

The homeless population and Covid-19: a study of the application of humanitarian *praxis* by non-profit organisations in Marseille

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While Marseille has received a lot of media attention since the beginning of the pandemic, the hard work undertaken by local medical and social service providers has remained hidden. This article provides the opportunity to measure their dedication. Above all, bringing together several experts alongside anthropologist Olivia Nevissas, it sets the stage for a potential revival of humanitarian action.

The current Covid-19 health crisis has changed the face of emergency humanitarian action. Usually deployed in areas perceived as being far away, humanitarian action has become a reality for certain public housing, medical and social support workers, who have found themselves facing complex challenges at the epicentre of the current health and social crisis. One of these challenges has been the need for workers to properly protect themselves when taking care of homeless people living in squats and/or slums, or dealing with drug addiction. All while the media focused on intensive care units becoming overwhelmed and the number of deaths caused by the new coronavirus. It was in this context – after rapidly assessing the risk¹ of infection and the impact of increasing uncertainty around public health (as defined by the World Health Organization [WHO]) – that local organisations were forced to use their imagination to adapt, improvise and innovate, striving for greater reactivity and effectiveness given the urgency of the situation.

We wanted to document these experiments. They should be viewed through the prism of a solid foundation of existing techniques and experiences in the area of solidarity and community action. However, we have observed that the constraints of the health and social crisis have pushed certain non-profit organisations in Marseille to change their standard discourse and practices (relating to healthcare, social assistance, housing, psychosocial support, partner relations and coordination), and to adopt unusual operating procedures and emergency protocols that fall under the umbrella of humanitarian action².

The aim of this article is to describe the perceptions of the various health and psychosocial risk factors that professionals from non-profit organisations faced in the field between July and the beginning of September 2020. In response to the perceived adversity, we have also analysed the tools and re-sources employed by each stakeholder to take care of themselves and others.

¹ Risk can be defined as an undesirable situation, with an uncertain outcome, in which something of value (health, safety or life itself) can potentially be lost. See Kirsten Stalker, "Managing risk and uncertainty in social work: a literature review", *Journal of Social Work*, vol.3 (2), 1 August 2003, p.211-233.

² Laëtitia Atlani-Duault et Laurent Vidal (dir.), *Anthropologie de l'aide humanitaire et du développement : des pratiques aux savoirs, des savoirs aux pratiques*, Armand Colin, 2009. See also the article by Sandrine Revet about this book in the review *Critique internationale*, 2010/1, n° 46, p.181-186, <https://spire.sciencespo.fr/hdl:/2441/eu4vqp9ompqllr09i6215i909/resources/2010-revet-anthropologie-de-l-aide-humanitaire.pdf>

Methodology

We integrated a qualitative component – two socio-anthropological studies – to the “Covidep Homeless” research project. The project is being conducted by the hospitals within the AP-HM network (Assistance Publique – Hôpitaux de Marseille [Marseille University Hospitals]), working in partnership with the NGO *Médecins du Monde* (Doctors of the World/MdM) and ASSAb³ in Marseille. Its main goal is to measure the morbidity and mortality of people living on the street, in emergency shelters, in squats or in slums. The sample for the study – some of the results of which we present in this article – includes twenty-seven employees from local emergency shelters, day centres for young workers and asylum seekers, outreach clinics designed to reduce the risks of drug addiction⁴, and healthcare and social services for vulnerable populations. The backgrounds of the people interviewed between July and September 2020 vary greatly, ranging from department heads to programme coordinators, social workers, nurses, psychologists, sociologists and anthropologists⁵. Another sociological study was conducted on the perception of the Covid-19 health crisis by homeless individuals.

Perceptions and acceptance of the health and psychosocial risks

The normal strains placed on the social organisation of work within the non-profits and at the intervention locations (environmental factors) were exacerbated from the start of lockdown: an often frenetic work pace that clearly had an impact on employees’ personal lives, emotionally and socially demanding tasks, ethical dilemmas, a feeling of helplessness, exposure to infection risks, violence, etc.

The lockdown began in a context of chronic lack of staff (employees and volunteers) and resources, shockingly so in certain front line social support facilities. It served as a catalyst for a pre-existing “malaise”⁶ at work for social workers in France. At every facility included in the study, the workload between March and July related to the reorganisation of services or the integration of new staff added another stress factor to other existing factors.

“When I worked here, I worked twelve to thirteen hours per day during lockdown – and with my mobile turned on all the time! It was even on when I was at home taking care of my kids.” – A medical-social programme coordinator

Although risk perception is primarily influenced not by the need for clear information but by the need for psychological protection relative to what is understood as being dangerous⁷, the absence of “clear directives from the government regarding protective measures” (department head) generated a feeling of (perceived) stress among the majority of the study participants. When exposed to the risk of being infected by the coronavirus due to a lack of protective equipment (masks, hand sanitiser, scrubs, etc.) between March and May, some professionals and volunteers either quit or asked to stay at home for medical reasons due to their age and/or morbidity factors related to their own personal health, or due to fears of being stigmatised by family members and friends.

Their social representations of the risks to their health and psychosocial well-being at work varied based on several factors, meaning the experience of working during lockdown and its subsequent lifting did not have the same repercussions for everyone. These factors included being assigned to a specific location (a centre, the streets, squats and slums) and different populations. More personal

³ A networking project focused on providing access to basic rights, healthcare and continuity of care for the homeless population of Marseille: <https://projetassab.org>

⁴ Non-profits in the sample: Groupe SOS (emergency accommodation unit), ADDAP 13 (slum project), CHRS Forbin, the Caso (Centre d’accueil, de soins et d’orientation) and “Squats et bidonvilles” projects by *Médecins du Monde*, the community mental health service run by the non-profit MARSS, and the risk reduction project led by the non-profit Bus 31/32.

⁵ This study received approval from the Comité de protection des personnes Île-de-France VI under registration number 20.05.11.70516.

⁶ Abraham Franssen, « Les travailleurs du non-marchand : héros et victimes. Demande de reconnaissance et transaction identitaire », *Recherches sociologiques*, vol. 30, n° 2, 1999, p. 159-181.

⁷ Helene Joffe, « De la perception à la représentation du risque : le rôle des médias », *Hermès, La Revue*, 2005/1, n° 41, p. 121-129.

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factors like age, family situation, overall physical and mental health, professional experience (level of knowledge and skills applying “outreach” strategies in public emergencies and epidemics and to different populations) also need to be considered. For a few of the people interviewed, the level of dedication to their work – somewhere between vocation and professional obligation – changed the manner in which they weighed up the risk. As a result, these two categories clearly influenced the relationship to professional risk.

“This is not only a vocation, but it’s more than just a job. When it comes to the risk of catching an infectious disease, we are used to it.” – *A nurse*

Facing staff shortages and an increase in the volume of interventions required to care for and protect populations in need, many workers remained in post in spite of their fears of catching the virus and the considerable emotional and physical fatigue they endured during lockdown.

“I was infected with the coronavirus in March and was extremely weak, but decided to quarantine myself at the CHRS⁸ so I could continue to work, as well as to protect my family.” – *A caseworker*

Interpreting coronavirus protocols presented a considerable challenge⁹, given the differences between service user populations and management teams, and even an additional source of stress. Faced with varying perceptions of the virus, staff needed to reassure and reduce anxiety among service users, as well as to prepare the sick and potential contacts for the possibility of accusations and stigmatisation.

“We started to provide more community information at the beginning of March. We never gave up. We had to make sure that the populations we care for clearly understood what the coronavirus was and that it could affect anyone. Very soon, there was some confusion, as they mistakenly thought that only white people could catch the virus.” – *CHRS nurse coordinator*

As illustrated by the following first-hand account from a project manager, there were two co-existing approaches to the management of the several hundred people in the emergency shelters of their non-profit. On one side, there was the “coercive” approach, tending towards “health [and safety] at all costs”, which ran the risk of creating additional suffering and anxiety among the service user population. The other more “understanding”¹⁰ (empathetic) approach, aimed at providing a more human response and asking that trust be placed in the staff’s cultural, health education, and psychosocial skills and experience.

“When we [wanted to organise] workshops with the people receiving assistance, several facilities [said no], saying that the risk [was] too high. We [...] believed that the population we serve would not be able to handle the isolation, and so we used the lockdown to reinforce our bond with these people. So, yes, we took risks. When playing Scrabble, for example, we didn’t disinfect the [...] letters [of the game], we followed all protective measures as best we could, we tested everyone, and in the end we had very few cases even though there were some. We made PPE available when we had it. Sure, we walked a tight line between a ‘health at all costs’ and a ‘we don’t care, it’s just the flu’ approach. We needed to find a happy medium, and to find this happy medium it’s clear that we needed to take into consideration the health situation and have a good knowledge of the populations we serve... and of our staff!” – *A department head*

Applying humanitarian praxis: when epidemiological risk and social crisis collide

We observed that certain non-profits applied different adaptation strategies when providing assistance

⁸ Centre d’hébergement et de réinsertion sociale (social crisis shelter).

⁹ Related to the perceived causes of a disease (aetiology), how suffering is expressed, perceived stigmatisation and treatments, based on subjectivity, language, religious and ethnic affiliation, and individual social codes and family customs. For more on this topic read Arthur Kleinman, *Patients and healers in the context of culture*, Berkeley, University of California Press, 1980.

¹⁰ Alain Epelboin, « L’anthropologue dans la réponse aux épidémies : science, savoir-faire ou placebo ? », *Bulletin Amades* [online], 78, 2009.

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by adopting an emergency doctor “mindset”, (re)defining their missions and different ways to (re)deploy their outreach programmes. Others relied heavily on a single intervention location or suspended their programmes for a given time before deploying them in a different manner. In addition, the modifications needed to ensure that employees and/or volunteers – some of whom were new – could be either physically present or work remotely required a lot of discussion and negotiation. This brings us to the notion of *praxis*, which takes into consideration stakeholder practices, from intention to implementation, alongside reflection on these practices.

At the start of lockdown, the “regular populations” these organisations served found themselves in unprecedented and sometimes critical situations. In addition, “new populations” appeared. In just a few days, people with no fixed abode had to lock down in one place. Various actions were taken, including triaging the user population by “at-risk category”, setting up Covid units in shelters, creating optimisation strategies for the area’s entire social housing pool in order to provide emergency shelter, forming groups to check in on vulnerable people living in hotels or at home, and increasing food bank and soup kitchen services tenfold, as well as organising the delivery of food, hygiene products and substitution treatments (like methadone). These actions were created to address both basic and specific needs. This led to better communication and cooperation between people with different skill sets and tasks.

“We wanted to do activist work through emergency interventions. The people living in squats could not lock down and shelter in place, so canvassing the city made sense. We went from risk reduction to food distribution through informal partnerships with other non-profits.” – *A social worker with a mobile team*

More than anything else, they needed to prevent the risk of coronavirus infection and to avoid clusters forming within the homeless population, which was considered “at risk”¹¹. For this to work, the medico-social and management teams needed to be protected. In certain cases, due to a conflict in values or administrative delays, teams on the ground took the initiative and/or negotiated with their directors, to take the lead and act on their own.

“There was a teamwork problem and a loss of activist values before the Covid crisis. We had stopped working on outreach. Lockdown allowed us to discuss and negotiate with our managers, and to start canvassing the area again to keep people from exposing themselves to risks on the streets, such as contracting the virus or being fined. We had to be persuasive. In the end we won, but barely.” – *A social worker*

Known for sometimes having undesirable side effects on the quality of the rapport between aid workers and the people receiving assistance, emergency measures often offer the opportunity to rethink how workers deliver assistance and their relationship with “lost populations”¹².

“We had to make sure that we did not antagonise them when we canvassed the streets during lockdown, and not act authoritarian or paternalistic. We were afraid that we would lose [sight] of our guys, our service users, and see our rapport with them deteriorate. In fact, the opposite occurred. We were able to do community education, something we had no longer been able to do.” – *A caseworker in a mobile team*

While the temporary postponement or halting of certain activities (like administrative follow-up) had an impact, other actions in such areas as group housing and emergency shelters quickly emerged. Changes in professional practices, the development of new approaches and the (co) creation of experiential

¹¹ People living on the street are especially vulnerable when it comes to somatic issues, with standardised mortality ratios (*ratios standardisés de mortalité* – RSM in French) three to thirteen times higher than the general population. The prevalence of chronic diseases – especially pulmonary – smoking, men and an aging street population represent some of the many serious risk factors. Specifically, the prevalence and transmission of respiratory viruses among the homeless population has been studied very little (Badiaga *et al.*, *Eur J Pub Health*, 2009; Rodwell *et al.* *Emerg Infe Dis*, 2010; Story *et al.*, *BMC Pub Health*, 2014). Difficulties accessing care, the prevalence of psychiatric disorders and of addictions can lead to difficulties in caring for people with Covid-19. Being infected with Covid-19 can increase this morbidity and mortality.

¹² Bernard Hours, *L’Idéologie humanitaire ou le spectacle de l’altérité perdue*, L’Harmattan, 1998.

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knowledge also emerged around the issue of the social and emotional well-being of locked down populations.

“We had to create and manage a collective during the day so that everyone abided by the lockdown. So [...] we started to organise activities, workshops, and began to allow alcohol consumption on site. There you have it. Things that did not exist at all before... Well not ‘not at all’, but nothing was official or the focus of a specific project.” – *A nurse and department head for an emergency shelter*

The stakeholders and user populations recognise that spending lockdown in shelters and the increase in canvassing offered the chance to reintroduce a clinical component to their presence, to rethink the framework of social work with regard to care.

“Relieved of their administrative tasks, the team used tools and respectful work modalities so that the duration of stay or care was adjusted appropriately, to create social bonds... that turned out to be very unique.” – *A CHRS psychologist*

More than the sum of each intervention (shelter, food assistance, medical care and Covid prevention, psychosocial clinical care, social work), the Covid crisis phase revealed a real capacity for all contributors to coordinate. The interdependent connections within a team, as well as within a network of stakeholders (non-profit and institutional), were strengthened, especially at the beginning of the process of finding emergency accommodation for the homeless and nomadic populations.

“Care for us includes the therapeutic relationship as much as it does the organisational framework. Our chosen social, decision-making, and organisational structure also has a political component. Going from caring for one person to caring for an entire population is no small step. Over the past weeks, our work on the ground to contain the virus and take care of the populations we serve, well, it should inspire the whole political sphere.” – *The head of a community project*

In addition, we will see how this allowed stakeholders in the field to reinvent themselves or to reaffirm their mandate, their organisational identity, or even to redefine their projects and objectives. For example, the “Squats and Slums” projects led by the Provence-Alpes-Côte d’Azur section of MdM recognised the need to reinforce community health practices, and to empower and train volunteers. The inclusion of peer workers or health mediators in virus prevention work clearly needed to be increased in order to address the socio-cultural barriers to accessing healthcare.

Learning lessons, leaving tracks for a new future

We have seen that the health and social crisis during lockdown presented itself, to certain professionals, as an opportunity to experiment with new ways to provide healthcare education, emotional support and social assistance to their user groups. Others saw functional relationships and/or mutual assistance pathways develop between professionals in different technical and scientific fields, each making very different yet complementary contributions.

Will these changes in practices last? Today, the stakeholders look at this “jerry rigging” (in the DIY sense), with its successes, inventions and failures, as a laboratory for new practices in health and social action. Some teams indicated that there were lessons to be learned from this experience of mobilisation. As a response to this, the idea of “leaving tracks” is being discussed by non-profit organisations and the professionals that work for them. “I see this as a platform of real-world experience that our collective memory has not yet forgotten”, acknowledges one stakeholder. However, in the context of the machine that is the health and social crisis, he adds: “After a crisis phase that encouraged creativity, I fear a return to the ways of the past”.

“We need to look back at the big picture to know what we should keep after the crisis is over. I’m pessimistic, since we all have a tendency to return to our old habits.” – *A health centre coordinator*

Even though the crisis revealed underlying or “invisible” social issues, which became especially intolerable and therefore object of struggles that have become crucial again, we nevertheless wonder if the non-profits working with the homeless population will have the same resilience and ability to “bounce back” in the future. Before the crisis, healthcare professionals and social workers feared a massive reduction in private and government funding, as well as much stricter policies regarding social programmes and asylum regulations. Today, they look at the pandemic situation in Marseille as having exacerbated professional challenges from the “world of before”, including being “out of action, affected by social and moral despair, undermined in terms of both their technical ability and their interventionist ideals”¹³.

This is why we urgently need to foster a dialogue between institutional stakeholders, non-profits involved in human rights projects, and interventional research in public health and human and social sciences. This will make it much easier to come up with an integrated response to the health, economic and social problems the crisis has caused among the most vulnerable population groups.

Translated from the French by Darin Reisman

Biographies

Olivia Nevissas • Since 2008, anthropologist Olivia Nevissas has been involved in crisis and post-crisis programmes run by *Médecins du Monde* and Handicap International (in Haiti, Iraq, Lebanon, Jordan, Somalia, Rwanda, the Democratic Republic of Congo, South Sudan, Bangladesh and Madagascar), either conducting anthropological studies or working as a technician in mental health and psychosocial support. Since June 2020, she has been in charge of a study for the Covidep Homeless programme (Marseille University Hospitals – Psychiatric Centre – MARSS Mobile Psychiatric Vulnerability Team, Marseille, France) and a study funded by Fondation Croix-Rouge française in relation to the Covid-19 crisis.

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Olivia Nevissas et al., “The homeless population and Covid-19: a study of the application of humanitarian praxis by non-profit organisations in Marseille”, *Humanitarian Alternatives*, n°15, November 2020, p.35-47,
<http://alternatives-humanitaires.org/en/2020/11/21/the-homeless-population-and-covid-19-a-study-of-the-application-of-humanitarian-praxis-by-non-profit-organisations-in-marseille/>
ISBN of the article (PDF): 978-2-37704-728-4

¹³ Christian Laval, Guillaume Pégon et Bertrand Ravon, « La sociologie dans le vif de la clinique psychosociale », *Rhizome*, n° 46-47, décembre 2012, p. 3-5.