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The isolation of ageing immigrants in Seine-Saint-Denis

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Résumé

La recherche ici présentée a été réalisée grâce au soutien conjoint de la Fondation Croix-Rouge française et la complémentaire retraite Agirc-Arrco, deux acteurs de référence mutuellement impliqués dans la lutte contre la précarité et l’isolement social des seniors. Dans la poursuite d’une étude précédente en anthropologie et santé publique qui avait déjà porté un certain éclairage sur les difficultés d’accès des immigrés âgés aux dispositifs de prévention du vieillissement, cette recherche s’appuie principalement sur une méthode ethnographique qui combine l’analyse des documents politiques et législatifs, l’observation participante sur le terrain, et des entretiens semi-directifs avec les acteurs locaux et les usagers issus de l’immigration de 55 ans ou plus. L’objectif est d’appréhender les raisons de leur moindre recours, voire du non-recours, et de favoriser leur accès aux services de prévention et de promotion du bien vieillir. L'importance de cette enquête repose sur la grande fragilité des immigrés âgés, face à laquelle les dispositifs existants nécessitent encore aujourd'hui une réflexion approfondie et une adaptation, afin d’étendre à toute la population les mêmes expectatives de bien vieillir.

Keywords: Le vieillissement des immigrés, la prévention, vieillir en forme, la précarité, l’isolement social.

Abstract

This research was carried out thanks to the joint support of the French Red Cross Foundation and the Agirc-Arrco supplementary pension fund, both involved in the fight against precarity and social isolation among seniors. Continuing from a previous study in anthropology and public health which had already shed some light on the difficulties of elderly immigrants to access “ageing well” prevention services, this research is mainly based on an ethnographic method which combines the analysis of political and legislative documents, participant observation in the field, and semi-structured interviews with local actors and immigrants aged 55 and over. The objective is to understand the reasons for the lesser use, or even non-use, of “ageing well” prevention services, and to promote their access. This research is significant because it examines the great vulnerability of elderly immigrants, for whom presently existing services still require in-depth reflection and change, in order to deliver the same expectations of ageing well to the entire population.

Keywords: elderly immigrants, prevention, successful ageing, precarity, social isolation.

The isolation of ageing immigrants in Seine-Saint-Denis

Introduction

Background

The fight against the isolation of the elderly in France lies at the heart of the "Law on the Adaptation of French Society to Ageing of its Population" promulgated on December 28, 2015[1]. In connection with this, the French Red Cross Foundation and the Agirc-Arrco supplemental retirement fund awarded a research grant to the project entitled, “The isolation of ageing immigrants in Seine-Saint-Denis”. This research project sought to understand the social dynamics and regional specificities that fundamentally explain the reasons why ageing immigrants tend not to turn to, or do not turn to locally contracted social services in their *département* for the prevention of loss of autonomy. This project encourages ageing immigrants to use these prevention services designed to help them age well.

To use the term “ageing immigrants” rather than “elderly immigrants” is not incidental, as it fundamentally represents different theoretical points of view. First, when we speak of “immigrant” we are referring to the official definition of the INSEE (National Institute of Statistics and Economic Studies), which states that an immigrant is “a person born abroad”[2]. This definition includes in the category of “immigrant” both naturalised immigrants (French nationals) and foreign immigrants, and corresponds to the standpoint of the host country, namely France, where our field of research is centred. Second, as for preventing the pathological consequences of ageing, which are responsible for dependency and a loss of autonomy, our proposal takes into account the several phases of old age onset: asymptomatic, pre-symptomatic, non-pathological. It is therefore a matter of focusing more on the process of ageing than on the definition of “old people”. The early phase of ageing can be defined, to a certain extent, from statistical studies which fix the age of entry into old age between 60 and 65 years, specifically at the time of retirement[3]. However, we chose to focus our study on immigrants aged 55 and over. This early phase impacts immigrants significantly sooner, given the instability of their professional trajectories and the precarity of their livelihood. Numerous sociological studies have shown that people arriving from the first migrations of the 1960s and 1970s represent a particularly vulnerable community[4] with a far

[1] BROUSSY, Luc, “L’adaptation de la société au vieillissement de sa population : FRANCE : ANNEE ZERO !”, Interministerial mission on the adaptation of French society to the ageing of its population, Report to Mme. Michèle DELAUNAY, Minister Delegate for the Elderly and Autonomy, 2013, 202 pp. [Online source] https://solidarites-sante.gouv.fr/IMG/pdf/Rapport_Broussy.pdf (Accessed August 21, 2021).

[2]INSEE definition. [Online source] https://www.insee.fr/fr/metadonnees/definition/c1328 (Date of consultation: June 30, 2021).

[3]BOURDELAIS, Patrick. *Le nouvel âge de la vieillesse. Histoire du vieillissement et des populations*. Paris: Odile Jacob, 1993, 29 pp. – GUILLEMARD, Anne-Marie, *La retraite, une mort sociale. Sociologie des conduites en situation de retraite*. Paris: Mouton, 1972, 343 pp.

[4]BAS-THERON, Francoise, MICHEL, Maurice. Ageing Immigrants Report. *Inspection générale des affaires sociales*. Report 2002, no. 126, Paris. [Online source] https://www.vie-

worse health status than the native population of the same age and with the same health condition[5]. Coming mainly from North and sub-Saharan Africa, they settled in working-class neighbourhoods and industrialised suburbs where they grew old[6]. Entering old age prematurely, they became dependent very early on[7].

The growing vulnerability of immigrants in the face of ageing corresponds to an especially exacerbated condition of *precarity* and *isolation,* two distinct, although often-associated, social disadvantages. The *precarity* of immigrants refers more particularly to legal and professional insecurity, poor housing conditions, meagre financial resources, and limited medical coverage. Isolation on the other hand refers to "a condition in which a person, who, because of relations that are durably insufficient in number or quality, is suffering and at risk[8] ". Therefore, *social isolation*, as a reflection of objective territorial marginalisation, social exclusion, and relational poverty, differs from *psychological isolation*, which rather designates a subjectively perceived sense of loneliness that can stem from social isolation and eventually lead to loss of autonomy. The impact of isolation on physical and psychological health of the elderly is now patent: it hastens the loss of autonomy, especially among the most elderly[9]. Combating the isolation of the elderly becomes therefore part of a public health policy whose objective is to prevent their dependency and loss of autonomy.

The lack of a public policy that anticipates the ageing of immigrants has resulted in an accumulation of the social and economic disadvantages that are the root cause of a

publique.fr/sites/default/files/rapport/pdf/034000107.pdf (Date of consultation: August 21, 2021) – BERCHET, Caroline, JUSOT, Florence, Inégalités de santé liées à l'immigration et capital social : une analyse en décomposition. *Économie publique*, 2009, c. 1-2, n. 24-25, p. 73-100 [Online] http://economiepublique.revues.org/8484 (Date of consultation: August 21, 2021).

[5] ATTIAS-DONFUT, Claudine, TESSIER, Philippe. Santé et vieillissement des immigrés. *Retraite et société*, 2005, c. 3, no. 46, pp. 89-129 [Online source] https://www.cairn.info/revue-retraite-et-societe1-2005-3-page-89.htm (Date of consultation: August 21, 2021) – BERCHET, Caroline, JUSOT, Florence. État de santé et recours aux soins des immigrés : une synthèse des travaux français. *Questions d'économie de la santé*, 2012, n. 172, p. 1-8 [Online Source] https://www.irdes.fr/Publications/2012/Qes172.pdf (Date of consultation: August 21, 2021).

[6] LILLO, Natacha, et al. Île-de-France, histoire et mémoires des immigrations depuis 1789. Histoire des immigrations, Panorama régional, *Hommes & migrations*, 2009, v. 2, no. 1278, p. 18-31 [Online source] https://journals.openedition.org/hommesmigrations/209 (Date of consultation: August 21, 2021) – BERNARDOT, Marc. *Loger les immigrés. La Sonacotra 1956-2006*. Bellecombe-en-Bauges: Editions du Croquant, 2008, 296 pp. – BERNARDOT, Mark. Le vieillissement des migrants dans les foyers. *Hommes & Migrations*, 1999, n. 1219, Connaître et combattre les discriminations, p. 99-102 [Online source] https://doi.org/10.3406/homig.1999.3335 https://www.persee.fr/doc/homig_1142-852x_1999_num_1219_1_3335 (Date of consultation: August 21, 2021).

[7]GALLOU, Rémi. Le vieillissement des immigrés en France. Le cas paroxystique des résidents des foyers. Politix, 2005, no. 72, p. 57-77 [Online source] www.cairn.info/revue-politix-2005-4-page-57.htm (Date of consultation: August 20, 2021).

[8]SERRE, Jean-Francois. Combattre l'isolement social pour plus de cohésion et de fraternité. Les éditions des journaux officiels. Conseil économique, sociale et environnemental. « Les avis du CESE, 2017, p. 8., 185 p. [Online source]: https://www.lecese.fr/sites/default/files/pdf/Avis/2017/2017_17_isolation_social.pdf (Date of consultation: August 17, 2021).

[9]AQUINO Jean-Pierre. Anticiper pour une autonomie préservée : un enjeu de société. Rapport 2013 sur la loi d'adaptation de la société française au vieillissement de sa population, Mission d'appui IGAS, Comité avancée en âge, prévention et qualité de vie [Online source] https://solidarites-sante.gouv.fr/IMG/pdf/Rapport_Aquino.pdf (Date of consultation : August 20, 2021).

deteriorating state of health[10]. Although socio-economic precarity is a leading contributor[11], social isolation and the absence of integration seem to have an even more harmful impact on immigrant state of health by blocking access to fundamental legal rights and healthcare[12]. The issue of ageing immigrants has become an ever-growing concern in matters of living together, citizenship, and equality, as evidenced by the National Assembly's Information Mission on Elderly Immigrants that was held between January and July 2013[13]. Created on November 20, 2012, "following President Bartolone’s visit to an Adoma retirement home in Bobigny with several fellow deputies”, its goal is to review the great precarity of elderly immigrants and their difficult access to legal rights in light of their past contribution to the growth of France, especially during the “Trente Glorieuses”. This mission had the merit of giving greater visibility to the ageing of migrants and of proposing recommendations to improve their living conditions and enhance their access to their legal rights and healthcare.

Our investigation took place in this context. Having observed immigrants’ minimal access to healthcare, our objective was to investigate their access to age-related prevention services. According to the few sociological studies on the subject, the migratory experience can "complicate the prospects of ‘ageing well’ for immigrants in France"[14], despite prevention services being available to all the elderly regardless of nationality or origin[15]. First, the immigrant, particularly the elderly immigrant, is affected by discrimination[16]. Then, marginalisation and isolation also influence their access to legal rights[17]. Finally, using preventive services also implies recognising the need for them and appreciating their value[18]. However, in very precarious situations (dwindling resources, financial hardship), health is not always prioritized, especially for an immigrant pensioner who must face social constraints due to migration: meeting the needs of his family and sending part of his small pension to his

[10]CHAOUITE, Abdellatif. Personnes âgées immigrées et politique publique. *Les cahiers de Profession Banlieue*. « Questions de santé : des outils au plan local », June 2007, p. 108 [pp. 107-118].
[11]FASSIN, Didier. Les inégalités de santé. In: Fassin D., Hauray B. (eds.). *Santé publique. L’état des savoirs*. Paris: Inserm, La Découverte, p. 413-424, 2010.
[12] ATTIAS-DONFUT, Claudine. *L’enracinement. Enquête sur le vieillissement des immigrés en France*. Paris: Armand Colin Editeur, 2006, pp. 121-151 - BEAUCHEMIN, Cris, HAMEL, Christelle, SIMON, Patrick (dir.) *Trajectoires et origines : enquête sur la diversité des populations en France*. Paris: Ined éditions (Coll. Grandes Enquêtes), 2015, 624 pp.
[13] BACHELAYS, Alexis. Rapport sur la Mission d’Information de l’Assemblée nationale sur les immigrés âgés January and July 2013. N° 1214, National Assembly, 14th Legislature [Online source] https://www.assemblee-nationale.fr/14/cr -mimage/12-13/c1213017.asp#P9_207 (Date of consultation: August 18, 2021).
[14]MARTINEAU, Aurélien, PARD, Mathilde. Les personnes âgées immigrées à l’épreuve du *successful aging*. Cybergeo: European Journal of Geography, “Politiques, culture, représentations”, document 853, March 2018 [Online source] http://journals.openedition.org/cybergeo/29118 (Date of consultation: August 20, 2021).
[15] CHAOUITE. Personnes âgées immigrées et politique publique, 2007, op. *cit*., p. 111.
[16]BEQUE, Maryline. Le vécu des attitudes intolérantes ou discriminatoires par les personnes immigrées et issues de l’immigration. Études et résultats, ministère de l’Emploi, du travail et de la cohésion sociale, Ministère de la santé et de la protection sociale, Direction de la recherche, des études et des statistiques (DRESS), n. 424, September 2005, p. 1-7 [Online source] URL: https://drees.solidarites-sante.gouv.fr/sites/default/files/er424.pdf (Date of consultation: August 23, 2021).
[17]CARDE, Estelle. Les discriminations selon l’origine dans l’accès aux soins. *Santé publique v*. 19, n. 2, 2007, p. 99-109.
[18]LOMBRAIL, Pierre., PASCAL, Jean. Inégalités sociales de santé et accès aux soins. *Les Tribunes de la Santé*, vol. 3, no. 8, 2005, p. 31-39.

home country[19]. According to anthropological studies[20], cultural differences also matter when it comes to old age and illness. As a result, programmes for the prevention of loss of autonomy described in “ageing well” plans and centred on the geriatric concept of “active ageing” fail to take elderly immigrants into account[21].

From the findings of prior studies, we anticipated that we would initially observe the ineffectiveness of certain interventions that addressed only the most blatantly visible signs of precarity, such as migrant worker shelters. We therefore directed our focus on immigrants in precarious situations residing in retirement homes or in scattered housing[22]. Among those immigrants, women living in scattered housing are the most isolated and the hardest to contact by any means[23]. We believe that one’s personal experience of ageing and state of health are influenced by the representations of "ageing well". We therefore wanted to examine the influence of certain cultural differences that can last over time, and to suggest ways or strategies to facilitate the access of immigrants to ageing-well programmes.

Research field

We chose to place the field of research in the *Département* of Seine-Saint-Denis, due to the socio-economic make-up of its residents and the problems of the elderly to age well. On average, the elderly population of the *Départément*, with a fragilty indicator of 5, is deemed more vulnerable than in the other *Départements* of Île-de-France. In addition, the presence of foreign nationals, very high in the *Département* (29.7%, compared to 19% in Île-de-France region, and to 9.3% nationally, according to the 2015 census), is likewise relatively high among the elderly[24]. Finally, as mentioned in the *Schéma départemental d’autonomie et d’inclusion 2019-2024,* "foreign nationality can be an indicator of social fragility in terms of access to or recourse to legal rights"[25]. This *Département* also has many migrant worker shelters for single men. These individuals, permanently residing in this type of collective housing, some of which has been converted since 1997 into social housing units as part of

[19]ATTIAS-DONFUT, Claudine, *L’enracinement. Enquête sur le vieillissement des immigrés en France* 2006, *op. cit.*

[20] NGATCHA-RIBERT, Laëtitia. Migrants âgés et maladie d’Alzheimer : cultures, diversités, identités, *Hommes & migrations*, n. 1309, p. 79-85.

[21] FRISONE, Gloria, COUILLOT, Marie-France. Le bien-vieillir et les immigrés en Seine-Saint-Denis. Les pistes d’une enquête. *Retraite et société,* n° 80, 2018, p. 35-55.

[22]For “scattered housing” we generally mean ordinary private housing for individuals (whether they are alone, as couples, or families). In this category we find furnished hotels, full board accomodation, and any rental room (Gallou 2007, p. 91).

[23]ATTIAS-DONFUT, Claudine, DELCROIX, Catherine. Femmes immigrées face à la retraite*. Retraite et société*, No. 43, 2004, p. 137-163 [Online source] https://www.cairn.info/revue-retraite-et-societe1-2004-3-page-137.htm (Date of consultation: August 19, 2021).

[24] In 2011, there were 66,000 foreigners over the age of 55 (i.e. 20% of the age group, compared to 11% in Ile-de-France. (Departmental Observatory Service, of the Department of strategy, organization and evaluation, DSOE. Elderly people in Seine-Saint-Denis, January 2016, p. 4 [Online source] https://ressources.seinesaintdenis.fr/IMG/2016_focus_n4_janvier.pdf (Date accessed: August 20, 2021).

[25]Schéma Autonomie et Inclusion 2019-2024, p. 82 [Online source] https://ressources.seinesaintdenis.fr/IMG/pdf/schema_departemental_autonomie_et_inclusion_2019-2024_-3.pdf (Date of consultation: August 20, 2021).

the National Plan for the Treatment of Migrant Workers' Homes[26], live run-down accommodation that is unsuitable for them in their senior age[27]. Other types of accommodation are scattered housing (furnished hotels, full-board accommodation, or other unsuitable rental arrangements), as well as ordinary housing[28].

In Seine-Saint-Denis, the poor housing conditions of elderly immigrants is becoming worrisome[29]. The *Département*'s public health policy is tied to municipal policies that address the "fight against territorial and social inequities regarding healthcare", particularly in "sensitive urban areas" that have been singled out by the central government’s decentralization policy for the benefit of local communities”[30]. To finalize this plan, the first local health contracts (LHC) were signed in 2011 and renewed in 2016. Finally, a third generation of LHCs was introduced starting from 2018. These contracts signed between the Regional Health Agencies and the territories, are the evidence that local public policies are engaged in battling uneven access to health services for the people who are the most vulnerable[31]. Other entities involved include the Prefecture, the Departmental Council, the CPAM (French public health insurance), MSA (French farm workers’ health insurance), the CCAS (French municipal social action centre), and the CDAS (French departmental social action centre), and non-profit associations and health professionals from the public and private sectors[32]. After having completed a detailed breakdown analysis of LHCs throughout the territory, we narrowed our investigation to five municipalities that provide "ageing well" programmes primarily aimed at ageing immigrants residing in neighbourhoods that the city has singled out as a priority[33]. We subsequently examined these prevention policies, as well as the interventions carried out by professionals in the health and social fields, and the expectations and perceptions of immigrants themselves in the face of ageing. Finally, semi-structured interviews were conducted with various social and healthcare professionals, and with elderly immigrants.

[26] DESRUMAUX, Gilles. Étranges étrangers, étranges foyers ! *Écart d’identité*, “ Lieux des mémoires de l’immigration : un patrimoine national ”, n° 115, 2009, p. 29 [29-37].
[27] SAMAOLI, Omar. Immigrants d’hier, vieux d’aujourd’hui : la vieillesse des Maghrébins en France, *Hommes & Migration*, no. 1126, 1989, p. 9-14.
[28]GALLOU, Rémi. Le vieillissement des immigrés dans la cité, *Les cahiers de Profession Banlieue*, « Questions de santé : des outils au plan local, June 2007, p.91 [83-105].
[29] SAMAOLI, Omar. *Retraite et vieillesse des immigrés en France*. Paris: L'Harmattan, 2007, p. 89 [276 pp].
[30] RICHARD, Katherine. La santé et la politique de la ville, Les cahiers de Profession Banlieue, « Questions de santé : des outils au plan local, June 2007, p. 9-32.
[31]MANNONI, Chantal. *Politique de la ville, territoire et santé. Réflexions autour des ateliers santé ville et de leurs enjeux en Seine-Saint-Denis*: Profession Banlieue, Prefecture of Seine-Saint-Denis, Departmental Directorate of Health and Social Affairs, 112 pp.
[32]PLARD, Mathilde., MARTINEAU, Aurélien, FLEURET, Sébastien. Les immigrés au seuil du grand âge. *Hommes & Migration*, n° 1309, 2015, p. 31-37.
[33]To respect of the anonymity of our referents and interlocutors who have clearly recognizable public duties, we will not quote the five communities concerned in this article, but we will use a numbering system arranged in alphabetical order (C1, C2, C3, etc.).

Methodology

This research, conducted within a micro-local context, was aimed at gathering the viewpoints of the interviewees. It adopted primarily an ethnographic approach that combines an analysis of political and legislative documents, both with participant observations in the field and semi-structured interviews with local actors and immigrants 55 years of age and older. From an anthropological emic perspective, this approach sought to examine the points of view of the respondents in such way as to highlight the complexity of their situation and the range of perspectives. This approach remains the best suited to determine how immigrants perceive risk when it comes to ageing, and this is influenced by their cultural representations of old age and actual experience of precarity and isolation. However, this approach can also serve to understand the perspectives of other stakeholders: heads of institutions, members of non-profit associations, health professionals, etc.

In order to better pinpoint the practical environmental, economic, and social health determinants, our field research was undertaken by examining in detail the health situation described to us by local public institutions. To do this, we conducted interviews with a representative (manager, director, project manager, etc.) of each of the participating institutions, which were of three types: public institutions (16 participants), non-profit associations (8 participants) and professional health groups (4 participants). The objective of these interviews was to determine from them whether the vulnerability of ageing immigrants had become a public health concern, and whether it had been addressed by existing prevention services, and, if so, how this preventive care had been provided. The factors that discourage or help ageing immigrants to have access to these prevention services was given special consideration. What obstacles must be overcome to reach out to ageing immigrants? What strategies have been used? How can a successful outreach policy be set up? On this last point, there is a vital question: should the care provided be specifically adapted to these people or it is preferable to help them gain better access to existing common law services?

As for immigrants aged 55 or over, we interviewed 16 in total with an overrepresentation of 12 men compared to 4 women. We met them in various non-profit associations, municipal centres, and social housing complexes where initiatives have been set up to help immigrants to integrate, such as help desks on access to legal rights and healthcare, language and cross-cultural workshops, “ageing well” workshops (therapeutic education, physical activities), and preventive health activities (chronic disease screening, anti-COVID-19 screening and vaccination, and so on). Except for one case, all the interviews were conducted at the place of residence. As far as women were concerned, we met them several times at the non-profit associations and in their home. Our inquires always focused on three main topics: the type of relocation (temporary or permanent migration, round-trip journey), their living arrangements in France while they transitioned between their professional activity and retirement, their current state of health, and their views on health and prevention. These interviews were meant to learn more about their perspectives on the initiatives that have been implemented, their needs and the resources they have available to have access to healthcare and prevention services, their concepts of “ageing well” which can differ culturally from those of the public administration, the healthcare system, the local collectivities, and the non-profit associations that lead the way in providing local services.

Our final goal was to demonstrate the complex dialectical relationships that exist between various realities in the region. It is a matter of understanding the intervention strategies of the various stakeholders (health professionals, qualified interpreters and mediators, non-profit associations) without overlooking the cultural representations of ageing and societal attitudes, and their impact on the loss of autonomy of ageing immigrants. The objective is to promote the access of ageing immigrants to “ageing well” programmes, and to bring to light the true needs of this migrant population. For these preventative programmes to be successful in enhancing the health of elderly immigrants and delaying their loss of autonomy, improving the systems that are already in place and setting up other strategies directly devoted to the ageing immigrant community must be set as a priority. Calling for more inclusive and diverse scientific, social, and political approaches is also important.

Results

As a whole, our interviews supported all the findings that have been published in the extensive body of current immigration literature. This fundamental body of work can be summarized into three major elements that were brought out in the Broussy report[34].

First, the history of migration influences the lifestyles and living arrangements of today's ageing immigrants. “Residents in migrant worker hostels built in the 1960s immigrated from North Africa and the sub-Sahara at times that date back to the initial waves of migration”[35]. For the men who came to France as temporary workers and still live in these shelters, we noted that their social and health vulnerability is tied to their residing in a shelter. These workers experience difficulties in gaining access to their legal rights and healthcare benefits due to their job insecurity, which affects the amount of their pension. In addition, they have trouble benefitting from the administrative management of their rights due to their transnational way of life (round-trip journeys, "commuting" to the home country). Furthermore, serious occupational diseases appear at the onset of retirement, and eating habits are strongly influenced by community lifestyles, etc. As for women, who "joined their husbands as part of a family reunification policy"[36], we noted stronger and more pervasive language barriers, more frequent occurrences of widowhood, a condition of isolation due to diminishing professional activity, a more overt feeling of loneliness, and an even more constrained social network that further distances them from common law services.

Second, the sociological profile of this community has not changed since immigrating to France. For these immigrant men and women, their shortage of financial resources is related to their difficult access to legal rights which continues into old age. When "the people who live in the hostels [...] realize that they have not taken advantage of their legal rights, that they’ll have only a small pension", the women who worked less "will find themselves with a very

[34]BROUSSY, Luc. L’adaptation de la société au vieillissement de sa population, 2013, *op. cit.*
[35]Social development manager of the Seine-Saint-Denis regional department of Adoma (in partnership with CDC Habitat), Face-to-face interview, Wednesday April 28, 2021, 9 a.m. to 12 p.m.
[36] Head of the Municipal Hygiene and Health Service, C4, face-to-face interview.

small retirement income or will receive minimal welfare payments”[37]. Their continuous financial precarity and social isolation as a result of a lack of resources persist throughout their lifetime.

Finally, social isolation and financial precarity are the root causes of their very vulnerable and fragile state of health. Their most prevalent pathologies are diabetes, obesity, overweightness, visual problems, dental issues, and, finally, arterial hypertension, a "silent disease" which hides behind a lack of symptoms[38] by encouraging an attitude of indifference or a delayed recourse toward healthcare. Mainly because of their financial situation and working-class background, the cumulative effect of social isolation immigrants over their lifetime, by rendering them extremely fragile, preventing them from finding a way to escape from their initial state.

Common law or special provisions?

The age-related vulnerability of immigrants has become a widespread issue involving local and national political organizations and non-profit associations.

Preventive action at the national level is governed by common law and is divided into three levels: primary prevention, which covers the initiatives of “ageing well” policies (physical activity, “ageing well” workshops, informational campaigns, screening for chronic diseases); secondary prevention concerning fall prevention workshops for those aged 60 and older and therapeutic education for patients with chronic pathologies requiring daily care (diabetes, hypertension, cardiovascular diseases, neurodegenerative diseases, etc.); finally, tertiary prevention, which entails a variety of services and home aids for elderly people who have lost their autonomy. These services are designed to prevent the loss of autonomy, to promote home care and delay entry into health institutions (assisted living facilities, retirement homes). When combined, these preventive measures are carried out at the local level.

Due to a decentralized health management policy, the State does not implement these programmes, but just provides funding. When the “Law on the Adaptation of French Society to Ageing of its Population” was passed, the conference of financiers, created in 2015 and coordinated by the National Old Age Insurance Fund (CNSA), set up a series of meetings for “the entire metropolitan territory and overseas, devoted to formulating a common strategy for preventing the loss of autonomy”[39]. Thus, preventive action takes shape at the local level. The State has the function of financier and oversees the effective management of local programmes.

However, the institutions and non-profit associations that work more closely with the underprivileged in the neighbourhoods realize that "national common law is inadequate in Seine-Saint-Denis"[40] because it fails to meet needs of the people in the priority

[37] Head of Public Health Service, Health Department, C5, Interview by videoconference, Tuesday December 8, from 10 a.m. to 11:15 a.m.

[38] Nurse in advanced practice, CMS C5, Foyers ADOMA C5, Master's internship at Paris 8 University, Interview by videoconference, Thursday January 21, from 10 a.m. to 11:30 a.m.

[39]Project manager at the Department of Compensation for Loss of Autonomy - Institutional Partnerships Department of CNSA, Interview by videoconference, Thursday, December 10, from 4 p.m. to 5 p.m.

[40] Socio-educational advisor of the Medical Expertise Unit in the Elderly Populations Department of the Department of Elderly and Disabled Persons of the Departmental Council of Seine-Saint-Denis, Interview by videoconference, Monday, December 7 from 2 p.m. to 3:45 p.m.

neighbourhoods where the elderly are more likely to be isolated. The most important measures, as part of a “voluntary local policy”, are thus executed by the Departmental Council. These local measures do not specifically target elderly immigrants in general; some benefit the elderly in general, while others provide for the care of foreigners and undocumented migrants. In both cases, these actions are incorporated in the city's priority neighbourhood support policy. However, as underprivileged individuals, ageing immigrants may be formally concerned by common law, which seeks to eliminate precarity in certain neighbourhoods. In general, local common law primarily targets territorial precarity, and, indirectly, the “issue of migration”. A “territorial” approach should therefore be taken both indirectly and transversally to address the “issue of migration”. Territorial management of precarity primarily entails contacting those who are the most vulnerable in priority neighbourhoods, and this requires affirmed “political will”[41]. This territorial approach to precarity can also serve to guarantee equal rights for everyone, including elderly immigrants, without having to set up specific measures for them that would expose them to discrimination. In compliance with the principle of user autonomy, “these people must have rights”, but at the same time “these rights must be guaranteed” everywhere. Creating specific programmes for these people would be tantamount to “locking them up and considering them as a community that is disqualified from the benefits of common law”.[42]

Yet, in practice, ageing immigrants are nevertheless waging a hard battle to gain access to prevention services provided by common law, and this may require them to apply “specific types of actions and ways of doing things”[43]. Without prejudicing ethical principles, if we wish to avoid positive discrimination against immigrants when creating specific measures on their behalf, we should, at the same time, allow them to assume their legal rights to avoid any form of negative discrimination. According to some, the paradox between positive and negative discrimination reflects the deep-seated desire of French political culture to uphold “the image of French equality”[44]. To assure a real “going towards” policy and prevent negative discrimination against ageing immigrants, the ethical values of the Nation State must be adapted to local contexts.

How to avoid negative discrimination without falling into to positive discrimination?

Having observed that, on the local level, immigrants fail to use health services and are unable to address the problem of ageing, local institutions are prone to carrying out specific measures targeting a defined group: the residents of migrant worker facilities. Interlocutors are reluctant to talk about former immigrant workers whose acute precarity and isolation have now been well documented. Failing to attribute immigrant care to a specific social welfare category, it consequently becomes fairly expected, and even asked, that actions be taken

[41]Head of Department of the Prevention and Health Promotion Unit, C2, Interview by videoconference, Friday 18 December, from 10:50 a.m. to 11:30 a.m.
[42]In charge of documentation, information management and health issues, C5 Association, face-to-face interview, Wednesday December 2, from 9 to 10:15 a.m.
[43]CMS C1 manager, face-to-face interview, Friday April 2, from 1 p.m. to 2 p.m.
[44]Director, Association C3, Face-to-face interview, Thursday April 22, from 2:30 p.m. to 4:30 p.m.

outside of common law for the benefit of migrant housing residents. Such specific initiatives, carried out by non-profit associations, are financed by regional health services and the *département*. This is a social welfare approach that seeks to combat precarity and isolation among those who are particularly vulnerable in the housing facilities. Their social condition is taken more into consideration than their “ethnic” background. In addition, these initiatives serve as opportunities for people isolated in housing facilities to open up to the provisions of common law.

This approach lies at the core of public service social mediation. It is outsourced to management companies and handled by social workers and non-profit associations. Social mediation and gerontological mediation are common law support programmes directly tied to foreign worker housing facilities. They each serve different age groups. “The social mediator works with everyone, regardless of age, and manages all the administrative procedures”[45]. On the other hand, “gerontological mediation is more oriented toward a 'going towards approach' and targets elderly residents with health issues”[46]. Gerontological services arise from of social welfare mediation and are a response to the observation that the elderly living in social housing facilities do not readily turn to administrative institutions and are unaware of their legal rights. At the same time, gerontological services provide access to live-in care services or transfer to an assisted living facility “in response to a request for hospitalization”[47]. In general, mediation is seen as a chance to take advantage of the provisions of common law, which formally avoids positive discrimination.

Elderly immigrants living elsewhere in scattered housing facilities go largely unnoticed, are unseen, and consequently they find themselves even further removed from their legal rights. The reason is twofold: first, immigrants residing in shelters, in certain cases, are definitely the most vulnerable, and second, they are thus more visible and better targeted by public authorities. This situation poses a major "ethical-political" dilemma: "if the ageing immigrant community is not specifically targeted", it is because "it may seem unethical to give precedence to a certain population group” [48]. The fact that immigrants residing outside of social housing remain unreported is because they do want to be stigmatised based on the statistical identification of their origins. However, non-profit associations that reach out to marginalized people, such as ageing immigrants in scattered housing, have developed mediation services specifically for them. These associations have set up help desks together with the Health Departments and municipal social support services (social workers, letter-writing services, adult services, referral services, peer helpers, etc.) to assist them accessing their legal rights.

[45]Social integration manager, Adoma, Face-to-face interview, Wednesday May 19, 2021, 10 a.m.-12 p.m.
[46] Social integration manager, Adoma.
[47] Social integration manager, Adoma.
[48]Head of the Prevention and Health Promotion Department, C2.

Several closely related reasons for not using services

Health and social professionals' observations of the challenges faced by ageing migrants in their quest to access their legal rights and healthcare services support our initial hypotheses that these challenges are caused by linguistic and cultural barriers, a lack of knowledge of their legal rights, and limited financial resources. Our interlocutors also have highlighted their inadequate medical insurance and low healthcare coverage in priority neighbourhoods. Ageing migrants also have a general mistrust of public administration. This mistrust, coupled with the lack of a trustworthy social network, keeps them cut off from support services and intensifies their social isolation, particularly that of immigrants residing in scattered housing.

Among these obstacles, the cultural divide is especially noteworthy. Those involved on the front line assisting these people perceive a cultural gap in the idea of ageing well, which explains the reason why immigrants are reluctant to voluntarily avail themselves of prevention services. "Beyond the language barrier, a wide variety of reasons", help to explain why elderly immigrants avoid or postpone their recourse to prevention services or are reluctant to use emergency healthcare or nursing aide[49]. While it is true that “everyone wants to age well, but when your day-to-day life is so difficult, when you have too few prospects, I’m not sure that prevention services are a top priority” [50].

Their reluctance to use prevention services mixed with their long-standing feeling of exclusion makes them feel unqualified and distrustful of institution. If ageing immigrants seem difficult for health personnel to approach, too little aware of their health issues, and even less engaged in prevention and the notion of ageing well, it is also because "throughout their lives, they have developed a mistrust and even a real dread of French institutions”. These misgivings arise from a sense of being disqualified and a lasting impression of having been "left to fend for themselves for several years".[51]

Furthermore, a new obstacle, the digital technology gap, has emerged as a pivotal factor that significantly affects how difficult it is for them to access prevention services. Many professionals believe that it is the contributing factor for the isolation of the elderly immigrant community. This obstacle makes it hard for elderly persons, especially if they are in a precarious situation, to independently perform administrative procedures, and this difficulty is compounded if they have an imperfect command of French. The language barrier and the digital divide are overlapping obstacles that reinforce one another. Added to these are also low financial resources, in addition to a closed social network that prevents elderly immigrants from connecting with any trustworthy person “who can help them, for example, schedule a medical appointment on the Doctolib app”[52]. To sum up, the digital divide is an obstacle that encapsulates all other obstacles: the language barrier, a lack of financial resources, and a limited social network.

[49] Advanced practice nurse, CMS C5, ADOMA.Shelters
[50] In charge of documentation, information management and health issues, Association C5.
[51] Project manager in public health, ARS Île de France, Departmental Delegation of Seine-Saint-Denis, Interview by videoconference, Thursday January 21, from 10 a.m. to 11:30 a.m.
[52] General practitioner, CMS C1, Face-to-face interview, Tuesday June 8, 11 a.m., medical office.

Viewpoint of users: ageing immigrants facing the challenge of ageing well

However, we cannot understand the causes for the non-use of social services without getting the viewpoint of the users. The first obstacles identified by ageing immigrants we encountered in the field were social and financial precarity. Madame T. is a 63-year-old woman of Congolese descent supported by non-profit associations. In France since 2002, she moved to be with her children after her husband died. Following the death of her eldest son whom she had lived with, Mrs. T. applied for social housing, because her two daughters residing in France were unable to take her in. Pending approval of her application, she was obliged to rent a small ground-level room furnished with a bed, a small fridge, two chairs, and a little toilet with a tiny lever for the flush. For this unacceptable accommodation, her rent was 500 euros, but her Active Solidarity Income (RSA) was only 450 euros: "Someone has to help me to pay for the shortfall", she said dejectedly.

Without a kitchen, she cannot eat properly, which leads to bad eating habits: “one has to eat, but how can I? So, I’ve gotten used to eating biscuits for dinner and that's it. If there aren’t any, there aren’t any”. To control her cholesterol and prevent heart disease, her doctor has prescribed treatment she cannot afford. "How can I?” Without private complementary medical insurance and unable to navigate through the maze to get national complementary health insurance (CSS), she would rather spend her money for rent than for her health: “It's something that I don't have a good grasp of. I'm struggling, but if you have somewhere to sleep, even if you must go without eating, it doesn't matter”[53]. So how can there be any plan for prevention if the starting conditions are so gruelling? Mrs. T. does not even know the meaning of prevention, or, at the very least, she does not spontaneously associate it to health. First, having to provide for basic necessities keeps her away from receiving treatment. Then, the challenging task of managing administrative procedures keeps the person away from dependable and regular medical follow-up. Finally, the same obstacles cited by social workers, professionals, and the non-profit associations relay their extremely illuminating observations: "It's very complicated, very complicated, and now when something comes up, I go straight to the association. At my age there’s always something, like even the Internet, but what is that? No clue. That’s for young people. At my age, I’ve simply got too many shortcomings”.

Poverty, precarity, a sense of exclusion and disqualification, inadequate medical coverage, administrative challenges all fundamentally form social conditions that run the danger of producing psychological isolation, a sense of loneliness, and eventually depression. "I spend all day locked up at home, all alone", laments Mrs. T. Her distress worsens as she gets older: “It’s my age too…I used to walk, go out on a stroll, and sit in the garden, but now I can't do anything, I'm trapped in my room". This woman’s psychological distress could anticipate her loss of autonomy. Ageing immigrants must be assured of a better environment as they grow older, in order to offset the impact of social isolation on their psychophysical health. In short, before we can offer them conditions that allow them to age well, we must first prevent them from ageing poorly.

Realising that there is no single way of understanding and experiencing well-being in old age calls into question the established prevention services that use a medicalized approach.

[53]Madame T., 63 years old, Congo-Brazzaville, Téké, Interview at home, C3, Tuesday May 18, 2021, 2-5 p.m.

First, choosing inclusive, pluralistic, and open strategies enables one to truly hear the needs and points of view of immigrant users. Mr. N. is a Malian man with a rather young demeanour, very quiet, confident, and poised. Aged 62, he works in collective catering, and would like to apply for early retirement. “I am worn out, I’ve given up, [...] I couldn't work for three more months”. He asserts that "ageing well means being retired and retirement gives me the freedom to live six months in Mali and six months here", because "here we are alone, there’s only work, whereas 'in the country we’ve got the whole family, we’ve got friends, real, real friends'.[54]

Second, talking about health prevention is not the best course of action; it would be better to conceive of ageing well as a particular type of “well-being” and “quality of life”. Mr. K. is a 76-year-old Kabyle man who lives in migrant housing. Followed by the same doctor whom he has relied on since arriving in France, he claims that in Algeria "there is no need for medication [...] because we live in better conditions there". According to Mr. H., an 85-year-old Algerian, also residing in a home in a sensitive neighbourhood, “if you are in good health you shouldn't have to worry about it” [55]. As for physical activity, as explained by Mrs. Z., a 56-year-old Tunisian woman we visited at her home: “We Africans are not used to playing sports or doing activities”. However, when non-profit associations offer sporting activities, immigrant women choose to participate in them, for it is a chance for them to connect with others on a social level. "I liked it when I saw I. riding a bike and doing everything, so I told him, let's go!"[56].

Finally, “to age well is first to live well” [57]. It would thus be appropriate to “work together on what they mean by well-being”, in order to “address issues like diabetes or hypertension” [58]. Health professionals who interact with immigrants even recognize the potential of intercultural training that incorporates an “analysis of professional practices”. The objective is “to give the caregiver the tools to better respond to the challenges of these people, who are easily identifiable and who have undergone a specific migratory journey” [59]. If it is true that “everyone wants to age well, what does this mean for immigrants, whose circumstances are precarious due to a number of socio-economic disadvantages, and who are quite old and in poor health?” [60]. To answer this question, it is important to maintain a critical eye on our own cultural representations. Our concepts of ageing, health and disease are also the product of a specific past.

[54]Mr. N. 62 years old, Mali, Bambara, Interview in FTM, C4, Thursday June 24, 2021, 2-6 p.m.
[55]Mr H., 85 years old, Algeria, Kabyle, Interview in FTM, C5, Wednesday June 23, 2021, 2-6 p.m.
[56]Madame Z., 65 years old, Tunisia, Interview at home, C3, Tuesday May 4, 2021, 10 a.m. to 12 p.m.
[57]In charge of documentation, information management and health issues, Association C5.
[58]Advanced practice nurse, CMS C5, Foyers ADOMA.
[59]Director, Association, C5, face-to-face interview, Thursday May 6, 2021, 10 a.m. to 11:30 a.m.
[60]Project manager in public health, ARS Île de France, Seine-Saint-Denis departmental delegation.

Conclusion

Beyond the practical challenges and ethical limitations that we encountered during our research, we have tried to find new of courses of action that can help lessen the isolation of ageing immigrants and improve their access to prevention services. To ensure that these strategies are compatible with actual local circumstances, the target audience and area participants were consulted.

Our findings were undoubtedly subject to methodological and scientific constraints that are specific to this research. Since statistical samples are quantitative methodological tools, our study was qualitative and did not rely on them. Working collaboratively with an expert in statistics would have admittedly resulted in gathering more accurate information. However, the problem of identifying migrants in dispersed housing would have remained. Another weakness of the study was related another practical limitation, I.e., the number of migrants aged 55 or older that we met and interviewed was typically too low to draw general conclusions about their condition and their needs. Securing access to places where elderly immigrants reside proved challenging to assure in our one-year study. As for the women, they mainly live in scattered housing and, except for the women who seek consultations on their own accord, they go unnoticed by the institutions. As for the men, they are more likely to be found in shelters and communal living spaces that are hard to access and hemmed in by hierarchical administrative control. Ultimately, a single encounter with an ageing immigrant was insufficient to discuss life events and more private topics, such as state of health, socio-economic status, lifestyle, etc. For this reason, our hope would have been to expand more deeply on the topics we discussed through an ethnographical study on the living conditions of the immigrants.

Despite the study’s technical faults and unfavourable circumstances, we can put forward a certain number of theoretical proposals and practical recommendations to enhance the course of action with the immigrant community in terms of prevention and ageing well.

The partitioning of services and a vertical information structure exclude a considerable number of ageing migrants from common law systems.

Although mediation services in the context of caregiving and in the social environment are increasingly popular, the social workers involved are neither institutionally recognised nor specifically trained on the intercultural aspect of their job.

The practice of social and gerontological mediation, based on the understanding of the mediators and the bond of trust they have established with the immigrants, is not implanted in a stable and consistent manner in the places where ageing immigrants reside (shelters or scattered housing).

Decompartmentalised services in support of ageing well and better use of accessible information would improve the health care for ageing migrants.

Local services, social mediation programmes and "gateway" schemes whose purpose is to direct ageing immigrants toward common law services (particularly in terms of medical

follow-up and prevention) would be able to draw a benefit from the input of resident immigrants as part of their professional development.

More specifically, our ethnographic research has revealed a discrepancy between State regulations and field practice. The “vertical alignment between funding organizations (CNAV, ARS-national and regional health services, Departmental Council, etc.) and non-profit associations, prevents local actors from developing appropriate programmes and implementing the policy of “going towards”. At the same time, the requirement that non-profit associations remain “financially dependent” on national institutions obliges project advocates to provide a “legitimate reason” in the approach to financiers[61]. The local initiatives aimed at aiding people in precarious conditions are not unrestricted, because they must comply with the criteria laid down for projects.

First, the programmes have been sponsored for “anyone over the age of 60”. And yet, if ageing well is our intention, the beneficiaries of preventive measures should be at least 55 years old. Second, if prevention only starts at the age of 60, then immigrants who age prematurely may be excluded. Moreover, several interlocutors have informed us, “These people need a longer transition time”, and “prep work is necessary” [62]. This is accomplished by providing long-term preventative or mediation services, whether conducted outside or inside the home. Those who provide local services and assist ageing immigrants, and who have planned for the long term, are confronted with a project's one-year time limit. This strict timing requires “associations to expend a tremendous effort to redefine their various strategies, methods, and intervention objectives”, in order to maintain consistency with the same community.

Overall, national sponsors of local projects do not address the precarity of certain population groups like ageing immigrants: "At the national level, we do not focus on this problem, which is generally situated at the regional level, like the special case of Seine-Saint-Denis”. The extent to which services for immigrants has been able to reach out the immigrant community has not been measured through the evaluations of sponsored programmes. “Nor do I know what proportion of the immigrant community takes part in prevention initiatives, because it's not necessarily a piece of information that we're going to ask them for” [63]. This is an engrained political attitude, which ends up ignoring complex situations, and further complicating the access of ageing immigrants to prevention services. These are all abrupt impediments that professionals and institutions erect to the detriment of immigrants' health and the possibility of ageing well. The social isolation that has been built throughout the lifetime of immigrants has made them extremely vulnerable, preventing them from extracting themselves from the conditions they started off with. This distress, originally tied to their financial situation and working-class background, has been heavily influenced by their way of life that has been conditioned by French policies on migration and integration. This has had repercussions on the lifestyles and housing situations of immigrant men and women who are

[61] Director, Prevention Service, CCAS, C5, Face-to-face interview, Wednesday May 21, 2021, 3:30 p.m.
[62] "Access to rights and social inclusion" project manager, C4 Association, Access to rights office, C4 social center, Videoconference interview, Thursday June 24, 2021, 2 p.m. to 6 p.m.
[63] Project manager at the Department of Compensation for Loss of Autonomy - Institutional Partnerships Department of the CNSA, Interview by videoconference, Thursday, December 10, from 4 p.m. to 5 p.m.

living their old age still in the same substandard accommodations that they were initially housed in.

This social isolation has the potential to lead to psychological isolation, thus severely reducing the possibilities of immigrants to age well. The "Law on the Adaptation of French Society to the Ageing of its Population" introduced to reduce the isolation of ageing immigrants is part of the public authorities’ plan to prevent the elderly from losing their autonomy. It has become a major collective concern in a society that places a value on the integration of people of diverse backgrounds and generations. The evolution of French public policies reflects the desire to identify weaknesses upstream and to combat social inequities in priority neighbourhoods by taking into account many variables, such as poverty, the territory, and the sense of isolation. Faced with this challenge, the regional approach is predicated on a financial or cultural determinism which is ill-suited to the multidimensional problems of the ageing immigrant community. Starting from the principle that the conditions for determining the precarity of aging immigrants are solely linked to territorial disadvantages, we end up ignoring the extent to which these inequitable conditions of access to legal rights and healthcare, as well as the history of immigration and integration policies in France are intertwined. We perceive the underlying need for a collective awareness of integration policies that addresses the precarity, isolation, and vulnerability of ageing immigrants in France. This major task is devoted to the great vulnerability of elderly immigrants, for whom the existing systems for preventing the loss of autonomy still require extensive thought and adaptation today.

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