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## Health systems and immigrants - a focus on urban France

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The study of immigrants' living conditions in urban Europe has prompted researchers to question the notions of precarity, poverty, and marginality in terms of their impact on immigrants' health and access to healthcare (Castaneda et al., 2015; Darlington-Pollock, Norman, Exeter, & Shackleton, 2018; Davies, Basten, & Frattini, 2016; Newbold, 2018; Thomas, 2016; Thomas & Gideon, 2013). Urbanisation and urban environments do not in themselves, constitute a threat to the health of populations, as shown by the experience in various cities in both developed and developing countries (Witten & Ivory, 2018). However, when urban growth is combined with economic and/or political difficulties in managing urban services and administrations, cities might not be able to protect inhabitants from environmental and human hazards. This is the case in European cities, in which urban poverty and inequalities have reemerged and are characterized by difficulties for vulnerable populations to find housing and access basic services. This situation raises the question of social insecurity as it is experienced by marginal populations, especially immigrants (Jordan et al. 2017), as well as healthcare professionals, social workers, and voluntary organisations, who provide care and support to these vulnerable people in various spatial environments (DeVerteuil, 2017). Urban areas, characterised by various forms of concentration, proximity, and plurality, are challenged by analyses that highlight the role of various economic and

social processes in increasing precarity and marginalising vulnerable groups (Amin and Thrift 2016). Precarity among some segments of the population, generated by different processes of classification, social hierarchisation, social differentiation in urban contexts, is part of a more global tendency towards an increasingly exclusive collective identity, based on the weakening of social links, which, in turn reinforces the exclusion of immigrants, racial minorities and asylum seekers (Amin 2012).

In this chapter, we aim to present the nexus between urban living and health as it occurs in France. We then focus on the particular situation of immigrants in terms of health. Our observation of their situation enabled us to make inferences not only about immigrants' experiences but also about the healthcare system, whose efficiency is not only challenged but called into question, particularly in urban environments. In this article, we focus our attention on the links between precarity and access to healthcare. Regarding social contexts, newly arrived immigrants are highly represented among economically deprived and precarious populations. In particular, they are more than others excluded from access to resources (by effects of direct or indirect discrimination processes), they are more represented among people who attend specific' healthcare centres (such as dispensaries run by humanitarian NGOs), and their healthcare pathways are mostly constrained by their living conditions, notably residential precarity.

French national statistical data can shed light on the 'concentration' of immigrants in urban areas. Thus, the data provided by the INSEE concerning the population distribution indicates that immigrants are more spatially concentrated than natives (Brutel 2016): 8 out of 10 immigrants reside in urban centers (against 6/10 for nonimmigrants). More specifically, 38% of all immigrants living in France, reside in the Paris area (against 17% for the nonimmigrant population). This reflects a historical tendency of the geographical concentration of immigrants in urban areas, which has recently been reinforced by new

migratory contexts: 89.6% of newly arrived immigrants (<5 years) settle in urban areas and one-third of these live in the Paris area. It must also be noted that immigrants represent an important part of the total population in urban centres outside of Paris. Apart from these demographic configurations, large cities have the particular characteristic of being home to sites considered as ‘places of exception’. This is the case of Calais, in Northern France (it embodies the border between France and the UK) and La Chapelle (a neighbourhood of Paris), which have, in recent years, been in the spotlight of the media for being precarious forms of collective shelter for newly arrived migrants.

Thus, issues related to health and precarity among immigrants living in urban environments have given rise to major political and social debates. We will establish a state of the art of how French academics approach these issues; issues which have led us to examine ‘the normalised city’ vs its ‘interstitial margins’, its constants/variables. To illustrate this we present two case studies based on our fieldwork, which reveals that the existence of an urban continuum should also be questioned in light of immigrants’ social realities, including their ability or inability to access healthcare services. For this purpose, we will analyse two local initiatives: one related to a specific sector of public action (mother-child-care); one related to living conditions (living in squats). The first one concerns Paris and the institutional organisation of the sector of perinatal healthcare: how does one approach the question of socio-medical services (pregnancy, childbirth, and mother and child care) and that of social services (for newly arrived immigrant women who find themselves in a highly precarious situation) in a specific area: Paris and its suburbs? The second initiative will show how and why local social and medico-social actors are mobilised around housing/living related questions. Through these two examples, we will underline the major issues related to the dynamics of urban environments, taking into account their social and political dimensions.

## **The nexus between urban living and health in France: the effects of precarity on immigrants' access to healthcare**

The subject of urban health in France—just as in other industrialized countries—has been widely investigated and described (Bouchayer et al. 1994; Chauvin and Parizot 2005; Fassin 1998; Marmot and Wilkinson, 2005; Townsend 1987; 1993; Vallée 2009). Studies have shown the differences in mortality or morbidity rates between rich and poor populations for example. However, social and economic indicators appear to be limited in their ability to explain those differences and in their potential as levers for change, as they do not take into account the individual level (how living conditions are experienced effectively and emotionally) and collective responsibilities (“new” social determinants of health such as phenomena of social exclusion that characterize processes of precarisation, inclusion/exclusion in the sphere of employment, social integration, psycho-social characteristics of individuals or family composition and dynamics). Let us emphasize, furthermore, that people experiencing these social and economic conditions cannot be excluded from the scope of public policies, which, as is implied by the principles underlying the welfare state, must aim to reduce inequalities.

France has adopted several laws and mechanisms to combat poverty, precarity, and exclusion. These mechanisms involve various partnerships between the state, public or semi-public organisations, healthcare centres and professionals, local authorities, institutional associations and various charities (Labbe 2007), which mostly involve the sector of socio-medical services. Precarity is defined by J. Wrezinski (1987, p. 6) as:

the absence of one or more of the forms of security, particularly employment, which enable individuals and their families to meet their professional, familial or social obligations and enjoy their fundamental rights. The resulting insecurity maybe more or less extensive and have more or less serious and permanent consequences. It leads to extreme poverty when it affects several areas of existence and becomes persistent,

and jeopardizes a person's chances of re-assuming his/her responsibilities and regaining his/her rights by him/herself, in the foreseeable future.

This definition illustrates the importance of considering a person's environment as having an impact on his/her well-being and therefore state of health.

Precarity affects various areas of existence, and differs from poverty and social inequalities in health in that precarity involves no social gradient, whereas poverty involves a gradual process of downward social mobility in which individuals or families find themselves due to an accumulation of unfavorable factors. Townsend (1987) and Wrezinski (1987) examined these aspects more closely by defining the EPICES score, which is now used in the field of public health and by French researchers specialized in spatial epidemiology, in order to identify and gain a better understanding of healthcare inequalities as they are experienced by individuals in their social worlds. Individuals in a situation of precarity have a higher incidence of more advanced stages of diseases, particularly homeless people and undocumented immigrants.

Spatial approaches to precarity help to grasp differences between territories and to identify populations who experience healthcare inequalities and are therefore victims of injustice: studying poverty or precarity always amounts to identifying situations perceived as unfair in a given context. Cases of poverty correspond to a particularly unacceptable degree of inequality between those at the bottom of the social scale and the rest of the population concerned. One's relationship to norms is therefore fundamental. In a society, like ours, which strives for some form of social justice and equity, situations of poverty are even more difficult to tolerate. They are associated with, among other things, ills that are perceived as those of a bygone era (inadequate housing conditions, malnutrition, difficult access to healthcare etc.), which immediately places people identified as poor in a humiliating position (Zaepfel 2012).

The connection between urban environments and the presence of immigrants raises many questions for social sciences, particularly for those that focus on the categorisations of populations, on administrative measures implemented to facilitate or prevent immigration in France and Europe, and on the body of knowledge and competencies used to address migrants' needs. Recent trends in the immigration landscape have prompted us to reframe academic thinking on the question of cities and immigration: recent arrivals of refugees/exiles/immigrants/asylum seekers have been accompanied by the re-emergence of undesirable urban forms inhabited by populations who, by extension, are also considered "undesirable" (Agier 2010, p. 4): 'camps, squatter camps, shanty towns, insalubrious housing' ... 'Calais, La Chapelle (Paris), La Poterie (Rennes)' ... 'refuge-cities, frontier-cities, crossroad-cities', places in which immigrants concentrate but which are often the types of places we thought had disappeared from European cities.

Since the implementation, between the end of the Second World War and the early-1970s, of measures to eradicate shanty towns, these types of informal settlements have had a stigmatising effect on the people living in them and their existence has been considered as inappropriate in welfare state countries in which people facing housing precarity are supposed to be given access to collective housing programmes. Thus, the recent re-emergence of informal settlements and slums, and more specifically, their high visibility in urban public spaces has reawakened a kind of "national nightmare" combining extreme poverty, economic delinquency, rising numbers of people in situations of exclusion, particularly among immigrants.

Researchers interested in the field of immigrant integration services pay particular attention to the health aspects of the type of housing, in which immigrants live, particularly in urban areas: Indeed the health and safety argument is often used to legitimise the expulsion of people and is therefore not always useful for initiating constructive debates on the type of

actions that should be implemented in order to give populations living in squatter camps access to healthcare (Bergeon and Hoyez 2015). Furthermore, the notion that the increase of immigration flows is due to the existence of a healthcare system that is open to all regardless of national origin is largely questionable (Carde 2009). France adheres to the principle of ‘universalism’, in which each and every citizen has universal access to the same fundamental rights regardless of race, gender, religion or nationality and ‘could be said to hold one of the most liberal and progressive healthcare systems in the world’(Larchanché 2012, p. 858). Thus, French institutions are governed by two principles enshrined in the constitution: (1) the Republic is one and indivisible and citizens should therefore not be categorised into distinct groups on the basis of race or ethnicity (2) public policies are guided by a strong sense of equality in the national territory and in each territorial unit that composes it (Hoyez and Thomas 2016). However, the imperative of controlling immigration—in France and other European countries—collides with the imperative of universal access to fundamental rights for immigrants. This generates different processes of discrimination (immigrants are for example more often excluded from health insurance coverage) as well as a tendency towards differentiation in the practices of healthcare professionals who find themselves having to ‘do something at all costs’ in a hurry to place immigrants in the mainstream healthcare system. This is reflected, in the field, by the wide range of healthcare and social care initiatives intended specifically for immigrants.

Beyond being a question of ‘public nature’, the question of where immigrants who have come to France live has become one of an ‘urban nature’: these places have to be incorporated into the ‘life cycle’ of cities, and into the continuity of immigrants' healthcare trajectories. They represent the exact opposite of the ‘sustainable city’, as defined by public policy objectives, in that they are places of exception, exclusion and extra-territoriality (Agier



2016)<sup>1</sup>, places characterised by living conditions unworthy of human habitation. They are places that are difficult to integrate into other public spaces; they are interstitial spaces that escape the city's institutional apparatus (Agier 2010; Agier et al. 2011). However, an analysis at micro level shows that these places are fully part of people's lives: as places of passage or as places of settlement, albeit short-term, they allow for some forms of socialisation to develop or offer their inhabitants the possibility of being connected to the mainstream system; but this is only possible if the social and institutional actors do not dissociate the place from its inhabitants (Bergeon and Hoyez 2015).

In this context, the question arises of immigrants' access to the city in all its dimensions, and more specifically two of them: housing and other resources present in the city (here we will more specifically examine health resources). In order to better understand the current situation in France, it is therefore important to focus on the local effects of these issues on the way immigrants are received (what places and networks are set up to help immigrants access the resources of the city?), and to take into account the process of integrating immigrants in the city (what place are they given in the city, whether in common or specific urban spaces?).

### **Local healthcare initiatives:**

#### **The example of a mother-child-care network in the Paris area.**

The question of the high levels of poverty and precarity among certain population groups arises acutely in the Ile-de-France region (whose capital is Paris) where most of the immigrant population lives. To cope with situations of growing inequalities in the urban context, some initiatives are being undertaken at the local level. Pregnant women and/or mothers with young children who do not have housing are the object of various initiatives, especially in the North of Paris: in 2006, the SOLIPAM network (SOLidaritéPARisMaman –

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<sup>1</sup>Michel Agier replaces the « 3E » of the sustainable city (economic, ecologic, ethic) by the « 3E » of indignity (exception, exclusion, extra-territoriality).

‘Paris Mother Solidarity’) was formed as a public sector initiative to help better coordinate the medical and social dimensions—generally disconnected—of the care services provided to women living in highly precarious conditions. In parallel, in 2007, another network was formed in the North of Paris, with the aim of bringing together the hospitals with similar patient profiles; since 2013, this network has been extended to cover the whole Paris region (implying that more healthcare actors have recognized the network's usefulness.)

All these initiatives seek to better coordinate the various professionals, to better communicate with and better understand the populations that they serve, in order to improve their healthcare situations. Healthcare professionals took it upon themselves to create this network, after observing that their patients were experiencing extreme difficulties and realizing that it was imperative to take some specific actions to prevent them from foregoing healthcare. This indicates that an unprecedented crisis is arising in the French public healthcare system, which until recently was praised worldwide for being guided by the principle of universalism. This crisis results in a specific institutional positioning, an ‘in-between’ where healthcare professionals from the public sector are pushed to create private organizations to meet the healthcare needs of all, especially immigrants.

(insert fig 1, with legend: *Reception desk at a shelter center in Paris. Conceived as a place where to welcome and offer spaces for discussions, the office offers children facilities and a professional interpreter to interact with families*).

The SOLIPAM network was originally formed as a non-profit medical organisation whose purpose was to better coordinate the healthcare services provided to pregnant women living in situations of extreme precarity. The network brings together medical and social professionals in the Ile-de-France region who care for this population. The network is intended to serve as a cross-organisational tool for coordinating and facilitating the activities of structures and actors involved in providing healthcare and social assistance to those

pregnant women, and for ensuring that adequate follow up care is provided to them. Furthermore, the network also seeks to raise awareness among, and train medical, social and institutional professionals. The Regional Health Agency (Agence régionale de santé) funds the SOLIPAM network because it considers that this network contributes to ensuring healthcare "continuity and quality". SOLIPAM aims to provide women living in extreme precarity with more comprehensive and more localized healthcare, but also to implement actions in order to help those women gain autonomy as well as stability in their living situations. But achieving this objective is dependent on the concrete ability to ensure continuity in the follow-up process.

Indeed, when health professional partners involved in the network encounter a woman in a situation of extreme precarity, they contact SOLIPAM to apply for the enrolment of the patient in the scheme. If the needs of a woman can effectively be met by SOLIPAM, and if the patient herself accepts the assistance offered by the network, she is contacted to set up an 'inclusion interview'. The interviews, generally conducted face-to-face (sometimes over the phone), consist in a medical check-up (performed by a midwife) or in a social interview (performed by a social worker)—even though, once enrolled, the patient will always be followed up by a team made of a midwife and a social worker. Once the patient is enrolled in the programme, this team works in collaboration with other professionals in the social and medical fields to ensure that comprehensive and coherent care is provided to the patient during her pregnancy (particularly around core issues such as housing, access to welfare benefits, coordination of prenatal and infant care until the child reaches the age of 3 months). By the time the mothers are supposed to leave the network (three months after the birth of their baby), they are supposed to have gained autonomy; but not all of them have been incorporated in the national mainstream system. This can be due to the complexity of their administrative situation, to the fact that many of them have not yet secured housing and their

administrative situations still uncertain. The limitations of these transversal measures, in time and space, quickly become clear.

Yet, SOLIPAM has developed an experimental scheme ('support scheme') to further assist women who cannot apply for medical or social follow-up services (this is the case of undocumented immigrant women): this helps to facilitate access to healthcare benefits and opening of health rights, and to other existing schemes, etc. This initiative is supported by both public and private funds (FondationSanofiEspoir). The need for private funds to support this type of initiative, and more broadly, the very existence of private organizations dedicated to providing assistance to a population living, locally (historically in the North of Paris), in conditions of precarity raises the question of the differential treatment of certain population groups by the State, and of the latter's disengagement from healthcare and social issues affecting parts of the urban population. The network was then extended to cover the whole Paris region (Solidarité Paris Maman – Ile de France). This regionalisation is taking place as part of the development of partnerships in healthcare networks, particularly in the perinatal healthcare networks of the public sector and charitable associations (working in the social, cultural and psychosocial sectors)' (Activity report, 2015).

Given the migratory context in the Paris region, immigrant pregnant women account for between 80 and 90% of the total number of women enrolled in the programme. For them, and for the network, housing is a major question. Indeed, a recent study (Rietsche 2014) underlines that at the time of their enrolment in the programme, women either rely on emergency housing (N=488) or are given shelter by third parties (N=318). The study also shows a decrease (-80%) in the use of makeshift accommodation by women, once they have left the maternity ward and receive post-natal care from the network, and a decrease in the use of housing provided by third parties (-50%), whereas the use of emergency housing, of accommodation in social centres and of social or private housing has increased by 5.5%,

119%, and 29% respectively. This tends to reveal at what stage the issue of housing becomes central for these women, not only in terms of basic housing comfort and safety but also in terms of medical follow-up and access to healthcare benefits.

The coordination activities of the network seem to have an impact on the housing situations of those women, as well as on their access to welfare benefits. In France, the type of residence permit (granted by the authorities) plays a central role in the type of healthcare and social services these women are entitled to. About two thirds of the women do not have any healthcare coverage at the time of their enrolment in the network; 15% are waiting for their application for residency to be processed, only 6% have a valid residence permit, 2% are waiting to know what type of residence title they will be applying for. It also should be noted that a large majority of these women have temporary residence permits (3 months to 3 years) and that each change in their status has an impact on their healthcare insurance. Moreover, there are many cases of women who do not take up their welfare benefits (about a quarter of the women are eligible for social welfare benefits but do not have access to them because they have not applied for them, either for economic reasons, or because they think they are not entitled to them.)

(insert fig. 2, with legend : “Temporary housing solution for immigrant women in 2017. Behind the fence (at the back of the picture) figure freight rails desserving Paris’ suburbs.”)

(insert fig. 3, with legend: “At the entrance of the health office in a temporary housing unit for immigrant women in Paris’ suburbs in 2017”.)

The evolution of SOLIPAM's actions must be analyzed from the point of view of public healthcare professionals who operate in a difficult context due to the exponential increase in the number of women in perinatal stages living in extreme precarity. This Paris-based network had to be extended to include other areas around Paris due to a double-sided situation. In effect, women in highly precarious situations are not all located within Paris

proper; indeed many of them live in other areas outside Paris in equally precarious conditions. The work carried out by the network has gradually been recognized throughout the whole region which has contributed to legitimizing the actions undertaken by an increasing number of professionals (in relation to coordination, training, advocacy, etc). At the same time, the network has great difficulty coordinating the medical care provided to patients at the local level. Paris is characterized by a serious shortage of housing, and there seems to be no room for debates on the possibility of facilitating access to housing for women living in highly precarious conditions and/or waiting for residence permits. Consequently, these women relocate mostly to other areas in the Paris region, which implies a necessity for collaboration at the regional level between professionals of the healthcare sector. Finally, in terms of research, this example brings to light the importance of taking into account the socio-historical and institutional contexts in urban areas, in order to better analyze the life trajectories of immigrants. The urban context highlights how a large number of actors work together thanks to a network, even though the latter faces severe budgetary limitations. This network addresses a major public health issue (perinatal care for women in precarious situations) and plays a central role in coordinating actions at the level of the Paris region, and therefore provides a good illustration of professional cultures, and of inter-disciplinary and inter-sector work such as it ought to be organized. This research study shows how partnerships in the healthcare sector consider immigrants, and highlights the importance of coordinating medical services in a more holistic manner, that is to say by taking into account immigrants' housing realities and their residential status.

### **Local actions in ‘squats and slums’**

The issue of housing for immigrants in France generates much heat in the media, which largely cover operations to evacuate illegally occupied sites in French cities or border crossing points. Moreover, a large number of immigrants live in situations of residential

precarity and poor housing conditions, such as in squats or camps. Today, these forms of ‘housing’ sometimes seem to be the only way for recently arrived immigrants to put a roof over their head: ‘living in a squat is better than living on the street’ is a comment often heard in the field. Places such as squats are often characterised by precariousness and insalubrity. This is often used by the local authorities to justify the evacuation of people from those places. These arguments are in keeping with the hygiene-related considerations put forward in the 1960s when measures were implemented to eradicate places of insalubrious housing and shantytowns. These precarious living spaces were then considered as hot spots in the ‘sick city’, as Fijalkow (2013, p. 137) puts it, with eradication being seen as the solution to prevent ‘the spread of infection throughout the country’. The reappearance of this type of space has awakened the collective memory; and squats, because of their characteristics (unfit for living in, unsafe, lack of waste management, lack of access to water, electricity, fuel and communication, overpopulation), are associated with strongly negative representations that have to be deconstructed (Bergeon and Hoyez 2015). Moreover, there is a persistent shortcut linking immigrants (especially those living in illegal situations and precarious places) to a ‘problematic’ population whose presence is illegitimate in the local area. These representations fail to consider the daily problems immigrants face and deny their difficult life realities.

(insert fig 4, with legend : “ *“Roofs with no people. For people without a roof: requisition!”*”, translation of the slogan of an association’s banner occupying an empty church sheltering approximately 200 immigrants in Rennes in 2015 ”)

Analysing health and access to healthcare through the prism of residential precariousness requires a threefold approach: (1) that of migrants (the difficulties they encounter in accessing/understanding the healthcare system and being cared for on a daily basis); (2) that of healthcare professionals and voluntary organisations (responding to the

needs of a vulnerable population sometimes difficult to access and for whom health is not a priority given the housing and administrative difficulties they are confronted with); and (3) that of local authorities (who use the health and safety argument to put pressure on the residents to vacate the premises). Thus, we conducted fieldwork in various squats in the cities of Rennes and Poitiers (France), to try to understand how a squat works, and to analyze the healthcare issues facing individuals living in precarity, in relation with their daily living environment. Housing precarity encompasses several dimensions: lack of housing, difficulties in accessing and maintaining housing, lack of comfort, insalubrity, forced mobility (Rapport, Abbé and Pierre 1995; Dietrich 2007; Fijalkow 2013). All these aspects of squatting have a direct impact on the squatters' state of health, and a detrimental effect on patients' adherence to treatments prescribed for specific conditions.

Most of the squats we investigated in Rennes and Poitiers had no running water, no electricity nor heating at the very beginning of the occupation. This was the case, for example, in the Squat of La Poterie in Rennes, until December 2016. Like many other squats in Rennes, La Poterie is a very organised and 'regulated' place. To help ensure the best possible functioning of the collective dwelling, a 'Squat Council' composed of representatives of each migrant community has been established. Every two weeks, they come together with the members of the support association for homeless immigrants, to take stock of the difficulties encountered by the residents.

(insert fig 5, with legend : "A social gathering at the squat 'La Poterie' in Rennes, sheltering 200 to 300 immigrants in Rennes in 2016-2017")

As part of our research, we attended those meetings on a regular basis and observed the exchanges, negotiations or tensions between the inhabitants. In December, with winter well on its way, the issue of heating was at the centre of the discussions. The members of the association were highly invested in the running of the collective dwelling and it was decided



that the installation of the heating equipment would be financed, in part by the residents (according to their means) and in part by the association. Basic comfort needs are identified and prioritized: making the premises habitable is of paramount importance for the residents, who also work together to fight against insalubrity in the collective dwelling. The layout of the space, the population density in the squat and the quality of the dwelling also affect the implementation and efficiency of the care processes for physically impaired immigrants. Besides physical health problems, a number of residents suffer from psychological disorders related to the context and conditions in which their migration took place, on the one hand, and to the uncertainty of their housing situation, on the other hand. Many of the immigrants we met told us about the anguish they experience in relation to their administrative status in France and their housing situation. The threat of being evicted is a constant source of stress for the families and gives rise to symptoms such as insomnia, anxiety attacks or night breathing difficulties. This stress is further amplified by their daily struggle, in a restrictive political context, to obtain residential rights, housing, and access to healthcare.

In the case of the immigrants we met, it is in fact precarity in its various manifestations, which compromises the efficiency of social care and healthcare. The accumulation of administrative and/or housing obstacles maintains individuals into situations of extreme precarity, which forces them to make day-to-day survival choices rather than medium-or long-term decisions. In the interviews we conducted, it became clear that, for these immigrants, their residential status and housing situation had priority over health issues. And that is one of the problems facing health professionals. Uncertainty about one's housing situation inevitably results in a lack of continuity and stability in care processes. Thus, the evacuation of a squat can result in the "loss" of a patient for a healthcare professional, who therefore can no longer follow up on his/her health status. Eviction can have a significant impact on healthcare in that it can put an end to the professional relationship between the

patient and the healthcare provider; a relationship which was often established before or while the patient was living in the squat. Once a patient has consulted a healthcare professional and trust is established between them, the latter often becomes a prominent figure in the daily life of the immigrant. A patient's care trajectory depends on the squat's temporality and life.

In the course of our fieldwork, particularly during the observation phases, we identified three stages in the life cycle of a squat, stages during which targeted actions can be implemented, particularly around healthcare. The first stage is the 'establishment of the squatter dwelling': this is when the future inhabitants settle down and familiarize themselves with their new living space. The priority is then to familiarize and position oneself in the space, to start negotiations about the sharing of the space in the dwelling. Thus, this is a time of excitement, albeit brief. The second stage in the life of the squat is when the occupants have settled and each occupant has his/her own space within the dwelling, and the squat is stabilised. It is precisely at this point that social, legal, or health actions can be implemented. Immigrants and associations know that once the squat is established, eviction cannot take place until a lengthy court process has been completed. In this regard, this phase is a 'period of calm' and housing stability during which residents can pay more attention to their health and professionals can identify health issues requiring urgent attention and treatment—in particular in the case of people with physical or mental disabilities—and follow up their patients' conditions more easily. Healthcare plans can be put in place for people suffering from serious pathologies, and monitoring becomes easier. Housing stability also facilitates the setting up of 'care routines' for individuals who could not care for their health when they were homeless. The squat is a dynamic place, a 'micro-society', the moves in and out set the tempo for the life of the squat. However, the population density in the dwelling increases continuously, which generates tensions between the residents, less peaceful cohabitation and conflicts related to the use of water, electricity, fuel and communication facilities. This

gradual emergence of tension marks the onset of the squat's last stage of life, before its evacuation. The local authorities then put forward the increasing insalubrity related to the overpopulation in the dwelling to legitimise its evacuation. The residents, aware of this development, start experiencing growing psychological distress, and healthcare becomes, once again, secondary. Following the residents' eviction, their trajectories change: some immigrants move to another squat in the city, others access temporary accommodation, while others are displaced to other cities or countries. In all cases, the routines and measures implemented while they were living in the squat are disrupted by the eviction and subsequent move to other squats, cities or countries. Housing precarity, beyond its material aspects, has a considerable impact on individuals' ability to care for their health and on the ability of healthcare professionals to follow up on their patients.

Facilitating people's access to healthcare constitutes an important part of the missions of social workers. Associations play a key role in helping immigrants access information about their rights, and represent, for healthcare professionals indispensable intermediaries between the population living in precarious housing conditions and themselves. Despite being the subject of media coverage, squats remain invisible urban places which healthcare professionals seldom invest in 'spontaneously'. In the fieldwork we conducted in Poitiers, a partnership has been set up between collectives and associations such as LA CIMADE in order to connect populations and healthcare professionals. The first contacts are made via the social workers, who visit the squats' residents and assist the immigrants in their administrative procedures (i.e. in the process involved in obtaining residential rights and in gaining access to housing). Once immigrants are granted access to welfare benefits, appointments are made with doctors in a 'mainstream' healthcare structure or in an organization that provides support for people living in very precarious situations. Various types of healthcare organizations are involved in the care provided to people living in precarity. But we have found that immigrants

tend to use specific support networks more than mainstream healthcare structures (Hoyez, 2011): our fieldwork revealed that networking initiatives are common in the two regions studied. In all cases, strong relations develop between associations and health professionals who decide, on the type of care and treatment that should be administered to patients ‘with specificities’, in a political context that is unfavorable to differentiation. The precarious conditions in which those immigrants live sometimes exacerbate an already vulnerable and fragile state of health. Living in a squat presents health risks (insalubrity, obstacles in the setting up of care pathways, etc.) at the physical and psychological levels. Thus, the combined effects of precarity further complicate the work carried out by healthcare professionals. Precarity forces immigrants to prioritize some basic needs over others, and addressing immediate needs related to one's legal residence rights and housing situation often takes priority over health-related needs. The constant need for health professionals to adapt to patients with such unstable and fragmented life trajectories raises the broader question of the effectiveness of the healthcare system in helping individuals in situations of precarity.

## **Conclusion**

A city's mission has, historically, been to provide services to and promote the integration of all its residents. What does the current situation in France show us in this respect? Taking into account, in urban studies, the effects of precarity on housing and healthcare helps to better understand the segregation processes developing in urban spaces, especially in the ‘interstitial urban spaces’ (either public or private). This analysis has enabled us to highlight the actions implemented by civic and institutional actors to counter segregation and to respond with a focus on urbanity. The question raised by the problems encountered by immigrants living in urban areas is not merely a question of local policy, but requires that urban governance be considered beyond the borders of municipalities (as the Solipam network shows).

We observe an increasing specialization of urban areas: the places to which immigrants are relegated and those to which they must go to receive medical care are becoming increasingly specific and differentiated from other spaces in the city. Spaces and services are supposed to exist in Europe to help immigrants become integrated into the host city. Yet there exist a large number of initiatives undertaken at the regional level by civic actors. The examples we have discussed here have enabled us to underline the fundamental aspects of the relations between social, medico-social and medical actors established in a territory around immigrants' condition of living or specific events occurring during life time. It should be noted that these networks are constantly working to raise funds (especially in order to be able to employ new social workers and midwives), while the number of immigrants included each year in these schemes is increasing. Another important aspect concerns the autonomy of immigrants and their families. Measures should be implemented to promote the autonomy of immigrants and their family once their rights have been acquired and once the first medical appointments have been made, and to inform them about the functioning of the various mainstream healthcare structures.

In this chapter, we have sought to outline the indefectible link between housing and health and to underline that in urban spaces, and have highlighted that these links should be examined by taking into account immigrants' individual situations. Researchers have the ability to highlight the visible degradation of the living conditions of immigrant populations in urban spaces while taking into account the contexts in which healthcare professionals work as well as the emergence of precarisation processes among populations. Furthermore, our examples show that healthcare professionals and social workers face serious difficulties on several levels: to understand the living conditions of immigrants (some professionals should go to the squat to gain a better understanding of the squatter's daily living conditions), to communicate with immigrant patients (problems related to language complicate exchanges

and call for a more regular use of interpreters) and finally to take into consideration the life trajectory of each immigrant when addressing his/her illnesses or health issues.

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