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Multidisciplinary call for papers on:

“Migration and health: coping with impeded access to care. Constraints, experiences, advocacy efforts”

for the third issue of RFAS of 2024.

The report will be coordinated by Estelle d'Halluin (Cens, Nantes Université, ICM), Chloé Tisserand (CeRIES, Université de Lille, ICM) and Simeng Wang (Cermes3, CNRS, ICM).

This call for papers is open to researchers in sociology, anthropology, economics, demography, statistics, law, political science, educational science, history and geography.

Submissions are due by Tuesday, 31 October 2023.

Interested authors are invited to send a brief note of intent (one page, approx. 500 words) indicating the provisional title of their article, the field that is to be explored, the issues that are to be addressed and an indicative bibliography, in Word format (Times New Roman 12, single-spaced).

Articles are due by Tuesday, 12 March 2024.

In this issue of *Revue française des affaires sociales*, we intend to shed light on the links between migration and health by examining the many social settings in which access to care is impeded in France. Care is understood here as efforts (by professionals and non-professionals) that aim to manage illness. Etymologically, an impediment is a link that hinders progress. It refers, on the one hand, to all the obstacles to care faced by the patient, and on the other, to the constraints, or specifically the products of policies (particularly socio-economic, organisational and administrative policies), that healthcare and medico-social actors face in providing care. What are these constraints? What is the experience of those directly affected? And how do they deal with them?

The proportion of migrants in the world, which is currently 3.6%, has grown steadily since the post-war period, and accelerated at the turn of the 1980s (IOM, 2023) against a backdrop of globalization of trade (material, financial, information...). The term "migrant" is used in the same way as by the International Organization for Migration, which offers a broad definition: it includes both "immigrants" (according to INSEE, those who were born abroad and reside in France) and people in the territory who are in transit and who are arguably non-resident (they evolve in marginal, transient spaces). Although it has been the subject of much criticism in the social sciences, we prefer to retain the term "migrant" here, due to the fact it includes both the emigration and immigration aspects, as does the critical perspective of Abdelmalek Sayad (1977). Europe is one of the main centres for the movement of people, either within the continent (and more specifically its free movement area), or on an intercontinental scale (Wihtol de Wenden, 2017). In 2021, according to INSEE data (2023), of the 447.3 million inhabitants of the 27 countries of the European Union (EU27), 37.5 million are foreigners and 55.4 million are immigrants, born in a foreign country, representing 8.4% and 12.4% of the European population respectively. The diversity of migratory paths, statuses and living conditions marks this experience of migration and settlement, in which the globalised elites (Wagner, 2020) of the major cities have little in common with marginalised foreigners in the migration hotspots along Greece's borders or in the "jungles" of the Calais region, or the "badanti" home helps – often foreign women – for people who are losing their autonomy. Consequently, the types of migration (work, family, higher education, war, etc.) that people undertake result in differences in social circumstances as well as differences in terms of exposure to health risks (Attias-Donfut and Tessier, 2005), but also in terms of healthcare use, medical treatment by health workers, and, more broadly, healthcare practices (Hollingshead and Redlich, 1958; Blanc and Monnais, 2007). Of these different types of migrants, this issue focuses on people in precarious situations[1], whether that be economic, which is often linked to job insecurity, or residential, administrative or relational. This is how the term "migrants in precarious situations" should be understood in this call for contributions.

There is an abundance of social sciences literature on the health of migrants (Charbit, 1990), and in particular on social inequalities in health and the difficulties in accessing healthcare for certain populations. Among others, vulnerability factors associated with work (Bennagi and Bourdillon, 1990; Izambert, 2010), gender (Lee, 2018; Kashnitsky, 2018; Pourette, 2012), age

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[1] In this sense, we focus on the different dimensions of precariousness highlighted by Jean-Claude Barbier in his article "La précarité, une catégorie française à l'épreuve de la comparaison internationale" (2005).

(Attias-Donfut and Tessier, 2005; Rodriguez and Tisserand, 2015) and place of origin (Carde, 2011) are explored. A number of issues are not specific to migrants: social inequalities in the face of illness, ageing well and death (Aïach, 2010; Fassin, 2000), obstacles to access to healthcare and the failure to seek care (Desprès, 2013), for example. People on the fringes of society are often apprehensive about the medical world, and leave it "until the last minute" to be treated (Ménoret-Calles, 1997). However, certain health issues are more specific to immigrants and have been highlighted. Firstly, in regard to the interlinking between the areas of focus of immigration policies (effects of control mechanisms, surveillance of a "threatening/contagious other", the precarious situations associated with certain administrative statuses, reduced rights to social protection), and secondly, in regard to processes of racialisation, which, more specifically, give rise to discrimination in healthcare on the basis of place of origin (Cognet, 2017)[2]. It should be remembered that the health status of immigrants tends to deteriorate as soon as they arrive in France, the host country (Desgrées du Loû *et al.*, 2017).

These findings have had an impact on public policies aimed at combatting social inequalities in health and improving the health of populations in precarious situations, including migrant populations. A number of collective actions – initiated in particular by associations – have contributed to a shift in healthcare policies. More comprehensive reforms of the healthcare system may have had an impact on access to care for groups identified as more vulnerable. In the 1980s, the spread of the concept of social exclusion – which has since been criticised (Fassin, 1996; Castel, 2013) – led to the development of policies that dovetailed social and medical aspects as a means of caring for "at-risk" groups of people. These individuals are the focus of specific healthcare systems provided by the state or voluntary bodies, as illustrated by the open-access healthcare units (*permanences d'accès aux soins de santé* – PASS) enshrined in the 1998 law against exclusion (Parizot, 2003), or even more recently, against the backdrop of territorialisation policies or "outreach" interventions (Sempé and Siffert, 2022; Lahya and Arapian, 2022; Einhorn *et al.*, 2018). Through regional health plans, or by placing such people at the heart of local initiatives, public authorities have been able to identify certain categories of immigrants as target populations and roll out initiatives specifically aimed at them.

However, there are flaws in these systems that are promoted, and access to care can be impeded. This issue focuses on this latter matter. Inequalities persist and tensions remain between the universal promotion of health and selective migration policies. A recent survey carried out by several associations (Cimade *et al.*, 2023) highlighted the ongoing refusal to provide healthcare to foreigners with an uncertain administrative status. The belief in the existence of "medical tourism" results in cases being sorted and prioritised accordingly (Geeraert, 2016) and different individuals receiving different levels of access to care. In a society where physical suffering has become associated with the awarding of certain rights (Mbaye, 2009), we find ourselves entering an era of suspicion (Bricaud and Thibaudeau, 2017). Faced with increasingly complex access to healthcare, partly for administrative (Gabarro, 2012) or even geographical reasons, patients also end up giving up on treatment or distancing themselves from French medical facilities. They then find themselves excluded from the care offered by the public authorities,

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[2] It should be noted here that such persons may also include French citizens, for example descendants of immigrants, who are subject to assignment processes based on ethnicity or race.

which is sometimes reduced to its most rudimentary form. These issues have been the focus of many different parties' advocacy efforts, including migrants themselves (Carde, 2007; Cognet, 2017; Adam-Vézina, & Bascougnano; Fassin, Carde, Ferré, & Musso, 2001). Finally, other studies show persistent discrimination in healthcare, which is linked in particular to the prejudices of certain health workers (Sauvegrain, 2021) or social workers (Mathieu, 2020).

With this in mind, this issue of the journal sets out to analyse how patients, professionals and public authorities deal with situations in which care is impeded. The aim is to explore the constraints on care work and the policies that underpin it, the experiences of patients, their families and the people who support them (professionals and non-professionals), and the advocacy efforts that have helped transform practices.

In this call for papers, we hope to gather empirical surveys. They may focus on less well explored areas of care, such as care practices in the context of confinement or transit, when crossing borders into France. They may also explore the barriers faced by specific categories of people within the population. In this sense, work on elderly migrants, unaccompanied minors (UMs), women, LGBTQI+ people or migrants with disabilities or mental health problems will be welcome. Finally, while the order negotiated with health workers is an essential aspect, in this case we are also interested in fields that take into account the family context and the intergenerational or intra-marital negotiation between subjects tested by illness in the face of decision-making regarding treatment (Weber, 2012) and its implementation in practice.

Focus 1 - Subjective experiences of migrant patients in insecure situations: formal care, marginal care and strategies

The first line of focus looks at the way in which disadvantaged migrant patients see themselves and perceive the health care and healthcare services available to them and how they make use of them, but also how they cope with difficulties in accessing care, and even with processes of marginalisation that take place within the established system.

The health status of migrants depends on a number of variables. By way of illustration, public health research has clearly established that one's place of residence influences one's degree of exposure to health risks (Lévy-Vroelant, 2006; Fassin, 2021). Thus, the risk of drug-related iatrogenesis (Rodriguez and Tisserand, 2017) exists particularly in spaces where there is no defined health framework, as could be seen in the "new jungle" of Calais, where well intended but sporadic efforts to provide medication resulted in it being delivered in excess. The margins deserted by the major healthcare systems provide a space in which less conventional and less regulated healthcare providers are emerging. Utilisation of care differs depending on where one lives. For example, a study carried out among elderly immigrant workers in a hostel in Nanterre shows that living in a restricted space results in limited use of healthcare (Pedrero, 2021). Remember that "immigrants are over-represented in the priority neighbourhoods of urban development policy (*quartiers prioritaires de la politique de la ville* – QPV), which have a large proportion of social housing: 23% of them live in such neighbourhoods, compared with 7% of the total population aged 18 to 59" (INSEE, March 2023). This is also the case for those in insecure employment (DARES, 2023). In light of these findings, how does being an immigrant impede the trajectory of care? How do migrants view this?

Specific medical measures are put in place as part of monitoring migration policies, reception policies and integration policies, and are likely to have an impact on their health. In this eclectic landscape of medicalisation, we are interested in how beneficiaries incorporate the differentiated and non-differentiated health standards (Fassin, 2019) on offer. Health interventions – which take into account the patient's environment (Parizot, 2003) – aim both to identify suffering in marginalised living environments, to reduce the “inequality of lives” (Fassin, 2020) and to redirect disadvantaged people towards the mainstream healthcare system. But these multiple systems for providing care also follow their own logic, with some preferring targeted care such as community health (Tessier *et al.*, 2004) or ethnopsychiatry (Devereux, 1998; Laplantine, 1988) to non-differentiated care. So why do some patients continue to face challenges in accessing care? Research questioning the reflexive nature of migrant patients and their use of care would be welcome, to capture their views on the established healthcare system and the new mediation, remediation and “outreach” schemes that have been put in place. The emotional work (Hochschild, 2003) that patients and their families (parents, spouses, children) must undertake in dealing with diagnoses and treatment methods (Wang, 2013), as well as the matter of how their relationship with care is intertwined with their administrative status and migratory trajectory (Wang, 2016a) are also of interest to us, as they help to shed light on continuity or breaks in treatment.

Looking beyond healthcare systems, Camille Schmoll (2011, 2020) reminds us how the body is transformed by migration. Migration is a process that accelerates ageing, just as the hardships of exile wear and tire people out, and are likely to engender physical (Tisserand, 2023) and psychological pathologies (Larchanché, 2017; Saglio-Yatzimirsky, 2018). It would be interesting, for this report, to explore in this context the experience of illness in its chronicity, through the somatization of the body (Dao, 2012), during specific periods in one’s life such as retirement (Madoui, 2015), or the openly held beliefs and unspoken assumptions about illness in relation to the social norms of the individual’s country of origin (Wang, 2017; Womersley and Kloetzer, 2018).

In this approach, the border has become central to how we think about the body, and is ultimately a determinant of health that is intrinsically linked to European security policies, giving rise to the concept of the “border-body” (Guénif-Souilamas, 2010). The mobility of the latter is impeded by “increasing frontierisation” (Andrijasevic and Walters, 2011) and the “systems of capture” that this process imposes (Bernardot, 2012; Bigo, Bocco and Piermay, 2009). Those in exile[3] are more exposed to vulnerability and are impacted by this to their very core. The border is an “embodied presence”. How does it reshape migrant patients’ relationship to their own health, to healthcare and to their bodies? It seems that this aspect, at the crossroads of anthropology and sociology, is still little explored by the humanities and social sciences.

The second part of this axis of focus deals with the “care” and “cure” strategies adopted by patients when their access to care is impeded. Here we ask: how do marginalised migrants manage to maintain their health? The neglect of mainstream treatment systems for marginalised populations results in differing capacities to act. As a result, some people turn to alternative

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[3] As Didier Fassin reminds us in his lecture at the Collège de France on observations on the condition of those in exile (January 18, 2021), this term covers the notion of forced movement, rejects the assumption that migration is spurred by economic or political reasons only, and links the two ends of the journey.

therapies for treatment, such as self-medication (Rodriguez, Jacques and Wachsberger, 2016) and informal channels. The community also becomes a resource. Think, for instance, of the circulation of medicines via transnational links or remote consultations (Tarrius, 2010). These parallel approaches to the formal healthcare system are also exercised through the use of so-called “alternative” medicines (Wang, 2022a). These diverse remedies reveal a therapeutic pluralism (Sicot and Touhami, 2018). We also expect to see work highlighting new ways of accessing personalised forms of care, or the day-to-day management of illness by migrants.

Focus 2 - Organisational, institutional and professional challenges of care for or by migrants

The second line of focus, at a meso level, is care organisations for migrants. Caring for migrant patients in unstable situations requires care systems that bring together multiple services and acteurs, even more so than for the rest of France’s population. The coordination of therapeutic and social pathways – including access to rights, accommodation, social support, etc. – is becoming a central issue (d'Halluin and Hoyez, 2012). The Covid-19 pandemic has accelerated the movement towards linking the medical and social sectors that was already underway (Gaudillière, Izambert and Juven, 2021), while exacerbating the crisis in the healthcare professions (Hassenteufel, Naiditch and Schweyer, 2020; Bergeron *et al*, 2020), and the use of care as an ethical value (Paperman and Laugier, 2005) and an instrument of social justice in the face of growing social inequalities in health (Bajos *et al.*, 2020; Mariette and Pitti, 2020; Azria *et al*., 2020).

What professional practices and organisational reforms are in the process of being implemented to care for migrants of varying statuses and reduce social inequalities in health? Contributors are invited to reflect on the working conditions of professionals in the health and social care sectors who work with immigrant populations, and the ways in which, in their eyes, they get in the way of “a job well done” (Clot, 2013). Subjected to the principles of New Public Management, which have been introduced within the bureaucratic structures of the public sector (Schweyer, 2006; Mas *et al.*, 2011), these professionals struggle to cope with the casualisation of work and navigate between order from management and humanitarianism in the care system. In the case of health insurance agents awarding state medical assistance (*Aide médicale d’État* – AME), suspicions of fraud are part of their daily work (Gabarro, 2021) and are weighed up against the granting of social protection that removes an economic barrier to access to care. Another professional body, that of interpreters, shows that care arrangements are becoming more integrated in order to overcome the language barrier, but in a differentiated way depending on the services in question, and not without reproducing social, moral and spatial divisions of labour in the healthcare that is provided to migrants (Pian, Hoyez and Tersigni, 2018).

Faced with the shortage of health workers in France, which increases the obstacles to care, contributions may also focus, from a “how to cope” perspective, on the working conditions of foreign doctors and carers (Fifaten Hounsou, 2014; Sirna, 2020; Cottereau, 2019), as well as on informal or even illicit healthcare networks, which are often intrinsically tied to ethnic networks in migration and used by migrants in unstable situations (Wang, 2019). On the fringes of the French healthcare system, paramedical care and care service networks are developing, mostly comprised of women of immigrant origin, as in the case of home helpers (Avril, 2014) or ancillary caregivers in the area of perinatal health (Wang, 2022b).

A final line of analysis focuses on the therapeutic relationships themselves, sometimes marked by a complex relationship of "otherness" between the caregiver and the person receiving care due to language barriers, differing social conditions, distancing from representations of disorder and illness, and shifting or even conflicting norms surrounding health and care in different societies. Contributions may be part of a reflexive approach – professional or research-based – on ways to analyse how therapeutic relationships are formed and their complex links with the processes through which social inequalities arise, for example based on practices in interpreting (Pian, 2020; Wang, 2016b) or in family mental health therapy, during which the child is helped to discover what the parents have said and not said about their migratory journey. Proposals for articles may also address the phenomena of discrimination in therapeutic relationships, highlighting the various criteria recognised in law, such as ethnic or racial origin, gender, age, religious affiliation, etc. (Carde, 2007; Cognet, Gabarro and Adam-Vezina, 2009; Prud'homme, 2016; Paillet, 2021; Sauvegrain, El Kotni and Racioppi, 2022).

Focus 3 – Health for all: the test of expenditure and migration control

A third line of focus is advocacy efforts to promote migrant health. In France, these efforts evolved over the course of the 20th century, with the emergence of a critique of the individualistic approach to migrant health, which focused on singular pathologies or differences in representations and practices in relation to illness and medicine (Fassin, 2009). Since the 1970s, they have been increasingly inspired by a universalist approach, which emphasises the social determinants of health, obstacles and discrimination in healthcare, the social consequences of illness and the ways in which this is experienced differently based on ethno-racial origin, gender, social group, age, etc.

Looking at the history of these advocacy efforts, the multiple demands made in the context of collective action have helped to ensure that reforms and target groups are placed on the agenda sooner or later. For example, in France, advocacy efforts as early as the 1970s to promote healthcare interpreting gave rise to lasting local initiatives, but it was only decades later that they led to a Charter of medico-social interpreting (2012) that was supported by interpreters' associations being drawn up and included in law no. 2016-41 of 26 January 2016, which served to modernize our healthcare system. Yet it had long been shown that interpreting contributes to the quality of care and enables the ethical requirement for informed patient consent to be met (Pian *et al.*, 2018). From the 1980s onwards, the fight against HIV marked an important, and now well-studied, milestone: initially overlooked, the immigrant issue was taken up by a coalition of associations, which led to the lasting creation of the monitoring centre on foreign nationals' right to health, the *Observatoire du Droit à la Santé des Etrangers* (ODSE) in France. This period also marks a turning point at which the question of effective access to rights and the limits of universal protection for foreign national become central elements of advocacy efforts (Izambert, 2018). While the "humanitarian grounds" seemed to take hold in the 1990s with the introduction of the right of residence for sick foreign nationals in 1998[4] (Fassin, 2001), they appear increasingly constrained by the growing illegitimisation of immigration and by factors of surveillance and selection (Mbaye, 2009) just as much as by policies to control public spending: it is becoming more difficult to assert this right (*Défenseur des droits*, 2019), and the seriousness of the illness may be subject to more restrictive interpretations, particularly in terms of mental health. As a result, collective action is continuing in the face of reforms restricting access to residency and health protection for foreigners, whether legal migrants or not. How do the players involved organise themselves in the face of these changes, and what repertoires do they use? Under what conditions can they assert these rights? Which populations, on the contrary, remain marginalised? How does this compare with other national areas? What changes has the Europeanisation of migration policies brought about in these means of collective action in France? What, moreover, are the conditions under which certain migrant health issues become overlooked in France, such as, for example, the occupational health of seasonal migrants, which the work of Frédéric Décosse (2008) has shown to be a marginal issue when it comes to advocacy efforts?

Understanding developments within movements to promote migrants' health also involves examining the profile and trajectory of the actors involved in this cause, and the power-based relationships that run through it: salaried employees and militant volunteers in the non-profit sector, but also actors in local authorities, agents of state services, etc. While the profile of campaigners working in the non-profit space on behalf of migrants is now well documented (Pette and Eloire, 2016), as is that of social doctors (Mariette and Pitti, 2021) or the more specific profile of doctors committed to helping displaced persons (d'Halluin-Mabillot, 2012), the less-studied profile of state or local authority agents remains to be explored in greater depth. As such, we hope to receive as many contributions as possible.

There is also the question of the transformation of modes of engagement, which have already been described in this healthcare field, in the light of developments in the dynamics of hospitality observed since 2015 (Agier and Le Courant, 2022; d'Halluin *et al.*, 2017), as well as the possible effects of campaigner burnout observed in work on non-profit and political circles, or burnout in the sociology of work concerning health workers. Above all, the history of advocacy efforts, particularly in regard to HIV, has highlighted the immigrants' ability to act as agents in their own right (Mellini *et al.*, 2018), far from being reduced solely to their status as a vulnerable group. In the case of HIV, advocacy efforts have opened up "an unprecedented universe of advocacy for immigrant populations"", and particularly for women, who are "dynamic actors in the various spheres of social life" (Gerbier-Aublanc, 2022 p. 18, 23).

Finally, it is important to gain a better understanding of the interplay between the various different levels, from actors' local roots to their international mobility. Their multiple affiliations and ability to occupy a number of different roles reveals, for example, how standards circulate and how alternative experiments (d'Halluin and Hoyez, 2012), such as

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[4] The right to residence on medical grounds was introduced by the 1998 Reseda law. It has undergone a number of reforms. At present, to obtain this residence permit (which can be extended by one year at a time), foreign nationals must be suffering from "a particularly serious illness that imperatively requires appropriate treatment that [they] would not be able to receive in [their] country of origin, given the healthcare available and the characteristics of the healthcare system in that country".

health centres in France and community centres in Quebec, are set up, as Audrey Mariette and Laure Pitti (2021) have shown. The latter are part of a system of social medicine aimed at subverting a model based on private practice and hospital-centrism that has existed since the 1960s. This third line of inquiry calls for better characterisation of the mobility of actors involved in these social movements and advocacy.

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