reach the shores of Europe (UNHCR, 2016).

Despite all the risks, the flow of migrants and refugees continues to grow and become a major concern for the organizations and institutions that are concerned with the management of the migratory phenomenon and the rights of migrants especially in the face of the policies of the governments that become more restrictive.

In fact, these mobile people are exposed to violations of their rights, their access to legal, social and health services is generally limited due to multiple socio-economic, linguistic, cultural and even legal barriers.

Faced with these realities, the United Nations (UN) Commission on Population and Development has planned to discuss the migration issue during its 51st session planned for the period 9-13 April 2018 for which it has chosen the theme «Cities sustainable mobility, human mobility and international migration»[1]. To this end and in preparation for this important event, UNFPA in charge of the secretariat of the commission, was responsible for conducting a multicenter survey in four cities (Tunis, Beirut, Cairo and Nairobi).) to produce knowledge on youth migration in this region of the world that will be used for advocacy and decision-making.

The four cities are in countries where there is forced and voluntary mobility, both internally and internationally, and in places where UNFPA has strong country support programs.

The survey is part of a global project entitled

[1]In : https://www.un.org/en/development/desa/population/commission/sessions/2018/index.shtml

«Youth Mixed Migration Project» conducted by UNFPA in partnership with the Mixed Migration Monitoring Mechanism Initiative (DRC / 4Mi). The project aims to:

- Describe the drivers of youth migration, including push and pull factors
- Explore sexual and reproductive health (SRH) vulnerabilities as well as the knowledge and service needs of young migrants in urban centers,
- Generate real-time data on the experience of young migrants, particularly with regard to sexual and reproductive health of adolescents / youth, gender-based violence and socio-economic empowerment
- Provide key actors and data planners with data to inform service delivery and advocacy efforts.

The choice of Tunisia among the urban centers chosen as the target area of the survey comes from the fact that since the Libyan humanitarian crisis followed by the Syrian crisis and political unrest in sub-Saharan Africa, particularly in Côte d'Ivoire, the profile of the migration in Tunisia has changed. Tunisia today has refugees, non-status asylum seekers, irregular migrants, «Harega» in addition to regular migrants from Maghreb countries, sub-Saharan Africa and neighboring European countries for various reasons.

On the other hand, few studies have attempted to analyze the situation of different groups of migrants: their needs in terms of health[2], their vulnerabilities[3], the legislative framework governing the access of these groups[4] to social and health services. In addition, in all these analyzes, migrants are generally distributed by nationality and migration profile (regular, refugee, irregular ...) not allowing extrapolation of data collected to certain groups with specific profiles such as young migrants.

As a result, this survey is expected to significantly improve knowledge on the drivers of mixed migration of young people to Tunisia, the determinants of their vulnerability and the barriers that hinder their access to SRH care.

[2] ONFP.2016 Evaluation of bases of social, economic and health vulnerabilities of migrants forward effective access to health services in Tunisia
[3] IOM.2013. Exploratory study about human trafficking in Tunisia
[4] MdM.2017 Advocacy for access of migrants to health rights in Tunisia

CHAPTER 1:
METHODOLOGY AND APPROACH

I. REVIEW OF THE LITERATURE

The documentary review was based on: (i) a review of the gray literature (Tunisian and foreign studies reports); (ii) a scientific journal using the PubMed database, and health systems evidence. The key research keywords were «migrant», «irregular migration», «migration to Tunisia», «emigration flows», «migrant, reproductive health»; (iii) visiting websites of international organizations dealing with migration and population issues (United Nations, UNFPA, IOM, UNHCR, ...) and the website of the National Institute of Statistics.

Research in the literature (see Appendix 1: Summary of a review of the literature) has made it possible to:

- √ Obtain definitions of technical terms for the object (see below),
- √ Find out about the legislative framework governing migration in Tunisia,
- √ Identify key stakeholders with vulnerable migrants in Tunisia,
- √ Also note the lack of data on migrants to Tunisia who are in an irregular situation, unlike the regular migrants on whom the data are available because of the general census of the population which is conducted every ten years in Tunisia and updates made by the National Institute of Statistics.

II. DEFINITIONS

ASYLUM SEEKER

A person seeking admission to the territory of a State as a refugee and waiting for the competent authorities to decide on his request.

PUSH AND PULL FACTORS

an explanatory model of migratory phenomena based on the combination of repulsive elements favoring emigration (such as economic, social and political problems in the country of origin) and attractive elements in the country of destination (IOM).

MIGRANT

According to the International Organization for Migration (IOM), a migrant is «anyone who crossed an international border without taking into account the reasons for the displacement, the status, or the length of his stay.

VULNERABLE MIGRANTS

Migrants who are exposed to risks threatening their existence or well-being requiring immediate specific assistance.[5]

MIGRANT IN A REGULAR SITUATION

A migrant whose entry and residence in the territory of a foreign state is in accordance with the applicable law.

MIGRANT IN AN IRREGULAR SITUATION

A migrant who contravenes the regulations of the country of origin, transit or destination, whether he has entered the territory of a State illegally, or has stayed there beyond the period of validity of the residence permit, even if it has evaded the execution of an expulsion measure.

MIXED MIGRATION

Mixed migration flows are made up of migrants and refugees who increasingly use the same routes and the same means of transport to travel abroad. If these people are unable to legally enter a country, they often use smugglers. They then engage in perilous journeys, whether by land or sea, trips in which many of them die.[6]

HUMAN TRAFFICKING

The term «the recruitment, transportation, transfer, accommodation or reception of persons by the threat of recourse or the use of force or other forms of coercion.

III. POPULATION AND METHODS

This is a quantitative questionnaire survey administered to 311 young migrants between 18 and 29
in Greater Tunis, carried out between 09 September and 13 October 2017.
The quantitative survey was supplemented by a qualitative focus group survey conducted in November 2017 with four (4) groups of migrants living in Greater Tunis, one (1) group of key players and one (1) group of health professionals.

III. 1 ABOUT THE QUANTITATIVE SURVEY

III. 1. 1 STUDY POPULATION

A. ESTABLISHMENT OF A MAP OF MIGRANTS IN GREATER TUNIS

The aim of this study was not representativeness in the statistical sense of the term, but rather the analysis of migrants' situation by approaching their reality. In addition, in the absence of a sampling frame on the mixed-migration population to Tunisia, the size of the reference population was estimated using a map drawn up by a consultant and refined through two focus groups with migrants, interviews with key actors and a field visit (see Annex 2: mapping migrants in Greater Tunis).

[5] IOM in: http://publications.iom.int/system/files/pdf/iml_9_fr.pdf (Visited on June 25, 2017)
[6] UNHCR in : http://www.unhcr.org/fr/migration-mixte.html (visited on December 08, 2017)

A table has been drawn up including:

- √ In lines: the localities (neighborhoods) in which young migrants have been identified[7],
- √ In columns: the estimated number of young migrants residing in the locality, the segments making up the locality whenever possible as well as the estimated number of young migrants aged 18-29 by segment, the meeting points, comments concerning the nationality of the migrants, the accessibility during the hours of the day and the weekdays and any other useful information. Table 1

TABLE 1: TABLE USED TO MAP

Locality	estimated number of young people 18-29 years	segments	estimated number of young people 18-29 years	meeting points (hot spots)	Comments
Locality 1	500	Segment 1	200	Point 1 Point 2	majority of the Ivory Coast women available during the weekend because they work as cleaners
		Segment 2	300		

The mapping allowed us to have the following information about our reference population:

- ▸ The distribution of places of residence in nine (09) localities and twenty-six (26) segments;
- ▸ A rough estimate of the population aged 18-29, which was about 2000 people by locality and segment within the locality;
- ▸ Accessible meeting points such as supermarkets, markets, churches, etc. ; (iv) some of its characteristics such as nationality, gender, category of migrants (regular, irregular), type of work performed etc.

However, it should be pointed out that the places of residence of Arab and Syrian Arab migrants have been less well defined for two main reasons: (i) this smaller sub-population than the sub-Saharan population is almost merged in the Tunisian population and (ii) it was less well known by the group of investigators who did not include a member of Syrian or Libyan origin.

[7] The meeting points were memorized by GPS to facilitate access to interviewers.

B. EXCLUSION CRITERIA

Migrants to Tunisia accompanied by their parents and those not intending to leave Tunisia were excluded from this study

C. SAMPLING

the survey protocol was not representative, especially since we did not have a database on the reference population more than it was intended to generate useful information that will enable UNFPA, its partners and the international community to better understand the drivers of migration, the vulnerability of migrants and especially the barriers that hinder their access to SRH services as young people.

However, we based the sample estimate on the basis of covering the 26 segments by recruiting at least 10% of the estimated population in each segment or locality and ensuring gender parity. This gave us a sample of 200 people. As the GBV was one of the priority variables to be studied, the sample was voluntarily extended with the aim of reaching a gender composition made up of 60% of women against 40% of men. Finally, our sample reached the size of 311 persons, 176 of whom were female, ie 56.6%.

D. MODE OF RECRUITMENT OF MIGRANTS

The survey protocol was based on location-based sampling and time-based sampling design. Recruitment was done directly by the interviewer at a segment benchmark. The interviews were conducted at the convenience of the interviewees either in public places (cafes, hairdressing salons, public gardens, supermarkets) or at the interviewees' homes, which was mostly the case.

III. 1.2 METHODS

A. DATA COLLECTION TOOLS

- An interview questionnaire comprising 187 questions has been prepared[8] in three English, Arabic and French versions comprising three parts:

1. Identification and demographic information about the interviewees,
2. The drivers of migration in terms of «push and pull factors»,
3. Sexual and reproductive health (SRH): knowledge, attitudes, use of SRH services, quality of SRH services (see Annex 3: questionnaire).

- A smartphone by interviewer serving as a data entry support

- A Qualtrix application on which the questionnaire was downloaded by a DRC / 4Mi expert and was used for data collection, monitoring and backup.

B.) DATA COLLECTION MEANS

Data collection was conducted in the field by a team of ten (10) interviewers and one (01) supervisor (team leader) under the direct responsibility of DRC / 4Mi who was also in charge of the data collection. data collection in the three (03) other cities (Cairo, Beirut and Nairobi). Eight (08) interviewers were selected from among

[8]The questionnaire was developed by the project team "Mixed migration Project" and translated and revised by the Tunisian team

the migrant population from sub-Saharan Africa through interviews (see Annex 4: interview guide for interviewer selection). In addition, two (02) Tunisians were recruited for interviews with Arabic-speaking migrants

For the training of interviewers, a training manual has been developed (see Annex 5: Training Manual). The interviewers benefited from two (02) training workshops:

√ the first from 21 to 24 August 2017 which focused on upgrading knowledge, strengthening skills in values and human rights, reading and discussing the questionnaire,

√ and the second on 02 and 03 September 2017 focused on the practicalities of conducting fieldwork on the basis of a guide developed for this purpose (see Annex 6: Conducting fieldwork) with exercises. on the use of the data collection instrument and familiarization with the questionnaire as well as on the rules to be respected for the safety of the interviewers during fieldwork.

C. PILOT TEST:

Before the start of the field survey, a pilot test was conducted with the objectives of:

√ test the questionnaire and the data collection instrument (smartphone and application);
√ appreciate the conditions of conducting the interview (security, confidentiality, accessibility to potential interviewees, interview environment),
√ estimate the duration of an interview,
√ And refine the mapping if necessary

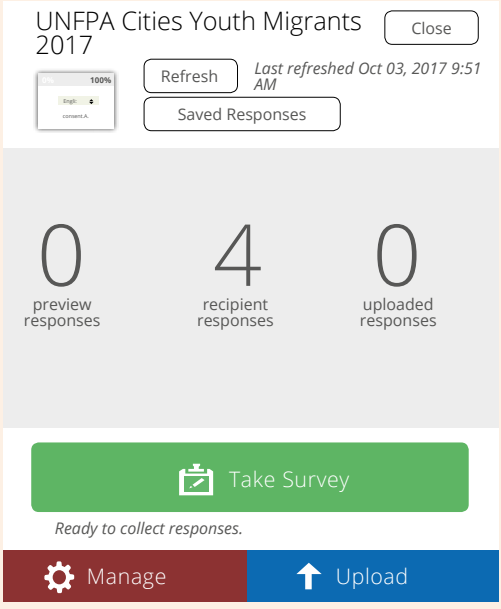
D. DATA COLLECTION

Field data collection extended from 09 September to 13 October 2017 according to a pre-established schedule by the team leader taking into account coverage of localities and segments, gender and number affected interviewees per day.

E. DATA PROCESSING:

Data processing was done in real time using Qualtrix by DRC / 4Mi. The exploitation of the data was done by the UNFPA Tunisia with the technical support of the national consultant.

FIGURE 1: QUALTRIX INTERFACE



III. 1.3 MONITORING

Field work was monitored directly by the 4Mi team (expert and team leader) with support and technical support from the national consultant. A daily monitoring log has been developed and uploaded to Google Drive allowing instantaneous and simultaneous sharing of information with members of the Tunisian team and also with other project members in other countries. In addition, the country team held weekly meetings to ensure compliance and consistency of fieldwork with the methodology.

This form was divided into two parts: (i) the first part corresponded to the daily schedule of the interviews (the localities to visit, by whom, the number and sex of the interviewees to be touched by the interviewer) and (ii) the second part was intended to collect the information collected at the end of the day by the team leader on the interviews conducted in comparison with the schedule, the complaints and feelings of the interviewees and the impressions of the interviewers including their security.

This tool helped monitor and evaluate the quality of fieldwork and make corrections as needed.

III.2 ABOUT THE QUALITATIVE SURVEY

The qualitative focus group survey aimed to complete the quantitative study and to deepen the analysis of the results obtained from groups of young people. More specifically, the survey sought to find explanations and identify specific key variations at the level of migration engines and the use of SRH services.

In addition, as the interviewees in the quantitative survey complained about the attitudes and behaviors of health professionals on the one hand, and urged non-governmental organizations (NGOs) for more support and action for the benefit of health professionals, two focus groups representing these two profiles have been added.

In total, six focus groups totaling forty-three (43) people were conducted covering the following profiles with specific objectives for each group: sub-Saharan women, trafficked women, Syrian women, sub-Saharan young people, health personnel (midwives and nurses) and key players representing associations and organizations with contact and experience closely related to the purpose of this study (Table 2). An animation guide for each focus group has been developed for a total of six (06) guides (see appendix 7: focus group guidance guides).

The recruitment of migrant participants was done through peer migrants except for Syrian women who were recruited with the help of the organization «Doctors of the World Tunisia» (MdM). The focus group of health professionals was facilitated by the director of a basic health cluster in Greater Tunis. As for the key stakeholder group, it was formed during a workshop to share the results of the quantitative survey.

All focus groups were recorded and transcripts were made.

TABLE 2: GROUPS PARTICIPATING IN THE QUALITATIVE SURVEY ACCORDING TO SPECIFIC OBJECTIVES

Group	number	Specific objectives
1. Young men migrants from sub-Saharan Africa	8	- Explore migration drivers (push and pull factors) - Better understand their attitudes towards gender-based violence (GBV) and possible violence between male migrants.
2. Young women migrants from sub-Saharan Africa	8	- Explore the female migration engines and detect any specificities (push and pull factors) - To raise their attitudes and practices regarding SRH services
3. Young migrant women trafficked[9]	8	- Better understand the phenomenon of human trafficking - Determine the different types of violence experienced by trafficked persons
4. Arabic-speaking migrant women of Syrian origin	8	- Explore migration drivers and use of SRH services as it has been difficult to interview Syrian women during the quantitative survey
5. Health staff	5	- Determine their attitudes and practices towards migrants
6. Key players	6	- Better identify the barriers to accessing SRH services according to the experience of key players.
TOTAL	43	

[9] In addition to this focus group, an interview with three women victims of trafficking from Ivory Coast was organized to explore the characteristics of trafficking and their impact on the situation of migrant women in Tunisia.

IV. ETHICAL APPROACH

The study protocol was submitted to the biomedical ethics committee of the Pasteur Institute of Tunis as a public health research institution. The visa was obtained on **27 July 2017 under the number CP 24/17** (see Annex 8: Ethical visa).

The adopted methodology was based on an approach that emphasizes respect for human rights and the ethics of research. Indeed, the steering team of this study in its two quantitative and qualitative aspects has fulfilled its commitments to:

- Inform the respondents of the objectives of the study,
- Have their consent,
- Guarantee the anonymity of the respondents and the confidentiality of the data.

V. IMPLEMENTING PARTNERS

The partners of the UNFPA Tunisia team implementing this study were:

- Internationally: UNFPA / HQ (headquarters) which oversaw the surveys at the four-city level, DRC, UNFPA regional offices for Arab countries (ASRO) and Eastern and Southern countries of Africa (ESARO),
- At the national level: the UNFPA office in Tunis, ATSR and 4Mi.

VI. ENCOUNTERED DIFFICULTIES

Some difficulties were encountered both during the quantitative and qualitative surveys. Among these difficulties, we cite the following:

1. RECRUITMENT DIFFICULTIES OF INTERVIEWEES:

these difficulties were related to age and nationality. Indeed, it was difficult to recruit migrants under the age of 24, especially women, both during the quantitative and qualitative phases. In addition, the recruitment of young Syrian women was particularly difficult during the quantitative survey for probably the following reasons: (i) the number of Syrians is low compared to migrants of other nationalities, (ii) we did not plan to recruit Syrian interviewers to facilitate communication, (iii) total dependence of Syrian women on their families who were not always favorable to participation in the interview,

2. LOGISTICAL AND PROCEDURAL DIFFICULTIES:

related to financial aspects and short turnaround times that have created a kind of pressure on the work of the country team,

3. TECHNICAL DIFFICULTIES:

were observed mainly during the qualitative survey. In fact, for the focus groups, the overall project team proposed standard questions in order to compare results between the four cities, but these questions were in fact more suited to an «in depth interview» than to a focus group and somehow hindered interactivity within groups.

CHAPTER 2

RESULTS OF THE QUANTITATIVE SURVEY

In this chapter, only the results of the quantitative survey will be presented. The results of the qualitative surveys are available in a separate report (see Annex 9: Qualitative Study on Mixed Youth Migration and Needs for Sexual and Reproductive Health Services, Synthesis Report 2017) and will be used in the discussion of the results of the quantitative survey.

I. DEMOGRAPHIC CHARACTERISTICS OF THE POPULATION

Of the 311 respondents, 56.6% were female (n = 176). The average age was 23 years for women and 24 years for men; 75.2% did not live in any form of conjugal relationship in Tunisia (not in a couple).

Ivorian nationality was predominant (29.5%) followed by Cameroonian and Malian nationalities (10.3% each) then Congolese (8.4%). Only 12 respondents were Syrian nationals, i.e. 3.9%. Table 3

TABLE 3: DISTRIBUTION OF RESPONDENTS BY NATIONALITY AND SEX

No.	Origin Country	Female	Male	Total
1	Côte d'Ivoire	58	34	92
2	Cameroon	19	13	32
3	Congo (Kinshasa)	19	7	26
4	Mali	13	19	32
5	Burkina-Faso	13	11	24
6	Senegal	8	5	13
7	Congo (Brazzaville)	7	4	11
8	Syria	6	6	12
9	Other sub Saharian*	31	24	55
10	Other non sub Saharian**	2	12	14
	TOTAL	176	135	311

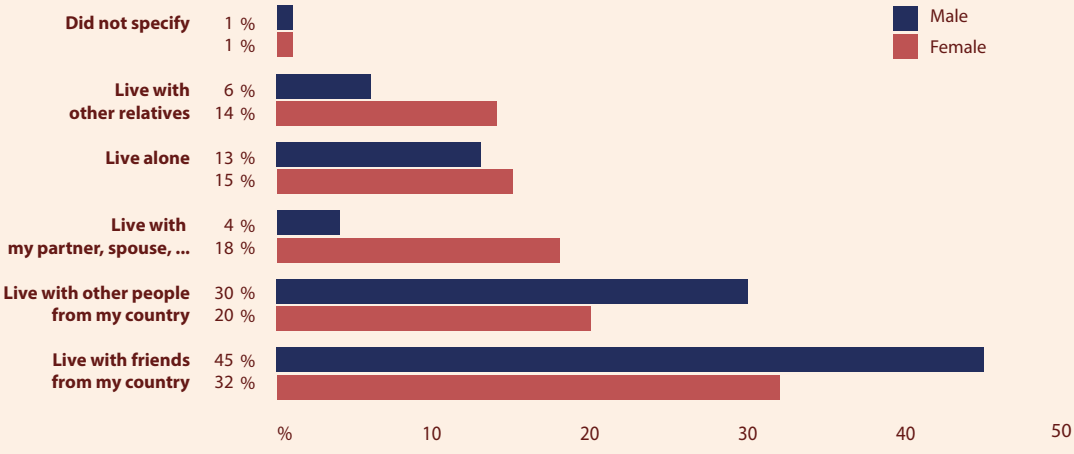
** Other sub Saharian: Guinea, Gabon, Benin, CAR, Liberia, Togo, Nigeria, Angola, Ghana, Comoros Islands, Equatorial Guinea, Niger, Chad, Gambia*
*** Other non sub Saharian: Mauritania, Morocco, Libya, Indonesia, Djibouti*

Of the 311 respondents, 95% of women (n = 167) and 88% of men (n = 119) arrived in Tunisia after 2013 (p = 0.03), 85% lived with relatives, friends, spouse or other and 15% lived alone without a statistically significant difference between men and women. (Table 4, Figure 1)

TABLE 4: PERIOD OF ARRIVAL OF MIGRANTS IN TUNISIA BY SEX

	Female	Male
2011 or before	2%	1%
2012	1%	1%
2013	2%	10%
2014	10%	17%
2015	24%	27%
2016	38%	29%
2017	23%	16%
TOTAL (%)	100%	100%
TOTAL (N)	176	135

FIGURE 1: DISTRIBUTION OF RESPONDENTS BY LIVING SITUATION AND SEX



Regarding the people to whom the migrants could confide in case of problems, 52% of the interviewees (n = 162) answered that they had someone. The family comes in first and the spouse in second place for women, while for men, the family comes first and the combination «family and friends» in second place. Table 5

TABLE 5: DISTRIBUTION OF MIGRANT RESPONDENTS BY GENDER AND PROFILE OF PEOPLE THEY TRUST

	Female	Male
Yes	51%	53%
No	47%	47%
Declined to answer	2%	0%
TOTAL (%)	100%	100%
TOTAL (N)	176	135

	Female	Male
Family members only	62%	59%
Combination of family and friends	3%	27%
Friends from this city	2%	8%
Migrant friends only	6%	4%
Others	2%	1%
Partner, spouse, Boy/Girlfriend	24%	0%
TOTAL (%)	100%	100%
TOTAL (N)	90	71

II. REPORTED AUTO MIGRATION DRIVERS

II.1 PUSH AND PULL FACTORS

About the factors that pushed migrants to leave their country (push factors), 70% of respondents (n = 217) cited a single factor that is the factor of studies in 27% of cases (n = 83), followed of the economic factor in 25% of cases (n = 77) then the reasons of safety in 7% of cases (n = 21). This same order is found among men, while among women, the economic factor took the first place while the security factor represented only 3% against 12% for men, the difference being statistically significant. Table 6

TABLE 6: DISTRIBUTION OF PUSH FACTORS BY GENDER

	Female		Male		Total		p
Single-faceted reasons	**n**	**%**	**n**	**%**	**n**	**%**	
Economic opportunity/Work	51	29%	26	19%	77	25%	0,002
Education	44	25%	39	29%	83	27%	
Personaland/or family reasons	16	9%	3	2%	19	6%	
Insecurity or violence (Security)	5	3%	16	12%	21	7%	
Other	4	2%	14	10%	17	5%	
Subtotal	120	68%	97	72%	217	70%	
Multi-faceted reasons	56	32%	38	28%	94	30%	
Total	176	100%	135	100%	311	100%	

As for the factors that attracted respondents according to their statements, to migrate to the country of final destination (pull factors) knowing that Tunisia was a transit country, we found that among the 307 respondents, 38% (n = 116) cited job opportunities and quality of life, 17% (n = 53) cited economic opportunities associated with safety, and third, opportunities to pursue education (14%, n = 42). This last factor seems less attractive for men than for women (5% versus 20%). Similarly for the factor related to security and individual freedoms, it was more cited by women than men: 10% against 2% (p = 0.003). Table 7

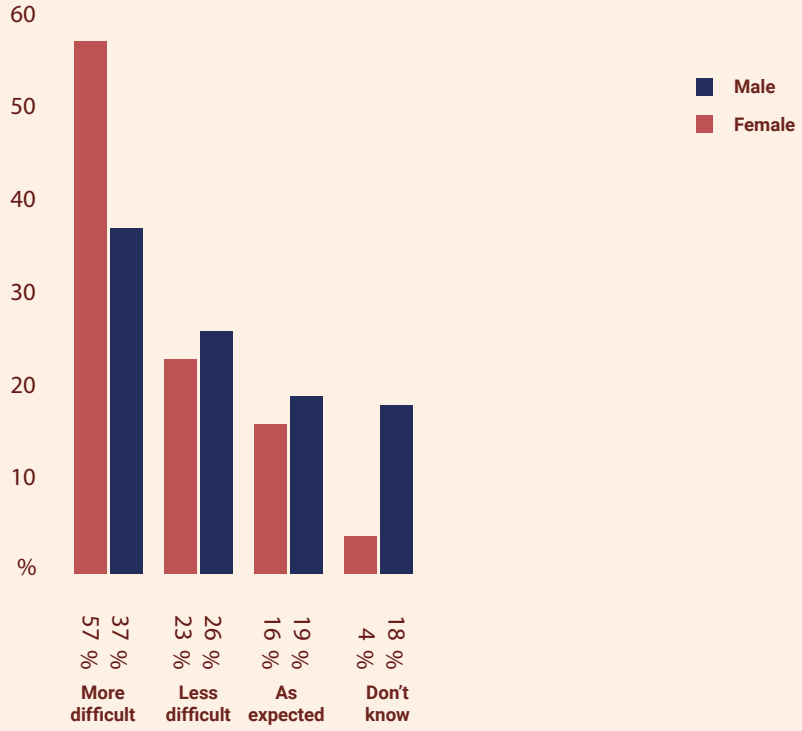
TABLE 7: DISTRIBUTION OF PULL FACTORS BY SEX

	Female		Male		Total		p
	n	%	n	%	n	%	
Economic and labor opportunities,improved standards	63	37%	53	39%	116	38%	0,003
Educationnel opportunities	35	20%	7	5%	42	14%	
General security & personnel freedoms	18	10%	3	2%	20	7%	
General security & economic opportunities	25	14%	28	21%	53	17%	
Others	32	18%	44	33%	76	25%	
Total	176	100%	134	100%	307	100%	

II.2 SELF-REPORTED EXPECTATIONS, RISKS INCURRED AND HYPOTHETICAL REASSESSMENT OF THE MIGRATORY ACT

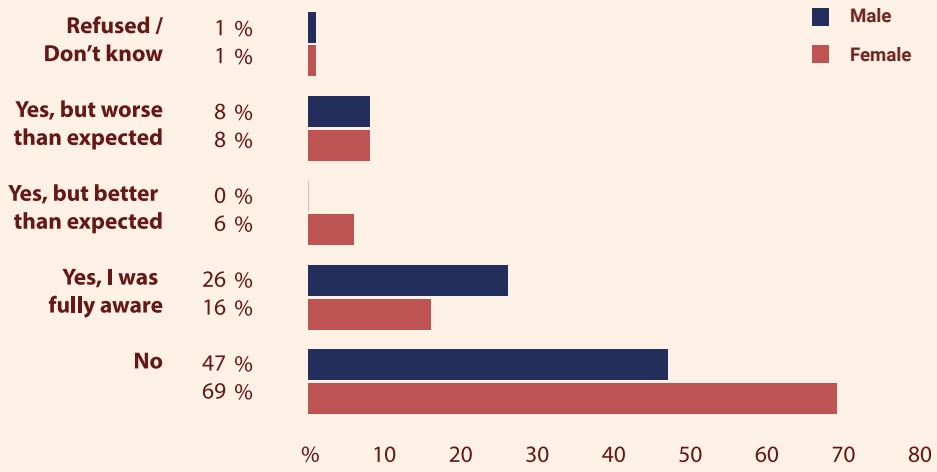
To the question «Was the time spent in Tunis more difficult than expected or as planned or less difficult than you had planned? 57% of women (n = 100) versus 37% of men (n = 50) answered «more difficult» (p <0.005). Figure2

FIGURE 2: DISTRIBUTION OF GENDER RESPONSES TO THE QUESTION: «WAS THE TIME SPENT IN TUNIS MORE DIFFICULT THAN EXPECTED OR AS PLANNED OR LESS DIFFICULT THAN YOU HAD PLANNED?»



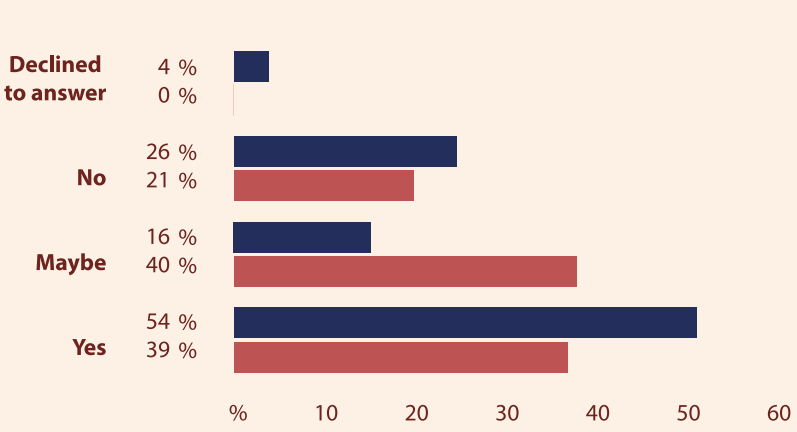
To the question «Before you started your trip, were you aware of the risks involved in the migration? 69% of women (n = 118) and 47% of men (n = 64) among 311 respondents said they were not aware of this, compared to 16% of women (n = 18) and 26% of men (n = 35) who were completely conscious with a statistically significant difference. On the other hand, 8% of the migrants (n = 25) who were aware of the risks thought it was worse than they expected and only 11 female migrants, 6% thought they were aware but that it was not worse than they expected. Figure 3

FIGURE 3: AWARENESS OF THE RISKS OF MIGRATION FROM THE COUNTRY OF ORIGIN



Of the 311 respondents to the question «would you have migrated knowing what you know? In order to appreciate their hypothetical self-assessment of the migratory act if they knew before migration what they knew after, we found an answer by «yes» or «maybe» in 79% of cases in women (n = 139) versus 70% in men (n = 95) (p <0.001). Figure 4

FIGURE 4: GENDER DISTRIBUTION TO THE QUESTION «WOULD YOU HAVE MIGRATED KNOWING WHAT YOU KNOW?»



II.3 COMMUNICATION ON THE EXPERIENCE OF MIGRATION

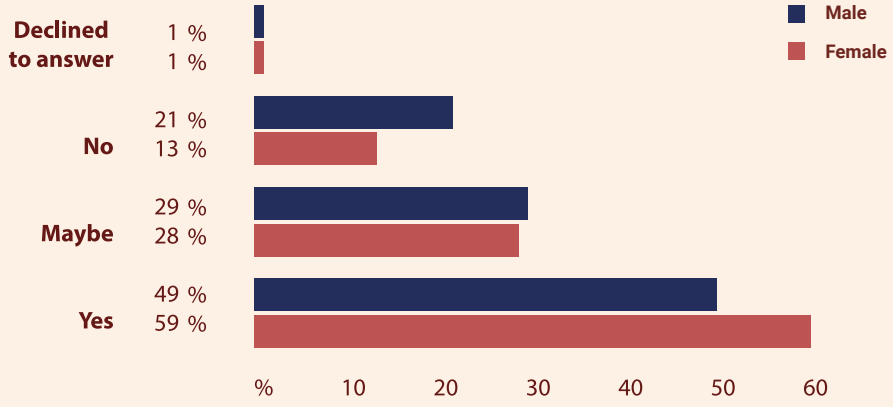
When asked the 311 respondents, «Did anyone encourage you to migrate? 36% (n = 113) said they made the decision alone, half of whom were women (n = 56) and 26% (n = 80) were encouraged by parents with no statistically significant difference between men and women. In addition, **10 migrants including 9 women were encouraged by traffickers / smugglers.** Table 8

TABLE 8: DISTRIBUTION OF RESPONSES TO THE QUESTION «DID ANYONE ENCOURAGE YOU TO MIGRATE?» BY GENDER

	Female		Male		Total		p
Single factors	**n**	**%**	**n**	**%**	**n**	**%**	
No, I made the decision alone	56	32%	57	42%	113	36%	0,12
Parents	49	28%	31	23%	80	26%	
Other family	25	14%	14	10%	38	12%	
Friends	16	9%	18	13%	33	11%	
Smugglers	9	5%	1	1%	10	3%	
Other	2	1%	1	1%	3	1%	
Multiple factors	19	11%	13	10%	32	10%	
Total	176	100%	135	100%	311	100%	

Finally, among the 311 migrants who answered the question «Would you encourage others to migrate irregularly knowing what you know now? The answer by «yes» was found in 59% of cases in the female sex (n = 103) against 49% in the male sex (n = 66) without a statistically significant difference. Figure 5

FIGURE 5: DISTRIBUTION OF RESPONSES TO THE QUESTION «WOULD YOU ENCOURAGE OTHERS TO MIGRATE IRREGULARLY KNOWING WHAT YOU KNOW NOW? »BY SEX



III. SEXUAL AND REPRODUCTIVE HEALTH (SRH)

III.1 GENERAL KNOWLEDGE

III.1.1 MAIN SOURCE OF INFORMATION IN SRH

Among young migrants, the main source of information in SRH was mother and school in 34% (n = 58) and 22% (n = 38) of female migrants, respectively. However, according to male migrants, the main source of information was school followed by mother in 34% (n = 47) and 17% (n = 23) respectively. Note that the third main source of information was among women the sister in 15% of cases (n = 26) while among men, she was friends and video films in 11% of cases (n = 15) for each of the two sources. Table 9

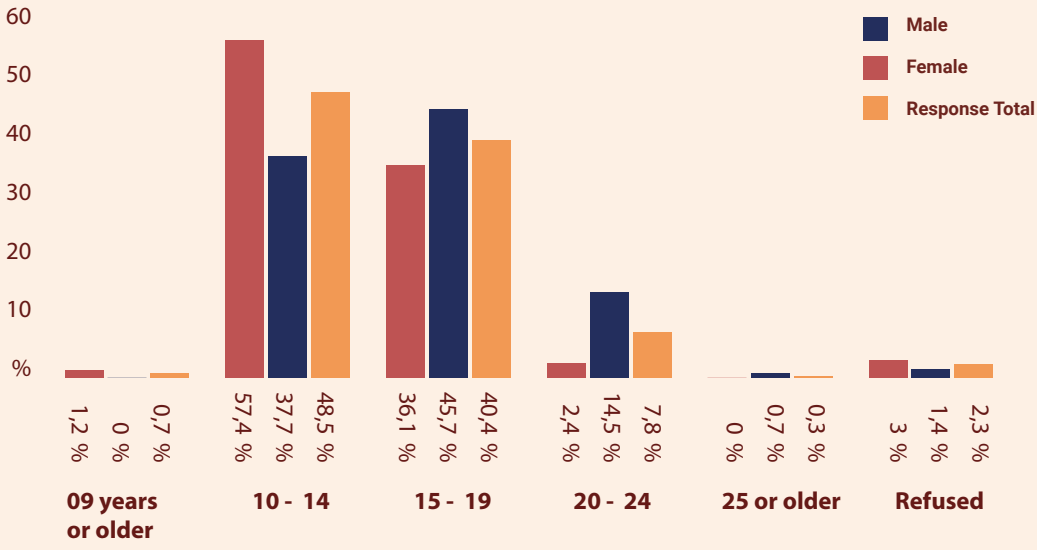
TABLE 9: DISTRIBUTION OF THE MAIN SOURCE OF INFORMATION ON SRH BY SEX

Response	Female		Male		Total	
	n	%	n	%	n	%
School teacher	38	22%	47	34%	85	28%
Mother	58	34%	23	17%	81	26%
Father	1	1%	14	10%	15	5%
Brother	0	0%	2	1%	2	1%
Sister	26	15%	2	1%	28	9%
Other family members	10	6%	10	7%	20	7%
Friends	19	11%	15	11%	34	11%
Doctors or nurses	1	1%	4	3%	5	2%
Books or magazines	2	1%	2	1%	4	1%
Posters or brochures	1	1%	0	0%	1	0%
Films or videos	3	2%	15	11%	18	6%
Place of worship	0	0%	0	0%	0	0%
Youth organisation	4	2%	2	1%	6	2%
Refused	6	4%	2	1%	8	3%
Total	169	100%	138	100%	307	100%

III.1.2 AGE OF YOUNG MIGRANTS TO WHOM THEY LEARNED ABOUT SRH

The age at which 307 respondents began to learn about SRH was included in girls between 10 and 14 in 57.4% of cases (n = 97) and between 15 and 19 in 36.1% of cases (n = 61) while in boys, the age between 10 and 14 years was found in 37.7% of cases (n = 52) and between 15 and 19 years in 45.7% of cases (n = 63) with a statistically significant difference between girls and boys. Figure 6
In addition, 94.7% (n = 160) of the women interviewed reported that they had not learned anything about SRH since their arrival in Tunisia, compared with 77.7% (n = 99) of men (p <0.001).

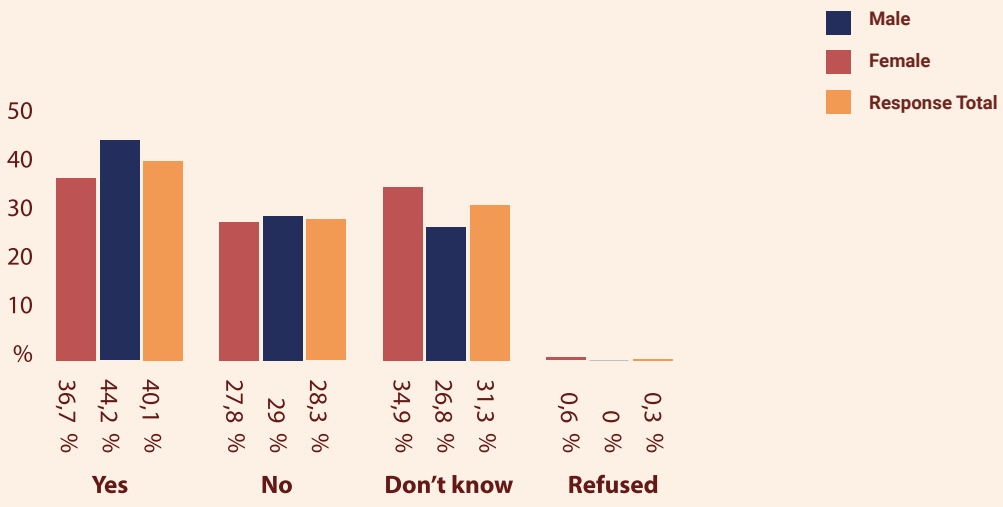
FIGURE 6: AGE DISTRIBUTION AT WHICH RESPONDENTS STARTED TO LEARN ABOUT SRH BY SEX



III. 1.3 PERCEPTION OF YOUNG MIGRANTS ABOUT THEIR LEVEL OF INFORMATION ON SRH

To the question «In general, do you think you are well informed about SRH? Women answered «yes» in 36.7% of cases (n = 62) and «I do not know» in 34.9% of cases (n = 59) while the same responses were observed successively 44.2% cases (n = 61) and 26.8% of cases (n = 37) in men with no statistically significant difference between the two sexes. Figure 7

FIGURE 7: DISTRIBUTION OF RESPONSES TO THE QUESTION BY SEX «IN GENERAL, DO YOU THINK YOU ARE WELL INFORMED ABOUT SRH? »BY SEX

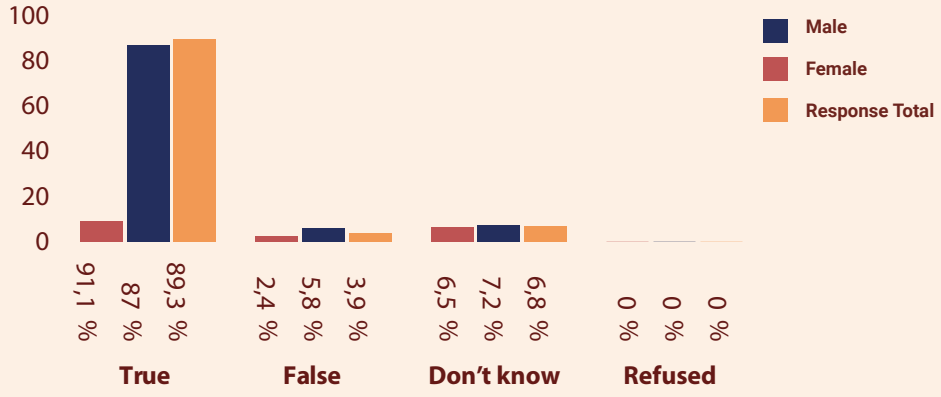


III.2 LEVEL AND CONTENT OF KNOWLEDGE

III.2.1 FIRST INTERCOURSE AND PREGNANCY

Of the 307 respondents, 89.3% (n = 274), 91.1% of women and 87% of men thought a woman could get pregnant the first time she had sex without a statistically significant difference between male and female sexes. Figure 8

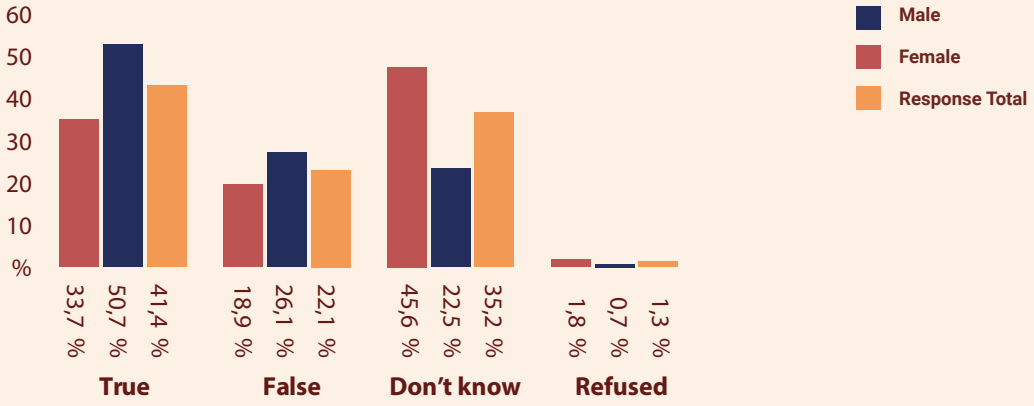
FIGURE 8: DISTRIBUTION OF GENDER RESPONSES TO THE STATEMENT «A WOMAN CAN GET PREGNANT THE VERY FIRST TIME SHE HAS SEX»



III.2.2 EFFECT OF MASTURBATION ON HEALTH

According to responses from 307 respondents, 33.7% of women (n = 57) and 50.7% of men (n = 70) thought that masturbation causes serious damage to health while 45.6% of women (n = 77) and 22.5% of men (n = 31) do not know (p <0.001). Figure 9

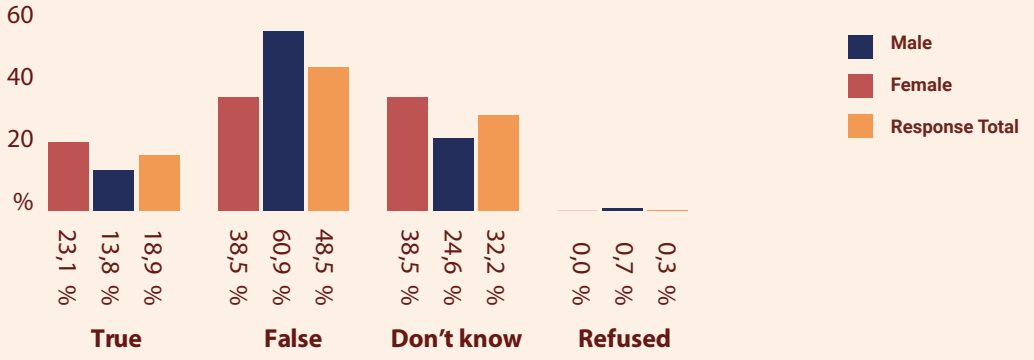
FIGURE 9: EFFECT OF MASTURBATION ON HEALTH BY SEX



III.2.3 KNOWLEDGE ABOUT HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION

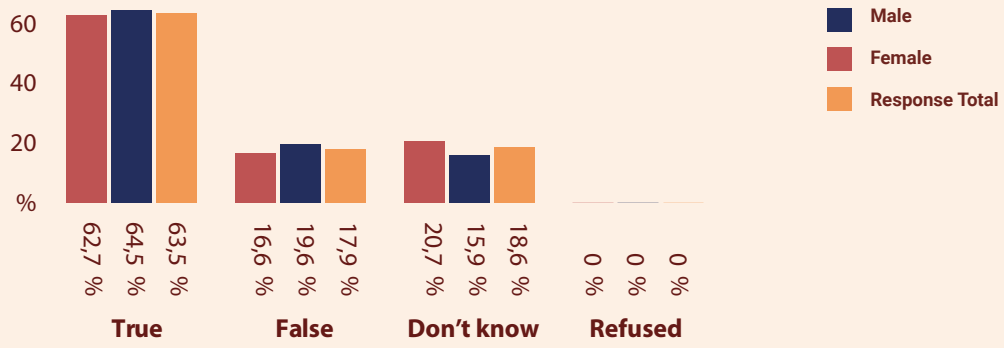
Of the 307 respondents to knowledge questions about HIV infection, 38.5% of women (n = 65) versus 60.9% of men (n = 84) thought that they could not cure acquired immunodeficiency syndrome (AIDS). The rest of the respondents thought that they could be cured in 18.9% of cases (n = 58) or did not know how to respond in 32.2% of cases (n = 99) with a statistically significant difference between men and women. Figure 10

FIGURE 10: DISTRIBUTION OF GENDER RESPONSES TO THE POSSIBILITY OF CURING AIDS



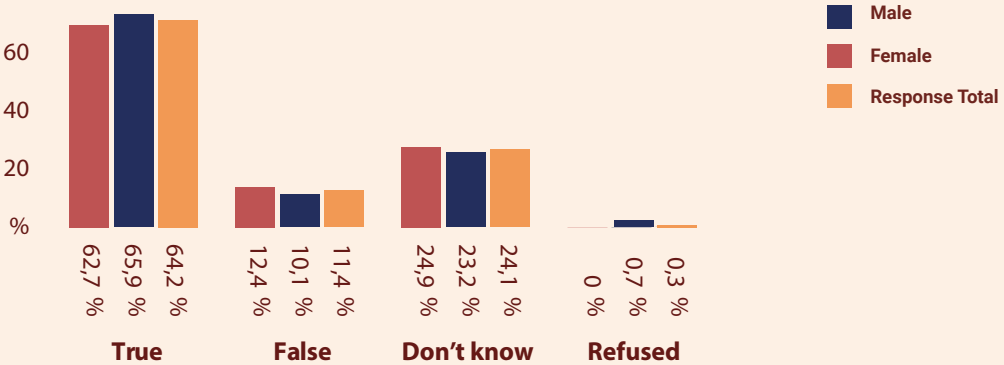
In addition, the interviewees answered «true» to the statement that one can contract HIV and lead a healthy life in 63.5% of cases (62.5% for women (n = 106) against 64.5% for men (n = 89)) (p = 0.5). Figure 11

FIGURE 11: GENDER BREAKDOWN OF RESPONDENTS TO THE STATEMENT «IT IS POSSIBLE TO CONTRACT HIV AND LEAD A HEALTHY LIFE»



Finally, we found that among the 307 interviewees, 197 (or 64.2%), including 106 women (62.7%), thought that a person could do a simple HIV test to find out if they were HIV-positive compared to 65.9% for men without difference. statistically significant. Figure 12

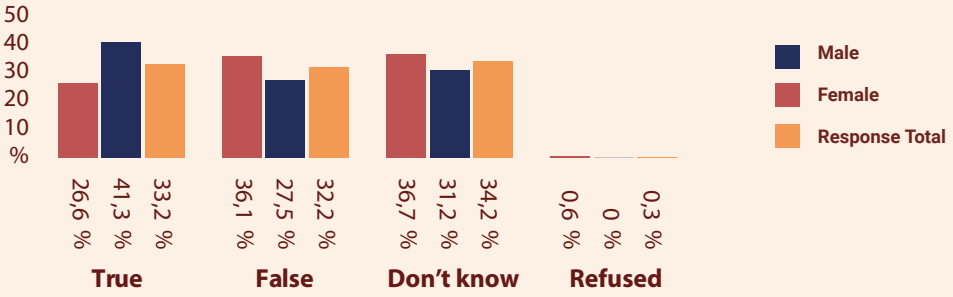
FIGURE 12: «A PERSON CAN KNOW IF HE OR SHE IS HIV POSITIVE BY SIMPLE HIV TEST» BROKEN DOWN BY SEX



III.2.4 ABOUT CONTRACEPTION

According to responses from 307 interviewees about the effect of contraception on female fertility, 26.6% of women (n = 45) versus 41.3% of men (n = 57) thought contraception made women infertile. 36.7% of women (n = 62) and 31.2% of men (n = 43) responded that they did not know (p = 0.025). Figure 13

FIGURE 13: DISTRIBUTION OF RESPONSES BY SEX TO THE STATEMENT «CONTRACEPTION MAKES THE WOMAN STERILE»



By asking 307 respondents to list the contraceptive methods they knew, both sexes cited an average of three contraceptive methods, but not in the same order for women as for men. In fact, the first three methods mentioned by women were in descending order: the pill (81%), the condom (78%) and the injection (49%), while for men it was: the condom (79%). %) then the pill (70%), then the injection (37%). And finally, the condom was the most cited (87% of respondents). Table 10

TABLE 10: DISTRIBUTION OF CONTRACEPTIVE METHODS BY SEX

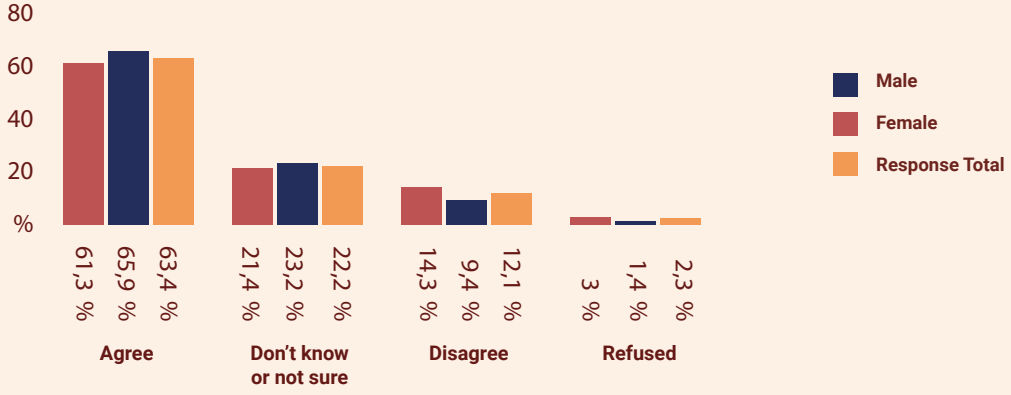
	Female		Male		Response Total	
	n	%	n	%	n	%
Pill	137	81%	118	70%	255	83%
Injection	82	49%	63	37%	145	47%
Condom	132	78%	134	79%	266	87%
IUD	48	28%	16	9%	64	21%
Implant	38	22%	13	8%	51	17%
Withdrawal	29	17%	39	23%	68	22%
Other	13	8%	20	12%	33	11%
Refused	10	6%	1	1%	11	4%

III.3 ATTITUDES

III.3.1 YOUNG MIGRANTS' VIEWS ON SEXUAL RELATIONS BETWEEN UNMARRIED GIRL AND BOY WHO LOVE EACH OTHER

According to the 306 responses, 61.3% of women (n = 103) and 65.9% of men (n = 91) agreed that a girl and boy who love each other should have sex (p = 0.4). Figure 14

FIGURE 14: GENDER DISTRIBUTION OF THE OPINION OF YOUNG MIGRANTS ON SEX BETWEEN UNMARRIED GIRLS AND BOYS WHO LOVE EACH OTHER

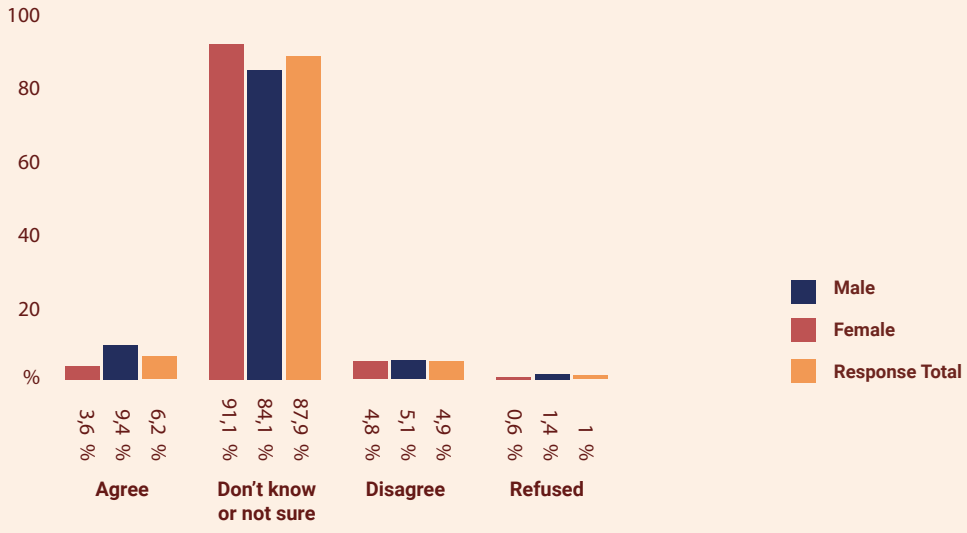


III.3.2 YOUNG MIGRANTS' VIEWS ON GENDER-BASED VIOLENCE (GBV)

The forms of GBV that were explored were sexual and physical abuse:

About sexual violence, of the 306 respondents, only 4.9% (n = 15) disagreed with the idea that a boy sometimes has to force a girl to have sex if he love her. The majority (87.9%) (n = 269) said they were not sure or did not know among which there were 153 women, i.e. 91.1% of female respondents and 116 men (84.1% of sex respondents) (p <0.01). Figure 15

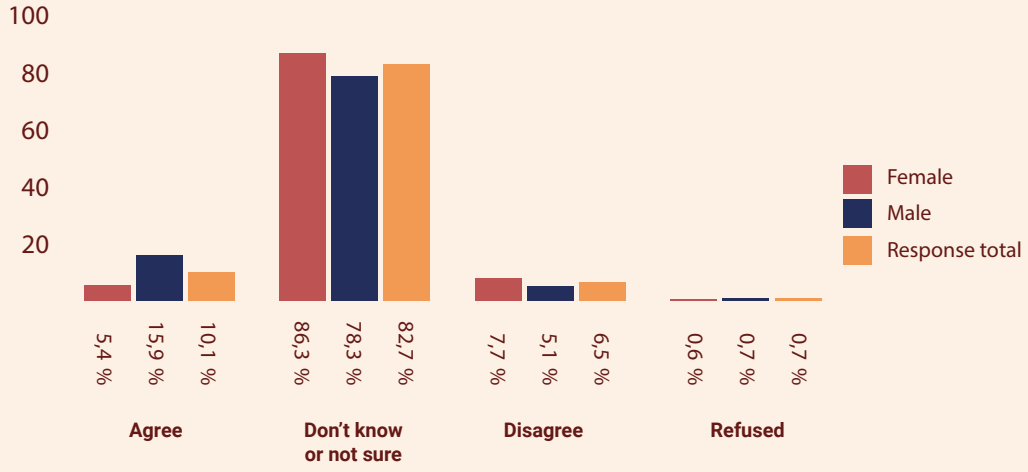
FIGURE 15: SEX DISTRIBUTION OF YOUNG MIGRANTS' VIEWS ON FORCED SEX[10]



Regarding physical violence, only 6.5% of respondents (n = 20) disagreed with the idea that it is justified for a boy to sometimes hit his girlfriend while 82.7% (n = 253) of whom 86.3% of female respondents (n = 145) and 78.3% of male respondents (n = 108) did not know or were not sure with a statistically significant difference between men and women. Figure 16

[10] "I think sometimes a boy has to force a girl to have sex if he likes her"

FIGURE 16: GENDER DISTRIBUTION OF YOUNG MIGRANTS' VIEWS ON PHYSICAL VIOLENCE[11]



III.3.3 YOUNG MIGRANTS' VIEWS ON CONTRACEPTION

In asking young migrants their opinion on «regular condom use by their friends», 23.9% (n = 73) agreed among 306 respondents, while 65% (n = 199) disagreed that they regularly used the condom during intercourse in (p = 0.6).
On the other hand, to the question whether they were convinced that they could insist on condom use every time they had sex, 58.8% of respondents (n = 180) agreed, including 109 women (64.9%) and 71 men (51.4%) with a statistically significant difference between men and women. Table 11

[11] Sometimes it's justified that a boy hits his girlfriend

TABLE 11: MIGRANT GENDER OPINION ON CONDOM USE

The majority of my friends who have sex with others regularly use condoms.

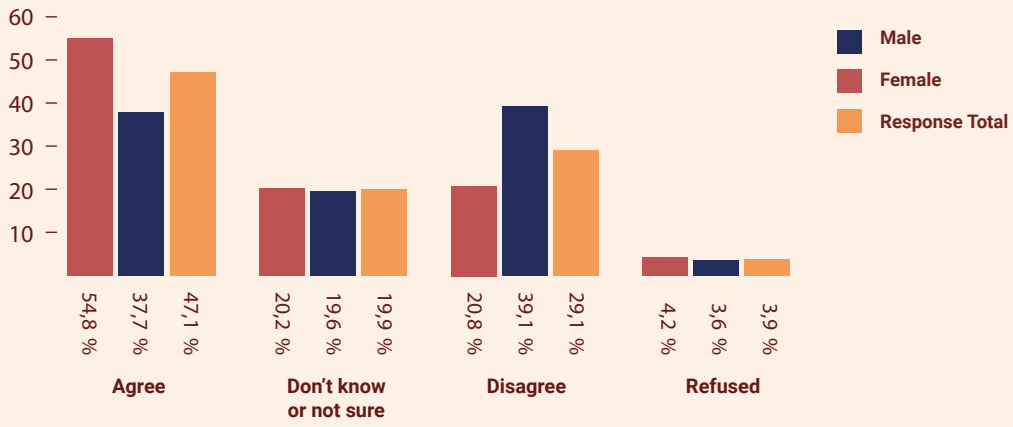
	Female		Male		Total	
Response	**n**	**%**	**n**	**%**	**n**	**%**
Agree	44	26,2%	29	21,0%	73	23,9%
Don't knoW or not sure	13	7,7%	11	8,0%	24	7,8%
Disagree	107	63,7%	92	66,7%	199	65,0%
Refused	4	2,4%	6	4,3%	10	3,3%
Total	168	100%	138	100%	306	100%

I am convinced that I can insist on the use of condoms every time I have sexual relationship.

	Female		Male		Total	
Response	**n**	**%**	**n**	**%**	**n**	**%**
Agree	109	64,9%	71	51,4%	180	58,8%
Don't knoW or not sure	5	3,0%	9	6,5%	14	4,6%
Disagree	38	22,6%	51	37,0%	89	29,1%
Refused	16	9,5%	7	5,1%	23	7,5%
Total	168	100%	138	100%	306	100%

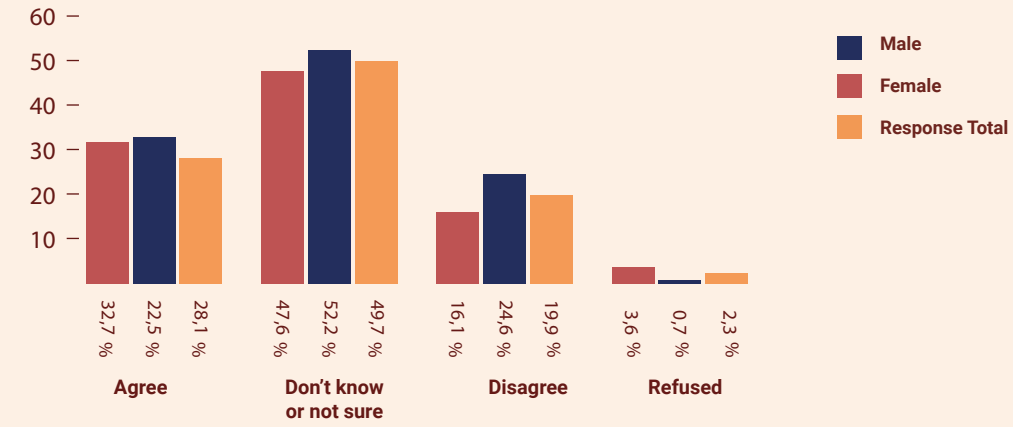
About their opinion on abortion (abortion), 54.8% of women (n = 92) versus 37.7% of men (n = 52) among 306 respondents, agreed that they would consider never have an abortion or have the partner suffer (p <0.001). Figure 17

FIGURE 17: GENDER DISTRIBUTION OF THE OPINION OF YOUNG MIGRANTS ON THE IDEA OF HAVING AN ABORTION OR HAVING THE PARTNER UNDERGO AN ABORTION



Finally, we asked the interviewees to give their opinion on the following statement: «It is the woman's responsibility to ensure that contraception is regularly used.» Of the 306 respondents, those who agreed were 32.7% (n = 55) for women versus 22.5% (n = 31) for men, those who did not know accounted for 47.6% (n = 80) for women against 52.2% (n = 72) for men with a statistically significant difference between the sexes. Figure 18

FIGURE 18: GENDER DISTRIBUTION OF MIGRANTS' VIEWS ON WOMEN'S RESPONSIBILITY FOR CONTRACEPTION[12]



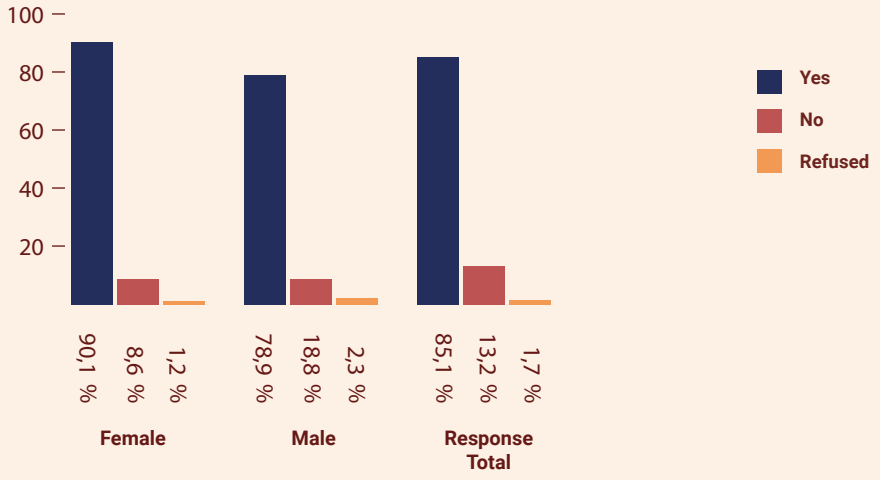
[12] «It is the woman's responsibility to ensure that contraception is regularly utilized»

III.4 HEALTH, SEXUAL AND REPRODUCTIVE HEALTH AND USE OF SERVICES

III.4.1 HEALTH AND SEXUAL AND REPRODUCTIVE HEALTH

To the question «Do you consider that overall you are in good health? We had 295 responses, of which 90.1% (n = 146) of women answered yes to 78.9% (n = 105) of men (p <0.01). Figure 19

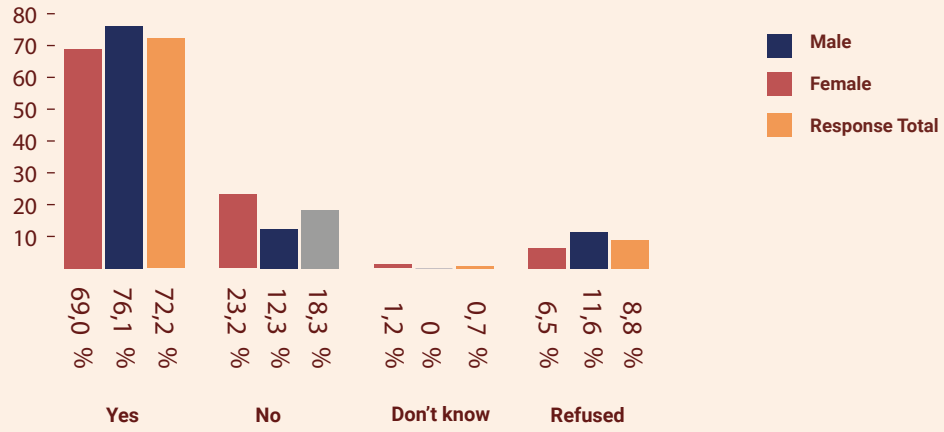
FIGURE 19: PERCEPTION OF HEALTH BY GENDER



Of the 306 respondents, 71.9% (n = 220) felt that their health was at risk during their trip and 74.8% (n = 229) reported that their health has not deteriorated or improved since their migration towards Tunisia.

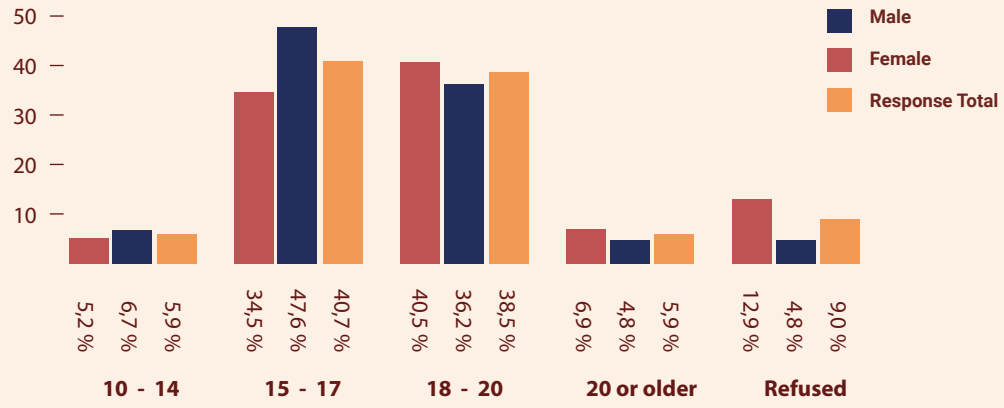
Considering SRH, among the 306 respondents, 72.2% (n = 221) reported having sex with 69% (n = 116) of women versus 76.1% (n = 105) of men (p <0.02). Figure 20

FIGURE 20: DISTRIBUTION OF SEXUAL RELATIONS ACCORDING TO AGE



Age at first intercourse was between 15 and 17 years in 40.7% of cases and between 18 and 20 years in 38.5% of cases without a statistically significant difference between girls and boys. Figure21

FIGURE 21: DISTRIBUTION OF AGE AT FIRST SEXUAL INTERCOURSE BY SEX



III.4.2 USE OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Knowledge of structures offering SRH services: among the 306 respondents, 83.3% of women (n = 140) versus 86.2% of men (n = 119) did not know where to access SRH services in Greater Tunis without a statistically significant difference between men and women. Figure 22

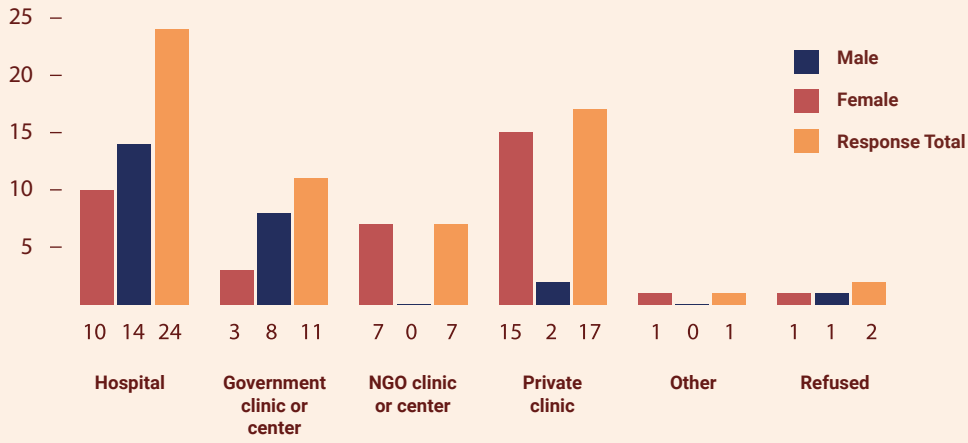
FIGURE22: KNOWLEDGE OF SRH SERVICES PROVIDED BY MIGRANTS BY GENDER

Use of health services: by asking interviewees if they consulted health facilities in general, only 90 of them answered, 62 of whom said they had consulted. Of these, 36 consulted for reasons unrelated to SRH while 24 respondents consulted for SRH-related reasons, including 15 for pregnancy and 07 for testing or diagnosis of HIV infection. Figure 23

FIGURE 23: DISTRIBUTION OF REASONS FOR CONSULTATION OF HEALTH STRUCTURES BY SEX

Types of health structures visited: among the 62 respondents who consulted health facilities, 35 visited public health establishments (hospital, health center), and 17 consulted in the private sector and 07 consulted NGOs structures. Figure 24

FIGURE 24: SEX DISTRIBUTION OF TYPES OF HEALTH FACILITIES VISITED



Response of SRH care services to the needs of migrants: As shown in Table 12, of the 62 respondents who used health care services, 55 (88.7%) reported receiving the service for which they consulted and 46 out of 55 respondents (74.2%) said that they had been informed that they could return at any time. In contrast, «do not know» responses were almost complete with respect to the question about information on the date of return to the follow-up consultation (53 out of 55 respondents). Finally, the option offered to see the same service provider was reported by 26 women out of 32 while the 23 men all responded with «I do not know

TABLE 12: YOUNG MIGRANTS AND CARE SERVICES RECEIVED

	Female				Male				Total
	Yes	No	Don't know / refused	Subtotal	Yes	No	Don't know / refused	Subtotal	
Did you receive the services that you came for?	32	4	1	37	23	2	0	25	62
Did you receive the option of seeing the same service provider during your follow up visit?	26	1	5	32	0	0	23	23	55
Have you been informed when to return for your follow-up visit?	1	1	30	32	0	0	23	23	55
Have you been informed that you can return at any time if you have questions or problems?	30	6	1	37	16	3	6	25	62

III.4.3 ABOUT «YOUTH-FRIENDLY» CARE FACILITIES

Reception and comfort: Table 13 presents the responses of the 62 migrants who used care services to four (04) questions about the quality of reception and comfort. The majority of male and female respondents found the waiting room comfortable and the facility clean. In addition, the majority of respondents stated that they felt comfortable asking questions during the consultation and that they received appropriate answers to the questions asked.

TABLE 13: RESPONDENTS' RATINGS BY SEX OF QUALITY OF HOME CARE

	Female				Male				Total
	Yes	No	Don't know / refused	Subtotal	Yes	No	Don't know / refused	Subtotal	
Do you think that the waiting room was comfortable?	29	7	1	37	21	1	3	25	62
Did you find the facility clean?	28	7	2	37	22	1	2	25	62
Did you feel comfortable enough to ask questions during the consultations?	28	8	1	37	20	1	4	25	62
Were the questions you asked during the consultations answered adequately?	24	2	2	28	19	1	0	20	48

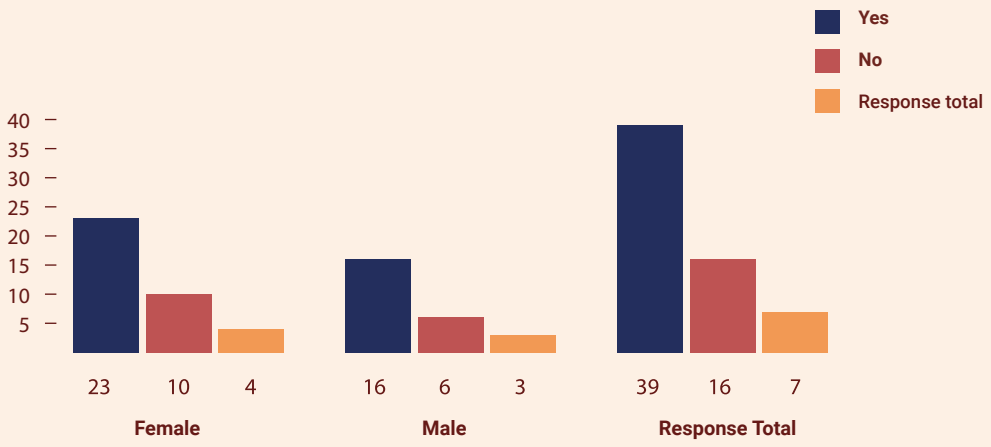
Information and confidentiality: among the 62 collected answers about the quality of information and confidentiality provided, the majority stated that the information on opening hours of the establishment were displayed in an understandable language (64.5%), that the posters and leaflets were useful (59.7%) and that privacy and confidentiality were respected (75.8% and 72.6% respectively). Figure 14

FIGURE 14: RESPONDENTS' APPRECIATION BY GENDER ON THE QUALITY OF INFORMATION RECEIVED AND CONFIDENTIALITY

	Female				Male				Total
	Yes	No	Don't know / refused	Subtotal	Yes	No	Don't know / refused	Subtotal	
Did you notice any signboard in a language you understand that mentions the operating hours of the facility?	19	16	2	37	21	1	3	25	62
Were there posters or booklets on display that were meaningful to you?	23	11	3	37	14	4	7	25	62
Do you feel your privacy was respected during the consultation?	29	7	1	37	18	3	4	25	62
Do you feel confidentiality was respected?	27	5	5	37	18	1	6	25	48

Cost of services provided: among 62 respondents, 23 women and 16 men, or 62.9% of respondents, found the cost of services affordable. Figure 25

FIGURE 25: ASSESSMENT OF THE COST OF BENEFITS RESPONDENTS BY GENDER



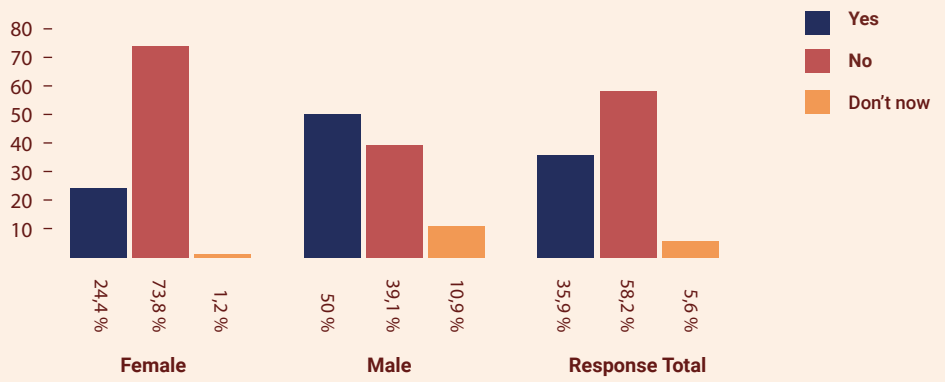
III.4.4 CASE OF MIGRANT WOMEN INTERVIEWED WHO HAVE GIVEN BIRTH SINCE THEIR ARRIVAL IN TUNISIA

Of the 26 young women migrants who reported having given birth since their arrival in Tunisia, 23 used SRH care services during pregnancy and / or childbirth, of which 12 women were not satisfied with the health services provided.

III.5 SRH ACCESS BARRIERS

The existence of possible barriers that would have prevented migrants in need of medical assistance from having this help, was explored by the question «Since you have been in this city, have there been times when you have felt that you would need medical help but you could not have it? « Among the 306 responses collected, the «yes» responses were recorded in 110 cases (35.9%), including 41 for women (24.4%) and 69 for men (50%) ($p < 0.001$). Figure 26

FIGURE 26: DISTRIBUTION OF RESPONSES BY GENDER TO THE EXISTENCE OF AN IMPEDIMENT TO SEEKING MEDICAL HELP



Among the cited reasons for this impediment, which were 126 for the 110 respondents because a respondent could give more than one reason, the lack of money was cited 86 times, thus representing 68% of all the reasons cited by the desire to seek treatment in the country of origin that has been cited 13 times (10%). Table 15

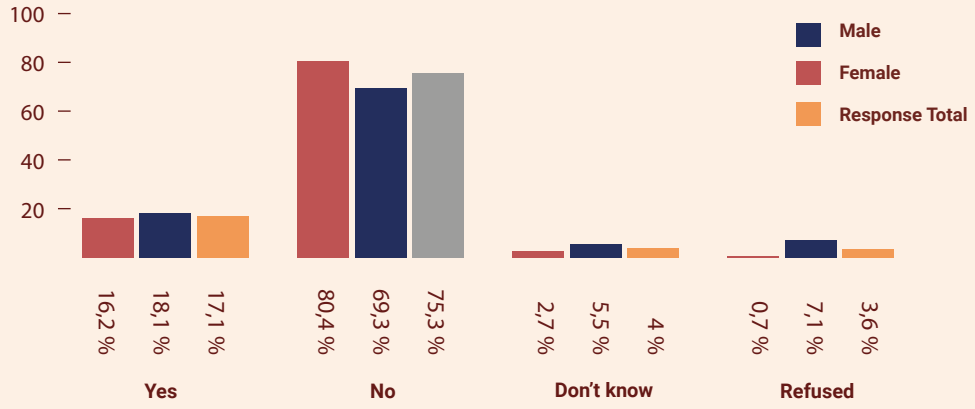
TABLE 15: DISTRIBUTION BY SEX OF REASONS THAT PREVENTED RESPONDENTS FROM SEEKING MEDICAL HELP

Response	Female		Male		Total	
	n	%	n	%	n	%
I did not have enough money to pay	29	58%	57	75%	86	68%
The clinic was too far	1	2%	2	3%	3	2%
The clinic was not open at the right time for me	2	4%	0	0%	2	2%
I was denied access because I am a foreigner	2	4%	2	3%	4	3%
I did not try because I think I cannot use the services because I am a foreigner	6	12%	3	4%	9	7%
The clinic has a bad reputation and service there is too poor	0	0%	2	3%	2	2%
I preferred going back to my country as the services are better and/or cheaper	7	14%	6	8%	13	10%
Other	2	4%	4	5%	6	5%
Refused	1	2%	0	0%	1	1%
Total	50	100%	76	100%	126	100%

In addition, to the question that was asked to all interviewees «Was there any staff working in a health facility in this country who treated you or your friends in a way that hurt you? comfortable? We collected 275 responses, of which 207 were negative (75.3%), of which 119 were women (80.4%) and 88 (69.3%) were men with no statistically significant difference between the sexes. Figure 27

As a source of this discomfort, nurses and home agents were cited 26 and 25 times respectively while doctors and guardians were cited 05 times for each category.

FIGURE 27: DISTRIBUTION OF RESPONSES BY GENDER TO THE QUESTION OF POSSIBLE UNEASE IN HEALTH FACILITIES



Of the 69 respondents to the question «Do you think that religious, cultural or other beliefs have influenced their interactions with you? A dozen respondents (14.5%) said they thought it was a lot, while 27 (39.1%) said they did not think it at all. Table 16

TABLE 16: SEX-SPECIFIC VIEWS OF RESPONDENTS ON THE INFLUENCE OF HEALTH SERVICE PROVIDER BELIEFS ON THEIR INTERACTION WITH MIGRANTS

	Female		Male		Total	
	n	%	n	%	n	%
Very much	4	12,1%	6	16,7%	10	14,5%
Somewhat	1	3,0%	9	25,0%	10	14,5%
Not at all	17	51,5%	10	27,8%	27	39,1%
Don't know	5	15,2%	3	8,3%	8	11,6%
Refused	6	18,2%	8	22,2%	14	20,3%
Total	33	100%	36	100%	69	100%

CHAPTER 3
DISCUSSION

I. METHODOLOGY

The aim of this study was not representativeness in the statistical sense of the term, but rather the situation analysis of migrants in the transit country of Tunisia. Despite this, for a reference population corresponding to young migrants between 18 and 29 years old and estimated at around 2000 people in Greater Tunis according to a rigorously established map (in the absence of a database), the quantitative survey encompassed a sample of 311 people, including 176 women (56.6%). In addition, the survey was completed by the completion of six focus groups, including four with migrants of different profiles. We think that the approach of their reality has been obtained.

Indeed, to our knowledge, no quantitative survey of migrants in transit has been conducted in Tunisia. We have found in the literature only some qualitative surveys (Dourgnon P. & Kassar H. 2014, IOM 2015, Jaouedi I. 2016, Médecin du Monde 2016).

However, the methodology adopted has some recruitment bias, especially for Arabic-speaking migrants whose number of interviewees did not exceed 12 out of the 311 interviewed, because of the difficulty encountered in accessing these groups. Also, the age group 15-17 years was excluded from the survey because the research team was faced with a methodological and ethical paradox: on the one hand, the recruitment of adolescents in this bracket of age required parental consent and, on the other hand, migrants accompanied by their parents were excluded from the survey.

Another methodological limitation concerned the analysis of the data in the sense that for multiple reasons, we could not have disaggregated data by age group and nationality, in particular for the data relating to the SRH.

On the other hand, it would have been necessary to make a scoring to objectify the number of migrants interviewed who answered just all the questions concerning knowledge on the SRH, those who answered just a certain number of questions and those who answered false to all questions and even to attitudes. But this has not been done.

II. MIGRATION DRIVERS

Push factors: More than 90% of migrants arrived in Tunisia after 2013. The factors that pushed them to migrate were mainly studies in 27% of cases, the economic factor in 25% of cases and the reasons in 7% of cases. These factors are found in another study (Jaouadi I., 2016) and confirmed by the focus groups. In focus groups, migrants expressed dissatisfaction with the socio-professional conditions, individual and family, in the country of origin (Ayari A. & Horcheni H., 2017).

> “FOR ME, TO MIGRATE IS TO CHANGE THE SITUATION OF MY FAMILY”
>
> Maurice, 26 years old

For many migrants from Côte d’Ivoire, the war made their social situation more difficult because, in addition to insecurity, many people lost their jobs.

> “AFTER THE WAR, MY HUSBAND AND I LOST EVERYTHING, I LOST MY JOB, FOR ME LIFE WAS VERY DIFFICULT AND VERY EXPENSIVE.”
>
> Mireille 40 years old, a victim of trafficking

Pull factors (attraction factors): 38% of migrants cited job opportunities and quality of life, 17% cited economic opportunities associated with safety and thirdly opportunities to pursue studies (14%). This is particularly the case of migrant women who were motivated to study in Tunisia because they had heard about the quality of Tunisian diplomas and therefore were encouraged by their family to do the migratory act.

> “IT’S MY FAMILY WHO TALKED TO ME AND ENCOURAGED ME TO COME HERE, IT’S A GOOD INTERNATIONAL DIPLOMA, AND IT’S NOT FAR HERE”
>
> Nadège, female, 27 years old

Tunisia attracts migrants because of its proximity to Europe and the visa-free entry facility for West African nationals (Boukari H., 2010). In our study, Côte-D'ivoire was the most frequent country of origin, accounting for more than 29.5% of the migrants interviewed.

> "I WANTED TO GO TO FRANCE, BUT I ARRIVED IN TUNISIA BECAUSE IT WAS EASY TO GET THE VISA; I REALLY DO NOT INTEND TO STAY HERE, I WANT TO GO SOMEWHERE ELSE"
>
> A participant in the focus group

Some women, especially the least educated, who find themselves in difficult situations of insecurity and unemployment as was the case of many Ivorian women, are recovered by traffickers who will present them the opportunity to work in Tunisia as an attractive migratory offer.

> "HE TOLD ME AND ASSURED[13] THAT IN TUNISIA HOUSEKEEPERS ARE WELL PAID"
>
> Jeanne, 50, a victim of trafficking

Expectations: 57% of women and 37% of men found the situation in Tunisia more difficult than they expected. Some complained about the slow procedures for obtaining the residence permit, others about the «racist» behavior of Tunisians.

> "IT IS DIFFICULT TO OBTAIN RESIDENCE PERMITS AND WE ARE FORCED TO PAY PENALTIES"
>
> Maurice, female, 26 years

In the IOM report on the 2013 exploratory study on human trafficking in Tunisia, we read: «At the national level, the entry, residence and exit of foreigners are regulated by the law 68-7 of 8/3/1968 relating to the situation of foreigners. Migrants arriving legally in the Tunisian national territory sometimes exceed the duration of the residence permit and are transferred to reception and orientation centers for migrants (detention centers) awaiting their return to their home country (native country).»

> “... THEY TELL ME KAHLOUCHA[13], THEY THROW ME PEBBLES, THEY ARE NOT NICE TO ME AND ME TOO I HATE THEM; IT'S HARD TO FIT IN HERE EVEN THOUGH I TRIED”
>
> A participant in the focus group

According to the key actors who participated in a focus group, the status of many irregular migrants (without a residence permit) makes them socially vulnerable and puts them in a situation of vulnerability exacerbated in the face of aggression because they cannot complain because they would be arrested: «there are many cases of victims of sexual assault, they are sometimes seen in the Garden Passage, they cannot complain because they are in an illegal situation and risk to be arrested because of the cumulative amounts of penalties which are of the order of 20 dinars / week and after, ... it blocks access to enjoy their fundamental rights and in the meantime we remove their employment visas. They cannot work or be paid «(a key player).

As for women victims of trafficking, the consultant said in his report on the focus group with women victims of trafficking: «the feeling of having lost everything, of having missed one's trip, of being robbed. Suddenly and without realizing it spreads to the victim a state of submission and inability to react as if she **had fallen into a hole.**[15]

Despite this difficult situation, 59% of migrant women and 49% of men said they would encourage others to migrate to Tunisia. In some focus groups, migrant women have justified this by the difficult situation of women in their country of origin and the unsustainable family responsibilities for which they are responsible on their own.

> “ME, I THINK HERE (TUNISIA), WOMEN ARE MORE FAVORED, HUSBANDS WILL WOO THEM AND I LIKE THIS SIDE. BUT IN IVORY COAST, IT'S THE WOMAN WHO DOES EVERYTHING, THE MAN DOESNOTHING BUT HIT YOU, MISTREAT YOU”
>
> Hélène

[13] speaking about smuggler (NdA)
[14] kahloucha means «black» in the tunisian ironic dialect.
[15] Expression of Mireille, a victim of trafficking (NdA)

III. SEXUAL AND REPRODUCTIVE HEALTH

Knowledge: the level of knowledge of young migrants in terms of SRH seems variable depending on the items discussed. While almost all migrants knew that a woman may become pregnant at first intercourse, the responses to the effect of masturbation on health were less sharp since more than 76% of respondents answered either wrong in thinking that masturbation harmed health either by «I do not know».

Similarly for AIDS, more than 50% of respondents answered either wrong thinking that we can cure of AIDS or by «I do not know». In the latter two cases, women's knowledge was lower than that of men.

In terms of contraception, respondents of both sexes cited an average of three contraceptive methods, the most common of which were: pill, condom and injections.

It should be noted that in focus groups, most migrants reported that they had no idea about SRH.

> "NO, I HAVE NO IDEA"
> (talking about the SRH)
> Cristelle, female, 27 years

Attitudes: about sexual relations between two unmarried people who love each other, more than 63% of respondents agreed without distinction of attitude between women and men. However, it should be noted that the number of Arabic-speaking interviewees was low (6 women and 6 men) and that this question was not explored during the focus groups with Syrian women to detect possible differences in attitudes with the SSA respondents.

With regard to GBV, 88% of respondents among whom we find 91% of women did not know or were not sure if a boy loving a girl had to force her sometimes to have sex with him and more than 6% agreed. To better understand the attitudes of migrants towards this issue, it was explored in focus groups by consultants who have identified three families of responses:

- «The majority who categorically refuses a man to force his companion to a forced relationship; it is a widely shared opinion among migrants of sub-Saharan origin and some Arab-speaking women.»

> NO, IT IS NOT NORMAL FOR A MAN TO FORCE HIS WIFE TO HAVE SEX WITH HER; IT'S A RAPE, IT'S NOT NORMAL, YOU NEED THE CONSENT OF THE WOMAN TO HAVE SEX

Agnès, Ivory Coast

▸ «Some men, of sub-Saharan origin, think that the man is entitled to practice a sexual relation even if the woman does not want it. This opinion is given in a watered down way but keeps its full scope»

> SOME WOMEN PREFER THAT THEIR MAN FORCES THEM TO HAVE SEX WITH HIM

Bancé, Burkina Faso

▸ «Arabic-speaking Syrian women who believe that in case of refusal of the woman, the man keeps whole and inalienable his right to practice a sexual relation. It is an opinion formulated with strong conviction because legitimized, as explained by these women, by a religious and canonical principle Muslim (shariaa). This perception is most widespread among the people met in this group.»

> YES HE HAS THE RIGHT, OUR PARENTS HAVE TAUGHT US THAT. ONE PREFERS THE CONSENSUAL INTERCOURSE BUT IF SHE REFUSES HE IS ENTITLED ACCORDING TO THE SHARIAA

Ryma, Syria, 26 years

Similarly for physical violence, 10% of respondents agreed that sometimes it is justified that a boy hits his girlfriend while 83% said they did not know. In focus groups, almost all participants, regardless of their profile, refused to allow a man to beat his wife.

> “NEVER, IT’S NOT NORMAL AT ALL, BEATING A WOMAN IS NOT NORMAL”
>
> Agnès, Ivory Coast

Use of SRH services: Use of SRH services: the survey showed that more than 80% of women and more than 86% of men did not know where to access SRH services in Greater Tunis. However, according to the mapping of key actors (R. Khouili, 2017), there are many governmental and non-governmental organizations that provide direct services to migrants including health services and SRH services in a free way, a synthesis of which is presented in table:

organizations	Features
Government agencies	
Department of Frontiers and Foreigners (Ministry of the Interior)	Issuance of stay cards
Department of International Cooperation (Ministry of Higher Education)	Study the applications of the foreign students and their authorization to register in the various universities in Tunisia
Ministry of Vocational Training and Employment.	Work authorization for foreign workers
National Anti-Trafficking Body	- Receipt of reports on trafficking in persons and seizure of competent judicial bodies - Coordination of efforts in the field of protection and assistance to victims of trafficking - Collection of information, data and statistics relating to trafficking in persons
National Office of the Family and the Population	SRH Services

Non-governmental organizations	
Doctors of the World	- Reception and orientation - Medical consultation - Permanence psychologist - Accompanying migrants to different services, including care services.
Terre d'Asile Tunisia	- Juridic assistance - Social support - Financial insertion (micro-project ...) - Medical accompaniment - Cultural integration (French classes, debates, cultural evenings, film screening ...)
Tunisian Red Crescent (CRT)	- Reception and orientation - Receipt of asylum applications - Refugee determination interview - Registration of asylum seekers and processing of files (definition of vulnerability criteria, home visits ...) - Financial assistance (if needed - Medical assistance
Caritas	- Accompanying migrants - Accommodation for migrants awaiting repatriation.
Beity	Sheltering of migrant women in vulnerable situations
Amal Association for Mother and Child	Sheltering of migrant women in vulnerable situations
Tunisian Women's Association for Research and Development (AFTURD)	Sheltering of migrant women in vulnerable situations
Tunisian Association against AIDS and Sexually Transmitted Diseases (ATL MST SIDA Tunis Section)	- Awareness and prevention around HIV and SRH - HIV testing
Tunisian League for the Defense of Human Rights (LTDH)	- Juridic assistance - Advocacy
The Adventist Development and Relief Agency (ADRA)	Economic insertion (employment contract + micro-project ...)
Association of African Students and Trainees in Tunisia (AESAT)	- Capacity building of migrants; - Accompanying African students and trainees - Advocacy
United Nations system	
IOM	- Medical assistance (hygiene kits, medical care ...) - Juridic assistance - Voluntary return assistance
UNHCR	- Study of asylum application files - Assignment of refugee status

In addition, it is interesting to note that most of the young migrants surveyed by both interview and focus group reported that they did not consult SRH care services. Among those who accessed SRH services, the majority said they received the requested service (over 88%), were informed (over 74%), felt comfortable asking questions during consultation, having received appropriate answers to the questions asked, and that their privacy and confidentiality were respected (76% for women and 73% for men).

These results indicated that we were in front of youth-friendly SRH services? The answer to this question was given by the focus groups. In fact, while men who did not consult very much for SRH care found the quality of service acceptable in both public and private sectors, most Sub-Saharan and Syrian women found the quality of services in the public sector very poor.

> “IT’S A VERY POOR SERVICE. I SUFFER FROM HEALTH SERVICES IN PUBLIC HOSPITALS. DOCTORS ARE NOT AVAILABLE IN PUBLIC HOSPITALS. THEY COME LATE AND GO HOME EARLY”
>
> Fatma, Syria

In contrast, the private sector was more popular than the public and considered better. «The arguments concerning reception, delays, availability and listening are the most advanced as comparisons» (Ayari A. & Horcheni H., 2017).

> “IN MY EXPERIENCE WITH THE CLINIC, WHERE I DID THE TESTS, THE SERVICES ARE REALLY PERFECT ”
>
> Hélène, Ivory Coast

These revelations seem to provide an explanation for the relative satisfaction of the interviewees found in the quantitative survey where they would have given favorable responses to SRH service structures by referring to the private sector.

As for the barriers of access to SRH services identified during the quantitative survey, the one related to lack of money was the most cited and some feelings of unease due to the behavior of certain health professionals, mainly nurses and agents. The focus groups revealed three main barriers: (i) the cost of care, especially in the private sector; (ii) migrant status in an irregular situation that deprives them of work permits and social security coverage and (iii) migrants' ignorance of their rights or the organizations that could support them.

Finally, it should be noted that an important barrier to access to SRH care was revealed by open question during the quantitative survey: the restriction of the free antiretroviral treatment (ARV) and biological monitoring of PLHIV that covers only Tunisians living in Tunisia and benefiting from no social security, in accordance with a ministerial circular dating from the year 2000[16]. Under this circular, foreigners residing in Tunisia and living with HIV are prohibited from having access to free ARVs and biological monitoring.

[16]Circular n°16/2000 of 27 February 2000.

CONCLUSION AND RECOMMENDATIONS

The study of migration drivers and SRH needs among young migrants to Tunisia living in Greater Tunis revealed the following conclusions:

Young migrants are pushed to leave their country of origin for economic reasons, studies and in third position to flee the political insecurity as it was the case of the Ivorian or Arabic speaking migrants (Syria and Libya).

Tunisia has attracted them to be a transit country because entry for certain nationalities does not require an entry visa, its proximity to Europe and the good reputation of its higher education diplomas.

Migrant women were more likely to report that they found the conditions more difficult than they had expected before they arrived, particularly in view of the slow procedures for obtaining the residence permit, which puts them in a difficult irregular migration and in relation to the attitude of Tunisians that they found «racist».

In terms of SRH, the majority of migrants were sexually active, started to learn about sexuality early, but less than half of them thought they were well informed, false ideas were found in relation to contraception and HIV, and especially at the level of the HIV test.

Beside, we found liberal attitudes towards sexual relations but less clear opinions about the GBV. The focus groups have also highlighted different attitudes ranging from those rejecting the GBV to those who tolerate it.

The knowledge of contraceptive methods is satisfactory since respondents cited an average of three contraceptive methods, but condom use seems limited.

Migrants who knew SRH care structures were few. Less than one-fifth of migrants used SRH services, including twenty-six women who gave birth in health facilities. Of these women, half were unmet with maternal services. On the other hand, the qualitative survey showed a level of satisfaction with the quality of services in the private sector much better than in relation to the public sector. Migrants complained mainly about the quality of reception and communication with nurses and reception officers in particular.

Thus, the results of this study made it possible to identify the following non exhaustive recommendations:

1 **Advocate** for the establishment of **a socio-sanitary management unit within the Ministry of Social Affairs responsible** for migrant affairs to Tunisia and those who are in a vulnerable situation. And in order for this unit to fully fulfill its mission and support role, it is recommended that the following conditions should be met:

- provide the unit with a special budget to meet pressing needs,
- to dissociate the socio-sanitary services from the judicial procedures vis-à-vis the vulnerable populations in order to allow the migrants in an irregular situation to claim their rights to the health and the protection especially in case of physical or sexual aggression,

2 Establish a **network** of government and non-governmental actors for a synergy of actions and complementarity interventions. It would be useful to define the roles of each stakeholder in this network and to put in place a mechanism for its sustainability,

3 Operationalize the national strategic plan against the AIDS in its component targeting the reduction of the vulnerability of the specific populations including migrants and the **guarantee of access to ARVs for the PLHIV,**

4 Put in place simple **communication** actions targeting different audiences: informing migrants of their rights and the structures that can help them, sensitize professionals providing health and social services, increase the public's awareness of tolerance and acceptability of the difference,

5 **Collaborate with national and international non-governmental** organizations in their work for certain subgroups of vulnerable migrants and at the level of professionals providing health and social services,

6 **Involve migrants** in decision making through their peers.

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APPENDIXES DOWNLOAD LINK

tunisia.unfpa.org/fr/publications/annexes-migrants