Violence Against Migrant Women, Health and Sexuality: Trajectories of Women from Sub-Saharan Africa Living with HIV/AIDS in France

Dolorès Pourette

Research into violence against women has shown the impact it has on their health (Jaspard et al 2003; Saurel-Cubizolles 2005). The experience of sexual violence in childhood or of intimate partner violence puts women at risk of health problems, particularly sexually transmitted diseases, as it makes women less able to negotiate safe sex or control their sexual and reproductive lives (Damant et al. 2003; Salomon and Hamelin 2008). Illness is a time of physical, physiological and social frailty. Research among people living with HIV/AIDS has shown that the diagnosis leads to isolation from family and society, marked social vulnerability and exclusion from the labour market (Pierret 2006), particularly for foreign migrants (Lot et al. 2004). For these migrants, however, illness can open the way to regularising their administrative status by means of a residence permit for medical reasons. Illness thus becomes a political issue (Fassin 2001) though these permits are becoming increasingly hard to obtain, so limiting immigrant patients' access to citizenship and employment.

Immigrant women are particularly disadvantaged. They are subject to inequality in a number of forms owing to their fragile administrative status, their gender, class and 'race', and their confinement to a limited fraction of the labour market, particularly formal or informal sector domestic service (Anderson 1997; Momsen 1999; Oso Casa 2005). The administrative exclusion of immigrants and their exclusion from the labour market are products of an institutionalised racism (Bataille 1999) which hampers their access to Europe and to social and political rights. It makes women particularly vulnerable and exposes them to multiple forms of exploitation and interpersonal violence, intimate partner violence in particular. Those suffering from a stigmatised disease for which treatment is not available in their country of origin are even more vulnerable. For these sick, destitute immigrant women, survival often involves exploitation of their bodies (Sayad 1999), through domestic labour and through sexual exploitation; women's sexuality is still

subject to control and violence (Tabet 2004), particularly in situations of social insecurity. While the link between intimate partner violence and the risk of HIV infection has been demonstrated (Van der Straten et al. 1995; Maman et al. 2000; Jewkes et al. 2003; Murray et al. 2006), few have analysed the combined effects of immigrant status and HIV status on the risk of being a victim of violence.

This paper, based on the narratives of African women living with HIV in France, will highlight the different types of institutional and interpersonal violence that shape their experience of migration and illness. We will show how the different types of violence they suffer form an interconnected pattern inherent in a particular social and political context. We will describe the strategies or tactics women adopt to cope with these constraints in situations where remaining in France is a matter of survival.

Background

One feature of the AIDS epidemic in Western Europe is the large number of foreigners among those living with HIV/AIDS. Most of these people are from Sub-Saharan Africa and many of them are women (O'Farrell et al. 1995; Del Amo et al. 1996; Low et al. 1996; Hamers and Downs 2004; Staehelin et al. 2004; Dieleman 2008). In 2009, approximately 4,000 new HIV infections were diagnosed in persons infected through heterosexual contact: around 1,600 women and 1,100 men born abroad, mainly in Sub-Saharan Africa (InVS 2010). The high proportion of Sub-Saharan Africans among HIV/AIDS patients in Europe is due to the severity of the epidemic in African countries[1], the lack of access to treatment in the countries of origin and the migration flows between European countries and their former colonies. The high proportion of women among the immigrant patients is due to the fact that in those countries HIV is transmitted primarily through heterosexual intercourse[2].

1 On UNAIDS estimates, of the 39 million people living with HIV in the world nearly 25 million live in Sub-Saharan Africa (UNAIDS 2006).

2 In Sub-Saharan Africa approximately 60% of HIV-positive individuals are women (UNAIDS 2006).

Residence rights increasingly hard to obtain

Research on immigrants living with HIV/AIDS in France, conducted in the late 1990s and early 2000s, highlighted the extent to which recognition of a person's HIV-positive status could be a condition for obtaining residence rights (Fassin 2004). HIV-positive foreigners living in France can apply for a temporary residence permit[3] for medical reasons[4]. This permit is intended for foreigners living in France and suffering from a serious illness that cannot be treated in their country of origin[5]. Since 2002, however, legal residence has become increasingly difficult to obtain and the conditions for the issue of permits increasingly restrictive (Sopena 2006); immigration policy now aims to restrict the number of residence permits issued for medical reasons. This has led to numerous malfunctions in the application of the law in this respect. The Observatoire du Droit à la Santé des Étrangers Malades (ODSE) has denounced the appalling reception conditions in the prefectures; the fact that applicants are asked to produce documents not required by law; demands for undue fees; failure to respect medical confidentiality; long processing delays, amongst others (ODSE 2008). As a result, since 2003 there has been a sharp drop in the application acceptance rate in *départements* (local authority areas) where demand is high (Veisse 2006). Every year since 2007 has seen an increase in the numbers of refusals to renew medically-based residence permits for people whose state of health has by no means improved, with more applicants detained and more sick foreigners deported. A study of local practice in processing applications for *Aide Médicale de l'État* (AME, the health coverage for undocumented foreign residents who are waiting permits shows how administrative practice and managerial organisation slow down the ap-

3 There are three types of residence permit in France: a provisional residence permit (*autorisation provisoire de séjour*), variable in length but rarely exceeding 6 months; the temporary residence permit (*carte de séjour temporaire*) valid for a year, and the ten-year permit (*carte de résident*).

4 'Unless his/her presence constitutes a threat to public order, the *carte de séjour temporaire* marked 'private and family life' is delivered as of right (*de plein droit*) to a foreigner living habitually in France and whose state of health requires medical care lack of which would have exceptionally serious consequences, provided he/she cannot in reality obtain appropriate treatment in their country of origin. The decision to issue a *carte de séjour* is taken by the prefect or, in Paris, by the chief of police, on the advice of a doctor, either the public health inspector from the health and social services office of the *département* where the applicant lives or, in Paris, the head of the police prefecture's medical service. The doctor in question can call in the applicant for medical examination before a regional medical commission whose composition is decided by the Council of State, by decree. The permit issued under the present clause gives the holder the right to work."

5 Based on a full medical report issued by a hospital doctor or other authorised doctor, a public health medical inspector pronounces on the severity of the illness and the necessity of having it treated in France. The prefect has the final decision, however.

plication process and so hamper access to care (Gabarro 2009; Carde 2006; 2007).

Discrimination in the labour market

Foreigners in France cannot legally work without a residence permit. The difficulty of acquiring one makes them vulnerable in the labour market. Neither a receipt for application for a residence permit, nor a provisional permit, nor refugee status gives the holder the right to work legally. Even the one-year *carte de séjour* does not necessarily bestow the right to work (the ten-year *carte de résident* does so). Nor do employment policies favour the inclusion of immigrants and foreigners in the labour market: foreign diplomas are not necessarily recognised by the French system. And access to vocational training is subject to highly restrictive conditions: one must be registered as a job seeker with the national employment agency, and to be so registered one must have at least a one-year residence permit marked 'salaried employee' (Langlet 2005).

As regards foreign and immigrant women specifically, even those with legal residency documents face discrimination in the labour market. As many studies of gender and international migration have shown, migrant women are to a very large extent confined to domestic work connected with the reproductive sphere (Anderson 1997; Momsen 1999; Oso Casas 2005). The main obstacle to finding work is the fact that most of these women have no qualifications, or at least are considered unqualified, having little professional experience in France and being marked out for discrimination by their physical appearance[6]. Social constructs also represent 'black' women as tougher and stronger than 'white' women and better able to endure difficult working conditions (Ferreira de Macêdo 2003). Further, migrant women's attempts to form businesses or open shops are by no means encouraged by the authorities. Such initiatives are rarely granted start-up subsidies and are restricted to 'traditionally' female occupations in the service industries, where sales volumes and wages are relatively low (Morokvasic Muller 1987).

6 In France, the 'rate of employment of women born in Sub-Saharan Africa (...) remains lower than the rate for economically active women as a whole' (Roulleau Berger and Lanquetin 2004: 21).

The survey

This paper is based on anthropological research conducted in 2005–2006 among women from Sub-Saharan Africa living with HIV/AIDS in France[7]. Thirty-two women were interviewed in anonymous, individual, semi-structured interviews. They were recruited in several hospitals in the Paris region and two community associations helping people living with HIV.[8] [9] The women interviewed were aged between 22 and 51, with an average age of 35. They came from eleven Sub-Saharan African countries, the main ones being Cameroon, Côte d'Ivoire, Democratic Republic of the Congo and Republic of the Congo (Congo-Brazzaville). Their personal, social, migratory and family trajectories varied widely. Although they often had several reasons for emigrating (Morokvasic 1983; Kofman, Phizacklea, Raghuram and Sales 2000), analysis of their migration trajectories brought to light three main profiles (Pourette 2008a).

The first profile was that of *migration for health reasons*. These women had discovered they were HIV-positive in Africa and had adopted the strategy of coming to Europe for treatment. They were between 28 and 34 years old at the time of the interview and had migrated alone, with the help of family or associations. They had arrived in France between 2000 and 2005. On arrival all had been, or were, in situations of extreme insecurity, living on the street or emergency hostels, without papers. Most were from middle class backgrounds. Five were without work, three were working full time and one part time. Two were married, one was cohabiting with a partner, four were in living-apart relationships and two were single. Only one woman said her papers were not in order. Four had one-year *cartes de séjour*, three had provisional permits and one a full *carte de résidente*.

A second profile was that of *economic migration*. These women had adopted a strategy of migrating to obtain work, education or training. Most were young women who had come to France on their own. They had learned of

7 This was post-doctoral research conducted at Inserm/INED research unit 569, and was funded by Sidaction and the Fondation de France (see also Pourette 2006, 2008a, 2008b).

8 The recruitment criteria were as follows: over 18 years of age, born in a country of Sub-Saharan Africa, having been living in France for at least a year and having been diagnosed as HIV-positive at least a year before the date of the survey. In the hospitals, the doctors were responsible for presenting the study to eligible patients and asking for their agreement to take part. The same principle was applied in the associations. The choice of location for the interview (at the hospital, in the association's premises or in my office) was left to the interviewee. Each interview lasted one to three hours and was recorded with the respondent's agreement. The interviews were transcribed and analysed using a biographical approach and a cross-thematic approach.

9 For the purposes of comparison, interviews were also conducted with ten men from Sub-Saharan Africa, under the same conditions as the interviews with women.

their HIV status after arriving in France (after 2000), and this had led them to redefine their initial migration project. They too had been in very insecure situations on arrival (including those from privileged backgrounds). They were between 22 and 45 years old at the time of the interviews. Most of these women were single and out of work at the time of the survey. Only one of them had a full time job (as an accountant). Four were working part time in the domestic service sector. They were from a variety of social backgrounds: six were working class, six were middle class and three were upper class. Most of these women's applications for work permits were being processed at the time of the survey; for the rest, four had three-month provisional permits and four had one-year *carte de séjour.* Only one woman said she had no papers.

A third profile was that of *family migration.* These women had come to France in the 1980s and 1990s through the family reunification procedure. They had discovered they were HIV-positive while living in a couple and had already been settled in France for over ten years. They had been tested for HIV in the 1990s and were between 30 and 51 years old at the time of the interview. All were or had been married (three were divorced). Their access to residence had come either under the rules for family reunification or in the context of marriage with a French national. Their social situations were varied. One was working full time, three part time, and four were not in work. Two of them had French nationality. Three had the full ten-year residence permit; three had one-year permits.

Institutional and interpersonal violence

Analysis of the interviews shows that the tougher legislation, migrants' insecure situations and their weak position in the labour market are forms of institutional violence that increase their vulnerability and make their experience of migration especially distressing when, as is often the case, they are very isolated. Their trajectories highlight the impact of this institutional violence on their lack of security and their living conditions as migrants. Although several women had been temporarily housed by acquaintances on arrival, most had to sleep in emergency shelters or even in the street, or were housed by associations for people living with HIV. In this type of collective accommodation, they found themselves with homeless or sick people and felt they were seen as belonging to these stigmatised categories. The women also deplored the fact that they could not bring their children to France[10] which

10 Ten of the 32 women interviewed had left one or more children in their home country.

reinforced their sense of isolation. As regards resources and employment, those without the right to work legally had to turn to the informal sector – unofficial domestic work (housework, childminding etc.) or prostitution – to survive (Moujoud and Pourette 2005). For those who had obtained a residence permit that allowed them to work, domestic work, often part time, was still the main job opportunity whatever qualifications they may have (one woman in the survey had a postgraduate diploma in history, another had begun medical studies). These jobs involved a certain amount of physical exertion, which these women could not always supply because of their state of health. Of the 32 women interviewed, only five had full time jobs; eight were working part time and 19 were not in paid work.

Discrimination and institutional violence against migrant women, and the resulting social, economic and administrative insecurity, made them particularly vulnerable when confronted with interpersonal violence.

Interpersonal violence

Exploitation and discrimination

The women's narratives show how their exclusion from the labour market exposes them to numerous forms of exploitation by unscrupulous people (men and women). Many of the women had suffered forms of violence from their informal 'employers'. One such was Ella:

> Ella is 22 years old, from Ghana. She came to Europe clandestinely, reaching Italy by boat, in the hope of finding work. Arriving in a French coastal town in December 2003, Ella slept in the open until she was taken in by a Ghanaian who offered her lodging in exchange for domestic services. But he also forced her to have sex with him. It was her first sexual experience. She managed to escape from him, stealing €30 to take the train to Paris. In the capital, she again slept in the street until a Ghanaian woman took her in. Ella had not only to do all the housework but also to work without respite in the woman's fabric shop. After a few months, feeling ill, with no papers and no medical insurance, she went to a hospital. The doctor who agreed to examine her found she was six months pregnant. A few days later she was told she had the AIDS virus. At the time of the interview, Ella was living in a maternity hostel with her six-month-old daughter, who was in good health.

This example is a classic case of exploitation of migrants by migrant men or women, sometimes from the same country. In addition, while these forms of violence are not directly related to health status, the way the women were seen by others (apart from medical staff and family who, when informed, generally provided considerable support), the malicious gossip and the dis-

crimination against HIV-positive people, constitute moral violence and were felt to be such by the women concerned. To avoid discrimination on account of their illness, the women did all in their power to keep it secret. But sometimes the truth came out. The consequences were often painful for the women concerned, as 45-year old Nayah from Cameroon explained:

> A woman with HIV is not happy. I'll tell you a story. My husband insulted me in front of a neighbour and the neighbour heard that I had AIDS. As I'm a home help and he knows the elderly family I work for, he went to see them and told them 'The lady who does your housework, she's got AIDS'. They asked me if it was true and I said no. But since then I feel ... shaken. I feel uncomfortable. I feel weird when I go to their place. You feel the rejection. As AIDS is not a disease like ... cancer... You can't tell people you have AIDS. They see you differently...

It is within the couple relationship that the women are particularly exposed to violence of various kinds.

Violence in the couple

Several studies have shown the links between intimate partner violence and HIV. In the first place, violence in the couple is an obstacle to taking preventive measures and is associated with a higher risk of infection (Van der Straten et al. 1995; Maman et al. 2000; Jewkes et al. 2003; Murray et al. 2006). Secondly, studies in African countries among women living with HIV/AIDS have shown that they are more often victims of violence than are uninfected women (Gielen et al. 1997; Gielen et al. 2000; Maman et al. 2002; McDonnell et al. 2003). The accounts of the women we met in this research highlight the different forms of violence involved. Nayah's account, though not exhaustive, illustrates the link between HIV infection and conjugal violence.

> Nayah is 45 and comes from Cameroon, where she lived until 2001. She has had no children but is raising her sister's daughter, whom she regards as her own. The child was 14 at the time of the interview. She had several couple relationships before coming to France. The last of these was a four-year relationship with a married man to whom she was much attached. Although Nayah was, in her own terms, his 'mistress', she knew his family and it was a firmly established relationship. Nayah had several HIV tests performed while undergoing medical examinations for her sterility. These were negative when the relationship began. Looking back she says she did not dare ask him to take a test because he was married and of a certain 'social rank'. When he ended the relationship (Nayah explains the breakup as being due to her failure to give him a child), she was very depressed and thought she would have more luck with an 'expat'[11]. She met the man who

11 As used by Nayah, the term 'expat' means a French person living in France (and who may never have lived anywhere else).

> was to become her husband via the Internet. The first virtual contact was in November 2000; he went to meet her in Cameroon in February 2001; in June 2001 she came to France with her daughter and they were married. Their first sexual relations were protected. They both had tests carried out before the marriage, but the future husband did not want to wait for the results before marrying; he said the test results would not change his decision to marry her. The test proved negative for him and positive for her. At first, Nayah's husband was supportive and considerate, but then his attitude changed radically:
>
> 'The man who accepted me as I was has turned against me very badly. That really hurts ... And I was grateful to him because it's thanks to him that I'm alive, it's thanks to him that I found out ... He used to say 'If I hadn't been there you'd already be buried in your village!' ... He forced me to work. I didn't have the right to have a cheque book or a credit card (...). He even forbade me to come and see the psychologist here'.
>
> A victim of psychological violence, Nayah also suffered physical and sexual violence: her husband beat her, forced her to have sex and did not always use a condom, so that Nayah feared he would be infected by her. This situation lasted for three years until he forced her to leave their home. The divorce proceedings were under way at the time of the interview. After the separation the moral hurts continued: her husband told her daughter her mother had AIDS and also betrayed the secret to his family:
>
> 'But I had kept my health status secret because he himself kept it secret for three years. He'd introduced me to his whole family. I was welcomed. The whole family liked me. He said that if I told them [that he beat me] he would tell them about my state of health ... I think he has told them now. Because I have no more news from anyone.'.

Nayah's narrative shows how a conjugal relationship based on unequal social and administrative integration in the host country and inequality in HIV status (serodifference) favours violence in the couple. Although the violence did not begin at the time of the positive test result (as it did for two other interviewees), the husband based his domination on the secret of his wife's HIV status. In immigrant situations, this is often a secret shared only with the spouse. The threat of revealing the facts to family, friends and neighbours is a particularly effective way to force submission in a social and administrative setting where immigrant women have few alternatives for working and surviving, and hence little freedom to denounce a violent husband's acts.

Nayah's narrative echoes several experiences of violence related by other interviewees in serodifferent couples (couples where one partner is HIV-positive, the other HIV-negative): threats to reveal HIV status; carrying out that threat after the separation; moral, physical and sexual violence; refusal to routinely use a condom; imposing on the partner a form of sexuality she de-

scribes as unwanted and distressing. Some women in seroconcordant couples (where both partners were HIV positive), or where the woman did not know whether her spouse was or not, told of other forms of violence. Several women learned that their spouse was infected, and knew it, when they discovered that they themselves were HIV-positive. Their spouse had not told them and had not practised safe sex. One such case was Clémence: only when she wanted to leave the man who had been her partner for a year did he tell her he was 'ill'. Tissina, who was tested for HIV when she was pregnant, supposed that her spouse already knew he was infected because he showed no surprise when she told him the positive test results. Further, couples who are both HIV-positive are advised to use condoms to avoid superinfection, but it seems this advice is rarely followed. The women interviewed told us how hard they found it to negotiate condom use with their partners. Though some spouses take risks with their own health this way, their refusal to wear condoms also puts their partner's health at risk, which can be regarded as a form of violence.

Denial of the wife's illness (leading to unprotected sex) can also be experienced as abuse. Sonia, aged 30 and from Senegal, had been married for two years when, following a high fever, she discovered she was HIV positive. She was then 24 years old. She tried to talk to her husband about it but he denied the illness, saying that *'it's something the whites invented, it doesn't exist'*. Since her positive test in 1999, Sonia had never managed to establish a dialogue with her husband about the illness, their sexual and reproductive life or the fact that he too might be infected. She did not know whether he had had himself tested. This denial of the illness goes hand in hand with physical and sexual violence in the couple, which had worsened since the diagnosis. Physical, psychological and sexual violence are not limited to the couple's life together; several of the life histories reveal violence by ex-spouses. After their divorce, Barbara's ex-husband harassed her by telephone until the police put a stop to it. He told his friends and neighbours she had HIV and he refused to pay maintenance for their two children. When Anne ended her relationship with a man after discovering that he was married, she learned from a friend that her ex-partner was telling people she 'killed people'.

For immigrant women living with HIV, institutional and interpersonal violence are often linked. It is because they are socially and administratively excluded that they enter into highly unequal relationships that nonetheless enable them to stay in France (as they must if they are to survive), or are subjected to some form of domestic or sexual exploitation. It is because they are socially and administratively excluded that they cannot denounce the violence they suffer or leave a violent husband.

Women confronted with violence

Having come to France to find work, better living conditions or treatment, all the women interviewed had adopted migration strategies to leave home for Europe, sometimes with the help of their families. Once in France, they were confronted with a set of structural forces that kept them in highly unequal relations of class, gender and 'race' and subjected them to institutional and interpersonal violence and exploitation. In view of the necessity of staying in France to receive treatment they developed 'strategies' or 'tactics' (de Certeau 1980) according to the resources available to them and the constraints placed on them. A clear example of such strategies is the decision to marry, marriage being the main legal way to acquire residence papers (Pourette 2008a). But as we have seen, this strategy can lead women into relationships of extreme domination and violence.

The other strategy women use to stay in France is to proclaim their illness and make it a 'profession' (Herzlich 1989). This means acknowledging themselves as people with HIV and establishing that identity in other people's eyes in a situation where HIV-positive people are stigmatised. They then make HIV their main preoccupation, joining AIDS prevention associations or HIV victims support associations. Three of the women interviewed had become health mediators in community associations helping patients (two were working part time, one full time). It was thanks to these associations that they had obtained residence permits giving them the right to vocational training and then the right to work in France. For these women the fight against their illness became the central focus of their lives, a profession and the basis of a particular but lasting form of social integration (Herzlich 1989).

Conclusion

In the current French political context, immigrants find it increasingly hard to acquire social rights, citizenship and medical treatment, while the women experience gender inequality in addition to the inequalities of 'race' and class. In this context, the fact of being infected with a sexually transmitted disease, a virus with strongly negative social connotations and for which the treatment is unavailable in many Southern countries, accentuates these women's isolation and confines them to the privacy of the marital home. And we know how seriously abusive a place that can be. Needing to live in France to receive treatment and survive, they are faced with painful choices: to stay among their family and friends but as a sick person with a shorter lifespan, or leave them to go far away to survive for an indefinite time. These women's

narratives show the strategies they adopted for leaving home and surviving as immigrants. But the situations they describe highlight the need for immigrant women to have access to official work contracts and financial independence so that they will not be forced into intimate partner relationships that often prove highly unequal, or so that they can leave a violent spouse or end an unsatisfactory relationship.

References

Anderson, Bridget (1997): Servants and Slaves: Europe's Domestic Workers. Race and Class 39,1, pp. 37–49.

Bataille, Philippe (1999): Racisme institutionnel, racisme culturel et discriminations. In: Dewitte, P. (1999): Immigration et intégration. L'état des savoirs. Paris: La Découverte, pp. 285–293.

Carde, Estelle (2006): On ne laisse mourir personne. Les discriminations dans l'accès aux soins. In: Travailler 6, pp. 57–80.

Carde, Estelle (2007): Les discriminations selon l'origine dans l'accès aux soins. In: Santé Publique 2, pp. 99–110.

Damant, Dominique/Trottier, Germain/Paré, Ginette/Binet, Lise/Noël, Linda/Lindsay, Jocelyn/Langevin, Marie-Ève (2003): Femmes, violence, ITS/VIH-SIDA. Rapport de recherche, Montréal, Centre de recherche interdisciplinaire sur la violence familiale et la violence faite aux femmes, 99 p.

De Certeau, Michel (1980): L'invention du quotidien. 1. Arts de faire, Paris, Gallimard.

Dieleman, Myriam (2008): Migrantes subsahariennes et VIH. Trajectoires et vulnérabilités. Bruxelles: Observatoire du Sida et des sexualités (FUSL).

Fassin, Didier (2001): Une double peine. La condition sociale des immigrés malades du sida. In: L'Homme 160, pp. 137–162.

Fassin, Didier (2004): Le corps exposé. Essai d'économie morale de l'illégitimité. In: Fassin, Didier/Memmi, Dominique (2004): Le gouvernement des corps. Paris: Editions de l'EHESS, pp. 237–266.

Ferreira de Macêdo, Maria Bernardete (2003): Femmes de ménage et veilleurs de nuit: une approche sexuée du travail précaire dans un hôtel en France. Cahiers du Genre 35, pp. 189–208.

Gabarro, Céline (2009): Instruction des demandes d'Aide Médicale de l'Etat: comment les pratiques managériales et administratives de l'Assurance maladie accroissent les difficultés d'obtention de cette prestation. Colloque « Migrations humaines et circulations des ressources. La santé en temps de mondialisation », Université Paris Diderot, 24–25 septembre 2009.

Gielen, A.C./O'Campo, P./Faden, R.R. et al. (1997): Women's disclosure of HIV status: experiences of mistreatment and violence in an urban setting. Women Health 25, 3, pp. 19–31.

Gielen, A.C./McDonnell, K.A./Burke, J.G. et al. (2000): Women's lives after an HIV-positive diagnosis: disclosure and violence. In: Matern Child Health J. 4, 2, pp. 111–20.

Hamers, Françoise F./Downs, Angela M. (2004): The Changing Face of the HIV Epidemic in Western Europe: What are the Implications for Public Health Policies? In: Lancet 364,3, pp. 83–94.

Herzlich, Claudine (1989/1992/2005): Santé et maladie, analyse d'une représentation sociale. Paris: Editions de l'EHESS.

InVS (Institut de Veille Sanitaire) (2010): Surveillance de l'infection à VIH-sida en France, 2009. Bulletin Epidémiologique Hebdomadaire 45–46, pp. 467–472.

Jaspard, Maryse/Brown, Elizabeth/Condon, Stéphanie/Fougeyrollas-Schwebel, Dominique/Houel, Annik/Lhomond, Brigitte/Maillochon, Florence/Saurel-Cubizolles, Marie-Josèphe/Schiltz, Marie-Ange (2003): Les violences envers les femmes en France. Une enquête nationale. Paris: La Documentation française.

Jewkes, R.K./Levin, J.B./Loveday, A. et al. (2003): Gender inequalities, intimate partner violence and HIV preventive practices: findings of a South African cross-sectional study. In: Soc Sci Med 56, pp. 125–134.

Kofman, Eleonore/Phizacklea, Annie/Raghuram, Parvati/Sales, Rosemary (2000): Gender and International Migration in Europe. Employment, welfare and politics. London, New York: Routledge.

Langlet, Marianne (2005): Accès à l'emploi: mirage inaccessible pour des étrangers malades? In: Journal du sida 181, pp. 21–2.

Lot, Florence/Larsen, Christine/Valin, Nadia/Gouëzel, Pascal/Blanchon, Thierry/Laporte, Anne (2004): Parcours sociomédical des personnes originaires d'Afrique subsaharienne atteintes par le VIH, prises en charge dans les hôpitaux d'Ile-de-France, 2002. In: Bulletin Epidémiologique Hebdomadaire 5, pp. 17–20.

Low, N./Paine, K./Clark, R./Mahalingam, M./Pozniak, A.L. (1996): AIDS Survival and Progression in Black Africans Living in South London, 1986–1994. In: Genitourinary Medicine 72, 1, pp. 12–16.

Maman, S./Campbell, J./Sweat, M.D. et al. (2000): The intersections of HIV and violence: directions for future research and interventions. In: Soc Sci Med 50, 4, pp. 459–478.

Maman, S./Mbwambo, J.K./Hogan, N.M. et al. (2002): HIV-positive women report more lifetime partner violence: findings from a voluntary counseling and testing clinic in Dar es Salaam, Tanzania. In: Am J Public Health 92, 8, pp. 1331–1337.

McDonnell, K.A./Gielen, A.C./O'Campo, P. (2003): Does HIV status make a difference in the experience of lifetime abuse? Descriptions of lifetime abuse and its context among low-income urban women. In: J Urban Health. 80, 3, pp. 494–509.

Momsen, Janet (1999): Gender, Migration and Domestic Service. London: Routledge.

Morokvasic, Mirjana. (1983): Women in migration. In: Phizacklea, Annie (ed.) (1983): One Way Ticket. London: Routledge, pp. 13–31.

Morokvasic Muller, M. (1987): Entreprendre au féminin en Europe: Cas des immigrées et des minorités en France, en Grande-Bretagne, en Italie, au Portugal et en République fédérale d'Allemagne: motivations, situations et recommandations pour action. Bruxelles: Commission des Communautés européennes.

Moujoud, Nasima/Pourette, Dolorès (2005): 'Traite' de femmes migrantes, domesticité et prostitution. À propos de migrations interne et externe. Cahiers d'Etudes Africaines 179–180, pp. 1093–1121.

Murray, L.K./Haworth, A./Semrau, K. et al. (2006): Violence and abuse among HIV-infected women and their children in Zambia: a qualitative study. In: J Nerv Ment Dis, 194, 8, pp. 610–615.

O'Farrell, Nigel/Lau, R./Yoganathan, Kathir/Bradbeer, C.S./Griffin, G.E./Pozniak, Anton (1995): AIDS in Africans Living in London. In: Genitourinary Medicine 71, 6, pp. 358–362.

Observatoire du droit à la santé des étrangers (ODSE) (2008): La régularisation pour raison médicale en France. Un bilan de santé alarmant. Rapport de l'ODSE (unpubl.).

Oso Casas, Laura (2005): Femmes, actrices des mouvements migratoires. In: Verschuur, Christine/Fenneke, Reysoo (2005): Genre, nouvelle division internationale du travail et migrations. Paris: L'Harmattan pp. 35–54.

Pierret, Janine (2006): Vivre avec le VIH. Enquête de longue durée auprès des personnes infectées. Paris: PUF.

Pourette, Dolorès (2006): Le couple migrant confronté au VIH. In: Hommes et migrations 1262, pp. 88–97.

Pourette, Dolorès (2008a): Migratory Paths, Experiences of AIDS and Sexuality: African Women living with HIV/Aids in France. In: Feminist Economics 14, 4, pp. 149–181.

Pourette, Dolorès (2008b): Couple et sexualité des femmes d'Afrique subsaharienne vivant avec le VIH/sida en France. In: Médecine/Sciences. Numéro spécial: Les femmes et le sida en France. Enjeux sociaux et de santé publique 24, 2, pp. 184–192.

Roulleau Berger, Laurence/Lanquetin, Marie-Thérèse (2004): Femmes d'origine étrangère. Travail, accès à l'emploi, discriminations de genre. Paris: La Documentation française.

Salomon, Christine/Hamelin, Christine (2008): Normes de genre, violences sexuelles et vulnérabilité au VIH/sida en Nouvelle-Calédonie. In: Médecine/Sciences. Numéro spécial: Les femmes et le sida en France. Enjeux sociaux et de santé publique 24, 2, pp. 103–110.

Saurel-Cubizolles, Marie-Josèphe (2005): Violences envers les femmes et état de santé mentale: résultats de l'enquête Enveff 2000. In: Bulletin Epidémiologique Hebdomadaire 9–10, pp. 36–37.

Sayad, Abdelmayek (1999): La double absence. Paris: Seuil.

Sopena, Antonin (2006): Nouvelle stratégie contre les malades étrangers. In: Plein Droit 71, pp. 26–29.

Staehelin, Cornelia/Egloff, Niklaus/Rickenbach, Martin/Kopp, Christine/Furrer, Hansjakob (2004): Migrants from Sub-Saharan Africa in the Swiss HIV Cohort Study: a Single Center Study of Epidemiologic Migration-specific and Clinical Features. In: AIDS Patient Care STDS 18, 11, pp. 665–75.

Tabet, Paola (2004): La grande arnaque. Sexualité des femmes et échange économico-sexuel. Paris: L'Harmattan.

Van der Straten, A./King, R./Grinstead, O. et al. (1995): Couple communication, sexual coercion and HIV risk reduction in Kigali, Rwanda. In: AIDS 9, 8, pp. 935–944.

Veïsse, Arnaud (2006): Le médecin, la santé et le séjour des étrangers. In: Plein Droit 69, pp. 32–35.