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Healthy and Wealthy Together

Rhône-Alpes Local Mapping

Report

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Benjamin COZET

Malorie GENY

CONTENTS

INTRODUCTION

Immigration policy in France and political concepts

France is historically and statistically one of the largest hosting country in Europe. Its modern history of immigration began in the postwar period, when France was the only country in Europe to encourage permanent immigration. Since then its relationship toward migration has been a permanent political debate, creating a complex environment where international situation meets with economical and political internal situation. Ever since the 1970's, and the first oil shock, French employers have needed less or no foreign labor[1], while periods of high unemployment has emboldened xenophobic current in the public. Political spheres have played these currents since then with securitarian policies and populist rhetoric.

In 2001 already Virginie Guiraudon[2] commented "while […] numbers do not point to a migration "crisis" in France, the issue has nonetheless been more highly politicized, and for a longer time, than elsewhere in Europe. Features of the French political system help explain this political attention. First, French electoral laws have encouraged a focus on immigration. Unlike the multi-polar party systems in other continental European countries, which encourage complex coalitions across multiple policy areas, France's winner-take-all electoral system has led the left and right to exaggerate partisan differences. As macroeconomic and industrial policy ceased to be divisive political questions in France—especially with the 1983 policy reversals of François Mitterrand's Socialist party—the political left and right seized on new societal issues such as immigration. […]The political debate expanded over time to include the role of immigration in such issues as national identity, migrant incorporation, security, and terrorism. Mobilization of both pro- and anti-migrant forces has fed the political fire. […]Counter-mobilization by the extreme right has also fed the political debate on immigration. It has pushed leading mainstream politicians on the right to address the immigration issue, in order either to win back voters from the far right, or to cause competing parties to lose votes to the National Front [i.e extreme right party]."

One of the most typically politicized and immigration derived concept is **communitarianism**. In France it has a different meaning than in England. It is interlinked with politics in that it defines the political and cultural claims of minorities. Those who use this terminology in France consider that it is the tendency to the division into cultural, ethnic or religious groups. Communitarianism systematically creates controversy. It refers to the principle that, by claiming their right to being

[1] That is legal labor, illegal labor being another issue for immigrants in France, especially in terms of retirement pension and health coverage.

[2] *Virginie Guiraudon is a permanent research fellow at the National Center for Scientific Research (CNRS) in France and author of Les politiques d'immigration en Europe. She holds a Ph.D. from Harvard University.*

different, these groups transgress republican ideals, equality and secularism. Even though it first originated in politics, it is now a common – and negative – concept in France.

Even if politically sensitive, immigration is still a reality, as much in terms of humanity as in terms of economy and demography.

French immigration in numbers

Over time, a foreign population, very diverse in its constitution or length of presence, formed in France[3].

It is a shifting population: some intend to acquire French nationality; others will return in their home country or leave for another destination. A January 1st 2006, the National institute of statistics and economical studies (INSEE) estimated the foreign population, residing in metropolitan France to be of 3.5 million people.

The proportion of foreigners within the total population fluctuates significantly depending on the referring periods. In 2006, it increased slightly from 1999 at about 5.7 % of the total population. Within this population, there were 528 700 foreigners born in France, most of them will become French due to "*droit du sol*" or "by birth" (*jus soli*), this possibility being available from the age of 13.

Two out of five foreigners are from Portugal, Algeria and Morocco, these three nationalities representing nearly 1.5 million people. Thus, the foreign population in France is composed of 35 % of nationals from the European Union (with 25 states), 31 % of nationals from one of the three Maghreb countries and 13 % of Asians.

In 2006, **three metropolitan regions account for 60 % of the foreigners**. Thus, four out of ten foreigners live in **Île-de-France**, the **Rhône-Alpes** region and **Provence Alpes Côte d'Azur** far behind with 11 % and 9 %. The proportion of foreigners is also higher than national average in Corsica and Alsace (about 8 %). In contrast, foreigners are rare in western France. In Britany, Basse-Normandy and Pays de la Loire, they represent less than 2 % of the population.

These numbers and above considerations are essential to understand the subject of this report; immigration in the Rhône-Alpes region. In three parts this report will go through the different step of migration: identity of the newcomer under the law and the culture of the host society, view of the region in terms of maps and process of integration and to conclude access to care in the region.

Each part of the study encloses lexicons introducing various elements of the national system and its repercussion on local reality.

National context – culture, politics and laws

[3] Following data summarized and translated from a survey « *Infos migrations* », Number 10 - October 2009, from the *Department of statistics, of studies and documentation*, under the authority of the *Ministry of immigration, integration, national identity and solidarity development*. Author is Corinne Régnard.

The first part will focus on migrant's reception in three sections: *immigration laws and statuses*, *housing of migrants in Rhône-Alpes* and *immigration and integration*.

Migration in Rhône-Alpes

In a second part the report introduces the Rhône-Alpes region to the reader, as much in terms of geography as in term of demography. How the process evolves and what kind of issues migrants encounter in the region.

Migrant health

In the context of local-mapping, this report will of course address the issue of access to care for migrants in the Rhône-Alpes region. In the process a close look at the French health care system is necessary, as the complexity of the various statuses might be baffling even for a native. Lexicons on the subject will thus be examined in the third part of the report. Following these, will be an analysis on practices in terms of medical care, mainly from the reports of Médecin du Monde (Doctors of the Wolrd) based in Lyon and Grenoble.

According to E.A. Stanajevich and A. Veisse[4] the migrant population is especially vulnerable, socially, juridically and epidemiologically. Issues in their access to care are numerous; a section will thus be devoted to the subject. Their specific vulnerabilities imply that any health politic undertaken has to take it in account in order to be efficient. This report will show how the evolutions of public health policies – such as HIV/SIDA prevention campaigns – have forced the authorities to take into account migrant's specificities and their vulnerabilities.

Finally alternative approaches and specific care in Rhône-Alpes will be examined in the last section of this part: initiatives from NGO's, les Ateliers santé ville – understand "workshops city health" - and an approach less known in psychiatry, the ethnopsychiatry; both elements that bring interesting suggestions to many issues about care for migrants.

Note: *Unfortunately French statistics on migrants are based on population censuses which are not published annually but periodically. Other data on migrants are extremely difficult to obtain, partly due to the political context, partly because epidemiologic data for instance are scarce and not compiled. Most data of this report thus rely on documents from 2006, 2007, 2008 and some of 2009, censuses, NGO's reports, government publications and various data from organizations linked with migrants in Rhône-Alpes. All documents were kindly given to us by professionals of each field.*

[4] In *La santé de l'homme*, n°392, November-December 2007, pages 21-24.

CHAPTER 1 - NATIONAL CONTEXT; CULTURE, POLITICS AND LAWS

A – IMMIGRATION LAWS AND STATUSES:

MIGRANTS' STATUS – NAMES AND DEFINITIONS

Migrant ➡ **Migrant**: Somebody who has lived in a foreign country and now living in France, name used in Public Health.
Immigré ➡ **Immigrant**: Somebody born in a foreign country and now living in France, term and definition used for demographic census. A person stays immigrant even if he or she acquires French nationality.
Etranger ➡ **Foreigner**: Somebody who hasn't French nationality, term used by authorities and associations for juridical help.
Exilé ➡ **Exiled**: Somebody who has to live outside its original country, term that refers to forced displacement and its psychological consequences.
Demandeur d'asile ➡ **Asylum Seeker**: Somebody who asked for the refugee status, in France under the Geneva Convention of 1951.
Réfugié ➡ **refugee**: Somebody who has acquired the refugee status or the subsidiary protection given by the Ofpra ("*Office français de protection des réfugiés et apatrides*" or French Office for Refugee and Stateless persons Protection).
Sans-papiers ou clandestin ➡ **Literally "without papers" or illegal also called "undocumented" in English** Illegal immigrants, terms used by people in order to underline a point of view toward the migrant and its situation – legitimate in France would be undocumented and illegal would be a reference to the illegitimacy of the situation.
Primo-arrivants ➡ **Literally "First-arriving"**: migrants who have arrived on the territory for the first time.

SOCIO-ECONOMICAL STATUS

Actif ➡ **Literally "active", designates a member of the working population.** Unemployed people (administrative term, understand who are registered as such) are, paradoxically, part of the working population.

Inactif ➡ **Literally "inactive" designates a person who doesn't belong to the working population** but who is not unemployed (registered as such). The "inactive population" includes children, older people, people whose physical state prevent from working and sometimes in a more general meaning, the fringe elements of society.

SOCIAL RIGHTS OF ASYLUM SEEKERS

1 – **The right to work** Contrary to popular believes asylum seekers have the right to seek a job. They are nevertheless subject, like other non-resident foreigners, to an administrative authorization from the DDTE[5].
2 – **Temporary allowance for waiting** (or Allocation temporaire d'attente – ATA) The allowance is about 10, 54 € per adult per day and is paid by the employment center to asylum seekers over 18 who have applied for asylum and have a receipt.
3 – **Accommodation** Upon admission to stay, an offer of support is given to all asylum seekers. When the first Temporary Residence Permit is issued in prefecture, the applicant is informed of this offer. If the applicant refuses, no allowance is paid.
4 – **Right to health coverage** Asylum seekers are entitled to medical coverage, first of which is the Universal Health Coverage (*see chapter 3, section A,* Health Care, CMU and AME how does it work?).

MIGRATION STATUSES

Labor migration

By the Act of 24 July 2006, France sought to reorganize the labor immigration to meet the real needs in matter of recruitment in some activities. Applications for work permits should be made by the employer in France to the Departmental Management of Work, Employment, and Training (DDTEFP). It is only after the agreement reached that the French Office for Integration and Immigration (OFII) may support the future employer in the process of introduction in France adapted to the situation of the employee.

Studying in France

[5] DDTE : Direction Départementale du Travail et de l'Emploi or Departmental Management of Work and Employment.

Level requirements and registration requirements are identical to those of French students. To access higher education in France, foreign students who do not have the equivalent of the French baccalaureate must fulfill two conditions:

- Be allowed access to higher education in their countries of origin and to have a level of understanding of the French language adapted to the future education.
- Depending on his or her situation, the foreign student may register directly in a chosen higher education institution or must complete an application form first.

After receiving the certificate of registration or pre-registration, and provided that the student has sufficient resources, the French Consulate will issue a visa marked “student” that allows him or her to enter French territory.

Family reunification

To bring one’s family on the territory certain requirements must be completed. Firstly, the applicant must reside in France continuously for at least 18 months and hold a residence permit valid for at least 1 year. He must have sufficient and secure resources to support his family. He must have an accommodation when filing his application, or a promise of housing for the day of the arrival of his family in France. Finally, the applicant must observe the fundamental principles of family life in France in accordance with the laws of the Republic; otherwise family reunification can be refused.

Asylum seekers

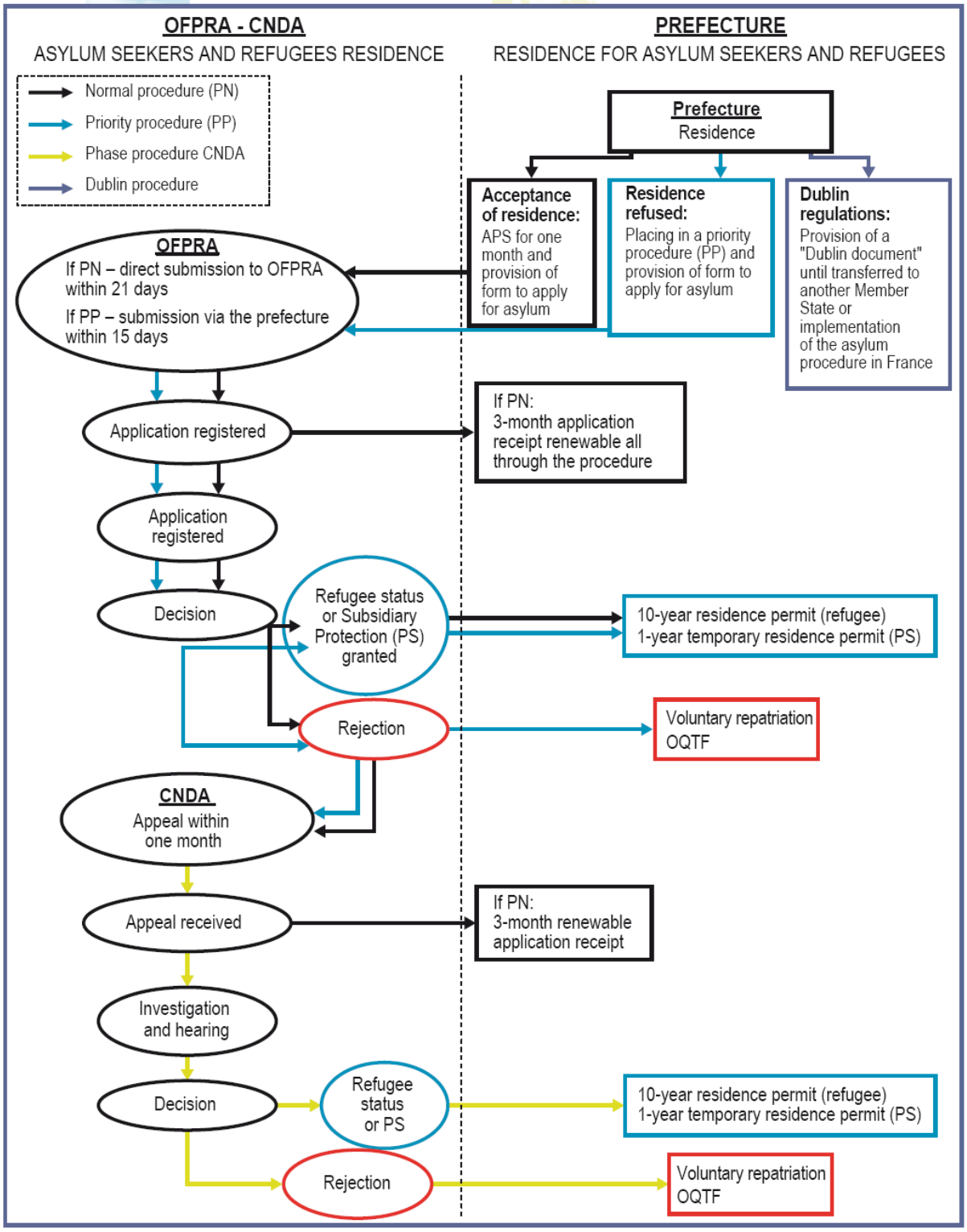
Asylum is the protection granted by a host State to a foreigner who can’t, under persecution, benefit from the protection of the authorities of one’s country of origin. The OFPRA (French Office for the Protection of Refugees and Stateless persons), which is at the center of the national organization for asylum, has exclusive jurisdiction to hear applications for asylum. Its decisions may be appealed before the National Court of asylum (CNDA), a specialized administrative court.

Refugees

In France, refugee status can be recognized for:

- Persons persecuted because of their action in promoting freedom
- Persons on which the United Nation High Commissioner for Refugees carries out its mandate
- Persons that meet the definition of Article 1 of the Geneva Convention of 28 July 1951 relating to the status of refugees

SUMMARY OF THE PROCEDURE BY AN ASYLUM SEEKER FOR ASYLUM AND RESIDENCE



B – MIGRANTS RECEPTION: FROM THE STATE TO THE "LOCAL"

French Office for Immigration and Integration (in French « **Office français de l'immigration et de l'intégration** » **– OFFI)**. A place where migrants arrived for the first time in France can find various services to meet their initial needs and expectations. In a short period of time, migrants will have a speech on life in France, pass a medical examination and have an interview on social issues. The said objectives of this office are to ease integration in the hosting society, to identify the needs of the migrants in various domains and to direct families toward the appropriate services.

GENERAL HOSTING PLACES FOR MIGRANTS IN FRANCE

A **Reception center for asylum seekers**, in French « ***Centre d'accueil de demandeurs d'asile (CADA)*** » is a shelter or a structure specialized in asylum seekers' housing during the examination of their application. It is funded by the state under welfare policy. The missions of these centers are the reception and housing of asylum seekers, help in terms of administrative, social and medical support, schooling of children and organizing activities in the center and finally management of the end of their stay at the center.

The **Centers for reception, orientation and care**, in French "***centres d'accueil, de soins et d'orientation (CASO)***" are centers managed by NGOs, Doctors of the World (Médecin du Monde) for instance. These care structures can host refugees and asylum seekers in order to treat them and direct them to the proper institutions.

A **center for hosting and social reintegration**, in French « ***centre d'hébergement et de réinsertion sociale*** *or* ***CHRS*** », is a category of social institution involved in the fields of reception, hosting, social and economical reintegration of people in state of exclusion.

The **Center for Temporary Accomodation** ("***Centre provisoire d'hébergement" – CPH***) is a kind of *center for hosting and social reintegration* (or CHRS) intended to host people, individually or in family, who have obtained the conventional refugee status or benefiting from the subsidiary protection. The center is funded by the state under social welfare and is meant for people without resources and/or housing. The CPH is thus a place for support towards social and professional integration. To do so, the CPH team of professionals is working in 5 areas: follow-up in health, social and administrative issues, access to housing, access to employment and training, psychological follow-up and organization of activities/management of waiting.

CENTERS FOR DETENTION AND REPATRIATION IN FRANCE

In France, **Administrative Retention Centers** (or ***Centres de rétention administrative – CRA***) are intended to receive foreigners who are not entitled to stay on French territory. Either these migrants are inadmissible, or they are isolated to allow their repatriation to their home countries and undertake the process of appeal. Also, there can be foreigners entering

the territory and waiting for regularization. The stay is between two and thirty-two days maximum, the average retention time being nine to ten days.

The **waiting Zone** (or "***zone d'attente***" in French) is a physical space created and defined by the act of July 6th, 1992. Before this law there was no legal ground for maintaining foreigners at the border. It can exist in harbor, airports and train stations open to international traffic. It goes from "boarding and disembarkation points up to those where people are controlled". In practical terms, this space corresponds to the area under customs which access is limited.

Le renouveau de la Sonacotra a commencé

Adoma[6] is a semi-public company controlled by the state. It builds and manages social housings. Its mission is to enable access to housing for the poorest people, with no regard to their nationality.

Originally designed to house migrant workers, Adoma today's mission is to welcome and support all those who are experiencing difficulties and cannot find their place in the traditional social housing. Since the late 90's, the reception of asylum seekers has become a priority for Adoma. In order to answer to that mission CADAs[7] were created, and today Adoma manages 57 of them.

TEMPORARY ACCOMMODATION AND HOUSING

Temporary accommodation comprises two very different realities: accommodation and housing. These two aspects do not meet the same needs and correspond to very different logics of production, funding and management. Numerous professionals work on these questions; it is therefore at a local level that the coherence of a global offering in temporary accommodation can be assessed. At present, the pressure on temporary accommodation is increasing, both upstream and downstream:

- Distress situations extend to people who may have a housing and income, but call for help in order to solve an urgent situation. Risk of losing housing, loneliness, marital crisis, violence and unemployment are all gateways to precariousness. These families in precarious situations do not find fitted solutions in temporary accommodation, whose structures are more suitable for small households.

[6] Definition summarized and translated from the following web-site : http://www.adoma.fr/

[7] See definition: *Reception centers for asylum seekers*.

- The current pressure on social housing stock makes it more difficult to leave temporary accommodation to a lasting housing. Temporary accommodation goes on even though people could integrate a standard accommodation.

Emergency housing

It corresponds to situations of great distress and precariousness (of all sorts).Battered women and homeless people are the main targets. Very often, integration is an objective and a method to overcome the emergency.

Integration housing

It corresponds to a step in the path of insertion and is not an end in itself. In addition to providing housing, it necessitates social support to allow integration in the labor market in parallel.

Housing for « passengers »

It involves young students, in training or in internship, people under temporary contracts, seasonal workers, etc. The need for temporary housing meets a context of increasing mobility, mostly young people.

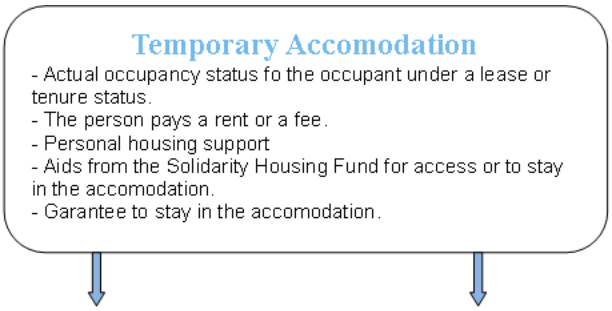
Changes in temporary accommodation structures

Traditionally, temporary accommodation facilities offer very small private rooms (bedrooms of 9 m²) offset by large common spaces. Renovations and new constructions tend to break with that organization: is now offered small apartments (from 15 m²) with individual comfort (bathroom, kitchen). If this new organization allows greater privacy for residents and corresponds better with the current standards of comfort, it breaks with a strong tradition of community life which is an important part of social support.

DIFFERENCE BETWEEN HOUSING AND TEMPORARY ACCOMMODATION

Temporary accommodation

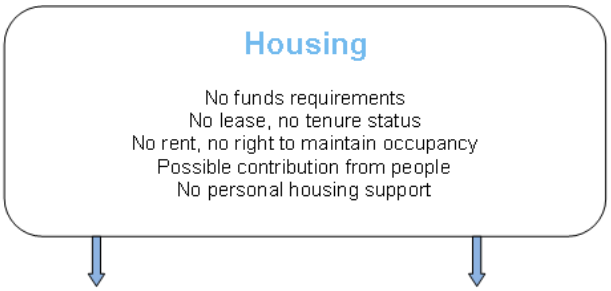
This type of accommodation is designed to answer a broader spectrum of needs.



	Emergency hosting	Integration hosting
Offer	• Lodging, often meals • Duration: transitional, short	• Housing and support based on an integration project • Duration: longer
Beneficiaries	• Reception center during the day • Hotel overnight stays • Emergency Accomodation Center • Housing outside centers contracted under ALT (« *Aide au logement temporaire* » or temporary housing assistance).	• Center for hosting and social reintegration: CHRS • Reception center for asylum seekers: CADA • Social hotel • Housing outside centers contracted under ALT (« *Aide au logement temporaire* » or temporary housing assistance).
Management	• Associations • Social action community centers	• Associations • Social action community centers
Funding	• Ministry of Housing • Ministry of Social Affairs • Department Council (« *Conseil général* ») • EPCI (public establishment for intermunicipal cooperation) and towns (« *communes* »)	• Ministry of Social Affairs • Center for hosting and social reintegration: CHRS • Reception center for asylum seekers: CADA • Department Council (« *Conseil général* ») • EPCI (public establishment for intermunicipal cooperation) and towns (« *communes* »)

Housing

This is the first stage in social support: the objective is to provide an immediate solution to urgent requests.



	Emergency hosting	Integration hosting
Offers	• Lodging, often meals • Duration: transitional, short	• Housing and support based on an integration project • Duration: longer
Structures	• Reception center during the day • Hotel overnight stays • Emergency Accomodation Center • Housing outside centers contracted under ALT (« *Aide au logement temporaire* » or temporary housing assistance).	• Center for hosting and social reintegration: CHRS • Reception center for asylum seekers: CADA • Social hotel • Housing outside centers contracted under ALT (« *Aide au logement temporaire* » or temporary housing assistance).
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AN EXAMPLE IN THE USES OF HOUSING: A SURVEY BY ADOMA

The segmentation in uses of Adoma's hostels is a good illustration of the various categories of migrant populations and their needs. The following analysis is based on a document provided by Adoma entitled "a resource for a better understanding of the residents: the segmentation in uses". Various criteria are crossed in the analysis; reason of entry, length of stay, use of housing, uses of common spaces and services, relationship with other residents etc.

The survey involved residents and professionals. Results show that migrants are divided into 9 groups of users.

- The "**intermittent"**, elderly residents, who frequently travel to the country of origin. They are characterized by a high frequency of comings and goings and by a length of stay in their home country important.

- In lasting categories there are three segments: "**retirement home**", "**settled and *active***[8]" (i.e installed with a job) and "**settled and *inactive***" (i.e installed without a job). People from these segments are long-term residents in Adoma hostels and they intend to occupy it durably. They are accustomed to live in a hostel.

  The first segment of users "occupies the hostel in logic of *end of life* or waiting for the resolution of their administrative situation before travelling more intensively between their home country and their host country."Adoma calls this the *round-trips practice*.

  The "settled and active" segment mostly counts workers whose daily presence in the hostel is limited.

  People from the third segment, "settled and inactive", are either occasionally or definitely out of the labor market. This inactivity has repercussions on times and moments of presence in the hostel and sometimes also on the *round-trips practice*."

- "**Passengers**", are residents who use the hostel in connection with a temporary employment status. They match their duration of stay in the residence with the duration of their work or training (itinerant employees, trainees, students).

- The "**springboard**" segment designates residents arrived in the hostel for want of anything better. For them, the housing is temporary. These residents are more or less estranged, alienated. Their situation can be solved if they are supported by a social worker who can be set in touch by Adoma.

- The segments "other structures" and "family hotel" are also people arrived in the hostel in the absence of something better. For the persons under the segment "other structures", their integration can only be achieved through important social support and close monitoring, which is not in Adoma's charges and involves other institutions such as CHRS – Centers for hosting and social reintegration[9] - or psychiatric hospitals. For people under the segment "family hotel" several forms of social support have been tried in vain. These residents have found a kind of stability in the hostel.

- Finally, the "asylum seekers" segment designates residents prescribed by the state, directly to Adoma or through *tiers-réservataires*, third parties such as cities or NGOs.

The above described typology enables managers of Adoma hostels a better understanding of the residents needs. "Indeed, for every segment of uses we have identified specific needs and expectations related to housing, furniture, costs, collective and semi-collective spaces, security, social support, activities etc." In addition the approach gives a better grasp of the dynamics of change, for instance the belonging to a segment of uses is not static, and on the contrary, users can very well change of categories. By taking into accounts the specificities of life in migrant workers

[8] See definitions, socio-economical status, "*actif* "and "*inactif*".

[9] See definitions: "General hosting places for migrants in France".

hostels or social housing, that typology allows for more detailed analysis that goes together with concrete actions.

Adoma in numbers

At December 31th 2009, more than **8500 residents** (outside dedicated CADA, rental and family hotel) were analyzed under the typology of the segmentation in uses in Rhône-Alpes.

- 56% of residents are divided among the lasting categories: the "settled and *inactive*" were the most numerous with nearly 1500 persons; other segments essentially correspond to residents who are working ("settled and *active*") and to the traditional public, ageing on site ("retirement home").
- Also in connection with the hosting of traditional residents (i.e usual residents), the segment "intermittent" represents 17 % of the total.
- 4 % belong to the segment "passenger", 13 % in the segment "springboard"
- The proportion of the segments "family hotel" and "other structure" remains small, but with more than 770 people, represent together 9 % of the residents.
- Asylum seekers represent 9 % of all residents.

CRISIS IN THE HOSTING ORGANIZATION, EMERGENCY HOSTING CENTERS ARE OVERLOADED[10]

Undocumented migrants or *sans-papiers* are sometimes expelled from specialized hosting centers (CADA) or are being refused entrance into emergency hosting centers. According to non-governmental actors this situation is mainly the result of an overload in emergency hosting organization. This saturation follows a growth demand on one hand and the difficulty to access appropriate organizations, especially for integration through housing, on the other hand. In that view, the additional places called up in winter are only a temporary fix to the constant overload.

In emergency hosting centers, the majority of those present does not require temporary shelter and thus are not within the competence of these structures. In particular, these centers face the issue of illegal immigrants. Frequently together with a family, they are being hosted in the long-term in these centers because it is their last resort. Overall, in 2007, about 7000 illegal immigrants, in family, expelled or refused by specialized hosting centers, were hosted by emergency hosting centers, with no other prospect[11].

[10] Section based on the article « Sortir de la rue les sans abris », conférence de consensus, Paris 29/30 November 2007 - *Fiche n°7 : Les dispositifs existant concernant la chaîne allant de la rue au logement.*

[11] Authors refer to both the Court of Auditors (Cour des comptes, *op. cit*., p. 81) and to a report (Autume C., Fourcade M., Sanson G., *Rapport sur la procédure de prévision et de gestion des crédits d'hébergement d'urgence,* IGAS-IGA, 2006).

Recently the situation has even got worse with the new policy on immigration (see: section below). Even if access to care and housing is still a civil right for migrants, the policy has consequences on their everyday life. Sometimes seen as a way to free space in emergency hosting centers, refusal or eviction of migrants is now common. As a consequence, when undocumented migrants are being refused shelter, they have to live on the streets, some of them with family. And there is no question this lifestyle put a strain on the body and mind. The issue is further examined in Chapter 3: *Migrant Health*. The problem might seem hypothetical but journalists and associations have been denouncing the situation for years. The following example is one of the most recent cases.

UNDOCUMENTED MIGRANTS DEPRIVED OF EMERGENCY HOSTING[12]

Last week in Grenoble, a Macedonian couple of asylum seekers had to leave their 3 children (8, 10 and 12 years old) to prevent them from sleeping outside. "*Given the overloading of hosting centers for asylum seekers and emergency hosting centers, the family had to resolve to social welfare services for children*" explained Françoise Bouchaud, head of the *Secours catholique* in Grenoble.

Officially there is no shortage of places in emergency hosting centers (CHU). However, in several regions, the shortage seems real. As a result, the state administrative services came up with questionable solutions in some departments: those to which was refused the status of asylum seeker, that is to say, undocumented migrants, are now seen as incidental; their eviction is the response to the shortage of places. Associations working with homeless people are now asked to select who they host, a demand in contradiction with their principles.

The newspaper *Libération* obtained several documents attesting this policy. The documents also contradict the recent comments by Benoist Apparu, Secretary of State for Housing. "*Our objective, is to adapt the system throughout the winter with a principle: no request goes unanswered*", had he specified recently. He also said to *Libération*, that "*Officials who advocate for a selection are "out of line""*.

The principle of « unconditional acceptance » was reasserted by the president in the fall of 2007. This adjustment came right after the controversial adoption by the Assembly of an amendment from MP Thierry Mariani (UMP, same political party as the president), specifically designed to exclude undocumented migrants from Emergency Hosting Centers. Confronted with an outcry, the amendment had been withdrawn in the final version of the immigration law Hortefeux (previous head of the Immigration department). But obviously, local officials took up the idea and enforce it.

The journalist Tonino Serafini presents examples of this enforcement in various regions, Calvados, Haut-Rhin and Yonne. In those departments either associations, social services or emergency services are, illegally, asked to take into account the idea that illegal immigrants are not a priority. Rather, they are a solution when hosting centers fall short of places.

[12] Title of an article by Tonino Serafini, *Des sans-papiers privés d'hébergement d'urgence* published in Libération, 29/11/2010, available online:http://www.liberation.fr/societe/01012304988-des-sans-papiers-prives-d-hebergement-d-urgence

CHAPTER 2 - MIGRATION IN RHÔNE-ALPES

A – INTRODUCTION TO THE RHÔNE-ALPES REGION

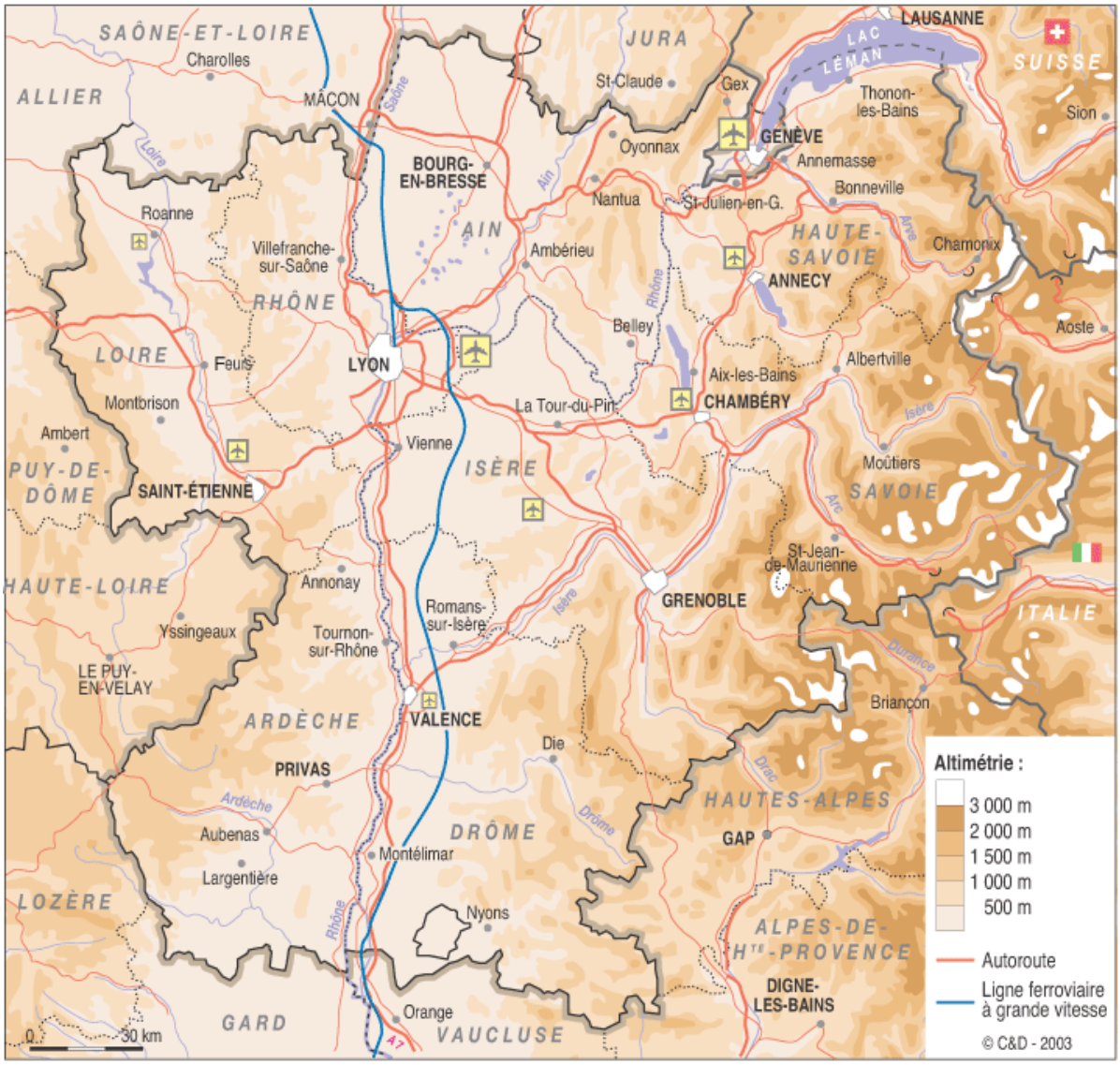
THE RHÔNE-ALPES REGION IN MAPS

(Information and maps come from the Rhône-Alpes Chambers of Commerce and Industry - http://www.rhone-alpes.cci.fr)

Rhône-Alpes territory stretches 250km from north to south and 250 km from east to west. With an area of 43 698 km², the region accounts for **8% of the national space**.

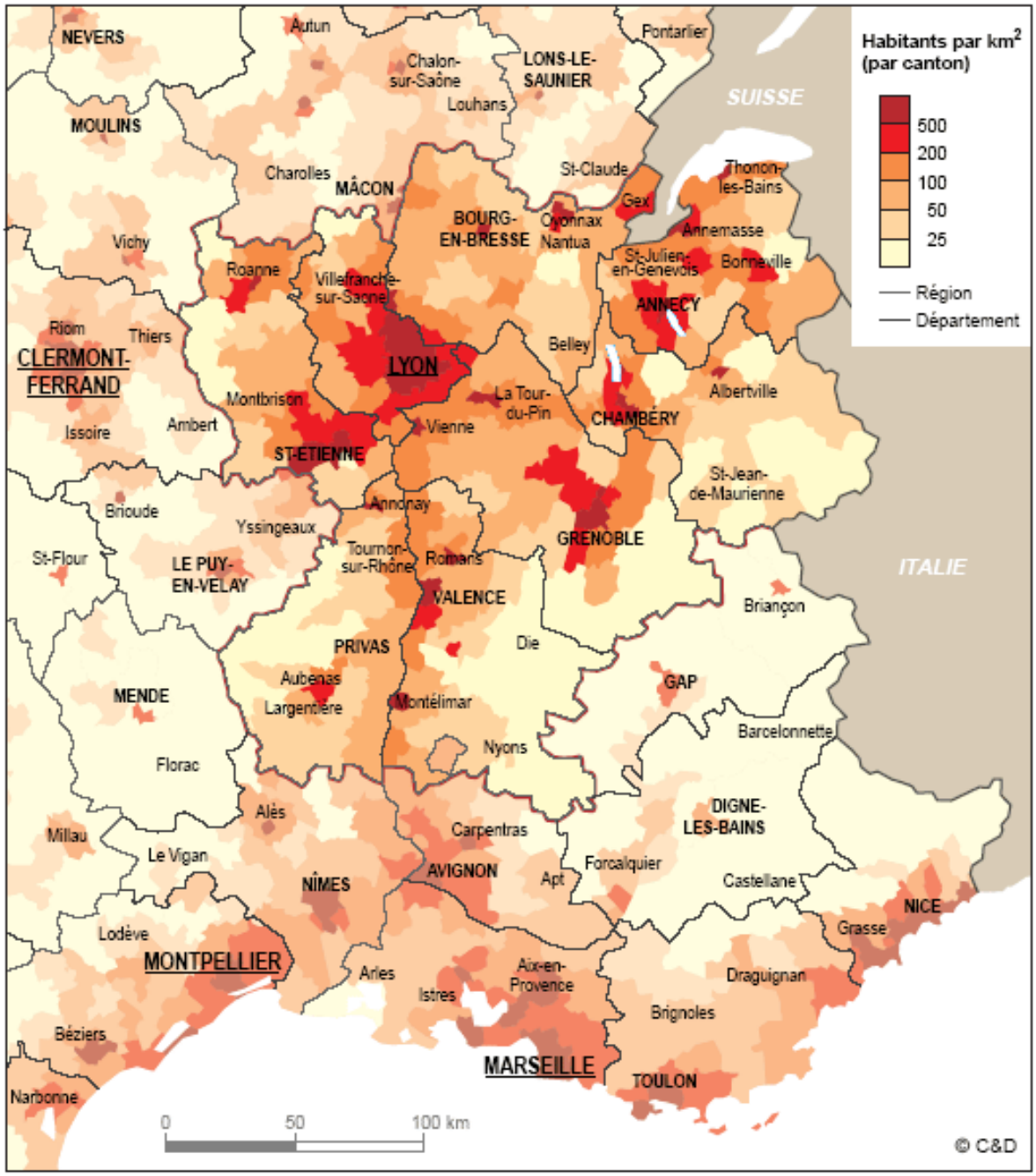
Its geography is varied even if largely mountainous and yet it has **major communication routes** that crisscross the territory. This is particularly true of the Saône-Rhône River, which flows through the region from north to south, central plains and western and alpine valleys connected to Italy and Switzerland.

From its position, the area provides a link between the northern and southern Europe, just as it is wide open on the Alpine central Europe. This geographic situation is extremely important in the understanding of the influx of immigrations in France and in this territory, as Rhône-Alpes in truly **a crossroad in Europe**. Historically migrants have crossed the border from Italy for instance and more recently influx of immigration from Switzerland is relatively important.



The discrepancies in density within the region are important. The Rhône is the French department most densely populated outside Ile-de-France (Paris and its region). It's well ahead of all other departments of the region. And the population of urban space, already concentrated, has generally increased, especially during the 1990's decade. The highest growths were for the built-up area around major cities. The population of many city centers has also increased (Lyon, Chambéry, Grenoble, Annecy).

On the other side, if the population of rural areas grew at the same rate as the regional population, the strong differences between rural areas has also increased, some areas losing population.



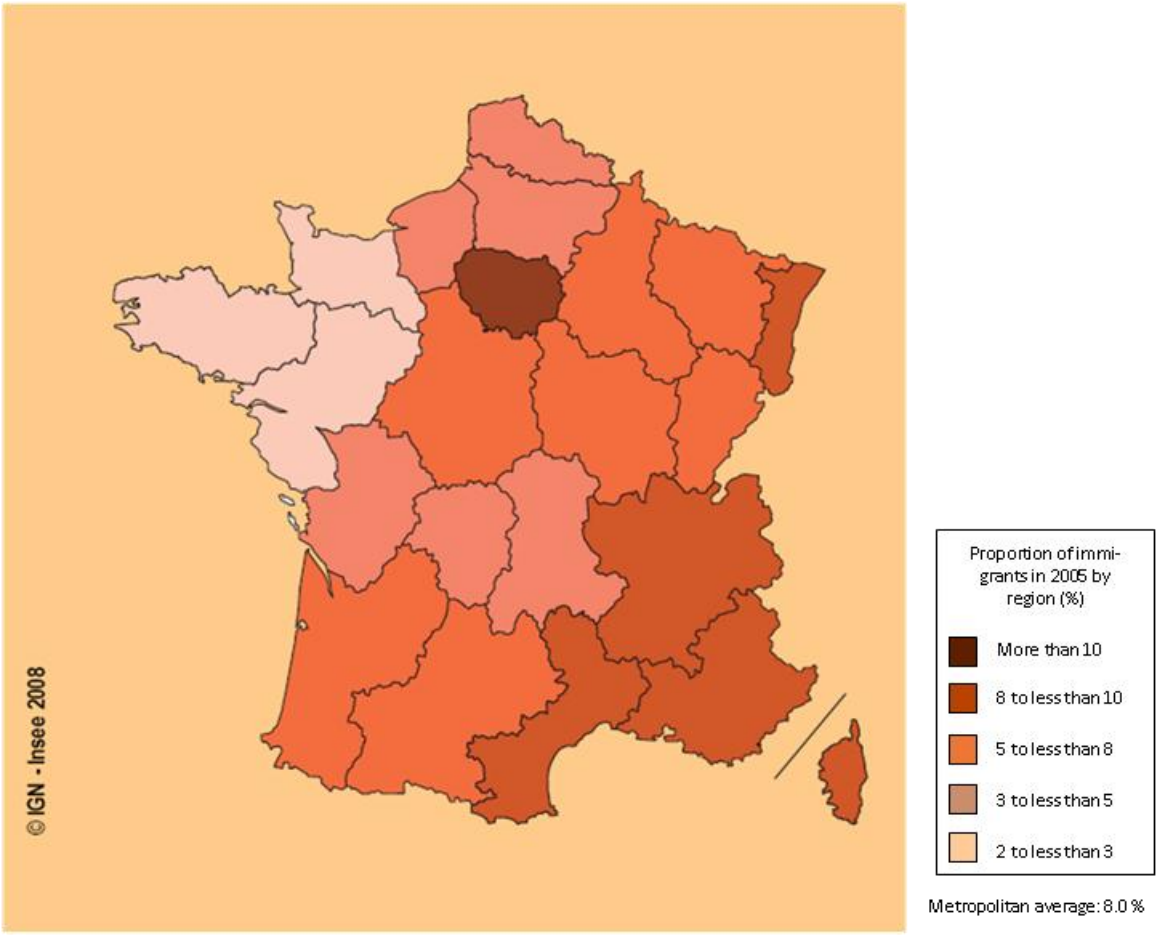
IMMIGRATION IN RHÔNE-ALPES

(Summary translated from the work of the National Institute of Statistics and Economic Studies Rhône-Alpes and more precisely the Letter-Results n°95 – September 2008. Website: http://www.insee.fr/en/default.asp)

In 2005, 515 000 immigrants were living in Rhône-Alpes[13]. There are in this category, persons born abroad under a foreign nationality. Many of them have acquired French nationality since. Thus, in 2005, 210 000 immigrants were French, that is 41% against 37% in 1999. That is why every immigrant is not necessarily from a foreign country and vice versa (see methodology).

With 8.9% of immigrants against 8.2% in 1999, Rhône-Alpes is above the metropolitan average (8.0%) and remains at the 6th place behind Île-de-France, Alsace, Provence-Alpes-Côte d'Azur, Languedoc-Roussillon and Corsica. The proportion of migrants increases, but the regional increase since 1999 is lower than the national level. At January 1st 2005, a majority of immigrants living in Rhône-Alpes is born in Europe[14] (44% against 36%, national average) or in Africa (39% against 42%).

Rhône-Alpes, one of the top six regions for the number of immigrants



[13] Results presented here only pertain to households population (see definition).

[14] Europe: consists of the European Union and other European countries, Switzerland for instance.

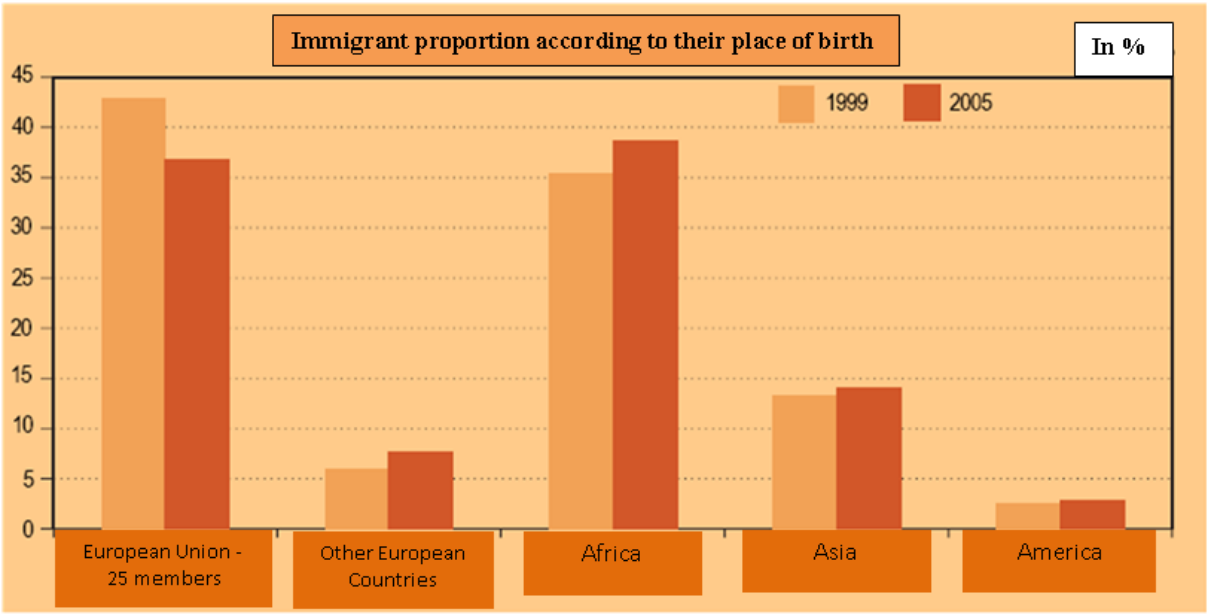
Among Europeans immigrants, 83% were born in a country of the European Union[15]. Their proportion has decreased since 1999 when 49% of immigrants were European including 88% from an EU country. The number of immigrants from Spain or Italy is decreasing significantly due to death in these aging populations and low numbers of newcomers.

On the contrary, immigrants from Africa are more numerous in 2005 than they were in 1999 (30% against 35%). The Maghreb (Northern Africa) is the most heavily represented on this continent. This population has grown between 1999 and 2005 from 31% to 33% of immigrants. The number people from Asia has also increased between 1999 and 2005 (from 13% to 14%). We are thus witnessing a globalization of arrivals. Even is numbers are low, it is from Europe outside the Union, Africa outside Maghreb and other continents that come the strongest progressions.

Thereby, the four most represented countries are Algeria, Italy, which, despite a decline since 1999, remains the second largest country of origin of immigrants, Portugal and Morocco. Immigrants from Italy and Algeria are more present in Rhône-Alpes than at the national level (13% against 7% and 18% against 13%). However, Portuguese and Moroccan immigrants are less present (9% against 13% and 11% against 12%).

After the top four, Turkey (7% of immigrants), Tunisia (6%), Spain (6%) and Switzerland (4%) are among the eight main immigrant's countries of birth. Due to the border characteristics of the region, immigrants from Switzerland are four times more present in Rhône-Alpes than in metropolitan France (1% of the immigrants at national level).

Rise of immigrants from Africa and European countries outside EU



Field: households 'population.

Source: Insee, annual census survey from 2004 to 2006

[15] European Union with, at the time, 25 members.

At January 1st 2005, nearly 67 000 immigrants (4 years old or more) are living in Rhône-Alpes for less than 5 years. They thus represent, as at the national level, 13 % of immigrants in the region. More than one in ten immigrants who arrived in France since 2000 has so settled in Rhône-Alpes. The region is at the second position concerning newcomers behind Île-de-France, which is consistent with its demographic weight.

Among the newcomers from 2000 to 2005, 27 700 were born in Europe. Those from African countries mostly native from Maghreb, are also well represented, with 24 400 arrivals.

Algeria is in first position for recent arrivals (10 100). These thus represent 11% of Algerian immigrants. It is among migrants from the United-Kingdom that the weight of new arrivals is the strongest (35%), although this population remains poorly represented in Rhône-Alpes. Meanwhile, the region differs from the others by a recent influx of immigrants from Switzerland. Over a quarter of these immigrants were not present in Rhône-Alpes in 2000. This phenomenon, already observed in 1999 is gradually increasing for several reasons. House prices are more attractive on the French side of the border. In addition, the French-Swiss bilateral agreements established in 2002 promote free movement of people on both side of the border, in order to open gradually the Swiss labor market to European nationals and the European labor market to Swiss workers.

Immigrants from America, although their numbers are low, gradually settled in Rhône-Alpes: they represent only 3% of immigrants but 7%of new arrivals.

Evolution in the number of immigrants since 1999

The number of immigrants in Rhône-Alpes is calculated at 515 000 people in 2005. They were 452 000 from the 1999 census.

Between these two dates, the number of immigrants living on the territory changes functions of deaths and ongoing movements in and out of the territory. An initial examination of data from different census and other available data shows that the census that took place in 1999 underestimated the number of immigrants. The growth calculated on the period 1999-2005 corresponds to a real situation, but perhaps partly overestimated. Proportionally, the data from 1999 and 2005 are still comparable.

The ageing and feminization of the immigrant population has been stable since 1999. Feminization, which begun in the early 1970's with the end of workforce immigration (mostly male) and family reunification measures, has stopped. Immigrant women are now as many as men. But the balance between men and women differs by age: immigrant women are the majority among the 15-50 years old and, because of their higher life expectancy, among those over 75 years old. It is the opposite between 50 and 75 where men are more numerous.

The immigrant population is older than average: the youngest are less numerous because immigrants are not born in France and that few children were involved in the family reunification measures, a process more often used for spouses. Thus, for all ages, immigrants represent 8.9 % of the

households' population but less than 2.5 % of those under 15. The proportion of immigrants is the highest among the 30-59 years old (11 %). It is so at age to be active, that immigrants are the most numerous: 55 % of them are between 30 and 59 years old. The age pyramid of the immigrant population is in shape of a whirligig: its base is expanding gradually, reaching its peak around age 50 and decreases after this age. Nevertheless, unlike the average age of non-immigrant people, that of immigrants decreases slightly between 1999 and 2005, going from 47 to 46, against stability at 38 for the regional population. Recent arrivals have generally balanced the ageing of older populations on the territory.

The education level has risen over the generations for immigrants as for the whole population. In 2005, non-graduate immigrants are relatively less numerous than in 1999 (55 % of non-graduate or CEP[16] against 58 %). Meanwhile, the proportion *baccalauréat** graduates (*equivalent to A-levels in the UK) or holder of higher education diplomas is increasing: 26 % of immigrants have one of these diplomas in 2005 against 20 % in 1999. This rise reflects a generational effect. Thus, six out of ten immigrants, from 15 to 29 years old who completed their studies, hold at least a BEPC[17], against only 2 out of ten for those over 60. In a similar fashion, the proportion of *baccalauréat** holders is of two out of ten among the 15-29 while it is less than one in ten for immigrants above 60 years old.

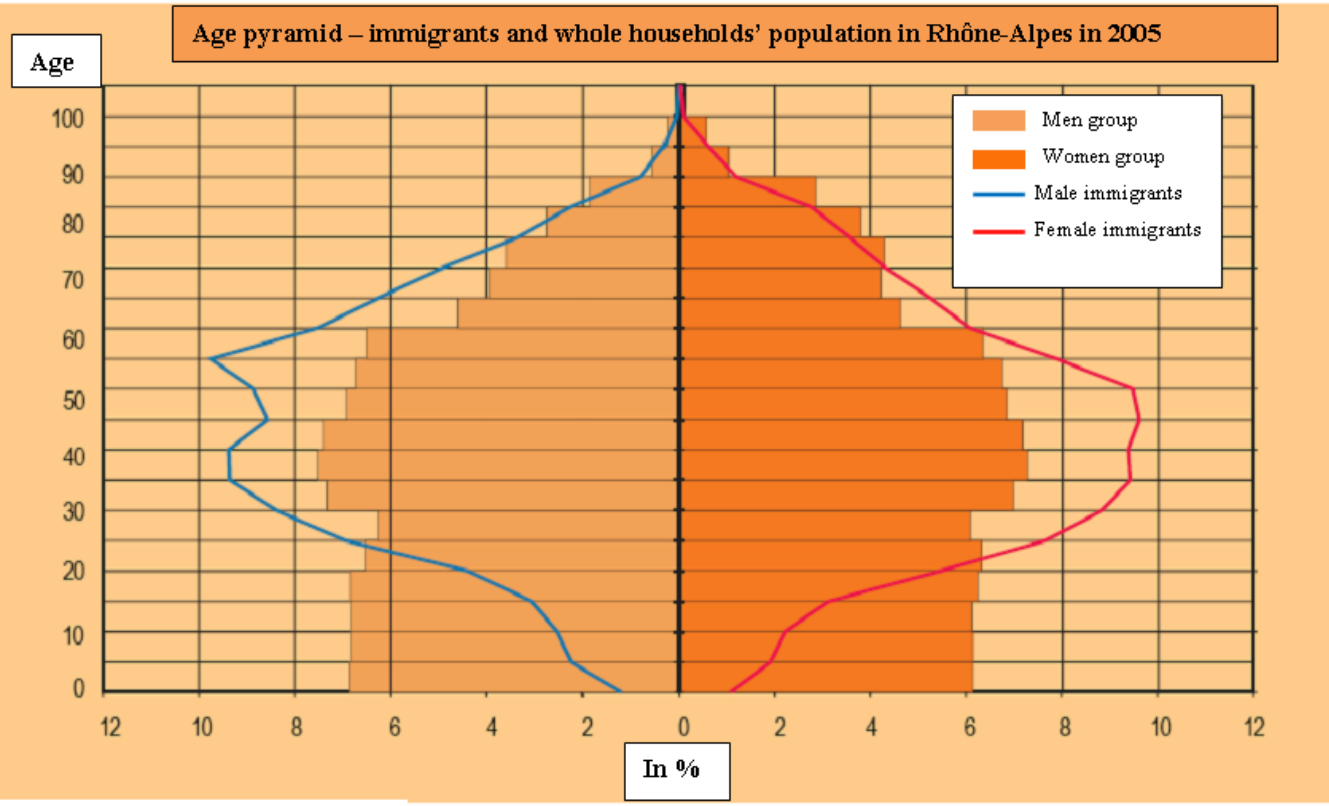
Likewise, recent immigrants, settled in Rhône-Alpes for less than 5 years et that have completed their studies, are on average more educated than older immigrants. In fact, more than half of the newcomers are *baccalauréat** holders or higher education graduates against a quarter of all immigrants. That difference, seemingly observed in all regions, is due to the age structure of newcomers, often younger.

However, immigrants from Rhône-Alpes have on average fewer graduates than the overall regional population. In fact, 31 % of people from Rhône-Alpes are non-graduates (against 55 % for the immigrants) and 39 % have a diploma equivalent to the *baccalauréat** or a higher degree (against 26 %). Immigrants have also fewer graduates in Rhône-Alpes than at the national level. Thus, in France, 30 % of immigrants have a degree equivalent or higher than the *baccalauréat**, or 4 points more than those from Rhône-Alpes. The skill level of employments held by immigrants in the region is surely one of the factors explaining this difference.

[16] CEP standing for Certificat d'Etude Primaire or Primary Certificate of Study.

[17] BEPC standing for Brevet d'études du premier cycle, former examination at the end of the first stage of secondary education.

A majority of immigrants at working age



Field: households 'population.

Source: Insee, annual census survey from 2004 to 2006

The distribution of graduate immigrants by sex is the same as the Rhône-Alpes population, except for higher degrees. As for the regional population, the proportion of non-graduate is higher among immigrant women (58 %) than men (52%). On the other hand, immigrant women still counts slightly fewer graduates than men (16 % of men hold a higher degree against 15 % for women) while it is the contrary in the total population (23 and 24 %).

METHODOLOGY

Data presented in this publication proceed from estimates made from the overlapping of three years of annual census survey: 2004, 2005 and 2006. The resulting data can be interpreted as describing the average situation at January 1st 2005. The new census method, implemented since 2004 is a strategy of annual census surveys replacing traditional counting organized every 8 or 9 years until 1999. This strategy sets apart cities of less than 10 000 inhabitants, where a population census is organized every five years, in rotation, and cities of more than 10 000 inhabitants where a census is organized every year for about 8 % of the population.

The concept of population implemented in French census and in estimates of population represents the residing population: are counted people who live for more than 6 months a year on the territory. As such, illegal immigrants are intended to be included in the population. However, population censuses are not immune to omissions, no doubt more frequent for illegal immigrants, but impossible to quantify.

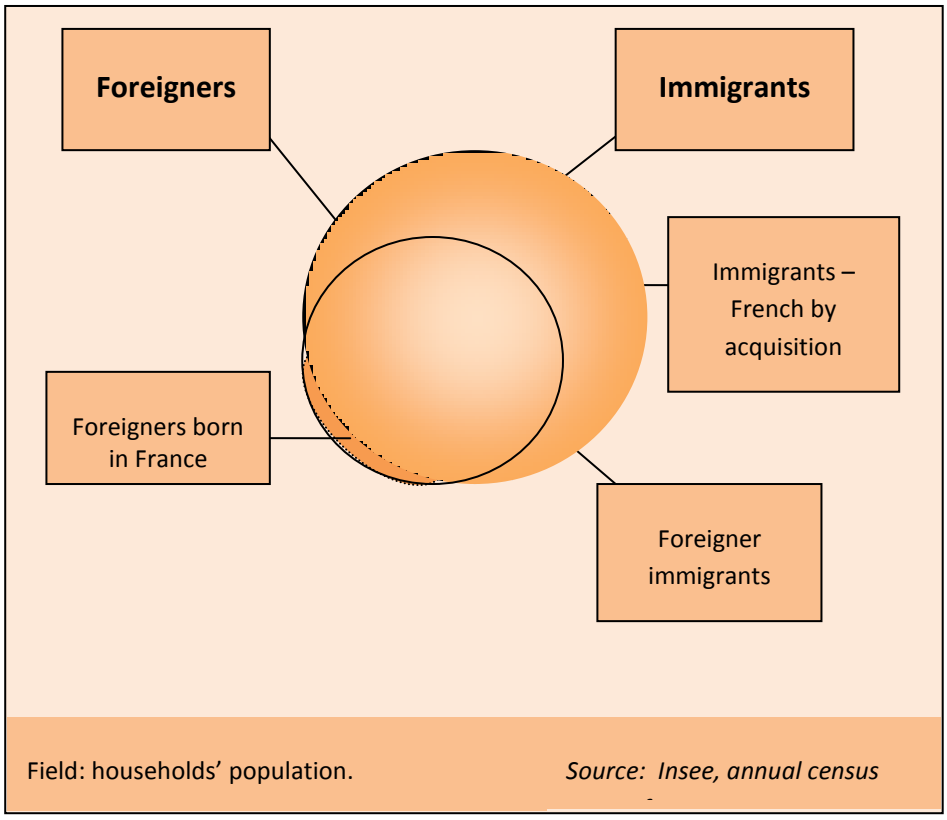
Definitions[18]

Age: it refers to the age (completed) at the time of the census.

Diploma: is considered here the last diploma obtained by all the people of the households' population aged 14 or more and having completed their studies.

Households' population: it refers to all persons sharing the same housing, not necessarily related (cohabitation for instance). The field studied here excludes the population living in communities (nursing home, hostels for workers…) and mobile homes. Immigrants in households represent about 96 % of the total immigrant population in Rhône-Alpes in 1999.

Immigrants and foreigners in Rhône-Alpes as at January 1st 2005



Field: households' population. *Source: Insee, annual census*

[18] See: lexicon for name and status.

REGIONAL PROGRAM FOR THE INTEGRATION OF IMMIGRANT POPULATIONS

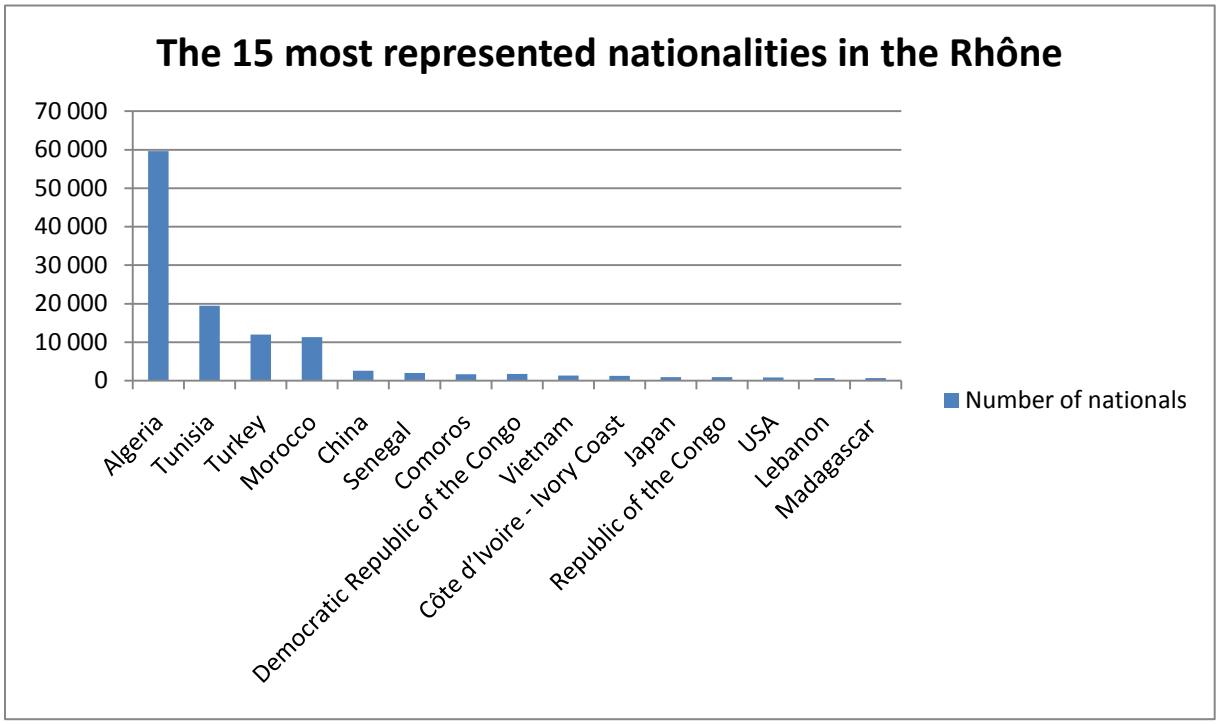
Essential facts from the departmental evaluation

The foreign population in the Rhône department comprises 117 000 people at December 31th 2008. 33 % of the adult foreign nationals live in Lyon and 13 % in Villeurbanne, these two cities gathering together about half of the foreign population in the department (46 %). Next is Vénissieux and Vaulx-en-Velin (7%), Bron (4%), Saint Priest and Villefranche sur Saône (3%).

LOCATION OF FOREIGN NATIONALS (ADULTS) IN THE RHÔNE AT DECEMBER 31TH 2008

The 15 most represented cities	**Number of foreign nationals (adults)**	%	**Number of women**	**% of women**
Lyon	41 929	33,1%	19 346	46,1%
Villeurbanne	16 992	13,4%	7 469	44,0%
Vénissieux	9 981	7,9%	4 500	45,1%
Vaulx en Velin	9 068	7,2%	4 366	48,1%
Bron	5 129	4,0%	2 457	47,9%
Saint Priest	4 571	3,6%	2 118	46,3%
Villefranche sur Saône	3 976	3,1%	1 884	47,9%
Saint Fons	3 612	2,8%	1 605	44,4%
Rillieux la Pape	2 653	2,1%	1 303	49,1%
Givors	2 357	1,9%	1 123	47,6%
Meyzieu	2 214	1,7%	1 034	46,7%
Caluire et Cuire	1 823	1,4%	865	47,4%
Décines	1 704	1,3%	818	48,0%
Oullins	1 634	1,3%	775	47,4%
Pierre-Bénite	1 221	1,0%	566	46,4%
Ecully	1 140	0,9%	555	48,7%
Tarare	809	0,6%	392	48,5%
Saint Genis Laval	769	0,6%	403	52,4%

Sainte Foy les Lyon	696	0,5%	359	51,6%
Feyzin	678	0,5%	318	46,9%



The most represented nationality in the Rhône department is clearly Algeria with almost 60 000 nationals, about 37 % of the foreign population on the territory). After Algeria, follow three countries between 10 000 and 20 000 nationals (Tunisia, Turkey and Morocco). These four nations represent 85 % of the total foreign population on the department. This population is related to family reunifications between 1960 and 1980 which occurred after the arrival of migrant workers up until 1973.

The priority groups in the department

- Newly arrived immigrants

About newly arrived immigrants (adults), the estimated number of **new entrance per year is 4000** and 20 000 people have been on the French territory for less than 5 years.

For 2009, **3555** Contracts for Reception and Integration (in French "*contrats accueil et d'insertion* – **CAI"**) were signed in the Rhône (4050 in 2008).

- Women

Women represent **52 % of the immigrant population in the Rhône** (Rhône-Alpes region: 51%). 47 % of immigrant women have no diploma, against 42 % of men, data equivalent to the region.

- Old migrants

The share of old migrants is the most important in the immigrant population: migrants over 55 accounts for 33 % against 25 % in the non-immigrant population. **19 % of the immigrant population is retired or in early retirement.**

Thematic approach

- Learning French

Learning French is of great importance for the French government. It is a milestone of the various integration policies. Also several programs, involving various partners have been initiated. Since 2009, the OFII monitors the follow-up of CAI trainings (for newcomers) and outside CAI. The new deal, since March 2010, mixes the two publics (newcomers with CAI and others) through two different training leading to different degrees.

- The DILF (*Diplôme Initial de Langue Française*, or initial diploma in French language) is a qualification in French as a foreign language that assesses basic users. It is and initial step towards:
- The DELF (*Diplôme d'études en langue française* or diploma of French language studies) and the DALF (*Diplôme approfondi de langue française* or advanced diploma in French language).

⇨ ***Prospects and Issues***

For the Rhône department, learning French is one of the top priorities for integration, and women represent the main target. The objective is to support women who have been in France for more than 3 years (outside CAI) as well as women who are struggling with the language after the departure of their children. Also the prefecture acknowledged the necessity to a better linking between the existing programs and partners. Another aspect is business French with the implementation of language training as preparation for employment. Mastering French is essential to access employment.

- **Parenting**

"Open school for parents"

The operation was launched by a bill on July 25th 2008, jointly signed by Brice Hortefeux (former minister for Immigration) and Xavier Darcos (former minister of National Education). The project is aimed at immigrant parents who have not followed the available services under the CAI. It was first introduced on an experimental basis in 12 departments, including the Rhône, with an effective start on November 12th 2008. According to the prefecture, the objective was to make available some training in schools in order to enable the parents to improve their knowledge of French language, their knowledge of Republican values and of the school institution. In the Rhône, the project was implemented in three schools for 2008-2009 and extended at five others for 2009-2010.

⇨ ***Prospects and Issues***

Parenting support is the second theme which needs to be developed for the department with a global approach parents/children. The objective is to improve the image of parents by giving value to their role and by fighting against estrangement. The said program *"Open school for parents"* is a first step in the process. In the mean time, it is necessary to encourage the creation of places to exchange, allowing dialogue between parents, associations and professionals. These places can provide help and attention to the families.

- **Access to employment**

Access to employment is more difficult for immigrant women: they are only 35 % having a job against 52 % of employed men. At a regional level, 42 % of immigrant women and 58 % of men are employed (source: INSEE RP 2006). The immigrant population is composed mainly of workers (37 %), employees (28 %) and intermediate occupations (15 %). According to the prefecture there are no major differences between immigrants and non-immigrants on the conditions of employment (temporary contracts, sustainable employment…).

⇨ ***Prospects and Issues***

The prefecture notes that despite real issues in the access to employment and training, few plans of actions were suggested. However important needs have been identified in terms of access to information about diploma equivalence and accreditation of prior and experiential learning. It seems necessary to simplify the rules and to support people through the procedures.

An agreement between the OFII and *Pôle emploi* (France's equivalent of the Job Centre) was signed in 2010 for the integration and professional immigration which will offer training and guidance to newly arrived migrants.

- **Access to care (older migrants)**

Elderly immigrants often face malnutrition, increasing deterioration of health and loss of autonomy which makes it difficult for them to stay at home and if so under what conditions (food delivery services, in-home care services…). Regarding access to collective organizations, only 1.6 % of immigrants over 60 are supported in nursing homes, against 3.3 % for non-immigrant people. After 85, they are only 11 % to be received in nursing homes (source: Aralis).

ADOMA has created **INTERMED**, an association involved in a health network since September 2009. Their action aims to develop **health mediation**[19] in ADOMA homes, with the help of five nurses.

⇨ ***Prospects and Issues***

In the Rhône, 55 000 immigrants are over 55 years old. Often without family support, older migrants are faced with loneliness and need assistance in dealing with procedures whether it is in relation to health or administration. In addition the prefecture admits that there is a real need for a social and legal support in the matter of access to retirement.

- **Access to housing**

ALPAR (Habitat and Humanism)

The ALPAR (*Accompagnement vers le logement des Primo Arrivants du Rhône* or Support to housing for immigrant newcomers in the Rhône) is support action that provides solutions to housing problems and support in the process for newly arrived immigrants and in some cases their family. Any new arriving immigrant who comes to the OFII receives information on this support. The management of the support has been entrusted to the association Habitat and Humanism (*Habitat et Humanisme*).

82 cases were considered in 2009, against 105 in 2008. 27 involve single-parent families. In 2009, the association has offered 40 accommodations and has exceeded conventional objectives set at 35 housing offers.

- **Other organizations**

[19] Health mediation is a recent field in France, it overlaps two professional spheres: social work and medical care. A health mediator or intercultural health mediator is familiar with a specific cultural environment (a district, a community…) and with medical institutions and professionals. He is thus able to link up the patients and the caregivers, and to help them overcome their cultural conflicts.

THE *ACCELAIR*[20] PROGRAM, A SUPPORT PROCESS FOR REFUGEES

This program, created in 2002, is aimed at people who have recently received refugee status and who require support in order to access employment and housing. The goal of the program is to provide beneficiaries of subsidiary protection living in the Rhône department, with a real integration project in the long-term: individualized social support and reception, access to secure housing, access to long-term employment and training if needed.

CONCEPT OF *TERRITORIALISATION* - "*Accelair fresh start*" was built on the principle of a "*territorialisation"*, an approach of public policies that puts the emphasis on the specificities of each territory, as opposed to a vertical organization. This approach allow for a decentralized reception of the public while ensuring unity of all services rendered. The objective was to improve the working conditions of the various integration professionals on a common territory. The department is thus divided into two areas, defined from 16 Local committees of integration (*Commissions locales d'intégration* or **CLI**) and of the Department Council. Also on both areas, one of the two project executives involved in the program (***Entraide Pierre Valdo*** and ***Forum réfugiés***) is the intermediary with the public (upon questions such as income support, access to a secure housing and employment).

A PROJECT IN PARTNERSHIP – Backed since its very beginning by the Prefect of the Rhône-Alpes region and the President of the Rhône department Council, the program currently enjoys a high legitimacy. Accelair is foremost a project in partnership: it involves both institutional partners (DDRASS, DDASS, OFII, Department Council, Regional Council etc.) and partners specialized in support to refugees (Entraide Pierre Valdo, Bleu nuit Rhône-Alpes, Adoma, Aralis, Alfa 3A, etc.). A departmental coordination program has been set up. It is composed of two technical committees who meet monthly, one dedicated to housing and the other to employment and training, through this program, key partners are brought together. Accelair seeks to meet the needs of local actors by offering support to the project executives so that they can show the kind of adaptation that must be undertaken when working with refugees (mobilisation of interpreters, mediation with lessors, etc.) and to raise awareness among field workers to improve their knowledge of the public.

In August 2008, the milestone of **1000 leases signed** was passed. Thus, 3274 people have been rehoused since the beginning of the program. During the program, **two thirds of the households have found a job**, which represent **more than 1000 contracts of employment** and **300 trainings**. Also, 53 training sessions/awareness campaigns were conducted in six years.

In 2009, the Rhône regional social services department (DDASS) published a report on the undertaken actions during the first half of 2009, which provides interesting data on the program. Thus, since 1 January 2009, 759 people were helped. This public is composed mostly of men (66 %), young (half of them were under 35), 39 nationalities are represented. With regards to housing, 76 leases were signed (199 people rehoused). And concerning employment, about 70 % of the people who were helped in 2009 have found a job or training since they are supported by Accelair.

[20] This part is based both the prefecture report and on Forum réfugiés (the NGO managing the project), website: http://www.forumrefugies.org

The ADLI organization

ADLI (*Agents de développement local pour* l'intégration or Agents of local development for integration) was created in Rhône-Alpes in 1996 to promote the integration of Turkish people. Its missions were reset in 2003 toward new issues: reception of foreing populations in general, social and professional promotion, fight against discrimination. Agents of the organization work to identify deadlocks on conditions of entitlement, relationship between public-services, local populations and immigrant populations and also to promote dialogue.

The ADLI intervenes in a given territory for a period of 3 to 5 years. Its practical details are on two levels: collective action through the organization of meetings and individual action with one objective; to find solutions to problematic situations by working with the law. This intervention is decided by the executive committee at the request of a city.

In the Rhône, the ADLI mission was entrusted to a local association, the CREFE (Centre resources enfance, famille, Ecole or Center resources childhood, family and school). Four cities were involved in the action; Bron, Saint-Fons and Givors/Grigny. Agents were also on an information campaign about the operation *"Open school for parents"*.

The Rhône department in figures

- The immigrant population is composed of **169 825 people**, representing **33 %** of the immigrant population in Rhône-Alpes.

- **4000 new arrivers signatories of the CAI** (Contracts for Reception and Integration) **every year, 20 000 people are under 5 years of presence in France (excluding foreign students).**

- **3500 CAI** were signed in 2009, **952 language training** and **2 371 skill assessments** were prescribed.

- **Women** represent **52 %** of the immigrant population.

- **19 %** of the immigrant population is either **retired** or in **early retirement**.

C- EVOLUTION: RESSOURCES AND ISSUES

IMMIGRANTS AGEING, A RECURRING PROBLEM IN FRANCE

For older immigrants, to access retirement involves lots of red tape. There is first the difficulty to piece their record of career together, having worked illegally, most of the time in harsh and even dangerous conditions. Health consequences of such careers are definite, but their situation toward health system being difficult, they are often unable to be supported. Their incomes are thus extremely scarce and their recourses very limited. How do they live and what happen of them is currently a sensitive issue in France.

Sociologist Choukri Hmed, from the center of political researches of the Sorbonne, has studied the question. In his paper "***Immigrants Growing Old in Workers' Hostels or the Residents of Nowhere"***[21] underlines two mechanisms. He first shows that a great part of these immigrants is "rooted" in worker hostels in which they reside as a result of a lifelong socialization in this type of accommodation. Secondly, older immigrants in this situation are also in a process of what the author calls "double disaffiliation" meaning they are lastingly disconnected from both their home society and their host society. Rooted and isolated at the same time. As a consequence to theses two mechanisms they progressively "give up" and withdraw to the lifestyle and sociability common to these hostels. They age in these "homes" which are then not always fitted for their needs.

Older immigrants - uprooted from their home country, tormented by the question or whether to return or not, partly integrated, partly rejected by the host country – are fully attached to one and only place: their life environment, their hostel, their district. They came as a workforce, economically desirable, socially unattractive. They age in a situation even worse; in the midst of retirement issues, when the senior population is still a major concern in our society and forever immigrants. They age in the same environment but with more or less no incomes and no health coverage. Choukri Hmed explains that they have established this lifestyle and their social interactions in the hostel based on a logic of "asceticism" - a unifying principle for this population.

It is also becoming a real challenge for hosting organizations, as hostels are mostly unequipped for older people, some in need of medical care. However some organizations have identified the needs of their residents, which is the case for the following example – ADOMA: uses segmentation.

WHEN ETHNICITY GOES ALONG WITH THE DIFFICULTY OF AGEING IN FRANCE: THE **CHIBANI**-IAS[22]

In the previous section, ageing of migrants and issues on retirement were examined, however, the living conditions of retired, old migrants living in France are also subject to restrictions. For the action group "*Justice and Dignity for the Chibani-a-s"*, these restrictions are obstacles for their right to live with dignity, in their country and in France as they culturally belong to both countries. Even today, after decades of life in France they face every day with discrimination and social inequity, forty to fifty years after their arrival, not much has changed.

[21] Published in the review « Retraite et société » 2006/1, n° 47, p. 137-159.

[22] Section based on information from the website http://www.chibanis.org/.

The action group fights the difficulties in access to civil rights and organizations under the common law, inequalities in access to care, difficulties in access to an appropriate housing, privatization of social rights, house arrest, freedom of movement under conditions, discrimination etc…

Chibani means elder in Arabic, a term now common even in some institutions, to designate the North African immigrants of the 1960's. But it could be used for the whole elder population, of all origins, with longstanding roots in France and now living miserably. The campaign to enforce access to rights for this population remains long and difficult, the action group *Justice and Dignity for the Chibani-a-s,* goes on with the struggle for the respect of their civil rights, and that their specificities are acknowledged.

Civil rights at stake:

- Access to health care without restrictions in their country and in France
- Access to social and political rights without restrictions in both countries
- Access to a decent housing, adapted to the fact that this population is ageing
- Recognition and visibility of History and memory of their struggles

IMMIGRANT: THE OBSTACLE COURSE[23]

Being an immigrant in France is very often an obstacle course, that's what Laurent Jeanneau describes in the economic magazine *Alternatives Economiques*. In an article based on a survey by INSEE and INED (National institute of statistics and economic studies and National institute of demographic studies), the journalist presents a situation where migrants are often victims of unequal treatments.

If ethnic statistics are banned in France, it is however possible to measure the discriminations against immigrants. It is the goal of the investigation "Trajectory and origins", conducted by INSEE and INED, based on a large sample of 21 000 people. The survey points out several key moments where discrimination occurs in the life of the 3.2 million migrants in France.

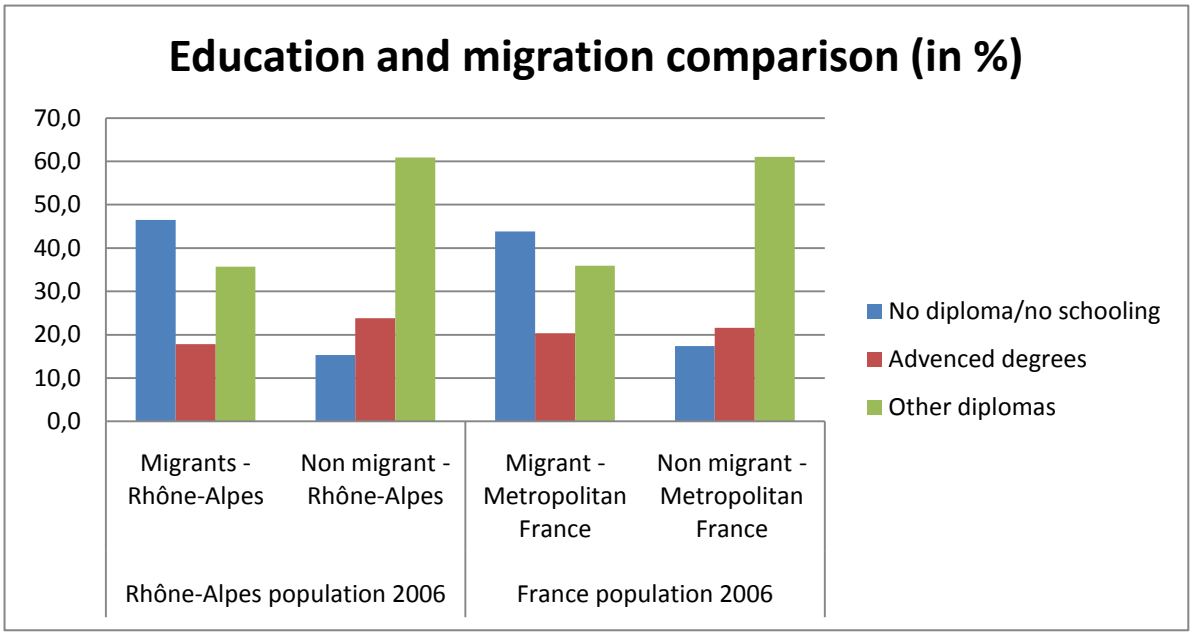
The educational level of immigrants strongly changes according to their origin, but this diversity reflects mainly the differences in time: how long ago the influx of migrants occurred. In fact, in general, the educational level is rising up over the years. This is the consequence of two facts: first, the educational progress made in the countries of origin and secondly and more importantly, the **hardening of the selection process in educational level for immigration applicants**. Thus upon departure, almost a third of immigrants has a diploma above the baccalaureate. If you have a higher education, you have better chances to leave your country. Insomuch that some groups have a higher average level of qualification than non-immigrants. 37 % of men from sub-Saharan Africa have higher education diplomas, against 32 % of the French population (outside immigration).

[23] The following section is based on an adapted translation of the article "*Immigrés: la course d'obstacles"* by Laurent Jeanneau in *Alternatives Economiques* n° 297 - décembre 2010. Graphics refer to the Rhône-Alpes region; they are the result of surveys led by various organizations (ONGs, Prefecure etc.).

EDUCATIONAL INEQUITY

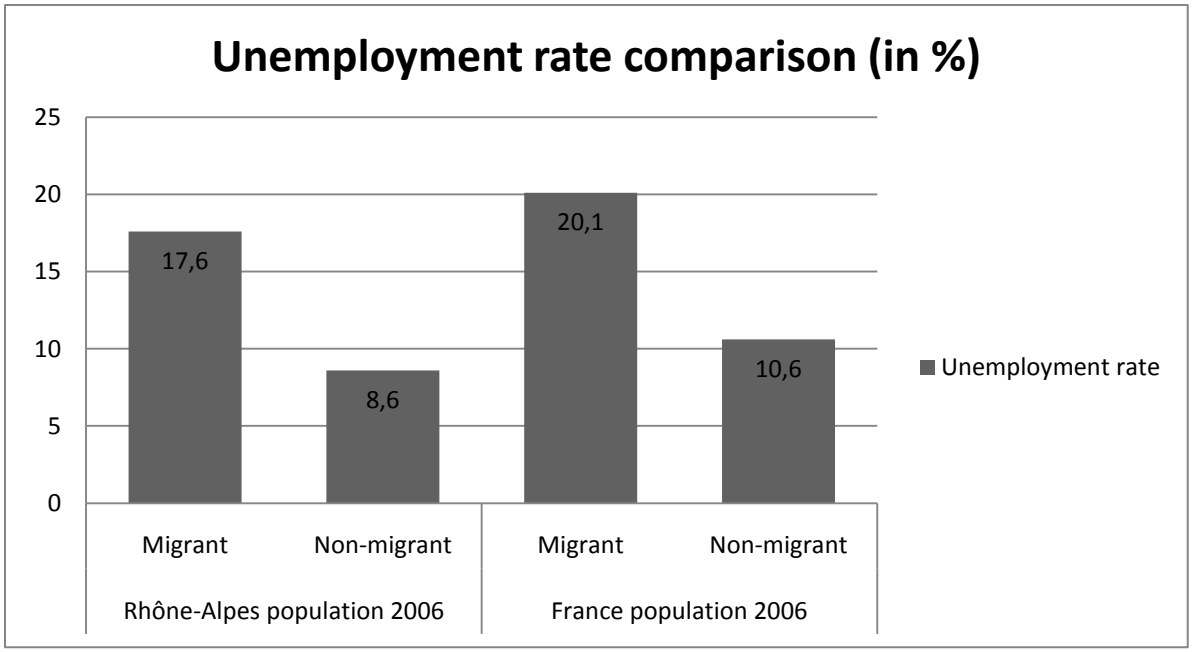
In general, however, educational backgrounds of children of immigrants living on the territory are full of obstacles. Many of them leave the educational system without any diploma (13 %, against 8 % for the rest of the population). This is especially true for children born from parents who came from Turkey (27 %) and, to a lesser extent, Maghreb or sub-Saharan Africa. In the same way, children of immigrants have fewer baccalaureates and are less often oriented toward general education.

These inequalities in educational levels are partly explained by the social background of young people born of immigrant parents. Most of them in fact belong to families whose fathers are workers (65 % against 41 % of young people whose parents have no foreign origins). But the children of immigrants see these difficulties as racial discrimination . They express a strong sense of injustice: 14 % of them consider to have been less well treated when they were oriented, which they attribute to their origins or their skin color. They question the impartiality of school.



HIGHER UNEMPLOYMENT RATE

On the labor market, obstacles are numerous too. Immigrants from Maghreb and sub-Saharan Africa are in fact twice as likely to be unemployed than non-immigrant. And this with equivalent qualifications, that is to say when differences are neutralized (age, gender, training, place of residence or family situation). This discrimination goes on even once crossed the barrier of employment: male immigrants from sub-Saharan Africa are less paid (hourly wage under 10 %) than other employees. A situation confirmed by the feelings of those who were questioned: people most vulnerable to unemployment are also those who said to have suffered unfair refusals of employment.


Unemployment rate comparison (in %)
25
20
15
10
5
0
17,6
8,6
20,1
10,6
Migrant
Non-migrant
Migrant
Non-migrant
Rhône-Alpes population 2006
France population 2006
Unemployment rate

CHAPTER 3 - MIGRANT HEALTH

When the displacement is forced, refugees are often taken aback by their host countries. How does it work, how to resolve administrative, economical and social issues. These concerns are essentials to any refugee, and health concerns will be secondary at first. As they get involved with the public health system, they find it is as complex and blurred as the rest. Communication problems will often occur with professionals – rendered even more difficult by their situation. It's a true cultural gap between representations and expressions of sickness. On top of that, psychological or physical suffering – from whatever nature they are – will make the gap deepen.

There is a real lack of epidemiological data in France; this rarity is mainly the consequence of unwillingness from the state as immigration is more than ever a controversial subject. Unfortunately these data would be priceless. We know for instance that migrants have a higher vulnerability to some sorts of diseases; HIV, chronic viral hepatitis and tuberculosis. But they also have a frailty on three main pathological groups: psychological traumas, infectious diseases and chronic diseases.

ACCESS TO HEALTH CARE

According to E.A. Stanajevich and A. Veisse[24], access to health care is a major issue in France and it is has been so for the last 20 years. Since it concerns all of the population it called the attention of politics. They engage various reforms and as a result favored access to health care for French and foreigners residence permits but to the price of the gradual exclusion of foreigners living in precariousness. In France, there is a complete health care coverage for the poor. [See: Table] If in theory migrants have access to this complete coverage after three months of stay, the complexity of the law does that undocumented migrants do not always get that coverage.

These issues can be solved by migration professionals and health professionals, other issues however seem to be impossible to solve. Especially the absence of a **Public service of translation** or **the refusal to give care** from some health professionals against those who beneficiate form the universal health care coverage or medical help from the state. A good example of this philosophy is given by the head of the MdM delegation in Grenoble: it is difficult, if not impossible, for them to offer proper dental care to their patients but the College of dentists to which they wrote had a simple answer to that: *charity work*. For them, heal someone who beneficiates from the CMU is considered as sponsorship.

THE CONSIDERATION OF MIGRANTS' SPECIFICITIES

The consideration of migrants' specificities in public policies is at the heart of debates on prevention. Like for care access and social welfare, the campaign against HIV has played a major role in the identification of especially vulnerable populations, of whom migrants from sub-Saharan Africa are

[24] In *La santé de l'homme*, n°392, November-December 2007, pages 21-24.

first rank members. The study of behaviors, beliefs and practices of these populations led field actors and public authorities to adapt and refine their approach.

A – DEFINITIONS AND HEALTH FACTS

HEALTH CARE, CMU AND AME HOW DOES IT WORK?

Basic Health Care (and basic Universal health care Coverage, in French CMU for "Couverture Médicale Universelle"): social welfare program concerning public health. It offers the possibility to all people who legally reside in France for more than three months to have health expenses reimbursed by the state(except for asylum seekers, who are free from this last condition).
Complementary CMU: for people with low incomes (and who can't get a private insurance), the CMU also offers a complementary health protection which adds itself to the standard Social Security. With this the patient doesn't have to pay for medical consult, laboratory tests or medication.
Medical Help from the State (In French AME for « Aide médicale de l'État »): health care system designed for people who have no residence permit and with low incomes.

ACCES TO CARE: WHERE TO GO IN RHÔNE-ALPES?[25]

Medical and psychological centers ("**centres médico-psychologiques**" – **CMP** in French) are public establishments that bring together specialists and offer a range of mental health care fully covered by the health care system (as opposed to private practitioners). There are CMP for adults and children. Such a center includes a psychiatrist, clinical psychologists, nurses, social workers, psychomotor therapists, speech therapists and specialized educators. It usually provides consultations, home visits or nursing.
Hospitals centers are supposed to be available for migrants, as they are so for the rest of the population; however access to care is a major concern, due to a **lack of recognition on migration issues**, and of the **cost of interpreters**. These issues interfere with the care, especially for mental health care. Also in question, is the **saturation of the ambulatory public psychiatry** which adds with the problem.

[25] The following definitions have been summarized and translated from various websites:
On HIV/AIDS prevention: http://www.sida-info-service.org/
French health department : http://www.sante-sports.gouv.fr/
About birth control: http://www.choisirsacontraception.fr/
About health care centers: http://www.cnam.fr/
National Institute for Prevention and Health Education (INPES): http://www.inpes.sante.fr/

A **Permanency Healthcare Access** or "***Permanence d'accès aux soins de santé"*** – **PASS** in French; is a unit of social and medical care intended for people with no resources and/or medical coverage. PASS exist in most major cities in France. Their role is vital for the wellbeing of the poorest, starting with illegal immigrants. Not only does it help them to access medical care in hospitals but also to institutional or associative networks for health care and social support.
Volunteer work: *Médecin du Monde* (missions in Lyon and Grenoble) is one of the foremost NGO working to bring medical care to migrants (see: section below) but others work on the same principles; help through the migration process (status, permit, housing etc.), bring social support or make access to medical care possible.
Centers for maternal and child health prevention (in French "**centres de prevention maternelle et infantile**" – **PMI**) and **centers for family planning and education** (in French "**centres de planification ou d'éducation familial**" – **CPEF**) may also offer free screening. If the person is under 18, examinations and treatments are free and anonymous.
CIDDIST – centers for Information, Screening and Diagnosis on IST (for **Sexually Transmitted Disease)** can make free screening, diagnosis and treatment of venereal diseases.
Tuberculosis centers (in French "**centres antituberculeux**" – **CLAT**) are there to provide information on tuberculosis, which affects particularly the poorest segments of the population. These centers provide tests and diagnosis, not only on TB but also for HIV in some cases. It facilitates access to care and treatment and keeps a close watch over the disease in the territory.

Somatic Emergency[26]

In France, the management of medical emergencies relies heavily on public hospitals and private institutions participating in the public hospital service. To complete this mission, hospitals have developed efficient services: the **SAMU** which stands for "Service d'Aide Médicale Urgente" or **urgent medical aid service**. This central hub is supported by resources including first response vehicles or ambulances provided by the fire service and physician led ambulance provision from SMUR ("Service Mobile d'Urgence et Reanimation" – "mobile emergency and resuscitation service") which are "mobile intensive care units"(MICU) that have one or more physicians on board.

In case of medical emergency, dial **15**. This number is the single telephone number for each department. It gives direct access to SAMU. The 15 is always accessible and the call is free. The other emergency numbers in France are **18** - fire services and **112** - the European emergency number, both number are free and always accessible.

[26] Summary from the following websites :

http://www.hopital.fr/

http://www.samu-de-france.fr

Emergency hospital services are responsible for reception and care to people who are sick or wounded and come by themselves or brought by emergencies services. In some hospitals especially the CHU (Centre Hospitalier Universitaire or teaching hospitals) there are specialized emergencies (maternity, psychiatry, cardiology…), in which you can go or be oriented to directly.

Public hospitals receive government funding. When operating in the public system, patients are asked to co-pay a portion of the cost for each type of care that they receive. To illustrate, a patient requiring hospitalization is liable for 20 percent of costs for the first month, and nothing thereafter.

What this means in terms of funding is that the SAMUs and their SMUR response teams are funded by the government, by means of the hospital funding scheme. They do charge a fee for service, and for a typical patient, 65% of this cost will be covered by the government health insurance scheme and the balance covered by optional additional private insurance. By French law, in an emergency any French hospital or SAMU must treat any patient, regardless of their ability to pay.

As a measure against system abuse, the SAMU physician may refuse to sign the patient's 'treatment certificate', resulting in the patient being liable for the full cost of services provided, although in practice, this is rarely done.

Psychiatric emergencies

In France, when you suffer from acute psychological distress, there are various forms of answers, in cases where the psychological distress is physically dangerous for the victim and people close to her, general emergency services will be the most efficient:

- The **SAMU**, which stands for “Service d’Aide médicale urgente” or Urgent Medical Help Service.
- **Police and fire services**, which may be the only professionals able to control difficult patients (agitated, threatening or suicidal).
- **Emergency services in general hospitals**.

However there are also more specialized responses to psychological distress:

- Most **psychiatric services** organize an emergency reception and sometimes have emergency reception and crisis centers open round-the-clock.
- **Emergency structures in private psychiatry**. For instance “*SOS psychiatry*” or « *psy Emergency* ».These structures have telephone switchboards open day and night and can load emergency interventions (depending on context, time, place etc. these interventions can be quite expansive).
- **Private psychiatrists** who you can find in medical or general directories or be oriented to from various care structures.

WORK FACTS ON CARE TO MIGRANTS: MÉDECINS DU MONDE, MISSIONS AND STATISTICS

GENERAL FACTS ON MÉDECINS DU MONDE

Médecins du Monde treats the most vulnerable populations, victims of armed conflicts and natural disasters. The NGO works on an international level and is based on solidarity; the action of MdM depends on the commitment of volunteers, logisticians, doctors, nurses, midwives… As an independent association, MdM acts beyond the treatment. It denounces violation of human rights and assaults on human dignity; it thus fights to improve the situation of all populations.

Asylum seekers and refugees are one of the populations targeted by the association. In 2009, the 21 CASO (Centers for reception, orientation and care[27]) received 27 % of patients affected by an application for asylum.

Exile generates physical and mental suffering, with full knowledge of the facts, the NGO counts teams of professionals for psychological supports in some centers. MdM advocates ensuring that all asylum seekers can effectively access to medical coverage and are directed to standard health facilities. MdM also advocates for foreigners who are critically ill, without the possibility of care and/or treatment in their countries of origin, so that they are granted residence for care.

Its local missions provide consultations, spread prevention messages and direct the patients. Testimonies on harsh living conditions, combined with analysis of social and medial data are recorded by each health center. These data then fuel the activity reports of the missions and the lobbying actions toward relevant institutions.

LOCAL MISSIONS: GRENOBLE AND LYON[28]

There are two missions in Rhône-Alpes; one in Grenoble and one in Lyon. Both missions reports their actions, epidemiological data and encountered issues annually. These reports are extremely interesting in terms of analysis of local care practices, national and local immigration policies and study of migrant populations. The following paragraphs summarized both missions reports from 2009.

As elsewhere in France, the mission of MdM in Grenoble aims to promote access to care and rights for people in precarious situations by establishing a center for reception, orientation and care (CASO) and mobile actions targeted on excluded populations (mission named *La Maraude*).

The delegation in Lyon has three different missions, the CASO, a street mission (with a bus – typical resource for MdM) and a specific mission for squat and slums. Each mission has its specificities and touches a different population.

MdM work is also dependant on a political context, according to both reports precariousness is worsening. In Grenoble people with a job consult at the CASO because they are unable to afford a

[27] See referring lexicon.

[28] Following parts are based on reports (written in 2009) from both missions– see bibliography.

mutual insurance company and therefore to pay for expenses not refund by welfare. This population is known as *poor workers*. In practical terms also, obtaining CMU and AME, both special status for underprivileged population, is quite complex. Head of the mission Robert Allemand suggests a simplification of procedures for the coverage to be indeed universal.

In 2009, the work of MdM in Lyon was also in a context marked by persistent insecurity in the Rhone department and a worsening of the most precarious situations. According to the report almost 90 % of those who came at the care center in Lyon live below the poverty line.

MIGRATION POLICY AND OBSTACLE TO ACCESS TO CARE

In 2009, according to MdM the strengthening of controls goes on; administrative reforms are getting more complex, restricting access to care and rights of foreigners. Making a tool of the right to medical assistance in order to legitimate the immigration policy is stated openly by members of the government. Indeed, on January 2009, the immigration minister has rejoiced with the fall in the number of illegal immigrants arguing about the declining number of AME. For the mission in Lyon and many associations, to use an indicator of access to care for a population already vulnerable in order to evaluate the effectiveness of a repressive policy is pointless and ridiculous. Even worse, it is a breach on fundamental right for medical care.

ACCESS TO CARE FOR PEOPLE WITH NO HOUSING (OR NOT PERMANENT HOUSING)

The delegation has been working since 2009, advocating for **access to care and housing of homeless people** in and around the city of Lyon[29]. The number of sick people, whether they live on the street or in a precarious accommodation, continues to grow. Emergency housing organization remains difficult, especially considering the local policy and the way homeless are put back on the street if places are scarce or if the weather is getting better. The mobilization of social workers and professionals of social emergency in Lyon since 2009 tends to prove the difficulty of the situation. In the mean time, several NGOs, including Médecins du Monde, have referred the matter to the Lyon Council for the Respect of Human Rights (CLRD). The resulting work is an operation of information to people put back on the street about their rights and possibilities of recourse for non-continuity of the housing. In April 2010, the case was referred to the Administrative Court. The judge suspended the decision to “terminate the benefit of emergency housing structures” and “ordered the prefect of the Rhône to reassess the situation of persons and their families within 48 hours”. For the involved NGOs, it’s a first legal battle won against the concept of **seasonal emergency housing** and the way homeless are put back on the street.

The advocacy work of MdM on the issue is all the more crucial considering health and epidemiological data. From a clinical point of view, life on the street, but also precarious housing, leads to prevalence or aggravation of health disorders. For MdM the right to health also goes through housing.

MEDICAL CARE

29 Case called « *Pas de Santé sans Toit ni Droit II* » - *No heath without roof or right II*.

MdM medical teams go to squats to provide a heath watch allowing them to deal with some diseases by directing and supporting people to the appropriate structures. In 2009, 522 medical cares were performed (medical consultation, nursing, counseling, medication) of this number, 479 were medical consultation. The main pathologies identified were the following:

Pathology (Grenoble)	%
Digestive	22,10%
Respiratory	20,50%
Osteo-Articular	12,60%
Cardio-vasculaire	11,20%
Dermatology	11,20%
Psychology	8,90%
Other	32,90%

Pathology (Lyon)	%
ENT	22.7
Gynecology - Obstetrics	16.6
Gastroenterology	9.2
Cardiovascular	9.2
Dermatology	8.3

NB: The same person can have several pathologies

619 people were oriented to the CASO for 1667 consultations (social, medical, psychological…). 66 % of these were medical, 22 % with a social worker and 5 % of gynecological consultations.

Case study: the Rom[30] population in Lyon.

In 2009, Rom populations treated on squats and slums have been oriented to the CASO for 930 consultations. A quarter of the patients had health problems that required treatment in the medium or long term (hypertension, pregnancy, asthma, diabetes…). The necessary health support is very difficult given the lifestyle and the numerous evictions and/or deportations suffered by these populations. In the following parts, the MdM delegation in Lyon made an interesting connection between living conditions and political and administrative context.

Health problems related to living conditions…

- Variation in temperature: both children and adults live outdoors, all year round in the slums or confined in squats. Variation in temperature during the winter, between the inside of sheds or

[30] Rom would be also Rom or Romani in English although the term has now a broader meaning in France, mainly due to confusion as to which population it designates (in politics as in everyday speech). The name Rom initially designates an ethnic group originating for the Indian sub-continent. In a broader sense it can mean *Gitan, Tsigane, Manouche, Romanichel, Bohémien* or even people from Romania, which is a non-sense because the name Rom people are dispersed upon Europe. They do live mainly in Central and Eastern Europe although there are communities in Southwestern Europe also, and in Southern France in particular. Thus, some cities, such as Lyon have large communities of Rom, which more than often will be the focus of political campaigns and of ethnic prejudices.

squats, often overheated and poorly ventilated, and the outside, is also an aggravating factor. In 2009, ENT diseases (including respiratory infections) were the leading diagnoses. 33 % of the consultations indicated respiratory diseases in 2009 against 15 % in the general population, so twice as much. Makeshift solutions to overcome the lack of heating and electricity are a permanent source of danger with regular poisoning and fires…

- Lack of hygiene: plots of land are not equipped and in squats, access to water and electricity are mostly nonexistent. There is generally no access to toilets and families manage differently which, in terms of sanitary conditions, constitutes a source of infections and explains the conditions listed in gastroenterology and dermatology.

- Garbage piling up: garbage collection is hardly ever organized. It quickly piles up, causing a deterioration of hygiene and the appearance of skins problems and infectious conditions.

- Soil poisoning: In 2008, an environmental report indicated the presence of arsenic and lead on a land, forcing the introduction of lead screening for children and pregnant women, results for children were positive. But the screening wasn't complete in the aftermath of another deportation. In 2009, the polluted land has again been occupied for several months, as well as other lands, including old factories, for which MdM strongly suspects the presence of pollutants. The mission suggests the establishment of a systematic screening of lead for populations at risk on these lands.

- Poor-feeding: Romeurope [31] reported an important nutritional unbalance of Rom populations, which makes medical care less efficient. The FAO[32] also reported malnutrition and food related problems among Rom people.

…But also to the political and administrative context.

- Most health facilities haven't the means or capabilities to host precarious populations which mean presence of professionals from various fields of expertise such as interpreters or social workers...

- Existing health facilities closing down: the closure of the maternity ward of the Hôtel Dieu in 2009 creates a void. Health access for pregnant women in precarious situations is now more difficult despite the efforts of professionals from the PASS.

- Increase in the number of evictions without the means to shelter people is problematic. For MdM it destroys all follow-ups established with local facilities and creates a social instability that makes any preventive action very difficult. Eviction and deportation policies do not take into account the vulnerability of women, babies, and sick people nor problematic on public health (TB, lead poisoning…). Thus in 2009, MdM listed 43 squats and sheds evicted counting 500 to 600 people.

ENTITLEMENT CONDITIONS TO HEALTH COVERAGE

[31] Romeurope is an action group for human rights and more specifically access to fundamental rights for Rom migrants in France, website: http://www.romeurope.org/

[32] Food and Agriculture Organization of the United Nations

Entitlement conditions to health coverage are difficult, especially in the absence of a home. Among the Rom population encountered in the squats, 69 % had no health coverage at all. Either because they were not eligible (living in France for less than 3 months or impossible to prove, no address…), or because they did not assert their rights for lack of information.

The work done by social workers, with the necessary help of interpreters is essential for Médecins du Monde. Administrative procedures to benefit from a health coverage is one of the priority objectives of MdM works in the slums. It often requires time:

- To explain the importance of such a procedure, especially when it's done preventively without immediate needs for medical care,
- And to gather the necessary documents, life in slums being harsh on papers, often lost, or destroyed during evictions. And to obtain missing papers from the home country is also a challenge.

Case study: child lead poisoning

In view of exclusion, poverty and disease, children are fragile. According to the report of the Council for employment, incomes and social cohesion (*Conseil de l'emploi, des revenus et de la cohesion sociale* – CERC), two million children live below the poverty line. The number of children affected by lead poisoning is estimates at about 85 000 in France. Médecins du Monde has since 1993 initiated missions to fight against lead poisoning, to identify and protect children and to educate families and health professionals.

Lead poisoning is mostly due to ingestion of lead contained in paint in houses built before 1948. When the building is heavily damaged, the paint peels and dust can be ingested by children, causing poisoning reaching the central nervous system. There is no cure; the only solution against lead poisoning is prevention. An effective action against this disease requires the involvement of different types of actors: care givers, social workers and housing professionals.

In partnership with the state and numerous health professionals, the intervention of MdM is based on three points:

- Identification of unsanitary housing and information to families for better scanning
- Follow-up of poisoned families to protect children, either by renovating the accommodation or by rehousing
- Mobilization and consciousness raising for local professionals in the fields of health, housing and law and development of networking for better efficiency.

B – ISSUES AND ANSWER OF THE PUBLIC HEALTH-SYSTEM

CONCLUSIONS OF THE REPORT "CARE FOR PEOPLE INFECTED WITH HIV" – RECOMMENDATIONS OF AN EXPERT GROUP[33]

[33] Extract from the report from 2002 under the direction of Pr J.F. Delfraissy "*Prise en charge des personnes infectées par le VIH*", Recommendations of the expert group in **Médecine-Sciences / FLAMMARION,** Chapter 23 - *Migrants/Foreigners and HIV*.

The **increasing number of cases of HIV infection in recent years among immigrants**/foreigners concerns mainly people from Central Africa or Western Africa (concentrated in Ile-de-France) and American (concentrated in the DFA, French Department of America). It affects more women. Meanwhile, access to care is belated in this population (clear over-representation of migrants among patients discovering their HIV when it has progressed to AIDS), especially among men. In the future, specific epidemiological studies on foreign patients in Ile-de-France and DFA should be regularly conducted in order to better monitor the seroprevalence (number of persons in the population who test positive for the disease) of HIV in these populations.

Taking into account the "specificity" of migrants to HIV/AIDS must be done within the law and not at the margin. These specificities are often linked to the administrative status of the patients (leading to real discrimination in access to social rights, care and housing), but also sometimes to a language barrier. **In terms of prevention**, contexts of life should be considered, even if disease, suffering and/or death is universal in that it affects the individual body and the social identity. From this perspective, the contributions of associations and the experiences of mediation in public health bring important insights.

From the point of view of **medical follow-up**, practitioners should take the time to ensure a thorough understanding of the issues and antiretroviral treatment modalities (no prescription on the first consultation, taking into account social obligations, frequency of monitoring adapted to the patient). A preparation with the patients of future stays in their home countries is vital. Predictable failures of treatment must be anticipated, therefore practitioners should insist on prevention within the couple or outside relationship, and the communication with medical teams on the country must be assured. Finally, some singularities in the experience of the disease must be taken into account: impact on the migratory project, on the social group, on the family, feeling of guilt toward relatives back home (sharing their drugs), parallel use of traditional medicines.

In access to care and rights, practical recommendations immediately attainable and substantive changes are to be implemented in the law for it is vital for a better care to migrants living with HIV.

HIGHLIGHTS AND RECOMMENDATIONS

- Training health professionals (including social workers) and administrative staffs in terms of immigration law in order to fight against discrimination and discrepancies in views about access to rights and care.
- Develop extensive use of professional interpreters, expenses being borne by public utility.
- Promote mediation teams in public health for a better prevention on the field and a better care for patients.
- Promptly apply the law and without restriction, so that no migrant living with HIV is kept in an administrative position below the legal status provided for the diseased, that is to say that patients should obtain a temporary residence permit with authorization to work.
- Access to basic rights (health insurance, government-guaranteed minimum social benefits, and housing) should be under criterion of *usual residence*, without requirements of regularity or length of residence in France.
- Access to CMU (universal health coverage) should be, for all, under criterion of usual residence, and should replace the current AME (medical help from the State).

- Access to a residence permit must be immediately matched with a work permit and a right to RMI (social welfare). The right to work and to financial independence is essential so that patients could live with dignity.
- All professionals from the health system should fight against discrimination in access to rights and care so that people suffering are not just "sick bodies", but are also people.

FOREIGNERS/MIGRANTS LIVING IN FRANCE: THE PRIORITY OBJECTIVES OF PUBLIC HEALTH[34]

1. Reduce the delay in AIDS testing by improving its accessibility.
2. Reduce HIV transmissions in the migrant population by developing prevention strategies adapted to the diversity of situations. It is also important to maintain a good quality access to care for pregnant women and to preventive treatment against mother/child transmission. And finally develop prevention among HIV patients.
3. Ensure the quality of medical care and acceptance to treatments:
   - Adapt care: overcome language barriers (use of interpreters), overcome obstacles related to care support which should be connected to medical care, take into account the specificities of the lifestyles.
   - Fight against stigma within the various environments; family, cultural, social and professional.
4. Improve the quality of follow-up and the evaluation of the program.

STRATEGIES

The foreign population is very diverse, especially considering the conditions of migration, the oldness of immigration, educational and social status, conditions of installation – with family or leaving parents behind –, the migration project, the links with the country of origin and integration in community groups. The public health programs and professional practices must take into account this diversity and avoid stereotypes that can lead to inappropriate actions, stigmatizing and therefore ineffective. They must allow the identification of a **diversity of relays that better reflects the cultural and social variety.**

ACTION TOWARDS MIGRANTS AS A COMPONENT OF THE FRENCH SOCIETY

Migrants living in France use the social and health services in their own rights. Every opportunity should be seized by the professionals of these services to guide migrants to prevention, screening or medical care. It is therefore necessary to **raise awareness in all services in the system of common law, that migrants are an important part of their public.**

Health and social programs:

[34] Extracts from the "National campaign against HIV/AIDS involving foreigners/migrants living in France" under the authority of Department of Health and Social Protection , General Management of Health and Management of Hospitalization and Care Organization, 2004/2006.

Contacts of migrants with medical structures of the common law should be used as an opportunity to establish a link with HIV prevention and to encourage screening in the standard conditions of information and consent: hospital services (especially PASS), gynecology-obstetrics services, industrial medicine etc… Organizations sharing medical and social activities (such as CPAM or social centers) can also be relays for prevention.

Associations for HIV prevention

It should be notified to associations working in the field of HIV that they have to take into account the large number of foreigners/migrants among the public they are supposed to reach and that they have to adapt their programs to this priority. To do this, the use of media that could reach the audience is advised (including television).

ACTION TOWARDS MIGRANTS AS SPECIFIC GROUPS

During the immigration process, migrants pass through specific services (administrative, social or medical) that should be identified in order to use them as additional ways to introduce HIV prevention and early screening. These places are particularly appropriate to highlight the specificities of what it is like to have AIDS as a migrant: problems of exclusion, isolation, reconsideration of the migration project; overcoming social problems; specific behavior towards sexuality, relationship, gender aspects etc.

Specific health and social organizations

Migrant associations or associations for support to migrants

Community-based NGOs with social or humanitarian purposes can also be interesting relays for the circulation of HIV prevention messages and as incentive for screening.

Community media (radio and to a lesser extent press)

Alongside the use of television, familiar to the entire population, migrants rather listen to radio programs which are mainly intended for them. These radios, national or local, should be used to broadcast information and prevention messages or programs.

IMPROVING ACCESS TO SCREENING

The delay in screening, noticed in the foreign population, especially for men, is a factor of poor prognosis in order to fully benefit the treatment. Primary care structures should therefore be invited to suggest most often HIV tests.

IMPROVING PREVENTION

Communication campaigns on HIV, national and local, should address all components of the French population, including migrants.

ADRESS TO MIGRANTS THROUGH GENERAL COMMUNICATION CAMPAIGNS ON HIV IN ORDER TO IMPROVE THE VISIBILITY OF THIS POPULATION

For the first time, migrants have been directed in one of three short films of the INPES (national institute for prevention and health education) screening campaign (in December 2002 and June 2003), aimed for the general public, on television (the film represented the difficulty of asking for an HIV test among partners, in that case upon return of the male partner from a trip in the country of origin). The tests after the campaign showed an **excellent appropriation of the messages by African populations and even by the general public, without any observed stigmatization against African migrants.** This type of communication should be strongly encouraged in the future, in national or local campaigns.

Taking into account specific situations of vulnerability

Raising the awareness of professionals and specific actions towards migrants can be necessary for people who experience specific situations of vulnerability:

- Homeless people or people living in squats
- Incarcerated people (house of correction, prisons, detention centers)

IMPROVING THE QUALITY AND PROMPTNESS OF SOCIAL CARE, IN ORDER TO ALLOW A PROPER MEDICAL CARE

- Develop local networks to ensure a good follow-up around the time of the announcement (resort to health mediators, associations…), and to reduce the time between HIV diagnosis and specialized care.

- Use, as often as necessary, qualified interpreters to ensure that messages are clear and to make the dialogue easier, while remaining confidential. Introduce a "third party" (physically or by telephone) in the doctor/patient relationship is not easy: that is why it is necessary to communicate on the interest of social interpreting and to prepare interventions.

Start social care by connecting it with medical care:

The optimal medical care requires maintaining access to health insurance, and to allow autonomy of the person: access to employment, housing, and social benefits or to a residence permit if nothing else.

These recommendations are extremely interesting to study as they echo the recommendations of the expert group on the subject, especially in terms of access to care through access to administrative status. With proper administrative status, beginning with a residence permit, one can access proper health coverage and has the possibility to legally consult a doctor. Through the same channels, one can be briefed on prevention messages, concerning HIV or other disease to which migrants are vulnerable. Yet the priority objectives of public health are in contradiction with the immigration policy led by other departments. A policy that according to associations and experts, clearly interfere with the well-being of migrants, whether they are sick or not. Also remarkable is the tendency for public health to rely heavily on the civil society at every stage of their program; prevention, support through discovery of the disease, support through care and social care. It does reflect a tendency in real life; a good part of the care system relies on the work of associations, especially for people without administrative status.

SPECIFIC APPROACH AND DISCRIMINATIONS[35]

The notion of « specific approach » on migrant health issues can sometimes initiate a debate when it's affiliated with a kind of "positive discrimination". As it is, migrants vulnerability and public health interests can justify the setting of preferential measures – like a vaccination policy or a targeted prevention campaign - however on the condition that the impact of the measure would not be disproportionate to the objective and that negative consequences, especially filing or stigmatization, keep being under control."

Like an echo to the immigration debate, fear of communitarianism and the argument of republican integration sometimes perpetuate an illusion of factual equality that equality by rights is not sufficient to guarantee.

IMPORTANCE OF TRANSLATION

Translation is one of the obstacle or support in access to care. Even if interpreters are scarce, especially in the public health system, their presence is sometimes vital for the understanding of the disease through symptoms and feelings. Moreover, the understanding has to be both ways; the patient should also understand the necessity of the treatment and what it means in terms of medication. Qualified interpreters, if possible patient relatives, should be used. Also communication between practitioners and interpreters should be encouraged for preparation and also because they can have insights on the patient' cultural specificities.

CULTURE AND TREATMENT

To take into account the culture of a patient does not require practitioners to leave behind their view of medicine but rather to be open minded to other cultural perspectives. Not only that exchanges with foreign patients are then getting easier but the quality and the efficiency of the treatment often depends on the understanding of the patients cultural views.

According to Professor Derrick Silove; ***"The golden rule is that cultural differences need to be considered at all levels of the diagnostic and treatment process, but not in a way that paralyzes the doctor into believing that they cannot make an informed judgment because of the cultural difference."***

It is a matter of exchange; if the practitioner is open to hear and discuss other treatment, traditional methods or cultural explanations then the patients can express more freely his feelings leading to a

[35] The following section was inspired by Professor Derrick Silove and the article "*mental health problems in migrants and refugees*" in How to treat, Australian Doctor | 16 July 2004.

better understanding of the problem. The more the practitioner shows **non-judgmental interest** and open-mindedness about alternative healing methods or healer, the more the patient will be ready to express himself.

MIGRATION TRAJECTORY

It's always important to know about the migrant's trajectory in that it may contain valuable insights in health issues. Even when the migration has taken place a few years back, events during the process, choices made in order to leave the home country, all these elements can lead to an accumulation of stress and other health issues. In any cases, practitioner good will and efforts are always crucial. There is no necessity to immediately refer to a transcultural specialist; there wouldn't be enough of them anyway. But it is **necessary for practitioners to build their own transcultural experience** in order to be able to heal migratory patients.

Explanation for the treatment to the migrant and his family is essential. Common mental health issues for migrants are depression and post-traumatic stress disorder (PTSD).

The practitioners also have to protect themselves from the consequences of their relationship with migrants. Firstly, physical or psychological suffering endured by the patients can be overwhelming, professionals have to be prepared for stories of torture, rape and any form of violence that their patients have endured. Moreover the migrants being subject to the stress of their situation toward administrative, economical, juridical or social issues, frustration can often rise, either for the practitioner or the patient. Professionals have to be prepared for that situation also for their own sake and their patients'.

SPECIFIC CARE: THE **HEALTH CENTER**, MANAGED BY *FORUM RÉFUGIÉS*[36]

The Health Center is aimed at people suffering from psychological pain or trauma in connection with exile, violence and tortures.

Managed by the association *Forum Réfugiés* (NGO working for the reception of refugees and the protection of the right for asylum, based in Lyon), the Center has open on September 2007 in partnership with the association *Parcours d'exil* specialized in therapeutic support for victims of torture. Its field of work covers mainly the Rhône-Alpes territory.

The Health Center provides medical consultations, psychological therapy, physical therapy, mediation workshops (on such topics as parent/children, art therapy, etc.), prevention campaigns and trainings. The reception in the Center is not under criterion of legal and social status but upon the mental health condition of the person. The variety of people received is large: asylum seekers, refugees, migrants or isolated children. A receptionist, a medical psychotherapist, three psychologists and a physiotherapist constitute the team of the Health Center.

[36] Section based on the information available on the website http://www.forumrefugies.org/.

The Health Center offers care adapted to the specific situation of victims of violence, torture or exile. Thus the Center insists on:

- The importance of reception
- The possibility to speak in one's native language through the use of interpreters
- Sensitivity on geopolitical issues and knowledge of the country of origin allowing for an intercultural approach of the therapy
- Care practices are related to trauma care, where the patient is considered as a whole; body and mind.

ATELIERS SANTÉ VILLE[37]

INTRODUCTION – The "*Ateliers santé ville"* (**ASV**) or city health workshops were launched in 2000, jointly by the Interdepartmental Delegation to the city, the General Management of Health and the General Management Social Action, in an effort to reduce health inequalities. These city health workshops aim at promoting networking and coordination of agents and actions in relation to health within the territory. Its goals are:

- Knowledge of the population state of health
- Definition of the objectives in health improvements and its critical elements
- Access to social rights, to care, to prevention and health
- Analysis of the main problems regarding access to care and prevention
- Questions related to professional practices in the various fields of health, social issues and integration
- The quality and organization of healthcare supply
- The needs for training professionals who host public in precarious situations

The ASV is more an approach than an organization. It is not intended to replace existing elements or to conduct actions – allowing for exceptions – but rather to adapt itself to the local context by connecting and strengthening the dynamics at work. The networking should enable health professionals and agents to develop public health programs at the local level and, if possible, with people.

ORIGIN – In the 1990's, public authorities became aware of the existence of neighborhoods known as "disadvantaged", non-equipped in transportation, healthcare, education, recreation, sports etc., with as a consequence an almost obligation to stay at home and the marginalization of a part of the population, especially young people. The government then introduced the « urban policy » and offered to the involved urban districts the development of contracts known as "Urban contracts", which became in 2006 the "Urban Contracts for Social Cohesion" or CUCS, intended to promote, in the neighborhoods in question, "positive" actions. These actions were identified as relevant after a shared local survey and as effective in various and coherent themes such as housing, education or employment. In June 2000, in order to shape the "health component" of the urban policy, a bill

[37] The following summary and comments are based on the article "*Ateliers santé ville : un outil de santé publique en plein essor"*, published in 2009 by Serge Canasse from an interview with El Ghozi Laurent, president of the association *Élus Santé Publique et Territoires* (Elected Officials Public Health and Territiories).The article was published on the website http://www.carnetsdesante.fr.

created the Ateliers Santé Ville (ASV), later confirmed by laws. A new impetus was given to them in 2006-2008. Local authorities find today this approach more and more interesting.

According to Laurent El Ghozi, these workshops combine three advantages: method, funding and legitimacy.

> *Firstly*, the ASVs offer to the cities a methodology supported by a local survey, complete and accurate, on the felt needs, main diseases, supply in medical and paramedical care and social and associative supply. A steering committee is then created, built around politicians and State officials and that gathers people, associations, health insurance, National Education and health professionals, with also, in theory, the hospital and the private sector. This committee indentifies priorities for action and modalities of implementation and evaluation.
>
> The new element with ASV is that the survey is done very close to the future action, that is to say, often to a level even lower than the district. Experience shows that inequalities between "sub-neighborhoods" are often significant, whether they concern care supply or access to various services that contribute to health or yet again health indicator.
>
> *Second advantage*: co-funding by the State, the Department Council and sometimes the Regional Council. This co-funding enables the recruitment of a coordinator, essential, but on an annual contract basis while a city council can only recruit with civil servant status, which requires him to commit for a few decades.
>
> *Third advantage*: ASVs give cities legitimacy to intervene in the health field.

These three benefits explain why ASVs were created by cities with various political sensitivities. Their elected officials grouped together in October 2005 in an association called "*Élus Santé Publique & Territoires"* (ESPT) or Elected officials, Public Health and Territories.

POVERTY AND LIFE IN DISADVANTAGED DISTRICTS - ASVs are not intended to solve specific health problems, they focus first on territories: districts covered by the *urban policy*, which involve about 10 % of the population. They are "pieces of city" cumulating a number of unfavorable indicators, such as the number of social housings, the number of income support beneficiaries, the rate of unemployment and poverty, poor health care supply, lack of equipment for transport, etc. There is no "pathology of the poor". However, some health issues are more frequent in those districts than elsewhere. First of all, psycho-social suffering, present in every ASV survey, whether people talk about depression, violence or addiction. Then oral problems: the connection between social, economical and cultural status and oral health of children is very strong. There is then the questions of diet, overweight, obesity and diabetes. Finally, health issues related to substandard accommodation, such as lead poisoning, allergies and bronchiolitis. El Ghozi, however, is wary of making any hasty interpretation on the causes of diseases.

34 ASV IN RHÔNE-ALPES

- Ain : Bourg-en-Bresse, Oyonnax
- Drôme : Valence, Romans-sur-Isère
- Isère : Metropolitan areas of Pays Viennois, Échirolles/Pont-de-Claix, Fontaine, Grenoble, Grenoble Alpes Métropole, Saint-Martin-d'Hères, Saint-Martin-le-Vinoux

- Loire : Saint-Étienne, Saint-Étienne Métropole
- Rhône : Bron, Décines, Écully, Feyzin, Fontaine sur Saône/Neuville sur Saône, Givors, Lyon, Meyzieu, Mions, Oullins, Pierre-Bénite, Rillieux-la-Pape, Saint-Fons, Saint-Priest, Tarare, Vaulx-en-Velin, Vénissieux, Villeurbanne, Metropolitan area of Villefranche-sur-Saône
- Savoie : Aix-les-Bains
- Haute-Savoie : Annemasse area

CONCLUSIONS

Immigration in Rhône-Alpes, as elsewhere in the world is concentrated in major cities and in the most populated areas, as the Rhône department and its capital city, Lyon. In this region also the population of immigrants is in general more vulnerable, fact due both to immigration circumstances and the following precarious living conditions and to the national context, political, social and economy.

A context in which in public institutions, anti-discrimination policies forbid the collection of data like status or origin. As a result, there is an obvious lack of data concerning migrants, including epidemiological data that would allow care-givers to be more efficient, both in terms of care and prevention. Despite this void, it is known that migrants are particularly vulnerable to certain diseases.

And yet, if the State recognizes the vulnerability of this population, as it has shown in the last prevention campaigns against HIV, in practice, it is mostly NGOs that work for the support and care to migrants. It is them who measure the fragility of this public, directly linked to the precarious situation of some migrants, their living conditions, housing and care. Therefore, if the law provides status and assures rights for the poorest, in practice, people are little if not informed, practitioners may be reluctant and rights are difficult to enforce. In everyday life, a great part of the access to care is in fact granted by the associations, when it's not orientation, housing and follow-up.

In major cities, the web of community based associations is dense and even if communication between professionals working with the same public is complex, work can be effective. The MdM mission in Grenoble for instance is well integrated into the network of associations thanks to its work among the population. And as such is quite efficient. However for Robert Allemand, head of the mission, their role should not be to replace the authorities in its missions to the citizens but to heal the most vulnerable and to call out to the state. He suggests that the PASS (Permanency Healthcare Access) for example should continue to increase its capacity of consultation. Again, the fundamental right to health should not rest with the associative work but indeed with the State. For him, it is a matter of respect for human rights, regardless of cultures and backgrounds.

In contrast, at a regional level or even across a department, communication between the various professional fields (health, social issues, juridical issues etc.) involved in immigration remains a major problem. Some initiatives, such as the ASV (for *Atelier santé ville* - health workshops in cities) are of great interest, however, increased collaboration between fields and development of networks remains a necessity. One can imagine that a network of health professionals on a large scale could extremely useful if they were to pool their resources and knowledge.

Yet this year professionals from the medical and social fields have witnessed the reform of the public policies and the enforcement of the *HPST* law – for Hospital, Patient, Health and Territories – which now separates the social field from the health field with the establishment of Regional Health Agencies (*ARS*). Unfortunately this reform is accompanied by the said objective to cut down the budget deficits by contracting with private organizations, raising fears of an overriding objective of expenditure management and privatization, to the detriment of health and social problems of people in precarious situations.

In addition, through this document it was shown that migrants' health is not only a matter of logistics but also a matter of culture. It would be absurd to treat an immigrant population - which is often the product of a forced immigration involving victims of conflicts suffering from various form of trauma – without considering their personal history and culture. A culture that may be very different from ours, including in terms of healthcare practices.

A healthy approach of immigration and access to healthcare in Rhône-Alpes would therefore be to pool the various professional resources and willpowers. Not only to clarify health issues with the State but also to think in common in order to make everyday work easier. Whether it is through a cultural approach of health or simply by taking into account the distinct characteristics of migrants.

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