



HAL
open science

Transcultural [i.e. Transcultural] health communication in action : Emerging health practices of Filipino immigrants in the French Riviera

Elizabeth Naui

► **To cite this version:**

Elizabeth Naui. Transcultural [i.e. Transcultural] health communication in action : Emerging health practices of Filipino immigrants in the French Riviera. Library and information sciences. Université Nice Sophia Antipolis, 2014. English. NNT : 2014NICE2032 . tel-01576701

HAL Id: tel-01576701

<https://theses.hal.science/tel-01576701>

Submitted on 23 Aug 2017

HAL is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.

L'archive ouverte pluridisciplinaire **HAL**, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d'enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.



Université Nice Sophia Antipolis

**LABORATOIRE I3M
ECOLE DOCTORAL LETTRES, ARTS, SCIENCES HUMAINES ET
SOCIAL**

**These de Doctoral en Science de l'information et de la
communication**

Presentee par Elizabeth Soliday NAUI

*Transcultural Health Communication in Action: Emerging Health
Practices of Filipino Immigrants in Cote d'Azur*

*Communication transculturelle sur la santé en action: les pratiques de
santé émergentes des immigrants philippins sur la Cote d'Azur*

Sous la direction de Messieurs les Professeurs Philippe Dumas et
Henri Alexis

Presente publiquement le 11 juillet 2014

Membres du Jury :

Henri Alexis Professeur en Sc. de l'information Communication, Université de Nice, Directeur de recherche

Philippe Dumas, Professeur en Sc. de l'information Communication, Université de Toulon, Co-Directeur de recherche

Didier Courbet, Professeur en Sc. de l'information Communication, Aix-Marseille Université, Rapporteur

Michaëla Tudor, Maître de conférences, Hdr, en Sc. de l'information Communication, Université de Montpellier, Rapporteur

Xavier Huetz de Lemps, Professeur en Histoire contemporaine, Université de Nice, suffragant

ABSTRACT

France is yet to have a standardized immigrant health data collection system. As such, data of immigrants' health is still irregularly determined. The closest immigrant health data available is the self-reported status of health. This is both a problematic state and surprising because France enjoyed the title of being one of the countries in the world with best health care system despite the lack of concrete immigrant health data. This put into question how immigrants are moving around the health care system of France.

Filipino immigrants living in the South of France are the main respondents of this research. Focusing on how their native culture and language interplay with the health system of France, this study utilized Survey, Key Informant Interview and Direct Observation to gather data.

This research hypothesized that language is still a barrier for Filipino immigrants seeking medical care. In addition to this, the traditional health culture also plays a very important part in the Filipino immigrants' practice of health despite their long years of stay in France. Despite this however, they were able to adopt to the French health care system however, this adoption needs to be properly identified and described. Within the interplay of culture, language and the health system of the host country, immigrants –knowingly or unknowingly– create an emerging health culture that is distinct to their cultural origin, understanding of a good or bad state of health and manner of expression.

This study revealed that despite the fact that Filipino immigrants in the South of France have been living here for a considerable amount of time, traditional health beliefs are still part of their health practices. Health matters are still a family affair and there some of their medicines are imported from the Philippines. On the other hand, they have also adopted some ways to take advantage of the French health care system. They visit their doctors more often, they religiously take their medications and they enjoy more treatment options. They were able to enjoy all these because they are covered by the Universal Health Insurance System of France.

On the other hand, Filipino immigrants remain a passive patient. He maintains a come and go attitude with their medical providers because language remains a barrier. In addition, Filipinos are natural shy people and they always try not to have long conversations. This remains a challenge for health professionals for they themselves are not properly trained and prepared to handle patients speaking another language.

Key words: culture, health communication, immigrants, language

Acknowledgement

The road to getting a doctorate degree has been an amazing journey of academic findings and personal awakenings. It transported me –literally- to places I have never thought I could be and I was able to meet wonderful people and visit wonderful places along the way.

I would like to thank my mentors and sisters who never failed to remind me that I have what it takes to be what I want to be; Dr. Alelie Quirante and Dr. Paz Diaz. I will forever be grateful for your presence in my life both as academics and life guides.

My research Directors in France, Dr. Philippe Dumas who remained patient and very understanding of my work phase. I salute your patience and I am hoping I will have your academic wisdom. Dr. Henri Alexis for telling me not to sleep and work harder. Dr. Paul Rasse for showing interest in my work despite the language difference.

I acknowledge the help of my dearest best friend, sister, mother and everything else in between, Claudine Torres. You made my stay in France fun and really meaningful.

I am grateful to the opportunity given to me by the Erasmus Mundus Mobility with Asia (EMMA) program. On behalf of the many beneficiaries of this program, we thank the European Union for opening their doors for Asian scholars. I also acknowledge the generosity of Far Eastern University. For more than a decade, you honed me to be an academician- in every sense of the word.

Mr. Romain Soler for making me part of his family and more. My friends Ann, Raquel, Gene, Joeven, Mike. Thank you guys for listening with my whining and spending time with me so I can regain my sanity. To my extended family in New Jersey, Rommel and Paz Ruby. You are the closest thing for a family to me. Thank you for opening your home whenever I need to be around people who understands. To Pauline Robvieux who painstakingly translated this work to French and never complain about the difficulty of doing so. I will be eternally grateful for your help, sis. My English editor Romulo Villanueva, merci beaucoup Mars.

I share this accomplishment with my parents, especially my mother who passed away while I am far- doing this research. My father who is within and all around me. There was never a day that I don't feel your presence. My sisters, Julieta and Evelyn who are both watching me from above- beaming with pride.

I dedicate this work to my children, Patrick, Marie and Patricia. I know it is you who sacrificed a lot. You endured being motherless for a few years. I hope I set the example that if you really want it, its possible. Despite the distance and time difference, we were able to live with a semblance of a family, thanks to the internet.

To Rodel, I hope I have half of your skills and dedication on parenting. Our children are tremendously lucky to have you as their father.

TABLE OF CONTENTS

	PAGE
ABSTRACT	1
ACKNOWLEDGEMENT	2
ABBREVIATIONS	6
LIST OF FIGURES	8
LIST OF TABLES	9
LIST OF GRAPHS	11
Chapter 1 INTRODUCTION	12
Background of the study	13
Rationale	17
Definition of Concepts	23
a. Defining Health	24
b. Contextualizing Culture	25
c. Placing Migration and Immigration	28
c.1 Effects of migration on Health management	29
c.2 Filipinos and their migration history in a nutshell	35
c.3 Benefits of Migration	38
d. Combining Health and Culture	42
e. Connecting Migration and Health	44
f. Relationship of Health and Communication	49
g. Defining Health Communication	54
h. Tracing the Development of Health Communication Research	55
Description of the Area of Research	59
Hypotheses	64
Statement of the Problem	64
Objectives	67
Chapter Synthesis	69
Chapter II REVIEW OF RELATED LITERATURE	71
Part 1: Health Communication Researches	72
a. Immigrant Status in Europe	72
b. Immigrant Statistics In France	80
c. Health Status of Immigrants in France	85
d. The role of language in Health	89
e. Language experience of Asian immigrants	95
f. Immigration experience of countries worldwide	96
g. Researcher's migration experiences and observations	110

h.	Sample Health Communication collaterals found in the South of France	112
	Factors that contribute to longer and healthier life-all over the world	116
Part II:	Relationship of France and the Philippines	
a.	France and the Philippines: The First Contact	119
b.	France and the Philippines: The Difference	128
c.	Philippines: the country, the people and the way of life	137
d.	Contribution of this study in the Literature about France and the Philippines vis-a vis Health Communication	143
	Chapter Synthesis	147
Chapter III	THEORETICAL PREMISE	
	Theoretical Background	149
	Theoretical Framework	156
	Operational Framework	159
	Definition of Terms	164
	Chapter Synthesis	170
Chapter IV	METHODS AND PROCEDURES	
	Research Design	172
	Data Gathering Procedure	174
	Data Analysis Guide and Procedure	189
	Instrumentation	191
	Scope and Limitation	192
a.	Challenges from the population	193
b.	Academic and language barrier	195
	Significance of the Study	197
a.	Health Professionals	
b.	Health Campaign Designers	
c.	Policy Makers	
d.	Immigrant groups	
e.	Academe	
	Chapter Synthesis	200
Chapter V	UNDERSTANDING FRENCH HEALTHCARE ENVIRONMENT	
	Statutory Health Insurance System	206
	Challenges of the French healthcare system	214
	Chapter Synthesis	219

Chapter VI PHILIPPINE HEALTH LANDSCAPE	
Foundation of the Filipino health belief system	220
Overview of Philippine healthcare: Department of Health	227
Philippine health beliefs and practices	229
Traditional/Indigenous Health beliefs and Practices	230
Philippine Health Environment	232
Philippine health statistics	235
Recent developments	237
Chapter Synthesis	241
Chapter VII DATA PRESENTATION	
Survey result	242
Key informant Interview (KII)	269
French Healthcare system at work	284
Chapter Synthesis	288
Chapter VIII FINDINGS AND IMPLICATIONS	
PART 1: Specific Findings	
Hypotheses	290
Research Objectives	297
Operational platform for non-French speaking Health information seekers	301
Filipino immigrants experiences and perceptions Of the French Health Care System	
Part 2: General Findings	
Chapter Synthesis	322
Chapter IX RECOMMENDATIONS	326
Chapter Synthesis	332
Chapter X SUMMARY AND CONCLUSION	323
Chapter Synthesis	337
Bibliography	
Appendices	

ABBREVIATIONS

AFSSAPS	Agence Francaise de la Securite Sanitaire des Produits Alimentaires <i>{French Agency for the Medical Safety of Food Products}</i>
ALFEDIAM	Association de Langue Francaise pour l'Etude du Diabete et des Malades Matabolique <i>{Association of French Language Studies of Diabetes and Diabetes Metabolic}</i>
ANAES	Agence Nationale d'Acceditation et d'Evaluation en Sante <i>{National Agency for Accreditation and Evaluation of Health Care}</i>
CADAM	Caisse Nationale s'Assurance Maladie des Professions Independantes <i>{National Insurance Fund for Self Employed Workers}</i>
CDC	Center for Disease Control
CLAS	Culturally and Linguistically Appropriate Services
CMU	Couverture Maladie Universelle (Universal Health Coverage)
CNAMTS	Caisse Nationale d'Assurance Maladie des Travailleurs Salaries <i>{National Insurance fund for Employed Workers}</i>
CSG	Contribution Social Generalisee <i>{Supplementary Social Security Contribution}</i>
DOH	Department of Health
EHESP	Ecole des Hautes Etudes en Sante Publique
EMMA	Erasmus Mundus Mobility with Asia
HAS	Haute Authority en Santé <i>{Higher Health Authority}</i>
HALE	Health Adjusted Life Expectancy

HBM	Health Belief Model
HCSP	Haut Comite de Sante Publique <i>{High Level Committee on Public Health}</i>
HiT	Health Systems in Transition
HVI	Voluntary Health Insurance
INED	Institut National d'Estudes Demographiques <i>{National Institute for the Demographic Study}</i>
INPES	Institut National de Prevention et d'Education pour la Sante <i>{Institute for Health Promotion and Health Education}</i>
INSEE	Institut National de la Statistique et des Etudes Economiques <i>{National Institute for Statistics and Economic Study}</i>
InVs	Institute Veille de Sanitaire <i>{French Institute for Public Health Surveillance}</i>
LED	Limited Language Proficient
LGU	Local Government Unit
MPI	Migration Policy Institute
OFII	l'Office Francais de l'Immigration et de l'Integration
ONDAM	Objectif National de Depenses d'Assurance Maladie <i>{National Ceiling for Health Insurance Expenditure}</i>
PhilHealth	Philippine Health Insurance Corporation
PNNS	Programme National Nutrition-Sante <i>{National Nutritional Health Programs}</i>
SCT	Social Cognitive Theory
THCM	Transcultural Health Communication Mode

List of Figures

- Figure 1 Determinants of Health for Migrants
- Figure 2 Map of French Riviera
- Figure 3 Photos of the French Riviera
- Figure 4 Immigration Distribution all over France
- Figure 5 Number of Foreign Residents in France since 1945
- Figure 6 Immigrant Population in France
- Figure 7 Statistics of Immigrants in France
- Figure 8 Immigrants' self-perceived health status and access to care in France 2002-2003

- Figure 9 Health collaterals from l'Assurance Maladie
- Figure 10 Health Collaterals from Doctor's Clinic
- Figure 11 Population distribution of the Philippines by age and gender
- Figure 12 Population distribution of France by age and gender
- Figure 13 Population comparison of France and the Philippines
- Figure 14 Map of the Philippines
- Figure 15 Uncertainty Reduction Model
- Figure 16 Health Belief Model
- Figure 17 S.P.E.A.K.I.N.G. Model
- Figure 18 Social Cognitive Theory Model
- Figure 19 Conceptual framework of the proposed Transcultural Health Communication Model

- Figure 20 Operational Framework of the proposed Transcultural Health Communication Model

- Figure 21 Photos of churches where data were gathered
- Figure 22 Filipino events and gatherings
- Figure 23 Formal Gatherings
- Figure 24 Cultural and social events
- Figure 25 Religious events
- Figure 26 Level of Complementary VHI coverage in France

- Figure 27 Social Health Insurance Contribution in France
- Figure 28 Healthcare expenditure by type of service in France
- Figure 29 Healthcare personnel in France
- Figure 30 Screenshot of lasantepourtous

List of Tables

Table 1	Countries of Birth of Foreign born population in selected countries
Table 2	Elements of Index of Academic achievement by newcomers
Table 3	Elements of Social Conditions for Successful Incorporation
Table 4	Migration inflows by legal status in selected countries
Table 5	Country comparison: France and the Philippines
Table 6	Hot and Cold Perceived Source of Illness
Table 7	Philippine Health Budget Expenditure
Table 8	Morbidity: 10 leading causes, number and rate
Table 9	Findings and Implications

List of Graphs

Graph 1	Sex Distribution
Graph 2	Age Distribution
Graph 3	Location of respondents
Graph 4	Length of stay in France
Graph 5	Work distribution
Graph 6	Perceived source of Illness
Graph 7	Traditional way of dealing with illness
Graph 8	Traditional health beliefs and practices still performed and believed Today
Graph 9	Factors that triggered Doctors visit
Graph 10	Comparison of doctors visit then and now
Graph 11	Reasons for more frequent doctors visit in France
Graph 12	Reasons for lesser doctors Visit
Graph 13	Aids in better understanding health issues for doctors
Graph 14	Level of understanding doctors explanation
Graph 15	French language as a barrier
Graph 16	Clarifying health information/ Issues
Graph 17	Use of medications from the Philippines
Graph 18	Perceived better health management

CHAPTER I INTRODUCTION

“Communication in Health and Illness constitutes the most vital human experiences. No other human phenomenon is more elemental than health and illness. None connects us more viscerally with our aspirations or confronts us more palpably with our limitations. Moreover, given the dynamics of these elemental experiences and especially given that they are constituted in the communicative interweaving of body, mind and society, health communication represents among the most complex, challenging and potentially rewarding areas for scholarly inquiry.”¹

When one talks about health, the discussion revolves not only around what constitutes well being but also what challenges it. Health as a multi-faceted multi-layered concept does not only explore the sociological, cultural and political make-up of a society in a broader sense but it also discovers how people live their lives in a deeper more personal level. The macro perspective on health issues (e.g. state guidelines, institutional policies, stakeholder interventions) directly affects the micro components (e.g. lifestyle, religious beliefs, cultural influences) of health practices of people. These are the complexities that inspire this researcher to explore the role of communication in health.

¹ Brashers, D.E, & Babrow A, S., (1996). *Theorizing Health Communication: Communication Studies*. SAGE Publication

As a long time academician as a communication professor and a health communication specialist by practice, she dedicated her higher studies on the role of communication in health. She has handled- from conceptualization to execution- integrated marketing communication campaigns for pharmaceutical products and this made her more interested to further explore the dynamics involve in health care management especially in the area of sociology of health care delivery. She later turned her rich experience in the field of health marketing communication into an academic problematique. Having had the first hand experience on how health issues are communicated to the target audience to gain their interest hoping to encourage a healthier lifestyle, she decided to academically investigate the phenomenon of health interconnecting the vast field of health, communication and culture.

Background of the Study

“Health is about people. Beyond the glittering surface of modern technology, the core space of every health system is occupied by the unique encounter between one set of people who need services and another who have been entrusted to deliver them”².

This statement highlights the fact that despite the dazzling array of medical technologies that are used today to diagnose diseases, the very core of health communication and understanding is still human interaction. Talking about health management is a sensitive matter that can be better understood through actual conversation. It cannot be contested that laboratory tests conducted using high – tech medical equipment are more accurate today than ever before, and its findings helped in better understanding of diseases prevention, management and cure. However, the weight of comprehending the dynamics of factors affecting health still lies in human interaction. This is proven by the positive effect of simple

² Frenck, J. et. al (2010). *Health Professionals for a New Century: Transforming Education to Strengthen Health Systems in an Interdependent World*. <http://nrs.harvard.edu/urn-3:HUL.InstRepos:4626403> (Accessed March 1, 2013)

conversation. It is a common practice for people experiencing anxiety to talk to a person they trust to unburden. It is surprising how one can immediately experience the feeling of lightness after simply talking to someone who listens. In effect, conversation has a therapeutic effect. Whether it is just for simple whining about the challenges of everyday living to more complex issues like health, a good conversation has always been the first step in comprehending complex matters of everyday existence.

Understanding health issues boils down to communication interaction between healthcare professionals (e.g. general practitioners, nurses) and auxiliary health staff (e.g. workers in health offices, public clinics and hospitals whose main job is to assist medical professionals and provide information to state institutions related to health) and the patients. True that the state and related institutions have a huge part to play in the dissemination of health messages, but the frontline soldiers in the battlefield however, are the health providers (everyone involve in the delivery of health) and it is them who make all the difference in their patients lives.

The pursuit of this study is not only for academic purposes. The researcher has a deeper and more personal attachment to this area of research. She is genetically pre-disposed to diabetes. Her father and only sister died at a young age due to the complications of this disease. Since genetic predisposition is already a given, she began to analyze the lifestyle of her own family and found out that her family's food intake is composed of high- calorie, high – sugar diet and they have sedentary lifestyle, a living condition conducive in harboring diabetes. Since diabetes is not a popular disease – not popular roughly translates to “not much is known”, her family members do not know how to manage it. There are no materials to read, no clear source of reliable information and there was a misconception that diabetes is a rich man's disease (probably because as a chronic disease, it require life long management and intake of medicine) thereby poor people who have the disease do not believe they can

have it. In addition, diabetes is asymptomatic. Patients can go on living a normal life without them knowing that they have impaired glucose tolerance (IGT) and this will soon developed into diabetes should left undiagnosed and untreated. It is the very nature of this disease to be undetected for a long time and this is the main reason why the incidence of diabetes in the Philippines is very high. Without early detection and standardized screening procedures, diabetes is often diagnosed 5-10 years after it occur. This predisposes the patient to the risk of early onset of complications. Two years ago, this researcher was diagnosed with Type 2 (Diabetes Mellitus) diabetes. Being genetically predisposed, this is expected but it appears to her at a very young age. The good thing is that she was diagnosed early which will enabled her to manage the disease, delay the onset of complications or probably reverse her condition. She is privileged enough to have access to valuable information to make her aware of her genetic predisposition. Millions all over the world do not have the same access to health information more so health services.

Concerned organizations, both government and private, are doing their share in information dissemination about diseases to lessen the cases as well as promote early detection of pre-disposed population for better management. All over the world, diabetes campaigns are gaining momentum, if not already at its peak. In April of 2010, this researcher was invited to be one of the committee members for the First Diabetes Congress held in Dresden, Germany. In this event, efforts of countries all over the world were showcased so each country can learn from each other. They can also do collaboration activities to duplicate success stories and experiment on how to better address challenges of diabetes management. An international online community called “who are active in diabetes prevention” was also launched a few years ago by Dr. Peter Schwartz from Germany, with the aim of bringing together people afflicted with diabetes, their family and friends as well as concerned groups to exchange ideas wherever in the world they maybe.

The diabetes scenario is just an example of an ongoing work in progress which showcases things that can be accomplished through synergized effort. It also put into the spotlight the role of each player in any health communication campaigns. Looking closely at the role of the state, it has indeed the heaviest responsibility to legislate and provide resources from epidemiological studies to implementation and evaluation of health campaigns.

It has become this researchers personal mission, through her academic research, to provide baseline information regarding health management and maintenance. Knowing the key role of information in the area of health, it is her desire to aid policy makers and health providers by providing timely and relevant research results. In the end, she strongly believes that it is the right of a person to have access to reliable information so he can make informed health choices.

This researcher also hopes that this research will pave the way and academically prepare her in becoming a social epidemiologist. It is her intention to work in the area of social epidemiology analyzing social factors may affect health. It is the social epidemiologists' role to determine possible sources of ailments outside of the usual medical definition. There has been a loud claim that health and disease are being medicalized. Pharmaceutical companies seem to have all the medications needed to cure even the slightest pain with the most mundane symptom. It cannot be more clear however that a pill is a not panacea- it cannot cure everything. The interplay of factors that affects health is a very complex process paving the way for some health scholars to conclude that a holistic approach to healing provides better results.

Rationale

*What difference can the field of health communication do to the public?*³

This question has encouraged much scholarship and has been answered using different perspective. One obvious answer to this question is the fact that it is through effective and organized communication interaction can health care and delivery be improved, epidemiological research be reliable, health laws be proposed and promulgated, health programs be planned, implemented and evaluated, and personal experiences concerning health and diseases be legitimized. To extensively cover all these areas, which constitute the field of health communication, research is a necessary tool on which to base policy and management decisions and are expected to be carried out by medical professionals, government institutions, concern groups and the academe. Synchronizing the efforts of these groups will lead to better health understanding, maximization of resources and project collaboration that will benefit the general public in the end.

The pragmatic nature of communication highlights the centrality of the communication process in understanding concepts about health. Through effective communication strategies, people are provided with health information that better inform and educate pre-disposition to certain diseases, either by genetics or lifestyle; conse

quences of contracting the disease and behaviors that will lead to either prevention or cure. For those who are already afflicted with a disease, their attending healthcare professionals would better understand the psychological and physical impact of their suffering as well as their current state of mind if patients have the ability to properly articulate and have the confidence to share information that would aid diagnosis and prognosis. On the other hand, medical professionals must also be knowledgeable about the members of the population

³ Kreps, G. 1989 Health Communication p. 2

they are serving. This roughly translates to having enough knowledge about the racial and ethnic backgrounds of the people there are serving. Knowing this will give them an upper hand during the diagnosis procedure for they will be able to put into practice cultural sensitivity.

In the article released online by Reuters Healthcare (February 26, 2013), the result of a study by John Hopkins University School of Medicine in Baltimore USA revealed that missed or wrong diagnosis in primary care may put thousands of patients at risk of complications each year. It reported that patient safety efforts are concentrated on mistakes during surgery and in medication prescribing and less attention has been paid to missed diagnoses in the doctor's office and this diagnostic error translates to approximately 150,000 deaths or disabilities per year. Most of the missed diagnoses were traced back to the office visit and the doctor not getting an accurate patient history, doing a full exam or ordering the correct tests. The study concluded that building up of diagnosis should be performed both by the health care provider and the patient himself. Patients are encouraged to be more engaged in conversation with their health providers to assess behaviors, lifestyle or genetic predisposition and current symptoms, that may have lead to the disease ⁴.

The findings of this study were indeed alarming and it highlights, yet again, the role of the patient in the maintenance of his health as well as the burden of responsibility of the care providers. It is equally important that the patient be taught to document all the symptoms experienced before or after the initial diagnosis and make sure to communicate all of it to their health provider. The health professionals on the other hand are expected to consider the peculiarities of the population they are serving and utilize all their faculties to extract the right information. Under the right circumstances this is the ideal scenario. However, in the context of cultural and language differences, health conversation between

⁴ Nicholson, L. (2013) *Missed diagnosis common in the Doctors Office*. <http://www.reuters.com/article/2013/02/27/us-misdiagnoses-idUSBRE91Q02420130227> (accessed April 2013).

patient and health providers are more complex. Often patients get more anxious when they cannot find the right words to express what they are experiencing. Care providers also get frustrated when interview takes more time and did not turn out to be as expected-yet these are normal human nuances. Within the context of intercultural health communication, where medical providers and the entire health system are different or new to the patient, there will always be a communication gap and often it is the patient who is on the losing end.

Those who do not have concrete information about the health care system of a country are the immigrants. They move into a new country for several reasons. Some of them are familiar already with the language of the host country that makes integration more manageable. Take the example of Filipinos who migrated to the United States or to Canada or to any English speaking countries. They were able to maneuver their way around because they are understood and they understand. This is the same scenario for people from Africa, Morocco and Algeria when they transferred to France. They speak French which makes seeking information faster and easier leading to an easier and faster integration.

This is not the case however for Filipinos who went to France. Although French is part of the Latin languages, and Filipinos are exposed to Spanish (some Filipino words are Spanish with the same signification e.g. silya, mesa, kuwarto, tumar etc.), still French is a foreign language for the Filipinos. One cannot help but wonder how long did it take for Filipinos to be socially assimilated (assuming that those who has been in the area for a long time has already been). Similarly, how were they able to find where to get health assistance when needed? This same scenario can be foreseen for people from France going to an English speaking country. True that is it the responsibility of the immigrant to know and learn the history, culture and language of the receiving county. On the other hand, host country once it opens its doors for immigration is also expected to perform responsibilities that will assist immigrants in the integration process, especially during the early transition phase. Their presence should also be maintained because immigrants face far different problems compared to the

concerns of the general population of the host country and addressing these requires a different approach.

Within the health context, documenting the intricate interconnectedness of language, culture and health, has its promises as an interesting academic discourse. Academically investigating these concepts applying it to a particular minority group situated in an environment completely different from what and where they use to be in terms of language, geography and culture- is expected to yield rich data. The researcher being accepted in the program Erasmus Mundus Mobility with Asia (EMMA)⁵ was placed in one of the Universities in the South of France. As a newbie in the South of France, totally naïve about the French way of life, her coping mechanism was to know the Filipinos in the area and develop a bond with them. She was enthusiastically welcomed by her people which somehow makes adjusting to a new environment, tolerable but not at all easier. They have been her source of valuable information on how to survive the every day life in Nice. Since majority of the Filipinos she's been associated with belong to the higher age group and whose been living in the French Riviera for more than 5 years, discussions often goes beyond the usual survival tips. Stories of emotional pain being away from family, the challenge of language, the psychological distress brought by underemployment, their effort to fit in – always comes up and they these stories comes from legitimate experiences of people who moved out of their country. These are the challenges that they have to endure for the sake of the almighty euro and the promise of a better life for them and their families. The socio-psychological impact of these challenges contributes to an unhealthy being. Strictly referring to health as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity as defined by the World Health Organization- a large number of Filipino immigrants in France therefore, are ill.

⁵ Erasmus Mundus Mobility with Asia (EMMA) is a scholarship program offered by the European Union to Asian scholars. EMMA is for funding Asia to Europe individual mobility flows (IMF) of academics from Partner Countries, fully sponsored by the EACEA run programme Erasmus Mundus External Cooperation Window. <http://math.unice.fr/EMMA/IsThisForMe.html> (accessed January 2010).

Luckily for Filipinos, they are considered to be from a country which belongs to the top 10 happiest countries in the world –ranked number 8⁶, their ability to cope and manage stressful and difficult situation is part of their cultural heritage (if not genetic inheritance). These people do not take things too seriously and they have the ability to retreat into their comfort zones- in this case being in the company of other Filipinos- enjoy activities with them and share stories and exchange advises. The Filipino did not invent the karaoke for nothing. A microphone accompanied by musical score is a panacea for this people. A cure for everything.

The researcher is certain even before she arrived in Nice, that she will study health issues about Filipinos in the South of France. Hearing the grand narratives of immigration and the sacrifices associated with it, as well as the rewards, the researcher was deeply motivated to explore more about her population's stories but she remained vigilant and focus on health related stories. Her interest in health communication stems from having work with health organizations on professional level as well as teaching communication in several universities in the Philippines. Her professional and academic background leads her to pursue health communication as a field of research. Having given the opportunity to pursue graduate studies abroad, she now became interested in how culture affects the lives of the immigrants; health as the focus.

This researcher believed that Filipino immigrants in the French Riviera, especially those who have been here for a long time, were able to assimilate effectively into the French way of life. Although there are strong traces of a belief system originating from their racial origin, there are emerging behaviors that are worthy of academic investigation.

In the area of health, Filipinos have a unique health belief system that is

⁶ Happiest People in the World (2013) Japan Times made available January 6, 2013. Accessed [June 7, 2013](#)

highly based on culture, influenced by religion and addressed by western trained medical professional. These concoctions of belief system crystalized into words and expressions used to describe health and diseases. In western medicine, pain is a symptom. In the Philippine context the word “sakit” {pain} is used in many ways, aside from meaning illness (e.g. sakit ng ulo for headache, sakit ng tiyan for stomachache)⁷. Filipinos also use different words to describe different qualities of pain; *hapdi* for stinging type, *kirot* for sharp recurring type, *antak* for internal continuous stinging type⁸. The distinctness of the Philippines’ topography, economy, politics, culture- help create and shaped the ever-changing health systems and considering how different it is from France, it is interesting to extract what are the emerging health beliefs system of the Filipino immigrants in the South of France and Monaco who have already been acculturated.

Since this study is partly ethnographic for the researcher immerse herself in her population’s lives by living amongst them. She was welcomed in events from social to personal and is highly involved in their conversations. She was able to experience Filipino immigrants work by working part time as a housekeeper and a nanny and she also felt the pain of being away from family. Although this researcher’s predicament is different from the actual situations of Filipino immigrants, she was able to be involved in the narratives of being an immigrant. This researcher however remained focused on observing the health beliefs and practices and of her population.

Medical anthropologists in the Philippines found out that there is not much distinction between the terms beliefs and practices. In popular medical culture, the metaphor allows people to express their concerns about the human condition,

⁷ Tan, M.L., (2008). *Revisiting Usug, Pasma, Kulam*. Quezon City. University of the Philippines Press.

⁸ Jocano, F.L., (1973). *Folk Medicine in a Philippine Municipality*. An analysis of the system of folk healing in Bay, Laguna and its implications for the introduction of modern medicine. The National Museum. Manila. p 75

even as their symbolism is acted out⁹. As such, these terms were used together in this study.

It is a worthy academic pursuit for it will highlight not only the cultural uniqueness of the Filipinos, but it will also bring into discussion how health communication campaigns in the South of France and Monaco can be designed and implemented specifically targeting the Filipino minority group. The Filipino immigrant group is just one of the many minority groups located in the French Riviera and one of the aims of this research is to re-open the public discussion highlighting the importance of gathering immigrant health data. The researcher is hoping that the proposed communication model could be utilized to understand and explain health belief system of other minority groups and findings hopefully will guide policy makers in the promulgation of laws that would assist in the design of health campaigns and improvement of face to face communication skills between health care providers and immigrant patients.

Definition of Concepts

Readers may find a thorough discussion of concepts included in this study. Keeping in mind that the readers are primarily French and Filipinos, the researcher felt the need to do detailed discussion of concepts to aid the readers in understanding where this study is coming from and the strong connection between the concepts: health, culture and communication. To add, Filipino readers will surely be interested on how French health care system works at so are the French about the Philippines. The countries under study are also discussed in brief to introduce French readers to the Philippines and vice versa.

The defined concepts were used frequently throughout this research. The discussions in the later part of this research are highly specific and there is a

⁹ Tan, M.L., (2008). *Revisiting Usug, Pasma, Kulam*. Quezon City. University of the Philippines Press. p 135

need to understand the basic concepts from the beginning for better understanding.

A. Defining Health

Health as a socio-cultural construct is interpreted and understood in many ways. The World Health Organization (WHO) defines health as the “state of complete physical, mental and social well being and not merely the absence of disease or infirmity”¹⁰. The International Academy of Classical Homeopathy defines health as “Health is freedom from pain in the physical body, a state of well being; freedom from passion on the emotional plane, resulting in a dynamic state of serenity and calm; and freedom from selfishness in the mental sphere, having as a result total unification with Truth. A truly healthy individual should therefore combine both divine qualities of Love and Wisdom”¹¹. Tones and Green stated that health is a basic human right¹². Human rights are the basic rights and freedoms to which all humans are entitled; the right to life, freedom of thoughts and expression and equal treatment before the law. Such rights are ascribed “naturally” which means they are not earned and cannot be denied on the basis of race, creed, ethnicity and gender”¹³. If health is stated and viewed as a basic human right, people should have free access to health information and care services that will enable for them to make informed decisions about their personal health. As reiterated in the Jakarta Declaration in 1997, the WHO and its allies have asserted that health is a basic human right and essential for social and economic development. This declaration states that “pre-requisites for health are peace, shelter, education, social security, the empowerment of women, a

¹⁰ <http://who.int/about/definition/en/print.html> (accessed May 10, 2008)

¹¹ Definition and Measure of Health. International Academy of Classical Homeopathy. <http://www.vithoukas.com/en/contributions-of-gv/definition-of-health.html> (accessed April 2012).

¹² Tones K. & Green J., (2004). *Health Promotion, Planning and Strategy*. Sage London

¹³ Maiese, M. (2003). *Rights. Beyond Intractability*. <http://www.beyondintractability.org/essay/rights/> (accessed July 2012).

stable ecosystem, sustainable resource use, social justice, respect for human rights and equity”¹⁴.

Analyzing the definitions of health set by different organizations and social scholars, the concept of health crystallized into freedom from stress of the mind and bodily pain which was effectively conveyed by the WHO is a short statement. The Classical Homeopathy’s definition basically echoes what was declared by the WHO in a detailed and elaborated manner, but basically within the same line of thought. Tones and Green also added that a socio-political touch to the definition by stating that it is basic human right that is a naturally ascribed right to a person which he cannot be denied on whatever basis. This pronouncement that health is a basic human right was recognized by the WHO and its allies but the conditions that constitute the state of health is complicated and dependent on so many societal factors which create an impression that to reach an ideal healthy state boils down to making everything else surrounding the person, conducive for health. Putting these words together: peace, shelter, education, social security, the empowerment of women, a stable ecosystem, sustainable resource use, social justice, respect for human rights and equity- as a pre-requisite to health, further complicates the idea of what it means to be healthy. For simplicity and clarity, the definition provided by the WHO was the primary definition in which the concept of health operates within this research. However, health was studied using a cultural lens in this research to understand how a group of people defines health, address health issues and practice healthy lifestyle under a new health environment.

B. Contextualizing Culture

The earliest definition of culture is by E.B. Taylor in 1871; “Culture or civilization, taken in its wide ethnographic sense is that complex whole which

¹⁴ Elder J.P. (2001) *Behavior Change and Public Health in the Developing World*. Sage London p 11

includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society”¹⁵.

Merriam Webster (2010) defines culture as the customary beliefs, social forms, and material traits of a racial, religious, or social group; the characteristic features of everyday existence (as diversions or a way of life) shared by people in a place or time. The Roshan Cultural Heritage Institute elaborately defines culture by describing what constitute culture¹⁶. These are:

1. Language as a the oldest and most sophisticated medium of expression
2. Arts and Sciences as the most advanced and refined forms of human expression
3. Thought as the ways which people understand and interpret the world around them
4. Spirituality as the value system transmitted through generations for the inner well-being, expressed through language and actions
5. Social activities as the shared pursuits of a cultural community demonstrated in a variety of festivities and life-celebrating events.
6. Interaction which is the social aspects of human contact, including the give and take socialization, negotiation, protocols and conventions

This multifaceted nature of culture makes it present in every aspect of a person’s life. Like the very nature of communication studies for example, culture is transactional for one cannot talk about way of life without taking into consideration the different cultural experiences of the person. This cultural background manifests itself in the way the person communicates, acts, makes decisions and deals with the social world. When this personal culture is shared

¹⁵ Jocano, F. L., (2001). *Filipino Worldview: Ethnography of Local Knowledge*. Punlad Research House Inc. Manila. p 3

¹⁶ Definition of Culture. Roshan Cultural Heritage Institute. <http://roshan-institute.org/474552>. Accessed March 2012

with the outside world, it creates a community of people with the same belief system. Referring to this example, one can easily relate to the idea that the whole cultural milieu because of its complexity and grandeur is made up of sub-cultures. Tedious as it may seem, to be able to understand the whole, studying the small parts, which constitutes the big picture, is the most important first step in the process. Today, the term culture is applied in other context other than its original definition as the customary beliefs, social forms, and material traits of a racial, religious, or social group. Terms like organizational culture, cultural health, cultural communication etc. are common in everyday lingo. This reinforces the idea that cultures exist and can be interpreted in different forms.

Culture is reflected in a group's values, norms, practices, system of meaning (including language and communication) and way of life¹⁷. Health beliefs and practices is a way of life, paving the way for health to have its own unique culture that can be defined and explored as an academic research. Diseases as the antitheses of health have very interesting diverse cultural background which on the other side creates a culturally based treatment system as well. Needless to say, understanding health concepts, health care systems as well as illnesses and management of diseases can be studied from a cultural perspective.

This study adopted the definition of culture postulated by Corcoran; culture is a way of life shared by people and reflected in language and communication. Health knowledge is an abstract concept. These concepts however are transformed into objective reality once these are shared with other members of a group or members of the society and validated through actions. Albeit, health culture then emerges where it is lived and experienced within a particular environment and specific epoch.

¹⁷ Corcoran, . (2007). (Ed). *Communicating Health: Strategies for Health Promotion*. London. SAGE Publication. p 54

Within the framework of this research, this definition of culture crystalizes into how health culture is presented and manifested through language. Language is not only the bearer of culture but also the medium through which events and things cultural are made explicit, communicated and experienced¹⁸. People have ways to create knowledge out of their own experiences. They have the ability to make sense of and process information out of their daily life experiences, with new knowledge as the byproduct, consciously or unconsciously.

C. Placing Immigration and Migration

Migration has been a part of the human history since the earliest time. The reasons have not changed much since then. People move from one place go to another in search for food and a more habitable environment to ensure survival. Immigration is defined by the Websters dictionary (2010) as the movement of people to move in and settle in country where they are not a native for permanent residence. Migration on the other hand has almost the same signification as immigration. The difference is that these people do not stay for a long time. The United Nations Recommendations on Statistics of International Migration define a long-term migrant as a “person who moves to a country other than that of his or her usual residence for a period of at least one year”¹⁹. It is important to understand at this point that the term “migrant” is highly contestable because the definition of this word varies from country to country. For the purposes of this study, the terms “migrant “ and “immigrant” were used interchangeably. Within the dynamics of Filipino movements in the French Riviera and Monaco which is just in the frontier of Italy, and the easy travel between European countries makes the Cote d’Azur accessible Therefore, immigration and migration, under this circumstance do not have a very strong difference. During summer season

¹⁸ Jocano, F. L., (2001). *Filipino Worldview: Ethnography of Local Knowledge*. Punlad Research House Inc. Manila. p 5

¹⁹UN (1998) Department of Economic and Social Affairs <http://www.un.org/esa/earthsummit/pilip-cp.htm> (accessed May 17, 2013). P 18

for example, when work abounds in the coast of the French Mediterranean, Filipino workers who are working originally in Italy and in the neighboring areas of the French Riviera, flock to the area because of there are more jobs available, there are longer hours of work which means higher pay. There were also some instances where the researcher met some Filipinos coming from as far as Spain, to work in the French Riviera during the bust summer season. As such, Filipino workers in the Riviera doubled during this period and these people are considered migrants for they stayed in the area for just a few months. For these reasons, the researcher contextualized migrants and immigrants within the dynamics of Filipinos moving in and out of the French Riviera. It might be problematic to inter-change these labels in other context, however within the framework of this study, it is was done for easy comprehension.

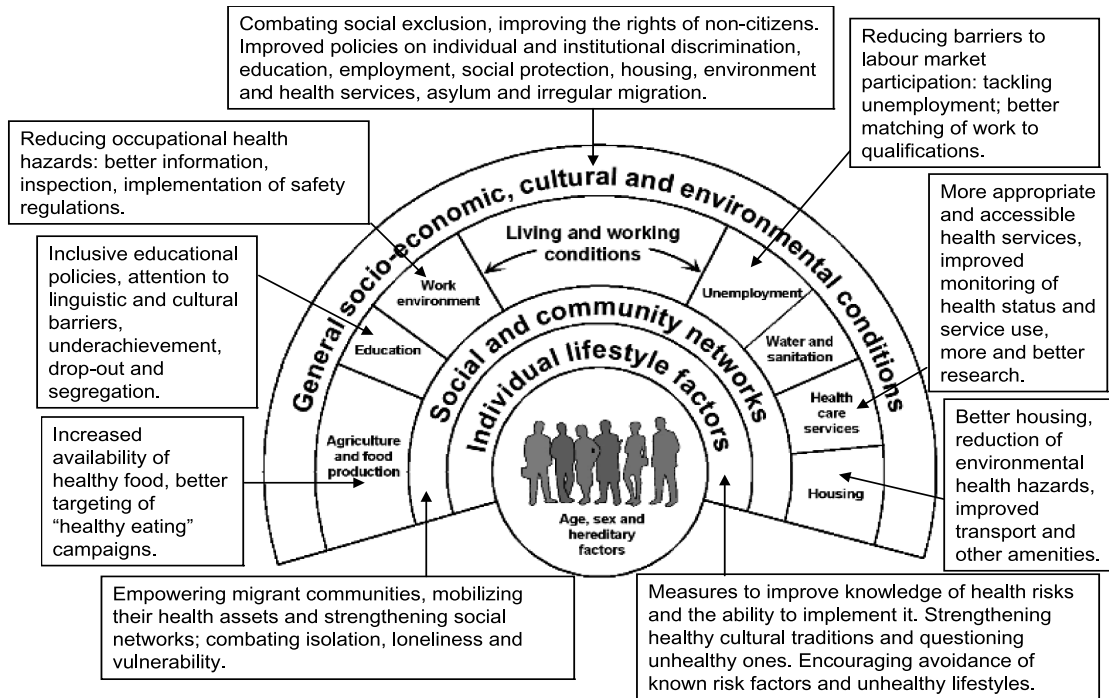
c.1 Effects of immigration on health management

The European Union is a region with continuously increasing cultural diversity²⁰. Within the bounds of European politics, culture and economics, it is recognized that specific health needs of migrants are poorly understood, communication between clients and providers remains poor and the entire health systems are not adequately equipped to properly respond²¹.

²⁰ Rechel, B. et al. (2011).(Eds). *Migration and Health in the European Union*. European Observatory on Health systems and Policy Series. Open University Press. McGraw Hill. Meer, N. & Modood T (2012). *Interculturalism, Multiculturalism or Both?* Political Insight April 2012.

²¹ Rechel, B. et al. (Eds). (2011). *Migration and Health in the European Union*. European Observatory on Health systems and Policy Series. Open University Press. McGraw Hill. p 2

Figure 1: Determinants of Health for migrants



Taken from: Migration and Health in the European Union. Originally adapted from WHO Regional Office for Europe 2010.

Figure 1 specifically identified factors that affect migrants' health within the framework (socio- economic, cultural, environment and social) of the European Union. Specifically identified factors that impede or improve migrant health constitute individual lifestyle factors, social and community networks as well as the general socio-economic, cultural and environmental conditions. Within these categorizations are more specific agendas that can serve as a jumping board for government programs to promote health. As migrants arrived in France, health concepts and practices must be identified to be able to determine how to address future health issues. It is also a good foundation to base design programs to further encourage healthy behaviors and correct unhealthy ones. Data from this enquiry will be the benchmark for the implementation of programs that discourage unhealthy behaviors and culturally practiced activities that are part of risk factors.

On the social level, Filipino immigrants must be encouraged to be part of a social network, aside from their regular social membership to other Filipino groups. They should be exposed to social activities to help combat loneliness, depression, isolation and vulnerability, which are inherent to an immigrants' life. Based on direct observation of this researcher, the local government of the Riviera does not have a strong program that promotes integration of Filipino immigrants to the larger French community. French has the tendency to be territorial and this contributes to the slower integration of foreigners to French social groups. On the other hand, Filipino immigrants seemed inclusive which makes it difficult for the state to penetrate. Either way, each group should devise a way to reach out to one another and the state has a big role in this process.

Promotion of activities that lessens the gap between the host country and its immigrants is one platform for encouraging these people to have a healthy lifestyle. Recognizing that social involvement is necessary for maintaining a healthy well being, providing programs that would better educate them about the country they move into, open windows of opportunity for each one to know more about each other.

In the area of language learning in community schools, this researcher has observed that teaching methodologies are not very encouraging to the students. All of the students in this informal school are foreigners in the South of France who want to learn how to speak the language, know the basics of everyday living and meet other people who are in the same predicament like them. Majority of the students are late-20's and above. Some are professionals in their own country but migrated to France for different reasons. As an academician for a very long time, this researcher observed that the teachers do not have a specific learning goal for the students. They read from books, administer activities and pay very little attention to student inquiries during classes. There were no activities that could have encouraged students to know one other and there are no clear ways on how student's progress is evaluated.

Going to other state and community institutions in the South of France for information, a foreigner can easily notice the dedication of the French people to their language. Despite the fact that the French Riviera is one of the most popular tourist destinations in the world and derives a significant portion of its economy from the tourism industry, the French language appears to be oblivious to the dynamics brought by the tourism industry. In terms of migration, majority of immigrants in France came from former colonies and these people speak French which adds to the preservation of the language. Compared to other European touristic cities like Venice and Barcelona, which speaks English good enough to give directions to tourists added to the genuine desire to help people, the French are not very enthusiastic and welcoming to foreigners. In the beginning, this researcher had the impression that she is experiencing this racial slur because she is Asian. After talking to expats living in the Riviera, it was made clear that it is indeed it is the very nature of French to be visibly distant to people who do not speak their language. French also, especially those belonging to the older generation, had cultural indifference to the English language because of the mere fact that the language originated from England, a country they has waged war with in the olden days. This mentality and behavior were carried on until today. Although the younger generation is more open to new ideas and thinking, a large number of residents in the French Riviera belong to the older age group because the Riviera is a retirement region. As such, distance between foreigners and French are probably more pronounced in this area compared to other cities in France, Paris for instance.

These dynamics set the stage for what kind of life awaits immigrants in the South of France. For the Filipino immigrants, the burden of adjustment lies primarily on their shoulder. They have to confront the reality that they are going to face social exclusion as well as cultural and language barrier. For immigrants coming from other parts of the world who are non-French speakers the challenges might be the same. The sad reality is that every aspect of successful

integration of immigrants relies heavily on language. In the case of French Riviera, immigrants face a more daunting task of going through the process of integration on their own slower phase.

Despite the challenges of integration for immigrants, one might wonder what makes it still a favorable destination for immigrants? As the playground of the rich and famous, the Riviera promises greater opportunities for people from countries with limited choices.

Healthwise, immigrants in France enjoy good health coverage once they register to the French health insurance system. They are secured to receive care from public hospitals when needed, have access to medical professionals and assistance for their medicines. Under certain conditions, they can even have 100% coverage which means medical services and medications are free. This is one of the reasons why some immigrants chose to stay in France despite the challenges of fitting in.

The United States of American is also a good reference point in terms of migration. It is a country with rich and long history of migrants. Majority of first immigrants in the United States were Irish Catholics. New York Times in the 1880's wrote a warning to the public of a class "who care nothing for our liberty or civilization, . . . who burrow at the roots of society, and only come forth in the darkness and in times of disturbance, to plunder and prey on the good things which surround them, but which they never reach"²². Time magazine described this group as the poorest and lowest laboring class, [who] drudge year after year in fruitless labor [but] never rise above their position. They hate the rich. They are densely ignorant, and easily aroused by prejudice or passion"²³. And since most of the immigrants are Irish, it is safe to say that this article is describing this race.

²² Hochschild, J. 2005. *Looking ahead: Racial trends in the United States*. Daedalus 134, no. 1: 70-81.<http://dash.harvard.edu/handle/1/3200608> (accessed March 22, 2013) p 73

²³ Ibid 22.

Comparing the scenario in the US then and some findings regarding immigrant studies today in Europe, nothing changes much. The First Annual Report on Migration and Integration reported that France admitted primarily immigrants with low level of education and qualifications only as low wage laborers²⁴. These temporary workers were then encouraged to go back home after they had completed their ill-paid work. In the health field, European countries -aside from the United Kingdom, Netherlands and Sweden- have no systematic way of collecting health data by migrant status or ethnic group. This literally transforms into a blind spot in any epidemiological studies. It is a wonder however how a country like France which is often regarded as having one of the best health care systems in the world managed to be highly regarded and highly satisfactory despite the fact that it lacks standardized health studies on immigrants. This researcher is under the impression that everyone is contented with the health care service simply because the benefits of the French Universal health care system is accessible to all.

In the changing volatile economy all over the world, governments are adopting measures to save resources. Having a health care system where the state is burdened with shouldering a large amount of its populations' healthcare cost is dangerous activity that will have inevitable fatal consequences.

In Europe, there are approximately 35-40 million foreign-born and these immigrants are among those who are particularly at risk of poverty and social exclusion. Several studies have concluded that health is highly related to social class²⁵. And because migrants are part of the marginalized group, their inclusion in social life is limited and their access to basic services are also different from the mainstream population in so many ways. This correlation vividly paints the

²⁴ Eurohealth (2009) *Measuring and Tackling Health Inequalities in Europe*. Volume 15. European Observatory of Health System and Policies. Belgium

²⁵ Barnes, L., Hall, P. & Taylor, R. (2009). *Why is wealthier healthier? Perspectives on Europe* 39(2): 4-8. <http://dash.harvard.edu/handle/1/4322128>. (accessed March 1, 2013). Mathews, Colin D. et. al. (2004). *Global patterns of healthy life expectancy in the year 2002*. BMC Public Health 4:66. <http://dash.harvard.edu/handle/1/4592100> (downloaded March 2, 2013)

health disparities in some countries in Europe that includes France. Given the fact that “wealthier is healthier”²⁶, immigrants in France may have challenges accessing health care because of the glaring reality that most of these immigrants are not part of the “wealthier”. Most of these immigrants belong to the working class.

c.2 Filipinos and their Migration story in a nutshell

Throughout history, immigration has been the most common response of Filipinos to several problems, but generally economics. Unemployment is a perennial problem in the Philippines and as such a stable source of income cannot be guaranteed. Government efforts fall short in providing a decent source of income for the Filipinos, more so consistent ones. As such and as history has revealed, Filipinos seek employment abroad in search for a “greener pasture”. This movement became a social norm reaching a point where the move is highly revered. One family will gain a higher status in the community if one member of their clan is working abroad. No matter what the job is, as long as he is working abroad, it was interpreted as a “blessing” because it directly translates to having enough resources to have a decent living. The United States has been the most popular destination of Filipino migrants and this can be attributed to the former ties with this country and the fact that Filipinos can speak the English language. There has also been a Filipino –American population in the US in the early start of the century which paved the way for more Filipinos to come to the US. Eventually Filipino will petition their family members to join them wherever they maybe. This is how Filipinos (and other immigrant groups maybe) developed a small community of their own in the host country. The Philippines up to now has continuing problems regarding unemployment, rapid population growth and disparity in resources allocation topped with never ending allegations of corruption and under the table transactions, and these are the reasons why Filipinos were driven out of the country to seek better job opportunities abroad.

²⁶ Ibid 25

Having experienced the working conditions in the country, the length of working hours, salary rate, raising taxes without legitimate service to the people and the declining purchasing power of the peso, most Filipinos would rather endure being away from their family, accept menial jobs and be underemployed if on the other side of the bargain is better pay. In one of this researchers' trips from France to Manila, she met Mr. Y. He is working as waiter in Dubai, the same job he had while still in the Philippines. He revealed that he used to get 7,000 pesos (around 140 euros) a month working as a waiter in one of the bars in Manila. He spends a large percentage of this salary on apartment rental and transportation. In Dubai, he gets 11,000 pesos (around 200 euros) monthly salary but he is housed in an apartment together with the other employees of the bars so he does not need to pay for the apartment. He does not pay for transportation also because his apartment is near his work. This, he said, makes his life less stressful. He also shared his excitement that every time he went to his province in the Philippines for vacation, he enjoys the attention given to him by his family and the community. He is treated as a very important person just because he works abroad. These are the economics and social benefits of working abroad for the Filipinos. The only sad part of Mr. Y's condition is that his contract expires every six months and even if he knows he can renew and work in the same bar again, he needs to go through the process of applying for the job as what he did in the first time. He spends money paying for the agency who will prepares his work papers. Despite these hassles, he chose to do it over and over again instead of working in the Philippines.

Philippine migration inflow is feminized. Surprisingly, in the Philippine setting meanings attached to gender in migration are different. Filipino men who work abroad carry the image of responsible breadwinner while women are contradictory portrayed as heroines and bad mothers ²⁷. Men were never

²⁷ Cruz, R. (2012). *Figures of Migration, gender, Kinship and the politics of representation*. Ateneo de Manila University Press . pp 513-514

interpreted as bad fathers when they decided to work far from home and leave everything to his wife. This double standard is present in several aspects of Filipino life but more pronounced in migration.

The current government (Aquino administration) has its own share of success in addressing some structural problems but it is not enough to keep its citizens from moving out of the country. The country benefits much from this migration because its economy has been kept afloat by the remittances of its citizens working abroad. As reported by the Banko Sentral ng Pilipinas {Central Bank of the Philippines}, the total remittance for 2011 reached 20 billion dollars, 7.2% higher than of 2010 and is the all time high. The growth was attributed to the high demand of Filipino skilled workers all over the world as well as government efforts to seal employment deals with other countries. The Philippine National Statistics Office reported that in 2011, there are approximately 2.2 million Overseas Filipino Workers (OFW's) and 95.3% are the so-called Overseas Contract Workers (OCW's) or those working with contract. The remaining 4.7%, roughly 103,400 are documented migrants but without work contract. It expected that the number is bigger because this does not include the number of undocumented Filipino migrants all over the world.

In the context of Filipino migration in the Riviera, this research analyzed the coping systems and adaptability of Filipino migrants in the area of health. It has been recognized that quite a number of immigrants were not able to adapt to the psycho-social stress brought about by moving in into a new country. This psycho-social stress manifests in terms of depression (persistent sadness, anxiousness, feeling of hopelessness, etc.) and mania (irritability, insomnia, poor judgment, inappropriate social behavior etc.). It can also be exhibited not only in behavioral terms but in physical terms as well. Some may experience headache, diarrhea, weakness, and other physical manifestations. The best way to diagnose and treat these types of psychological and physical challenges is to seek medical advice in addition to being a part of a social group to balance adaption options. The problem is what if the mere idea of seeking medical advice adds more

stress? Are there platforms that migrants can access without fearing discrimination? Are there institutions and programs that are at place to assist migrants while they are in the process trying of fitting in?

Anxiety and depression will manifest if the person seeking medical help is not knowledgeable enough, in terms of language usage, to express his feeling and describe the discomfort he is experiencing. The patient may also feel alienated within the bounds of the new healthcare system he finds himself into. On the other end of the spectrum, medical providers will not have complete understanding of the medical case presented before them that will make diagnosis and prognosis more difficult, moreso, dangerous. This dynamics has been part of complex relationship between migrants and medical professionals. It is within this premise that this researcher made this issue an academic discourse. Not much, if not none at all, has been done in the area of improving health communication interaction between Filipino migrants and health providers in French Riviera.

c. 3 Benefits of Migration

Migration brings with it diversity. Terms like multiculturalism, interculturalism, racial diversity, cultural diversity and the likes were used to label migration and interaction of immigrants with the local citizens of the host country. The Prime Minister of the United Kingdom, James Cameron admitted in the Munich Security Conference (February 2013) that multiculturalism did not work in the UK. Looking at the British multiculturalism history, racial equality law was enacted in the 1960's, which secured equal opportunity accompanied by cultural diversity in an atmosphere of mutual tolerance. In the 1988-89, the Salman Rushdie affair challenge the minority-majority relations stating that aside from race, ethno-religious factors must also be given importance. In 2000, the report of the Multi Ethnic Britain called for a re-think of the national story so that the UK can genuinely become an inclusive community of communities and individuals; to which all ethno-religious minorities had a sense of belonging. The riots in 2001,

9/11 and 7/7 were interpreted by some as the end of multiculturalism. Others preferred alternative rhetoric of “community cohesion’ and “intercultural”²⁸.

The debate about the rhetoric of embracing diversity is a never-ending process. It is because nations and groups have attached multi – layered meanings to the concepts that constitute diversity. From the initial recognition that race as a primary consideration in immigrant assimilation, recent discussions include the issue of religion which is a more sensitive issue to tackle. In this scenario, communication plays’ a vital role to enable and empower members to engage in constant dialogue and constantly re-shape values and beliefs and be more accommodating to the oddities and peculiarities of different cultures. Peaceful co-existence is the new order of the day- maintaining inherent values but taking the higher moral ground of respecting the uniqueness of others.

Even the other old immigration countries in Europe especially France and the Netherlands, share the same sentiment that multiculturalism has failed. Germany, as conveyed by German Chancellor Angela Merkel, stated that multiculturalism failed in her country too despite the fact that Germany has not really adopted a multiculturalist policy agenda. The rhetoric embedded in this so - called failure states that “multiculturalism facilitated social fragmentation and entrenched divisions; it has displaced attention to economic disparity, encouraged a moral hesitancy amongst native population and some even blame it for international terrorism”²⁹.

Making cultural and religious diversity work is not at all an exercise in futility. There are challenges indeed as experienced by England in 2001 (Bradford riot), France in 2005 when migrants rioted demanding for better inclusion in state

²⁸ Meer, N. & Modood T. (2012) *Interculturalism: Multiculturalism or Both?* Political Insight. April 2012. p 31

²⁹ Meer, N. & Modood T. (2012) *Interculturalism: Multiculturalism or Both?* Political Insight. April 2012. p 30

rights. The challenges were also experienced by immigrants themselves in the workplace and in the performance of their everyday life. However, the past cannot be reversed, people and government can only learn from it. It is important to remind groups and institutions involved in the promotion of multiculturalism that this concept must operate within the bounds of mutual integration. The majority should not be burdened to bear the cost of providing platforms and resources to accommodate migrants, nor the immigrants' be the unwitting victims for the simple reason that they move in a different country. Mutual integration can be exercised by educating the local citizens about the existence of immigrants within their midst. They maybe different but let this difference allow them to learn more about this race. Part of immigrant integration orientation is to teach them how to respect the way of life of the local citizen of the country they move into.

Finding a good example in understanding the dynamics of racial diversity, the United States is a fine example. In the most recent report of Migration News; a scholarly publication that "summarizes the most important immigration and integration developments" in the US, provided data on race and ethnicity from the U.S. Census Bureau³⁰. As of 2000, US residents are composed of 69% white, 13% Hispanics, 13% black and 6% Asians and others. By 2050, the percentage would be 50% white, 24% Hispanic, 15% Black and 15 % Asian and others. What is new in this report is the idea that by 2050, there is a possibility that racial and ethnic categorizations will no longer be in use. Definition and usage of race and ethnicity are needed to understand peoples' interactions and everyday life. As pointed out by Hochschild:

³⁰ Hochschild, J. 2005. *Looking ahead: Racial trends in the United States*. Daedalus 134, no. 1: 70-81.<http://dash.harvard.edu/handle/1/3200608> (accessed March 22, 2013) p 2

“if immigrants are regarded as a race apart, biologically distinct from the rest of us, they will be treated very differently than if they are regarded as belonging to another ethnicity, similar in crucial ways to all the others”³¹.

In terms of health assessment and delivery, immigrants indeed should be treated differently to ensure they remain in a good state of health. Their genetic pre-disposition to certain diseases is totally different from the mainstream population of the receiving country. Immigrants from India for instance should be monitored for the onset of high blood glucose because Asians in general are genetically pre-disposed to diabetes – Indians having the most number- and their eating habits and lifestyle aggravate the situation. As reported by the British Broadcasting Corporation (BBC) in one of its documentaries, India’s diabetes problem is rooted in genetic predisposition as well as the phenomenon of deprivation of food during childhood while having it in excess in their adult life.

In a conference entitled Cultural Diversity: advantage or liability sponsored by the European University Institute in Florence, Italy and which this researcher had the privilege of being a participant, discussions revolved around how immigrant population change the dynamics – political, economic and cultural- of the host country. Although the conference did not categorically answer the question it posted, there was a general sentiment that despite the challenges brought about by cultural diversity, the benefit it brings to the receiving country as well as the sending country is undeniable. The host country benefits from the work contribution of immigrants as well as their taxes. The host country benefits from the immigrants’ earnings sent to their family. The presence of immigrants also changes the culture of the host country because of their exposure to a different way of life of the immigrants. This does not necessarily mean adopting how they do things but the wealth of knowledge gained merely from their presence is a benefit, if the locals are open minded enough to look at it this way. Immigrants also learned from the environment and ways of life of the host

³¹ Ibid 30 p 73

country that they can adopt to improve their lives. There are many ways in which local citizens of the host country and the immigrants' can learn from one another.

D. Combining Health and Culture

As already established, health is a reflection of culture and it cannot be taken out of its cultural context. As such, health scholarship must look into the cultural context of health and diseases. With the interconnectedness of these two concepts, discussion about health issues carries with it the need to study its cultural background. Realizing the complexities of the very nature of culture, this study limits the discussion of culture to the four walls of the definition of health according to the WHO. Health is a state of complete physical, mental and social well-being and culture is a significant contributor in achieving a sound state of well-being.

There are many cultural practices around the world that are directly connected to health. In Bangladesh for example, during the feast of Id-al-Adha, ritual slaughters of animals with flowing blood is repeated for countless times across the country's capital, Dhaka. In this celebration, the Muslim faithful share meat with the poor, but this tradition carries risk. The country imports more cows for this feast, which makes monitoring for bovine, TB and other diseases difficult. In the Democratic Republic of Congo, a butchered half-cook monkey is a usual sight in the market. This bush meat is the only source of animal protein in impoverished part of sub-Saharan Africa³². In Thailand, even with the threat of catching bird flu, owners of fighting cocks still suck blood from their animal after a match to revive it³³. These cultural practices show a strong connection between culture and health, exposure to diseases and cure practices. On the other end of the spectrum, certain cultural practices are altered through a mixture of

³² Quammen, D. (2007). *Deadly Contact: How Animals and Humans Exchange Disease*. National Geographic October 2007. pp 91-102

³³ Appenzeller, T. (2005). *Tracking the next Killer Flu*. National Geographic Magazine October 2005 p 18

interventions to better safeguard the population against the threat of diseases. In Nigeria for example, although a family might have very little possession, they own a mosquito net to protect them from being bitten by mosquitoes thereby preventing the spread of malaria. In Serbian prison, masked health workers closely monitor inmates taking TB drugs to prevent it from spreading to other prisoners. In such a place where people are close to one another, the spread of this disease might happen in an instant that is why strict monitoring of those who are already inflicted with the disease is needed³⁴. In 2003, there were rumors of a respiratory disease in the mainland China and around its borders and as a response, people boil vinegar to ward off the illness³⁵. This disease however was later identified as Severe Acute Respiratory Syndrome (SARS) and that vinegar cannot kill the virus.³⁶

To lessen or avoid contracting diseases, even the Catholic church has change the way they distribute bread during communion. Traditionally, the holy host is put directly into the person's tongue. This process allows the transfer of saliva from one person to the other, which is a way for the transmission of disease. To remedy the situation, the church devised a way to lessen the spread of disease by allowing people to receive the host on their palm and they are the ones who put the host in their own mouth.

These examples show that indeed certain cultural practices were proven to be agents in spreading diseases. Yet, for cultural reasons, these practices still thrive because of lack of proper information regarding their health risks and limited options for source of food. There are cases however when certain cultural

³⁴ Weiss, R., (2002). *War on Disease. Challenges for Humanity*. National Geographic October 2002 pp 5-17

³⁵ Walsh in Time Magazine. *It's Gone Viral*. February 2013, p 50

³⁶ Karan, K., Aileen, L., & Elaine, P., (2007). *Emerging Victorious Against as Outbreak: Integrated Communication Management of SARS in Singapore Media Coverage and Impact of the SARS Campaign in Moving a Nation to be Socially Responsible*. SAGE Publication. pp 383-403.

practices were changed for the better because interventions were introduced and people could have understood the need to alter the way they used to do things. With the new acquired knowledge, certain cultural practices were altered to accommodate disease prevention and because of this, the culture of health within the community changes.

E. Connecting Migration and Health

In the area of migration history, it is served well if we refer to the United States of America's migration experience. The immigrant population in this country continues to grow always surpassing previous records. As of 2004, estimated number of immigrants reached 34.2 million 12% of its total population and 62% of this number are not citizens. Connecting immigrants to the wealth distribution, immigrants have a higher rate of poverty, (16.8%) compared to the US native population (11.8%), and comprise 22% of the nations uninsured population. Authors Eamranond and Hu stated that:

“immigrants comprise an underprivileged population that continues to be neglected from various standpoints, including environmental and occupational health exposures. Disparities in immigrant health are exacerbated by lack of adequate health care access and culturally –inappropriate health care. Observers in some States have asserted that immigrants place an extra burden on health care systems, which may explain the low priority given to immigrant health care. However, immigrants contribute as much as \$10 billion per year to the US economy and pay taxes in excess of \$80,000 per capita more than the value of government services received over their lifetime. Overestimates of utilization of resources and underestimates of immigrant contribution to the US economy may give rise to the general reluctance to provide health services to the immigrant populations.”³⁷

The last two sentences summarized the probable root cause of under prioritizing health services for the immigrants in the US. It is very easy to determine the numbers of immigrants coming into the US soil but their economic

³⁷ Eamranond, P & Hu, H (2008). *Environment and Occupational Exposures in Immigrant Health*. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3091353/> (accessed September 2013)

and social contribution can easily be dismissed partly because of prejudice. The “otherness” of immigrants has its consequences. Immigrant stories are also jaded with reports about unauthorized migration and more seriously the attachment of the concept of spreading fear to a particular group of immigrants. This overwhelming perception is not only happening in the US. Indifference to immigrants has been going since time immemorial and is still going on in the present time, only in different form.

Looking back further down into history and connecting people’s movement and diseases, colonizers from Europe brought with them 14 new diseases to the New World, including influenza, measles, smallpox, scarlet fever, cholera and typhoid – diseases for which the native Americans have no natural immunities. These diseases were presumed to have played greater role than European’s war technology in conquering the native tribes. This scenario makes the native tribes weaker, less able to support themselves and more vulnerable to diseases. On the other hand, the colonizers, after being able to adjust to the new environment, live longer compared to those who stayed in Europe. They were able to take advantage of the agricultural resources of the new land they have conquered to protect them from malnutrition as well as avoiding overcrowding which is very common in Europe during this epoch³⁸.

This is a concrete example that migration contributes to the unintended dissemination of diseases. Viruses travel with the people on the move and passing them on to the unsuspecting population- as history had shown- is lethal. Learning from the lessons taught by historical experience, Europeans who travel to Africa for example, are required to have shots for yellow fever and hepatitis 2 injections before and one injection a month after return. This is to make sure that contracting these diseases as well as the possibility of spreading it upon arrival to the home country is prevented. Other countries also require that people visiting

³⁸ Weitz, R. (1996). *The sociology of Health, Illness and Healthcare: A critical Approach*. Wadsworth Publishing Company. U.S.A. pp 20-21

show health certificate stating that they have not been exposed to certain type of viruses or are not carrying any type of virus that would endanger those who will be travelling with them on the plane or the people they will interact with in the receiving country.

In Europe, there has also been a rich discussion regarding effects of migration. In a conference in Florence, Italy (May 6-8, 2013) sponsored by the European University Institute, and which this researcher had the privilege of being invited, the question was: “Cultural Diversity: Advantage or Liability?”. Although arriving at a concrete answer requires complex and detailed discussion, there was a general sentiment among the participants that diversity carries with it benefits both by the sending and receiving countries. One of the speakers Tariq Modood pointed out that;

“a high degree of racial, ethnic and religious mix in its principal cities will be the norm in the 21st century Europe and will characterize its national economic, cultural and political life, as it has done in the 20th century USA. Even as if members of ethnic minorities are fully integrated in in terms of legal rights, access to employment or education does not mean they have achieved full social integration. This also requires certain degree of subjective identification with the society or the country as a whole- what the commission on Multi-Ethnic Commission called “ a sense of belonging” – and acceptance from the majority population that the minority persons are full members of society and have the right to feel that they belong”.³⁹

This researcher happens to meet the author in person in a cultural diversity conference in Italy. Mr. Modood’s work zeroes in mainly on cultural diversity debates in Europe. He pointed out that most of the largest, mostly capital cities in north-west Europe are 25-40% non – white and unlike the US, most of the non-whites in Europe are Muslims. As such, the political dynamics concerning immigrant integration in Europe rotates around equality, racism and Islam. He also stressed out in his article “Citizenship in a Diverse Cultural Society” that in general European countries have limited realization how ethnic mix is changing European

³⁹ Modood, T. (2007). *Multiculturalism: A Civic Idea*. Cambridge. Polity Press

societies. Policy makers and social scientists never predicted that discussions about race, ethnicity and multiculturalism would be dominated by the aspects of religion.

This limited understanding of immigrants has implications on how they live in the new country and how local citizens deal with immigrants based on their perceptions or stock knowledge. It is indeed in the hands of the social scientists, media and government to set up integration platforms to ensure immigrants were given the necessary education and training to peacefully co-exist and competitively compete for job opportunities. These rights must be protected by policy initiatives. When immigrants realize that they are not treated equally, problems arise. Immigrants in France rioted for 22 days in more than 250 localities in the autumn of 2005 leading then President Chirac to speak about “crisis of identity”⁴⁰. These uprisings highlight the desire of immigrants to be properly integrated and lessen the cultural divide which makes them feel “different”. This desire to “belong” is a basic social need that needs to be fulfilled. Although in some aspects, immigrants might be integrated, the society should make them feel that they are full members of the society. By arriving at this state, the anxiety brought about by being an alien in a new environment is minimized thereby lessening the psychological stressors which sometimes are the cause of discomfort.

Movement of people around the world brings carries health risks. Sixteen percent of world’s population moved every year; 52% for tourism, 23% for family/religion and health, 16% for business, 3% immigration and the remaining 6% are unidentified⁴¹. This translates to the idea that when there is an outbreak

⁴⁰ Simon, P. and Sala Pala, V. (2010). “*We are not all Multiculturalists Yet: France Swings between Hard Integration and soft anti-discrimination*” in S. Vertovec and S. Wenssendorf (eds). *The Multiculturalism backlash: European discourses, Policies and Practices*. Abingdon and New York. Routledge.

⁴¹ Casanova, M. (2013). *Social and Economic Management in the XXist century*. Lecture delivered in the conference “Cultural diversity: Advantage or Liability?”. European University Institute. May 7-9, 2013. Florence, Italy.

of a disease in China for example, it can reach anywhere in the world in a matter of hours because movements of people these days are continuous and fast. This scenario is not just for a movie or straight from a science fiction book. It actually happened in the past and there is a huge possibility that it can happen again.

There was a mysterious disease in China that no one had no inkling where it came from and how to cure it. The corona Virus which is responsible for SARS was kept secret for a while by the Chinese government. The international community was kept at bay for months before disclosure of the source of the disease. When the virus was identified by scientist in Hong Kong, it was passed on to the US scientist in Atlanta who successfully broken it down and then ultimately decoded by computers in Vancouver⁴². However, as fast as the virus was identified, the disease already claimed lives because the Chinese government tried to contain the information concerning the disease for reasons only them can understand. Not having complete knowledge about the genetic make up of the virus, how it is transferred, how it can be addressed; more people are becoming at risk of contracting the virus as well as possible fatal outcomes for those who had been inflicted by the disease.

Today, the platforms, tools, technologies and manpower in disease identification are at place. They work efficiently and fast provided scientists are given the right information. No matter how the global health infrastructures are efficiently built and inter-connected as long as information is withheld, the war for disease identification and eradication will never be won. By gatekeeping valuable health information, more people are put at risk and scientists are blindsided.

⁴² Walsh in Time Magazine. Its gone Viral. February 2013. p 50

F. Relationship of Health and Communication

“Communication is clearly the primary process used in health care to disseminate and gather relevant health information”⁴³.

This statement strengthens the role of communication in health promotion and management. Their connection is not new. Communication is the very fiber that connects facts with human thinking and emotions. Many researches have been written within the bounds of health and communication giving links to these domains⁴⁴.

Communication is the central social process in health delivery. Health information is the knowledge gathered from laboratory tests and patient interviews that become the basis in diagnosing health problems. The dynamics of communication in health context are also very complex. It examines different levels of communication (intrapersonal, interpersonal, group, societal and organizational). It also involved different communication channels-face to face, telephone, fax, and mass communication which involves the use of different media to convey/ disseminate health information. The setting for health communication is also very diverse⁴⁵.

Kreps and Query identified two perspectives in health communication inquiry. First is the healthcare delivery branch that examines how communication influences the delivery of healthcare. The second is the health promotional branch that studies the persuasive use of communication messages and media to promote public health.

⁴³ Kreps, G. & Kunimoto, E. (1994). *Effective Communication in Multi-cultural Healthcare Settings*. London. Sage Publication

⁴⁴ Hornik R., Ramirez S., (2006) *Racial/Ethnic Disparities and Segmentation in Communication Campaigns*, American Behavioral Scientist, Sage Publication. Schoberberger R., Nodes, M., (2005). *Health Campaign for Atherosclerosis Prevention*, Institute of Social Medicine, Center of Public Health, Medical University of Vienna, Vienna Austria, Springer –Verlag

⁴⁵ Kreps, G. et. al. (1998). *The history and development of the field of health communication*. Health Communication research. A guide to the development and direction. Westport. Greenwood.

While it is highly acknowledged that communication is at the center of healthcare delivery and health maintenance, communication within the bounds of health is very complex. One of the many roles of communication in health is to “demystify the complexity of the multi-faceted roles performed by communication in healthcare and health promotion”⁴⁶. In health communication, the goal of communication efforts is often to provide informed choice; decisions should be based on a patient’s “accurate” understanding of the facts and be consistent with patient values⁴⁷. This means that in the design of communication messages, the main consideration should always be the how congruent are the messages and communication tools with the patients belief system. This philosophy also holds true with the how auxiliary health providers should carry out communication interaction with patients, especially immigrants because they came from a different background. This is where communication plays a very important role. Perloff stated that communication could play a huge part in reducing health care inequalities in the United States, because there is still a striking racial and class-based disparities in health care, “despite the nations philosophical commitment to equality”⁴⁸. Given this observation from one of the countries that has the richest migration history, it is alarming how other countries such as France, are handling immigrants healthcare inequalities, if there was even a recognition that this exists. What is glaring in the US healthcare scenario is that this country has long recognized the contribution of immigrants in their country’s growth. They have also put in place programs, including that of health- to address immigrant needs. Despite these efforts however, reports still revealed that immigrants’ still face

⁴⁶ Jackson, L. & Duffy. B (eds) (1998). *Health Communication: A guide to the Developments and Directions*. Greenwood Publishing Group, Inc. pp 1-15

⁴⁷ Peters, E. et al (2006). *The Functions of Affect in Health Communications in the Construction of Health Preferences*. Journal of Health Communication. S 140-162. International Communication Association.

⁴⁸ Perloff, R., (2006). *Communication and Healthcare Disparities*. American Behavioral Scientists. Volume 49. Number 6

health challenges and putting into perspective the immigrants in France, one can only wonder what is the status of immigrants health in this country.

The creation of highly targeted health messages is one of the tools to combat health inequalities and better communicate health information. However, the task of coming up with highly targeted health messages is costly, time consuming and needs political will from governments and concerned organizations. It is a daunting task because it means that message creators need to take into consideration the multi-faceted factors that operate within a group's life. Some of these factors are racial origin, religious affiliation, personal health beliefs etc. However challenging it may sound, many health organizations are slowly embracing the idea that this is the best way to combat diseases, save lives and resources.

Preservation of a good state of health is highly dependent on the kind of information provided to the public. Prevention messages are highly encouraged to be carried out to prevent the much higher cost of emergency care, hospitalization or lifetime medication in the case of chronic diseases. However, prevention campaigns have their share of challenges that emanates from bureaucracy, minimal support from concerned groups, lack of interest of the predisposed segment of the population and limited monitoring system on the impact of the campaign. To highlight how valuable information is in fighting diseases, in 2004, the bird flu that swept Asian poultry was considered more frightening because not much is known about the H5N1 virus. Medical workers are frustrated because they cannot determine how many people and animals are infected? And that mystery has practical implications for fighting the disease⁴⁹. This shows the implication and fatal consequences of not knowing basic information about a disease. It is only when basic questions are answered that solutions be recommended for immediate action.

In cases of sudden epidemic outburst like the one mentioned above, communication plays a more crucial role because time is of the essence. The

⁴⁹ Appenzeller, T. (2005). *Tracking the Next Killer Flu*. National Geographic Magazine. pp 20-21

sooner credible information is shared among stakeholders, the better it is for the population to be protected, thereby saving lives. Obviously, not all communication efforts in disease prevention are successful. Despite the challenges however, the role of communication cannot be denied in many successful stories of disease prevention and elimination and in the maintenance of general well-being of people.

There are several huge successes in combating epidemic and which can also be attributed to effective health communication campaigns. A global vaccination program against smallpox launched in 1967 eliminated the disease in 1980. There is awareness in Nigeria about the use of mosquito nets to prevent malaria. In Bangladesh, the use of folded sari before placing it over the mouth of a jar before collecting water creates a barrier against plankton to which the cholera bacteria are attached. There are almost 3.5 million people suffering from a disease caused by a parasite called guinea worms in the remote parts of Africa where only contaminated water is available for drinking. By 2013, through the efforts of the Carter Center, the number of people suffering from this disease was reduced to 148 (provisional) from 3.5 million in 1986. The founder of this center, former President of the USA Jimmy Carter, acknowledges that “as a community and as a nation, it is important to educate the citizens, legislate ethically and wisely, and support organizations that conduct research and help those who are ill ⁵⁰.

These success stories show that when efforts are synchronized, eliminating diseases could be possible. Alterations of some daily activities, educating the population of the positive effects of the changes that are being proposed often yield positive results and lives were saved. This knowledge/learnings will go with these people wherever they may go. What is good about health concepts is that the basic premise of health maintenance is universal- eating fruits and vegetables, exercise benefits, drinking lots of water and maintaining a healthy

⁵⁰ Guinea Worm Eradication Program.

http://www.cartercenter.org/health/guinea_worm/index.html. Accessed March 6, 2014.

lifestyle. Encouraging people to follow this is a whole different ballgame. The availability of fast calorie laden food is the best companion of a busy lifestyle. Unhealthy food seems to have the upper hand and in control of the people's diet these days. This means that advocates of healthy living must triple their effort to bring people back into their fold.

From information gathering to information dissemination, communication tools are used to better assist health clients (patients), their relatives and friends. These tools range from the use of different media to communicate better health options, identification and utilization of diverse communication collaterals to better reach the target audiences and maximization of research results to better aid health providers.

Health information can be gathered through different means. Today modern medical information gathering is aided with a dazzling array of technologies. The era where gathering health data can be as easy as "slapping on a band" has come. In the emerging field of bioelectronics, leaders are developing a small, wearable, wi-fi enable sensors that can detect vital information –heart rate, body temperature, hydration levels and communicate it in real time to the doctors or to a smart phone. With this kind of technology, invasive tests, bulky and expensive devices can be avoided. Cost of health care will go lower, patients can be proactive about their health and they will have better relationship with their doctors ⁵¹.

Despite these developments however, the role of human communication still plays a crucial role in the process. Doctors and medical professionals need to fully understand the psychology, biological make up, cultural background and personal preferences of the client. This way, medical intervention in terms of what regimen best suits the client would be prescribed. Medical regimen includes the preference of the patients in taking medications, hours and best time to do

⁵¹ Time Magazine March 2013 p 39

exercise, diet that she can tolerate etc. Similarly, clients are also expected to communicate with healthcare providers, specifically clarifying their position about taking medicines, doing exercise and the kind of food that they can eat. They are expected to be actors of their own health, empower themselves by reading literatures about diseases that they are exposed to because of genetics or lifestyle.

G. Defining Health Communication

Research about health communication has its roots firmly planted on peoples need for more information about health. In as much as the primary source of health information is concerned, still the medical providers, patients and concern groups demand for information beyond the usual medical definition. Medicalization of illness and diseases has long been questioned by stakeholders thereby re-directing medical practitioners to look at diseases beyond laboratory results. This paradigm shift in health psychology gives birth to new scientific and humanistic researches that tried to answer health questions beyond the microscopic lens. Connecting health issues to poverty, social status, culture, communication, gender and other factors, constitute the scholarship of health communication.

Therefore, health communication is defined as an applied behavioral science. It is applied because it examines the pragmatic influences of human communication on the provision of health care and the promotion of public health⁵². Because of its grand scholarly scope, transcending boundaries and disciplines in addition to its being a young area of research, it has become a promising area of academic inquiry and scholarship. As a matter of fact, academic institutions are offering courses in the field of health communication whose aim is to train health communication professionals on how to better communicate with their

⁵² Kreps, G. et. al. (1998). *The history and development of the field of health communication. Health Communication research. A guide to the development and direction.* Westport, CT. Greenwood Press. http://www.russcomm.ru/eng/rca_biblio/k/kreps.shtml (accessed February 2010). pp 1-15

patients, taking into consideration their sensitivities. Courses are also leaning towards preparing health campaign designers in coming up with sensitive yet sensible messages that would better appeal to the target audience.

Put simply, health communication involves creating shared meaning about health care and conditions. It covers a wide -ranging array of topics including disease control and prevention, emergency preparedness and responses and a lot more⁵³.

At its main core, health communication field focuses on two major elements; message production and processing and the creation of shared meaning about health issues in relationship⁵⁴.

H. Tracing the Development of Health Communication

The term health communication has only been around since the mid-70's but it has grown exponentially in the past 25-30 years⁵⁵. Its main role is to examine the powerful roles performed by humans and mediated communication in health care delivery and health promotion. Research results from this area are often used to make significant positive changes to health care delivery and promotion. As noted by Gary Kreps, who made extensive research in the field of health communication, the inquiry in this area is often problem based, examining and solving health care and health promotion problems.

⁵³ Sparks, L., (in press). *Health communication and caregiving research, policy, and practice*. In S. S. Travis & R. Talley (Eds.) *Multi-disciplinary Coordinated Caregiving: Professional Contributions*. Springer. p 7

⁵⁴ Kreps, G. et. al. (1998). *The history and development of the field of health communication*. Health Communication research. A guide to the development and direction. Westport. Greenwood. p10

⁵⁵ Kreps, G. et. al. (1998). *The History and Development of the Field of Health Communication*. *Health Communication Research. A Guide to the Development and Direction*. Westport, CT. Greenwood Press. http://www.russcomm.ru/eng/rca_biblio/k/kreps.shtml (accessed February 2010). pp 1-15. Sparks, L., (in press). *Health communication and caregiving research, policy, and practice*. In S. S. Travis & R. Talley (Eds.) *Multi-disciplinary Coordinated Caregiving: Professional Contributions*. Springer.

This field emerged as an exciting applied behavioral science research. It is an applied science because it examines the pragmatic influences of human communication on the provision of health care and the promotion of public health⁵⁶. There are a few points of references as to how health communication as an area of research started. One very strong starting point is the communication discipline's emulation of other disciplines such as psychology and sociology, which are doing research on health communication.

Moreover, scholars in these social sciences were beginning themselves to examine communication variables in health care⁵⁷ which encouraged communication scholars to follow suit⁵⁸. Among academic disciplines, it is the field of psychology that has the highest impact on the development of health communication.

Korsch and Negrete's write –up entitled “Doctor Patient Communication” published in *Scientific America* is still regarded as the foundation of the field of Health Communication⁵⁹. In 1963, the *Journal of Communication* devoted an entire issue on the topic “Communication and Mental Health”. In 1967, a book

⁵⁶ Ibid 54.

⁵⁷ Bandura, A. (1969). *Principles of behavior modification*. New York: Holt, Rinehart, & Winston. Kosa, J., Antonovsky, A., & Zola, I.K. (1969). *Poverty and health: A sociological analysis*. Cambridge, Harvard University Press. McGuire, W.J., (1969). *Attitude and attitude change*. In G. Lindzey & E. Aronson (Eds.), *Handbook of social psychology* (2nd. ed., pp. 136-314). Reading, MA: Addison-Wesley. McGuire, W.J. (1984). *Public communication as a Strategy for Inducing Health promoting behavioral change*. *Preventive Medicine*, 13, 299-319. Tichenor, P.J., Donohue, G.A., & Olien, G.N. (1970). *Mass media flow and differential growth in knowledge*. *Public Opinion Quarterly*, 34(2), 158-170. Zola, I.K. (1966). *Culture and symptoms: An analysis of patients presenting complaints*. *American Sociological Review*, 3, 615-630.

⁵⁸ Kreps, G. et. al. (1998). *The history and development of the field of health communication. Health Communication research. A guide to the development and direction*. Westport, CT. Greenwood Press. http://www.russcomm.ru/eng/rca_biblio/k/kreps.shtml (accessed February 2010). pp 1-15. Sparks, L., (in press). *Health communication and caregiving research, policy, and practice*. In S. S. Travis & R. Talley (Eds.) *Multi-disciplinary Coordinated Caregiving: Professional Contributions*. Springer.

⁵⁹ Thompson, T. et. al. (2003)(Eds.) *Handbook of Health Communication*. Lawrence Erlbaum Associates, Inc. New Jersey. Wright, B., Sparks, L. & O' Hair. D. (2008). *Health Communication in the 21st Century*. Blackwell Publishing. M.A., U.S.A.

was written entitled “ The Pragmatics of Human Communication” by Watzlawick, Bevin and Jackson, which provided a very strong baseline for humanistic psychology, intermarrying the areas of humanistic psychology and human communication⁶⁰. This book stressed that “the quality of relational communication can lead to pathological and therapeutic outcomes, which serves as the springboard to the current interest in health communication studies”⁶¹ Today, the area of health communication is widely recognized as vibrant, theoretically driven, pragmatic and key contributor in shaping health policies⁶².

Health communication as a field of research is continually attracting scholarly work. As a very young field of research, much can be expected from research results from this discipline. Academic institutions all over the world are now offering health communication courses. The Harvard School of Public Health offers Health Communication Concentration. University of Boston has an online course for Master of Science in Health Communication and the Nottingham in the United Kingdom offer a web -based masters distance learning. In France, the Ecole de Hautes Etudes en Sante Publique (EHESP) located in Renne, Sourbonne offers a wide array of courses that deals with public health. This researcher made some communication with this University through email and one student is doing her research in health communication and marketing. This field of health communication is different from studying health communication focusing on the dynamics between stakeholders within the health care delivery system. Health communication focusing on marketing is simply on the other side of the playing field. It is important to note however that the courses in the French university are concentrated on health institutional administrative programs.

⁶⁰ Sparks, L., (in press). *Health communication and caregiving research, policy, and practice*. In S. S. Travis & R. Talley (Eds.) *Multi-disciplinary Coordinated Caregiving: Professional Contributions*. Springer. p 7

⁶¹ Ibid 59 pp 1-18

⁶² Sparks, L., (in press). *Health communication and caregiving research, policy, and practice*. In S. S. Travis & R. Talley (Eds.) *Multi-disciplinary Coordinated Caregiving: Professional Contributions*. Springer. p 6

Despite the studies however, countries often look at research in health care as a minor player in health inequalities⁶³. It is not surprising because the very nature of research cannot be quantified or bears immediate measurable outcomes and it is easy to make assumptions that research is another exercise in futility. However, ineffective health policy, wrong health campaigns can partly be attributed to lack of baseline information which only research can provide. However, the statement downplaying the role of research became true in the case of France. Because of the very nature of the country's universal health care system and the big allocation of resources to health, everyone simply has access to health care. Healthcare management in this country can be easily understood as when someone is sick, he is free to go to a doctor or hospital of his own choice and demand care. However, this is translated to sky rocketing cost of health care expenditures because emergency care costs more than actually setting up prevention campaigns to prevent illness complications. Now that nations are becoming more aware of the budget deficits and while some countries economy have already collapsed, measures are being taken to ensure expenditures are controlled. In France there are actions to control the rising cost of healthcare. Patients now share the burden of consultation costs and concerned institutions are making sure medicines are properly disposed to avoid waste.

In the end, the application of health communication principles advocated by proponents of this discipline as well as research results will aid entire health system of countries and open a wealth of knowledge for all sectors of the healthcare industry. For now, the aim to do one research at a time and spread the results to stakeholders.

⁶³ Polton, D. (2009). *What is the Role of Healthcare System in Reducing Health Inequalities in France?* In *Measuring and Tackling Health Inequalities Across Europe*. EuroHealth. Volume 15. Number 3. pp 19-20

I. Describing the area of research: the French Riviera

The South of France became the area of research because this researcher was granted a scholarship to do her doctoral studies in one of the Universities located in the area, University de Nice Sophia Antipolis. She lived in Nice, the biggest city in the Cote d'Azur area and there is a good number of Filipinos in the cities belonging to this region because of job availability. The three main cities where the research was conducted were chosen because of their proximity. It is convenient to travel for there is an efficient public transport system that operates across these cities.

Figure 2: Map of the French Riviera



Taken from: <http://1french-riviera.com/about-us-french-riviera/map-french-riviera> (accessed July 19, 2013)

The French Riviera, also known as Cote d'Azur (which means Azure Coast) is a popular destination for tourists as well as retirees. It is located in the southeast of France along the coast of Mediterranean sea. There is no clear boundary but it stretches from the town of Menton- frontier to Italy- in the east to Toulon in the west. It totals 550 miles including the Principaute of Monaco, the

second smallest country in the world –next to Vatican- and is ruled by the Grimaldi family. The area is popularly known for its coastline, mountain ranges, museums, well –kept parks, ski resorts and its array of artists that include Pablo Picasso, Henri Matisse, Marc Chagall and many more. The famous actress Brigitte Bardot further elevated the Riviera when she made a movie – And God created Woman- shot in St. Tropez. The region is proud of its temperate weather-warm summer, more sunny months and tolerable winter season. It now bears the image as the playground of the rich and famous. The streets of St. Tropez are literally littered with international stars and personalities from the business and political scene during summer season. The coasts of Antibes, Villefrance sur Mer, Cap Ferrat are some of the favorite docks of the yachts of the wealthy.

Some of its most known cities includes Nice-its largest city; Cannes- the venue for the famous Cannes Film Festival and Monaco- for its casino and lavish lifestyle. Tucked in between these cities are restaurants, museums, historic sites, chateau and lavish vineyards. Any one who visits the region will be in for a treat because of the vast activities and point of interests that the Riviera is known for. The cities, although located in one region, promises different experience for the traveler because each has its own character.

Monaco is technically not part of the French Riviera because it is another country therefore does not belong to France. However, it is under the protection of France. Monaco as part of this study was not viewed as another county. Instead it was referred to as part of the French Riviera. This was intentionally done by the researcher for identification of Filipino immigrants between two countries would complicate the choice of location for this research. Basing on the geographic location Monaco is part of the Mediterranean coast close to the French Riviera. For easier labeling, the researcher referred to the area of her research – Nice, Cannes and Monaco – as the French Riviera.

Each city in the Riviera boasts of its own yearly activities. Nice has its yearly celebration of Carnaval de Nice and Music Festival. Cannes is host for the glittery Cannes Film Festival which makes this small city a venue to be seen for the people in the film and entertainment business. Menton is famous for its Festival de Citron (Lemon Festival) where mardi gras type parades are enjoyed by thousands of people and where the floats are made primarily of the main product of the city, lemon. Biot, a small village located between Cannes and Nice, known for its glass blowing industry also celebrates a few days of Medieval Festival where the grandeur of the Knights Templar is commemorated and their lives were re-lived at least for a few days. Participants and even audience of this event are encouraged to dress, live and eat like the medieval times which makes it a very interesting thing to experience. In the summer season, those who are bold and adventurous can spend a significant amount of money to have a few days stay in St. Tropez and experience how people bare themselves in the Nude Beaches of this city. Although there are areas like this all over the Riviera, St. Tropez is the leading city when it comes to literally stripping someone of their inhibitions.

These are activities that make the French Riviera a popular tourist destination of people who can afford to travel and splurge in the warm Mediterranean Sea. Tourist abounds even during winter season because it does not get very cold and in the outskirts of the main city are several ski resorts like Isola and Valberg. The Riviera offers a lot of things to those who are trying to escape the stressful life of the city. Despite robust tourism, the French people were able to preserve their cultural roots especially their language. They remained French in many ways, which most tourists do not find welcoming. Regardless of these traits, tourist keeps on coming to the Riviera that maintains keep businesses afloat. This results to availability of jobs especially the service industry. Immigrants' flock to the Riviera because job abounds.

Figure 3: Photos of the French Riviera



Promenade des Anglais, Nice



Cannes Film Festival 2013

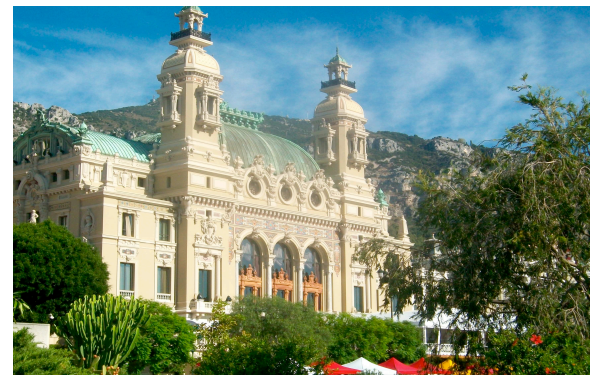


Eze Village, located between Nice and Monaco

Medieval Festival, Biot



Lemon Festival, Menton



Monaco, Monte Carlo

Note: All photos were taken by the researcher

Figure 3 shows places and events within the French Riviera. It vividly shows the touristic places and interesting activities that attract people all over France as well as international travellers to either visit or live in the region. Museums also abound like the Marc Chagall and Henri Matisse museums in Nice and the Picasso Museum in Antibes. French society is also very supportive of older generation. There are a lot of local organizations composed of old people and handicapped. The local government is making sure that there are enough activities for these people, one thing worth praising about the French. Organization like Bellage provides activities for old people. Valentin Hauy is on organization for the blind and Osons la difference is for people on wheelchairs. In 2012, Valentin hauy, Osons la difference tie up with Lions Club and Conseille General des Alpes Maritimes and sends three handicapped – blind, mute, and paralyzed- accompanied by a small group of people, to climb Kilimanjaro. This done to send a message to the world that even if limited physical mobility, great things can be accomplished when efforts are put together. This activity showcases the dedication of the French government in supporting activities that promote the welfare of the minority group and underprivileged members of its society.

Having given these examples, immigrants should also strengthen their effort to be recognized by the government by creating programs that highlight their contribution to the French society. No matter how small these activities maybe, the main aim should be to reach out and build a better line of communication, lessening the gap that divides immigrant groups and the local citizens as well as the French local government.

The region was selected for as the research area for this study because the researcher was given the opportunity to pursue her doctoral studies in Nice under a scholarship grant by the European Union. The region is a good place to

study the Filipino community because there is quite a concentration of this group of people in the Riviera primarily because of availability of work.

Hypotheses

This study hypothesizes that:

1. For Filipino immigrants in the South of France, French language is still a barrier in accessing health care.
2. Current health practices are still highly influenced by the past health belief system (past: health belief system when they are still living in the Philippines and the health environment where they are exposed to)
3. Filipino immigrants were able to adopt to the French health system but their level of assimilation is still yet to be identified and described
4. There are emerging health practices based on intentional or unintentional combination of the past and the present health beliefs
5. First generation Filipino immigrants are not aware that there are differences between the health system of France and the Philippines.

Statement of the Problem

The Philippine health belief system is a rich combination of factors that generally affects a persons' life. Culture, geographical location, religious beliefs and weather are just some factors that influence the traditional notion of illness and health in Philippine health culture. Traditional/Indigenous or folk medicine- however one labels it, is not just a random collection of exotic beliefs and practices. Instead it is a reflection of a system of knowledge⁶⁴. This health belief system becomes part of the inner wiring of the Filipinos and they will carry it wherever they may decide to live.

⁶⁴ Tan, M.L., (2008). *Revisiting Usug, Pasma, Kulam*. Quezon City. University of the Philippines Press.
p5

Major part of the immigrants' grand narrative is how they face the challenges of adjustment and later on assimilation to the host country. Coping in a country whose language and culture is totally alien to the immigrant is a more complicated process than those who already have background about the country they are moving into. Citing the global movement of Filipinos as an example, they adjust better and faster when they move into an English speaking country rather than a French speaking country. At the same time, somebody from Algeria will have an easier time adjusting to a French-speaking county because he or she speaks French. Putting the Filipinos in a French speaking country and an Algerian to an English speaking country, could make assimilation more complex.

For Filipino immigrants in the French Riviera, this study aims to find out how the health belief system deeply ingrained into the very fabric of being from the Philippines, is altered or influenced by the healthcare system of France.

Generally, this research identified the emerging health practices of the Filipinos living in the French Riviera through examination and analysis of their current health practices. Results will then be reviewed against two backdrops; one is the most common health belief and practices in the Philippines and the traditional way dealing with these diseases, and on the other side is the health care system of France.

Through identification and analysis of the common health practices vis-a vis the current health practices of the Filipinos in the Riviera, the researcher hopes to extract what emerges when Filipino health beliefs were practiced under the French health system. Theorizing that practicing old health practices (intentionally or unintentionally) under a new health care system, creates a hybrid which needs to be problematized and investigated. Not knowing the result of this mix seems to waste valuable resources and can jeopardize lives. It is the responsibility of the social scholars particularly social epidemiologists, to be precise -to identify emerging health belief system of an immigrant group to provide campaign designers with timely and relevant information, create culturally sensitive medical collaterals and assist policy makers in the formulation of sound state policies.

Once an immigrant set foot in the host country, theoretically, assimilation and integration must begin. Narrowly, an immigrant is considered integrated into the host country if he can land on a decent job enough to sustain a family, acquire necessary skills to speak the language for everyday conversation, engage in public affairs and have access to basic health services. In a more broader and complex scenario, an immigrant is said to be well integrated if he can practice religious, cultural, and possibly nationality-based values and practices can be expressed in the host country without penalty or denigration, and that one can make some demands on the polity without fearing retribution or total failure⁶⁵. Focusing primarily on the initial part of integration, an immigrant must have access to health information. He should be made fully aware of his rights as a resident and must be given materials addressing basic questions such as basic health terms, how the French system operates, which institutions to go to, different health care providers/professionals, where to go to get specific information, emergency numbers and the likes. It is important that these things come from a reliable source and there should be a standard operating procedure on where are these materials available and where to go if immigrants have further clarifications.

This study intends to answer the following questions: 1. What are the emerging health practices of the Filipinos living in the French Riviera? 2. Are the Filipinos satisfied of their health performance in reference to how the French healthcare system is accommodating them? 3. What are their health experiences with regard to maintaining health, seeking cure and gathering health information in the French Riviera?

⁶⁵ Hochschild, J, & Cropper, P. (2009). *Immigration Regimes and Schooling Regimes: Which Countries Promote Successful Immigrant Incorporation?* Harvard University, Government and Social Policy Ph.D. Program. pp 3-4

Objectives

Generally, this research will identify and describe the health experiences of Filipino immigrants in the French Riviera and extract the emerging health practices coming from the intentional or unintentional practices of traditional health belief systems. Being able to identify Filipino immigrants health performance, this study aims to provide baseline data that can be used by health providers and legislators. Knowing the stand and mentality of these immigrant group in terms of health issues would better equip health workers on how to better communicate with them. Findings of this research may also inspire scholarship within the line of health and other minority immigrant groups.

Specifically, this research identifies the challenges and benefits of being a Filipino immigrant in the French Riviera in terms of accessing health services leading to better health management or otherwise.

This research will:

1. Identify and describe the traditional health beliefs and practices of the Filipinos living in the French Riviera
2. describe how traditional health beliefs influence current health practices with the French health care system as the backdrop
3. identify the emerging health practices of the Filipino population and describe how it merges with the health landscape of the French Riviera
4. identify barriers that contribute to unsuccessful health assimilation as well as factors that encourage better health maintenance among Filipino immigrants
5. propose a health model that explains how immigrants emerging health practices are formed and operationalized

Answering these research objectives would bring into the open the health lifestyle of the Filipino immigrants in the French Riviera. Bringing their issues to the academe hopefully may inspire public discussion about immigrant health issues, as well as re-think the social and political responses to immigrants' health concerns.

Chapter Synthesis

Chapter 1 sets the background for this study. Its primary aim is to introduce the readers to how and why the study was conceptualized, referring to the academic background and the personal passion of the researcher about the subject matter.

Academically, this chapter provides the main problematique that strengthens the academic claim of this research to be unique and highly plausible research area because there has not been much (if not non at all) studies regarding Filipino immigrants in the French Riviera, moreso in the area of health. The topic is also a complex research area that makes it both interesting for the researcher but also very challenging. The expected reward in the end however, is not just academic benefit but a contribution to the literature on health communication, providing baseline data regarding the health lifestyle of Filipino immigrants in the French Riviera. This study theorized that for Filipino immigrants, language is still a barrier in accessing health information and services, that the current health practices are still highly influenced by the traditional beliefs which means that they have not fully adapt to the French healthcare system.

The statement of the problem highlights concepts that need to be clarified through academic investigation. The health belief system of immigrants is not only a product of collective random experiences but it is also based on a system of knowledge and as such, cannot be easily dismissed as folklore. Knowing the origins and benefits of these beliefs to the immigrants, may provide background information about psyche of the immigrants regarding health. This group of people appears to be marginalized in the receiving country because of so many contributory factors. In most cases the fault lies not on the state or the people nor was it always intended. People are always indifferent towards those who are not their own kind. Prejudice exists amongst people who have limited information about each other and these indifferences spills over to other aspects of immigrants' life.

It is the role of the state to ensure immigrants' assimilation and integration into the mainstream society is carried on swiftly. In the area of health, this can be done by providing health providers of the host country with enough information about a particular group of immigrants to properly prepare them on how to handle immigrants' health inquiries and issues.

The statement of the problem, research questions, objectives and hypotheses were presented in this first chapter to set the tone as to what this study is all about and what it is trying to accomplish at the end of the day.

CHAPTER II

Review of Related Literature

“Whether or not a particular behavior or behavior is viewed... as a sign or symptom of illness depends on cultural values, social norms and culturally shared rules of interpretation”⁶⁶

This section explores the studies carried out revolving around the three main concepts in this study: communication, culture and health. Narrowing down on health challenges faced by migrants in the host country, particularly in Europe, this part of the study paints a clear picture of health status of these migrants by identifying the challenges encountered in the process of assimilation and integration to the new health environment as well as the factors that encourage healthy behaviors.

Due to the vast information discussed in this chapter, the researcher divides this section into two parts. The first part contains results of academic and institutional studies that highlight issues about health and migration. It also presents experiences of countries in handling migration related issues. The second part showcases the relationship between France and the Philippines focusing on the first contact and how early French immigrants to the Philippines observed the lifestyle of the inhabitants of these islands. It is interesting to point out at this early stage that the early Frenchmen who decided to stay in Manila were medical doctors.

This part of the study widely discussed issues that are contributing factors to the state of immigrants' health in Europe. These include politics, economics, social and cultural components of the host country. Interesting enough, even if immigrants moved to a much stable country than their country of origin, that is

⁶⁶ Mishler, E. (1981). *Critical Perspective of the Biomedical Model*. In Brown, P. (Ed). *Perspective in Medical Sociology*. Belmont. Wadsworth. p 141

not a guarantee that they will be entitled to good health care. On the contrary, immigrants are often the marginalized in the area of health.

PART 1: Research studies and related data about health, communication, and immigration

“The growing pace of economic globalization has created more migrant workers than ever before. Unemployment and increasing poverty have prompted many workers in developing countries to seek work elsewhere, while developed countries have increased their demand for labour, especially unskilled labour. As a result, millions of workers and their families travel to countries other than their own to find work. At present there are approximately 175 million migrants around the world, roughly half of them workers (of these, around 15% are estimated to have an irregular status).”⁶⁷

a) Immigrant Status in Europe

The First Annual Report on Migration and Integration (Brussels, European Commission, 2004) stated that European countries have no systematic way of collecting health data by migrant status or ethnic group. The only countries in Europe who were able to do this are the United Kingdom, Sweden and Netherlands. As a result, not much is known about the health of immigrants once they settle in their host country and interact with the new health care system. A study conducted by Mladovsky et.al. claimed that migrants often face particular health challenges and vulnerable to a number of threats to their physical and mental health. Although these migrants are often healthy, this phenomenon is known as the “healthy migrant effect”, the authors reiterated that specific health concerns of migrants are poorly understood, communication between health care

⁶⁷ ILO: *Towards a Fair Deal for Migrant Workers in the Global Economy*, Report VI, International Labour Conference, 92nd Session, Geneva, 2004; P. Stalker: *Workers without frontiers: The impact of globalization on international migration* (Geneva, ILO, 2000).
<http://www.ilo.org/global/standards/subjects-covered-by-international-labour-standards/migrant-workers/lang-en/index.htm> (accessed March 9, 2014)

providers and migrant clients remains a challenge and in general health systems are not ready to respond adequately⁶⁸.

This poses as a problem for the host country because of the growing number of immigrants, documented and otherwise, for they constitute a percentage of the population and as such utilize health care services. Ideally once these people entered a country, they should have access and should not be denied access to health care when the need arises and no matter how basic it maybe. Historically Western countries tended to view immigrants ethnic identities with indifference or suspicion and sought to assimilate newcomers into a common national culture⁶⁹. Prejudice exists and it is strongly felt by immigrants coming from developing countries. It is not only the people who have negative pre-conceived idea about certain ethnic origins but the state as well has its share. The mere fact that immigrant professionals are hindered to practice their profession when they arrived in the new country, in some angle can be viewed as discriminating. In other countries, not having an interpreter in a hospital or health clinic is considered patient discrimination.

The belief is that the more immigrants enter a country like France as an example, the more person partake in the health budget. The trouble is, the bigger the number of people who seek medical assistance, the bigger the number of those who will share in the allocated health budget and resources. This mind set may serve true to other aspect of social life and might be the main reason why two-thirds of the French would prefer less immigration⁷⁰. However, in a study

⁶⁸ Mladovsky P., et. al. (2011). Migration and Health in the European Union. European Observatory on Health Systems and Policies Series. McGrawHill. Open University Press. p 3

⁶⁹ Banting, K. et. al. (2011) Are diversity and solidarity Incompatible? Canada in Comparative Context. In Roads 28. Diversity through three lenses. Available online at: http://www.researchgate.net/publication/243964181_Are_Diversity_and_Solidarity_Incompatible. Accessed February 2010. p 41

⁷⁰ Hochschild, J, & Cropper, P. (2009). *Immigration Regimes and Schooling Regimes: Which Countries Promote Successful Immigrant Incorporation?* Harvard University, Government and Social Policy Ph.D. Program. p 2

done by Alberto Alesina, Reza Baquir and William Easterly in 2001 they claimed that public spending tends to be lower in cities and states with higher levels of racial heterogeneity, even when other relevant factors are held constant. Alesina and Edward Glaeser have extended this approach to cross national differences. They concluded that almost half of the difference in social spending between the United States and European countries can be explained by differences in the level of racial diversity ⁷¹. Indifference in cultural diversity might be due to research findings in the area in the early 1990's. A number of large scale cross-national studies suggested that "countries with high levels of ethnic diversity were susceptible to a wide range of pathologies: they were more prone to violent conflicts, were less likely to develop into democracies, were less likely to enact redistributive welfare policies, displayed lower levels of trust and so on ⁷²". Some of these findings are being challenged today. Canada, as one of the most culturally diverse countries in the world, continued to display economic stability and solidarity despite its highly multicultural environment. A study done by Banting et. al. revealed that there is no clear relationship between the proportion of the population born outside the country and growth in social spending over the last three decades of the 20th century. On the other hand, greater changes in diversity are linked to smaller increase in spending ⁷³. These more recent research findings suggest that the mentality that immigrants further divide the now very limited health budget is being debunked. It is very easy to overlook the fact that these immigrants too are workers, pay their taxes therefore contributing to the economic growth of the country they moved into. They also contribute to the growth of local businesses for they spend their hard earned money to where they are living.

⁷¹ Banting, K. et. al. (2011) Are diversity and solidarity Incompatible? Canada in Comparative Context. InRoads 28. Diversity through three lenses. Available online at: http://www.researchgate.net/publication/243964181_Are_Diversity_and_Solidarity_Incompatible. Accessed February 2010. p 38

⁷² Ibid 71 p 32

⁷³ Ibid 71 p 40

Referring once more to the study conducted by Hochschild and Cropper, a migrant health policy should be at place to effectively respond to the problems affecting migrants and to identify if these concerns are the same problems affecting the general population at the same time find out if these migrants have equity of access to health.

Data from countries who did migrant health studies suggest that immigrants' suffer from unequal access to health care particularly in terms of utilization of prevention programs such as screening and vaccination. Evidence also suggests that barriers (in accessing health prevention programs) often lead to delaying care resulting in the increased consumption of more expensive emergency treatment⁷⁴. This proves that if a country is serious in its effort to control health spending, it must place a program that is accessible to all patients across the board. Concerned organizations must realize that health programs- specifically prevention campaigns- should be highly targeted in culturally diverse cities. A one-size fits all campaign will surely not work in this environment because of the diversity of its population. Immigrant minority groups might have a hard time understanding health campaigns that do not appeal to them.

In another study highlighting racial categories in medical practice, Braun et. al. pointed out that there is a need to keep records based on racial and ethnic categories. The US Institute of Medicine explains that race should not be considered as a biological reality but rather a “construct of human variability based on perceived differences on biology physical appearance and behavior”⁷⁵. As such, race cannot be medicalized by looking at the color of the skin and other physical make up because race is constituted in language, family history, lifestyle

⁷⁴ Mladovsky P., et. al. (2011). *Migration and Health in the European Union*. European Observatory on Health Systems and Policies Series. McGrawHill. Open University Press.

⁷⁵ Braun, L. et. al. (2013). *Racial Categories in Medical Practice: How useful they are?* <http://dash.harvard.edu/handle/1/3008241> (downloaded March 1, 2013). p 27

etc. On the other hand, differentiating patients by race may work when there is a limited time for interview, but rapid racial assessment has its own dangers: misdiagnoses and inappropriate treatments. To solve the problems posed on health in the basis of race, the authors reiterated that clinicians will make a better educated evaluation if they familiar with the history of the community they serve. In the clinical encounter, cultural competency based paradigm is suggested to improve care. This paradigm was suggested as a tool to combat the prevalence or racial and ethnic health disparities ⁷⁶. In addition, improved cultural knowledge can sharpen diagnostic skills. Cultural competency instruction should include studies about history of racial categories, challenges and controversies about their biological significance and limits of their utility. Understanding the concept of race should clarify race as a population concept and its meaning when applied to the lives of individuals for surely there are differences. Despite the benefits brought by racial consideration in medical practice, rapid racial profiling in medicine can lead to serious medial errors and is problematic in nature. One reason is the fact that throughout the 20th century, race does not have a standard definition in medical, epidemiological or health service research ⁷⁷.

In the US, racial categories are poorly defined and became reified in biomedical research practices, partly because of census categories ⁷⁸. Lacking standard definition, issues connecting race to health status is at the moment problematic in clinical practice as well as in biomedical research although it is a promising area of research.

These findings highlight the current problems faced by the immigrants themselves as well as the host country. On the part of the migrant, simple

⁷⁶ Braun, L. et. al. (2013). *Racial Categories in Medical Practice: How useful they are?* <http://dash.harvard.edu/handle/1/3008241> (downloaded March 1, 2013). p 73

⁷⁷ Ibid 76 pp 18-21

⁷⁸ Ibid 76 p 24

physical pains are either dismissed, left untreated or worst self –medicated if patients do not have enough information on how to access health care, limited vocabulary in explaining their condition and little knowledge about genetic predisposition. The anxiety or fear brought by the fact that they need to explain the symptoms that they are experiencing, as detailed as possible, in a language they are not familiar with and with no translator, often hinders or delays patients in seeking medical care. If health information on the other hand is not readily available for these immigrants, they remedy the situation by delaying care and seeking help when the sickness has already worsened. In cases like this, the host country has no choice but to extend assistance often spending on the more expensive emergency treatment ⁷⁹. In Europe, the rising rate of unemployment threatens to pose additional challenges to health systems, including ensuring appropriate services for more vulnerable or poorer population. It is recommended that monitoring of these groups be done on a regular basis and should be made part of the standard operating procedure for health maintenance ⁸⁰.

On health professionals' side, not knowing the cultural and racial composition of the community they are serving is a barrier in delivering care. Not having the training on how to handle patients with different cultural and linguistic background makes their work less effective; not having interpreters in a clinic or hospital setting lowers the chances of an immigrant patient to quality care. In either case, patients are on the losing end and governments will continue to spend more on emergency care service as well as on long treatments for delayed diagnosis of chronic diseases; which might have all sprung from patients not understanding their doctors and vice versa.

Without the much needed data to determine the basic health concerns of the migrant population the state is ill-equipped in assessing health issues of this

⁷⁹ Mladovsky, P., (2007). *Migration and Health in EU Health Systems*. Euro Observer. The Health Policy Bulletin of the European Observatory on Health Systems and Policies. Volume 9 Number 4.

⁸⁰ WHO Health Report 2012. p 51

minority group because they often do not understand them- which eventually leads to bigger problems. It is surprising to know that France, one of the most economically stable countries in Europe is lagging behind in terms of health data collection on immigrants considering that other neighboring European countries are doing it. To add, France was awarded as the country with the best healthcare system in the year 2000 and as far as this category is concern, France has always been one of the top contenders. This scenario contradicts the health equity as far as immigrants in France are concerned. The European countries who did data collection about their own immigrants noted that immigrants suffer from unequal access to health care and prevention program and since France is one of the countries that do not have a systematic immigrant data collection system, there is little information about how are the immigrants are adapting to their new health environment. Results of this lack of information put into question the challenges faced by the immigrants in the process of their assimilation and integration considering the intricacies and uniqueness of the French health care system. What does it mean for immigrants in France that their host country is considered as the best healthcare system in the world? On the other end, how is the French government responding to the ever-changing composition of its citizenry? Similarly, how relevant are the State's health measures as far as its immigrant population is concerned? These questions can only be answered once a standardized information collection system collecting data from the people coming inside the country is at placed. At the moment that this is not standard procedure in France, Filipino immigrants in the French Riviera have just patches of information regarding the health care system of the country they move into. They are generally very aware that they have access to health care and services when the need arises, but have limited knowledge about prevention programs carried out by government health institutions that target them because of their genetic pre-disposition and lifestyle. These immigrants rely mostly on the people they know for information. This process however helpful it may seem, often creates delay and confusion. Setting up a centralized health information center, who is manned by people who are knowledgeable enough to discuss to the

patients the rules of the state and know the patient well enough to consider their cultural sensitivity in the discussion – should be experimented on to determine how it will affect immigrants health performance.

In the 2012 European Health Report, WHO reported that lessening health inequalities is an important priority in the European region. There was recognition that these inequalities continue to increase and take in many forms from lack of access to health services to excess premature mortality hindering social development and well – being. Pre-requisite for tackling health inequalities include being appropriately informed about the magnitude and distribution, both absolute and relative and understanding how pathways from social determinants, other intermediary factors and health system affect the disease, health and well being⁸¹.

These are the factors that immigrants themselves, concerned institutions and the state must discuss to lessen health inequalities. Current state of immigrants' health data must be updated because the basis of their health status is based on self-reported assessment. In as much as this is a good source of information, it should be further explored by research to determine contributory factors leading to health inequality. In the case of Filipino immigrants in the French Riviera, health inequality might be a foreign word because they have access to health services and care under the Universal Health Insurance Coverage standard in France. However, access to care and services addresses emergency care and cure practices thus have limited impact on prevention campaigns for these immigrants. Addressing health inequalities for Filipino immigrants in the French Riviera is a reverse process because technically health inequality does not exist in accessing health care but since these immigrants have limited access to prevention campaigns and programs, health inequality exists in this area. Now that health programs are geared towards prevention

⁸¹ WHO Health Report 2012. p 46

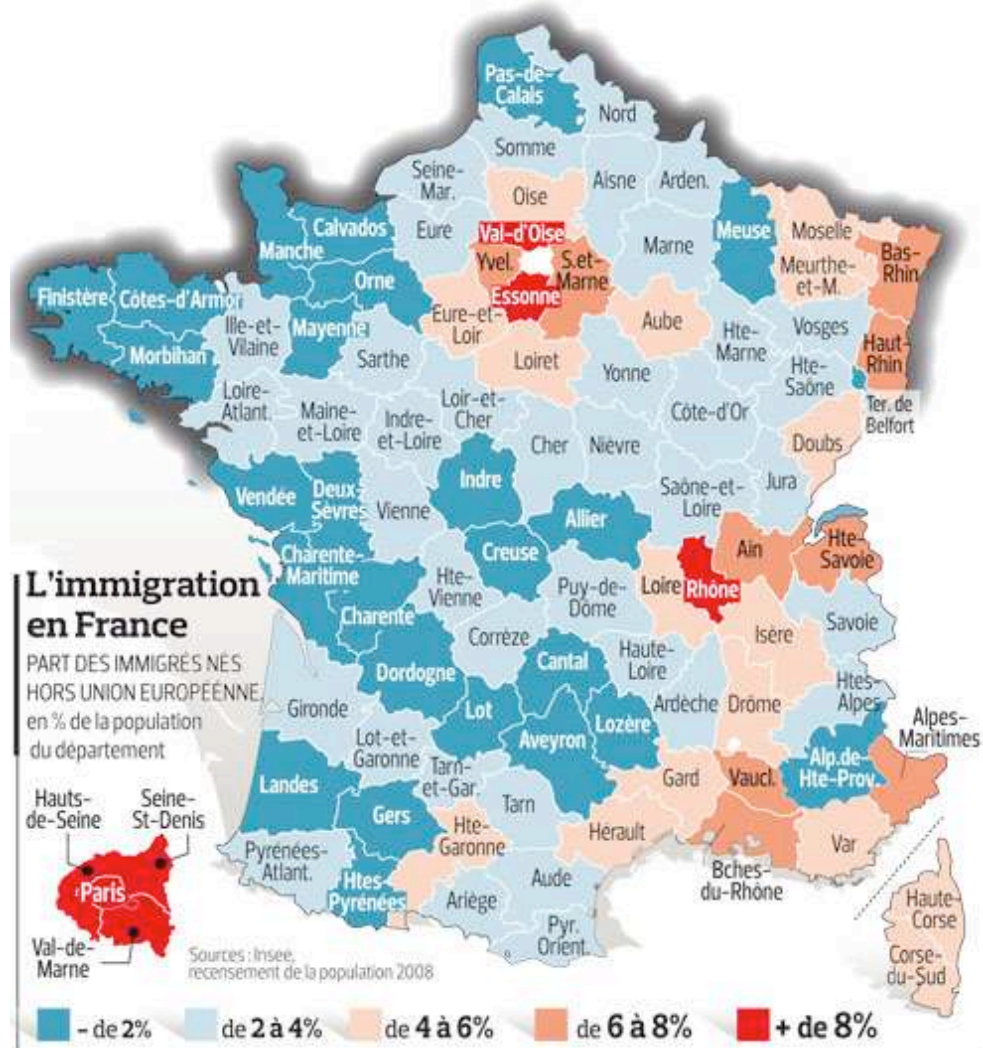
rather than cure, proactive rather than reactive, efforts to lessen health inequalities must be concentrated on prevention campaigns.

b) Immigrant Statistics in France

In a recent report about immigrants in France, the online edition of the French newspaper, Figaro stated that the number of second-generation immigrants outnumbered the first. The study conducted by the Institut National de la Statistique et des Etudes Economique) (INSEE) {National Institute of Statistics and Economic Studies} highlighted that the total number of immigrants including their descendants is almost 7 million or 11% of the population. Mr. Gerard Bouvier, Head of Division in the Department of Statistics Studies and Documentation of the General Secretariat for Immigration and Integration stated that in the 1970's migration in France is generally movements of men, purely economic and are limited to five countries: Algeria, Spain, Italy, Morocco and Portugal. Today, migration includes a lot of women and the reason for moving in is not mainly due to economics but familial. Meaning, they are moving in to France because their family members are already in France. There has also been a strong growth in immigration of people from Africa (excluding North Africa), Turkey and China.⁸²

⁸² France: 12 Million d'immigres et d'enfants d'immigres: <http://www.lefigaro.fr/actualite-france/2012/10/10/01016-20121010ARTFIG00262-immigration-les-chiffres-de-l-insee.php> (accessed April 22, 2013)

Figure 4: Immigrant Distribution all over France



Taken from: <http://www.lefigaro.fr/actualite-france/2012/10/10/01016-20121010ARTFIG00262-immigration-les-chiffres-de-l-insee.php> (accessed April 24, 2013)

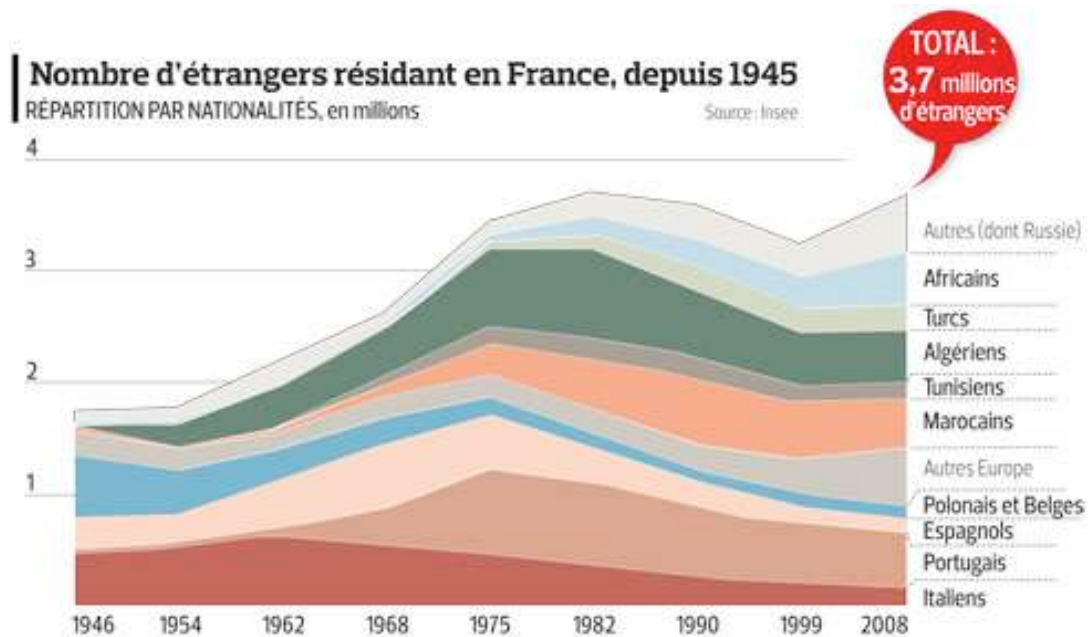
Figure 4 shows in color, the distribution of immigrants all over France in relation to its percentage to the population of the area. The highest is around 8% (in red) and the lowest is negative 2 (in dark blue). Immigrants mainly settle in border areas and urban and industrial areas. Ile-de France, where the capital city of France is located, shares the same high concentration of immigrants as Rhone, where Lyon (the second largest metropolitan city in France) is located.

Having 6-8% of its population being immigrants are the departments of Yvel, Siene et Marne, Bas Rhin, Haute Rhin, Haute Savoie, Alpes Maritimes, Bouches du Rhone, Vaucl and Ain. It is highly noticeable that these departments are located in the border areas. France' neighbors include Germany, Italy, Luxembourg, Spain, Switzerland and Monaco. Figure 4 shows that there is a larger number of immigrants in departments bordering Germany, Italy and Switzerland, Alpes Maritimes as one of these departments and where the French Riviera is included.

Some 43% of immigrants and 32% of their descendants live in Ile-de-France, while the Paris population represents only 18% of the total population. The proportion of immigrants in the labor force is also above average (between 10 and 20%) in the regions of South-East (PACA, Languedoc-Roussillon, Corsica) and Alsace ⁸³.

⁸³ *France: 12 Million d'immigres et d'enfants d'immigres* <http://www.lefigaro.fr/actualite-france/2012/10/10/01016-20121010ARTFIG00262-immigration-les-chiffres-de-l-insee.php> (accessed April 22, 2013)

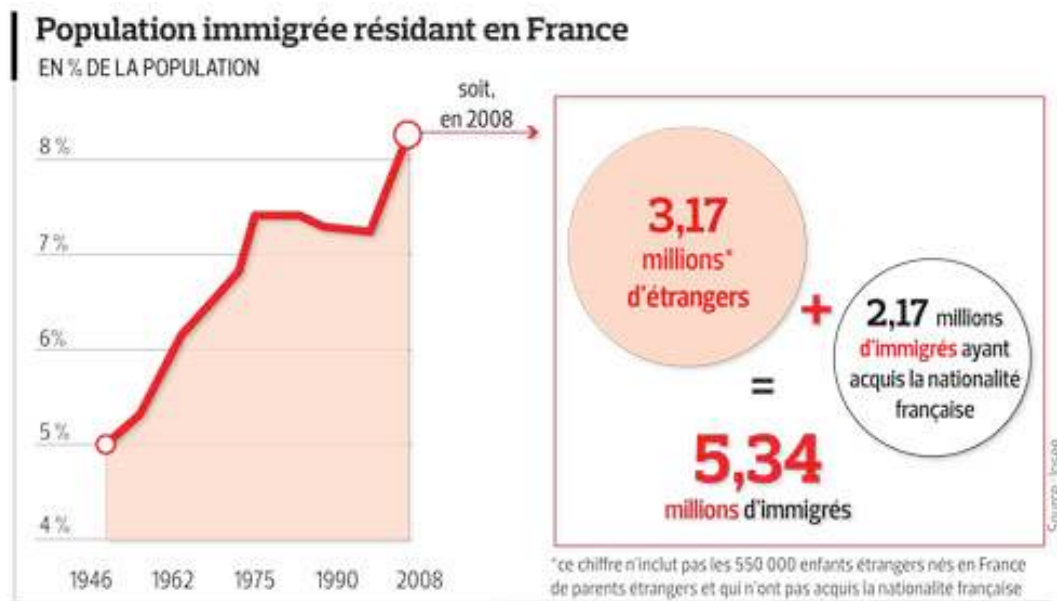
Figure 5: Number of Foreign residents in France since 1945



Taken from: <http://www.lefigaro.fr/actualite-france/2012/10/10/01016-20121010ARTFIG00262-immigration-les-chiffres-de-l-insee.php> (accessed April 22, 2013)

Figure 5 shows the growth of immigrants in France from 1946 to 2008. There are almost 4 million foreigners in France from nine countries of origins. The increase in number is highly visible between late 60's to mid 80's both immigrants from inside and outside Europe. It is noteworthy to mention that immigrants from Poland, Belgium, Spain, Portugal and Italy remained stable – meaning there is no alarming change in number. However, immigrants from Africa, Turkey, Algeria, Tunisia and Morocco as well as the Russians seem to be attracted to France as their numbers continue to rise.

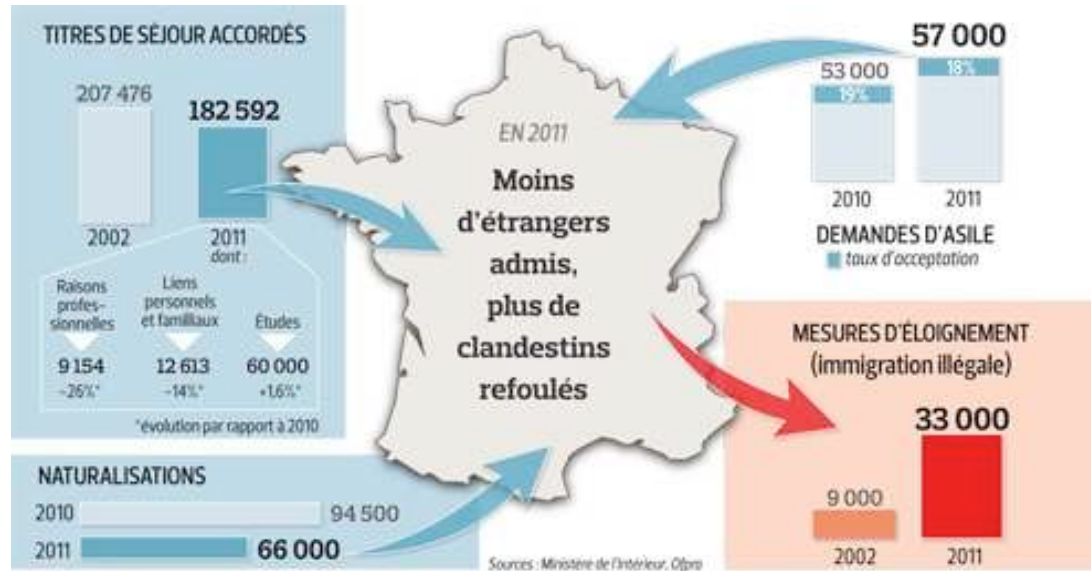
Figure 6: Immigrant Population in France



Taken from: <http://www.lefigaro.fr/actualite-france/2012/10/10/01016-20121010ARTFIG00262-immigration-les-chiffres-de-l-insee.php> (accessed April 22, 2013)

Figure 6 shows a more complex yet complete scenario of the number of foreigners in France. Counting the 2.17 million immigrants who were granted French nationality, the number of immigrants in France totaled 5.34 million. However, this does not include the 550,000 children born from foreigner parents who are not yet French nationals. To sum it all up, the total number of foreigners residing in France including the second generation is almost 6 million. This number however, does not include undocumented migrants. As of 2008, roughly 8% of the total population of France are immigrants.

Figure 7: Statistics of Immigrants in France



Taken from: <http://www.lefigaro.fr/actualite-france/2012/01/11/01016-20120111ARTFIG00265-immigration-net-recul-des-naturalisations.php>

The left side of Figure 7 entitled Titres de sejour accordés {Card of long stay distributed) shows the number of papers given to foreigners that allowed them to stay legally in France. The number decreases from 207, 476 in 2002 to 182, 592 in 2012. Twenty six percent of those who were allowed to stay are for professional reason, 16% for studies and 14% came to France for family reasons. Similarly, naturalization decreased to 66,000 in 2011 from almost 95,000 in 2010. In 2002, the total of illegal immigrants that were kicked out of France totaled 9,000 but in 2011 it reached 33,000. This is a very strong indication of the country's commitment in limiting the number of immigrants staying in France as well as the success of the country's campaign for immigration.

c) Health Status of Immigrants in France

In a study conducted by Catherine Berchet and Florence Jusot (Immigrant Health status and the use of healthcare services: A Review of French Research)

revealed that there is a wide disparity between immigrants and the French population. Compared to the French status, immigrants' health status has deteriorated over the past thirty years. In addition, office based medical practices and prevention programs for immigrants have notably weakened. Although immigrants registered a better health status at the beginning, their economic level, loss of social connection, informational barrier and discriminating attitudes of health providers are major contributing factors for their health deterioration in France⁸⁴.

Studies regarding immigrants' health status in the past revealed a better health status of foreigners in France⁸⁵. Male Moroccan immigrants for example reported a higher rate of longevity and lower rate of invalidity compared to their female counterpart. Immigrant women in France reported 16% and 33% men reported lesser illness compared to French households.

Research results starting in the year 2000 revealed a different scenario. It was reported that the subjective health status of immigrants in France is poorer than that of the population as a whole whatever the age and gender⁸⁶. Immigrants' health deteriorated as they stay longer in France, which was confirmed by the Life History survey⁸⁷. Result of the project SHARE (Survey of

⁸⁴ Berchet, C. & Jusot, F. (2012). *Immigrants Health Status and Use of Healthcare Services: A review of French research*. Questions d'économies de la Santé. No. 172. pp 1-2. Wanner P., Bouchardn C., Khlat M. (1997). *Causes de décès des immigrés en France 1979-1985*. Migration Santé, 91. Bouviern-Colle M.H., Magescas, .B., Hatton F. (1985). *Causes de décès et jeunes étrangers en France*. Revue d'épidémiologie et de santé publique, 49. Khlat M. & Courbage Y. (1995). *Mortalité des immigrés marocains en France, de 1979 - 1991*. Il-leses causes de décès. Population, 5n(2). Mizrahi A., Mizrahi A., Wait S. (1993). *Accès aux soins et état de santé des populations immigrées en France*. Rapport CREDES. Khlat M., Sermet C., Laurier D. (1998). *La morbidité dans les ménages originaires du Maghreb, sur la base de l'enquête santé Insee 1991-1992*. Population 6.

⁸⁵ Brahimi M. (1980). *La mortalité des étrangers en France*. Population, 3

⁸⁶ Attias-Donfut C., Wolff, F. C. (2005). *Le lieu d'enterrement des personnes nées hors de France*. Population, 6n (5).

⁸⁷ Lert F., Melchior, M., Villel, I. (2007). Functional limitations and overweight among migrants in the Histoire de Vie studn. Revue d'épidémiologie et de santé publique, 55 (6).

Health Ageing and Retirement in Europe), highlighted that immigrants' health status is more deteriorated than that of the native populations in terms of perceived health and activity limitations in France, Germany, the Netherlands, Sweden and Switzerland⁸⁸. Concerning access to preventive health services, French studies observe differences between the immigrant and French populations in terms of vaccination or screening⁸⁹. For equivalent health care needs and socio-economic conditions, immigrants' self-report fewer hepatitis B vaccinations and fewer AIDS tests over the last twelve months⁹⁰.

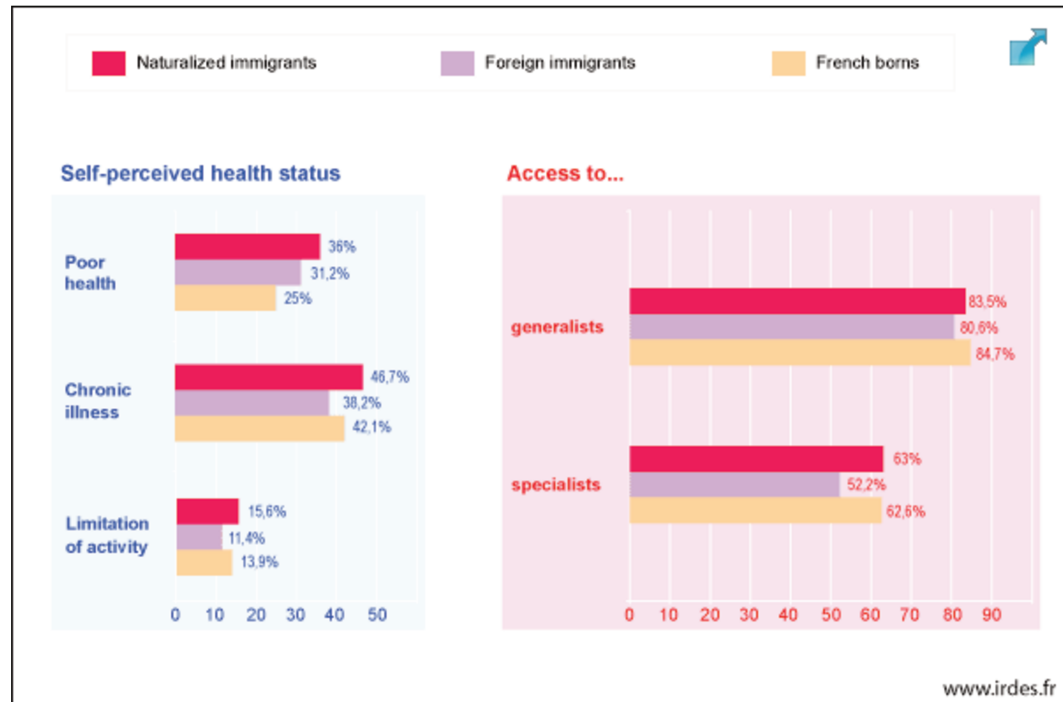
The current findings with regard to immigrants' health are products of recent investigation. Deterioration of immigrants' health is due to several factors that have already been identified but need to be continually monitored. Research focused on investigating a particular immigrant group must be encouraged to specifically determine the intricacies of their cultural beliefs and how it can be used to anchor health campaigns of the host country or serve as the foundation in the creation of a standard communication guide between health providers and immigrant patients. As the cultural environment of the host country changes due to the arrival of different immigrant groups so is the overall landscape. Accommodation should be afforded to these immigrants for they have become members of the population.

⁸⁸ Solé- Auro A., Crimmins E.M. (2008). Health of Immigrants in European countries. *International Migration Review*. 42(4).

⁸⁹ Berchet, C. & Jusot, F (2012). *Immigrants Health Status and Use of Healthcare Services: A review of French research*. *Questions d'économies de la Sanet*. No. 172. p 4

⁹⁰ Dourgnon P., Nusot F., Silva N., Sermet C. (2009). *Le recours aux soins de ville des immigrés en France*. *Questions d'Economie de la Santé*, 146.

Figure 8: Immigrants' self-perceived health status and access to care in France, 2002-2003



Taken from:

<http://www.irdes.fr/EspaceAnglais/ChartOfTheMonth/ChartOfNovember2009.html>
(downloaded August 2013).

Figure 8 shows the study conducted by the Institute for Research and Information in Health Environment (IRDES) in 2002-2003. Combining the number of naturalized citizen and foreign immigrants, there is a sweeping finding that these people perceived that they have poor health, they suffer from chronic illness and have greater limitations of activity. Both naturalized immigrants and French born perceived that they have good access to generalists and specialists.

This shows the high level of satisfaction as far as accessing doctors are concerned for a large number of the immigrant population in France. However, the same large number also believed that they are in poorer health condition. This is ironic because the French healthcare system seems to perform well in taking care of the health of its people. This negative health perception of immigrants as

regards to their health can be translated to more frequent doctors visit (since they are accessible) more medicine consumption, more medical tests and higher state participation in their medical expenses. Where this self – perceived poorer health emanates is still a mystery because there has not been a formal study conducted yet. It would be an interesting area to investigate for it might reveal the relationship between immigrant health status and societal factors in health maintenance. By identifying the root cause of these low health perceptions of immigrants, health professionals and legislatures would be guided with the right information on how to move forward.

d) The Role of Language in Health

Speaking and understanding the language is still the best aid for incorporation. Knowing the host country's language facilitates incorporation, no matter how broadly defined, since it greatly facilitates one's capacity to succeed in all other domains of life ⁹¹. This is further reinforced in a study about patients who were identified as Limited English Proficient (LEP) by Ngo- Metzger et. al. in the United States. They examined the effect of language discordance on the degree of health education and the quality of interpersonal care that patients received and examined its effect on patients' satisfaction. They also evaluated how the presence/ absence of a clinic interpreter might have affected those outcomes. Their population are the Spanish speakers and Asian American, specifically Vietnamese and Chinese ⁹². Language as a barrier for the LEP is associated with less health education, worse interpersonal care and low patient satisfaction. It adversely impacted the quality of medical care that patients receive, resulting in longer hospital stay, more medical errors and lower patient

⁹¹ Hochschild, J, & Cropper, P. (2009). *Immigration Regimes and Schooling Regimes: Which Countries Promote Successful Immigrant Incorporation?* Harvard University, Government and Social Policy Ph.D. Program. p 11

⁹² Ngo-Metzger, Q. et. al. (2007). *Providing High-Quality care for limited English proficient patients: the importance of language concordance and interpreter use.* Journal of Internal Medicine. pp 324-325

satisfaction. LEP patients are also found to be less satisfied with their care, less likely to come back for a follow-up, have more problems understanding medication instruction and more medication related problems⁹³. These patients also reported worse interpersonal care and were less satisfied with their health providers.

The US Department of Health and Human Services recognized that the lack of adequate interpretation is a form of discrimination so they developed a set of mandates and guidelines for Culturally and Linguistically Appropriate Services (CLAS). The CLAS standards require that health care organizations offer and provide language assistance services to LEP patients and exclude the use of family members as interpreters except by the specific request of the patient⁹⁴. Despite this effort however, there are still a significant number of LEP patients who do not have access to interpreters. They still rely on family members and do their best to communicate in English. Health care providers found this effort of the patient problematic for they find it difficult to elicit symptoms, explaining treatment and eliciting patient references, even if there is an interpreter. However, in terms of patients' ratings of their providers and the quality of interpersonal care, having the interpreter does not serve as a substitute for language concordance between patient and provider. In a medical consultation where language is a barrier, even with the presence of an interpreter, providers often ignore the comments of the patients⁹⁵. This translates to the fact that despite the gains derived from the presence of a translator in the delivery of health care, his or her power is limited because patients are still looking for a more personalized relationship with their health providers. It is said to be true that health information can be transmitted to the patients by the interpreter but the boundaries get visible when patients demand more personal care beyond knowing the basic information about their

⁹³ Ngo-Metzger, Q. et. al. (2007). *Providing High-Quality care for limited English proficient patients: the importance of language concordance and interpreter use*. Journal of Internal Medicine. pp 17-18

⁹⁴ Ibid 93 p 328

⁹⁵ Ibid 93 p 328

disease. To prove the potent power of medical providers who speak the same language as their patients, diabetic and hypertensive patients reported a better health outcomes. Patients asked more questions and better understand health information⁹⁶.

Despite the recognized contribution of interpreters in the United States, there is no minimum requirement for medical interpreter training. The National Council on Interpreting in Health Care recommends at least 40 hours of instruction on medical terminology, interpreting skills, ethical issues, role-playing and cultural awareness⁹⁷. Reiterating patients perception regarding the role of interpreter as mediator between him and his provider, it would be ideal if trainings had also been provided to doctors so they will become fully aware of the intricacies of the cultural gap that is present between them and their community. Narrowing this cultural gap might will lead to health equity as proven by many studies about health and language. In a study conducted by Mark Johnson, he highlighted the idea that issues of communication should become a fundamental part of future research and more importantly in the training of health workers⁹⁸.

The use of medical interpreter for the non-French speakers living in the French Riviera, is a good idea might be very helpful. Previous studies strengthen this claim by reporting that having access to a clinic interpreter can facilitate the transmission of health education⁹⁹. Even if the presence of interpreters did not meet the desired objectives this researcher still strongly pushes for its utilization in the Riviera because the outcome maybe different. France is a country which takes pride in its language. They are proud to say that French was once the most widely

⁹⁶ Ngo-Metzger, Q. et. al. (2007). *Providing High-Quality care for limited English proficient patients: the importance of language concordance and interpreter use*. Journal of Internal Medicine. p 14

⁹⁷ Ibid 96 p 43

⁹⁸ Johnson, M. (1999). *Communication in Healthcare: A review of some key issues*. Nursing Times Research Vol 4. No 1. SAGE Publication. 18-29. p 19

⁹⁹ Ibid 96 p 324

spoken language in the world and most French seem to live in that era until today. The French Riviera is not an ideal place for people who do not speak French. It has to be remembered that the South of France and the Monaco areas are retirement places which mean that majority of the population are older. In terms of language usage, they are expected speak French and are not very open in conversing with any other language especially English because of the tumultuous years of war between the United Kingdom and France. Moving around on daily basis is very challenging and it gets more complicated if someone seeks more complex information. For the length of time this study was conducted in the French Riviera, this researcher visited several doctors' clinics and public health offices, specifically l'Assurance Maladie. All medical advisories and health communications in these offices are in French and in the government health office, no one is assigned to assist non-French speakers. To add insult to injury, government workers are not trained to be service providers. The information they gave and the amount of time they spent on people who require much needed information is highly dependent on their mood. Most of the time, they advice people to visit their web site -amelie.fr. It is true that almost all information is provided on their web site but for people who do not speak French, it serves nothing. The reasons why they come to an office is to talk to someone who can possibly guide them on what to do and where to go. Hence, the presence of someone who speaks other language than French is very much welcome. Once a non-French speaker starts to speak in English or broken French, employees of this office immediately say – verbally or through non- verbal cues – I cannot help you.

It is not all bad after all, for those who are lucky enough, they can find that there is a platform for non-French speakers. They can call the official number of l'Assurance Maladie, initially talk to the speaker in French and request to be transferred to an English speaking person. The operator will then transfer the caller to someone who speaks English who is capable of answering basic questions about the French health care system. The downside is that this English speaking person is trained only to answer frequently asked questions and for more complex inquiries, she always refers the caller to the website or to go to the

nearest hospital. For a non-French speaker, visiting the website which is written in French is an exercise in futility. In the hospital, patients can surely find English speaking medical staff or doctors but since they are not so many, patients need to wait for a long time to be able to talk to an English-speaking medical professional. As the conversation progresses between the patient seeking health information and the medical professional it is very obvious that they do not have any idea how to deal with a patient from a different cultural and language background. Doctors doing private practice seemed to be more accommodating with patients because for the obvious reason that they are dealing with their patients on a one-on-one basis. Health care with them seems to be more personalized and they seem to be more humane.

There are many English speaking private doctors in the Riviera and it is the patients' role to ask around. In an ideal situation, a list of foreign language speaking doctors could have been provided by local health offices. This is an ideal scenario for foreign language speaking patients for all they need to do is to get in touch with the local health office and get health information from a centralized source. Resourceful Filipino immigrants often rely on referrals. If they need to consult a generalist or even a specialist they ask members of the Filipino community if they know one. They also try to find out how approvable the doctor is, if he speaks English and other information that would make them comfortable. Settling these things lessens their anxiety. In several instances, this researcher accompanied some Filipino patients as they consult their doctors. This researcher observed that between a French doctor who speaks little English and a Filipino patient who speak little French, communication interaction relies heavily on body language, facial expressions and hand signs. Doctors seem not to have the patience to better understand his non- French-speaking client. The patient on the other hand seems to be in a hurry to get the consultation done. In one instance, a Filipino patient just gave the results of his laboratory test to the doctor, the doctor read it without saying anything and then wrote the prescription. Explains a little that a certain medication needs to be taken three times a week for ten days because it is an anti-biotic and that the patients test results looks normal. The

consultation ended in less than five minutes. When I asked the patient what he is consulting for, he said that he was experiencing pain when he urinates. Being sexually active, he was worried that he might have contracted sexually transmitted disease (STD). This researcher further inquired if he was able to communicate his worries to his doctor, and obviously he was not able to do so because he lacks the language faculty to explain. The doctor might have thought that what the patient was just experiencing is a classic symptom of urinary tract infection (UTI) that is why he ordered a laboratory test. Basing on the doctors prescription, it might be just a UTI because he just prescribed an anti-biotic. Another possible outcome of this scenario is misdiagnosis. What if the patient really acquired STD and UTI is just an initial manifestation of the disease? Language barrier can indeed cost someone's life and medical professional's lack of cultural knowledge can have fatal consequences.

In another consultation where this patient was allowed to be tugged along, the patient knows how to speak French. She's been seeing her doctor for a long time and they were able to develop a healthy doctor-patient relationship through time. The consultation went well, as the patient articulately presented her case and the doctor has a ready record of her patients' history. The flow of communication is reciprocal and genial. At the end of the consultation, the doctor told the patient that she saw on the news that there was a big typhoon in the Philippines and that some areas are inundated. The atmosphere changes as the communication becomes more humane and current. As the patient and this researcher left the doctors' clinic, the patient immediately told stories about how kind her doctor was. It is obvious that the patient did not only feel medically satisfied with her doctors' visit but also feel important. This state of mind has a healing effect, no matter how superficial or short-lived it maybe.

e) Language experiences of Asian Immigrants

There has been a wide array of misconceptions about Asians as a group of people and Asian as patients. Several countries have categorized Asians as a single entity- ignoring all other factors such as linguistic, educational differences

etc. - rather than a diverse cultural group ¹⁰⁰. Its implications may include oversimplification of the term Asians that will surely spill in all facets of an Asians' life as an immigrant. In the area of health, language barrier with Asian patients may lead to under-diagnosis of communication impairments. Non-verbal gestures and nuances were also significant for these clients ¹⁰¹. It was also revealed in another study ¹⁰² that Asians are not keen in asking advice from the telephone while other studies suggest that these people prefer to do medical visit in person. This may be explained by the desire of these patients to talk face to face, using body language to compensate for what they cannot express verbally ¹⁰³. Drawing from personal experience of this researcher belonging to the Asian race, Asians value face to face communication compared to other mediums of communication especially for things that are very important to them. Health troubles require a long conversation because Asian patient would almost always talk about their health issues in a story telling manner. For the doctors whose income depends on how many patients he sees in a day, he has limited time to listen to a patient story more so adding more time studying the cultural and racial composition of the population he is serving. Communication difficulty may lead to poor health management¹⁰⁴.

This is problematic considering the huge differences between and within Asian cultures. Having such misconceptions, the host countries administrative

¹⁰⁰ Johnson, M. (1999). *Communication in Healthcare: A review of some key issues*. Nursing Times Research Vol 4. No 1. SAGE Publication. 18-29. P 20

¹⁰¹ Robinson, TN., et. al. (1998). *An Evidence-Based Approach to Interactive Health Communication: A Challenge to Medicine in the Information Age*. Science Panel on Interactive Communication and Health. US National Library of Medicine. National Institute of Health. JAMA. 280 (140) 1264-9

¹⁰² Rashid, A. & Jagger, C. (1992). *Attitudes to and Perceived Use of Healthcare Services among Asian and Non-Asian Patients in Leicester*. British Journal of General Practice 42 (358) 197-201.

¹⁰³ Johnson, M. (1999). *Communication in Healthcare: A review of some key issues*. Nursing Times Research Vol 4. No 1. SAGE Publication. 18-29. P 22

¹⁰⁴ Johnson, M. (1999). *Communication in Healthcare: A review of some key issues*. Nursing Times Research Vol 4. No 1. SAGE Publication. 18-29. P 24

procedures are often not designed to accommodate members of the minority ethnic community. In the process of diagnosis for instance, Asian patients may have under-diagnosis due to communication impairments ¹⁰⁵. This is a major issue to be addressed to because communication in healthcare encompasses all forms of health information transmission, and attempts by patients or potential users to access health service ¹⁰⁶.

f) Immigration experiences of countries worldwide

When Hochschild and Cropper did their research in 2009, the initial impression was that in terms of successful immigration integration, Canada is the best and France is the least successful. The study reported that Canada has constitutional commitment to multiculturalism and many strong policies designed to foster mutual respect and minority empowerment. These commitments are engraved in the country's federal and provincial governments policy. Author James Fearon reported that Canada is one of the most multicultural countries in the world. Immigrants in Canada are well- educated and lived in decent places. Banting et. al. added that Canada has adopted a more expansive immigration program as well as policies that gave greater public recognition to difference through Aboriginal rights, official language policies and multiculturalism¹⁰⁷. France on the other hand has always been the model on how not to handle immigration and immigrants. In this country, immigrants are reluctantly admitted and encouraged to go back home after completing their needed but ill-paid work. A large number of immigrants and their descendants live in isolated deeply poor communities with high – crime rates,

¹⁰⁵ Robinson, TN., et. al. (1998). *An Evidence-Based Approach to Interactive Health Communication: A Challenge to Medicine in the Information Age*. Science Panel on Interactive Communication and Health. US National Library of Medicine. National Institute of Health. JAMA. 280 (140) 1264-9

¹⁰⁶ Johnson, M. (1999). *Communication in Healthcare: A review of some key issues*. Nursing Times Research Vol 4. No 1. SAGE Publication. p 20

¹⁰⁷ Banting, K. et. al. (2011) Are diversity and solidarity Incompatible? Canada in Comparative Context. In Roads 28. Diversity through three lenses. Available online at: http://www.researchgate.net/publication/243964181_Are_Diversity_and_Solidarity_Incompatible (accessed February 2010)

few jobs and poor schooling. Descendants of immigrants rioted in 2005 to protest their exclusion from full membership in the French society but between then and now, little has changed. Naturalization in France is also a very complicated process. France does not encourage official recognition of race and ethnicity in favor of shared republicanism. The lack of systematic data collection and reporting makes it very challenging to determine group-based disadvantages. The study further reiterated that France admitted primarily immigrants with low level of education and qualifications only as low wage laborers. Recently, things are slowly beginning to change. Authors Steward and Lindburg highlighted in their report “Gaining from Diversity”, that one practice by McDonalds restaurants in France takes the religious practices of their employees into consideration by adjusting the hours of Muslim employees during Ramadan ¹⁰⁸. To show to the international community that France indeed has set-up policies to respect diversity in all its forms, it can set the record straight by sharing doing research results about immigrants, providing basic statistics as well as government efforts to address immigrant issues.

As stated earlier, immigrants are important component of a growing society. For the idea that cultural diversity erodes some aspects of identity (referring to the cultural and personal identity of the natural born citizen of the country), Banting et. al. found out that “diversity affects trust only for those who have little interaction with their neighbors. Those who live in diverse setting but interact with their neighbors more regularly are not adversely affected by diversity ¹⁰⁹. European countries have their share of embracing cultural diversity. In Sweden, the Stockholm City Council offered a course on racism and xenophobia at work for

¹⁰⁸ Wrench, J. (2004). *Managing Diversity: Fighting Racism, or Combating Discrimination? A Critical Exploration*. In Titley, G. (Ed). *Resituating Culture*. Directorate of youth and Sport Council of European Publishing. p 115

¹⁰⁹ Banting, K. et. al. (2011) *Are diversity and solidarity Incompatible? Canada in Comparative Context*. InRoads 28. Diversity through three lenses. Available online at: http://www.researchgate.net/publication/243964181_Are_Diversity_and_Solidarity_Incompatible (accessed February 2010). P 46

work supervisors and teachers from a health care college, addressing prejudices and hostile attitudes and providing the opportunity to discuss xenophobia and racism. In Germany, A ‘Living with Foreigners” campaign was started by the German trade union and employees federations, the Deutscher Gewerkschaftsbund (DGB) and the Bundesvereinigung der Deutschen Arbeitgeberverbände (BDA) {German Employees Association}. They provide training packages and media materials aimed at countering attitudes of intolerance and xenophobia. A Belgian electrocoating company highly considered the religious practices of their Maghreb origin employees. The company allows them to go to the changing rooms to pray during breaks. The Dutch Department of Public Works added a few words in their recruitment advertisement which in affect says that all other things are equal, ¹¹⁰. Despite all these efforts, there is much to be done. Author John Wrench suggested six levels of activity to combat discrimination and improve the employment inclusion of immigrants and ethnic minorities. These are: 1) training the migrants 2) Making cultural allowances 3) Challenging racist attitudes 4) Combating discrimination 5)equal opportunities policies with positive action 6) diversity management¹¹¹. These actions are on the shoulder of the receiving country. These countries may cry foul for the heavy load put on their shoulder. However, as movement of people is an inevitable product of globalization, there is nothing else that can be done but to manage diversity.

From 1995-2006, movement of people from one country to another was monitored to determine who are the people moving in and to what countries. The results are interesting for it revealed rich information about the preferences of particular race as far as which country to transfer to is concerned.

Table 1: Countries of Birth of Foreign-Born Population in Selected Countries, 1995 to 2006

<i>Country</i>	<i>Countries of birth of</i>	<i>% of foreign-born</i>	<i>% of total inflow,</i>
----------------	------------------------------	--------------------------	---------------------------

¹¹⁰ Wrench, J. (2004). *Managing Diversity: Fighting Racism, or Combating Discrimination? A Critical Exploration*. In Titley, G. (Ed). *Resituating Culture*. Directorate of youth and Sport Council of European Publishing. p 115

¹¹¹ Ibid 100

	<i>largest number of immigrants</i>	<i>population</i>	<i>annual average for 1995-2005</i>
Australia	UK	(2005) 23.6%	12.5%
	New Zealand	9.4	13
	Italy	4.6	--
	China	4.0	8.0
	Vietnam	3.7	--
	India	2.9	5.5
	South Africa	2.4	5.0
Belgium	France	(2005) 12.3	13
	Morocco	11.7	10
	Italy	9.9	4.0
	Netherlands	8.8	12
	Turkey	6.6	4.5
	Germany	6.6	5.0
Canada	UK	(2001) 11.1	2.5
	China	6.1	13.5
	Italy	5.8	--
	India	5.8	11.0
	US	4.4	3.0
	Philippines	4.2	6.0
	Pakistan	--	5.0
France	Algeria	(2005) 13.7	17.5
	Morocco	12.6	16.0
	Portugal	11.5	--
	Italy	6.9	--
	Spain	5.7	--
	Turkey	4.6	7.0
	Tunisia	4.5	6.0
	Cameroon	--	2.5
Germany*	Turkey	(2005) 26.1	8.0
	Italy	8.0	5.0
	Poland	4.8	13.0
	Greece	4.6	--
	Serbia & Montenegro	4.4	--
	Russian Federation	2.8	5.0
	Romania	--	3.0
Switzerland*	Italy	(2005) 19.6	7.0
	Serbia & Montenegro	13.0	8.0
	Portugal	11.0	9.0
	Germany	10.4	15.0
	Turkey	5.0	3.0
	France	4.6	7.5
United Kingdom	India	(2006) 10.0	4.5
	Ireland	7.2	--
	Pakistan	4.8	3.0
	Germany	4.7	4.0
	Poland	4.0	--
	Australia	2.0	9.5
	France	1.0	7.5
	United States	2.9	7.5
	New Zealand	--	5.5
United States	Mexico	(2005) 30.4	19
	Philippines	4.5	3.0
	India	4.0	3.0
	China	3.8	3.0
	El Salvador	3.1	2.0
	Vietnam	2.9	4.0

Taken from Hochschild and Cropper ¹¹²

Sources: column 3:(Organisation for Economic Co-operation and Development 2007a): Tables B.1.4, B.1.5. Column 4:(Organisation for Economic Co-operation and Development 2008c), pp. 42-43

* Stocks of foreign population, not foreign-born, in column 3.

Table 1 shows the largest groups of foreign-born populations in selected countries. Under France, it has to be highlighted that the immigrants are former colonies thereby advantageous in terms of assimilation to the French culture- especially in language- compared to those who have no historical connection to the country.

Filipinos main area of destination for migration is the United States. They comprise 4.5% of the population of the US in 2005 with an annual average inflow of 3% for a period of 10 years (1995-2005). Second favorite area of destination for the Filipinos is Canada. A total of 4.2% of the Canadian population are from the Philippines with an average annual inflow of 6% from 1995-2005. France is obviously not the country that Filipinos chose to live and work. Those countries included in the list of countries with most number of immigrants in France are mostly former colonies or under the French protectorate in the past like in the case of Tunisia. French people primarily chose Belgium to migrate. In 2005, 12.3% of the population are French with a steady annual inflow of 13% over a period of 10 years. Second choice for French immigrants is Switzerland with 4.6% of its population came from France with a steady annual inflow of 7.5% from 1995-2005. French immigrants also go to the United Kingdom. Approximately 1% of UK's population is French with a steady inflow of 7.5% for a period of ten years. Germany is not a preferred destination for French immigrants and vice versa. It is interesting to note however that French and Germans live side by side in Belgium where they both belong to the biggest number of immigrants. Also, Canada is not a

¹¹² Hochschild, J, & Cropper, P. (2009). *Immigration Regimes and Schooling Regimes: Which Countries Promote Successful Immigrant Incorporation?* Harvard University, Government and Social Policy Ph.D. Program. p 12

popular destination for the French although there are areas of Canada (Quebec and Ontario) that speak French.

This movement of people shows the dynamics of migration. Filipinos influx to the US as an example, can be attributed to the Philippines long standing relationship with the US. The Philippines is a former US colony, has always been a US ally, and the government and educational system was patterned after the US educational system which makes English- the Philippines' second language. It is widely spoken, a large number Filipinos can speak and understand English and this skill is a major contributing factor to the Filipinos migration success in the US. Without claiming to be academically true, this researcher postulates that if this is scenario holds true to easier assimilation of an immigrant to its host country, this may also be true in the case of France and its former colonies. Taking the personal experience of this researcher as a student in France and comparing her process of integration to that of students from former French colonies, it was very obvious that these students easily adapt to the new learning environment as well as integrated to the society in terms of finding a job, involvement in social activities and learning the basics of how to live in a new country. Assimilation for immigrants who have very limited if not none at all, background information about the receiving country, certainly takes longer.

The main contribution of this study by Hochschild and Cropper in the field of immigration research is how they measure assimilation on the basis of educational achievements which is focused on scores on standardized achievement tests of the immigrants. For them, the higher one's test score, the better are one's chances for a good job, fluency in the host country's language, good health, effective social and political participation, and cultural engagement. Test scores, especially measured as relative change over time, are also a good indicator of how hard a host country is trying to incorporate newcomers. If a country educates all of its students fairly well or if it is improving on its capacity to educate those at the

bottom of the test score distribution, it stands a good chance of succeeding in other incorporative efforts as well ¹¹³.

In the same study, Hochschild and Cropper presented an index that identified elements of academic achievement of newcomers. Elements that connect to academic achievements were rated between 1 to 3, three being the highest and 1, the lowest.

Table 2: Elements of Index of Academic Achievement by Newcomers, PISA, 2000 - 2006

Element	High (level of achievement by newcomers): 3 points	Medium: 2 points	Low: 1 point
Average achievement score across 9 test --immigrants	Australia Canada	UK US	Germany France Switzerland Belgium
-- second generation	Australia Canada	UK France Switzerland US	Germany Belgium
Disparity between native-born and immigrants	Australia Canada	UK US France	Germany Switzerland Belgium
Change in disparity between native-born and immigrants, 2000-2006	Australia France UK	Canada Switzerland Germany	Belgium US
Mobility between immigrants and second-generation	Switzerland UK France	US Belgium Germany	Australia Canada
Change in mobility between immigrants and second-generation, 2000-2006	Belgium	US	Australia Canada France Germany Switzerland UK
Educational assimilation between immigrants and second-generation	Australia Canada	US UK France	Switzerland Belgium Germany
Change in assimilation between immigrants and second-generation, 2000-2006	Belgium	Australia France UK US	Switzerland Germany Canada

¹¹³ Hochschild, J, & Cropper, P. (2009). *Immigration Regimes and Schooling Regimes: Which Countries Promote Successful Immigrant Incorporation?* Harvard University, Government and Social Policy Ph.D. Program. p 9

Taken from Immigration Regimes and Schooling Regimes: Which Countries Promote Successful Immigrant Incorporation? ¹¹⁴

Table 2 presented that immigrants from France scored low on average achievement score across 9 tests together with Germany, Switzerland, Belgium and Australia. The second-generation immigrants on the other hand, do better and they are at par with the United Kingdom, Switzerland and the United States. From 2000 to 2006, France scored high on change in disparity between native born and immigrants and mobility between immigrants and second-generation. Immigrants and the second generation in France are moderately assimilated in the educational system.

The authors also presented elements of successful incorporation.

¹¹⁴ Hochschild, J, & Cropper, P. (2009). *Immigration Regimes and Schooling Regimes: Which Countries Promote Successful Immigrant Incorporation?* Harvard University, Government and Social Policy Ph.D. Program.

Table 3: Elements of Scale of Conditions for Successful Incorporation, c. 2005

Element	Highly favorable conditions: 3 points	Moderately favorable conditions: 2 points	Unfavorable conditions: 1 point
% foreign- borns who are undocumented	France Canada Australia	Belgium Germany Switzerland	US UK
% of immigration slots for work	Switzerland Germany	UK Belgium Australia France	Canada US
Policy re temporary high-skilled workers	UK Australia	France US Canada	Germany
Policy re permanent high-skilled workers	Australia Canada UK	France	US Germany
Ratio of tertiary education for native-born vs. foreign-born	Australia Canada UK	Switzerland France	US Belgium Germany
Ratio of primary education for native-born vs. foreign-born	Australia Canada	Belgium UK	US Switzerland France Germany
Ratio of professional jobs for native-born vs. foreign-born men	Australia Belgium Canada France UK		Switzerland Germany
Stock of foreign-born with contextual knowledge of host country	Australia Switzerland Belgium UK	Canada	France Germany US
1995-2005 flow of foreign-born with contextual knowledge of host country	Australia Belgium Switzerland UK		France Germany US Canada
Legal ease of citizenship acquisition	Belgium France UK US Canada	Germany Australia	Switzerland
Proportion of foreign born (or foreign) who are citizens of host country	Canada Australia	Belgium US France	Switzerland Germany
Access to nationality	Australia US	Belgium Canada France UK	Germany Switzerland

*Taken from Immigration Regimes and Schooling Regimes: Which Countries Promote Successful Immigrant Incorporation?*¹¹⁵

¹¹⁵ Hochschild, J, & Cropper, P. (2009). *Immigration Regimes and Schooling Regimes: Which Countries Promote Successful Immigrant Incorporation?* Harvard University, Government and Social Policy Ph.D. Program

Table 3 identified clear and concise elements of successful incorporation on several issues. France has a high satisfaction percentage among undocumented migrants, although it was not further elaborated what constituted this concept. Also, France scored high in the ratio of professional jobs for native-born vs. foreign-born men as well as in legal ease of citizenship acquisition. On the other hand, France scored low on ratio of primary education for native-born vs. foreign-born and in the 1995-2005 flow of foreign-born with contextual knowledge of the host country. This has dire consequences on the quality of life for the immigrants as well as policy concerns for the host country. Since immigrants in France do not have much stock knowledge about the country, when they enter, this is the only time they are learning about new things and often the culture shock is highly pronounced. The length of coping is highly dependent on the social infrastructure. In the case of Filipino immigrants in France, community support is evident amongst Filipinos. A new comer just simply needs to attend a mass on a Sunday and there is where most Filipinos are. A new face in the small community is easily noticed and from there the new comer has started to become part of the Filipino community.

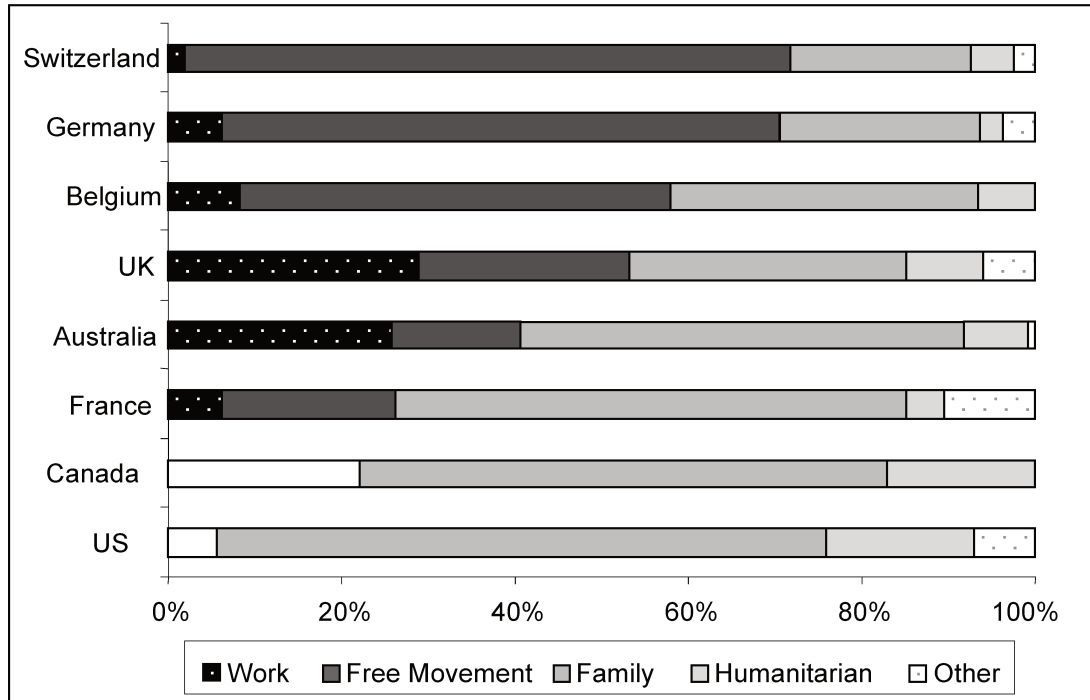
In the area of ease of citizenship acquisition, France has become stiffer in granting naturalization. The number of naturalized citizen dropped to 182,582 in 2012 compared to 207,476 in 2002. The number of illegal migrants who were kicked – out of France also reached 33,000 in 2011 from 9,000 in 2001 as reported by the French paper Figaro (Figure 7).

There have been many changes in citizenship acquisition but France still has amnesty programs for immigrants. A few months ago, there was a call from the Mairie de Nice calling the attention of undocumented immigrants that if they can prove that they have lived in France for the last five years, they can apply for papers that will legitimize / legalize their stay in France.

Incorporation however is dependent on several factors. Education as pointed out by the authors mentioned above is one. However, any other aspect of incorporation is dependent on the legality of the migrants. Those who enter a country employing the legal means have better access to information because the state recognizes their entry. For the undocumented migrants, the process of integration is very different. Having no legal documents to support their stay in the receiving country, these undocumented migrants are forced to move within the shadows, reducing them to citizens without countries, people with no rights. Rough estimates suggest that there are approximately 6% irregular migrants in France ¹¹⁶.

¹¹⁶ Hochschild, J, & Cropper, P. (2009). *Immigration Regimes and Schooling Regimes: Which Countries Promote Successful Immigrant Incorporation?* Harvard University, Government and Social Policy Ph.D. Program

Table 4: Migration Inflows by Legal Status in Selected Countries, 2006



Source: Hochschild and Cropper ¹¹⁷

Table 4 reflects the reasons for migration. Analyzing the case of France, large number of its immigrants flock the country because of some of their family members are already in the country. People from France' former colonies are flocking to the country, Algeria leading the number. France' immigrants that entered the city for reasons other than family, work, free movement and humanitarian are bigger in number compared to the countries. The reasons for this phenomenon are yet to be identified when there a standardized immigrant data collection is already at placed.

In a research about migration conducted by Hochschild & Cropper (2009) comparing Canada and France, emphasized the role of the state and its legislation to protect the rights of the migrants. These rights are recognized under the

¹¹⁷ Hochschild, J, & Cropper, P. (2009). *Immigration Regimes and Schooling Regimes: Which Countries Promote Successful Immigrant Incorporation?* Author's revision of (Organisation for Economic Co-operation and Development 2008b), Harvard University, Government and Social Policy Ph.D. Program. p 38

Canadian law and were protected under the constitution. This empowers the immigrants because their basic right is constituted in the supreme law of the land. This set – up recognizes the rights of the migrants and any individual or institution who violates any of these rights will be subjected to the rule of law. Since these rights are inscribed in the constitution, the immigrants themselves feel and act empowered. By the end of the study however, by some normative standard France has a better immigration regime than Canada. One of these standards is in the area of education. According to this study, France and the US are quite effective in incorporating the children of low-skilled newcomers through schooling. This same study found out that the UK, Canada, and Australia show success in educational incorporation, mainly by promulgating policies to encourage those migrants most likely to succeed. Empirically, it is a smart policy; normatively, it does not deserve great praise. Having promulgated laws that recognize the rights of the migrants seems not to be enough to ensure successful assimilation. The laws on immigration and the laws governing immigrants must be taken into parallel context to ensure that the normative compliments the empirical. Again, as highlighted by this study and most worthy of mentioning is the fact that the phenomenon of immigration and immigrant (non) incorporation is embedded in the lives of the migrants and studying these two separately, distorts any understanding of newcomers' actual circumstances ¹¹⁸. Another factor that highly contributes to the complexities of assimilation is the relationship of the receiving country to the country of origin of the migrants. Immigrants from countries who are former colonies of the receiving country may have little advantages when moving in, although not necessarily easier.

These findings highlight that despite the availability of health services and infrastructure in Europe, not all have access to health care. Among other groups, migrants have less access to health services due to the interplay of factors

¹¹⁸ Hochschild, J, & Cropper, P. (2009). *Immigration Regimes and Schooling Regimes: Which Countries Promote Successful Immigrant Incorporation?* Harvard University, Government and Social Policy Ph.D. Program. p 2

embedded in the health care system of the receiving country and the cultural background of the immigrants. There is a need to lessen the gap between these two often opposing forces that may disturb the delivery of effective health on the part of the health professionals and enjoyment of excellent health assistance on the part of the patients.

g) Researchers migration experiences and observations

Having lived amongst French people for a few years as a student of higher studies and academic investigator, not having enough knowledge about the French way of life, language and culture, before coming to the South of France to pursue graduate studies, is an enormous challenge. Observing other students who are from former French colonies like Algeria, Tunisia Morocco to name some, have better chances of integration because for one they speak the language and they are very familiar with the French culture. For someone like this researcher who comes from a country half way across the world, the process of assimilation and acculturation takes longer. To cite some an example, registration in the University takes a lot of courage and patience because as an international student, this researcher needs to process her registration at the International Relations Office in the University where she belongs, yet in that office, no one speaks English (referring to her first registration which is in 2009). It was the Secretariat of the Erasmus Mundus Mobility with Asia (EMMA) the organization who managed the scholarship of Asian students who were carefully selected to pursue graduate studies in their partner Universities in Europe, who place this scholar at the University de Nice Sophia Antipolis, Faculte de Lettre. She was strategically placed in this Faculte because the laboratoire (13M-Information, Media, Milieux, Mediation) offering PhD in communication and it is located in the Faculte de Lettre. The aim of the European Union to invite Asian scholars to study in Europe is an exciting and an academically fulfilling opportunity for any student. However, there are some factors that need to be highly considered for a more successful international mobility program. In the case of this researcher, in as much as she is ready to take on the challenges of

pursuing graduate studies in a foreign country, the problem is that the educational institution in which this scholar was placed is not ready for a student like her. The laboratoire is not aware of the EMMA program, there is not one conference or seminar in English within the laboartoire. For an English speaking student, the best option is always to look outside of her own University and look for conferences carried out in English. The laboratoire on the other hand constantly sends out invitation to for conferences and seminars outside of the University. True that the scholars under the EMMA program were given a one month extensive course in the French language while some were given a few months to learn however, given the reality that most of the Asian scholars have not had the opportunity to interact with the French culture before coming to France, the general action was, instead of trying to integrate, most of the scholars retreated and find comfort mingling with their people from the same racial origin. This only suggests that acculturation takes more than a few months. Taking the same sample group and talking about health issues, understanding membership to Carte Vitale is also a tedious process because of language barrier. Visiting l'Assurance Maladie in Nice, the health office that is tasked to assist the health concerns of the population, non-French speakers will find it impossible to find answers to her health inquiries for there is no one who speaks any other language other than French. There is not a single person assigned to handle questions for non-French speakers. Finding this situation frustrating and unacceptable, this researcher seeks the assistance of her French-speaking friends to know if there is a platform in France who could answer health inquiries of English speakers, and there is one. However, it is understandable that it is not encouraged to speak English in France. As the French always say to this researcher, "if you are in France, you speak French". This is quite understandable knowing how the French puts value on their language. It is important to note however that there are more English speakers in the world today. Combining the population of native English speakers and those who use it as a second language outnumbers the French speakers are outnumbered. As such, for a country who has a steady flow of immigrants and whose income

comes largely from tourism, the language spoken by these groups of people must be learned by the receiving county. In Nice for example, there are several organizations - private and government funded- established to educate immigrants about French everyday life including language teaching. One is called Association NOUS (Nice Ouverture Union Solidarite) whose main mandate is to prepare immigrants for integration in the area as they offer courses that include language, everyday French life and how institutions work under the French system. However, looking back at the compositions of immigrants in France who are mostly from its former colonies, it is quite easy to disregard the importance of other language because these immigrants are French speakers. Again, as this researcher has been reiterating from the very start of this study, other language must be considered, especially English because there are members of the French society who speak English.

h) Sample Health Communication Collaterals found in the South of France

In any of the l'Assurance Maladie and Cabinet Medicale {Medical Clinic} that this researcher visited, one cannot find any health communication collateral in any other language other than French. There are many reading materials addressing multiple health issues. What it failed to address however is the fact that there are other members of the community who do not speak French.

Here are some examples of reading materials one can find in l'Assurance Maladie offices:

Figure 9: Health collaterals from l'Assurance Maladies

zoom sur ...



La Participation Forfaitaire et la Franchise Médicale ?

- Participation Forfaitaire**

La participation forfaitaire de 1€ s'applique à toutes les consultations ou actes réalisés par un médecin (généraliste ou spécialiste) à son cabinet, à votre domicile ou à l'hôpital. Elle concerne aussi les examens de radiologie et les analyses de biologie dans la limite de 4€ par jour pour un même professionnel de santé.

Le plafond de la participation forfaitaire est de 50€ par an et par personne.
- Franchise Médicale**

La franchise médicale s'applique aux médicaments, aux actes paramédicaux et aux transports sanitaires. Elle est de 0,50€ par boîte de médicaments ; 0,50€ par acte médical dans la limite de 2€ par jour ; 2€ par transport sanitaire dans la limite de 4€ par jour.

Le plafond de la franchise médicale est de 50€ par an et par personne.
- Êtes-vous concerné ?**

Toutes les personnes sont concernées par la participation forfaitaire et la franchise médicale sauf les enfants et les jeunes de moins de 18 ans, les bénéficiaires de la CMU complémentaire ou de l'AME (Aide médicale d'état), les femmes enceintes dès le 1^{er} jour du 6^{ème} mois de grossesse, et jusqu'au 12^{ème} jour après l'accouchement.



mon parcours d'assuré



INFORMATION

JE SOUHAITE ACCOMPAGNER À DOMICILE UN PROCHE EN FIN DE VIE






In private doctors' clinic this is the same scenario as far as health collaterals are concern.

Figure 10: Health Collaterals from doctors' clinic


Une méningite C
et soudain *c'est sa vie qui bascule*



Aujourd'hui
vous pouvez protéger
efficacement votre enfant
par la **VACCINATION**

Baxter

Petit précis sur la **contraception
progestative**



Pilule
Stérilet
Contraceptif
injectable
Implant

MSD

Bien protéger
son bébé en hiver

— GUIDE PRATIQUE N°1 —
Parlez-en avec votre médecin




**Nestlé
NIDAL²**
Bien grandir, c'est pour la vie

Document destiné aux parents de bébés de plus de 6 mois

le **Sucre,**
les **Sucres**

Quelle place dans l'alimentation ?



Repères santé,
Astuces culinaires,
Recettes gourmandes,
Réponses à vos questions...



One glaring observation about these collaterals is the fact that they are created by different organizations mostly pharmaceutical companies. The vaccination poster (upper left hand corner) is provided by Baxter, a healthcare company. The poster for contraception (upper right hand corner) has a prominent logo of MSD (also known as Merck in the US and Canada) is one of the biggest pharmaceutical companies in the world operating in France for more than 50 years.

The differences between the makers of health collaterals in France signify the dynamics between the state- represented by the l'Assurance Maladie, doctors and pharmaceutical companies. As expected, the health collaterals produced by the state is non-partisan general information kind of communication regarding disease prevention and management. One of the posters is not about disease management. Instead it is encouraging subscription to the website-amelie.fr- where people may seek answers regarding health concerns.

On the other hand, posters created and provided by pharmaceutical companies found in doctors' clinics create awareness for patients about their health choices by providing information. At the same time it is a subtle reminder to the doctors what brand of vaccine or contraception to be recommended and prescribed to their patients. These flyers also serve as marketing collaterals for the pharmaceutical companies that produce the brand.

There are several flyers and reading materials that warn the population about diseases or educate them about prevention. The only concern is that it cuts the non-French speaking members of the population because the materials were not made available in other language.

i) Factors that contribute to longer and healthier life all –over the world

In November 2005, the National Geographic magazine came up with an issue that talked about the secrets of living longer. They featured old people, who, despite their age, are still living healthy, fruitful and active life. The Okinawans (from Okinawa, Japan) attributed their long life to "*Ikigai* ", "that which makes one's

life worth living". It is a life with a purpose. Elder Okinawan women are well-respected spiritual leaders in many villages. This role gives them a greater sense of purpose and belongingness. They also keep the relationship with their friends intact. Regular chatting session with friends is one of the activities of people living in Okinawa that provide reciprocal support-social, mental and financial. Studies suggest that seniors who stay social are less prone to heart disease and depression. In Sardinia, Italy Gerontologists found out that seniors who live near loved ones tend to live longer. It was also noted that the isolation of these mountain villages has helped preserve the traditional Sardinian way of life; the one that promotes longevity. Their diet is another factor. They consume home-grown fruits vegetables which lessen the chances of getting heart disease and colon cancer. They also consume dairy products such as milk from grass fed sheep and pecorino cheese that are good sources of protein and omega -3 fatty acids. They grow their own wine that contains two to three times as much of a component found in other wines that prevent cardiovascular disease. Sardinians move a lot around the house. They pasture sheep, attend to their plants, butcher animals and share good food with their family members. Faith has something to do with living longer also. People who go to church on a regular basis live as much as 2 years longer than non-churchgoers. Adventist has always preached and practiced a message of health. This belief forbids the smoking, drinking alcohol and eating biblically unclean foods such as pork, other meats, rich food, caffeinated drinks, and stimulating condiments and spices. They also observed the Sabbath and they spend it with the company of people, either family or church members, and indulge in activities that relieve stress. In a study conducted by the National Institute of health found out that the average Adventist lived four to ten years longer than the average Californian¹¹⁹ .

The common factor between these people living a long life is keeping a balance in the biological, societal and psychological level. Diet and environment play a part in maintaining a healthy life; familial, societal and religious attachment

¹¹⁹ Buettner, D. (2005) *The Secrets of Long Life* National Geographic Magazine pp 4- 27

provide a greater sense of purpose that motivates them to continue on living. These concepts are not new. Epistemological studies have long been conducted, determining the lifestyle of people and how they are trying to improve the quality of their life. Medical epistemologists are determining sources, origins of diseases, statistics and medical related information to better assist the population in health maintenance and promotion. Social epistemologists on the other hand are set to determine the social factors that determine health and illnesses. As stated earlier, health discussions can no longer be confined to their biological roots. As such, government and concerned institutions must consider factors outside of the medical definition of health and diseases.

The stories of people living a health and fruitful lives were presented to clearly cite factors that contribute to quality of life. These factors might also be considered in designing an architectural health landscape for immigrants giving considerations to the role of their culture, religious belief and social life. Old people who still have active social life have lower cases of heart disease and depression. What it is communicating to health communication designers is that this can be replicated to migrant population. By providing healthy social activities that can piggy back with immigrant organizations' other activities, the government not only making itself visible but also working directly with the grassroots. This activity would subscribe to the bottom – up approach of program implementation which is good considering the intricacies of the people involved. Implementing a health program that is designed for the general population would be an exercise in futility for immigrants. Their health belief system cannot be addressed by a program they cannot identify with. Echoing the social cognitive theory; people are likely to follow behaviors modeled by someone they can identify with. Thereby designing a health communication campaign targeting a specific immigrant group is expected to yield better result. The concern however is that campaign like that is time consuming, drain resources and requires intricate implementation and coordination. To answer these challenges, one can easily argue that seeking prevention information is less costly than seeking emergency care, the number casualties is lower and it provides people with longer and better quality life.

PART 2: Relationship of France and the Philippines

a) France and the Philippines: First Contact

One of the earliest French scholars who did a research on the Philippines was Denis Nardin. He wrote his dissertation documenting the affairs of the Philippines, for a degree in Social Sciences from the Ecole des Hautes Etudes in 1974. The limited academic work by French intellectuals about the Philippines in the early years is caused by several reasons. First, is that research resources were allocated to the French-speaking small islands in the Far East. Second is the non-participation of France in the missionary partition of the Philippines¹²⁰ .

With a hazy relationship between France and the Philippines, it is interesting to know how the relationship of these countries evolved and developed. Since this research is also trying to draw the cultural connection of these countries, the observations of the French men who experienced how it is living in the Philippines in the past, provides a background in the establishment of cultural connections, if there are any, between these countries.

There are a few French men who wrote about their experiences in the Philippines. Author P. de Pages describes the Philippines and the Filipinos very profoundly. He is a navy officer overpowered by his passion for adventure by serving in Saint Dominique.

“these people whose gentle manners reveal contentment. The men are easy going and open, the women gay and promiscuous, without debauchery. Although not inclined to overworked, they do not fear it in the least. They are slightly vain, untruthful and interested in Europeans, but they are trusting and trustworthy. Their love of friendship made me see outpourings of the heart that I had nor found elsewhere. I believe them extremely sensitive to different kind

¹²⁰ Nardin, D., (1989). *France and the Philippines: From the Beginning to the End of Spanish Regime*. National Historical Institute. Manila

of emotions. I would not know how to stop talking favorably about this country, which is the most congenial I have seen ”¹²¹.

Domeni de Reinzi describes the civilized Indians (another term for Filipinos in the ancient time) as:

“intelligent but lazy, with a propensity for amusement, especially gambling and believe all kind of superstitions. They are submissively malleable tools in the hands of the friars, whose power over their spirit is unlimited”¹²².

August Haussmann added that

“the Tagals (those inhabiting the island of Luzon) devote greatest care to cleanliness of the body. The native are superior in intelligence to the majority of the Malay race. Laziness and lack of sincerity are the most deeply ingrained faults”¹²³.

Charles de Montblanc stated that the Indians noted this trait about close family ties. He also mentioned that the most remarkable trait of these people is excessive shyness or pride. This manifests itself in everyday life “through extreme sensitiveness of their feelings and great consideration for other peoples’ feelings”¹²⁴.

The physician, Mallat gave this diagnosis about the country;

“The Indian is by nature lazy, superstitious, unconcerned and a lover of pleasures: music, cigarillio [cigarette] and cocks”¹²⁵.

¹²¹ Nardin, D., (1989). *France and the Philippines: From the Beginning to the End of Spanish Regime*. National Historical Institute. Manila. P 22

¹²² Ibid 121 p 98

¹²³ Ibid 121 p 105

¹²⁴ Ibid 121 p 107

¹²⁵ Ibid 121 p 106

These observations show how early European settlers experienced the Philippines and interacted with the Filipinos. There was a general observation that the Filipinos are a lover of pleasure, they do not work much, they are vain, they lack sincerity and they believe in all kinds of superstitions. On the other hand, the Filipinos are referred to as congenial, trusting and trustworthy as manifested in outpouring of the heart and they pay attention to the cleanliness of their body. They also love sharing stories and enjoy the company of others. Through the years, these traits basically remained the same although in it now comes different variations brought about by the ever-changing tides of time. The influence of colonizers adds different shades to the already colorful culture of the Filipinos. However, the traits mentioned by the Europeans are the blueprint of the characteristics of Filipinos as a race.

Another Frenchman, Detabet, who lived in the Philippines takes notice of the richness of the Philippines:

*“ she is unquestionably the most precious and richest part of Asia, perpetual spring reigns, one eats fresh peas all year round, all the Asian food are found here, all the mother-of-pearl exported to Europe, come from the Philippines, gold abounds “*¹²⁶.

This documented description of the richness of the Philippines highlights the reason why she is of extreme interest to Spain and worth keeping as a colony, although Spain stated that it is not making money in the Philippines. Instead they are only keeping it for *ad majorem Dei gloriam* {for the greater glory of God}. One must note however, that the actual monetary benefits of the Philippines might not have reached Spain’s treasury because of extreme corruption in the country. In addition, Spaniards are not interested in enriching the resources and maximize in maximizing the resources at hand. Noted by Jules Itier, Customs Administration representative in the Lagrene Mission:

¹²⁶ Nardin, D., (1989). *France and the Philippines: From the Beginning to the End of Spanish Regime*. National Historical Institute. Manila. P 30

“the miserable condition of the sugar industry in the Philippines is due to the laziness of the Spaniards who will not be convinced to leave his beloved city of Manila and turn into a farmer. The imperfect quality of the indigo, whose preparation is likewise, left to the Indians, further illustrates the lack of intelligent management in the country’s production. When, then, will the Spaniards start to interest himself in the people he conquered? When will he decide to make profitable use of the invaluable gift that Providence has given him by making him the master of the Philippines, this Pearl of the Oceania?”

¹²⁷

(Translated online through Google translate. Improved by French speakers)

The observations established the nature of the Filipinos as a people. Everything they do within or beyond these traits, are but extensions of the same qualities. By nature, Filipinos are warm to others. They are very trustworthy which makes it is easy for them to reveal information -even personal matters. This same trait gives the friars a power over them during the Spanish colonization in the Philippines. This was observed by P. de Page when he states that the Jesuit knows the inmost thoughts of the Indians (Filipinos) who openly consult their smallest deeds to their parish priests ¹²⁸. In cases where priests are not very secretive, the affairs of a person which is supposed to be within the sacred walls of the confession, becomes talk of the town. The poor Indio on the other hand had no power to confront the representative of God in her town. For more than three hundred years, the friars exercised power over the Filipinos, denying them of learning the Spanish language because learning the language is reserved for the Spanish aristocracy in the country.

It is important to draw the connection between France and the Philippines to determine the influences they have on each other, if there are any. By looking at the earliest contacts, this researcher tries to establish the very little connection between these two countries, which will lead to the conclusion that the relationship between these countries developed very recently. France, from its first contact in

¹²⁷ Nardin, D., (1989). *France and the Philippines: From the Beginning to the End of Spanish Regime*. National Historical Institute. Manila. P 92

¹²⁷ Ibid 127 p 22

the Philippines until the end of the 19th century remained neutral even with the flee of the revolutionary to assist them on their fight against Spain. The reasons given is that France fears contamination of the neighboring Indochina and the France does not see the need for practical intervention because other areas are given priority ¹²⁹. This phenomenon can be justified by citing the indifference of the Indians to the Europeans, which can be attributed to the influence of the friars to the people. To keep the status quo, the ruling Spanish clergy lessened the contact between the natives and foreigners. For centuries, the native Filipinos were blind followers of the Spanish clergy and the church took advantage of this by controlling the psychology of the natives through the power of the cross and religion. The indifference of the natives to foreigners was manifested when the people blame the Europeans for the cholera epidemic in the Philippines in 1820.

As far as the first contact of French men to the Philippines is concerned, Nardin reported that there are 15 Frenchmen in the fleet of Ferdinand Magellan who reached the Philippine archipelago in 1521. A theory by Charles de Ronciere stipulates that Pierre – Olivier Malherbe might have been the first Frenchman to circumnavigate the world between 1592-1609, with a stop in the Philippines. This theory however has not been proven by any document ¹³⁰. In the course of the great maritime exploration, at least four French vessels made stops in the Philippines¹³¹. From 1968, Nardin also noted about the first mention of commercial exchange in the Philippines. He states:

¹²⁹ Nardin, D., (1989). *France and the Philippines: From the Beginning to the End of Spanish Regime*. National Historical Institute. Manila. P 11

¹³⁰ Ibid 129 p 1

¹³¹ Ibid 129 p 3

“French reserves herself as the African presidios and the Philippines in succession of Spain should the King die without a male offspring. In 1685, Veret, a company agent in Siam writes “sugar, shells and above all pesos maybe procured in the Philippines”. Sugar remains the main export¹³²” .

(Translated online through Google translate. Improved by French speakers)

Despite this recognition of trade between France and the Philippines, a system of monopoly exists during the Spanish occupation but it did not discourage the French to do business in the Philippines. However, J.B. Guillot de la Houssaye states that:

“Highly significant trade relations exist in the Chinese and the Manila or Philippine islands.. rarely are Europeans allowed there and never without risk”¹³³ .

(Translated online through Google translate. Improved by French speakers)

Nardin noted that over all, nothing much has happened in the trade relations between the Philippines and France. In the 18th century, the Philippines is not an important market for France. However, something about the Philippines attracted the French: spices¹³⁴ .

Among the French settlers in the Philippines at the end of the 18th century included at least one naturalist physician, Victor Godefroid and Guillaume le Gentil de la Galassiere, an Assistant Astronomer stayed briefly in Manila and noted: “ In Manila, it is a kind of phenomenon like a doctor, several years passed without seeing them”. The most common ailments are diarrhea and insanity, highly rampant and which particularly afflicts friars and women. In the villages,

¹³² Nardin, D., (1989). *France and the Philippines: From the Beginning to the End of Spanish Regime*. National Historical Institute. Manila.

¹³³ Ibid 132 p 6

¹³⁴ Ibid 132 pp 7-8

one sees nothing but little children, pregnant women and sucking infants¹³⁵. It was also reported that cholera is an epidemic in Manila, a disease which in 1820 was attributed to the Europeans. The friars instigated that the foreigners poisoned the water. They are doing all these things to control the wider opening of the Philippines to Europeans. During the epidemic, “the unfortunate inhabitants suffered the consequences of their aversion to science by receiving care from only a handful of doctors from Europe. Full of prejudices against those who are not from their country, they attacked their American, British and French benefactors and caused horrible carnage”¹³⁶. Leprosy is prevalent in the country¹³⁷. It is important to note that one of the most enterprising French men in the name of Paul de la Ginoniere from Nantes France, had an opportunity to experience Manila and he fell in love with the place. He decided to stop his seafaring life and settle in Manila as a physician in time of the cholera epidemic in 1820. His medical practice was one of the most prosperous in Manila¹³⁸.

Another French physician practiced in the Philippines, Dr. J. Mallat who serves as Chief Surgeon at the San Juan de Dios Hospital. He is the type of man who has mediocre abilities but knows how to place himself in the favors of the authorities. He was able to secure a position in the Lagrene mission as one of the Foreign Affairs Attaches¹³⁹.

The presence and the role of French doctors in the Philippines is an excellent findings for this study. It emphasize that the earliest interaction and most successful between French and Filipinos is in the area of health care. French do not see the importance of the Philippines as a trade partner and it

¹³⁵ Nardin, D., (1989). *France and the Philippines: From the Beginning to the End of Spanish Regime*. National Historical Institute. Manila. pp 19-20

¹³⁶ Ibid 135 p 52

¹³⁷ Ibid 135 p 62

¹³⁸ Ibid 135 p 76

¹³⁹ Ibid 135 p 82

does not pursue doing business with the Philippines because of the strong presence of the Spanish who exercise strong control over the archipelago. Despite this hindrance however, several medical doctors choose to stay in the Philippines and practice their profession because of what the country promises to foreigners. The abundance of food and freshness of the environment, the hospitality of its native inhabitants and the general view that the archipelago promises of a better life. In a country with many cases of leprosy and under cholera epidemic, medical profession is a profitable profession especially dealing with people who have higher reference for foreign doctors and for foreigners in general. Knowing that the first French settlers in the Philippines were doctors, it is interesting to know in what language these doctors communicate with their patients. Under the premise that French doctors speak French and the patients speak the native language and government authorities speak Spanish, what is the language utilized by doctors and patients and how are they understanding each other? This question is worthy of another academic research.

In the political arena, France was the first power to obtain installation of a quasi consul in Manila¹⁴⁰, but it was only in 1835 that a French consul was appointed in Manila, Adolphe Barrot. He noted that Spain curtail his powers. His successor however, Consul Fabre was more successful as far as business is concerned because he was able to secure franchise to providing supplies for military ships.

During the American occupation, author William Gueraiche writes lengthily about the political role of French consuls to the Philippines during. He states:

“Toutefois, pour un consul, une nomination à Manille devait plus prendre l’allure d’une punition que d’une récompense. Certains diplomates firent un passage météoritique comme Albert Pinard, calotin et antidreyfusard. Entre novembre 1904 et mars 1905, il saisit tous les pré- textes pour déverser son

¹⁴⁰ Nardin, D., (1989). *France and the Philippines: From the Beginning to the End of Spanish Regime*. National Historical Institute. Manila. p 42

venin antirépublicain. À l'inverse, son prédécesseur, G. de Bérard, était resté dix ans à Manille. Six autres consuls ont été les témoins des premiers temps de la colonisation américaine”.

English Translation

However, a consul, an appointment in Manila would take over the character of a punishment than a reward. Some diplomats made a passing meteorite as Albert Pinard, black cap and anti-Dreyfus. Between November 1904 and March 1905, he took all the pre-texts to pour venom anti-republican. In contrast, his predecessor, G. Berard, had been ten years in Manila.

(Translated online through Google translate. Improved by French speakers)

He further added:

“Certes, les diplomates ont fait leur métier, c'est-à-dire qu'ils ont transmis toutes les informations qu'ils jugeaient pertinentes, sans prétention d'objectivité, mais celles-ci ne permettent pas de « revisiter » l'histoire coloniale de ce pays. La matière brute dégage plus une ambiance, au sens juridique du terme, qu'elle ne fournit des données directement utilisables par l'historien. Dans ces conditions, il importe de prendre ces documents pour ce qu'ils sont : des discours (sur la colonisation, les races primitives, les enjeux stratégiques, etc.). Les opinions des diplomates français sont fortement dépendantes de leurs sources d'information. Certains consuls se contentent de fréquenter les milieux officiels américains ou de lire la presse ; d'autres, plus audacieux, n'hésitent pas à établir des contacts avec l'élite philippine. À cet égard, il est aussi intéressant de noter ce qui est consigné dans les rapports et ce qui ne l'est pas. En mesurant le décalage entre les faits, tels qu'ils ont pu se produire, et leur perception par ces diplomates de métier, on apprécie ce que d'aucuns appelleraient l' « idéologie dominante » ou l'état des mentalités dans un espace-temps donné – à savoir, les deux premières décennies de la colonisation américaine aux Philippines”

English Translation

While the diplomats did their job is to say they have sent all the information they considered relevant, without pretention of objectivity, but they do not "revisit" the colonial history of this country. The raw material generates more atmosphere in the legal sense, it provides data directly usable by the historian. Under these conditions, it is important to take these documents and they are: speech (on the colonization, the primitive races, strategic issues, etc.). The views of French diplomats are highly dependent on their sources of information. Some consuls are content to attend the U.S. official circles or

read the press and others, more daring, do not hesitate to make contact with the Filipino elite. In this regard, it is also interesting to note what is included in the reports and what is not. By measuring the gap between the facts as they occurred, and their perception by the diplomats of business, we appreciate what some would call the "dominant ideology" or the state of thinking in a space- given time - that is, the first two decades of American colonization in the Philippines.

(Translated online through Google translate. Improved by French speakers)

This observation highlights that for the French, being assigned to a post in Manila is a big sacrifice above than anything else. As mentioned earlier, Manila is not a promising country to do business with because of the monopoly of business and the negative mentality of people in power-mostly Spaniards- towards the foreigners. This reservation of the French continued even during the American colonization. The French post in the Philippines is just a manifestation of French presence in the country but it does not perform any significant political power to do business or engage actively in civic and political affairs of the country. French dignitaries are a stable presence in state and social parties though.

b) France and the Philippines: The Differences

There is a huge difference between France and the Philippines; France is a developed country while the Philippines belongs to the developing world. For the purposes of this research however there is a needed to identify what are these differences to put things in proper perspective. Each country's state policy, economics, political system affects every aspect of its citizens' life as well as programs promoting well-being.

Table 5: France and the Philippines Country comparison

Concepts	France	Philippines
Type of Government	Republic	Republic
Administrative Divisions	27 regions <i>France is divided into 22 metropolitan regions (including the "territorial collectivity" of Corsica) and 5 overseas regions (French: Guiana, Guadeloupe, Martinique, Mayotte, and Reunion) and is subdivided into 96 metropolitan departments and 5 overseas departments (which are the same as the overseas regions)</i>	80 provinces 120 chartered cities
Land Area (in sq km)	643,801	300,000
GDP	\$2,253 trillion 2012 estimate	\$ 416.7 billion 2012 estimate
GDP per Capita	\$35,500 (2012 est.) country comparison to the world: <u>35</u> \$34,600 (2010 est.) \$34,300 (2009 est.) note: data are in 2011 US dollars	\$4,100 (2011 est.) country comparison to the world: <u>158</u> \$4,000 (2010 est.) \$3,800 (2009 est.) note: data are in 2011 US dollars
Population	65, 630,692 (July 2012 est)	105,720,644 (July 2013 estimate)
Population Growth Rate	0.497% (2012 est.) country comparison to the world: <u>150</u>	1.873% (2012 est.) country comparison to the world: <u>63</u>
Age Structure	0-14 years: 18.5% (male 6,180,905/female 5,886,849) 15-64 years: 64.7% (male 21,082,175 /female 21,045,867) 65 years and over: 16.8% (male 4,578,089/ female 6,328,834) (2011 est.)	0-14 years: 34.6% (male 17,999,279/female: 17,285,040) 15-64 years: 61.1% (male 31,103,967/ female 31,097,203) 65 years and over: 4.3% (male 1,876,805/ female 2,471,644) (2011 est.)
Religion	Roman Catholic 83%-88%, Protestant 2%, Jewish 1%, Muslim 5%-10%, unaffiliated 4% overseas departments: Roman Catholic, Protestant, Hindu, Muslim, Buddhist, pagan	Catholic 82.9% (Roman Catholic 80.9%, Aglipayan 2%), Muslim 5%, Evangelical 2.8%, Iglesia ni Kristo 2.3%, other Christian 4.5%, other 1.8%, unspecified 0.6%, none 0.1% (2000 census)
Birthrate	12.72 (2012 est)	24.98 (2012 est)
Death Rate	8.85 (NA)	4.98 (July 2012 est)

Net Migration Rate	1.10 (2012 est)	-1.27 (2012 est)
Maternal Mortality Rate	8.00 (2008)	94.00 (2008)
Infant mortality Rate	3.37 (2012 est)	18.75 (2012 est)
Life Expectancy at Birth	81.46 (2012 est)	71.94 (2012 est)
Health Expenditures	11.9 % of GDP (2010)	3.6% of GDP (2010)
Physician Density	3.497/1000 (2008)	1.53/1,000 (2004)
Obesity	16.9% (2007) country comparison to the world: <u>26</u>	4.3% (2003) country comparison to the world: <u>62</u>
Literacy rate <i>definition: age 15 and over can read and write</i>	total population: 99% male: 99% female: 99% (2003 est.)	total population: 92.6% male: 92.5% female: 92.7% (2000 census)
Unemployment rate	9.8% (2012 est.)	6.9% (2012 est.)
Population below poverty line	6.2% (2004 estimate)	26.5% (2009 estimate)
Revenue	revenues: \$31.99 billion expenditures: \$36.71 billion (2011 estimate)	revenues: \$1.383 trillion expenditures: \$1.547 trillion (2011 estimate)

Source: CIA World Fact Book ¹⁴¹ (Researchers' highlight)

Table 5 provides basic yet very rich information comparing basic components of France and the Philippines. Although this study is not comparative in nature, simple analysis of the elements of these countries government systems would pave the way in better understanding health institutions operation much better.

Both countries have a Republic type of government. France has vast land area totaling almost 650 thousand sq. km while the Philippines in an archipelago

¹⁴¹ <https://www.cia.gov/library/publications/the-world> (Accessed May 2012)

comprising 1,107 islands with a total land area of 300 thousand sq. km. This is an important factor to look at because the solidity of France' land area has several advantages and the disconnectedness of Philippine islands affects the delivery of health care and medicines. Referring still to the land area of France and the Philippines and cross-referencing it to the population, it is obvious that Filipinos have less space than French. There are approximately 106 million Filipinos living in the Philippines, and the big cities (Manila, Cebu, Davao) have the highest concentration. These cities are densely populated which severely affects the environment. France' population is around 67 million and they have bigger areas to move around. Their population however is ageing with 16.8% of this population belongs to the 65 yrs. old above bracket. Comparing it to that of the Philippines, there are only 4.3% of the population who are 65 yrs. old and above. Translating it into numbers, there are approximately 4.5 million Filipinos (male and female) age 65 and above. Birthrate in the Philippines is double in number at 24.98 compared to France at 12.72. This rate fuels population growth.

Figure 11: Population Distribution of the Philippines by age and gender

Source: CIA World Fact Book (downloaded July 2013)

Figure 11 represents age distribution with reference to age and gender. It shows a perfect pyramid with the younger age group on the baseline. Men and women have almost the same life expectancy. This population distribution means that the current workforce needs to support the high number of very young people (0-14) which is approximately 19 million. The population is continuously growing in an unhealthy magnitude. As a developing country, the income of the state cannot support the burgeoning number of its population. This explains why majority of state projects intended for those who are in dire state of poverty are underfunded. Even the basic services which should be afforded to members of the population like healthcare suffer from lack of appropriate funding. The bright side is that the Philippines is secured of workers in the future and if the current work trend will continue, there will never be a shortage of Filipino workers to be sent abroad.

Figure 12: Population Distribution of France by age and gender

Source: CIA World Fact Book (downloaded July 2013)

Figure 11 graphically shows the general population distribution of France with reference to age and gender. Middle age French (starting from 35 years old) up to 64 years old comprises a large number in the French population. The age group 20-54, which is the most productive working age can obviously support the young generation because its number is lesser. In both male and female It is also worthy to mention that in France, women enjoy visible higher life expectancy.

French population is an ageing population having more than 30% of its population above 55 years old. It has its implications to the country's health care system. This includes higher premium for the salaried workers, higher health expenditures and more health workers.

Comparing the two graphs, the Philippines is certain that there will be enough young people who will inherit the country. There will be enough workforce in the future while France' strength is in the workforce of today. Relating these figures to this research and the fact that the Philippines is a good source of workforce all over the world, it can be assumed that mobility will continue to be the dynamics for Filipinos seeking employment abroad. For France however, the French anti-multiculturalism discourse creates a rejection for plural belongings by the mainstream society and thus leading to marginalization of visible minorities¹⁴². This means that the current conditions in France are not conducive for immigrants. French authorities have also tightened their immigration policies limiting the granting of legalization papers as well as strengthening its campaign to deport unauthorized migrants.

In the health sector, expenditure of France is 11.9% of its GDP while the Philippines spends 3.6% of its GDP. This percentage of France' expenditure on health translates to 78,855 trillion US dollars, allotted to 67 million people. Comparing that to the Philippines mere 3.6% of its GDP equivalent to 15 billion US dollars, serving 105 million people, health disparity is written all over this equation.

To add, there are 3.4 physicians for every 1,000 population in France while in the Philippines, the ratio is 1.53 per 1,000 population. The number itself has dire implications to access to health care, quality of health services and medicine distribution. Medical practitioners are also concentrated in big cities. As such, those who are living in remote places of this archipelago suffer the most.

¹⁴² Simon, P. (2012). French National Identity and Integration: Who belongs to the National Community? Institut national d'études démographiques. <http://www.migrationpolicy.org/pubs/FrenchIdentity.pdf> (accessed August 2013). P 1

However, it is important to highlight the effort of the Philippine government to better serve the public. In 2010 the Philippine Department of Health issued an Administrative Order (No. 2010-0036) pertaining to the Aquino Health Agenda which sets the background for Universal Health Care for all Filipinos. This highlights the need to further increase enrollment coverage of indigent Filipino families, improve availment of benefits and increase support value for claims. This agenda was brought about by the data that the poorest members of the population are the main users of government health facilities and deterioration of government health facilities directly hit the poor, who needs the service the most. In addition, proper compensation to health workers as well as inadequacies in health information systems to guide planning and implementation of health programs needs to be re-assessed and acted upon. This move of the Philippine government emphasizes the political will of the current administration to better its health service to the people.

Figure 13: Population Comparison of France and the Philippines



Placing the two graphs together, it is easy to see the big difference in population composition between France and the Philippines. The Philippines is a steadily growing population with the younger generation forming the base of its pyramid shaped population structure. One of the disadvantages of this type of population figure is that the workforce needs to produce enough resources to be able to support a very wide base. Jobs should also be made available because there are millions who will need it in the future. The Philippine economy however is driven by sending its citizens abroad to work. Given the niche of the Filipinos in the world labor market, the country will never run out of people to export.

In the case of France, the middle age part of its population who produce its current resources is its best asset to date. The younger generation however is lesser in number and France, as a highly industrialized country surely needs workers in the future. It can be predicted through the current statistics of the younger members of its population that the country might need to import workers from other countries. To put it simply, France might have a future need that the Philippines could be able to fill in.

Given this reality and a glimpse of the future, French government must put in place an immigrant integration program that best addresses integration challenges. It should also strengthen its campaign for immigrant tolerance among its citizen. Foreigners who are in the South of France often observed that French people are not very welcoming. For immigrants, this poses a huge barrier for integration because for them to participate in social and civic activities, the population of the host country should also exert effort to welcome immigrants. As pointed out by the Honorable Peter Sylvester, Associate Deputy Minister for Citizenship and Immigration, Canada; integration is a life-long process of mutual adjustments between the migrants and the receiving society. For Canada, their assistance to immigrants went as far as sending message overseas to prepare immigrants who are about to arrive in Canada. The government is expecting them to be able to effectively adapt to the Canadian life and fully participate in civic, economic and social life. The French system however has a different take

on immigrants and migration. “Ethnic minorities were accused of “balkanization” of French society with their “communitarianism” and prompting the decline of social cohesion ¹⁴³ “. These sentiments of the French towards immigrants’ have its historical roots. Outlined in Ernest Renan’s *Discours sur la Nation* (1882), the incorporation of common norms and values is tied to the sharing of memory, history, sentiments and attitudes constitute the definition of a national body and the very foundation of the French nation-state. The identity of migrants and their descendants is subject to an array of expectations, questions and suspicions ¹⁴⁴ .

The indifference of French towards migrants and in general to the “others” is embedded in the very fabric of its society. It has its roots in the formation of the country and in the forging of what it is to be French. Anything that goes beyond the purest definition of what it means to be French is dealt with extreme caution.

Philippines: The country and its people

The Philippines is a country with tumultuous yet rich past and a promising future. It is an archipelago located in the South East Asia poetically called the Pearl of the Orient Seas. It is a country that is rich in natural resources and abundance of sunlight all year round. It would very well qualify as a tropical paradise because of its pristine beaches, exotic fruits, enthralling panoramic sights and warm-hearted people. The richness of its lands and the abundance of its seas made her one of the most coveted possessions to conquer for colonizers in the distant past. History has revealed that she had been under many colonizers, Spain holding the record for almost 333 years. The country was discovered by a Portuguese explorer named Ferdinand Magellan in 1521, who sailed under the favor of King Charles V of Spain. He circumnavigated the globe

¹⁴³ Simon, P. (2012). *French National Identity and Integration: Who belongs to the National Community?* Institut national d’etudes demographiques. <http://www.migrationpolicy.org/pubs/FrenchIdentity.pdf> (accessed August 2013). P 1

¹⁴⁴ Ibid 143 p 2

under the resources of Spain and when he reached an island in the Pacific, he named it Philippines in honor of King Charles V son, Philip who was later known as King Philip II.

Figure 14: Map of the Philippines



Source: CIA Worldfact Book (Accessed April 2, 2013)

The Philippines is an archipelago located in the Southeast Asia, between Philippine Sea and South China Sea. It is composed of 7,107 islands. The weather is tropical marine with a combination of northeast and southwest monsoon. It is estimated that by the middle of 2013, the 300 square kilometer land area of this country will be inhabited by approximately 106 million people (CIA Worldfact Book). Philippines has a Republican type of government and the current President of the Republic is Benigno Aquino Jr.

The country was a Spanish colony in the 16th century and this colonization lasted for more than 300 years. In 1898, following the Spanish-American war, the Treaty of Paris was signed surrendering the Philippines to the United States upon payment of 20 million dollars. In 1935 the Philippines became a self-governing Commonwealth after 10 years under American tutelage.

People of the Philippines are called Filipino and the official language share the same name. Filipino as the language is based on Tagalog while English is also an official language and widely spoken. The Philippines is home to more than 4 million indigenous people, who at the same time belongs to 60 ethnolinguistic groups although eight are considered major dialects. Majority of the indigenous Filipinos live in the mountains and near the sea. They have different culture, language, religions and lifestyles¹⁴⁵. More recent data revealed that there are 185 individual languages, 181 are living. Out of the living, 43 are institutionalized, 70 are developing, 45 are vigorous, 13 are troubled and 10 are dying¹⁴⁶.

The Philippines is a Catholic country with more than 80% of its population belonging to the Roman Catholic Church. This strong religious influence is attributed to more than three decades of Spanish presence. With majority of Filipinos highly religious in their own way, every facet of Filipino life is influenced by religious belief. Feast days of saints are celebrated in every town, meat is not supposed to be eaten during the lenten season as a form of penitence and sacrifice, hanging the Holy Rosary in cars, motorbikes and even in pocket is believed to protect the owner against bad luck. Old couples named their children after saints and in general children are baptized before reaching the age of one.

¹⁴⁵ Palaganas E., Bagamaspad, A., Cardenas, M., Josef, J., Tolentino, L.(2001). *Mainstreaming Health Knowledge and Practices*. University of the Philippines, Press. Center for Investigative and Development Studies. Quezon City. P 1

¹⁴⁶ <http://www.ethnologue.com/country/PH> (accessed April 2011)

The CIA World Factbook estimated that by 2013, there will be about 106 million Filipinos. People are concentrated in major cities Manila being the capital of the country having 11. 449 million residents. It was followed by Davao, 1.48 million, Cebu with 845,000 and Zamboanga 827,000 as of 2009.

The influence of the Catholic faith is manifested in every aspect of Filipinos everyday life and the same time influences the affairs of the state, no matter how clear it has been stipulated in the Philippine Constitution that there should be a clear separation between church and the state. This separation is a blurry line and it is always the church who is accused of crossing the line.

It was widely acknowledged and a proven fact that in the 1986 People Power revolution, the catholic church played an important role in encouraging the people to oust the then dictator President Ferdinand Marcos. Nothing much has changed since then. The Catholic church has cemented its place in the very fabric of Filipinos public and private life as well as in political affairs of the nation. To highlight the ongoing influence of the church in state affairs until today, the Catholic church loudly opposes the passing of Responsible Parenthood and Reproductive Health Bill popularly known as the RH Bill. This bill operates under the premise that everyone should be given universal access to methods of contraception, fertility control, sexual education and maternal care. The government with the support of public sector, concerned groups and individuals will provide funding for distribution of condom, IUD's, birth control pills as well as educational collaterals for responsible intercourse and the likes. This bill posits " The State recognizes and guarantees the human rights of all persons including their right to equality and nondiscrimination of these rights the right to sustainable human development, the right to health which includes reproductive health, the right to education and information, and the right to choose and make decisions

for themselves in accordance with their religious convictions, ethics, cultural beliefs, and the demands of responsible parenthood ¹⁴⁷“.

The church strongly opposes this bill citing the sins that will be brought about by false sense of security that might eventually lead to risky sexual behaviors. These acts run counter to the teachings of the Catholic church on morals and faith. The call to not support this bill is preached using the pulpit during Sunday masses and in every opportunity the Church has. Just like any other state apparatuses, the Church also conducts regular press conference, more frequently when there are important issues that need to be addressed. On February 16, 2011, the bill was endorsed by the House Appropriations Committee with amendment and referred back to the Population Committee for finalizing the language. From the very moment that the bill was introduced for discussion, the Catholic church, together with its allies, exercise all their might to oppose the passing of this bill. They cited the role of the church to protect the morals of its flock and educating them about the benefits of condom and other contraception tools will only corrupt the minds of the parishioners. This line of discussion and reasoning is a never-ending battle between what is logical and what is morel. At the end of the day, it is the people who will eventually decide and that is the very essence and beauty of democracy.

This example was drawn from the many clashes between the Philippine Government and the Church for it showcases the delicate relationship between these state apparatuses. The church is often criticized for interfering with the affairs of the state. The church on the other hand states that it is only doing what he is supposed to do which is making sure the teachings of the catholic faith remained timely and relevant; terms which are highly contestable. This debate is again, worthy of another academic discourse and this study will veer away from. This researcher only cites this example to help the readers understand that in the

¹⁴⁷ House of the Representative. Republic of the Philippines. Fifteenth Congress. Committee Report number 664.http://www.congress.gov.ph/download/basic_15/HB04244.pdf (accessed September 2013)

Philippines, the Catholic faith is strongly present in the lives of the Filipino people. Even how disease and ailments are dealt with, are influenced by the faith.

Economically, the Philippines relies heavily on remittances from Overseas Filipino Workers (OFW). Remittances from Filipino immigrants and overseas workers have grown to become the Philippine economy's second biggest source of foreign capital, next to the local value added exports. The first ten months of 2010 brought in a total of US\$15.46 billion almost 8% more than the US\$ 14.32 billion in 2009. Economically, The 2010 rebound of Philippine economy and its export market and the sustained flow of remittances from the overseas Filipino workers provided a support to the newly elected President of the Republic, Benigno "Noy Noy" Aquino Jr. Foreign exchange flow has given renewed power to the Philippine peso lowering the peso –US\$ exchange rate of 46.4 to below 44 by the end of 2010. The growth can be attributed to the raising consumer and investor confidence¹⁴⁸. This goes to show that the Philippine economy is highly dependent on its citizens working abroad. These workers were dubbed as Bagong Bayani {Modern Heroes} because their sacrifices make the country's economy afloat.

In the 1970's the main destination of Filipino migrants are the United States and Canada. In more recent years however, there has been a steady flow of Filipino migrants in the Gulf Region and East Asia¹⁴⁹. To date, Filipinos working in European countries are also increasing. In Italy for example, this researcher was privileged to visit the cities of Milan, Tuscany area, Rome and Venice. Travelling in these areas is like roaming around the streets of Manila. In the city of Milan, Filipinos gathered in the Doumo area during weekend or every day after

¹⁴⁸ De Jesus in Singh, D.,(2011). (Ed). Southeast Asian Affairs 2011. Institute of Southeast Asian Studies. Singapore. p 225

¹⁴⁹ Carino, B. in Battistella, G. & Paganoni, A. (1992) (Eds). *Philippine Labor Migration: Impact and Policy*. Scalabrini Migration Center, Philippines. pp 4-5

work to relax and have a nice chat with other Filipinos. This is the same scenario with the other cities in Italy. Simple conversation with these people revealed that the main reason why they left the country is to earn bigger and be able to send enough money to provide better life for their families back in the Philippines. And just like in other countries in Europe, the main type of work for Filipinos is in the domestic arena. They are mostly involved in domestic work or service oriented jobs even if they are degree holders. It is a common story that a graduate of Information technology for example works as a waiter or a cook in a restaurant, a graduate of commerce takes care of an old person, a teacher works as a nanny. For many of the OFW's in Europe, the pull of euro is mightier than the will to practice their profession.

Place of this study in the Literature about France and the Philippines vis-à-vis health communication research

Although there are earlier studies citing the link between France and the Philippines in the area of medicine, this research fills the gap in the area of Filipino immigrants health status in the French Riviera. Having established the fact that France and the Philippines are continuously strengthening their relatively new found friendship, academic research dealing with Filipino immigrants in France is just beginning to take shape. This research is a pioneering effort because this area has not been investigated before.

In the book *Guide to Asian Studies in Europe* (1998) published by the International Institute for Asian Studies whose main office is located in The Netherlands, the identified areas of research in Asian scholarship are Agriculture, Art History, Anthropology, Archeology, Cultural Studies, Developmental Studies, Economics, Education, Environmental Studies, Gender Studies, Geography, History, International Relations, law, Linguistics, Literature, Performing Arts, Philosophy, Political Science, Psychology, Religion and Sociology. These are the areas well explored in Asian studies both by Asians and foreign scholars. The Asian countries included in this list are: Afganisthan, Bangladesh, Bhuttan, Brunei Darussalam, Cambodia, China, Hong Kong, India, Indonedia, Japan, Kazakhstan,

Korea (n/s), Kyrgystan,, Ladakh, Laos, Macau, Madagascar, Malaysia, Mongolia, Myanmar, Nepal, Pacific Islands, Pakistan, Papua New Guinea, Philippines, Seychelles, Sikkim, Singapore, Sri Lanka, Tadjhikistan, Taiwan, Thailand, Tibet, Tukkmenia, Uzbekistan and Vietnam. With all these countries in Asia and the diverse research areas explored by scholars, it is not surprising that the health communication was not identified as an explored research, probably because of two reasons. One, health communication is diverse that it can be constituted in Cultural studies, environmental studies, Sociology etc. Second, health communication is a new discipline that is just being explored by scholars.

Bernard Pot published a book entitled Philippines: Bibliographie thematique en langue francaise: annotee et commentee (Philippines: Thematic Bibliography in French: Annotated). This book presents the researches by Filipino and French scholars about the Philippines. Here are some scholarships through the years related to the study of medicine and health written or translated in French:

1. L'hygiene et les tropiques (Bulletin de la Societe de Geographie. Montano, J. 1878.
2. Le cholera aux Philippines. Journal de voyages et des adventures de terre et de mer (Cholera in the Philippines: Travel journal) Anonyme. 1883
3. La medicine a l'ile de Lucon. Archipel des Philippines (the medicine in the island of Luzon) Journal de medicine de Paris. 1884.
4. L'oeuvre sanitaire de Ameracains aux Philippines (The American sanitary works in the Philippines). Revue Scientific. Chamboseau, M. 1911.
5. Sauvee a Manille par un chirurgien aux mains nues (Saved in Manila by a surgeon with bare hands). Succes de livre, Paris. Vincent, C. 1988.
6. Les Philippines face au fantome du gange: le cholera dans la seconde moitie du XIX siecle. Annales de demographie historique (The Philippines facing the Gange ghost: the cholera in the second half of the 19th century). Huetz de Lempis. X. 1990.
7. Le triangle jaune (The Yellow Triangle). Publie par le laboratoire pharmaceutique SmilthKline Beecham. L'action se passé Palawan. Horizons Associes S.A 1992.

8. Les maladies chez les Palawan. Presentation de la nomenclature et des representations a la recherche d'un principe classificatoire. (The disease of the Palawan people: Presentation of the naming and the representation for research of classificatory principle) Revel Macdonald C. 1981.

Previous research highlights ranges from the observations of the first French settlers in the Philippines and interestingly enough, they are medical doctors to academic inquiry of other scholars who wrote various topics about the Philippines in French or were published in French journals. One very interesting book that this list shared is the one written by Charlotte Vincent. The author talks about traditional healers in the Philippines doing surgery with their bare hands. The book shared a story about a 36 year -old woman who has cancer. Her doctors all told her that she has very little time left on her hands. Desperate to seek cure, she flew to the Philippines and underwent surgery with a traditional healer. Seven years after that operation, she is still alive, which puzzles medical doctors. These kinds of stories are very common in the Philippines and the main reason why the faith in these traditional healers lingers.

Needless to say, topics written about the Philippines cuts across discipline and epoch. The interest in illnesses causation, unexplained healing practices has been around for quite a while. As things in the environment change, so are people's responses to the challenges of the times, and the area of health is not shielded from these changes. This research being a study about health of a particular minority group in a specific area in France, is a promising and timely contribution to the clamor of organizations around the world for a highly specific health research. Large scale studies targeting general members of the population seem not to answer the demands needed to improve immigrant health status.

There is also a need to deconstruct the myths surrounding immigrants. There is a general misconception that immigrants carry diseases and they are burden to the healthcare system of the receiving country. In reality, labor migrants are relatively younger and healthier than the native population and they tend to underutilize health services of the receiving country. The deterioration of

immigrants' health increases during the migration process. This can be attributed to lack of adequate health insurance, poverty, lack of social activities and uncertain legal status ¹⁵⁰.

¹⁵⁰ Calderon, J. et. al. (2012). *Asian Labour Migrants and Health*. Exploring Policy Routes. Issues in Brief. Migration Policy Institute. Issue No.2. p 1

Chapter Synthesis

The Review of related literature sets the background for the place of this study in the field of health communication research, highlighting immigrants' experience. It has been reported that in Europe, there are only a few countries that implement immigrant standard health collection system, and unfortunately France is not one of them. The major implication of a non-existent immigrant data collection system is lack of knowledge of the disadvantages of a minority group. The sad reality regarding immigrants belonging to the vulnerable groups and as such, receive less services than the native population.

The myth surrounding the negative health images of immigrants' should also be demystified. Immigrants are able workers who contribute to the growth of the economy and should not be viewed as a group of people who come carrying diseases and deplete the host country of their resources. This mentality often sets the tone for indifference towards immigrants. As cited by countries that have a long and satisfying relationship with immigrants, mutual adjustment is needed for better immigrant assimilation. It is the state that set the stage and every one involved are expected to play his or her part to assist immigrants in the integration process. Apparently, France has a lot to learn from countries that best handle immigrant integration.

Canada and France have always been head-to head in the claim as the country with the best healthcare system in the world. In terms of migration, Canada has been reported to be leading, while France is bitterly criticized for its immigration policies. Albeit, one research revealed that French immigration policy is not too bad after all. However, in terms of immigrant self- reported health status, immigrants in France felt they are not in better good, while another study revealed that in the past 30 years immigrants' health has deteriorated.

The differences between France and the Philippines were presented to put things into proper perspective. The aim of that discussion is not to be confused as a comparison. There is no merit in comparing these countries for they are different in many ways. The first French settlers in the Philippines, who were medical doctors (which is very good for this study) have made their keen observations about the country and the people. Although there is a general experience that the Filipinos are kind, clean and pious, they are also lazy, gossipers and gamblers. Filipinos were also observed to be superstitious which can be a very good reference point why they have a strong and enduring belief with traditional healers.

This chapter discussed the Filipino migration dynamics. The Philippine economy is kept afloat by the remittances of the Overseas Filipino Workers. The Philippines biggest export is its people. Endemic in the process of sending people abroad are the challenges of migration. The reality of separation and uncertainty of future status in the receiving country contributed greatly to the anxiety of these migrants. Common health complaints of Filipinos immigrants are headache, stomach pains which that are attributed to being far away from home. These are often psychosomatic but nevertheless need attention –either medical or social.

CHAPTER III

Theoretical Premise

Theoretical Background

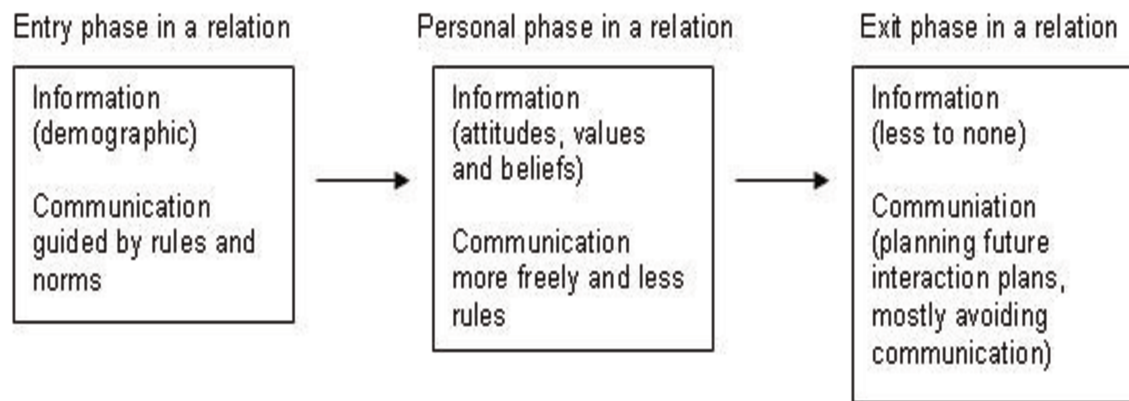
Health communication is not an exclusive property of one academic discipline and as such, theories used in understanding the dynamics of this rich field emanates from diverse academic fields. Theories come from communication, sociology, anthropology and medicine are employed to advance knowledge pertaining to health communication. Patient-doctor relationship comes from interpersonal communication. Studies about health campaigns are tied – up with social psychology and studies about cultural related health issues, used theories from anthropology¹⁵¹. As such, health communication is a rich and complex field of research.

This study utilized theories coming from different disciplines that contribute to have better understanding of health communication. Specifically, these theories explain the how human relationships are developed, how beliefs systems are formed and how experiences are legitimized by language. In the case of immigrants, all these concepts (relationship, experiences and language use) are necessary tools to survive in their new environment.

This study primarily draws inspiration from Uncertainty Reduction Theory (Berger & Calabrese, 1975), Health Belief Model (Rosenstock, 1974), and Speech Code Theory (Philipsen, 1997) and Social Cognitive Theory (Bandura 1977). Although inspired by other cultural, health and communication theories, the above mentioned theories fit perfectly into this study.

¹⁵¹ Sparks, L., (in press). *Health communication and caregiving research, policy, and practice*. In S. S. Travis & R. Talley (Eds.) *Multi-disciplinary Coordinated Caregiving: Professional Contributions*. Springer.

Figure15: Uncertainty Reduction Theory



Taken from: <http://images.search.yahoo.com/images/view> (downloaded May 2013)

Uncertainty Reduction theory posits that people communicate to lessen the uncertainty about others by gaining information about them. This information is then used to predict their behavior. Uncertainty reduction is necessary if a person desires to develop a deeper relationship with someone, or if institutions want to know more about their stakeholders. The best technique to lessen uncertainty is by investigation. Asking question to gather more information about a person or a group diminishes uncertainty leading to better understanding therefore developing trust and confidence. When a good level of confidence is achieved, communication becomes easier and information flows freely.

This study applied uncertainty reduction theory in micro and macro perspective. In the general point of view, the governance of French Riviera is viewed as the main institution bridging the gap between the government and its citizens. To lessen the information divide between the government and its citizens, the institution is expected to set-up projects that will facilitate interaction. In the micro perspective, this research applies uncertainty reduction theory between Filipino patients and medical professionals and auxiliary health staff. These health providers are the front liners in delivering care. As such illumination or addressing of uncertainty must happen in the interaction between patients and

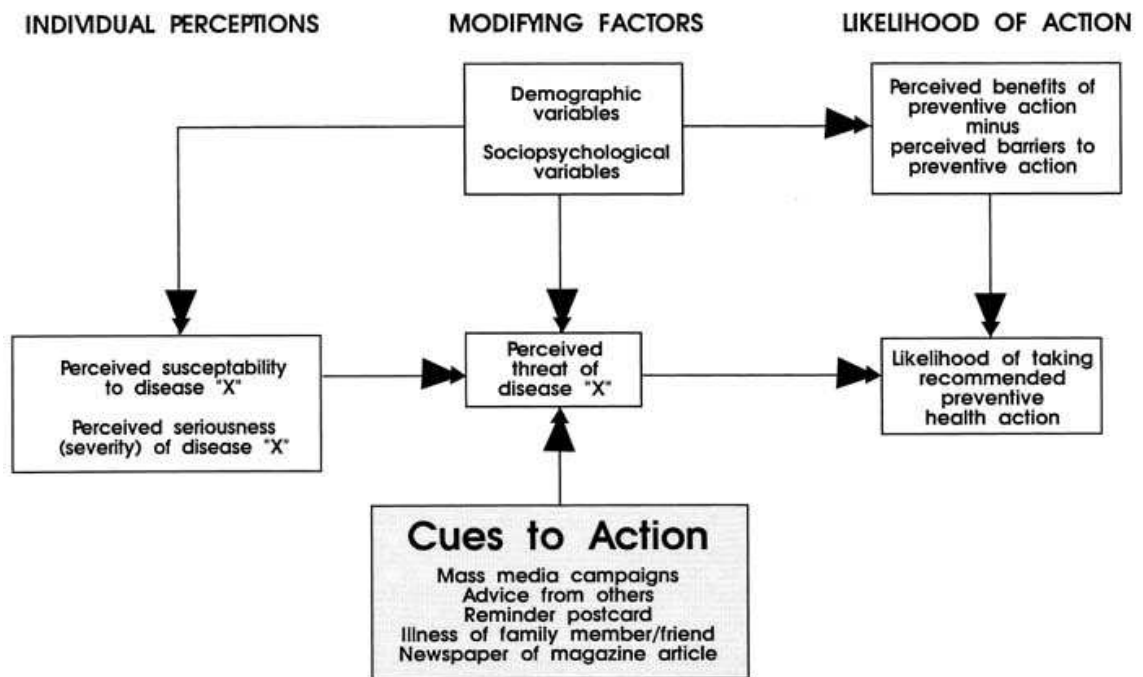
health providers. To equip health providers with the necessary tools to serve their population, the state must provide a standardized health collection program, that would monitor and analyze immigrants' health status and performance. In a culturally diverse community like the French Riviera, it is given that its community is composed of people and families from different ethnic and racial origins. By knowing the health background of Filipino immigrants for example, local health professionals will be better equipped in addressing health challenges of this specific immigrant group. The areas in France where immigrants are concentrated was already identified and this is the best laboratory where "knowing" the immigrant population should take place. By obtaining immigrant health data, uncertainty of stakeholders will be reduced for information is to be made available where both can learn from one another. Basic questions like what comprises Filipino diet, how is eating behavior affected by cultural beliefs, how food choices are influenced by religion and the likes, will be answered and this can be the basis in the design of health communication campaigns that best address their health concerns and executed in a culturally sensitive way. This will also pave the way for the micro perspective: lessening the uncertainty between individuals: doctors and patients, medical professionals and law makers, medical providers and health campaign designers as well as many more combinations of the players involved in health care delivery and management.

Put simply, when questions were answered, the less worries there would be. Having enough cultural and religious knowledge about the Filipinos, health professionals serving in the French Riviera might become more prepared with the necessary information to better address health concerns of this group of people. They may know that coming from the Asian race, Filipinos are genetically pre-disposed to diabetes. Being so, priority campaigns for this race should revolve around promotion of diet that encourages less intake of sugar-laden food. In terms of health behavior, health professionals will find out that most Filipino patients experiment on treatments, that they stop taking anti-biotics when the

pain stops etc. As such, campaigns addressing the importance of taking medicines religiously do not only prolong life but also uplift the quality of life.

Another theory that was used in this research is the Health Belief Model (HBM) (Rosenstock, 1974).

Figure 16: Health Belief Model



Taken from: http://search.yahoo.com/search;_ylt=A0oG7meKXOVRqUcAE (accessed July 16, 2013)

Health Belief Model (TBM) was originally introduced by a group of psychologists in the 1950s to help explain why people would or would not use available preventive services, such as chest x-rays for tuberculosis screening and immunizations for influenza. These researchers assumed that people feared diseases and that the health actions of people were motivated by the degree of fear (perceived threat) and the expected fear reduction of actions, as long as that possible reduction outweighed practical and psychological barriers to taking action (net benefits). It provides a strong framework for public health initiatives by

focusing on five clear dimensions. These are: 1) perceived susceptibility (subjective perceptions of risk in relation to the health threat); 2) perceived severity (evaluations of the consequences of the threat); 3) perceived benefits (assessments of the efficacy of preventive actions); 4) barriers (assessment of difficulties and negative consequences of preventive behavior); and 5) cues to action (triggers for the decision making process. More recently, health motivation, that is, an individual's readiness to be concerned about their health, was added to the model. Drawing on this model, public health initiatives need to identify a link between an individual's risk behavior and disease to highlight the severity of the disease and to make it relatively easy to engage in behavior likely to lead to a reduction in risk for that disease¹⁵².

The dimensions constituted in the HBM are the motivating factors for a patient to seek medical advice and eventually medical care. This theory assumes that the patient has already enough information about his possible ailments and his action to seek medical help is motivated by his knowledge of his health treat, consequences for not pursuing medical help, rewards for doing preventive measures which all encouraged him to engage in action and take care of his health.

Putting into consideration the culture of an immigrant patient juxtaposed with the health care system of the receiving country, knowledge of diseases based on genetic predisposition or acknowledgement of ongoing health concerns are not enough to address health related issues. Understanding of the what rights are accorded to him by the laws of the state he now belongs to as well as the resources and services he can have access are basic steps in health integration. This is the reason why in this research, the HBM is aided with other complimentary theories that specifically addresses culture and language in health care.

¹⁵² Murphy, S. & Bennet, P., (2004). *Health Psychology and Public Health: Theoretical Possibilities*. Journal of Health Psychology. Sage Publication. P 19

In Speech Code Theory, Gery Philipsen states that wherever there is a distinctive culture, there is to be found a distinctive speech code. Embedded in this code are psychology, sociology and rhetoric. These are complex concepts that suture the individual, social and the idea of truth of an individual. Once a persons' philosophy is shared with the community and is able to gather supporters and starts community discussions and debates, the idea now becomes a sub – culture of belief system.

This group of people will start to speak in codes only they can understand. They now create a language that takes life of its own. To promote analysis of discourse of speech acts and speech events in a cultural context, Dell Hymes formulated the S.P.E.A.K.I.N.G. model.

Figure 17: S.P.E.A.K.I.N.G. Model

Situation (setting or scene)

Participants (analysis of personalities and social positions or relationships)

Ends (goals and outcomes)

Arts (message form, content etc.)

Key (zone or mode)

Instrumentalities (channels or modalities used)

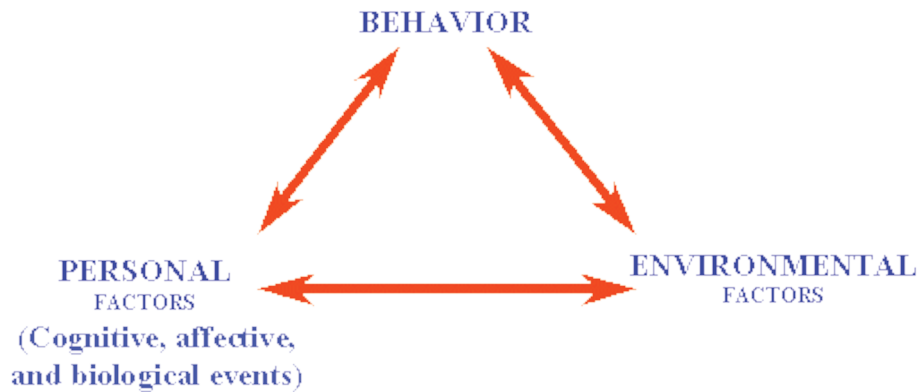
Norms (framework for producing or processing messages)

Genre (interaction type)

Taken from: <http://www1.appstate.edu/~mcgowant/hymes.htm> Accessed July 2, 2013

This model puts a structure on what are the merits to pay attention to in a human interaction specifically in verbal face-to-face communication. Although on initial analysis the concepts seem to be broad in scope, the identified specific concepts that correspond to the SPEAKING acronym clearly guide researches as to key areas to focus on. For this study, the researcher utilized all these concepts under the communication aspect of her proposed health theory.

Figure 18: Social Cognitive Theory Model



Taken from: <http://www.des.emory.edu/mfp/eff.html>. Accessed May 2, 2013

The development of Social Cognitive Theory is attributed to its main proponent Albert Bandura. It started when he initiated a study to determine social explanations for why and when children displayed aggressive behaviors during the time when human functioning is solely explained using behavioral models. This study introduced the idea of modeling- learning from watching behaviors of other people.

In the end Social Cognitive Theory (SCT) highlights the role of social context in learning. Learning happens within a social context and much of what is gained is done through observation. SCT explains that a person's functioning is a product of continuous interaction between cognitive, behavioral and contextual factors. This theory does not deny the importance of the environment in determining behavior, but it does argue that people can also, through forethought, self reflection and self regulation processes exert substantial influence over their own outcomes and the environment more broadly¹⁵³.

¹⁵³ Denler, H. et al (2013). Social Cognitive theory. The Gale Group. <http://www.education.com/reference/article/social-cognitive-theory> (accessed August 2013)

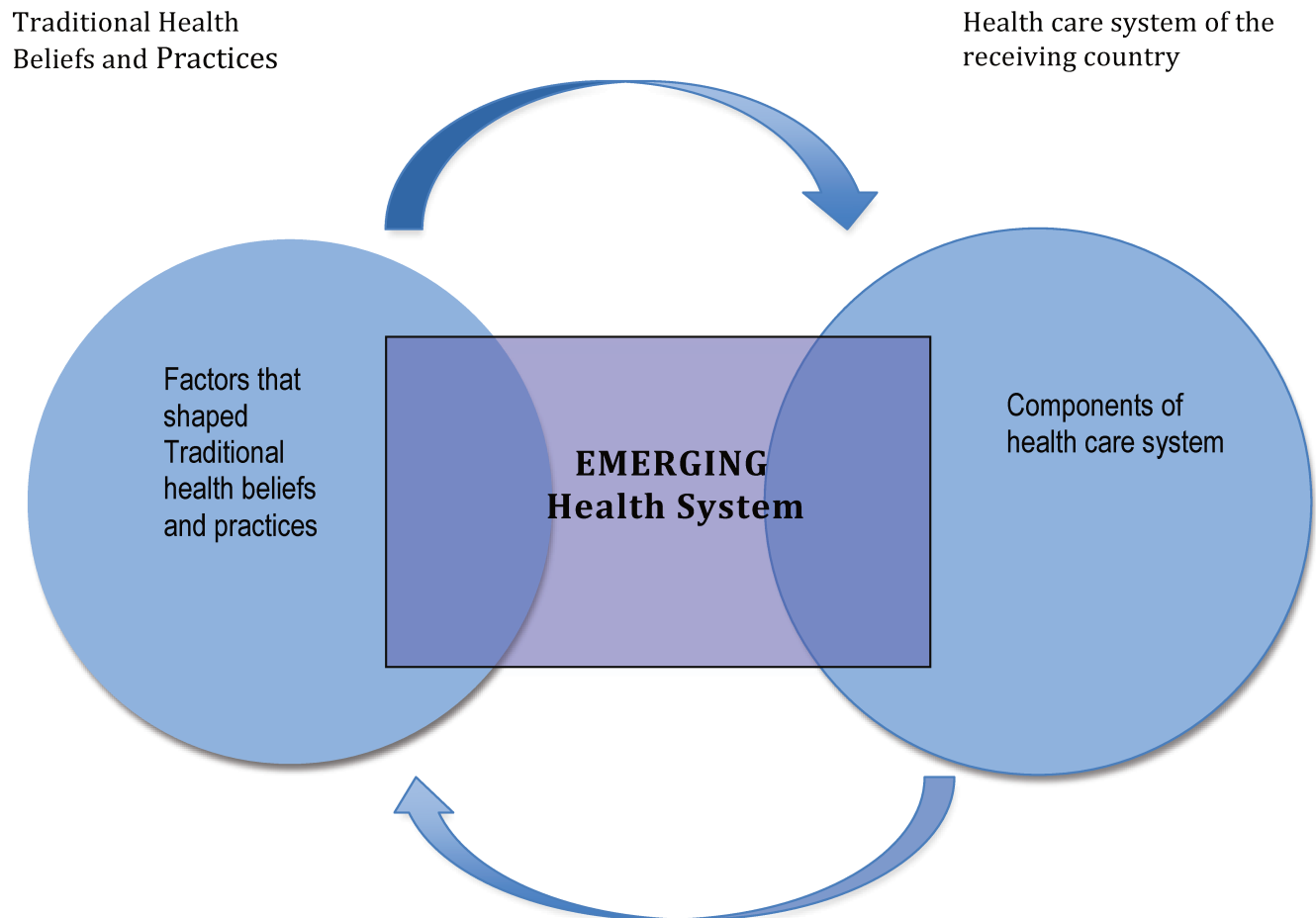
This theory reiterated that learning though driven by social factors also came from self-realization through the ever - reliable trial and error process. Anchoring on the premise that every person is a thinking individual, he has all the faculties to arrive at a decision which best serves his interest. He might mirror behaviors and actions of others but if do not work for him, he will try to adjust some of its components to fit into his lifestyle and needs.

Aided with other theories like Structuration and other cultural and language theories, it is the aim of this research to propose a Transcultural Health Model which would incorporate the concepts of culture, health and communication (language) within the framework of how an immigrant group adapts, health wise, to the environment totally different from its origin, contextualized in the French Riviera area and the immigrant group is the Filipino community. Transcultural Health Communication Model aspires to be the grid in studying other minority groups by looking at the connection between culture and health, manifested through language.

Theoretical Framework

The researcher is proposing a health communication model that encapsulates important concepts that originated from the theories that inspired this study. The proposed Transcultural Health Communication Model encapsulates the factors that can identify immigrant patients' health behavior orientation and how these factors may affect current health performances. By reviewing the factors that shaped traditional health beliefs and practices and superimposing them with the healthcare system of the host country, the products are a crystallized health concepts party devoid of old beliefs but filled with the new health ideas from the receiving country. Finding out what are these emerging health belief systems is an interesting area of academic research for the information it may yield will be a new and added information in the field of health communication inquiry.

Figure 19: Conceptual Framework of the proposed Transcultural Health Model



This proposed Transcultural Health Model (THM), Figure 18, aims to determine the emerging health system of the people who migrated to another place. Having had the stored health knowledge, immigrants' bring to their new environment, these traditional health beliefs and practices are then introduced to the health care system of the receiving country, with no direct intention of influencing or altering the healthcare system of the host country nor the health practices of the local population. However, when the process of integration begins, challenges arise for the cultural differences often take center stage. This results in longer process of integration for the immigrants especially when the

receiving country is not familiar with the cultural make up and religious background that affect their health decisions and performance of the new comers. It is can also be worsened when the state does not have a concrete guide to assist immigrants. The process of adoption and adaptation becomes a challenge when then the expectations of the moving in party do not jive with the standard set by the receiving party. However, under the premise that both parties are aware of their roles and rights in health maintenance, the process of integration to the health care system will be a little easier for the immigrants and at the same time, receiving country can now plan a culturally sensitive health programs.

Given the fact that there are two health cultures at work, it is expected that the immigrants may still perform health practices that are congruent to their traditional cultural and religious beliefs. Immigrants will find a way to fit their traditional beliefs to the new health environment and as a result, emerging health system will be created which is often unknown, both to the immigrants and the state because it is not investigated.

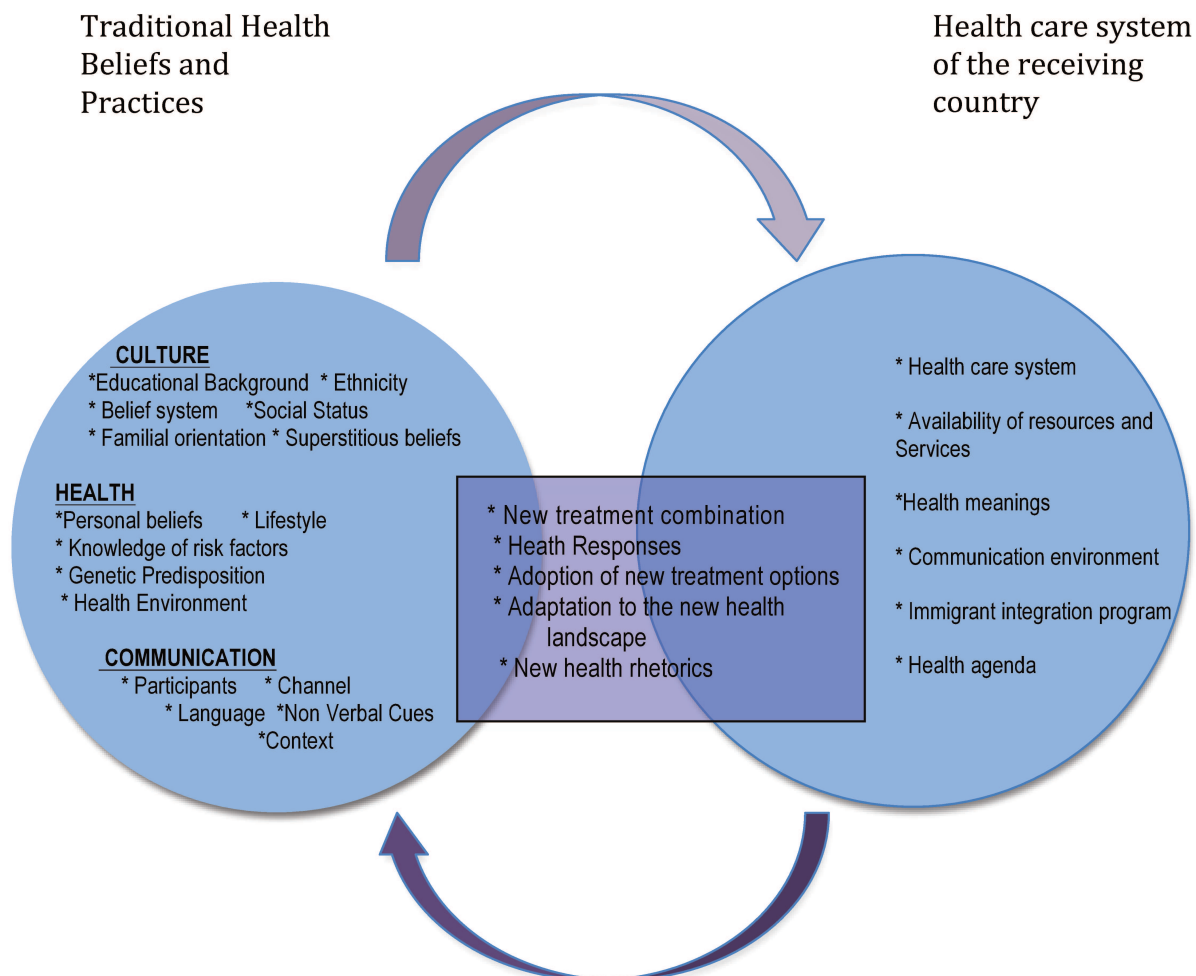
Referring to the conceptual model of transcultural health communication model (Figure 19), the traditional health beliefs and practices influence the healthcare system of the receiving country as represented by the top arrow. In return, once the immigrants understand the health concept of their host country, it also alters their traditional health belief system, represented by the arrow at the bottom. This now becomes a process of heath culture influencing and altering each other. The concepts now are freely flowing from one cultural milieu to the other following the essence of transcultural movement. *TRANS*cultural was preferred by this researcher – instead of cross cultural, inter-cultural, multi-cultural - aligning with the idea of Professor Crispin Thurlow that the term transcultural creates a fluid moving through and across cultural system, in whatever way they might be constituted or conceived¹⁵⁴. Although cultures are

¹⁵⁴ <http://faculty.washington.edu/thurlow/research/transculturalcommunication.html> (accessed July 2010)

often highlighted by clear -cut boundaries, the concepts involved in the discussion of health practices can only be identified but will never be confined. Discussions about health can no longer be restricted to biological factors. It cannot be emphasized enough that issues about health are intricately interwoven with social position, cultural and religious influences as well as economics and political factors, and this is highly manifested in the metanarratives of immigrants process of assimilation.

These constructs make social research about health very complicated yet a rewarding academic endeavor.

Figure 20: Operational Framework of the proposed Transcultural health communication model



Transcultural Health Communication Model posits that people from another cultural health environment, create unique health practices that accommodate their traditional health belief system and the health landscape of their new environment. These emerging health practices move in and out two cultural milieu, inadvertently create a new system totally different from its source yet completely part of each one. People performing merging practices may or may not know that they are engaging in new health practices adapting to the new health environment.

On the personal/individual level, health practices are shaped by culture and communication interactions. Culture is made up of educational background, family orientation, social status, religious and superstitious belief and ethnicity. Communication interaction constitutes participants, channel, non-verbal cues, language and context. All these factored in, a person is developed into a cultural being- a carrier and interpreter of meaning. He manifests his belief system through everyday performance of what he thinks best suits his needs. In the domain of health, a person's health practices are influenced by several factors that like belief system (religious affiliation superstitious beliefs etc.), lifestyle (which includes eating and exercise habits, type of work, working environment etc.), and health environment (refers to workings of established state institutions that encourage healthy lifestyle and set rules for health and disease management). Knowledge of genetic predisposition and risk factors to diseases also help the person in assessing what proper and healthy lifestyle he needs to adapt to avoid diseases or delay complications, as well as to determine future medical care. For some culture, religious belief is a big part of their identity formation and identification. The everyday life practices are highly dependent on the religious belief and these include how to deal with health issues. Taking care of one's health for the faithful members of a religious groups is highly influenced by their faith. Religious affiliation becomes a variable in the performance of health for faithful members of a religious organization.

Superstitious beliefs also have an impact on health management. This belief system varies from one country to another or from one region to another within one country. Belief in the supernatural is not just random performance of unfounded faith. Rather it is a product of centuries old practices. As such, health belief founded on superstitious beliefs cannot be easily erased in the consciousness of people wherever they maybe because it is embedded in their subconscious. This reality, like a chronic disease, can only be managed.

Health perceptions of people may be influenced by their education attainment and social status. Needless to say, these variables change the way people think about health maintenance and disease management.

Communication is like a glue that put concepts regarding health and diseases together to make sense of this issue. To be able to engage in an interactive, pro-active communication the setting must be in accordance with the target objectives, participants are properly identified and channels of communication are open to encourage an interactive flow of information exchange. The way people use language and non-verbal cues are important factors in facilitating learning and understanding.

The role of these three identified concepts and the specific ideas attached to them, formed the traditional health belief system. This belief system is then put into practice and is highly influenced by culture, religious and superstitious beliefs, commonly held health meanings and commonly understood language. These factors could be considered to be present in an individual who migrated to a new environment, and in this study, a new country. These health beliefs and practices are ingrained into the very fabric of a persons' identity and sense of self. This does not mean however that it can completely change after being exposed to the new health environment, nor the health system where he now belongs to, will be completely changed to accommodate his traditional health beliefs. Echoing

Klienman people moved between worlds and identities. They can be modern or traditional, depending on circumstances and convenience¹⁵⁵.

For immigrants their current health belief system is influenced by the health system of the country they now belong to. It is not clear however, if the health care system of France is affected by the presence of immigrants and if it is, in what way. Putting things into proper perspective, this study is concentrated on analyzing the health care system of the host country in relation to the traditional belief system of the Filipino immigrants, rather than the traditional health beliefs of the general population of the receiving country. This is to clarify for some questions might arise regarding why there is no mention of the traditional health beliefs of the host country. Including that aspect would further widen the already broad scope of this research.

Diverse meanings attached to health concepts affects health perceptions of the native population as well as the immigrants. It either reinforces or questions their current beliefs and practices. In any case, the merging of the new and the traditional always paves the way for a dialogue. What this researcher is postulating is that the Filipino immigrants in the French Riviera have an emerging health practices that they may or may not be aware of, and identifying the factors that lead to the alteration of traditional beliefs as well as identifying what are these emerging practices is what this researcher is set out to do.

In addition to the health care system of the receiving country, changes in health practices of the population are also affected by the availability and access to health services as well as resources. In a country like France where health resources are readily available and services are given freely, it is interesting to know how Filipino immigrants are enjoying these privileges given the fact that there are cultural and language barriers in addition to migration policies and health agenda.

¹⁵⁵ Kleinman, A. (2010). *Four Social Theories for Global Health*. The Lancet 375 (9725): 1518-1519. <http://dash.harvard.edu/handle/1/5142663>. (downloaded March 1, 2013)

This researcher strongly believes that there are emerging health practices taking shape that come from the traditional beliefs of people which were shaped by cultural factors from their country of origin and they might have changed over time by the health environment of the new country where they now belong. These emerging health systems manifest strongly when applied to immigrant groups. As a group of people who already have an established view of the world based on their experiences in their own country, it is assumed that this belief system affects the way they operate in the new country they now belong to. Since these immigrants are now under the protection of the host country, it is their responsibility to know who these immigrants are, what are their needs are and how they can fulfill them. In the area of health, not knowing the intricacies of immigrants health belief system can be compared to a blind man leading another blind. It has already been established that the immigrants' health in France has deteriorated over the years. One probable cause of the problem is that health campaigns in general inadvertently (or otherwise) exclude immigrants. In terms of health, they are marginalized due to the fact that they are different from the mainstream population. Campaign designers are planning and implementing health programs under the premise that their message will cut across all members of the population. Sadly for the immigrants, this is not the case as proven by the fact that their health has significantly deteriorated over the past few decades.

Immigrants might have little or no idea that they are performing a new set of health behavior but it is indeed necessary for the host country to act accordingly and set up policy initiatives to properly articulate its position as protectors of its citizens.

Health costs have been skyrocketing and against the backdrop of ongoing economic volatility, it is not a good sight. Budget cuts are happening everywhere and the health sector is not spared. Even in the case of one of the best healthcare systems in the world, there is a wide clamor for improved resource allotment and better budget management. The concern is that prevention and

highly targeted campaigns seem to be the most promising way to save resources and most importantly, lives. The problem is that prevention is a long process and very costly. Given the pros and cons, it is in the hands of policy makers which program to give the go signal to.

Definition of Terms

1. Adoption – the process of accepting the new health belief system
2. Adaptation- the process of altering old health belief system to fit in with the new
3. Albularyo (herbalist)- a person who performs healing through the use of different concoction of plants and oils and sometimes through the use of animals.
4. Assimilation – a situation when the process affecting change and the relationship between social groups are seen as one way¹⁵⁶
5. Clients/ Patients – people who are pre-disposed or inflicted with a disease. These words were used interchangeably in this study
6. Chronic Illness- illness that develops in an individual gradually or is present from birth. A disease that cannot be cured but can be managed. It includes diabetes and cardiovascular disease
7. Compliance- when patients do what they are told by the doctors
8. Cultural Competence- a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations." "Competence" in the term *cultural competence* implies that an individual or organization has the capacity to function effectively "within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities"¹⁵⁷
9. Demedicalization – the process through which a condition or behavior becomes defined as a natural condition or process rather than an illness

¹⁵⁶ Modood, T. (2007). *Multiculturalism: A Civic Idea*. Cambridge. Polity Press

¹⁵⁷ <http://www.cdc.gov/socialdeterminants/Definitions.html> (accessed January 2012)

10. Difference- how people are identified: how people identify themselves and how they identify others ¹⁵⁸
11. Disease – Biological problem within an organism. Disease- diagnostics category, a conceptual entity which classifies particular illnesses, symptoms or pathological components of illnesses or stages of illness ¹⁵⁹. The emphasis of this concept is biomedical. Idler (1979) points out that disease is a biological-medical conception of pathological abnormalities in people's bodies therefore presents no data for sociological analysis, it reveals no social facts ¹⁶⁰
12. Deviance- behavior that violates a particular culture's norms or expectations for proper behavior therefore resulting in negative social sanctions ¹⁶¹
13. Disability- restrictions or lack of ability to perform activities resulting from physical limitations or from the interplay among those limitations, social responses and the built or social environment ¹⁶²
14. Endemic- have established itself within a population and maintain a fairly stable prevalence ¹⁶³
15. Epidemic- a significant increase in the number affected by a certain disease or to the first appearance of the disease
16. Epidemiology- distribution of disease within a population
17. Health Equity- When all people have "the opportunity to 'attain their full health potential' and no one is 'disadvantaged from achieving this potential because of their social position or other socially determined circumstance' ¹⁶⁴

¹⁵⁸ Modood, T. (2007). *Multiculturalism: A Civic Idea*. Cambridge. Polity Press

¹⁵⁹ Frake, C., (1961). *The Diagnosis of Disease among the Subanun Mindanao*. AA 63:113. p113

¹⁶⁰ Idler, E., (1979). *Definitions of Health and Illness and Medical Sociology*. SSM13A. p 723

¹⁶¹ Weitz, R. (1996). *The sociology of Health, Illness and Healthcare: A critical Approach*. Wadsworth Publishing Company. U.S.A. p 428

¹⁶² Ibid 161

¹⁶³ Ibid 161 p 19

¹⁶⁴ <http://www.cdc.gov/socialdeterminants/Definitions.html> (accessed May 2011)

18. Health gradient- people of higher economic status are healthier compared to those below in the social status measuring stick
19. Health Inequality - Differences, variations, and disparities in the health achievements of individuals and groups of people ¹⁶⁵
20. Health care- this refers to what is being done to the patient when s/he seeks medical assistance
21. Health disparity - A type of difference in health that is closely linked with social or economic disadvantage. Health disparities negatively affect groups of people who have systematically experienced greater social or economic obstacles to health. These obstacles stem from characteristics historically linked to discrimination or exclusion such as race or ethnicity, religion, socioeconomic status, gender, mental health, sexual orientation, or geographic location. Other characteristics include cognitive, sensory, or physical disability¹⁶⁶
22. Health System- The entire health scenario of a country or a community. This includes statutory health policies, hierarchy of health organizations, organization make –up of health organizations. This also echoes the definition by Landy ¹⁶⁷. A society's medical system is the total organization of its social structure, technologies and personnel that enable it to practice and maintain its medicine (as defined), and to change its medicine in response to varying intracultural and extracultural challenges.
23. Hilot (Massage Therapist) – ancient tribal priestess. In modern time, a person who perform healing by touching the patient in a form of massage.
24. Illness – social experience and consequences of having a disease. Illness- a single instance of being sick ¹⁶⁸. Idler states that illness is the human experiencing of disease... an explicitly social phenomenon with both objective and subjective reality ¹⁶⁹

¹⁶⁵ <http://www.cdc.gov/socialdeterminants/Definitions.html> (accessed May 2011).

¹⁶⁶ Health Disparity: Definition. . <http://www.cdc.gov/socialdeterminants/Definitions.html> (accessed May 2011).

¹⁶⁷ Landy, D., (1977). *Medical System in Transcultural Perspective*. In *Culture, Disease and Healing*. Ed. David Landy, New York. Hackmillan Publishing. p13

¹⁶⁸ Frake, C., (1961). *The Diagnosis of Disease among the Subanun Mindanao*. AA 63:113. p113.

¹⁶⁹ Idler, E., (1979). *Definitions of Health and Illness and Medical Sociology*. SSM13A. p 723

25. Immigrants – a person who moves to another country usually for permanent residence (American Heritage Dictionary). For the purposes of this research, the population being studied will always be referred to as immigrants.
26. Incidence- number of new occurrences of an event ¹⁷⁰(diseases, birth, deaths etc.)
27. Intercultural Communication- communication between culture through the people who are interacting
28. Internal colonialism – the treatment of minority groups within a country in ways that resemble the treatment of native peoples' by foreign colonizers ¹⁷¹
29. Interviewees- the people who were the subject of the Key Informant Interview (KII)
30. Life expectancy- the average number of years an individual of a given group born in a given time can expect to live ¹⁷²
31. Maladie- a psychological or physical affliction that cannot be explained by medicine. This can be psychosomatic (in the mind)
32. Marginal practitioners- occupational groups, such as faith healers who treat a wide array of physical ailments but have low social status ¹⁷³
33. Medical Surveillance- a form of social control in which doctors tell people how to live their lives, watch to see if people follow thru advice and punish those who do not ¹⁷⁴
34. Medicalization – process through which a condition or behavior becomes defined as a medical problem requiring a medical solution ¹⁷⁵

¹⁷⁰ Weitz, R. (1996). *The sociology of Health, Illness and Healthcare: A critical Approach*. Wadsworth Publishing Company. U.S.A. p 18

¹⁷¹ Ibid 170 p 432

¹⁷² Ibid 170 p 18

¹⁷³ Ibid 170 p 433

¹⁷⁴ Ibid 170 p 434

¹⁷⁵ Ibid 174

35. Medicine – this refers to things that are taken in to prevent diseases, relieve discomfort, or cure. This includes pills, tables and liquids that are scientifically proven to help people. This also draws from the definition of Landy:
A society’s medicine consists in those practices, methods, techniques, and substances embedded in a matrix of values, traditions, beliefs and patterns of ecological adaptation that provide the means for maintaining health and preventing or ameliorating disease and injury to its members ¹⁷⁶
36. Minority groups- this refers to a small group of people living in a community which is not originally their own. They are either migrants or workers who have lived in that community for a few years and their number is not significantly big.
37. Morbidity- refers to symptoms, illnesses and impairments ¹⁷⁷
38. Mortality- deaths
39. Pandemic- worldwide epidemic ¹⁷⁸
40. Placebo- anything that is offered as a cure but known to have no biological effect ¹⁷⁹
41. Prejudice- suspicion or dislike to another person because they are different or they belong to a particular race or religion
42. Prevalence- total number of cases within a given population within a given time ¹⁸⁰
43. Respondents – the people who answered the Survey
44. Sick- a state of not being well. It can either be because of diseases that can be explained medically or other afflictions that have no medical basis.
45. Social epidemiology – the study of the distribution of disease within a population according to social factors (such as social class, use f alcohol or

¹⁷⁶ Landy, D., (1977). *Medical System in Transcultural Perspective*. In *Culture, Disease and Healing*. Ed. David Landy, New York. Hackmillan Publishing. p13

¹⁷⁷ Weitz, R. (1996). *The sociology of Health, Illness and Healthcare: A critical Approach*. Wadsworth Publishing Company. U.S.A. p 18

¹⁷⁸ Ibid 177 p 19

¹⁷⁹ Ibid 177 p 436

¹⁸⁰ Ibid 176

unemployment) as oppose to biological factors ¹⁸¹(such as blood pressure or genetics)

46. Sociology of medicine – an approach to the sociological study of health, illness and healthcare to answer research question of interest to sociologists in general. This approach often requires researchers to raise questions that challenge medical views of the word or existing power relationships within the health care world ¹⁸²
47. State- government and its branches

¹⁸¹ Weitz, R. (1996). *The sociology of Health, Illness and Healthcare: A critical Approach*. Wadsworth Publishing Company. U.S.A. p 440

¹⁸² Ibid 181

Chapter Synthesis

This chapter presented the theories that inspired the researcher to study immigrants' health. Coming from different disciplines, concepts within these theories solidify into a health communication model that was formulated to identify and explain factors that lead to the creation –intentionally or unintentionally- of a hybrid health belief system which was identified as emerging. The Transcultural Health Communication model posits that people from another cultural health environment, create a unique health practices that accommodate their traditional health belief system and include the health landscape of their new environment. This model is highly applicable to minority groups within a population because it identifies the concepts imbedded in the person as well as the factors present in the new environment that challenges and inevitably influences immigrants traditional health beliefs.

The influence of Uncertainty Reduction Theory, Health Belief Model, Speaking Model and the Social Cognitive theory leads to the formulation of Transcultural Health Communication Model which is the contribution of this research in the field of health communication research. The immediate expected response to the findings of this research is the acknowledgement from the local government of French Riviera of the fact that minority immigrant groups have more specific health needs that are totally distinct from those of the general population and the majority immigrant groups. It should not end there however. Now that there is a comprehensive, action-oriented research local authorities can start experimenting on programs that promote better immigrant participation on health programs.

Terms that were used throughout the research were defined in this chapter, depending on how these terminologies were used in this research. Some meanings of words were taken from definition of authors while some were simply

defined based on how they were contextualized within this study. Although loaded terminologies – health, culture, health communication etc.- were defined in the earlier part of this study, there is a need to fully understand key words as they were utilized to perfectly suture concepts together. This is helpful for the readers of this study, especially to the intended recipients.

The Transcultural Health Communication model was introduced in this chapter, with explanation of the concepts constituted in the model.

CHAPTER IV METHODS AND PROCEDURES

Research Design

This research is a qualitative descriptive case study making it both qualitative and quantitative. It employs Survey, Key Informant Interview (KII) and Direct Observation. As such this study is a triangulated study employing three research methods.

Under a descriptive study the researcher will observed and then described what was observed. Researchers usually go on to examine why the observed pattern exist and its implications¹⁸³. The researcher includes direct observation of the population in relation to how they talk and act in the presence of their support group (their Filipino friends) and within their comfort zones (Filipino gatherings). Their actions in these events are reflective of how they get different support that empowers them to make informed choices with regard to their everyday life in the French Riviera. The researcher also observed how Filipino immigrants performed as patients and how they interacted with medical providers. The results of direct observation were later on imbedded in the discussion and analysis of the results.

This research was carried out to explore an area with which not much is known. There have been several studies about the Philippines by Filipino and French scholars. However, the health communication field, as a young area of research has not been explored, more so by a Filipino scholar who immersed herself in the population. The research design is intended to capture perceptions and experiences of the immigrant population under study as they were exposed to

¹⁸³ Babbie, E. (1998). *The Practice of Social Research*. 8th Ed., Wadsworth MA:Wadsworth. pp 91-92

health communication collaterals and how they experienced and continued to discover the healthcare system of France.

From the earliest stage of conceptualization, this research was designed to follow a triangulated study. The researcher experimented with several research method combinations that would capture the intricacies of her population. After several attempts and a few failed experiments, the researcher finally subscribed to Survey, KII and Direct Observation.

Survey was formulated to determine the demographic data of the population under study. This includes age, gender, type of work and the number of years living in the French Riviera. By knowing this basic information, it is the aim of this researcher to understand the correlation between age and work, for example, to their health performance. Another example is to understand the relationship between the length of stay in the French Riviera and the health beliefs system of Filipino migrants. Questions under this method were designed to solicit health concepts, beliefs and concerns of the population under study and how they are addressing these challenges or how they are adjusting to the health system of France. By understanding the co-relation of concepts, this research aims to identify the role of language and culture in the overall health beliefs and practices.

Key Informant Interview (KII) was targeted to those who have experienced or experiencing a more serious or more complicated medical conditions (operations, chronic diseases, etc.). Having experienced the medical care here in France and knowing (or have also experienced) how it was in the Philippines, it is the interest of this researcher to find out how this experience influence, altered or changed the health belief system of the respondents.

Direct Observation was done all throughout the data gathering procedures. During the administration of the survey, the researcher paid close attention to how the respondents were seeking approval or clarifying some concepts not from the researcher who was administering the questionnaire but from their friends. The researcher also observed the displayed behavior during the administration of

the survey and the behavior during KII activities. Data gathered from direct observation validates and questions some of the concepts in the survey and KII instruments. It also provides a rich source of information not captured by the written text.

Data Gathering Procedure

Survey questionnaires were designed and pre-tested in a small group of the population under study. The instrument was revised several times to address the challenges of language and to ensure convenience and practicality in answering the research instrument.

Describing the questionnaire in a broader sense, it is specifically designed to be in a bilingual format. English is used primarily for French readers. Although almost all of the respondents understood English, the researcher felt the need to translate it in Filipino because she got the impression during the previous testing of the questionnaire that her population tended to clarify more English concepts which they did less when they the questions were in Filipino. Question number 1 asked about the most common diseases that the respondents experience. This is to find out the most basic health complains. Question 2 asked about the most common source of the ailments they most frequently experienced. This is to determine how aware they are regarding origins of diseases. One of the options under Question 2 (Q2) is genetics predisposition. This researcher presumes that the more a person knows about her/his genetically predisposition to certain diseases, the more s/he pays attention to simple symptoms that might be connected to the diseases that is expected to occur. This way, s/he will not treat simple symptom as just a sign of fatigue for example, instead will deal with it more cautiously. On the another hand, persons who lack information about their genetic predisposition to diseases tend to attribute pains to long hours or tedious work, stress or other things less alarming. It is important to remember at this point that simple pains can be manifestations of more complex health problems and having very limited knowledge of family disease history might have fatal consequences. This was one of the options in Q2 because in the analysis, the

number that this concept may provide an insight into the how the population under study is connecting their physical pain to its source. It would later on help in finding out what solutions are they seeking to address their health concerns. Q3 solicit answers on how the population are responding to their most common health complaints while they are still in the Philippines. The aim of this question is to determine the methods or platforms of easing pain are most sought after while they are still in their home country. This aims to discover the role of medical doctor, traditional healer and self-medication to remedy the pain. It also provides an idea into how seeking medical help constitutes a concoction of traditional beliefs and modern science. Q4 seeks to specifically identify health beliefs and practices of the population while still living in the Philippines. Beliefs in “pasma”, hot and cold sources of illness and other health practices will prove that Filipinos believe sources of illness and in remedies that do not have a scientific proof in curing diseases. However, by choosing the best answer to this question, they will show what beliefs and practices they believe in. Q5 aims to determine how soon or how late Filipinos seek medical help. Q6 verifies if there is a difference in seeking medical advice/help now that they are in France. This is a leading question because Q7 and Q8 are follow up questions. Q7 tries to find out what are the reasons why the population is visiting doctors more now that they are in France while Q8 determines the reasons for not visiting the doctor more now. Question 9 tries to find out what are the things that the Filipinos are doing when they have not fully understood the explanations of the doctors. It is important to remember that not all medical professionals especially doctors in France, speak very good English nor the Filipino speak good French. The main challenge in the process of communication between doctor and patient who are using two languages is that when one cannot find the exact word of what he is trying to explain, he switches immediately to his native language and replaces the word. This often leads to confusion because a lot of things are lost in translation. As such, Q9 clarifies how Filipino patients cope with the language barrier and how they supplement lost information. Q10 further asked the respondents if they somehow understand doctor’s explanation even if it is in French. Q11

categorically asked if language is barrier in seeking and understanding medical information. By knowing the answer to this basic question, both the patients and health care providers can make adjustments on how they better understand one another. It is a probability that Filipinos should spend more time and exert more effort in learning the French language. At the same time, the French health care system might need to adopt measures to further lessen health disparities brought about by language difference. Question 12 sought to elucidate other means which respondents seek medical information. Responses to this question further reinforces the ideas solicited from Q9 while at the same time finding out how the respondents are supplementing the information they get from their medical providers. Q13 asked if the respondents are still taking medicines from the Philippines, and is an open question. This researcher is under the impression that Filipinos have a concept of “hiyang” {suited}. Many still believe that even if medications have the same bioequivalence, the body still reacts differently to different drugs. One brand of medicine might be “best suited” than the other even if the compositions are the same. Under this scenario, some Filipinos who know that they have high blood pressure for example while they are still in the Philippines, might still be taking their old medicines and buying them in the Philippines because they are “hiyang”. This is why the respondents were asked to provide a short explanation of their answer.

This interpretation also holds true when taking branded medicines versus generic medicines. In the Philippines, many patients still believe that generic medicines do not have the safe efficacy as the branded ones, even if the generic drugs passed the test conducted by the Bureau of Food and Drugs- a government agency that approves safety of food and drugs. As such, even if the branded medicines are more expensive than generics, many people still prefer to take them.

Q14 is a general questions that seeks to determine the overall point of view of the respondents on how they are taking care of their health.

The questionnaire was a 3 page white paper with questions in English with Filipino translation, for better understanding of the concepts being asked. One

information being asked though is written in English 'Contact Number". English is widely spoken in the Philippines and it is used simultaneously and interchangeably with the national language. The term "contact number" is better understood by the Filipinos because it does not have a direct translation in Filipino. Another English phrase "Please Check" is used in asking for the age of the respondents.

Age is bracketed into five (20-25; 25-30.. .60 and above) taking into consideration the sensitivity of the respondents regarding the age question. Some are not very comfortable revealing their real age and by bracketing it somehow lessens the uneasiness of answering this question.

The survey method of this research is very challenging. Coming from the Philippines, this researcher knows the difficulty of getting data from the Filipinos. They are often very timid and directly approaching them and asking questions often yield unfavorable result. To add, Filipinos are suspicious and direct introduction of the researcher then asking them to answer the survey questions immediately will take a long time and the answer to the survey instrument might be done haphazardly. It is important to note that some Filipino migrants in France are still working on their legal papers to stay and work and answering questions even from a fellow Filipino is dealt with extreme caution. Issues about legal documents is an open secret and it is understandable why Filipinos are very adamant in answering questions even from a fellow Filipino especially if it includes personal questions like contact information and type of work. The researcher then realized that the best way to make the data gathering efficient in terms of time and resources is to be introduced by someone who the Filipinos have known for a long time, someone they already trust. The researcher experimented several ways to get in touch with her population. First, she researched on the different Filipino organizations in Nice, Cannes and Monaco. She then got in touch with these organizations' leaders, introduced herself in detail making sure there is an establishment of trust. These leaders were tapped to introduce the researcher to their group members. She was then invited to some of their gatherings/meetings and by the end of each event that this researcher attended, she was introduced by

the leader and was given a few minutes to introduce herself, discuss a little about her work and assure the members that the data will only be used for academic purposes, and answering the questionnaire will not put them in jail. The researcher observed that there is a common joke among the members of her population that when they give their contact details, they will be picked up by the police and will be put to jail. Although, this is a running joke, it somehow affects the willingness of the population to answer questions. Sometimes they make reasons like they can't read the questions because they don't have their reading glasses on, they want their wives to answer for them, or they will answer the questionnaire at home and it will be given back the following week, or saying that they don't live in the area, they are just visiting and more excuses not to answer the survey. It was very obvious that those people who made these excuses don't want to be involved in any way. Answering the survey is not a mandatory but a simple request so the researcher thanks them anyway. When this researcher tried to deal with the organized groups in the French Riviera, she immediately felt the distancing of the population. There was just a handful that showed interest in this researcher's request. Sometimes the researcher felt that she is not one of "them", and she is very alienated despite the fact that they all speak the same language. This behavior has its impact on how fast or slow the Filipinos are learning the French language. If these people are not very open in talking to someone who speaks the same language as they are, what more to a French speaker. With this behavior, despite the significant number of Filipinos who attended French language classes, a great number still don't speak the language primarily because they don't practice. They are very conscious of how they sound, the grammar and the general utmost rejection of speaking French. The researcher understood however because Filipinos by nature are very shy and timid and these traits can be misinterpreted as being a snob often because they do not try to strike up a conversation and they shy away from people especially to foreign language speakers. It becomes apparent at this point that the researcher needs to do more than simple introduction to make her respondents answer the survey more so the interview.

Because of these challenges, the researcher decided to try another approach in administering the survey questions.

This researcher got in touch with the Filipino parish priest in Nice. Filipinos, being predominantly Catholic, go to church every Sunday and this is a good opportunity for this researcher to meet her target population. She then contacted Fr. Guerrero Clavero who held Filipino mass (in Tagalog) in St Martin-St Agustin church in Vieux Nice {Old Nice}. She was able to get his schedule of masses every Sunday. In the morning at 9:30, he says mass in Nice, at 12:00 noon he says another mass in Cannes (Chapelle St. Paul) and in the afternoon at 5:00 o'clock, he says mass in Monaco (Chapelle des Franciscains). This researcher asked permission from Fr. Clavero if she could go with him in Cannes and in Monaco to do her data gathering. The priest agreed and what he did was to introduce this researcher after every mass and she was given a few minutes to introduce herself and explain her work. This process was carried on for more or less 20 weeks (5 months) spread between May to November 2011. These months were specifically targeted for several reasons. One, the weather is good so there are many Filipinos who go to church. Second, the five –month data gathering for the survey ensures maximum output because it saturates the community. Third, those who were not able to go to church during the summer season because their employers were around, are still included because of the May, August and September months, which is pre and post summer months. However, administering the survey took longer than originally planned. It stretched until March 2012.

This strategy worked the best because within the confines of the church, Filipinos became very open and trusting. It largely also because Fr. Clavero knows a lot of Filipinos in these areas because he has been their parish priest for almost twenty years. It is important to highlight that in this method, it is the Filipinos who came to the researcher to know her, inquire about her studies and ask how they can be of help. They even started sharing their personal health experiences and suggested people who can be a good interviewees. They seemed in awe of

someone from the Philippines coming to the South of France just to study. Many of them take pride that there is someone from their country who comes to the Riviera, not to work but to study and a scholar by the European Union. In their own words and I quote “aba, proud yata kami na at least meron naman iba na di kagaya nami ang trabaho” {It makes us proud that there are some Filipinos who are here not to do what we are doing}. As previously stated, the industry dominated by Filipino workers in the French Riviera is domestic work. Quite a large number of these workers finished University studies; thus they are actually degree holders. They chose to engage in this type of work, swallow their pride because at the end of the day, it is the money they take home at the end of every month that matters anyway. This researcher often encounters stories of the hardship of the adjustment process; from being a professional to cleaning toilets, as they often describe this domestic work. Sometimes they find solace by telling themselves that what they are doing at the moment is just temporary and that they will find a job that matches their qualifications and educational attainment later on. That job never came and soon enough, they became comfortable where they are. Pay is good, less responsibility, less stress and work environment is better than in the Philippines. The aura of prestige is also present because when they go home to the Philippines, the question being asked is not what is your work abroad, rather how much euro are you earning a month? Despite the monetary benefit however, the professionals often state that if they have a choice, they would rather engage in jobs related to their educational background. The main hurdle is, France does not recognize degrees earned in the Philippines. For a medical nurse for example, those who came from the Philippines need to study all over again to get a degree in France before they get hired. In other countries such as the U.S. and Canada, Filipino nurses are so in demand that often after graduating from the University, these nurses are directly hired by hospitals and clinics. Recently, these countries require new nurses to pass a state administered exams but that’s how far it goes. France has a totally different story in hiring professionals who earned their degrees from the Philippines. This researcher is not in the position to cite if the same phenomenon applies with other race. In one instance, the researcher met an

Arab woman who is a licensed gynecologist in her country. She speaks a little French but she is not allowed to practice her profession in Nice. It is a sad story because it seems that if a professional chooses to live in the South of France, it is almost inevitable that he needs to give up his profession.

Probably this is why some Filipinos are proud that there are Filipino students who they can relate to for they are those who have the opportunity to do what the first generation Filipino immigrants in the Riviera dreamed of yet the opportunity did not present itself to them. For the second generation however, the presence of Filipino students from the Philippines was somehow viewed as normal because they have not experienced the challenges of integration, not as much as what their parents have gone through. Most second generation are attend French school, speak French and are living the French ways. Going back to the Filipinos this researcher met them in three churches every week for 20 weeks, they were able to fill out about 200 survey forms. It is important to note that not all Filipinos attend church or are Catholics. The researcher decided to find another way to get in touch with the other members her research population.

She took advantage of the linkages she got from the previous method. She informed the people she got close with to inform her should there be informal gatherings like picnics, get-togethers and religious trips, or cultural events. She was then invited to several activities and she was able to see the everyday life of Filipinos in the Riviera. From christening to birthdays, religious trips to cultural events and even a simple gathering on the beach, she was invited and it was in these informal events that she was able to raise the number of her survey.

There was an instance where this researcher conducted the survey during a renewal of passport service in Monaco sponsored by the Philippine Embassy in Paris. Another time, there was a same service carried out in Nice and this researcher used the event to conduct her survey.

In Cannes, there is a Philippine store owned by couple and the woman is from the Philippines. This researcher asked permission if she can leave a few

survey forms there and requested the owner if she can ask the Filipino clients to fill out the form. Using the same method for a money transfer business owned by a Filipino woman in Nice, the researcher placed a few survey forms in the shop. Both methods however, were not able to yield positive results. This is probably because the owners of these businesses do not have enough time to explain what the survey is all about. Also, the cautiousness of the population under research prevents them in participating in something that they do not fully understand and there is no face behind the questionnaires. This researcher only got 12-15 fill-out survey forms and there were a lot of questions left unanswered. These survey forms were later on disregarded.

This researcher despite the challenge of directly approaching her population, still tried to go to other places to saturate her population. She sometimes visited the church Notre Dame in Jean Medicine to target the Filipinos who were attending the catholic mass in French. After mass, she waited for them outside of the church, approached them and introduced herself and asked for a few minutes to answer the survey. Usually, she got a no because they were in a hurry to go home and some would tell her they would answer the survey some other time. In some cases, the researcher was even requested to look after a child or two while they were answering the survey. This researcher also has always a ready questionnaire in case she sees a Filipino in the tram, bus or restaurant.

In the end, the introduction of the Priest was the best way where this researcher were able to maximize her time and got the best result in terms of number of survey forms properly filled out. The success of this method was attributed to the place where questions were asked (church) and the trust Filipinos give to their priest. This researcher observed that Filipinos are more accommodating when they are in the church and when introduced for by someone they trust. Asked the same people in a difference context the result might be totally different.

Figure 21: Churches where data were gathered



Chapelle des Franciscains, Monaco
Nice



Chapelle St. Martin-St. Agustin,



Chapelle St. Paul, Cannes

These different methods for survey were utilized to reach a good number that would be justifiable enough as a representation of a population. In addition, gathering as many as the researcher can produce would validate the number of Filipinos living in the three cities under study previously estimated by key informants.

In the selection for the interviewee for Key Informant Interview (KII), this researcher, while conducting the survey, noted the respondents who revealed some information about their own medical conditions or those of their loved ones. Initially designed KII questions were readily at hand to follow up the survey with informal KII questions. The initial results of the KII were reviewed and revised several times to further clarify concepts and better frame the questions. When the instrument for the KII was already finalized, the researcher called the identified interviewees for the KII and sought permission for the interview. Majority of the pre-selected interviewees granted permission for the interview and so a schedule was then finalized. Most of the time, the interviewees schedule the interview when there were going to attend a certain gathering or event, mostly birthday parties. The interviewees seem to be more open and comfortable talking about their medical conditions in the company of close friends. They also tend to talk more in details when surrounded by people they know. Some however, chose the sacredness of their homes and the researcher did some interviews in the houses of the respondents. Some also opted to talk over coffee in the center of the city usually after their work. The researcher also used snowball sampling. The interviewees recommended other members of the Filipino community who have the same experiences with them and the researcher immediately got in touch with them, told them who gave the researcher their contact details, explained a little about herself and her study and made an appointment. Most of the time, they respond positively to the request.

In gatherings (or celebrations) where KII was carried out, male interviewees were very cooperative in answering questions. They talked more than their female counterparts and openly discussed about their health concerns and medical experiences in the company of other men and with a little help from beers or wine. The researcher recorded the interview either by audio or video depending on the permission given by the interviewee. Some of the respondents requested not to have any recording at all. Operating under the bounds of research ethics, this researcher does not have a choice but to follow their request. The same principle of secrecy applies to those who requested that their real

names be concealed. The researcher however, kept written notes during the interview, both for recorded and not recorded ones, upon permission from the interviewee, which they often grant. As it is impossible to write everything within the conversation, the researcher is conscious to write key words or phrases that answer the questions written in the guide and provide further clarifications to the concepts being asked. The KII was carried out as a regular conversation where the researcher seldom looked at her questionnaire. She did this consciously for in the testing of the efficacy of the guide questions, the researcher observed that interviewee lost their line of thought when there was a gap between questions. The mood was also informal to ensure interviewees were comfortable enough and not have the feeling that they are being scrutinized. The researcher had some experiences in the past where interviewees were so tensed and became very conscious of how they spoke, how they acted and how they answered questions. In cases like this, interviewees tend to give answers that they think the researcher is expecting to get rather than how their real answers to the question. In this study, the researcher veered away from tension and made the interviewee comfortable enough to discuss health issues. After all, health issues are very personal and should be discussed with utmost sensitivity.

The researcher at each and every KII, started with a brief introduction of herself, the nature of research she is doing, what the interview is for and ensured everyone that the information that will be gathered will be used solely for academic purposes. Their names and personal information will not be revealed without their permission.

She then subtly starts the interview by asking the interviewees to ask a question to the researcher. This is strategically done to make the interviewees feel that they are in control. By answering questions posted by the interviewees, the researcher is given a chance to set the tone of the activity. She answers with sincerity so the interviewees were given an example to emulate.

Figure 22: Filipino Events and Gatherings



Figure 22 is a gathering organized by the Filipino community at the end of every summer. Usually on a weekend between the first week to the third week of September every year. This is their way of keeping in touch with the other members of the community after a long summer. They were not able to talk to one another much during the summer season because often their ‘amo” (boss) are present or there are a lot of visitors in the villa where they are working. For those whose work is yacht base, they are often out at sea. For the freelancers, they are taking advantage of the abundance of extra jobs available and they are maximizing the time they have. When the summer season is about to end, they were able to breathe and have one night of eating and catching up with their friends along the Promenade des Anglais. The people who are organizing this event are usually the “kapampangans”. They are the Filipinos who

came from a particular part of the Philippines, a place called Pampanga. It is a given that Filipinos love to eat and they eat all the time. However, the kapampangan's are particularly known to be very good cook and the photographs are a proof that celebration equates to food parade. It is important to understand that this gathering is based on friendship and not in religious affiliations. These people although most are Roman Catholics, are not devout. There is politics that divides the church and the parishioners. The kapampangans are very critical of the Filipino parish priest assigned in the area. They openly say their criticism about the priest without reservations.

Figure 23: After Summer Church Thanksgiving



Figure 23 is the catholic church version of summer thanksgiving. It is led by the priest and supported by the different religious organizations. It is consisted of

sharing food, praying together as a community, blessing from the priest and later on games, singing and dancing.

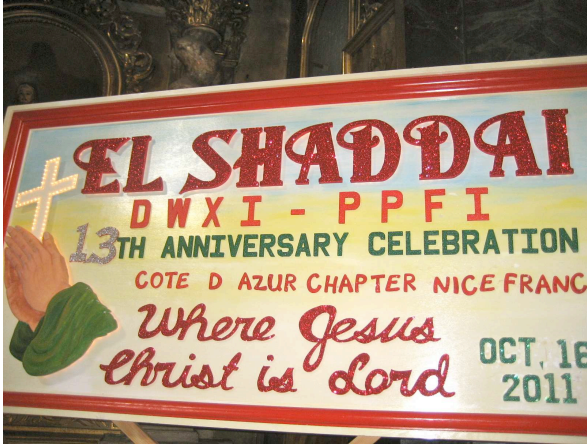
Figure 24: Cultural and Social Events



Figure 24 was an event sponsored by a Filipino Channel which also has a large following from the Filipino community in the South of France. The TV station, ABS CBN held a free movie screening in Acropolis in Nice and it was attended by a large number of Filipinos because it also showcased Filipino stars. It was the largest Filipino gathering that this researcher has witnessed. Filipinos as far as Marseille and Aix en Provence were present, on top a large population coming from Nice, Cannes and Monaco. This researcher arrived a few hours before the movie screening and was able to talk to a large number of the population.

Figure 25 Cultural Activities and Religious events





A religious group's Anniversary

Independence day celebration



Pilgrimage to Lourdes



Figure 25 are photos that showcased religious and cultural events hosted and participated by the Filipino community in the South of France. This group of people although divided by religious and personal beliefs, shared a common love for their country. As such, although every religious group holds different feasts, they come together to celebrate cultural events like Independence day, Flores de mayo, etc. And in every event where researcher was invited, she took the opportunity to interview people and observe how each of them connected with one another.

In the end, this researcher made twenty five key informant interviews.

Data Analysis Guide and Procedure

This study is partly focused on language analysis and description of a cultural phenomenon through the use of three research methods: Survey, Key Informant Interview and Direct Observation. Following the line of thought derived from the theories that inspired this research coupled with the descriptive nature of this study, were analyzed by using simple excel for the survey method and for Key Informant Interview and Direct Observation is aided by a coding guide based on the study hypotheses. This researcher puts premium on language because it contains rich data that “provide rich insights into how people look at the world around them”¹⁸⁴.

Survey results are encoded using the excel program and was later interpreted in terms of distribution since the main aim of this method is to determine the distribution of the concepts asked from the population. The survey forms are numbered and grouped according to location. Numbering starts from the forms filled out by respondents from Nice followed by those from Cannes then Monaco. In the encoding process, data were entered in excel by group. This was done intentionally for referencing and easy access if needed later on. In the general sense however, the grouping does not have a direct impact on the analysis of the general result of the survey. Initially the survey data were interpreted using simple statistical treatment. The results were then transformed into a pie graphs revealing the answers of the respondents in terms of percentage. It was later treated more vigorously and cross analysis of concepts was done to determine the relationship of the concepts. This method might seem mundane. However, it is important to remember that for a research that has never been done before with a community that has never been studied, the

¹⁸⁴ Tan, M.L., (2008). *Revisiting Usug, Pasma, Kulam*. Quezon City. University of the Philippines Press

most basic questions must be covered before venturing into a more profound research.

Key Informant Interview (KII) was processed and interpreted using a coding guide. Guided by the theories used in this study, a coding matrix was designed to highlight words and statements that directly or indirectly disclose and explain the ideas of the population regarding their old and new health knowledge and practices. The guide questions for this method were geared towards eliciting specific answers to the questions that were asked. The questions were written in English because it is intended for the researcher. She automatically translates it in Filipino during the interview.

Direct Observation was carried out from the beginning to end of the data gathering activity although the intensity and purpose varies. In the beginning, the observation was carried out merely to know how the Filipino community is interacting with one another in a more general superficial level. This researcher observed the kind of relationship they have with their social peers based on similar religious beliefs, regional belonging to a more personal and intimate relationship as friends and family members. In the later part of the data gathering process, the researcher observed how the interviewees for KII are responding to sensitive questions, share stories and partake in the stories of others which they can relate to. The researcher wrote down her observations from the beginning of the study until the end. In the analysis of the Survey and KII results, her observations will then serve as the backdrop for the findings. It will be cross-referenced against the results of the direct observation results to find out if the results of KII and Survey have a direct connection thereby can be explained using the data generated from direct observation.

This researcher employ Survey, Key Informant Interview and Direct Observation, because she believes that this are the methods that would best answer the research question, validate or refute the research hypotheses and generate data that would answer the research problem. By using a triangulated

study, results of each research method are validated by the results of the other methods. This seals the cogency of the findings.

Instrumentation

Survey method was carried out to gather the basic information about the research population. As stated earlier, no organization, both from the Philippines side and the French government, are willing to give concrete data about the Filipinos living in Cote d'Azur area. For the French side, they state that information being asked by the researcher cannot be revealed because it is a privileged information and thereby protected by law- referring to the number of Filipino immigrants in the area. The Philippine embassy in Paris on the other hand, cannot give a solid statistics too because if they give the number of Filipinos living in the south of France, it would highlight the discrepancy between number of people they have on their records and the actual number of people on the field or the number from the Prefecture. This would jeopardize the position of some Filipino immigrants in the French Riviera whose residency papers are still in process, moreso those whose status are undetermined. This posts as a challenge for the researcher at the beginning of this research. To address this, the researcher went generic in gathering data- she went to key personalities of Filipino organizations to have a rough estimate of the population and this works very well in both in terms of getting numbers and linkages to the community.

Key Informant Interview will validate some concepts already established in the survey. The survey method provided the basic idea- gender, age and location distribution, basic health beliefs and practices etc. KII provide in-depth discussion about health concepts-beliefs and practices- then and now. In addition, discussions under this method paved the way for a deeper and broader source of health beliefs and how it directly affects their health choices now. And to complicate it even more, their health beliefs which was shaped by their country of origin have taken a steep curve as Filipinos in the French Riviera adopt to the new health care system of their host country. All these rich information came out during the FII.

Scope and Limitation

It should be made clear that although this research talks about healthcare system of two countries, this is not a comparative study. The aim of this research is to identify the current health practices of Filipinos who are in the Riviera. To be able to identify these concepts from the population, there is a need to extract what is the kind of healthcare beliefs system they were exposed to. At the same time present the health system of the country they now belong to. In the process, basic country information were presented in a manner that might be misinterpreted as resembling a comparative study. The comparison is only done to arrive at a more valid findings at the end of the research.

The researcher presented the sources and influences of Filipino health belief system to paint a clear picture of what it traditional/folk/indigenous Filipino health beliefs and practices are. In addition, the researcher discussed the Philippine health environment to determine how responsible the state institutions are in implementing health programs as well as how sound are the current state policy and how budget affects health of the population in general. When it comes to the discussion of health issues in France, this research focused only on the health care system and not on the belief system of French. This was done because the focus of this study is the health belief and practice of Filipino immigrants and how it changed – if there are changes, or influenced by the French health care system. Throwing the traditional health beliefs of French is in this study will surely produce data overload.

The following challenges were observed:

a) Challenges from the Population

The population of this study is the Filipino immigrants in the French Riviera. They were chosen primarily because the researcher is from the Philippines, she live in Nice and her University in located in the same city. She chose Cannes, Nice and Monaco to be the key cities to carry on her data gathering because there is a large concentration of Filipinos in these areas. The main reason for this

- the researcher theorize- is because jobs are more available in these areas. The researcher also finds it practical to travel to conduct her interviews between these cities than going to larger cities like Marseilles, Paris or St. Tropez. The three selected cities to conduct the research were chosen as representative of the French Riviera or South of France- terms which were often used in this study.

The researcher was able to find contact persons with different Filipino organizations in these areas. Filipinos who have been living for a long time in the area seems to know everyone and every activity there is. They easily gave this researcher names of contact person for religious and social organizations. However, getting her research population involve in the actual research is a challenge. Filipinos are not very trusting with other Filipinos. It takes a while for them to warm up with someone thereby conducting the survey and the KII has not been an easy task. Even during the initial stage of this research, where the researcher is merely an observant on events, questions thrown at her by the Filipino community seems to measure if she is a threat- threat to what – it was never clear.

There is difficulty in determining the exact number of Filipinos living in the research area because the Prefecture located in Nice is not allowed to release these data under the French law. This researcher relied on information from leaders of different Filipino organizations in the area as to how many are their members. This researcher only came up with the best number estimate of her population, which is between 600-800 Filipinos living in the area.

The Filipinos have some reservations in answering questions from strangers but once they feel comfortable, they will open up about almost about anything. The KII was conducted in an informal set up so that the respondents do not feel intimidated. The researcher intended it to be that way. However, once the story telling starts, so much is revealed that it takes a lot of time for one interview to finish. The few initial interviews that this researcher did were indeed very time consuming and tiring. She adjusted by having a time limit to each question.

Without being rude, she would ask another question when the respondent starts to drift away from the topic.

In terms of schedule, the planned time frame to carry out the data gathering was not followed especially in the Key Informant Interview phase. There were a lot of changes made in interview schedule, the researcher spends a lot of time re-setting interview appointments, places to meet and travel time. It was a set-back because of the intended time this research is suppose to finish. Although majority of the interviewees were like this, some who were very participative and accommodating. Some even went to the extent of opening their homes and inviting this researcher to dinners, lunches and coffee to make the researcher comfortable and welcome. It is worthy to mention the generosity of the Filipinos. They often offer to pay for food or coffee citing that the researcher is just a student.

b) Academic and Language Challenge

It was not difficult to communicate with the population she is studying because they usually engage in conversation using their native tongue. Communication with French organizations however is tantamount to not getting anything. Since the researcher is a newbie in France and she deeply struggled with the language, most of her communication to French institutions to gather data- which should be done in French- were translated using a Google translator program through the internet- especially during the first few months of her arrival in Nice- and often grammatical lapses are highly visible. Often, communication, mostly email, takes a very long time to get an answer because the French organization or person that the researcher is trying to communicate with, often end up clarifying a lot of things before a question is clearly understood. It must be mentioned too that certain email and snail mails were not returned even after a number of follow-ups by the researcher. Language barrier has been the primary blocking matter to the researcher. It is worthy to mention that by November of 2009, three months after the arrival of this researcher in Nice and after attending an intensive language course in the University of Nice, the researcher questioned

the need to carry on the research. The challenges brought about by new environment, new culture and new language makes coping and adopting seems to be an unbearable task and an unconquerable challenge. The better of her takes over and she decided to continue her research. This blockade however slows her down leading to the prolonged study time. In the end, instead of finishing after 34 months, she needs one more year. The reason why this is mentioned as a limitation is to inform European scholarship granting bodies that intense preparation is needed before accepting students from other countries to France. Expectations about language should be made completely clear to the students as well as the what to expect from the receiving University. Citing the experience of this researcher, she is well aware that most of the courses/seminars in her laboratoire are in French but she never expect that everything will be in French. Should she have known, she could have selected other universities or other laboratoire where she can somehow fit in. Although it is obvious that this researcher benefited much from the opportunity to study in a European University, she could have achieved more academically if she was affiliated with a more culturally diverse learning environment. On a personal level, her denial that she needs the French language also limits her integration to the academic community. It was to late when she finally realized that it was mistake on her part not to have taken learning the French language seriously.

On the other hand, French universities must also be made aware of the Europeans Unions' scholarship programs. A better coordination between scholarship granting bodies together with the people who implement them and the partner University where the invited scholar will be placed, is needed to make sure the objectives of the scholarship program are met. When this researcher arrived in her laboratoire and she doesn't speak a single word in French, nobody knows what she is doing there or under what program she was able to register in the University. This immediately becomes a psychological blocking matter for this researcher. She finds it difficult to understand the academic situation where she is now into. Under normal circumstances, a laboratoire must know who are the students they are accepting and if the students can truly benefit from their course

offering. In defense to this researchers laboratoire however, it is the first time they have accepted a student who have no stock knowledge about France more so the language. They have assumed that this researcher can cope with the academic works and activities even if they are mainly in French. Also, the coordinators of the EMMA program was not able to communicate with them effectively, what the program is all about and if the invited student can truly fit within the laboratoire. These barriers brought challenges mainly to the researcher both academically and personally.

Significance of the Study

Health studies regarding health of immigrants in Europe have revealed a different scenario through the years. This put into question the role of different health players as well as immigration policies. There has been a wide interest in immigrants health status all over Europe and results are often diverse because of different strategies to measure health outcome, health inequalities etc. This study aims to contribute to the literature about immigrants' heath status by providing specific health practices of the Filipinos in the French Riviera.

Findings of this study intend to provide health professionals, concerned institutions and policy makers with data that could aid in their quest to improve health services. Filipino immigrants as well as other immigrant groups might also benefit from expanded policies and improved health communication campaigns. In a more general perspective, this research attempts to contribute to the improvement of health delivery to immigrant groups. Specifically:

a. Health professionals

Health professionals include not only the medical doctors and nurses but all those who are working in the health arena to make sure quality service are delivered to the patient. This includes social epidemiologists, health researchers, front liners in health offices and all those whose work is related with providing health information to the general public. The front liners of every health

programs are these people and being so they should know the very sensitive role they play in health management.

The understanding of immigrant culture remains a challenging task to health workers. Findings of this research will give the health professionals an idea of what are the intricacies, oddities and sensitivities of the Filipino patients they are serving in their community. This immigrant group comes from a different health environment and knowing the cultural and religious sensitivities of these people will help health professionals in the Riviera to communicate with them in a manner that is more suited to their long held beliefs about health maintenance and managing cure by designing culturally congruent health activities. It was reported earlier that French health care professionals are dismissive, lacks listening skills and ill-prepared to handle culturally diverse environment. By providing them with the information regarding Filipino culture and religious beliefs, they will know better this immigrant group with the hope that other immigrant groups will do the same, especially the minorities.

b) Immigrant groups

Hopefully immigrant groups will exert more effort in knowing France and the region they belong to; its culture and its people and not remain a passive worker of the country. They should also be encouraged to participate in social events and engage in active dialogue which would enable the national and local governments to determine their needs and design programs addressing them. It is not the sole responsibility of the state to provide services for its immigrants. Now more than ever, synergy is demanded from all sectors of the health industry to address health related issues.

Provided that the results of this research open the possibility of a more collaborative efforts between health institutions and immigrants, organized immigrants groups should then reach out to these state health institutions to come up with health campaigns that target diseases which the immigrants are culturally or genetically disposed to, in a language they fully understand and in a manner

that appeals to them. This type of activity undoubtedly cost more time and resources but with result of previous strategies that doesn't work, there is no way to go but bottom-up. The top-down approach has its gains but it doesn't work with the immigrant population because of their unique qualities as a people.

c) Healthcare Planners

In the South of France, health communication collaterals such as flyers and posters are intended for the general population. It is clear by now that these materials which are often intended for preventive measures, does not have a direct impact on immigrants. Primary reason probably is because it is in a language they do not fully understand, designs might not be appealing to them that is why it doesn't speak to them in a way it was intended to be.

Results of this research will provide health campaign designers a glimpse of how the Filipino people are wired in terms of health performance. Operating under an ideal scenario, health collaterals specifically for a particular immigrant group is ideal. However, using English as the language for health communication collaterals would reach other English speaking immigrant groups not just the Filipinos. It would surely have its benefits if patients who go to health offices to gather health information will be presented with choices of health collaterals.

d) Policy makers

The Director of the World Health Assembly, Margaret Chan stated that much of the blame for health inequality rest at the policy level. This is an alarming reality that policy makers are faced with and which they need to address as soon as possible because all roads leads to the institutionalization of policies. A law that requires the creation of a standardized normative guidelines in the area of immigrant health data collection is a good start.

e. Academe

Health communication is a very young area of research. There are other disciplines which the ideals of health communication can be applied and studied.

Studying immigrant population sheds light to the causes and effects of the processes involve in immigrant assimilation and integration.

Members of the academe can explore French health policies concerning addressing immigrants health. It is important to know how responsive are the current policies to the needs of these people. It will also bring into the light policies that limits or encourages better immigrant assimilation.

Researchers can apply the proposed transcultural health communication model to other immigrant groups or other members of the population.

Chapter Synthesis

Chapter explained in detail, how questionnaires were formulated and tested, how data gathering procedure was designed and planned and more importantly how data were analyzed. To set the boundaries of this research, the scope and limitation was discussed together with the challenges faced by the researcher.

Like other research endeavors, the plan for this research changes as soon as the initially formulated questionnaires and data gathering techniques were put to the test. There were several revisions of the research tools and data gathering plans because of factors unforeseen by the researcher. This cost times and resources but its changes have to be done to be able to meet the objectives and answers to the hypotheses of this research. To cite an example, the researcher planned to approach Filipinos on gatherings to answer survey questions. She found out that this strategy would not work that is why she sought the help of people who the Filipino community have known for a long time and who they trust.

In terms of limitations, reading literature in French is the main challenge for the researcher. She utilized available online translation applications and it proves useful. The only thing is that online translation is not highly reliable. There were a lot of times when the translation did not make sense. To address this issue, she sought the help of her French friends. To add to the language barrier problem, calling is a challenge, visiting a health clinic is also an impediment. In these cases, she relied on her friends who are either French speakers or native French, depending on the need and sensitivity of the information required.

The direct intended recipients of this study were identified as well as how they can benefit from this research. They can use the data from this study as a jumping board to another health related research, as a guide in the design and implementation of health campaigns for immigrants and to aid policy makers.

CHAPTER V

Understanding the French Healthcare Environment

France reflects the benefits and challenges of a socialized healthcare system. With the strong presence of the government in its healthcare system, in terms of policy and economic assistance, much has been achieved through the years making France's health care system the best in some categories. There are some areas where attention is needed, including the rising costs of the maintenance of this kind of system. Given the uniqueness of France's healthcare system, it surely affects the health beliefs and practices of the people from other countries who decided to settle in France for good. As for the Filipino community, it has been established in the early part of this study that the historical connection between France and the Philippines did not reach a level where certain beliefs of Filipinos can be attributed to the French. The Philippines is highly influenced by the Spanish and current generation is highly Americanized. For Filipinos, it is very easy to spot which part of our culture comes from the Spanish and American colonizers. The "manana" habit (delaying things for later) of the Filipinos is often attributed to the Spanish as well as their love for "siesta". The open mindedness and being go-getter were traits Filipinos got from the Americans.

The population of France in 2001 was 59 million plus 1.7 million from the four French departments; Martinique, Reunion, Guadelupe, and French Guyana. Life expectancy increases regularly, 3 months a year for men and 2 months for women. Although life expectancy varies from region to region, the average life of men is 74.2 and 82 for women (Figure 8). Midi Pyrenees and Loire Valley have the highest life expectancy for women (82.7) and Midi Pyrenees for men (76). Life expectancy and life expectancy without disability show that the health of the population is good. On the other hand, France suffers from a high rate of male premature mortality due to smoking and accidents. The main causes of death in France are cardiovascular disease (31.1%), cancer (27.7%), accidents (8.3%),

and respiratory system (8.1%)¹⁸⁵. France has a decreasing rate of fertility and it has an increasing life expectancy. As a result, the French population is aging. Demographic projections state that from 2020 onwards, those aged over 60 will outnumber those aged under 20; 27% and 23% respectively¹⁸⁶.

The French health care system was ranked number 1 by the World Health Organization in 2000. The French healthcare system combines universal coverage with a public–private mix of hospital and ambulatory care and a higher volume of service provision. Although the system is far from perfect, its indicators of health status and consumer satisfaction are high; patients have an extraordinary degree of choice among providers¹⁸⁷. It was cited as the best in the world mainly because of the availability of a plentiful supply of providers, a high degree of freedom for physicians and patients, few restrictions on the range of services covered by statutory health insurance, easy access to health care, and the absence of waiting lists for treatment—all of which resulted in substantial levels of patient and public satisfaction with the health care system¹⁸⁸.

Equity emerged as an issue in response to a growing recognition of inequalities in mortality and access to treatment. Recent reforms of the 1999 Universal Health Coverage Act (CMU) explicitly aims to increase the access and consequently, health care expenditures from people on the low-income bracket.

All citizens are required to be a member of the National Health Insurance. Management of France's health care is through the Social Security System. Health

¹⁸⁵ Sandier, S. et.al. (2004). *Health Care Systems in Transition*. Copenhagen. WHO Regional Office for Europe. p 5

¹⁸⁶ Sandier, S. et.al. (2004). *Health Care Systems in Transition*. Copenhagen. WHO Regional Office for Europe. p 1

¹⁸⁷ Rodwin, V. (2003). *The Health Care System under French National Health Insurance: Lessons for Health Reform in the United States*. American Journal of Public Health 93.(1)

¹⁸⁸ Ibid 186 p 117

care funds are mostly derived from incomes of France's working population. It is estimated that almost 20% of an employee's compensation including employer contribution is remitted to the government. Of this amount, 12.5% is contributed from the employer while 0.75% by the employee and 7.5% social security tax also collected from employees. These account for 60% of the Social Security fund while other fund sources include indirect taxes from alcohol and tobacco.

Health care is highly socialized. It does not discriminate any income levels wherein everyone is entitled to an equal level and quality of service in both public and private institutions. There is also no waiting list for the conduct of surgical procedures. Everyone can consult any health practitioner he/she wants in any public or privately-run hospitals or clinics. There are also specialized insurance schemes aside from the general insurance, such as the self-employed, artist, traders, farmers, and specialized occupational groups. The poorest population and those suffering from long-term illnesses are fully covered by the government.

The usual rates for professional consulting are €21 for a *médecin traitant*, (attending physician), €24 for children aged two to six years old, and €25 for children under 2 years old. An additional euro is charged but is non-reimbursable by the patient. Services and prescribed medicines are not fully reimbursed, oftentimes, based on the income level of the individual or a family. Typical reimbursement rate is 95% for a major surgery, 80% for a minor surgery, 95% to 100% for pregnancy and childbirth, 65% for prescribed medicine with blue labels and 35% for white labels, 70% for x-ray, and 75% to 80% for GP/specialist consultations and treatment. Thus around 80% of the French population still avail of supplemental health insurance to cover the difference in actual cost and reimbursed amount. This again costs employees about 2.5% of their salaries. Most supplemental health insurance is provided by employers as part of their employment benefit (Moveforward, 2008).

The French health care system is a mixed system combining elements of various organizational models. It lies between the Beveridge and Bismarck models,

with health insurance funds and strong state intervention. William Beveridge was a British economist and social reformer. He was asked to advise David Lloyd George (British politician and statesman), on old age pension and national insurance. He published his report in 1942 and recommended that the government find ways of fighting the Five Devils of Want, Disease, Ignorance and Idleness. His report paved the way for the establishment of a National Health Service with free medical treatment for all. A national system of benefit also introduced social security so that the population would be protected from cradle to grave. This healthcare model is provided and financed by the government. Many hospitals and clinics are owned by the government. Because some doctors are government employees, the government controls what doctors can do and what they can charge.

The Bismarck healthcare model (named after Otto Van Bismarck, a Prussian Chancellor) on the other hand, uses an insurance system called “sickness funds” which is usually financed by employers and employee through salary deduction. In this system, doctors and hospitals tend to be private, although there are multi-payers, too. Because of the presence of tight regulations, the system gives the government most of the cost-control clout compared to the single payer of the Beveridge model.

French health insurance combines public and private health insurance which finances the same services by the same providers for the same populations. It combines public and private care including private-for-profit hospitals. It is a publicly funded system characterized by freedom of choice and unrestricted access for patients and freedom of practice for professionals. It is complex and pluralistic in its management, with co-management by the state and the health insurance funds. This concoction reflects a balance between values such as equity freedom and efficiency but it also generates structural difficulties which in

turn provide the impetus for health care reform ¹⁸⁹. This health care system falls under the National Health Insurance model, where it has the elements of both the Beveridge and Bismarck Model. It uses private sector providers but payment comes from government-run insurance programs that every citizen pays into. This system limits cost by limiting the medical services they will pay for or by making patients wait to be treated. This way, patients are also stakeholders of their own health. To cover for the treatments and medications not to be provided by the national insurance to which they subscribe to, they need to be a member of a private insurance called “mutuelles”, paid for out of their own pocket.

Jurisdiction in terms of health policy and regulation of the health care system is divided among the state (parliament, government and various ministries); the statutory health insurance funds; and, to a lesser extent, local communities particularly at the department level. The institutional organization of the system was affected by the Juppe Reform of 1996. This reform shifted power from the health insurance funds to the state and decentralized at the regional level. Every year since 1996, the parliament has passed an Act on Social Security Funding based on the reports of the Accounts Commission and the National Health Conference. This yearly Act sets a projected target for health insurance spending for the following year known as the national ceiling for health insurance expenditure. It also approves report on trends on policy for health and social security and it contains new provisions concerning benefits and regulations ¹⁹⁰.

The Ministry of Health which has been recently reorganized, includes the

¹⁸⁹ Sandier, S. et.al. (2004). *Health Care Systems in Transition*. Copenhagen. WHO Regional Office for Europe. P 116

¹⁹⁰ Sandier, S. et.al. (2004). *Health Care Systems in Transition*. Copenhagen. WHO Regional Office for Europe. p 19

following structure:

- 1) a general directorate of health responsible for health policy;
- 2) a directorate of hospital and health care responsible for the management of resources; its scope, previously limited to hospitals, has been extended to the whole healthcare system;
- 3) a directorate of social security responsible for financial matters and for supervising social security organizations (including the health insurance funds);
- 4) a general directorate for social policy responsible for the specifically social aspects of health care (such as care for the disabled, elderly or vulnerable people);
- 5) the Ministry which has external services to local levels;
- 6) the Ministry which controls a large part of the regulations of the health care expenditures on the basis of the overall framework established by the Parliament.

Despite the plus points attributed to the French healthcare system which includes self-regulating market coupled with widespread diversity where consumers can choose when to go and who to see for medical care, there should be more strict gate-keeping protocols. The French economy is burdened by the increasing healthcare cost that is why in 2005, health reforms were put in place to address the economic deficit brought about by the increasing health costs.

The French health care system is indeed very far from being perfect despite world recognition and patient satisfaction. It is complicated because of multiple players involve as well as several sources of funds.

The Statutory Health Insurance System

France has three main insurance schemes:

1. General Scheme (Regime General) covers employees in commerce and

industry and their families (about 84% of the population) and CMU beneficiaries (estimated in 2001 to be 950,000 people or 1.6% of the population);

2. Agricultural Scheme (MSA) covers farmers and agricultural employees and their families (about 7.2% of the population); and
3. Scheme for non-agricultural self-employed people (CANAM) covers craftsmen and self-employed people, including self-employed professionals such as lawyers etc (about 5% of the population). Other schemes (such as those for miners, employees of the national railway company, the clergy, the seamen and the national bank) have their own particular form of organization and function autonomously ¹⁹¹.

Figure 26: Level of complementary VHI coverage in France, as a percentage of total, 2000

	VHI % of total	CMU % of total
Employment status		
Employed	89.9	2.2
Unemployed	60.1	20.3
Retired / widowed	88.7	1.5
Housewife	80.1	9.1
Other non-employed	66.1	12.8
Students, children	84.6	6.9
Occupation		
Farmers	89.3	1.5
Artisans, retailers	82.0	5.9
Executives and professionals	93.5	0.9
Intermediary professions	94.4	1.0
Office clerks	85.2	8.1
Customer-service clerks	69.2	12.4
Skilled workers	84.0	5.0
Unskilled workers	71.8	12.1
Total	85.7	*5.0

¹⁹¹ Sandier, S. et.al. (2004). *Health Care Systems in Transition*. Copenhagen. WHO Regional Office for Europe. P 23

Source: Health and Health Insurance Survey (ESPS) 2000. ¹⁹²

Figure 25 shows the percentage of the population who subscribe to the Voluntary Health Insurance (VHI) vis-à-vis those who are under the Universal Coverage (CMU). All legal resident of France are required to subscribe to public health insurance. Recent development put the basis of subscription to public insurance on employment status. Since the Universal Health Coverage Act (CMU) came into force in January 2000, the small proportion of the population without public health insurance is now entitled to public coverage on the basis of legal residence in France.

Three main health insurance schemes cover 96% of the population, with the National Fund for the Insurance of Employed Workers (CNAMTS) covering about 83% of the population. The population has no choice of insurer. All residents are automatically affiliated to a health insurance scheme on the basis of their professional status and place of residence.

In 2000 86% of the population had additional (complementary) voluntary health insurance (VHI) coverage. Since the introduction of CMU in 2000, which provides free complementary VHI coverage for low-income people, an additional 7.2% have gained VHI coverage, bringing the proportion of the population covered by complementary VHI to over 90%.

The quality of VHI is highly variable. For example, in most contracts the level of reimbursement for a basic dental prosthesis is 150% of the official rate. A quarter of contracts reimburse less than 55%, while 10% reimburse more than 285%. People with higher incomes tend to have better contracts.

There is no significant difference in levels of coverage between men (85.3%) and women (86.1%), although levels of coverage are lower for young people (81% between 20 and 30 years old) and elderly people (82%).¹⁹³

¹⁹² Health and Health Insurance Survey (ESPS) 2000. ^{192*} Figures in mid 2000; this figure has since about 7%. Taken from http://www.gesundheitspolitik.org/01_gesundheitssystem/ausland/gesundheitsysteme/HC-Systems-in-8-Countries.pdf. Downloaded August 2013

¹⁹³ Sandier, S. et.al. (2004). *Health Care Systems in Transition*. Copenhagen. WHO Regional Office for Europe

Figure 27: Social Health Insurance Contributions in France

Salaried workers in industry and commerce	Total contribution	Employer's contribution	Employee's contribution
	13.55% of gross earning (no ceiling)	12.80% (no ceiling)	0.75% (no ceiling)
Self-employed people	6.50% of net earnings up to an annual ceiling of EUR 28 000 5.90% of net earnings between EUR 28 000 and EUR 141 000 the minimum contribution is 6.50% of EUR 11 000		
Farmers	8.13% up to an income ceiling of EUR 164 000		

Source: Official rules found at www.gesundheitspolitik.org¹⁹⁴

Figure 27 shows that social health insurance contributions are regressive for self-employed people and farmers, but proportional for salaried workers (although they could be considered to be regressive because they only apply to earned income, which accounts for a larger proportion of total income among the poor than among the rich). Social health insurance contributions rates are set by parliament through the annual Financing of Social Security Act. Non-contributing people are funded from the global pool of social health insurance revenues¹⁹⁵.

¹⁹⁴ <http://vosdroits.service-public.fr/ARBO/17011201-NXSAN115.html>. Taken from http://www.gesundheitspolitik.org/01_gesundheitssystem/ausland/gesundheitsysteme/HC-Systems-in-8-Countries.pdf. Downloaded August 2013

¹⁹⁵ Sandier, S. et.al. (2004). *Health Care Systems in Transition*. Copenhagen. WHO Regional Office for Europe. P 34

Figure 28: Healthcare expenditure by type of service in France, in million euro and as a percentage of total, 2000

	National current expenditure		Health care consumption	
	Amount (million EUR)	% of total	Amount (million EUR)	% of total
Health insurance schemes	10 2428	72.8%	92 290	75.5%
State and local authorities	6 110	4.3%	1 285	1.1%
Private	32 083	22.8%	28 623	23.4%
- <i>Mutual associations</i>	11 004	7.8%	9 110	7.5%
- <i>Provident institutions</i>	2 569	1.8%	2 569	2.1%
- <i>Commercial insurers</i>	3 372	2.4%	3 372	2.8%
- <i>Households</i>	13 610	9.7%	13 571	11.1%
- <i>Other private</i>	1 528	1.1%	0	0%
Total	140 628	100%	122 197	100%

Source: www.gesundheitspolitik.org¹⁹⁶

Figure 28 shows that in 2000, total expenditure on health care in France was estimated at EUR 140.6 billion or 10% of Gross Domestic Product (GDP). This figure is twice the amount recommended by the WHO which is 5% of GDP as a country's ideal health budget. Health care consumption accounted for EUR 122.2 billion or 86.9% of total health care expenditure -EUR 2017 per capita on average¹⁹⁷.

¹⁹⁶ DREES. National Health Accounts. Paris: DREES; 2001. Taken from http://www.gesundheitspolitik.org/01_gesundheitssystem/ausland/gesundheitsysteme/HC-Systems-in-8-Countries.pdf. Downloaded August 2013

¹⁹⁷ Sandier, S. et.al. (2004). *Health Care Systems in Transition*. Copenhagen. WHO Regional Office for Europe. P 38

Figure 29: Health care personnel in France, 2000

	Total		Private practice	
	Numbers	per 100 000 population	Numbers	per 100 000 population
Doctors	194 000	330	117 041	199
-of which GPs*	95 000	161	67 072	114
-of which specialists	99 000	169	49 969	85
Midwives	14 000	24	1 938	3
Dentists	40 500	69	37 834	64
Pharmacists	58 000	99	52 603	90
Speech therapists	13 000	23	10 675	18
Nurses	383 000	652	57 023	97
Physiotherapists	52 000	89	40 327	69
Orthoptists (eye disease)	2 100	4	1 686	3
Chiropodists	8 800	15	0	0

Source: www.gesundheitspolitik.org¹⁹⁸

Figure 28 shows that in 2000 there were a total of 194 000 doctors in France; 51% are specialists and 49% are general practitioners. The number of doctors providing ambulatory care is estimated at 110 000 (186 per 100 000 inhabitants), of which 60% are GPs (50% are GPs without a specialized practice) and 40% specialists (50% if we include GPs with a specialized practice). There are 114 GPs per 100 000 inhabitants. 62 000 nurses work in the ambulatory

¹⁹⁸ Here GPs are defined as doctors without a specialist diploma, but some of them may have specific training in areas such as sports medicine, angiology, homeopathy, emergency care etc; this is the case for 22 000 doctors, which leaves 72 000 doctors who actually practice as general practitioners. Source: Audric et al., 2001 and Darriné and Niel, 2001. Taken from http://www.gesundheitspolitik.org/01_gesundheitssystem/ausland/gesundheitsysteme/HC-Systems-in-8-Countries.pdf. Downloaded August 2013

sector.

To provide out-of-hours services, all GPs in a given geographical area are on a duty roster (this is increasingly difficult in rural areas). There are also specialized call centres, but people increasingly turn to hospital emergency departments. It is usually possible to obtain an appointment with a primary care doctor on the same day. In consumer surveys people generally express a high level of satisfaction with their GP ¹⁹⁹.

The National Fund for the insurance of salaried employees/employed workers (CNAMTS) plays a supervisory role in relation to the general scheme's regional and local fund. CNAMTS board of director comprises 33 members; 13 representing employees, 13 representing salaried workers, 3 representing the mutual insurance associations and 4 people appointed by the Ministry of Health. The three insurance schemes are under the Social Security Directorate of the Ministry of Social Security. Since 1996, they have carried out their function as managers of the statutory health insurance system within the framework of an agreement on targets and management drawn up with the state for a minimum period of three years ²⁰⁰. Their budget must be discussed and agreed upon by the Ministry of Health. An agreement was reached in 2000 but in 2001, they were not able to reach an agreement and in 2002, the target budget was not defined.

The scheme for self-employed people consists of regional funds and professional funds composed of 31 individuals. Anyone can choose to be insured with any of the listed organizations which have an agreement with the regional fund that is authorized to receive contributions and reimburse treatments. Patients now play a big part in the management of their own health. Health care users'

¹⁹⁹ Sandier, S. et.al. (2004). *Health Care Systems in Transition*. Copenhagen. WHO Regional Office for Europe. P 40

²⁰⁰ Ibid 198 p 24

expectations have been an important issue in public debate. Recently, associations related to health care have re-grouped to form a collective unit (CISS), thereby increasing the pressure to accommodate the interests of health care user. These organizations seek to influence the direction of research and reinforce the role of the patient as an active agent in his or her own health care. For professional practice, there are several bodies that monitor and regulate professional practice.

Recently, two sets of recommendations (for diabetes and hypertension) were used by the medical service of the main insurance scheme to establish a diagnostic on the quality of outpatient care for these two conditions and to improve medical practice. However, there is no evaluation at the level of the individual health professional which resulted to patient complaints²⁰¹.

In the 1980's, there was a growing number of unemployed being deprived of their right to health insurance because the right was linked to professional activity. Legislations were made to accommodate the individual insurance contributions for a certain group of the population. An important Act was passed in June 1999 and took effect on January 1, 2000. This Act is known as the Universal Health Coverage Act (CMU) which establishes the universal health coverage, opening up the right to statutory health insurance coverage on the basis of residence in France. In addition, the remaining 1.8 % of the population whose income is below a certain level are entitled to free coverage. This act also shifted the health insurance system away from the work-based system towards a system of universal health coverage. Therefore, these are the developments in France health insurance system: universal health coverage based on residence; the substitution of tax-on-income for wage contributions in the funding of the system; and a more active role for parliament in determining policy directions and

²⁰¹ Sandier, S. et.al. (2004). *Health Care Systems in Transition*. Copenhagen. WHO Regional Office for Europe. P 33

expenditure targets²⁰².

Challenges of France Healthcare system

Despite the good points, public health policy and practice in France are difficult to describe because they involve numerous actors and sources of finances²⁰³. Upon the advice of special agencies, the national authority issues basic regulations on environmental matters, thereby relegating power to the local authorities to implement their own program for environmental protection. However, not all municipalities have the resources to carry their own program and in these cases, they are assisted by the Directorates of Health and Social Affairs at the regional or department level. The National Institute for Monitoring Health (INVS) monitors the population's state of health. The organization is mandated by law to provide public authorities with its findings regarding health risks and to participate in the collection of epidemiological data.

Health promotion and health education involve a large number of actors. In the public sector, the Ministry of Health organizes national campaigns, while the DRASSs implement regional health promotion programs. The French Institute for Prevention and Health Education (INPES) contributes by implementing prevention programs on national scale. They are assisted by 17 other committees in the regions and departments who carry out activities in the field. The Ministry of Health's High Level Committee on Public Health set up in 1991 is responsible for developing the monitoring of health status and of presenting a report annually to the national health conference and the parliament. The need to strengthen programs and activities to promote public health in France became apparent in the 1990's. Regional health conferences now define priorities for public health within

²⁰² Sandier, S. et.al. (2004). *Health Care Systems in Transition*. Copenhagen. WHO Regional Office for Europe. P 9

²⁰³ Ibid 201 p 57

each region ²⁰⁴.

Another weakness of the French Health Care System lies in the lack of coordination and continuity provided by often isolated professionals, leading to over-prescription and waste, in addition to inadequate care paths. As mentioned in a national study conducted by the main insurance funds, it was revealed that only 40% of patients with diabetes have an eye examination once a year as part of the practice guidelines issued by Agence Nationale d'Accréditation et d'Evaluation en Santé (ANAES). Even if doctors advise their patients correctly, they are not in a position to monitor the whole process of care. The lack of coordination is not limited to self-employed professionals: the interface between hospital care on the one hand and between health care and social care on the other hand, is also often a problem²⁰⁵. To address this problem, two experiments were put up: the referring doctor and the provider network. Under the referring doctor, patients consult the general practitioner (except in emergencies) to bring their medical record to consultation and to follow the general practitioner's recommendations regarding prevention program and screening.

General practitioners serve as gatekeepers at the same time that they apply the consultation fee stated in the agreement, shelter the patients from direct payment, keep patients' medical records, provide continuous service, ensure continuity of care, participate in public preventive programs, comply with practice guidelines, ensure that at least 15% of prescribed drugs are affordable, and 5% are generic. The other solution to address the problem of waste in the French health care system is the experimentation with different forms of provider networks at the local level. The purpose of this is to invite creativity and promote new forms of organization. It may not yet be proven to be successful, but it is a welcome development since it encourages innovation in the system.

²⁰⁴ Sandier, S. et.al. (2004). *Health Care Systems in Transition*. Copenhagen. WHO Regional Office for Europe. P 61

²⁰⁵ Ibid 203 pp 66-67

Following global trends in terms of slow economic growth and unemployment problems, a health care system which relies on wages is difficult to sustain. It is in such a premise that effective cost management remains a primary objective of health care reforms in France. This objective on the other hand is difficult to achieve given the present health care system in France where the “freedom of the patients and providers are unrestricted, where care is largely publicly funded and retrospectively reimbursed and where health insurance funds have no real financial responsibility”²⁰⁶.

Another issue is the institutional complexity of the French health care system and the issues associated with it as far as the relationship between the state and the health insurance organizations are concerned. In addition, the budget deficit that skyrocketed is an issue that needs to be addressed for the healthcare system to work. Patient satisfaction is also a challenge since patients are not satisfied with paying at the point of service then waiting to be reimbursed.

In general, factors that greatly affect healthcare system in France include multiple financiers, the dilution of responsibilities, and the fragmentation of actors which hinders their efficacy. The public health Bill discussed in 2003 aims to enforce a more ambitious and more effective health care policy. The Bill contains a set of objectives for a five-year period and proposes the implementation of a five national public health plans between 2004 and 2008. It also wants to clarify the roles of different actors and developing more power to regional levels through the creation of “public associations” putting together all the actors in a particular region.

Authors Dixon and Mossialos have specifically identified the challenges of the French health care system and they are:

²⁰⁶ Sandier, S. et.al. (2004). *Health Care Systems in Transition*. Copenhagen. WHO Regional Office for Europe. P 116

- a. The dissatisfaction of doctors and other professionals and the increasing difficulty of concluding agreements with health care professionals

There has been a rift between the government and the doctors with regards to the professional fee that doctors should be charging the state and the patient. Since so agreement have been signed by both parties, some General Practitioners (GP) are on strike over out-of-hours care while some increase their fees without authorization.

- b. The demography of the medical profession and other health professionals

A quota has been set for medical schools and the feared result would be shortage of medical professionals. This shortage will cascade to limited number of doctors in rural areas.

- c. Patients' rights and the use of 'patients' voice' in the system

While other developed countries put premium on the synergy and concerted effort from health players, French parliament is currently debating on the patients' rights. The bill contains measures to increase and enforce patients' rights and more generally to enhance the ability for health care consumers to use have their views heard within the system, in order to improve responsiveness and accountability²⁰⁷.

- d. The general management of the health care system

With the reform that took place in 1996, the management of French health system was transferred to the state and to the local level from the national insurance scheme. What this does is to decentralized health coverage of the

²⁰⁷ Dixon, A. & Mossialos, E. (eds) (2002). *Health Care Systems in Eight countries: Trends and Challenges*. European Observatory on Health Care Systems (http://www.gesundheitspolitik.org/01_gesundheitssystem/ausland/gesundheitsysteme/HC-Systems-in-8-Countries.pdf). Accessed August 2013. pp 43-44

people and until now there is much confusion as to who will take full responsibility for the coverage, who will implement and under which institution.

e. Costs and sustainability of public finances

This will be an ongoing concerns given that French population is becoming more diverse, disease prevention and treatment becomes more complicated and medical technologies are becoming more complex and expensive. The question of what to prioritize in health spending will be a never – ending question and justification.

f. The emphasis on public health issues

Despite the intricacies of the mixed health system in France, it has its gains as well as its losses. The increasing number of premature deaths and avoidable deaths is a growing concern. There as also been a clamor for safety in the health care field.

Chapter Synthesis

Chapter 4 discussed in detail the French health care environment. This constitute health management, types of insurance schemes, universal health coverage, third party insurers, budget sources and spending patterns, access to health care services and medicine and the challenges of its health care system.

The French health care system has its positive points. The accessibility of doctors-both GP's and specialist coupled with low cost (or no cost) of medicine give rise to the high patient satisfaction. The philosophy that the young should take care of the old which translates to the young workers pay higher health premium to partly cover the health expenditure allotted to the older people seems to be working in the French society. Although employers seldom air their voices against raising cost of taxes and other payments like health insurance, the law mandates the proportion that they need to pay and as such the employee is protected.

The main concern of the French health care system is over spending. With volatile economy, France' health spending is skyrocketing and is now gaining attention because of budget deficit. To add, French doctors are complaining about the ceiling of their professional fee that was set by the government. In retaliation, they limit their off-work service hours and some raises their fee without permission. In the end, it is patient who is on the losing end. Currently, patients' do not have a voice in the French health care system. He remained a passive receiver of medical information and treatment without a voice, to air his experience with the disease, his observation of the medical treatment he received and his over-all view of the French health care system.

The reality is French health care system is in a process of transformation and the transmission period is always the most challenging. The passing on of authority to plan and implement health programs is on a delicate position at the moment. What the French patients can do is wait and hopes that they will be accorded with the authority to let their voice be heard in the end.

CHAPTER VI

Philippine Health Landscape

a) Foundation of Philippine health practices

A noted medical anthropologist and educator in the Philippines, Michael Tan, wrote extensively about illness causation in the Philippine health system. His research made him conclude that medical culture is not just a random collection of exotic beliefs and practices but a system of knowledge²⁰⁸. He further categorized where the traditional concept of illness in the Philippines, emanates: mystical, personalistic and naturalistic. The mystical embody the concept of forces believed to be ever present in illness and health. This dichotomy represents good and evil, good as health and evil as illness. Filipinos believed in “what –you – saw-is –what –you reap” thereby cementing the fact that health and illness are natural consequences of good and evil. The personalistic refer to the beliefs in the supernatural entities as well as alive human beings who can cause harm and illness to others. These entities are again labeled as good and evil but they can cause harm depending on their relationship with the “others” and to the society. These beliefs are also applied to witches and sorcerers who are ascribed with power to cause illness and misfortune²⁰⁹. Naturalistic health belief system separates natural occurrences and food into ‘hot’ and ‘cold’ categories. The challenge is to keep the balance of the natural environment and not to upset the body by taking too much of hot or cold food, or exposing oneself to hot and cold elements in the environment.

People from the Philippines believed in the power of the natural forces. Forces that are present in the environment that affect their entire being, including the aspect of health. Several Filipino authors and scholars made studies about this phenomenon and have come up with a concrete and precise description of the

²⁰⁸ Tan, M.L., (2008). *Revisiting Usug, Pasma, Kulam*. Quezon City. University of the Philippines Press.
p 5

²⁰⁹ Ibid 207 p 113

Filipino health belief system. The most popular names in this area of academic discourse are Landa Jocano and Michael Tan.

Filipinos believe in the power of the psychic forces that they refer to as karma or suwerte (luck). Many people donate to charitable institutions because they believe that it will be given back to them ten folds. They also perform rituals to give them good luck, safe journey and protection from bad forces. They perform the sign of the cross when alighting a vehicle, pray the rosary while travelling and they visit mystical mountains like Mt. Banahaw to invoke its healing power. They believe in kapalaran (destiny). They believe that their faith is pre-written by forces greater than themselves and to determine what their future holds, they go to the manghuhula (fortuneteller). These fortunetellers use different cards or refer to the alignment of the stars to predict the future of an individual. Although there is often a disclaimer that a person is still in control of his destiny, Filipino still believes in these predictions. Filipinos also go on pilgrimage to miraculous and popular religious sites, local and abroad for several reasons. These include spiritual guidance, moral strength, inner peace, to be healed of a dreadful disease, bring home a wayward spouse, give thanks for being healed, and thanksgiving for a good life ²¹⁰.

Filipinos also believed in aswang (witches) and multo (ghosts). There are several cities and sites all over the country which are known to be inhabited by these creatures. The capital of the Philippines, Manila, is not spared from this phenomenon. Balete Drive located in Quezon City-a major in Manila - is reported to be the home of a white lady (a ghost) who appears to passersby during wee hours of the night. It has become an urban legend that drivers who pass by this area needs to check his rear view mirror to know if someone uninvited is at the back seat. Some people also demands cab drivers not to pass by this long street

²¹⁰ Jocano, F. L., (2001). *Filipino Worldview: Ethnography of Local Knowledge*. Punlad Research House Inc. Manila. p 10

during the night. Ghosts are believed to be wayward spirits who roam the world of the living and they make their presence known by appearing to people. Filipinos' beliefs in this phenomenon are strong that there are television programs, especially during the Halloween season, where ghosts sightings were shown and accepted with much gusto by the people. Michael Tan provided an elaborate discussion on this belief; how it originates as well as the social and health implications of this entire belief system. He states:

*“ghost or souls of the dead – multo—apparently derived from the Spanish word muerte. Among the Philippine groups, ancestral spirits seem to be the most frequently cited ill-causing ghosts. This is clearly a reflection of the importance attached to kinship ties...Ancestral spirits are not generally perceived as malevolent. There are even instances where illness is believed to be caused by kinship ties of affection between the living and the dead. Deceased traditional healers may also cause illness when they call on a descendant to take up his or her vocation. Besides the ancestral spirits, there seems to be a fairly widespread belief in the souls of unborn children as a cause of illness. The belief in ghosts is obviously related again to social control, reinforcing kinship ties as well as discouraging certain practices such as abortion”*²¹¹.

If ghosts are spirit and does not have physical manifestation, witches are people who have the capability to change into animals. Engkanto (supernatural beings) can also make their presence felt by giving strange seizure to young men and women²¹². Tan describes these beings as having “Caucasian features, sometimes compared to Spanish friars or Americans”. They are said to be extremely wealthy and may even send their children to Europe or America to study. In other words, the engkantos are very much like the human beings, inhabiting a world parallel to our own but nevertheless different from the human domain”²¹³.

²¹¹ Tan, M.L., (2008). *Revisiting Usug, Pasma, Kulam*. Quezon City. University of the Philippines Press. pp 55-58

²¹² Jocano, F. L., (2001). *Filipino Worldview: Ethnography of Local Knowledge*. Punlad Research House Inc. Manila. p 10

²¹³ Ibid 210 p 62

He further describes the engkantos based on how it is perceived and recognized in the urban areas.

“It involves young woman supposedly being courted by an unseen being. Stories of such “affairs” appear frequently in women’s magazine and has been described as the “Prince Charming” syndrome, where women enter a fantasy world, where the expected difficulties including what some would label as psychopathology - depression, wasting even hysteria. Engkantos are a projection of asymmetrical social relationships. In the context of a long and harsh colonial occupation in the Philippines, the description of the engkanto as a Caucasian is not accidental. Contact with the colonizer, represented by the engkanto, is understandably depicted as dangerous and a potential cause of suffering and illness”²¹⁴.

Tan effectively connect the concepts of culture, history and health in his discussion about the engkantos and ghosts. There are layers of meanings embedded in the stories about these beings and they represent social realities. This also reflects the other belief that close family ties are related to ghost sightings. It is believed that spirits of the dead come back to communicate with their loved ones to talk about unfinished business. Sometimes, their presence can cause sickness but it is not intentional.

F. Landa Jocano vividly emphasize in his book “Filipino Worldview: Ethnography of Local Knowledge” that the Filipino believed in the binary system. Environment for example, is composed of physical and non-physical parts. Disease and illnesses originates from “hot” and “cold” sources that is why many things in the environment and inside the body are labeled as hot and cold. Table 1 shows what body parts, foods, celestial bodies and things around are considered to be hot and cold.

²¹⁴ Tan, M.L., (2008). *Revisiting Usug, Pasma, Kulam*. Quezon City. University of the Philippines Press. pp 64-65

Table 6: Hot and Cold perceived sources of illness

		Hot	Cold	Implications on Health
Body Parts	Chest	X		This is the seat of love and affection therefore naturally warm. Stress causes chest pains and can be relieved by rubbing the painful area with coconut oil
	Womb	X		Women who just gave birth are advised to wear long clothes so the cold wind will not enter their body. Menstruating women are also advised not to take a bath or to over exposed themselves to the cold weather or else they will suffer menstrual pains. Withdrawal as a form of family planning is not encouraged because of the belief that when a man withdraws his penis, cold air enters the womb and harms the heated wombs, which in the end destroys the semen.
	Puson (lower portion of the stomach)	X		These lower portions of the body is considered hot because a little friction
	Genitals	X		on them generates heat all over the body and awakens the dormant
	Hita (Thighs)	X		energies of the individual. If a person is suffering from pain in any of these areas, a cold concoction is applied in the area to maintain the balance.
	Likod (Back)		X	Over exposure of this part of the body to wind, rain, draft, cold water and other similar elements might result to cold, tuberculosis, asthma, pneumonia, and other physical pain
	Sikmura (Stomach)		X	When this is over exposed, a person might suffer from gas pain. If one is hungry or has been exposed to the heat of the sun, he should rest first, take a handful of sugar, or a pinch of salt before drinking. Before taking a full meal, a person who has been exposed to the heat of the sun must first take warm food or liquid or else he will suffer a stomachache.
Water	Seawater	X		
	Lakewater		X	
	Ice coldwater	X		Causes painful reactions to the skin and muscles when handled
	Spring water		X	
Celestial Bodies	Sun- late morning high noon, late afternoon	X		Good for health, planting crops, building houses and starting new business ventures
	Sun Early morning and before sun set		X	
	Clouds- In general		X	Cold because they bring rain

	Comet, shooting star	X		The appearances of these things signify a possible long summer or drought
	Moon - Full moon		X	
	Half moon	X		
	Stars		X	Visibility in the sky connotes good weather, cool atmospheric conditions and good time for planting crops and building a house.
	Stars - Fleecy scattered in clusters in the eastern sky early in the morning or in large masses of deep violet-red in the western sky at dusk for a few days	X		Indicates the coming of strong winds or storms
Wind	Southwest (Habagat)	X		It brings typhoid fever, cholera and headaches
	North wind and northwest wind (Amihan and Amihangmura)		X	This type of wind brings common colds, joint pains and muscular cramps
	Southwind (Hanging Timog)		Neutral	Brings about rashes and minor ailments
Food	Beans	X		If cooked without leafy vegetables, they cause skin rashes, lip eruption, shortness of breath and painful defecation
	Newly harvested rice rains and ripe corn grain	X		This needs sometime off before cooking "pasingaw"
	Fruits and veggies	X		These are good because they contain juice and freshly substances that cool the mouth and the stomach
Meat	Water buffalo	X		
	Dogs, cats, pigs	X		
	Cattle, lean meat of pork		X	
	Chicken, goose, turkey, other fowls		X	
Fish	Ells	X		When cooking the fishes which are considered hot, it must be mixed with
	Large fishes	X		green vegetables which are considered
	Saltwater fishes	X		cold to neutralize its harmful effects on the body
	Freshwater fish		X	
Medicine	Modern drugs	X		When taken orally or injected, it upsets the internal balance of elements in the body and lower its resistance to the power of the disease

Researcher's table from the book: Filipino Worldview. Ethnography of Local Knowledge. F. Landa Jocano. 2001. Punlad Press, Philippines

Table 6 provides a rich source of information that pinpoints the clear distinction between the hot and cold division of the environment, the physical body, food, celestial body positions, wind direction and medicines. The concepts where the idea of hot and cold were attached, connects with what Tan has identified as the mystical, naturalistic and personalistic view of the Filipinos and was attributed as causes of illness. Most of the suggestions to maintain balance presented in Table --- were results of practices and observed benefits. It has not been scientifically proven however that to avoid stomach pain, one who has been exposed to the heat of the sun or hungry, should take a pinch of salt or a handful of sugar before drinking anything. Neither it is proven that in the process of withdrawal, cold wind that enters a woman's womb kills the semen. These represent the personalistic view of Filipino patients. These belief systems came from words and practices of the elderly which was handed down from generation to generation. The Filipinos have this mentality that there is no harm in trying these old practices. In the end, if it can help them avoid getting diseases, it is for their own good.

The belief that the positions of the celestial bodies and wind blow direction represents the belief in the natural opposition of things in the natural environment. Because there are always two sides in every story, there is a need to keep the balance in everything to maintain a healthy equilibrium and eschew all forms of maladies. Morning sunshine is considered hot and should be enjoyed because it brings health and is good for starting new business or starting the construction of a house. Afternoon sun on the other hand is considered cold. Different wind blows brings with it different ailments. Even the neutral (not cold nor hot) Southwind brings rashes and minor diseases. Amihan (Southwind) comes to the Philippines from October to March. It brings with it heavy clouds called stratocumulus which makes this time of the year wet and cold. Habagat (Southwest wind) visits the Philippines from May to August and it brings with it hot temperature but with rain. Varied weather patterns brings different types of disease.

In another study Jocano (1973) made an ethnographic study about a system of folk healing in Bay, Laguna- a municipality in the southern part of the Philippines. She reported that people living in this area believe that changes of wind flows affect human beings.

“the body is said to be sensitive to weather conditions and it reacts even to slight changes in the temperature of the surrounding world. When temperature is relatively cool, sickness is not widespread. When the temperature becomes warm and humid, there is a general feeling of malaise and irritability even among healthy individuals.”²¹⁵

This observation may be attributed to how the body reacts to the irritants present in the environment. As a tropical country with wet and dry season, even the mood of the people depends upon how hot or how wet it is. In the summer season where temperature can reach as high as 39 degree Farenheight, people tends to be more irritable. The summer heat becomes unbearable that it affects people’s mind set and attitude. In the colder season when temperature allows people to enjoy the outdoors, people tends to be more patient.

b) General Overview of the Philippines’ Department of Health (DOH)

The Philippines’ Department of Health was declared as the “national technical authority on health, one that will ensure the highest achievable standards of quality health care, health promotion and health protection from which local government units, non-government organizations and individual members of the civil society will anchor their health programs and strategies”²¹⁶. The Department is headed by a

²¹⁵ Jocano, F.L., (1973). *Folk Medicine in a Philippine Municipality*. An analysis of the system of folk healing in Bay, Laguna and its implications for the introduction of modern medicine. The National Museum. Manila. p 46

²¹⁶ Bautista, V. et. al. (2002). *National and Local Government Roles in Public Health under Devolution*. UP Press. p 11

Secretary and he has three under Secretaries for Luzon, Visayas and Mindanao. The Department aims to provide “health for all” as stipulated in the National Objectives for Health for 1999-2004. Its mission is to “ensure accessibility and quality of healthcare to improve the quality of life of all Filipinos, especially the poor (DOH 1999 a:15). The Department launched a program called the Health Sector Reform Agenda (HSRA) which is created to solve health problems of the people and to introduce reforms in In 1991 however, the Local Government Code was enacted transferring responsibilities in health to Local Government Units (LGU’s). This means that in the provincial level, the provision of medical care services incorporating the services of medical practitioners to treat in – patients requiring either basic hospital facilities (secondary level) or specialist treatment for advanced or complicated cases (tertiary level). The municipal level is in charge of promotion and prevention of diseases and this is carried out by the Municipal Health Office through its Rural Health Unit (RHU) and satellite stations based in Baranggay called Baranggay Health Stations (BHS) (Bautista et al, 2002, p 9). Under these conditions, the LGU’s seem like a powerful entity in the implementation of health programs. Ironically, the Local Government Code however stipulates that the Baranggay have very little substantive responsibility for health care except that of maintaining public health facilities. Under the commitment made by the Philippine government in the Alma Ata Conference in Russia in 1978, the Department of Health “transfers to the municipality, the responsibility to motivate and enable community members and other sectors of the civil society to get involve in the local decision making processes for local health development”²¹⁷.

The financial requirement of DOH is sustained by the national allocation from the national budget and can be supplemented by Congressional allocations and foreign funding institutions. In the year 2000, 14.7 billion pesos was allocated for health which comprises 2.3% of the proposed national budget of 651 billion pesos. Similarly in 2001,

²¹⁷ Bautista, V. et. al. (2002). *National and Local Government Roles in Public Health under Devolution*. UP Press. p 10

health budget was at 11.3 billion pesos (2.3%) of the proposed 483.8 billion pesos proposed budget for the year.

The key to managing chronic diseases, which includes diabetes, is change in lifestyle and religious intake of prescribed medication. In the Philippines, where unemployment and underemployment stood at a staggering 22.7% in 2007 (UNESCAP, 2007), healthcare maintenance is dictated by a person's economic status. Moreover, dutiful intake of medicine is a myth among those who can barely buy food. One can often hear stories of people with very little resources splitting a pill just to comply with the doctor's advice of taking a pill twice a day: one half in the morning and the other half in the afternoon. It is funny in a way but it is a pity that it happens in real life. Since diabetes is a disease that requires long, even lifetime management, people from low-income families die from the complications of this disease simply because they cannot afford the long haul of medication.

The aforementioned statements show that the role of economics in health management is crucial. The Philippines as a developing nation has its challenges and limitations. Limited resources for one, is always a big obstacle to overcome. Second is the political will of the government to continuously support efforts from different sectors to promote health and well-being. Third is the little knowledge of the at-risk population about their possible disease. Given this stark reality, it is important to find alternative ways and new allies, either within or outside of the country that can assist efforts of both government and private organizations to fight diseases.

c) Philippine Health Beliefs and Practices

Before focusing on the health beliefs and practices of the Filipinos, the first concept to be clarified is to know who are Filipinos from a micro-perspective. Who are they as a people? What do they believe in? What are their values? What is their culture and how does it affect their everyday lives? Specifically and in relation to this research, the researcher asked: health wise, who are the Filipinos when they are placed outside of their country? What are the values and beliefs they hold still? How

are they adapting to their new environment? How are they altering their personal beliefs in relation to their new environment when it comes to health maintenance?

This research inter-changes the terms traditional and indigenous health beliefs and practices.

d) Traditional/Indigenous Health Practices

Indigenous health knowledge continues to persist despite the popularity and developments in modern medicine. The concept of indigenous knowledge was describe by Olanyan (1982) as the “ability to survive in harmony with the environment and to cope with traditional occupations like hunting-gathering, agriculture, handicraft and healing”. This phenomenon may partly be attributed to the delay of the introduction of western medicine in far-flung areas and to peoples’ strong attachment to their traditional health beliefs, which are culturally rooted. However, there are a lot of instances where people mixed the indigenous and the new health concepts introduced by modern medicine. This concoction might have promising or harmful results. Often, it is difficult to distinguish harmful superstitious beliefs from useful and scientific ones ²¹⁸. The Rural Advancement Foundation International asserts that they are not an accidental accumulation of knowledge but are “organized, dynamic system(s) of investigation and discovery. They are based on experienced and often tested over centuries of use. The International Development Research Center classifies the knowledge embedded in indigenous knowledge systems into eleven (11) categories: 1. Information 2. Practices. 3. Technologies 4. Beliefs 5. Tools 6. Materials 7. Experimentation 8. Biological resources 9. Human resources 10. Education 11. Communication. ²¹⁹. These various forms of knowledge are ‘stored in people’s memories and activities and expressed in stories, songs, folklore, proverbs dances, myths, cultural values, beliefs, rituals, community laws, local language and

²¹⁸ Palaganas E., Bagamaspad, A., Cardenas, M., Josef, J., Tolentino, L.(2001). *Mainstreaming Health Knowledge and Practices*. University of the Philippines, Press. Center for Investigative and Development Studies. Quezon City

²¹⁹ Ibid 217 p 44

taxonomy, agricultural practices, equipment, materials, plant species and animal breeds²²⁰. The value of indigenous knowledge and practices as an alternative to healthcare services becomes paramount in light of governments inadequate health care delivery mechanisms²²¹. Indigenous knowledge systems are by and large ecological. They present a holistic view of reality²²².

Tan (1987) did an extensive study documenting the traditional theories of the causes of illnesses in Philippine society, which provides a strong connection between medicine, social relations, magic and religion. Tan (1987) enumerated three general classifications of theories (1) personalistic (2) mystical (3) naturalistic. He defines personalistic theory as based on the premise that impairment of health is an automatic consequence of the victim's act or experience. Mystical theories assume that illness is caused by "the active, purposeful intervention of a sensate agent who may be a supernatural being or a deity or an *engkanto*, a nonhuman being such as ghost, ancestor, or evil spirit, or a human being or a *mangkukulam* or *aswang*. Theories that attributed disease to 'natural forces or conditions as cold, heat, winds, dampness, dampness and above all, an upset in the balance of the basic body elements" are referred to as naturalistic. Tan (1987) added that Filipinos define health as being free from disease, hence the description "*walang sakit*" (no illness), "*walang nararamdaman*" (no health trouble). A health person is "*malusog*" (healthy) and health is called "*kalusugan*" (good state of health). The usual indicator of this state of good health is a person ability to do usual tasks.²²³

²²⁰ Grenier as cited in Palaganas et al, 2001 p 44

²²¹ Palaganas E., Bagamaspad, A., Cardenas, M., Josef, J., Tolentino, L.(2001). *Mainstreaming Health Knowledge and Practices*. University of the Philippines, Press. Center for Investigative and Development Studies. Quezon City. P 5

²²² Shiva 1997 as cited in Palaganas et al, 2001 p 44

²²³ Tan, M.L., (1987). *Usug, Kulam, Pasma: Traditional Concepts of Health and Illness in the Philippines*. Quezon City . Alay Kilusang Pangkalusugan (AKAP)

Health and treatment seeking behaviors are determined by beliefs about the causes of health problems²²⁴. These concepts are deeply engrained in cultural beliefs. In the Philippines, people believed that “traditional healers are (generally) empowered by gods and spirits’²²⁵.

Philippine Health Environment

The Philippine healthcare system was said to be under devolution²²⁶. With the enactment of the Local Government Code in 1991, responsibilities in health management were transferred to Local Government Unit (LGU’s) from the central health authority. Provinces were in charge of “medical care services incorporating the services of medical practitioners to treat in-patients requiring either basic hospital facilities (secondary level) or specialist treatment for advanced or complicated cases (tertiary level)”²²⁷. Promotion and prevention of diseases is the responsibility of the municipality and often carried out by the Municipal Health Office, through the Rural Health Unit (RHU) or Health Clinic. In general, the municipality is tasked to carry out its functions within the framework of the Primary Healthcare Approach (PHC), a commitment made by the Philippine government in the Alma Ata Conference in Russia in 1978. The code transfers from Department of Health to the municipality the responsibility to motivate and enable community members and other sectors of civil society to get involved in local decision-making processes for local health development.

²²⁴ Becker. M. H., (1974). *The Health Belief Model and Personal Health behavior*. The Education Monographs

²²⁵ Jocano, F.L., (1973). *Folk Medicine in a Philippine Municipality*. An analysis of the system of folk healing in Bay, Laguna and its implications for the introduction of modern medicine. The National Museum, Manila. Kaba, M., (1996). *Utilization of Plant Medicine for the Treatment of Health Problems: The case of the Oromo of Chora District, Illubador Region Western Utopia*. Medical Journal of De La Salle University

²²⁶ Bautista, V. et. al. (2002). *National and Local Government Roles in Public Health under Devolution*. UP Press.

²²⁷ Ibid 225 p 9

The Local Government Code states that Barangay's have very little substantive responsibility expect for maintaining public health facilities in the area, but a highly motivated baranggay captain can be very active in public heath service delivery. Since the adoption of the PHC approach by the Philippine government, practically all baranggay's have Baranggay Health Workers (BHW), they are volunteer workers motivated by the DOH to assist in the promotion of basic health services and the mobilization of community participation. The baranggay captain can extend monetary assistance to the BHW's as provided for in Republic Act No.7883 of February 15, 1995 (Baranggay Health Workers Benefits and Incentives Act). In cities, all facilities and services of the municipality and the province are implemented in the LGU level (p 10).

The Department of Health remained the national health agency of the Philippines. Its main duty is to maintain the "national standards to guide various implementors of health programs at the local level in planning, carrying out and efficiently using limited resources for health" ²²⁸. The Department was reorganize in 1999, mandated in Executive Order No. 102, May 24 1999 signed by then President Joseph Estrada. The DOH was declared as the "national technical authority on health, one that will ensure the highest achievable standards of quality health care, health promotion and health protection, from which local government units, non-government organizations, other private organizations and individual members of civil society will anchor their health programs and strategies" ²²⁹. The Department is headed by the Secretary with the assistance of three undersecretaries based in Luzon, Visayas and Mindanao.

Financial resources of the DOH came from the financial allocation from the national budget, with possible supplementation from congressional allocations and foreign funding institutions. Table 1 shows the data from the Department of Budget and Management, indicate that budget for health fluctuates from 3.8 percent to 2.3

²²⁸ Philippine Department of Health 1999 as cited in cited in Bautista et al, 2002 p 10

²²⁹ Estrada 1999 as cited in cited in Bautista et al, 2002 p 11

percent of the national budget since 1989. It also shows increase in the budget from P6.5 billion in 1989 to P14.7 billion in 2000.

Table 7. Budget of Expenditures in Health (in billions)

Year	Total Budget	Health Budget	Percent
1989 (actual)	173.3	6.5	3.8
1990 (actual)	255.8	7.8	3.1
1991 (current)	298.9	9.5	3.2
1992 (actual)	286.6	9.9	3.5
1993 (actual)	313.7	7	2.2
1994 (actual)	327.8	7.9	2.4
1995 (actual)	372.1	8.4	2.2
1996 (actual)	416.1	11.2	2.7
1997 (current)	493.5	15	3
1998(actual)	537.4	13.5	2.5
1999 (current)	93.6	15.1	2.5
2000 (Proposed)	651	14.7	2.3
2001 (proposed)	483.8	11.3	2.3

Source: Department of Budget and Management, Budget of Expenditures and Sources of Financing. FY 1991-1992, 1994-1998, and 2000²³⁰

As far as human resources is concerned, health personnel devolved in LGU's, the most number of personnel available is the midwife who was able to serve 1:4, 572 persons in 1997, which is close to the standard 1:5,000. Doctors and Dentists are the most burdened with an average of 1:22, 907 and 1:40, 145, respectively. The ideal ratio is 1:20, 000 persons. Among the regions in the country, Region IX (Southern Mindanao) is the most deprived since it has the highest ratio of population served by each health personnel. The National Capital Region has the most number of doctors and dentists while Cordillera Administrative Region (CAR) has the most number of nurses and midwives²³¹.

²³⁰ The annotation of 'actual' shows the actual expenditure of the government; 'current' means that the budget is the one operating at the year of reckoning and 'proposed' means that it is to be implemented yet.

²³¹ Bautista, V. et. al. (2002). *National and Local Government Roles in Public Health under Devolution*. UP Press. p 17

There are many Baranggay Health Stations (BHS) in the country with the ratio of 1:16,612 population. Rural Health Unit (RHU) has a ratio of 1:31,638 and headed by a health practitioner (a doctor or a nurse). In 2001, there are 645 government hospitals all over the Philippines. These hospitals offered a total of 43,332 bed capacity with a population ratio of 1:1, 738. Government hospitals in the country are classified into fourteen: medical center, regional, provincial, district, city, chartered city, municipal, medicare, general, military, sanitary, specialty, university, and research hospitals are categorized as primary, secondary and tertiary hospitals. Forty percent (261) of the total number of government hospitals are district hospitals. One hundred eight are nationally-based with 71 as DOH-run hospitals with a total bed capacity of 24,685 as of January 2001 ²³².

Philippine Health Statistics

The Department of Health reported that the average life expectancy at birth in 1999 is up to 68.6 years. This is a lot higher than 61.6 in 1980 and 64.6 in 1990. However report from the United Nations Development Fund (UNDP) states that the Philippines is behind its South East Asian neighbors; Malaysia with 72, Thailand 68.8, Singapore 77 and Japan 80 as of 1997²³³. In a more recent statistics from the CIA World Fact book, life expectancy at birth in the Philippines at birth (estimated in 2008) is 70.8 years (male: 67.89' female: 73.85). Malaysia got 73.03 years (male: 70.32, female: 75.94), Singapore 81.89 (male: 79.29, female: 84.68), Thailand 72.83 years (male: 70.51, female: 75.27) and Japan 82.02 (male: 70.51, female:75.27). This recent data supports the DOH and UNDP findings in the earlier years. The Philippines still pales compared to its South East Asian neighbors.

²³² Bautista, V. et. al. (2002). *National and Local Government Roles in Public Health under Devolution*. UP Press. pp 17-25

²³³ Ibid 23 p 26

The leading causes of morbidity remains to be caused by infectious diseases. Table 2 shows that diarrhea, pneumonia, tuberculosis, malaria, chicken pox and dengue are main causes of death in the country. It is interesting to note that between 1998-2002, dengue fever was not in the list of causes of mortality in the statistics of the DOH between 2000-2004, it is in the number 10 spot.

Table 8: Morbidity: 10 Leading Causes, Number and Rate*
5 Year Average (2000-2004) & 2005

Diseases	Number 2000-2004	Rate 2000-2004	Number 2005	Rate 2005
1. Acute lower respiratory tract infections and pneumonia **	694,209	884.6	6990,566	809.9
2. Bronchitis/ Bronchiolitis	669,800	854.7	616,041	722.5
3. Acute Watery Diarrhea	726,211	928.3	603,287	707.6
4. Influenza	459,624	587.0	406,237	476.5
5. Hypertension	314,175	400.5	382,662	448.8
6. TB Respiratory	109,369	139.7	114,360	134.1
7. Diseases of the Heart	43,945	56.1	43,898	51.5
8. Malaria	35,970	46.1	36,090	42.3
9. Chicken Pox	79,236	41.1	30,063	36.3
10. Dengue Fever	15,383	19.6	20,107	23.6

Source: <http://portal.doh.gov.ph/kp/statistics/morbidity>²³⁴

*per 100,00 population

** Does not include ALRI Pneumonia cases only from 2000-2002

Degenerative diseases like diseases of the heart and vascular system also claimed the lives of Filipinos. Other causes of death include chronic obstructive

²³⁴ *per 100,00 population

** Does not include ALRI Pneumonia cases only from 2000-2002

pulmonary diseases, diabetes mellitus, nephritis and related illnesses and other diseases of the respiratory system²³⁵.

Health situation in the country can also be attributed to several factors like economics and education. Seven of the ten poorest ranking provinces are in Mindanao (Agusan del Sur, Basilan, Lanao del Norte, Lanao de Sur, Maguindanao, Sulu and Tawi-Tawi) while two are in Luzon (Ifugao and Masbate) and one is in Visayas (Northern Samar). These provinces have life expectancy of 52-64. Income of these area ranges from P9,637-P14,352. On the whole, the poor health situation has been aggravated by the low educational and economic situation of the families²³⁶.

Development in the Philippine Health Landscape

DOH's main objective is to provide health for all as mandated by the National Objectives for Health for 1999-2004. Its mission is "to ensure accessibility and quality of healthcare to improve the quality of life of all Filipinos especially the poor"²³⁷. In 2000, the Department initiated the Health Sector Reform Agenda (HSRA) whose specific task is to solve health problems of the people, who are plagued by both infectious and degenerative diseases, and environment and work related illnesses. HSRA is also to solve management problems like inappropriate health service delivery system, inadequate regulatory mechanism and poor healthcare financing. These problems resulted in lack of access to health facilities, poor quality of health care and high cost of services²³⁸.

²³⁵ Bautista, V. et. al. (2002). *National and Local Government Roles in Public Health under Devolution*. UP Press. p 27

²³⁶ ²³⁶ Bautista, V. et. al. (2002). *National and Local Government Roles in Public Health under Devolution*. UP Press. p 30

²³⁷ Philippine Department of Health 1999 as cited in cited in Bautista et al, 2002 p 31

²³⁸ Ibid 234 p 31

These challenges embedded in Philippine health scenario were further recognized by organizations and personalities directly involved in health care management in the country. In a forum held at the University of the Philippines Forum Roundtable, Dr. Alberto Roxas, Dean of the College of Medicine, University of the Philippines Manila stated that with limited resources, it is imperative for government to prioritize its expenditures and focus on the essentials, like preventive and wellness programs, basic medical services focused on the poor and efficacy in health care delivery. At the same time, a multi-sectoral and multidisciplinary study group should be engaged to define the strategies to achieve universal health care. He also admitted that there is a need to reorganize the entire system to be able to serve the Filipino patients better and that this is the time for the different sectors of the society to do their share. The government must have the political will to secure the necessary funds to provide an effective social health insurance system in the country by spending at least 5% of our Gross Domestic product (GNP) for health.

Dr. Jaime Galvez-Tan gave statistics that highlights the need for health care financing reform is the extent of out-of-pocket expenditure in the Philippines: 48 centavos for every one peso spent on health (2005 National Health Accounts) as compared to 29 centavos from government and 11 centavos from social insurance. This pattern of health fund sourcing has dire implications for many Filipinos. The rich can fully pay out-of-pocket payments while the lower middle class and the near poor can become impoverished in struggling to meet out-of-pocket payments.

The Philippine Health Insurance Corporation (PhilHealth) is also facing a big problem. There are acknowledged gaps in PhilHealth's coverage due to low awareness about PhilHealth and the value of social health insurance among various population segments, especially outside the cities. Participation of the informal sector and the self-employed needs improvement. The existing benefit package and the current system of spending upfront for medical services and supplies for later reimbursement make Philhealth unattractive and thus underutilized even by the poor.

Experts in the field of health, identified issues in the Philippine healthcare. Health

services are fragmented and inefficient according to the former Secretary of the Department of Health, Dr. Alberto Romualdez. Dr. Leizel Lagrada, OIC of Health Policy at the DOH, made the point that enrollment coverage in Philhealth, favors the rich due to a weak policy of targeting poverty. Two thirds of reimbursements made by Philhealth are to private hospitals that cater to the rich. Health facilities that are accessible to the poor are often not accredited. Dr. Suzette Lazo, Professor of Pharmacology at the UP School of medicine, pointed out that drug prices in the Philippines are among the highest in the world – a situation that increases the risk of poor Filipinos dying from curable diseases because they cannot afford to buy medicine. Although cheaper generic drugs have been produced in the Philippines for twenty years, Filipinos who can afford to buy medication, tend to prefer brand names. Former DOH secretary Dr. Jaime Galvez Tan stated that healthcare financing is inadequate, health resources are market-driven, and decoupled from actual needs, and unevenly distributed. Health management information is rudimentary. The government must enact and implement necessary reforms, with private sector support, for health care reform to succeed²³⁹.

On December 16, 2010 Administrative Order Number 2010-0036 was released from the Office of the Secretary of the Philippine Department of Health Appendix 14). The subject of the administrative order is the Aquino Health Agenda, which is focused on achieving Universal Health Care for All Filipinos. With the introduction of the Health Reform Agenda in 1999 and its implementing framework, FOURmula One (F1) for health in 2005, much have been achieved in the health sector specially in the areas of health insurance coverage and benefits, allotment of DOH budget and its use to leverage LGU performance etc. However, despite these developments, poor Filipino families have yet to experience equity and access to critical health services. To address this concern, the Aquino Health Agenda (AHA) is being launched to improve, streamline and scale up reform interventions. The deliberate focus on the

²³⁹ Romulo, B.D. (2010) U.S. and Philippine Health Care, Manila Bulletin

poor under this program, will ensure that as the implementation of health reforms move forward, nobody is left behind. The overall goal of the Universal health coverage shall be directed towards achievement of the health system goals of better health outcomes, sustained health financing and responsive health system by insuring that all Filipinos, especially the disadvantaged group have access to affordable healthcare.

The clamor for improved health services in the Philippines was made more visible by different organizations and personalities directly engaged in the healthcare delivery. The infrastructure for health delivery improvement was set and now that the current government has the political will to implement change, the implementing guidelines for Universal Health coverage was finally drafted and will soon be implemented.

Chapter Synthesis

Chapter V is all about the Philippine health belief system as well as the role of established state institutions mandated to take care of the population's health. It is very obvious that the Filipino health belief system is an interesting concoction of beliefs highly influenced by religion, environment, superstitions and colonizers existing presence. This rich and varied source of Filipino health beliefs and practices makes it more complex to communicate health issues, reach out to the people and design a campaign that is appealing to them. To add insult to serious injuries, the budget allotted to health budget cannot support and sustain programs intended to assist people, mainly because of burgeoning population and the endemic problem of low GDP turn-over of a developing country like the Philippines.

The government through its health institutions is addressing the recurring problems associated with limited budget against a huge population. A universal health coverage system is being reviewed to ensure indigent members of the population have access to basic health care. It is a long shot because of societal, political and economic constraints but it is a major step for there is a recognition that indeed, the Philippine healthcare system needs overhauling.

To ensure that Filipinos will be better actors of their own health, there is a need to strengthen education and provide income -generating programs. Studies have shown that provinces where peoples' health is the lowest, consist of people who are less educated and are poor. These people are often the hardest to reach because of they live far from the center and their problem is aggravated by the fact that there is not enough medical workers in terms of number and just quite a handful who are willing to service those who are located in the far flung areas of the country.

In general, the health care system of the Philippines is the one that needs immediate medical attention. Proposed reforms in the health sector needs political will both from the parties promulgating the laws and the people who will implement the much needed improvements.

CHAPTER VII

Data Presentation

In the past, research deals primarily with hard science. Today, more and more researches are experimenting with the boundaries of interpretation. Research is no longer rigid, mechanistic and self-contained scientific system, as it used to be. Research now is taking into account social change and characteristics of race, ethnicity, gender age and culture to fully understand a social phenomena. Instrumental to these paradigm shift are the researchers themselves. The embracing of new research methods such as ethnography, unstructured interviews, textual analysis and historical studies further enrich the more widely accepted methods of research such as statistical studies, experimental deigns and survey research²⁴⁰.

The emerging health belief system of the Filipinos in the French Riviera, is not just a health topic. It is a social phenomenon because of the different social factors which contributes to the change in health behaviors leading to altered health practices. Health experiences of Filipinos in the Riviera are reflective of the challenges faced by larger immigrant population in France and an echo of research findings in the past regarding immigrant state of health.

a) Survey Result

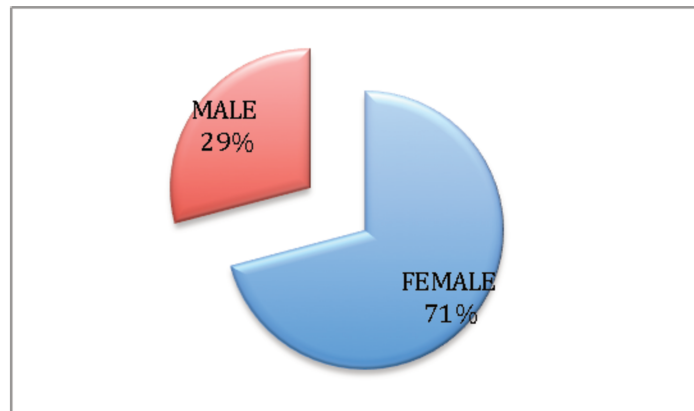
Survey questionnaires were compiled and then tabulated using excel program to determine how the population understands and responds to the concepts under study. Using the colored exploded pie graph, the frequency distribution were then vividly presented and easily understood.

Each graphical representation is followed by a thorough discussion. The implications of the concepts will be determined after the graphs were cross -

²⁴⁰ Palaganas E., Bagamaspad, A., Cardenas, M., Josef, J., Tolentino, L.(2001). *Mainstreaming Health Knowledge and Practices*. University of the Philippines, Press. Center for Investigative and Development Studies. Quezon City. P 69

analyzed. At first glance, the concepts might look mundane, but the profoundness came after the concepts were connected to the others.

Graph 1: Gender Distribution



Graph 1 shows that majority of the survey respondents are female representing 71% of the research population. It was observed that there are more women than men in almost all of the gatherings that this researcher attended although she cannot claim that there are more Filipino women than men in the area, although it seems evident that that is the case. Without the statistical data that could have been provided by the Prefecture of Nice, gender distribution based on valid statistical data is highly dependent on assumption through direct observation by the researcher and by information provided by those whose been living in the area for a long time (more than 5 years). The researcher asked these people and it was commonly observed that indeed, there are more women than men living and working in the French Riviera.

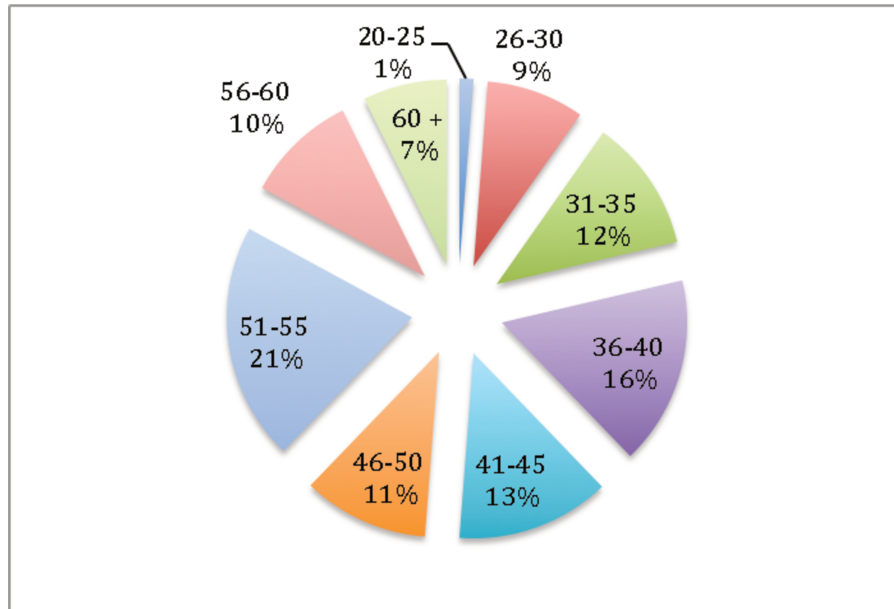
This result supports the idea of feminization of migration. It was earliler observed that Philippine migration flows is feminized. In Philippine migration dynamics, men were observed to have less discursive visibility than females, but men were seen as responsible breadwinners, virile while women who decided to leave

their family behind to work abroad are contradictory portrayed as heroines and bad mothers. A woman working abroad is always confronted with the question “how can you leave your children behind?” and this often comes from other woman from their own country. There is also a misconception that the children who were left behind are “kawawa” (needs pity). This is where the image of being a bad mother comes in. When it is the father who goes abroad to work, the label of being a bad father is non-existent. In contrast, his action is revered because it has noble intention to provide for his family. This is highly connected to the culture of masculinity in the Philippines and double standard in gender roles. Men were given the role of family breadwinner and are expected to travel far and wide to provide a descent living for his family.

Beginning of the 1990 the proportion of newly hired female overseas Filipino workers increased relatively to their male counterpart, reaching as high as 74% in 2004. ²⁴¹. It is important to note however that men are not very keen in answering survey questions. They often shun any form of interview and this may be a contributing factor in the low turn out of their number. However, the big gap (almost 300%) in the number is undeniably due to the fact that women are indeed greater in number.

²⁴¹ Cruz, R. (2012). *Figures of Migration, gender, Kinship and the politics of representation*. Ateneo de Manila University Press. pp 513-514

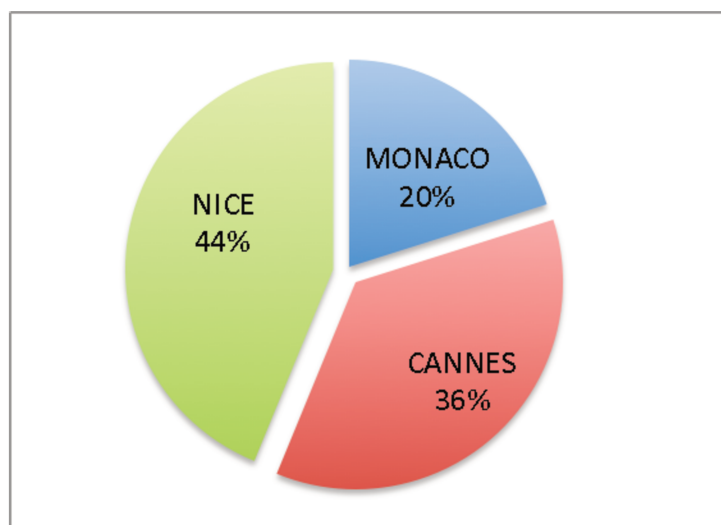
Graph 2: Age Distribution



Graph 2 shows the disparity in age distribution of the respondents. The 51-55 age group leads the number comprising 21% of the total number followed by 36-40 age group at 16 percent. The youngest age, 20-25 years old bracket has the lowest representation at 1%. This is mainly because this age group represents the first generation immigrants (the first generation of a family to be born in France). This researcher has observed that this group is relatively young. There are very few first generation Filipino immigrants who are more than 17 years old. This reflects the very young migration of Filipinos to the South of France. The 7% of respondents belonging to 60 years old and above demonstrate that Filipino migration in the Riviera France started less than a decade ago because they are considered to be the first batch of Filipino workers to come to this area. Compared to the Filipino immigrants in the same age range, who migrated to the U.S. for example, their parents or even grandparents came before them. Filipino migration in France is relatively new. A big percentage of respondents have already started a family and already have children in the Philippines before they came to France. Later on, they petition their children to join them. These children who later joined their parents in France, are outside the

definition of first generation immigrants because they were not born in France. Majority of the respondents (62%) belong to 41 to 60 plus years old. As such it is safe to say that Filipino immigrants in the South of France belong to the older age group. The 20-40 years old age group constitutes the remaining 38% and does not include majority of the second- generation immigrants. Therefore it can be assumed that in the South of France, the current Filipino population is ageing, belonging to the middle age bracket (26-40 years old) 37% and very small number of second generation. The actual statistics of the second generation though cannot be determined because of lack for reliable sources at the moment. Direct observation though suggests that there is a significant number of first generation Filipino immigrants but they are young and the statistics of second generation might be greater than the first generation.

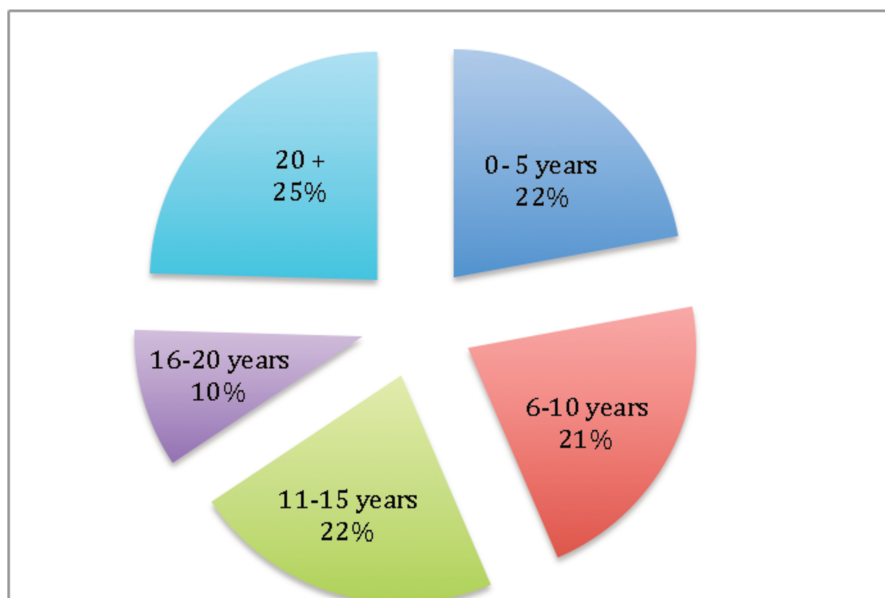
Graph 3: Location of the Respondents



Almost half of the respondents live in Nice (44%). This is primarily because a large number of Filipinos who are working in Monaco chose to live in Nice for practical reasons. Living expenses in Nice is more manageable and travelling between these cities is convenient because of an efficient transport system. Majority of those living in Nice either work in Nice or in Monaco. Respondents who are working in towns between Nice and Monaco chose to live in Nice because as a

bigger city there are more things to do after work or during weekends. Those who were living in Cannes and its nearby communities, comprise 36 percent of the respondents. Although the South of France is popularly known for yachts, Cannes and its nearby communities are the main area for this industry. As such, most of the Filipinos located here are working in boats. In the summer months, when extra workers are needed for chartered yachts or restaurants, the number of Filipinos in the South of France double. Filipino workers as far as Spain and Italy or from other parts of France, come to the Riviera because they get better pay and longer working hours. They often stayed with their friends or relatives who are based in the area. Monaco has the least number of respondents because there is a minimal number of Filipinos living in this city.

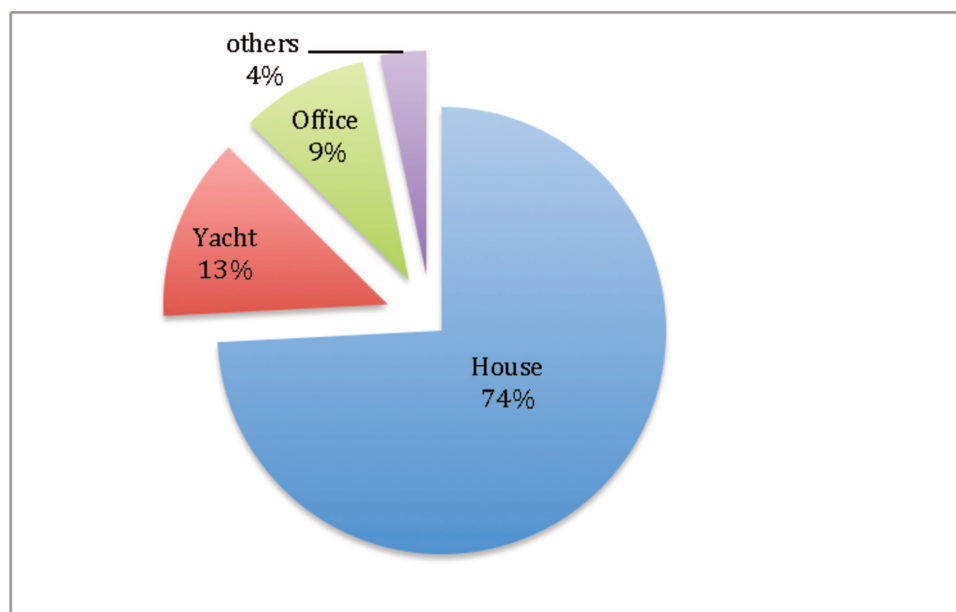
Graph 4: Lengths of stay in the French Riviera



A quarter (25%) of the respondents have been living in the French Riviera for more than 20 years. They represent the largest portion of the studied population. Following closely at 22%, are those whose been living in the area for the more or less five years and those between 6-15 years almost have the same percentage.

The largest group which can also be called the first wave, arrived in the South of France more than 20 years ago. They basically know each other. They share similar stories of hardships and sacrifices as they arrive in a country whose language and culture are totally new to them. They often cite that they were able to adjust quite easily to the physical environment compared to the culture and the French people. Even in the earlier migration movement, the work available for Filipinos was generally domestic work. However, the bosses are not always French. Many are from other parts of Europe and most of them speak English, making it manageable for Filipino workers. Outside of their job however, lies the challenge of language barrier and cultural difficulty. They find it hard to move around, seek information that is relevant to their stay, have a social life and integrate to the community. Despite the difficulty however, they were not able to see the real importance of learning the language. They speak English at work and that's all that matters to them. This mentality contributed to the delay in progress in many aspects of their life in France. Today, most of them speak French because they were able to pick it up from everyday life and from their long years of living in the Riviera.

Graph 5: Work Distribution



The industry dominated by the Filipinos workers in the French Riviera is household work, comprising of 74% of the respondents. Whether male or female, this area is the most lucrative jobs for the Filipinos. Household works include being a gardener, cleaner, guardians of villas, caretakers, nanny and drivers. A significant number, 13%, also work in yacht as part of the crew. Some have jobs in offices as administrators and staff. Others work in shops and hotels.

There are several reasons why the domestic work is dominated by the Filipinos in the South of France. One glaring reason is that the first wave of Filipino workers came to France as domestic workers. When they petition their family members, one of the major requirement then was to for them to have a sponsor or an available job waiting for them when they arrive. What the first wave did was to ask their employers to issue a paper stating that they are the sponsor of this people coming in and that when these people being imported from the Philippines arrive, they will work for them. This strategy paved the way for Filipinos working within the same industry. Even if these immigrants are well educated, they chose to work as *femme de ménage* (cleaning lady), driver or gardener because it is an easy job, not too much responsibility and the salary is good.

On the part of the employer, Filipino workers are often praised for their dedication to their work. They are trustworthy and they make things possible. One employer that this researcher was able to informally had a conversation with said that when there is an impossible job, give it to a Filipino and it will be done. It is a good quality considering that they don't even speak very good French. Filipino workers also are reliable and very considerate. Most of the time they work on an hourly basis. When work is not yet finish, even if it is time to stop, they will spend whatever time is needed to finish the job without demanding for extra charge. In formal jobs, this practice is not encouraged. In the domestic work however, human relationship is highly valued so a few minutes of extra work is not a big deal for Filipino workers. They know anyway if they are being abused though. There are some stories in the past where Filipino domestic workers leave their employers because of abusive

behaviors. Today, they often complain that even if they are not treated based on what was previously agreed upon, they don't complain because job is hard to find.

Filipinos take pride in their job. They often verbalize how descent their work is despite the fact that it is considered menial by many. While they were saying this however, it sounds like they are convincing themselves rather than stating a fact. Many domestic workers in the South of France are well educated Filipinos. They are engineers, pharmacists, military officer, teachers and information technologists In one instance, this researcher was recognized by a young Filipino working in Monaco. This young woman who graduated as medical technologist was this researchers former student in the Philippines. She is working now as a caretaker of an old person, a profession not related to his University degree. She lamented that she's been looking for a job in her field in the Philippines and all is in vain. When the opportunity to come to Europe arrived, she grabbed it and she conditioned herself that she will do any job in Europe instead of going back to her difficult life in the Philippines. Hers is a common story for Filipinos working abroad.

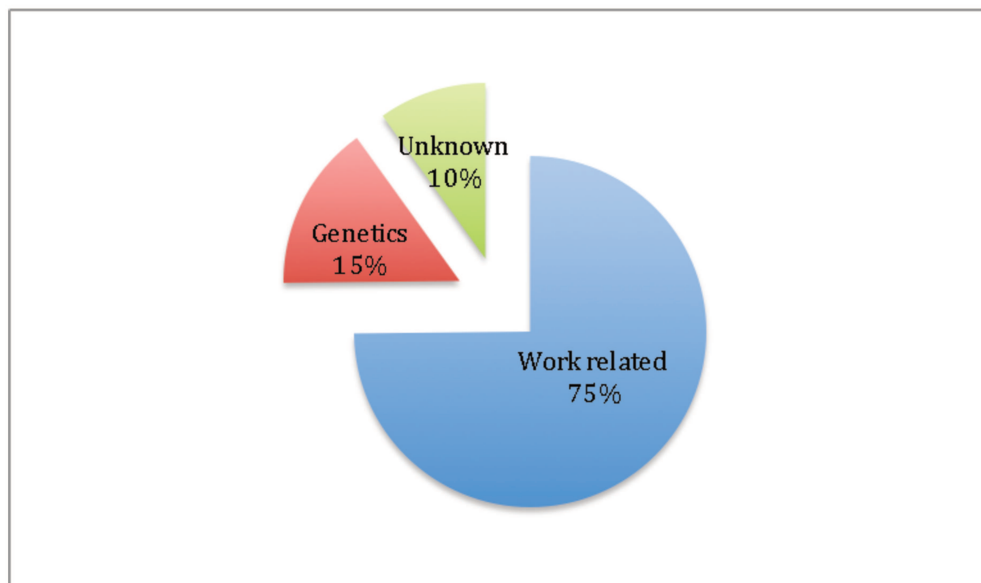
Indeed, if salary would be the sole basis of successful career, Filipino workers in the Riviera are very successful. They receive as high as three thousand euros per month guarding villas which is visited by their employers once or twice a year, often staying as long as two months during the summer season. Often after the stay, they were given bonuses for taking care of the house. For the rest of the year, they stay in the villa making sure everything is in pristine condition. They are also enjoying all the benefits of an employee- securite sociale, mutuelle, vacation with pay and other perks. Since this job is relationship based and not result oriented, perks are dependent on the relationship between the employer and the employee. Some Filipino employees were even given long vacation with pay plus plane ticket for the entire family; benefits that an ordinary French employee do not have. Although the condition is tougher these days because of global crisis, there are still many Filipino domestic workers in the South of France who are enjoying this employment status. Because of the lightness of work expectations and good pay, Filipinos who petition

their family members from the Philippines give them the same job. They cannot find any other job anyway because they do not speak French.

They shared to this researcher that when they arrived in the Riviera, they have high hopes for themselves. They say that they will learn French and their domestic work is just temporary. Those who were able to finish University degree dreams of being involve in the industry more appropriate for their educational preparations. After a few years of complacent, they just ended up being comfortable with their domestic jobs. Excuses start to come out; they are getting old, there is no more time, they need to work more etc. They also mentioned that the adjustment from being a professional in the Philippines to being a domestic worker is not an easy transition. It's a huge sense of pride to swallow. They admit that the change affect their self worth, view of the world and it all manifested in physical pain. They have trouble eating, defacating, sleeping etc. It surely affect their social life because their movement is just among family members. They feel really alienated because they do not understand anything in the environment and the worst thing is, they cannot be understood.

There are very few working in offices but this will surely change in the next few years because the first generation Filipinos who were educated in France will be working in industries appropriate to their educational degree.

Graph 6: Perceived source of illness



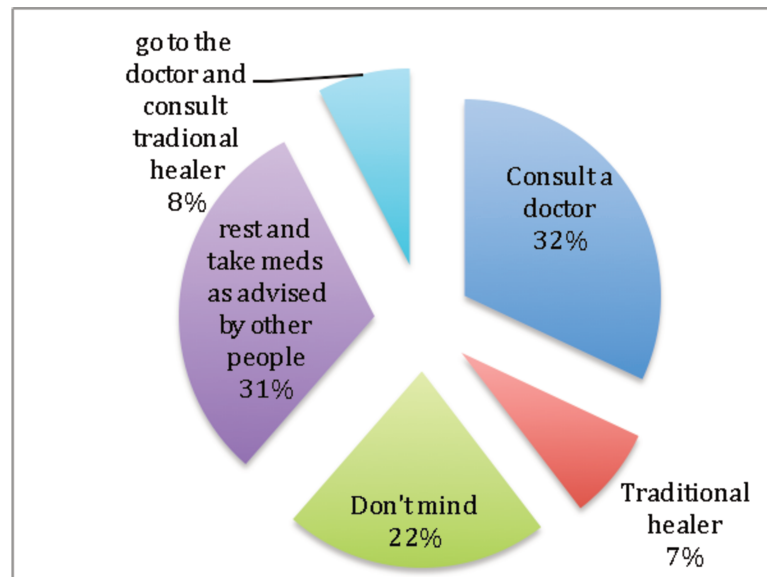
Graph 6 looks into perception of the respondents regarding source of illness. Seventy five percent attributed their most common ailment to work related activities. They think that whatever health concerns they have comes from working too much and being exposed to hot and cold condition because of the nature of their work. Only 15% respondents answered they review their genetic pre-disposition to certain diseases. Ten percent answered they do not any idea what causes their ailments.

This perceived source of illness has a direct connection to the response of the respondents to their health concern. Since majority of the population states that their most common ailments/pains are work related, they are looking at illness from a superficial perspective. A simple headache or back pain might be a symptom of something more complex than a simple stressful day at work. Once a symptom is easily dismissed as manifestation of fatigue, it is no longer pursued as something else. On the other hand, when a person knows that s/he is genetically pre-disposed to high blood pressure for example, a simple headache is treated differently. The more a person knows about his genetic pre-disposition to diseases, the more he is aware of his state of health. Although this knowledge does not automatically translate to better taking care of health, at the very least, there is deeper health awareness. They became more health conscious and might even have the personal initiative to seek medical help.

The ten percent who states that they have no idea where their ailments are coming from is an alarming number. Although it is the least among the choices, the fact that there are people in the community who seems not to pay much attention to health issues even if they are experiencing some health troubles, should be properly addressed. This 10% when added to the 75% who superficially treat their ailments as work related constitutes majority of the population. This translates to the idea that even while in France where the healthcare system is supportive of health promotion, Filipino patients still doesn't have enough health information. If three fourths of Filipino immigrants still do not understand the role that genetics play in health and ailments despite their long years of living in the South of France, health

communication campaigns should therefore be questioned. By virtue of being in France for a long time, it is the French health system who takes care of their immigrants. To add, French healthcare system is basking on its image of being one of the best in world, its benchmarks should be properly be identified given the status of immigrants health.

Graph 7: Dealing with Illness the Philippine way



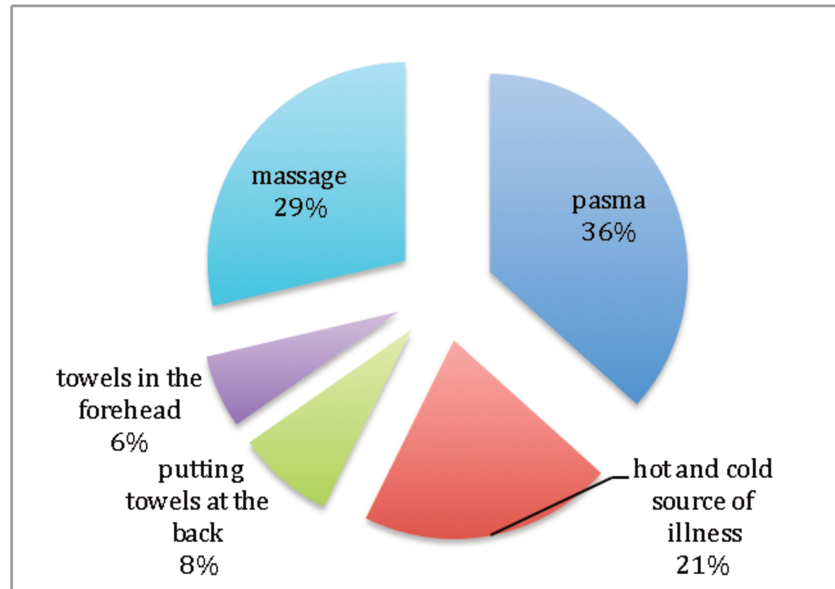
Graph 7 shows how Filipinos are dealing with illness while they are still in the Philippines. Noticeable is the almost equal percentage of those who visit traditional healers (7%) and those who visits both traditional healers and medical doctors (8%). It suggests that those who seek the healing power of the traditional healers are also seeking advice from western trained doctors. In this scenario, traditional healing and western medicine appears complimenting each other rather than competing against each other. However, it does not reveal which advice the patient is following more so imply which medication the patient is taking.

The graph also shows the significant relationship between those who seek medical advice (32%) and those who take matters into their own hands by just resting and following the advice of people they know who experience the same symptoms (31%). This numbers reveal some risky behaviors because not all symptoms come

from a single disease. More so, taking medications referred by a non- doctor impose more danger to ones health. In this research however, the ailments being referred to are within the context of the simple, every day aches and pains. The researcher made it clear that the ailments being asked in the survey are not the serious ailments that require complex medical interventions nor chronic diseased that require lifelong maintenance. The researcher therefore conclude that within this premise of simple disease, the respondents answered that they just take rest and ask for medications from the people they trust, who are mostly family members. The medications being referred to are simple pain reliever and muscle relaxant. In as much as the medicines post no direct threat to ones health, the lack of proper medical intervention is what is threatening.

For the 22% who answered they just don't pay much attention to whatever discomfort they might be feeling is directly connected to many factors. One of them is financial constrain. Seeking medical advice entails paying directly from the pocket and to be taken out from the family budget. The national health insurance coverage does not include payment for doctors visit and majority do not have private insurance (the counterparty of mutuelles in France). This is why in the Philippines, simple aches and pains are easily dismissed. The result of this behavior is often fatal. In the case of diabetes for example, patients often consult doctors 5-7 years after they got diabetes. In this case, the patient is already diabetic and needs to take medications. The onset of complications will be earlier because the patient was diagnosed late. This can be related to Graph 7 (above) where Filipino patient answered they are not aware of the diseases they are genetically pre-disposed to. The simple and often easily dismissible symptoms of diabetes can lead to fatal consequences as it had proven in the statistics of Philippine morbidity. Therefore it is essential that patients be encouraged to get information about their family health history.

Graph 8: Traditional Health Concepts still believed by Filipinos in the French Riviera



Majority of the respondents believed in pasma. Pasma is defined as:

*A "folk illness" in the Philippines which has no equivalent medical term in English. The symptoms of **pasma** are trembling hands and sweaty palms occurring after strenuous use of the hands in manual labor. Farmers who work in the fields dragging plows, women who handwash laundry, pianists and athletes suffer from **pasma**. (<http://tagaloglang.com/Tagalog-English-Dictionary/English-Translation-of-Tagalog-Word/pasma.html>. Accessed September 13, 2012)*

This is a complex illness because it cannot be medicalized, that is why it is labeled as a folk illness. This ailment however is recognized and accepted in the Philippines. It is said that one can experience pasma if he work too much and will be exposed to cold elements immediately after. For example, a person who just finished ironing clothes is discouraged to wet her/his hands. It is believed that the hands will be numb and will tremble. A woman who has her monthly period is discouraged to take a bath because the water is cold and her body is hot. A person who is tired from a long walk or has been standing for a long time is not allowed to wash the feet. He needs to rest for a few minutes before he can clean up. Pasma does not manifest in a specific part of the body. The hands can experience pasma, the feet, the stomach, the eyes even the entire body. The belief in this ailment is widely accepted in the

Philippines. Part of the mystery about pasma is that it can be experienced by people, it can be described in detail yet there is not medical procedure that specifically support that the physical manifestation of exposure to extreme temperatures can be labeled as pasma. Physicians in the Philippines sometimes focus on the tremors and try to explain it as a neurological condition while others will use endocrinology connecting to thyroid problems. A study done by a physician in the Philippines about pasma with the ironing women as the subject revealed that even those who claimed to have experienced or experiencing pasma were not able to come up with a concise definition of pasma. They all agreed however that pasma leads to varicose veins, indicating that pasma is seen as an affliction of the veins ²⁴².

Not far behind is the belief in massage. To put in proper context, massage refers to the therapies performed by Hilot (traditional massage therapists) using traditional techniques (e.g. using baba leaves to specifically identify body parts that are in pain, tracing the veins and muscles that are believed to be not in good condition etc.) and specially oils and ointments to be used in the ritual of traditional massage therapy. Respondents feel relief and comfort when someone gave them a massage. This does not necessarily mean the learned massage but a simple touching of the body to relax the muscle. This is usually done by family members although there are some people within the community who offer this service in the comfort of the patient's home. Today however, there are a lot of spa houses/clinics in the Philippines which offer massage. It is a thriving business because of the comfort and relaxation it offers. Although not medically proven to cure anything, massage alleviates pain which is the first step in addressing diseases. It has to be made clear however, that the massage offered in spa houses is not the traditional massage therapy that this research is referring to. This was just mentioned to arrived at a conclusion that massage is a very popular form of simple relaxation for those who are living in the city. For those who

²⁴² Tan, M.L., (2008). *Revisiting Usug, Pasma, Kulam*. Quezon City. University of the Philippines Press. p 131

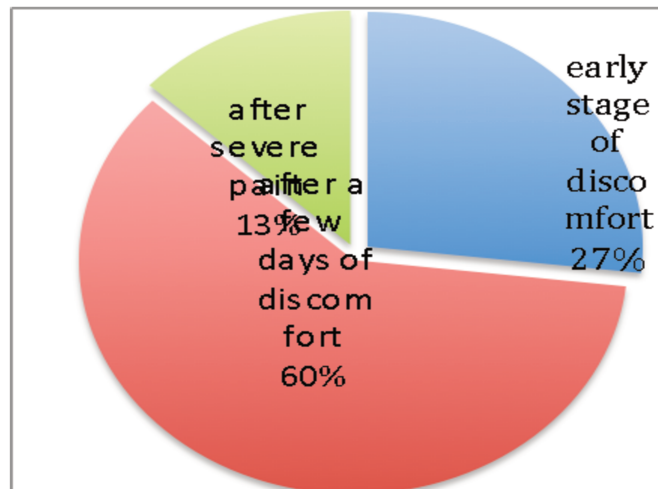
are in the outskirts of big cities, massage has a different meaning. It is almost viewed having medical effects for it is believed to cure simple ailments.

Third on the list is the belief that exposure to too much cold and hot temperature causes pains leading to illnesses. Cross-referenced with the findings of Jocano in 2001, regarding sources of hot and cold and its implications to the human body, it can be drawn that indeed, Filipinos believe that sudden change in temperature causes discomfort and illness although not medically proven be so.

Some (8%) still practice putting a piece of cloth on their back while working so the perspiration will not be absorb by the lungs which is believed to cause cough and other lung related ailments. Putting towels in the head especially during early night is practiced in some parts of the Philippines because it is believed that the dew that arrives in the early evening, cause certain abnormalities in the body temperature leading to aches and pains. For Filipinos living in the South of France, this practice is done only by 6% of the population. They clarified that they do not put a piece of cloth rather they wear head gear- hats specifically- because it looks weird walking around in the city with a piece of cloth in the forehead. They usually do this while going home after work especially when the weather is cold. They mentioned that walking out from their place of work they need to shield their head from the different temperature outside or else they will have headache.

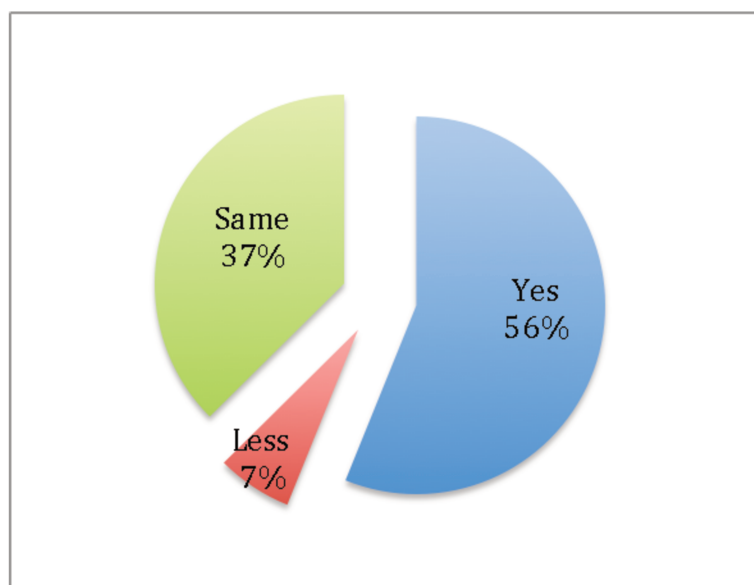
Graph 8 might look confusing to some because it contains mixed concepts. It should me made clear that these health concepts (pasma, massage, hot and cold sources of illness, putting towel on the forehead and on the back) are part of illness causation and health state. In the minds of the population of this study, these concepts still affects their health state and as such, it can either be avoided (in the case of pasma and putting cloth at the back and on the head), relieved (in the case of massage) and to be conscious of (referring to the changes in temperature). These concepts are put together because they are part the most common health beliefs and practices of the Filipinos. The qualifier in this graph is what are the beliefs and practices that are still being practiced and believed today while living in France.

Graph 9: The best time to consult a doctor (now that they are in France)



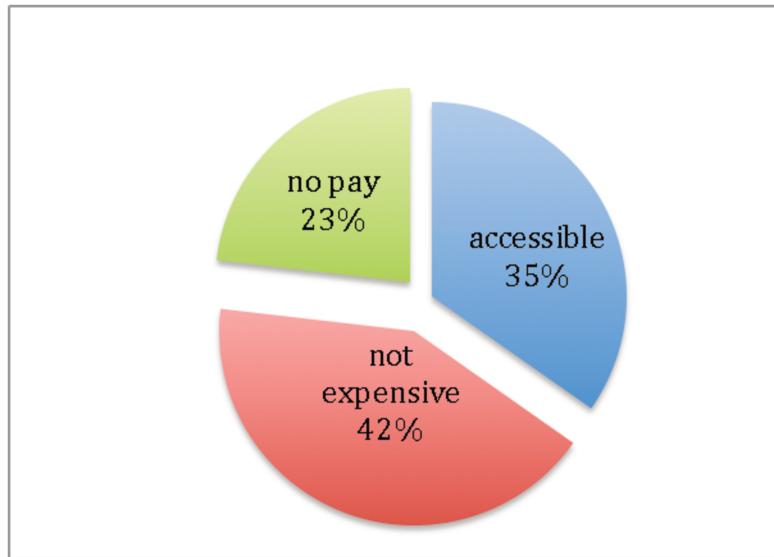
More than half (60%) responded said they visit doctors after a few days of discomfort. Just like majority of patients, they are observing and listening to their body if their condition will get better or worse. If they still feel uncomfortable or is still in pain after a few days, they will then set a consultation date with their doctor. Almost one third of the studied population said they set an appointment with their doctor at an early stage of discomfort because to secure an appointment is often a few days after calling. By the time the patient sees a doctor, it is either the discomfort already disappear or it gotten much worse. For the 27% of respondents, they seek medical advice on first symptoms. This percentage of the population can be those who already know that they have medical conditions that they need to be wary about.

Graph 10: Frequency of Doctors visit before (in the Philippines) and now (in France)



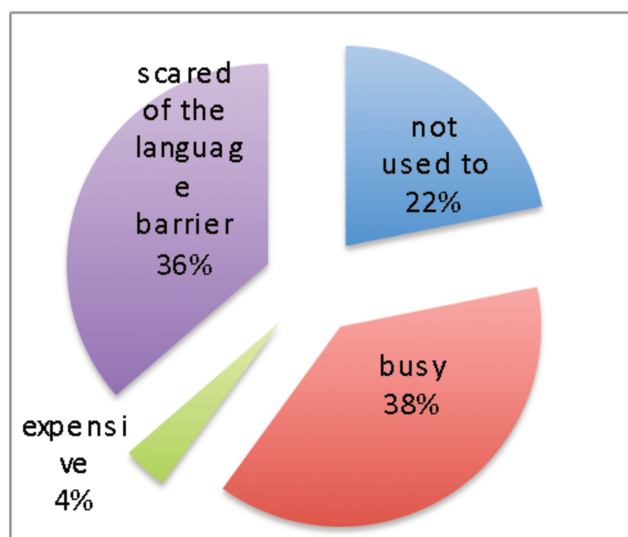
More than half (56%) of the studied population said they are visiting their doctor more often here in France than when they were in the Philippines. This is a significant finding for it shows a change of behavior in addressing health concerns. From the medical perspective, visiting a doctor as often as needed is a major step in combating a lot of diseases because of seeking medical advice is tantamount to early disease detection. Thirty seven percent stated that they are visiting doctors in France as much as when they were still in the Philippines. The 7% who answered they visit doctors less can be interpreted as those belonging to the younger age group who do not have frequent manifestations of pain or previous medical history thereby do not have the need to frequently consult medical professionals.

Graph 11: Reasons for more frequent doctors visit in France



Almost half of the respondents (42%) stated that the main reason that encourages them to visit doctor is because the out of the pocket expense is minimal if not nothing at all. Thirty –five percent also said that doctors are readily available. One look at the yellow pages and one call and they have an appointment. For the Filipino immigrants knowing a doctor is done through referral system. A Filipino patient looking for a general practitioner for example will request for a referral from members of the Filipino community. The usual main consideration is the English proficiency of the doctor, followed by questions about how friendly the doctor is and how open is he to answering questions. Although there is a significant number of Filipino immigrant who speak a good level of French, majority are still more comfortable conversing in English especially if there are sensitive matters that needs to be discussed.

Graph 12: Reasons for lesser Doctors visit in France

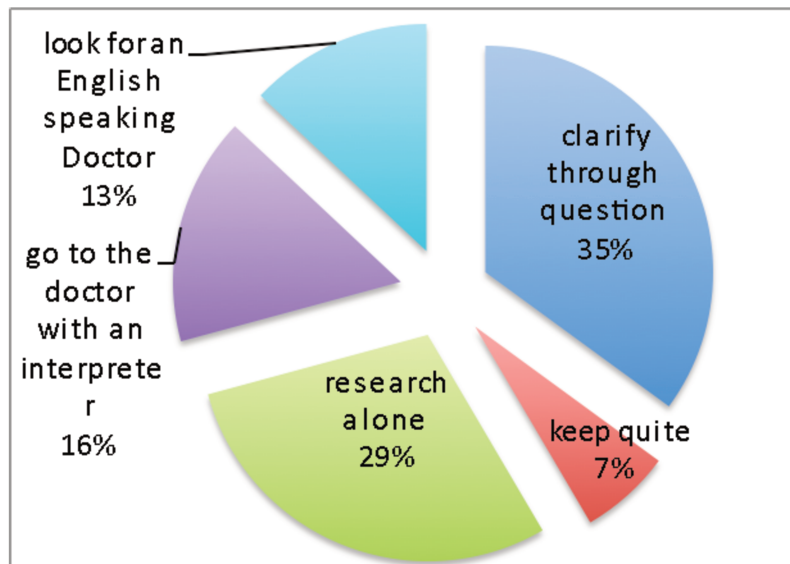


For the minimal number of respondents who answered they do not visit doctors, attribute this behavior to work pre-occupation. For the 38% of the studied population, it is not that they intentionally do not visit doctors, but often their appointment falls on working days or hours and they do not have time to look for another doctor or re-schedule appointment. The usual scenario is that the patient sets-up a doctor's appointment but often failed to show up because once something came up, they pass on their doctor's appointment. For the 36% however, French language prevents them from going to a doctor consultation. If they are not very confident that they can ask questions or clarify information from the medical professionals, they often ask their friends or family members to accompany them on their doctor's visit. This process however is complicated because involving more people in scheduling requires more time and coordination. The 4% that says a doctor's visit is expensive are probably those who are not *carte vitale* holders for whatever reason.

Under the French healthcare system, even if the patient has *carte vitale*, he is required to pay as much as 30% of the doctor's fee if he goes to a specialist. For example, if a patient goes to a gynecologist who charges 60 euros per consultation, the state reimburses the patient with the standard 23 euros and remaining 37 euros

will be paid by the patient who doesn't have a complimentary insurance. This computation is also applicable to laboratory tests. In this case, the patient might view doctors consultation as expensive. However, it is important to point out that the best way not to pay more is to consult first a general practitioner and then ask the GP to refer the patient to a specialist if he really needs to see one.

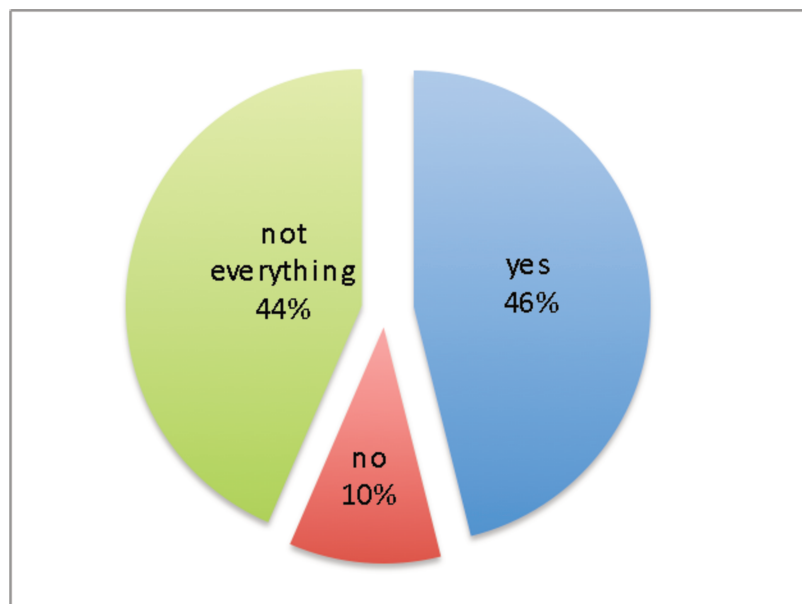
Graph 13: Factors assisting in better understanding explanations from doctors



Graph 13 presents how Filipinos take control of their health through understanding. They chose their own way to gather information with regards to their health condition. As shown in Graph 4, majority of the respondents have been living in the area for more than 5 years, most of them somehow speak a certain level of French. This empowers 35% of the Filipino population to clarify health information from health care professionals. This number is not far from the 29% who do personal research. This research may come in different forms. Getting information from people who have experienced or are experiencing the same symptoms like them, is considered as research. Reading materials, mostly from the internet that somehow corresponds to what they are feeling is a form of research. Experimenting on medicine either taking in or in the form of ointments can be another form of research. These experiments will surely give the patient more information. However, these information

must be processed by a properly trained medical personnel. Information that patients get from their own efforts, no matter how helpful it maybe must be counter checked. There are dangers when patient start making their own prescription or change lifestyle according to their own understading of what is good for them. The percentage (29%) of those who do their own research compared to the percentage (35%) who directly clarify information from their doctors, has a little difference. This can be attributed to many factors like the natural shyness of the Filipino people to ask question. Filipinos by nature are shy people and this can manifest in the form of moving away from things they do not know or remain quite and passive observers. Instead of asking question to understand unclear concepts, they refrain from asking questions because for them it is “nakaka hiya” {shameful}, especially if the person they will address the question to belongs to another race.

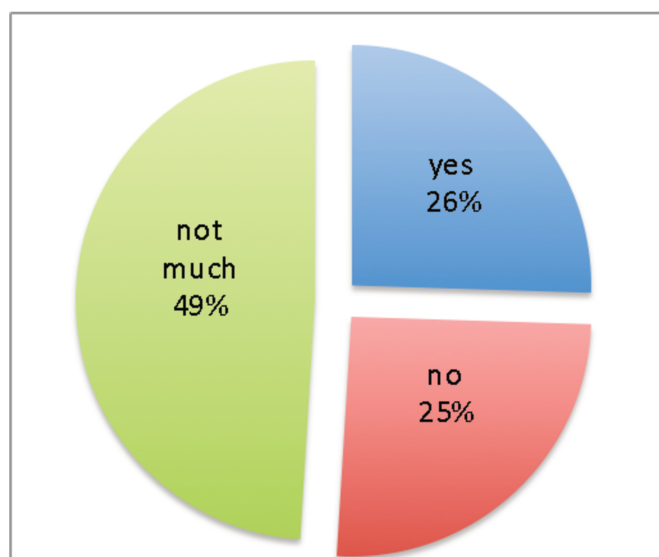
Graph 14: Levels of understanding Doctors explanation



Graph 14 answered a loaded question of Filipino patient's understanding of doctors explanation. The difference between those who answered they have understood and those who answered not fully (46% and 44% respectively), is not significant at 2%. This question is anchored not on not understanding health concepts on the merit of technical terms, but on how doctors discuss health related issues and

how language somehow becomes a barrier between a French doctor and a Filipino patient. It is important to bear in mind that the diseases this research is focused on just the simple aches and pains of everyday life. It does not concern itself to complicated maladies that require complex treatments and complicated scenarios that needs to be discussed in detail to the patient. As such, the level of communication between the health provider and the patient is simple as well as the language that they are expected to have used during their interaction. The 10% who indicated that they have not understood doctors explanation might be due to several factors like they went to a doctor who only speak French or the patients themselves do not speak French at all.

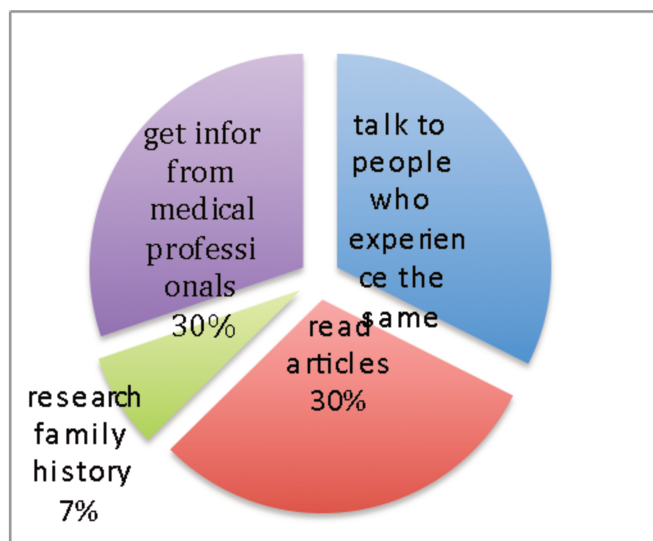
Graph 15: French language as a barrier



In asking the population if the French language is still a barrier for them to fully understand certain health issues, half of the respondents states that it is an issue but not the main reason why they do not fully understand doctors explanations. They somehow were able to decipher what the doctors are communicating to them. A quarter of the respondents revealed that they still find the French language as a barrier while the same percentage states that they fully understand information coming from their doctors. Combining those who answered they do not find the French language as a barrier in understanding health concepts with those who stated they

did not find French language as a huge barrier, majority of the respondents were able to communicate and understand using French as language for communication. The 26% who revealed that they still find French as a hindrance to communicate to health providers must not be set-aside. This is a significant number that needs to be addressed. They might provide information that would fill the gap in understanding immigrant intricacies and peculiarities as well as aid in better delivery of language courses in the South of France.

Graph 16: Clarifying Health Information / Issues

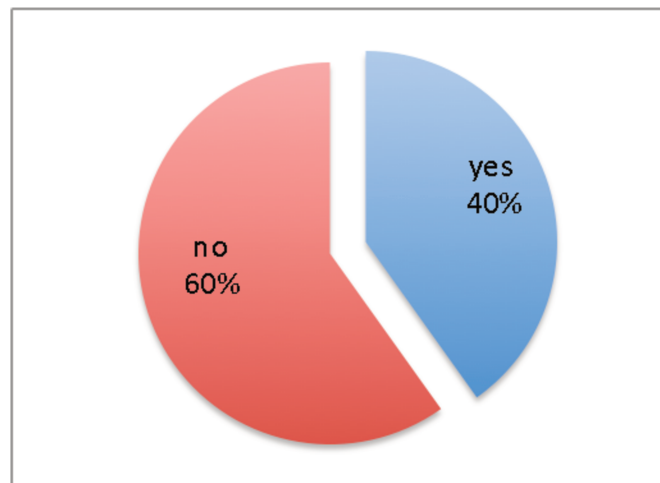


Graph 16 clarify what additional things the respondents are doing to enrich their understanding about their own health issues. A large percentage of the population (33%) states that they get extra information from people who experienced or are experiencing the same symptoms as they are. This proved the sense of community that exist between Filipinos in the South of France. It also indicate that Filipinos are still more open to discuss personal matters including health concerns to their support group which are members of the Filipino community. Thirty percent revealed that they read articles concerning their health issues. This indicates that Filipinos are into reading and highly literate. They read materials mostly from the internet. With the wealth of materials found online, finding health tips comes must be guided

accordingly. That is why the main source of health information must be observed by legitimate health organizations to monitor the information seeking activities of the general population. More than a quarter of the respondents said that they get health information from their doctors and other health providers. Seven percent states that they research their family history to know their genetic predisposition to certain diseases and to analyze if the simple symptoms they are experiencing at the moment are probable manifestations of diseases they are genetically predisposed to.

This graph yields multiple answers from the respondents because they often do two or more things to better understand their health issues. They seek medical advice but at the same time they do things that would satisfy their curiosity (thereby reading) ease anxiety (interacting with peers) and settling unknown health issues (researching family health history).

Graph 17: Utilization of medicines from the Philippines

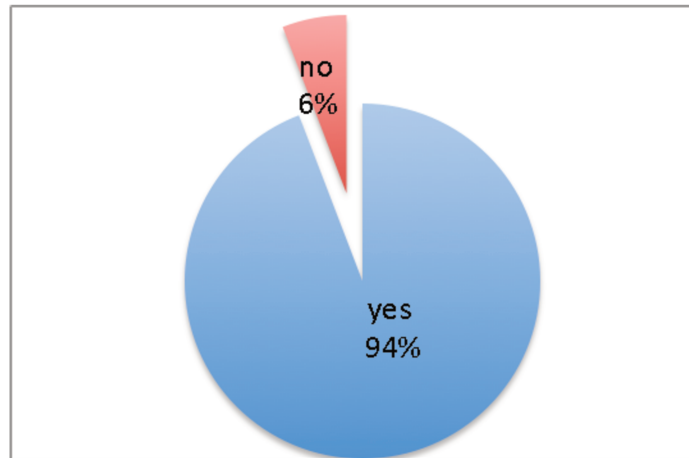


This question was asked to determine how adjusted the Filipinos are in the health environment in the French Riviera in terms of medicine intake or medicine belief. Again, highlighting that the ailments under discussion in this study are the simple ones, medicines related to these health complaints are limited to muscle pain relaxant, paracetamol and ointments. This is what is being referred to as medicines that might still be imported by Filipino patients from the Philippines.

Interestingly enough, there are still a large percentage of Filipinos in the French Riviera who patronize medicines from the Philippines. Biogesic, a well-known and trusted paracetamol and pain reliever as well as Alaxan, a muscle relaxant are still quite popular brands. Filipinos admit that they still ask some people to buy for them. Medicines to address stomach problems were also mentioned. Filipinos still used this medicine because of the concept of “hiyang” (fitted). They believe that the effect of these medicines are good for them because they have been using it for years, it doesn't have any side effects –thereby making it fitted (hiyang) to them. As far as ointments are concerned, Oil of Wintergreen, Omega pain killer are popular brands in the Philippines and are still used by Filipinos located in the South of France. Surprisingly, some people also mentioned using oils believed to have healing powers because it undergone some religious rituals. These oils have several uses. It is more commonly used for massage although in some cases, it is taken orally. These oils often come from the Philippines although in some instances when religious figures bless the oil, it is believe to be transformed into something else that is capable of healing. This goes to show that there are health elements that are heavily anchored on personal and religious beliefs of these people.

More than half of the respondents (60%) state that they are no longer importing any types of medications from the Philippines. Main reason given is that because everything is available where they are anyway. It is also cheap and accessible. The deeper reason given by the respondents is the fact that they are questioning the effectivity of the drugs. They are in doubt of the drugs bioequivalence hearing stories back in the Philippines that some unscrupulous pharmaceutical companies are not putting in enough active pharmaceutical ingredients (API) to the medicines they are manufacturing. Some even confessed their personal experience that when they take the medicine from the Philippines containing the same milligram of API, it does not have the same effect as the one they are taking which are from France. Regardless of who manufacture the medicine, some Filipinos believed that medicines from the Philippines do not have the same bioequivalence as the medicine from France. As such, they now refrain from taking medicines from the Philippines.

Graph 18 Perceived better health management



Graph 18 is the last question in the survey and another open-ended question. Its aim is to determine the populations perception of how they are taking better care of their health now that they are living in France. The answer was a sweeping yes and the main reason cited was the fact that they do not worry about out-of-pocket cost. The Universal coverage of the French healthcare system empowers the Filipino patients in the South of France to freely seek medical assistance. A huge plus is the availability and access to medicine. When a patient goes to a pharmacy with a doctors prescription and a securite sociale card, there will be only two things that will happen: either the patient get the medicine free or he pays minimal amount. In either scenario, the patients win because they have access to life saving medicines. The patient in France will not go out of the pharmacy empty handed. One of the criticisms of the French care coverage, which the government is addressing, is the issue of surplus. Patients in France have been taking medicines out of the pharmacy counter, mostly for free but they often do not take them. There were even some observations that patients in France go doctor hopping because they do not pay anything. Some of these patients just need someone to talk to. Although these are not academically researched or proven, it is a possibility because of the health scenario. Taking the South of France as an example, access to doctor is a given right and patients have the freedom to chose their providers. The South of France is highly populated by old-retired people whose health is deteriorating everyday and they are often far away

from their family. It would be very tempting for them to go to a doctor to complain even about the most mundane discomfort.

b) Key Informant Interview (KII) Presentation

The several cases presented below are just some of the many interesting interviews this researcher did. The names of the interviewees were intentionally changed for anonymity that the interviewees requested. These people represent the different belief system that Filipinos in the French Riviera has. The health stories narrated- often in detail- by members of this population are often repetitive and collective. This means the cases presented below have almost the same plot as with the rest of the stories of the interviewee.

Case 1: GREG

Greg (not his real name) is a 67 year-old Filipino working in a restaurant in Nice. He has been living in this city for almost 13 years. He arrived in Europe- in Italy to be exact in 1984. He used to work as a gardener for an Italian family but he used to frequent the Riviera especially during summer to have extra work. He started to think of finding a full time job and transfer permanently in this side of France. He finally found an opportunity to work in an Asian restaurant. He never changed job since then.

In the process of interviewing Greg, the researcher observed that age and years of work is taking a toll on him. He speaks very slow and soft, often with a long pause in between sentences. He is not the type who would open up a conversation or change a topic. He strikes this researcher as someone who is wise enough to know that much of the experiences the younger ones are bantering to one another were not better than his own and that he knows better. He answered questions as it was thrown to him, careful enough not to say too much or share too much personal details. He usually complains of muscle pains and headache which he attributed primarily to his ripening age as well as his work condition. He said that the kitchen is the worst place to be because the temperature is very hot yet he is also always wet. He specifically experience more aches and pains during the winter season because the

kitchen is hot and while going home after service, it is very cold outside. He believed that being exposed to these two extreme temperatures gives him pasma. This is why at night, he experience uncontrollable trembling of his calf and arm muscles. In the early days of his working in Nice, he said he was not able to consult doctors as much as he wants to because of language limitations. He does not speak French at all. In his work, most of the staff are Asian and they all speak English to each other.

He visits the Philippines on a regular basis –once a year- with his family. Even if he's been away from the Philippines for a very long time, he still vividly remembers the health practices in their household. His mother is a strong believer of traditional healing practices, taking her kids to traditional healers before bringing them to medical doctors. Filipino elders are known to practice dual system of health care ((Anderson, 1983; McBride, et al., 1996; Miranda, McBride, and Spangler, 1998). His father on the other hand leaves child care to his wife which directly translates to mothers decision regarding health rests on the mothers shoulders. Gerry remembers going to the hilot (ancient tribal priestess) or albularyo (herbalist) a person who has special skills, perform rituals and prepare liquid infusion from plants often taken from his own garden. In all these practices, he is a believer of the benefits he got from hilot. Even up to now, he constantly request his wife to give him a little massage every time he feels not good, either from long hours of work or from simple stress of everyday life.

He was medically diagnosed more than ten years ago that his cholesterol level is high, uric acid also and sugar level is above average. As such, he is taking medications to be sure that these bad things in his system be contained. He is following his doctors advice but at the same time follow some recommendations from friends. For example, it was known in the Philippines that the water from boiled maize hair is said to lower

Case 2: SUSAN

Susan is a 50 year old Filipina whose been living in the Riviera for more than 20 years. She met her husband (another Filipino) here, got married and now has a 19

year old daughter. Her first few years of working in the area has not been easy. She arrived in the South of France with a degree in Pharmacy from one big University in the Philippines, yet she landed a job as a house help in Monaco. She mentioned the psychological and emotional difficulty she's been through trying to wrap her mind around the idea that she will not be able to put into practice what she is academically and professionally prepared to do. During this period of difficult adjustment, she experienced physical pain which she attributes to severe anxiety and depression. As a pharmacist, she knows that the physical pains are psychosomatic symptoms. She finds comfort in the fact that she was able to send money to her siblings and parents back home. She also found strength being in the company of people coming from her own province from the Philippines who are also working in the Riviera. She reiterated the important role that her social life plays in her adjustment to her new life and career path in the South of France.

As a person of science she is skeptical of Filipinos belief in the non-scientific origin and cure of diseases. Despite the fact that she grows up in a small town in the outskirts of Manila and was raised by a family who adheres to the traditional way of addressing health issues, she is not comfortable following cultural norms in disease prevention and control. She belongs to a big family of seven siblings and her parents do not earn much. The implication of this in terms of health maintenance is that seeking a medical advice is not widely practiced because medical consultation is expensive. They do not have health insurance which means paying for medical consultation will be an out of pocket expense, which is not a good thing if there are nine mouths to feed. To summarize, she is used to being taken to a herbalist and drinking liquefied plants as medicines.

As she gets older, she started to make her own health choices and seeking traditional healers diagnosis is not on the top of her list. She was further drawn away when she started attending university to become a pharmacist.

Looking at Susan intently, no one can guess that she is already 50. She looks young and the vitality is still present. She attributes that to good diet, good genes, moderation in every activity and strictly following doctors' advice and religiously

taking medications. She is genetically pre-disposed to high blood pressure and she is taking daily maintenance. She also never failed in her doctors visits and laboratory tests that she needs to go through every so often.

When asked what traditional health practices she is still doing to date, she said:

“ never ko ginawa kung ano ang ginagawa ng nanay ko dati (laughing). Natatandaan ko kung paano nya kami pinapainom ng kung ano-ano para sa ubo at sipon. Tapos pinapahilot kami pag nilalagnat kasi daw baka may pilay kami. Alam ko may ilang Pilipino na manggagamot dito, pero di ko naman inisip na dalin si Rose (her daughter) sa kanila pag may sakit yun. Pag may nararamdaman na di maganda sa doctor agad. Libre naman e, pati gamot”.

English translation:

{I never did what my mother used to do (laughing). I still remember that she make us drink so many things to cure common cold and cough. Then she will bring us to a priestess who do massage because she thinks the reason why we have fever is because we have swollen muscle or dislocated bones. I know that there are some Filipino healers in the area but I never thought of bringing my daughter Rose to them when she is sick. Doctors are free as well as the medicines}

The only thing that comes close to traditional practices she is subscribing to is the massage she request from her husband when she feels really tired. In most cases, she goes to kenisitherapuete (physiotherapist) – often referred to as keni- to address her muscle pains.

Despite her minor health problems, she feels good about her state of health. She attributes this to her very good relationship with her doctor. She said:

“English speaking ang doctor ko kaya madali makipag usap sa kanya. Di ako nahihiyang magtanong. Alam nya ang family history ko, yung aking mga past health complains at saka nakikinig sya pag nagsasalita ako. Nagtatanong din sya sa akin pag may sinasabi ako na di nya maintindihan. Yung mga ginagawa sa akin ng mother ko noon, tinatanong ko rin sa kanya kung may bisa ba. Tinatawanan nya lang ako.

Bago ko nakita itong doctor ko na ito, naku palipat lipat din ako ng doctor dati. At karamihan sa mga nauna kong doctor, di nag e-english o kaya naman ayaw mag - effort makipag communicate sa English kahit marunong naman. Sa isip ko nga, bakit ang burden ng pagsasalita ng Pranses nasa pasyente lang? Di ba dapat meet

halfway? Kaya lang pag sinabihan na ako ng nasa France ka kaya dapat French ang salita mo, wala na akong magawa. Tapos karamihan sa mga doctor ko nung una, very dismissive. Pag kumukunsulta ako sa kanila feeling ko nakaka abala ako sa kanila. Lagi silang nagmamadali o di kaya naman di nakikinig sa sinasabi ko. Feeling ko tuloy walang kwenta yung mga sinasabi ko. E pano kaya sila makakapag reseta ng gamut kung di tama ang diagnosis nila. Lagi na lang ako pinadadala sa laboratory. Yung manner of diagnosis nila based primarily sa result ng lab test. Di naman lahat ng sakit kayang malaman sa lab results di ba? Pano kung psychological pala. Kaya nga kontento na ako dito sa doctor ko ngayon. Nag aral kasi sa US kaya may ibang paraan ng pag alaga sa pasyente”. Yun namang mga nasa l’Assurance Maladie office, naku, napaka susungit. Di ka man lang tingnan pag kinakausap. Nakakawala ng self-worth ba. Parang wala akong kwentang tao..

English Translation

I have an English speaking doctor that is why it is very easy to communicate with her. I don't feel awkward asking questions. She knows my family history, my previous health complaints and she listens when I talk. She also ask me questions if there are things she doesn't understand. I even ask her opinion regarding the health practices of my mother and if it has any medical weight. She just laughed at me.

Before I found this doctor, I went doctor hopping before. Most of my previous doctors do not speak English or they don't make any effort even if they know how to speak a little English. In my mind, why is the burden of speaking French lies solely on patients shoulder? Shouldn't it be half –way? But when people say I am in France therefore I should speak French, I just stay quite. I cannot do anything. Most of my previous doctors are also very dismissive. When I do my consultation, I felt like I am getting in the way of something. They are always in a hurry and they don't even listen to the things I say. How can they make a valid diagnosis if they will not be listening to me, right? They always ask me to do laboratory test and their diagnosis will be highly based on those tests. But not all diseases can be determined by lab tests right? What if it is psychological? Right now I am very happy with my doctor. She did her studies in the Unites States that is why she has a better way of dealing with patients. Those who are working in l’Assurance Maladies, they are very rude. They don't even look at you when you talk to them. It lessens my self-worth. I felt very insignificant”

The experience of Susan is a usual story among Filipinos whose been living in the Riviera for a long time. It is a given that there has been a lot of changes in the medical landscape in the area in the past 20 years. There are more doctors coming from different parts of the world, changes in policies were put at place and resources were made available. This changes directly affects the services provided for the patients. For the Filipino immigrants in this area, they assist one another –especially

the new ones- by referring their trusted doctors. The experiences of Greg and Susan are confined to the first Filipinos who came to the Riviera to work. These things rarely happens these days partly because of the interconnectedness of Filipinos and changes in the medical environment.

What is interesting in the statement of Susan is when she said her doctor studies in the States that is why she knows how to better take care of her patients. This is a loaded statement because it can be interpreted in many ways. It might mean in her perception, doctors who were trained in other countries are more culturally sensitive, competent and well-trained. On the other hand, it questions the competency of the French trained doctors in terms of patient -doctor relationship.

Case 3: BRIGETTE

Brigette is in her mid 30's. She arrived in Nice in 2008 with her 2 daughters. Her husband arrived a year before. She's been diagnosed with severe case of rheumatoid arthritis when she was in her early 20's. She's been suffering from this debilitating disease for such a long time that she has forgotten how not to live without it. She related to the researcher how her family initially responded to her condition:

“naku, ang dami ko ng napuntahan na mga mang gagamot. Mula sa tawas, soub, spiritista, hilot- naku lahat na yata. May mga araw na di ako makalad. Sobrang sakit ng mga joints ko o di kaya naman di ko na halos mai -unat ang aking braso o itong tuhod ko. Saka lagi akong walang ganang kumain, lagi akong pagod. There was even a time, naka wheelchair na ako kasi nga di na ako maka lakad. Yung mga parents ko naman alaga ako seimpre. May manggagamot na laging pumupunta sa bahay para masahihin ako. Kaya lang wala naman pagbabago after the masahe. Lalo pa nga akong namamaga at saka mas masakit kasi feeling ko nabubugbog lang ang muscles ko”.

Translation in English

“ I've been through a lot of healers. I've been through traditional healers, massage therapist, religious healers- I've tried them all. There were days that I was not able to walk because my joints are is unbearably painful. I cannot stretch my elbows and my knees. There was even a time that I am in a wheelchair because I cannot walk. My parents of course are taking care of me. There is always a healer or a therapist who comes to house to massage. However, I am not relieved by any of these things. I felt even worst because my muscles are more sore after the massage.

The researcher then clarify if she was ever taken to a medical doctor and if she gets some sort of comfort from the healers. She responded:

“ oo naman. Kaya nga nalaman na ang sakit ko pala ay rheumatoid arthritis. Kaya lang, alam mo naman sa atin, kahit may doctor na, may albularyo pa rin. Saka di kasi naming kayang ma sustain ang gamutan saka therapy kasi nga ang mahal. Ang asawa ko naman e maliit lang ang sweldo, may dalawa pa kaming anak. So minsan may gamut at therapy, pero kadalasan yung mga manggagamot pa din. Mahirap din kasing tanggihan ang mga matatanda. Sila kasi yung mapilit. Minsan nga yung isang manggamot ang sabi may bata daw na laging nasa tabi ko at yun ang nag cause ng sakit ko. Iba –iba naman ang sinasabi nila. Yung isa naman namamangang ugat daw kaya panay ang hilot.

Kung meron man akong nakukuhang comfort sa mga manggagamot, yun yung hope na binibigay nila. Yun bang sasabihin nila na gagaling ako. It gives me strength. Kaya lang ang masakit nito, after a few days at mahina na naman ako at di na naman makalakad, sobra naman ang frustration na nararamdaman ko ”

Translation in English

“of course yes. that is why we were able to find out that I am suffering from rheumatoid arthritis. But you know how it is in the Philippines, even if there is a doctor, the traditional healer is still included. Also, we were not able to sustain the medicine and the therapy because it is very expensive. My husband earns very little and we have two kids. Sometimes there are medicine and therapy but most of the time its healers. It is also very difficult to say no to the elders. They are the ones who are intently pushing me to seek help from them. One healer told me that she sees a child who is always with me who is causing my sickness. They are saying a lot of things. One healer told me I am suffering from swollen veins she keeps on massaging me.

If there is something good that I got from all these healers, it could be the fact that they gave me hope that I will get better. It gives me strength. The problem is; after a few days and I feel week again and I cannot walk again, I feel so much frustration”.

Just a few months after arriving in France, she had her first hip operation to address her swollen joints. It was done for free because she was able to secure a carte vitale and her disease was covered 100%. This means that whatever tests, medicines, doctors consultation or operation she requires in relation to her disease, is will be fully covered and she need not pay anything. After the operation, she was relieved from the pain and after some period of recovery, she was able to walk on her two feet again, an activity she wasn't able to do in a long time. She has all praises for her doctor and her therapist because they have not only taken cared of her

immediate medical needs, but they also made her understand that her road to recovery is long and tedious. She will be able to perform regular everyday activities but in a slower phase and not too soon. She needs years of therapy, a reality she open mindedly accept. Her real health situation is complex requiring complicated and long therapeutic process which healers in the Philippines failed to explain. They all gave false hopes that when they perform rituals today or massage her today, she will be better tomorrow. She also compared her experience with medical doctors in the Philippines to her doctors here. She states:

“alam mo dito, pag may pain, di nila ako pinipilit. Sa ‘Pinas ang sasabihin pa sayo ipilit mo, ipilit so lalong namamaga ang mga joints ko. I mean, eto yung mga hilot ha. Ang kalaban kasi ng sakit ko pain talaga so dito pag sinasabi ko sa kanila na may pain ako di nila ako hinahawakan. Yung mga doctors naman sa atin, puro gamot, puro gamut. Saka parang wala naman silang paki alam ba sa akin. Titingnan ka lang sandali tapos tapos reseta na”.

Translation in English

“ you know what here, if I have pain they are not forcing me (to do anything). In the Philippines they would even tell me “force it, force it” so my joints gets more swollen. I am referring to the healers. The friend of my disease is pain. Here if I tell them (doctors) that I have pain, they will not even touch me. The doctors from our country are all medicines. And I felt that they don’t really pay attention to me. They will just examine me for a while and then its prescription time.”

Interestingly, Brigette also shared her social experience in the Philippines that somehow hinders her desire to fight and bounce back. She revealed:

“ ang pinaka ayaw ko kasi sa atin yung pag naglalakad ako grabeng naka tingin ang mga tao. Ang layo ko na, lilingunin pa ako. Nakaka conscious ba. Feel na feel ko ba iba ako so ang result, ayaw ko na lang lumabas o maglakad. Dito kasi, wala silang paki alam sayo. Kung iba kang mag lakad they don’t pay much attention- or di nila pinapahalata- so feeling ko dito normal ako. Tapos nakatulong din sa akin yung life ko sa church. Kasi active ako sa church naming e. May mga tasks na naka assign sa akin so ginagawa ko para sa kapwa ko at the same time para sa akin seimpre. Iba ang pakiramdam ng may silbi

French ang doctor ko ngayon pero magaling mag English so nagkakaintindihan kami. Naku, she is the best. Alagang alaga ako. Sinusulat nya ang

progress ko kasi gusto nyang mag sulat ng libro about sa mga cases na hina handle nya. Sabi nya so far maganda daw ang progress ko kasi positive ako”.

Translation in English

“ the thing that I detest in our country is how people look at me when I am walking. Even if I am far away already, they would still back to check me out. That made me very conscious and as a result I don’t want to walk or go out. Here, they don’t really care. If you walk differently they don’t pay much attention –or at lest they don’t make it obvious- so I feel normal. It also helps that I am active in my church. I am very active in my church. There are tasks that are assigned to me and I am doing it for my fellowmen but also for myself. It feels better to know that I am of worth

My doctor now is French and she speaks very good English so we understand each other very well. She is the best. I am very well taken cared of. She is documenting my progress because she wants to come up with a book about the case she has handled. She said I am progressing well because I am positive ”.

Brigette’s case is a rich source of traditional Filipino health beliefs and practices and how it changes when the health system which she belongs to, changes also. It might be quite obvious that the main reason why the western medicine approach of addressing her disease is economics. Her family’s income cannot sustain regular doctors visit, religious medicine intake and regular therapy. However, it cannot be denied that the line dividing the main reason and the second reason is blurry. For highly complex diseases, the usual initial reaction especially for the old folks is to seek traditional healers advice. They do not discourage seeking medical diagnosis but the healers assessment is given as much weight as the doctors’. That is why it is not uncommon to find patients taking pills at the same time going to healers performing some rituals.

In Brigette’s case, she mentioned that she subjected herself to healers to give in to the demands of her parents and not to disrespect them as well. Her parents believed that what they are doing are for the good of their daughter without them knowing that they are aggravating her situation. It goes to show how traditional Filipino family works and how diseases becomes a family affair and the elders decision on how to address it, is almost often the heaviest. Personal relationship is at

play in this scenario and it shows very clearly the make up and decision-making process of the most basic unit of Philippine society.

It also shows the societal make –up of both France and the Philippines. The social environment in France according to Brigette’s story reveals a more tolerant environment for people with disability. This can be proven not only by how normal people treats physically challenge individuals, but by how the cities are lay-out to accommodate people with limited mobility and the available resources and help for these people. In the city of Cannes for example, there is an area of the beach (by the end of the famous La Croisette) allocated for people with special needs. Amenities are set up like shower and toilet, a ramp for people on wheelchairs, lifeguards to assist handicaps, umbrellas and chairs and assigned parking for special vehicles. In this place, people with special needs are given an opportunity not only to exercise but to be part of society. They might be separated in a way from the main population but they are within the convenience of people who understands them. In France, there was a period not so long ago when people who are identified as 80% handicapped were given pension from the government to make sure they can take care of themselves. With that government support, they are encouraged to rent their own apartment and live a normal life. Today, people with special needs might not be given monetary compensation but the government still provide help in the form of paying for people who takes care of disabled individuals, making sure they have access to their required medical care, provide transportation and provide funds for institutions that create projects for people with special needs. These somehow ease the burden of these people because it empowers them by being a part of the society.

It was a revelation when Brigette shared her experience with the Filipino doctors. Brigette describes them as being detached and cold. Even though both doctor and patient in this case speaks the same language, that seems not be the main component in understanding medical issues between them. Brigette’s English speaking French doctor was able to provide the best care for her because there is

willingness to be a health care professional rather than the ran of the mill medical doctor.

Brigette's case is a rich source of information regarding doctor –patient interaction as well as another proof that an excellent doctor-patient relationship can exist even in a multi- cultural provided there is one common factor that connects them- and in Brigette's case- it is the English language. This highlights the very important role of language in health promotion and disease prevention.

Health workers in the French Riviera must have the professional training on how to accommodate people who have difficulty speaking French. Auxiliary medical staffs are at the forefront of the fight for diseases and they should be made aware of the delicate role they play in health promotion and disease prevention.

Case 4: MYRNA

Myrna is a 61 year old Filipina, has been living in Antibes for almost 20 years. She is married to a French and they do not have children. She came from one of the provinces from the Southern part of the Philippines. She was raised with a traditional family and taking care of her family's health while she was still in the Philippines are largely done by herbalist and religious healers. She explained to the researcher in details how she suffered from a disease which was cured by a herbalist.

“ one time alam mo namaga ako. As in boung katawan ko maga. Nagpatingin ako sa doctor kasi seimpre matandan na ako ng mangyari ito e, dito na ito sa France mga 5-6 years ago. E seimpre dito naman sa France puro doctor, so nagpa tingin ako, nagpa test pero wala naman silang nakitang abnormal sa blood test ko, sa internal organs ko kasi nag pa ECG po ako e. Wala rin naman akong sakit na nararamdaman maliban sa parang bloaded, pakiramdam ko naka lutang ako, malaming ang pawis at saka namamaga ako. Mula ulo hanggang paa. E di naman nagbabago ang pag kain ko e. Yun pa rin naman ang dati kong kinakain tapos yung amount same lang naman. E nagkataon naka schedule kami na umuwi sa 'Pinas. Sabi ko buti na lang kasi albularyo ang kailangan ko kako. So nagpasabi na ako sa mga kamag anak naming doon na yung dati naming albularyo sabihan na parating ako at kailangan ko tulong nya. Alam mo, pagkakitang pagkakita nya sa akin,

napansin nya agad siguro ang simtomang sa katawan ko, sabi nya agad “naku, ang dami mong hangin sa katawan kaya ka maga. May manas hangin ka”. Gumawa sya agad ng pangmasahe sa akin.. manzanilla, kamantigue tapos dahon ng malunggay na presko. Piniga nya yun sa isang malaking plato tapos yun ang pinanghilot nya sa akin from head to foot. Narararamdaman ko talaga yung thumb nya na dumadaan sa mga ugat ko, sa katawan sa muka. Alam mo after a few days unti- unting humupa ang manas ko. After ilang hilot pa habang nandun kami, tuluyan ng nawala ang manas ko. Sinabihan nya ako na mag ingat sa hangin kasi yun daw ang kalaban ng katawan ko. Madali daw akong pasukin ng malamig na hangin. Ang payo nya, pag medyo lumalamig na ang panahon, dapat balot na ako. Kailangan daw may sombrero ako parati.

English Translation

“you know what one time I was swollen. As in my whole body was swollen. I went to a doctor because when that happens I am old already, I am already here in France, probably 5-6 years ago. Of course here in France its all about doctors, so I consulted, did some laboratory tests. They haven’t seen anything wrong with my blood test, nothing wrong with internal organs also when they saw the ECG result. I don’t also feel pain except from I felt bloated sometimes, I felt like I am floating, my perspirations are cold and I can see that I am swollen from head to foot. My diet haven’t change. I eat the same food and the same amount. When this happens we are scheduled to have a vacation in the Philippines. I said to myself, I need a herbalist. So I communicated with my family in our province instructing them to get hold of the herbalist and tell him I need his help. The moment he saw me, probably he noticed the abnormalities in my body he said “ you have so much air in our body that is why you are swollen. You (are suffering from) are swollen from too much air”. He immediately make a special blend of stuff that he will use to massage me. He uses manzanilla, kamantigue and fesh malunggay leaves. He extracts the juice on a large plate and that's what he used to massage me from head to foot. I can actually feel his thumb going through my every veins, in my body .. in my face. After a few days, the swell slowly went away and after a few more massages, it eventually went away.

He told me that air is the number one enemy of my body. He said air can easily enter my body. His advised was when it starts to get cold, I should be wrapped good. I should wear hat all the time”.

Myrna’s experience with disease revealed a very good case of unexplained physical manifestation of disease vis-a vis- Filipino traditional health belief system. It was clear that she did sought medical help while in France but when laboratory tests failed to yield concrete explanations, she immediately attributes his malady to disease she is familiar with, which is attached to her cultural roots. Swelling of the

body due to air is unknown in medical science, yet it is very common in the Filipino health belief system. In fact, almost every pain in the body is attributed to the presence of “cold air” which alters the natural temperature of the body which is suppose to be warm. When a manghihilot (massage therapist) massage the patient, he always talks about feeling or touching pockets of air in specific parts of the body which exhibits pain. In Myrna’s case, she believed that it is the presence of too much cold air in her body that causes her body to swell. Strangely enough, after seeking help from the traditional healers, she feels better and the swelling goes away. In medical science, Myrna’s recovery might be due to her state of mind and that her disease is purely psychosomatic. Because the answer to this is unknown, what can be pointed out from this case is the role of cultural beliefs in

Case 5: NELLIE

Nellie is a 27 year old young Filipina who is schooled in Monaco. She arrived in Nice when she was 15 years old and continued her studies in the International School of Monaco and later on earned her University degree in Finance. Her parents work as a guardian of a villa and they really work hard to send her to school. She speaks French, English and Filipino. Her language competency enabled her to live in France without difficulty. She is fully integrated to French life. Health wise however, she is very traditional in a lot of ways, practicing a lot of Filipino health beliefs. She refrain from taking a shower when she has her monthly period, she follow instructions to avoid pasma (rest before taking a shower when tired, not washing the feet immediately after a long walk etc.). She attributes this to her mothers’ very strong influence in her health life. She believes that having very strong consideration to these traditional health beliefs will not cost any harm anyway. In fact, it can be helpful to the person, as it has proven to be helpful to her.

She shared to this researcher her experience with lower abdominal pain every time she will have her monthly period. In the past, she would take medications for the pain. He r mother advised her to take warm shower and should be very fast if she is really uncomfortable not taking a shower during this period. She is also told not to

have cold drinks. She followed this advice and she never experience menstrual camps at all and as result there was no need to take medications. This experience left a very strong impression on her that not all medical conditions can be addressed by medical doctors. She continue to have medical check-ups and preventive screening procedures but she also follow traditional preventive and cure Filipino practices, mixing it doctors advice. When asked what are the benefits she get from this practice, she categorically stated that her treatment combination is complimentary and not contradictory. Although she admitted to drink some concoctions prepared by herbalist, she said it is not medicine so there is such thing as counter indications. The herbal preparations are just boiled plants therefore there is no direct harm done. In fact, even if the herbal preparations have placebo effect, the psychological belief that it might be of help, somehow assist patients in their quest for better state of health. This mentality is very common among Filipino patients: there is no harm in trying.

Health experiences like this will surely be passed on to other members of the Filipino community. Having someone testifying the effect of this practice would encourage people to try. Having observed how Filipinos talk about health issues and practices, it is very obvious how they responded to each other's story in a very supportive and approving ways. When someone talks about her personal practices in preventing common cough and cold for example, there will always be a handful of people who would compliment what she is saying and would injected their own personal version of that practices too, which are often almost the same with just little configuration. The liquid extraction of the oregano plant, heating it a little and adding a dash of sugar to make it palatable is a common practice that everyone is familiar with.

Case 6: BOBUY

Buboy is a 20 year-old young guy, born in Cannes and both parents are from the Philippines. Obviously he is French in so many ways, except the physical attributes. When this researcher asked if he has any knowledge about the differences between French and Filipino health beliefs and practices, he seemed lost. He has no

idea what this researcher is talking about. All he knows is that when someone is sick in his family, they go to medical doctors. Although there are some discussions about Philippine health practices at times, he never really saw anyone in his family practice it. As part of the first generation immigrant, he does not have enough information about his racial origin, more so specific aspect of his cultural roots. After asking a few questions, this researcher found out that first generation immigrants do not have a concrete grasp of their racial origin. They have very little knowledge about their country's customs and traditions. Except from loving Filipino food, they seemed oblivious to the huge differences between their country of birth France and the Philippines. They often refer to the Philippines as where their parents came from but seldom acknowledge that they too are part of this country. This is not to say that they detest the Philippines. What this clear is that they have not enough knowledge to cite differences healthwise, between France and the Philippines. In terms of language, first generation immigrants like Buboy speaks French and English and a few words in Filipino but they have good understanding of it because their parents speaks Filipino at home. They often served as interpreter of their parents and for some close Filipino friends as well.

Buboy's case highlights the need for programs that properly educate immigrants about their racial origin. It cannot be disputed that their parents tell them about who they are as a people, the history and current state of their country of origin. This effort can be further strengthened by encouraging Filipino organizations to have a youth formation activities that would inculcate a sense of cultural pride for the young Filipino immigrants. Setting-up activities like this will help them in many ways.

The researcher interviewed 25 members of her population. The stories presented above were the most interesting because they represented different health experiences and how they addressed them under the benefit they as formal residents of France. Results of other KII were repetitive of the same story with just slight difference. The common sentiments for those who have experience life threatening conditions were: "kung nasa Pilipinas ako, matagal na akong patay" (If I was in the

Philippines, I could have been long dead). This is said in reference to how healthcare is delivered in the Philippines. The level of healthcare is tantamount to how much the patient is willing to spend. Knowing that a large proportion of the population is poor, one can easily do the math.

c). French health care system at work

Dr. Elias is an English -speaking General Practitioner in Nice who has been helping this researcher in her studies. His clinic (Cabinet Medicale) is a one of the many clinics inside Centre de Santé Mutuelles de France (7 Bd Pierre Sola 06300, Nice). He said that two in every 10 of his patients are English speakers and he has two patients who are from Asia but this researcher is the more regular one. This is because this researcher needs to see her doctor regularly for the prescription of her medication for diabetes. Dr. Elias said, as a Generalist, he is seeing patients from 20 to 90 years old but majority are early 30's up to 60 years old and mostly women. A consultation to a Generalist, which is 23 euros, is reimbursed by the state with the requirement that the patient has Carte Vitale. Subscription to this card is mandated by the State before anyone living in France can have access to healthcare. This card entitles the patient to a free consultation to a generalist but if he needs to see a specialist, he needs to pay in excess of the 23 euros which is shouldered by the State. In some cases, patients pay out -of -pocket but most have Mutuelles or third party health insurance. This mutuelles are chosen by the patient based on what they can afford to pay or for those who are working, the company pays for the mutuelle and becomes one of the benefits provided for the employee. In some cases, doctors can write to l'Assurance Maladie requesting that a certain patient be given 100% reimbursement based on the disease. Justification for this type of health benefit in France must come from the patients' doctor after carefully analyzing the patients health state and considering the amount of care the patient need in contrast to the patients capacity to sustain treatment. Once the doctor made his conclusions, he will make a request to health decision-making institution to accommodate the health demands of the patient. This means that the patient will have 100% coverage of the disease identified by his doctor. This is privilege is only extended to patients who do

have no capacity to pay for his/her medical needs but a holder of Carte Vitale. Patients under this condition are those who do not have jobs, students and indigent individuals. Under this case, the patient who is suffering from diabetes as an example, will be given 100% reimbursements on all consultations and medications related to diabetes. Treatment of other diseases however is not fully reimbursed. In this case, the patient has an option to subscribe to CMU which is the French Universal Health Coverage. For people who cannot afford to have a mutuelle, it is the State who provides and pays for the third party insurance for these indigent patients. Subscription to a CMU is a tedious process for the patient but at the end of the day, he has a government that is willing to support his medical needs and that is a huge burden that is lifted from the patients shoulder.

There were also doctors who looks at their patient as costumers. One interviewee shared to this researcher that she used to see one doctor who, despite the few consultation she did with her- do not remember her name nor keep records of her medical check ups, laboratory tests and the medicines she is taking. Every time she goes to see her, she needs to start all over again with the medical history and all and she even have to be the one listing all her medications and showing it to her doctors. This researcher demanded why did she stick with this doctor and the simple answer is because she speaks English. She is not seeing her lately anyway because after asking around, she found someone she likes and speaks English as well. What this experience revealed is that language is not the main thing that matters in doctor-patient relationship. Surely it is more on the expected practice of utmost professionalism and better communication skills.

Visiting a public hospital is different scene. The patient who seeks medical assistance will be asked of insurance coverage status: carte vitale, CMU or mutuelle. The health cases that does not require immediate medical attention, the patient will be requested to wait for doctors consultation. Because of the sheer number of patients, the waiting is often too long. Contrary to seeking medical advice from

doctors working in clinics outside of the hospital where patients have a choice of rendezvous schedule, patients in hospitals should be prepared to wait.

In doing exams, the patient will go to his desired laboratory and submit the request form his doctor. The lab personnel will ask for his carte vitale, CMU or mutuelle. She will then make computations of the payment that needs to be settled or inform the patient that everything is covered and schedule the needed laboratory tests.

If there is an amount that should be settled for doctors consultation and laboratory tests, the patient sends the receipt to his mutuelle and it will be reimbursed on the basis of the patients coverage. This dynamics is how financial settlement is settled in the health care system of France. Patients pay first and will be reimbursed later.

In the Pharmacies

In France, dispensing medicine is the monopoly of the pharmacy including the over-the-counter (OTC) drugs. A pharmacist is only allowed to have one while each hospitals have their own pharmacy. There were approximately 22,700 retail pharmacies in France and they were regulated depending on the size of the population they serve and how the distance involved in getting to the nearest pharmacy²⁴³.

In terms of medicines, if a patient has Carte Vitale but not a mutuelle, he needs to pay a little amount for his medications. The State, through the Carte Vitale, shoulders 50%-80% of the cost of medicines and the remaining amount will be paid

²⁴³ Dixon, A. & Mossialos, E. (eds) (2002). Health care systems in eight countries: Trends and Challenges . European Observatory on Health Care Systems (http://www.gesundheitspolitik.org/01_gesundheitssystem/ausland/gesundheitsysteme/HC-Systems-in-8-Countries.pdf). Accessed August 2013. P 42

by the patient either through their mutuelle or from their own pocket. Vitamins, food supplements and over the counter medicines are not included in this benefit. If a patient on the other hand was able to secure a CMU, the state will reimburse 100% of the medicine cost.

This researcher as an example was able to get 100% reimbursement for her diabetes maintenance which constitutes doctor consultation fee (Generalist) and laboratory fee (ideally once every three months or as needed) medicine and sugar test kits. For other medicines however like what she takes for high uric acid, she pays 30% for this while the State pays for 70% of the amount and the same ratio for laboratory fees. This proportion is almost the same for other ailments outside of her diabetes concerns.

It is quite easy to see why the French healthcare system is heralded as one of the best. French patients have access to medical care and medicines which encourages health maintenance. Compared to other European countries, Spain for example, Spanish people pay 50-70 percent of doctor consultation and medicines. Old population- retirees and those who are more than 60 years old pay 10% of their medicine cost compared to 100% coverage in France. French workers and business owners might have complains about the high health premium but at the end of the day, they know that when the time comes for them to seek medical help, they do not need to pay anything including medications and medical tests which is the most expensive part of medical care.

CHAPTER SYNTHESIS

The results of the survey in this chapter presented the basic make-up of the Filipino population in the South of France. Filipino migrants in this area are mostly women, supporting the idea of feminized migration, migration of this race is relatively new, age of Filipino immigrants is evenly distributed, there is a consistent flow of Filipino immigrants through the years and it cannot be said that there is a significant spike in the number of Filipinos coming in. Filipinos dominate the industry of domestic work. Majority are contented with their pay and their work responsibility and their work environment as a whole.

In the area of health, they are generally satisfied with how they have access to medical care. Although there is no significant changes in the frequency of doctors visit between now that they are France and when they were in the Philippines, they feel that they are taking care of their health better now.

Belief in traditional health concepts are still strongly present and highly affect health choices and disease management; and yet these belief system were altered as a form of adoption to accessible modern medical cure. Filipino immigrants are also adapting to the healthcare system of France. They are now more conscious of taking care of their health knowing that then can visit doctor anytime or have laboratory tests for free because it is provided by the state. This confidence is non-existent when they were still in the Philippines for they know the medical cost and it is a huge barrier in seeking care.

The interview revealed detailed experiences of Filipino migrants. Those who have experienced how to be really sick, praised the care they received for they did not worry about financial burden. In addition, they realized that traditional healing cannot address diseases that are highly medical. One interviewee who recently migrated to France and received much needed hip operation was freed from years of pain. While in the Philippines, she cannot afford sustained medical care more so an operation because of economic constraints. As a result, she finds comfort in going to

traditional healers and the only comfort she gets from them is having someone to talk to. After experiencing the kind of care in France, she confessed that there is no going back to the traditional healers.

In contrast, one interviewee expressed her consistent belief in the traditional healing practices in the Philippines. Having experienced a sickness which was not addressed by medical doctors in France, she seeks help from the traditional healers and for whatever reasons, she was relieved and eventually cured.

This dichotomy will always be present in patients. After all they have treatment options and it is their decision at the end of the day which one to follow. Everyone has a set of health belief system that guides them in their health and disease management. For immigrants, the process of choosing is a complicated process because of the many factors that they have to consider. In the end, they often try to strike a balance between what they know and what they have been doing in the past and the current – the health system they found themselves into. Often, the result is a navigating health practices: one that constantly shifts from one health culture to another.

CHAPTER VIII FINDINGS and IMPLICATIONS

A. Hypotheses

Here are the findings of the study in reference to the hypotheses set by this research:

Hypotheses 1: For the Filipino immigrants in the French Riviera, language is a barrier in healthcare integration

Findings of this research found out that although language barrier is still present, it does not directly affect health-seeking behavior of Filipino immigrants. They make a way to lessen the language gap by seeking English-speaking doctors or bring a close friend or a family member to doctors' consultation to act as translators and interpreters. With the length of stay in France, a large percentage of Filipino immigrants in the French Riviera already knows how to speak French and they were able to converse in the language. It does not mean though that they were able to express in detail their health concerns nor fully understand doctors' explanation. The conversation between doctors and patients are mostly superficial and basic. It is mostly confined within "what is painful, where, how long have you been feeling like that and here is your prescription". This type of interaction happens when patients are complaining about simple aches and pains. In severe cases like the case of Brigette, her doctor is taking very good care of her but maybe because she is writing a book that is why she needs to document everything that's happening with Brigette. For a more in-depth intervention, patients needs more than band-aid type of medical care, especially immigrants whose wounds often have deeper and have multiple causes.

Filipino patients in the Riviera have also been complacent in not knowing more about their diseases through clarifying health information from their doctors. They are passive patients who just followed doctors' advice in terms of medicine intake while continuing to do traditional practices on the side. To compensate for the lack of expected information from their doctors, they read materials to know more about

their disease but it is not clear if this activity has a direct impact on how they take care of their health.

Results of this study also suggest that more than the French language as a barrier, it is the attitude of French healthcare professionals that needs more immediate attention. They are often dismissive to the point of being rude, non-accommodating which makes immigrant patients feel discriminated and they don't exert effort to somehow understand what a non-French speaker is trying to say in a broken French way. This was mentioned by Susan and many more interviewees of this study. The immigrants do not contest the fact that as foreigners who decided to live in France, it is their responsibility to learn the language. However, stating this as not a form of excuse, there should be an accommodation for immigrants who are on their transition period. Statistics show that the dynamics of immigrants in France is changing. They are no longer solely coming from previous French colonies who have stock knowledge of France. An increasing number are also coming from other parts of the world who do not speak French, and during the transition phase, where they need help the most and where so many papers have to be filled up and filed to the proper office, an extra ounce of patience is not too much to ask.

French healthcare professionals –specifically referring to the front liners in public run health institutions- should also realize they are occupying a public service position. As such, it is their obligation to allot time, assist, give relevant and timely information to everyone who comes to their office expecting to be clarified after the consultation. It is clear by now that there is a need for interpreters for immigrants in transition, it is the state who has the responsibility to provide one. Assigning a specific person who is knowledgeable about how the French health system works from the inside and out and specifically trained to help foreigners and immigrants is the one of the best way in lessening the communication gap between health professionals and immigrant patients. It has been operational in other countries and France can experiment and see how it will work under their health system.

Hypotheses 2: Current health practices are still highly influenced by the traditional health belief system

The level of influence is diminishing through time spent in France. Surely, traces of these health beliefs are still present in health choices and treatment options. A large percentage of Filipino immigrants in the Riviera still remember and talk about traditional health practices in the Philippines but it does not translate to actual practice. Some of the interviewees mentioned to this researcher that there are some Filipinos who practice traditional healing techniques in the area and they can be reached if someone is in desperate need to consult traditional healers. However, Filipino immigrants prefer to go to medical professionals. The main reason provided by the interviewee is because they have more faith in medically trained doctors than traditional healers. They also shared that medical doctors are more accessible and more reliable. This goes to show that the belief in traditional healing techniques is overshadowed by the availability of western trained doctors and accessibility of medicines. In the past, Filipino patients especially those who do not have enough resources, seek first the assistance of traditional healers. They go to medical doctors when they have already exhausted all effort with regards to traditional healing. The reason for this is primarily because they are scared of the cost of doctors and medicine. Here in France that these barriers are no longer present, Filipino patients goes primarily to the doctors and which shows the paradigm shift in their mindset. However, doctors visit is just one factor in taking care of ones health. In a foreign environment, the process of going to a doctor for a check-up is not as easy as it sounds. When there is no common language, patients often have second thoughts of going to a doctors' visit.

Filipinos embrace the idea of treatment combination. This study revealed that Filipino patients often consult a medical doctor and go to traditional healers at the same time. Now that they are in France, treatment combination is also present but in different form; they go to a doctor and go to another medically trained specialist like kinesitherapeute (physiotherapist), commonly referred to as "kene" which is very similar to a massage therapist who is called "hilot" in the Philippines or to an

osteopathe- a doctor concerned with maintaining patients health through balance of body and mind concentrating on the musculoskeletal system.

Hypotheses 3: Filipino immigrants were able to adapt to the French health system

The first wave of Filipino immigrants who came to the Riviera have been mostly successfully acculturated and integrated into the French healthcare and to the French way of life primarily because of their long stay in France and their ability speak French. This integration however does not extend to being part of the larger French society. They remained within the bounds of their comfort zones-meaning their social activities are still limited to being with other Filipinos. This has an effect on their everyday life including health management. Sharing health concerns with other Filipinos, they also share disease management, preventive activities and treatment options which are mostly based on their first hand experiences with the disease. Traditional healing techniques are almost often part of the discussion. Talks about traditional medicine do not literally translate to putting it in action. Most Filipinos do not take these things seriously. They said that they would rather go to a medical doctor, do some tests when they are suspecting that there is something wrong, rather than putting their health in the hands of the untrained or take untested concoction of herbal medicines which are not medically proven to prevent or cure diseases. This mind-set highlights the adaptation of Filipino immigrants to the French healthcare system, which is highly based on hard medical science and this belief system spills over to its patients.

Integration in the health system is a broad concept and it has to be quantified. If the factor on which to measure health integration is registration to the system and having a carte vitale, Filipinos then have successfully integrated. Most, if not all, are registered to the French healthcare system. They are receiving care when needed, have access to medicine and they know that if something goes wrong, they have the right to access medical care in hospitals.

If the measure for integration is access to health information and preventive measures, there is so much to be done. It is clear that preventive behaviors can be encouraged by health messages. If these messages however do not reach or do not appeal to a specific group who are considered to be the most vulnerable and genetically pre-disposed to certain diseases, behavior and lifestyle is not likely to change. In addition, if these preventive campaigns lump immigrants into a single category, is it problematic for the immigrants in the Riviera are culturally fragmented, and this is what should be realize by campaign designers. In as much as immigrants' health status has been investigated, it lacks categorizations in terms of ethnicity and race, thereby creating a single health analysis for term "immigrants". This paves the way for misconception about immigrant health experiences.

In the end, Filipino immigrants adaptation and integration to the French healthcare system is still limited to the being a passive part of it. They remained to be receivers of information and services. There has been no real effort to communicate with them and find out what they exactly need information and health wise. As such, when they are expose to health campaigns, they are totally detached from it because primarily it is not in the language that communicate with them, the graphics are not familiar and the over-all appeal do not connect with their long held beliefs. As such, they are often not affected by the campaign and they continue to practice health the way they know how to.

Hypotheses 4: There are emerging health practices based on intentional or unintentional combination of the past and the present health beliefs

A revised version of treatment combination is a glaring finding of this study. Instead of combining traditional health practices with doctors' advice, it has now become combination of two or more medical treatments. A patient would go to a GP and go to a physiotherapist or an osteopath. Their mind set is to have medical treatment instead of looking for Filipinos who perform traditional healing practices. It is not that there are no Filipino traditional healers in the Riviera because there are few. But the general mind frame of the Filipinos is to go to medical professionals.

Seeking medical help is treatment focus rather than preventive. Filipino immigrants seek medical advice when symptoms start to manifest. In chronic diseases which claims most lives and most costly to manage, delayed diagnosis is synonymous with disease management because once the symptoms are present it means the disease has been present for a long time and it is irreversible. This treatment/cure focus behavior needs to be addressed to prevent costly disease management and save lives. Specifically crafting preventive health messages and carrying out preventive activities that appeal to the target specific population can do it.

Mainly due to access to healthcare, Filipinos immigrants in the Riviera are now open to other medical treatment options. When doctors advice them to go to a specialist or do more tests, they do not hesitate to follow. In the Philippines, patients say yes to these advices because they know that's what their doctor wants to hear. But they don't often do it because there are a lot of considerations before moving forward in seeking medical care and the heaviest burden is economics, especially when they do not feel the urgency to do so. When this blocking matter is removed, there is big chance that patients will follow doctors' advice. This is what happens to Filipino immigrants in the Riviera. They are empowered for they are given free range of choices in managing their health and the huge factor is that they worry less about financial costs.

Despite the availability of medicines in the Riviera, there are still a handful who would import simple medicines from the Philippines because they believe it is "hiyang" (suited) to them. These medicines are often what they take for everyday aches and pains like muscle pain, headache etc. Some mentioned that they feel that the counterpart of these medicines in France are too strong for them so they still chose to take medicines from the Philippines. Those who oppose this practice reiterated that medicines from the Philippines are not effective because the dosage is not what it is suppose to be even if the label says so. They do not believe that medicines from the Philippines have the same bioequivalence with the medicines

they get here in France. What these mind-sets have proven is that the belief of taking what is “suited” is very much alive in the psyche of the Filipino immigrants. This term has cultural as well as personal undertone, carrying meaning that goes beyond the superficial. For the Filipinos, suited means something that gels with their beliefs and feelings; something, someone or a place where they are comfortable with. This state of comfortability is also what Filipinos are looking for in their everyday lives. They would rather have a suited health care professional, a suited hospital etc. because it makes them feel at ease. Health care providers should take this into consideration when taking care of Filipino patients, especially those who are in the front line. Doctors and nurses are trained on this aspect of care but there might be a need for auxiliary members of health care to have more training in handling a multi cultural health environment.

The emerging health beliefs includes:

- a. revised treatment combination
- b. doctor centered health management
- c. mixing simple medicines from the Philippines and from France
- d. lesser (or diminishing) reference and practice of traditional health beliefs
- e. reference to taking medicines that are “suited”

Hypotheses 5: First generation Filipino immigrants are not aware that there are differences between the health system of France and the Philippines.

The first generation Filipino immigrants in the Riviera are those who were born in France of Filipino parents. Today, these first generation immigrants are relatively young and barely out of University (or roughly between 17-23 yrs. old). Being young, they are highly aware of their racial origin but they are not very familiar with customs and traditions especially in the area of health. It is understandable because they grew up in the French environment. They shared to this researcher that their parents talk about traditional health beliefs and techniques in addressing illness, but they do not

really understand what it means. They do not practice it nor their parents encourage them to do so.

When their parents or other elder members of the Filipino community talks about how difficult and expensive health management is in the Philippines, first generation immigrants do not really understand what this means for they have never faced or experienced such hardship. This maybe because they do not have a grasp of how challenging it is to be sick nor how expensive it is to be sick in a country that do not have a strong health insurance coverage for its citizens. Over all, their knowledge of the differences between the healthcare system of the France and the Philippines are just within the bounds of concept- they have heard about it but they don't know more than that.

B. Research Objectives

Aside from the research hypotheses, the research objectives of this study were also addressed. These objectives stated in the earlier part of the study aims to paint a clear picture of the health beliefs system of the Filipinos and how these are operating with the French healthcare backdrop.

Below is the table format of the findings of this research based on the objectives set by this study.

Table 9: Findings and Implications

Research Objectives	Findings	Implications
1. <i>Identify and describe the traditional health beliefs and practices of the Filipinos living in the French Riviera</i>	<ul style="list-style-type: none"> * highly influenced by superstitious beliefs, religious affiliation and forces present in nature * prevention and treatments of diseases are family affairs * preventive behaviors and activities are not a commonly prioritized * often combine traditional healing techniques and western 	This belief system is a product of generations of passed on health practices and will not disappear wherever Filipinos go. It will also not be dissolve immediately through time, although it will diminish its influence on the health performance of immigrants. Whenever there is a chance, Filipino immigrants will still perform traditional health practices but it is often a distant choice from

	<p>medicine</p>	<p>their medical treatment options.</p>
<p>2. Describe how traditional health belief influences current health practices with the French health system as the backdrop</p>	<p><u>A: Traditional Health beliefs</u></p> <ul style="list-style-type: none"> * treatment combination is still practiced but under a different premise * basic medicines (paracetamol, ibuprofen and ointments) are still imported from the Philippines * there are still significant health practices related to superstitious and religious beliefs but it is diminishing through time <p><u>B: Traits of French healthcare</u></p> <ul style="list-style-type: none"> * Universal Health Coverage, where everyone have access to healthcare * freedom in doctors consultation * free medicines (or low out of the pocket expense) * reimbursement for specialist consultation * high – cost for the government * high patient satisfaction ratings * patients are passive participants 	<p>The system is encouraging and supportive of the populations' quest for better health maintenance. It empower the patients in such a way that they are aware that health care will be provided for them when they need it. The system needs to focus however on programs that specifically targets vulnerable population. One way of doing it is to start building link between the system and the population they are targeting. It can be done by implementing programs that aims to better understand the cultural and racial make –up of the population. Patients can be further empowered by allowing him to express his thoughts and giving him a platform to air grievances and demand change, should he felt there is a need. He should play an active role in the management of his own health. French health professionals must be made aware of the health belief system of the Filipinos for them to be able to make culturally sound health campaigns that would correct health practices that are not medically sound. It would also help them to communicate sensitively to this population.</p>

<p>3. <i>Identify the emerging health practices of the Filipino population and describe how it merges with the French health landscape</i></p>	<ul style="list-style-type: none"> * adhering to treatment combination * new language/ vocabulary * more visit to medical doctors * strictly following treatment advice * higher awareness of health maintenance * complacency in voicing out their difficulties in communicating with auxiliary medical staff * come and go attitude * looking for something “suited” to their health beliefs 	<p>The word ‘massage therapist’ has now a new meaning for the Filipino immigrants in the Riviera. These medical professionals are medicalized, because their title says it all (Kenetherapeute and Osteopathe). This complementary medical professionals resembles the work done by traditional therapists in the Philippines, the only difference is that they are licensed to practice their profession. Filipino immigrants somehow might feel a semblance of their old health practices with the combination of medical doctors and osteotherapists and physiotherapists.</p>
<p>4. <i>Identify barriers that contributes to unsuccessful health assimilation as well as factors that encourages better health maintenance among Filipino immigrants in the French Riviera</i></p>	<p><u>A: Barriers</u></p> <ul style="list-style-type: none"> * prejudice to immigrant patients * limited training for medical workers regarding how to handle culturally diverse communities * challenges associated with language difference * limited health communication and health programs that specifically target immigrants * lack of translators for non-French speakers * lack of programs that would bridge the gap between the immigrants and the host country <p><u>B: Factors that encourage better health maintenance</u></p> <ul style="list-style-type: none"> * compulsory membership to the universal health coverage * access to medical care and medicine * openness and support to 	<p>These factors discourages somehow discourages Filipino immigrants to seek medical help, especially in the prevention phase. They will not subject themselves to situations where their language proficiency will be scrutinized. Answering questions from medical workers who were not prepared to handle multi cultural environment is also a daunting activity for some immigrants.</p> <p>The idea that doctors’ consultation as well as medicines are covered by social security a huge encouraging factor for Filipino immigrants in seeking medical help. This was translated into high level of patient satisfaction regarding this part of the French healthcare system. The progressive taxation is also applicable to immigrant workers and that is a huge factor for the ageing immigrants. Immigrant patients also can choose their own third party insurance depending on the type of coverage they require and the monetary ceiling they can afford.</p>

	<p>treatment options</p> <ul style="list-style-type: none"> * patients choice in supplemental insurance (mutuelles) * high doctor- patient ratio * progressive taxation (those who earn more, pay more taxes which enables the government to shoulder the health cost of the poor members of the population) 	
<p>5. Proposed a health model that explain how immigrants emerging health system are formed</p>	<p>Transcultural Health Communication Model (THCM)</p>	<p>This model can be applied in any culturally diverse health environment .</p>

Table 9 highlights the findings and implications of the research objectives. It shows how the French healthcare system is prepared (or otherwise) to accommodate the intricacies and uniqueness of immigrants in France whose number are increasing every year. It is a realization that French society is becoming more culturally diverse that requires new methodologies in addressing the populations' health issues. The composition of immigrants in France is different from what it used to be 20 years ago. There has been a huge Asian immigration turn out in the past years and as such, their presence has to be acknowledge by the French government and the French society, and including them in health campaigns is one way of integrating them into the host country's health system.

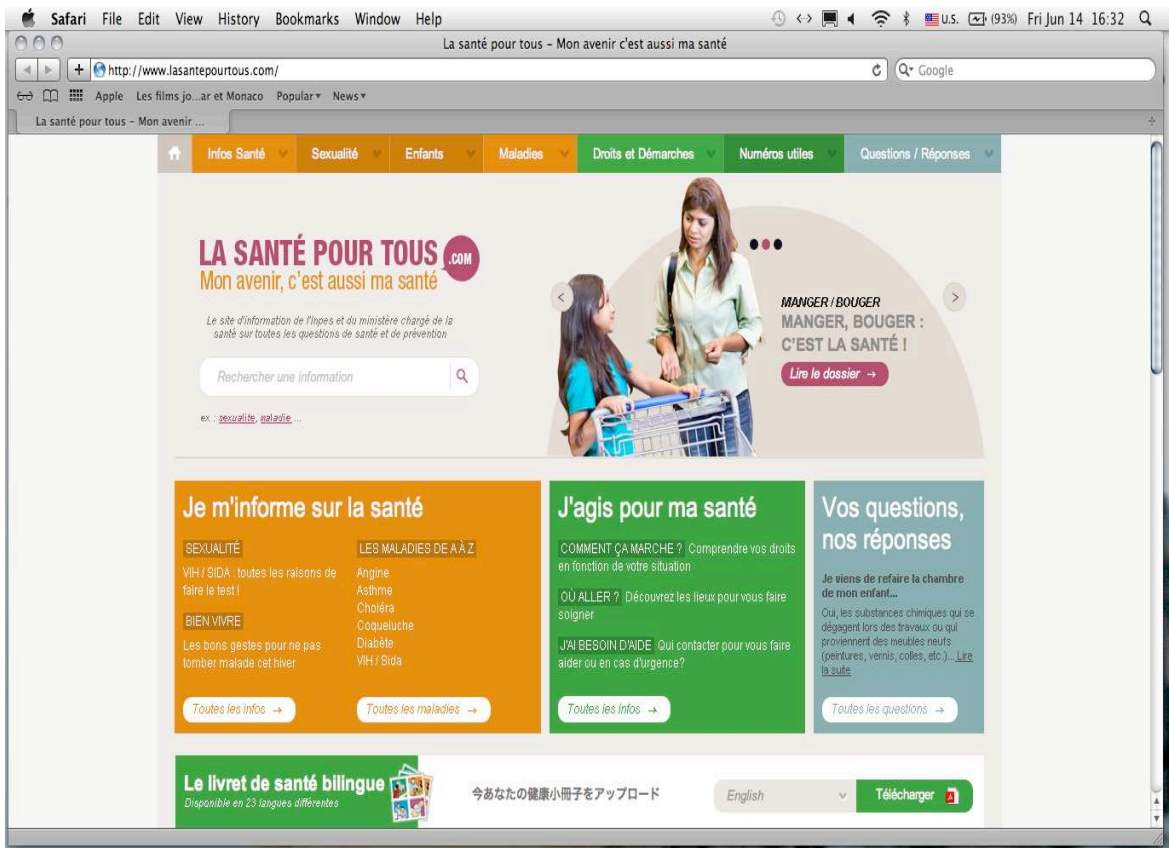
Immigrants and other minority groups have different ways in dealing with diseases, illness, health and death compared to local citizens and it should be a matter of consideration for healthcare providers. On top of it, different expectations regarding communication interaction hinders the patients understanding of doctors advice and doctors do not often receive the right information to do proper diagnosis and prognosis. Scratching the surface will not affect significant change in the way immigrants take care of their health, as shown in recent data regarding the continued

deterioration of immigrants' health all over Europe. It is worthy to investigate also that despite high patient satisfaction in accessibility to doctors and medicines, why did it not translate into immigrants' better health performance? Surely, in terms of addressing immigrants' health concerns there are factors that are at play beyond the usual medicalization of diseases and health. Filipino immigrants' health experience in the South of France is definitely satisfying. However, there are certain areas that need improvement and the first factor that needs to be addressed is the need for auxiliary health personnel to have better training in assisting patients from a different cultural and ethnic background. A standardized health data collection system should also be placed to monitor immigrants' health performances.

C: Operational Platform for non-French speaking health information seekers

The French health care system is not at all lacking in actions when it comes to adopting measures to lessen the health gap between the majority population and different immigrant groups. For instance, to accommodate health inquiries of non-French speakers, the Ministry of Health and INPES came up with a website that can be translated into several languages and was able to answer basic questions in the language the patient is highly verse with. Health information seekers can download a "livret" (booklet) (Appendix 12) containing an array of health topics that they can benefit from. In addition, when calling the hotline of l'Assurance Maladie, a non-French speaker will be directed to call another hotline where someone speaks English. This platform for non-French speakers however is not well publicized and because of that, it limits its potential to be helpful to health information seeking members of the population.

Figure 29: Screen Shot of the website santepourtous



Source: <http://www.lasantepourtous.com/> (accessed June 2013)

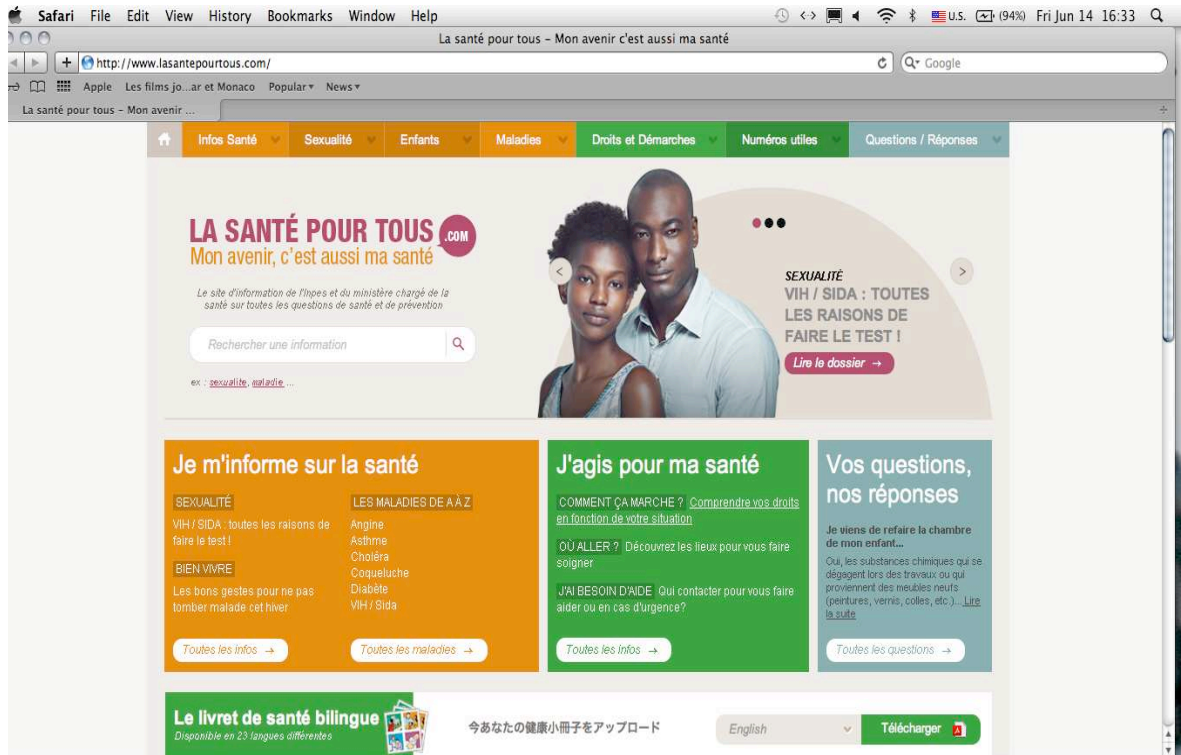


Figure 29 shows the website which can be accessed by those who want to know more about healthcare in France and basic health questions. In 2008, the Institut national de Prévention et d'Éducation Pour la Santé (INPES) {National Institute for Prevention and Health Education in cooperation with the Minister Charge de la Santé {Ministry of Health} created the website lasantepourtous.com. However, it was not made fully operational. It took 5 years for INPES and the French Ministry of Health to redesign and fully launch the website in 2013. Updated and enriched with new features, it offers migrants (and non-French speakers) simple and practical information on health, but also access to care and what steps to take. The full re-launch of the website was promoted on national television on January 19, 2013 at the launch of the Africa Cup of Nations (CAN) 2013. To sustain the information dissemination, additional communication campaign was carried out in three weeks time after the big re-launch. The communication campaigns to promote the website includes TV spot broadcast on African channels, and the media who broadcast the CAN 2013. On top of above the line advertising, the website was also promoted in radio, newspapers and below the line advertising in the form of posters and flyers.

It is highly noticeable that the full launch of the website was strategically done during the Africa Cup of Nations. This event is the highly attended edition of the Africa Cup of Nations under the current, 16-team format. The television station Canal+ won the contract to exclusively air the event. Football is a huge sports event in Europe and by strategically choosing this event to re-launch the website, the French Ministry of Health is making sure to get the message across using a single event reaching the maximum number of its target audience. Messages re-introducing the website was also placed on radio broadcasted on radio Africa No. 1 and RFI. Communication tools were also displayed in places frequented by migrants (hairdressers, shops tropical fruit, payphones, etc.), Insertions in community newspapers and online web banners on affinity sites are also provided. The redesigned website features more icons to illustrate topics that are discussed, reader

friendly design and it was also positioned as the only reliable source of health information for the migrant population in France²⁴⁴.

It is obvious that this campaign is primarily targeted on immigrants and by launching it in a huge sports event, it surely have an impact on the target audience. The question now however is sustainability of the campaign. Three weeks of additional information dissemination surely is not enough to continually inform the public about the presence of a platform where they can get health information. Immigrants arrived in France everyday and under this premise of constant mobility, sustained effort to communicate health issues must be strategically sustained. The effect of this website to the immigrants in France is yet to be seen. There has been no studies made public if this campaign was able to meet its objectives or how it impact immigrants health behavior. It is an area worthy of another academic discourse.

At the point of sale (office of l'Assurance Maladie or other health clinics), there are no reading collaterals that would suggest, direct and instruct health information seekers that there is an available media where health information is available. What is present is the poster encouraging those who have carte vitale to register to amelie.fr. However, this website is totally different form the [lasantepourtous](http://lasantepourtous.fr). This researcher have visited several of this clinics in Nice and Cannes, yet there are no communication collaterals (posters, flyers etc.) that tells residence that a multi-lingual website exist. In addition, health workers in these offices are ready to answer administrative questions (how to apply for a carte vitale, papers needed for hospitalization, how to have 100% reimbursement and how to apply for CMU, etc.) and yet they do not know that there is a website called [lasantepourtous](http://lasantepourtous.fr). This has to be addressed to maximize the information that can be provided for the immigrants since these offices are the front liner in disseminating health information. This can be included in the standardized data collection procedure to monitor health activities of immigrants.

²⁴⁴ <http://www.inpes.sante.fr>

The challenge with the use above the line advertising (television, radio newspaper) to communicate to the public is that once it is gone, the information cannot be retrieve. Unlike below the line advertising – posters and flyers as a best example- the information last longer and have greater impact because of the lifespan of the medium. Those who visits health offices surely needs health information. Having access to posters and flyers that tells migrants of a platform where they can get answers to their most basic questions surely makes more people informed about their health choices, preventive actions as well as treatment options.

When this researcher arrived in France in 2009, she seeks a platform where health information is accessible and in a manner she can understand- therefore English. She later discovered that finding general health information in language other than French is an exercise in futility. She is often given the “look”- the you speak French because you are in France kind of look- which she often interpret as discrimating rather than encouraging. As a new comer in France, this researcher does not know a word in French. She was on her transition period and just registered in a language course. The tone of voice and the body language of people from the l’Assurance maladie highly suggest that they cannot help her. Given this dim scenario, the researcher was confined to exchanging emails or snail mails for the information she needs and as expected this process is more complex and it takes longer than actually speaking to a real person.

The French governments program for immigrant integration is being handled by the l’Office Francais de l’Immigration et de l’ Integration (OFII). It welcomes and supports aliens when they move to France, and it assists French nationals and workers when moving outside France. The mandate of this office is to ensure that legal immigrants are prepared to adjust in the life in France. Specifically, OFII ensures that the following rules are applied:

“Article L.311-9 of the French Code of Admission and Residence of Foreign Persons stipulates that foreign people admitted to stay in France, or who legally enter France for the first time between the age of sixteen and eighteen, and who wish to reside here, must prepare for their integration into French society. As provided for by Decree No. 2006-1791 dated 23 December 2006 (Official bulletin dated 31 December 2006), the foreign person enters into an accommodation and integration

contract with the Government. This contract aims to establish "a relationship of confidence and mutual obligation" between France and the persons wishing to reside here. The accommodation and integration contract has been compulsory since 1 January 2007".²⁴⁵

The age bracket mentioned in this rule is indeed limiting. This researcher had an impression that the establishment of confidence and mutual obligation is confined to those who come to France at a young age, probably mostly to study. This age categorization put into question what has been done or what were the programs targeting immigrants who are older than the age stated above.

Still fascinated by the fact that there is no health collateral in English in France and the only platform for non-French speakers are none existent, this researcher continued to explore more and dig deeper. The researcher keeps on experimenting every possible way to get health information in English. She asked one of her French friends to call l'Assurance Maladie to know if there is someone she can talk to answer her health queries. The operator said that the number to call is 0811363646 for people living in France who seek health information in English. The researcher then dialed the number and indeed, the person on the other line speaks English. The problem however is that the answers she provided are canned answers intended for frequently asked questions. As such, she was able to provide minimal information which is not of much help to this researcher in her studies. The operator suggested to write a letter to the head of their department, which the researcher did. She got her answer after a few months directing her to connect to amelie.fr (Appendix 4). This is the website provided and managed by l'Assurance Maladie. Every Carte Vitale holder is encourage to open an amelie account to manage their transactions with Securite Social. In the l'Assurance Maladie office located in Nice (Rue Pertinax) there is huge poster that tells people to register in this website. However, for immigrants it does not mean anything because it is written in French. There is no supplementary material in other language that explains the importance of registering to this site therefore non-French speakers do not feel the need, importance and urgency to use this platform to

²⁴⁵:http://www.ofii.fr/s_integrer_en_france_47/all_you_need_to_know_about_the_cai_458.html (downloaded September 2013)

know more about how health care is managed in France. It is a sad reality because this website provides a lot of information that could aid immigrants in their quest for better health.

Seeking information through the health information providers located in any l'Assurance Maladie offices is an exercise in futility. The office staff are not very welcoming and they don't reflect the attitude that they like what they are doing. In the many times that this researcher visited these offices hoping to get the information she needs for her research and for her health insurance, she is often shut down as soon as she begins to start asking questions in an accented –broken French. This happened in the public health office located in the South of France and surely does not reflect the entire French scenario, although there are several studies citing a general dissatisfaction to services provided by auxiliary health professionals. It could have been a positive experience if both parties will try to understand each other or if there is someone assigned in every public health clinic to accommodate inquiries from non-French speakers. Under an ideal scenario, the person who is assigned to handle specific immigrant group must have at least a cultural background of the community they are serving, if not directly coming from the actual group. An interpreter can also be an added service to clients/patients who needs help in communication. This will surely lessen patient's anxiety and assist front line health professionals.

D. Filipino Immigrants experiences and perceptions of the French healthcare system

Survey and Interview data revealed that in general, Filipino immigrants in the South of France and Monaco believe that they are taking care of their health better now that they are in France compared to when they were still in the Philippines. This can be attributed to several factors that includes a socialized health management, high ratio of doctors to patients, access to care and medicine and the over-all make up of the French health care system.

This same immigrant group is highly feminized –meaning there are more Filipino women migrants than men and they are ageing. A large percentage of this research' population are above 60 years old and majority are women. This is a health issue for it translates to more medical visits and procedures because of diseases associated with ageing. Women are also more prone to long debilitating illnesses than men and they live longer too. Factoring all these, Filipino immigrants in the South of France visit doctors more often, do more laboratory tests and require more medications.

Filipino immigrants are also highly engage in physical work for they are generally employed in domestic work. This exposes them more to the physical pain and physical stress. No wonder, they almost always attribute their aches and pains to the kind of job they do. This attribution however is mere speculation for there has not been a study linking the most basic aches and pains of this immigrant group to the kind of work that they do.

Majority of the respondents visit their doctor after a few days of discomfort. They often observed their own pain and see if it will naturally go away after a days of rest. If the pain persists, that's the time they seek appointment with their doctors. This behavior is expected for people do not normally go to their doctors on the first manifestation of pain. The big change for Filipino immigrants is that in seeking medical help, the physical condition is the main deciding factor in going to doctors. In the past, even under severe pain, they often refuse to be taken to a doctor for they worry about the huge expenses that would burden their family. It is in this scenario where a traditional healer is best suited. Patients would seek these healers, follow their advice and take the medicines that they prepare. Only after all these were tried and nothing works, patient goes to doctors.

A large percentage of the population also stated that they visit doctors more often now than when they were still in the Philippines. They are also more compliant when it comes to taking their medication. This is solely attributed to the fact that patients do not spend on doctors visit and medications are just taken from the

pharmacy with minimal (or none at all) cost. However, challenges in going to doctors are mainly work schedule, not used to doing doctors consultation especially if patients perceived that there is no immediate threat to their health-thereby they don't feel the urgency to seek medical help- and some mentioned the fear of communicating to a French speaking doctors. The latter was remedied by bringing in personal translators. The downside of this action is that although the translator can explain to the patient, in verbatim if needed, what the doctor is saying, the translator is still not knowledgeable enough to explain concepts related to how the French health system works and might personally interpret some concepts that is might be dangerous both for the doctor and the patient. What is ideal is for the health institutions to heighten the promotion of platforms that not-French speakers can utilize or better yet assign a well –trained interpreters for non-French speaking patients. In the area of Catalonia in Spain, Filipino immigrants used to bring their own interpreters whenever they go to public offices who only speaks Catalan or Spanish. When the government saw what the benefits of having translators to the patients, they placed their own interpreters and translators to assist immigrants in the area have expressed their highly satisfaction with this move. This is an example worthy of emulating and the South of France can be a good testing ground for this experiment because there is quite a number of immigrants and the area and they are manageable enough to be a control group.

It is also important to point out that there are still a significant number who brush aside simple ached and pains and not do anything about it. The danger of course is that sometimes these are maybe manifestations of something more complex than simple fatigue. Left undiagnosed, it might have some fatal consequences especially to those who are genetically pre-disposed to certain type of diseases like diabetes and hypertension. That is why, patients should be encourage to seek medical help as soon as they feel something is wrong with their body. To encourage that health seeking preventive behavior, patients should feel comfortable in seeing and talking to their doctors and other health professionals.

Before visiting a medical professional, there are some considerations that need to be addressed. First is the kind of doctor to go to. For the Filipino immigrants they choose doctors who speak English. Having a common language to understand one another is an important consideration. For those whose been living in the Riviera for a long time, they already found a doctor who they felt comfortable with. This did not happen overnight though. They've been through the experience of constantly changing doctors until they found someone that fits their expectations. (In the Filipino health vocabulary, there is a term "hiyang"- which means suited, which translates to medication being suited to a particular person; a doctor who makes the patient comfortable, a medical procedure which makes the patient more at ease, etc). They also often recommended this doctor to their friends and family members. It is common to meet a general practitioner who takes care of a lot of Filipino patients because of recommendations. It is quite easy to find a doctor because there are many who speaks English or at least make the effort to do so. Private GP's who are paid per patients visit, should also prepare themselves to be ahead of their competitors.

Should the Filipino immigrant patient need more information to be enlightened about his discomfort, his initial reaction is to clarify things he did not understand from medical professionals. Since most of the Filipino immigrants in the Riviera have been here for quite a while, they speak French well enough to construct a simple question and familiar enough to the language to understand doctors' explanation. For those who do not have the opportunity to clarify things with their doctors, they often talk to close friends and family members who experienced the same symptoms or just mainly to share their story, solicit advice on how to manage the discomfort and listen to the experiences of others. This is a cultural phenomenon because as pointed out earlier, disease management and treatment decisions are almost often a family affair, that is why this behavior is being extended to the whole community. In a foreign land, Filipinos treat each other as family just because they came from the same country. This kind of verbal interaction and sharing has psychological effect on the patient and it is also a social activity. The downside is that the patient might get confused from all

the information he is hearing and might be lost if he does not have the complete understanding of what his discomfort is about, its probable causes and how to deal with it. This is why it is always safe to clarify things from the medical perspective and should be encourage. Reading additional articles from the Internet is a good supplementary source of information. However, patients should also be well guided in interpreting information from online sources. Whatever confusing or alarming information they would find must be discussed with medical professional as not to arrive at the wrong conclusions or cause further anxiety.

Filipinos while still living the Philippines did not developed the habit of consulting medical doctors. This can be attributed to several factors endemic in a developing economy. These includes minimal (and in severe cases lack of) presence of medical doctors, high cost of doctors fee, fear of long time treatment, anxiety over finding out what is wrong and the option of consulting traditional healers which is less complicated and less costly. However, now that they are in France, these issues were addressed because health professionals are available, health facilities are set, and medicines are obtainable. These services however are reactive rather than proactive. The French health care system is all set to take care of the sick but not lacking in effort to teach its citizen not to be sick or to avoid diseases. Citing again the deteriorating health of the immigrants, it goes to show that preventive effort targeting immigrants, fall short.

Filipino immigrants cite the lack of good communication skills and cultural knowledge of French health professionals is a blocking matter for them for seeking early medical care. More than the language, which this researcher theorized as the main cause of discomfort between French health care professionals and Filipino patients, it is the indifference that hinders immigrants' better health performance.

This indifference is brought about by lack of knowledge of the French health care professionals regarding the intricacies of the Filipino health belief system and the cultural and social gap that has not been addressed, despite Filipinos long presence in the Riviera. Not much research (if not none at all) has been done

concerning the health status of Filipino immigrants in the area. This can be attributed to the fact that health communication as an academic research is on its early stage and Filipino immigrants are a minority population in the Riviera. These are very strong contributory factors that limit mutual understanding. Filipino immigrants still continue to exist in a vacuum which makes them somehow invisible. To add, they are minority migrants because they are fewer compared to immigrants from Morocco, Tunisia for example. Nevertheless, their contribution to the French economy and society should also be acknowledged.

The survey and the KII revealed a highly favorable view of the Filipino immigrants concerning the French health care system. Coming from the country whose health system is not as strong as France, Filipino immigrants are highly satisfied with what services are provided and are available for them. Because of this, other aspects of health care delivery that needs to be pointed out for improvement are easily brushed aside. The lack of time spent by medical doctors during the interview for diagnosis, the limited knowledge of the auxiliary health personnel's about who the Filipinos as a people, the lack of standard operating procedures on how to deal with immigrant patients as well as the limited knowledge of immigrants contribution to the economy and social life in the French Riviera are the major issues that needs to be addressed to improve health services to the immigrant population. The Filipinos are naturally shy and timid people and they do not usually rock the boat. They choose to remain quiet instead of pointing out what needs to be done and demand the kind of service they deserve. They are also labeled as race dedicated for servitude which solidify the claim that they are indeed pleasers that is why it is not in their nature to complain and point out what they is wrong in the system they are a part of. As such, health providers and institutions are not made aware of what needs to be done because there is no information from the population as to what their needs are. Providing a platform for Filipino immigrants to air their sentiments and observations within the comfort of anonymity, might shed light on how this particular group of immigrants view health providers, the service provided for them and the entire health system as well.

As far as health management is concerned, they are satisfied knowing that they can do to the doctor anytime without direct out of the pocket expense, demand service from a hospital should the need arise and go to a pharmacy to get their medication with limited (or none at all) expense. Is this activity translated into better health management? Apparently the answer is yes. Filipino immigrants living the South of France said they are taking good care of their health now than before. Does this translate to better health for migrants? Better treatment management yes, but better health for migrants, sadly the answer is no. This study found out that Filipino immigrants are not expose to preventive campaigns, nor was there a program that would encourage them to review their lifestyle under the premise of health check. As such, they continue to lead a life based on what they know and without proper guidance on how to prevent diseases. They seek medical help upon manifestation of symptoms and in the case of chronic diseases which is the main culprit in morbidity, the illness is asymptomatic is often long present before it is diagnosed. What is left to do is to manage the disease to delay complications or to engage in a more drastic medical procedure. This has implications in the use of medical personnel, resources and lives of the patient. This is the reason why there is a synergized effort from concern groups, all over the world, calling for a stronger preventive campaigns.

The French health care system accommodates its legal residents and they succeed in providing quality life, as shown by the high life expectancy of its people. The society is also conducive to aging because of active organizations and activities, funded by the government that adapts to the lifestyle of the ageing members of its population. If this works with the French people, Filipino might also petition government institutions to support recognized Filipino groups to have activities that would better introduce them to the French society. One of the aspects of a healthy living is to have a social life and it has been pointed out by this study that Filipinos are isolated to their own comfort zones. This means that they are a part of a group but they limit it to the people belonging to their own race. It has already been established that there are already operational Filipino groups in South of France. These groups can be tap by the government to serve as the bridge to strengthen the ties between

the immigrants and the host country. This kind of relationship building has been done in other countries and has its share of success.

In Barcelona for example, there is a very strong Filipino organization called Centro Filipino. It is a church based organization that offers a lot of services to the Filipino immigrants. Its activities include language teaching, immigrant mentoring, publications, cultural and religious activities, and many more. Under this organization are other specific organizations that assist migrants. What makes these organizations successful is strong leadership and strong support from the Catalonia government. The state gives premium to the Filipino immigrants because they recognize their contribution to the economy and the social life and it was translated into support to activities, either through finances or logistics. Filipino leaders on the other hand continue to deliver for continued service to the Filipino migrants in the Catalonia area and to ensure continued support from the government.

This can be emulated in other countries where there is a strong immigrant population. A sustained support from the government instead of sporadic presence, should happen now to bridge the gap between the government and the targeted groups. Barcelona has proven that it can be done, all that is needed in France is the political will to do it and the dedication of Filipino leaders to do what is good for the entire Filipino immigrants in the Riviera.

Specifically, this research highlights the following findings:

1. Basic health complaints and its implications

The most common health complaints of the Filipinos living in the French Riviera are back pains, headache and muscle pains. These are mainly attributed to work related activities and were not taken as symptoms of a more serious medical condition. As such, Filipinos deal with it the best way they know how to: rest and take paracetamol or muscle relaxant. These medications are either from the Philippines or in France or those recommended by people they trust who are not necessarily medical professionals. With the predisposition of this group of people to certain diseases due to racial origin, simple aches and pains may not be so simple. For

prevention and early detection, it is advisable that patients be empowered to seek medical advice and under the French healthcare system, immigrants are given access to medical care and medicines.

2. Feminization of Filipino migration

Although there is no concrete statistical data stating the actual number of Filipino immigrants located in the French Riviera, available data revealed that there are more Filipino women than men in the area. This has implications in the delivery of health care service because research data revealed that women immigrants self reported poorest health status. Previous research also highlight that women suffer long and debilitating diseases than men. This translates to This finding provides health communication professionals who to target when planning and designing health communication campaigns as well as what diseases to prioritized.

3. Filipino dominated industry

The domestic frontier is the industry dominated by the Filipinos working the French Riviera. These can be ascribed to several factors like the lack of enthusiasm for these people to try to work in other field; the lack of willingness to better learn the French language, not having the entrepreneurial spirit, being contented with lesser responsibilities and enjoying better pay than working in other equivalent jobs in the same pay level. This phenomenon can also be attributed to the “familialization” of domestic work. Family members who arrived in the Riviera petitioned their family members from the Philippines and placed them in the domestic job. Even if these people are University degree holders, the fact that they do not speak French and the French Riviera society on is not ready to admit foreign professionals especially those who came from countries they have little knowledge about hinder Filipino professionals in landing jobs which they are academically prepared. This reality limits the options of Filipinos as far as job choices are concerned and their answer is to work in the industry where they are known to excel.

4. Traditional health belief and practices

A big percentage of the Filipinos still believe in pasma, experience the same symptoms and share tips on how to avoid it. However, although they try to prevent possible causes of pasma, they were not able to do it completely because of work routines as well as a more medicalized belief that there is a pill for almost every type of pain and it is available in the pharmacy, free of charge. They still do perform some rituals highly related to traditional belief system like preventing sudden changes in temperature enter their body. They put towels on their back to prevent drying the perspiration directly on their back, wear protective head gear after being exposed to a heated working environment like kitchen and ironing especially during winter season. Part of the belief system surrounding pasma is the entrance of cold temperature to the body and women should avoid taking a shower during her monthly period because the water is cold and the body is hot during this time. Doing so is believed to cause stomach cramps. Women are generally the followers of this health belief while most men viewed these as superstitious rather than a genuine medical condition.

5. Filipino French language proficiency and health

This research hypothesized that the French language is a huge barrier in health maintenance for the Filipinos in the Riviera. Results of this study revealed that despite the language divide, it is not a huge barrier in health maintenance because Filipinos are creative enough in finding ways to get health information. To cite some examples, they ask members of the community for English speaking doctors, request trusted French- speaking friends to accompany them in their medical visits to act as translators and they also do their own research regarding their ailments. This shows however that the burden of getting additional information is on the shoulders of the immigrants.

The French health system accept patients whoever they maybe which drives patients satisfaction up but the budget is burgeoning in an unprecedented proportion. In a volatile economy, sustainability of free services delivered to the public is almost always the first to go when the need to downsize and cut spending costs. However, it

should be made clearer (there has been many studies that have proven that prevention is better than cure) that although preventive campaign often takes longer and seems to be resources draining because results often takes years, disease prevention and early diagnosis not only saves live but also resources. As such, healthcare professionals must strengthen its effort to reach the vulnerable groups of its population. In the case of the French Riviera, Filipino immigrants, although a minority group, should be reached by targeted preventive health communication campaigns.

To lessen the language barrier, it should therefore be a mandatory requirement for Filipino moving to France to have language courses. Employers must also be required to send their foreign workers to attend French language courses, even if their job does not necessarily require them to speak French. One of the excuses not to learn the language is that their “amo” (bosses) are English speakers and they speak English at work. However, as a worker in a foreign land, the importance of learning the language could not be stressed enough.

Medical professionals in the South of France seem not to have enough knowledge of the community they are serving, therefore their service seems to be lacking with the needs and expectations of the immigrant groups as far as having access to preventive programs, additional health information and administrative processes are concerned. Filipino immigrants create their own way to address these blocking matters. However, the their own way of doing it takes time and tend to be more confusing.

A culturally sound diagnostic tool made up of language that is culturally neutral will surely be of help. Tone of voice, body movement and eye contact must also be reinforced to healthcare providers to gain trust and confidence of patients. When a medical professional shows aggressive behavior, chances are the patients will shut down. Even if they have the capacity to explain their condition in broken French, intimidation and frustration gets the better of them. Language adjustments must be done both by the immigrant patient and the whole French health care system. After

all, it is also the recommendations of several health organizations that have studied the entire European health system.

6. French health system and its role in immigrants health

Several studies have concluded that the countries with the best health care system in the whole world are Canada and France. In terms of immigrant assimilation, the scenario changes: Canada has been applauded for its good policies in immigrant assimilation, while France was reduced to a country whose policies regarding immigrants should not be emulated. Despite this however, Canada and France enjoys positive patients response when it come to the health care delivery, and the immigrant is part of the patient population. In France, there was finding that in the past 30 years, patients health have deteriorated, yet in the year 2000, France health care was heralded as the best in the world. Evidence has suggested that patients' satisfaction can be attributed to the accessible health care and the benefits of a Universal health care coverage. When it comes to healthcare providers service, it is a different story. French health care professionals were not able to connect with their patients, because they do not have enough information about who their patients are. If this is what empirical studies have revealed, and those studies are concentrated on immigrants with the higher population share- it is impossible to imagine the experiences of immigrant minority groups like the Filipinos. Moroccans, Algerians, South Africans are majority immigrants in France. When studies about immigrants are set, it is basically talking about this group of people-the majority immigrants. The advantage of these immigrants is that they speak the language. If they are claiming that they are not fully integrated in the French society, they do have limited social activity, they self –report that their health is deteriorating- the health experiences of Filipino immigrants as a minority group is problematic. There have been no research studies about health status of minority migrants in the French Riviera and its effect is the invisibility of their experience.

The French health care system has high satisfaction ratings due to the dynamics between preventive seeking behavior of patients and the cure driven mentality of the state. This means that even if patients wants to engage in disease

prevention activities, their access to preventive information and prevention medications are limited. Therefore, they either self-medicate, look for informal source of medical information (e.g. internet, friends and family members, similar experiences of people) which often lead to a more serious medical condition later on and the states' only option is to respond to a more complex health condition of the patient. It is often the vulnerable groups, immigrants in particular who are more prone to situations like this. This can be attributed to language barrier, limited social activities, immigrants tendency to be inclusive- participate only in their social circle, the states tendency not to prioritize social integration programs and the lack of promotional information educating the locals about the social, cultural and economic contribution of the immigrants. The later will enlighten the citizenry of the presence of the immigrants in their community at the same time give immigrants a sense of pride, knowing that their contribution to the French society is being recognized.

Over all, the French health care system is effectively responding to the curative approach of the immigrants. This means that the Universal health coverage of France is doing what it is suppose to do. The downside of this system however is the high maintenance cost shouldered by the government and the continued deterioration of immigrants health. The decline is due to several factors that include late diagnosis, under diagnose and continued lifestyle conducive to developing diseases.

7. Barriers to a successful immigrant health assimilation

It cannot be stressed enough that the primary barrier in immigrants' health assimilation is largely language proficiency. On the other end, the states' lack of standardized health monitoring system, absence of culturally sound diagnostic procedure and the lack of training of medical professionals on how to handle culturally diverse population, post as a huge barrier in immigrants health assimilation. Specifically citing the experiences of Filipino immigrants in the South of France, it should be reiterated to them that there is a need to learn French even if they are working in an English speaking environment. The fact that they are in France, they are obliged to learn the language so they can be fully integrated to the French way of life.

Healthcare professionals should also update their knowledge regarding racial compositions of the community they are serving and re-evaluate their take on their job as public servants. The attitude of health providers should be geared towards serving the public. Filipino immigrants on the other hand should also realize the culture of French pertaining to their people skills. French have the reputation of being distant to the point of being rude. This trait is not exclusively performed for immigrants but it is an endemic part of their culture. They are not service oriented and this contradicts with the servitude culture of the Filipinos. However, since Filipinos are people pleasers they do not complain so not to incite debate. They take what they want and leave. For the French, they perform their work with pride and since they do not hear complains or corrections from the community they are serving, they are under the impression that all is well.

8. Altered treatment combinations

Filipinos often mix traditional treatments with western medicine. Now that they are in France, the treatment combination is still practiced but in the form of medical doctor and another medical practitioner. A patient who seeks doctors' advice also goes to a physiotherapists or an osteopath upon doctors' recommendations and they are often compliant. This ensures that the patients overall well being is taken cared of, and their health complains, addressed. Patients are more confident that they are on top of their health because all areas are covered. Everything is on their side: doctors, specialist, osteopaths and physiotherapist as well as free medicine.

Having all of these available, Filipinos have a wider range of options and their choices are leaning more towards being more medical than traditional. This goes to show that when medical treatments are available, Filipino immigrants gravitate towards these medical treatments above anything else. Although some Filipino immigrants still opt for traditional healers, they are lesser in number and often, they only resort to it as a complimentary treatment for medical treatment instead of the other way around, which is how it used to be when they were still in the Philippines.

Part 2: General Findings

A. Addressing Health Issues in France

In December of 2009, this researcher had the opportunity to interview Mr. Fabrice MOREAU, Chargé de Mission Communication Nutrition Département de la Communication Direction de la Communication et des Outils Pédagogiques {In Charge of Communication, Department of Communication, Health Ministry of France} (Appendix 6). He mentioned that health campaigns of the government are based on epidemiological studies. As health practices are based on health beliefs, they often asked the population what can make them change their mind and eventually their unhealthy habits? He cited the example of people not eating enough fruits and vegetables. They survey people from low -income bracket to find out their challenges in not eating fruits and vegetables and the answer is that they find it expensive. To address this issue, his department then will create communication campaign that says frozen and canned fruits and vegetables is the answer to the expensive fresh products. They will then communicate this to the target public utilizing both above the line and below the line advertising platforms. They also work closely with other institutions, state based or private organizations to maximize the spread of information.

This is just an example of how a state health institution operated within the framework of the French health care system. No different from how other countries are doing it, contents of health communication campaigns in France are highly based on epidemiological studies in close cooperation with stakeholders. The results of these consultations however, do not reflect the experiences of minority migrants, because until today no health campaigns are targeted to them. Using the same principle, extracting information from the grassroots and developing a health campaign based on their belief system, diet, cultural orientation and religious sensitivities health communication designers in France will get into the very core of immigrants lives which might open the opportunity for them to change unhealthy

behaviors and inspire change. The positive result of this will spill towards other behaviors related to the promotion of a more healthy lifestyle.

B. Challenges of the French Healthcare system that affects immigrants

All across Europe, immigrants are generally younger, poorer, most likely to become ill from communicable disease and have less access to health services. (European Health Report 2012). To add, immigrants work choices are limited and as a result, they are more exposed to jobs with less-takers and they often settle for lower pay. This condition creates a snowball effect which include limited choices in homes, food, education and even re-creation.

The current challenges of health care system in France will directly impact on patients more so the immigrant population. Medical doctors are not happy with the current standard professional fee set by the government. As such, there are some who already raise their tariff even without permission from regulating bodies. Doctors are even on strike on over-the-hours care.

If doctors are abundant in France at the moment, it might not be the case in the future. French medical schools have set a quota for how many medical students will be allowed to register. This is a major concern in the future considering that the population in France is ageing and the over-all fear of less supply of doctors in the future. If one of the strong points of the French healthcare system today is the accessibility of doctors and patients can visit them as much as they want, in the future, patients might need to wait for a few days before they can talk to one. Imagining this scenario and putting immigrants in this picture creates an alarming effect on immigrants health.

There has also been a move to strengthen patients' participation in the health care system of France to encourage responsiveness and accountability. This ideology is an ongoing debate and the system seems not to be ready to hear the patients' voice. For a country which was founded on liberte (freedom) egalite (equality) and fraternite (brotherhood), it is difficult to believe that patients voice is muted in its healthcare system.

Changes in the over-all make up the French health care system also have an impact on delivery of programs and financing of projects. Since the reform in 1996 giving the power to the state (from the national insurance scheme) and then from the national to the regional level, there has been much discussion and confusion around this area. This mixed system is accused to have caused premature and avoidable deaths.

In terms of financing, this a major concern for the future because of budget deficit and increasing costs of medicine and medical procedures. With new technologies that are created everyday, the costs of health maintenance is skyrocketing coupled with the increasing and diversifying demands from the population. With each concern group rallying behind the importance of preventing certain disease, the French government will have a hard time determining which projects to fund and prioritize. On top of it all, budget should also be reserve for emergency cases like in case of epidemic outbreak as well as regular epidemiological research.

All of these affect the status of immigrants' health in France. Sadly, the future looks dim at the moment because of the fast changes that are taking place adding to the volatile economy that surely changes the ball game. The system needs to adapt to the changing time and in the process, some areas are sacrificed.

Chapter Synthesis

Chapter VIII presented the rich findings of the study and how it addressed the hypotheses and the research objectives. In a nutshell, the research found out that language is not the main blocking matter that discourages Filipino patients to seek medical help, but the attitude of healthcare professionals in delivering health service. Filipino immigrants were able to remedy the language barrier by going to English speaking doctors or bringing their own friends to act as translators. Their major concerns was when they go to public health offices to seek health information, face to face contact with health professionals is often blocked by human factors like the lack of willingness to serve. Auxiliary medical professionals seem not to realize that the position they are occupying is a service position and not a seat of privilege to exercise prejudice on the community they are serving. Findings also highlight the seeming lack of communication between health institutions and immigrant groups. This can be partly attributed to the fact that there is no mandate from higher authorities to carry out programs to lessen the gap between health institutions and immigrant groups. By actively participating (under the condition that local authorities know the existing immigrant groups in their area) in immigrant activities, local authorities will have a feel of how the immigrants' live, their way of life, things they believe in and from there make a concrete recommendation of what health issues should be prioritized and how to effectively cascade the message to a particular group. This researcher strongly believes that there is no other way but this if governments are serious in protecting the health of its citizens and save a lot of money. Despite these challenges, Filipino immigrants are satisfied with the kind of health services available for them and are highly contented with how the healthcare system in France is including immigrants into the community they are serving. This satisfaction is translated into the perception that they are taking better care of their health because of the availability of health services and medicines. This has to be challenged though because this a self-reported state of good health and not proven through research. This statement is contradictory to the report that stated immigrants health has deteriorated over the past 30 years.

The influence of traditional health belief system of Filipino immigrants in the Riviera is also losing its grip because of the availability and practicality of western medicine. It is safe to say that for the Filipino immigrants in the South of France, it is the hard science of medicine that eats up the traditional beliefs and not the other way around. This is due to the very nature of the French health care system which is highly medical. Given this scenario, this immigrant groups perceived that they are now taking better care of their health because they know they have access to care. This perception is all in their head because result from this research show that there is no significant difference in the number of times they visit doctors now that they are in France and while they were still in the Philippines. The big difference lies in the way they are compliant in medicine intake and change in lifestyle.

One interesting findings of this study is the huge communication gap that exist between health providers and immigrant patients. French are not known to be a highly hospitable race and the French themselves are aware of their own characteristics. The importance of people skills should be reiterated especially to those who are in the service industry including the area of health.

CHAPTER IX

Recommendations

Based on the findings of this research, here are the recommendations that aim to assist healthcare providers and patients to bridge the gap that affects delivery of care and health management.

1. Creation and Implementation of culturally sensitive communication guide for French medical professionals and care providers

Here are some guidelines worthy of consideration in the planning of this guide:

- A. *Warm greetings from the part of the provider to make the patient feel at ease.*

French medical professionals and providers have to always be conscious that an immigrant patient has to overcome a lot of anxiety before finally deciding to visit a doctor and the last thing they need is a dismissive behavior. It will surely shut them down and will try to cut the consultation fast when they feel unease with the consultation. For the auxiliary medical staff especially those who are working as front liners, an ounce of extra patience is required when dealing with patients who are not native French speakers. For the first time health information seekers, auxiliary medical staff should be ready to spend as much time as needed to address all concerns of the patients. Rushing the session with them will only make matters worst because if they will not understand the information given to them, they will be more confused than clarified. As a result they will come back anyway or worst they will express their agitation and frustration in a way that will irritate the others too, exactly the things that should be avoided. A firm handshake or a welcoming smile while looking in the eye would make every patient feel accepted and important. Spending time answering each question, making sure everything is understood will surely help both parties.

- B. *Give the patient more time to talk about his health concerns and manifest encouraging verbal and non-verbal cues*

This is a good way to better understand the health issues of the patient and at the same time gives the health provider a glimpse of the psychology of the patient

which can lead to a better diagnosis and prognosis. Knowing the personal, cultural and religious background of the patient – especially immigrant patients-should be the primary step before moving any further in the health management process.

C. Directly tell the patient that the doctor/ medical staff is open for questions and clarification

This will encourage the patient to clarify concerns not very clear. It was stated earlier that Filipinos by nature are very shy people and as such, they seldom ask questions especially in this scenario where they might have trouble finding the right word to express their thoughts. Verbally stating they are free to ask questions, will encourage patients to express their thoughts even though they know there is language barrier. Telling them that doctors/ staff will try to understand them even if their French is not good might encourage patients to try to be understood and might use other tools to communicate like non-verbal tools. All they might need to hear is that the medical professional have the patience and the time to listen to their questions.

D. Ask follow up questions after explaining a health concept to make sure the patient understand what the doctor/medical staff just said.

Inviting patients to echo what the medical professional just said is one way of measuring how they understand what was just explained to them. Doing this will make sure the patient know what to do next.

E. An interpreter/translator should be made available.

If the patient is comfortable with the idea of having an interpreter or a translator, it should be afforded to him. It is his right to access information and this information is not understandable for him, it is the responsibility of the state to provide him with someone who can interpret and translate for him. Not providing that is a form of discrimination. Although at the moment, it is the patients who bring their own interpreter/ translator, it is the state who have greater responsibility to provide this service. This interpreters and translators should also be trained by the state to make

sure they know the health guidelines of the government regarding the immigrant population as well as the sensitivity to the culture of these people.

F. Advice the patient to prepare their questions in the next visit and report any changes

Patients can be better actors of their own health if they will be encouraged to monitor their own health and report to the doctor any significant changes that feel or have observe. Preparing a list of questions and keeping a record of health concerns will make things easier, clearer and faster for both the patient and the doctor in the next visit. Having a record would also provide patients with their own record which they can refer to anytime they want. It can be an online data base where they can have an access or a booklet (like baby health books that keeps tract of all their immunizations and doctors visit) that will make them more in control of their own health.

Inform the patients to that if there is an online application that they can use that would automatically translate the one language to another. A Filipino patient can write in Tagalog and the application will automatically translate it into French. This application is readily downloadable on smart phones too. This bridge the language divide in a way not possible before. The first way to do it is to spread the information that online translation is possible.

2. Dissemination of health materials to immigrants entering France.

Having concrete ideas on how to access health information will surely avoid immigrants confusion and anxiety. This health information can be but not limited to:

- a. general information about healthcare in France
- b. location of health offices in the area where the immigrant intends to stay
- c. list of doctors who speaks other language than French
- d. guidelines and procedures on how to register to the Universal Health coverage
- e. patients right and obligations
- f. access to medicines
- g. filled up form that they have read and understood how the French health care system works before they be awarded the Carte Vitale.

3. Encourage and support immigrant research programs

One major criticism of the French health care system is its lack of standardized data collection system about immigrants. This is a blind spot that needs to be addressed if the French government is serious in combating problems related to immigrants' health. The 2005 incident is a wake up call for the French government about the sentiments of immigrants in France and this kind of protest should at all cost be avoided for it feeds immigrant discontent in the country. This for sure does not reflect a good image of France on how it is handling its immigrant population.

Encouraging and supporting immigrant scholarship is another step in lessening the divide between the state, the native born and the immigrants in France. In the area of health, understanding the cultural -make up, religious beliefs and personal preferences of immigrants will provide the health system of France rich information on how to encourage immigrant population to lead a healthier lifestyle and subscribe to the programs set by the government. It can also provide baseline data that will best set the guidelines for other health programs targeting specific immigrant groups.

4. Pilot programs for the use of institutionalized translators/interpreters.

As set by other countries, a translator has its share of success stories as far as mediating between doctors and patients. It is important to realize that health care is a basic human right. As such, patients are entitle to quality health care from provides. Lack of available translators for non-French speakers can be considered a form of discrimination for they are considered one in the Unites States. A country who opens its doors to immigrants are oblige to set rules to accommodate the needs of these immigrants. In situations where immigrants do not speak the language of the host country, it is the states' responsibility to provide educational programs that would teach language proficiency to new comers. In the transition period, these immigrants should be provided with people who will transact business on their behalf especially in government offices. To avoid unscrupulous people from taking advantage of this window of weakness, translators and interpreters must be trained and provided by

recognized state authorities to make sure the information that would reach the immigrants are the correct ones.

5. Strengthen language proficiency requirement for immigrants

There are a lot of organizations in France who assist immigrants to be able to fast track integration. The challenge is that immigrants have limited access (or completely do not know these organizations) where to get the lists of this organizations and how to get in touch with them. As immigrants arrived in the Riviera, they rely on other people for advices regarding almost everything. It would be more organized if immigrants will be briefed by a designated organization to orient them on the ABC's of living in France that includes what to expect from the region, culture, food, state support, as well as expectations of the state from the immigrants. It will be extremely helpful for immigrants to have guidance during the early stage of their stay.

The language barrier is being addressed in the South of France for there are several organizations whose aim or mandate is to give language courses for a minimal fee. Some of these organizations are state funded some legitimate language school like Alliance Francaise and some are operated by private citizen groups. It is obvious that the infrastructure is there but the information that they exist is not well disseminated for immigrants do not know about them especially the new ones.

Since language is the main step towards integration, language organizations must be introduced to the immigrants as easy as possible, for them to know which schedule, location and institution meet their needs. At the same time, this researcher highly suggest that employers of immigrants provide or include French language trainings to their immigrant employees and set – up a monitor language trainings of immigrants.

It has been strong and repeatedly reiterated that language proficiency is a major requirement for immigrant assimilation. To be able to better assist immigrants to learn the language, the state must tell the immigrants the way to do it and which organizations can help them. Telling them that they need to learn French but not giving them the steps on how to do is another exercise in futility.

6. Strengthen relationship with immigrants organize groups

Reaching out to immigrants through their organized associations or groups can be one effective way of communicating with the community. Having a strong presence in the activities of immigrants can open opportunities for other collaborations at the same time making the immigrants feel that the state is hands – on and serious in its effort to take care and listen to their needs. By being actively involve in immigrant activities, French institutions (or people) will have a first hand experience about the intricacies and uniqueness of these people which needs to be highly considered in any campaigns intended for them.

There are several Filipino organized organization in the South of France and they have regular meetings and activities that celebrates important events as an immigrant. They have strong member support and some of their events were attended by officials from Philippine Consulate in Monaco (there used to be a Consular Office in Nice but it was dissolve in 2010 and has not been re-created up to this date) but this researcher has never heard that a French political figure ever graced their event. This says a lot about the relationship between the local government of the Cote d’Azur and the Filipino immigrant groups. Maybe it is about time to reach out to one another and bridge the gap. After all, Filipino are already a part of the local French society in terms of their presence (and not as participant in societal affairs) even if they are considered a minority immigrant group.

Chapter Synthesis

The findings of this research crystalized into this chapter that contains the recommendations of the researcher.

General suggestions include the creation of culturally sensitive programs that would better prepare health professionals and providers in handing patients with different cultural background. Local health institutions can also implement different communication campaigns in their area. This researcher is suggesting dissemination of health collaterals to immigrants or visitors entering France. They should be briefed on what health services to expect now that they are entering France. Studies focusing on immigrant health must also be given priority since this will provide baseline data on what is happening on the ground. In as much as resources are made available for the discovery of new medicines are made available, funding for epidemiological studies should also be strengthened since diseases are not only medical but also highly cultural.

Addressing the barrier of language will surely lessen (if not eradicate) the gap between medical professionals and patients. Assigning an interpreter in health clinics has surely proven its merits as reported by different researches. Canada and the US have its share of success and this strategy can also be adopted in France. On top of this, the state should empower the migrants by strengthening the campaign for language proficiency. A well planned and properly implemented language programs for immigrants with clear vision of what it wants to achieve, will help lessen the language divide leading to a better understanding of one another. Local governments should also take advantage of organized immigrants groups. By working closely with these groups, health campaigns, immigrant data collection etc. can easily be coordinated.

CHAPTER X

Summary and Conclusion

In studying the relationship between immigrants and sociology of health, there is a term called “internal colonialism” which referred to the similarity of treatment of minority groups within a country and of native peoples by foreign colonizers²⁴⁶. In today’s period of human history where no country is colonizing another (at least in the traditional definition of the term), colonization is taking a different form. Mass immigration of people in one country can be considered a modern form of colonization. These immigrants moved into a new country, bringing their own cultures and traditions influencing the way of life of the host country. This results into a new form of psychology, creating a new cultural phenomenon.

Under this condition, “reverse colonization” is happening. This term coined by this researcher refers to the gradual penetration of immigrants in the country slowly changing the very fabric of the local population’s way of life. In the past, colonizers are those who are powerful and more advanced in terms of weaponry, education and naval ships that enable them to reach far off lands; assert command and demand subordination from the natives of the land they set foot on.

In today’s world, the rule of the game is changed. Colonizers are those who came from less developed countries, settled in a host country and develop their own way of life. They often came in few but through the years, they were able to create their own community and demand integration from the country they chose to settle in. Integration and assimilation becomes their right and in some case, protected by the supreme law of the country they now belong to. The process of integration is often long and sometimes leads to violent protest like in the case of immigrant rallies in the

²⁴⁶ Weitz, R. (1996). *The Sociology of Health, Illness and Healthcare: A critical Approach*. Wadsworth Publishing Company. U.S.A. p 77

UK and France. When this happens, the host country has no other option but to promulgate laws that would secure proper integration of these immigrants'. Reverse colonization happens almost unnoticeable because these new breed of colonizers did not come loudly proclaiming that they will rule and take over. They remained passive, studied the internal movement of the country they move into. Upon knowing what is rightfully their rights as immigrants, demanded what due them. Integration however is a metanarrative. It is a huge concept that needs to be shredded into pieces first before arriving at a valid definition- if there will be any. The process however is highly complex and tedious. As such, host countries try to strike a balance between protecting its immigrants while preserving its own culture. It is undeniable however, that the over-all landscape of the host country will change to accommodate the needs of the immigrants'. As expected some sectors of the society of the host country are not happy about it but the influx of immigrants can only be managed for immigration is inevitable- is here to stay.

In the early stages of integration, confusion and anxiety are high for the immigrants because of uncertainty and on this phase, strong intervention is needed both from the government of the host country as well as private organizations that assist immigrants. As far as France is concerned, its government should strengthen health campaign to educate the new comers to give them the right information for them to know how to operate within the French health care system. A lists of offices where information for immigrants are available, and lists of doctors who can be of better help for the patients because they speak other languages and other support groups will surely be the best way to encourage the immigrants to know where they stand in the health system of France. This can also be a way to lessen health care cost. The Universal Health Insurance in France mandates that everyone has access to healthcare. True that the issuance of *carte vitale* monitors those who can only be given care, but it does not address the problem of late diagnosis that leads to urgent emergency care. It has been established that patients seek medical help often when it is too late, and this costs the government because the medical assistance that the patient needs involves pricey medical tests, hospitalization and highly potent drugs which are often very expensive.

Longitudinal studies should be encouraged to determine health performances of immigrants through time and on a per race basis. This might be an ambitious academic endeavor but there is nowhere else to go. It should be done to address a myriad of health concerns regarding immigrants' health behavior and performance, cultural preparedness and sensitivity of health professionals as well as health expenditure.

Reverse colonization has been happening unnoticeable for a very long time. It is only now that it is being given attention because immigrants' issues took center stage when they aired their grievances outside of the traditional peaceful means. Today, they are not the almighty and powerful countries which are the invaders. Rather, are the people from small countries who silently move into a bigger more stable countries and start their colonies there. Their presence has change and will continue to change the landscape of the host country. If that is a good or bad thing, this researcher believes that is would be a very interesting Doctoral research.

In the area of health which is often a priority service by governments, managing and disseminating information for the immigrants is a complex and sensitive process. Multiple approaches are needed to address both the concerns of the immigrants and the balance that the state has to maintain. What this study has been fervently proposing is the experimentation and start of immigrant health data collection per race to be started in the French Riviera which can be later on emulated in other parts of France. Lumping immigrants into one homogenized group does not do justice to the term itself because within the word lies oddities and peculiarities inherent into the very fabric of the word immigrant.

This research is a communication study above anything else because it has proven time and again, that communication is at the very center of health discussion. From health research to health campaign implementation, the principles of communication apply.

It is worthy to mention that this researcher, upon her visit to one of the libraries in Barcelona, Spain (Biblioteca Jaume Fauster, Plaza Lesseps) she found one very

interesting information collateral (Appendix 13) that is written in Filipino. This flyer contains basic information on how to use the resources from the library. What is interesting in this very simple print –out is the recognition that there are people living in Barcelona who do not speak Spanish or Catalan. The Local government of Catalonia specifically identified Filipinos as one of the immigrant groups who are part of the community. Through this very simple act of, the Filipino community felt that they belong and that they are recognized as part of the population.

Materials like this should be made available in institutions where immigrants flock and where information is needed the most. It cannot be denied that health offices need this material the most since there is no greater place of urgency than a health clinic or a hospital.

With the fervent desire of this researcher to put her research results into actions, she did not hesitate to propose a health project to the Director de la Sante Publique through the office of the Mayor of Nice (Appendix 14). She proposed a project with the following objectives:

1. to determine the state of Filipino immigrants health in the region
2. to find out the health challenges faced by Filipino immigrants
3. to determine how responsive are the current government health projects to the health needs of immigrants; and
4. to make recommendations on how to address immigrants' health needs

She believed that this is a pioneering project because a health research focusing on a specific migrant group has never been done by any department in France. After a few weeks, the Direction Generale Adjointe du Vivre Ensemble et de la Proximite sent their answer to this researcher that the proposal was sent to the person in charge. When there is a call for projects like what I have proposed, they will let me know. This researcher is not oblivious to the fact that the opportunity to make her proposal a reality may not come. However, she can never be blamed for trying.

Chapter Synthesis

The last chapter of this study talks about how a silent social phenomenon is taking shape. The researcher takes the idea of internal colonization where foreign colonizers similarly treat minority group and native people within a country. Obviously this philosophy existed during a specific era in human history, when colonizers came in mighty Viking-like ships, claimed the land and proclaimed themselves superior. Time has changed and colonization is no longer a proclaimed act of taking.

The researcher toyed with the idea of internal colonization and created the term “reverse colonization” which connotes silent take over. This concept applied within the context of immigrant assimilation, suggests a gradual change in the system of the host country without the grandeur and loudness of a proclaimed colonization. Instead, reverse colonization slowly weaves itself into the very fabric of the host country. There will come a time when the rights of the immigrants and that of the native population became one and the same. Identifying where the other starts and the on the other one ends will be an impossible task to determine. The only thing that can be done is to manage the changes and strike a balance in order to keep social equilibrium. To achieve this however requires a complex process of working together.

The researcher also showed her desire to put the result of her research into practice. By submitting a proposal to the department in charge of Public Health, her desire is to carry on a research that would address key health issues of Filipino immigrants in the area. With a promise from the local institution that when there is a need for such research - she will be informed but all she can do for the meantime is to wait.

Selected Bibliography

Books

- Abel-Smith, B. et al (1995). *Chopices in Health Policy: An Agenda for the European Union*. Luxembourg: office for Official Publications of the European Communities/ Aldershot: Dartmouth Publishing Co.
- Adler, R. B. and Rodman, G. (1991). *Understanding Human Communication*. Holt, Rinehart, and Winston. Chicago
- Abraham, L. (1993). *Mama might be better off dead. The failure of Health Care in Urban America*. Chicago. University of Chicago Press
- Agoncillo, T., & Guerrero, M. (1987). *History of the Filipino people*. Quezon City, Philippines: Garcia Publishing Company.
- Alba R, Nee V. 2003. *Remaking the American Mainstream: Assimilation and Contemporary Immigration*. Cambridge, MA: Harvard Univ. Press
- Ariola, C. (1993). *The body book*. Quezon City. GCF Books
- Babbie, E. (1998). *The Practice of Social Research*. 8th Ed., Wadsworth MA:Wadsworth
- Backer, T. & Rogers, E. (1993). *Organizational aspects of health communication campaigns: What works?* London SAGE Publication.
- Bandura, A. (1969). *Principles of behavior modification*. New York: Holt, Rinehart, & Winston.
- Barker, L. L. and Barker, D. L. (1993). *Communication*. Prentice Hall.
- Battistella, G. & Paganoni, A. (1992) (Eds). *Philippine Labor Migration: Impact and Policy*. Scalabrini Migration Center, Philippines.
- Bautista, V. et. al. (2002). *National and Local Government Roles in Public Health under Devolution*. UP Press.
- Begley, S. (1997). *Train your mind, change your brain*. New York. Ballantine Books
- Beltran, R. & Rodriguez G. (1996). *Filipino woman migrant workers: at the crossroads and beyond Beijing*. Giraffe Books, Philippines
- Berger P, Luckmann T. (1967). *The social construction of reality*. Garden City: Anchor Books
- Bersales, L. (2001). *Philippine health information system assessment using the health metrics network procedure*.

- Biddle, K., Locke, K. (2007). *Composing Qualitative Research: 2nd Edition*. SAGE
- Bauböck, R., ed. (2006). *Migration and Citizenship: Legal Status, Rights and Political Participation*. Amsterdam, the Netherlands: Amsterdam University Press, IMISCOE Reports
- Brubaker, R. (1992). *Citizenship and Nationhood in France and Germany*. Cambridge, MA. Harvard University Press
- Burgoon, M., Hunsaker, F. G., and Dawson, E. J. (1994). *Human Communication*. Thousand Oaks, CA; Sage
- Carey, J. W. (1989). *Communication as culture: Essays on media and society*. Winchester, MA: Unwin Hyman.
- Clifford, J. (1998). *The predicament of culture: Twentieth century ethnography, literature, and art*. Cambridge, MA: Harvard University Press.
- Corcoran, N (ed.) (2007). *Communicating Health: Strategies for Health Promotion*. London. SAGE Publication.
- Cruikshank, J.K. & Beevers, D.G. (1989). *Ethnic Factors in Health and Diseases*. Guildford. Wright
- Curran, J., Morley, D., & Walkerdine, V. (1996). *Cultural Studies and Communications*. NY: St. Martin Press.
- Daniel, L. (Editor, 2011), *The Far East and Australasia 2012. Europa Regional Surveys of the word*. 43rd Edition. Routledge London and New York
- Devito, J. A. (1994) *Human Communication: The Basic Course*. New York; HarperCollins.
- Elder J.P. (2001). *Behavior Change and Public Health in the Developing World*. Sage London.
- Epstein, S. (2007). *Inclusion: The Politics of Difference in Medical Research*. Chicago. University of Chicago Press.
- Evans, D. (2004). *Placebo*. London. Haper Collins
- Faas, D. (2010). *Negotiating Political Identities. Multiethnic Schools and Youths in Europe*. Farnham. Ashgate.
- Feldman, J. (1966). *The dissemination of health information*. Chicago: Aldine.

- Ford, L., Yep, G. (2003) *Working along the Margins: Developing Community Based Strategies for Communicating about Health with marginalized Groups*. Thompson
- Fremont A, Lurie N: The role of racial and ethnic data collection in eliminating disparities in health care. In *Eliminating Disparities: Measurement and Data Needs*. Edited by: Ver Ploeg M, Perrin E. Washington, DC: National Academies Press; 2004:202-29, National Research Council Report.
- Gerrish, K. Husband, C. & Mackenzie, J. (1996). *Nursing for multi-ethnic society*. Buckingham, Open University Press
- Glaser B.G., (1978). *Theoretical sensitivity*. Mill Valley, CA. Sociology Press
- Glaser B.G., (1992) *Basics of Grounded Theory Analysis: Emergence vs Forcing*. Mill Valley CA. Sociology Press
- Geist-Martin, P., Ray, E. & Shaft, B. (2003). *Communicating health: Personal, cultural and political complexities*. Canada: Thompson-Wadsworth.
- Gerstle G, Mollenkopf JH. (2001). *E Pluribus Unum: Contemporary and Historical Perspectives on Immigrant Political Incorporation*. New York: Russell Sage Found.
- Gilroy, P. (2000). *Against race: Imagining Political Culture beyond the color line*. Cambridge, MA. Harvard University Press
- Griffin, E. (2009). *A First Look at Communication Theory* (7th ed.). New York, NY: McGraw-Hill.
- Griffin, E. (2008). "Speech Codes Theory." *Introduction to Communication II*. New York: McGraw-Hill Primis.
- Guide to Asian Studies in Europe. International Institute for Asian Studies. 1998. Curzon Press. The Netherlands.
- Hall, P.A and Lamont, M. eds. (2009). *Successful Societies: How institutions and Culture affect health*. Cambridge UK: Cambridge University Press
- Hall, S. (1997). The local and the global: Globalization and ethnicity. In Anthony D. King (ed.), *Culture, Globalization and the World-System: Contemporary Conditions for the Representation of Identity*. Minneapolis: University of Minnesota Press.
- Hall, S. (1992a). New Ethnicities. In J. Donald and A. Rattansi (eds). *Race Culture and Difference*. London. Sage.

- Harrington, A. (Forthcoming). God and health: What more is there to say? In *Spiritual Information 100 Perspectives on Science and Religion*, Vol. 2, ed. C. L. Harper Jr. Philadelphia: Templeton Foundation Press.
- Harper, D. *Chicago Manual of Style* (2010). 16th Edition. University of Chicago Press
- Heibert, D. 1999. *Local Geographies of Labor Market segmentation*. Montreal, Toronto, and Vancouver. Economic Geography
- Hopkins, A. & Bahl, V. (1993). *Access to Health Care for people from black and ethnic minorities*. London. Royal College of Physicians
- Jackson, L. & Duffy, B. (eds) (1998). *Health Communication: A guide to the Developments and Directions*. Greenwood Publishing Group, Inc.
- Jocano, F.L., (1973). *Folk Medicine in a Philippine Municipality*. An analysis of the system of folk healing in Bay, Laguna and its implications for the introduction of modern medicine. The National Museum. Manila
- Jocano, F. L., (2001). *Filipino Worldview: Ethnography of Local Knowledge*. Punlad Research House Inc. Manila
- Johnson, M.R.D. & Verma, C. (1998). *Its our health too: Asian men's perspective*. Research Paper 26. Coventry: Center for Research and Ethnic Relations. University of Warwick.
- Kelly, P. 2012. Migration, Transnationalism and the space of class identity. *Philippine Studies* 1:154-185
- Kaba, M., (1996). *Utilization of Plant Medicine for the Treatment of Health Problems: The case of the Oromo of Chora District, Illubador Region Western Utopia*. Medical Journal of De La Salle University
- Kanseras, P. & Hopkins, V. (1989). *British Asians' Health care in the Community*. Cardiff.
- Kibria N. 2003. *Becoming Asian American: Second Generation Chinese and Korean American Identities*. Baltimore, MD: Johns Hopkins Univ. Press
- Kosa, J., Antonovsky, A., & Zola, I.K. (1969). *Poverty and health: A sociological analysis*. Cambridge, Harvard University Press.
- Kreps, G.L. (1988). The pervasive role of information in health care: Implications for health communication policy. In J. Anderson (Ed.), *Communication Yearbook* 11, (238-276). Newbury Park, CA, Sage.

- Kreps, G.L. (1990). Communication and health education. In E.B. Ray & L. Donohew (Eds.), *Communication and health: Systems and applications*, 187-203. Hillsdale, NJ: Lawrence Erlbaum.
- Kreps, G. & Kunimoto, E. (1994). *Effective Communication in Multi-cultural Healthcare Settings*. London. Sage Publication
- Kreps, G.L. & O_Hair, H.D. (1995). *Communication and health outcomes*. Cresskill, NJ: Hampton Press.
- Kress, Gunther. (1985). *Linguistic Processes in Sociocultural Practice*. Geelong: Deakin University Press.
- Lancry, P.-J. & Sandier, S. (1999). Twenty years of cures for the French health care system. Health care and cost containment in the European Union. E. Mossialos and J. Le Grand. Aldershot, Ashgate.
- Landy, D., (1977). *Medical System in Transcultural Perspective. In Culture, Disease and Healing*. Ed. David Landy, New York. Hackmillan Publishing
- Littlejohn, S. (2002, 2001). *Theories of human communication*. USA: Wadsworth.
- Littlejohn, S. & Foss, K. (2005). *Theories of human communication*, (8th ed). Canada: Thompson-Wadsworth.
- Levitt P. (2001). *The Transnational Villagers*. Berkeley: Univ. Calif. Press
- Macdonald, C. 1977. *Une Societe Simple. Parente et Residence chez les Palawan, Philippines*. Institut d'ethologie. Paris
- Marcus, G.E. & Michael, M.J. 1986. *Anthropology as cultural Critique*. Chicago. University of Chicago Press
- Marmot, M. (2004). *The status syndrome*. New York: Henry Holt &Co.
- Martinez, E. (2006). *Stop RB: A comprehensive analysis of tuberculosis communication campaign*. World Vision ReachOut Foundation and the Department of Health, University of the Philippines.
- McBride, M., Morioka-Douglas, N., & Yeo, G. (1996). *Asian/Pacific Islander American elders (2nd ed.)* SGEC Working Paper # 3, Stanford, CA: Stanford Geriatric Education Center.
- McGuire, W.J. (1984). *Public communication as a Strategy for Inducing Health promoting behavioral change*. Preventive Medicine, 13, 299-319,

- McGuire, W.J., (1969). *Attitude and attitude change*. In G. Lindzey & E. Aronson (Eds.), *Handbook of social psychology* (2nd. ed., pp. 136-314). Reading, MA: Addison-Wesley.
- Mendez, P. & Jocano, L. (1991). *A Philosophy of Education for Filipinos*. Kayumanggi Press, Manila
- Miller, K. (2005). *Communication Theories*. New York: McGraw Hill
- Mishler, E. (1981). *Critical Perspective of the Biomedical Model*. In Brown, P. (Ed). *Perspective in Medical Sociology*. Belmont. Wadsworth. pp 153-166
- Modood, T. (2007). *Multiculturalism: A Civic Idea*. Cambridge. Polity Press
- Nardin, D., (1989). *France and the Philippines: From the Beginning to the End of Spanish Regime*. National Historical Institute. Manila
- Palaganas E., Bagamaspad, A., Cardenas, M., Josef, J., Tolentino, L.(2001). *Mainstreaming Health Knowledge and Practices*. University of the Philippines, Press. Center for Investigative and Development Studies. Quezon City
- Panganiban, J., (1972). *Diksyunardo Tesouro Filipino-English*. Manlapaz Publishing Co. Quezon City, Philippines
- Parekh, B. (2000). *Rethinking Multiculturalism. Cultural Diversity and Political Theory*. London. Palgrave
- Pearce, W. B. (1989). *Communication and the human condition*. Carbondale, IL: Southern Illinois University Press.
- Pritchett, L. & Summer L.H. (1993). *Wealthier is healthier: Policy research working paper series, No1150*. Washington D.C. The World Bank
- Rechel, B. et al. (Eds). (2011). *Migration and Health in the European Union*. European Observatory on Health systems and Policy Series. Open University Press. McGraw Hill.
- Rodriguez, R., (2010). *Migrants for exports: how the Philippine state brokers labor to the world*. Minneapolis. University of Minnesota Press.
- Rodriquez, R., (2005). *Domestic Insecurities: Female Migration from the Philippines, Development and subject –status*. University of California.
- Schwarz, P. et al. (2010). *Diabetes Prevention in Practice*. TUMAINI Institute for Prevention Management, Dresden Germany

- Seale, C. (2004). *Health and the media*. UK: Blackwell.
- Simon, P. and Sala Pala, V. (2010). "We are not all Multiculturalists Yet: France Swings between Hard Integration and soft anti-discrimination" in S. Vertovec and S. Wessendorf (eds). *The Multi culturalism backlash: European discourses, Policies and Practices*. Abingdon and New York. Routledge.
- Singh, D.,(2011). (Ed). *Southeast Asian Affairs 2011*. Institute of Southeast Asian Studies. Singapore
- Smedley BD, Stith Ay, Nelson AR. EDS. (2003) *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*. Washington, DC: The National Academies Press; 2003.
- Tan, M.L., (2008). *Revisiting Usug, Pasma, Kulam*. Quezon City. University of the Philippines Press
- Tan, M.L., (1987). *Usug, Kulam, Pasma: Traditional Concepts of Health and Illness in the Philippines*. Quezon City . Alay Kilusang Pangkalusugan (AKAP)
- Tan, M.L., (1991). *The Philippine Health Matters*. Quezon City. Health Action Information Network
- Tan, M.L., (1992). *Philippine Health Matters 1992. Women Health in the Philippines – A Critical Analysis*. Quezon City. Health Action Information Network
- Taylor, C. (1992). *The Politics of Recognition*. In A. Gutmann, (ed)., *Multiculturalism and Politics of Recognition*. Princeton, NJ: Princeton University Press
- Thompson, T. et. al. (2003)(Eds.) *Handbook of Health Communication*. Lawrence Erlbaum Associates, Inc. New Jersey.
- Tichenor, P.J., Donohue, G.A., & Olien, G.N. (1970). *Mass media flow and differential growth in knowledge*. *Public Opinion Quarterly*, 34(2), 158-170.
- Tones K. & Green J., (2004). *Health Promotion, Planning and Strategy*. Sage London
- Tyner, J. A. (2004). *Made in the Philippines: Gendered discourses and the making of Migrants*. London: Routledge.
- Ulmer C, McFadden B, Nerenz DR, Eds. (2009). *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*. Washington, DC: National Academic Press
- Van de Water HP, Perenboom RJ, Boshuizen HC. (1996). Policy relevance of the health expectancy indicator: an inventory of European Union countries. *Health Policy*
- Waldron, J. (1991). *Minority Cultures and Cosmopolitan Alternative*. University of Michigan Journal of Law Reform 25

- Weitz, R. (1996). *The Sociology of Health, Illness and Healthcare: A critical Approach*. Wadsworth Publishing Company. U.S.A.
- Wilkin, R. (2005). *The impact of Inequality*. New York :Free Press
- Witkinson, R. (2005). *The impact of Inequality*. New York Free Press
- Wright, B., Sparks, L. & O' Hair. D. (2008). *Health Communication in the 21st Century*. Blackwell Publishing. M.A., U.S.A.
- Wuthnor, R. et al (1984). *Cultural Analysis*. London. Routledge and Kegan Paul.
- Zhou, M. (2001) *Progress, decline, stagnation? The New Second Generation Comes of Age*. In WALDINGER R. (ed.), *Strangers at the Gates. New Immigrants in Urban America*, Berkeley, University of California Press
- Zola, I.K. (1966). *Culture and symptoms: An analysis of patients presenting complaints*. *American Sociological Review*, 3, 615-630.

Internet Searches

- Ackerson, Leland K., and Kasisomayajula Viswanath. 2009. *Communication Inequalities, Social Determinants, and Intermittent Smoking in the 2003 Health Information National Trends Survey*. *Preventing Chronic Disease* 6(2): A40. <http://dash.harvard.edu/handle/1/4569479>. (accessed March 1, 2013).
- Allan M. Brandt. 1991. *Emerging Themes in the History of Medicine*. *Milbank Quarterly* 69(2): 199-214. (accessed March 1, 2013).
- Barnes, L., Hall, P. & Taylor, R. (2009). *Why is Wealthier Healthier? Perspectives on Europe* 39(2): 4-8. <http://dash.harvard.edu/handle/1/4322128>. (accessed March 1, 2013)
- Banting, K. et. al. (2011) *Are Diversity and Solidarity Incompatible? Canada in Comparative Context*. In *Roads 28. Diversity through three lenses*. Available online at: http://www.researchgate.net/publication/243964181_Are_Diversity_and_Solidarity_Incompatible (accessed February 2010)
- Batangan, D. (2005). *The Prices People have to Pay for Medicines in the Philippines*. Institute of Philippine Culture, Ateneo de Manila University, Philippines in collaboration with Health Action International/World Health Organization, Department of Health, Philippines. Retrieved July 21, 2009 from http://www.haiweb.org/medicineprices/surveys/200502PH/sdocs/survey_report.pdf. (accessed September 23, 2009)
- Bhopal, P. & Ronaldo, L. (1998). *White European, Western, Caucasian or What? Inappropriate Labeling in Research on Race, Ethnicity and Health*. *American Journal of Public Health* 88.
- Breslow, L. & Cengage, C. (2002). (Eds). *Noncommunicable Disease Control. Encyclopedia of Public Health*. eNotes.com. 2006. 7 Aug, 2010 <http://www.enotes.com/public-health-encyclopedia/noncommunicable-disease-control> (accessed January 2011)
- Braun, L. et. al. (2013). *Racial Categories in Medical Practice: How useful they are?* <http://dash.harvard.edu/handle/1/3008241> (downloaded March 1, 2013)
- Clements, B. (2011). *Global Trends in Basic Health Spending and the outlook*. International Monetary Fund. (<http://www.imf.org/external/np/seminars/eng/2011/paris/pdf/BClements.pdf>) accessed August 2013
- Cultural Competence Definition. <http://www.cdc.gov/socialdeterminants/Definitions.html> (accessed January 2012)

- Definition of Culture. Roshan Cultural Heritage Institute. <http://roshan-institute.org/474552>. Accessed March 2012
- Denler, H. et al (2013). *Social Cognitive Theory*. The Gale Group. <http://www.education.com/reference/article/social-cognitive-theory> (accessed August 2013)
- Dutton, P. (2007). *France model healthcare system*. Retrieved June 17, 2009 from United Nations Economic and Social Commission for Asia and the Pacific, <http://www.unescap.org/survey2007/notes/philippines.asp> (Accessed: Dec 12, 2009)
- Eamranond, P. & Hu, H. (2008). *Environment and Occupational Exposures in Immigrant Health*. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3091353/> (accessed September 2013)
- Erasmus Mundus Mobility with Asia (EMMA) is for funding Asia to Europe individual mobility flows (IMF) of academics from Partner Countries, fully sponsored by the EACEA run programme Erasmus Mundus External Cooperation Window. <http://math.unice.fr/EMMA/IsThisForMe.html> (accessed January 2010)
- Epstein, M. (1995). *After the Future: The Paradoxes of Postmodernism and Contemporary Russian Culture*. Available (31/11/99): <http://www.emory.edu/INTELNET/af.culturology.html>
- Farmer, P. (1996). *Social inequalities and emerging infectious diseases*. *Emerging Infectious Diseases* 2(4): 259-269. (Accessed March 1, 2013)
- France: 12 Million d'immigres et d'enfants d'immigres <http://www.lefigaro.fr/actualite-france/2012/10/10/01016-20121010ARTFIG00262-immigration-les-chiffres-de-l-insee.php> (accessed April 22, 2013)
- Frenck, J. et. al (2010). *Health Professionals for a new Century: Transforming Education to Strengthen Health Systems in an Interdependent World*. <http://nrs.harvard.edu/urn-3:HUL.InstRepos:4626403> (Accessed March 1, 2013)
- Guinea Worm Eradication Program. http://www.cartercenter.org/health/guinea_worm/index.html. (accessed March 6, 2014).
- Happiest people in the World:
<http://www.japantimes.co.jp/opinion/2013/01/06/editorials/happiest-people-in-the-world/#.UbHt0172in8> (accessed June 7, 2013)

- Harrington, A. (Forthcoming). *God and health: What more is there to say? In Spiritual Information 100 Perspectives on Science and Religion*, Vol. 2, ed. C. L. Harper Jr. Philadelphia: Templeton Foundation Press.
<http://dash.harvard.edu/handle/1/3996841>. (Accessed March 1, 2013)
- Definition and Measure of Health. International Academy of Classical Homeopathy.
<http://www.vithoukas.com/en/contributions-of-gv/definition-of-health.html>
 (accessed April 2012).
- Health and Health Insurance Survey (ESPS) 2000. Figures in mid 2000; this figure has since about 7%. Taken from
http://www.gesundheitspolitik.org/01_gesundheitssystem/ausland/gesundheitsysteme/HC-Systems-in-8-Countries.pdf. Downloaded August 2013
- Health Disparity: Definition. . <http://www.cdc.gov/socialdeterminants/Definitions.html>
 (accessed May 2011).
- Health Equity Definition. <http://www.cdc.gov/socialdeterminants/Definitions.html>
 (accessed May 2011).
- Health Inequality. Definition <http://www.cdc.gov/socialdeterminants/Definitions.html>
 (accessed May 2011).
- Hochschild, J. L. (2005). *Looking Ahead: Racial Trends in the United States*. *Daedalus* 134, no. 1: 70-81.<http://dash.harvard.edu/handle/1/3200608> (accessed March 22, 2013)
- House of the Representative. Republic of the Philippines. Fifteenth Congress. Committee Report number 664.
http://www.congress.gov.ph/download/basic_15/HB04244.pdf (accessed September 2013)
- ILO: *Towards a Fair Deal for Migrant Workers in the Global Economy*, Report VI, International Labour Conference, 92nd Session, Geneva, 2004; P. Stalker: *Workers Without Frontiers: The impact of Globalization on International Migration* (Geneva, ILO, 2000). <http://www.ilo.org/global/standards/subjects-covered-by-international-labour-standards/migrant-workers/lang--en/index.htm> (accessed March 9, 2014)
- Jorgensen, S., Thorlby, R., Weinick, R., and Ayanian, J. (2010). *Responses of Massachusetts Hospitals to a State Mandate to Collect Race, Ethnicity and Language Data from Patients: A Qualitative Study*. *BMC Health Services Research* 10: 352.
<http://dash.harvard.edu/handle/1/4889445>. (downloaded March 4, 2013)
- Kleinman, A. & Hall-Clifford, R. Forthcoming. *Stigma: A Social, Cultural, and Moral Process*. *Journal of Epidemiology and Community Health* 63(6).
<http://nrs.harvard.edu/urn-3:HUL.InstRepos:2757548> (downloaded March 1,

2013)

- Kleinman, A. (2010). *Four Social Theories for Global Health*. The Lancet 375 (9725): 1518-1519. <http://dash.harvard.edu/handle/1/5142663>. (downloaded March 1, 2013)
- Kreps, G. et. al. (1998). *The History and Development of the Field of Health Communication*. In L.D. Jackson & B.K. Duffy (Eds). Health Communication research. A guide to the development and direction. Westport, CT. Greenwood Press. pp 1-15. http://www.russcomm.ru/eng/rca_biblio/k/kreps.shtml (accessed February 2010).
- Lamont, M, & Small, M. L. (2008). *How Culture Matters: Enriching our Understandings of Poverty*. In *The Colors of Poverty: Why Racial and Ethnic In Disparities Persist*, A. Chih Lin and D. R. Harris (Eds), 76-102. New York: Russell Sage Foundation. <http://dash.harvard.edu/handle/1/3710395> (downloaded March 1, 2013)
- Mathews, Colin D. et. al. (2004). *Global Patterns of Healthy Life Expectancy in the Year 2002*. BMC Public Health 4:66. <http://dash.harvard.edu/handle/1/4592100> (downloaded March 2, 2013)
- McBride, M., *Health and Health care of Filipino American Elders*. Stanford Geriatric Education Center. Stanford University School of Medicine. Stanford California <http://www.stanford.edu/group/ethnoger/filipino.html> (downloaded June 2013)
- Moon, S, et. al. (2010). *The Global Health System: Lessons for a Stronger Institutional Framework*. PLoS Medicine 7(1): e1000193. <http://dash.harvard.edu/handle/1/4460875>. (downloaded March 3, 2013)
- Maiese, M. (2003). *Rights. Beyond Intractability*. <http://www.beyondintractability.org/essay/rights/> (Accessed July 2012).
- Making Health Communication Programs Work: A Planners Guide. US Department of Health and Human Services. National Institute of Health. National Cancer Institute http://www.cancer.gov/cancertopics/cancerlibrary/pinkbook/Pink_Book.pdf (downloaded May, 2011)
- Muhlberger, N. et. al (2009). *HVC- Related Burden of Diseases in Europe: A systematic Assessment of Incidence Prevalence, Morbidity, and Mortality*. BMC Public health 9:34 (downloaded March 1, 2013)
- Nicholson, L. (2013) *Missed diagnosis common in the Doctors Office*. <http://www.reuters.com/article/2013/02/27/us-misdiagnoses-idUSBRE91Q02420130227> (accessed April 2013).

- International Migration Outlook. OECD 2006. Organisation for Economic Co-operation and Development 2006 a): 46). <http://dx.doi.org/10.1787/828518448448>; (accessed June 2013)
- Pittman, G. (2013). *Patient Safety Effort may Prevent Diagnostic Error*. <http://www.reuters.com/article/2013/03/05/us-patient-safety-idUSBRE92417|20130305> (accessed June 2013).
- Reduire les inequities inequalities sociales des santé.
<http://www.irdes.fr/EspaceAnglais/ChartOfTheMonth/ChartOfNovember2009.htm> (accessed August 2013)
- Organisation internationale pour la migration. (2010). L'état de la migration dans le monde 2010, L'avenir des migrations : Renforcer les capacités face aux changements. Genève : Organisation International pour les migrations, 295 p. Disponible à http://publications.iom.int/bookstore/free/WMR_2n1n_FRENCH.pdf (accessed May 2012)
- Sen, A. (2008). *Why and How is Health a Human Right?* The Lancet 372, no. 9655: 2010-2010. <http://dash.harvard.edu/handle/1/3124128>. (downloaded March 1, 2013)
- Simon, P. (2012). French National Identity and Integration: Who belongs to the National Community? Institut national d'études démographiques. <http://www.migrationpolicy.org/pubs/FrenchIdentity.pdf> (accessed August 2013)
- The French Health Care System, <http://www.medicalnewstoday.com/articles/9994.php> (downloaded August 11, 2010)
- Waters, M., & Jimenez, T. (2005). *Assessing immigrant assimilation: New empirical and theoretical challenges*. Annual Review of Sociology 31: 105-125. <http://dash.harvard.edu/handle/1/3203280>. (downloaded March 1, 2013)
- Waters, M., & Eschbach, K. (1995). *Immigration and Ethnic and Racial Inequality in the United States*. Annual Review of Sociology 21: 419-446. <http://dash.harvard.edu/handle/1/3203265> (downloaded March 1, 2013)
- <http://www.cartesfrance.fr/carte-france-departement/carte-departement-Alpes-Maritimes.html> (downloaded October 2011)
- <http://www.diabetes.org> (accessed April 2011)
- <http://faculty.washington.edu/thurlow/research/transculturalcommunication.html> (accessed July 2010)
- <https://www.cia.gov/library/publications/the-world> (Accessed May 2012)

<http://www.ethnologue.com/country/PH> (accessed April 2011)

<http://bit.ly/MbBLbb> JAMA Internal Medicine, online February 25, 2013.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447687/#r45> (accessed May 2012)

http://www.ofii.fr/s_integrer_en_france_47/all_you_need_to_know_about_the_cai_458.html (accessed September 2013)

http://www.sante.gouv.fr/IMG/pdf/Actes_du_colloque_inegalites_sociales_de_sante_ministere_sante_sports_11012010b.pdf (accessed August 2013)

<http://www.rivieratimes.com/index.php/provence-cote-dazur-article/items/french-population-hits-6535-million.html> (accessed April 30, 2013)

<http://www.un.org/esa/earthsummit/pilip-cp.htm> (accessed May 17, 2013)

<http://www.hspm.org/countries/france25062012/> (accessed August 12, 2013)

http://www.le-site-de.com/association-nous-nice-ouverture-union-solidarite-nice_158167.html (accessed May 1, 2013)

<http://showbizandstyle.inquirer.net/lifestyle/lifestyle/view/20080620-143877> (accessed February 2011)

<http://nccam.nih.gov/health/whatiscam/> (accessed May 2012)

<http://www.cdc.gov/socialdeterminants/Definitions.html> (accessed July 2013)

<http://www.ethnologue.com/country/PH> (accessed August 2013)

<http://www.whitehouse.gov/issues/health-care/plan> (accessed December 2011)

<http://www.expatsforum.com/articles/health/health-care-in-france.html> (accessed September 2012)

<http://rhbill.net> (accessed May 16, 2013)

http://www.congress.gov/ph/download/basic_15/HB04244.pdf (accessed May 16, 2013)

http://www.who.int/whosis/mort/profiles/mort_euro_fra_france.pdf
(accessed August 10, 2010)

<http://www.answers.com/topic> (accessed September 2012)

<http://medical-dictionary.thefreedictionary.com/transcultural> (accessed February 2012)

http://www.inpes.sante.fr/CFESBases/equilibre/numeros/90/prevention_sante_migrants.asp (accessed June 11, 2013)

<http://who.int/about/definition/en/print.html> (accessed May 10, 2008)

<http://www.migrationpolicy.org/europe/> (accessed August 17, 2013)

Journals

- Adams, T. & Gardiner, T., (2005). *Dementia. Communication and Interaction within Dementia Care Triads: Developing a Theory for Relationship Centered Care*. Sage Publication
- Adler, S. (1995). *Refugee Stress and Folk Belief. Among Sudden Deaths*. SSM 40 (12):1623-29
- Al-alawy, K. et. al. (2011). *Implementing Public Health in Secondary Care: A Rotherham perspective on Strategy development and implementation*. Perspective in Public Health. Sage Publication.
- Anderson, J. (1983). *Health and illness in Pilipino immigrants. In Cross-Cultural Medicine [Special issue]*. Western Journal of Medicine, 139(6), 811-819.
- Alba, R., Silberman R., (2002). *Decolonization immigrations and the social origins of the second generation: The case of North Africans in France*. International Migration Review, 36(4)
- Appenzeller, T. (2005). *Tracking the next Killer Flu*. National Geographic Magazine.
- Arango, J. (2013). *Exceptional in Europe? Spain's Experience with Immigration and Integration*. Migration Policy Institute
- Asis, M. & Agunias, D. (2012). *Strengthening Pre-Departure Orientation Programmes in Indonesia, Nepal and the Philippines*. Issues in Brief. Migration Policy Institute. No 5.
- Attias-Donfut C., Wolff, F. C. (2005). *Le lieu d'enterrement des personnes nées hors de France*. Population, 6n (5).
- Attstrom, K (2007). *Discrimination Against Native Swedes of Immigrant Origin in Access to Employment*. A research study on Stockholm. Malmo and Gothenburg utilizing the ILO testing approach. ILO, Geneva
- Audit Commission (1993). *What Seems to be the Matter: Communication with Non-English Speaking Patients*. London. HMSO
- Avison, R & Turner, J. (1988). *Stressful Life Events and Depressive Symptoms: Disaggregating the Effects of Acute Stressors and Chronic Strains*. Journal of Health and Social Behavior. 29: 253
- Baker, D., Hayes, R., Fortier, J. (1998). *Interpreter Use and Satisfaction with Interpersonal Aspect of Care for Spanish-Speaking Patients*. Medical Care.

- Bal, S. (1986). *Psychological Symptomatology and Health Beliefs of Asian Patients*. In Dent, H. *Clinical Psychology Research and Developments*. London. Croom Helm. 101-110
- Banulescu- Bogdan, N. (2011). *The Role of the Civil Society in the EU Migration Policy: Perspective in the EU's Engagement in its neighborhood*. Migration Policy Institute.
- Bhatt, R. & Dickinson, R. (1992). An Analysis of health Education materials for minority communities by cultural and linguistic group. *Health Education Journal* 51:2 , 72-77
- Bhopal, R.S. et al (1991). *Inappropriate use of the Term "Asian": An Obstacle to Ethnicity and Health Research*. *Journal of Public Health medicine* 13:4, 244-246
- Bauchet, M. et. al. (2007). *Measuring European Population Stratification with Microarray Genotype Data*. *American Journal of Human Genetics*.
- Becker. M. H., (1974). *The Health Belief Model and Personal Health Behavior*. The Education Monographs
- Berchet, C. & Jusot, F (2012). *Immigrants Health Status and Use of Healthcare Services: A Review of French Research*. *Questions d'economies de la Sante*. No. 172
- Bernstein, J. et. al. (2002). *Trained Medical Interpreters in the Emergency Department: Effects on Services, Subsequent Charges and follow-up*. *Journal of Immigrant Health*
- Bertrand, M., Chugh, D., & Mullainathan, S., (2004). *Implicit Discrimination*. *The American Economic Review*. Papers and Proceedings of the 117th Annual Meeting of the American Economic Association. Philadelphia.
- Bevan, G., (2007). *How Might Information Improve Quality of Care in the English NHS?* *EuroObserver* Volume 9. No.3
- Bocognano A., Couffinhall A., Dumesnil S., Grignon M., (2001) *La complémentaire Maladie en France: Qui Bénéficie de Quels Remboursement?*, *Questions d'Economie de la Santé* n°32, Octobre 2001, CREDES
- Bouviern-Colle M.H., Magescas, .B., Hatton F. (1985). *Causes de décès et jeunes étrangers en France*. *Revue d'épidémiologie et de santé publique*, 49.
- Bowler, I (1993a). *They are not the same as us. Midwives Stereotypes of South –Asian Descend Maternity patients*. *Sociology of health and illness*. 15:2, 157-178
- Boyd, M. (2002). *Educational attainment of immigrants offspring: Success or segmented assimilation?* *International Migration Review*. 36(4)

- Brashers, D.E. & Babrow A, S., (1996). *Theorizing Health Communication: Communication Studies*. SAGE Publication
- Brahimi M. (1980). *La Mortalité des Etrangers en France*. Population, 3
- Brick, K. (2011). *Regulations in the EU. The Contentious Policy Tool*. Migration Policy Institute.
- Burbridge, L. (1993). *The Labor Market for Home Care Workers*. Gerontologist 33
- Buettner, D. (2005). *The Secrets of long life*. National Geographic Magazine. November 2005
- Burstin, H. et al (1992). *Socioeconomic Status and Risk for Substandard Medical Care*. Journal of the American medical Association 268
- Capps, R et.al. (2013) *A Demographic , Socioeconomic and Health Coverage Profile of Unauthorized Immigrants in the US*. Issue Brief. Migration Policy Institute. No.5
- Carlsson, M. & Rooth D.O., (2006). *Evidence of Ethnic Discrimination in the Swedish Labour Market Using Experimental Data*. Discussion Paper 2281. Bonn.
- Caldwell, J. (1993). *Health Transition: The Cultural, Social and Behavioral Determinants of Health in the Third World*. Social Science and Medicine 36
- Calderon, J. et. al. (2012). *Asian Labour Migrants and Health*. Exploring Policy Routes. Issues in Brief. Migration Policy Institute. Issue No.2.
- Casanova, M. (2013). *Social and Economic Management in the XXist century*. Lecture delivered in the conference "Cultural diversity: Advantage or Liability?". European University Institute. May 7-9, 2013. Florence, Italy.
- Cho, H., Witte, K.,(2005). *Managing Fear in Pubic Health campaigns: A Theory Based Formative Evaluation Process*. Health Promotion Practice, SAGE Publication.482-490
- Cho, H. & Salmon, C. (2007). *Unintended Effects of Health Communication*. Campaigns. Journal of Communication. 294-312
- Cole, F.C., (1913). *The Wild Tribes of Davao District Mindanao*. Field Museum of Natural History, Anthropological Series 12: 49-203
- Collett, E. (2013). *The Integration Needs of Mobile EU Citizens: Impedements an Opportunities* . Migration Policy Institute.

- Collett, E. (2013). *Facing 2020: Developing a new European Agenda for Immigration and Asylum policy: Policy Brief Series*. Research for Migration Policy Institute, Europe. Issue No.1
- Commission on Filipino Overseas Employment Handbook for Filipino Overseas. Fifth Edition. Department of Foreign Affairs. Philippines
- Commission on the Future of multi-ethnic Britain (CMEB) (2000). *The Future of multi-ethnic Britain*. London. Profile books.
- Commission on Social Determinants of Health (CSDH), *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*. Final report of the Commission on Social Determinants of Health. 2008, World Health Organization: Geneva.
- Corburn, J., (2007). *Reconnecting with our roots: American Urban Planning and Public Health in the Twenty – First Century*. Urban Affairs Review. Sage Publication.
- Cottrol, R. () *The Long Lingered Shadow: Law, Liberalism, and Cultures of Racial Hierarchy and Identity in the Americas*. Tulane Law Review 76
- Crul, M., Vermeulen H. (2003). *The Second Generation in Europe*. International Migration Review. 37(4)
- Cruz, R. (2012). *Figures of Migration, Gender, Kinship and the Politics of Representation*. Ateneo de Manila University Press
- Curtis, S., (2008). *How can we Address Health Inequality through Public Health Policy in Europe*. European Urban and Regional Studies. Sage Publication.
- Day, C., (2007). *Diabetes: A New World Order?* British Journal of Diabetes and Vascular Diseases, SAGE Publication
- Dearing, J. & Rogers, E. (1996). *Agenda Setting*. Thousand Oaks, California: Sage.
- Developing Health Management Information Systems. (2004). *A practical guide for developing countries*. WHO Regional Office for the Western Pacific.
- Dixon, A. & Mossialos, E. (eds) (2002). *Health Care Systems in Eight Countries: Trends and Challenge* . European Observatory on Health Care Systems
http://www.gesundheitspolitik.org/01_gesundheitssystem/ausland/gesundheitsysteme/HC-Systems-in-8-Countries.pdf. Accessed August 2013
- Downing, J. & Mohammadi, A. (Eds). (1995). *Questioning the media: A critical introduction* (2nd ed). Thousand Oaks, Calif. Sage Publication

- Dourgnon P., Nusot F., Silva N., Sermet C. (2009). *Le recours aux soins de ville des immigrés en France*. Questions d'Economie de la Santé, 146.
- Downs, D. (1993). *Codes Say darnedest Things*. Quill; October Vol. 81 Issue 8
- Duranti, A., (2005). *On Theories and Models. Discourse Studies*. Sage Publication
- Enhelhardt, H. et al (1980). *Philosophy of medicine. In a Guide to the culture of Science, technology and medicine*. Dubrin, P. (ed). 361-461. New York. The Free Press
- EUMC (2006). Annual Report on the Situation Regarding Racism and Xenophobia of the Member State of the European Union.
- EUMC. (2005). *Racism and Xenophobia in the EU memberstates: Trends, Developments and Good Practice*. Annual Report 2005. European Center on Racism and Xenophobia. Vienna.
- Eurohealth (2009) *Measuring and Tackling Health Inequalities in Europe*. Volume 15. European Observatory of Health System and Policies. Belgium
- EuroObserver (2012). Efficiency in Health Care Volume 18 Number 3
- Evangelista, T. et al (2007). Clinical and neurophysiological profile of lanudrywomen with and without self-perceived Pasma: A cross sectional survey. Unpublished report. University of the Philippines. College of Medicine
- Fargues, P. et. al. (2011). *Shared Challenged and Opportunities for EU and Immigration Policy Makers*. European University Institute and Migration Policy Institute.
- Fearon, J., (2003). *Ethnic and Cultural diversity per Country*. Journal of Economic Growth. Vol 8.
- Feinstein, J. (1993). *The Relationships Between Socioeconomics Status and Health. A review of the Literature*. Milbank Quarterly 71
- Fierro, L, & Christie, C. (2011). *Understanding Evaluation Training in Schools and Programs of Public Health*. American Journal of Evaluation. SAGE Publication
- Figueras, J., McKee, M., et. al. (2004). *Health System in Transition: Learning from Experience*. European Observatory on Health Systems and Policies. WHO Regional Office for Europe
- Finau, S. (2000). *Communicating Health Risks in the Pacific: Scientific Construct and Cultural Reality*. Asia-pacific Journal of Public Health. SAGE Foundation.90-97

- Folland S. (2007). *Does Community Social Capital Contribute to Population Health?* Social Science & Medicine, 64(11).
- Foster, G. M., (1976). *Disease Etiologies in Northwestern Medical System*. AA 78:773-82
- Frake, C., (1961). *The Diagnosis of Disease among the Subanun Mindanao*. AA 63:113
- Freudenberg, N., (2005). *Public Health Advocacy to Change Corporate Practices: Implications fro Health Education Practice and Research*. Health Education and Behavior. Sage Publication
- Garcia, R. (2003). *The Misuse of Race in Medical Diagnosis*. Chronicle of Higher Education.
- Gregory and Williams (2003). *Literacy*. Nov 2006, Vol. 40 Issue 3
- Greeley, A (1989). *Ethnic Minorities in the Unites States: Demographic Perspectives*. International Journal of Group Tensions 7
- Gueraiche, W., (2003) *Regards Francais sur la Colonization Americaine aux Philippines (1898-1916)*. Press Universitaires de France. Guerres Mondiales et Conflicts Contemporains
- Glynn, C. & Huye, M., (2007). *Opinions as Norms: Applying a Return Potential Model to the Study of Communication Behaviors*. Communication Research.Sage Publication
- Golding, L. & Rubin, D, (2011). *Training for Public Information Officers in Communication to Reduce Health Disparities: A needs Assessment*. Health Promotion Practice. Sage Publication
- Goodfellow, B. & Moorley, C. (2010). *Reaching Unreachable Groups and Crossing Cultural Barriers in Communicating Health Promotion*. In Working on Health Communication. Nova Corcoran. SAGE
- Goets, L., & Dwiggins S. (1998). *Teaching Public Health Practitioners about Health Communication. The MPH Curriculum Experience*. Journal of Community Health Vol. 23, No 2. 127-135
- Gray, J., Cole, G., Kennedy, M.,(2007). *Guidance for Evaluating Mass Communication Health Initiatives: Summary of an Expert Panel Discussion* Sponsored by the Center for Disease Control and Prevention, Evaluation and the Health Profession, SAGE Publication
- Greenstone, C., (2007). *Type 2 Diabetes: A Disease of Epidemic Proportion that is Largely Preventable- But How?* Clinicians' Corner, American Journal of Lifestyle Medicine, SAGE Publication

- Griffiths, S. & Thorpe, A., (2007). *Public Health in Transition: Views of the Specialist Workforce*. The Journal of the Royal Society for the Promotion of Health. Sage Publication
- Gruesser, M., Hoffstadt, K, Joergens, V. (2003). *Structured outpatient education and treatment programs for patients with diabetes mellitus and/or hypertension: The German experience, practical disease management, disease manage health outcomes*
- Gueraiche, W., (2003). *Regards Francais sur la Colonization Americaine aux Phillipine (1898-1916)*. Presses Universitaires de France. *Guerre Mondiales et Conclicts Contemporains*. 1 number 209
- Harper, G. et. al., (2008). *Transdisciplinary Research and Evaluation for Community Health Initiatives*. Health promotion and practice. Sage Publication.
- Haut Comite de la Sante Publique. (2000). *Pour une politique nutritionelle desanet publique en France*. Editions ENSP
- Hawley, S. et.al. (2011). *Competency Based Impact of Statewide Public Health Leadership Training Program*. Health Promotion Practice. Sage Publication
- Heckman, J. (1998). *Detecting Discrimination*. Journal of Economic Perspective. Vol. 12.
- Hemingway, A et. al. (2011). *An emerging Model for Publishing and Using Open Educational Resources in Public Health*. Perspective in Public Health. Sage Publication.
- HiT Summary, France (2004): *Health Care Systems Iin Transition*. European Observatory on Health Systems and Policies.
- Hochschild, J, & Cropper, P. (2009). *Immigration Regimes and Schooling Regimes: Which Countries Promote Successful Immigrant Incorporation?* Harvard University, Government and Social Policy Ph.D. Program
- Hornik R., Ramirez S., (2006). *Racial/Ethnic Disparities and Segmentation in Communication Campaigns*, American Behavioral Scientist, Sage Publication
- Hughey, J. et. al., (2007). *Empowerment and Sense of Community: Clarifying their Relationship in Community Organization*. Health Education and Behavior. Sage Publication.
- Idler, E., (1979). *Definitions of Health and Illness and Medical Sociology*. SSM13A.
- International Inequalities linked to Immigration. Labour Market outcomes for Immigrants and their descendants in France. Population 2006.

<http://www.cairn.info/revue-population-english-2006-5-page-645.htm>
(accessed August 15, 2013).

- Jacobs, E.A. et.al. (2001). *Impact of Interpreter Services on Delivery of Health Care to Limited English Proficient Patients*. Journal of General Internal Medicine
- Johnson, M. (1999). *Communication in Healthcare: A review of some key issues*. Nursing Times Research Vol 4. No 1. SAGE Publication. 18-29
- Jones, E., Kreuter, M., Pritchett S., Matulionis, R., Hann, N., (2006). *State health policy makers: whats the message and who's listening*. Health Promotion Practice. SAGE Publication
- Jones, L., & Watson, B., (2009). *Complex Health Communication: A Language and Social Psychological Perspective*. Journal of language and Social Psychology. SAGE Publication
- Joppke, C. (2012). *The Role of the State in Cultural Integration, Trends, Challenges and Ways Ahead*. University of Bern. Migrant Policy Institute.
- Journal of contemporary Asia. November 2012. Volume 42 Number 4
- Journal of Southeast Asian Studies. February 2013 Volume 44. Number 1
- Journal Officiel de l'Union européenne. (2007). Avis du Comité Economique et Social Européen sur Santé et Migration. C256/123,
- Kahn, J. (2004). *How a Drug Becomes Ethnic: Law, Commerce and the Production of Racial Categories in Medicine*. Yale Journal of Health Policy Health Ethics
- Kaplan, JB. & Bennet, T. (2003). *Use of race and Ethnicity in Biomedical Publication*. JAMA.
- Karan, K., Aileen, L., Elaine, P., (2007). *Emerging Victorious Against as Outbreak: Integrated Communication Management of SARS in Singapore Media Coverage and Impact of the SARS Campaign in Moving a Nation to be Socially Responsible*. SAGE Publication.383-403.
- Karliner ,LS., et. al. (2004). *The Language Divide: The Importance of Training in the Use of Interpreters for Outpatient Practice*. Journal of General Internal Medicine
- Kate, SL. (2001). Health problems of tribal population groups from the state Maharashtra. Indian Journal of Medicine.
- Khlat M. & Courbage Y. (1995). Mortalité des immigrés marocains en France, de 1979 - 1991. Il-leses causes de décès. Population, 5n(2).

- Khlat M., Sermet C., Laurier D. (1998). La morbidité dans les ménages originaires du Maghreb, sur la base de l'enquête santé Insee 1991-1992. Population 6.
- King, H., Gruber, W., Lander. T. (1995). Implementing National Diabetes Program: Report of a WHO meeting. Geneva: WHO Division of Non-communicable Disease.
- Kirkman-Liff, B. & Mondragon, D. (1991). Language of Interview: Relevance of research in of southwest Hispanics. American Journal of Public Health
- Kreps, G.L. (1996a). Communicating to promote justice in the modern health care system. Journal of Health Communication, 1(1), 99-109
- Kreps, G.L. (1996b). Promoting a consumer orientation to to health care and health promotion. Journal of Health Psychology, 1(1), 41-48.
- Kreps, G.L. (1989). Setting the agenda for health communication research and development: Scholarship that can make a difference. Health Communication, 1(1), 11-15.
- Kreps, G. et. al., (1994). A Conceptual Model of Communication and Health outcomes. A paper presented at the annual meeting of the International Communication Association. Sydney, Australia.
- Kreps, G., (2006). Communication and Racial Inequalities in Health Care. American Behavioral Scientist. SAGE Publication. 760-774
- Kreps, G. & Kunimoto, E. (1994) Relational Multi Cultural Communication in Health Care Effective Communication in Multi-Cultural Health Care Setting. SAGE Publication, London
- Krieger, N, (2005). Stormy weather: race gene expression and the science of health disparities. American Journal of Public Health
- Krishnatray, P., Melkote, S., Krishnatray, S., (2006). Providing Care to Persons with Stigmatized Illness: Implications for Participatory Communication. Journal of Health Management. Sage Publication
- Ku, L. & Jewers, M. (2013). Healthcare for Immigrant Families: Current policies and Issues. Migration Policy Institute
- Kulukulalani, M. et.al, (2008). Using Participatory Four-Step protocol to Develop Culturally targeted Cancer Education Brochures. Health Promotion Practice. Sage Publication.
- Layug, R. M.D. (2005). A randomized controlled study on the effectiveness of group patient education versus standard individual patient education on the knowledge,

quality of life, patient adherence and glycemic control among adult type 2 diabetes mellitus patients seen at the Philippine General Hospital Family Medicine Clinic (FMC), *The Filipino Family Physician*, 43(4).

- Lear, J., Mossialos, E., (2008). EU law and Health policy in Europe. EuroObserver. Volume 10 No.3
- Leclere F.B., Nensen L., Biddlecom A.E. (1994). Health care utilisation, familn context and adaptation among immigrants to the United States. *Journal of Health and Social Behavior*, 35(4).
- Lee, S. (2005).Racializing drug design: implications of pharmacogenomics for health disparities. *American Journal of Public Health*.
- Lee, S., et. al. (2008). *Interplay of Negative Emotion and health self-efficacy on the use of Health information and its outcome*. Communication Research. Sage Publication.
- Lert F., Melchior, M.,Villel, I. (2007). Functional limitations and overweight among migrants in the Histoire de Vie studn. *Revue d'épidémiologie et de santé publique*, 55 (6).
- Loring, M. & Powell, B. (1988). Gender, race and DSM III: A study of the objectivity of Psychiatric diagnostic behavior. *Journal of Health and Social behavior* 29: 1-22.
- Maibach, E., Parrott, R.L.(1995) *Designing Health Messages*. Thousand Oaks, CA: Sage Publications
- Martel, W., Renaud, L., Bouchard, M.,Gagnon, L., Pelletier M., (200-) Implication des partenaires dans la campagne quebewise de promotion de la Sante "Defi Sante 5/30", *Revue Internationale Communication Sociale et Publique*
- Martin, S. et al (1988). Gender and medical Socialization. *Journal and of Health and Social Behavior*. 29.333-43
- Mayes, R. & McKenna S., (2011). *Public Health and Primary Care: Stragglng to win friends and influence people*. *Journal of Primary Care and Community Health*. Sage Publication.
- McBride, M., Pasick, R., Stewart, S., Tuason, N., Sabogal, F., & Duenas, G. (1998). Factors associated with cervical cancer screening among Filipino women in California. *Asian American and Pacific Islander Journal of Health*, 6: 358-367.
- McQueen, D., Wisman, M. (2012). Intersectoral governance in Health in all Policies: Structures, Actions and Experiences. WHO on behalf of European Observatory on Health System and Policy

- Meer, N. & Modood T (2012) Interculturalism, Multiculturalism or Both? Political Insight. April 2012.
- Mihelj, S., (2007). *The European and the National Communication Research*. European Journal of Communication. Sage Publication
- Miller, D., (1995). *On Nationality*. Oxford Uk. Oxford University Press
- Mizrahi A., Mizrahi A., Wait S. (1993). *Accès aux soins et état de santé des populations immigrées en France*. Rapport CREDES.
- Mladovsky, P., Allin, S., et. al. (2009). *Health in the European Union: Trends and Analysis*. WHO on behalf of European Observatory on Health System and Policy
- Mladovsky, P., (2007). Migration and Health in EU Health Systems. Euro Observer. The Health Policy Bulletin of the European Observatory on Health Systems and Policies. Volume 9 Number 4.
- Mladovsky P., et. al. (2011). Migration and Health in the European Union. European Observatory on Health Systems and Policies Series. McGrawHill. Open University Press.
- Morales, D. et al (2008). Metabolic Syndrome in the Philippine general population: prevalence and risk for atherosclerotic cardiovascular disease and diabetes mellitus. Diabetes and Vascular Disease Research. SAGE Publication
- Morehouse, C. & Blonfield, M. (2011). Irregular Migration in Europe. Migration Policy Institute
- Mosco, V. (1996). *The political economy of communication*. London: SAGE Publication.
- Mozere, L., (2002). *Philippine Servants in Paris: A Global Market of Domestic Servants*. Tiers Monde 2002, Volume 43 n 170. pp 373-396
- Mudde, C. (2012). The Relationship between immigration and nativism in Europe and North America. Transatlantic Council on Migration. Migration Policy Institute
- Mukhopadhyay, B., Sattar, N., Fisher, M., (2005). *Review: Diabetes and Cardiac Disease in South Asians*. The British Journal of Diabetes and Vascular Disease. SAGE Publication
- Mumford, D.B. et al (1991). The Bradford Somatic Inventory- a multi-ethnic inventory of somatic symptoms reported by anxious and depressed patients in Britain and the Indo-Pakistan sub-continent. British Journal of Psychiatry. 158: 379-386

- Munro, A. & Bloor M. (2010). *Process Evaluation: The new miracle ingredient in Public Health Research*. Qualitative Research. SAGE Publication
- Muntaner, C. et. al. (1996). The bell curve: On race, social class and epidemiological research. *American Journal of Epidemiology*.
- Murphy, S. & Bennet, P., (2004). *Health Psychology and Public Health: Theoretical Possibilities*. Journal of Health Psychology. Sage Publication
- Muus, P., (2002). Migration, immigrants and labour markets in EU Countries: ThemEs. Occasional papers and reprints on ethnic studies 3. University of Linkoping. Center for Ethnic and Urban Studies.
- National Geographic Magazine October 2007 pp 91-102
- National Geographic Magazine 2005 p 18
- National Geographic October 2002 pp 5-17
- New California Media (NCM). Bringing Language Barriers in Health Care: Public Opinion Survey of California Immigrants from Latin America, Asia and the Middle East. The California Endowment. 2003.
- Ngo-Metzger, Q. et. al. (2000). Linguistic and cultural barriers to care: perspective on Chinese and Vietnamese immigrants. *Journal of General Internal Medicine*.
- Ngo-Metzger, Q. et. al. (2007). Providing High-Quality care for limited English proficient patients: the importance of language concordance and interpreter use. *Journal of Internal Medicine*
- Ngo-Metzger, Q. et. al. (2004). Surveying minorities with limited English proficiency: does data collection data affect data quality among Asian Americans? *Medical Care*.
- Nobles, M. (2000). *Shades of Citizenship: race and the census in modern politics*: Palo Alto California. Stanford University Press
- Nykiforuk, C. & Flaman, L., (2011). *Geographic Information Systems (GIS) for Health Promotion and Public Health: A Review*. Health Promotion Practice. Sage Publication
- Oppenheimer, G. (2001). Paradigm lost: race, ethnicity, and a research for a new population taxonomy. *American Journal of Public Health*
- Organisation Internationale pour la Migration. (2010). L'état de la migration dans le monde 2010, L'avenir des migrations: Renforcer les capacités face aux changements. Genève : Organisation International pour les migrations, 295 p. Disponible à http://publications.iom.int/bookstore/free/WMR_2010_FRENCH.pdf

- Parsons, L & Day, S. (1992). Improving Obstetrics Outcomes in Ethnic Minorities: An evaluation of health advocacy in Hackney. *Journal of Public Health Medicine*. 14:2, 183-191
- Pechmann, C. (2001). *A Comparison of Health Communication Models: Risk Learning vs Stereo type Priming. Media Psychology* 3. Lawrence Erlbaum Associates Inc. pp 189-210
- Percoff, R., (2006). *Communication and Healthcare Disparities*. American Behavioral Scientists. Volume 49. Number 6
- Perrin-Haynes, j. (2008) L'activite de immigrees 2007. Insee Premiere 1212.
- Peters, E. et al (2006). Th Functions of Affect in Health Communications in the Construction of Health Preferences. *Journal of Health Communication*. S 140-162. International Communication Association.
- Philippine Studies 2011. Headhunting and Christianity. Volume 59. Number 2. Ateneo de Manila University Press.
- Philippine Studies Historical and Ethnographic Viewpoint. 2012. Transnational Migration. Part 1. Class Identity and marital intimacy. Volume 60. Number 2. Ateneo de Manila University Press
- Pickert, K., & Calabresi, M. (2012) United Sates High Noon for Health Care. *TIME Magazine* (April 2012)
- Piper, N., (2005). *Gender and Migration*. A paper prepared for the Policy Analysis and Research programme of the Global Commission on International Migration. Global Commission on International Migration.
- Polton, D. (2009). What is the Role of Healthcare System in Reducing Health Inequalities in France? In *Measuring and Tackling Health Inequalities Across Europe*. EuroHealth. Volume 15. Number 3.
- Proceedings of the 8th Health Research for Action, National Forum. (2007, June 28-29). New evidence and policy directions progressing towards the Millennium Development Goals. Manila, Philippines.
- Quammen, D., (2007). *Deadly Contact. How Animals and Humans Exchange Disease*. National Geographic Magazine.
- Quigley, H., McKee, M., et. al. (2008). *Assuring the quality of Healthcare in the European Union: A Case for Action*. WHO on behalf of the European Observatory on Health System and Policy
- Rains, S., (2008). *Health at High Speed: Broadband and Internet Access, Health Communication and the Digital Divide*. SAGE

- Rashid, A. & Jagger, C. (1992). *Attitudes to and Perceived Use of Healthcare Services among Asiana and Non-Asian Patients in Leicester*. British Journal of General Practice 42 (358) 197-201.
- Rimer, B. & Kreuter, M. (2006). *Advancing Tailored Health Communication: A Persuasion and Message Effect Perspective*. Journal of Communication 56. International Communication Association
- Rivadeneira, R. et.al. (2000). *Patient centeredness in medical encounters requiring an interpreter*. American Journal of Medicine
- Robinson, TN., et. al. (1998). *An Evidence-Based Approach to Interactive Health Communication: A Challenge to Medicine in the Information Age*. Science Panel on Interactive Communication and Health. US National Library of Medicine. National Institute of Health. JAMA. 280 (140) 1264-9
- Rocco, M., McKee, M., (2007). *Health: A vital Investment for economic development in Eastern Europe and Central Asia*. WHO
- Rodwin, V. (2003). *The health care system under French National Health Insurance: Lessons for health reform in the United States*. American Journal of Public Health 93.(1)
- Rooth, D. & Ekberg, O. (2003) *Unemployment and earnings for second generation immigrants in Sweden. Ethnic background and parent composition*. Journal of Population Economics, 16
- Romulo, B.D. (2010) U.S. and Philippine Health Care, Manila Bulletin
- Romon I, Jouglu E, Balkau B, Fagot-Campagna A. (2008) The burden of diabetes-related mortality in France in 2002: an analysis using both underlying and multiple causes of death, French Institute for Public Health Surveillance, Institut de Veille Sanitaire (InVS)
- Rosenblum, M. (2010). Immigrant Legalization in the United States and the European Union. Policy goals and program design . Policy Brief. Migration Policy Institute
- Ruddock, A. (2001). *Understanding audiences: Theory and method*. London: Sage
- Saggar, S. & Somerville, W. (2012). Building a British model of Integration in an era of immigration: Policy lessons for Government. University of Sussex and Migration Policy Institute.
- Saltman, R., Figueras, J., (1997). European Health Care Reform: Analysis of current strategies. WHO Regional Publications. European Series No. 72

- Sandier, S. et.al. (2004). *Health Care Systems in Transition*. Copenhagen. WHO Regional Office for Europe
- Sankar, P. (2003) MEDLINE definition of race and ethnicity and their application to genetic research. *Natural Genetics*.
- Saroca, C. (2006). *Filipino Women, Migration, Violence in Australia: Lived Reality and Media Image*. Kasarinlan: Philippine Journal of Third World Studies
- Sheldon, T.A. & Parker, H. (1991). Race and Ethnicity. *Journal of Public Health medicine*. 14;2, 104-110
- Schoberberger R., Nodes, M., (2005). *Health Campaign for Atherosclerosis Prevention*, Institute of Social Medicine, Center of Public Health, Medical University of Vienna, Vienna Austria, Springer –Verlag
- Seki, K. 2012. Difference and Alliance in Transnational Social Fields. The Pendular Identity of the Filipino Middle Class. *Philippine Studies* Volume 60 Number 2. Ateneo Univesity Press. 187- 221
- Shen, L., & Dilland, J., (2007). *The Influence of Behavioral Inhibition/ Approach Systems and Message Framing on the Processing of Persuasive messages*. Communication Research. Sage Publication.
- Sifferlin, A., (2013). Wear your Doctor. *Time Magazine* March 2013
- Simon, P. (1997). La statistique des origines. Race et ethnicité dans les recensements aux États-Unis, Canada et Grande-Bretagn. *Sociétés contemporaines*, n° 26
- Solé- Auro A., Crimmins E.M. (2008). Health of Immigrants in European countries. *International Migration Review*. 42(4).
- Solis, JM. et. al. (1990). Acculturation, access to care and use of preventive services by Hispanics: Findings from the HHANES 1982-84. *American Journal of Public Health*
- Soto Mas, F., Plass, J., Kane, W., Papenfuss R. (2003). *Health Education and Multi Media Learning: Educational Psychology and Health behavior Theory(Part 1)*. Health Promotion Practice. Sage Publication
- Sperling, J. (2011). Communicating more for less: Using translation and interpretation technology to serve limited English proficient individuals. *Migration Policy Institute's National Center on Immigrant Integration Policy (NCIIP)*

- Sparks, L., (in press). *Health communication and caregiving research, policy, and practice*. In S. S. Travis & R. Talley (Eds.) *Multi-disciplinary Coordinated Caregiving: Professional Contributions*. Springer.
- Squires, A. & Beltran-Sanchez, H. (2013) *Strengthening Health Systems in North and Central America. What Role for Migration?* The Regional Migration Study Group. Migration Policy Institute
- Stein, J. & Fox, S., (1990). *Language Preference as an indicator of mammography use among Hispanic Women*. Journal of National Cancer Institute
- Steiner, G., (2006). *Implications of global diabetes epidemic*. Diabetes and Vascular Disease Research, SAGE Publication
- Stewart, M. & Lindburg, L. (1997). *Gaining from Diversity*. Brussels. European Business Network for Social Cohesion
- Stirba, I., Kunst AE., et al. (2006). *Differences in Avoidable Mortality between Migrants and the Native Dutch in the Netherlands*. Baic Public Health.
- Tebbe, S., Figueras, J., (2005). *Snapshots of Health Systems*. WHO on behalf of the European Observatory on Health Systems and Policies, Belgium
- The European Health Report 2012. *Charting the way to well-being*. World Health Organization. WHO Regional Office, Europe.
- Thatcher, B., (2001). *Issues of Validity in Intercultural Professional Communication Research*. Journal of Business and Technical Communication. SAGE Publication
- Thomas, V.J. & Rose, F.D. (1991). *Ethnic differences in the experience of Pain*. Social Science and Medicine. 32:9, 1063-1066
- Timmins. C. (2002). *The impact of language barriers on the health care of Latinos in the United States: A review of the literature and guidelines for practice*. Journal of Midwifery Women's Health
- Titley, G. (2004). (Ed) *Resituating Culture*. Directorate of Youth and Sport. Council of Europe Publishing
- Tocher, TM. & Larson, E. (1998). *Quality of Diabetes for non-English Speaking Patients. A Comparative Study*. West Journal of Medicine
- Torres, B. & Rao, N., (2007) *Disclosure and Truth in Physician- Patient Communication: An Exploratory Analysis in Argentina, Brazil, India, and the United States*. Journal of Creative Communication. Vol 2. No 3. 279-305. SAGE Publication
- Turner, J., Thomas, R., Reinsch, L., (2004). *Willingness to Try a New Communication Technology: Perceptual Factors and Task Situations in a Health Care Context*. Journal of Business Communication. Sage Publication

- Vallgarda, S., (2011). *Addressing Individual Behaviors and Living Conditions: Four Nordic Public Health Policies*. Scandinavian Journal of Public Health. SAGE Publication.
- Versini, D. (2004). *Rapport sur la Diversité dans la Fonction Publique*. Report presented to Mr Renaud Dutreil, Minister of the Civil Service and State Reform, Paris, La Documentation Française
- Viswanath, K. & Emmons, K. (2006). *Message Effects and Social Determinants of Health. It's Implications to Cancer Disparities*. Harvard School of Public Health. International Communication Association. S238-S256
- Walsh, B. (2013). It's Gone Viral. Time Magazine. March 2013.
- Wanner P., Bouchardn C., Khlal M. (1997). Causes de décès des immigrés en France 1979-1985 . Migration Santé, 91.
- Weiss, R., (2002). *War on Disease. Challenges for Humanity*. National Geographic Magazine
- World Health Organization (WHO). Global Strategy on Diet, Physical Activity and Health Resolution of the Fifty Seventh World Assembly. WHA57. Geneva
- Wise, L.R. & Tschirhart M. (2000). *Examining Empirical Evidence on Diversity Effects: How Useful is Diversity Research for Public Sector Managers*. Public Administration Review. Vol. 60. No 5.
- Wild, S., Roglic, G., Green, A., Secree, R. & King, H. (2004). *Global prevalence of diabetes : Estimates for the year 2000 and projections for 2030*. EU Workshop entitled: Towards a European Framework for Diabetes Prevention and Care of the European Region and the Diabetes Federation Ireland, Dublin.
- Wismar, M., et. al. (2011). *Health Professional Mobility and Health systems: Evidence from 17 European countries*. EurObserver. Volume 13. No.2
- Wismar, M., et. al. (2006). *Health Targets and (good) governance*. EurObserver Volume 8 No.1.
- Wise, L.R. & Tschirhart, M. (2000). *Examining Empirical Evidence on Diversity Effects: How Useful is Diversity Research for Public Sector Managers?* Public Administration Review, Vol. 60. No.5.
- Wittenberg-Lyles, E. Et al (2009). *Medical Students' Views and Ideas about Palliative Care Communication Training*. American Journal of Palliative Care. SAGE Publication. 1-12

- Worz, M., et. al. (2006). *Access to Health Care in the EU Member State*. EurObserver Volume 8 no. 2.
- Woloshin S. et. al. (1995). Language Barriers in Medicine in the United States. JAMA.
- Wrench, J. (2004). *Managing Diversity: Fighting Racism, or Combating Discrimination? A Critical Exploration*. In Titley, G. (Ed). *Resituating Culture*. Directorate of youth and Sport Council of European Publishing.
- Youdelman, M. & Perkins, J. (2002). *Providing Language Interpretation Services in Health care setting: Examples from the Field*. New York, NY. The Commonwealth Fund
- Zakaria, F., (2012) *Health Insurance is for Everyone*. Time Magazine March 2012
- Zambrana R.E., Ell K., Dorrington C., Wachsman L., Dee H. (1994). *The Relationship Between Psychosocial Status of Immigrant Latino Mothers and Use of Emergency Pediatric Services*. Health and Social Work, 19: 2
- Zegers de Beijl, R. (2000). *Documenting Discrimination Against Migrant Workers in the Labour Market: A Comparative Study of Four European Countries*. Geneva. International Labor Office
- Zouwen, J., (2010). Report on the European Survey Research Association Conference 2009 in Warsaw Bulletin de Methodologie Sociologique. Sage Publication
- World Health Statistics 2008
- WHO Health Report 2012
- Health in Asia and the Pacific, WHO 2008
- The Western Pacific Declaration on Diabetes, Kuala Lumpur 2000, Manila, Philippines 2000
- The European Health Report 2012. Charting the well-being. World Health Organization. Regional Office Europe.
- Preventing Chronic Diseases and Vital Investment: WHO Public Agency of Canada, 2005
- American Diabetes Association
- Time Magazine (January 2012)

Appendices

Appendix 1

Request for Filipino statistics in the French Riviera

Office of Public Information
Prefecture, Route de Grenoble
Nice France

August 25, 2011

Dear Sir/ Madame,

Bonjour.

I am Elizabeth Soliday-NAUI, a doctoral student from the University de Nice Sophia Antipolis, I3M Laboratory. My major is health communication and I am studying the health belief system of the Filipinos living in Nice, Cannes and Monaco.

In relation to my research, I would like to find out how many Filipinos are in these area. I hope you can provide me with the statistics/numbers of Filipinos registered at your office. I am assuring you that this data will be used for academic purposes only and will not be used for any other reason, other than as background data for my research.

I have attached a copy of my carte de sejour and my student card to prove my legitimacy as a student and researcher.

As to when I can get the documents or if someone from your office needs see me personally for the documents that I need, you may reach me at 0642080550 or through email, nauibeth@gmail.com. I would greatly appreciate if you could give me the information by last week of September until October 2011.

I thank you in advance for your assistance to this student, who traveled far in the name of academic pursuit.

Respectfully yours,

Elizabeth Soliday-NAUI
PhD Student
University de Nice Sophia Antipolis
Nice, France

APPENDIX 2
Request for Filipino Immigrant Statistics
(French Translation)

Bureau d'Information du Public
Prefecture, Route de Grenoble
Nice France

August 25, 2011

Cher (e)Monsieur/ Madam,

Je suis Elizabeth Soliday-NAUI, une étudiante en doctorat de l'Université de Nice Sophia Antipolis, Laboratoire I3M. Mon majeur est la communication en santé. Je suis étudiante en système de croyance de santé de la Filipino vivant à Nice, Cannes et Monaco.

En ce qui concerne mes recherches, je voudrais savoir combien de Philippins sont dans ces secteurs géographiques. J'espère que vous pouvez me fournir les statistiques / nombre de Philippins inscrits à votre bureau. Je vous assure que ces données seront utilisées à des fins d'études académiques et ne seront pas utilisées pour toutes autres raisons, autre que celles des données de base pour mes recherches.

Je joins une copie de ma carte de séjour et ma carte d'étudiante pour prouver ma légitimité en tant qu'étudiante et chercheur.

Restant à votre disposition pour tout renseignements complémentaires pour les documents dont j'ai besoin, vous pouvez me joindre au 0642080550 ou par email, nauibeth@gmail.com. Un rendez vous dans vos bureaux est possible, si nécessaire. Je vous serais très reconnaissant si vous pouviez me donner les informations avant fin Septembre 2011.

Je vous remercie d'avance pour votre airté cette étudiante.

Respectfully yours,

Elizabeth Soliday-NAUI
PhD Student
University de Nice Sophia Antipolis
Nice, France

APPENDIX 3
Answer of Prefecture de Nice

Sujet : Tr: votre demande du 25/08/2011
Date : Tue, 06 Sep 2011 16:00:41 +0200
De : etrangers@alpes-maritimes.pref.gouv.fr
Pour : nauibteh@gmail.com

Madame,

Par courrier du 25 août 2011, vous m'avez demandé de vous communiquer diverses statistiques concernant l'immigration de ressortissants de nationalité philippine, dans les Alpes-Maritimes.

J'ai le regret de vous faire savoir que je ne peux donner une suite favorable à votre requête, dans la mesure où les données statistiques relatives à la présence des ressortissants étrangers sur le territoire national, sont confidentielles et protégées par la loi.

Cordialement,

**Le Chef de Bureau,
de l'admission des étrangers au séjour**
Jean-Yves ORLANDINI

APPENDIX 4
Answer of the English Speaking Platform

Answer to the researcher's query
Sent May 28, 2013 12:04 pm

Bonjour Madame,

Nous avons reçu un courrier de votre part adressé au service communication de notre caisse primaire.

Nous avons un service langue étrangère ouvert en langue anglaise du lundi au vendredi de 9h à 18h au 0811 36 36 46 ainsi que des "fiches informations" en langue anglaise sur notre site ameli.fr

ameli.fr / vous êtes assurés / votre caisse : "taper" 50100 (code postal)
vous trouvez : **depending-upon-your-situation/contact-our-french-health-insurance_manche.php**

Cordialement,

--

Corinne ALMIN
Superviseur pfs Manche
et service langue étrangère
02.33.08.82.04

"Le contenu de ce courriel et ses éventuelles pièces jointes sont confidentiels. Ils s'adressent exclusivement à la personne destinataire. Si cet envoi ne vous est pas destiné, ou si vous l'avez reçu par erreur, et afin de ne pas violer le secret des correspondances, vous ne devez pas le transmettre à d'autres personnes ni le reproduire. Merci de le renvoyer à l'émetteur et de le détruire.

Attention : L'Organisme de l'émetteur du message ne pourra être tenu responsable de l'altération du présent courriel. Il appartient au destinataire de vérifier que les messages et pièces jointes reçus ne contiennent pas de virus. Les opinions contenues dans ce courriel et ses éventuelles pièces jointes sont celles de l'émetteur. Elles ne reflètent pas la position de l'Organisme sauf s'il en est disposé autrement dans le présent courriel."

Appendix 5 Interview with Mr. MOREAU

Fabrice MOREAU

Chargé de mission communication Nutrition
Département de la communication
Direction de la communication et des outils pédagogiques
fabrice.moreau@inpes.sante.fr
(t) + 33 1 49 33 23 99 / (f) + 33 1 49 33 22 60

1. How do you know which among the health issues is to be prioritized?

We base our approaches on epidemic studies. All our actions are based on accurate survey of the health of population.

2. Where does the call to create a health communication campaign emanate? Does it come from higher authorities or do you suggest to the higher authorities which ones should be done first?

We just ask ourselves the following question : regarding a specific health situation, is communication the most relevant way to address this issue. For example, is there a lack of knowledge of the population, what are the main hurdles for people to act on a positive way for their health, do people have representations and beliefs on any particular topic, on which communication can change something....Sometimes communication isn't relevant.

3. Can you describe the process of planning a health campaign?

We ask ourselves : what's the problem ? The matter is to identify the topic of the campaign. For example, we can see, on the nutrition issue, that people don't eat enough fruit and vegetables. We then decided to address this issue.

We gather all materials we need to understand this problem. For example : which are the main segments of the population that don't eat enough fruits and veg, why do they don't do it... On the basis of the information below (mentioned), we define a strategy. For example, we're going to try to help parents from low sociological categories of the population eat more fruits and veg. As we could have stated that if this segment of the population doesn't eat enough fruits and veg, it is because they consider fruits and veg too expensive for them, we're gonna try to define a message that suit to that problem, for example : "if you want to eat fruits and veg, you can also eat them frozen or as canned.

Once this message defined is, we try to build a communication strategy : which media (TV, radio, web...) and we'll produce the strategic message into a creative version (TV ad, website...)

4. What are the policies that you need to observe when planning health campaigns.

Actually, all our actions in terms of nutrition are built in a global public health frame dedicated to nutrition. It is called the PNNS, the "French National Nutrition Program". It defines the main orientations for this public policy. We also work with the different stakeholders relied (aligned) to that issue (other Ministeries, Industries, Local authorities, Associations...). it is a global approach.

5. How do you select the people/institution who will design and implement health communication campaign?

We implement that campaign and are helped in this task by a certain number of communication agencies that work for us.

6. Do you tie up with other organizations? Why? How?

Yes, lots, as I said before. We're working in a collaborative way with many organizations : ministeries, industries, associations, experts...Concentration is a key word in the way we do communication. More concretely, it means that we discuss about our campaigns with all these organizations before we launch them.

7. How do you go about selecting the organizations that you will tie-up with?

Because of the specific look they can give on the communications project we have. The aim is to have the widest point of view on any topic.

8. How do you evaluate your health campaigns?

We do "post test" that measure the immediate efficacy of a campaign.

9. What are your indications of success?

As the final aim is to make people change, it is quite difficult to identify the consequence of a communication campaign on people's behavior. Nutrition behavior is the consequence of many causes : public information, but also agro-food company ads, price of food...For that reason, it would be uncertain to say "that campaign has had these specific effects on health situation of the population".

Appendix 6

Introduction to the Filipino Community



Magandang Araw po sa inyong lahat

Ako po si ELIZABETH SOLIDAY-NAUI, estudyante na nag aaral sa University de Nice Sophia Antipolis, 13M Laboratoire, Carlone. Tinatapos ko po ang aking Doctoral sa tulong ng European Union bilang Erasmus Scholar.

Ang akin pong pinag- aaralan ay ang health practice ng mga Pilipino na naninirahan dito sa Cote d'Azur area. Halimbawa po nito ay ang kung naniniwala pa po ba kayo sa kunsepto ng init at lamig, pasma etc. Parte po ng aking research ang pag survey sa mga Pilipino na nasa Nice, Cannes, Monaco at Menton.

Ang akin pong survey ay walang kinalaman sa inyong papel dito sa France. Ang information po na ipagkakatiwala ninyo sa akin ay gagamitin lamang sa academe/University at hindi po ibibigay sa anumang government agency, dito sa France o sa Pilipinas na may kinalaman sa isyu ng pananatili o pagta-trabaho ng mga Pilipino sa France.

Maraming salamat po sa pag sagot sa aking survey at sa pagtitiwala

Elizabeth Soliday-Naui

Doctorant
13M Laboratoire, Fac de Lettre
University de Nice Sophia Antipolis
+33 6 42080550
nauibeth@gmail.com

APPENDIX 7
Survey form

Name (Pangalan) _____

Sex (Kasarian) _____ Babae _____ Lalaki

Telephone _____

Work (Uri ng trabaho) _____ sa bahay _____ sa yate _____ sa opisina _____ etc.

Age (Edad)

_____ 20-25 _____ 26-30 _____ 31-35 _____ 36-40 _____ 41-45

_____ 46-50 _____ 51-55 _____ 56-60 _____ 60+

Address (Tirahan) _____

Number of years living in (Nice, Cannes, Monaco) *Bilang ng taon na naninirahan sa Nice, Cannes o Monaco*

_____ 0-5 _____ 6-10 _____ 11-15 _____ 16-20 _____ 20+ _____

1. What are the most common disease/ailments you have? Anong mga pangkaraniwang karamdaman ang iyong nararanasan?

- _____ a. Headaches (*Sakit ng ulo*)
- _____ b. Backaches (*Sakit ng likod*)
- _____ c. Muscle pains (*Sakit ng kasu-kasuan*)
- _____ d. Colds (*Sipon*)
- _____ e. Fever etc. (*Lagnat atp*)

2. What are the sources of these ailments? (Ano sa palagay mo ang pinagmulan ng iyong madalas na karamdaman?)

- _____ a. Work related (*May kinalaman sa trabaho*)
- _____ b. Genetical predisposition (*Namanang sakit*)
- _____ c. It's new and you still don't know where and why it developed (*Bago ito at di pa matukoy ang pinagmulan*)

3. How do you deal with these ailments when you were still in the Philippines? (Paano mo ginagawan ng lunas ang ganitong mga karamdaman noong ikaw ay nasa Pilipinas pa?)

- _____ a. Go to the doctor (*Kumukunsulta sa doctor*)
- _____ b. Go to a traditional healer (*Kumukunsulta sa traditional na manga-gamot*)
- _____ c. Wait for it to go away (*Hinihintay na lamang na kusa itong mawala*)
- _____ d. Just rest and take what the elders tell me to take (*Magpahinga at uminon ng gamut ayon sa payo ng mga nakatatanda*)
- _____ e. Go to the doctor and see a traditional healer after (*Kumunsulta sa doctor at magpatingin sa traditional na manga-gamot*)

4. What are the health beliefs/practices when you were still in the Philippines? Anong mga gawaing pangkalusugan ang pinaniniwalaan mo at ginagawa noong ikaw ay nasa Pilipinas pa?

- _____ a. *Pasma (*naniniwala sa pasma*)
- _____ b. Hot and cold sources of diseases (*paniniwala sa "init" at "lamig" na pinagmumulan ng sakit*)
- _____ c. Putting a piece of cloth in a person back to absorbed his/her perspiration, which is believed to lessen the possibility of backache and bronchitis (*naglalagay ng damit sa likod para maiwasan ang pagkakaroon ng sakit sa likod at bronchitis*)
- _____ d. Putting a towel on the forehead when it start to get dark, usually in the late afternoon (*paglalagay ng bimpo sa ulo lalo na pag sapit ng dapit-hapon*)

_____ e. Massage therapy (*nagpapamasahe kung may nararamdamang sakit sa kau – kasuan o pilay*)

5. When do you decide to visit your doctor? (Kailangan ka nag dedesisyon na kumunsulta na sa doctor?)

_____ a. As soon as I experience discomfort (*Sa simula pa lamang na mag nararamdaman na akong kakaiba sa aking katawan*)

_____ b. After a few days of discomfort (*Pakalipas ng ilang araw na di maayos na pakiramdam*)

_____ c. If I cannot take the pain anymore (*Pag hindi ko na kayang tiisin ang sakit*)

6. Do you visit your doctor now more often than when you were in the Philippines? (mas madalas ka bang kumunsulta sa doctor ngayon kumpara nung nasa Pilipinas ka pa?)

_____ a. Yes (*Oo*) b. No (*Hindi*) c. Same (*pareho lang*)

7. If YES, what is/are the reasons? (Kung Oo, ano ang mga dahilan?)

_____ a. Accessible (*madaling puntahan*)

_____ b. Not expensive (*mura ang bayad*)

_____ c. No out of the pocket pay expense (*walang bayad*)

8. If NO, why? (Kung hindi, bakit?)

_____ a. not used to consulting doctors all the time (*hindi nakasanayan na madalas kumunsulta sa doctor*)

_____ b. getting in the way of job (*nakaka abala sa trabaho*)

_____ c. expensive (*mahal*)

_____ d. scared of the language barrier (*natatakot sa pag uusap na Pranses*)

9. What do you do when you do not completely understand your doctors explanation/instruction? (Ano ang iyong ginagawa kung di mo lubos na maintindihan ang paliwanag at instruction ng doctor?)

_____ a. Ask questions to clarify (*Nagtatanong hanggang sa lubos na maintindihan*)

_____ b. I just keep quite (di na ako nagtatanong pa)

_____ c. Will do research on my own (*maghahanap na lamang ng iba pang paraan upang masagot ang mga bagay na hindi maliwanag*)

_____ d. Ask someone to come with me as an interpreter (*Nagpapasama sa isang marunong mga salita ng French bilang interpreter*)

10. Do you usually understand the explanation of your doctor even if it is in French?? (Nauunawaan mo bang madalas ang paliwanag ng mga doctor kahit ito ay nasa salitang Pranses?)

_____ a. Yes (*Oo*) _____ b. No (*Hindi*) _____ c. not much (*hindi masyado*)

11. Is language still a barrier for you? (Ang lengwahe ba ay isa pa ring balakid sa inyo?)

_____ a. Yes (*Oo*) _____ b. No (*Hindi*) _____ c. not much (*hindi masyado*)

12. Aside from consulting a doctor, what other means do you do to know more about your disease? (Maliban sa pag kunsulta sa doctor, ano pang ibang paraan ang inyong ginagawa upang lubos na maintindihan ang inyong karamdaman?)

_____ a. talk to people who experience the same symptoms (*nakikipag usap sa mga taong nakaranas o nakakaranas ng parehong simtomas*)

_____ b. read articles (*nagbabasa ng mga artikulo*)

_____ c. research on family health history (*nagtatanong sa mga kamag-anak sa posibleng pinagmulan ng sakit*)

_____ d. get information from medical professionals (*humihingi ng impormasyon sa mga medical professionals*)

13. Do you still take medicines coming from the Philippines? (*Umi-inom ka pa ba ng mga gamot na galing sa Pilipinas?*)

_____ a. Yes (*Oo*) b. ____ No (*Hindi*)
Why? (*Bakit?*)

14. Do you think you take care of your health better now that you are in France? (*Sa palagay mo a ay mas higit mong napapangalagaan ang iyong kalusugan ngayong ikaw ay naninirahan na sa France?*)

_____ a. Yes (*Oo*) b. ____ No (*Hindi*)
How? (*Paano?*)

* A "folk illness" in the Philippines which has no equivalent medical term in English. The symptoms of **pasma** are trembling hands and sweaty palms occurring after strenuous use of the hands in manual labor. Farmers who work in the fields dragging plows, women who handwash laundry, pianists and athletes suffer from **pasma**. (<http://tagaloglang.com/Tagalog-English-Dictionary/English-Translation-of-Tagalog-Word/pasma.html>. Downloaded September 13, 2012)

APPENDIX 8

Guide questions for Key Informant Interview (KII)

1. What are your health practices while you were still in the Philippines?
 - a. Consult doctors / medical professionals for a regular check up or when needed?
 - b. Seek assistance from traditional healers?
 - c. Strictly follow medical advice?
 - d. Combine medical and traditional medicine?
 - e. Do you self medicate?

2. What types of traditional health practices do you do?
 - a. Hilot/ tawas/ soub and the likes?
 - b. Put towel in the back while working? Putting a piece of cloth on the head when dusk appears?

3. What are the health practices you do now that you are in France? Why?

4. Do you follow what your doctors tell you or you still apply what you used to know?

5. How do you let your doctor know about your health concerns?
 - a. Do you talk to them and ask questions?
 - b. Do you clarify health concepts that you don't understand?
 - c. Do you tell them how you deal with your illness before?

6. Do you talk to your peers (other Filipinos) about your health concerns?
 - a. Do they give advices?
 - b. Do you follow these advices?

APPENDIX 9
Key Informant Interview (KII) Transcription

CASE 1: VOICE RECORDED INTERVIEW

Context: MARIA (not her real name), a 50 plus woman whose been living in France for more than 20 years. She recently had an operation of the thyroid because of recurring pain.

ME: aside from the operation, ano yung mga pang karaniwan na sakit na nararanasan..

MARIA: sakit sa ulo, sakit sa likod, muscles pain, sipon, ubo

ME: yung sipon ubo related sa panahon?

MARIA: depende sa klima

ME: yung sakit sa ulo, sakit sa likod, related na sa trabaho

MARIA: Oo, yung mga yun, related na sa trabaho, sobrang pagod na

ME: a doon mo na nararamdaman

MARIA:

ME: nung nasa pilipinas ka, siempre medyo bata bata ka pa noon

MARIA: naku, tagal ko ng wala sa pinas, 25 yrs na, pero kahit noon pa man, trabahador na ako..

ME: so yung mga sakit sa ulo, sakit sa likod, pangkaraniwan nay an sayo.. noon pa man nararamdaman mo nay an..

MARIA: Oo,

ME: Nung nasa pilipinas ka pa, paano mo dini deal ang mga pangkaraniwang sakit nay an? Dinadala mob a sa doctor? Sa albularyo

MARIA: Hindi, ini inuman ko nalang ng kagaya sa atin na biogesic (pain reliever), neozep

ME: yung naka sanayan na

MARIA: pero di naman usual na kung kalian grabe na saka ka pupunta sa doctor

ME: nararanasan mo na bang pumunta sa mga hilot, sa mga albularyo, tradional healers

MARIA: nararanasan ko rin naman yun kasi nag mamasage ako e

ME: a nagmamasage ka

MARIA: Oo, nagmamasaha ako dito dati sa France, sa Monaco

ME: E bakit umayaw ka na?

MARIA: Kasi sobrang pagod, yung force sa edad na natin, di ko na kaya

ME: Dito sa France pag nakakaramdam ng di maganda, doctor ka agad?

MARIA:Depende

ME: pag kaya pa..

MARIA: pag kaya pa, ok lang.. (meaning di muna pupunta sa doctor)

ME: pag di na kaya ..

MARIA: Pag di na kaya, tumakbo ka na (sa doctor) total wala ka naman binabayaran..

ME: malaking Factor yun sayo?

MARIA: malaking factor yun na di ka na nagbabayad .. at least na ti check ka na kung ano ba

ME: di ka na nag aalala sa bayarin ano?

MARIA: oo, di ka na nag aalala sa kaliangan mong bayaran. Ultimong gamut mo e pwedeng ma reimburse.

ME: ok, naniniwala ba sa pasma? Mga hindi naliligo pag may menstration .. mga ganun?

MARIA: a hindi ko rin alam yan.. pero nung kabataan ko, yung parents ko yan din ang sinasabi sa amin. Kailangan ingatan rin naman naming ang sarili naming.. kailangan di malamigan yung.. alam mo na.. yung part na .. exclusive part.. kailangan di malamigan yun, di ka dapat kumain ng malamig, maasim, yung mga ganun ba

ME: so nung nasa pilipinas pina practice yun ..

MARIA: ay oo, kasi may magulang .. pero dito yung mga kabataan ngayon di na ini implement yan

ME: ikaw ba sinasabi mo yan sa mga anak mo?

MARIA: OO naman, dahil naranasan ko rin yun e .. dahil nung nandun ako sa pilipinas nung kabataan ko, pag kumain ako ng malamig tapos kumain ako ng maasim, sasakit ang t'yan ko.. totoo yun

ME: so proven mo yun

MARIA: proven ko yun kaya sinasabi ko sa mga anak ko na careful kayo pag may menstration.. mabuti na rin yung nag iingat

ME: ok.. kailangan ka nag de decide na bumisita na sa doctor? Pag yung talagang di na kaya?

MARIA: oo, dito naman kasi like kami every six months kailangan magpa check up dahil yun ang rules nila (referring to the French rule on health) kailangan

APPENDIX 10

Key Informant Interview

Case 2

Context: Zaldy (not his real name) 57 years old and has been living in Antibes for 18 years has all but praises to the French health care system. Coming from a family genetically predisposed for diabetes and heart problems, he started to have high cholesterol level by age 40. He started to see his doctor regularly and has been taking drugs to lower his cholesterol level.

Documentation technique: Written notes for the interviewee doesn't want to be recorded

Researcher (R): Magandang hapon Zaldy. Salamat sa pag oo sa interview na ito

Zaldy (Z): Ok lang, relax time na kasi tapos na ang trabaho

R: So, kumusta naman ang pag aalaga mo sa iyong health?

Z: Naku, ok na ok ako. Fit na fit! Maganda daw naman ang results ng mga laboratory exams ko sabi ng doctor ko.

R: Ilang beses ka bumibisita sa doctor mo?

Z: Once a month, kasi yung ---ko, par mois ang pag bibigay nya... kailangan rin nya kasi akong makita para mamonitor

R: English speaking and doctor mo?

Z: di masyado, French lagi ang usapan namin

R: Naiintindihan mo naman ?

Z: oo naman kasi binabagalan nya ang salita pag ako ang kausap. Saka nagpipilit mag English pag nakikita nya na di ko naiintindihan ang sinasabi nya

R: nagtatanong ka naman pag di mo naiintindihana ng sinasabi nya

Z: oo naman. Lalo na yung mga bawal na pagkain, ano yung mas magandang kainin at saka ano ang mga stress reliever ba... kasi ang pakiramdam ko nagkakasakit lang naman ako pag na I stress ako sa trabaho at issue sa pamilya

R: ano naman ang nakaka stress sa trabaho

Z: naku, pag maarte ang amo. O kaya may mga bisita palagi na magugulo. Kailangang i-drive, ipamilya o kaya naman pag delayed ang sweldo

R: meron bang mga pangyayaring nade delay ang sweldo

Z: naku crisis ngayon. Minsan delayed sila ng halos isang buwan.. so pag ganun, delayed din ang pagpapadala sa pinas. Nai stress ang pamilya ko doon kasi seimpre ako lang naman ang ina asahan nila.. may isa akong anak na may asawa na at walang hanap buhay yung napangasawa tapos 2 na ang anak.. sa akin pa rin naka sandal .. so ayun, kailangan kong kumayod ng double time

R: Pag ganyang stress ka, ano ang nararamdaman mo

Z: sumasakit ang batiok ko. Pakiramdam ko kasi aatakihin ako (laughing) at saka masakit ang likod ko

R: anong ginagawa mo pag ganun na may pain na nararamdaman

Z: imi inom na lang ng mga pain reliever... may alaxan naman o kaya dolfenal

R: Alaxan?

Z: Oo, galing pinas

R: Bakit meron ka nun?

Z: nagpapabili ako pag may umu uwi sa atin, Hiyang ba

R: e yung dolfenal?

Z: kasi effective din at saka mura lang

R: e yung mga gamut mo sa cholesterol mo

Z: buti na nga lang at nandito na ako sa France nang magkaroon ako nyan. Biruin mo naman ang gamutan at saka mga tests ko.

APPENDIX 11
Key Informant Interview (KII) Transcription

CASE 3: Couple Interview

Context: Juliet (not her real name) has been living in France for 2 years with her family (her husband Gilbert and their two little girls). She has severe case of Rheumatoid Arthritis (RA) and she's been operated on (two sides of her hips) so she can walk normally. She is undergoing therapy and needs to continue doing that for a long time.

Documentation technique: Video Interview

Juliet (J): (while in the Philippines), I take pain reliever, steroids, may once a month ako na injection for vitamins in my bones, may pain reliever

Researcher (R): nag try ka ba na mag consult sa mga manghihilot, mga tradional healers ...

J: hay naku, shocking.. ang dami ko ng experience .. ang byenan ko dinadala ako sa mga ganun .. siempre kinuha muna ang consent nya (referring to the husband) and then sabi nung healer may sumusunod daw sa akin na bata .. so sabi ng healer yun daw ang pinag mumulan ng sakit ko.. so may mga seremonyas syang ginawa pero hinihilot nya rin naman ako

R: nakaka relieved yung hilot?

J: hhhmmm... hindi.. kasi very light lang naman ang hilot,, di nya ako hinahawakan ng husto

R: psychologically, ano ang effect sayo pag nag co consult ka sa mga healers...

J: well, psychologically na I strengthen ako.. kasi yung hope ba .. binibigyan nila ako ng hope na "o after nito, magiging ok ka na, makakalakad ka na .. kaya lang ako kasi yung tipo na pag di nangyari mapo-frustrate ako at madali ako mag give-up

R: yung mga healers na kinu-consult mo ba e affiliated sa religion o yung mga natuto lang

J: naku, marami na .. iba – iba .. pero mas marami yung di affiliated sa religion

GIL (G): (husband) .. Actually, hindi ko inin – tertain kasi hindi ako nananiniwala sa ganyan kahit na lumaki ako sa hilot at tawas..

R: A ok..

J: yung last na lang nab ago kami pumunta ditto sa France, yun yung may pinakamaraming seremonyas.. pero yung all the rest.. panay hilot lang

G: mula kasi nung maging member ako ng church (referring to Jesus is Lord Movement, an organization of born again Christian which is different in teaching and practices from the Catholic Church)...

R: Paano nabago ang paniniwala mo about healing or cure pagmula nung dumating ka ditto sa France? Di ba nung nasa Pinas complementary ang pag –gamot sayo.. may medical doctor may mga albularyo..?? Nung dumating ka dito sa France, medical doctor na lang ang tumitingin sayo, so paano nabago ang paniniwala mo about treatment ng sakit mo?

G: it's the major part.. pero ganito kasi yan.. may na meet kasi sya nan a operahan din pero sa isang hip lang, but the operation went a little wrong

J: Di pantay, yung isa mababa

G: so inoperahan sya ulit, and then there's another one naoperahan sya at ganun din iika –ika pa rin ang lakad nya but theres one case na ok ang operation nya but she remained seated at walang ginagawa .. her body changes but she remained in the same state.. sa case nya (referring to Jen) she is very active in the church .. nagkaroon sya ng responsibility sa church and at the same time nagkaroon sya ng very competent na therapist, tapos of course motivation ..

R: yung therapist nya French?

G: Oo, French,, nag e- English

J: ang difference kasi sa pilipinas, hilotin lang kita ngayon bukas ok ka na..instant ba na healing

R: doctor yan?

J: hindi, yung healer ba .. yung therapist ko ngayon na Pranses, at least sinasabi sa akin na mahabang proseso yan... hindi ko sasabihin sayo na bukas ok ka na.. so ngayon alam ko na years pa talaga ang therapy ko

R: so nakatulong ba say o yung change of perspective ba?

J: Oo, may confidence na ako..kasi sa pilipinas, na yun pa naman ang pinaka ayaw ko,, yung tinititigan ka ng mga tao,, yung hinahabol ka ba ng tingin, ayaw na ayaw ko yun..at saka sa Pilipinas ang payo, pag may pain ilakad mo yan, kaya nag i- inflame sya dito pag may pain wag mo ipilit kasi ang kalaban ng rayuma pain.. dito pag may pain ako di nila ako hinahawakan, di nila ako pinipilit na gumalaw

Appendix 12 Website of lasantepourtous

The screenshot shows the website <http://www.lasantepourtous.com/> in a Safari browser window. The browser's address bar shows the URL and a search engine (Google). The website's navigation menu includes: **Infos Santé**, **Sexualité**, **Enfants**, **Maladies**, **Droits et Démarches**, **Numéros utiles**, and **Questions / Réponses**.

The main banner features the logo **LA SANTÉ POUR TOUS .COM** with the tagline **Mon avenir, c'est aussi ma santé**. Below the logo is a search bar with the text "Rechercher une information" and a magnifying glass icon. A small example text reads "ex : sexualité, maladie...". To the right of the search bar is a featured article titled **MANGER / BOUGER** with the sub-headline **MANGER, BOUGER : C'EST LA SANTÉ !** and a button **Lire le dossier →**. The article image shows a woman pushing a shopping cart while talking to a child.

Below the banner are three columns of information:

- Je m'informe sur la santé** (orange background):
 - SEXUALITÉ**: VIH / SIDA : toutes les raisons de faire le test!; BIEN VIVRE : Les bons gestes pour ne pas tomber malade cet hiver.
 - LES MALADIES DE A À Z**: Angine; Asthme; Choléra; Coqueluche; Diabète; VIH / Sida.Buttons: **Toutes les infos →**, **Toutes les maladies →**
- J'agis pour ma santé** (green background):
 - COMMENT ÇA MARCHE ?** Comprendre vos droits en fonction de votre situation.
 - OÙ ALLER ?** Découvrez les lieux pour vous faire soigner.
 - J'AI BESOIN D'AIDE** Qui contacter pour vous faire aider ou en cas d'urgence?Button: **Toutes les infos →**
- Vos questions, nos réponses** (blue background):
 - Je viens de refaire la chambre de mon enfant...** Ou, les substances chimiques qui se dégagent lors des travaux ou qui proviennent des meubles neufs (peintures, vernis, colles, etc.)... Lire la suite.Button: **Toutes les questions →**

At the bottom of the page, there is a section for **Le livret de santé bilingue** (Available in 23 different languages) with a download button **Télécharger** and a language selector set to **English**.

Appendix 13
English pages of the website

LIVRET DE SANTÉ ANGLAIS/FRANÇAIS BILINGUE

**Ce livret bilingue est disponible en FRANÇAIS/
ALBANAIS/ANGLAIS/ARABE/ARMÉNIEN/BENGALI/BULGARE/CRÉOLE HAÏTIEN
CHINOIS (MANDARIN)/ESPAGNOL/GÉORGIEN/HINDI/KURDE/LINGALA/OURDOU
PORTUGAIS/PULAR/ROUMAIN/RUSSE/SERBE/SONINKÉ/TAMOUL/TURC/WOLOF**

Texte : décembre 2005

Première impression : avril 2006

Réimpression : juin 2007

Attention : certaines informations contenues dans ce livret
sont susceptibles de modifications ultérieures.

BILINGUAL HEALTHCARE FRENCH/ENGLISH HANDBOOK

Text: december 2005

Note: some of the information in this booklet may be changed in the
future.



TO RECEIVE HEALTHCARE
POUR SE SOIGNER

- 8 "Basic" public health insurance
Sécurité sociale « de base »
- Supplementary universal medical cover
- 12 **CMU complémentaire**
- State medical aid (AME)
- 16 **Aide médicale État (AME)**
- Public Hospital PASS
- 20 **PASS de l'hôpital public**
- Specialised public healthcare services (free of charge)
- 22 **Services spécialisés de santé publique (gratuits)**
- Your regular doctor
- 24 **Médecin traitant**
- Interpretation
- 26 **Interprétariat**



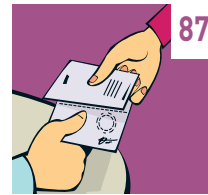
TO TAKE CARE OF YOUR HEALTH
POUR VEILLER À SA SANTÉ

- Medical check-up
- 32 **Bilan de santé**
- HIV-AIDS
- 36 **VIH-sida**
- Sexually-transmitted diseases (STD)
- 44 **Infections sexuellement transmissibles (IST)**
- Hepatitis B and C
- 46 **Hépatites virales B et C**
- Tuberculosis
- 50 **Tuberculose**
- Vaccination
- 54 **Vaccination**
- Lifestyle
- 56 **Mode de vie**
- Contraception
- 62 **Contraception**
- Your children's health at home
- 66 **La santé de vos enfants à la maison**



FOR LEGAL AND SOCIAL ASSISTANCE
POUR UN SOUTIEN JURIDIQUE ET SOCIAL

- Right of asylum
- 72 **Droit d'asile**
- Right of residence in the case of very serious illness
- 74 **Droit au séjour en cas de maladie très grave**
- Legal support
- 76 **Soutien juridique**
- Social protection
- 80 **Protection sociale**
- Everyday needs
- 84 **Besoins du quotidien**



PERSONAL AND PRACTICAL INFORMATION
VOS INFORMATIONS PERSONNELLES ET PRATIQUES

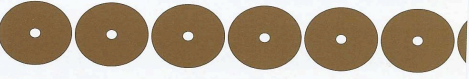
- Paris Metro Map
- 88 **Plan du métro parisien**
- Ile-de-France RER Map
- 89 **Plan du RER francilien**
- Marseilles Metro Map
- 90 **Plan du métro marseillais**
- Lyon Metro Map
- 91 **Plan du métro lyonnais**
- 2007-2008 Calendars
- 92 **Calendriers 2007/2008**
- Your contacts
- 94 **Vos contacts**
- Your upcoming appointments
- 95 **Vos prochains rendez-vous**
- Your care organisation
- 96 **La structure qui vous accueille**

Appendix 14
Information Flyer in Filipino

**Sasamahan
mo ako?**

Mga babasahin 

Mga aklat 

Musika 

Mga pelikula 

Mga Pahayagan 

Grupo ng
mga mambabasa 

Internet 

Mga kurso 



Bibliotèques de Barcelona

Appendix 15
Project Proposal to the Mayor of Nice

A l'attention de Monsieur Estrosi
Depute Mairie de Nice
NAUI

President de la Metropole de la Cote d'Azur
5 rue de l'Hotel de Ville
06300 Nice, France

Elizabeth Soliday-

Doctorant
i3M Laboratoire
Faculte de Lettre

University de Nice Sophia Antipolis

23 octobre, 2013

Monsieur,

Mon nom est Elizabeth Soliday – Nai, je suis une étudiante en doctorat et sur le point de finir mes études du Laboratoire I3M à la Faculté de Lettres, Université de Nice Sophia Antipolis. Je suis originaire des Philippines et je suis venue en France par le biais de l'Union Européenne à travers le projet Erasmus Mundus Mobility avec l'Asie (EMMA). Mon domaine d'études est la communication de la Santé et mes recherches se concentrent sur l'identification des nouveaux systèmes et des pratiques des immigrants philippins situés dans trois villes (Nice, Cannes, Monaco) dans le domaine de la santé dans la Côte d'Azur. Bien que la Principauté de Monaco ne fasse pas techniquement partie de la France, je l'ai incluse en raison d'un grand nombre de Philippins qui travaillent et vivent dans cette ville.

Ma recherche a permis d'identifier le nouveau système et les croyances dans la santé émergeant des immigrants philippins, et c'était ma contribution à la littérature de la communication de la santé tout en mettant l'accent sur les immigrants Philippins. Il y a lieu de mentionner toutefois que mon étude a également constaté qu'il y a un besoin pour davantage de recherches dans le processus d'intégration de la santé des immigrants .

C'est dans cette hypothèse que je vous écris cette lettre. J'espère que l'Administration Locale de Nice peut accueillir et financer un système de collecte de données sur la santé des immigrants à commencer par les immigrants philippins. Ce groupe d'immigrants est idéal pour une expérience parce qu'ils sont gérables en terme de taille et ils sont établis en groupes sociaux.

Ce projet que je propose est le reflet d'un projet similaire réalisé au Canada appelé « LIPs » (Local Immigration Partnerships) que l'on peut traduire par : « partenariats locaux en matière d'immigration ». L'objectif principal de ce programme est de réunir les autorités et les individus ensemble pour définir les besoins des immigrants et collaborer pour aider à organiser et trouver des solutions. C'est une triste réalité

que malgré le fait que la France possède un des meilleurs systèmes de soins dans le monde, il manque un système de collecte des données standardisées des immigrants. Ce serait un projet pionnier pour les politiciens locaux de Nice, à monter et soutenir ce programme qui pourrait par la suite faire des émules dans d'autres régions de France .

Je propose un projet qui permettra de relier tous les acteurs de la promotion et de la maintenance dans le domaine de la santé pour la Côte d' Azur. Ce projet est provisoirement appelé "PAIS"(Programme d'Aide aux Immigrants pour la Santé). L'intention est de faire réaliser des projets qui permettraient de déterminer ce qui suit:

- 1 . L'autoévaluation de l'état de santé des immigrants Philippins dans la région
- 2 . Problèmes de santé rencontrés par les immigrants Philippins
- 3 . La réactivité des projets actuels de santé publique aux besoins de santé des immigrants
- 4 . Recommandations sur la façon d'aborder les besoins de santé des immigrants

J'espère que vous aurez le temps d'examiner la proposition de projet attachée à cette lettre. Pour toute précision ou demande de renseignements, vous pouvez me joindre à : nauibeth@gmail.com. Dans l'attente de votre réponse la plus favorable, recevez Monsieur le Député Maire mes plus respectueuses salutations.

"PAIS"

(Programme d'Aide aux Immigrants pour la Santé)

Promoteur du projet: Elizabeth Soliday - NAUI
Présenté au: Bureau de Monsieur le Maire Christian Estrosi
Député Maire de Nice
Président de la Métropole de la Côte d' Azur
5 rue de l' Hôtel de Ville
06300 Nice , France
Date: 23 Octobre 2013

INTRODUCTION

La santé des immigrants en France s'est détériorée au cours des 30 dernières années, selon une étude menée par Catherine Berchet et Florence Jusot . En outre, les pratiques médicales établies par des bureaux et les programmes de préventions pour les immigrants ont diminués. Les immigrants ont enregistré un bon état de santé à leur arrivée mais leur niveau économique, la perte de lien social, les barrières de l'information et les attitudes discriminatoires des professionnels de la santé sont les principaux facteurs contributifs à la détérioration de leur santé (Bechet & Jusot 2012 p 1-2). Une autre étude menée par l'Institut de Recherche et d'Information en Santé Environnementale (IRDES) en 2002-2003 , en combinant le nombre de citoyens naturalisés et les immigrants étrangers, il s'agit d'une conclusion radicale que les immigrants ont des problèmes de santé, ils souffrent de maladies chroniques et de limitations d'activité. Considérant que la population des immigrants en France a continué de croître et qu'elle atteint 5,34 millions en 2008 (INSEE), le statut de leur état de santé signalé est une menace à la fois pour les immigrants et pour l'Etat. La même étude a également signalé que 6-8 % de la population des Alpes Maritimes sont des immigrants et que cette région est une destination populaire pour les immigrant .

Il a été établi que la France ne dispose pas d'un système standard de collecte des données de santé pour les immigrants par rapport à d'autres homologues européens comme la Suède, les Pays-Bas et le Royaume-Uni. Sans les données nécessaires pour déterminer les problèmes de santé de base de la population migrante l'Etat est mal équipé pour évaluer les difficultés de ce groupe minoritaire ce qui peut éventuellement conduire à des problèmes plus graves. Les résultats de ce manque d'informations remet en question les difficultés rencontrées par les immigrants dans leur processus d'assimilation et d'intégration compte tenu de la complexité et l'unicité du système de soins français.

Qu'est-ce que cela signifie pour les immigrants : que leur pays d'accueil est considéré comme le meilleur système de soins de santé dans le monde ? A l'autre extrémité, comment le gouvernement français répond à la composition en constante

évolution de ses citoyens ? De même, la pertinence des mesures de l'état pour la santé quand la population immigrée est concernée ?

RAISON

Les données sur la santé des immigrants doivent être mises à jour parce que la connaissance de leur état de santé est basée sur l'évaluation auto-déclarée. L'État doit avoir ses propres recherches qui pourraient confirmer ou infirmer ce rapport. Il existe un programme au Canada appelé LIPS (partenariats locaux en matière d'immigration) , qui met toutes les personnes impliquées en relation pour déterminer les besoins des immigrants de façon à trouver des solutions stables et réalisables dans les soins des immigrants .

Le Département des services de santé des États-Unis a reconnu que, dans leur communauté la barrière de la langue est le facteur de division majeure entre les immigrants et les soins. Ils ont reconnu aussi que l'absence d'interprétation adéquate est une forme de discrimination. Ils ont donc développé un ensemble de directives nommées : « Culturally and Linguistically Appropriate Services » (CLAS) que l'on peut traduire par : services appropriés culturellement et linguistiquement. Les normes du CLAS exigent que les organisations de santé offrent et fournissent des services d'assistance linguistiques aux patients (LEP) et excluent l'usage des membres de la famille comme interprètes à moins que le patient en fasse la demande expresse (Ngo - Metzger et . al. 2007).

Ceci est encore renforcé dans une étude sur les patients qui ont été identifiés comme « LEP » (Limited English Proficient) ou limités en anglais expérimenté par Ngo - Metzger et al. Les États-Unis ont aussi examiné l'effet de la discordance des langues sur le degré d'éducation sanitaire et la qualité des soins interpersonnels que les patients ont reçus, également évalué les effets sur la satisfaction des patients ou comment la présence / absence d'un interprète de la clinique affecte ces résultats. Leurs populations migrantes sont les hispanophones et les Américains d'origine asiatique, en particulier vietnamienne et chinoise (Ngo - Metzger et . al .). La langue comme obstacle pour les LEP est associée à moins d'éducation pour la santé, à des soins interpersonnels et une faible satisfaction du patient.

Ces études ont non seulement identifié les défis auxquels sont confrontés les immigrants dans le processus d'assimilation et d'intégration de la santé, mais plus important encore, elles ont souligné la réponse du Gouvernement aux problèmes de santé des immigrants.

Ma proposition est un projet pionnier dans le Sud de la France. Il n'y a eu aucune étude récente sur la santé des immigrants, à plus forte raison d'un groupe minoritaire, l'aide actuelle accordée aux immigrants par «lasantepourtous» basée à la Mairie de Nice, comprend des cours de langue et la façon de gérer les documents pour être enregistré dans les systèmes sociaux en France. Il n'y a eu aucune étude récente spécifiquement basée sur la santé des immigrants.

Pourquoi les immigrants philippins ?

Ce groupe d'immigrants a cimenté leur place dans le tissu même de la vie française. Ils ont acquis une excellente réputation en tant que gardiens des villas, des aides à domicile, nounous et à peu près tous les travaux liés au domaine domestique. Cependant, certains se sont aventurés dans des emplois liés à l'économie et la première génération d'immigrants philippins ont de meilleures opportunités car ils sont déjà français à bien des égards. Les Philippins sont populairement connus comme travailleurs acharnés, ils représentent la poussée des travailleurs dignes et fiables enfin ils sont des citoyens respectueux de la loi dont l'objectif principal est de gagner une descente de vie pour leur famille.

Pour ce projet, le groupe d'immigrants philippins est un bon début pour tester les théories et répondre aux questions concernant la façon dont les immigrants s'adaptent à être assimilés et intégrés dans le système Français de santé. Leur nombre est restreint ce qui les rend facile à gérer, ils sont organisés ce qui les rends accessibles et ils sont ouverts et donc communiquent facilement.

OBJECTIFS:

- 1 . Déterminer l'état de santé des immigrants philippins dans la région
- 2 . Détecter les difficultés rencontrées par les immigrants philippins concernant la santé
- 3 . Comparer les différences entre les projets actuels de santé publique et les besoins des immigrants
- 4 . Formuler des recommandations sur la façon d'aborder les besoins des migrants pour la santé

METHODOLOGIE ET CALENDRIER

Phase 1 : 6 semaines
½ mois)

(1

TABLE RONDE / documents et examens des projets

Rassemblement de toutes les parties qui comprend : des professionnels de la santé, des politiciens locaux, les concepteurs de la Campagne de la Santé, des chercheurs et des représentants de groupes d'immigrants philippins. Ils détermineront les programmes de santé destinés aux immigrants et qu'elles seront les réalisations de ces programmes, ce qui pourra être amélioré ainsi que l'identification et la définition des besoins de santé de ces groupes d'immigrants

Phase II : Enquête 8 semaines (2 mois)

Effectuer des sondages. Un questionnaire permettra de déterminer les questions / préoccupations des immigrants qui les empêchent de s'intégrer dans le système de soins Français. Ils seront également questionnés sur leur perception de leur état de santé actuel ainsi que d'autres problèmes de santé annexes qui doivent être identifiés.

Phase III : groupes de discussions 18 semaines (4 ½ mois)

Pour valider le résultat de l'enquête, les immigrants sélectionnés seront invités à une discussion approfondie avec des questions liées à leur sentiments d'immigrés dans le sud de la France et à leur état de santé.

Phase IV- rédaction et la finalisation des recommandations 12 (3 mois)

Tous les acteurs dirigés par l'Equipe de Recherche élaboreront et finaliseront un rapport qui sera soumis au bureau du Maire, qui a financé le projet.

Institutions / PERSONNES IMPLIQUEES

- 1 . Politiques des gouvernements locaux
- 2 . Les bureaux de santé locaux et les professionnels de la santé
- 3 . Organisations qui appuient l'intégration des immigrants dans la région
- 4 . Groupes d'immigrants philippins

BUDGET - à déterminer

Appendix 16
Answer from the office of the Mayor



VILLE DE NICE

Madame Elisabeth SOLIDAY-NAUI
Doctorant
13M Laboratoire
Faculté de Lettres, Arts et Sciences
Humaines
Université de Nice Sophia Antipolis
98 boulevard Edouard Herriot
BP 3209
06204 NICE CEDEX 3

Nice, le **15 NOV. 2013**

Madame,

J'ai pris connaissance avec une particulière attention de votre courrier du 23 octobre 2013 par lequel vous avez bien voulu me transmettre le Programme d'Aide aux Immigrants pour la Santé que vous avez élaboré dans le cadre de vos études de doctorat.

J'ai aussitôt saisi de votre démarche Monsieur le Directeur de la Santé Publique, afin qu'il étudie celle-ci avec soin.

Soyez assurée que vous serez tenue informée, dans les meilleurs délais possibles, de la suite qui pourra lui être réservée.

Dans l'attente et demeurant à votre écoute, je vous prie de croire, Madame, à l'assurance de mes respectueux hommages.

Pour le Maire et par délégation
Le Directeur Général du Vivre Ensemble
et de la Proximité


Monique BAILET

Les informations recueillies font l'objet d'un traitement informatisé. Conformément aux articles 39 et suivants de la loi n° 78-17 du 06 janvier 1978 modifiée relative à l'informatique, aux fichiers et aux Libertés, vous bénéficiez d'un droit d'accès et de rectification aux informations qui vous concernent en vous adressant au Service Santé Inspection de Santé 10, rue Hansy.

E-courrier N° 345856/349758 -PL./sm
Ville de Nice - Direction Générale Adjointe du Vivre Ensemble et de la Proximité
Direction de la Santé Publique — 06364 Nice Cedex 4
eglantine.castanet@ville-nice.fr

RESUME EN FRANCAIS

La France n'a pas encore de système de collecte d'informations sur les immigrants standardisé. Ainsi, l'état de santé des immigrants est, aujourd'hui encore, déterminé de manière irrégulière. La seule information de santé des immigrants disponible correspond au statut de santé déclaré par l'immigrant. Ceci est à la fois problématique et surprenant car la France est considérée comme une des nations au monde à avoir le meilleur système de santé malgré le manque de données concrètes sur l'état de santé des immigrants. Une question se pose alors : « comment les immigrants se fraient un chemin dans le système de soin français ? ».

Les Philippins vivant dans le sud de la France sont la cible de cette étude. Cette étude utilise le sondage, le « Key Informant Interview » et l'observation directe pour rassembler des données afin de comprendre comment leur culture et leur langage maternel interfèrent avec le système de soin français.

Dans cette étude, l'hypothèse émise était que le langage est une barrière pour les immigrants Philippins cherchant l'accès aux soins médicaux. De plus, la culture traditionnelle de santé joue aussi un rôle important dans la pratique de santé des Philippins, même si ces derniers sont en France depuis de nombreuses années. Ils ont réussi malgré tout, à s'adapter au système de soin français. Cependant, cette adaptation doit être clairement identifiée et décrite. A l'interface de la culture, du langage et du système de soin de santé du pays d'accueil, les immigrants, consciemment ou non, créent une culture de santé émergente, différente de leur culture d'origine, qui identifie mieux un bon ou un mauvais état de santé ainsi que la manière de l'exprimer.

Cette étude révèle que malgré le temps passé dans le sud de la France, la culture de santé traditionnelle des Philippins joue toujours un rôle dans leur pratique de santé. Les problèmes de santé sont toujours une affaire de famille. Ainsi certains médicaments sont importés des Philippines. D'un autre côté, ils profitent aussi des avantages du système de soin de santé français. Ils rendent visite à leur docteur plus souvent, ils prennent religieusement leurs médicaments et ils profitent des nombreuses options de traitements disponibles en France. Ils peuvent profiter de tout cela parce qu'ils sont couverts par le système universel d'assurance maladie français.

D'un autre côté, les immigrants Philippins restent des patients passifs. A cause de la langue qui reste encore une barrière, leur comportement vis à vis de médecin est fait de hauts et de bas. Les Philippins sont d'un naturel timide. Ainsi ils essayent toujours de ne pas avoir de longues conversations. Ceci reste un défi pour les professionnels de santé qui ne sont ni formés ni préparés à gérer des patients parlant un langage étranger.

Mots clés : culture, communication de la santé, immigrants, langage

CHAPTER I

INTRODUCTION

*** “Communication in Health and Illness constitute the most vital human experiences. No other human phenomenon is more elemental than health and illness. None connects us more viscerally with our aspirations or confronts us more palpably with our limitations. Moreover, given the dynamics of these elemental experiences and especially given that they are constituted in the communicative interweaving of body, mind and society, health communication represents among the most complex, challenging and potentially rewarding areas for scholarly inquiry ²⁴⁷”**

Quand il est question de santé, la discussion tourne non seulement autour du bien être mais elle s'intéresse aussi aux défis auxquels la santé doit faire face. La santé est décrite comme un concept multicouche, multi-facettes, qui n'explore pas uniquement l'aspect sociologique, culturel et politique d'une société au sens large, mais qui s'intéresse aussi au mode de vie des gens sur un plan plus personnel. Ainsi les problèmes liés à la santé touchent, non-seulement, la société au sens large e.g. les recommandations de l'Etat, les institutions politiques, les interventions des parties prenantes, mais affectent aussi la société à un niveau plus intime tel que le rapport à la santé des personnes e.g. mode de vie, les croyances religieuses, les influences culturelles. Cette complexité a inspirée le chercheur et l'a amené à étudier le rôle de la communication dans le domaine de la santé.

En tant qu'académicien de longue date, en tant que professeur en communication et en tant que spécialiste de la communication pour la santé, l'auteur a consacré ses études supérieures au rôle de la communication dans le domaine de

²⁴⁷ Brashers, D.E, & Babrow A, S., (1996). *Theorizing Health Communication: Communication Studies*. SAGE Publication. P 243. Traduction: *Communication en santé et de la maladie constituent des expériences humaines les plus vitales. Aucun autre phénomène humain est plus élémentaire que la santé et la maladie. Aucun nous relie plus viscérale avec nos aspirations ou nous confronte plus palpable avec nos limites. En outre, étant donné la dynamique de ces expériences élémentaires et en particulier étant donné qu'ils sont constitués dans l'imbrication de la communication de corps, l'esprit et de la société, la communication de la santé représente parmi les zones les plus complexes, difficiles et potentiellement enrichissantes pour la recherche savante "*.

la santé depuis la conceptualisation de campagnes de communication à la mise en place de campagnes de communication pour la commercialisation de produits pharmaceutiques. Cette expérience l'a conduite à s'intéresser davantage à la dynamique impliquée dans la gestion des soins de santé et notamment dans le domaine de la sociologie des prestations des soins de santé. Plus tard, elle utilisera sa riche expérience dans le domaine de la communication sur le marché de la santé dans une problématique académique. Ayant eu l'expérience, dans un premier temps, sur la façon dont les problèmes de santé sont communiqués au public cible afin d'obtenir leur intérêt dans l'espoir d'encourager un mode de vie plus sain, elle a décidé d'enquêter sur le phénomène de l'interconnexion des vastes champs de la santé, de la communication et de la culture.

Contexte de l'étude

*** *“Health is about people. Beyond the glittering surface of modern technology, the core space of every health system is occupied by the unique encounter between one set of people who need services and another who have been entrusted to deliver them²⁴⁸”.***

Cette déclaration souligne le fait que, malgré le nombre impressionnant de technologies médicales qui sont aujourd'hui utilisées pour diagnostiquer les maladies, le cœur même de la communication et de la compréhension de la santé nécessite toujours une interaction humaine. Parler de la gestion de la santé est une question sensible qui peut être mieux comprise à travers une conversation réelle. Il ne peut être contesté que les tests de laboratoire effectués en utilisant un équipement médical de haute technologie sont plus précis que jamais, et ses conclusions ont contribué à la meilleure compréhension de la prévention des maladies, leur gestion et les soins.

²⁴⁸ Frenck, J. et al (2010). *Health Professionals for a new Century: Transforming Education to Strengthen Health Systems in an Interdependent World*. <http://nrs.harvard.edu/urn-3:HUL.InstRepos:4626403> (Accessed March 1, 2013. Traduction : *La santé est sur les gens. Au-delà de la surface brillante de la technologie moderne, l'espace de base de tout système de santé est occupé par la rencontre unique entre un groupe de personnes qui ont besoin de services et un autre qui a été confiée à les délivrerz* »

Toutefois, l'interaction humaine est indispensable pour bien comprendre la dynamique des facteurs affectant la santé. L'effet positif d'une simple conversation a déjà été prouvé. Il n'est pas rare que des personnes en situation d'anxiété, aient besoin de parler à une personne de confiance pour se soulager. Il est surprenant de voir combien le simple fait de parler à quelqu'un qui nous écoute, soulage. En effet, la conversation a un effet thérapeutique. Que ce soit pour parler des défis de la vie quotidienne à des questions plus complexes comme la santé, une bonne conversation a toujours été la première étape dans la compréhension des questions complexes de la vie quotidienne.

Comprendre les enjeux de la santé se résume à la communication entre les professionnels de santé (par exemple médecins généralistes, infirmières), le personnel de santé auxiliaire (par exemple les travailleurs dans les bureaux de santé, les cliniques et les hôpitaux publics dont l'emploi principal est d'aider les professionnels de la santé et de fournir des informations aux institutions de l'Etat en matière de santé) et les patients. Il est vrai que l'Etat et les institutions liées à l'Etat ont un rôle très important à jouer dans la diffusion de messages sur la santé, mais les soldats de première ligne, dans la bataille pour la santé, sont cependant les professionnels de la santé (toutes personnes impliquées dans la prestation de santé) et c'est eux qui font toute la différence dans la vie de leurs patients.

La mission personnelle de l'auteur est donc devenue, à travers sa recherche académique, de fournir des informations de base concernant la gestion et l'entretien de la santé. Sachant le rôle clé de l'information dans le domaine de la santé, son désir est donc d'aider les décideurs et les prestataires de santé en fournissant des résultats de recherche pertinents et opportuns. En fin de compte, elle croit fermement que c'est le droit d'une personne d'avoir accès à des informations fiables afin qu'il puisse faire des choix de santé éclairés.

Rationale

What difference can the field of health communication do to the public²⁴⁹?

Cette question a encouragé beaucoup de bourses d'études et la réponse a été donné à travers différentes perspectives. Une réponse évidente à cette question est le fait que grâce à une communication efficace et organisée il est possible : d'améliorer les soins et les prestations de santé, de rendre plus fiable les recherches épidémiologiques, de proposer et promulguer des lois sur la santé, de planifier, exécuter et évaluer des programmes de santé, et de légitimer les expériences personnelles concernant les maladies. Pour couvrir largement tous ces domaines, qui constituent le domaine de la communication santé, la recherche est un outil indispensable sur lequel se base la politique et les décisions de gestion. Cette recherche devrait être effectuée par des professionnels médicaux, des institutions gouvernementales, des groupes de préoccupation ainsi que par le monde universitaire. La synchronisation des efforts de ces groupes va conduire à une meilleure compréhension de la santé, la maximisation des ressources et la collaboration de projet qui profitera, à terme, au grand public.

Le caractère pragmatique de la communication souligne la centralité du processus de communication dans la compréhension des concepts sur la santé. Grâce à des stratégies de communication efficaces, les gens reçoivent de l'information sur la santé qui les informe et les éduque mieux sur la prédisposition à certaines maladies, que ce soit par la génétique ou de mode de vie, les conséquences de la contraction d'une maladie et les comportements qui permettront la prévention ou la guérison. Pour ceux qui sont déjà malades, leurs médecins traitant comprendraient mieux l'impact psychologique et physique de leurs

²⁴⁹ Kreps, G.L. (1988). The Pervasive Role of Information in Health Care: Implications for Health Communication Policy. In J. Anderson (Ed.), *Communication Yearbook* 11, (238-276). Newbury Park, CA, Sage. P 2. Traduction: *Quelle différence le domaine de la communication santé peut faire pour le public?*

souffrances. De plus, les patients en confiance seraient plus à même de communiquer sur leur état d'esprit et partageraient ainsi plus d'information qui aideraient le personnel soignant à établir un diagnostic ou un pronostic. D'autre part, les professionnels médicaux doivent également être informés sur l'origine des membres de la population qu'ils servent. Cela se traduit par avoir suffisamment de connaissances sur les origines raciales et ethniques de la population qu'ils servent. Ainsi ils pourront adapter les procédures de diagnostic et les actes médicaux en fonction des sensibilités culturelles.

Dans l'article publié en ligne par Reuters Santé (25 Février 2013), le résultat d'une étude de Johns Hopkins University School of Medicine à Baltimore USA a révélé qu'un diagnostic précoce manqué ou mauvais pouvait mettre en danger, chaque année, des milliers de patients à cause des complications liées à la maladie²⁵⁰. Cette étude a indiqué que les efforts, pour la sécurité des patients, sont concentrés sur les erreurs pendant la chirurgie et à la prescription de médicaments. Moins d'attention a été accordée aux diagnostics manqués dans le bureau du médecin et cette erreur de diagnostic se traduit par environ 150.000 décès ou handicaps par an. La plupart des erreurs de diagnostic sont faites au moment de la visite chez le médecin soit ce dernier ne dispose pas d'un historique médical précis du patient, soit il ne réalise pas un examen complet ou alors il ne commande pas les tests appropriés. L'étude conclut que la constitution de diagnostic doit être réalisée à la fois par le fournisseur de soins de santé et par le patient lui-même. Les patients sont encouragés à être plus engagés dans une conversation avec leurs prestataires de santé afin d'évaluer si le comportement, le mode de vie, la prédisposition génétique et les symptômes actuels, peuvent avoir conduit à la maladie.

²⁵⁰ Nicholson, L. (2013) *Missed diagnosis common in the Doctors Office*. <http://www.reuters.com/article/2013/02/27/us-misdiagnoses-idUSBRE91Q02420130227> (accessed April 2013).

Les résultats de cette étude sont alarmants et mettent en évidence, une fois encore, le rôle du patient dans le maintien de sa santé ainsi que le poids de la responsabilité des prestataires de soins. Il est tout aussi important que le patient soit incité à documenter tous les symptômes ressentis avant ou après le diagnostic initial et s'assure de communiquer tout cela avec les professionnels de la santé. D'autre part, les professionnels de la santé devraient prendre en considération les particularités de la population qu'ils servent et utiliser toutes leurs facultés pour extraire la bonne information. Dans les bonnes circonstances, c'est le scénario idéal. Cependant, dans le contexte des différences culturelles et linguistiques, la conversation sur la santé entre patients et professionnels de la santé sont plus complexes. Souvent, les patients deviennent plus anxieux quand ils ne peuvent pas trouver les mots justes pour exprimer ce qu'ils éprouvent. Les fournisseurs de soins sont aussi frustrés quand l'entrevue prend plus de temps que prévu mais n'apporte pas les informations attendues. Dans le cadre de la communication interculturelle en santé, où les prestataires de soins et le système de santé dans son ensemble sont différents ou nouveaux pour le patient, il y aura toujours un manque de communication et, souvent, c'est le patient qui est le perdant.

Ceux qui ne disposent pas d'informations concrètes sur le système de soins de santé d'un pays sont les immigrants. Ils se déplacent dans un nouveau pays pour plusieurs raisons. Certains d'entre eux sont déjà familiers avec la langue du pays d'accueil qui rend l'intégration plus facile à gérer. Prenons l'exemple des Philippins qui ont émigré aux États-Unis ou au Canada ou dans tous autres pays anglophones. Ils sont capables de se débrouiller, car ils comprennent et sont compris. C'est le même scénario pour les personnes originaires d'Afrique, du Maroc et de l'Algérie quand ils ont immigré en France. Ils parlent français ce qui rend la recherche d'informations plus rapide et plus facile menant à une intégration plus facile et plus rapide.

Ce n'est pas le cas cependant pour les Philippins qui viennent en France. Bien que le français fasse partie des langues latines, et que les Philippins sont exposés à

l'espagnol (quelques mots philippins sont espagnol avec la même signification ex Silya, mesa, kuwato, tumar etc), le français reste une langue étrangère pour les Philippins. On ne peut pas s'empêcher de se demander combien de temps faut-il aux Philippins pour s'intégrer socialement (en supposant que ceux qui sont dans la région depuis longtemps le sont déjà). De même, comment ont-ils pu trouver où obtenir de l'assistance médicale en cas de besoin? Ce même scénario peut être envisagé pour les français émigrant dans un pays anglophone. Il est vrai que c'est la responsabilité de l'immigrant de connaître et d'apprendre l'histoire, la culture et la langue du pays d'accueil. D'autre part, le pays d'accueil est-il prêt, une fois qu'il a ouvert ses portes à l'immigration, à assumer ses responsabilités et ainsi aider les immigrants dans leur processus d'intégration, en particulier pendant la phase de transition précoce. L'accompagnement devrait également être maintenu après la phase de transition parce que les immigrants sont confrontés à des problèmes différents de ceux de la population générale du pays hôte et nécessitent une approche différente.

Dans le contexte de la santé, l'apport de données sur l'interdépendance complexe de la langue, de la culture et de la santé, est une intéressante promesse de recherche académique. Enquêter académiquement sur ces concepts, les appliquer à un groupe minoritaire particulier situé dans un environnement complètement différent en termes de langue, la géographie et de culture devrait produire des données riches. L'auteur a été accepté dans le programme Erasmus Mundus Mobility avec l'Asie (EMMA)²⁵¹ et a été placé dans une des universités du Sud de la France. Comme un débutant dans le sud de la France, totalement naïf sur le mode de vie français, son mécanisme d'adaptation était de connaître les Philippins dans la région et de développer un lien avec eux. Elle a été accueillie avec enthousiasme par son peuple qui rend l'adaptation à un nouvel environnement, tolérable, mais pas du tout facile. Ils ont été sa source d'informations précieuses sur

²⁵¹ Erasmus Mundus Mobility with Asia (EMMA) is for funding Asia to Europe individual mobility flows (IMF) of academics from Partner Countries, fully sponsored by the EACEA run programme Erasmus Mundus External Cooperation Window. <http://math.unice.fr/EMMA/IsThisForMe.html> (accessed January 2010)

la façon de survivre à Nice dans la vie de tous les jours. Parce que la majorité des Philippins qu'elle a côtoyé appartiennent à une tranche d'âge plus élevée et vivent sur la Côte d'Azur depuis plus de 5 ans, les discussions allaient souvent au-delà des conseils de survie habituels. Histoires de douleur émotionnelle d'être loin de leur famille, le défi de la langue, la détresse psychologique apportée par le sous-emploi, leurs efforts pour s'adapter-revient toujours et ces histoires proviennent d'expériences légitimes de personnes qui ont quitté leur pays. Tels sont les défis qu'ils ont à supporter pour l'intérêt de l'argent et la promesse d'une vie meilleure pour eux et leurs familles. L'impact socio-psychologique de ces défis contribue à un mal-être. En ce référant à la santé, au sens strict, comme «un état de complet bien-être physique, mental et social, et pas seulement l'absence de maladie ou d'infirmité » tel que défini par l'organisation de la santé, un grand nombre d'immigrants philippins en France sont donc malades.

Heureusement pour les Philippins, ils sont considérés comme provenant d'un pays qui appartient au top 10 des pays les plus heureux du monde classé numéro 8²⁵², leur capacité à faire face et à gérer une situation stressante et difficile fait partie de leur patrimoine culturel (si ce n'est pas l'héritage génétique). Ces gens ne prennent pas les choses trop au sérieux et ils ont la capacité de se retirer dans leurs zones de confort, comme être en compagnie d'autres Philippins, profiter des activités avec eux et partager des histoires et échanger des conseils. Le Philippin n'a pas inventé le karaoké pour rien. Un microphone accompagné de partition musicale est une panacée pour ce peuple. Un remède à tout.

Le chercheur était certain, avant même son arrivée à Nice, qu'elle étudiera les questions de santé relatives aux Philippins dans le sud de la France. Entendre les grands récits de l'immigration et les sacrifices qui lui sont associés, ainsi que les récompenses, le chercheur a été profondément motivée pour explorer les histoires

²⁵²[Happiest people in the World: http://www.japantimes.co.jp/opinion/2013/01/06/editorials/happiest-people-in-the-world/#.UbHt0172in8.](http://www.japantimes.co.jp/opinion/2013/01/06/editorials/happiest-people-in-the-world/#.UbHt0172in8) Japan Times mis à la disposition 6 Janvier 2013, (accessed June 7, 2013)

de sa population, mais elle est restée vigilante et s'est concentrée sur les histoires liées à la santé. Son intérêt pour la communication sur la santé découle de son travail avec les organismes de santé à un niveau professionnel ainsi que l'enseignement de la communication dans plusieurs universités aux Philippines. Son parcours académique et professionnel l'amène à poursuivre la communication en santé comme un domaine de recherche. Après avoir obtenue la possibilité de poursuivre des études supérieures à l'étranger, elle a maintenant commencé à s'intéresser à la façon dont la culture influe sur la vie des immigrants en se concentrant sur leur santé.

Ce chercheur croit que les immigrants philippins dans la Côte d'Azur, en particulier ceux qui sont là depuis longtemps, ont pu assimiler efficacement le mode de vie français. Bien qu'il persiste de fortes traces d'un système de croyances provenant de leur origine raciale, il y a des comportements émergents qui méritent une enquête académique.

Dans le domaine de la santé, les Philippines ont un système de croyance à la santé unique qui est fortement basé sur la culture, influencée par la religion et sont informés par des professionnels de la santé formés en occident. Ce mélange de systèmes de croyances sont cristallisées dans les mots et expressions utilisés pour décrire la santé et les maladies. En médecine occidentale, la douleur est un symptôme. Dans le contexte philippin le mot "sakit" (douleur) est utilisé de plusieurs façons, en dehors de sens maladie (par exemple sakit ng ulo pour des maux de tête, sakit ng Tiyan de maux d'estomac)²⁵³. Les Philippines utilisent aussi des mots différents pour décrire les différentes sortes de douleur : hapdi pour le picotement, kirot pour récurrence forte, Antak pour brûlure interne continue²⁵⁴. La distinction de la topographie des Philippines, de l'économie, de la politique, de la culture aide à créer et façonner des systèmes de santé en constante évolution. En considérant

²⁵³ Tan, M.L., (2008). *Revisiting Usug, Pasma, Kulam*. Quezon City. University of the Philippines Press. P 21

²⁵⁴ Jocano, F.L., (1973). *Folk Medicine in a Philippine Municipality*. An analysis of the system of folk healing in Bay, Laguna and its implications for the introduction of modern medicine. The National Museum. Manila. p 75

combien c'est différent de la France, il est intéressant d'extraire ce qui, dans le système de croyances de santé émergent des immigrants philippins dans le Sud de la France et Monaco, a déjà été acculturés.

Comme il s'agit d'une étude en partie ethnographique, le chercheur s'est immergé dans la vie de sa population en vivant parmi eux. Elle a été bien accueillie dans les événements sociaux et personnels et elle s'est fortement impliquée dans leurs conversations. Elle a pu faire l'expérience de travail des immigrants philippins en travaillant à temps partiel comme femme de ménage et comme nounou et elle a aussi ressenti la douleur d'être loin de sa famille. Bien que la situation difficile de ce chercheur est différente des situations réelles d'immigrants philippins, elle a pu être impliquée dans les récits traitant du fait d'être un immigrant. Ce chercheur est toutefois restée centrée sur le respect des croyances et des pratiques de santé de sa population.

Des anthropologues médicaux aux Philippines ont découvert qu'il n'y a pas beaucoup de distinction entre les termes «croyances» et «pratiques». Dans la culture populaire médicale, la métaphore permet aux gens d'exprimer leurs préoccupations au sujet de la condition humaine, même si leur symbolisme est caricaturé²⁵⁵. Ainsi ces termes ont été utilisés ensemble dans cette étude.

Il s'agit d'une activité académique digne qui mettra en lumière, non seulement la spécificité culturelle des Philippins, mais qui discutera aussi sur la façon dont les campagnes de communication sur la santé dans le Sud de la France et Monaco peuvent être conçues et mises en œuvre en ciblant spécifiquement la minorité philippine. Le groupe d'immigrants philippins est juste l'un des nombreux groupes minoritaires situés dans la Côte d'Azur et l'un des objectifs de cette recherche est de rouvrir le débat public en soulignant l'importance de la collecte de données sur la santé des immigrants. Le chercheur espère que le modèle de communication

²⁵⁵ Tan, M.L., (2008). *Revisiting Usug, Pasma, Kulam*. Quezon City. University of the Philippines Press. P 135

proposée sera également utilisé pour comprendre et expliquer le système de croyance à la santé des autres groupes minoritaires. Les résultats, si tout va bien, permettront de guider les décideurs dans la promulgation de lois qui pourraient aider à la conception de campagnes de santé et d'amélioration la communication, face à face, entre les soigneurs et des patients immigrés.

Définition des concepts

Les lecteurs peuvent trouver une discussion approfondie des concepts inclus dans cette étude. Gardant à l'esprit que les lecteurs sont principalement des Français et des Philippins, le chercheur a ressenti le besoin de faire une discussion détaillée des concepts pour aider les lecteurs à comprendre d'où vient cette étude et le lien étroit entre les concepts : santé, culture et communication. De plus, les lecteurs philippins seront sûrement intéressés sur le fonctionnement du système de soins de santé français et vice versa. Les pays étudiés sont également discutés brièvement afin de présenter les Philippines aux lecteurs français et vice versa.

Les concepts définis ont été utilisés fréquemment tout au long de cette recherche. Les discussions dans la dernière partie de cette recherche sont très spécifiques et il est nécessaire de comprendre les concepts de base depuis le début pour une meilleure compréhension

A. Définir la santé

La santé, comme construction socio-culturelle, est interprétée et comprise de plusieurs manières. L'Organisation Mondiale de la Santé (OMS) définit la santé comme «l'état de complet bien être physique, mental et social, et pas seulement l'absence de maladie ou d'infirmité» (OMS, 1948). L'Académie classique de l'homéopathie classique définit la santé comme "la liberté de la douleur dans le corps physique, un état de bien-être, la liberté de la passion sur le plan émotionnel, ce qui entraîne un état dynamique de sérénité et de calme, et de la liberté de l'égoïsme

dans la sphère mentale, ayant comme résultat, l'unification totale avec la vérité²⁵⁶. Tones et Green estiment que la santé est un droit humain fondamental²⁵⁷. Les droits humains sont des droits basiques et des libertés fondamentaux pour tous les êtres humains : le droit à la vie, le droit à la liberté de pensée et d'expression et l'égalité de traitement devant la loi. Ces droits sont attribués «naturellement» ce qui signifie qu'ils ne sont pas acquis et ne peuvent être refusés sur la base de la race, l'origine ethnique et du sexe²⁵⁸. Si la santé est indiquée et considérée comme un droit humain fondamental, les gens devraient avoir le libre accès à l'information de santé et de soins qui leur permettrait de prendre des décisions éclairées au sujet de leur santé personnelle. Comme l'a réaffirmé la Déclaration de Jakarta en 1997, l'OMS et ses alliés ont affirmé que la santé est un droit humain fondamental et essentiel pour le développement économique et social. Cette déclaration stipule que « les prérequis pour la santé sont la paix, le logement, l'éducation, la sécurité sociale, l'autonomisation des femmes, un écosystème stable l'utilisation durable des ressources, la justice sociale, le respect des droits de l'homme et l'équité²⁵⁹ » .

En analysant les définitions de la santé établies par différentes organisations et chercheurs sociaux, le concept de santé comme un état sans stress de l'esprit et sans douleur physique tel qu'il a été effectivement transmis par l'OMS est une simplification. La définition de la Classique Homeopathy fait écho à ce qui a été déclaré par l'OMS mais d'une manière plus détaillée et plus élaborée, en restant dans la même ligne de pensée. Tones et Green ont ajouté une touche socio-politique à la définition en déclarant que c'est un droit humain fondamental, naturellement attribué à une personne et qui ne peut être bafoué. Cette prise de position a été

²⁵⁶ Definition and Measure of Health. International Academy of Classical Homeopathy. <http://www.vithoukas.com/en/contributions-of-gv/definition-of-health.html> (accessed April 2012).

²⁵⁷ Tones K. & Green J., (2004). *Health Promotion, Planning and Strategy*. Sage London

²⁵⁸Maiese, M. (2003). *Rights. Beyond Intractability*. <http://www.beyondintractability.org/essay/rights/> (Accessed July 2012).

²⁵⁹ Elder J.P. (2001). *Behavior Change and Public Health in the Developing World*. Sage London. P 11

reconnu par l'OMS et ses alliés, mais les conditions qui constituent le bon état de santé sont complexes et dépendent de nombreux facteurs sociétaux qui donnent l'impression que pour atteindre cet état de santé idéal c'est un processus très complexe. Associer les mots : paix, logement, éducation, sécurité sociale, autonomisation des femmes, écosystème stable, utilisation durable des ressources, justice sociale, respect des droits de l'homme et de l'équité, comme un prérequis à la santé, complique encore l'idée de ce que signifie être en bonne santé. Pour plus de simplicité et de clarté, la définition donnée par l'OMS a été la définition primaire dans laquelle la notion de santé opère dans cette recherche. Toutefois, la santé a été étudiée, dans cette thèse, à travers un filtre culturel, pour comprendre comment un groupe de personnes définit la santé, s'intéresse aux problèmes de santé et pratique un mode de vie sain dans un nouvel environnement.

B. Contextualiser culture

La première définition de la culture est par É.B. Taylor en 1871, «La culture ou la civilisation, pris dans son sens ethnographique large est un ensemble complexe qui comprend les connaissances, les croyances, l'art, la morale, le droit, la coutume et toutes autres capacités et habitudes acquises par l'homme en tant que membre de la société»²⁶⁰.

Merriam Webster (2010) définit la culture comme les croyances coutumières, les formes sociales et les traits matériels d'un groupe racial, religieux ou social; les traits caractéristiques de la vie quotidienne (comme les détournements ou d'un mode de vie) partagées par les gens dans un endroit ou dans le temps. L'Institut du patrimoine culturel Roshan définit minutieusement la culture en décrivant ce qui la constitue :

²⁶⁰ Jocano, F. L., (2001). *Filipino Worldview: Ethnography of Local Knowledge*. Punlad Research House Inc. Manila. p 3

1. La langue comme le plus ancien et le plus sophistiqué moyen d'expression
2. Les arts et la Science comme les formes les plus avancées et raffinées de l'expression humaine
3. La pensée comme la façon dont les gens comprennent et interprètent le monde qui les entoure
4. La spiritualité comme le système de valeurs transmises de génération en génération pour le bien-être intérieur, exprimé par le langage et les actions
5. Les activités sociales comme les activités partagées par une communauté culturelle se déclinant en une variété de festivités et d'événements célébrant la vie
6. L'interaction qui est un des aspects sociaux du contact humain, y compris la négociation, les protocoles et les conventions

Ce caractère multidimensionnel de la culture la rend présente dans tous les aspects de la vie d'une personne. Comme la nature même des études de communication par exemple, la culture est transactionnelle car on ne peut pas parler de mode de vie, sans prendre en considération les différentes expériences culturelles de la personne. Ce contexte culturel se manifeste dans la façon de communiquer de la personne, ses actes, ses prises de décisions et sa façon de traiter avec le monde social. Lorsque cette culture personnelle est partagée avec le monde extérieur, il crée une communauté de gens avec le même système de croyance. Se référant à cet exemple, on peut facilement comprendre l'idée que l'ensemble du milieu culturel, en raison de sa complexité et de sa grandeur, est constitué de sous-cultures. Aussi pénible que cela puisse paraître, le fait d'être en mesure de comprendre l'ensemble des petites pièces qui constitue la grande image, est la première étape la plus importante dans le processus. Aujourd'hui, le terme culture est appliqué dans d'autres contextes que sa définition d'origine comme les croyances coutumières, les formes sociales et les traits matériels d'un groupe racial, religieux ou social. Des termes tels que la culture organisationnelle, la santé culturelle, la communication culturelle, etc. sont monnaie courante dans le jargon quotidien. Cela renforce l'idée que les cultures existent et sont interprétées de différentes formes.

La culture est reflétée dans les valeurs d'un groupe, les normes, les pratiques, système de sens (y compris la langue et de la communication) et le mode de vie ²⁶¹. Les croyances et les pratiques de santé sont un mode de vie, ouvrant la voie à un mode de santé ayant sa propre culture unique qui peut être définie et étudiée comme une recherche universitaire. Les maladies comme l'antithèse de la santé ont un contexte culturel très intéressant et diversifié qui d'un autre côté, crée un système de traitement lui aussi fondé sur la culture. Inutile de dire que la compréhension des concepts de santé, les systèmes de soins de santé ainsi que des maladies et la gestion des maladies peuvent être étudiés dans une perspective culturelle.

Cette étude a adopté la définition de la culture postulée par Corcoran, la culture est un mode de vie partagé par le gens et qui se refléchit dans la langue et dans la communication. La connaissance sur la santé est un concept abstrait. ²⁶²Ces concepts sont cependant transformés en réalité objective quand ceux-ci sont partagés avec d'autres membres d'un groupe ou membres de la société et validés par des actions. Bien que la culture de la santé émerge alors où elle est vécue et expérimentée dans un environnement et une époque particuliers.

Dans le cadre de cette recherche, cette définition de la culture se clarifie avec la manière dont la culture de la santé est présente et se manifeste à travers le langage. Le langage n'est pas seulement porteur de la culture, mais aussi le moyen par lequel les événements et les choses culturelles sont rendues explicites, communiquées et expérimentés ²⁶³. Les gens ont des façons de créer des connaissances sur leurs propres expériences. Ils ont la capacité de donner un sens et de traiter des informations sur leurs expériences de la vie quotidienne, avec de nouvelles connaissances comme sous-produit, consciemment ou inconsciemment.

²⁶¹ Corcoran, N. (ed.) (2007). *Communicating Health: Strategies for Health Promotion*. London. SAGE Publication. P 54

²⁶² Ibid 14

²⁶³ Jocano, F. L., (2001). *Filipino Worldview: Ethnography of Local Knowledge*. Punlad Research House Inc. Manila. p 5

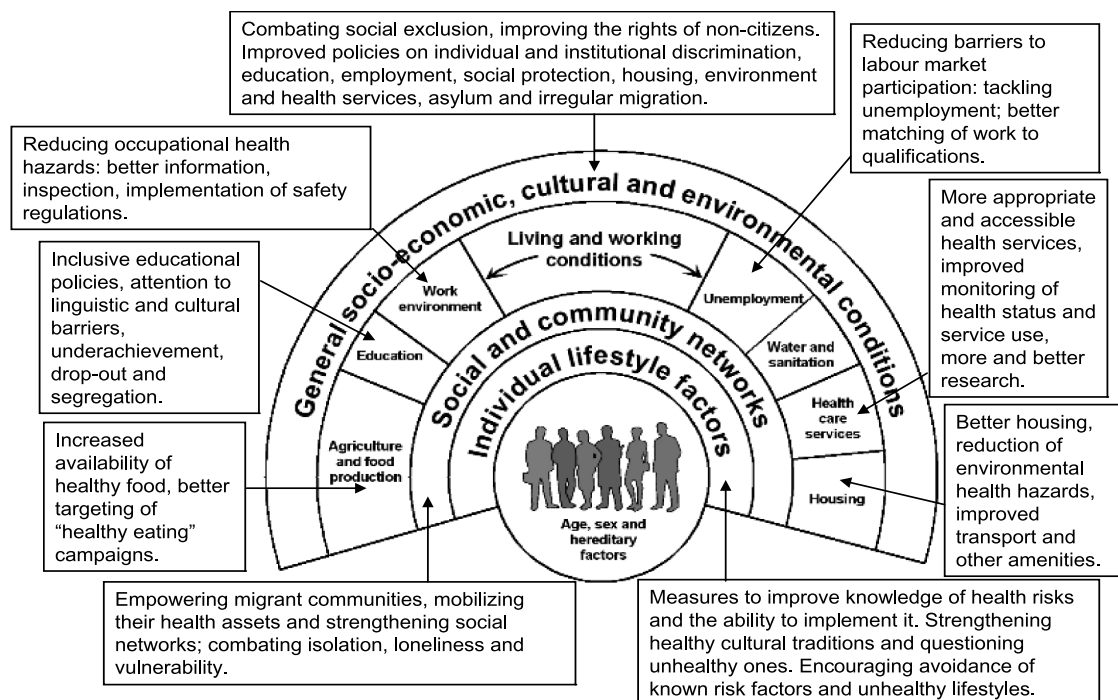
C. Placement de l'immigration et de l'émigration

La migration fait partie de l'histoire de l'humanité depuis la nuit des temps. Les raisons n'ont pas beaucoup changé depuis lors. Les gens se déplacent d'un endroit à un autre à la recherche de nourriture et d'un environnement plus habitable pour assurer leur survie. L'immigration est définie par le dictionnaire de Webster comme la capacité des personnes à se déplacer et s'installer dans un pays, d'où elles sont pas natives, de façon permanente. La migration d'autre part a presque la même signification que l'immigration. La différence étant le temps de résidence, qui est plus court dans le cas d'une migration. Les recommandations des Nations Unies sur les statistiques des migrations internationales définissent un migrant à long terme comme une « personne qui se rend dans un pays autre que celui de sa résidence habituelle pour une période d'au moins un an »²⁶⁴. Il est important de comprendre à ce moment que le terme « migrant » est très contestable parce que la définition de ce mot varie d'un pays à l'autre. Dans cette étude, les termes « migrant » et « immigré » ont été utilisés de manière interchangeable. Dans la dynamique des philippins la facilitation des déplacements entre la Côte d'Azur et Monaco, qui se trouve juste à la frontière de l'Italie, et les pays européens rendent la Côte d'Azur accessible. Dans ce contexte, l'immigration et les migrations n'a pas une très forte différence. Pendant la saison estivale, par exemple, lorsque le travail abonde sur la côte de la méditerranéenne française, les travailleurs philippins qui travaillent à l'origine en Italie et dans les régions voisines de la Côte d'Azur, affluent dans la région en raison des emplois disponibles. Il y a plus d'heures de travail et un salaire plus élevé. Le chercheur a aussi rencontré quelques Philippins, originaire d'Espagne, et venant travailler sur la Côte d'Azur au cours de la saison estivale. À ce titre, le nombre de travailleurs philippins sur la Côte d'Azur double au cours de cette période et ces gens sont considérés comme des migrants car ils ne restent que quelques mois dans la région. Pour ces raisons, le chercheur a contextualisé les migrants et les immigrants au sein de la dynamique du mouvement Philippins dans et hors de la Côte d'Azur. Il

²⁶⁴ Département des affaires économiques et sociales des Nations Unies 1998 p 18

pourrait être difficile d' inter-changer ces étiquettes dans un autre contexte, mais dans le cadre de cette étude, cela a été fait pour une meilleure compréhension.

Figure 1: Déterminants de la santé pour les immigrants



Taken from: Migration and Health in the European Union. Originally adapted from WHO Regional Office for Europe 2010.

Figure 1 identifie spécifiquement les facteurs qui affectent la santé des migrants dans le cadre (socio-économique, culturel, environnemental et social) de l'Union européenne. Les facteurs spécifiquement identifiés qui empêche ou améliore la santé

des migrants constituent des facteurs de mode de vie, les réseaux sociaux et communautaires ainsi que les conditions socio-économiques, culturelles et environnementales générales. Dans ces catégorisations se trouve des programmes plus spécifiques qui peuvent servir de tremplin pour des programmes gouvernementaux pour promouvoir la santé. Comme les migrants arrivent en France, les concepts et les pratiques de santé doivent être identifiés pour être en mesure de déterminer la façon d'aborder les problèmes de santé futurs. C'est aussi une bonne base pour concevoir des programmes de base afin d'encourager davantage les comportements sains et de corriger les comportements malsains. Les données de cette enquête seront la référence pour la mise en œuvre de programmes qui découragent les comportements malsains et les activités culturelles pratiquées qui font partie des facteurs de risque.

Sur le plan social, les immigrants philippins doivent être encouragés à faire partie d'un réseau social différent de leurs réseaux philippins réguliers. Ils devraient être exposés à des activités sociales pour aider à combattre la solitude, la dépression, l'isolement et de la vulnérabilité, qui sont inhérents à la vie d'un immigrants. L'observation directe de ce chercheur, le gouvernement local de la Riviera n'a pas un programme solide qui favorise l'intégration des immigrants philippins à la communauté française. Les français ont tendance à être territorial et cela contribue à la lente intégration des étrangers à des groupes sociaux français. D'autre part, les immigrants Philippines semblaient aussi être communautaires ce qui rend difficile leur intégration. De toutes façons, chaque groupe devrait trouver un moyen d'aller vers l'autre et l'Etat a un grand rôle dans ce processus.

Favoriser des activités qui diminue l'écart entre le pays hôte et ses immigrants est une plate-forme pour encourager ces gens à avoir une vie saine. Afin de permettre à chaque communauté de se connaître, il faudrait reconnaître que l'implication sociale s'inscrit dans le cadre du maintien d'une bonne santé et d'un bien-être, et mieux informer les immigrants sur le pays où ils se sont installés.

Dans le domaine de l'apprentissage au sein des écoles publiques, ce chercheur a observé que les méthodes d'enseignement ne sont pas très encourageantes pour les étudiants. Tous les élèves de cette école informelle sont des étrangers dans le sud de la France qui veulent apprendre à parler la langue, connaître les bases de la vie quotidienne et rencontrer d'autres personnes qui sont dans la même situation qu'eux. La majorité des étudiants sont presque trentenaires, certains sont des professionnels dans leur propre pays et ont émigré en France pour diverses raisons. En tant qu'académicien depuis longtemps, ce chercheur a observé que les enseignants n'ont pas un objectif d'apprentissage spécifique pour les étudiants. Ils lisent des livres, donnent des activités et octroient très peu d'attention aux demandes des étudiants pendant les cours. Il n'y avait aucune des activités qui encouragent les étudiants à se connaître mutuellement et il n'y a pas de moyens clairs sur la façon dont les progrès des élèves sont évalués.

Quand il va dans des institutions de l'Etat et de la communauté dans le sud de la France pour demander des informations, un étranger peut facilement constater le dévouement du peuple français pour leur langue. Malgré le fait que la Côte d'Azur est l'une des destinations touristiques les plus populaires dans le monde et tire une part importante de son économie de l'industrie du tourisme, la langue française semble être insensible à la dynamique engagée par l'industrie du tourisme. En termes de migration, la majorité des immigrés en France est issue des anciennes colonies et ces gens parle français ce qui ajoute à la préservation de la langue. Comparé à d'autres villes européennes touristiques comme Venise et Barcelone, qui parle suffisamment bien l'anglais pour donner des informations aux touristes auquel s'ajoute le désir sincère d'aider les personnes, les Français ne sont pas très enthousiastes et accueillants envers les étrangers. Au début, ce chercheur a eu l'impression de subir une réponse raciste parce qu'elle est asiatique. Après avoir parlé aux expatriés vivant dans la Riviera, il a été clairement établi que c'est bien la nature même des français d'être froids et distants envers les gens qui ne parlent pas leur langue. Les français, surtout ceux qui appartiennent à l'ancienne génération, ont aussi une indifférence culturelle de la langue anglaise à cause du simple fait que la

langue est originaire d'Angleterre, un pays qu'ils ont jadis combattu avec rage. Cette mentalité et ce comportement ont été préservés jusqu'à aujourd'hui. Bien que la jeune génération est plus ouverte à de nouvelles philosophies, un grand nombre de résidents de la Côte d'Azur appartiennent au 3ème âge parce que la Côte d'Azur est une région convoitée par les retraités. De ce fait, la distance entre les étrangers et les français est probablement plus prononcée dans cette région par rapport à d'autres villes de France, Paris par exemple.

Cette dynamique a ouvert la voie au style de vie qui attend les immigrés dans le sud de la France. Pour les immigrants philippins, le fardeau de l'intégration repose uniquement sur leur épaule. Ils vont faire face à l'exclusion sociale et vont devoir affronter la réalité de la barrière culturelle et linguistique. Pour les immigrants venant d'autres parties du monde non-francophones, les défis pourraient être les mêmes. La triste réalité est que chaque aspect d'une intégration réussie des immigrants s'appuie fortement sur la langue. Dans le cas de Côte d'Azur, les immigrants font face à un processus d'intégration plus lent.

Malgré les défis de l'intégration des immigrants, on peut se demander ce qui rend toujours cette destination favorable pour les immigrants? Comme le terrain de jeu des riches et célèbres, la Côte d'Azur promet plus d'emplois résultant à une vie meilleure pour ceux qui viennent de pays privés de ressources.

En matière de santé, les immigrés en France bénéficient d'une excellente couverture de santé dès qu'ils s'inscrivent au régime français d'assurance maladie. Ils ont la garantie de recevoir des soins dans les hôpitaux publics en cas de besoin, avoir accès à des professionnels de la santé et une aide financière pour leurs médicaments. Sous certaines conditions, ils peuvent même avoir une couverture de 100 %, ce qui signifie que les services médicaux et les médicaments sont gratuits. C'est l'une des raisons pour lesquelles certains immigrants choisissent de rester en France malgré les défis.

Les Etats-Unis d'Amérique sont aussi un bon point de référence en matière de migration. C'est un pays avec une histoire riche et longue de migrants. La majorité des premiers immigrants aux États-Unis étaient des catholiques irlandais. Le New York Times, dans les années 1880, écrit un avertissement au public à propos de cette classe sociale "qui n'ont rien à faire de notre liberté ou d'une civilisation . . . qui s'enfoncent les racines de la société, et ne sortira dans les ténèbres et en temps de troubles, de piller et de proies sur les bonnes choses qui les entourent, mais qui n'atteignent jamais²⁶⁵. Le magazine Time décrit ce groupe comme la classe ouvrière la plus pauvre et la plus faible qui trime année après année dans le travail infructueux, sans jamais s'élever au-dessus de leur position. Ils détestent les riches. Ils sont densément ignorants et facilement excités par des préjugés ou de la passion²⁶⁶. Et puisque la plupart des immigrants sont irlandais, il est prudent de dire que cet article décrit cette race.

En comparant les scénarii aux États-Unis et quelques résultats concernant les études d'immigrés aujourd'hui en Europe, rien n'a beaucoup changé. Le premier rapport annuel sur la migration et l'intégration (Bruxelles, Commission européenne, 2004), a indiqué que la France accueille principalement des immigrants ayant un faible niveau d'éducation et de qualifications seulement en tant que travailleurs à bas salaires. Ces travailleurs temporaires ont ensuite été incités à rentrer chez eux une fois leur travail mal payé terminé. Dans le domaine de la santé, les pays d'Europe, mis à part le Royaume-Uni, les Pays-Bas et la Suède, n'ont aucun moyen de collecter systématiquement des données sur la santé par le statut ou le groupe ethnique du migrant. Aucune donnée n'existe dans le cadre d'études épidémiologiques. Il est étonnant cependant qu'un pays comme la France, qui est souvent considéré comme ayant l'un des meilleurs système de santé dans le monde, réussit à être très apprécié et très satisfaisant malgré le fait qu'il manque des études de santé standardisés sur les immigrants. Ce chercheur a l'impression que tout le

²⁶⁵ Hochschild, J. L. (2005). *Looking Ahead: Racial Trends in the United States*. Daedalus 134, no. 1: 70-81. <http://dash.harvard.edu/handle/1/3200608> (accessed March 22, 2013). P 73

²⁶⁶ Ibid 19. P 73

monde est content avec le service de soins de santé tout simplement parce que les avantages du système français de soins de santé universel sont accessibles à tous.

Dans l'évolution de la volatilité de l'économie partout dans le monde, les gouvernements adoptent des mesures pour économiser les ressources. Avoir un système de soins de santé où l'Etat est tenu d'assumer une grande quantité du coût des soins de santé de sa population est une activité dangereuse qui va avoir des conséquences mortelles inévitables.

En Europe, il y a environ 35 à 40.000.000 de personnes nées à l'étranger et ces immigrants sont parmi ceux qui sont particulièrement exposés au risque de pauvreté et d'exclusion sociale. Plusieurs études ont conclu que la santé est fortement liée à la classe sociale²⁶⁷. Et parce que les migrants font partie du groupe marginalisé, leur insertion dans la vie sociale est limitée et leur accès aux services de base sont également différents de la population à bien des égards. Cette corrélation peint vivement les disparités de santé dans certains pays en Europe qui comprend la France. Compte tenu du fait que «les plus riches sont plus sains²⁶⁸», les immigrants en France peuvent avoir des difficultés à accéder aux soins de santé en raison de la réalité criante que la plupart de ces immigrants ne font pas partie de la classe la "plus riches". En effet, la plupart de ces immigrants appartiennent à la classe ouvrière.

Philippines et leur histoire de migration en bref

Tout au long de l'histoire, l'immigration a été la réponse la plus fréquente des Philippines à plusieurs problèmes dont le principal est l'économie. Le chômage est un problème récurrent dans les Philippines ainsi une source de revenus stable ne peut être garantie. Les efforts du gouvernement sont loin de fournir une source de revenus descendantes pour les Philippines. C'est pourquoi comme l'histoire l'a montré, les

²⁶⁷ Barnes, L., Hall, P. & Taylor, R. (2009). *Why is Wealthier Healthier? Perspectives on Europe* 39(2): 4-8. <http://dash.harvard.edu/handle/1/4322128>. (accessed March 1, 2013). Mathews, Colin D. et al. (2004). *Global Patterns of Healthy Life Expectancy in the Year 2002*. BMC Public Health 4:66. <http://dash.harvard.edu/handle/1/4592100> (downloaded March 2, 2013)

²⁶⁸ Barnes, L., Hall, P. & Taylor, R. (2009). *Why is Wealthier Healthier? Perspectives on Europe* 39(2): 4-8. <http://dash.harvard.edu/handle/1/4322128>. (accessed March 1, 2013).

Philippines cherchent un emploi à l'étranger à la recherche d'un "green pasteur". Ce mouvement est devenu une norme sociale à tel point que le mouvement est très vénéré. Une famille va gagner un statut plus élevé dans la communauté si un membre de leur clan travaille à l'étranger. Quelque soit le travail, aussi longtemps qu'il travaille à l'étranger, il est considéré comme une «bénédiction» car elle se traduit directement par l'accès à une vie descente. Les Etats-Unis ont été la destination la plus populaire des migrants philippins, ceci peut être attribué aux anciens liens entre les deux pays et le fait que les Philippines peuvent parler anglais. Il y a également eu une population filipino-américaine aux États-Unis au début du siècle qui a ouvert la voie à d'autres Philippines pour venir aux États-Unis. Finalement les philippins vont présenter une demande pour que les membres de leur famille les rejoigne. C'est ainsi que les Philippines (et d'autres groupes d'immigrants peut-être) ont établi une petite communauté dans le pays d'accueil. Les Philippines continuent d'avoir des problèmes de chômage, une croissance rapide de la population et la disparité dans la répartition des ressources ainsi que des allégations de corruption et de dessous de table. Ce sont les raisons pour lesquelles les Philippines ont été chassés du pays à la recherche de meilleures opportunités d'emploi à l'étranger. Ayant connu les conditions de travail dans le pays, la durée du travail, le taux de salaire, l'augmentation des impôts sans service légitime pour le peuple et la baisse du pouvoir d'achat et du peso, la plupart des Philippines préfèrent supporter d'être loin de leur famille, d'accepter des petits boulots et d'être sous-employés. Au cours d'un de ses voyages de la France à Manille, le chercheur a rencontré Mr. Y. Il travaille comme serveur à Dubaï, le même travail qu'il avait aux Philippines. Il a révélé qu'il gagnait 7.000 pesos par mois (environ 140 euros) en travaillant comme serveur dans l'un des bars de Manille. Une grande partie de son salaire lui sert alors à la location de son appartement et au transport. À Dubaï, il gagne 11.000 pesos de salaire mensuel (environ 200 euros), mais il est logé dans un appartement avec les autres employés des bars, donc il n'a pas besoin de payer pour l'appartement. Il ne paie pas pour le transport aussi parce que son appartement est proche de son travail. Cela, dit-il, rend sa vie moins stressante. Il a aussi partagé son excitation sur le fait que chaque fois qu'il rentre aux Philippines pour les vacances, il reçoit beaucoup d'attention de la part

de sa famille et de la communauté. Il est traité comme une personne très importante, simplement parce qu'il travaille à l'étranger. Ce sont les avantages sociaux et économiques qui incite les Philippins à travailler à l'étranger. La seule partie triste de l'état de Mr. Y, c'est que son contrat expire au bout de six mois, et même s'il sait qu'il peut le renouveler et retravailler dans la même bar, il doit passer par le processus de demande pour le travail que ce qu'il a fait dans la première fois. Il dépense de l'argent pour payer l'agence qui va préparer ses documents de travail. Malgré ce tracasserie, il a choisi de le faire maintes et maintes fois au lieu de travailler aux Philippines.

L'afflux de migrants philippins se féminise. Pourtant l'égalité des sexes dans la migration n'est pas respectée. Les hommes philippins qui travaillent à l'étranger portent l'image du chef de famille responsable tandis que les femmes sont dépeintes de deux manières contradictoires comme des héroïnes et des mauvaises mères²⁶⁹. Les hommes n'ont jamais été considérés comme de mauvais pères quand ils ont décidé de travailler loin de chez eux. Ce double standard est présent dans plusieurs aspects de la vie philippine, mais plus prononcée dans la migration.

Le gouvernement actuel (administration Aquino) a sa part de responsabilité concernant les succès dans la lutte contre certains problèmes structurels, mais ce n'est pas assez pour inciter ses citoyens à rester dans leur pays. Le pays profite beaucoup de cette migration parce que son économie a été maintenu à flot par les envois de fonds de leurs citoyens travaillant à l'étranger. Tel que cela a été rapporté par le Banko Sentral ng Pilipinas (Banque centrale des Philippines), la remise totale pour 2011 a atteint 20 milliards de dollars, soit 7,2 % de plus qu'en 2010 et le plus haut historique. La croissance a été attribuable à la forte demande de travailleurs qualifiés philippins partout dans le monde ainsi que les efforts du gouvernement pour sceller des offres d'emploi avec les autres pays. Le Bureau national des statistiques a indiqué qu'en 2011, il y avait environ 2,2 millions de travailleurs philippins à

²⁶⁹ Cruz, R. (2012). *Figures of Migration, Gender, Kinship and the Politics of Representation*. Ateneo de Manila University Press . pp 513-514

l'étranger (OFW) et 95,3 % sont des travailleurs dits de contrat à l'étranger (OCW) ou ceux qui travaillent avec un contrat. Les 4,7% restant, soit environ 103.400 migrants travaillent mais sans contrat de travail. On s'attendrait à ce que le nombre soit plus grand parce que cela n'inclut pas le nombre de migrants philippins en situation irrégulière dans le monde entier.

Dans le contexte de la migration philippine sur la Côte d'Azur, cette recherche a analysé les systèmes d'adaptation et capacité d'adaptation des migrants philippins dans le domaine de la santé. Il a été reconnu que bon nombre d'immigrants n'étaient pas en mesure de s'adapter au stress psycho-social provoqué par le déplacement dans un nouveau pays. Le stress psycho-social en termes de dépression (tristesse persistante, anxiété, sentiment de désespoir, etc.) et la manie (irritabilité, insomnie, manque de jugement, le comportement social inapproprié, etc.). Ce stress peut également se manifester en termes de comportement mais aussi en termes physiques. Certains peuvent éprouver des maux de tête, de la diarrhée, de la faiblesse et autres manifestations physiques. La meilleure façon de diagnostiquer et de traiter ces types de problèmes psychologiques et physiques est de consulter un médecin en plus de faire part d'un groupe social qui permet de trouver un équilibre. Le problème est que faire quand la simple idée de consulter un médecin augmente ce stress? Existe-t-il des plates-formes accessibles aux migrants sans craindre la discrimination? Existe-t-il des institutions et des programmes pour aider les migrants dans leur processus d'adaptation?

L'anxiété et la dépression se manifestent si la personne qui demande l'aide médicale n'ont pas les connaissances nécessaires, en termes d'utilisation de la langue, pour exprimer leurs sentiments et décrire le malaise qu'ils éprouvent. Le patient peut également se sentir perdu dans les limites du nouveau système de soins de santé, où il se retrouve. À l'autre extrémité du spectre, les professionnels de la santé n'auront pas une compréhension complète du dossier médical qui se présente à eux ce qui rendra le diagnostic et le pronostic plus difficile et dangereux. Cette dynamique a été le cadre de la relation complexe entre les migrants et les

professionnels de la santé. C'est dans cette idée que ce chercheur fait de cette question un discours académique. Peu ou rien n'a été fait dans le domaine de l'amélioration de l'interaction de communication santé entre migrants philippins et les prestataires de santé sur la Côte d'Azur.

Avantages de la migration

La migration apporte avec elle la diversité. Les termes tels que le multiculturalisme, l'inter culturalisme, la diversité raciale, la diversité culturelle et les goûts ont été utilisés pour labéliser l'interaction entre les immigrants et les citoyens du pays d'accueil. Le Premier ministre du Royaume-Uni, James Cameron a admis à la Conférence de sécurité de Munich (Février 2013) que le multiculturalisme n'a pas fonctionné au Royaume-Uni. En regardant l'histoire du multiculturalisme britannique, la loi sur l'égalité raciale a été adoptée dans les années 1960, elle garantit l'égalité des chances accompagnées par la diversité culturelle dans une atmosphère de tolérance mutuelle. En 1988-89, l'affaire Salman Rushdie a défié les relations majorité-minorité en affirmant qu'en dehors de la race, les facteurs ethno- religieux aussi sont importants. En 2000, le rapport de la multi-ethnique grande Bretagne a appelé à repenser de l'histoire nationale afin que le Royaume-Uni puisse véritablement devenir une communauté inclusive des communautés et des individus, à laquelle toutes les minorités ethno-religieuses auraient un sentiment d'appartenance. Les émeutes en 2001, 9/ 11 et 7/7 ont été interprétés par certains comme la fin du multiculturalisme. D'autres ont préféré la rhétorique alternative « cohésion communautaire » et « interculturelle »²⁷⁰.

Le débat sur la rhétorique de l'acceptation de la diversité est un processus sans fin. C'est parce que les nations et les groupes ont attaché à plusieurs-couches de significations aux concepts qui constituent la diversité. A partir de la

²⁷⁰ Meer, N. & Modood T. (2012) *Interculturalism: Multiculturalism or Both?* Political Insight. April 2012. p 31

reconnaissance initiale que la race, comme considération première, dans l'assimilation des immigrants, des discussions récentes incluent la question plus délicate de la religion. Dans ce scénario, la communication joue un rôle essentiel pour permettre et encourager les membres à s'engager dans un dialogue constant et de constamment réformer les valeurs et les croyances et d'être plus accommodant pour les bizarreries et les particularités des différentes cultures. La coexistence pacifique est le nouvel ordre du jour en maintenant les valeurs intrinsèques mais en prenant le terrain moral plus élevé du respect de l'unicité d'autrui.

Même les autres vieux pays de l'immigration en Europe, notamment en France et aux Pays-Bas, partagent le même sentiment que le multiculturalisme a échoué. En Allemagne, telle que véhiculée par la chancelière allemande, Angela Merkel a déclaré que le multiculturalisme a échoué dans son pays aussi, malgré le fait que l'Allemagne n'a pas vraiment adopté un agenda politique multi culturaliste. La rhétorique ancré dans cette soi-disant états d'échec que le "multiculturalisme facilite la fragmentation sociale et accentue les divisions; il a déplacé l'attention sur les disparités économiques, encouragé une hésitation morale parmi la population indigène et certains ont même été blâmé pour le terrorisme international ²⁷¹.

Faire en sorte que la diversité culturelle et religieuse fonctionne n'est pas du tout un exercice de futilité. Il y a des défis tel qu'en Angleterre en 2001 (émeute de Bradford), en France en 2005, lorsque les migrants se sont révoltés exigeant une meilleure intégration dans les droits de l'Etat. Les immigrants ont aussi dû faire face à des défis dans le milieu de travail et dans l'exercice de leur vie quotidienne. Cependant, le passé ne peut pas être inversé, les gens et le gouvernement ne peut qu'apprendre de lui. Il est important de rappeler aux groupes et institutions impliqués dans la promotion du multiculturalisme que cette notion doit opérer dans les limites de l'intégration mutuelle. La majorité ne devrait pas pâtir de supporter le coût de la fourniture des plateformes et des ressources pour accueillir les migrants, ni les immigrants d'être "la victime" involontaire pour la simple raison qu'ils se déplacent dans

²⁷¹ Nasar & Modood politiques aperçu 2012 , p 30

un autre pays. L'intégration mutuelle peut être réalisée à travers l'éducation des citoyens indigènes sur l'existence d'immigrants au sein de leur milieu. Ils sont peut-être différents, mais il faut leur permettre d'apprendre davantage au sujet de cette race. Une partie de l'intégration des immigrants est de leur apprendre à respecter le mode de vie des citoyens locaux du pays où ils s'installent.

Les États-Unis sont un bel exemple pour comprendre la dynamique de la diversité raciale. Dans le plus récent rapport de Nouvelles migrations; une publication savante qui "résume l'évolution de l'intégration des immigrants le plus important" aux États-Unis, ont fourni des données sur la race et l'origine ethnique de l' US Census Bureau ²⁷². À partir de 2000, les résidents américains sont composés de blanc à 69 %, 13% d'Hispaniques, 13% de noirs et 6 % d'Asiatiques et autres. En 2050, le pourcentage serait de 50 % de blanc, 24 % d'Hispaniques, 15 % de Noirs et 15 % d'Asiatiques et autres. Ce qui est nouveau dans ce rapport, c'est l'idée que d'ici 2050, il y a une possibilité que les catégorisations raciales et ethniques ne seront plus d'usage. La définition et l'utilisation de la race et l'origine ethnique sont nécessaires pour comprendre les interactions des gens et la vie quotidienne. Comme l'a souligné Hochschild "si les immigrants sont considérés comme une race à part, biologiquement distinct du reste d'entre nous, ils seront traités très différemment que si ils sont considérées comme appartenant à une autre ethnie, même de manière cruciale à tous les autres ²⁷³.

En termes d'évaluation et la prestation des soins, les immigrants devraient en effet être traités différemment pour s'assurer qu'ils demeurent dans un bon état de santé. Leur prédisposition génétique à certaines maladies est totalement différente de la population générale du pays d'accueil. Les immigrants en provenance d'Inde par exemple doivent être surveillés pour l'apparition de la glycémie élevée parce que les Asiatiques en général sont génétiquement prédisposés au diabète – les Indiens

²⁷² Hochschild, J. L. (2005). *Looking Ahead: Racial Trends in the United States*. *Daedalus* 134, no. 1: 70-81. <http://dash.harvard.edu/handle/1/3200608> (accessed March 22, 2013). P 2

²⁷³ Ibid 26 p 73

ayant le plus grand nombre - et leurs habitudes alimentaires et mode de vie aggravent la situation. Tel que rapporté par la British Broadcasting Corporation (BBC) dans un de ses documentaires, le problème du diabète en Inde est enraciné dans la prédisposition génétique ainsi que le phénomène de privation de nourriture pendant l'enfance et l'excès dans leur vie d'adulte.

Dans une conférence intitulée "La diversité culturelle: un avantage ou un passif" parrainée par l'Institut universitaire européen de Florence en Italie et auquel ce chercheur a eu le privilège d'être un participant, les discussions tournent autour de la façon dont la population immigrante change la dynamique politique, économique et culturelle du pays d'accueil. Bien que la conférence n'a pas catégoriquement répondu à la question annoncée, il y avait un sentiment général que, malgré les défis posés par la diversité culturelle, le pays d'accueil comme le pays d'origine peuvent tirer un avantage à cette diversité. Le pays hôte bénéficie de la contribution du travail des immigrants ainsi que leurs impôts. Le pays hôte bénéficie des gains des immigrants envoyés à leur famille. La présence d'immigrants modifie également la culture du pays d'accueil en raison de leur exposition au mode de vie des immigrants. Cela ne signifie pas nécessairement l'adoption de leur façon de faire, mais la richesse des connaissances acquises simplement par leur présence est un avantage, si les habitants sont assez ouvert d'esprit pour regarder cela de cette façon. Les immigrants apprennent aussi de l'environnement et du mode de vie du pays d'accueil et ainsi améliore leur mode de vie. Les citoyens locaux du pays d'accueil et les immigrants peuvent apprendre les uns des autres de plusieurs façons.

La combinaison de la Santé et de la Culture

Comme il a déjà établi, la santé est un reflet de la culture et ne peut être prise hors de son contexte culturel. En tant que tel, une bourse d'étude sur la santé doit se pencher sur le contexte culturel de la santé et des maladies. Avec l'interdépendance de ces deux concepts, la discussion sur les questions de santé porte en elle le besoin d'étudier son contexte culturel. Conscient de la complexité de la nature même

de la culture, cette étude limite la discussion de la culture aux quatre murs de la définition de la santé selon l'OMS. La santé est un état de complet bien être physique, mental et social. Le bien-être et de la culture est un facteur important dans la réalisation d'un bon état de bien-être.

Il y a beaucoup de pratiques culturelles à travers le monde qui sont directement liés à la santé. Au Bangladesh, par exemple, lors de la fête de l'Aïd -al-Adha, l'abattage rituel des animaux est répété d'innombrables fois dans la capitale du pays, Dhaka. Dans cette célébration, le fidèle musulman partager la viande avec les pauvres, mais cette tradition comporte des risques. Le pays importe plus de vaches pour cette fête, ce qui rend la surveillance des bovins, de la tuberculose et d'autres maladies difficiles. En République démocratique du Congo, un singe à moitié cuisinier est un spectacle habituel sur le marché. Cette viande de brousse est la seule source de protéines animales dans cette partie pauvre de l'Afrique subsaharienne²⁷⁴. En Thaïlande, même avec la menace de contracter la grippe aviaire, les propriétaires de coqs de combat sucent encore du sang de leur animal après un match pour les faire revivre²⁷⁵. Ces pratiques culturelles montrent un lien étroit entre la culture et la santé, l'exposition aux maladies et les pratiques de guérison. À l'autre extrémité du spectre, certaines pratiques culturelles sont modifiées par un mélange d'interventions afin de mieux protéger la population contre la menace des maladies. Au Nigeria par exemple, même si une famille n'a que très peu de possession, ils possèdent une moustiquaire pour se protéger contre les piqûres de moustiques, empêchant ainsi la propagation du paludisme. Dans les prisons serbes, les travailleurs de la santé sont masqués et surveillent étroitement les détenus qui prennent des médicaments contre la tuberculose pour l'empêcher de se propager à d'autres prisonniers. Dans un tel endroit où les gens sont proches les uns des autres, la propagation de cette maladie pourrait arriver en un instant, c'est pourquoi un

²⁷⁴ National Geographic Octobre 2007 pp 91-102

²⁷⁵ National Geographic 2005 p 18)

contrôle strict de ceux qui sont déjà infectés par la maladie est nécessaire²⁷⁶ En 2003, il y avait des rumeurs d'une maladie respiratoire en Chine continentale et autour de ses frontières, et en réponse, les gens ont fait bouillir du vinaigre pour conjurer la maladie²⁷⁷. Cette maladie a cependant été plus tard identifiée comme le syndrome respiratoire aigu sévère (SRAS) et prouvé que le vinaigre ne pouvait pas tuer le virus.

Pour réduire ou éviter les maladies contagieuses, l'église catholique a changé sa façon de distribuer le pain pendant la communion. Traditionnellement, la Sainte Hostie est mise sur la langue des personnes. Ce processus permet le transfert de la salive d'une personne à l'autre, ce qui est un moyen de transmission de maladies. Pour remédier à la situation, l'église a trouvé un moyen de réduire la propagation de la maladie en permettant aux gens de recevoir l'hostie sur leur paume et ce sont eux qui mettent l'hostie dans leur propre bouche.

Ces exemples montrent que certaines pratiques culturelles favorisaient la propagation des maladies. Pourtant, pour des raisons culturelles, ces pratiques continuent de prospérer en raison du manque d'information adéquate concernant les risques pour la santé et les options limitées pour la source de nourriture. Il y a des cas cependant où certaines pratiques culturelles se sont améliorées parce que les gens ont compris la nécessité de modifier leur façon de faire. Avec les nouvelles connaissances acquises, certaines pratiques culturelles ont été modifiées pour s'adapter à la prévention des maladies et de ce fait, la culture de la santé a aussi changé au sein de la communauté.

Connexion Migration et santé

Dans le cadre de l'histoire des migrations, l'expérience de la migration aux États-Unis d'Amérique sert de référence. La population immigrée dans ce pays

²⁷⁶ National Geographic Octobre 2002 pp 5-17.

²⁷⁷ Walsh dans le magazine Time 2-13, p 50

continue de croître et de toujours dépasser les records précédents. En 2004, le nombre estimé d'immigrants atteint 34,2 millions soit 12% de sa population totale et 62% de ce nombre ne sont pas citoyens. En connectant les immigrants à la répartition des richesses, les immigrés ont un taux de pauvreté plus élevé (16,8%) par rapport à la population indigène américain (11,8%) et représentent 22% de la population non assurée. Les Auteurs Eamranond et Hu ont déclaré que:

“immigrants comprise an underprivileged population that continues to be neglected from various standpoints, including environmental and occupational health exposures. Disparities in immigrant health are exacerbated by lack of adequate health care access and culturally –inappropriate health care. Observers in some States have asserted that immigrants place an extra burden on health care systems, which may explain the low priority given to immigrant health care. However, immigrants contribute as much as \$10 billion per year to the US economy and pay taxes in excess of \$80,000 per capita more than the value of government services received over their lifetime. Overestimates of utilization of resources and underestimates of immigrant contribution to the US economy may give rise to the general reluctance to provide health services to the immigrant populations²⁷⁸”

Les deux dernières phrases résument le cas de la racine probable au titre des services de santé priorité pour les immigrés aux États-Unis. Il est très facile de déterminer le nombre d'immigrants qui arrivent sur le sol américain, mais leur contribution économique et sociale peut facilement être rejetée en partie à cause des préjugés. L'«altérité» des immigrés a ses conséquences. Les histoires des immigrants sont également entachées par des rapports sur la migration clandestine et plus sérieusement par le concepts de répandre la peur sur un groupe particulier d'immigrants. Cette perception écrasante ne se passé pas seulement aux États-Unis.

²⁷⁸ Eamranond, P. & Hu, H. (2008). *Environment and Occupational Exposures in Immigrant Health*. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3091353/> (accessed September 2013). Traduction : "Les immigrants représentent une population défavorisée qui continue à être négligé de différents points de vue, y compris les expositions environnementales et de santé au travail. Les disparités en matière de santé des immigrants sont exacerbés par le manque d'accès à des soins de santé adéquats et culturellement inapproprié des soins de santé. Observateurs dans certains États ont affirmé que les immigrants font peser une charge supplémentaire sur les systèmes de soins de santé, ce qui peut expliquer la faible priorité accordée aux soins de santé des immigrants. Toutefois, les immigrants contribuent jusqu'à 10 milliards de dollars par année à l'économie américaine et paient des impôts au-delà de 80.000 dollars par habitant supérieur à la valeur des services gouvernementaux reçus au cours de leur vie. Surestimation de l'utilisation des ressources et une sous-estimation de la contribution des immigrants à l'économie des États-Unis peuvent donner lieu à la réticence générale à fournir des services de santé pour les populations immigrées "

L'indifférence envers les immigrants est en cours depuis des temps immémoriaux et se poursuit dans le temps présent, seulement sous une forme différente.

En s'intéressant à l'histoire et à la connexion entre le mouvement des maladies et des gens, les colonisateurs venus d'Europe apporte avec eux 14 nouvelles maladies vers le Nouveau Monde, dont la grippe, la rougeole, la variole, la scarlatine, le choléra et la typhoïde - maladies pour lesquelles les Américains indigènes ne sont pas immunisés naturellement. Ces maladies ont peut être joué un rôle plus important que la technologie de la guerre européenne pour conquérir les tribus indigènes. Ce scénario rend les tribus indigènes faible, moins en mesure de se soutenir et plus vulnérables aux maladies. D'autre part, les colons, après avoir été en mesure de s'adapter à ce nouvel environnement, ont vécu plus longtemps par rapport à ceux qui sont restés en Europe. Ils ont pu profiter des ressources agricoles de la nouvelle terre qu'ils ont conquis pour les protéger contre la malnutrition ainsi que d'éviter la surpopulation qui est très commune en Europe au cours de cette époque²⁷⁹

Il s'agit d'un exemple concret où la migration a involontairement contribué à la diffusion de maladies. Les virus voyagent avec les gens en mouvement et se transmettent à la population sans méfiance, comme l'histoire l'a montré. Apprendre des leçons enseignées par l'expérience historique, les Européens ont appris de leur histoire. Quand ils voyagent en Afrique par exemple, ils sont tenus d'être vaccinés pour la fièvre jaune et l'hépatite soit 2 injections avant et une injection un mois après le retour. Il s'agit de s'assurer qu'ils ne contracteront pas ces maladies. D'autres pays exigent aussi que les gens qui viennent en visite, présentent un certificat sanitaire déclarant qu'ils n'ont ni été exposés à certains types de virus ni qu'ils sont porteurs de virus qui mettrait en danger ceux qui voyageraient avec eux dans l'avion ou les personnes avec lesquelles ils vont interagir dans le pays d'accueil.

En Europe, il y a également eu une discussion riche en ce qui concerne les effets de la migration. Lors d'une conférence à Florence, Italie (6-8 mai 2013),

²⁷⁹ Weitz, In Time Magazine 1996, p 20-21.

parrainé par l'Institut universitaire européen , et auquel ce chercheur a eu le privilège d'être invité, la question était: "La diversité culturelle : un avantage ou responsabilité?" Ce débat est complexe et n'a trouvé aucune réponse à ce jour. Durant le congrès, il y avait un sentiment général parmi les participants que la diversité profite à la fois au pays d'origine et au pays d'accueil. Un des orateurs Tariq Modood a souligné que :

"a high degree of racial, ethnic and religious mix in its principal cities will be the norm in the 21st century Europe and will characterize its national economic, cultural and political life, as it has done in the 20th century USA. Even as if members of ethnic minorities are fully integrated in in terms of legal rights, access to employment or education does not mean they have achieved full social integration. This also requires certain degree of subjective identification with the society or the country as a whole- what the commission on Multi-Ethnic Commission called " a sense of belonging" – and acceptance from the majority population that the minority persons are full members of society and have the right to feel that they belong²⁸⁰".

Ce chercheur a réussi à rencontrer l'auteur en personne à une conférence sur la diversité culturelle en Italie. Le travail de M. Modood s'intéresse aux problématiques de la diversité culturelle en Europe. Il a souligné que la plupart des grandes villes, principalement des capitales Européenne du nord-ouest ne sont pas "blanches" à 25-40% et contrairement aux États-Unis, la plupart des "non-Blancs" en Europe sont

²⁸⁰ Modood, T. (2007). *Multiculturalism: A Civic Idea*. Cambridge. Polity Press. Traduction : "Un haut degré de mélange racial, ethnique et religieuse dans ses principales villes sera la norme dans l'Europe du 21^e siècle et de caractériser sa vie économique, culturelle et politique nationale, comme il l'a fait au 20^{ème} siècle Etats-Unis. Même que si les membres de minorités ethniques sont pleinement intégrés dans en termes de droits juridiques, l'accès à l'emploi ou l'éducation ne signifie pas qu'ils ont atteint la pleine intégration sociale. Cela nécessite également certain degré d'identification subjective avec la société ou le pays dans son ensemble, ce que la commission sur la Commission multi-ethnique appelé "un sentiment d'appartenance» - et l'acceptation de la population majoritaire que les personnes de minorités sont membres à part entière de la société et avoir le droit de sentir qu'ils appartiennent ».

musulmans. Les dynamiques politiques concernant l'intégration des immigrés en Europe tourne autour de l'égalité, du racisme et de l'islam. Il a fait remarquer dans son article intitulé "citoyenneté dans une société culturelle diversifiée", qu'en général les pays européens ont une conscience limitée sur la manière où le mélange ethnique est en train de changer dans les sociétés européennes. Les décideurs et sociologues n'ont jamais prédit que les discussions sur la race, l'ethnicité et le multiculturalisme seraient dominés par les aspects de la religion.

Cette compréhension limitée des immigrés a des implications sur la façon dont ils vivent dans leur nouveau pays et sur la perception des citoyens locaux à leur égard. La mise en place de plate-formes d'intégration visant à assurer aux immigrants une formation nécessaire pour coexister pacifiquement, est entre les mains des chercheurs en sciences sociales, les médias et les pouvoirs publics. Ces droits doivent être protégés par des initiatives politiques. Lorsque les immigrants se rendent compte qu'ils n'ont pas été traités de manière égale, des problèmes surgissent. Les immigrés en France se sont révoltés pendant 22 jours dans plus de 250 localités à l'automne 2005 ce qui a abouti à une déclaration du président Chirac qui a évoqué une «crise d'identité»²⁸¹. Ces soulèvements mettent en évidence le désir des immigrants d'être correctement intégrés et de réduire le fossé culturel qui les font se sentir «différents». Cette volonté «d'appartenir» est une nécessité sociale de base qui doit être respecté. Bien que dans certains aspects, les immigrants pourraient être intégrés, la société doit leur faire sentir qu'ils sont des membres de la société à part entière. L'anxiété provoquée par le fait d'être un étranger dans un nouvel environnement est diminué, diminuant ainsi le stress psychologique qui est parfois la cause de l'inconfort.

La circulation des personnes à travers le monde comporte des risques sanitaires. Seize pour cent de la population du monde voyagent chaque année, 52 % pour le

²⁸¹ Simon, P. and Sala Pala, V. (2010). "We are not all Multiculturalists Yet: France Swings between Hard Integration and soft anti-discrimination" in S. Vertovec and S. Wessendorf (eds). *The Multi culturalism backlash: European discourses, Policies and Practices*. Abingdon and New York. Routledge.

tourisme, 23% pour la famille/la religion et la santé, 16% pour le travail, 3% concernent l'immigration et les 6% restants n'ont pas été identifiés (Casanova 2013). Cela se traduit par l'idée que quand il y a le début d'une épidémie en Chine par exemple, la maladie peut arriver n'importe où dans le monde en quelques heures parce que les mouvements de personnes ces jours-ci sont continus et rapides. Ce scénario n'est pas juste celui d'un film ou tout droit issu d'un livre de science-fiction, il s'est réellement passé dans le passé et il y a une énorme possibilité que cela puisse se reproduire.

Il y avait une mystérieuse maladie en Chine que personne ne semblait connaître ni soigner. Le coronavirus responsable du SRAS a été gardé secret pendant un certain temps par le gouvernement chinois. La communauté internationale a été tenu en échec pendant des mois avant la divulgation de la source de la maladie. Lorsque le virus a été identifié par un scientifique à Hong Kong, il a été transmis au scientifique américain à Atlanta qui a réussi à décoder le virus grâce aux ordinateurs de Vancouver²⁸². Cependant, aussi rapidement que le virus ait été identifié, la maladie avait déjà coûté la vie à de nombreuses personnes parce que le gouvernement chinois avait essayé de contenir les informations concernant la maladie pour des raisons. L'absence de connaissance sur la constitution génétique du virus, son mode de transfert et la façon de l'éradiquer, augmente le risque que de nombreuses personnes soient infectées et meurent.

Aujourd'hui, les plates-formes, les outils, les technologies et la main-œuvre dans l'identification de la maladie sont au place. Les scientifiques travaillent de manière efficace et rapide quand ils sont en possession de la bonne information. Peu importe que les infrastructures sanitaires mondiales soient efficacement intégrées et inter-reliées, s'il n'y a pas de partage des connaissances, la guerre pour l'identification de la maladie et de son éradication ne sera jamais gagnée. A cause de la restriction des

²⁸² Walsh, B. (2013). It's Gone Viral. Time Magazine. March 2013. P 50

informations, plus de personnes risquent leur vie et les scientifiques ne peuvent pas faire leur travail.

Relation de la Santé et de la Communication

“Communication is clearly the primary process used in health care to disseminate and gather relevant health information²⁸³”

Cette déclaration renforce le rôle de la communication dans la promotion et la gestion de la santé. Leur relation n'est pas nouvelle. La communication est la fibre même qui relie les faits à la pensée et aux émotions humaines. Beaucoup de recherches ont été écrites dans les limites de la santé et de la communication donnant les liens entre ces domaines²⁸⁴.

La communication est le processus social central dans la prestation de santé. L'information sur la santé est issue de la connaissance issue de tests de laboratoire et des interviews de patients qui sont à la base dans le diagnostic des problèmes de santé. La dynamique de la communication dans le contexte de la santé est également très complexe et examine les différents niveaux de communication (intra, interpersonnelle, de groupe, sociétal et organisationnel). Il s'agit aussi de communication à travers différents canaux : face à face, par téléphone, fax, et la communication de masse qui implique l'utilisation de différents médias pour

²⁸³ Kreps, G. & Kunimoto, E. (1994). *Effective Communication in Multi-cultural Healthcare Settings*. London. Sage Publication. Traduction: «*La communication est clairement le processus primaire utilisée dans les soins de santé pour diffuser et recueillir de l'information pertinente sur la santé* »

²⁸⁴ Hornik R., Ramirez S., (2006). *Racial/Ethnic Disparities and Segmentation in Communication Campaigns*, American Behavioral Scientist, Sage Publication. Schoberberger R., Nodes, M., (2005). *Health Campaign for Atherosclerosis Prevention*, Institute of Social Medicine, Center of Public Health, Medical University of Vienna, Vienna Austria, Springer –Verlag

transmettre/diffuser l'information sur la santé. Le réglage de la communication de la santé est également très diversifiée ²⁸⁵.

Kreps et Query ont identifié deux perspectives dans l'enquête de communication santé. La première concerne la prestation de soins de santé qui examine comment la communication influe sur la prestation des soins de santé. La seconde s'intéresse à la promotion de la santé qui étudie l'utilisation persuasive des messages de communication et les médias pour promouvoir la santé publique.

Bien qu'il soit reconnu que la communication est au centre de la prestation des soins de santé et du maintien de la santé, la communication dans le domaine de la santé est très complexe. Un des nombreux rôles de communication en matière de santé est de "démystifier la complexité des rôles de la communication dans les soins de santé et de promotion de la santé ²⁸⁶". Dans la communication de la santé, l'objectif des efforts de communication est souvent d'offrir un choix éclairé. Les décisions doivent être fondées sur une compréhension «juste» des faits d'un patient et être compatibles avec les valeurs du patient ²⁸⁷. Cela signifie que dans la conception des messages de communication, la principale considération doit toujours être d'adapter les messages et les outils de communication avec le système de croyance des patients. Ceci est également vrai lorsqu'il s'agit d'une interaction entre un auxiliaire de santé et les patients, particulièrement les immigrants parce qu'ils viennent d'un milieu différent. C'est là que la communication joue un rôle très important. Percoff a déclaré que la communication peut jouer un rôle énorme dans la réduction des inégalités de santé aux États-Unis, parce qu'il y a encore de frappantes disparités raciales dans les soins de santé, "malgré l'engagement philosophique de

²⁸⁵ Kreps, G.L., Bonaguro, E.W., & Query, J.L. (1998). In L.D. Jackson & B.K. Duffy (Eds.), *Health Communication Research: A guide to Development and Directions*, Westport, CT: Greenwood Press. pp 1-15

²⁸⁶ L.D. Jackson & B.K. Duffy (Eds.), *Health Communication Research: A guide to Development and Directions*, Westport, CT: Greenwood Press. pp 1-15

²⁸⁷ Peters, E. et al (2006). The Functions of Affect in Health Communications in the Construction of Health Preferences. *Journal of Health Communication*. S 140-162. International Communication Association.

cette nation pour l'égalité"²⁸⁸. Compte tenu de cette observation dans l'un des pays ayant la plus riche histoire de la migration, il est alarmant de voir comment la France gère les inégalités envers les immigrants en matière de santé. On peut se demander si l'existence de ces inégalités est reconnue. Ce qui est flagrant dans le scénario de la santé américaine est que ce pays a depuis longtemps reconnu la contribution des immigrants à la croissance de leur pays. Ils ont également mis en place des programmes dont certains répondent aux besoins des immigrants. Malgré ces efforts, les rapports révèlent cependant toujours que les immigrants doivent encore faire face à des difficultés en matière de santé. On peut se demander quel est le statut des immigrés santé dans ce pays.

La création de messages de santé très ciblés est l'un des outils pour lutter contre les inégalités de santé et mieux communiquer les informations sur la santé. Cependant, la réalisation de messages de santé très ciblés est coûteux, prend du temps et nécessite la volonté politique des gouvernements et des organisations concernées. C'est une tâche ardue, car cela signifie que les créateurs de message doivent prendre en considération de multiples facteurs qui opèrent dans la vie d'un groupe. Certains de ces facteurs sont l'origine raciale, l'appartenance religieuse, les convictions personnelles de santé, etc. Toutefois aussi difficile que cela puisse paraître, de nombreux organismes de santé adoptent lentement l'idée que c'est la meilleure façon de lutter contre les maladies, de sauver des vies et des ressources.

La préservation d'un bon état de santé est fortement tributaire de la nature de l'information fournie au public. Les messages de prévention sont fortement encouragés afin d'éviter le coût beaucoup plus élevé des soins d'urgence, d'hospitalisation ou de médicaments à vie dans le cas de maladies chroniques. Toutefois, les campagnes de prévention ont leur part de défis qui émanent de la bureaucratie, d'un soutien minime des groupes concernés, du manque d'intérêt de la

²⁸⁸ Percoff, R., (2006). *Communication and Healthcare Disparities*. American Behavioral Scientists. Volume 49. Number 6

population et du système de contrôle limité sur l'impact de la campagne. En 2004, pour mettre en évidence l'importance des informations dans la lutte contre les maladies, la grippe aviaire qui a touché la volaille asiatique, a été jugé plus effrayante parce que peu de données existe au sujet du virus H5N1. Les travailleurs médicaux sont frustrés parce qu'ils ne peuvent pas déterminer combien de personnes et d'animaux ont été infectés ? Et ce mystère a des implications pratiques pour la lutte contre la maladie ²⁸⁹. Cela montre l'implication et les conséquences fatales du manque d'informations de base sur la maladie. C'est seulement lorsque les questions fondamentales sont traitées que des solutions sont recommandés pour une action immédiate.

Il y a plusieurs énormes succès dans la lutte contre l'épidémie qui peuvent être attribués à des campagnes efficaces de communication sur la santé. Un programme mondial de vaccination contre la variole lancé en 1967 et a éliminé la maladie en 1980. Il y a une prise de conscience au Nigeria sur l'utilisation de moustiquaires pour prévenir le paludisme. Au Bangladesh, l'utilisation de sari plié placé sur l'ouverture d'un pot avant de recueillir l'eau, crée une barrière contre le plancton à laquelle la bactérie du choléra est attachée. Trois millions et demi de personnes souffrent d'une maladie causée par un parasite appelé le ver de Guinée dans les régions reculées de l'Afrique où seule l'eau contaminée est disponible pour la consommation. En 2002, grâce aux efforts du Centre Carter, le nombre de personnes souffrant de cette maladie a été réduite de 98% ²⁹⁰. Le fondateur de ce centre, l'ancien président des Etats-Unis Jimmy Carter, reconnaît que « en tant que communauté et en tant que nation, il est important d'éduquer les citoyens, légiférer de façon éthique et de soutenir à bon escient les organisations qui effectuent des recherches et aider ceux qui sont malades » ²⁹¹.

²⁸⁹ National Geographic Magazine 2005 pp 20-21

²⁹⁰ National Geographic Magazine 2000, p 3

²⁹¹ Ibid 44

Ces réussites montrent que lorsque les efforts sont synchronisés, l'élimination des maladies est possible. Les modifications de certaines activités quotidiennes, l'éducation de la population sur l'effet positif des changements proposés donne souvent des résultats positifs et sauvent des vies. Ces connaissances/apprentissages resteront avec les gens où qu'ils aillent. Ce qui est bon avec les concepts de santé est que le principe de base du maintien de la santé est universel : manger des fruits et des légumes, faire des exercices physiques, boire beaucoup d'eau et conserver un mode de vie sain. Encourager les gens à suivre ces concepts est un autre challenge. Les aliments riches en calories sont les meilleurs compagnons d'une vie bien remplie. La nourriture malsaine semble avoir le dessus et le contrôle de l'alimentation des personnes de nos jours. Cela signifie que les défenseurs de la vie saine doivent tripler leurs efforts pour ramener les gens dans leur giron.

De la collecte à la diffusion d'informations, des outils de communication sont utilisés pour mieux aider les clients de la santé (patients), leurs parents et amis. Ces outils vont de l'utilisation de différents médias pour communiquer les meilleures options de santé, l'identification et l'utilisation de divers modes de communication pour mieux atteindre les publics cibles et la maximisation des résultats de recherche afin de mieux aider les fournisseurs de soins.

Les informations sur la santé peuvent être recueillies par différents moyens. Aujourd'hui, la collecte de renseignements médicaux modernes sont aidés avec une pléiade de technologies. Malgré ces développements, la communication humaine joue encore un rôle crucial dans le processus. Médecins et professionnels de la santé doivent bien comprendre la psychologie, le maquillage biologique, le fond culturel et les préférences personnelles du client. De cette façon, le client recevra le traitement le plus approprié. Le traitement médical comprend la préférence des patients dans la prise de médicaments, le meilleur moment pour faire de l'exercice, l'alimentation qu'elle peut tolérer etc. A l'inverse, les patients doivent aussi communiquer avec les médecins, en précisant expressément leur position au sujet de la prise de médicaments, l'exercice physique et le genre de nourriture qu'ils

peuvent manger. Ils sont censés être les acteurs de leur propre santé, se responsabiliser en lisant la littérature sur les maladies auxquelles ils sont exposés à cause de la génétique ou de mode de vie.

Définir la communication de la santé

La recherche sur la communication de la santé a ses racines fermement plantées dans les besoins des peuples d'avoir plus d'informations sur la santé. Dans la mesure où la majeure partie des informations sur la santé provient des professionnels de la santé, les patients et les groupes de préoccupation exigent des informations au-delà de la définition médicale habituelle. La médicalisation des maladies et les maladies ont longtemps été mises en doute par les parties prenantes qui ont ainsi incité les médecins à regarder les maladies au-delà des résultats de laboratoire. Ce changement de paradigme en psychologie de la santé donne naissance à de nouvelles recherches scientifiques et humanistes qui ont essayé de répondre aux questions de la santé au-delà de la lentille microscopique. Connecter les problèmes de santé à la pauvreté, au statut social, à la culture, à la communication ou au sexe constitue la bourse de communication sur la santé.

Par conséquent, la communication de la santé est définie comme une science appliquée du comportement. Elle est appliquée parce qu'elle examine les influences pragmatiques de la communication humaine sur la procuration de soins de santé et la promotion de la santé publique²⁹². En raison de sa grande portée scientifique, qui transcende les frontières et les disciplines et du fait d'être un jeune domaine de recherche, la communication est devenu un domaine prometteur de la recherche universitaire et de l'érudition. En fait, les institutions universitaires offrent des cours dans le domaine de la communication de la santé dont l'objectif est de former des professionnels sur la façon de mieux communiquer avec leurs patients, en tenant

²⁹² Kreps, G.L., Bonaguro, E.W., & Query, J.L. (1998). In L.D. Jackson & B.K. Duffy (Eds.), *Health Communication Research: A guide to Development and Directions*, Westport, CT: Greenwood Press. pp 1-15

compte des différentes sensibilités. Des cours sont également orientés vers la préparation des concepteurs de campagnes d'informations mieux adaptées à l'auditoire cible.

En d'autres termes, la communication de la santé implique un sens du partage et de la création sur les soins de santé et les conditions. Elle couvre un large éventail de sujets, y compris le contrôle des maladies et leur prévention, la préparation à d'urgence et les réponses et beaucoup plus²⁹³. La communication en santé met principalement l'accent sur deux éléments principaux : la production et le traitement de messages et la création d'un sens commun sur les questions de santé²⁹⁴.

Retraçant l'évolution de la communication santé

Le terme « communication de la santé » existe depuis le milieu des années 70, mais il a connu une croissance exponentielle au cours des 25-30 dernières années²⁹⁵. Son rôle principal est d'examiner les puissants rôles exécutés par des humains et de la communication méditée par la prestation et la promotion des soins de santé. Les résultats des recherches de ce domaine sont souvent utilisés pour faire des changements positifs importants dans la prestation et la promotion des soins de santé. Comme l'a souligné Gary Kreps, qui a fait des recherches approfondies dans le domaine de la communication de la santé, la demande dans ce domaine est souvent l'examen et la résolution des soins de santé et les problèmes de promotion de la santé.

Cette discipline est apparue comme une recherche passionnante en sciences comportementales appliquées. C'est une science appliquée, car elle examine les

²⁹³ Sparks, L., (in press). *Health communication and caregiving research, policy, and practice*. In S. S. Travis & R. Talley (Eds.) *Multi-disciplinary Coordinated Caregiving: Professional Contributions*. Springer. P 7

²⁹⁴ Sparks, L., (in press). *Health communication and caregiving research, policy, and practice*. In S. S. Travis & R. Talley (Eds.) *Multi-disciplinary Coordinated Caregiving: Professional Contributions*. Springer. P 10

²⁹⁵ Kreps, G.L., Bonaguro, E.W., & Query, J.L. (1998). In L.D. Jackson & B.K. Duffy (Eds.), *Health Communication Research: A guide to Development and Directions*, Westport, CT: Greenwood Press. pp 1-15. Ibid 44

influences pragmatiques de la communication humaine sur la procuration de soins de santé ainsi que la promotion de la santé publique²⁹⁶. Il y a quelques points de références quant à la façon dont la communication de la santé comme un domaine de recherche a commencé. Un point de départ très fort est l'émulation des disciplines de la communication avec d'autres disciplines telles que la psychologie et la sociologie, qui font de la recherche sur la communication de la santé. En outre, les chercheurs dans ces sciences sociales ont eux-mêmes commencé à examiner les variables de communication dans les soins de santé²⁹⁷. Ce qui a encouragé la poursuite des recherches. Parmi les disciplines académiques, c'est le domaine de la psychologie qui a le plus d'impact sur le développement de la communication pour la santé²⁹⁸.

Korsch et Negrete ont écrit un article scientifique intitulé « Doctor Patient Communication », publié en Amérique et toujours considéré comme le fondement du domaine de la santé Communication²⁹⁹. En 1963, le Journal de la Communication a consacré un numéro entier sur le thème « Communication et santé mentale». En 1967, un livre écrit par Watzlawick Bevin et Jackson et intitulé « la pragmatique de la communication humaine », offre une référence de très haut niveau pour la psychologie humaniste, en mariant les domaines de la psychologie humaniste et de

²⁹⁶ Ibid 49

²⁹⁷ Bandura, A. (1969). *Principles of behavior modification*. New York: Holt, Rinehart, & Winston. Feldman, J. (1966). *The dissemination of health information*. Chicago: Aldine. Kosa, J., Antonovsky, A., & Zola, I.K. (1969). *Poverty and health: A sociological analysis*. Cambridge, Harvard University Press. McGuire, W.J., (1969). *Attitude and attitude change*. In G. Lindzey & E. Aronson (Eds.), *Handbook of social psychology* (2nd. ed., pp. 136-314). Reading, MA: Addison-Wesley. Tichenor, P.J., Donohue, G.A., & Olien, G.N. (1970). *Mass Media Flow and Differential Growth in Knowledge*. *Public Opinion Quarterly*, 34(2), 158-170. Zola, I.K. (1966). *Culture and symptoms: An Analysis of Patients Presenting Complaints*. *American Sociological Review*, 3, 615-630.

²⁹⁸ Kreps, G.L., Bonaguro, E.W., & Query, J.L. (1998). In L.D. Jackson & B.K. Duffy (Eds.), *Health Communication Research: A guide to Development and Directions*, Westport, CT: Greenwood Press. pp 1-15. Sparks, L., (in press). *Health communication and caregiving research, policy, and practice*. In S. S. Travis & R. Talley (Eds.) *Multi-disciplinary Coordinated Caregiving: Professional Contributions*. Springer.

²⁹⁹ Thompson, T. et al. (2003)(Eds.) *Handbook of Health Communication*. Lawrence Erlbaum Associates, Inc. New Jersey.

la communication humaine. Ce livre a souligné que " la qualité de la communication relationnelle peut conduire à des résultats pathologiques et thérapeutiques, qui sert de tremplin à l'intérêt actuel pour les études de communication santé ³⁰⁰. Aujourd'hui, le domaine de la communication pour la santé est largement reconnu comme un contributeur dynamique, pratique et fondé sur la théorie qui façonne les décisions politiques en matière de santé³⁰¹.

La Communication de la santé comme domaine de recherche attire constamment des travaux académiques. Comme c'est un très jeune domaine de recherche, on attend beaucoup des résultats de recherche de cette discipline. Les établissements universitaires partout dans le monde offrent maintenant des cours de communication en santé. La Harvard School of Public Health offre des cours de spécialisation en communication de la santé. L'université de Boston a un cours en ligne de Master en science de la Communication pour la Santé et la Nottingham au Royaume-Uni offre un master basé sur une formation à distance sur le web. En France, l'Ecole des Hautes Etudes en Santé Publique (EHESP) situé à Rennes offre un large éventail de cours qui traite de santé publique. L'auteur a communiqué par e-mail avec cette université et un étudiant faisant ses recherches en communication de la santé et en commercialisation. Ce domaine de la communication santé est différent de l'étude de la communication de la santé en mettant l'accent sur la dynamique entre les intervenants dans le système de prestation des soins de santé. La communication de la santé en mettant l'accent sur le marketing est tout simplement de l'autre facette de cette discipline. Il est important de noter cependant que les cours de l'université française sont concentrées sur les programmes administratifs institutionnels de la santé.

³⁰⁰ Ibid 53

³⁰¹ Sparks, L., (in press). *Health communication and caregiving research, policy, and practice*. In S. S. Travis & R. Talley (Eds.) *Multi-disciplinary Coordinated Caregiving: Professional Contributions*. Springer. P 6

Malgré les études, les pays considèrent souvent la recherche en soins de santé comme un acteur mineur dans les inégalités de santé³⁰². Ce n'est pas surprenant parce que la nature même de la recherche ne peut ni être quantifiée ni apporter des résultats mesurables immédiats. Il est facile de considérer la recherche comme étant un exercice futile. Cependant, la politique de santé inefficace ou les mauvaises campagnes de santé peuvent être attribuées en partie au manque d'informations de base qui ne peuvent être fournies que par la recherche. Toutefois, le faible rôle de la recherche est réel dans le cas de la France. En effet, la nature même du système de soins de santé universel du pays et la grande allocation des ressources de santé, permettent tout simplement à tout le monde d'avoir accès aux soins de santé. La gestion des soins de santé dans ce pays peut être facilement comprise, quand quelqu'un est malade, il est libre d'aller voir le médecin ou de se rendre à l'hôpital de son choix. Toutefois, cela entraîne des coûts de dépenses en soins de santé vertigineux parce que les soins d'urgence coûtent plus cher que la mise en place des campagnes de prévention pour prévenir les complications liées à la maladie. Aujourd'hui les nations sont de plus en plus conscientes de leurs déficits budgétaires, de plus l'économie de certains pays s'est déjà effondrée, des mesures sont donc prises pour s'assurer du contrôle des dépenses. En France, il y a des actions pour lutter contre la hausse du coût des soins de santé. Les patients partagent désormais le fardeau des coûts de consultation et les institutions concernées veillent à ce que les médicaments soient correctement éliminés pour éviter le gaspillage.

En fin de compte, l'application des principes de communication de la santé préconisée par les tenants de cette discipline ainsi que des résultats de recherche aideront le système de santé du pays et d'ouvrir une mine de connaissances pour tous les secteurs de l'industrie de la santé. Pour l'instant, dans le but est de faire à la fois une recherche et diffuser les résultats aux parties prenantes.

³⁰² Polton, D. (2009). What is the Role of Healthcare System in Reducing Health Inequalities in France? In *Measuring and Tackling Health Inequalities Across Europe*. EuroHealth. Volume 15. Number 3. pp 19-20

Décrivait le domaine de la recherche: la Côte d'Azur

L'aire de recherche est le Sud de la France car la bourse de doctorat a été obtenu dans l'une des universités situées l'Université de Nice Sophia Antipolis. Elle a vécu à Nice, la plus grande ville de la région Côte d'Azur et un bon nombre de Philippins vivent dans les villes appartenant à cette région en raison de la disponibilité des emplois. Les trois principales villes où la recherche a été menée ont été choisies en raison de leur proximité. Il est commode de voyager car un système de transport public efficace traverse ces villes.

Figure 2: Plan de la French Riviera



Downloaded from: <http://1french-riviera.com/about-us-french-riviera/map-french-riviera> (accessed July 19, 2013)

La Côte d'Azur est une destination populaire pour les touristes ainsi que les retraités. C'est une région située dans le sud de la France le long de la côte de la mer Méditerranée. Il n'y a pas de frontière claire mais elle s'étire de la ville de Menton à l'est, à la frontière italienne, à Toulon à l'ouest. Cette région s'étend sur 550 miles, Principauté de Monaco comprise. Il s'agit du deuxième plus petit pays du monde

avec le Vatican et est dirigée par la famille Grimaldi. La zone est populairement connu pour son littoral, ses montagnes, ses musées, ses parcs bien entretenus, ses stations de ski et ses nombreux artistes qui comprennent Pablo Picasso, Henri Matisse, Marc Chagall et beaucoup d'autres. La célèbre actrice Brigitte Bardot a élevé davantage la Côte d'Azur où elle le film - Et Dieu créa la femme – a été tourné à Saint-Tropez. La région est fière de son temps d'été - chaud et tempéré, et sa saison d'hiver tolérable. Elle porte maintenant l'image d'être le terrain de jeu des riches et célèbres. Les rues de Saint- Tropez sont littéralement jonchées de stars internationales et de personnalités du monde des affaires et de la politique pendant la saison estivale. Les côtes d'Antibes, Villefranche sur Mer, Cap Ferrat sont quelques-uns des docks préférés des yachts des riches.

Certaines de ses villes les plus connues sont Nice, la plus grande ville, Cannes où a lieu le célèbre Festival du Film de Cannes et Monaco, pour son casino et son style de vie somptueux. Nichés entre ces deux villes on trouve des restaurants, des musées, des sites historiques, des châteaux et des vignobles somptueux. Quelqu'un qui visite la région se réglera en raison des vastes activités et points d'intérêts que la Côte d'Azur. Les villes, bien que située dans une région, promettent une expérience différente pour le voyageur parce que chacun a son propre caractère.

Monaco ne fait pas techniquement partie de la Côte d'Azur, car il s'agit d'un autre pays qui n'appartient pas à la France. Cependant, il est sous la protection de la France. Monaco dans le cadre de cette étude n'était pas considéré comme un autre comté. Au contraire, il a été mentionné comme une partie de la Côte d'Azur. Cela a été fait intentionnellement par le chercheur car l'identification des immigrants philippins entre deux pays ne ferait que compliquer le choix de l'emplacement pour cette recherche. En s'appuyant sur l'emplacement géographique, Monaco fait partie de la côte méditerranéenne près de la Côte d'Azur. Pour faciliter l'étiquetage, le chercheur fait référence à la zone de sa recherche - Nice , Cannes et Monaco - comme la Côte d'Azur .

Chaque ville de la Riviera est boostée par ses propres activités annuelles. Nice célèbre chaque année le Carnaval de Nice et le Festival de musique jazz. Cannes est l'hôte du Festival de Cannes ce qui rend cette petite ville, un lieu à voir pour les gens de l'industrie du cinéma et du divertissement. Menton est célèbre pour son Festival de Citron (Fête du Citron) où le défilé pour mardi gras est apprécié par des milliers de personnes et où les chars sont fabriqués à partir du principal produit de la ville, le citron. Biot, un petit village situé entre Cannes et Nice, est connue pour son industrie de soufflage de verre et célèbre également pendant quelques jours le festival médiéval où la grandeur de l'ordre des Templiers est commémorée et leur vie est revécue au moins pour quelques jours. Les participants et les spectateurs même de cet événement sont invités à s'habiller, vivre et manger comme à l'époque médiévale ce qui est une chose très intéressante à vivre. Durant la saison estivale, ceux qui sont audacieux et aventureux peuvent passer une quantité importante d'argent pour séjourner quelques jours à Saint-Tropez et faire l'expérience d'être nu sur les plages nudistes de la ville. Bien qu'il existe des lieux comme celui-ci partout dans le Côte d'Azur, Saint- Tropez est la ville principale lorsqu'il s'agit de littéralement désinhiber quelqu'un.

Ce sont ces activités qui font de la Côte d'Azur une destination touristique populaire pour les gens qui peuvent se permettre de voyager et de faire des folies dans la Mer Méditerranée. Les touristes abondent même pendant la saison d'hiver, car il ne fait pas très froid et plusieurs stations de ski comme Isola et Valberg se trouvent dans la périphérie de la ville principale. La Côte d'Azur offre beaucoup de choses à ceux qui tentent d'échapper à la vie stressante de la ville. Malgré tourisme robuste, les Français ont réussi à préserver leurs racines culturelles en particulier leur langue. Ils sont restés français à bien des égards ce que la plupart des touristes ne trouvent pas accueillant. Indépendamment de ces traits, les touristes ne cessent de venir sur la Côte ce qui maintient de nombreuses entreprises à flot. Il en résulte de nombreux emplois, en particulier dans le secteur des services. De nombreux immigrants abondent sur à la Riviera parce que le travail abonde.

Figure 3 : Photos de la French Riviera



Promenade des Anglais, Nice



Cannes Film Festival 2013



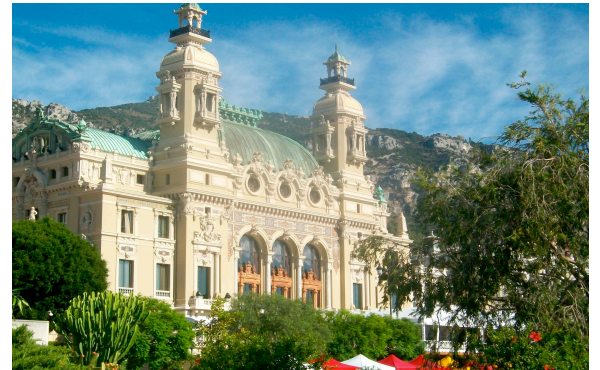
Eze Village, située entre Nice et Monaco



Medieval Festival, Biot



Fete de Citron, Menton



Monaco, Monte Carlo

Remarque: Toutes les photos ont été prises par le chercheur

La figure 3 montre les endroits et les événements au sein de la Côte d'Azur. Elle montre de façon frappante les lieux touristiques et les activités intéressantes qui attirent les gens de toute la France ainsi que les voyageurs internationaux soit pour visiter ou de vivre dans la région. Les musées abondent également comme les musées Marc Chagall et Henri Matisse à Nice et le Musée Picasso à Antibes. La société française est également très favorable à l'ancienne génération. Il y a beaucoup d'organisations locales composées de personnes âgées et handicapées. Le gouvernement local s'assure qu'il y ait suffisamment d'activités pour ces personnes, ce qui mérite un éloge. Une organisation comme Bellage propose des activités pour les personnes âgées. Valentin Haüy est l'organisation pour les aveugles et Osons la différence est celle des personnes en fauteuil roulant. En 2012, Valentin Haüy, Osons la différence associées au Lions Club et au conseil Général des Alpes Maritimes envoient trois handicapés, un aveugle, un muet, et un paralysé, qui accompagnés d'un petit groupe de personnes, effectuent l'ascension du Kilimandjaro. Cela envoie un message au monde que même si la mobilité physique est limitée, de grandes choses peuvent être accomplies lorsque les efforts sont mis ensemble. Cette activité met en valeur l'engagement du gouvernement français à soutenir les activités qui favorise le bien-être du groupe minoritaire et les membres défavorisés de la société.

Après avoir présenté ces exemples, les immigrants doivent également renforcer leurs efforts pour être reconnu par le gouvernement en créant des programmes qui soulignent leur contribution envers la société française. Peu importe que ces activités soient « petites », l'objectif principal doit être de tendre la main et de construire une meilleure ligne de communication, ce qui réduit l'écart qui sépare les groupes d'immigrants et les citoyens locaux ainsi que le gouvernement local français.

La région a été choisie car le chercheur a obtenu la possibilité de poursuivre ses études doctorales à Nice grâce à une bourse d'études de l'Union européenne. La

région est un bon endroit pour étudier la communauté philippine, car un grand nombre de Philippins se sont installés dans la région pour y travailler.

Hypothèses

Cette étude émet l'hypothèse que :

1. Pour les immigrants philippins vivant dans le sud de la France, la langue française est encore un obstacle à l'accès aux soins de santé.
2. Les pratiques de santé actuelles sont encore très influencées par le système de croyance de santé passé quand ils vivaient encore aux Philippines et qu'ils étaient exposés à un environnement sanitaire différent.
3. Les immigrants philippins ont pu adopter le système de santé français, mais leur niveau d'assimilation est encore à identifier et être décrit
4. Il y a des pratiques émergentes pour la santé basée sur la combinaison intentionnelle ou non des croyances du passé et du présent.
5. La première génération d'immigrants philippins ne sont pas conscients qu'il existe des différences entre le système de santé de la France et les Philippines.

Énoncé du problème

Le système de croyance de santé des Philippines est une riche combinaison de facteurs qui influencent généralement la vie d'une personne. Leur culture, leur localisation géographique, leurs croyances religieuses ainsi que les conditions météorologiques ne sont que quelques facteurs qui influent sur « la notion traditionnelle de la maladie et de la santé dans la culture de la santé des Philippines ». L'étiquette de guérisseurs traditionnels/indigènes ou folkloriques, n'est pas seulement une collection aléatoire de croyances et de pratiques exotiques, au contraire, elle est le reflet d'un système de connaissances³⁰³. Ce système de croyance de santé devient une partie du fil interne des Philippins et ils vont le transporter partout où ils peuvent décider de vivre.

³⁰³ Tan, M.L., (2008). *Revisiting Usug, Pasma, Kulam*. Quezon City. University of the Philippines Press. P 5

La majeure partie du grand récit des immigrants est de savoir comment ils font face aux défis d'ajustement et plus tard sur l'assimilation au pays d'accueil. Faire face à un pays dont la langue et la culture sont totalement étrangères à l'immigrer est un processus plus complexe que ceux qui ont déjà des connaissances sur le pays où ils se déplacent. Citant le mouvement mondial des Philippins à titre d'exemple, ils s'adaptent mieux et plus vite quand ils se déplacent dans un pays anglophone plutôt que dans un pays de langue française. Dans le même temps, un algérien aura plus de facilité à s'adapter à la France parce qu'ils parlent français. Mettre les Philippins dans un pays de langue française et des Algériens dans un pays anglophone, rend leur assimilation plus complexe.

Pour les immigrants philippins dans la Côte d'Azur, cette étude vise à savoir comment le système de croyance de santé profondément ancré dans le tissu même d'être des Philippines, est modifié ou influencé par le système de soins de santé de la France.

En règle générale, cette recherche permettra d'identifier les pratiques émergentes pour la santé des Philippins vivant dans la Côte d'Azur à travers l'examen et l'analyse de leurs pratiques médicales actuelles. Les résultats seront ensuite examinés en deux fonds, l'un est la croyance la plus commune de la santé et des pratiques dans les Philippines et la manière traditionnelle face à ces maladies, et de l'autre côté, c'est le système de soins de santé de la France.

Grâce à l'identification et à l'analyse des pratiques de santé courants vis-à-vis des pratiques actuelles des Philippins dans la Riviera, le chercheur espère extraire ce qui émerge lorsque les croyances de santé philippins sont pratiquées dans le cadre du système de santé français. L'hypothèse est que les pratiques de santé anciennes (intentionnellement ou non) au sein d'un nouveau système de soins de santé vont créer un hybride qui doit être étudié et faire l'objet d'une enquête. Ne connaissant pas le résultat, ce mélange, représente très certainement un gaspillage

de ressources précieuses et peut mettre en péril des vies. Il est de la responsabilité des partenaires académiques sociaux épidémiologistes, pour être précis, de déterminer les nouveaux systèmes de croyance de santé d'un groupe d'immigrants afin de fournir aux concepteurs des campagnes d'informations opportunes et pertinentes, de créer des professionnels médicaux sensibles aux cultures et d'aider les décideurs dans l'élaboration de règles solides.

Une fois que les immigrants ont posé le pied dans le pays d'accueil, en théorie, l'assimilation et l'intégration commence. Un immigrant est considéré comme intégré dans le pays d'accueil s'il peut avoir un emploi descente pour soutenir sa famille, acquérir la maîtrise de la langue courante, s'engager dans les affaires publiques et avoir accès aux services de santé de base. Dans un scénario plus large et plus complexe, un immigré est bien intégré s'il peut pratiquer ses valeurs religieuses, culturelles dans le pays d'accueil sans pénalité ni dénigrement. Il doit aussi pouvoir faire des remarques sur la politique sans craindre ni châtement ni échec total³⁰⁴. En se concentrant principalement sur la partie initiale de l'intégration, un immigrant doit avoir accès aux informations sur la santé. Il doit être pleinement informé de ses droits en tant que résident et doit pouvoir répondre à des questions fondamentales telles que les clauses de santé de base, comment le système français fonctionne, quelles institutions aller voir, les différents professionnels de la santé, où aller pour obtenir des renseignements précis, les numéros d'urgence. Il est important que ces choses proviennent d'une source fiable et il devrait y avoir une procédure précise qui permettent aux immigrants de savoir où chercher ces informations.

Cette étude vise à répondre aux questions suivantes : 1. Quelles sont les pratiques émergentes pour la santé des Philippins vivant dans la Côte d'Azur ? 2. les Philippins sont ils satisfaits de leur performance en santé, par rapport à l'aide venant du système de santé ? 3. Quelles sont leurs expériences de santé en ce qui

³⁰⁴ Hochschild, J. L. (2005). *Looking Ahead: Racial Trends in the United States*. Daedalus 134, no. 1: 70-81. <http://dash.harvard.edu/handle/1/3200608> (accessed March 22, 2013). Pp 3-4

concerne leur maintien en bonne santé, en cherchant à guérir et la collecte de renseignements sur la santé de la Côte d'Azur?

Objectifs

En règle générale, cette recherche permettra d'identifier et de décrire les expériences de santé des immigrants philippins dans la Côte d'Azur et extraire les pratiques émergentes pour la santé provenant des pratiques volontaires ou non de systèmes de croyances traditionnels de la santé. Cette étude vise à fournir des données de base qui peuvent être utilisés par les prestataires de santé et les législateurs afin de comprendre le mode de soin des immigrants philippins. Connaissant la position et la mentalité de ces groupes d'immigrants, en termes de problèmes de santé, permettrait de fournir des données aux professionnels de la santé sur la façon de mieux communiquer avec eux. Les résultats de cette recherche pourraient aussi inspirer d'autres recherches dans le domaine de la santé et d'autres groupes minoritaires d'immigrants.

Plus précisément, cette étude identifie les défis et les avantages d'être un immigrant philippin sur la Côte d'Azur en termes d'accès aux services de santé conduisant à une meilleure gestion de la santé.

Ce projet vise à:

1. Identifier et décrire les croyances et les pratiques traditionnelles des Philippins vivant dans la Côte d'Azur
2. Décrire comment les croyances de santé traditionnelles influencent les pratiques de santé actuelles avec le système de soins de santé français comme toile de fond
3. Identifier les pratiques émergentes pour la santé de la population philippine et décrire comment il se confond avec le paysage de la santé de la Côte d'Azur
4. identifier les obstacles qui contribue à l'assimilation de la santé échec ainsi que les facteurs qui favorise une meilleure préservation de la santé chez les immigrants philippins

5. Proposer un modèle de santé qui explique comment les pratiques émergentes des immigrants pour la santé sont formées et opérationnalisées

Répondre à ces objectifs de recherche mettrait en pleine lumière le mode de vie sur la santé des immigrants philippins sur la Côte d'Azur. En apportant leurs problèmes dans le milieu universitaire, nous espérons susciter un débat public sur les questions de santé des immigrants, ainsi que repenser les réponses sociales et politiques aux problèmes de santé des immigrants.

CHAPITRE II

Prémisse théorique

Contexte théorique

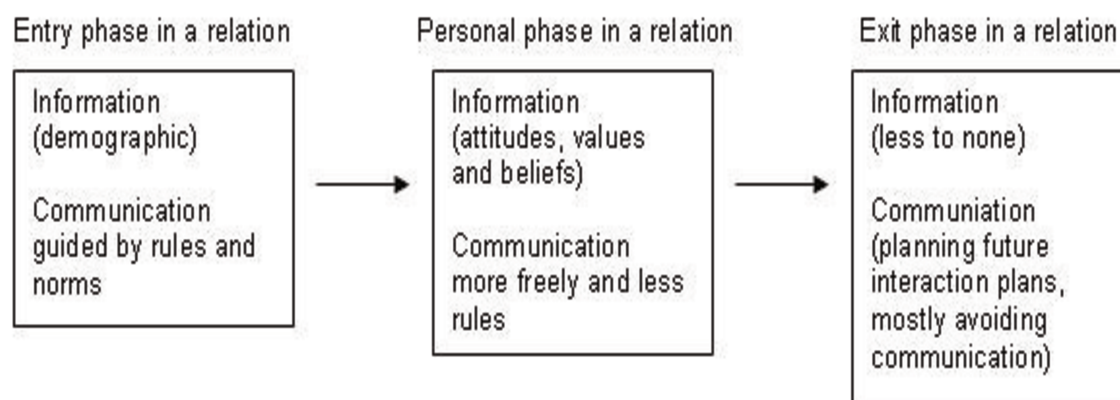
La communication de la santé n'est pas une propriété exclusive d'une discipline académique. Les théories utilisées dans la compréhension de la dynamique de ce riche domaine proviennent de divers domaines académiques. Les théories provenant de la communication, de la sociologie, de l'anthropologie et de la médecine sont utilisées pour faire avancer les connaissances relatives à la communication de la santé. La relation médecin-patient vient de la communication interpersonnelle. Les études sur les campagnes de santé sont liées à la psychologie sociale et les études sur les questions culturelles de santé, ont utilisé les théories de l'anthropologie³⁰⁵. Ainsi, la communication de la santé est un domaine riche et complexe de la recherche.

Cette étude utilise les théories provenant de différentes disciplines qui contribuent à une meilleure compréhension de la communication de la santé. Plus précisément, ces théories expliquent la façon dont les relations humaines sont développées, comment les systèmes de croyances sont formés et comment les expériences sont légitimées par la langue. Dans le cas des immigrants, tous ces concepts (relation, expériences et usage de la langue) sont des outils nécessaires pour survivre dans leur nouvel environnement.

Cette étude s'appuie principalement sur "inspiration Uncertainty Reduction Theory" (Berger & Calabrese, 1975), "Health Belief Model" (Rosenstock, 1974), "Speech Code Theory" (Philipsen, 1997) et "Social Cognitive Theory (Bandura 1977). Bien qu'inspiré par d'autres théories culturelles, de santé et de communication, les théories mentionnées ci-dessus conviennent parfaitement dans cette étude.

³⁰⁵ Sparks, L., (in press). *Health communication and caregiving research, policy, and practice*. In S. S. Travis & R. Talley (Eds.) *Multi-disciplinary Coordinated Caregiving: Professional Contributions*. Springer.

Figure4: Uncertainty Reduction Theory



Pris à partir de: <http://images.search.yahoo.com/images/view> (telechatrge May 2013)

“Uncertainty Reduction théorie” pose comme principe que les gens communiquent pour réduire l'incertitude qu'ils ont sur les autres par l'obtention d'informations à leur sujet. Cette information est ensuite utilisée pour prédire leur comportement. La réduction de l'incertitude est nécessaire si une personne désire développer une relation plus profonde avec quelqu'un, ou si les institutions veulent en savoir plus sur ces parties prenantes. La meilleure technique permettant de réduire l'incertitude est d'enquêter. Poser des questions pour recueillir plus d'informations sur une personne ou un groupe diminue l'incertitude et conduit à une meilleure compréhension et donc au développement de la confiance. Quand un bon niveau de confiance est atteint, la communication devient plus facile et l'information circule librement.

Cette étude applique la théorie de la réduction de l'incertitude en perspective micro et macro. Dans le point de vue général, la gouvernance de la Côte d'Azur est considérée comme la principale institution à combler le fossé entre le gouvernement et ses citoyens. Pour réduire le fossé existant entre le gouvernement et ses citoyens, l'institution devrait mettre en place des projets qui faciliteront l'interaction. Dans une micro perspective, cette recherche applique la théorie de la réduction de l'incertitude

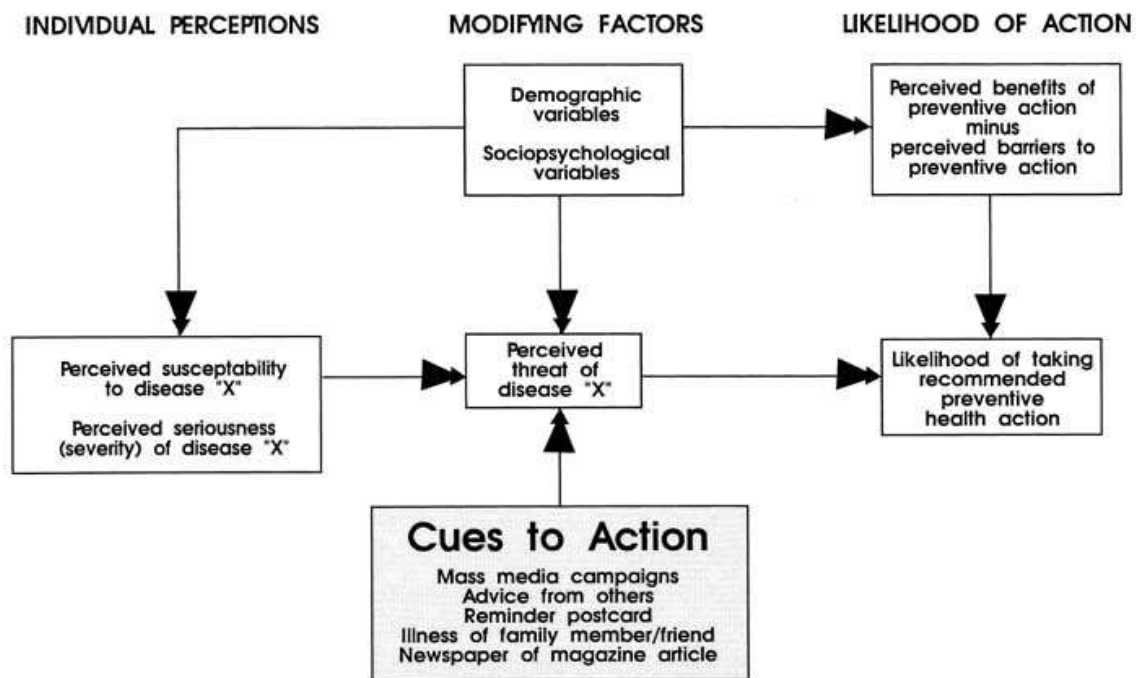
entre les patients philippins, les professionnels de la santé et le personnel de santé auxiliaire. Ces professionnels de la santé sont en première ligne des prestations de soins. Ainsi la disparition des incertitudes doit se produire dans l'interaction entre les patients et les prestataires de santé. Pour équiper les prestataires de santé d'outils nécessaires pour servir leur population, l'État doit fournir un programme de collecte d'information de santé standardisée, qui permettrait de surveiller et d'analyser l'état et les performances de la santé des immigrants. Dans une région comme la Côte d'Azur, la communauté est culturellement diversifiée et est ainsi composée de personnes et de familles d'origines ethniques et raciales différentes. En connaissant l'historique de santé des immigrants philippins, par exemple, les professionnels de la santé locaux seront mieux équipés pour relever les défis de la santé de ce groupe spécifique d'immigrants. Les régions de France, où les immigrants sont concentrés, ont déjà été identifiées et c'est le meilleur laboratoire pour apprendre à «connaître» la population immigrée. Les données de santé sur les immigrants ainsi obtenues, réduisent l'incertitude des intervenants. L'information permet ainsi aux deux parties d'apprendre l'une de l'autre. Les questions de base telles que de quoi est constitué le régime des Philippins, comment le comportement alimentaire est touché par les croyances culturelles, comment les choix alimentaires sont influencés par la religion et les goûts, trouveront réponse et cela peut être la base de la conception des campagnes de communication de santé qui répond le mieux à leurs préoccupations en matière de santé et exécuté d'une manière culturellement sensible. Ceci ouvrira également la voie à la perspective micro : réduire l'incertitude entre les individus : les médecins et les patients, les professionnels médicaux et les législateurs, les prestataires de soins et les concepteurs de la campagne de santé ainsi que de nombreuses autres combinaisons d'acteurs impliqués dans la prestation et la gestion des soins de santé.

En d'autres termes, lorsque des questions ont trouvé une réponse, il y aurait moins de problèmes. En ayant suffisamment de connaissances culturelles et religieuses sur les Philippins, les professionnels de la santé au service de la Côte d'Azur seront préparés grâce aux informations nécessaires pour mieux gérer les problèmes de santé de ce groupe de personnes. Ils savent ainsi que les Philippins,

qui sont des asiatiques, sont génétiquement prédisposés au diabète. Les campagnes prioritaires pour cette race devraient encourager l'alimentation pauvre en sucre. En termes de comportement de santé, les professionnels de la santé vont découvrir que la plupart des patients philippins expérimentent les traitements, ils arrêtent de prendre des antibiotiques quand la douleur s'arrête etc. Ainsi, les campagnes abordant l'importance de la prise de médicaments ne prolonge pas seulement la vie, mais améliore la qualité de vie.

Une autre théorie qui a été utilisé dans cette étude est la Health Belief Model (HBM) (Rosenstock, 1974).

Figure 5: Health Belief Model



Pros a partir de : http://search.yahoo.com/search;_ylt=A0oG7meKXOVRqUcAE
(telecharge July 16, 2013)

Health Belief Model (TBM) a été introduit à l'origine par un groupe de psychologues dans les années 1950 pour aider à expliquer pourquoi les gens utiliseraient ou n'utiliseraient pas les services de prévention disponibles, tels que les

rayons X pour le dépistage de la tuberculose et la vaccination pour la grippe. Ces chercheurs ont supposé que les gens craignaient les maladies et que les mesures de santé ont été motivées par le degré de crainte (de la menace perçue) et la réduction de la peur des actions tant que la réduction possible compense les obstacles pratiques et psychologiques à prendre des mesures (avantages nets). Ceci offre un cadre solide pour les initiatives de santé de la population en se concentrant sur cinq dimensions claires : 1) la vulnérabilité perçue (les perceptions subjectives du risque par rapport à la menace pour la santé) ; 2) la gravité perçue (l'évaluation des conséquences de la menace) ; 3) les avantages perçus (évaluer l'efficacité des actions de prévention) ; 4) les obstacles (évaluation des difficultés et des conséquences négatives de comportements préventifs) et 5) les indices à l'action (déclencheur du processus décisionnel). Plus récemment, la motivation de la santé, c'est la volonté d'un individu de se préoccuper de sa santé, a été ajoutée au modèle. S'appuyant sur ce modèle, des initiatives de santé publique ont besoin d'identifier un lien entre le comportement à risque d'un individu et la maladie afin de mettre en évidence la gravité de la maladie et de rendre l'adoption d'un comportement susceptible de conduire à une réduction du risque pour cette maladie relativement facile à adopter³⁰⁶.

Les dimensions constituées dans le HBM sont les facteurs de motivation pour un patient de consulter un médecin et éventuellement des soins médicaux. Cette théorie suppose que le patient a déjà assez d'informations sur ses possibles maux. Son action de demander une aide médicale est motivée par sa connaissance de son traitement de la santé, les conséquences de ne pas poursuivre l'aide médicale, les récompenses pour faire des mesures de prévention qui l'ont encouragé à s'engager dans l'action et prendre soin de sa santé.

³⁰⁶ Murphy, S. & Bennet, P., (2004). *Health Psychology and Public Health: Theoretical Possibilities*. Journal of Health Psychology. Sage Publication. P 19

Prendre en considération la culture d'un malade immigrant juxtaposée avec le système de soins de santé du pays d'accueil, la connaissance des maladies fondée sur la prédisposition génétique ou la reconnaissance de problèmes de santé en cours ne suffisent pas à résoudre les problèmes de santé. En comprenant la nature des droits qui lui sont accordées par l'État auquel il appartient maintenant ainsi que les ressources et les services auquel il peut avoir accès sont les étapes de base de l'intégration de la santé. C'est la raison pour laquelle dans cette recherche, le HBM est facilité par d'autres théories gratuites qui traitent spécifiquement de la culture et de la langue dans les soins de santé.

Dans la théorie du code du discours, Gery Philipsen stipule que là où il y a une culture distinctive, il se trouve un code de parole distinctif. La psychologie, la sociologie et la rhétorique sont intégrées dans ce code. Ce sont des concepts complexes qui suture l'individu, le social et l'idée de la vérité d'un individu. Une fois que la philosophie d'une personne est partagée avec la communauté, a pu recueillir des partisans et commence les discussions et les débats communautaires, l'idée devient une sous - culture de système de croyance.

Ce groupe de personnes va commencer à parler en codes qu'ils sont les seuls à comprendre. Ils créent maintenant une langue qui prend sa propre vie. Pour promouvoir l'analyse des discours des langages des actes et des événements de la parole dans un contexte culturel, Dell Hymes a formulé la S.P.E.A.K.I.N.G. model :

Figure 6: S.P.E.A.K.I.N.G. Model

Situation (setting or scene)

Participants (analysis of personalities and social positions or relationships)

Ends (goals and outcomes)

Arts (message form, content etc.)

Key (zone or mode)

Instrumentalities (channels or modalities used)

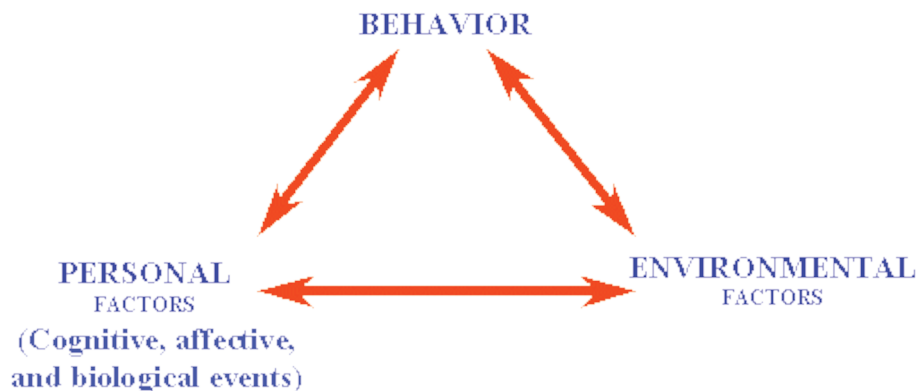
Norms (framework for producing or processing messages)

Genre (interaction type)

Pris a partir de <http://www1.appstate.edu/~mcgowant/hymes.htm> (Télécharge July 2013)

Ce modèle met un structure sur quels sont les mérites de prêter attention à une interaction humaine en particulier dans la communication verbale en face-à-face. Bien que l'analyse initiale des concepts semble être de portée générale, les concepts spécifiques identifiés qui correspondent à l'acronyme SPEAKING guident clairement les recherches comme des domaines clés sur lesquels se concentrer. Pour cette étude, le chercheur a utilisé tous ces concepts sous l'aspect de la communication de sa théorie de la santé proposée.

Figure 7: Social Cognitive Theory Model



Pris a partir de: <http://www.des.emory.edu/mfp/eff.html>. (Télécharger May 2013)

Le développement de la théorie sociale cognitive est attribué à son principal promoteur Albert Bandura. Tout a commencé quand il a lancé une étude pour déterminer les explications sociales pour pourquoi et quand les enfants considérés comme agressifs pendant la période où le fonctionnement humain est uniquement expliquée à l'aide des modèles de comportement. Cette étude a introduit l'idée de la modélisation de l'apprentissage en regardant les comportements d'autres personnes.

Finalement la théorie cognitive sociale (Social Cognitive Theory) met en évidence le rôle du contexte social dans l'apprentissage. L'apprentissage se fait dans un contexte social et beaucoup de ce qui est obtenu, l'est par l'observation. La SCT explique que le fonctionnement d'une personne est un produit de l'interaction continue entre les facteurs cognitifs, comportementaux et contextuels. Cette théorie

ne nie pas l'importance de l'environnement pour déterminer le comportement, mais elle soutient que les gens peuvent aussi, grâce à des processus de prévoyance, d'auto réflexion et d'autorégulation exercer une influence considérable sur leurs propres résultats et l'environnement plus large ³⁰⁷.

Cette théorie a réitéré que l'apprentissage, bien que guidé par des facteurs sociaux, vient aussi de la réalisation de soi à travers le processus de tâtonnement fiable. Ancré sur le principe qu'une personne est un individu pensant, il a toutes les facultés d'arriver à une décision qui sert le mieux ses intérêts. Il pourrait refléter les comportements et les actions des autres, mais si cela ne fonctionne pas pour lui, il va essayer de régler certains de ces éléments pour les adapter à son style de vie et les besoins.

Aidé d'autres théories comme Structuration et autres théories linguistiques et culturelles, le but de cette recherche est de proposer un modèle de santé transculturel qui incorporerait les concepts de la culture, de la santé et de la communication (la langue) dans le cadre de la façon dont un groupe d'immigrants s'adapte, de manière sage, dans un environnement totalement différent de leur origine. Dans cette étude le nouvel environnement est la région Côte d'Azur et le groupe d'immigrants est la communauté philippine. Le model de communication de santé transculturelle aspire à être la grille dans l'étude d'autres groupes minoritaires en regardant le lien entre la culture et la santé, qui se manifeste à travers le langage.

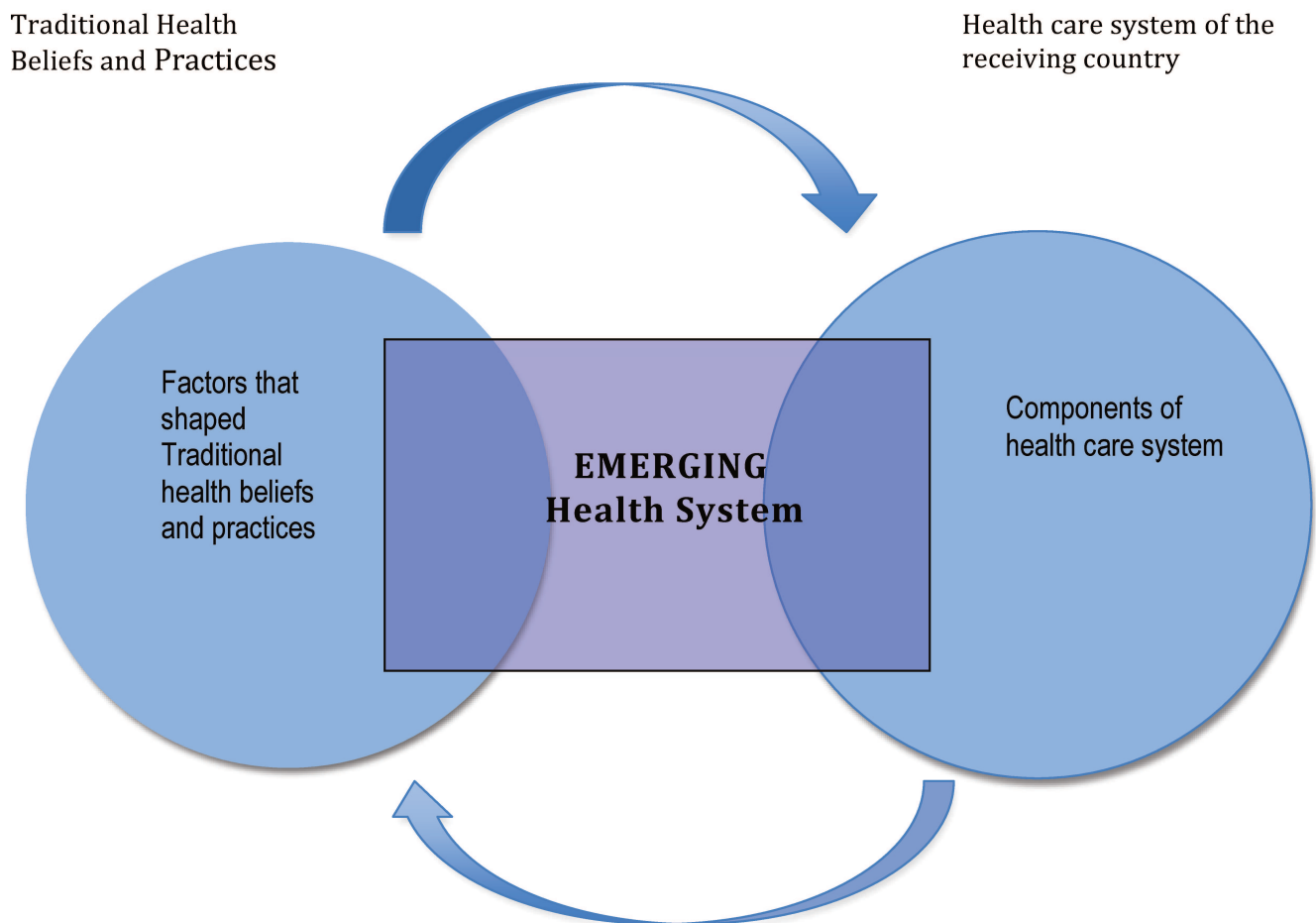
Cadre théorique

Le chercheur propose un modèle de communication santé qui encapsule des concepts importants qui proviennent des théories qui ont inspiré cette étude. Le modèle de communication de santé transculturelle proposé, encapsule les facteurs

³⁰⁷ Denler, H. et al (2013). *Social Cognitive Theory*. The Gale Group. <http://www.education.com/reference/article/social-cognitive-theory> (accessed August 2013)

qui permettent d'identifier l'orientation des comportements de santé des patients immigrés et comment elle affecte les performances de santé actuelles. En passant en revue les facteurs qui ont façonné les croyances, les pratiques de santé traditionnelles et la superposition avec le système de santé du pays hôte, les produits sont un condensé des concepts de santé dépourvu de vieilles croyances, mais rempli de nouvelles idées en matière de santé du pays d'accueil. Découvrir quels sont ces nouveaux système de croyance à la santé est un domaine intéressant de la recherche universitaire. Les informations qu'il fournira seront ajoutées dans le domaine de l'enquête de communication santé.

Figure 8: Cadre conceptuel du modèle de santé transculturelle proposé



Ce modèle de santé transculturel proposé (THM), figure 8, vise à déterminer les systèmes de santé émergents des personnes qui ont migré vers un autre endroit. Les immigrants apportent à leur nouvel environnement des connaissances en matière de santé. Ces croyances et pratiques de santé traditionnelles sont ensuite introduites dans le système de soins de santé du pays d'accueil, sans intention directe d'influencer ou de modifier le système de santé du pays d'accueil, ni les pratiques de santé de la population locale. Toutefois, lorsque le processus d'intégration commence, les défis se posent pour les différences culturelles qui deviennent centrales. Il en résulte un processus d'intégration plus long pour les immigrants en particulier lorsque le pays destinataire n'est pas familier avec la composition culturelle et religieuse qui affecte leurs décisions et les performances de santé des nouveaux venus. Ceci peut également s'aggraver lorsque les États n'ont pas un guide concret pour aider les immigrants. Le processus d'adoption et d'adaptation devient un défi quand les attentes des migrants ne concorde pas avec la norme fixée par la partie réceptrice. Toutefois, en vertu du principe que les deux parties sont conscientes de leurs rôles et leurs droits en matière d'entretien de la santé, le processus d'intégration au système de soins de santé sera un peu plus facile pour les immigrants et dans le même temps, le pays de réception peut maintenant planifier un programme culturel sensible à la santé.

Compte tenu du fait qu'il y a deux cultures de la santé au travail, il est prévu que les immigrants effectuent encore des pratiques de santé qui sont conformes à leurs croyances culturelles et religieuses traditionnelles. Les immigrants vont trouver un moyen de répondre à leurs croyances traditionnelles dans leur nouvel environnement de santé et, par conséquent, le système de santé émergents seront créés qui est souvent inconnu, à la fois pour les immigrants et l'état car ce n'est pas étudié.

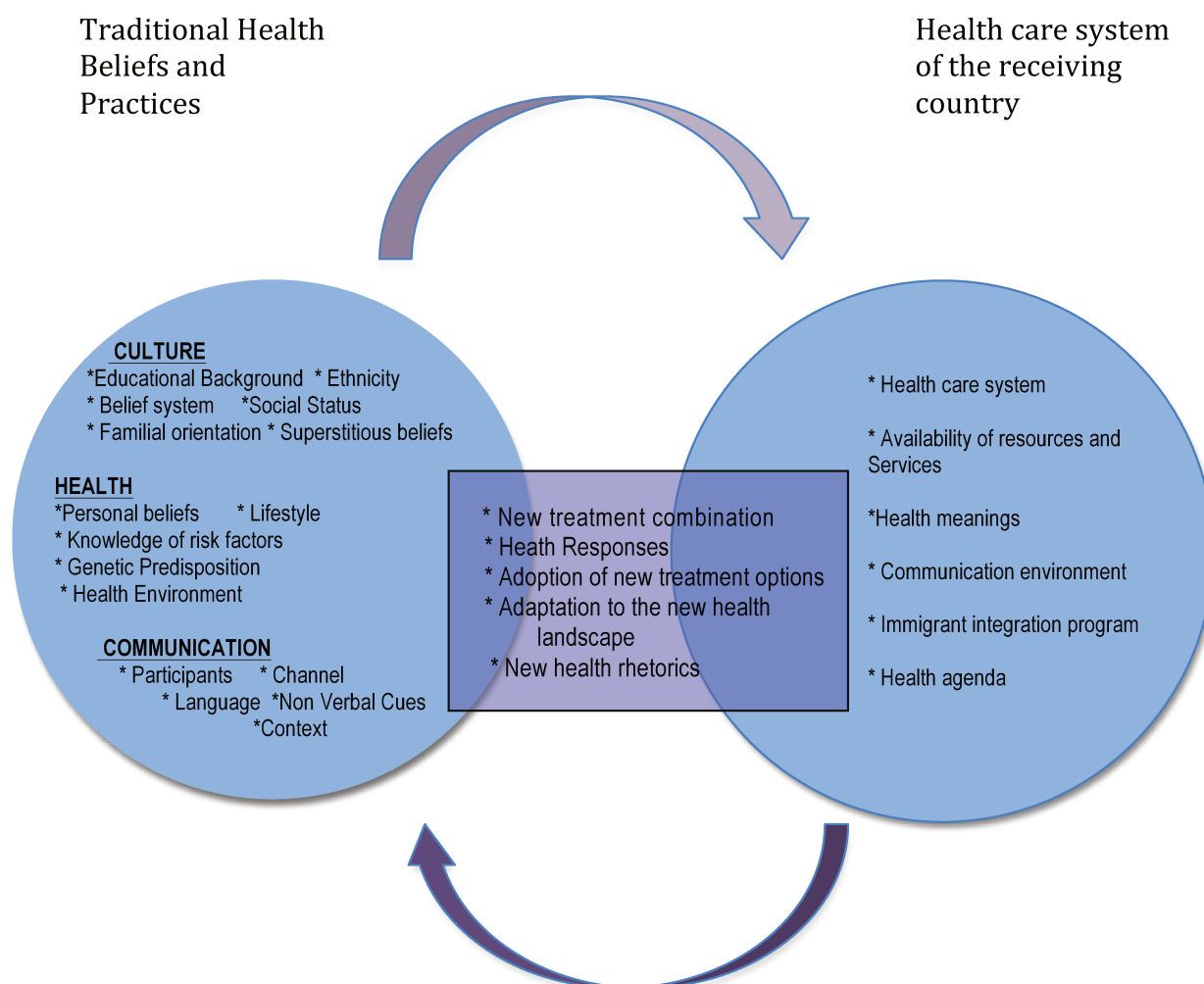
En se référant au modèle conceptuel du modèle de communication transculturelle de santé (Figure 18), les croyances et les pratiques de santé traditionnelles influencent sur le système de santé du pays d'accueil comme représenté par la flèche du haut. En retour, une fois que les immigrants comprennent le concept de santé de leur pays d'accueil, ils modifient aussi leur système de croyance

traditionnel de la santé, représenté par la flèche en bas. Cela devient maintenant un processus de cultures de santé qui s'influencent et se transforment mutuellement. Les croyances circulent ainsi librement d'un milieu culturel à l'autre suivant le but du mouvement transculturel. Le terme transculturel a été préféré par ce chercheur -au lieu de croisement culturel, inter-culturel, multi-culturel- s'alignant sur l'idée du professeur Crispin Thurlow que le terme transculturel crée un fluide se déplaçant à travers le système culturel, de quelque manière qu'ils pourraient être constitués³⁰⁸. Bien que les cultures sont souvent définies par des limites claires, les concepts impliqués dans la discussion sur les pratiques de santé peuvent être identifiés, mais ne seront jamais restreints. Les discussions portant sur la santé ne peuvent plus se limiter à des facteurs biologiques. On ne peut que trop insister que les questions relatives à la santé sont étroitement liées à la position sociale, aux influences culturelles et religieuses ainsi qu'à l'économie et aux facteurs politiques. Cela est évident dans les grands récits de processus d'assimilation des immigrants.

Ces constructions font de la recherche sociale sur la santé un domaine très complexe mais très enrichissant.

³⁰⁸ <http://faculty.washington.edu/thurlow/research/transculturalcommunication.html> (accessed July 2010)

Figure 9: Cadre opérationnel du modèle de communication santé transculturelle proposé



Le modèle de communication de santé transculturel postule que les gens issu d'un milieu culturel de santé différent, créent une pratique de santé unique qui concilie leur système de croyance traditionnel de la santé et le paysage de la santé de leur nouvel environnement. Ces pratiques de santé émergentes issues de deux milieux culturels créent par inadvertance un nouveau système totalement différent de ses sources tout en étant une partie de chacune d'elles. Les personnes qui effectuent des pratiques fusionnées peuvent savoir ou non qu'ils sont engagés dans de nouvelles pratiques de santé s'adaptant au nouvel environnement de la santé.

Sur le plan personnel / individuel, les pratiques de santé sont déterminées par des interactions culturelle et de communication. La culture est constituée de la

formation scolaire, l'orientation familiale, le statut social, la croyance religieuse et superstitieuse et l'origine ethnique. L'interaction de communication représente les participants, le canal, les signaux non verbaux, la langue et le contexte. Tout cela pris en compte, une personne se développe en un être culturel - un support et interprète de pensée. Son système de croyance se manifeste par des performances quotidiennes de ce qu'il pense et de ce qui convient le mieux à ses besoins. Dans le domaine de la santé, les pratiques de santé d'une personnes sont influencées par plusieurs facteurs comme le système de croyance (affiliation religieuse des croyances superstitieuses, etc.), le mode de vie (qui comprend les habitudes alimentaires et sportives, le type et l'environnement de travail etc.), et l'environnement de santé (se réfère au fonctionnement des institutions de l'Etat établies qui encouragent un mode de vie sain et fixe des règles de santé et de gestion de la maladie). La connaissance de la prédisposition génétique et des facteurs de risque de maladies aide aussi la personne à évaluer quel mode de vie il doit adopter afin d'éviter certaines maladies ou de retarder les complications, ainsi que de déterminer de futures soins médicaux. Pour certaines cultures, la croyance religieuse prend une grande place dans leur formation de l'identité et de l'identification. Les pratiques de la vie quotidienne sont très dépendantes de la croyance religieuse, ce qui comprend la façon de traiter les questions de santé. Pour les membres fidèles de groupes religieux, prendre soin de sa santé est très influencé par leur foi. L'appartenance religieuse devient une variable dans l'exercice de la santé pour les membres fidèles d'une organisation religieuse.

Les croyances superstitieuses ont aussi un impact sur la gestion de la santé. Ce système de croyance varie d'un pays à l'autre ou d'une région à l'autre dans un même pays. La croyance dans le surnaturel n'est pas seulement la performance aléatoire de foi sans fondement. Au contraire, c'est le produit de pratiques séculaires. En tant que tel, la croyance de la santé fondée sur les croyances superstitieuses ne peut pas être facilement effacée de la conscience des gens où qu'ils soient parce que c'est ancré dans leur subconscient. Cette réalité, comme une maladie chronique, ne peut être que géré.

Les perceptions de la santé des personnes seront influencées par leur niveau d'éducation et leur statut social. Inutile de dire que ces variables changent la façon dont les gens pensent de maintien de la santé et de la gestion de la maladie.

La communication est comme une colle qui mélange les concepts en matière de santé et de maladies pour donner un sens à cette question. Pour être en mesure de s'engager dans une communication interactive et pro-active, les actions doivent être en conformité avec les objectifs visés, les participants sont correctement identifiés et les canaux de communication sont ouverts à encourager un flux interactif d'échange d'informations. La façon dont les gens utilise le langage et les signes non verbaux sont des facteurs importants facilitant la compréhension et l'apprentissage.

Le rôle de ces trois concepts identifiés et les idées spécifiques qui s'y rattachent, ont formé le système de croyance traditionnel de la santé. Ce système de croyance est alors mis en pratique et est fortement influencé par la culture, les croyances religieuses et superstitieuses, des pensées de santé communes et un langage commun compris. Ces facteurs étaient présents chez un individu qui a migré vers un nouvel environnement, et dans cette étude, un nouveau pays. Ces croyances et pratiques de santé sont ancrées dans le tissu même de l'identité et le sens du soi. Cela ne signifie pas cependant qu'il va complètement changer après avoir été exposé à son nouvel environnement de santé, ni au système de santé auquel il appartient maintenant. Il changera complètement pour adapter ses croyances en matière de santé traditionnelle. Faisant écho à Klienman, les personnes sont ballotées entre les mondes et des identités. Ils peuvent être modernes ou traditionnels, en fonction des circonstances et de commodité³⁰⁹.

³⁰⁹ Kleinman, A. & Hall-Clifford, R. Forthcoming. *Stigma: A Social, Cultural, and Moral Process*. Journal of Epidemiology and Community Health 63(6). <http://nrs.harvard.edu/urn-3:HUL.InstRepos:2757548> (downloaded March 1, 2013)

Pour les immigrants, leur système de croyance de santé actuel est influencé par le système de santé du pays auquel ils appartiennent désormais. Il n'est pas clair cependant si le système de soins de santé de la France est affecté par la présence d'immigrants et si c'est le cas, de quelle manière. Cette étude se concentre sur l'analyse du système de soins de santé du pays d'accueil en relation avec le système de croyances traditionnelles des immigrants philippins, et non sur les croyances de santé traditionnelles de la population générale du pays d'accueil. C'est pour clarifier quelques questions qui peuvent se poser quant à la raison pour laquelle il n'est pas fait mention des croyances traditionnelles de la santé du pays d'accueil. Inclure cet aspect élargirait en outre la portée déjà vaste de cette recherche.

Diverses significations attachées aux concepts de santé influent sur la perception de la santé de la population autochtone ainsi que celle des immigrants. Ceci renforce ou interroge leurs croyances et leurs pratiques actuelles. Dans tous les cas, la fusion du nouveau et du traditionnel ouvre toujours la voie du dialogue. Ce que le chercheur postule est que les immigrants philippins à la Côte d'Azur ont une pratique de la santé émergente dont ils n'ont pas forcément conscience. Dans cette étude le chercheur a voulu identifier les facteurs qui mènent à la modification des croyances traditionnelles ainsi qu'à l'identification que sont ces pratiques émergentes.

En plus du système de soins de santé du pays d'accueil, les changements dans les pratiques de santé de la population sont également affectés par la disponibilité et l'accès aux services de santé ainsi qu'aux ressources. Dans un pays comme la France où les ressources de santé sont facilement disponibles et les services sont donnés librement. Il est intéressant de savoir comment les immigrants philippins bénéficient de ces privilèges étant donné qu'il existe des barrières culturelles et linguistiques. Les barrières proviennent aussi de la politique de migration et des programmes de santé.

Ce chercheur croit fermement que les pratiques de santé émergentes prennent forme à partir des croyances traditionnelles de personnes qui ont été façonnées par

les facteurs culturels de leur pays d'origine. Leurs croyances traditionnelles ont ensuite été modifiées, au fil du temps, par le milieu de la santé du nouveau pays auquel ils appartiennent maintenant. Ce système de santé émergent se manifeste fortement lorsqu'il est appliqué à des groupes d'immigrants. Comme un groupe de personnes qui a déjà une vision du monde basée sur leurs expériences dans leur propre pays, il est supposé que ce système de croyance affecte la façon dont ils fonctionnent dans le nouveau pays auquel ils appartiennent désormais. Étant donné que ces immigrants sont maintenant sous la protection du pays d'accueil, il est de leur responsabilité de savoir qui sont ces immigrés, quels sont leurs besoins et comment ils peuvent les combler. Dans le domaine de la santé, ne pas connaître les subtilités du système de croyance de santé des immigrants peut être comparé à un aveugle conduisant un autre aveugle. Il a déjà été établi que la santé des immigrés en France s'est détériorée au fil des ans. Une cause probable du problème est que les campagnes de santé, en général par inadvertance ou non, n'incluent pas les immigrants. En matière de santé, ils sont marginalisés en raison du fait qu'ils sont différents de la population générale. Les concepteurs de campagne planifient et mettent en œuvre des programmes de santé en vertu du principe que leur message passera à travers les membres de la population. Malheureusement pour les immigrés, ce n'est pas le cas comme le prouve le fait que leur santé s'est considérablement détériorée au cours des dernières décennies.

Les immigrants pourraient avoir peu ou pas conscience qu'ils exercent un nouvel ensemble de comportements de santé, mais il est en effet nécessaire pour le pays hôte d'agir en conséquence et mettre en place des initiatives politiques ainsi que de se positionner clairement en tant que protecteurs de ses citoyens.

Les coûts de santé ont monté en flèche et s'opposent au contexte économique instable actuel. Ce qui n'est pas bon signe. Les restrictions budgétaires se produisent partout dans le monde et le secteur de la santé n'est pas épargné. Même dans le cas de l'un des meilleurs systèmes de santé dans le monde, il y a une grande revendication pour une meilleure allocation des ressources et une meilleure gestion du budget. Le problème est que la prévention et les campagnes très ciblées semblent être la voie la plus prometteuse pour économiser les ressources et, surtout,

des vies. Le problème est que la prévention est un processus long et très coûteux. Compte tenu des avantages et des inconvénients, les politiques devront prendre la décision de développer ou non la prévention.

CHAPITRE III MÉTHODES ET PROCÉDURES

Conception de la recherche

Cette recherche est une étude de cas qualitative et descriptive la rendant à la fois qualitative et quantitative. Elle emploie l'enquête, l'interview des (DICI) et l'observation directe. Comme telle, cette étude est une étude triangulaire utilisant trois méthodes de recherche.

Selon une étude descriptive, le chercheur observera et décrira ce qui a été observé. Les chercheurs examinent habituellement pourquoi la tendance observée existe et ses implications ³¹⁰ (Babbie, 1988, pp 91-92). Le chercheur inclut l'observation directe de la population en relation à leur façon de parler et d'agir en présence de leur groupe de soutien (leurs amis philippins) et au sein de leurs zones de confort (des rassemblements philippins). Leurs actions dans ces événements sont le reflet des différents soutiens qu'ils reçoivent qui leur permet de faire des choix éclairés en ce qui concerne leur vie quotidienne sur la Côte d'Azur. Le chercheur a également observé la manière d'être des immigrants philippins en tant que patients et la façon dont ils interagissent avec les professionnels de santé. Les résultats de l'observation directe ont été plus tard intégrés dans la discussion et l'analyse des résultats.

Cette recherche a été effectuée pour explorer un domaine inconnu. Il y a eu plusieurs études sur les Philippines par des Philippins et des chercheurs français. Cependant, le domaine de la communication en santé, qui est un jeune domaine de recherche n'a pas été exploré, encore moins par un érudit philippin qui s'immerge dans la population. Le plan de recherche est destiné à capter les perceptions et les

³¹⁰ Babbie, E. (1998). *The Practice of Social Research*. 8th Ed., Wadsworth MA:Wadsworth

expériences de la population immigrée étudiée quand ils ont été exposés aux avantages de la communication en santé et comment ils vivent et continuent de découvrir le système de soins de santé en France.

De la première étape de la conceptualisation, cette recherche a été conçue pour suivre une étude triangulée. Le chercheur a expérimenté plusieurs combinaisons de méthodes de recherche qui permettent de saisir les subtilités de sa population. Après plusieurs tentatives et quelques expériences ratées, le chercheur adhère enfin au sondage, KII et l'observation directe.

Le sondage a été conçu pour déterminer les caractéristiques démographiques de base de la population étudiée. Cela inclut l'âge, le sexe, le type de travail et le nombre d'années vécu sur la Côte d'Azur. En connaissant ces informations de base, le but de ce chercheur est de comprendre la corrélation entre l'âge et le travail, par exemple, et la performance de la santé. Un autre exemple consiste à comprendre la relation entre la durée de séjour sur la Côte d'Azur et le système de croyances de santé des migrants philippins. Les questions liées à cette méthode ont été conçues pour solliciter les concepts de santé, les croyances et les préoccupations de la population à l'étude ainsi que la façon dont ils abordent ces défis et comment ils s'adaptent au système de santé français. En comprenant la co-relation des concepts, cette recherche vise à identifier le rôle de la langue et de la culture dans les croyances et les pratiques de santé globale.

Key Interview Informant (ERIC) a été la cible de ceux qui ont connu ou connaissent une des conditions les plus graves ou les plus complexes médicales (opérations, maladies chroniques, etc.). Ce chercheur connaît les soins médicaux en France et aux Philippines, il est de l'intérêt de ce chercheur de savoir comment cette expérience influence, modifie ou change le système de croyance de la santé des répondants.

L'observation directe a été faite tout au long des procédures de collecte de données. Au cours de l'administration de l'enquête, le chercheur a porté une attention

particulière à la façon dont les répondants sont à la recherche d'approbation ou de clarification de certains concepts non pas du chercheur qui administre le questionnaire mais de leurs amis. Le chercheur observe aussi le comportement affiché lors de l'administration de l'enquête et le comportement lors d'activités KII. Les données recueillies à partir de l'observation directe valident ou questionnent certains concepts de l'enquête et l'outil KII. Il fournit également une riche source d'informations non capturée par le texte écrit.

Procédure de collecte de données

Des questionnaires ont été conçus et pré-testés dans un petit groupe de la population d'étude. L'outil a été révisé à plusieurs reprises pour répondre aux défis de la langue et s'assurer de la commodité à y répondre.

En décrivant le questionnaire dans un sens plus large, il est spécialement conçu pour être dans un format bilingue. L'anglais est utilisé principalement pour les lecteurs français. Bien que presque tous les répondants comprennent l'anglais, le chercheur a senti le besoin de le traduire en philippin parce qu'elle a eu l'impression pendant les essais précédents du questionnaire que sa population tend à clarifier plusieurs concepts anglais ce qu'ils font moins quand les questions étaient en philippin. La question numéro 1, de quelles maladies souffrent le plus les répondants, permet de savoir les besoins médicaux de base en santé. La question numéro 2, quelle est la principale source des maladies, permet de déterminer s'ils sont conscients de l'origine de leurs maladies. L'une des options de la question 2 (Q2) concerne la prédisposition génétique. Ce chercheur suppose que plus une personne connaît son / sa prédisposition génétique à certaines maladies, plus il / elle accorde de l'attention à des symptômes simples. De cette façon, il / elle ne traitera pas simplement le symptôme de fatigue, par exemple, fera plus attention au moindre signe de fatigue. D'un autre côté, les personnes qui n'ont pas d'informations sur leur prédisposition génétique médicale ont tendance à attribuer leur douleur aux longues heures de travail ou à un travail fastidieux, au stress ou à d'autres choses moins

alarmantes. Il est important de rappeler, à ce stade, que les douleurs simples peuvent être des manifestations de problèmes de santé plus complexes et une connaissance limitée de l'histoire médicale de la famille pourrait avoir des conséquences fatales. Ce fut l'une des options en Q2 parce que dans l'analyse, le nombre que ce concept donnera, fournira un aperçu de la manière dont la population à l'étude connecte leur douleur physique à sa source. Ce sera une aide pour savoir quelles sont les solutions recherchées pour répondre à leurs préoccupations en matière de santé. La question 3 sollicite des réponses sur la façon dont les populations répondent aux plaintes de santé les plus communes quand elles sont encore aux Philippines. Le but de cette question est de déterminer quelles sont les méthodes ou les plates-formes, qui soulagent la douleur, les plus recherchés alors qu'ils sont encore dans leur pays d'origine. L'objectif est de découvrir le rôle de médecin, guérisseur traditionnel et auto-médication pour remédier à la douleur. Elle fournit également une idée de la façon dont la recherche de l'aide médicale constitue un mélange des croyances traditionnelles et la science moderne. La question 4 cherche à identifier spécifiquement les croyances et les pratiques de santé de la population aux Philippines. La croyance dans le "pasma", les sources chaudes et froides des maladies et d'autres pratiques de santé prouveront que les Philippins croient en des sources de maladie et en des remèdes non reconnus scientifiquement. Toutefois, en choisissant la meilleure réponse à cette question, ils montreront à quelles croyances et pratiques ils croient. La question 5 vise à déterminer pendant combien de temps et comment les Philippins cherchent de l'aide médicale. La question 6 vérifie si la recherche de conseil médicale / d'aide est différente maintenant qu'ils sont en France. C'est une question de premier plan, car les questions 7 et 8 sont des questions de suivi. La question 7 cherche à savoir quelles sont les raisons pour lesquelles la population va plus voir les médecins maintenant qu'ils sont en France tandis que la question 8 détermine les raisons qui ne nécessitent pas plus de visite chez le médecin maintenant. La question 9 cherche à savoir quelles sont les choses que les Philippins font quand ils n'ont pas bien compris les explications des médecins. Il est important de rappeler que tous les professionnels de la santé, en particulier des médecins en France, ne parlent pas très bien l'anglais

et que le Philippin ne parle pas toujours bien français. Le principal défi dans le processus de communication entre le médecin et le patient qui utilisent deux langues différentes, c'est que quand l'un ne trouve pas le mot exact correspondant à ce qu'il veut dire, il repasse immédiatement à sa langue maternelle et remplace le mot. Cela conduit souvent à de la confusion parce que beaucoup de choses sont perdues dans la traduction. Ainsi, la question 9 clarifie la façon dont les patients philippins font face à la barrière de la langue et comment ils complètent les informations perdues. La question 10 s'intéresse davantage à la compréhension des explications médicales des philippins même si c'est en français. La question 11 demande catégoriquement si la langue est une barrière dans la recherche et la compréhension de l'information médicale. En connaissant la réponse à cette question fondamentale, à la fois les patients et les professionnels de santé peuvent faire des ajustements sur la façon de mieux se comprendre les uns, les autres. Il est probable que les Philippins devraient passer plus de temps et fournir plus d'efforts dans l'apprentissage de la langue française. Dans le même temps, le système de soins de santé français a besoin d'adopter des mesures visant à atténuer les disparités de santé provoquées par la différence de langue. La question 12 vise à élucider par quels autres moyens les répondants cherchent des informations médicales. Les réponses à cette question renforcent les idées sollicitées par la question 9 et permettent aussi de découvrir comment les répondants complètent l'information qu'ils reçoivent de leurs fournisseurs de soins médicaux. La question 13, qui est une question ouverte, demandait si les répondants prennent toujours des médicaments des Philippines. Ce chercheur a l'impression que les Philippins ont une notion de «Hiyang » (adapté). Beaucoup croient encore que même si les médicaments ont la même bioéquivalence, le corps réagit toujours différemment aux différents médicaments. Une marque de ce médicament pourrait être " mieux adapté " que l'autre, même si les compositions sont les mêmes. Dans ce scénario, certains Philippins qui savent qu'ils ont une pression artérielle élevée par exemple, alors qu'ils sont encore aux Philippines, pourraient encore prendre leurs vieux médicaments et les acheter aux Philippines parce qu'ils sont « Hiyang ». C'est pourquoi les répondants ont été invités à fournir une brève explication de leur réponse.

Cette interprétation est également vraie lors de la prise des médicaments de marque par rapport aux médicaments génériques. Aux Philippines, de nombreux patients croient encore que les médicaments génériques n'ont pas la même efficacité que ceux de marque ; même si les médicaments génériques ont réussi le test mené par le Bureau des aliments et drogues - un organisme gouvernemental qui approuve la sécurité des aliments et des médicaments. En tant que tel, même si les médicaments de marque coûtent beaucoup plus, beaucoup de gens préfèrent toujours les prendre.

La question 14 est une des questions générales qui cherche à déterminer le point de vue global des répondants sur la façon dont ils prennent soin de leur santé.

Le questionnaire faisait 3 pages en papier blanc avec des questions en anglais et leur traduction en philippin, pour une meilleure compréhension des concepts posés. Une information demandée était cependant écrite uniquement en anglais "Numéro de contact". L'anglais est largement parlé aux Philippines et il est utilisé simultanément et de façon interchangeable avec la langue nationale. Le terme « numéro de téléphone » est mieux compris par les Philippines, car il n'a pas de traduction directe en philippin. Une autre expression anglaise "S'il vous plaît Check" est utilisée pour demander l'âge des répondants.

L'âge est entre crochets par tranche de cinq (20-25 ; 25-30 ... 60 ans et plus) en tenant compte de la sensibilité des répondants en ce qui concerne la question de l'âge. Certains ne sont pas très à l'aise pour révéler leur âge réel donc en faisant des tranches d'Age cela diminue en quelque sorte le malaise de répondre à cette question.

La méthode d'enquête de cette recherche est très difficile. Venant des Philippines, ce chercheur connaît la difficulté d'obtenir des données à partir des Philippines. Ils sont souvent très timide et de les approcher et de poser des questions

directement donnent souvent un résultat défavorable. De plus, les Philippins sont suspects et la présentation directe du chercheur, puis sa demande de répondre aux questions de l'enquête immédiatement nécessitera beaucoup de temps et la réponse à l'instrument de l'enquête pourrait être fait à moitié au hasard. Il est important de noter que certains migrants philippins en France continuent de travailler sur leurs documents juridiques pour rester et travailler en France. Le fait de répondre aux questions, même d'un collègue philippin, est traité avec une extrême prudence. Les questions sur les documents juridiques sont un secret de polichinelle et il est facile de comprendre pourquoi les Philippins sont très catégoriques en répondant aux questions, même d'un collègue philippin, surtout si ces questions concernent des données personnelles comme des informations de contact et le type de travail. Le chercheur s'est alors rendu compte que la meilleure façon de rendre les données de collecte efficaces en termes de temps et de ressources, est d'être introduit par quelqu'un que les Philippins connaissent depuis une longue période, une personne de confiance. Le chercheur a expérimenté plusieurs façons d'entrer en contact avec sa population. Tout d'abord, elle a fait des recherches sur les différentes organisations philippines à Nice, Cannes et Monaco. Elle a ensuite pris contact avec les dirigeants de ces organisations, s'est présentée en détail en s'assurant que la confiance s'établisse. Ces dirigeants ont été mis à contribution pour présenter le chercheur aux membres de leur groupe. Elle a ensuite été invitée à certains de leurs rassemblements / réunions. A la fin de chaque événement, auquel ce chercheur a assisté, elle a été introduite par le chef de file. A chaque fois, quelques minutes lui ont été accordées pour se présenter, discuter un peu plus de son travail et assurer les membres que les données ne seront utilisées qu'à des fins académiques, et que répondre au questionnaire ne les enverra pas en prison. La chercheuse a observé qu'il y a une plaisanterie courante parmi les membres de sa population que quand ils donnent leurs coordonnées, ils seront ramassés par la police et seront mis en prison. Bien que ce soit une blague, elle affecte, en quelque sorte, la volonté de la population de répondre aux questions. Parfois, ils inventent des excuses tel qu'ils ne peuvent pas lire les questions parce qu'ils n'ont pas leurs lunettes de lecture, qu'ils veulent que leurs épouses répondent pour eux, ou qu'ils vont répondre au

questionnaire chez eux et qu'il sera rendu la semaine suivante, ou enfin de dire qu'ils ne vivent pas dans la région, qu'ils sont juste en visite. Ils inventent d'autres excuses pour ne pas répondre à l'enquête. Il est évident que ces gens qui ont inventé ces excuses ne veulent pas être impliqués de quelques façons que ce soit. Répondre à l'enquête n'est pas une obligation mais une simple demande, le chercheur les remercie de toutes les façons. Lorsque ce chercheur a essayé de traiter avec les groupes organisés de la Côte d'Azur, elle a immédiatement senti une distance de la part de la population. Il y avait juste une poignée qui a montré un intérêt à la demande de ce chercheur. Parfois, le chercheur a estimé qu'elle n'était pas l'un des leurs, et elle était très exclue malgré le fait qu'ils parlent tous la même langue. Ce comportement a son impact sur la vitesse rapide ou lente à laquelle les Philippins apprennent la langue française. Si ces gens ne sont pas très ouverts pour parler à quelqu'un qui parle la même langue qu'eux qu'en est il avec un interlocuteur français. Avec ce comportement, malgré le nombre important de Philippins qui ont assisté à des cours de français, beaucoup ne parlent pas encore la langue, principalement parce qu'ils ne la pratiquent pas. Ils sont très conscients de la façon dont ils parlent, la grammaire est le plus grand rejet de la langue française. Le chercheur a toutefois compris parce que les Philippins sont par nature très timide et ces traits de caractères peuvent être interprété comme étant du snobisme souvent parce qu'ils ne cherchent pas à entamer une conversation et qu'ils évitent les gens surtout pour les interlocuteurs des langues étrangères. Il devient évident à ce stade que le chercheur doit faire plus qu'une simple présentation pour faire répondre la population à l'enquête et plus encore pour avoir une entrevue. En raison de ces défis, le chercheur a décidé de tenter une autre approche dans la gestion des questions de l'enquête.

Ce chercheur a pris contact avec le curé de la paroisse philippine à Nice. Les philippins, étant majoritairement catholiques, vont à l'église chaque dimanche et c'est une bonne occasion pour ce chercheur pour faire répondre sa population cible. Elle a alors contacté le père Guerrero Clavero qui tenait sa messe en philippin (en tagalog) à St Martin-St Agustin église dans le Vieux Nice. Elle a réussi à obtenir l'horaire de

ses messes tous les dimanches. Dans la matinée, à 9h30, il dit la messe à Nice, à 12h00, il dit une autre messe à Cannes (Chapelle Saint-Paul) et dans l'après-midi à 17h00 heures, il dit la messe à Monaco (Chapelle des Franciscains). Ce chercheur a demandé la permission au père Clavero d'aller avec lui à Cannes et à Monaco pour faire sa collecte de données. Le prêtre a accepté et ce qu'il a fait, est d'introduire ce chercheur après chaque messe et de lui donner quelques minutes pour se présenter et expliquer son travail. Ce processus a été réalisé sur plus ou moins 20 semaines (5 mois) réparties entre mai et novembre 2011. Ces mois ont été particulièrement choisis pour plusieurs raisons. Premièrement, le temps est bon, donc il y a beaucoup de Philippins qui vont à l'église. Deuxièmement, la collecte de données de cinq mois pour l'enquête assure la production maximale, car il sature la communauté. Troisièmement, ceux qui n'ont pas pu aller à l'église pendant la saison d'été parce que leurs employeurs étaient autour, sont toujours inclus grâce aux mois de mai, août et septembre, qui sont des mois avant et après l'été. Cependant, l'administration de l'enquête a pris plus de temps que prévu initialement. Elle s'est étendue jusqu'à Mars 2012.

Cette stratégie a le mieux fonctionnée parce que dans l'enceinte de l'église, les Philippins deviennent très ouverts et confiants. Cette stratégie a fonctionné en grande partie grâce au père Clavero qui connaît beaucoup de Philippins dans cette région car il a été leur curé pendant près de vingt ans. Il est important de souligner que, dans cette méthode, ce sont les Philippins qui sont venus vers le chercheur pour la connaître, en savoir davantage sur ses études et lui ont demandé comment ils pouvaient lui apporter leur aide. Ils ont même commencé à partager leurs expériences personnelles de santé et ont proposé des personnes susceptibles d'être la bonne cible pour l'étude. Ils semblaient émerveillés que quelqu'un des Philippines vienne dans le Sud de la France juste pour étudier. Beaucoup d'entre eux sont fiers que quelqu'un de leur pays soit venu sur la Côte d'Azur, non pas pour travailler, mais pour étudier et avoir une bourse de l'Union européenne. Je cite: « aba, proudy ata kami na méron naman iba na di kagaya nami ang trabaho " {Cela nous rend fiers qu'il y ait quelques Fiipinos ici qui ne font pas ce que nous faisons}. Comme indiqué

précédemment, le secteur dominé par les travailleurs philippins sur la Côte d'Azur est le travail domestique. Un assez grand nombre de ces travailleurs a terminé des études universitaires, et ils sont en réalité porteurs d'un diplôme. Ils ont choisi de s'engager dans ce type de travail, en ravalant leur fierté parce que, en fin de compte c'est l'argent qu'ils rapportent chez eux à la fin de chaque mois qui est le plus important. Ce chercheur entend souvent des témoignages sur la difficulté du processus d'ajustement ; d'être un professionnel qui nettoie les toilettes, car ils décrivent souvent ce travail domestique. Parfois, ils trouvent du réconfort en se disant que ce qu'ils font à l'heure actuelle n'est que temporaire et qu'ils trouveront un emploi plus adapté à leurs qualifications et à leur niveau de scolarité plus tard. Ce travail n'est jamais venu et très vite, ils sont devenus à l'aise là avec ce qu'ils ont. Le salaire est bon, les responsabilités moins grandes, le stress est plus faible et l'environnement de travail est meilleur qu'aux Philippines. L'aura est prestigieuse parce que quand ils rentrent à la maison aux Philippines, la question posée n'est pas quel est votre travail à l'étranger, mais plutôt combien d'euros gagnez-vous par mois ? Malgré l'avantage monétaire cependant, les professionnels déclarent souvent que s'ils avaient le choix, ils préféreraient être engagés dans des emplois liés à leur formation. Le principal obstacle est que la France ne reconnaît pas les diplômes obtenus aux Philippines. Pour une infirmière médicale par exemple, ceux qui sont venus des Philippines doivent à nouveau étudier pour obtenir un diplôme en France avant de se faire embaucher. Dans d'autres pays tels que les États-Unis ou le Canada, les infirmières philippines sont tellement demandées que, souvent, après avoir fini l'Université, ces infirmières sont directement embauchées par les hôpitaux et les cliniques. Récemment, ces pays demandent aux nouvelles infirmières de passer un examen d'État administré mais pas plus. La France a une histoire totalement différente concernant l'embauche des professionnels qui ont obtenu leurs diplômes en provenance des Philippines. Ce chercheur n'est pas dans la position de dire si le même phénomène s'applique à d'autres races. Dans un cas, le chercheur a rencontré une femme arabe qui est gynécologue agréé dans son pays. Elle parle un peu français, mais elle n'est pas autorisée à exercer sa profession à Nice. C'est une

histoire triste, car il semble que si un professionnel choisit de vivre dans le Sud de la France, il est presque inévitable qu'il doive abandonner sa profession.

C'est probablement la raison pour laquelle certains Philippins sont fiers qu'il y ait des étudiants philippins à qui ils peuvent s'identifier car ils auront la possibilité de faire ce que la première génération d'immigrants philippins de la Riviera a rêvé mais qui n'ont pas encore eu l'occasion de réaliser ce rêve. Pour la deuxième génération, toutefois, la présence d'étudiants philippins en provenance des Philippines a en quelque sorte été considéré comme normal, car ils n'ont pas connu les défis de l'intégration, pas autant que ce que leurs parents ont vécu. La plupart de deuxième génération sont à l'école française, parle français et vivent la vie française. Pour en revenir aux Philippins, ce chercheur s'est réuni dans trois églises chaque semaine pendant 20 semaines, 200 formulaires d'enquête ont été remplis. Il est important de noter que tous les Philippins vont à l'église ou sont catholiques. Le chercheur a décidé de trouver un autre moyen pour entrer en contact avec les autres membres de la population de sa recherche.

Elle a profité des liens qu'elle a obtenus de la méthode précédente. Elle a informé les gens dont elle était devenue proche de l'informer des réunions informelles, comme les pique-niques, des rencontres et des voyages religieux, ou des événements culturels qui pourraient avoir lieu. Elle a ensuite été invitée à plusieurs activités et elle a été en mesure de voir la vie quotidienne des Philippins dans la Côte d'Azur. Elle a été invitée à des baptêmes, des anniversaires, des voyages religieux, des manifestations culturelles et même à un simple rassemblement sur la plage ; c'est dans ces événements informels qu'elle a pu augmenter le nombre de son enquête.

Il y avait un cas où ce chercheur a mené l'enquête au cours d'un renouvellement du service des passeports de Monaco parrainé par l'ambassade des Philippines à Paris. Une autre fois, il y avait un même service effectué à Nice et ce chercheur a utilisé cet événement pour mener son enquête.

A Cannes, il y a un magasin philippin détenu par un couple dont la femme est des Philippines. Ce chercheur a demandé la permission pour laisser quelques formulaires d'enquête et elle a demandé au propriétaire si ce dernier pouvait demander aux clients philippins de remplir le formulaire. En utilisant la même méthode pour une entreprise de transfert d'argent appartenant à une femme philippine à Nice, le chercheur a placé quelques formulaires d'enquête dans la boutique. Cependant, les deux méthodes ne sont pas en mesure de donner des résultats positifs ; probablement parce que les propriétaires de ces entreprises n'ont pas assez de temps pour expliquer le sujet et le but de l'enquête. En outre, la population cible de cette recherche est très prudente et ne veut pas participer à quelque chose qu'elle ne comprend pas bien. De plus, pour eux, il n'y a pas de visage derrière les questionnaires. Ce chercheur a seulement obtenu 12-15 formulaires d'enquête remplis, beaucoup de questions restent sans réponse. Ces formulaires d'enquête ont été abandonnés par la suite.

Ce chercheur, malgré le défi d'aborder directement la population, a toujours essayé d'explorer d'autres endroits afin de saturer sa population. Elle s'est parfois rendue à l'église Notre-Dame de Jean médecin afin de cibler les Philippins qui fréquentent la messe catholique en français. Après la messe, elle les a attendus à l'extérieur de l'église, les a approchés, s'est présentée et leur a demandé quelques minutes pour répondre au sondage. Habituellement, elle obtient un non parce qu'ils sont pressés de rentrer chez eux. D'autres lui disent qu'ils répondront à l'enquête à un autre moment. Dans certains cas, le chercheur sera invité à s'occuper d'un enfant ou deux alors qu'ils répondent à l'enquête. Ce chercheur a également toujours un questionnaire prêt au cas où elle voit un Philippin dans le tram, le bus ou le restaurant.

En fin de compte, l'aide du prêtre a permis d'obtenir les meilleurs résultats en termes de nombre de formulaires d'enquête dûment remplis. Le succès de cette méthode a été attribué à l'endroit où ont été posées (église) et la confiance que les Philippins ont en leur prêtre. Ce chercheur a observé que les Philippins sont plus conciliants quand ils sont dans l'église et lorsque le chercheur est introduit par une

personne de confiance. Demandez aux mêmes personnes dans un contexte différent, le résultat est totalement différent.

Figure 10: Places pour principale collecte de données



Chapelle des Franciscains, Monaco



Chapelle St.Martin-St. Agustin, Nice



Chapelle St. Paul, Cannes

Ces différentes méthodes de sondage ont été utilisées pour atteindre un nombre de personnes assez représentatif d'une population. En outre, collecter autant de données que le chercheur peut produire, permettrait de valider le nombre de Philippins, vivant dans les trois villes étudiées, précédemment estimés par les informateurs clés.

Dans la sélection des personnes interrogées pour les Key Informant Interview (KII), ce chercheur, tout en menant l'enquête, a noté les répondants qui ont révélé quelques informations sur leurs propres conditions médicales ou celles de leurs proches. Les questions KII initialement conçues étaient à portée de main pour assurer le suivi de l'enquête avec des questions de KII informelles. Les premiers résultats de l'ERC ont été examinés et révisés plusieurs fois afin de clarifier les concepts et mieux encadrer les questions. Lorsque l'outil pour le KII a été finalisé, le chercheur a appelé les personnes interrogées et identifiées pour le KII et demandé l'autorisation d'une entrevue. La majorité des personnes interrogées pré-sélectionnées ont accordé leur permission pour l'interview et un calendrier a ensuite été finalisé. La plupart du temps, les personnes interrogées profitent d'un rassemblement ou d'une manifestation, pour la plupart des fêtes d'anniversaire, pour l'interview. Les personnes interrogées semblent être plus ouvertes et plus à l'aise pour parler de leur état de santé en compagnie d'amis proches. Ils ont aussi tendance à parler plus en détails quand ils sont entourés par des gens qu'ils connaissent. Toutefois, certains ont choisi le caractère sacré de leurs maisons et le chercheur ont fait des entrevues dans les maisons des répondants. Certains ont aussi choisi de parler autour d'un café dans le centre de la ville en général après leur travail. Le chercheur utilise aussi la méthode de l'échantillonnage boule de neige. Les personnes interrogées recommandent d'autres membres de la communauté philippine qui ont les mêmes expériences qu'eux. Le chercheur entre alors immédiatement en contact avec eux. Elle leur dit comment elle a eu leurs coordonnées, leur explique un peu son parcours et son étude et fixe un rendez-vous. La plupart du temps, ils répondent positivement à la demande.

Dans les rassemblements (ou célébrations) où KII a été réalisée, les hommes interviewés ont été très coopératifs en répondant aux questions. Ils parlent plus que leurs homologues féminins et discutent ouvertement de leurs problèmes de santé et des expériences médicales en compagnie d'autres hommes et avec un peu d'aide de bières ou de vin. Le chercheur enregistre l'interview soit par audio ou par vidéo en

fonction de l'autorisation donnée par la personne interrogée. Certains des répondants ont demandé de ne pas avoir d'enregistrement du tout. Opérant sous les limites de l'éthique de la recherche, le chercheur n'a pas de choix que de suivre leur demande. Le même principe du secret s'applique à ceux qui ont demandé que leurs noms réels être dissimulés. Le chercheur prend cependant, toujours des notes écrites lors de l'entretien, qu'il soit enregistré ou non, et ce toujours avec l'autorisation de la personne interrogée, autorisation qu'elle obtient souvent. Comme il est impossible d'écrire l'ensemble de la conversation, le chercheur est conscient d'écrire des mots ou des phrases clés qui répondent aux questions écrites dans le guide et fournissent des précisions supplémentaires sur les concepts étant posées. Le KII a été réalisé comme une conversation régulière où le chercheur regarde rarement son questionnaire. Elle l'a fait consciemment dans le test de l'efficacité des questions de guidage, le chercheur a observé que l'interrogé perd le fil de sa pensée quand il y a un écart entre les questions. L'ambiance était aussi informelle pour s'assurer que les personnes interrogées étaient assez confortables et n'avaient pas le sentiment d'être examinées. Le chercheur a eu quelques expériences dans le passé où les personnes interrogées étaient tendues et conscientes de leur façon de parler, d'agir et de répondre aux questions. Dans de tels cas, les personnes interrogées ont alors tendance à ne pas donner les vraies réponses mais celles qu'ils pensent être la bonne réponse. Dans cette étude, le chercheur diminue la tension et fait en sorte que la personne interrogée soit à l'aise pour discuter des questions de santé. Après tout, les problèmes de santé sont très personnels et doivent être discutés avec la plus grande sensibilité.

Le chercheur à chaque KII, commence par une brève introduction d'elle-même, de la recherche qu'elle fait, du but de l'entrevue et fait en sorte que les informations qui seront recueillies, seront utilisées uniquement à des fins académiques. Leurs noms et leurs renseignements personnels ne seront pas divulgués sans leur permission.

Elle commence alors subtilement l'interview en demandant aux personnes interrogées de poser une question au chercheur. Ceci est stratégiquement fait pour que les personnes interrogées estiment qu'ils sont en contrôle. En répondant aux questions posées par les personnes interrogées, le chercheur a une chance de donner le ton de l'activité. Elle répond avec sincérité afin que les personnes interrogées reçoivent un exemple à suivre.

Figure 11: Evènements et assemblages philippins



La figure 11 est un rassemblement organisé par la communauté philippine chaque année à la fin de chaque été, habituellement sur un week-end entre la première et la troisième semaine de septembre. C'est leur façon de rester en contact avec les autres membres de la communauté après un long été. Ils n'étaient pas en mesure de beaucoup se parler pendant la saison d'été parce que souvent leur « amo » (patron) sont présents ou il y a beaucoup de visiteurs dans la villa où ils travaillent. Pour ceux dont le travail est sur un yacht, ils sont souvent en mer. Pour les travailleurs indépendants, ils profitent de l'abondance des emplois supplémentaires disponibles et ils maximisent le temps dont ils disposent. Lorsque la saison d'été est sur le point de finir, ils sont en mesure de respirer et d'avoir une nuit pour manger et rattraper le temps avec leurs amis le long de la Promenade des Anglais. Les gens qui organisent cet événement sont généralement les « kapampangans ». Ce sont des Philippines qui sont venus d'une région particulière

des Philippines, un endroit appelé Pampanga. C'est connu que les Philippines aiment manger et qu'ils mangent tout le temps. Toutefois, les Kapampangan sont particulièrement connus pour être de très bon cuisinier et les photographies sont une preuve que la célébration équivaut à une parade de nourriture. Il est important de comprendre que cette rencontre est basée sur l'amitié et non sur une affiliation religieuse. Ces personnes, bien que la plupart soit des catholiques, ne sont pas pieux. Des opinions politiques divisent l'église et les paroissiens. Les kapampangans sont très critiques envers le curé de la paroisse philippine affecté à la région. Ils disent ouvertement leurs critiques du prêtre sans réserves.

Figure 12: Après Thanksgiving dans l'Église été



La figure 12 est la version catholique du Thanksgiving de l'été. Elle est dirigée par le prêtre et prise en charge par les différentes organisations religieuses. Ce rassemblement consiste à partager de la nourriture, prier ensemble en tant que communauté, à la bénédiction du prêtre et plus tard à des jeux, des chants et de la danse.

Figure 13: Evènements Culturel et sociaux



La figure 13 montre un événement parrainé par un canal philippin qui est largement suivi par la communauté philippine dans le Sud de la France. La chaîne de télévision, ABS CBN tient une projection de film libre de l'Acropole à Nice et il a été suivi par un grand nombre de Philippins, car il présente également le spectacle des étoiles philippines. C'était le plus grand rassemblement philippin que ce chercheur a connu. Des philippins venant principalement de Nice, Cannes et Monaco étaient présents. Certains venaient même de Marseille et Aix-en-Provence. Ce chercheur est arrivé quelques heures avant la projection de film et a été en mesure de parler à un grand nombre de personnes.

Guide de l'analyse des données et de la procédure

Cette étude est en partie axée sur l'analyse de la langue et de la description d'un phénomène culturel grâce à l'utilisation de trois méthodes de recherche : Enquête,

Interview des informateurs clés et l'observation directe. En suivant la ligne de pensée dérivée des théories qui ont inspiré cette recherche, couplé avec le caractère descriptif de cette étude, les données seront analysées en utilisant de simples fichier excel pour la méthode d'enquête. Pour le KII et l'observation directe l'analyse sera facilitée par un guide de codage basé sur les hypothèses de l'étude. Ce chercheur met l'accent sur la langue, car il contient des données riches qui « fournit des indications précieuses sur la façon dont les gens regardent le monde autour d'eux »

311 .

Les résultats du sondage sont codés en utilisant le programme Excel et ont été plus tard interprétés en termes de répartition puisque le but principal de cette méthode est de déterminer la distribution des concepts posées de la population. Les formulaires d'enquête sont numérotés et regroupés en fonction de l'emplacement. La numérotation commence à partir des formulaires remplis par les répondants de Nice suivis par ceux de Cannes, puis Monaco. Dans le processus de codage, les données sont saisies dans Excel par groupe. Cela a été fait intentionnellement pour le référencement et l'accès facile si nécessaire plus tard. Dans le sens général, cependant, le groupement n'a pas un impact direct sur l'analyse du résultat général de l'enquête. Initialement les données de l'enquête ont été interprétées par un traitement statistique simple. Les résultats ont ensuite été transformés en un graphique « camembert » qui révèle les réponses des répondants en termes de pourcentage. Il a ensuite été traité avec plus de vigueur et l'analyse transversale de concepts a été effectuée afin de déterminer la relation entre les concepts. Cette méthode peut sembler banale, cependant, il est important de se rappeler que pour une recherche qui n'a jamais été faite avant, avec une communauté qui n'a jamais été étudiée, les questions les plus fondamentales doivent être couvertes avant de s'aventurer dans une recherche plus profonde.

³¹¹ Tan, M.L., (2008). *Revisiting Usug, Pasma, Kulam*. Quezon City. University of the Philippines Press. P 8

Key Informant Interview (KII) a été traitée et interprétée à l'aide d'un guide de codage. Guidée par les théories utilisées dans cette étude, une matrice de codage a été conçue pour mettre en évidence les mots et les déclarations qui décrivent et expliquent directement ou indirectement ainsi que les idées de la population en ce qui concerne leurs connaissances et leurs pratiques de santé anciennes et la nouvelles. Les questions de guidage pour cette méthode ont été orientés vers susciter des réponses précises aux questions qui ont été posées. Les questions ont été rédigées en anglais, car elles sont prévues pour le chercheur. Elle les traduit automatiquement en philippin lors de l'entrevue.

L'observation directe a été réalisée tout au long de l'activité de collecte de données, bien que l'intensité et le but varient. Au début, l'observation a simplement été réalisée pour savoir comment la communauté philippine est en interaction avec l'autre sur un niveau général superficiel. Ce chercheur a observé le type de relation qu'ils ont avec leurs pairs, fondées sur des croyances religieuses similaires, des appartenances régionales à une relation plus personnelle et intime comme les amis et les membres de la famille. Dans la dernière partie du processus de collecte de données, le chercheur a observé comment les personnes interrogées pour KII répondent à des questions sensibles, partagent des histoires et prennent part aux histoires des autres dans lesquelles ils peuvent s'identifier. Le chercheur a noté ses observations depuis le début de l'étude jusqu'à la fin. Dans l'analyse des résultats de l'enquête et KII, ses observations serviront de toile de fond pour les résultats. Elles seront recoupées avec les résultats de l'observation directe afin de savoir si les résultats de KII et les enquêtes ont un lien direct qui peut être expliqué en utilisant les données générées à partir de l'observation directe.

Ce chercheur emploie les enquêtes, les KII et l'observation directe, parce qu'elle croit que ce sont des méthodes qui pourraient le mieux répondre à la problématique de recherche. Elles valideraient ou réfuteraient les hypothèses de recherche et généreraient des données qui répondraient à la problématique de recherche. En

utilisant une étude triangulaire, les résultats de chaque méthode de recherche sont validés par les résultats d'autres méthodes. Ceci scelle le bien-fondé des conclusions.

Instrumentation

La méthode d'enquête a été réalisée pour recueillir les informations de base sur la population de la recherche. Comme indiqué précédemment, aucune organisation, tant du côté des Philippins que du gouvernement français, n'est prête à fournir des données concrètes sur les Philippins vivant dans la région de la Côte d'Azur. Pour la partie française, ils affirment que l'information demandée par le chercheur ne peut pas être révélée parce que c'est une information confidentielle et donc protégée par la loi - se référant au nombre d'immigrants philippins dans la région. L'ambassade des Philippines à Paris d'autre part, ne peut pas donner de solides statistiques parce que s'ils donnent le nombre de Philippins vivant dans le sud de la France, on peut souligner la différence entre le nombre de personnes qu'ils ont dans leurs dossiers et le nombre réel de personnes ou celui de la Préfecture. Cela compromettrait la position de certains immigrants philippins sur la Côte d'Azur dont les papiers de résidence sont toujours en cours, surtout pour ceux dont le statut est indéterminé. Ceci représentait un défi pour le chercheur au début de cette étude. Pour résoudre ce problème, le chercheur est devenue générique dans sa collecte des données elle est allée voir des personnalités clés des organisations philippines afin d'avoir une estimation approximative de la population. Ceci a fonctionné aussi bien pour obtenir des chiffres que pour connaître les liens entre les communautés.

Les KII valideront certains concepts déjà établis dans l'enquête. La méthode d'enquête a fourni les données de base telles que le sexe, l'âge et la répartition des sites, les croyances de santé, les pratiques etc. KII ont fourni une discussion approfondie sur les concepts/croyances de santé et les pratiques - ici et maintenant. De plus, les discussions dans cette méthode ont ouvert la voie à une source plus profonde et plus large de croyances en matière de santé et comment cela affecte-t-il directement leurs choix de santé maintenant. Et pour compliquer encore plus, leurs

croyances en matière de santé qui ont été façonnées par leur pays d'origine, ont pris une courbe raide car les Philippins dans la Côte d'Azur adoptent le nouveau système de soins de santé de leur pays d'accueil. Toutes ces informations riches sont sorties au cours de la FII.

Portée et limites

Il convient de préciser que, bien que cette recherche parle de système de soins de santé de deux pays, ce n'est pas une étude comparative. Le but de cette recherche est d'identifier les pratiques de santé actuelles des Philippins vivant sur la Côte d'Azur. Pour être en mesure d'identifier ces concepts de la population, il est nécessaire d'extraire quel est le type de système de croyances de soins de santé auxquels ils ont été exposés. Dans le même temps, il est nécessaire de présenter le système de santé du pays, auxquels ils appartiennent désormais. Dans le processus, les informations de base du pays ont été présentées d'une manière qui pourrait être interprétée comme ressemblant à une étude comparative. La comparaison n'est faite que pour arriver à des conclusions plus valides à la fin de la recherche.

Le chercheur a présenté les sources et les influences du système de croyances de santé des Philippins afin de peindre une image claire de ce que sont les croyances et les pratiques de santé traditionnelles/folkloriques/indigènes des philippins. En outre, le chercheur a examiné l'environnement de santé des Philippines afin de déterminer quelle est la responsabilité des institutions de l'Etat dans la mise en œuvre des programmes de santé, quelle est l'actuelle politique de l'état et de quelle façon le budget affecte la santé de la population en général. Quand il s'agit du débat des questions de santé en France, cette recherche a porté uniquement sur le système de soins de santé et non sur le système de croyance français. Cela a été fait parce que l'objet de cette étude est la croyance et la pratique de la santé des immigrants philippins et comment elles ont changé - si changements il y a - ou ont été influencées par le système de soins de santé français. Rejeter les

croyances de santé traditionnelles des français dans cette étude va sûrement produire une surcharge de données.

Les défis suivants ont été observés :

a) Les défis de la Population

La population de cette étude est les immigrants philippins à la Côte d'Azur. Ils ont été choisis principalement parce que le chercheur est des Philippines, qu'elle vit à Nice et que son université est située dans la même ville. Elle a choisi Cannes, Nice et Monaco pour être les principales villes pour mener sa collecte de données, car il y a une grande concentration de Philippins dans ces villes. La principale raison à cela - ce n'est qu'une supposition du chercheur - est parce que les emplois sont plus nombreux dans ces villes. Le chercheur a également constaté qu'il était plus pratique de se rendre dans ces villes pour mener ses entretiens que d'aller dans les grandes villes comme Marseille, Paris ou même Saint-Tropez. Les trois villes choisies pour conduire les recherches ont été choisies en tant que représentant de la Côte d'Azur ou Sud de la France - des termes qui ont souvent été utilisés dans cette étude.

Le chercheur a réussi à trouver des contacts avec différents organismes philippins dans ces villes. Les philippins qui vivent depuis longtemps dans la région semblent connaître tout le monde et toutes les activités. Ils donnent facilement les noms des contacts des organisations religieuses et sociales au chercheur. Cependant, obtenir sa population de recherche impliquée dans la recherche proprement dite est un défi. Les philippins ne font pas très confiance aux autres philippins. Ils ont besoin d'un certain temps pour être en confiance avec quelqu'un qui mène une enquête et le KII n'a pas été une tâche facile. Même au cours de la phase initiale de cette recherche, où le chercheur est simplement un observateur des événements, des questions lancées sur elle par la communauté philippine semble servir à mesurer si elle est une menace – quelle sorte de menace, cela n'a jamais été clair.

Il est difficile de déterminer le nombre exact de Philippins vivant dans la zone de recherche, car la préfecture située à Nice n'est pas autorisée à publier ces données en vertu de la loi française. Ce chercheur s'est appuyé sur les informations des chefs des différentes organisations philippines dans la région. ; combien de membres comptent leurs organisations. La meilleure estimation obtenue par le chercheur se situe entre 600-800 Philippins vivant dans la région.

Les Philippins ont des réserves à répondre aux questions des étrangers, mais une fois qu'ils se sentent à l'aise, ils vont se confier sur presque n'importe quoi. Le KII a été menée dans un cadre informel, mis en place afin que les répondants ne se sentent pas intimidés. Le chercheur a voulu qu'il en soit ainsi. Cependant, une fois que le récit de l'histoire commence, tant de choses sont révélées que cela prend beaucoup de temps pour une seule entrevue à la fin. Les quelques premières entrevues que ce chercheur a faites prenaient en effet beaucoup de temps et étaient fatigantes. Elle a adapté l'entrevue afin d'instaurer une limite de temps pour chaque question. Sans être désagréable, elle pose alors une autre question lorsque le répondant commence à s'éloigner du sujet.

En termes de calendrier, le délai prévu pour procéder à la collecte de données n'a pas été suivi en particulier dans la phase de l'entretien avec l'informateur. Beaucoup de modifications ont été apportées au calendrier des entrevues, le chercheur a passé beaucoup de temps à réorganiser les rendez-vous des entrevues, les lieux de rencontre et le temps de voyage. Cela a retardé la fin prévue de cette étude. Bien que la majorité des personnes interrogées étaient comme cela, certains ont été très coopératifs et accommodants. Certains sont même allés jusqu'au ouvrir leurs maisons en invitant ce chercheur à des dîners, des déjeuners et des cafés pour rendre le chercheur à l'aise et pour qu'ils se sentent bienvenu. Il est intéressant de mentionner la générosité des Philippins. Ils proposent souvent de payer pour la nourriture ou le café avançant que le chercheur est juste un étudiant

b) Les défis académiques et du langage

Il n'était pas difficile de communiquer avec la population étudiée parce qu'ils s'engagent généralement dans la conversation en utilisant leur langue maternelle. La communication avec les organisations françaises équivaut cependant à ne pas faire n'importe quoi. Comme le chercheur est nouveau en France, elle profondément lutte avec la langue. La plupart de sa communication avec les institutions françaises afin de recueillir des données, devait être faite en français. Les traductions ont été faites en utilisant le programme de traduction de Google sur Internet en particulier au cours des premiers mois après son arrivée à Nice, les erreurs grammaticales sont alors très visibles. Souvent, la communication, principalement par email, prend beaucoup de temps pour obtenir une réponse parce que l'organisation ou la personne que le chercheur tente de contacter, doivent souvent clarifier beaucoup de choses avant que la question soit clairement comprise. Il faut dire aussi que certains mails n'ont pas été retournés, même après un certain nombre de relances du chercheur. La barrière des langues a été la principale cause de blocage du chercheur. Il est intéressant de mentionner qu'en Novembre 2009, trois mois après l'arrivée de ce chercheur à Nice et après avoir suivi un cours intensif de langue à l'Université de Nice, le chercheur s'interroge sur la nécessité de poursuivre la recherche. Les défis posés par ce nouvel environnement, cette nouvelle culture et cette nouvelle langue semblent rendre la tâche de l'adaptation et de l'adoption insupportable et un défi insurmontable. Le meilleur de son caractère a alors pris le dessus et elle a décidé de poursuivre ses recherches. Ce blocage l'a ralenti entraînant une prolongation de la durée de son étude. En fin de compte, au lieu de terminer après 34 mois, elle a besoin d'une année supplémentaire. La raison pour laquelle cela est mentionnée comme une limitation, est d'informer les organismes qui octroient les bourses européennes doivent prévoir qu'une préparation intense est nécessaire avant d'accepter des étudiants d'autres pays à la France. Les attentes concernant la langue devraient être présentées clairement aux étudiants ainsi que ce qu'ils peuvent attendre de l'Université de réception. S'appuyant sur sa propre expérience, elle est bien consciente que la plupart des cours / séminaires de son laboratoire sont en

français, mais elle ne s'attendait pas à ce que tout soit en français. Si elle avait su, elle aurait pu choisir d'autres universités ou d'autres laboratoires dans lesquels l'adaptation se serait mieux passer. Bien qu'il soit évident que ce chercheur a bénéficié de la possibilité d'étudier dans une université européenne, elle aurait pu plus s'épanouir académiquement parlant si elle avait été affiliée à un environnement d'apprentissage plus culturellement diversifié. Sur un plan personnel, son déni d'avoir besoin de la langue française a limité son intégration à la communauté universitaire. Il était trop tard quand elle a finalement réalisé que c'était une erreur de sa part de ne pas avoir pris l'apprentissage de la langue française plus au sérieux.

D'autre part, les universités françaises doivent également être mises au courant des programmes de bourses d'études de l'union Européen. Une meilleure coordination entre les organismes qui octroient les bourses, les personnes qui les mettent en œuvre et l'université partenaire où le chercheur invité sera placé, est nécessaire pour s'assurer que les objectifs du programme de bourses d'études sont remplis. Lorsque ce chercheur est arrivé dans son laboratoire, elle ne parlait pas un seul mot en français, personne ne savait ce qu'elle faisait là et/ou sous quel programme elle s'était enregistrée à l'Université. Cela a immédiatement constitué un blocage psychologique pour ce chercheur. Elle a du mal à comprendre la situation scolaire dans laquelle elle est à présent. Dans des circonstances normales, un laboratoire doit savoir qui sont les étudiants qu'ils acceptent et si les élèves peuvent vraiment bénéficier de leur offre de formation. Cependant, en défense de ce Laboratoire de recherche, c'est la première fois qu'ils acceptaient un étudiant totalement étranger à la culture et à la langue française. Ils ont supposé que ce chercheur pouvait faire face aux travaux et aux activités académiques, même si elles sont principalement en français. En outre, les coordonnateurs du programme EMMA n'étaient pas en mesure de communiquer efficacement avec eux, sur ce qu'est le programme EMMA et si l'étudiant invité pouvait véritablement s'intégrer dans ce laboratoire. Ces obstacles ont constitué des défis pour ce chercheur sur le plan scolaire et personnel.

Importance de l'étude

Les études de santé en matière de santé des immigrés en Europe ont révélé un scénario différent au cours des années. Ceci questionne le rôle des différents acteurs de la santé ainsi que des politiques d'immigration. Le statut de santé des immigrants constitue un grand intérêt dans toute l'Europe et les résultats sont souvent différents en raison de stratégies différentes pour mesurer les résultats de santé, les inégalités de santé etc. Cette étude vise à contribuer à la littérature sur l'état de santé des immigrants en informant sur les pratiques de santé spécifiques des Philippins dans la Côte d'Azur.

Les résultats de cette étude ont l'intention de fournir aux professionnels de santé, aux institutions concernées et aux décideurs, des données qui pourraient les aider dans leur quête pour améliorer les services de santé. Les immigrants philippins ainsi que d'autres groupes d'immigrants pourraient aussi bénéficier de politiques élargies et de campagnes de communication sur la santé améliorées. Dans une perspective plus générale, cette recherche vise à contribuer à l'amélioration de la prestation de santé à des groupes d'immigrants. Plus précisément :

a) Les professionnels de santé

Le terme « professionnels de la santé » comprend non seulement les médecins et les infirmières médicales, mais tous ceux qui travaillent dans le domaine de la santé pour s'assurer qu'un service de qualité est livré au patient. Cela comprend des épidémiologistes sociaux, des chercheurs en santé, toutes les personnes travaillant dans les bureaux de santé (« premières lignes ») et tous ceux dont le travail est lié à la fourniture d'informations de santé pour le grand public. Les « premières lignes » de tous les programmes de santé sont ces gens et ainsi ils devraient connaître le rôle très sensibles qu'ils jouent dans la gestion de la santé.

La compréhension de la culture des immigrants reste une tâche difficile pour les travailleurs de santé. Les résultats de cette recherche donneront aux professionnels de santé une idée de ce que sont les subtilités, les bizarreries et les sensibilités des patients philippins qu'ils servent dans leur communauté. Ce groupe d'immigrants provient d'un environnement de santé différent et connaître les sensibilités culturelles et religieuses de ces personnes ce qui permettra d'aider les professionnels de santé de la Côte, à communiquer avec eux d'une manière qui est plus adapté à leurs convictions de longue date sur l'entretien de leur santé et la gestion de leur guérison par la conception d'activités de santé en harmonie avec leur culture. Il a été rapporté plus tôt que les professionnels de soins de santé français sont dédaigneux, qu'ils manquent de compétences et qu'ils sont mal préparés à gérer un environnement culturellement diversifié. En leur fournissant les informations concernant la culture philippine et ses croyances religieuses, ils connaîtront mieux ce groupe d'immigrants dans l'espoir que d'autres groupes d'immigrants feront la même chose, en particulier les minorités.

b) Les groupes d'immigrants

Espérons que les groupes d'immigrants feront plus d'efforts pour connaître la France et la région à laquelle ils appartiennent ; sa culture et son peuple et ne doivent pas rester des travailleurs passifs du pays. Ils devraient également être encouragés à participer à des activités sociales et à s'engager dans un dialogue actif qui permettrait aux gouvernements nationaux et locaux de déterminer leurs besoins et de concevoir des programmes appropriés. La responsabilité de l'État ne consiste pas uniquement à fournir des services à ses immigrants. Aujourd'hui plus que jamais, une synergie est exigée de tous les secteurs de l'industrie de la santé pour traiter des questions liées à la santé.

À condition que les résultats de cette recherche ouvrent la possibilité d'une plus grande collaboration entre les institutions de santé et les immigrants, les groupes d'immigrants organisés devraient réussir à inciter ces établissements de

santé de l'Etat à réaliser des campagnes de santé dans une langue qu'ils comprennent pleinement et d'une manière qui leur plaît et qui ciblent les maladies pour lesquelles les immigrés ont une prédisposition culturelle ou génétique. Ce type d'activité demande sans aucun doute plus de temps et de ressources, mais les résultats des stratégies précédentes montrent que ça ne fonctionne pas, il n'y a donc pas d'autre choix que d'améliorer la stratégie. L'approche top-down a ses gains, mais cela ne fonctionne pas avec une population immigrée en raison de leurs uniques qualités en tant que peuple.

c) Les planificateurs de santé

Dans le Sud de la France, les outils de communication de santé tels que des dépliants et des affiches sont destinés à la population générale. Il est clair maintenant que ces matériaux qui sont souvent destinés à des mesures préventives, n'ont pas un impact direct sur les immigrants. La principale raison est probablement parce qu'ils sont dans une langue qu'ils ne comprennent pas pleinement. Le design pourrait ne pas être attrayant pour eux, c'est pourquoi il ne leur parle pas de la manière dont ils sont supposés le faire.

Les résultats de cette recherche fourniront aux concepteurs de la campagne de santé un aperçu de la façon dont le peuple philippin est sensibilisé en termes de performances de la santé. Opérant sous un scénario idéal, des outils de la santé spécifique à un groupe d'immigrants particulier sont idéals. Cependant, en utilisant l'anglais comme langue de communication pour les outils de la santé permettrait de toucher d'autres groupes d'immigrants et pas seulement les Philippins. Cela constituerait un avantage certain les bureaux de santé dans lesquels les patients vont pour obtenir des renseignements sur la santé fournissent plusieurs choix d'outils de santé.

d) Les décideurs

Le directeur de l'Assemblée mondiale de la Santé, Margaret Chan a déclaré que les inégalités en terme de santé sont la conséquence des fautes du niveau de la politique. C'est une réalité alarmante à laquelle est confrontée les décideurs et à laquelle ils ont besoin de répondre dès que possible parce que toutes les routes mènent à l'institutionnalisation des politiques. Une loi qui exige la création de directives standardisées et normalisées dans le domaine de la collecte de données sur la santé des immigrants est un bon début.

e) L'université

La Communication de la santé est un très jeune domaine de recherche. Il existe d'autres disciplines auxquelles les idéaux de la communication sur la santé peuvent être appliqués et étudiés. Étudier une population immigrée met en lumière les causes et les effets des processus impliquant l'assimilation et l'intégration des immigrants.

Les membres du milieu universitaire peuvent explorer la politique de santé française concernant la communication sur la santé des immigrants. Il est important de savoir comment les politiques actuelles sont réceptives aux besoins de ces personnes. Cela permettra de mettre en lumière ce qui limite ou favorise une meilleure assimilation des immigrants.

Les chercheurs peuvent appliquer le modèle de communication santé transculturelle proposé à d'autres groupes d'immigrants ou d'autres membres de la population.

CHAPITRE IV

Résultats et les implications

Partie 1

A. Hypothèses

Voici les résultats de l'étude en référence aux hypothèses établies par cette recherche :

Hypothèses 1 : Pour les immigrants philippins à la Côte d'Azur, la langue est un obstacle à l'intégration des soins de santé

Les résultats de cette recherche ont découvert que, bien que la barrière de la langue est toujours présente, elle n'affecte pas directement le comportement de recours aux soins des immigrants philippins. Ils se débrouillent pour réduire le fossé linguistique en cherchant des médecins anglophones ou en amenant un ami proche ou un membre de la famille à la consultation pour jouer le rôle de traducteurs et d'interprètes. Avec la durée du séjour en France, un grand pourcentage d'immigrants philippins à la Côte d'Azur sait déjà parler français et ils étaient capables de converser dans la langue. Cela ne signifie pas cependant qu'ils étaient capables d'exprimer en détail leurs problèmes de santé ni de totalement comprendre les explications des médecins. La conversation entre les médecins et les patients est, le plus souvent, superficielle et basique. Elle se résume surtout à « Qu'est ce qui est douloureux, où avez vous mal ? Depuis quand ? Voilà votre prescription ». Ce type d'interaction se produit lorsque les patients se plaignent seulement de douleurs simples. Dans les cas graves, comme le cas de Brigitte, son médecin prend très bien soin d'elle, mais peut-être uniquement parce que son médecin est en train d'écrire un livre, c'est pourquoi elle a besoin de documenter tout ce qui se passe avec Brigitte. Pour une intervention plus en profondeur, les patients ont besoin de plus que de ce type de soins médicaux, en particulier les immigrants dont les blessures ont souvent des causes plus profondes et plus multiples.

Les patients philippins de la Riviera font également preuve de suffisance quand ils ne cherchent pas à en apprendre plus sur leur maladie en essayant de clarifier l'information provenant de leur médecin. Ils sont des patients passifs qui ne font que suivre les conseils de leurs médecins en termes d'apport de la médecine tout en continuant à pratiquer leur médecine traditionnelle de leur côté. Pour compenser le manque d'information de leurs médecins, ils lisent de la documentation pour en savoir plus sur leur maladie, mais l'impact de cette activité sur la façon dont ils prennent soin de leur santé n'est pas clair.

Les résultats de cette étude suggèrent également que l'attitude des professionnels de santé français représente un obstacle plus grand que la langue française, et nécessite une attention plus immédiate. Ils sont souvent dédaigneux au point d'être grossiers et non conciliants ainsi les patients immigrants se sentent discriminés. Les professionnels ne font pas l'effort de comprendre ce qu'un interlocuteur non - français est en train de dire dans un français approximatif. Cela a été mentionné par Susan et beaucoup d'autres personnes interrogées dans cette étude. Les immigrants ne contestent pas le fait qu'il est de la responsabilité des étrangers qui ont décidé de vivre en France, d'apprendre la langue. Cependant, bien que ce ne soit pas une forme d'excuse, il devrait y avoir un arrangement pour les immigrants qui sont en période de transition. Les statistiques montrent que la dynamique des immigrés en France est en train de changer. Ils ne viennent plus seulement des anciennes colonies françaises qui connaissent la France. Un nombre croissant d'immigrants viennent d'autres parties du monde qui ne parlent pas français, et pendant la phase de transition, où ils ont le plus de besoin et où tant de documents doivent être remplis et déposés au bureau approprié, plus de patience n'est pas trop demandée.

Les professionnels de la santé français se référant aux « premières lignes » en terme d'institutions publiques devraient aussi réaliser qu'ils occupent une position de service public. Ainsi, il est de leur obligation d'attribuer le temps, d'aider, de donner des informations pertinentes et du temps à tous ceux qui viennent à leur

bureau, pour avoir une clarification après la consultation. Il est clair maintenant que le besoin d'interprètes pour les immigrants en transition existe. C'est la responsabilité de l'État de leur en fournir un. L'assignation d'une personne qui connaît bien la façon dont le système de santé français fonctionne de l'intérieur et qui est spécifiquement formé pour aider les étrangers et les immigrés, est la meilleure façon pour diminuer le manque de communication entre les professionnels de santé et les patients issus de l'immigration. Cette technique est opérationnelle dans d'autres pays et la France pourrait l'expérimenter et voir comment elle fonctionne dans son système de santé.

Hypothèse 2 : les pratiques de santé actuelles sont encore très influencées par le système de croyance traditionnel

Le niveau d'influence diminue en fonction du temps passé en France. Certes, des traces de ces croyances en matière de santé sont encore présentes dans les choix de santé et les options de traitement. Un grand pourcentage d'immigrants philippins de la Riviera se souvient et parle encore des pratiques de santé philippines traditionnelles, mais cela ne se traduit pas en une pratique réelle. Certaines des personnes interrogées ont mentionné au chercheur qu'il y a des Philippins qui pratiquent des techniques de guérison traditionnelles dans la région et qui peuvent être contactés si quelqu'un est dans un besoin désespéré de consulter des guérisseurs traditionnels. Toutefois, les immigrants philippins préfèrent s'adresser à des professionnels médicaux. La principale raison fournie par la personne interrogée, c'est parce qu'ils ont plus confiance dans les médecins ayant une formation médicale que dans les guérisseurs traditionnels. Ils ont également partagé que les médecins sont plus accessibles et plus fiables. Cela montre que la croyance dans les techniques traditionnelles de guérison est éclipsée par la disponibilité des médecins occidentaux formés et l'accessibilité des médicaments. Dans le passé, les patients philippins en particulier ceux qui n'ont pas assez de ressources, cherchaient d'abord l'aide des guérisseurs traditionnels. Ils allaient voir des médecins quand ils avaient déjà épuisé toutes les ressources de la médecine traditionnelle. La raison principale est qu'ils ont peur du coût des médecins et des médicaments. Ici en France où ces

obstacles ne sont plus présents, les patients philippins vont principalement voir les médecins ce qui montre le changement de paradigme dans leur état d'esprit. Toutefois, les visites chez les médecins ne sont qu'un facteur pour prendre soin de ceux santé. Dans un environnement étranger, le processus d'aller chez un médecin pour un check-up n'est pas aussi facile qu'il y paraît. Quand il n'y a pas de langue commune, les patients ont souvent des doutes à aller voir le médecin.

Les philippins embrassent l'idée d'une combinaison de traitement. Cette étude a révélé que les patients philippins consultent souvent un médecin et vont voir des guérisseurs traditionnels en parallèle. Maintenant qu'ils sont en France, la combinaison de traitement est également présente mais sous une forme différente : ils vont voir un médecin et vont voir un autre spécialiste médical formé comme un kiné (physiothérapeute), communément appelé « kene » qui est très similaire à un massothérapeute qui est appelé « hilot » aux Philippines ou à un Ostéopathe - un médecin concerné de maintenir la santé des patients par l'équilibre du corps et de l'esprit en se concentrant sur le système musculo-squelettique.

Hypothèse 3 : immigrants philippins ont pu s'adapter au système de santé français

La première vague d'immigrants philippins qui sont venus à la Riviera ont été la plupart du temps acculturés et intégrés avec succès dans les soins de santé en français et le mode de vie français principalement en raison de leur long séjour en France et de leur capacité à parler français. Mais cette intégration ne s'étend pas à faire partie de la société française au sens large. Ils sont restés dans les limites de leurs zones - ainsi leurs activités sociales sont toujours limitées à être avec d'autres Philippins. Cela a un effet sur leur vie quotidienne, y compris dans la gestion de la santé. Ils partagent leurs problèmes de santé avec d'autres Philippins, ils partagent également la gestion de la maladie, les activités de prévention et les options de traitement qui sont principalement basées sur leurs expériences de première main avec la maladie. Les techniques traditionnelles de guérison font presque toujours partie de la discussion. Parler de la médecine traditionnelle ne se traduit pas

littéralement à la mettre en action. La plupart des Philippins ne prennent pas ces choses au sérieux. Ils ont dit qu'ils préféreraient aller voir un médecin, faire des tests quand ils soupçonnent qu'il y a quelque chose de grave, plutôt que de mettre leur santé dans les mains de l'inexpérimenté ou prendre des concoctions non testées à base de plantes qui ne sont pas médicalement approuvées pour empêcher ou guérir les maladies. Cet état d'esprit met en évidence l'adaptation des immigrants philippins au système de santé français, qui est fortement basé sur la science médicale dure et ce système de croyance se répand à ses patients. L'intégration dans le système de santé est un concept large et il doit être quantifié. Si le facteur sur lequel mesurer l'intégration de la santé est l'inscription au système et le fait d'avoir une carte vitale, alors les philippins l'ont intégré avec succès. La plupart, sinon tous, sont enregistrés dans le système de santé français. Ils reçoivent des soins en cas de besoin, ont accès aux médicaments et ils savent que si quelque chose va mal, ils ont le droit d'accéder aux soins médicaux dans les hôpitaux.

Si la mesure de l'intégration est l'accès à l'information sur la santé et les mesures de prévention, il y a beaucoup à faire. Il est clair que les comportements préventifs peuvent être encouragés par les messages de santé. Si ces messages n'atteignent pas ou ne font pas appel à un groupe spécifique qui sont considérés comme les plus vulnérables et génétiquement prédisposés à certaines maladies, le comportement et le mode de vie n'est pas susceptible de changer. En outre, si ces campagnes de prévention regroupent les immigrants dans une seule catégorie, c'est problématique pour les immigrants de la Riviera qui sont culturellement fragmentés. C'est pourtant ce qui devrait être réalisé par les concepteurs de la campagne. Dans la mesure où l'état de santé des immigrants a été étudié, il manque une catégorisation en termes d'ethnicité et de la race, créant ainsi une analyse de santé unique pour le terme «immigrés». Cela ouvre la voie à un malentendu à propos des expériences de santé des immigrants.

En fin de compte, l'adaptation et l'intégration des immigrants Philippins au système de santé français est encore limité à être une partie passive de celui-ci. Ils

se sont contentés d'être destinataires de l'information et des services. Il n'y a pas eu de réels efforts pour communiquer avec eux et savoir quels sont les informations et les conseils de santé dont ils ont vraiment besoin. Ainsi, quand ils sont exposés à des campagnes de santé, ils sont totalement détachés parce qu'elles ne sont pas dans une langue qui permette de communiquer avec eux. Les graphiques ne sont pas familiers et le message général ne se connecte pas avec leurs convictions de longue date. Comme tels, ils ne sont pas souvent touchés par la campagne et ils continuent de pratiquer la santé de la manière qu'ils connaissent.

Hypothèses 4 : Il y a des pratiques de santé émergentes basées sur une combinaison intentionnelle ou non des croyances passées et présentes en matière de santé

Une version révisée de la combinaison de traitements est un constat flagrant de cette étude. Au lieu de combiner les pratiques de santé traditionnelles avec les conseils des médecins, il s'agit maintenant de combiner au moins deux traitements médicaux. Un patient ira voir un GP et un physiothérapeute ou un ostéopathe. Leur état d'esprit est d'avoir un traitement médical plutôt que de chercher des philippins qui effectuent des pratiques de guérison traditionnelles. Ce n'est pas qu'il n'y a pas des guérisseurs traditionnels philippins sur la Riviera, car il y en a quelques uns. Mais l'état d'esprit général des philippins est de s'adresser à des professionnels médicaux.

Demander de l'aide médicale s'inscrit dans une recherche de traitement plutôt que dans un cadre préventif. Les immigrants philippins consultent un médecin si les symptômes commencent à se manifester. Dans les maladies chroniques qui coûtent sont plus coûteuses à gérer et en terme de survie, un diagnostic tardif est synonyme de gestion de la maladie, car une fois que les symptômes sont présents, cela signifie que la maladie est présente depuis longtemps et qu'elle est irréversible. Ce comportement de mise au point / traitement de cure doit être traité pour éviter la gestion de la maladie coûteuse et sauver des vies. La confection de messages de santé préventifs spécifiques et la mise en oeuvre d'activités de prévention qui font

appel à la population cible spécifique peuvent permettre d'identifier les maladies plus tôt et ainsi de mettre en place des soins plus rapidement.

Principalement en raison de l'accès aux soins de santé, les philippins immigrés de la Riviera sont maintenant ouverts à d'autres options de traitement médical. Lorsque les médecins conseillent d'aller voir un spécialiste ou de faire plus de tests, ils n'hésitent pas à suivre ces conseils. Aux Philippines, les patients disent oui à ces conseils, car ils savent que c'est ce que leur médecin veut entendre. Mais ils ne le font pas souvent parce qu'il y a beaucoup de considérations avant d'avancer dans la recherche de soins médicaux et le fardeau le plus lourd est l'économie, surtout quand ils ne sentent pas l'urgence de le faire. Lorsque cette question de blocage est enlevée, il y a de grandes chances que les patients suivront les conseils des médecins. C'est ce qui arrive aux immigrants philippins de la Riviera. Ils sont responsabilisés parce qu'ils reçoivent gratuitement un éventail de choix dans la gestion de leur santé. Un autre facteur important est qu'ils s'inquiètent moins des coûts financiers.

Malgré la disponibilité des médicaments dans la Côte d'Azur, il y a encore une poignée de philippins qui importe des médicaments simples des Philippines, car ils estiment qu'il est « Hiyang » (adapté) pour eux. Ces médicaments sont souvent ce qu'ils prennent pour les douleurs de tous les jours comme des douleurs musculaires, les maux de tête etc. Certains ont mentionné qu'ils estiment que les effets secondaires de ces médicaments en France sont trop forts pour eux, ils choisissent donc de prendre des médicaments en provenance des Philippines. Ceux qui s'opposent à cette pratique ont réaffirmé que les médicaments en provenance des Philippines ne sont pas efficaces parce que le dosage n'est pas ce qu'il est censé être, même si l'étiquette dit. Ils ne croient pas que les médicaments en provenance des Philippines ont la même bioéquivalence avec les médicaments qu'ils reçoivent ici en France. Ce que ces mentalités ont prouvé, c'est que la croyance de prendre ce qui est « approprié » est très vivante dans la psyché des immigrants philippins. Ce terme a une nuance culturelle ainsi bien que personnelle, portant une signification qui

va au-delà du superficiel. Pour les philippins, « adapté » signifie quelque chose qui unie leurs croyances et leurs sentiments ; quelque chose, quelque'un ou un endroit où ils sont à l'aise. Cet état de confort est aussi ce que les philippins recherchent dans leur vie quotidienne. Ils préfèrent avoir un professionnel de soins de santé adaptés, un hôpital adapté car ils se sentent à l'aise. Les professionnels de santé devraient en tenir compte lors de la prise en charge des patients philippins, en particulier ceux qui sont dans la ligne de front. Les médecins et les infirmières sont formés sur cet aspect des soins, mais les membres auxiliaires de soins de santé pourraient avoir besoin de plus de formation dans la gestion d'un environnement de santé multiculturel.

Le croyances de santé émergentes comprennent :

- a . une combinaison de traitement révisé
- b . une gestion de la santé centrée sur le médecin
- c . un mélange des médicaments simples des Philippines et de la France
- d. une diminution des références et de la pratique des croyances de santé traditionnelles
- e . une référence à la prise de médicaments qui sont " adaptés "

Hypothèses 5 : La première génération d'immigrants philippins n'est pas consciente qu'il existe des différences entre le système de santé de la France et les Philippines.

La première génération d'immigrants philippins de la Riviera comprend ceux qui sont nés en France de parents philippins. Aujourd'hui, ces immigrants de première génération sont relativement jeunes et à peine sorti de l'université (ou à peu près entre 17-23 ans). Etant jeunes, ils sont très conscients de leur origine raciale, mais ils ne sont pas très familiers avec les coutumes et les traditions en particulier dans le domaine de la santé. C'est compréhensible parce qu'ils ont grandi dans l'environnement français. Ils ont partagé avec ce chercheur que leurs parents parlent des croyances traditionnelles de la santé et des techniques dans la lutte contre la maladie, mais ils ne comprennent pas vraiment ce que cela signifie. Ils ne pratiquent pas et leurs parents ne les encouragent pas à le faire.

Lorsque leurs parents ou d'autres membres âgés de la communauté philippine parle de la difficulté et du coût de la gestion de la santé aux Philippines, les immigrants de première génération ne comprennent pas vraiment ce que cela signifie car ils n'ont jamais fait face à de telles difficultés. Ce peut-être parce qu'ils n'ont pas une bonne compréhension de la façon dont il est difficile d'être malade, ni combien il est coûteux d'être malade dans un pays qui ne dispose pas d'une couverture d'assurance de santé solide pour ses citoyens. Dans l'ensemble, leurs connaissances des différences entre le système de soins de santé de la France et des Philippines sont juste limités, ils en ont entendu parler, mais ils n'en savent pas plus que cela.

B. Objectifs de recherche

Mis à part les hypothèses de recherche, les objectifs de recherche de cette étude ont également été abordés. Ces objectifs énoncés dans la première partie de l'étude visent à dresser un portrait clair du système de croyances de la santé des Philippins et comment ceux-ci fonctionnent dans le contexte de santé français.

Ci-dessous est les résultats de cette recherche sont présentés, sous la forme d'un tableau, sur la base des objectifs fixés par cette étude.

Tableau 1: résultats et implications

Les objectifs de recherche	Résultats	Implications
1. Identifier et décrire les croyances en matière de santé et les pratiques traditionnelles des Philippins vivant dans la Côte d'Azur	<p>* Fortement influencée par les croyances superstitieuses, l'appartenance religieuse et les forces présentes dans la nature</p> <p>* La prévention et les traitements des maladies sont des affaires de famille</p>	Ce système de croyance est un produit des générations du passé sur les pratiques de santé et ne disparaîtra pas quelque soit l'endroit où se trouvent les philippins. Les croyances traditionnelles ne vont pas disparaître

	<ul style="list-style-type: none"> * Des comportements et des activités de prévention ne sont pas une priorité courante * Les techniques traditionnelles de guérison et la médecine occidentale sont souvent combinées 	<p>immédiatement même si leur influence dans la santé des patients diminue. Chaque fois qu'il y a une chance, les immigrants philippins effectuent encore des pratiques de santé traditionnelles, mais c'est souvent un choix loin de leurs options de traitement médical.</p>
<p>2. Décrire comment la croyance de santé traditionnelle influence les pratiques de santé actuelles avec le système de santé français comme toile de fond</p>	<p>A: <u>Les croyances traditionnelles de la santé</u></p> <ul style="list-style-type: none"> * La combinaison de traitement est encore pratiquée, mais selon un principe différent * les médicaments de base (paracétamol, ibuprofène et pommades) sont encore importés des Philippines * Il y a encore des pratiques de santé importantes liées à des croyances superstitieuses et religieuses, mais elles diminuent dans le temps <p>B: Traits de santé français</p> <ul style="list-style-type: none"> * Couverture maladie universelle, où tout le monde a accès aux soins de santé * Liberté dans la consultation des médecins * Médicaments gratuits (ou peu chers) * Remboursement pour consulter un spécialiste 	<p>Le système encourage et soutient la quête des populations pour une meilleure préservation de la santé. Il responsabilise les patients de manière à ce qu'ils soient conscients que les soins de santé leurs seront fournis quand ils en auront besoin. Le système a besoin de se concentrer sur les programmes qui ciblent spécifiquement les populations vulnérables. Une façon de le faire est de commencer à tisser un lien de confiance entre le système et la population qu'ils ciblent. Cela peut être fait par la mise en œuvre de programmes qui visent à mieux comprendre la composition culturelle et raciale de la population. Les patients peuvent en outre être responsabilisés en leurs permettant d'exprimer leurs pensées et en leurs</p>

	<ul style="list-style-type: none"> * Haut - coût pour le gouvernement * Les cotes de satisfaction des patients sont élevées * Les patients sont des participants passifs 	<p>donnant une plate-forme de doléances et de demande de changements, s'ils estiment en avoir besoin. Le patient doit jouer un rôle actif dans la gestion de sa propre santé.</p> <p>Les professionnels de santé français doivent être mis au courant du système de croyance à la santé des Philippines pour être en mesure de faire des campagnes de santé adapté à la culture philippine afin de corriger les pratiques de santé qui ne sont pas médicalement. Il serait également intéressant de les aider à communiquer sensiblement avec cette population.</p>
<p>3. Identifier les pratiques émergentes pour la santé de la population philippine et décrire comment il se confond avec le paysage français de la santé</p>	<ul style="list-style-type: none"> * Adhérer à la combinaison de traitement * Nouveau langage / vocabulaire * Plus de visite chez les médecins * Suivre de manière stricte les conseils sur le traitement * Une conscience plus aiguë de l'entretien de la santé * Suffisance à identifier leurs difficultés à communiquer avec le personnel médical auxiliaire 	<p>Le mot «massothérapeute» a maintenant une nouvelle signification pour les immigrants philippins de la Riviera. Ces professionnels de la santé sont médicalisés, parce que leur titre dit tout (Kenetherapeute et Osthéopathe). Cette complémentarité des professionnels de la santé ressemble au travail accompli par les thérapeutes traditionnels dans les Philippines, la seule différence est qu'ils sont</p>

	<ul style="list-style-type: none"> * Etat d'esprit d'aller et venir * La recherche de quelque chose d'«adapté» à leurs croyances en matière de santé 	<p>autorisés à exercer leur profession. Les immigrants philippins pourraient en quelque sorte ressentir une ressemblance avec leurs pratiques de santé anciennes et l'association des médecins, des ostheotherapeutes et des physiothérapeutes.</p>
<p>4. Identifier les obstacles qui contribuent à l'échec de l'assimilation de la santé ainsi que les facteurs qui encouragent un meilleur entretien de la santé des immigrants philippins à la Côte d'Azur</p>	<p>A: Obstacles</p> <ul style="list-style-type: none"> * Préjugés envers les patients immigrés * Une formation limitée des travailleurs médicaux sur la façon de gérer les diverses communautés culturelles * Défis liés à la différence de la langue * Limite des programmes de santé et des programmes de communication de la santé qui ciblent spécifiquement les immigrants * Manque de traducteurs pour les non-francophones * Manque de programmes qui comblent le fossé entre les immigrants et les pays d'accueil <p><u>B: Les facteurs qui favorisent un meilleur entretien de la santé</u></p>	<p>Ces facteurs découragent en quelque sorte les immigrants philippins à demander de l'aide médicale, en particulier dans la phase de prévention. Ils ne vont pas se soumettre à des situations où leur maîtrise de la langue sera examinée. Répondre aux questions des travailleurs de la santé qui n'ont pas été préparés à gérer l'environnement multiculturel, est également une activité difficile pour certains immigrants.</p> <p>L'idée que la consultation de médecins ainsi que des médicaments sont couverts par la sécurité sociale est un facteur encourageant énorme pour les immigrants philippins à demander de l'aide médicale. Cela a</p>

	<ul style="list-style-type: none"> * L'adhésion obligatoire à la couverture maladie universelle * L'accès à des soins médicaux et à la médecine * Ouverture d'esprit et soutien envers les différentes options de traitement * Les patients ont le choix dans l'assurance complémentaire (mutuelles) * Ratio de médecin-patient élevé * Imposition progressive (ceux qui gagnent plus, payent plus d'impôts qui permet au gouvernement d'assumer le coût de la santé des membres les plus pauvres de la population) 	<p>été traduit par un niveau de satisfaction élevé des patients en ce qui concerne cette partie du système de santé français. L'imposition progressive est également applicable aux travailleurs immigrés et est un facteur très important pour les immigrants âgés. Les patients immigrants peuvent également choisir leur propre assurance responsabilité civile selon le type de couverture dont ils ont besoin et le plafond monétaire qu'ils peuvent se permettre.</p>
5. Proposer un modèle de santé qui explique comment les systèmes de santé émergents des immigrants sont formés	Modèle de communication de la santé transculturel (MCST)	Ce modèle peut être appliqué dans n'importe quel environnement de santé culturellement diversifié.

Le Tableau 1 présente les conclusions et les implications des objectifs de recherche. Il montre comment le système de santé français est prêt (ou non) à accueillir les subtilités et l'unicité d'immigrés en France, dont le nombre est de plus en plus grand chaque année. Il s'agit d'une prise de conscience que la société française est de plus en plus culturellement diversifiée et nécessite de nouvelles méthodes pour traiter les problèmes de santé des populations. La composition des immigrants en France est différente de ce qu'elle était il y a 20 ans. Il y a eu une énorme immigration asiatique dans les dernières années et de ce fait, leur présence

doit être reconnue par le gouvernement français et la société française. Les inclure dans les campagnes de santé est une façon de les intégrer dans le système de santé du pays d'accueil.

Les immigrants et les autres groupes minoritaires ont des façons différentes de faire face aux maladies, à la santé et à la mort par rapport à la population locale et ce devrait être un point important pour les fournisseurs de soins de santé. En plus de cela, des attentes différentes en ce qui concerne l'interaction de communication entravent la compréhension des patients et des médecins conseils. Les médecins ne reçoivent pas souvent la bonne information pour faire le diagnostic et le pronostic corrects. Gratter la surface n'affecte pas de changement significatif dans la façon dont les immigrants prennent soin de leur santé, comme indiqué dans les données récentes relatives à la dégradation continue de la santé des immigrants dans toute l'Europe. Il est essentiel de savoir que malgré la forte satisfaction des patients en matière d'accessibilité aux médecins et aux médicaments, pourquoi la santé des immigrants n'est-elle pas meilleure? Certes, en termes de réponse aux préoccupations de santé des immigrants, il y a des facteurs qui entrent en jeu au-delà de la médicalisation habituelle des maladies et de la santé. L'expérience de santé des immigrants philippins dans le sud de la France est vraiment satisfaisante. Cependant, il y a certains domaines qui doivent être améliorés et le premier facteur qui doit être abordé est la nécessité pour le personnel de santé auxiliaires d'avoir une meilleure formation pour aider les patients d'une origine culturelle et ethnique différente. Un système de collecte de données de santé normalisé devrait aussi être instauré pour surveiller les performances de la santé des immigrants.

D : Plate-forme opérationnelle pour les demandeurs d'informations sur la santé ne parlant pas français

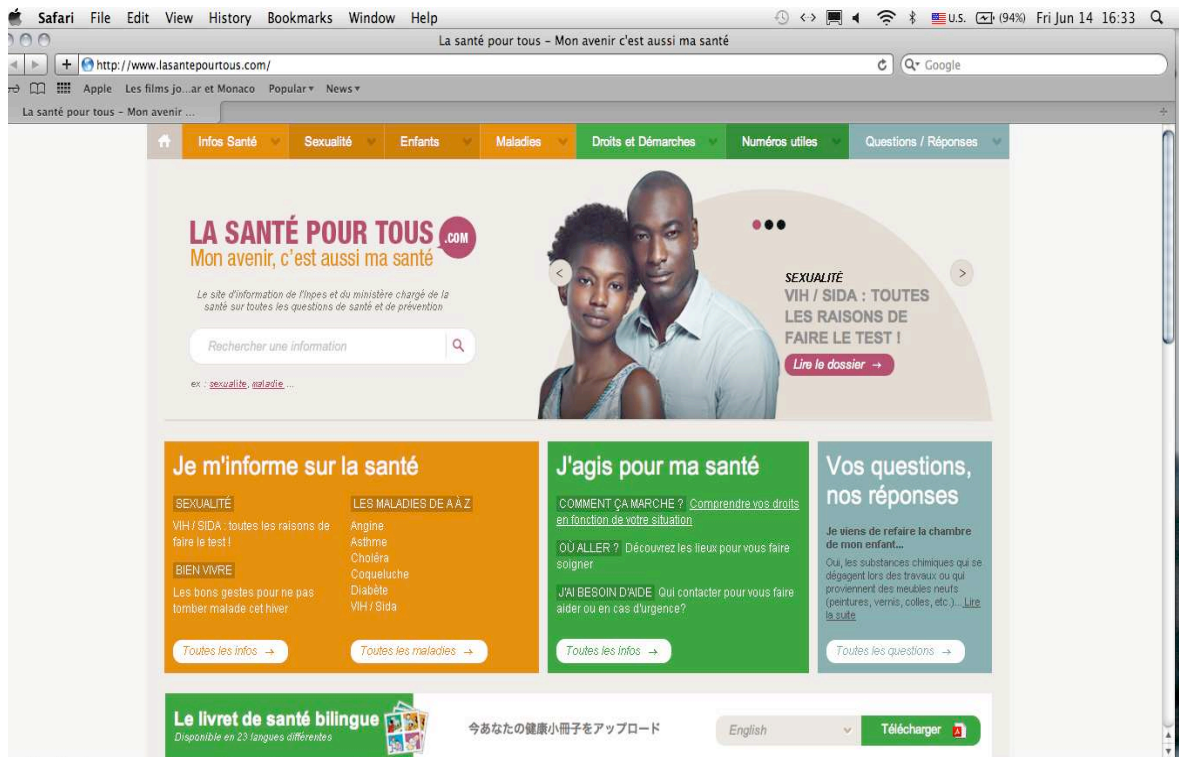
Le système de soins de santé français ne manque pas du tout de mesures quand il s'agit de diminuer l'écart de santé entre la population majoritaire et les différents groupes d'immigrants. Par exemple, pour tenir compte des enquêtes sur la santé des non-francophones, le ministère de la Santé et l'INPES est venu avec un

site qui peut être traduit en plusieurs langues et a été en mesure de répondre aux questions de base dans la langue du patient. Les demandeurs d'information sur la santé peuvent télécharger un «livret » (annexe 12) contenant un éventail de sujets de santé dont ils peuvent bénéficier. En outre, lors de l'appel de la hotline de l'Assurance Maladie, un interlocuteur non-français sera dirigé vers une autre ligne téléphonique où une personne parle anglais. Cette plate-forme pour les non-francophones n'est cependant pas une bonne publicité et de ce fait, limite son potentiel d'être utile à la recherche d'information sur la santé des membres de la population.

Figure 14: Screen Shot of the website santepourtous



Source: <http://www.lasantepourtous.com/> (accessed June 2013)



La figure 14 montre le site qui peut être consulté par ceux qui veulent en savoir plus sur les soins de santé en France et les questions de santé de base. En 2008, l'Institut national de prévention et d'éducation pour la santé (INPES) {Institut national de prévention et éducation pour la santé en collaboration avec le Ministère de la Santé} a créé le site « lasantepourtous.com ». Cependant, il n'a pas été pleinement opérationnel. Il a fallu 5 ans à l'INPES et au ministère français de la Santé pour revoir et entièrement lancer le site en 2013. Mis à jour et enrichi de nouvelles fonctionnalités, il offre aux migrants (et aux non-francophones) des informations simples et pratiques sur la santé, mais aussi sur l'accès aux soins et sur les mesures à prendre. La relance complète du site a été promue à la télévision nationale le 19 Janvier 2013 pendant le lancement de la Coupe d'Afrique des Nations (CAN). Pour soutenir la diffusion de l'information, une campagne de communication supplémentaire a été effectuée pendant trois semaines après la grande relance. Les campagnes de communication pour promouvoir le site comprennent un spot TV diffusés sur les chaînes africaines, et les médias qui diffusent la CAN 2013. En plus

de la publicité en ligne, le site a également été promu en radio, dans les journaux et sous la forme d'affiches et de dépliants.

Il est très remarquable que le lancement complet du site ait été stratégiquement fait lors de la Coupe d'Afrique des Nations. Cet événement est une édition très fréquentée de la Coupe d'Afrique des Nations en vertu de la formule actuelle, 16 équipes. La chaîne de télévision Canal+ a remporté le contrat de diffusion exclusive de l'événement. Le football est un grand événement sportif en Europe et en choisissant stratégiquement cet événement pour relancer le site, le ministère français de la Santé s'est assuré de faire passer le message à l'aide d'un seul événement et d'atteindre le nombre maximum de son public cible. Les messages réintroduisant le site ont également été diffusés sur les radios Afrique N°1 et RFI. Des outils de communication ont également été affichés dans les lieux fréquentés par les migrants (coiffeurs, magasins de fruits tropicaux, cabines téléphoniques, etc.). L'insertion dans les journaux communautaires et des bannières web en ligne sur des sites d'affinité ont également été fournies. Le nouveau site Web comporte plusieurs icônes pour illustrer les sujets qui sont discutés, le design est convivial et le site s'est positionné comme étant la seule source fiable de renseignements sur la santé de la population migrante en France (<http://www.inpes.sante.fr>).

Il est évident que cette campagne s'adresse principalement aux immigrants et son lancement pendant un grand événement sportif, a sûrement eu un impact sur le public cible. Aujourd'hui, cependant, se pose la question de la durabilité de la campagne. Trois semaines de diffusion de l'information supplémentaire n'est sûrement pas assez pour informer continuellement le public sur la présence d'une plate-forme où ils peuvent obtenir des informations sur la santé. Les immigrants sont arrivés en France tous les jours et dans cette hypothèse de la mobilité constante, l'effort de communiquer les questions de santé doit être stratégiquement soutenu. L'effet de ce site pour les immigrés en France reste encore à définir. Il n'y a pas eu d'études rendues publiques permettant de savoir si cette campagne a réussi à

atteindre ses objectifs ou comment elle a influé sur les comportements de santé des immigrants. Il s'agit d'un domaine digne d'un autre discours académique.

Au point de vente (bureau de l'Assurance Maladie ou d'autres centres de santé), il n'y a pas de matériel de lecture qui conseillerait, dirigerait et instruirait les demandeurs d'information sur la santé qu'il existe un média où l'information de santé est disponible. Ce qui est présent est l'affiche encourageant ceux qui ont la carte vitale à s'inscrire sur « ameli.fr ». Cependant, ce site est totalement différent de la « lasantepourtous ». Ce chercheur a visité plusieurs de ces cliniques à Nice et Cannes, mais il n'y a pas de matériel de communication (affiches, dépliants, etc.) qui indique l'existence d'un site Web multilingue. En outre, les travailleurs de la santé dans ces bureaux sont prêts à répondre à des questions administratives (comment faire une demande de carte vitale, quels sont les papiers nécessaires à une hospitalisation, comment avoir 100 % de remboursement et la façon d'appliquer la CMU, etc) et pourtant, ils ne savent pas qu'il existe un site Internet appelé « lasantepourtous ». Ils doivent maximiser l'information qui peut être fournie pour les immigrants puisque ces bureaux sont en première ligne pour diffuser des informations de santé. Ce peut être inclus dans la procédure de collecte de données normalisées pour surveiller les activités de santé des immigrants.

Le défi de l'utilisation de la publicité en ligne (télévision, journaux radio) pour communiquer avec public, c'est que une fois qu'elle est partie, l'information ne peut plus être récupérée. Contrairement à la publicité en ligne - les affiches et les dépliants par exemple - l'information dure plus longtemps et a plus d'impact en raison de la durée de vie du media. Ceux qui visitent les bureaux de santé ont sûrement besoin d'information sur la santé. Avoir accès à des affiches et des dépliants qui expliquent aux migrants d'une plate-forme où ils peuvent obtenir des réponses à leurs questions les plus fondamentales, informe sûrement plus de gens sur leurs choix en matière de santé, les actions de prévention ainsi que les options de traitement.

Lorsque ce chercheur est arrivé en France en 2009, elle a cherché une plateforme où l'information de santé serait accessible et compréhensible – donc en anglais. Elle a découvert plus tard que la recherche d'information sur la santé générale en langue autre que le français est un exercice futile. Elle est souvent reçue le "regard" - on parle français parce qu'on est en France. Ce regard est souvent interprété comme discriminatoire plutôt qu'encourageant. Comme tout nouvel arrivant en France, ce chercheur ne connaît pas un mot de français. Elle était en période de transition et seulement inscrite dans un cours de langue. Le ton de la voix et le langage corporel des gens de l'Assurance maladie indiquent qu'ils ne peuvent pas l'aider. Compte tenu de ce scénario sombre, le chercheur a été limité à l'échange d'e-mails pour obtenir l'information dont elle avait besoin et comme prévu ce processus est plus complexe et prend plus de temps que de parler réellement à une personne réelle.

Le programme des gouvernements français de l'intégration des immigrants est géré par l'Office Français de l'immigration et de l'Intégration (OFII). Il accueille et soutient favorablement les étrangers quand ils se déplacent en France. Il aide les nationaux et les travailleurs français lors de déplacements hors de France. Le mandat de ce bureau est de veiller à ce que les immigrants légaux soient prêts à s'ajuster à la vie en France. Plus précisément, l'OFII assure que les règles suivantes sont appliquées :

« Article L.311- 9 du Code français de l'admission et du séjour des étrangers prévoit que les étrangers admis à séjourner en France, ou qui entrent légalement en France pour la première fois entre l'âge de seize ans et dix-huit ans, et qui souhaitent résider ici, doivent se préparer à leur intégration dans la société française. Comme prévu par le décret n ° 2006-1791 en date du 23 Décembre 2006 (bulletin officiel en date du 31 Décembre 2006), la personne étrangère conclut un contrat d'hébergement et d'intégration avec le gouvernement. Ce contrat vise à établir « une relation de confiance et d'obligation mutuelle » entre la France et les personnes qui souhaitent résider ici. Le contrat d'hébergement et d'intégration est obligatoire depuis le 1er Janvier 2007. »³¹²

³¹² http://www.ofii.fr/s_integrer_en_france_47/all_you_need_to_know_about_the_cai_458.html
(téléchargé Septembre 2013)

La tranche d'âge mentionné dans cette règle est en effet un facteur limitant. Ce chercheur a l'impression que l'établissement de la confiance et de l'obligation mutuelle se limite à ceux qui viennent en France à un âge jeune, probablement surtout à étudier. Cette catégorisation d'âge remet en question ce qui a été fait ou les programmes ciblant les immigrants qui sont plus âgés que l'âge indiqué ci-dessus.

Toujours fasciné par le fait qu'il n'y a pas de garantie de santé en anglais en France et que la seule plate-forme pour les non-francophones est inexistante, ce chercheur a continué d'explorer plus et de creuser plus profondément. Le chercheur continue à expérimenter tous les moyens possibles pour obtenir des informations de santé en anglais. Elle a demandé à un de ses amis français d'appeler l'Assurance Maladie pour savoir s'il y a quelqu'un à qui elle peut parler pour répondre à ses questions de santé. L'opérateur a déclaré que le numéro à appeler est le 0811363646 pour les personnes vivant en France qui recherchent des informations de santé en anglais. Le chercheur a ensuite composé le numéro et en effet, la personne sur l'autre ligne parlait anglais. Le problème cependant est que les réponses qu'elle a fournis, sont des réponses destinés à des questions fréquemment posées. En tant que tel, elle a été en mesure de fournir un minimum d'informations qui n'est pas d'un grand secours pour les études de ce chercheur. L'opérateur a proposé d'écrire une lettre au chef de leur département ce que le chercheur a fait. Elle a obtenu la réponse de son dirigeant, après quelques mois, de se connecter à « ameli.fr » (Annexe 4) (le site fourni et géré par l' Assurance Maladie). Chaque titulaire de la Carte Vitale est encouragé à ouvrir un compte sur « ameli.fr » pour gérer leurs transactions avec la Sécurité sociale. Dans le bureau de l'Assurance Maladie situé à Nice (Rue Pertinax), il y a une énorme affiche qui dit aux gens de s'inscrire sur ce site. Toutefois, pour les immigrants, il ne veut rien dire parce qu'il est écrit en français. Il n'y a pas de matériel supplémentaire dans une autre langue qui explique l'importance de l'enregistrement sur ce site donc les non-francophones ne

sentent pas la nécessité, l'importance et l'urgence d'utiliser cette plateforme pour en savoir plus sur la façon dont les soins de santé sont gérés en France. C'est une triste réalité parce que ce site fournit un grand nombre d'informations qui pourraient aider les immigrants dans leur quête d'une meilleure santé.

La recherche d'informations par les fournisseurs d'information de santé situés dans des bureaux l'Assurance Maladie est un exercice futile. Le personnel du bureau n'est pas très accueillant et ils ne reflètent pas l'attitude qu'ils aiment ce qu'ils font. Les nombreuses fois où ce chercheur a visité ces bureaux dans l'espoir d'obtenir l'information dont elle avait besoin pour ses recherches et son assurance maladie, elle est souvent arrêtée dès qu'elle commence à poser des questions dans un français non parfait. Ce qui s'est passé dans le bureau de santé publique situé dans le Sud de la France ne reflète sûrement pas l'ensemble du service français, bien qu'il existe plusieurs études qui réfèrent à une insatisfaction générale des services fournis par les professionnels de santé auxiliaires. Cela aurait pu être une expérience positive si les deux parties avaient essayé de se comprendre l'une l'autre ou s'il y avait quelqu'un dans chaque centre de santé publique spécialisé dans la réponse aux demandes des non-francophones. En vertu d'un scénario idéal, la personne qui est spécifiquement assignée au groupe d'immigrants, doit avoir au moins un minimum de connaissance sur la culture de la communauté qu'ils servent, s'il ne provient pas directement du groupe. Un interprète peut aussi être un service supplémentaire aux clients / patients ayant besoin d'aide dans la communication. Cela diminuera certainement l'anxiété du patient et cela aidera les professionnels de la santé.

E. Les expériences des immigrants philippins et les perceptions du système de santé français

Les données du sondage et des entrevues ont révélé que, en général, les immigrants philippins dans le sud de la France et Monaco croient qu'ils prennent mieux soin de leur santé maintenant qu'ils sont en France par rapport à quand ils

étaient encore aux Philippines. Cela peut être attribué à plusieurs facteurs dont une gestion socialisée de la santé, un taux élevé de médecins pour les patients, l'accès aux soins et à la médecine et d'une manière générale au système de soins de santé français.

Ce même groupe d'immigrants est très féminisée - il y a plus de femmes philippines migrantes que d'hommes et elles vieillissent. Un grand pourcentage de la « population » cible de la recherche ont 60 ans et plus et la majorité sont des femmes. Il s'agit d'un problème de santé car il se traduit par plus de visites et de procédures médicales en raison de maladies associées au vieillissement. Les femmes sont également plus sensibles aux longues maladies que les hommes et elles vivent plus longtemps aussi. Ainsi, tous ces philippins immigrés dans le Sud de la France visitent les médecins plus souvent, font plus de tests de laboratoire et exigent plus de médicaments.

Les immigrants philippins sont également très engagés dans un travail physique puisqu'ils sont généralement employés dans les travaux domestiques. Ce qui les expose davantage à la douleur et au stress physique. Il n'est pas étonnant qu'ils attribuent presque toujours leurs maux et douleurs au type de travail qu'ils font. Cette attribution est cependant une pure spéculation car il n'y a pas eu une étude reliant les maux les plus élémentaires et les douleurs de ce groupe d'immigrants au genre de travail qu'ils font.

La majorité des répondants visitent leur médecin après quelques jours d'inconfort. Ils étudient leur propre douleur et voient si elle va naturellement disparaître après quelques jours de repos. Si la douleur persiste, ils prennent rendez-vous avec leur médecin. Ce comportement est attendu de la part des personnes qui ne vont pas normalement voir leurs médecins dès la première manifestation de la douleur. Le grand changement pour les immigrants philippins, c'est que dans la recherche de l'aide médicale, la condition physique est le principal facteur déterminant pour consulter des médecins. Dans le passé, même quand la douleur

est sévère, ils refusent souvent d'aller voir un médecin car ils s'inquiètent des dépenses énormes qui chargent sa famille. C'est dans ce scénario qu'un guérisseur traditionnel est le mieux adapté. Les patients chercheraient ces guérisseurs, suivraient leurs conseils et prendraient les médicaments qu'ils préparent. Seulement après quand tout ce qu'ils ont essayé et que rien ne fonctionne, le patient va aux médecins.

Un grand pourcentage de la population a également déclaré qu'ils visitent les médecins plus souvent maintenant que quand ils étaient encore aux Philippines. Ils sont aussi plus conciliant quand il s'agit de prendre leurs médicaments. Ceci est uniquement attribuable au fait que les patients ne payent pas ou peu les médecins et les médicaments à la pharmacie avec un coût minimal (ou pas du tout). Cependant, les défis d'aller chez les médecins est du à des problèmes de calendrier. Les patients n'ont pas l'habitude d'aller voir les médecins surtout si les patients perçoivent qu'il n'y a pas de menace immédiate sur leur santé. Ils ne voient pas l'urgence de demander une aide médicale. Certains ont aussi mentionné la crainte de communiquer avec les médecins de langue française. Ce dernier blocage est corrigé en amenant des traducteurs personnels. L'inconvénient de cette action est que, bien que le traducteur peut expliquer au patient, textuellement, si nécessaire, ce que le médecin dit, le traducteur n'a pas encore assez de connaissances pour expliquer les concepts liés à la façon dont le système de santé français fonctionne et pourrait personnellement interpréter certains concepts ce qui peut-être dangereux à la fois pour le médecin et pour le patient. Ce qui est idéal pour les institutions de santé est d'augmenter la promotion de plates-formes que les interlocuteurs non-français peuvent utiliser ou mieux encore attribuer des interprètes bien formés pour les patients non-francophones. Dans la région Catalogne en Espagne, les immigrants philippins apportent leurs propres interprètes quand ils vont dans des fonctions publiques qui parlent catalan et en espagnol uniquement. Lorsque le gouvernement a vu les avantages d'avoir des traducteurs pour les patients, ils ont placé leurs propres interprètes et traducteurs pour aider les immigrants dans la région qui ont exprimé leur satisfaction quant à cette initiative. Ceci est un exemple digne et le Sud de la

France pourrait être un bon terrain d'essai pour cette expérience. Un grand nombre d'immigrants habitent la région et ils sont un groupe assez gérable pour être un groupe contrôle.

Il est également important de souligner qu'il existe encore un nombre important de personnes qui ne font rien pour calmer leur douleur. Le danger est bien sûr que, parfois, ce sont peut-être des manifestations de quelque chose de plus complexe qu'une simple fatigue. Elle n'est pas diagnostiquée, elle peut avoir des conséquences fatales particulièrement pour les personnes qui sont génétiquement prédisposées à certains types de maladies comme le diabète et l'hypertension. C'est pourquoi, les patients doivent être encouragés à demander de l'aide médicale dès qu'ils sentent que quelque chose ne va pas dans leur corps. Pour encourager ce recours aux soins préventifs, les patients doivent se sentir à l'aise d'aller voir et de parler à leurs médecins et aux autres professionnels de la santé.

Avant de visiter un professionnel de la santé, il y a quelques considérations qui doivent être abordées. La première est le genre de médecin chez qui aller. Pour les immigrants philippins, ils choisissent les médecins qui parlent anglais. Avoir un langage commun pour se comprendre les uns les autres est un facteur important. Pour ceux qui vivent depuis longtemps sur la côte d'Azur, ils ont déjà trouvé un médecin avec lequel ils se sentent à l'aise. Ce n'est pas arrivé du jour au lendemain. Ils ont rencontré plusieurs médecins jusqu'à ce qu'ils trouvent celui qui répond à leurs attentes. (Dans le vocabulaire de la santé des Philippines, il y a un terme « Hiyang » - ce qui signifie adapté, qui se traduit par des médicaments étant adapté à une personne en particulier, ou à un médecin qui rend le patient plus à l'aise etc.). Ils ont également souvent recommandé ce médecin à leurs amis et aux membres de leur famille. Il est fréquent de rencontrer un médecin généraliste qui prend soin d'un grand nombre de patients philippins en raison de recommandations. Il est assez facile de trouver un médecin, car il y a beaucoup de gens qui parle anglais ou font l'effort de le faire. Les GP privés qui sont payés en fonction des visites des patients, doivent se préparer à être en avance sur leurs concurrents.

Si le patient philippin immigré a besoin de plus d'informations pour être éclairé sur son malaise, sa première réaction est de clarifier les informations des professionnels de la santé qu'il n'a pas comprises. Comme la plupart des immigrants philippins de la Riviera sont ici depuis un certain temps, ils parlent assez bien français pour construire une question assez simple et ils sont assez familiers avec la langue pour comprendre l'explication des médecins. Pour ceux qui n'ont pas l'occasion de clarifier les choses avec leurs médecins, ils parlent souvent à des amis proches et des membres de la famille qui ont ressenti les mêmes symptômes. Ils parlent aussi simplement et essentiellement pour partager leur histoire, solliciter des conseils sur la façon de gérer l'inconfort et écouter les expériences des autres. Il s'agit d'un phénomène culturel, car comme cela a été souligné précédemment, les décisions de gestion et de traitement des maladies sont presque souvent une affaire de famille. C'est pourquoi ce comportement est étendu à l'ensemble de la communauté. Dans un pays étranger, les philippins traitent l'autre comme la famille juste parce qu'ils viennent du même pays. Ce type d'interaction verbale et de partage a un effet psychologique sur le patient et est aussi une activité sociale. L'inconvénient est que le patient peut devenir confus de toutes les informations qu'il entend et peut être perdu s'il ne comprend pas complètement la nature de son malaise, ses causes probables et la façon de le traiter. C'est pourquoi, il est toujours plus sûr de clarifier les choses du point de vue médical et cela devrait être encouragé. Lire des articles supplémentaires de l'Internet est une bonne source d'information complémentaire. Cependant, les patients doivent également être bien guidés dans l'interprétation de l'information à partir de sources en ligne. Quelle que soit l'information, confuse ou alarmante, elle doit être discutée avec le professionnel de la santé afin de ne pas arriver à des conclusions erronées ou augmenter l'anxiété.

Les philippins, tout en vivant aux Philippines, n'ont pas développé l'habitude de consulter des médecins. Cela peut être attribué à plusieurs facteurs endémiques à une économie en développement. Celles-ci comprennent un minimum et dans les cas graves un manque de la présence de médecins, le coût élevé des honoraires des

médecins, la peur du traitement de longue date, l'anxiété de trouver quel est le problème et la possibilité de consulter des guérisseurs traditionnels qui est moins compliquée et moins coûteuse. Cependant, maintenant qu'ils sont en France, ces questions ont été abordées parce que les professionnels de la santé sont disponibles, les établissements de santé sont définis, et les médicaments sont disponibles. Ces services sont toutefois réactifs plutôt que proactifs. Le système de santé français fait tout pour prendre soin des malades, mais aussi pour enseigner aux citoyens à ne pas être malade ou pour éviter les maladies. Citant à nouveau la détérioration de la santé des immigrants, les efforts de prévention ciblant les immigrés restent insuffisants.

Pour les immigrants philippins, le manque de bonnes compétences en communication et le manque de connaissances culturelles des professionnels de santé français constituent un blocage dans leur recherche de soins médicaux précoces. Plus que la langue, ce chercheur a émis l'hypothèse que la principale cause de l'inconfort entre les professionnels français de la santé et les patients philippins, c'est l'indifférence qui entrave une meilleure performance de la santé des immigrants.

Cette indifférence est provoquée par le manque de connaissance des professionnels français de la santé concernant les subtilités du système de croyance de santé philippin ainsi que le fossé culturel et social qui n'a pas été abordée, malgré la présence dans la Côte d'Azur de philippins depuis longtemps. Peu de recherches (sinon pas du tout) a été fait concernant l'état de santé des immigrants philippins dans la région. Ceci peut être attribué au fait que la communication de la santé en temps que recherche universitaire n'est qu'à un stade précoce et que les immigrants philippins sont une population minoritaire dans la Côte d'Azur. Ce sont des facteurs contributifs importants qui limitent la compréhension mutuelle. Les immigrants philippins continuent à exister dans un vide qui les rend en quelque sorte invisible. De plus, ils représentent des migrants en situation minoritaire parce qu'ils sont moins nombreux que les immigrants en provenance du Maroc ou de la Tunisie par exemple.

Néanmoins, leur contribution à l'économie et la société française doit également être reconnu.

L'enquête et le KII ont révélé une vue très favorable des immigrants philippins concernant le système de soins de santé français. En venant de pays dont le système de santé n'est pas aussi fort qu'en France, les immigrants philippins sont très satisfaits des services fournis et disponibles pour eux. Pour cette raison, d'autres aspects de la prestation de soins de santé qui devraient être améliorés sont facilement écartés. Le manque de temps passé par les médecins lors de l'entrevue pour le diagnostic, la connaissance limitée des auxiliaires personnel de santé sur les Philippines en tant que peuple, l'absence de procédures d'exploitation normalisées sur la façon de traiter les patients de l'immigration ainsi que la connaissance limitée de la contribution des immigrés à l'économie et à la vie sociale de la Côte d'Azur sont les principales questions qui doivent être abordées pour améliorer les services de santé à la population immigrée. Les Philippins sont des gens naturellement timides et ne font généralement pas de vagues. Ils choisissent de rester calme au lieu de pointer ce qui doit être fait et d'exiger le genre de service qu'ils méritent. Ils sont également étiquetés comme étant une race dédiée au service ce qui consolide l'affirmation selon laquelle ils plaisent à tout le monde c'est pourquoi il n'est pas dans leur nature de se plaindre et de montrer ce qui est mauvais dans le système. En tant que tel, les fournisseurs et les établissements de santé ne sont pas informés de ce qui doit être fait parce qu'il n'y a aucune information de la population quant à ce que sont leurs besoins. Fournir une plate-forme pour les immigrants philippins pour diffuser leurs sentiments et leurs observations dans le confort de l'anonymat, pourrait faire la lumière sur la façon dont ce groupe d'immigrants voit les prestataires de santé, le service mis à leur disposition et le système de santé.

En ce qui concerne la gestion de la santé, ils sont satisfaits de savoir qu'ils peuvent voir le médecin à tout moment sans directe charge, aller à l'hôpital s'ils ont besoin et aller dans une pharmacie pour obtenir leurs médicaments avec peu (ou pas du tout) de frais. Cette activité se traduit-elle par une meilleure gestion de la santé ? Apparemment, la réponse est oui. Les immigrants philippins vivant dans le Sud de la

France ont dit qu'ils prennent mieux soin de leur santé qu'auparavant. Cela se traduit-il par des migrants en meilleure santé ? Une meilleure gestion de traitement oui, mais une meilleure santé pour les migrants, malheureusement, la réponse est non. Cette étude a révélé que les immigrants philippins ne sont pas exposés à des campagnes de prévention, il n'y a pas de programme qui les inciterait à revoir leur mode de vie en vertu du principe de bilan de santé. Comme tels, ils continuent à mener une vie basée sur ce qu'ils savent et sans orientation adéquate sur la façon de prévenir les maladies. Ils cherchent de l'aide médicale quand des symptômes se manifestent et dans le cas des maladies chroniques, qui est la principale cause de décès, la maladie est souvent asymptomatique avant qu'elle ne soit diagnostiquée. Ce qui reste à faire est de gérer la maladie, de retarder les complications ou de se livrer à un acte médical plus drastique. Ceci a des implications dans l'utilisation du personnel, des ressources et des conditions de vie des patients. C'est la raison pour laquelle il y a un effort synergique de groupes concernés, partout dans le monde, appelant à un renforcement des campagnes de prévention.

Le système de soins de santé français accueille ses résidents légaux et ils réussissent à avoir une qualité de vie, comme le montre l'espérance de vie élevée de ses habitants. La société est également propice au vieillissement, car des organisations et des activités en cours, financées par le gouvernement qui s'adapte au style de vie des membres vieillissants de sa population. Si cela fonctionne avec le peuple français, les philippins pourraient également demander aux institutions gouvernementales de soutenir les groupes philippins reconnus pour avoir des activités qui permettraient de mieux les intégrer à la société française. L'un des aspects d'une vie saine est d'avoir une vie sociale et il a été souligné par cette étude que les Philippins sont isolés de leurs zones de confort. Cela signifie qu'ils font partie d'un groupe mais ils se limitent aux personnes appartenant à leur propre race. Il a déjà été établi qu'il existe déjà des groupes philippins opérationnels dans le Sud de la France. Ces groupes pourraient être utilisés par le gouvernement pour servir de pont pour renforcer les liens entre les immigrants et les pays d'accueil. Ce type de construction de la relation a été fait dans d'autres pays et a eu sa part de succès.

A Barcelone par exemple, il existe une organisation philippine très forte appelée Centro philippine. Il s'agit d'une organisation basée sur l'Eglise qui offre beaucoup de services aux immigrants philippins. Ses activités comprennent l'enseignement de la langue, une aide à l'immigration, publications, activités culturelles et religieuses, et beaucoup plus. En vertu de cette organisation, d'autres organisations spécifiques aident les migrants. Ce qui rend ces organisations prospères est un fort leadership et un fort soutien du gouvernement de la Catalogne. L'Etat donne une prime aux immigrants philippins parce qu'ils reconnaissent leur contribution à l'économie et à la vie sociale et cela se traduit par un soutien de leurs activités, même par la finance logistique. Les dirigeants philippins d'autre part continuent de fournir un service continu aux migrants philippins dans la région de la Catalogne et à assurer un soutien continu du gouvernement.

Ce peut être imité dans d'autres pays où il y a une forte population immigrée. Un appui soutenu du gouvernement à la place d'une présence sporadique, devrait permettre de combler le fossé entre le gouvernement et les groupes ciblés. Barcelone a prouvé que c'était possible, tout ce qui est nécessaire en France, c'est la volonté politique de le faire et le dévouement des dirigeants philippins à faire ce qui est bon pour l'ensemble des immigrants philippins de la Riviera.

Plus précisément, cette recherche met en évidence les conclusions suivantes :

1 . Les plaintes de santé de base et leurs implications

La plainte de santé la plus commune des Philippins vivant dans la Côte d'Azur sont les maux de dos, de tête et les douleurs musculaires. Ceux-ci sont principalement attribués aux activités de travail et ne sont pas considérés comme les symptômes d'une maladie plus grave. Ainsi, les philippins se traitent de la meilleure façon qu'ils connaissent : se reposer et prendre du paracétamol ou des relaxants musculaires. Ces médicaments sont soit des Philippines soit de France ou sont

recommandés par des personnes de confiance qui ne sont pas nécessairement des professionnels médicaux. Avec la prédisposition de ce groupe de personnes à certaines maladies dues à leur origine raciale, les maux et les douleurs simples peuvent ne pas être si simple. Pour la prévention et la détection précoce, il est recommandé que les patients soient habilités à demander un avis médical. Dans le système de santé français, les immigrants ont accès à des soins médicaux et des médicaments.

2 . Féminisation de la migration philippine

Bien qu'il n'y ait pas de données statistiques concrètes, indiquant le nombre réel d'immigrants philippins situés dans la Côte d'Azur, les données disponibles révèlent que les femmes sont plus nombreuses que les hommes philippins dans la région. Ceci a des implications dans la prestation des services de soins de santé parce que les données de recherche ont révélé que les femmes immigrées ont rapporté un état de santé plus pauvre. Des recherches antérieures soulignent également que les femmes souffrent de maladies plus longues et affaiblissantes que les hommes. Cette constatation fournit des informations aux professionnels de la communication de la santé sur leur cible quand ils planifient et réalisent les campagnes de communicationnel sur les maladies auxquelles donner la priorité.

3 . L'industrie dominée par les philippins

Le travail domestique est la branche dominée par les Philippins travaillant la Côte d'Azur. Ceci peut être attribué à plusieurs facteurs tels que le manque d'enthousiasme de ces gens à essayer de travailler dans un autre domaine, le manque de volonté de mieux apprendre la langue française, ne pas avoir l'esprit d'entreprise, se contenter de responsabilités moindres et bénéficier d'un meilleur

salaires qu'en travaillant dans d'autres emplois équivalents dans le même niveau de rémunération. Ce phénomène peut également être attribué à la « familiarisation » du travail domestique. Les membres de la famille qui sont arrivés sur la Côte, recommandent les membres de leur famille des Philippines et les placent dans le travail domestique. Même si ces personnes sont titulaires d'un diplôme universitaire, le fait qu'ils ne parlent pas français et que la société de la Côte d'Azur n'est pas prête à admettre des professionnels étrangers en particulier ceux qui viennent de pays qu'ils connaissent peu, empêche les professionnels philippins d'accéder à des emplois pour lesquels ils ont un diplôme académique. Cette réalité limite les options de Philippines en ce qui concerne leur choix d'emploi et leur réponse est de travailler dans le secteur où ils sont connus pour exceller.

4 . Les croyances et les pratiques de santé traditionnelles

Un grand pourcentage des Philippines croient encore à pasma, vivent les mêmes symptômes et partagent des conseils sur la façon de l'éviter. Cependant, bien qu'ils essaient de prévenir les causes possibles de pasma, ils n'étaient pas en mesure de le faire complètement à cause de routines de travail ainsi que d'une croyance plus médicalisée qu'il y a une pilule pour presque tous les types de douleur. Il est disponible dans la pharmacie, gratuitement. Ils réalisent encore des rituels très liés à un système de croyances traditionnelles comme la prévention des changements brusques de température entre leur corps. Ils mettent des serviettes sur le dos pour éviter le dessèchement par la transpiration du dos, portent un casque de protection après avoir été exposés à un environnement de travail chauffé comme la cuisine et le repassage surtout pendant la saison d'hiver. Une partie du système de croyance environnant le pasma est l'entrée de température froide dans le corps et les femmes devraient éviter de prendre une douche pendant leur période mensuelle parce que l'eau est froide et le corps est chaud à cette période. Cela serait à l'origine des crampes d'estomac. Les femmes sont généralement plus adeptes à cette croyance de la santé alors que la plupart des hommes consultés pensent que ce sont des superstitions plutôt qu'un véritable état de santé.

5 . La compétence des philippins pour le français et la santé

Cette recherche a émis l'hypothèse que la langue française est un énorme obstacle à l'entretien de la santé des Philippins de la Riviera. Les résultats de cette étude ont révélé que, malgré le clivage linguistique, il n'est pas un obstacle majeur dans le maintien de la santé parce que les Philippins sont assez créatifs pour trouver des moyens d'obtenir des informations de santé. Pour citer quelques exemples, ils demandent aux membres de la communauté les médecins anglophones, demandent à des amis francophones de confiance de les accompagner dans leurs visites médicales et à agir en tant que traducteurs et ils font aussi leurs propres recherches concernant leurs maux. Cela montre cependant que la charge d'obtenir des informations supplémentaires est sur les épaules des immigrants.

Le système de santé français acceptent les patients quels qu'ils puissent-être ce qui entraîne la satisfaction des patients mais le budget est en plein essor dans une proportion sans précédent. Dans une économie volatile, les services gratuits offerts au public sont presque toujours les premiers à disparaître quand il est nécessaire de réduire les effectifs et les coûts de dépenses. Cependant, de nombreuses études ont prouvé que prévenir vaut mieux que guérir ainsi bien que les campagnes de prévention sont souvent plus longues et semblent ponctionner plus de ressources parce que les résultats nécessitent souvent des années, la prévention de la maladie et le diagnostic précoce permettent non seulement de vivre, mais aussi d'économiser des ressources. De ce fait, les professionnels de santé doivent renforcer leurs efforts visant à atteindre les groupes vulnérables de la population. Dans le cas de la Côte d'Azur, les immigrants philippins, même si c'est un groupe minoritaire, devraient être atteints par des campagnes de communication de santé préventives ciblées.

Pour réduire la barrière de la langue, il devrait donc être exigé que les philippins qui s'installent en France doivent avoir des cours de langue. Les

employeurs doivent également être tenus d'envoyer leurs travailleurs étrangers suivre des cours de français, même si leur emploi ne nécessite pas forcément de parler français. Une des excuses pour ne pas apprendre la langue, c'est que leur « amo » (patrons) sont anglophones et ils parlent l'anglais au travail. Cependant, en tant que travailleur dans un pays étranger, l'importance de l'apprentissage de la langue ne peut pas être assez souligné.

Les professionnels de la santé dans le Sud de la France ne semblent pas avoir suffisamment de connaissances sur la communauté qu'ils servent. Par conséquent, les besoins et les attentes des groupes d'immigrants manquent à leur service dans la mesure où l'accès à des programmes de prévention, à des informations de santé supplémentaires et à des processus administratifs sont concernés. Les immigrants philippins créent leur propre façon d'aborder ces questions de blocage. Cependant, leur propre façon de faire prend du temps et a tendance à être plus confuse.

Un outil de diagnostic culturellement composé de la langue qui est culturellement neutre aidera sûrement. Le ton de la voix, le mouvement corporel et le contact visuel doivent également être renforcés pour les fournisseurs de soins de santé pour gagner la confiance de leurs patients. Quand un professionnel de la santé montre un comportement agressif, le risque est que les patients partiront. Même s'ils ont la capacité d'expliquer leur état dans un mauvais français, l'intimidation et la frustration les bloquent. Des ajustements linguistiques doivent être effectués à la fois par le patient de l'immigration et par l'ensemble du système de soins de santé français. Après tout, ce sont aussi les recommandations de plusieurs organismes de santé qui ont étudié l'ensemble du système de santé en Europe.

6 . Le système de santé français et son rôle dans la santé des immigrants

Plusieurs études ont conclu que les pays ayant le meilleur système de soins de santé dans le monde entier sont le Canada et la France. En termes de

l'assimilation des immigrants, le scénario change : le Canada a été applaudi pour ses bonnes politiques dans l'assimilation des immigrants, tandis que la France a été réduit à un pays dont les politiques concernant les immigrés ne devait pas être imité. Malgré cela, le Canada et la France bénéficient de réponses positives des patients quand il s'agit de prestation des soins de santé, et l'immigrant fait partie de la population de patients. En France, au cours des 30 dernières années, la santé des patients s'est détériorée. En 2000, en France, les soins de santé ont été salués comme les meilleurs dans le monde. Les preuves suggèrent que la satisfaction des patients peut être attribuée aux soins de santé accessibles et aux avantages d'une couverture de soins de santé universel. Quand il s'agit de services des professionnels de santé, c'est une autre histoire. Les professionnels de santé français ne sont pas en mesure de communiquer avec leurs patients, parce qu'ils n'ont pas suffisamment d'informations sur leurs patients. Si c'est ce que les études empiriques ont mis en évidence, et ces études se concentrent sur les immigrants issus des populations les plus importantes - il est impossible d'imaginer les expériences de groupes minoritaires immigrés comme les Philippins. Les marocains, les algériens, les sud-africains sont les immigrants majoritaires en France. Lorsque les études sur les immigrés sont définies, elles s'intéressent essentiellement à ce groupe de personnes - immigrés de la majorité. L'avantage de ces immigrants est qu'ils parlent la langue. S'ils prétendent qu'ils ne sont pas pleinement intégrés dans la société française, ils ne sont pas limités dans leurs activités sociales, ils auto-déclarent que leur santé se détériore. Les expériences de santé des immigrants philippins comme un groupe minoritaire est problématique. Il n'y a pas eu d'études de recherche sur l'état de santé des migrants en situation minoritaire dans la Côte d'Azur et son effet est l'invisibilité de leur expérience.

Le système de soins de santé français a un taux de satisfaction élevés en raison de la dynamique entre les comportements de recherche préventive des patients et la mentalité de soin de l'État. Cela signifie que même si les patients veulent s'engager dans des activités de prévention des maladies, l'accès à l'information et de prévention des médicaments préventifs sont limitées. Par

conséquent, soit ils font de l'automédication, soit ils cherchent de l'information sur une source médicale informelle (par exemple des expériences similaires de personnes sur Internet, auprès des amis ou des membres de la famille). Cette attitude conduit souvent à une affection médicale plus grave plus tard et la seule option pour les Etats est de répondre à un état de santé plus complexe du patient. Ce sont souvent les groupes vulnérables, en particulier les immigrants qui sont plus enclins à ce genre de situations. Cela peut être attribué à la barrière de la langue, aux activités sociales limitées, les immigrants tendance à être fermé et participent seulement aux activités de leur cercle social. Les Etats ont tendance à ne pas donner la priorité à des programmes d'intégration sociale et le manque d'informations promotionnelles qui éduquent les habitants à la vie sociale, culturelle et à la contribution économique des immigrants. Cette dernière éclairera les citoyens à la présence des immigrants dans leur communauté tout en offrant aux immigrants un sentiment de fierté, en sachant que leur contribution à la société française est reconnue.

Dans l'ensemble, le système de soins de santé français répond efficacement à l'approche curative des immigrants. Cela signifie que la couverture de santé universelle de la France est en train de faire ce qu'elle est supposée faire. L'inconvénient de ce système est cependant le coût de maintenance élevé, épaulé par le gouvernement et la détérioration continue de la santé des immigrants. La baisse est due à plusieurs facteurs, dont le diagnostic tardif, sous diagnostic et la poursuite d'un mode de vie propice au développement de maladies.

7 . Les obstacles à la réussite de l'assimilation de la santé des immigrants

Il ne peut pas être assez souligné que le principal obstacle à l'assimilation de la santé des immigrants est largement la maîtrise de la langue. À l'autre extrémité, l'absence de système de surveillance de la santé normalisé, l'absence de procédure de diagnostic culturel et le manque de formation des professionnels de la santé sur la façon de traiter une population culturellement diversifiée, se posent comme un

obstacle majeur à l'assimilation de la santé des immigrants. Citant spécifiquement les expériences des immigrants philippins dans le sud de la France, il convient de rappeler qu'il leur est nécessaire d'apprendre le français, même s'ils travaillent dans un environnement anglophone. Comme ils sont en France, ils sont obligés d'apprendre la langue afin de pouvoir être pleinement intégrés au mode de vie français.

Les professionnels de santé doivent également mettre à jour leurs connaissances sur les compositions raciales de la communauté qu'ils servent et de réévaluer leur prise sur leur travail en tant que fonctionnaires. L'attitude des prestataires de santé devrait viser à servir le public. Les immigrants philippins, d'autre part, doivent aussi comprendre la culture française se rapportant à leurs aptitudes en relations humaines. Les français ont la réputation d'être distant au point d'être grossier. Ce trait n'est pas réalisé exclusivement pour les immigrants, mais il est une partie endémique de leur culture. Ils ne sont pas tournés vers le service et cela contredit avec la culture de la servitude des Philippins. Cependant, comme les Philippins sont des gens qui plaisent, ils ne se plaignent pas et n'incitent pas le débat. Ils prennent ce qu'ils veulent et partent. Pour les Français, ils effectuent leur travail avec fierté et puisqu'ils n'entendent pas de plainte ou de corrections de la communauté qu'ils servent, ils ont l'impression que tout va bien.

8 . Les combinaisons de traitements modifiés

Les philippins mélangent souvent les traitements traditionnels avec la médecine occidentale. Maintenant qu'ils sont en France, la combinaison de traitement est encore pratiquée, mais sous la forme d'un médecin et d'un autre médecin. Un patient qui demande l'avis des médecins va également voir un physiothérapeutes ou un ostéopathe sur les recommandations des médecins et elles sont souvent conformes. Cela garantit que les patients dans l'ensemble prennent soin de leur bien-être, et s'occupent de leur santé. Les patients ont plus confiance et pensent qu'ils sont au sommet de leur santé parce que tous les domaines sont

couverts. Tout est de leur côté : des médecins, des spécialistes, des ostéopathes et des physiothérapeutes ainsi que des médicaments gratuits.

Ayant toutes ces disponibilités, les philippins ont une plus large gamme d'options et leurs choix se penchent plus vers la médecine occidentale que traditionnelle. Cela montre que lorsque les traitements médicaux sont disponibles, les immigrants philippins gravitent vers ces traitements avant toute autre chose. Bien que certains immigrants philippins optent encore pour les guérisseurs traditionnels, ils sont moins nombreux et souvent, ils ont recours uniquement à elle comme un traitement complémentaire au traitement médical au lieu de l'inverse, ce qui était la façon dont il avait l'habitude de se soigner quand ils étaient encore dans le Philippines.

Partie 5: Conclusions générales

A. Aborder les questions de santé en France

En Décembre 2009, ce chercheur a eu l'occasion d'interviewer M. Fabrice MOREAU, Chargé de Mission de Communication Nutrition au Département de la communication de la Direction de la Communication et des Outils Pédagogiques {En charge de la communication, au ministère de la Santé de la France} (Annexe 6). Il a indiqué que des campagnes de santé du gouvernement sont basées sur des études épidémiologiques. Comme les pratiques de santé sont fondées sur les croyances de santé, ils ont souvent demandé à la population ce qui peut les faire changer d'avis et éventuellement leurs habitudes malsaines ? Il cite l'exemple de personnes qui ne mangent pas assez de fruits et de légumes. Ils enquêtent auprès des personnes à faible revenu pour comprendre pourquoi ils ne mangent pas de fruits et de légumes et la réponse est qu'ils trouvent que c'est cher. Pour résoudre ce problème, son département va alors créer une campagne de communication qui dit que les fruits et les légumes surgelés et en conserve est la réponse aux produits frais mais coûteux.

Ils communiqueront ensuite ces résultats au public cible en utilisant à la fois les outils en ligne et des plateformes de publicité en ligne. Ils travaillent également en étroite collaboration avec d'autres institutions basées sur l'état ou des organismes privés afin de maximiser la diffusion de l'information.

Ceci est juste un exemple de la façon dont un établissement de santé de l'Etat fonctionne dans le cadre du système de soins de santé français. Pas différent de la façon dont d'autres pays font, le contenu des campagnes de communication sur la santé en France est fortement basé sur des études épidémiologiques, en étroite coopération avec les parties prenantes. Les résultats de ces consultations ne reflètent pas les expériences des migrants en situation minoritaire, parce que jusqu'à aujourd'hui aucune des campagnes de santé n'était ciblée pour eux. Sur le même principe, les designers de communication de santé français vont extraire les informations de base et développer une campagne de santé en fonction de leur système de croyance, d'alimentation, d'orientation culturelle et leur sensibilité religieuse, permettrait d'entrer dans le cœur des immigrants ce qui ouvrirait la possibilité pour eux de changer leurs comportements malsains et inspirer le changement. Le résultat positif de cette campagne débordera vers d'autres comportements liés à la promotion d'un mode de vie plus sain.

B. Les défis du système français de soins de santé qui affecte les immigrants

Dans toute l'Europe, les immigrants sont généralement jeunes, les plus pauvres, les plus susceptibles de devenir malades de maladies transmissibles et ont moins accès aux services de santé (Rapport européen de la santé 2012). De plus, les choix de travail des immigrants sont limités et, par conséquent, ils sont plus exposés à des emplois avec moins de preneurs et ils s'installent souvent pour un salaire inférieur. Cette condition crée un effet boule de neige qui comprend des choix limités dans les maisons, la nourriture, l'éducation et même les récréations.

Les défis actuels de système de soins de santé en France auront un impact direct sur les patients surtout ceux issus de populations immigrées. Les médecins ne sont pas heureux avec la taxe professionnelle standard actuellement fixée par le gouvernement. En tant que tel, certains élèvent déjà leur tarif, sans l'autorisation des organismes de régulation. Les médecins sont encore en grève sur les heures de soins.

Si les médecins sont abondants en France à l'heure actuelle, ce ne serait pas le cas dans l'avenir. Les facultés de médecine françaises ont fixé un quota sur le nombre d'étudiants en médecine autorisés à s'inscrire. Il s'agit d'une future préoccupation majeure étant donné que la population en France est vieillissante. Si l'un des points forts du système de santé français aujourd'hui est l'accessibilité des médecins. Les patients peuvent en effet leur rendre visite autant qu'ils veulent. A l'avenir, les patients pourraient avoir besoin d'attendre quelques jours avant de pouvoir parler à l'un d'eux. Imaginer ce scénario et mettre les immigrants dans cette image crée un effet alarmant sur la santé des immigrants.

Il a également eu un mouvement de renforcer la participation des patients dans le système de soins de santé de la France pour encourager leur réactivité et leur responsabilité. Cette idéologie est un débat permanent et le système ne semble pas être prêt à entendre la voix des patients. Pour un pays qui a été fondé sur la liberté, l'égalité et la fraternité, il est difficile de croire que la voix des patients est coupée dans ce système de santé.

Les variations l'ensemble du système de soins de santé français ont également un impact sur la prestation de programmes et de financement de projets. Depuis la réforme de 1996 donnant le pouvoir de l'État (par le régime national d'assurance). Du niveau national au niveau régional, il a eu beaucoup de discussions et de confusion autour de cette zone. Ce système mixte est accusé d'avoir causé des décès prématurés et évitables.

En termes de financement, ceci est une préoccupation majeure pour l'avenir en raison de déficit budgétaire et de l'augmentation des coûts de la médecine et des procédures médicales. Avec les nouvelles technologies qui sont créés tous les jours, les frais d'entretien de la santé couplés à la demande croissante et la diversification de la population sont en pleine ascension. Avec chaque groupe de préoccupation se rallie l'importance de prévenir certaines maladies, le gouvernement français aura du mal à déterminer les projets à financer et établir des priorités. En plus de tout cela, le budget devrait également être réservé pour les cas d'urgence comme en cas de flambée épidémique, ainsi que la recherche épidémiologique régulière.

Tous ces facteurs influencent l'état de santé des immigrants en France. Malheureusement, l'avenir s'annonce sombre pour le moment en raison des changements rapides et à la volatilité de l'économie qui change certainement les règles du jeu. Le système doit s'adapter au changement et dans le procédé, certaines zones sont sacrifiées.

CHAPITRE V

Recommandations

Sur la base des résultats de cette recherche, voici les recommandations qui visent à aider les fournisseurs de soins de santé et les patients à combler le fossé qui touche la prestation des soins et de la gestion de la santé.

1 . Création et mise en œuvre d'un guide de communication adapté à la culture pour les professionnels médicaux et les fournisseurs de soins

Voici quelques lignes directrices dignes de considération dans la planification de ce guide :

A. Chaleureuses salutations de la part du prestataire de rendre le patient à l'aise.

Ils doivent garder à l'esprit qu'un malade immigrant doit surmonter beaucoup d'anxiété avant de finalement décider de consulter un médecin et la dernière chose dont il a besoin, est un comportement méprisant. Il va sûrement les arrêter et essayer de raccourcir la consultation. Pour le personnel médical auxiliaire en particulier ceux qui travaillent comme « première ligne », une once de patience supplémentaire est nécessaire lorsqu'il s'agit de patients qui ne sont pas francophones. Pour la première fois, les demandeurs d'information de santé devraient être prêts à passer autant de temps à répondre à leurs questions. Accélérer la session avec eux ne fera qu'empirer les choses, car s'ils ne comprennent pas l'information qui leur est donnée, ils reviendront de toute façon ou pire, ils vont exprimer leur agitation et leur frustration d'une manière qui irrite aussi les autres aussi. Bien sûr, il y a les choses qui devraient être évitées. Après tout, la raison principale d'un patient qui se rend dans une clinique de santé ou un bureau de santé est de se sentir mieux et pas l'inverse. Une poignée de main ferme ou un sourire accueillant tout en regardant dans les yeux feraient que le patient philippin se sentirait accepté et important.

B. Offrir au patient plus de temps pour parler de ses problèmes de santé et des indices verbaux et non verbaux encourageants se manifestent

C'est un bon moyen de mieux comprendre les problèmes de santé du patient et en même temps cela donne au fournisseur de santé un aperçu de la psychologie du patient qui peut conduire à un meilleur diagnostic et le pronostic. Connaissant les antécédents personnels, culturels et religieux du patient - en particulier les patients immigrants - devraient être la première étape avant d'aller plus loin dans le processus de gestion de la santé.

C. Dire directement au patient que le médecin / personnel médical est ouvert pour des questions et des précisions

Cela encouragera le patient à clarifier les préoccupations pas très claires. Il a été indiqué plus tôt que les philippins, par nature, sont des gens très timides et en tant que tel, ils posent rarement des questions en particulier dans ce scénario où ils pourraient avoir du mal à trouver le mot juste pour exprimer leurs pensées. En affirmant verbalement qu'ils sont libres de poser des questions, ils sont encouragés à exprimer leurs pensées, même si ils savent qu'il y a la barrière de la langue. En leur disant que les médecins / personnel va essayer de les comprendre, même si leur français n'est pas bon pourrait encourager les patients à essayer d'être compris et d'utiliser d'autres outils pour communiquer comme des outils non-verbaux. Tout ce qu'ils pourraient avoir besoin d'entendre est que le professionnel de la santé a la patience et le temps d'écouter leurs questions.

D. Poser des questions de suivi après avoir expliqué un concept de santé pour s'assurer que le patient a compris ce que le médecin / personnel médical vient de dire.

Inviter les patients à répéter ce que le professionnel de la santé vient de dire, est une façon de mesurer la façon dont ils ont compris ce que l'on vient de leur expliquer. Faire cela permet de s'assurer que le patient sait quoi faire.

E. Un interprète / traducteur devrait être disponible.

Si le patient est à l'aise avec l'idée d'avoir un interprète ou d'un traducteur, il devrait lui être fourni. C'est son droit d'accès à l'information et cette information n'est pas compréhensible pour lui, il est de la responsabilité de l'Etat de lui fournir quelqu'un qui peut traduire pour lui. Ne pas leur fournir d'interprète est une forme de discrimination. Bien que pour le moment, ce sont les patients qui apportent leur propre interprète / traducteur, c'est l'État qui a la responsabilité de fournir ce service. Ces interprètes et traducteurs devraient également être formés par l'Etat pour s'assurer qu'ils connaissent les lignes directrices de la santé du gouvernement concernant la population immigrée ainsi que la sensibilité à la culture de ces peuples.

F. Conseiller le patient à préparer ses questions lors de la prochaine visite et signaler tout changement

Les patients peuvent être de meilleurs acteurs de leur propre santé si ils sont encouragés à suivre leur propre santé et à signaler au médecin toute modification qu'ils estiment importante ou qu'ils ont pu observer. Préparer une liste de questions et tenir un registre des problèmes de santé va rendre les choses plus faciles, plus claires et plus rapides à la fois pour le patient et le médecin lors de la prochaine visite. Avoir un dossier permettrait également aux patients de s'y référer quand ils le veulent. Ce pourrait être une base de données en ligne à laquelle ils pourraient avoir accès ou un livret (comme des livres de santé de bébé qui maintient les voies de toutes leurs vaccinations et les médecins rencontrés) qui les rendra plus en contrôle de leur propre santé.

Informez les patients qu'il existerait une application en ligne qu'ils peuvent utiliser et qui traduit automatiquement d'une langue à l'autre. Un patient philippin peut écrire en tagalog et la demande sera automatiquement traduite en français. Cette application est facilement téléchargeable sur les téléphones intelligents aussi. Cette technique comblerait le fossé de la langue d'une manière n'était pas possible avant. La première façon de le faire est de diffuser l'information que la traduction en ligne est possible.

2 . Diffusion de matériel de santé pour les immigrants entrant en France

Avoir des idées concrètes sur la façon d'accéder à l'information de santé va sûrement éviter aux immigrants de la confusion et de l'anxiété. Ces informations de santé peuvent être les suivantes, mais sans s'y limiter:

- a . informations générales sur les soins de santé en France
- b . emplacement des bureaux de santé dans la région où l'immigrant a l'intention de rester
- c . liste des médecins qui parle une autre langue que le français
- d . lignes directrices et procédures sur la façon de s'inscrire à la couverture maladie universelle
- e . droits et obligations des patients
- f . l'accès aux médicaments
- g . formulaire à remplir prouvant qu'ils ont lu et compris comment le système de soins de santé français fonctionne avant de se voir attribuer le Carte Vitale.

3 . Encourager et soutenir les programmes de recherche sur les immigrants

La principale critique du système de santé français est son manque de système normalisé de collecte de données sur les immigrants. C'est un point aveugle qui doit être résolu si le gouvernement français est sérieux dans la lutte contre les problèmes liés à la santé des immigrants. L'incident de 2005 est un appel au réveil pour le gouvernement français sur les sentiments des immigrés en France et ce genre de manifestation doit à tout prix être évitée car elle nourrit le mécontentement des immigrants dans le pays. Cette certitude ne reflète pas une bonne image de la France sur la façon dont ce pays gère sa population immigrante.

Encourager et soutenir les bourses d'immigrant est une autre étape dans la réduction de la fracture entre l'État, les natifs et les immigrés en France. Dans le domaine de la santé, comprendre les croyances religieuses, culturelles et les préférences personnelles des immigrants fournira au système de santé de la France de riches informations sur la façon d'encourager la population immigrante de mener une vie plus saine et de souscrire aux programmes fixés par le gouvernement. Il peut

également fournir des données de base qui permettront de mieux définir les lignes directrices pour d'autres programmes de santé ciblant certains groupes d'immigrants.

4 . Des programmes pilotes pour l'utilisation institutionnalisée de traducteurs / interprètes

Comme indiqué par d'autres pays, un traducteur a sa part de réussite dans la médiation entre les médecins et les patients. Il est important de réaliser que les soins de santé sont un droit humain fondamental. En tant que tel, les patients ont droit à des soins de santé de qualité. Le manque de traducteurs disponibles pour les non-francophones peut être considéré comme une forme de discrimination. Un pays qui ouvre ses portes aux immigrants est obligé de fixer des règles pour répondre aux besoins de ces immigrants. Dans les situations où les immigrants ne parlent pas la langue du pays d'accueil, il est de la responsabilité des Etats à fournir des programmes éducatifs qui enseignent la maîtrise de la langue pour les nouveaux arrivants. Dans la période de transition, ces immigrants doivent être accompagnés par des gens qui parlent à leur place en particulier dans les bureaux du gouvernement. Pour éviter que des personnes sans scrupules profitent de cette fenêtre de faiblesse, les traducteurs et les interprètes doivent être formés et les autorités de l'Etat doivent s'assurer que l'information qui atteindrait les immigrants est la bonne.

5 . Renforcer les exigences de maîtrise de la langue pour les immigrants

Il y a beaucoup d'organisations en France qui aident les immigrants dans leur intégration. Le défi est que les immigrants ont un accès limité (ou ne connaissent pas les organisations) où obtenir la liste de cette organisation et comment entrer en contact avec eux. Comme les immigrants sont arrivés dans la Riviera, ils s'appuient sur d'autres personnes pour des conseils concernant presque tout. Il serait plus organisé si les immigrants étaient informés par un organisme voué à les orienter sur le B.A. BA de la vie en France qui comprend : à quoi s'attendre de la région, la

culture, la nourriture, le soutien de l'Etat, ainsi que les attentes de l'état envers les immigrés. Il sera extrêmement utile pour les immigrants d'avoir des conseils pendant la première phase de leur séjour.

La barrière de la langue est abordée dans le Sud de la France il y a plusieurs organisations dont le but ou le mandat est de donner des cours de langue pour un coût minime. Certaines de ces organisations sont financées par l'État, une certaine école de langue légitime comme l'Alliance Française et certains sont exploités par des groupes de citoyens privés. Il est évident que l'infrastructure est là, mais l'information de leur existence n'est pas bien diffusée pour les immigrants en particulier les nouveaux.

Puisque la maîtrise de la langue est l'étape principale vers l'intégration, les organisations de la langue doivent être introduites pour les immigrants aussi facilement que possible, pour qu'ils sachent les horaires, les lieux et les institutions qui répondent à leurs besoins. Dans le même temps, ce chercheur suggère fortement que les employeurs d'immigrants fournissent des formations en français à leurs employés immigrants et organisent la formation linguistique de guides d'immigrants.

Il a été répété à plusieurs reprises que la maîtrise de la langue est une condition importante pour l'assimilation et l'intégration des immigrants. Pour être en mesure de mieux aider les immigrants à apprendre la langue, l'état doit indiquer aux immigrants la façon de le faire et les organisations qui peuvent les aider. En leur disant qu'ils ont besoin d'apprendre le français, mais ne pas leur donner les étapes sur la façon de le faire est un autre exercice futile.

6 . Renforcer les liens avec les groupes d'immigrés organisés

Tendre la main aux immigrants par le biais de leurs associations ou de groupes organisés peut être un moyen efficace de communiquer avec la communauté. Avoir une forte présence dans les activités des immigrants peut ouvrir

des opportunités pour d'autres collaborations tout en faisant que les immigrants sentent que l'État est sérieux dans son effort pour prendre soin d'eux et d'être à l'écoute de leurs besoins. En étant impliqué activement dans les activités de l'immigration, les institutions françaises (ou les personnes) auront une expérience de première main sur les subtilités et les particularités de ces personnes qui doivent être hautement considéré dans les campagnes qui leur sont destinées.

Il y a plusieurs organisations philippines organisées dans le Sud de la France et ils font des réunions régulières et des activités qui célèbrent les événements importants comme un immigrant. Ils ont le soutien des membres forts et certaines de leurs manifestations ont réuni des représentants du Consulat des Philippines à Monaco (il y avait autrefois un bureau consulaire à Nice, mais il a été dissout en 2010 et n'a pas été recréées à ce jour). Mais ce chercheur n'a jamais entendu dire qu'un homme politique français n'a jamais honoré leur événement. Cela en dit long sur la relation entre le gouvernement local de la Côte d'Azur et les groupes d'immigrants philippins. Peut-être qu'il est temps d'aller vers l'autre et de combler l'écart. Après tout, les Philippines font déjà partie de la société française locale de part leur présence (et non en tant que participant dans les affaires de la société), même si elles sont considérées comme un groupe d'immigrants minoritaire.

Selected Bibliography

Books

- Abel-Smith, B. et al (1995). *Chopices in Health Policy: An Agenda for the European Union*. Luxembourg: office for Official Publications of the European Communities/ Aldershot: Dartmouth Publishing Co.
- Adler, R. B. and Rodman, G. (1991). *Understanding Human Communication*. Holt, Rinehart, and Winston. Chicago
- Abraham, L. (1993). *Mama Might be Better Off Dead. The Failure of Health Care in Urban America*. Chicago. University of Chicago Press
- Agoncillo, T., & Guerrero, M. (1987). *History of the Filipino people*. Quezon City, Philippines: Garcia Publishing Company.
- Alba R, Nee V. 2003. *Remaking the American Mainstream: Assimilation and Contemporary Immigration*. Cambridge, MA: Harvard Univ. Press
- Ariola, C. (1993). *The body book*. Quezon City. GCF Books
- Babbie, E. (1998). *The Practice of Social Research*. 8th Ed., Wadsworth MA:Wadsworth
- Backer, T. & Rogers, E. (1993). *Organizational Aspects of Health Communication Campaigns: What Works?* London SAGE Publication.
- Bandura, A. (1969). *Principles of Behavior Modification*. New York: Holt, Rinehart, & Winston.
- Barker, L. L. and Barker, D. L. (1993). *Communication*. Prentice Hall.
- Battistella, G. & Paganoni, A. (1992) (Eds). *Philippine Labor Migration: Impact and Policy*. Scalabrini Migration Center, Philippines.
- Bautista, V. et. al. (2002). *National and Local Government Roles in Public Health Under Devolution*. UP Press.
- Begley, S. (1997). *Train Your Mind, Change Your Brain*. New York. Ballantine Books
- Beltran, R. & Rodriguez G. (1996). *Filipino woman migrant workers: at the crossroads and beyond Beijing*. Giraffe Books, Philippines
- Berger P, Luckmann T. (1967). *The Social Construction of Reality*. Garden City: Anchor Books

- Bersales, L. (2001). *Philippine health information system assessment using the health metrics network procedure*.
- Biddle, K., Locke, K. (2007). *Composing Qualitative Research: 2nd Edition*. SAGE
- Bauböck, R., ed. (2006). *Migration and Citizenship: Legal Status, Rights and Political Participation*. Amsterdam, the Netherlands: Amsterdam University Press, IMISCOE Reports
- Brubaker, R. (1992). *Citizenship and Nationhood in France and Germany*. Cambridge, MA. Harvard University Press
- Burgoon, M., Hunsaker, F. G., and Dawson, E. J. (1994). *Human Communication*. Thousand Oaks, CA; Sage
- Carey, J. W. (1989). *Communication as culture: Essays on media and society*. Winchester, MA: Unwin Hyman.
- Clifford, J. (1998). *The Predicament of Culture: Twentieth century ethnography, literature, and art*. Cambridge, MA: Harvard University Press.
- Corcoran, N (ed.) (2007). *Communicating Health: Strategies for Health Promotion*. London. SAGE Publication.
- Cruikshank, J.K. & Beevers, D.G. (1989). *Ethnic Factors in Health and Diseases*. Guildford. Wright
- Curran, J., Morley, D., & Walkerdine, V. (1996). *Cultural Studies and Communications*. NY: St. Martin Press.
- Daniel, L. (Editor, 2011), *The Far East and Australasia 2012. Europa Regional Surveys of the word*. 43rd Edition. Routledge London and New York
- Devito, J. A. (1994) *Human Communication: The Basic Course*. New York; HarperCollins.
- Elder J.P. (2001). *Behavior Change and Public Health in the Developing World*. Sage London.
- Epstein, S. (2007). *Inclusion: The Politics of Difference in Medical Research*. Chicago. University of Chicago Press.
- Evans, D. (2004). **Placebo**. London. Haper Collins
- Faas, D. (2010). *Negotiating Political Identities. Multiethnic Schools and Youths in Europe*. Farnham. Ashgate.

- Feldman, J. (1966). *The Dissemination of Health Information*. Chicago: Aldine.
- Ford, L., Yep, G. (2003) *Working along the Margins: Developing Community Based Strategies for Communicating about Health with Marginalized Groups*. Thompson
- Fremont A, Lurie N: *The Role of Racial and Ethnic Data Collection in Eliminating Disparities in Health Care*. In *Eliminating Disparities: Measurement and Data Needs*. Edited by: Ver Ploeg M, Perrin E. Washington, DC: National Academies Press; 2004:202-29, National Research Council Report.
- Gerrish, K. Husband, C. & Mackenzie, J. (1996). *Nursing for Multi-ethnic Society*. Buckingham, Open University Press
- Glaser B.G., (1978). *Theoretical Sensitivity*. Mill Valley, CA. Sociology Press
- Glaser B.G., (1992) *Basics of Grounded Theory Analysis: Emergence vs Forcing*. Mill Valley CA. Sociology Press
- Geist-Martin, P., Ray, E. & Shaft, B. (2003). *Communicating health: Personal, cultural and political complexities*. Canada: Thompson-Wadsworth.
- Gerstle G, Mollenkopf JH. (2001). *E Pluribus Unum: Contemporary and Historical Perspectives on Immigrant Political Incorporation*. New York: Russell Sage Found.
- Gilroy, P. (2000). *Against Race: Imagining Political Culture Beyond the Color Line*. Cambridge, MA. Harvard University Press
- Griffin, E. (2009). *A First Look at Communication Theory* (7th ed.). New York, NY: McGraw-Hill.
- Griffin, E. (2008). *Speech Codes Theory. Introduction to Communication II*. New York: McGraw-Hill Primis.
- Guide to Asian Studies in Europe. International Institute for Asian Studies. 1998. Curzon Press. The Netherlands.
- Hall, P.A and Lamont, M. eds. (2009). *Successful Societies: How Institutions and Culture Affect health*. Cambridge UK: Cambridge University Press
- Hall, S. (1997). *The Local and the Global: Globalization and Ethnicity*. In Anthony D. King (ed.), *Culture, Globalization and the World-System: Contemporary Conditions for the Representation of Identity*. Minneapolis: University of Minnesota Press.
- Hall, S. (1992a). *New Ethnicities*. In J. Donald and A. Rattansi (eds). *Race Culture and Difference*. London. Sage.

- Harrington, A. (Forthcoming). *God and Health: What more is there to Say?* In *Spiritual Information 100 Perspectives on Science and Religion*, Vol. 2, ed. C. L. Harper Jr. Philadelphia: Templeton Foundation Press.
- Harper, D. *Chicago Manual of Style* (2010). 16th Edition. University of Chicago Press
- Heibert, D. 1999. *Local Geographies of Labor Market segmentation*. Montreal, Toronto, and Vancouver. *Economic Geography*
- Hopkins, A. & Bahl, V. (1993). *Access to Health Care for People from Black and Ethnic Minorities*. London. Royal College of Physicians
- Jackson, L. & Duffy, B. (eds.) (1998). *Health Communication: A guide to the Developments and Directions*. Greenwood Publishing Group, Inc.
- Jocano, F.L., (1973). *Folk Medicine in a Philippine Municipality. An analysis of the system of folk healing in Bay, Laguna and its implications for the introduction of modern medicine*. The National Museum. Manila
- Jocano, F. L., (2001). *Filipino Worldview: Ethnography of Local Knowledge*. Punlad Research House Inc. Manila
- Johnson, M.R.D. & Verma, C. (1998). *Its Our Health Too: Asian men's Perspective*. Research Paper 26. Coventry: Center for Research and Ethnic Relations. University of Warwick.
- Kelly, P. 2012. *Migration, Transnationalism and the Space of Class Identity*. *Philippine Studies* 1:154-185
- Kaba, M., (1996). *Utilization of Plant Medicine for the Treatment of Health Problems: The case of the Oromo of Chora District, Illubador Region Western Utopia*. *Medical Journal of De La Salle University*
- Kanseras, P. & Hopkins, V. (1989). *British Asians' Health Care in the Community*. Cardiff.
- Kibria N. 2003. *Becoming Asian American: Second Generation Chinese and Korean American Identities*. Baltimore, MD: Johns Hopkins Univ. Press
- Kosa, J., Antonovsky, A., & Zola, I.K. (1969). *Poverty and Health: A sociological analysis*. Cambridge, Harvard University Press.
- Kreps, G.L. (1988). *The Pervasive Role of Information in Health Care: Implications for Health Communication Policy*. In J. Anderson (Ed.), *Communication Yearbook* 11, (238-276). Newbury Park, CA, Sage.

- Kreps, G.L. (1990). *Communication and Health Education*. In E.B. Ray & L. Donohew (Eds.), *Communication and health: Systems and Applications*, 187-203. Hillsdale, NJ: Lawrence Erlbaum.
- Kreps, G. & Kunimoto, E. (1994). *Effective Communication in Multi-cultural Healthcare Settings*. London. Sage Publication
- Kreps, G.L. & O'Hair, H.D. (1995). *Communication and Health Outcomes*. Cresskill, NJ: Hampton Press.
- Kress, Gunther. (1985). *Linguistic Processes in Sociocultural Practice*. Geelong: Deakin University Press.
- Lancry, P.-J. & Sandier, S. (1999). *Twenty Years of Cures for the French Health Care System. Health care and cost containment in the European Union*. E. Mossialos and J. Le Grand. Aldershot, Ashgate.
- Landy, D., (1977). *Medical System in Transcultural Perspective*. In *Culture, Disease and Healing*. Ed. David Landy, New York. Hackmillan Publishing
- Littlejohn, S. (2002, 2001). *Theories of Human Communication*. USA: Wadsworth.
- Littlejohn, S. & Foss, K. (2005). *Theories of Human Communication*, (8th ed). Canada: Thompson-Wadsworth.
- Levitt P. (2001). *The Transnational Villagers*. Berkeley: Univ. Calif. Press
- Macdonald, C. 1977. *Une Societe Simple. Parente et Residence chez les Palawan, Philippines*. Institut d'ethologie. Paris
- Marcus, G.E. & Michael, M.J. 1986. *Anthropology as cultural Critique*. Chicago. University of Chicago Press
- Marmot, M. (2004). *The Status Syndrome*. New York: Henry Holt &Co.
- Martinez, E. (2006). *Stop RB: A Comprehensive Analysis of Tuberculosis Communication Campaign*. World Vision ReachOut Foundation and the Department of Health, University of the Philippines.
- McBride, M., Morioka-Douglas, N., & Yeo, G. (1996). *Asian/Pacific Islander American elders* (2nd ed..) SGEN Working Paper # 3, Stanford, CA: Stanford Geriatric Education Center.
- McGuire, W.J. (1984). *Public Communication as a Strategy for Inducing Health Promoting Behavioral Change*. Preventive Medicine, 13, 299-319,

- McGuire, W.J., (1969). *Attitude and attitude change*. In G. Lindzey & E. Aronson (Eds.), *Handbook of Social Psychology* (2nd. ed., pp. 136-314). Reading, MA: Addison-Wesley.
- Mendez, P. & Jocano, L. (1991). *A Philosophy of Education for Filipinos*. Kayumanggi Press, Manila
- Miller, K. (2005). *Communication Theories*. New York: McGraw Hill
- Mishler, E. (1981). *Critical Perspective of the Biomedical Model*. In Brown, P. (Ed). *Perspective in Medical Sociology*. Belmont. Wadsworth. pp 153-166
- Modood, T. (2007). *Multiculturalism: A Civic Idea*. Cambridge. Polity Press
- Nardin, D., (1989). *France and the Philippines: From the Beginning to the End of Spanish Regime*. National Historical Institute. Manila
- Palaganas E., Bagamaspad, A., Cardenas, M., Josef, J., Tolentino, L.(2001). *Mainstreaming Health Knowledge and Practices*. University of the Philippines, Press. Center for Investigative and Development Studies. Quezon City
- Panganiban, J., (1972). *Diksyunardo Tesauro Filipino-English*. Manlapaz Publishing Co. Quezon City, Philippines
- Parekh, B. (2000). *Rethinking Multiculturalism. Cultural Diversity and Political Theory*. London. Palgrave
- Pearce, W. B. (1989). *Communication and the Human Condition*. Carbondale, IL: Southern Illinois University Press.
- Pritchett, L. & Summer L.H. (1993). *Wealthier is Healthier: Policy research working paper series, No1150*. Washington D.C. The World Bank
- Rechel, B. et al. (Eds). (2011). *Migration and Health in the European Union*. European Observatory on Health systems and Policy Series. Open University Press. McGraw Hill.
- Rodriguez, R., (2010). *Migrants for Exports: How the Philippine State Brokers Labor to the World*. Minneapolis. University of Minnesota Press.
- Rodriquez, R., (2005). *Domestic Insecurities: Female Migration from the Philippines, Development and Subject –Status*. University of California.
- Schwarz, P. et al. (2010). *Diabetes Prevention in Practice*. TUMAINI Institute for Prevention Management, Dresden Germany

- Seale, C. (2004). *Health and the media*. UK: Blackwell.
- Simon, P. and Sala Pala, V. (2010). *We are not all Multiculturalists Yet: France Swings between Hard Integration and soft anti-discrimination*. IN S. Vertovec and S. Wessendorf (eds). *The Multi culturalism backlash: European discourses, Policies and Practices*. Abingdon and New York. Routledge.
- Singh, D.,(2011). (Ed). *Southeast Asian Affairs 2011*. Institute of Southeast Asian Studies. Singapore
- Smedley BD, Stith Ay, Nelson AR. EDS. (2003) *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*. Washington, DC: The National Academies Press; 2003.
- Tan, M.L., (2008). *Revisiting Usug, Pasma, Kulam*. Quezon City. University of the Philippines Press
- Tan, M.L., (1987). *Usug, Kulam, Pasma: Traditional Concepts of Health and Illness in the Philippines*. Quezon City . Alay Kilusang Pangkalusugan (AKAP)
- Tan, M.L., (1991). *The Philippine Health Matters*. Quezon City. Health Action Information Network
- Tan, M.L., (1992). *Philippine Health Matters 1992. Women Health in the Philippines – A Critical Analysis*. Quezon City. Health Action Information Network
- Taylor, C. (1992). *The Politics of Recognition*. In A. Gutmann, (ed), *Multiculturalism and Politics of Recognition*. Princeton, NJ: Princeton University Press
- Thompson, T. et. al. (2003)(Eds.) *Handbook of Health Communication*. Lawrence Erlbaum Associates, Inc. New Jersey.
- Tichenor, P.J., Donohue, G.A., & Olien, G.N. (1970). *Mass media flow and differential growth in knowledge*. *Public Opinion Quarterly*, 34(2), 158-170.
- Tones K. & Green J., (2004). *Health Promotion, Planning and Strategy*. Sage London
- Tyner, J. A. (2004). *Made in the Philippines: Gendered Discourses and the Making of Migrants*. London: Routledge.
- Ulmer C, McFadden B, Nerenz DR, Eds. (2009). *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*. Washington, DC: National Academic Press
- Van de Water HP, Perenboom RJ, Boshuizen HC. (1996). *Policy Relevance of the Health*

Expectancy Indicator: an Inventory of European Union countries. Health Policy

- Waldron, J. (1991). *Minority Cultures and Cosmopolitan Alternative*. University of Michigan Journal of Law Reform 25
- Weitz, R. (1996). *The Sociology of Health, Illness and Healthcare: A critical Approach*. Wadsworth Publishing Company. U.S.A.
- Wilkin, R. (2005). *The impact of Inequality*. New York :Free Press
- Witkinson, R. (2005). *The impact of Inequality*. New York Free Press
- Wright, B., Sparks, L. & O' Hair. D. (2008). *Health Communication in the 21st Century*. Blackwell Publishing. M.A., U.S.A.
- Wuthnor, R. et al (1984). *Cultural Analysis*. London. Routledge and Kegan Paul.
- Zhou, M. (2001) *Progress, Decline, Stagnation? The New Second Generation Comes of Age*. In WALDINGER R. (ed.), *Strangers at the Gates. New Immigrants in Urban America*, Berkeley, University of California Press
- Zola, I.K. (1966). *Culture and symptoms: An Analysis of Patients Presenting Complaints*. American Sociological Review, 3, 615-630.

Internet Searches

- Ackerson, Leland K., and Kasisomayajula Viswanath. 2009. *Communication Inequalities, Social Determinants, and Intermittent Smoking in the 2003 Health Information National Trends Survey*. Preventing Chronic Disease 6(2): A40.

- <http://dash.harvard.edu/handle/1/4569479>. (accessed March 1, 2013).
- Allan M. Brandt. 1991. *Emerging Themes in the History of Medicine*. *Milbank Quarterly* 69(2): 199-214. (accessed March 1, 2013).
- Barnes, L., Hall, P. & Taylor, R. (2009). *Why is Wealthier Healthier? Perspectives on Europe* 39(2): 4-8. <http://dash.harvard.edu/handle/1/4322128>. (accessed March 1, 2013)
- Banting, K. et. al. (2011) *Are Diversity and Solidarity Incompatible? Canada in Comparative Context*. In *Roads 28. Diversity through three lenses*. Available online at:
http://www.researchgate.net/publication/243964181_Are_Diversity_and_Solidarity_Incompatible (accessed February 2010)
- Batangan, D. (2005). *The Prices People have to Pay for Medicines in the Philippines*. Institute of Philippine Culture, Ateneo de Manila University, Philippines in collaboration with Health Action International/World Health Organization, Department of Health, Philippines. Retrieved July 21, 2009 from
http://www.haiweb.org/medicineprices/surveys/200502PH/sdocs/survey_report.pdf. (accessed September 23, 2009)
- Bhopal, P. & Ronaldo, L. (1998). *White European, Western, Caucasian or What? Inappropriate Labeling in Research on Race, Ethnicity and Health*. *American Journal of Public Health* 88.(Accessed June 2012)
- Breslow, L. & Cengage, C. (2002). (Eds). *Noncommunicable Disease Control. Encyclopedia of Public Health*. eNotes.com. 2006. 7 Aug, 2010
<http://www.enotes.com/public-health-encyclopedia/noncommunicable-disease-control> (accessed January 2011)
- Braun, L. et. al. (2013). *Racial Categories in Medical Practice: How useful they are?*
<http://dash.harvard.edu/handle/1/3008241> (downloaded March 1, 2013)
- Clements, B. (2011). *Global Trends in Basic Health Spending and the outlook*. International Monetary Fund.
(<http://www.imf.org/external/np/seminars/eng/2011/paris/pdf/BClements.pdf>) accessed August 2013
- Cultural Competence Definition. <http://www.cdc.gov/socialdeterminants/Definitions.html> (accessed January 2012)
- Definition of Culture. Roshan Cultural Heritage Institute. <http://roshan-institute.org/474552>. Accessed March 2012
- Denler, H. et al (2013). *Social Cognitive Theory*. The Gale Group.

<http://www.education.com/reference/article/social-cognitive-theory> (accessed August 2013)

Dutton, P. (2007). *France model healthcare system*. Retrieved June 17, 2009 from United Nations Economic and Social Commission for Asia and the Pacific,

<http://www.unescap.org/survey2007/notes/philippines.asp> (Accessed: Dec 12, 2009)

Eamranond, P. & Hu, H. (2008). *Environment and Occupational Exposures in Immigrant Health*. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3091353/> (accessed September 2013)

Erasmus Mundus Mobility with Asia (EMMA) is for funding Asia to Europe individual mobility flows (IMF) of academics from Partner Countries, fully sponsored by the EACEA run programme Erasmus Mundus External Cooperation Window. <http://math.unice.fr/EMMA/IsThisForMe.html> (accessed January 2010)

Epstein, M. (1995). *After the Future: The Paradoxes of Postmodernism and Contemporary Russian Culture*. Available (31/11/99): <http://www.emory.edu/INTELNET/af.culturology.html> (accessed MARCH 2010)

Farmer, P. (1996). *Social inequalities and emerging infectious diseases*. *Emerging Infectious Diseases* 2(4): 259-269. (Accessed March 1, 2013)

France: 12 Million d'immigres et d'enfants d'immigres <http://www.lefigaro.fr/actualite-france/2012/10/10/01016-20121010ARTFIG00262-immigration-les-chiffres-de-l-insee.php> (accessed April 22, 2013)

Frenck, J. et. al (2010). *Health Professionals for a new Century: Transforming Education to Strengthen Health Systems in aninterdependent World*.

<http://nrs.harvard.edu/urn-3:HUL.InstRepos:4626403> (Accessed March 1, 2013)

Guinea Worm Eradication

Program.http://www.cartercenter.org/health/guinea_worm/index.html. (accessed March 6, 2014)

Happiest people in the World:

<http://www.japantimes.co.jp/opinion/2013/01/06/editorials/happiest-people-in-the-world/#.UbHt0I72in8> (accessed June 7, 2013)

Harrington, A. (Forthcoming). *God and health: What more is there to say? In Spiritual Information 100 Perspectives on Science and Religion*, Vol. 2, ed. C. L. Harper Jr. Philadelphia: Templeton Foundation Press.

<http://dash.harvard.edu/handle/1/3996841>. (Accessed March 1, 2013)

- Definition and Measure of Health. International Academy of Classical Homeopathy. <http://www.vithoukas.com/en/contributions-of-gv/definition-of-health.html> (accessed April 2012).
- Health and Health Insurance Survey (ESPS) 2000. Figures in mid 2000; this figure has since about 7%. Taken from http://www.gesundheitspolitik.org/01_gesundheitssystem/ausland/gesundheitsssysteme/HC-Systems-in-8-Countries.pdf. Downloaded August 2013
- Health Disparity: Definition. . <http://www.cdc.gov/socialdeterminants/Definitions.html> (accessed May 2011).
- Health Equity Definition. <http://www.cdc.gov/socialdeterminants/Definitions.html> (accessed May 2011).
- Health Inequality. Definition <http://www.cdc.gov/socialdeterminants/Definitions.html> (accessed May 2011).
- Hochschild, J. L. (2005). *Looking Ahead: Racial Trends in the United States*. Daedalus 134, no. 1: 70-81. <http://dash.harvard.edu/handle/1/3200608> (accessed March 22, 2013)
- House of the Representative. Republic of the Philippines. Fifteenth Congress. Committee Report number 664. http://www.congress.gov.ph/download/basic_15/HB04244.pdf (accessed September 2013)
- ILO: *Towards a Fair Deal for Migrant Workers in the Global Economy*, Report VI, International Labour Conference, 92nd Session, Geneva, 2004; P. Stalker: *Workers Without Frontiers: The impact of Globalization on International Migration* (Geneva, ILO, 2000). <http://www.ilo.org/global/standards/subjects-covered-by-international-labour-standards/migrant-workers/lang-en/index.htm> (accessed March 9, 2014)
- Jorgensen, S., Thorlby, R., Weinick, R., and Ayanian, J. (2010). *Responses of Massachusetts Hospitals to a State Mandate to Collect Race, Ethnicity and Language Data from Patients: A Qualitative Study*. BMC Health Services Research 10: 352. <http://dash.harvard.edu/handle/1/4889445>. (downloaded March 4, 2013)
- Kleinman, A. & Hall-Clifford, R. Forthcoming. *Stigma: A Social, Cultural, and Moral Process*. Journal of Epidemiology and Community Health 63(6). <http://nrs.harvard.edu/urn-3:HUL.InstRepos:2757548> (downloaded March 1, 2013)
- Kleinman, A. (2010). *Four Social Theories for Global Health*. The Lancet 375 (9725): 1518-1519. <http://dash.harvard.edu/handle/1/5142663>. (downloaded March 1,

2013)

- Kreps, G. et. al. (1998). *The History and Development of the Field of Health Communication*. In L.D. Jackson & B.K. Duffy (Eds). Health Communication research. A guide to the development and direction. Westport, CT. Greenwood Press. pp 1-15. http://www.russcomm.ru/eng/rca_biblio/k/kreps.shtml (accessed February 2010).
- Lamont, M, & Small, M. L. (2008). *How Culture Matters: Enriching our Understandings of Poverty*. In *The Colors of Poverty: Why Racial and Ethnic In Disparities Persist*, A. Chih Lin and D. R. Harris (Eds), 76-102. New York: Russell Sage Foundation. <http://dash.harvard.edu/handle/1/3710395> (downloaded March 1, 2013)
- Mathews, Colin D. et. al. (2004). *Global Patterns of Healthy Life Expectancy in the Year 2002*. BMC Public Health 4:66. <http://dash.harvard.edu/handle/1/4592100> (downloaded March 2, 2013)
- McBride, M., *Health and Health care of Filipino American Elders*. Stanford Geriatric Education Center. Stanford University School of Medicine. Stanford California <http://www.stanford.edu/group/ethnoger/filipino.html> (downloaded June 2013)
- Moon, S, et. al. (2010). *The Global Health System: Lessons for a Stronger Institutional Framework*. PLoS Medicine 7(1): e1000193. <http://dash.harvard.edu/handle/1/4460875>. (downloaded March 3, 2013)
- Maiese, M. (2003). *Rights. Beyond Intractability*. <http://www.beyondintractability.org/essay/rights/> (Accessed July 2012).
- Making Health Communication Programs Work: A Planners Guide. US Department of Health and Human Services. National Institute of Health. National Cancer Institute http://www.cancer.gov/cancertopics/cancerlibrary/pinkbook/Pink_Book.pdf (downloaded May, 2011)
- Muhlberger, N. et. al (2009). *HVC- Related Burden of Diseases in Europe: A systematic Assessment of Incidence Prevalence, Morbidity, and Mortality*. BMC Public health 9:34 (downloaded March 1, 2013)
- Nicholson, L. (2013) *Missed diagnosis common in the Doctors Office*. <http://www.reuters.com/article/2013/02/27/us-misdiagnoses-idUSBRE91Q02420130227> (accessed April 2013).

- International Migration Outlook. OECD 2006. Organisation for Economic Co-operation and Development 2006 a): 46). <http://dx.doi.org/10.1787/828518448448>; (accessed June 2013)
- Pittman, G. (2013). *Patient Safety Effort may Prevent Diagnostic Error*. <http://www.reuters.com/article/2013/03/05/us-patient-safety-idUSBRE92417J20130305> (accessed June 2013).
- Reduire les inequaities inequalities sociales des santé. <http://www.irdes.fr/EspaceAnglais/ChartOfTheMonth/ChartOfNovember2009.htm> (accessed August 2013)
- Organisation internationale pour la migration. (2010). L'état de la migration dans le monde 2010, L'avenir des migrations : Renforcer les capacités face aux changements. Genève : Organisation International pour les migrations, 295 p. Disponible à http://publications.iom.int/bookstore/free/WMR_2n1n_FRENCH.pdf (accessed May 2012)
- Sen, A. (2008). *Why and How is Health a Human Right?* The Lancet 372, no. 9655: 2010-2010. <http://dash.harvard.edu/handle/1/3124128>. (downloaded March 1, 2013)
- Simon, P. (2012). French National Identity and Integration: Who belongs to the National Community? Institut national d'études démographiques. <http://www.migrationpolicy.org/pubs/FrenchIdentity.pdf> (accessed August 2013)
- The French Health Care System, <http://www.medicalnewstoday.com/articles/9994.php> (downloaded August 11, 2010)
- Waters, M., & Jimenez, T. (2005). *Assessing immigrant assimilation: New empirical and theoretical challenges*. Annual Review of Sociology 31: 105-125. <http://dash.harvard.edu/handle/1/3203280>. (downloaded March 1, 2013)
- Waters, M., & Eschbach, K. (1995). *Immigration and Ethnic and Racial Inequality in the United States*. Annual Review of Sociology 21: 419-446. <http://dash.harvard.edu/handle/1/3203265> (downloaded March 1, 2013)
- <http://www.cartesfrance.fr/carte-france-departement/carte-departement-Alpes-Maritimes.html> (downloaded October 2011)
- <http://www.diabetes.org> (accessed April 2011)
- <http://faculty.washington.edu/thurlow/research/transculturalcommunication.html> (accessed July 2010)
- <https://www.cia.gov/library/publications/the-world> (Accessed May 2012)

<http://www.ethnologue.com/country/PH> (accessed April 2011)

<http://bit.ly/MbBLbb> JAMA Internal Medicine, online February 25, 2013.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447687/#r45> (accessed May 2012)

http://www.ofii.fr/s_integrer_en_france_47/all_you_need_to_know_about_the_cai_458.html (accessed September 2013)

http://www.sante.gouv.fr/IMG/pdf/Actes_du_colloque_inegalies_sociales_de_sante_ministere_sante_sports_11012010b.pdf (accessed August 2013)

<http://www.rivieratimes.com/index.php/provence-cote-dazur-article/items/french-population-hits-6535-million.html> (accessed April 30, 2013)

<http://www.un.org/esa/earthsummit/pilip-cp.htm> (accessed May 17, 2013)

<http://www.hspm.org/countries/france25062012/> (accessed August 12, 2013)

http://www.le-site-de.com/association-nous-nice-ouverture-union-solidarite-nice_158167.html (accessed May 1, 2013)

<http://showbizandstyle.inquirer.net/lifestyle/lifestyle/view/20080620-143877> (accessed February 2011)

<http://nccam.nih.gov/health/whatiscah/> (accessed May 2012)

<http://www.cdc.gov/socialdeterminants/Definitions.html> (accessed July 2013)

<http://www.ethnologue.com/country/PH> (accessed August 2013)

<http://www.whitehouse.gov/issues/health-care/plan> (accessed December 2011)

<http://www.expatsforum.com/articles/health/health-care-in-france.html> (accessed September 2012)

<http://rhbill.net> (accessed May 16, 2013)

http://www.congress.gov.ph/download/basic_15/HB04244.pdf (accessed May 16, 2013)

http://www.who.int/whosis/mort/profiles/mort_euro_fra_france.pdf (accessed August 10, 2010)

<http://www.answers.com/topic> (accessed September 2012)

<http://medical-dictionary.thefreedictionary.com/transcultural> (accessed February 2012)

http://www.inpes.sante.fr/CFESBases/equilibre/numeros/90/prevention_sante_migrants.asp (accessed June 11, 2013)

<http://who.int/about/definition/en/print.html> (accessed May 10, 2008)

<http://www.migrationpolicy.org/europe/> (accessed August 17, 2013)

Journals

- Adams, T. & Gardiner, T., (2005). *Dementia. Communication and Interaction within Dementia Care Triads: Developing a Theory for Relationship Centered Care*. Sage Publication
- Adler, S. (1995). *Refugee Stress and Folk Belief. Among Sudden Deaths*. SSM 40 (12):1623-29
- Al-alawy, K. et. al. (2011). *Implementing Public Health in Secondary Care: A Rotherham perspective on Strategy development and implementation*. Perspective in Public Health. Sage Publication.
- Anderson, J. (1983). *Health and Illness in Pilipino Immigrants. In Cross-Cultural Medicine [Special issue]*. Western Journal of Medicine, 139(6), 811-819.
- Alba, R., Silberman R., (2002). *Decolonization Immigrations and the Social Origins of the Second Generation: The case of North Africans in France*. International Migration Review, 36(4)
- Appenzeller, T. (2005). *Tracking the Next Killer Flu*. National Geographic Magazine.
- Arango, J. (2013). *Exceptional in Europe? Spain's Experience with Immigration and Integration*. Migration Policy Institute
- Asis, M. & Agunias, D. (2012). *Strengthening Pre-Departure Orientation Programmes in Indonesia, Nepal and the Philippines*. Issues in Brief. Migration Policy Institute. No 5.
- Attias-Donfut C., Wolff, F. C. (2005). *Le Lieu d'Enterrement des Personnes Nées hors de France*. Population, 6n (5).
- Attstrom, K (2007). *Discrimination Against Native Swedes of Immigrant Origin in Access to Employment*. A research study on Stockholm. Malmo and Gothenburg utilizing the ILO testing approach. ILO, Geneva
- Audit Commission (1993). *What Seems to be the Matter: Communication with Non-English Speaking Patients*. London. HMSO
- Avison, R & Turner, J. (1988). *Stressful Life Events and Depressive Symptoms: Disaggregating the Effects of Acute Stressors and Chronic Strains*. Journal of Health and Social Behavior. 29: 253
- Baker, D., Hayes, R., Fortier, J. (1998). *Interpreter Use and Satisfaction with Interpersonal Aspect of Care for Spanish-Speaking Patients*. Medical Care.

- Bal, S. (1986). *Psychological Symptomatology and Health Beliefs of Asian Patients*. In Dent, H. *Clinical Psychology Research and Developments*. London. Croom Helm. 101-110
- Banulescu- Bogdan, N. (2011). *The Role of the Civil Society in the EU Migration Policy: Perspective in the EU's Engagement in its neighborhood*. Migration Policy Institute.
- Bhatt, R. & Dickinson, R. (1992). *An Analysis of Health Education Materials for Minority Communities by Cultural and Linguistic Group*. *Health Education Journal* 51:2 , 72-77
- Bhopal, R.S. et al (1991). *Inappropriate use of the Term "Asian": An Obstacle to Ethnicity and Health Research*. *Journal of Public Health medicine* 13:4, 244-246
- Bauchet, M. et. al. (2007). *Measuring European Population Stratification with Microarray Genotype Data*. *American Journal of Human Genetics*.
- Becker. M. H., (1974). *The Health Belief Model and Personal Health Behavior*. The Education Monographs
- Berchet, C. & Jusot, F (2012). *Immigrants Health Status and Use of Healthcare Services: A Review of French Research*. *Questions d'economies de la Sante*. No. 172
- Bernstein, J. et. al. (2002). *Trained Medical Interpreters in the Emergency Department: Effects on Services, Subsequent Charges and follow-up*. *Journal of Immigrant Health*
- Bertrand, M., Chugh, D., & Mullainathan, S., (2004). *Implicit Discrimination*. *The American Economic Review*. Papers and Proceedings of the 117th Annual Meeting of the American Economic Association. Philadelphia.
- Bevan, G., (2007). *How Might Information Improve Quality of Care in the English NHS?* *EuroObserver* Volume 9. No.3
- Bocognano A., Couffinhal A., Dumesnil S., Grignon M., (2001) *La complémentaire Maladie en France: Qui Bénéficie de Quels Remboursement?*, *Questions d'Economie de la Santé* n°32, Octobre 2001, CREDES
- Bouviern-Colle M.H., Magescas, .B., Hatton F. (1985). *Causes de décès et jeunes étrangers en France*. *Revue d'épidémiologie et de santé publique*, 49.
- Bowler, I (1993a). *They are Not the Same as Us. Midwives Stereotypes of South –Asian Descend Maternity patients*. *Sociology of Health and Illness*. 15:2, 157-178

- Boyd, M. (2002). *Educational Attainment of Immigrants Offspring: Success or Segmented Assimilation?* International Migration Review. 36(4)
- Brashers, D.E. & Babrow A, S., (1996). *Theorizing Health Communication: Communication Studies*. SAGE Publication
- Brahimi M. (1980). *La Mortalité des Etrangers en France*. Population, 3
- Brick, K. (2011). *Regulations in the EU. The Contentious Policy Tool*. Migration Policy Institute.
- Burbridge, L. (1993). *The Labor Market for Home Care Workers*. Gerontologist 33
- Buettner, D. (2005). *The Secrets of long life*. National Geographic Magazine. November 2005
- Burstin, H. et al (1992). *Socioeconomic Status and Risk for Substandard Medical Care*. Journal of the American medical Association 268
- Capps, R et.al. (2013) *A Demographic , Socioeconomic and Health Coverage Profile of Unauthorized Immigrants in the US*. Issue Brief. Migration Policy Institute. No.5
- Carlsson, M. & Rooth D.O., (2006). *Evidence of Ethnic Discrimination in the Swedish Labour Market Using Experimental Data*. Discussion Paper 2281. Bonn.
- Caldwell, J. (1993). *Health Transition: The Cultural, Social and Behavioral Determinants of Health in the Third World*. Social Science and Medicine 36
- Calderon, J. et. al. (2012). *Asian Labour Migrants and Health*. Exploring Policy Routes. Issues in Brief. Migration Policy Institute. Issue No.2.
- Casanova, M. (2013). *Social and Economic Management in the XXist century*. Lecture delivered in the conference "Cultural diversity: Advantage or Liability?". European University Institute. May 7-9, 2013. Florence, Italy.
- Cho, H., Witte, K.,(2005). *Managing Fear in Pubic Health campaigns: A Theory Based Formative Evaluation Process*. Health Promotion Practice, SAGE Publication.482-490
- Cho, H. & Salmon, C. (2007). *Unintended Effects of Health Communication*. Campaigns. Journal of Communication. 294-312
- Cole, F.C., (1913). *The Wild Tribes of Davao District Mindanao*. Field Museum of Natural History, Anthropological Series 12: 49-203

- Collett, E. (2013). *The Integration Needs of Mobile EU Citizens: Impedements and Opportunities*. Migration Policy Institute.
- Collett, E. (2013). *Facing 2020: Developing a new European Agenda for Immigration and Asylum policy: Policy Brief Series*. Research for Migration Policy Institute, Europe. Issue No.1
- Commission on Filipino Overseas Employment Handbook for Filipino Overseas. Fifth Edition. Department of Foreign Affairs. Philippines
- Commission on the Future of multi-ethnic Britain (CMEB) (2000). *The Future of multi-ethnic Britain*. London. Profile books.
- Commission on Social Determinants of Health (CSDH), *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*. Final report of the Commission on Social Determinants of Health. 2008, World Health Organization: Geneva.
- Corburn, J., (2007). *Reconnecting with our roots: American Urban Planning and Public Health in the Twenty – First Century*. Urban Affairs Review. Sage Publication.
- Cottrol, R. () *The Long Lingered Shadow: Law, Liberalism, and Cultures of Racial Hierarchy and Identity in the Americas*. Tulane Law Review 76
- Crul, M., Vermeulen H. (2003). *The Second Generation in Europe*. International Migration Review. 37(4)
- Cruz, R. (2012). *Figures of Migration, Gender, Kinship and the Politics of Representation*. Ateneo de Manila University Press
- Curtis, S., (2008). *How can we Address Health Inequality through Public Health Policy in Europe*. European Urban and Regional Studies. Sage Publication.
- Day, C., (2007). *Diabetes: A New World Order?* British Journal of Diabetes and Vascular Diseases, SAGE Publication
- Dearing, J. & Rogers, E. (1996). *Agenda Setting*. Thousand Oaks, California: Sage.
- Developing Health Management Information Systems. (2004). *A Practical Guide for Developing Countries*. WHO Regional Office for the Western Pacific.
- Dixon, A. & Mossialos, E. (eds) (2002). *Health Care Systems in Eight Countries: Trends and Challenge*. European Observatory on Health Care Systems
http://www.gesundheitspolitik.org/01_gesundheitssystem/ausland/gesundheitsysteme/HC-Systems-in-8-Countries.pdf. Accessed August 2013

- Downing, J. & Mohammadi, A. (Eds). (1995). *Questioning the Media: A Critical Introduction* (2nd ed). Thousand Oaks, Calif. Sage Publication
- Dourgnon P., Nusot F., Silva N., Sermet C. (2009). *Le Recours aux Soins de Ville des Immigrés en France*. Questions d'Economie de la Santé, 146.
- Downs, D. (1993). *Codes Say Darnedest Things*. Quill; October Vol. 81 Issue 8
- Duranti, A., (2005). *On Theories and Models. Discourse Studies*. Sage Publication
- Enhelhardt, H. et al (1980). *Philosophy of Medicine. In a Guide to the Culture of Science, Technology and Medicine*. Dubrin, P. (ed). 361-461. New York. The Free Press
- EUMC (2006). Annual Report on the Situation Regarding Racism and Xenophobia of the Member State of the European Union.
- EUMC. (2005). *Racism and Xenophobia in the EU memberstates: Trends, Developments and Good Practice*. Annual Report 2005. European Center on Racism and Xenophobia. Vienna.
- Eurohealth (2009) *Measuring and Tackling Health Inequalities in Europe*. Volume 15. European Observatory of Health System and Policies. Belgium
- EuroObserver (2012). *Efficiency in Health Care*. Volume 18 Number 3
- Evangelista, T. et al (2007). *Clinical and Neurophysiological Profile of Laundrywomen With and Without Self-Perceived Pasma: A Cross Sectional Survey*. Unpublished report. University of the Philippines. College of Medicine
- Fargues, P. et. al. (2011). *Shared Challenged and Opportunities for EU and Immigration Policy Makers*. European University Institute and Migration Policy Institute.
- Fearon, J., (2003). *Ethnic and Cultural diversity per Country*. Journal of Economic Growth. Vol 8.
- Feinstein, J. (1993). *The Relationships Between Socioeconomics Status and Health. A review of the Literature*. Milbank Quarterly 71
- Fierro, L, & Christie, C. (2011). *Understanding Evaluation Training in Schools and Programs of Public Health*. American Journal of Evaluation. SAGE Publication
- Figueras, J., McKee, M., et. al. (2004). *Health System in Transition: Learning from Experience*. European Observatory on Health Systems and Policies. WHO Regional Office for Europe

- Finau, S. (2000). *Communicating Health Risks in the Pacific: Scientific Construct and Cultural Reality*. Asia-pacific Journal of Public Health. SAGE Foundation.90-97
- Folland S. (2007). *Does Community Social Capital Contribute to Population Health?* Social Science & Medicine, 64(11).
- Foster, G. M., (1976). *Disease Etiologies in Northwestern Medical System*. AA 78:773-82
- Frake, C., (1961). *The Diagnosis of Disease among the Subanun Mindanao*. AA 63:113
- Freudenberg, N., (2005). *Public Health Advocacy to Change Corporate Practices: Implications fro Health Education Practice and Research*. Health Education and Behavior. Sage Publication
- Garcia, R. (2003). *The Misuse of Race in Medical Diagnosis*. Chronicle of Higher Education.
- Gregory and Williams (2003). *Literacy*. Nov 2006, Vol. 40 Issue 3
- Greeley, A (1989). *Ethnic Minorities in the Unites States: Demographic Perspectives*. International Journal of Group Tensions 7
- Gueraiche, W., (2003) *Regards Francais sur la Colonization Americaine aux Philippines (1898-1916)*. Press Universitaires de France. Guerres Mondiales et Conflicts Contemporains
- Glynn, C. & Huge, M., (2007). *Opinions as Norms: Applying a Return Potential Model to the Study of Communication Behaviors*. Communication Research.Sage Publication
- Golding, L. & Rubin, D, (2011). *Training for Public Information Officers in Communication to Reduce Health Disparities: A needs Assessment*. Health Promotion Practice. Sage Publication
- Goodfellow, B. & Moorley, C. (2010). *Reaching Unreachable Groups and Crossing Cultural Barriers in Communicating Health Promotion*. In Working on Health Communication. Nova Corcoran. SAGE
- Goets, L., & Dwiggin S. (1998). *Teaching Public Health Practitioners about Health Communication. The MPH Curriculum Experience*. Journal of Community Health Vol. 23, No 2. 127-135
- Gray, J., Cole, G., Kennedy, M.,(2007). *Guidance for Evaluating Mass Communication Health Initiatives: Summary of an Expert Panel Discussion* Sponsored by the Center for Disease Control and Prevention, Evaluation and the Health Profession, SAGE Publication

- Greenstone, C., (2007). *Type 2 Diabetes: A Disease of Epidemic Proportion that is Largely Preventable- But How? Clinicians' Corner*, American Journal of Lifestyle Medicine, SAGE Publication
- Griffiths, S. & Thorpe, A., (2007). *Public Health in Transition: Views of the Specialist Workforce*. The Journal of the Royal Society for the Promotion of Health. Sage Publication
- Gruesser, M., Hoffstadt, K, Joergens, V. (2003). *Structured outpatient education and treatment programs for patients with diabetes mellitus and/or hypertension: The German experience, practical disease management, disease manage health outcomes*
- Gueraiche, W., (2003). *Regards Francais sur la Colonization Americaine aux Phillipine (1898-1916)*. Presses Universitaires de France. *Guerre Mondiales et Conclicts Contemporains*. 1 number 209
- Harper, G. et. al., (2008). *Transdisciplinary Research and Evaluation for Community Health Initiatives*. Health promotion and practice. Sage Publication.
- Haut Comite de la Sante Publique. (2000). *Pour une politique nutritionelle desanet publique en France*. Editions ENSP
- Hawley, S. et.al. (2011). *Competency Based Impact of Statewide Public Health Leadership Training Program*. Health Promotion Practice. Sage Publication
- Heckman, J. (1998). *Detecting Discrimination*. Journal of Economic Perspective. Vol. 12.
- Hemingway, A et. al. (2011). *An Emerging Model for Publishing and Using Open Educational Resources in Public Health*. Perspective in Public Health. Sage Publication.
- HiT Summary, France (2004): *Health Care Systems Iin Transition*. European Observatory on Health Systems and Policies.
- Hochschild, J, & Cropper, P. (2009). *Immigration Regimes and Schooling Regimes: Which Countries Promote Successful Immigrant Incorporation?* Harvard University, Government and Social Policy Ph.D. Program
- Hornik R., Ramirez S., (2006). *Racial/Ethnic Disparities and Segmentation in Communication Campaigns*, American Behavioral Scientist, Sage Publication
- Hughey, J. et. al., (2007). *Empowerment and Sense of Community: Clarifying their Relationship in Community Organization*. Health Education and Behavior. Sage Publication.

- Idler, E., (1979). *Definitions of Health and Illness and Medical Sociology*. SSM13A.
- International Inequalities linked to Immigration. Labour Market outcomes for Immigrants and their descendants in France. Population 2006. <http://www.cairn.info/revue-population-english-2006-5-page-645.htm> (accessed August 15, 2013).
- Jacobs, E.A. et.al. (2001). *Impact of Interpreter Services on Delivery of Health Care to Limited English Proficient Patients*. Journal of General Internal Medicine
- Johnson, M. (1999). *Communication in Healthcare: A review of some key issues*. Nursing Times Research Vol 4. No 1. SAGE Publication. 18-29
- Jones, E., Kreuter, M., Pritchett S., Matulionis, R., Hann, N., (2006). *State health policy makers: whats the message and who's listening*. Health Promotion Practice. SAGE Publication
- Jones, L., & Watson, B., (2009). *Complex Health Communication: A Language and Social Psychological Perspective*. Journal of language and Social Psychology. SAGE Publication
- Joppke, C. (2012). *The Role of the State in Cultural Integration, Trends, Challenges and Ways Ahead*. University of Bern. Migrant Policy Institute.
- Journal of contemporary Asia. November 2012. Volume 42 Number 4
- Journal of Southeast Asian Studies. February 2013 Volume 44. Number 1
- Journal Officiel de l'Union européenne. (2007). Avis du Comité Economique et Social Européen sur Santé et Migration. C256/123,
- Kahn, J. (2004). *How a Drug Becomes Ethnic: Law, Commerce and the Production of Racial Categories in Medicine*. Yale Journal of Health Policy Health Ethics
- Kaplan, JB. & Bennet, T. (2003). *Use of Race and Ethnicity in Biomedical Publication*. JAMA.
- Karan, K., Aileen, L., Elaine, P., (2007). *Emerging Victorious Against as Outbreak: Integrated Communication Management of SARS in Singapore Media Coverage and Impact of the SARS Campaign in Moving a Nation to be Socially Responsible*. SAGE Publication.383-403.
- Karliner ,LS., et. al. (2004). *The Language Divide: The Importance of Training in the Use of Interpreters for Outpatient Practice*. Journal of General Internal Medicine

- Kate, SL. (2001). *Health Problems of Tribal Population Groups from the State Marahashtra*. Indian Journal of Medicine.
- Khlat M. & Courbage Y. (1995). *Mortalité des Immigrés Marocains en France, de 1979 - 1991. Il-leses causes de décès*. Population, 5n(2).
- Khlat M., Sermet C., Laurier D. (1998). *La Morbidité dans les Ménages Originaires du Maghreb, sur la base de l'enquête Santé*. Insee 1991-1992. Population 6.
- King, H., Gruber, W., Lander. T. (1995). *Implementing National Diabetes Program: Report of a WHO meeting*. Geneva: WHO Division of Non-communicable Disease.
- Kirkman-Liff, B. & Mondragon, D. (1991). *Language of Interview: Relevance of Research in of Southwest Hispanics*. American Journal of Public Health
- Kreps, G.L. (1996a). *Communicating to Promote Justice in the Modern Health Care System*. Journal of Health Communication, 1(1), 99-109
- Kreps, G.L. (1996b). *Promoting a Consumer Orientation to Health Care and Health Promotion*. Journal of Health Psychology, 1(1), 41-48.
- Kreps, G.L. (1989). *Setting the Agenda for Health Communication Research and Development: Scholarship that can Make a Difference*. Health Communication, 1(1), 11-15.
- Kreps, G. et. al., (1994). *A Conceptual Model of Communication and Health outcomes*. A paper presented at the annual meeting of the International Communication Association. Sydney, Australia.
- Kreps, G., (2006). *Communication and Racial Inequalities in Health Care*. American Behavioral Scientist. SAGE Publication. 760-774
- Kreps, G. & Kunimoto, E. (1994) *Relational Multi Cultural Communication in Health Care Effective Communication in Multi-Cultural Health Care Setting*. SAGE Publication, London
- Krieger, N, (2005). *Stormy Weather: Race Gene Expression and the Science of Health Disparities*. American Journal of Public Health
- Krishnatray, P., Melkote, S., Krishnatray, S., (2006). *Providing Care to Persons with Stigmatized Illness: Implications for Participatory Communication*. Journal of Health Management. Sage Publication
- Ku, L. & Jewers, M. (2013). *Healthcare for Immigrant Families: Current Policies and Issues*. Migration Policy Institute

- Kulukulalani, M. et.al., (2008). *Using Participatory Four-Step Protocol to Develop Culturally Targeted Cancer Education Brochures*. Health Promotion Practice. Sage Publication.
- Layug, R. M.D. (2005). *A Randomized Controlled Study on the Effectiveness of Group Patient Education versus Standard Individual Patient Education on the Knowledge, Quality of Life, Patient Adherence and Glycemic Control Among Adult Type 2 Diabetes Mellitus Patients seen at the Philippine General Hospital Family Medicine Clinic (FMC), The Filipino Family Physician*, 43(4).
- Lear, J., Mossialos, E., (2008). *EU law and Health policy in Europe*. EuroObserver. Volume 10 No.3
- Leclere F.B., Nensen L., Biddlecom A.E. (1994). *Health Care Utilisation, Family Context and Adaptation Among Immigrants to the United States*. Journal of Health and Social Behavior, 35(4).
- Lee, S. (2005). *Racializing Drug Design: Implications of Pharmacogenomics for Health Disparities*. American Journal of Public Health.
- Lee, S., et. al. (2008). *Interplay of Negative Emotion and Health Self-Efficacy on the Use of Health Information and Its Outcome*. Communication Research. Sage Publication.
- Lert F., Melchior, M., Villel, I. (2007). *Functional Limitations and Overweight Among Migrants in the Histoire de Vie studn*. Revue d'épidémiologie et de santé publique, 55 (6).
- Loring, M. & Powell, B. (1988). *Gender, Race and DSM III: A Study of the Objectivity of Psychiatric Diagnostic Behavior*. Journal of Health and Social behavior 29: 1-22.
- Maibach, E., Parrott, R.L.(1995) *Designing Health Messages*. Thousand Oaks, CA: Sage Publications
- Martel, W., Renaud, L., Bouchard, M., Gagnon, L., Pelletier M., (200-) *Implication des Partenaires dans la Campagne Québécoise de Promotion de la Santé "Défi Santé 5/30"*, Revue Internationale Communication Sociale et Publique
- Martin, S. et al (1988). *Gender and Medical Socialization*. Journal and of Health and Social Behavior. 29.333-43
- Mayes, R. & McKenna S., (2011). *Public Health and Primary Care: Stragglng to Win Friends and Influence People*. Journal of Primary Care and Community Health. Sage Publication.

- McBride, M., Pasick, R., Stewart, S., Tuason, N., Sabogal, F., & Duenas, G. (1998). *Factors Associated With Cervical Cancer Screening among Filipino Women in California*. Asian American and Pacific Islander Journal of Health, 6: 358-367.
- McQueen, D., Wisman, M. (2012). *Intersectoral Governance in Health in all Policies: Structures, Actions and Experiences*. WHO on behalf of European Observatory on Health System and Policy
- Meer, N. & Modood T (2012) *Interculturalism, Multiculturalism or Both?* Political Insight April 2012.
- Mihelj, S., (2007). *The European and the National Communication Research*. European Journal of Communication. Sage Publication
- Miller, D., (1995). *On Nationality*. Oxford Uk. Oxford University Press
- Mizrahi A., Mizrahi A., Wait S. (1993). *Accès aux soins et état de santé des populations immigrées en France*. Rapport CREDES.
- Mladovsky, P., Allin, S., et. al. (2009). *Health in the European Union: Trends and Analysis*. WHO on behalf of European Observatory on Health System and Policy
- Mladovsky, P., (2007). *Migration and Health in EU Health Systems*. Euro Observer. The Health Policy Bulletin of the European Observatory on Health Systems and Policies. Volume 9 Number 4.
- Mladovsky P., et. al. (2011). *Migration and Health in the European Union*. European Observatory on Health Systems and Policies Series. McGrawHill. Open University Press.
- Morales, D. et al (2008). *Metabolic Syndrome in the Philippine General Population: Prevalence and Risk for Atherosclerotic Cardiovascular Disease and Diabetes Mellitus*. Diabetes and Vascular Disease Research. SAGE Publication
- Morehouse, C. & Blonfield, M. (2011). *Irregular Migration in Europe*. Migration Policy Institute
- Mosco, V. (1996). *The Political Economy of Communication*. London: SAGE Publication.
- Mozere, L., (2002). *Philippine Servants in Paris: A Global Market of Domestic Servants*. Tiers Monde 2002, Volume 43 n 170. pp 373-396
- Mudde, C. (2012). *The Relationship Between Immigration and Nativism in Europe and North America*. Transatlantic Council on Migration. Migration Policy Institute

- Mukhopadhyay, B., Sattar, N., Fisher, M., (2005). *Review: Diabetes and Cardiac Disease in South Asians*. The British Journal of Diabetes and Vascular Disease. SAGE Publication
- Mumford, D.B. et al (1991). *The Bradford Somatic Inventory- a multi-ethnic inventory of somatic symptoms reported by anxious and depressed patients in Britain and the Indo-Pakistan sub-continent*. British Journal of Psychiatry. 158: 379-386
- Munro, A. & Bloor M. (2010). *Process Evaluation: The new miracle ingredient in Public Health Research*. Qualitative Research. SAGE Publication
- Muntaner, C. et. al. (1996). *The Bell Curve: On Race, Social Class and Epidemiological Research*. American Journal of Epidemiology.
- Murphy, S. & Bennet, P., (2004). *Health Psychology and Public Health: Theoretical Possibilities*. Journal of Health Psychology. Sage Publication
- Muus, P., (2002). Migration, immigrants and labour markets in EU Countries: ThemEs. Occasional papers and reprints on ethnic studies 3. University of Linkoping. Center for Ethnic and Urban Studies.
- National Geographic Magazine October 2007 pp 91-102
- National Geographic Magazine 2005 p 18
- National Geographic October 2002 pp 5-17
- New California Media (NCM). *Bringing Language Barriers in Health Care: Public Opinion Survey of California Immigrants from Latin America, Asia and the Middle East*. The California Endowment. 2003.
- Ngo-Metzger, Q. et. al. (2000). *Linguistic and Cultural Barriers to Care: Perspective on Chinese and Vietnamese immigrants*. Journal of General Internal Medicine.
- Ngo-Metzger, Q. et. al. (2007). *Providing High-Quality Care for Limited English Proficient Patients: The Importance of Language Concordance and Interpreter Use*. Journal of Internal Medicine
- Ngo-Metzger, Q. et. al. (2004). *Surveying Minorities with Limited English Proficiency: Does Data Collection Affect Data Quality Among Asian Americans?* Medical Care.
- Nobles, M. (2000). *Shades of Citizenship: Race and the Census in Modern Politics*: Palo Alto California. Stanford University Press

- Nykiforuk, C. & Flaman, L., (2011). *Geographic Information Systems (GIS) for Health Promotion and Public Health: A Review*. Health Promotion Practice. Sage Publication
- Oppenheimer, G. (2001). *Paradigm Lost: Race, Ethnicity, and a Research for a New Population Taxonomy*. American Journal of Public Health
- Organisation Internationale pour la Migration. (2010). *L'état de la Migration dans le Monde 2010, L'avenir des Migrations: Renforcer les Capacités Face aux Changements*. Genève : Organisation International pour les migrations, 295 p. Disponible à http://publications.iom.int/bookstore/free/WMR_2010_FRENCH.pdf
- Parsons, L & Day, S. (1992). *Improving Obstetrics Outcomes in Ethnic Minorities: An evaluation of health advocacy in Hackney*. Journal of Public Health Medicine. 14:2, 183-191
- Pechmann, C. (2001). *A Comparison of Health Communication Models: Risk Learning vs Stereo type Priming*. Media Psychology 3. Lawrence Erlbaum Associates Inc. pp 189-210
- Percoff, R., (2006). *Communication and Healthcare Disparities*. American Behavioral Scientists. Volume 49. Number 6
- Perrin-Haynes, j. (2008) *L'activite de Immigrees 2007*. Insee Premiere 1212.
- Peters, E. et al (2006). *The Functions of Affect in Health Communications in the Construction of Health Preferences*. Journal of Health Communication. S 140-162. International Communication Association.
- Philippine Studies 2011. *Headhunting and Christianity*. Volume 59. Number 2. Ateneo de Manila University Press.
- Philippine Studies Historical and Ethnographic Viewpoint. 2012. *Transnational Migration. Part 1. Class Identity and marital intimacy*. Volume 60. Number 2. Ateneo de Manila University Press
- Pickert, K., & Calabresi, M. (2012) *United States High Noon for Health Care*. TIME Magazine (April 2012)
- Piper, N., (2005). *Gender and Migration*. A paper prepared for the Policy Analysis and Research programme of the Global Commission on International Migration. Global Commission on International Migration.

- Polton, D. (2009). *What is the Role of Healthcare System in Reducing Health Inequalities in France? In Measuring and Tackling Health Inequalities Across Europe*. EuroHealth. Volume 15. Number 3.
- Proceedings of the 8th Health Research for Action, National Forum. (2007, June 28-29). New evidence and policy directions progressing towards the Millennium Development Goals. Manila, Philippines.
- Quammen, D., (2007). *Deadly Contact. How Animals and Humans Exchange Disease*. National Geographic Magazine.
- Quigley, H., McKee, M., et. al. (2008). *Assuring the quality of Healthcare in the European Union: A Case for Action*. WHO on behalf of the European Observatory on Health System and Policy
- Rains, S., (2008). *Health at High Speed: Broadband and Internet Access, Health Communication and the Digital Divide*. SAGE
- Rashid, A. & Jagger, C. (1992). *Attitudes to and Perceived Use of Healthcare Services Among Asian and Non-Asian Patients in Leicester*. British Journal of General Practice 42 (358) 197-201.
- Rimer, B. & Kreuter, M. (2006). *Advancing Tailored Health Communication: A Persuasion and Message Effect Perspective*. Journal of Communication 56. International Communication Association
- Rivadeneira, R. et.al. (2000). *Patient Centeredness in Medical Encounters Requiring an Interpreter*. American Journal of Medicine
- Robinson, TN., et. al. (1998). *An Evidence-Based Approach to Interactive Health Communication: A Challenge to Medicine in the Information Age*. Science Panel on Interactive Communication and Health. US National Library of Medicine. National Institute of Health. JAMA. 280 (140) 1264-9
- Rocco, M., McKee, M., (2007). *Health: A Vital Investment for Economic Development in Eastern Europe and Central Asia*. WHO
- Rodwin, V. (2003). *The Health Care System Under French National Health Insurance: Lessons for Health Reform in the United States*. American Journal of Public Health 93.(1)
- Rooth, D. & Ekberg, O. (2003) *Unemployment and Earnings for Second Generation Immigrants in Sweden. Ethnic Background and Parent Composition*. Journal of Population Economics, 16

- Romulo, B.D. (2010) *U.S. and Philippine Health Care*, Manila Bulletin
- Romon I, Jouglu E, Balkau B, Fagot-Campagna A. (2008) *The Burden of Diabetes-Related Mortality in France in 2002: An Analysis Using both Underlying and Multiple Causes of Death*. French Institute for Public Health Surveillance, Institut de Veille Sanitaire (InVS)
- Rosenblum, M. (2010). *Immigrant Legalization in the United States and the European Union. Policy goals and Program Design* . Policy Brief. Migration Policy Institute
- Ruddock, A. (2001). *Understanding Audiences: Theory and Method*. London: Sage
- Saggar, S. & Somerville, W. (2012). *Building a British Model of Integration in an Era of Immigration: Policy Lessons for Government*. University of Sussex and Migration Policy Institute.
- Saltman, R., Figueras, J., (1997). *European Health Care Reform: Analysis of Current Strategies*. WHO Regional Publications. European Series No. 72
- Sandier, S. et.al. (2004). *Health Care Systems in Transition*. Copenhagen. WHO Regional Office for Europe
- Sankar, P. (2003) *MEDLINE definition of Race and Ethnicity and their Application to Genetic Research*. Natural Genetics.
- Saroca, C. (2006). *Filipino Women, Migration, Violence in Australia: Lived Reality and Media Image*. Kasarinlan: Philippine Journal of Third World Studies
- Sheldon, T.A. & Parker, H. (1991). Race and Ethnicity. *Journal of Public Health medicine*. 14;2, 104-110
- Schoberberger R., Nodes, M., (2005). *Health Campaign for Atherosclerosis Prevention*, Institute of Social Medicine, Center of Public Health, Medical University of Vienna, Vienna Austria, Springer –Verlag
- Seki, K. 2012. *Difference and Alliance in Transnational Social Fields. The Pendular Identity of the Filipino Middle Class*. Philippine Studies Volume 60 Number 2. Ateneo Univesity Press. 187- 221
- Shen, L., & Dilland, J., (2007). *The Influence of Behavioral Inhibition/ Approach Systems and Message Framing on the Processing of Persuasive messages*. Communication Research. Sage Publication.
- Sifferlin, A., (2013). *Wear your Doctor*. Time Magazine March 2013

- Simon, P. (1997). *La Statistique des Origines. Race et Ethnicité dans les Recensements aux États-Unis, Canada et Grande-Bretagne*. Sociétés contemporaines, n° 26
- Solé- Auro A., Crimmins E.M. (2008). *Health of Immigrants in European countries*. International Migration Review. 42(4).
- Solis, JM. et. al. (1990). *Acculturation, Access to Care and use of Preventive Services by Hispanics: Findings from the HHANES 1982-84*. American Journal of Public Health
- Soto Mas, F., Plass, J., Kane, W., Papenfuss R. (2003). *Health Education and Multi Media Learning: Educational Psychology and Health behavior Theory(Part 1)*. Health Promotion Practice. Sage Publication
- Sperling, J. (2011). *Communicating more for less: Using translation and interpretation Technology to Serve Limited English Proficient Individuals*. Migration Policy Institute's National Center on Immigrant Integration Policy (NCIIP)
- Sparks, L., (in press). *Health Communication and Caregiving Research, Policy, and Practice*. In S. S. Travis & R. Talley (Eds.) *Multi-disciplinary Coordinated Caregiving: Professional Contributions*. Springer.
- Squires, A. & Beltran-Sanchez, H. (2013) *Strengthening Health Systems in North and Central America. What Role for Migration?* The Regional Migration Study Group. Migration Policy Institute
- Stein, J. & Fox, S., (1990). *Language Preference as an Indicator of Mammography Use Among Hispanic Women*. Journal of National Cancer Institute
- Steiner, G., (2006). *Implications of Global Diabetes Epidemic*. Diabetes and Vascular Disease Research, SAGE Publication
- Stewart, M. & Lindburg, L. (1997). *Gaining from Diversity*. Brussels. European Business Network for Social Cohesion
- Stirba, I., Kunst AE., et al. (2006). *Differences in Avoidable Mortality between Migrants and the Native Dutch in the Netherlands*. Baic Public Health.
- Tebbe, S., Figueras, J., (2005). *Snapshots of Health Systems*. WHO on behalf of the European Observatory on Health Systems and Policies, Belgium
- The European Health Report 2012. *Charting the Way to Well-Being*. World Health Organization. WHO Regional Office, Europe.

- Thatcher, B., (2001). *Issues of Validity in Intercultural Professional Communication* Research. Journal of Business and Technical Communication. SAGE Publication
- Thomas, V.J. & Rose, F.D. (1991). *Ethic Differences in the Experience of Pain*. Social Science and Medicine. 32:9, 1063-1066
- Timmins. C. (2002). *The impact of Language Barriers on the Health Care of Latinos in the United States: A Review of the Literature and Guidelines for Practice*. Journal of Midwifery Women's Health
- Titley, G. (2004). (Ed). *Resituating Culture*. Directorate of Youth and Sport. Council of Europe Publishing
- Tocher, TM. & Larson, E. (1998). *Quality of Diabetes for non-English Speaking Patients. A Comparative Study*. West Journal of Medicine
- Torres, B. & Rao, N., (2007) *Disclosure and Truth in Physician- Patient Communication: An Exploratory Analysis in Argentina, Brazil, India, and the Unites States*. Journal of Creative Communication. Vol 2. No 3. 279-305. SAGE Publication
- Turner, J., Thomas, R., Reinsch, L., (2004). *Willingness to Try a New Communication Technology: Perceptual Factors and Task Situations in a Health Care Context*. Journal of Business Communication. Sage Publication
- Vallgarda, S., (2011). *Adrressing Individual Behaviors and Living Conditions: Four Nordic Public Health Policies*. Scandinavian Journal of Public Health. SAGE Publication.
- Versini, D. (2004). *Rapport sur la Diversité dans la Fonction Publique*. Report presented to Mr Renaud Dutreil, Minister of the Civil Service and State Reform, Paris, La Documentation Française
- Viswanath, K. & Emmons, K. (2006). *Message Effects and Social Determinants of Health. It's Implications to Cancer Disparities*. Harvard School of Public Health. International Communication Association. S238-S256
- Walsh, B. (2013). *It's Gone Viral*. Time Magazine. March 2013.
- Wanner P., Bouchardn C., Khlat M. (1997). *Causes de décès des immigrés en France 1979-1985 . Migration Santé, 91*.
- Weiss, R., (2002). *War on Disease. Challenges for Humanity*. National Geographic Magazine
- World Health Organization (WHO). *Global Strategy on Diet, Physical Acctivity and Health Resolution of the Fifty Seventh World Assembly. WHA57*. Geneva

- Wise, L.R. & Tschirhart M. (2000). *Examining Empirical Evidence on Diversity Effects: How Useful is Diversity Research for Public Sector Managers*. Public Administration Review. Vol. 60. No 5.
- Wild, S., Roglic, G., Green, A., Secree, R. & King, H. (2004). *Global prevalence of diabetes : Estimates for the year 2000 and projections for 2030*. EU Workshop entitled: Towards a European Framework for Diabetes Prevention and Care of the European Region and the Diabetes Federation Ireland, Dublin.
- Wismar, M., et. al. (2011). *Health Professional Mobility and Health systems: Evidence from 17 European countries*. EurObserver. Volume 13. No.2
- Wismar, M., et. al. (2006). *Health Targets and (good) Governance*. EurObserver Volume 8 No.1.
- Wise, L.R. & Tschirhart, M. (2000). *Examining Empirical Evidence on Diversity Effects: How Useful is Diversity Research for Public Sector Managers?* Public Administration Review, Vol. 60. No.5.
- Wittenberg-Lyles, E. Et al (2009). *Medical Students' Views and Ideas about Palliative Care Communication Training*. American Journal of Palliative Care. SAGE Publication. 1-12
- Worz, M., et. al. (2006). *Access to Health Care in the EU Member State*. EurObserver Volume 8 no. 2.
- Woloshin S. et. al. (1995). *Language Barriers in Medicine in the United States*. JAMA.
- Wrench, J. (2004). *Managing Diversity: Fighting Racism, or Combating Discrimination? A Critical Exploration*. In Titley, G. (Ed). *Resituating Culture*. Directorate of youth and Sport. Council of European Publishing.
- Youdelman, M. & Perkins, J. (2002). *Providing Language Interpretation Services in Health care setting: Examples from the Field*. New York, NY. The Commonwealth Fund
- Zakaria, F., (2012) *Health Insurance is for Everyone*. Time Magazine March 2012
- Zambrana R.E., Ell K., Dorrington C., Wachsman L., Dee H. (1994). *The Relationship Between Psychosocial Status of Immigrant Latino Mothers and Use of Emergency Pediatric Services*. Health and Social Work, 19: 2
- Zegers de Beijl, R. (2000). *Documenting Discrimination Against Migrant Workers in the Labour Market: A Comparative Study of Four European Countries*. Geneva. International Labor Office

Zouwen, J., (2010). Report on the European Survey Research Association Conference 2009 in Warsaw Bulletin de Methodologie Sociologique. Sage Publication

World Health Statistics 2008

WHO Health Report 2012

Health in Asia and the Pacific, WHO 2008

The Western Pacific Declaration on Diabetes, Kuala Lumpur 2000, Manila, Philippines 2000

The European Health Report 2012. Charting the well-being. World Health Organization. Regional Office Europe.

Preventing Chronic Diseases and Vital Investment: WHO Public Agency of Canada, 2005

American Diabetes Association

Time Magazine (January 2012)

Appendices

Appendix 1

Request for Filipino statistics in the French Riviera

Office of Public Information
Prefecture, Route de Grenoble
Nice France

August 25, 2011

Dear Sir/ Madame,

Bonjour.

I am Elizabeth Soliday-NAUI, a doctoral student from the University de Nice Sophia Antipolis, I3M Laboratory. My major is health communication and I am studying the health belief system of the Filipinos living in Nice, Cannes and Monaco.

In relation to my research, I would like to find out how many Filipinos are in these area. I hope you can provide me with the statistics/numbers of Filipinos registered at your office. I am assuring you that this data will be used for academic purposes only and will not be used for any other reason, other than as background data for my research.

I have attached a copy of my carte de sejour and my student card to prove my legitimacy as a student and researcher.

As to when I can get the documents or if someone from your office needs see me personally for the documents that I need, you may reach me at 0642080550 or through email, nauibeth@gmail.com. I would greatly appreciate if you could give me the information by last week of September until October 2011.

I thank you in advance for your assistance to this student, who traveled far in the name of academic pursuit.

Respectfully yours,

Elizabeth Soliday-NAUI
PhD Student
University de Nice Sophia Antipolis
Nice, France

APPENDIX 2
Request for Filipino Immigrant Statistics
(French Translation)

Bureau d'Information du Public
Prefecture, Route de Grenoble
Nice France

August 25, 2011

Cher (e)Monsieur/ Madam,

Je suis Elizabeth Soliday-NAUI, une étudiante en doctorat de l'Université de Nice Sophia Antipolis, Laboratoire I3M. Mon majeur est la communication en santé. Je suis étudiante en système de croyance de santé de la Filipino vivant à Nice, Cannes et Monaco.

En ce qui concerne mes recherches, je voudrais savoir combien de Philippins sont dans ces secteurs géographiques. J'espère que vous pouvez me fournir les statistiques / nombre de Philippins inscrits à votre bureau. Je vous assure que ces données seront utilisées à des fins d'études académiques et ne seront pas utilisées pour toutes autres raisons, autre que celles des données de base pour mes recherches.

Je joins une copie de ma carte de séjour et ma carte d'étudiante pour prouver ma légitimité en tant qu'étudiante et chercheur.

Restant à votre disposition pour tout renseignements complémentaires pour les documents dont j'ai besoin, vous pouvez me joindre au 0642080550 ou par email, nauibeth@gmail.com. Un rendez vous dans vos bureaux est possible, si nécessaire. Je vous serais très reconnaissant si vous pouviez me donner les informations avant fin Septembre 2011.

Je vous remercie d'avance pour votre airté cette étudiante.

Respectfully yours,

Elizabeth Soliday-NAUI
PhD Student
University de Nice Sophia Antipolis
Nice, France

APPENDIX 3
Answer of Prefecture de Nice

Sujet : Tr: votre demande du 25/08/2011
Date : Tue, 06 Sep 2011 16:00:41 +0200
De : etrangers@alpes-maritimes.pref.gouv.fr
Pour : nauibteh@gmail.com

Madame,

Par courrier du 25 août 2011, vous m'avez demandé de vous communiquer diverses statistiques concernant l'immigration de ressortissants de nationalité philippine, dans les Alpes-Maritimes.

J'ai le regret de vous faire savoir que je ne peux donner une suite favorable à votre requête, dans la mesure où les données statistiques relatives à la présence des ressortissants étrangers sur le territoire national, sont confidentielles et protégées par la loi.

Cordialement,

**Le Chef de Bureau,
de l'admission des étrangers au séjour**
Jean-Yves ORLANDINI

APPENDIX 4
Answer of the English Speaking Platform

Answer to the researcher's query
Sent May 28, 2013 12:04 pm

Bonjour Madame,

Nous avons reçu un courrier de votre part adressé au service communication de notre caisse primaire.

Nous avons un service langue étrangère ouvert en langue anglaise du lundi au vendredi de 9h à 18h au 0811 36 36 46 ainsi que des "fiches informations" en langue anglaise sur notre site ameli.fr

ameli.fr / vous êtes assurés / votre caisse : "taper" 50100 (code postal)
vous trouvez : **depending-upon-your-situation/contact-our-french-health-insurance_manche.php**

Cordialement,

--

Corinne ALMIN
Superviseur pfs Manche
et service langue étrangère
02.33.08.82.04

"Le contenu de ce courriel et ses éventuelles pièces jointes sont confidentiels. Ils s'adressent exclusivement à la personne destinataire. Si cet envoi ne vous est pas destiné, ou si vous l'avez reçu par erreur, et afin de ne pas violer le secret des correspondances, vous ne devez pas le transmettre à d'autres personnes ni le reproduire. Merci de le renvoyer à l'émetteur et de le détruire.

Attention : L'Organisme de l'émetteur du message ne pourra être tenu responsable de l'altération du présent courriel. Il appartient au destinataire de vérifier que les messages et pièces jointes reçus ne contiennent pas de virus. Les opinions contenues dans ce courriel et ses éventuelles pièces jointes sont celles de l'émetteur. Elles ne reflètent pas la position de l'Organisme sauf s'il en est disposé autrement dans le présent courriel."

Appendix 5 Interview with Mr. MOREAU

Fabrice MOREAU

Chargé de mission communication Nutrition

Département de la communication

Direction de la communication et des outils pédagogiques

fabrice.moreau@inpes.sante.fr

(t) + 33 1 49 33 23 99 / (f) + 33 1 49 33 22 60

1. How do you know which among the health issues is to be prioritized?

We base our approaches on epidemic studies. All our actions are based on accurate survey of the health of population.

2. Where does the call to create a health communication campaign emanate? Does it come from higher authorities or do you suggest to the higher authorities which ones should be done first?

We just ask ourselves the following question : regarding a specific health situation, is communication the most relevant way to address this issue. For example, is there a lack of knowledge of the population, what are the main hurdles for people to act on a positive way for their health, do people have representations and beliefs on any particular topic, on which communication can change something....Sometimes communication isn't relevant.

3. Can you describe the process of planning a health campaign?

We ask ourselves : what's the problem ? The matter is to identify the topic of the campaign. For example, we can see, on the nutrition issue, that people don't eat enough fruit and vegetables. We then decided to address this issue.

We gather all materials we need to understand this problem. For example : which are the main segments of the population that don't eat enough fruits and veg, why do they don't do it... On the basis of the information below (mentioned), we define a strategy. For example, we're going to try to help parents from low sociological categories of the population eat more fruits and veg. As we could have stated that if this segment of the population doesn't eat enough fruits and veg, it is because they consider fruits and veg too expensive for them, we're gonna try to define a message that suit to that problem, for example : "if you want to eat fruits and veg, you can also eat them frozen or as canned.

Once this message defined is, we try to build a communication strategy : which media (TV, radio, web...) and we'll produce the strategic message into a creative version (TV ad, website...)

4. What are the policies that you need to observe when planning health campaigns.

Actually, all our actions in terms of nutrition are built in a global public health frame dedicated to nutrition. It is called the PNNS, the "French National Nutrition Program". It defines the main orientations for this public policy. We also work with the different stakeholders relied (aligned) to that issue (other Ministeries, Industries, Local authorities, Associations...). it is a global approach.

5. How do you select the people/institution who will design and implement health communication campaign?

We implement that campaign and are helped in this task by a certain number of communication agencies that work for us.

6. Do you tie up with other organizations? Why? How?

Yes, lots, as I said before. We're working in a collaborative way with many organizations : ministeries, industries, associations, experts...Concentration is a key word in the way we do communication. More concretely, it means that we discuss about our campaigns with all these organizations before we launch them.

7. How do you go about selecting the organizations that you will tie-up with?

Because of the specific look they can give on the communications project we have. The aim is to have the widest point of view on any topic.

8. How do you evaluate your health campaigns?

We do "post test" that measure the immediate efficacy of a campaign.

9. What are your indications of success?

As the final aim is to make people change, it is quite difficult to identify the consequence of a communication campaign on people's behavior. Nutrition behavior is the consequence of many causes : public information, but also agro-food company ads, price of food...For that reason, it would be uncertain to say "that campaign has had these specific effects on health situation of the population".

Appendix 6

Introduction to the Filipino Community



Magandang Araw po sa inyong lahat

Ako po si ELIZABETH SOLIDAY-NAUI, estudyante na nag aaral sa University de Nice Sophia Antipolis, 13M Laboratoire, Carlone. Tinatapos ko po ang aking Doctoral sa tulong ng European Union bilang Erasmus Scholar.

Ang akin pong pinag- aaralan ay ang health practice ng mga Pilipino na naninirahan dito sa Cote d'Azur area. Halimbawa po nito ay ang kung naniniwala pa po ba kayo sa kunsepto ng init at lamig, pasma etc. Parte po ng aking research ang pag survey sa mga Pilipino na nasa Nice, Cannes, Monaco at Menton.

Ang akin pong survey ay walang kinalaman sa inyong papel dito sa France. Ang information po na ipagkakatiwala ninyo sa akin ay gagamitin lamang sa academe/University at hindi po ibibigay sa anumang government agency, dito sa France o sa Pilipinas na may kinalaman sa isyu ng pananatili o pagta-trabaho ng mga Pilipino sa France.

Maraming salamat po sa pag sagot sa aking survey at sa pagtitiwala

Elizabeth Soliday-Nauai

Doctorant

13M Laboratoire, Fac de Lettre

University de Nice Sophia Antipolis

+33 6 42080550

nauibeth@gmail.com

APPENDIX 6
Survey form

Name (Pangalan) _____

Sex (Kasarian) _____ Babae _____ Lalaki

Telephone _____

Work (Uri ng trabaho) _____ sa bahay _____ sa yate _____ sa opisina _____ etc.

Age (Edad)

_____ 20-25 _____ 26-30 _____ 31-35 _____ 36-40 _____ 41-45

_____ 46-50 _____ 51-55 _____ 56-60 _____ 60+

Address (Tirahan) _____

Number of years living in (Nice, Cannes, Monaco) *Bilang ng taon na naninirahan sa Nice, Cannes o Monaco*

_____ 0-5 _____ 6-10 _____ 11-15 _____ 16-20 _____ 20+ _____

3. What are the most common disease/ailments you have? Anong mga pangkaraniwang karamdaman ang iyong nararanasan?

- _____ a. Headaches (*Sakit ng ulo*)
- _____ b. Backaches (*Sakit ng likod*)
- _____ c. Muscle pains (*Sakit ng kasu-kasuan*)
- _____ d. Colds (*Sipon*)
- _____ e. Fever etc. (*Lagnat atp*)

4. What are the sources of these ailments? (Ano sa palagay mo ang pinagmulan ng iyong madalas na karamdaman?)

- _____ a. Work related (*May kinalaman sa trabaho*)
- _____ b. Genetical predisposition (*Namanang sakit*)
- _____ c. It's new and you still don't know where and why it developed (*Bago ito at di pa matukoy ang pinagmulan*)

3. How do you deal with these ailments when you were still in the Philippines? (Paano mo ginagawan ng lunas ang ganitong mga karamdaman noong ikaw ay nasa Pilipinas pa?)

- _____ a. Go to the doctor (*Kumukunsulta sa doctor*)
- _____ b. Go to a traditional healer (*Kumukunsulta sa traditional na manga-gamot*)
- _____ c. Wait for it to go away (*Hinihintay na lamang na kusa itong mawala*)
- _____ d. Just rest and take what the elders tell me to take (*Magpahinga at uminon ng gamut ayon sa payo ng mga nakatatanda*)
- _____ e. Go to the doctor and see a traditional healer after (*Kumunsulta sa doctor at magpatingin sa traditional na manga-gamot*)

4. What are the health beliefs/practices when you were still in the Philippines? Anong mga gawaing pangkalusugan ang pinaniniwalaan mo at ginagawa noong ikaw ay nasa Pilipinas pa?

- _____ a. *Pasma (*naniniwala sa pasma*)
- _____ b. Hot and cold sources of diseases (*paniniwala sa "init" at "lamig" na pinagmumulan ng sakit*)
- _____ c. Putting a piece of cloth in a person back to absorbed his/her perspiration, which is believed to lessen the possibility of backache and bronchitis (*naglalagay ng damit sa likod para maiwasan ang pagkakaroon ng sakit sa likod at bronchitis*)
- _____ d. Putting a towel on the forehead when it start to get dark, usually in the late afternoon (*paglalagay ng bimpo sa ulo lalo na pag sapit ng dapit-hapon*)

_____ e. Massage therapy (*nagpapamasahe kung may nararamdamang sakit sa kau – kasuan o pilay*)

5. When do you decide to visit your doctor? (Kailangan ka nag dedesisyon na kumunsulta na sa doctor?)

_____ a. As soon as I experience discomfort (*Sa simula pa lamang na mag nararamdaman na akong kakaiba sa aking katawan*)

_____ b. After a few days of discomfort (*Pakalipas ng ilang araw na di maayos na pakiramdam*)

_____ c. If I cannot take the pain anymore (*Pag hindi ko na kayang tiisin ang sakit*)

6. Do you visit your doctor now more often than when you were in the Philippines? (mas madalas ka bang kumunsulta sa doctor ngayon kumpara nung nasa Pilipinas ka pa?)

_____ a. Yes (*Oo*) b. No (*Hindi*) c. Same (*pareho lang*)

7. If YES, what is/are the reasons? (Kung Oo, ano ang mga dahilan?)

_____ a. Accessible (*madaling puntahan*)

_____ b. Not expensive (*mura ang bayad*)

_____ c. No out of the pocket pay expense (*walang bayad*)

8. If NO, why? (Kung hindi, bakit?)

_____ a. not used to consulting doctors all the time (*hindi nakasanayan na madalas kumunsulta sa doctor*)

_____ b. getting in the way of job (*nakaka abala sa trabaho*)

_____ c. expensive (*mahal*)

_____ d. scared of the language barrier (*natatakot sa pag uusap na Pranses*)

9. What do you do when you do not completely understand your doctors explanation/instruction? (Ano ang iyong ginagawa kung di mo lubos na maintindihan ang paliwanag at instruction ng doctor?)

_____ a. Ask questions to clarify (*Nagtatanong hanggang sa lubos na maintindihan*)

_____ b. I just keep quite (di na ako nagtatanong pa)

_____ c. Will do research on my own (*maghahanap na lamang ng iba pang paraan upang masagot ang mga bagay na hindi maliwanag*)

_____ d. Ask someone to come with me as an interpreter (*Nagpapasama sa isang marunong mga salita ng French bilang interpreter*)

10. Do you usually understand the explanation of your doctor even if it is in French?? (Nauunawaan mo bang madalas ang paliwanag ng mga doctor kahit ito ay nasa salitang Pranses?)

_____ a. Yes (*Oo*) _____ b. No (*Hindi*) _____ c. not much (*hindi masyado*)

11. Is language still a barrier for you? (Ang lengwahe ba ay isa pa ring balakid sa inyo?)

_____ a. Yes (*Oo*) _____ b. No (*Hindi*) _____ c. not much (*hindi masyado*)

12. Aside from consulting a doctor, what other means do you do to know more about your disease? (Maliban sa pag kunsulta sa doctor, ano pang ibang paraan ang inyong ginagawa upang lubos na maintindihan ang inyong karamdaman?)

_____ a. talk to people who experience the same symptoms (*nakikipag usap sa mga taong nakaranas o nakakaranas ng parehong simtomas*)

_____ b. read articles (*nagbabasa ng mga artikulo*)

_____ c. research on family health history (*nagtatanong sa mga kamag-anak sa posibleng pinagmulan ng sakit*)

_____ d. get information from medical professionals (*humihingi ng impormasyon sa mga medical professionals*)

13. Do you still take medicines coming from the Philippines? (*Umi-inom ka pa ba ng mga gamot na galing sa Pilipinas?*)

_____ a. Yes (*Oo*) b. ____ No (*Hindi*)
Why? (*Bakit?*)

14. Do you think you take care of your health better now that you are in France? (*Sa palagay mo a ay mas higit mong napapangalagaan ang iyong kalusugan ngayong ikaw ay naninirahan na sa France?*)

_____ a. Yes (*Oo*) b. ____ No (*Hindi*)
How? (*Paano?*)

* A "folk illness" in the Philippines which has no equivalent medical term in English. The symptoms of **pasma** are trembling hands and sweaty palms occurring after strenuous use of the hands in manual labor. Farmers who work in the fields dragging plows, women who handwash laundry, pianists and athletes suffer from **pasma**. (<http://tagaloglang.com/Tagalog-English-Dictionary/English-Translation-of-Tagalog-Word/pasma.html>. Downloaded September 13, 2012)

APPENDIX 7

Guide questions for Key Informant Interview (KII)

7. What are your health practices while you were still in the Philippines?
 - a. Consult doctors / medical professionals for a regular check up or when needed?
 - b. Seek assistance from traditional healers?
 - c. Strictly follow medical advice?
 - d. Combine medical and traditional medicine?
 - e. Do you self medicate?

8. What types of traditional health practices do you do?
 - a. Hilot/ tawas/ soub and the likes?
 - b. Put towel in the back while working? Putting a piece of cloth on the head when dusk appears?

9. What are the health practices you do now that you are in France? Why?

10. Do you follow what your doctors tell you or you still apply what you used to know?

11. How do you let your doctor know about your health concerns?
 - a. Do you talk to them and ask questions?
 - b. Do you clarify health concepts that you don't understand?
 - c. Do you tell them how you deal with your illness before?

12. Do you talk to your peers (other Filipinos) about your health concerns?
 - a. Do they give advices?
 - b. Do you follow these advices?

APPENDIX 8

Key Informant Interview (KII) Transcription

CASE 1: VOICE RECORDED INTERVIEW

Context: MARIA (not her real name), a 50 plus woman whose been living in France for more than 20 years. She recently had an operation of the thyroid because of recurring pain.

ME: aside from the operation, ano yung mga pang karaniwan na sakit na nararanasan..

MARIA: sakit sa ulo, sakit sa likod, muscles pain, sipon, ubo

ME: yung sipon ubo related sa panahon?

MARIA: depende sa klima

ME: yung sakit sa ulo, sakit sa likod, related na sa trabaho

MARIA: Oo, yung mga yun, related na sa trabaho, sobrang pagod na

ME: a doon mo na nararamdaman

MARIA:

ME: nung nasa pilipinas ka, siempre medyo bata bata ka pa noon

MARIA: naku, tagal ko ng wala sa pinas, 25 yrs na, pero kahit noon pa man, trabahador na ako..

ME: so yung mga sakit sa ulo, sakit sa likod, pangkaraniwan nay an sayo.. noon pa man mararamdaman mo nay an..

MARIA: Oo,

ME: Nung nasa pilipinas ka pa, paano mo dini deal ang mga pangkaraniwang sakit nay an?

Dinadala mob a sa doctor? Sa albularyo

MARIA: Hindi, ini inuman ko nalang ng kagaya sa atin na biogesic (pain reliever), neozep

ME: yung naka sanayan na

MARIA: pero di naman usual na kung kalian grabe na saka ka pupunta sa doctor

ME: naranasan mo na bang pumunta sa mga hilot, sa mga albularyo, tradional healers

MARIA: naranasan ko rin naman yun kasi nag mamasage ako e

ME: a nagmamasage ka

MARIA: Oo, nagmamasage ako dito dati sa France, sa Monaco

ME: E bakit umayaw ka na?

MARIA: Kasi sobrang pagod, yung force sa edad na natin, di ko na kaya

ME: Dito sa France pag nakakaramdam ng di maganda, doctor ka agad?

MARIA: Depende

ME: pag kaya pa..

MARIA: pag kaya pa, ok lang.. (meaning di muna pupunta sa doctor)

ME: pag di na kaya ..

MARIA: Pag di na kaya, tumakbo ka na (sa doctor) total wala ka naman binabayaran..

ME: malaking Factor yun sayo?

MARIA: malaking factor yun na di ka na nagbabayad .. at least na ti check ka na kung ano ba

ME: di ka na nag aalala sa bayarin ano?

MARIA: oo, di ka na nag aalala sa kailangan mong bayaran. Ultimong gamut mo e pwedeng ma reimburse.

ME: ok, naniniwala ba sa pasma? Mga hindi naliligo pag may menstration .. mga ganun?

MARIA: a hindi ko rin alam yan.. pero nung kabataan ko, yung parents ko yan din ang sinasabi sa amin. Kailangan ingatan rin naman naming ang sarili naming.. kailangan di malamigan yung..

alam mo na.. yung part na .. exclusive part.. kailangan di malamigan yun, di ka dapat kumain ng malamig, maasim, yung mga ganun ba

ME: so nung nasa pilipinas pina practice yun ..

MARIA: ay oo, kasi may magulang .. pero dito yung mga kabataan ngayon di na ini implement yan

ME: ikaw ba sinasabi mo yan sa mga anak mo?

MARIA: OO naman, dahil naranasan ko rin yun e .. dahil nung nandun ako sa pilipinas nung kabataan ko, pag kumain ako ng malamig tapos kumain ako ng maasim, sasakit ang t'yan ko.. totoo yun

ME: so proven mo yun

MARIA: proven ko yun kaya sinasabi ko sa mga anak ko na careful kayo pag may menstration.. mabuti na rin yung nag iingat

ME: ok.. kailangan ka nag de decide na bumisita na sa doctor? Pag yung talagang di na kaya?

MARIA: oo, dito naman kasi like kami every six months kailangan magpa check up dahil yun ang rules nila (referring to the French rule on health) kailangan

APPENDIX 9

Key Informant Interview

Case 2

Context: Zaldy (not his real name) 57 years old and has been living in Antibes for 18 years has all but praises to the French health care system. Coming from a family genetically predisposed for diabetes and heart problems, he started to have high cholesterol level by age 40. He started to see his doctor regularly and has been taking drugs to lower his cholesterol level.

Documentation technique: Written notes for the interviewee doesn't want to be recorded

Researcher (R): Magandang hapon Zaldy. Salamat sa pag oo sa interview na ito

Zaldy (Z): Ok lang, relax time na kasi tapos na ang trabaho

R: So, kumusta naman ang pag aalaga mo sa iyong health?

Z: Naku, ok na ok ako. Fit na fit! Maganda daw naman ang results ng mga laboratory exams ko sabi ng doctor ko.

R: Ilang beses ka bumibisita sa doctor mo?

Z: Once a month, kasi yung ---ko, par mois ang pag bibigay nya... kailangan rin nya kasi akong makita para mamonitor

R: English speaking and doctor mo?

Z: di masyado, French lagi ang usapan namin

R: Naiintindihan mo naman ?

Z: oo naman kasi binabagalan nya ang salita pag ako ang kausap. Saka nagpipilit mag English pag nakikita nya na di ko naiintindihan ang sinasabi nya

R: nagtatanong ka naman pag di mo naiintindihana ng sinasabi nya

Z: oo naman. Lalo na yung mga bawal na pagkain, ano yung mas magandang kainin at saka ano ang mga stress reliever ba... kasi ang pakiramdam ko nagkakasakit lang naman ako pag na I stress ako sa trabaho at issue sa pamilya

R: ano naman ang nakaka stress sa trabaho

Z: naku, pag maarte ang amo. O kaya may mga bisita palagi na magugulo. Kailangang i-drive, ipamilya o kaya naman pag delayed ang sweldo

R: meron bang mga pangyayaring nade delay ang sweldo

Z: naku crisis ngayon. Minsan delayed sila ng halos isang buwan.. so pag ganun, delayed din ang pagpapadala sa pinas. Nai stress ang pamilya ko doon kasi seimpre ako lang naman ang ina asahan nila.. may isa akong anak na may asawa na at walang hanap buhay yung napangasawa tapos 2 na ang anak.. sa akin pa rin naka sandal .. so ayun, kailangan kong kumayod ng double time

R: Pag ganyang stress ka, ano ang nararamdaman mo

Z: sumasakit ang batiok ko. Pakiramdam ko kasi aatakihina ako (laughing) at saka masakit ang likod ko

R: anong ginagawa mo pag ganun na may pain na nararamdaman

Z: imi inom na lang ng mga pain reliever... may alaxan naman o kaya dolfenal

R: Alaxan?

Z: Oo, galing pinas

R: Bakit meron ka nun?

Z: nagpapabili ako pag may umu uwi sa atin, Hiyang ba

R: e yung dolfenal?

Z: kasi effective din at saka mura lang

R: e yung mga gamut mo sa cholesterol mo

Z: buti na nga lang at nandito na ako sa France nang magkaroon ako nyan. Biruin mo naman ang gamutan at saka mga tests ko

APPENDIX 10

Key Informant Interview (KII) Transcription

CASE 3: Couple Interview

Context: Juliet (not her real name) has been living in France for 2 years with her family (her husband Gilbert and their two little girls). She has severe case of Rheumatoid Arthritis (RA) and she's been operated on (two sides of her hips) so she can walk normally. She is undergoing therapy and needs to continue doing that for a long time.

Documentation technique: Video Interview

Juliet (J): (while in the Philippines), I take pain reliever, steroids, may once a month ako na injection for vitamins in my bones, may pain reliever

Researcher (R): nag try ka ba na mag consult sa mga manghihilot, mga tradional healers ...

J: hay naku, shocking.. ang dami ko ng experience .. ang byenan ko dinadala ako sa mga ganun .. siempre kinuha muna ang consent nya (referring to the husband) and then sabi nung healer may sumusunod daw sa akin na bata .. so sabi ng healer yun daw ang pinag mumulan ng sakit ko.. so may mga seremonyas syang ginawa pero hinihilot nya rin naman ako

R: nakaka relieved yung hilot?

J: hhhmmm... hindi.. kasi very light lang naman ang hilot,, di nya ako hinahawakan ng husto

R: psychologically, ano ang effect sayo pag nag co consult ka sa mga healers...

J: well, psychologically na I strengthen ako.. kasi yung hope ba .. binibigyan nila ako ng hope na "o after nito, magiging ok ka na, makakalakad ka na .. kaya lang ako kasi yung tipo na pag di nangyari mapo-frustrate ako at madali ako mag give-up

R: yung mga healers na kinu-consult mo ba e affiliated sa religion o yung mga natuto lang

J: naku, marami na .. iba - iba .. pero mas marami yung di affiliated sa religion

GIL (G): (husband) .. Actually, hindi ko inin - tertain kasi hindi ako nananiniwala sa ganyan kahit na lumaki ako sa hilot at tawas..

R: A ok..

J: yung last na lang nab ago kami pumunta ditto sa France, yun yung may pinakamaraming seremonyas.. pero yung all the rest.. panay hilot lang

G: mula kasi nung maging member ako ng church (referring to Jesus is Lord Movement, an organization of born again Christian which is different in teaching and practices from the Catholic Church)...

R: Paano nabago ang paniniwala mo about healing or cure pagmula nung dumating ka ditto sa France? Di ba nung nasa Pinas complementary ang pag -gamot sayo.. may medical doctor may mga albularyo..?? Nung dumating ka dito sa France, medical doctor na lang ang tumitingin sayo, so paano nabago ang paniniwala mo about treatment ng sakit mo?

G: it's the major part.. pero ganito kasi yan.. may na meet kasi sya nan a operahan din pero sa isang hip lang, but the operation went a little wrong

J: Di pantay, yung isa mababa

G: so inoperahan sya ulit, and then there's another one na operahan sya at ganun din iika -ika pa rin ang lakad nya but theres one case na ok ang operation nya but she remained seated at walang ginagawa .. her body changes but she remained in the same state.. sa case nya (referring to Jen) she is very active in the church .. nagkaroon sya ng responsibility sa church and at the same time nagkaroon sya ng very competent na therapist, tapos of course motivation ..

R: yung therapist nya French?

G: Oo, French,, nag e- English

J: ang difference kasi sa pilipinas, hilotin lang kita ngayon bukas ok ka na..instant ba na healing

R: doctor yan?

J: hindi, yung healer ba .. yung therapist ko ngayon na Pranses, at least sinasabi sa akin na mahabang proseso yan... hindi ko sasabihin sayo na bukas ok ka na.. so ngayon alam ko na years pa talaga ang therapy ko

R: so nakatulong ba sayo o yung change of perspective ba?

J: Oo, may confidence na ako..kasi sa pilipinas, na yun pa naman ang pinaka ayaw ko,, yung tinititigan ka ng mga tao,, yung hinahabol ka ba ng tingin, ayaw na ayaw ko yun..at saka sa Pilipinas ang payo, pag may pain ilakad mo yan, kaya nag i- inflame sya dito pag may pain wag mo ipilit kasi ang kalaban ng rayuma pain.. dito pag may pain ako di nila ako hinahawakan, di nila ako pinipilit na gumalaw

Appendix 11

Website of lasantepourtous

The screenshot shows the website <http://www.lasantepourtous.com/> in a Safari browser window. The browser's address bar shows the URL and a search engine (Google). The website's navigation menu includes: **Infos Santé**, **Sexualité**, **Enfants**, **Maladies**, **Droits et Démarches**, **Numéros utiles**, and **Questions / Réponses**.

The main banner features the logo **LA SANTÉ POUR TOUS .COM** with the tagline **Mon avenir, c'est aussi ma santé**. Below the logo is a search bar with the text *Rechercher une information* and a magnifying glass icon. Below the search bar, there are example search terms: *ex : sexualité, maladie...*

The banner also includes a photograph of a woman and a child in a grocery store. To the right of the photo, there is a text box: **MANGER / BOUGER**, **MANGER, BOUGER : C'EST LA SANTÉ !**, and a button **Lire le dossier →**.

The page is divided into three main content blocks:

- Je m'informe sur la santé** (orange background):
 - SEXUALITÉ**: VIH / SIDA : toutes les raisons de faire le test!; BIEN VIVRE : Les bons gestes pour ne pas tomber malade cet hiver.
 - LES MALADIES DE A À Z**: Angine; Asthme; Choléra; Coqueluche; Diabète; VIH / Sida.
 - Buttons: **Toutes les infos →** and **Toutes les maladies →**.
- J'agis pour ma santé** (green background):
 - COMMENT ÇA MARCHE ?** Comprendre vos droits en fonction de votre situation.
 - OÙ ALLER ?** Découvrez les lieux pour vous faire soigner.
 - J'AI BESOIN D'AIDE** Qui contacter pour vous faire aider ou en cas d'urgence?
 - Button: **Toutes les infos →**.
- Vos questions, nos réponses** (blue background):
 - Je viens de refaire la chambre de mon enfant...**
 - Text: *Où, les substances chimiques qui se dégagent lors des travaux ou qui proviennent des meubles neufs (peintures, vernis, colles, etc.)...* **Lire la suite**.
 - Button: **Toutes les questions →**.

At the bottom of the page, there is a section for **Le livret de santé bilingue** (Available in 23 different languages) with a button **Télécharger**. To the right, there is a language selector set to **English** and a button **ダウンロード** (Download).

Appendix 12
English pages of the website

LIVRET DE SANTÉ
ANGLAIS/FRANÇAIS
BILINGUE

**Ce livret bilingue est disponible en FRANÇAIS/
ALBANAIS/ANGLAIS/ARABE/ARMÉNIEN/BENGALI/BULGARE/CRÉOLE HAÏTIEN
CHINOIS (MANDARIN)/ESPAGNOL/GÉORGIEN/HINDI/KURDE/LINGALA/OURDOU
PORTUGAIS/PULAR/ROUMAIN/RUSSE/SERBE/SONINKÉ/TAMOUL/TURC/WOLOF**

Texte : décembre 2005

Première impression : avril 2006

Réimpression : juin 2007

Attention : certaines informations contenues dans ce livret
sont susceptibles de modifications ultérieures.

BILINGUAL HEALTHCARE
FRENCH/ENGLISH
HANDBOOK

Text: december 2005

Note: some of the information in this booklet may be changed in the
future.



5

TO RECEIVE HEALTHCARE
POUR SE SOIGNER

- 8 "Basic" public health insurance
Sécurité sociale « de base »
- Supplementary universal medical cover
- 12 **CMU complémentaire**
- State medical aid (AME)
- 16 **Aide médicale État (AME)**
- Public Hospital PASS
- 20 **PASS de l'hôpital public**
- Specialised public healthcare services (free of charge)
- 22 **Services spécialisés de santé publique (gratuits)**
- Your regular doctor
- 24 **Médecin traitant**
- Interpretation
- 26 **Interprétariat**



28

TO TAKE CARE OF YOUR HEALTH
POUR VEILLER À SA SANTÉ

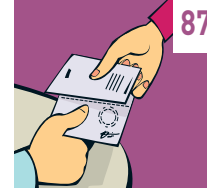
- Medical check-up
- 32 **Bilan de santé**
- HIV-AIDS
- 36 **VIH-sida**
- Sexually-transmitted diseases (STD)
- 44 **Infections sexuellement transmissibles (IST)**
- Hepatitis B and C
- 46 **Hépatites virales B et C**
- Tuberculosis
- 50 **Tuberculose**
- Vaccination
- 54 **Vaccination**
- Lifestyle
- 56 **Mode de vie**
- Contraception
- 62 **Contraception**
- Your children's health at home
- 66 **La santé de vos enfants à la maison**



69

FOR LEGAL AND SOCIAL ASSISTANCE
POUR UN SOUTIEN JURIDIQUE ET SOCIAL

- Right of asylum
- 72 **Droit d'asile**
- Right of residence in the case of very serious illness
- 74 **Droit au séjour en cas de maladie très grave**
- Legal support
- 76 **Soutien juridique**
- Social protection
- 80 **Protection sociale**
- Everyday needs
- 84 **Besoins du quotidien**



87


PERSONAL AND PRACTICAL INFORMATION
VOS INFORMATIONS PERSONNELLES ET PRATIQUES

- Paris Metro Map
- 88 **Plan du métro parisien**
- Ile-de-France RER Map
- 89 **Plan du RER francilien**
- Marseilles Metro Map
- 90 **Plan du métro marseillais**
- Lyon Metro Map
- 91 **Plan du métro lyonnais**
- 2007-2008 Calendars
- 92 **Calendriers 2007/2008**
- Your contacts
- 94 **Vos contacts**
- Your upcoming appointments
- 95 **Vos prochains rendez-vous**
- Your care organisation
- 96 **La structure qui vous accueille**

Appendix 13
Information Flyer in Filipino

**Sasamahan
mo ako?**

Mga babasahin 

Mga aklat 

Musika 

Mga pelikula 

Mga Pahayagan 

Grupo ng
mga mambabasa 

Internet 

Mga kurso 



Biblioteques de Barcelona

Appendix 14

Project Proposal to the Mayor of Nice

A l'attention de Monsieur Estrosi
Depute Mairie de Nice
Elizabeth Soliday-NAUI
President de la Metropole de la Cote d'Azur
Doctorant
5 rue de l'Hotel de Ville
i3M Laboratoire
06300 Nice, France
Faculte de Lettre
University de Nice Sophia Antipolis

23 octobre, 2013

Monsieur,

Mon nom est Elizabeth Soliday – Naui, je suis une étudiante en doctorat et sur le point de finir mes études du Laboratoire I3M à la Faculté de Lettres, Université de Nice Sophia Antipolis. Je suis originaire des Philippines et je suis venue en France par le biais de l'Union Européenne à travers le projet Erasmus Mundus Mobility avec l'Asie (EMMA). Mon domaine d'études est la communication de la Santé et mes recherches se concentrent sur l'identification des nouveaux systèmes et des pratiques des immigrants philippins situés dans trois villes (Nice, Cannes, Monaco) dans le domaine de la santé dans la Côte d'Azur. Bien que la Principauté de Monaco ne fasse pas techniquement partie de la France, je l'ai incluse en raison d'un grand nombre de Philippins qui travaillent et vivent dans cette ville.

Ma recherche a permis d'identifier le nouveau système et les croyances dans la santé émergeant des immigrants philippins, et c'était ma contribution à la littérature de la communication de la santé tout en mettant l'accent sur les immigrants Philippins. Il y a lieu de mentionner toutefois que mon étude a également constaté qu'il y a un besoin pour davantage de recherches dans le processus d'intégration de la santé des immigrants .

C'est dans cette hypothèse que je vous écris cette lettre. J'espère que l'Administration Locale de Nice peut accueillir et financer un système de collecte de données sur la santé des immigrants à commencer par les immigrants philippins. Ce groupe d'immigrants est idéal pour une expérience parce qu'ils sont gérables en terme de taille et ils sont établis en groupes sociaux.

Ce projet que je propose est le reflet d'un projet similaire réalisé au Canada appelé « LIPs » (Local Immigration Partnerships) que l'on peut traduire par : « partenariats locaux en matière d'immigration ». L'objectif principal de ce programme est de réunir les autorités et les individus ensemble pour définir les besoins des immigrants et collaborer pour aider à organiser et trouver des solutions. C'est une triste réalité que malgré le fait que la France possède un des meilleurs systèmes de soins dans le monde, il manque un système de collecte des données standardisées des immigrants. Ce serait un projet pionnier pour les politiciens locaux de Nice, à monter et soutenir ce programme qui pourrait par la suite faire des émules dans d'autres régions de France .

Je propose un projet qui permettra de relier tous les acteurs de la promotion et de la maintenance dans le domaine de la santé pour la Côte d'Azur. Ce projet est provisoirement appelé "PAIS"(Programme d'Aide aux Immigrants pour la Santé). L'intention est de faire réaliser des projets qui permettraient de déterminer ce qui suit:

- 1 . L'autoévaluation de l'état de santé des immigrants Philippins dans la région
- 2 . Problèmes de santé rencontrés par les immigrants Philippins
- 3 . La réactivité des projets actuels de santé publique aux besoins de santé des immigrants
- 4 . Recommandations sur la façon d'aborder les besoins de santé des immigrants

J'espère que vous aurez le temps d'examiner la proposition de projet attachée à cette lettre. Pour toute précision ou demande de renseignements, vous pouvez me joindre à : nauibeth@gmail.com. Dans l'attente de votre réponse la plus favorable, recevez Monsieur le Député Maire mes plus respectueuses salutations.

"PAIS"

(Programme d'Aide aux Immigrants pour la Santé)

Promoteur du projet: Elizabeth Soliday - NAUI
Présenté au: Bureau de Monsieur le Maire Christian Estrosi
Député Maire de Nice
Président de la Métropole de la Côte d'Azur
5 rue de l' Hôtel de Ville
06300 Nice , France

Date: 23 Octobre 2013

INTRODUCTION

La santé des immigrés en France s'est détériorée au cours des 30 dernières années, selon une étude menée par Catherine Berchet et Florence Jusot . En outre, les pratiques médicales établies par des bureaux et les programmes de préventions pour les immigrés ont diminués. Les immigrés ont enregistré un bon état de santé à leur arrivée mais leur niveau économique, la perte de lien social, les barrières de l'information et les attitudes discriminatoires des professionnels de la santé sont les principaux facteurs contributifs à la détérioration de leur santé (Bechet & Jusot 2012 p 1-2). Une autre étude menée par l'Institut de Recherche et d'Information en Santé Environnementale (IRDES) en 2002-2003 , en combinant le nombre de citoyens naturalisés et les immigrés étrangers, il s'agit d'une conclusion radicale que les immigrés ont des problèmes de santé, ils souffrent de maladies chroniques et de limitations d'activité. Considérant que la population des immigrés en France a continué de croître et qu'elle atteint 5,34 millions en 2008 (INSEE), le statut de leur état de santé signalé est une menace à la fois pour les immigrés et pour l'Etat. La même étude a également signalé que 6-8 % de la population des Alpes Maritimes sont des immigrés et que cette région est une destination populaire pour les immigrés .

Il a été établi que la France ne dispose pas d'un système standard de collecte des données de santé pour les immigrés par rapport à d'autres homologues européens comme la Suède, les Pays-Bas et le Royaume-Uni. Sans les données nécessaires pour déterminer les problèmes de santé de base de la population migrante l'Etat est mal équipé pour évaluer les difficultés de ce groupe minoritaire ce qui peut éventuellement conduire à des problèmes plus graves. Les résultats de ce manque d'informations remet en question les difficultés rencontrées par les immigrés dans leur processus d' assimilation et d'intégration compte tenu de la complexité et l'unicité du système de soins français.

Qu'est-ce que cela signifie pour les immigrés : que leur pays d'accueil est considéré comme le meilleur système de soins de santé dans le monde ? A l'autre extrémité, comment le gouvernement français répond à la composition en constante évolution de ses citoyens ? De même, la pertinence des mesures de l'état pour la santé quand la population immigrée est concernée ?

RAISON

Les données sur la santé des immigrés doivent être mises à jour parce que la connaissance de leur état de santé est basée sur l'évaluation auto-déclarée. L'État doit avoir ses propres recherches qui pourraient confirmer ou infirmer ce rapport. Il existe un programme au Canada appelé LIPS (partenariats locaux en matière d'immigration), qui met toutes les

personnes impliquées en relation pour déterminer les besoins des immigrants de façon à trouver des solutions stables et réalisables dans les soins des immigrants .

Le Département des services de santé des États-Unis a reconnu que, dans leur communauté la barrière de la langue est le facteur de division majeure entre les immigrants et les soins. Ils ont reconnu aussi que l'absence d'interprétation adéquate est une forme de discrimination. Ils ont donc développé un ensemble de directives nommées : « Culturally and Linguistically Appropriate Services » (CLAS) que l'on peut traduire par : services appropriés culturellement et linguistiquement. Les normes du CLAS exigent que les organisations de santé offrent et fournissent des services d'assistance linguistiques aux patients (LEP) et excluent l'usage des membres de la famille comme interprètes à moins que le patient en fasse la demande expresse (Ngo - Metzger et . al. 2007).

Ceci est encore renforcé dans une étude sur les patients qui ont été identifiés comme « LEP » (Limited English Proficient) ou limités en anglais expérimenté par Ngo -Metzger et al. Les États-Unis ont aussi examiné l'effet de la discordance des langues sur le degré d'éducation sanitaire et la qualité des soins interpersonnels que les patients ont reçus, également évalué les effets sur la satisfaction des patients ou comment la présence / absence d'un interprète de la clinique affecte ces résultats. Leurs populations migrantes sont les hispanophones et les Américains d'origine asiatique, en particulier vietnamienne et chinoise (Ngo - Metzger et . al .). La langue comme obstacle pour les LEP est associée à moins d'éducation pour la santé, à des soins interpersonnels et une faible satisfaction du patient.

Ces études ont non seulement identifié les défis auxquels sont confrontés les immigrants dans le processus d'assimilation et d'intégration de la santé, mais plus important encore, elles ont souligné la réponse du Gouvernement aux problèmes de santé des immigrants.

Ma proposition est un projet pionnier dans le Sud de la France. Il n'y a eu aucune étude récente sur la santé des immigrants, à plus forte raison d'un groupe minoritaire, l'aide actuelle accordée aux immigrants par «lasantepourtous» basée à la Mairie de Nice, comprend des cours de langue et la façon de gérer les documents pour être enregistré dans les systèmes sociaux en France. Il n'y a eu aucune étude récente spécifiquement basée sur la santé des immigrants.

Pourquoi les immigrants philippins ?

Ce groupe d'immigrants a cimenté leur place dans le tissu même de la vie française. Ils ont acquis une excellente réputation en tant que gardiens des villas, des aides à domicile, nounous et à peu près tous les travaux liés au domaine domestique. Cependant, certains se sont aventurés dans des emplois liés à l'économie et la première génération d'immigrants philippins ont de meilleures opportunités car ils sont déjà français à bien des égards. Les Philippins sont populairement connus comme travailleurs acharnés, ils représentent la poussée des travailleurs dignes et fiables enfin ils sont des citoyens respectueux de la loi dont l'objectif principal est de gagner une descente vie pour leur famille.

Pour ce projet, le groupe d'immigrants philippins est un bon début pour tester les théories et répondre aux questions concernant la façon dont les immigrants s'adaptent à être assimilés et intégrés dans le système Français de santé. Leur nombre est restreint ce qui les rend facile à gérer, ils sont organisés ce qui les rends accessibles et ils sont ouverts et donc communiquent facilement.

OBJECTIFS:

- 1 . Déterminer l'état de santé des immigrés philippins dans la région
- 2 . Détecter les difficultés rencontrées par les immigrants philippins concernant la santé
- 3 . Comparer les différences entre les projets actuels de santé publique et les besoins des immigrants
- 4 . Formuler des recommandations sur la façon d'aborder les besoins des migrants pour la santé

METHODOLOGIE ET CALENDRIER

Phase 1 : 6 semaines (1 ½ mois)

TABLE RONDE / documents et examens des projets

Rassemblement de toutes les parties qui comprend : des professionnels de la santé, des politiciens locaux , les concepteurs de la Campagne de la Santé, des chercheurs et des représentants de groupes d'immigrants philippins. Ils détermineront les programmes de santé destinés aux immigrants et qu'elles seront les réalisations de ces programmes, ce qui pourra être amélioré ainsi que l'identification et la définition des besoins de santé de ces groupes d'immigrants

Phase II : Enquête 8 semaines (2 mois)

Effectuer des sondages. Un questionnaire permettra de déterminer les questions / préoccupations des immigrants qui les empêchent de s'intégrer dans le système de soins Français. Ils seront également questionnés sur leur perception de leur état de santé actuel ainsi que d'autres problèmes de santé annexes qui doivent être identifiés.

Phase III : groupes de discussions 18 semaines (4 ½ mois)

Pour valider le résultat de l'enquête, les immigrants sélectionnés seront invités à une discussion approfondie avec des questions liées à leur sentiments d'immigrés dans le sud de la France et à leur état de santé.

Phase IV- rédaction et la finalisation des recommandations 12 (3 mois)

Tous les acteurs dirigés par l'Equipe de Recherche élaboreront et finaliseront un rapport qui sera soumis au bureau du Maire, qui a financé le projet.

Institutions / PERSONNES IMPLIQUÉES

- 1 . Politiques des gouvernements locaux
- 2 . Les bureaux de santé locaux et les professionnels de la santé
- 3 . Organisations qui appuient l'intégration des immigrants dans la région
- 4 . Groupes d'immigrants philippins

BUDGET - à déterminer

Appendix 15
Answer from the office of the Mayor



VILLE DE NICE

Madame Elisabeth SOLIDAY-NAUI
Doctorant
13M Laboratoire
Faculté de Lettres, Arts et Sciences
Humaines
Université de Nice Sophia Antipolis
98 boulevard Edouard Herriot
BP 3209
06204 NICE CEDEX 3

Nice, le **15 NOV. 2013**

Madame,

J'ai pris connaissance avec une particulière attention de votre courrier du 23 octobre 2013 par lequel vous avez bien voulu me transmettre le Programme d'Aide aux Immigrants pour la Santé que vous avez élaboré dans le cadre de vos études de doctorat.

J'ai aussitôt saisi de votre démarche Monsieur le Directeur de la Santé Publique, afin qu'il étudie celle-ci avec soin.

Soyez assurée que vous serez tenue informée, dans les meilleurs délais possibles, de la suite qui pourra lui être réservée.

Dans l'attente et demeurant à votre écoute, je vous prie de croire, Madame, à l'assurance de mes respectueux hommages.

Pour le Maire et par délégation
Le Directeur Général du Vivre Ensemble
et de la Proximité

Monique BAILET

Les informations recueillies font l'objet d'un traitement informatique. Conformément aux articles 39 et suivants de la loi n° 78-17 du 06 janvier 1978 modifiée relative à l'Informatique, aux Fichiers et aux Libertés, vous bénéficiez d'un droit d'accès et de rectification aux informations qui vous concernent en vous adressant au Service Santé Inspection de Santé 10, rue Hancy.

E-courrier N° 345856/349758 -PL /sm
Ville de Nice - Direction Générale Adjointe du Vivre Ensemble et de la Proximité
Direction de la Santé Publique — 06364 Nice Cedex 4
eglantine.castanet@ville-nice.fr

