The 6th IHSA Conference on Humanitarian Studies
Panel: Humanitarianism and Inequality

Territorial and social inequalities in aging prevention for elderly immigrants in Seine-Saint-Denis (France)

Gloria FRISONE
Docteure en anthropologie sociale (EHESS)
Chercheuse associée (CESPRA)
Post-doc, Croix rouge française

PAPER

1. Statement of the purpose of the paper, the research question this issued to be reflected upon

Since the 1980s, medical anthropologists analyzed the impact of sociopolitical inequalities on the health of people and their access to the welfare system (Taussing, 1980; Young, 1982; Brodwin, 1996; Sargent & Johnson, 1996; Kleinman & al., 1997; Brown, 1998; Whiteford & Manderson 2000; Fassin, 1997, 2002; Harper, 2002; Farmer, 2003; Cargo & Mercer 2008; Hahn 2009). In contemporary aging societies, the promotion of health focuses on the prevention of chronic diseases and the loss of autonomy, inviting people to manage their “active” or “successful” aging (Rowe & Kahn 1997; Edwards, 2002). Nevertheless, social inequalities persistently limit the access of elderly immigrants to the prevention of aging devices (Martinau & Plard, 2018; Frisone & Couillot, 2018). With this speech, I propose an analytical synthesis of my last research in medical anthropology, focusing on the aging experience of the so-called "first generation immigrants".

My research field is extended between the central districts of Paris and the urban agglomerations on the North of the capital. Here, most of the immigrant population over 60 comes from North Africa, especially Algeria, but also Morocco and Tunisia. More recently, with the consolidation of further migratory flows, it is possible to meet elderly immigrants from Central Africa (Congo-Brazavielle) and Western Africa (Mali, Senegal, Burkina Faso, Mauritania). Coming from a previous study in anthropology and public health which had already demonstrated the social inequalities limiting the access of elderly immigrants to aging prevention devices in Seine-Saint-Denis, I have been recently involving in a post-doc research supported by the *Fondation Croix rouge française* and Agirc-Arrco. This research aims at understanding the reasons for their lesser use, or even the non-use of this programs, with the intention of promoting their access to prevention devises and successful aging.

2. Background, context setting and/or literature review section

Numerous studies have already shown the socio-economic precariousness of elderly immigrants with certain recurring difficulties linked to access to rights (Bas-Theron 2002; Attias-Donfut, 2006; Gallou, 2005; 2006; 2007; Beauchemin, 2016). Due to their uncertain professional trajectories, migrants have long been seen as a labor force in transit. However, in the wake of the family

reunification policies, they have been recently involved in a process of settlement migration (Sayad 1977; 1991; 1999). As a result, stranger aging people is also increasing today, and the gerontological dimension of immigration arises for institutional and associative actors (Samaoli 2007, p. 85). Nowadays, the public authorities deal with the aging of immigrants and their needs for social, economic and health care. Still living in much more painful conditions than the rest of the population (Samaoli, 2007), these migrants more often report a degraded state of health (Berchet 2012). These inequalities worsen when they move into retirement. For many immigrants this passage represents an additional precariousness. Older immigrant people have much lower resources than non-immigrants and less or later recourse to the full pension rate, in particular because of the precarious career paths they practiced. Although socio-economic precariousness plays a leading role (Fassin 2010; Chauvin & Parizot 2010), it does not explain why their health fragility and loss of autonomy is significantly higher than national people of the same age and condition (Dunn 2000, Berchet 2009). The lack of stable immigration policy seems even better to explain the accumulation of all the socio-economic disadvantages which are at the basis of their unfavorable living conditions (Chaoutie 2007, p. 108).

We have chosen to place the research field in the Seine-Saint-Denis department because of the socio-economic characteristics of its populations and the issues linked to successful aging of elderly immigrants. On average, the elderly population of the department, with a fragility indicator of 5, is more fragile than in the other departments of Ile-de-France. In addition, the presence of a population of foreign nationalities, very marked in the department (29.7%, versus 19% in Île-de-France, versus 9.3% nationally, at the 2015 census), is also strong among seniors. Finally, this department also has many migrant workers' hostels (« *Foyers des travailleurs migrants* », FTM), accommodating a lot of isolated and retired men. Permanently settled in these collective dwellings, some of which have been transformed into Social Residences as part of the National Plan for the Treatment of FTM since 1997, these residents are getting old in these unsuitable housings for advanced age. Other types of unhealthy housing for elderly immigrants in Seine-Saint-Denis are diffuse housing and ordinary housing.

More particularly, we decided to restrict our investigation to five municipalities where prevention measures specifically target aging immigrants living in the neighborhoods. Here, public health policy is associated with city policy in the "fight against territorial and social inequalities in health", of which elderly immigrants are double victimized. To finalize this project, the first CLS (« *Contrats locaux de santé* ») were signed in 2011 and relaunched in 2016. Finally, a third generation of CLS was created from 2018. Signed between the Regional Health Agencies (ARS) and the territories, these contracts demonstrate the interest of local public policies in investing in the fight against disparities in access to health services for the most fragile population. Other actors also involved are the Prefecture, the Departmental Council, CPAM, MSA, CCAS or CDAS, associations and health professionals from the public or private sector. Despite these political efforts, elderly immigrants are still living in a particular condition of social isolation and economic precarity. Facing with this great fragility, the existing system for aging prevention must be adapted, to extend to all population the same expectations for a successful aging.

3. Description of research methodology

This research mainly adopts an ethnographic method that combines analysis of policy and legislative documents, participatory field observations, and semi-structured interviews with local actors and users with an immigrant background aged 55 or over.

The examined institutions were categorized into three categories: public institutions (16 stakeholders), associations (8 stakeholders) and health or social professionals (4 stakeholders). The objective of these interviews is to understand whether the condition of vulnerability of aging immigrants has emerged as a public health issue, whether it has been approached by existing prevention systems and how this treatment has been carried out. Particular attention was paid to the obstacles and resources in the access to these preventive measures by aging immigrants. What are the difficulties encountered in reaching this audience? What strategies are adopted to overcome these difficulties? How to successfully implement a policy of "going to" (« *aller vers* ») this population? A central question arises on this point: should provision be made for support specifically adapted to this population or is it better to promote their access to common law services?

Regarding the immigrants aged 55 or over, we met 12 men during participant observations within associative structures, municipal centers, and social residences, and we visited 4 women at associations settings, or at home. The questions concern the following themes: the migration project (temporary, permanent migration, round trips of life trajectories), living conditions in France in the transition between professional activity and access to retirement, their state of health and their approaches to health and prevention. The objective of these interviews was to understand their points of view in relation to the actions that are implemented, the felt needs and the modalities of access to care and prevention, as well as the representations associated with the concepts of successful aging which may subjected to a cultural gap with the public administration, the health system, local communities, and associations which provide local services.

With a strictly emic vocation, the anthropological approach aims to questioning the point of view of all subjects to highlight the complexity of the situations and the plurality of perspectives. This approach remains the best suited to identifying the perception of risk of immigrants in the face of aging, which depends on cultural representations of old age, and on real experiences of precariousness and isolation. However, this perspective is also used to understand the perspective of all the other stakeholders: heads of institutions, members of associations, health professionals, etc. The final ambition of our proposal is to show the complex dialectical relationships that exist between the different realities of the territories and their population. As a result, this research shows that it is now urgent to improve existing systems and adopting more open and pluralistic scientific, social, and political approaches.

4. Presentation of results or description of practices reviewed

Our interviews confirm the general frame of the vast literature available today on immigration issues. First, the history of migration influences the lifestyles and housing conditions of today's aging immigrants: social and health vulnerability, difficulties in maintaining rights and administrative management due to a transnational way of life, language barrier, social isolation, disqualified professional activity, feelings of loneliness, and restricted social networks which moves them further away from the common law. Second, the sociological profile of this population has not changed since the migration to France. For these men and women with an immigrant background, a persistent link between scarcity of economic resources and difficulties in accessing rights continues into old age. Third, social isolation and economic precariousness are the basis of a very vulnerable and fragile health condition (diabetes, obesity, overweight, vision problems, oral damage and, hypertension).

As a result, the reasons for non-recourse of local prevention devices are multiple and strictly associated. The observations and interviews confirm our initial assumptions: linguistic and cultural barrier, ignorance of rights, and low economic resources. Our interlocutors also underline insufficient medical coverage and a reduced supply of care in priority neighborhoods. There is also a certain mistrust towards the administration. This mistrust, reinforced with the absence of a social network of trust, keeps aging migrants away from assistance and support services, and emphasizes their social isolation. Among these brakes, a particular place is given to the cultural gap. The actors dealing with this public perceive a discrepancy in the cultural representations of successful aging, which explains the reluctance of immigrants to spontaneously undertake a prevention process. Finally, a recently emerging difficulty in accessing prevention is the digital divide which stresses the isolation of all elderly people, and particularly elderly immigrants.

By asking all these questions to aging immigrants encountered in the field, the first obstacles noted are due to social and economic precariousness. Poverty, precariousness, feeling of exclusion and lack of legitimacy, low medical coverage, administrative difficulties are all reasons for the non-recourse cited by elderly people from immigrant backgrounds. Their condition of social isolation risks causing psychological isolation, and a feeling of loneliness, which can even end up at a pathological depression.

5. Analysis of results or practices

The realization that there is no one way to understand the experience of aging raises questions about classic prevention systems based on institutional and biomedical approaches.

Common law or specific device? In general, local common law targets, first, “territorial precariousness” and, indirectly, the "migration issue". Therefore, the territorial management of precariousness makes it possible, first, to "go to" (« *aller vers* ») the most fragile population of priority neighborhoods, and second, aging immigrants.

How to avoid negative discrimination without switching to positive discrimination? The observation made at the local level of the non-recourse of immigrants to care and prevention in the respect of their fragility in the face of aging, leads local institutions to carry out specific actions within the FTM. In this case, the approach is social and aims to fighting precariousness and isolation among the particularly fragile population of households. In other words, it is their social condition and not their "ethnic" origin that is considered. According to this approach, social mediation and gerontological mediation are support systems for common law, implemented directly in the FTM. Rather, immigrants aging in diffuse housing are still largely unrecognized, even invisible, and consequently further removed from the common rights system. The intention of institutions is to avoid any form of stigmatization based on the statistical identification of their origins. However, in contact with a public in very precariousness, several associations, health departments and municipal social services develop specific devices for access to rights and set up mediation mechanisms directly dedicated to the foreign public.

6. Conclusions draws

Intervention strategies were put forward by the representatives of the institutions and the professionals we have questioned:

- Opting for inclusive, pluralistic, and open approaches makes it possible to truly hear the needs and points of view of immigrant users.

- Talking about prevention in terms of health is not a good solution; it would be more favorable to conceive the successful aging as a particular form of “well-being” and “quality of life”.

- It would be better to work together to understand what they consider as well-being, to be able to tackle questions concerning the successful aging

7. Recommendation for future research or action

Thanks to this research results, we might propose now several practical recommendations to improve intervention with the immigrant population in terms of prevention and successful aging:

- The compartmentalization of services and a vertical information system exclude many aging migrants from the provisions of common law.

- Mediation practices in the context of care and in social settings are becoming popular, but the social workers involved do not benefit from institutional recognition or specific training on the intercultural dimension of their profession.

- The practices of social and gerontological mediation are not established in a stable and regular way in the places of residence of aging immigrants.

- Decompartmentalization of services dedicated to successful aging and better integration of available information would facilitate better care for aging migrants.

- Proximity services, social mediation practices and "bridging" mechanisms whose mission is to guide aging immigrants towards common law (particularly in terms of medical monitoring and prevention) could benefit from the contribution of elderly immigrants (or not) as part of a new professional recruitment.

8. Bibliography

Attias-Donfut C., 2006, *L’enracinement. Enquête sur le vieillissement des immigrés en France*, Armand Colin Éditeur, Paris, pp. 121-151.

Bas-Theron F., Michel M., 2002, « Rapport sur les immigrés vieillissants », Inspection générale des affaires sociales, rapport n. 2002, 126, Paris.

Beauchemin C. (dir.) et al., 2016, *Trajectoires et origines : enquête sur la diversité des populations en France*, Paris, Ined éditions (Coll. Grandes enquêtes), 624 pp.

Berchet C., Jusot F., 2009, « Inégalités de santé liées à l’immigration et capital social : une analyse en décomposition », *Économie publique*, v. 1-2, n. 24-25, pp. 73-100.
http://economiepublique.revues.org/8484

Berchet C., Jusot F., 2012, « État de santé et recours aux soins des immigrés : une synthèse des travaux français », *Questions d’économie de la santé*, n. 172, pp. 1-8.
https://www.irdes.fr/Publications/2012/Qes172.pdf

Brown P. (1998), *Understanding and Applying Medical Anthropology*, Mountain View, Mayfield.

Brodwin P. (1996), *Medicine and Morality in Haiti: The Contest of Healing Power*, New York - Cambridge, Cambridge University Press.

Cargo M. and Mercer S. (2008), « The Value and Challenges of Participatory Researches: Strengthening its Practice », *Annual Review of Public Health*, n. 29, pp. 325-351.

Chaouite A., « Personnes âgées immigrées et politique publique », Les cahier de Profession Banlieue, juin 2007, pp. 107-118.

Edwards P., 2002, « Vieillir en restant actif. Cadre d'orientation », Organisation mondiale de la santé (OMS), Deuxième Assemblée mondiale des Nations Unis sur le vieillissement, Madrid, Espagne.

Farmer P. (2003), « On Suffering and Structural Violence. Social and economic rights in the global era », in Farmer P. (dir.), *Pathologies of Power. Health, Human Right and New War on the Poor,* Berkeley - Los Angeles - London, University of California Press, p. 29-50.

Fassin D. (1997), « L'internationalisation de la santé publique, entre culturalisme et universalisme, *Esprit*, n. 229, p. 83-105.

Fassin D. (2002), « L'invention française de la discrimination », *Revue française de science politique*, v. 52, n. 4, p. 395-415

Fassin D., 2010, « Les inégalités de santé », in Fassin D., Hauray B. (dir.), *Santé publique. L'état des savoirs*, Paris, Inserm, La Découverte, p. 413-424.

Frisone G., Couillot M.-F., 2018, « Le bien-vieillir et les immigrés en Seine-Saint-Denis. Les pistes d'une enquête », Retraite & Société, Caisse nationale d'assurance vieillesse (CNAV), n. 80, v. 2, pp. 35-55.

Gallou R., 2007, « Le vieillissement des immigrés dans la cité », Les cahiers de Profession Banlieue, juin 2007, p. 83-105.

Gallou R., 2006, « Le vieillissement des immigrés en France : le cas des femmes et des hommes vivant seuls », in Bousnane M., Ba A., Skanari F. (dir.), *Le vieillissement dans l'immigration. L'oubli d'une génération silencieuse,* (Coll. Espaces interculturelles), Paris, L'Harmattan, Édition Kindle.

Gallou R, 2005, « Les immigrés isolés : la spécificité des résidents en foyer. », Retraite et société 1/2005, no 44, pp. 106-147.
https://www.cairn.info/revue-retraite-et-societe-2005-1-page-106.htm

Harper J. (2002), *Endangered Species: Health, Illness and Death among Madagascar's People of the Forest*, Newark, Carolina Academic Press
Hahn R. A (2009), « Anthropology and the Enhancement of the Public Health Practice », in Hahn R. A et Inhorn M. C. (dir.), *Anthropology of Public Health, Bringing Differences in Cultural and Society*, New York, Oxford University Press.

Kleinman A., Das V. & Lock M. (1997), « Introduction », in Kleinman A., Das V. et Lock M. (dir.) *Social Suffering*, Berkeley - Los Angeles - London, University of California Press.

Martineau A., Plard M., 2018, « Les personnes âgées immigrées à l'épreuve du successful aging », Cybergeo – *European Journal of geography*, Politique, culture, représentations, document 853.

Rowe J. W., Kahn R. L., 1987, « Human aging: usual and successful », *Science*, n. 237, pp. 143-149.

Samaoli O., 2007, *Retraite et vieillesse des immigrés en France*, Paris, L'Harmattan, 276 pp.

Sargent C. F. & Johnson T. M (1996) (dir.), *Medical anthropology: Contemporary theory and method*, Westport, CT, Praeger.

Sayad A. (1991). L'immigration ou les paradoxes de l'altérité. Bruxelles : De Boeck.

Sayad A, 1999, *La double absence. Des illusions de l'émigré aux souffrances de l'immigré*, Paris, Le Seuil, 437 pp.

Sayad A, 1977, « Les trois âges de l'émigration en France », *Acte de la recherche en science sociales*, n. 15, pp. 59-79.

Taussig M. (1980), « Reification and the consciousness of the patient », *Social Science & Medicine*, v. 14b, p. 3-13.

Whiteford L. & Manderson L. (2000), « Introduction. Health, Globalization and the Fallacy of the Level Played Field », in Whiteford L., Manderson L. (dir.), *Global Health Policy, Local Realities*. *The Fallacy of the Level Played Field*, Boulder (Colorado) - London, Lynne Rienner Publishers, p. 1-19.

Young A. (1982), « The Anthropology of Illness and Sickness », *Annual Review of Anthropology*, v. 11, p. 257-285.