ALTERNATIVE REPORT ON THE IMPLEMENTATION OF THE UNITED NATIONS CONVENTION OF THE RIGHTS OF THE CHILD BY FRANCE

« When structural islamophobia violates the rights of children of Muslim faith or children perceived as such »

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TABLE OF CONTENTS

INTRODUCTION

The Human Rights Association – Collective Against Islamophobia in France (ADDH-CCIF) is a human rights organisation created in 2003 which goal is the fight against Islamophobia. Islamophobia is all acts of discrimination and violence towards physical persons or legal entities due to their real or perceived Muslimness.

The CCIF is specialised into Islamophobia, yet it condemns all forms of racism and intolerance.

The visibility of Muslim communities in France has entailed public authorities' tension as well as an increase in Islamophobic acts. In 2019, the ADDH-CCIF recorded a new increase in Islamophobic acts – a 17% increase over the year 2018 and a 77%[1] increase over the year 2017. The year 2019 was marked by a strong and crucial willingness from the State to implement tough security measures and basic human rights restriction that blatantly target Muslim citizens or people perceived as such.

Our expertise attests that Islamophobia does not only encompasses acts of discrimination and violence targeting adults – indeed, Muslim children and youth or people perceived as such are by extension victims too. This observation leads us to the submission of this report.

This report has been drafted based on the reporting recorded by the ADDH-CCIF, on its legal monitoring work as well as on public policies analyses which outreach concerns Muslim (or perceived as such) children's rights.

The ADDH-CCIF records all information requests, testimonies and recording it receives. Only Islamophobic acts – which are all acts of discrimination and violence towards physical persons or legal entities due to their real or perceived Muslimness - are considered into our database. ADDH-CCIF's jurists determine whether the request or recording is a proven Islamophobic fact. Their analysis is based on the victim's account, on the gathered elements as well as on the interviews and exchanges, notably in the form of letters including all involved parties. While the legal service remains the central pole of the association, it is necessary to recall that ADDH-CCIF offers the victims it supports assistance through its psychological pole. It develops its analysis through its Research Unit and raises awareness of the whole population to the Islamophobic phenomenon through its Communication Unit.

Just like any other anti-racist organisations, the ADDH-CCIF faces the phenomenon of under-reporting of Islamophobic acts, also known as the dark figure. Therefore, it is necessary not to forget this phenomenon when it comes to analysing the statistics presented in this report. Indeed, it reflects only partially the Islamophobic reality.

The ADDH-CCIF oversees cases implying children whose rights to non-discrimination were violated. Nonetheless, this difference in treatment experienced by Muslim children (or perceived as such) only constitutes a single dimension amid the myriad of others that are being violated. Indeed, too often, treating children in a different manner due to their beliefs inevitably entails the violation of other human rights well rooted in the International Convention on the Rights of the Child, ratified by France in 1990. The Convention can only be appreciated as a whole, due to the strong correlation between Articles. Therefore, some of the multidimensional issues shall be presented in several sections of the so-called report.

[1] http://www.islamophobie.net/rapport-2020/

Following the terrorist attacks that occurred in January and November 2015, the establishment of the state of emergency and its institutionalization in ordinary law through the Internal Security and Fight against Terrorism Act, as well as the many debates on the religion, several laws have been adopted in order to prevent all acts of violent extremism and to avoid any communitarian divide. The new public policies have identified, as part of the fight against radicalisation, communitarianism and separatism, some solutions to the above societal phenomena. These solutions are based on the "weak signals", which deserve many observations.

The ADDH-CCIF shall demonstrate that those solutions infringe some of the fundamental rights of the child notably the ones guaranteed in the International Convention on the Rights of the Child.

I/ GENERAL MEASURES OF IMPLEMENTATION

A. THE IMPLEMENTATION OF THE CONVENTION

Regarding the reservation in Article 30

In its fifth periodic report analysing the implementation of the Convention on the Rights of the Child, France maintains its reservation regarding the implementation of Article 30, stating that "the French legal framework does not allow for the recognition of collective rights of any group whether the later is defined by its origin, culture, language or belief". Besides, this reservation is asserted in the third and fourth reports' argument in which France recalls that the principle of indivisibility of the Republic impedes the implementation of Article 30. France considers that equality of rights including principle of non-discrimination, as well as unity and indivisibility of the Republic implying population and national territory, shape the minorities' French approach. Moreover, France considers that equality and non-discrimination principles should be sufficient to provide satisfactory protection for all citizens.

Several comments can be made at this stage. First and foremost, it appears that France recognises the existence of "minorities" as well as their legal status abroad like certified by its international implication in the fight against persecutions towards minorities in the Middle East[2]. This recognition abroad carry protection of the cultural, ethnic, and religious diversity of the States in which France is being involved. Then, we call the reality of the French cultural diversity into question if the latter does not come along with the legal recognition of minorities in France.

Therefore, we urge France to revise its interpretation of indivisibility principle enshrined in Article 1 of 1958 Constitution. We recommend that the reach of this principle be limited to the Republican territory and not to the French population. It is highly necessary that the French Constitution does recognise the very notion of "minorities". It is said that this recognition would be hampered by "the risks of communitarian abuses"[3]. These abuses would be defined by a minority's willingness to place its own law above the Republican one[4]. However, to date, no scientific research does back the existence of such a social phenomenon. No research has shown that minorities in France implement or wish to implement another law than the French one. This restriction would enable the necessary recognition of ethnic and religious minorities and a better implementation of the Convention on the Rights of the Child.

The lifting of the reservation to article 30 would enable a better understanding and respect of the best interests of each child as set out in article 3 of the Convention, which is a fundamental concept running through the whole Convention and of which well-being is a constituent element. The well-being of children is social, spiritual and moral. The protection of all its components requires, in fact, the recognition of the identity of the minority to which the child belongs.

[2] https://onu.delegfrance.org/Laurent-Fabius-propose-une-Charte

[3] Eighth item in the third and fourth french periodic reports on the Convention on the Rights of the Child.

[4] Coronavirus et risques de replis communautaristes, appendix

B. THE EXISTING MECHANISMS TO CONTROL THE GOOD IMPLEMENTATION OF THE CONVENTION AND TO COORDINATE THE ACTION IN FAVOUR OF THE CHILD

A parliamentarian study group on the Rights of the Child and the protection of the Youth which goal is the good implementation of the Convention on the Rights of the Child was settled in 2018. We hope that this group shall raise the appropriate concerns regarding the recognition of the rights of the child from ethnic and religious minorities and shall hear civil society organisations that promote and defend the rights of the minorities in France. Indeed, the reality of discrimination suffered by ethnic and religious minorities affects both adults and children. These hearings will provide a better understanding of the identity and difficulties encountered by children from minorities and thus a better grasp of their best interests.

C. OBSERVATORY REMARKS

ADDH-CCIF recommends that the Prime Minister should propose to the President of the Republic to revise the 1958 Constitution, as permitted under article 89, in order to recognize the very concept of minorities and to restrict the principle of indivisibility to the national territory alone. Failing that, and still in accordance with article 89 of the Constitution, the ADDH-CCIF recommends that a parliamentary group be set up to work on a draft constitutional revision covering the same measures.

ADDH-CCIF requests that the study group on the Rights of the Child and the protection of the Youth should hear at least once a year from NGOs working to fight discrimination, and not only from NGOs specializing in the defence of children's rights.

II/ GENERAL PRINCIPLES

A. Non-discrimination

In its last report, France stated not to have observed any stigmatisation nor global intolerance towards children and youth whether it be at school or in the media. France notably recalls that principle of equality is at the basis of the French legal system and that the fight against discrimination is an integral part of the French policy. The ADDH-CCIF does not share those views.

1.About the abusive alarming reports and child reporting

Indeed, notably at school, the CCIF has observed the emergence of abusive alarming reports and child reporting targeting Muslim children. The alarming report is defined in Article R226-2-2 of the Social Action and Family Code to be "an information transmitted to the departmental unit mentioned in the Second Alinea of the Article L. 226-3 in order to alert the President of the Departmental Council on the situation of a minor with or without accompaniment:

- That would let think that their heath, security, or morality are jeopardized or at risk
- Or that the conditions of their education or physical, emotional, intellectual and social development are seriously jeopardized or at risk".

In contrast, the reporting refers to the process that consists for the National Education staff of directly approaching the Public Prosecutor.

This new phenomenon of alarming reports and child reporting targeting Muslim children has appeared in 2015, after the terrorist attacks. The phenomenon has then largely increased following the Plan for the Prevention of Radicalisation in February 23, 2018 and after the statement of the President Macron in October 8, 2019 establishing that society ought to be most vigilant based on "weak signals" of radicalisation. Since the 1st of January 2019, our legal department has accompanied 49 families falsely accused of radicalisation and that must have complied with the rules of alarming reports and reporting. This statistic does not reflect the reality of the phenomenon: the phenomenon of underreporting of Islamophobic acts allows us to establish with confidence that the number is much greater.

The Minister of the Interior, Mr. Castaner, said on October 8, 2019 :

"Among the signs that should be a warning, there is a rigorous religious practice, particularly exacerbated during Ramadan, a change in the behavior of the individual or his entourage, the wearing of a beard, the fact of no longer kissing - we have mentioned it in this case, even if the information is contradictory -, the fact that the individual does not agree to team up with a woman, the regular and ostentatious practice of ritual prayer, the presence of hyperkeratosis in the middle of the forehead - the tabaâ - or the wearing of the full veil on the public highway for a female civil servant. »

This statement shows that the radicalisation like understood by the public authorities only describes the regular practice of Islam. Thus, many children that randomly expressed their religious identity, described social behaviours within the family, or whose parents are overtly practicing Muslims, were reported for radicalisation. These reporting are discriminatory from the fact that there are based on the real or perceived children or parents' belonging to Islam. Hence, children shall automatically be treated in a different way due to groundless suspicions.

Indeed, the ADDH-CCIF was called upon for a case in which a 5-years old child playing with their friends in kindergarten would have allegedly said "my father will kill them all, he's got guns at home". Following this statement, the Headmaster immediately contacted the Academy which then reported the child to the unit in charge of gathering and evaluating alarming reports. No dialogue with the family was engaged to understand the words of the child. If so, the family would have rapidly provided an explanation since the child did refer to a video game known as "Call of Duty" in which the father indulged in. After the groundless accusation, the family house and restaurant were raided. The father was placed in custody one day and only after the hearing of his spouse and his child he was released. The Prosecutor did apologise.

2. About the difficulties faced by the accompanying veiled Muslim mothers

Since 2012, the CCIF accompanies an increasing number of veiled Muslim mothers wishing to accompany classes in school outings and activities occurring within and without the school premises. On December 19, 2013, following the referral of the Human Rights Defender, the Council of State released a study on the issue, establishing that parents are users of public services. The Council of State considers "parents to be users whose behaviours may be submitted to requirements that can rise from particular texts or considerations linked to public order or the great implementation of services"[5].

The Administrative Court of Nice, called upon as part of a refusal of accompaniment in school outing because of the mother wearing the headscarf, condemned this refusal through a judgment released on the 9th of June 2015 n°1305386 in which it recognises the discrimination in such a restriction and prohibits it once "it is clear that the Administration refused to pursue it without using any legal means such as a precise regulation nor considerations linked to public order and to the great implementation of services. Therefore, the decision taken on the 6th of January 2014, in which Mrs D was unauthorised to accompany children in school outing in Nice is illegal".

Thus, given the state of the case law, no text expressively prohibits the wearing of the headscarf or any other religious signs by parents accompanying children in school outings.

Nonetheless, in July 23, 2019, a judgement of the Administrative Court of Appeal of Lyon stated that parents and teachers are bound by the principle of neutrality during school activities organised in the classroom.

In this case, two mothers wearing the headscarf contested the Rector's decision of the Academy of Lyon that allows the two mothers to participate only if they wear "neutral clothes". The Administrative Court of Lyon had to determine the question of neutrality imposed to parents within their children's school. The plaintiffs asserted that the decision taken by the Rector did blatantly target Muslim veiled mothers and turned into a general prohibition to participate in activities. The Court rejected this argument stating that the decision "does not have the object or the effect of establishing a general ban targeting veiled mothers to participate in school activities".

For the judges, the principle of laicité in the public education, which is an element that directly builds the State laicité and the neutrality of public services, "imposes that on the one hand education be taught in respect of this neutrality (through programs and teachers) and that on the other hand, in respect of children's freedom of conscience". Under the same principle, the Court

[5] https://www.defenseurdesdroits.fr/sites/default/files/atoms/files/ddd_avis_20130909_laicite.pdf

considers that "whatever the capacity in which they act, people that participate in activities within the school premises, assimilable to the ones provided by teachers, must abide by the principle of neutrality".

However, it is hard to assert by fact which are "the activities assimilable to the ones provided by teachers". The complicated factual qualification involves an inaccuracy in the definition of the applicable legal status. This jurisprudence seems de facto discriminating Muslim veiled mothers and their children who shall not be accompanied by their mothers owing to religious affiliation. On the 11th of October 2019, the ADDH- CCIF was called upon the following case:

During a school visit at the Bourgogne-Franche-Comté Regional Council, Fatima E was verbally abused by the MP Julien Odoul, representative of the Rassemblement National (far-right wing party). Odoul said to the Council President that "on behalf of our principle of neutrality, I kindly ask you to demand the accompanying mother to withdraw her Islamic veil". He purported that they were in a public area.

The Minister of Education Jean Michel Blanquer declared on French television that the behaviour of Mr. Odoul was to be condemned whereas he added that "the veil is not desirable in our society". This ambivalence from the Minister contributes to fuel suspicions towards Muslim parents.

3. <u>About the relationship with the public authorities</u>

It is a truism that the ADDH-CCIF warmly welcomes the implementation of the plan "Espoir-banlieue" created in 2008 as well as the dialogue police-youth in 2009, albeit we remain vigilant regarding police practices in relation with children from Muslim (or perceived as such) poor areas.

The ADDH-CCIF brings to the Committee's attention the decision of the Human Rights Defender (HRD) in 12 May 2020. The HRD was asked to intervene in a case of systematic identity checks targeting minors living in a Parisian popular neighbourhood. The HRD shed light upon the existence of a systemic discrimination defined by checks always targeting the same minors. Those checks were always ordered by the Administration that wanted the youth to leave. We bring to the Committee's attention that these minors were called "the unwanted people" in the police official records.

The investigations carried out by the General Inspection of the National Police and by the Human Rights Defender have proved that "police officers systematically scroll down the wanted people register in case of identity checks – every time, even if the person had already been checked in the week. These practices are not illegal, yet they target this specific population constituting de facto an unfavourable treatment that inevitably entails tension in the relationship between the checked youth and the police officers".

We urge for better homogeneous territorial distribution of officers, broaden investigation measures, and fair sanctions according to the infringement. It is necessary that during contempt and rebellion proceedings against police officers, the investigation be systematically relocated so it cannot be conducted by police officers belonging to the same service than the ones who have launched the proceedings.

B. THE BEST INTERESTS OF THE CHILD AND THE RESPECT OF THE CHILD'S VIEWS

The CCIF rejoices with the direct applicability and legal certainty of the Convention by the Council of State and the Court of Cassation.

In its final comments regarding the fifth Periodic Report of France in 2016, the Committee has noted that "the principle of child's best interests has become a constitutional principle and the Court of Cassation and the Council of State have agreed on a common position".

However, just as the Committee, the CCIF laments that such a basic principle is not defined and integrated in public policies. This non-systematic application causes harm that echoes on public and private structures working with children and youth. The well-being of the child is an obvious pillar of the child's interest. This lack of conceptualization leads to several difficulties.

1. The right of the child to be heard in proceedings in which they are involved and the respect of their opinion

The CCIF draws the Committee's attention on parents' custody proceedings managed by some judges. It has been shown that during divorce proceedings involving a Muslim parent, the mere accusation of radicalisation by the ex-spouse and the biased listening of children are likely to provoke disrespectful decisions when it comes to the child's best interests.

As follows, the illustration of previous point through a succinct yet accurate case for which the CCIF was called to act in 30 December 2019.

A few times after her divorce, Farida (the name has been changed) wants to convert to Islam. Farida and her ex-husband have got a 7-years old child that lives with the mother whereas the father has got right of access and accommodation. Parents do live in the same region. However, in 2019, Farida is eligible as a civil servant and must move out in another region with her child. Her ex-husband seizes the Family Court and wants to have the full custody of the child.

The first judge orders the hearing of the child before the Court hearing pursuant to Art 388-1 of the French Civil Code.

As follows, an excerpt of the judgment that establishes the custody in favour of the non-Muslim father:

"Whereas after interpellation the child notably declared:

- "At my mom's, I don't eat pork. My mum said I cannot eat it."

- "I'd like to learn Arabic."

- "My mum's got friends that come visiting her. Sometimes one, sometimes another one. They are Muslims."[6]

Whereas taken in isolation, each of these statements is anecdotal; that their conjunction in the current context can only raise questions and even worry."

[6] Appendix

In this case, the child's opinion was considered, however, the interpretation made was hazardous. It seemed that the child himself wished to learn Arabic and that he did not express any form of suffering or unhappiness regarding their mother food requirements or relationships.

The child's interest is not precisely defined, yet it is obvious that the wellbeing is a fundamental pillar mentioned in Art 3. Herein, without no correlation between any violation of the child's best interests and the mother's religious and social habits, the judge granted the full custody to the father only based on an Islamophobic judgement.

2. About alternative meals in school canteens

We would like to bring to your attention the increasing difficulties encountered by Muslim children that want to have alternative meals (meals without meat) in school canteens. These meals enable Muslim children to enjoy meals without meat in accordance with their alimentary habits. Every year, parents reach out to the ADDH-CCIF flagging that alternative meals are not available in their children's school canteen or even are suppressed.

The Administrative Court of Dijon, in a judgement n° 1502100 dated 28 August 2017, annulled a decision to abolish the pork substitute menus in the school canteens of the city of Chalon-sur-Saône considering that: "the measure consisting in putting an end to such a practice affects in a sufficiently direct and certain manner the situation of the children attending the school canteen and thus constitutes a decision in the assessment of which its author must, by virtue of article 3 (1) of the CRC, give primary consideration to the best interests of the child". The Court specified that the choice of an alternative menu "allowed religious or cultural concerns to be taken into account, while respecting the freedom of conscience of children and parents; that the contested decisions took away this choice from the users of the service, [...] whereas families are not necessarily able to resort to another mode of catering". The same decision will be handed down on 25 September 2018 by the Administrative Tribunal of Nîmes.

We warmly welcome the HRD's decision adopted in June 2019 that recalls that "the application of the principle of laicité which is correlated to the principle of civil service neutrality, does not justify the suppression of alternative meals but only constitutes discrimination based on religious beliefs and therefore jeopardises child's freedom of conscience and best interests". We fully support their request of pondering on the generalisation of vegetarian alternative meals, wherever it is possible to implement such a measure. The latter would enable the resolution of numerous litigations due to the request of alternative meals in school canteens, pursuant to Art L.230-5-6 of the French Rural and Fishing Code. While the above-mentioned case law condemns the withdrawal of menus replacing pork, it does not yet oblige canteens to constantly offer non-meat menus that respect the spiritual well-being of children whose religion imposes different dietary requirements. Taking these requirements into account by school canteens will ensure respect for the well-being of the child and, consequently, respect for his or her best interests.

C. OBSERVATORY REMARKS

Following the call of the Government stating that the society ought to be most vigilant based on the "weak signals of radicalisation", governmental public policies have inevitably targeted the French Muslims whose children are the most vulnerable. The institutional suspicion towards the French Muslim citizens, and therefore towards their children, causes discriminatory practices which consequences do not only imply the non-respect of the principle of equality. Those practices imply a violation of Article 3 of the Convention.

We recommend the creation of a mandatory module in the initial training session of the public agents that work with children and youth (teachers, police officers…). This module would cover the fight against Islamophobia, discrimination, and prejudices. In addition, we urge the public authorities to review the definition of radicalisation as well as the so-called weak signals of radicalisation.

We recommend fostering a synergy between organisations fighting discrimination and civil services working with children and youth such as teachers and police officers.

We urge for better homogeneous territorial distribution of officers, broaden investigation measures, and fair sanctions according to the infringement. It is necessary that during contempt and rebellion proceedings against police officers, the investigation be systematically relocated so it cannot be conducted by police officers belonging to the same service than the ones who have launched the proceedings.

We recommend that the study group on the Right of the Child and the protection of the youth can work on a more accurate definition of the notion of the child's best interests. It is of paramount importance that child's life quality be recognized as an indicator of the child's best interests, as defined by the Word Health Organisation. Life quality establishes the way one sees their own social position, as part of the culture and life principles they grow up with, in relation to their objectives, expectations, norms and concerns. It is a broad concept that encompasses in a complex manner one's physical health, psychological state, degree of independence, social relationships, personal beliefs, and relationship with important element of the environment in which they live. The WHO recognises that personal beliefs and spirituality are key for one's life quality. The concept of spiritual wellbeing, as defined in article 17 of the Convention, must be at the core of public policies' concerns, so the general principles of the Convention be respected.

III/ LIBERTIES AND CIVIL RIGHTS

A. THE RIGHT TO A NAME AND THE PROTECTION OF THE IDENTITY OF MUSLIM CHILDREN (OR PERCEIVED AS SUCH)

The ADDH-CCIF draws the Committee's attention on an issue noticed since January 2019. Article 8 of the Convention carry engagement for Member States to respect and preserve children's identity, including their nationality, name and family relationships.

Since January 2019, our legal service must have helped a dozen of families that noticed that the timeframe for issuing their identity document was abnormally long. The average time for issuing an ID card is 35 days and 60 days during peak times. The average time for issuing a passport is 20 days and it takes 35 days during peak times[7].

However, in the cases we dealt with, documents are issued in average after 4,4 months that is 133 days. It reached 11 months in extreme cases.

This excessively long issuing time is due to an administrative flagging of the French Muslim parents who are under administrative investigation due to their real or perceived Muslimness. Indeed, often, the investigated parents have no criminal record.

Moreover, the CCIF draws the Committee's attention on a 2017 case in which Art 7 of the Convention was not respected. Article 7 states that the child has the right to a name as from birth. Yet, some service servants seize the Public Prosecutor when they feel like the baby name refers to radicalisation.

In this case, in 2017, a family called the CCIF explaining that a civil servant from Toulouse seized the Public Prosecutor since the parents called their new-born after the name of "Jihad". After investigation, the Public Prosecutor declared the suppression of the name "Jihad" from the baby's civil status record arguing that the name "Jihad" was "not in the child's best interests and rather seemed to be a provocative process in which the child will be the first victim".

Herein, the Prosecutor grounds his decision on a personal interpretation of the name "Jihad" - which meaning is notoriously poorly understood[8], to better justify his decision of suppression invoking child's best interests. Herein, the inadequate conceptualisation of the notion around the child's best interests is doubled with moral judgment based on Islamophobic prejudices. This moral and legal lack entails a violation to the right to a name, even if the latter is temporary. It is important to recall that child's best interests' notion can be invoked in order to protect them from a name on the condition that the child's best interests are fairly determined. Without any clear determination of the child's best interests, the legal vagueness may grant to the civil servant and to the Prosecutor an unreasonable and potentially freedom-destroying power that would not comply with Art 7.

7 http://www.nord.gouv.fr/content/download/12247/73621/file/Consultez%20les%20d%C3%A9lais%20de%20traitement%20en%20pr%C3%A9fecture%20du%20Nord%20(Lille)%20-%20voir%20le%20d%C3%A9tail.pdf

8 https://orientxxi.info/mots-d-islam-22/djihad,1128

B. ABOUT FREEDOM OF THOUGHT, CONSCIENCE, AND RELIGION AND FREEDOM OF SPEECH

1. About the law of 15 March 2004 prohibiting, in accordance with the principle of neutrality (laicité), the wearing of religious signs and clothes in public primary and secondary schools

In its final remarks released on the 22nd of June 2009, the Committee recalled regarding law number 2004-228 of 15 March 2004 prohibiting the wearing of religious signs and clothes in public primary and secondary schools, that it is necessary to respect Art 4 of the Convention that guarantees the child's right to freedom of thought, conscience and religion.

The 1st Article of 1905 Law states that "the Republic ensures the freedom of conscience. It guarantees the free practice of religious worships under the very existing restrictions (…) in the respect of public order".

The religious neutrality that was originally addressed to civil servants is, since 15 March 2004, imposed to students who yet are not civil servants but users of civil services. According to the French Government, this law comes after the huge space that religions take into society for two decades. In its last report, France expresses the necessity "to teach students about the different aspects of religion, its diversity and its meaning".

However, Article 14 of the Convention, paragraph 3, states that "Freedom to manifest one's religion or beliefs are only submitted to the very existing restrictions enshrined in the law, and which are necessary to protect public safety, public order, public health and morality as well as the other's fundamental rights and liberties".

The recognition of religions seen as a pedagogical exercise cannot justify the restriction of those religious expressions when coming from students. The restriction of freedom of religion in primary and secondary schools cannot be justified as a necessity to ensure public safety, public order and public health and morality. The fact that Muslim students used to wear the veil before the 15 March 2004 law did not entails any consequence on the above aspects.

Moreover, this law has brought out new forms of discrimination within public schools. Indeed, the ADDH-CCIF is frequently contacted by Muslim students whose clothes are perceived as religious.

As follows, the illustration of the above paragraph:

In March 2020, the ADDH-CCIF was contacted about a 10-years old pupil who was criticized and threatened to be expelled from her school. Indeed, the young girl decided by herself to wear the veil. She did respect the law and the school regulation, therefore, she used to take off her veil when entering the school and only put it on once out. The Headmaster started then criticizing her and threatening her about her "not occidental and ostentatious costume". It is important to note that this so-called "costume" was nothing else than a long skirt or a long shirt. Thus, a direct correlation was made between her wearing the veil outside the school and her wearing long skirts or long shirts. This correlation would not have been made if the child were not Muslim. The Headmaster indulged into a differentiated treatment by censoring the child's freedom of clothes guaranteed by her freedom of expression.

2. About the factsheets of the Ministry of the National Education

The ADDH-CCIF questions the proliferation of factsheets addressed to parents and their children in which directives that jeopardize freedom of thought, conscience and religion are expressed. Article 13 states that the practice of freedom of speech "can only be subject to the very existing restrictions written in the law and which are necessary: A) Respect of one's rights and reputation; or B) Protection of national safety , public order, public health or morality".

The ADDH-CCIF notes that those factsheets incite teachers who focus on some thoughts freely expressed by children.

As follows, the analysis of the attached factsheet "Coronavirus and the risks of a communitarian isolation" attached :

On 5 May 2020, in the middle of the Covid-19 pandemic, the Minister of National Education releases a document in response to an observation which reality was not proved. It is said that "some questions and reactions from students may be rude and full of hostility and mistrust: questioning of Republican values, distrust of scientific discourses. In the factsheet, communitarianism is defined as "an abuse contrary to the Republican ideal where the group's rules prevail over the French Republican universalist and inclusive law". No scientific research conducted by the Government has proved the veracity of this observation which establishes a will to separatism coming from several "extremist groups". Yet, it justifies the use of a public policy that pushes for the identification and reporting of sayings that criticises the French management of the pandemic. Beyond its accuracy and objectivity, this criticism is protected by child's freedom of thought and speech.

The ADDH-CCIF experience shows that criticism, when coming from minorities, is perceived as a sign of "communitarianism" or "separatism" that in public authorities' view, jeopardises the fundamental principles of the Republic such as its indivisibility.

C. THE IMPACT OF ISLAMOPHOBIC MEDIATIC RHETORIC ON CHILD'S WELLBEING IN VIEW OF ARTICLE 17 OF THE CONVENTION

The CCIF worries about the room in the mediatic sphere allocated to notorious Islamophobic polemicists still visible in the media although their multiple criminal convictions based on incitement to discrimination, hate, and violence.

Eric Zemmour's numerous interventions on CNEWS, LCI and BFM-TV channels are the perfect example of discriminatory speeches on air. It is unthinkable that under the guise of freedom of speech such discriminatory, hateful and violent sayings are heard by Muslim children. Children are vulnerable people. They cannot be given access to information and materials that deeply diminishes their spiritual, moral and social wellbeing (by seeing their religious, social and moral beliefs depicted as and behaviours).

D. OBSERVATORY REMARKS

The ADDH-CCIF recommends that France be heard about its non-delivery of official documents practices (ID, passport) and that parental flagging does not jeopardise child's civil rights and liberties.

The ADDH-CCIF recommends an assessment of the law of 15 March 2004 in the light of the study carried out by Stanford researchers.

The ADDH-CCIF urges public authorities not to justify anymore the implementation of public policies such as the one referring to communitarianism, without conducting scientific research.

The ADDH-CCIF urges the Audio-visual Council to apply binding effect sanctions.

IV. FAMILY ENVIRONMENT AND REPLACEMENT PROTECTION

A. ABOUT MUSLIM CHILDREN'S SEPARATION FROM THEIR PARENTS FOLLOWING ABUSIVE ALARMING REPORTS AND REPORTING

Article 9 establishes child's right not to be separated from their parents without agreement. It states that the potential separation must be necessary regarding child's best interests.

Like stated in II.B.1 section, divorce proceedings implying a Muslim spouse increasingly tarnished by false accusations of radicalisation leading to reservation or withdrawal of children's custody from the Muslim parent. Those separations do consider child's best interests.

Like stated in II.1 section, abusive alarming reports and reporting constitute a real violation of non-discriminatory principle. Those can involve a judiciary judgment following a social investigation, withdrawing children's custody from Muslim parents (or perceived as such). Here again, separation without child's agreement and against child's best interests violates Article 9 of the Convention.

Let us illustrate this difficulty with a case dated June 10, 2020. A child was separated from his Muslim mother against her will and placed with his grandparents following his aunt's report against his mother. The mother, who had converted to Islam several years ago, was accused of radicalisation solely because of her religious practice. The aunt, who made the report, was psychologically unstable. However, her testimony was sufficient to justify the decision and prevailed over that of the mother, who was by the way psychologically stable.

B. HEALTH AND HEALTH SERVICES, PRIMARY HEALTH IN PARTICULAR

The ADDH-CCIF wishes to ask about these practices, which fail to comply with article 24 of the International Convention on the Rights of the Child, which guarantees: "the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. They shall strive to ensure that no child is deprived of the right of access to such services".

The ADDH-CCIF is regularly seized of cases of denial of access to health care to children on the grounds of their real or supposed membership of Islam. We would therefore like to highlight a problem on which France has not been questioned but which it is nevertheless necessary to address.

In our files, there are cases of health practitioners refusing to consult or making the consultation conditional on the removal of the mother's headscarf, even though an appointment for the child had been made. More serious cases involve medical emergencies that go untreated and require patients to go to a hospital emergency department. We note that the discrimination suffered by parents impacts, in turn, their children, who find themselves deprived of the right of access to

medical services. Moreover, the Defender of Rights recalls in his reports that access to health care suffers from the phenomenon of discrimination.

The Medical Association and the criminal justice system do very little in this area and find in the majority of cases extenuating circumstances justifying the discriminatory behaviour of the practitioner, despite the obvious ethical and legal breaches.

C. OBSERVATORY REMARKS

The CCIF recommends that initial training should be provided for judges on religious practice, discrimination and on child's best interests.

The CCIF recommends that the Medical Association should impose penalties commensurate with the seriousness of the discriminatory acts experienced by parents and their children in accessing health care. The CCIF recommends the establishment of regular meetings between anti-discrimination associations and the National Order of Physicians, as proposed by the Commission in charge of assessing healthcare refusals to the National Council of the Order of Physicians on 20 September 2018.

V. EDUCATION, LEISURE AND CULTURAL ACTIVITIES

A. RIGHT TO EDUCATION, NOTABLY TO TRAINING AND CAREER COUNSELLING

Article 28 of the Convention recognises the child's right to education.

The CCIF shares the analysis of two researchers from Stanford University (USA): Aala Abdelgadir and Vasiliki Fouka, in their article entitled "Political Secularism and Muslim Integration in the West: Assessing the Effects of the French Headscarf Ban[9]", which explains the abuses of the 2004 law. Indeed, it is argued that despite intense public debate, there is little systematic evidence of the influence of policies on the behaviour of the religious minorities they target. These researchers are evaluating the effects of the headscarf ban on the socio-economic integration of young French Muslim girls. They find that the law reduces their school enrolment rates and, in the longer term, negatively influences their trajectory in the labour market and the future composition of their families. In this study, the two researchers provide evidence that the headscarf ban is de facto discriminatory and reduces assimilation by making religion and national identities incompatible.

B. OBJECTIVES AND QUALITY OF EDUCATION

1. About the principle of laïcité (secularism) taught as a Republican value in public school

The question of secularism has been at the centre of national debates for thirty years. The very definition of this concept and its legal scope are subject to new interpretations, raising difficulties with regard to the application of Article 29 of the Convention.

In the present case, it seems natural that France should wish to transmit republican values in public primary and secondary schools. To this end, and following the attacks of 7, 8 and 9 January 2015, the French Government has introduced a new plan aimed at transmitting republican values and secularism, known as the "Grande mobilisation de l'École pour les valeurs de la République" (Great mobilisation of schools for the values of the Republic). This plan is still relevant today[10]. It mentions that:

"Secularism is one of the essential values of the Republic. It is a principle that protects pupils. The right to think and believe freely for every pupil requires schools, middle schools and high schools to be protected from any political, religious or ideological influence. »

However, we wonder about the real teaching concerning the secular "value". If the teaching concerns the contours of the 1905 law, i.e. the separation between the State and the religion, which includes the requirement of neutrality of public agents only (with the exception of pupils in public schools, middle schools and high schools), no observation should be made. In this sense, the

[9] https://vfouka.people.stanford.edu/sites/g/files/sbiybj4871/f/abdelgadirfoukajan2019.pdf, appendix
[10] https://www.education.gouv.fr/les-valeurs-de-la-republique-l-ecole-1109

secularism taught is above all a principle of State organisation with a clear and regulated legal scope. The CCIF sees no difficulty in transmitting this principle.

However, it appears from the latest statements of 19 February 2020 by the current Minister of National Education, Jean-Michel Blanquer, that the teaching transmitted could be different:

"In fact, the republican project, it's not only... It couldn't just be a defensive project, certainly not, it's an offensive project in all respects, including on the social level obviously. So, it is both the principles of the Republic, in a certain way in terms of law, and also the principles of society. »[11]

If, by "offensive" teaching, the Minister understands a misguided vision of secularism, i.e. understood as a "value" imposing the discretion of the religious practice on all citizens, whether minors or adults, restricting their freedom of conscience and religion, it becomes necessary to recall the requirements of Article 29.

While the latter clearly allows national values to be respected, it nevertheless requires that education should transmit to the child respect for fundamental freedoms and respect for his or her identity and cultural values. It is therefore necessary for France to specify what teaching is transmitted with regard to secular values.

2. <u>On the systematic refusal by the Ministry of Education to open independent Muslim private schools and the avoidance of schooling</u>

Article L131-1 of the Education Code provides that:

"Education is compulsory for every child from the age of 3 until the age of 16."

Article L131-2 of the Education Code states that:

"Compulsory education may be given either in public or private establishments or schools, or in families by the parents, or one of them, or any person of their choice"

Thus, instruction can be carried out in a public or private establishment or even in the family setting with instruction at home. However, recent government positions seem to force the Muslim community to restrict their choice to public education alone. Indeed, the Circular of the Ministry of Justice of January 10, 2020 "stressed the importance of combating the phenomenon of so-called school avoidance, through the operation of non-contractual schools or online teaching, which are likely to constitute as many vectors fuelling communitarianism divides. »[12]

The CCIF is concerned that the free choice of education by parents, although allowed under French law, is, in the view of the Ministry of Justice, a societal phenomenon that must be combated. The free choice of parents to enrol their children in private schools outside the contract system or to educate them themselves are decisions protected by Article 29 of the Convention. These decisions cannot be subject to any other assessment.

On February 19, 2020, the Minister of National Education said, in response to a question about the number of non-contractual private schools and Muslim schools that he had closed:

"So first you have what you prevent from opening and then you have what you close**<u>". So I prevented, for example, the opening of 27 schools last school year on the basis of the Gatel law that we had passed. So this is a very important point. And I've closed four schools in</u>**

[12] http://www.justice.gouv.fr/bo/2020/20200131/JUSD2000897C.pdf

the last year and I'm going to be closing more in the next little while. "Closing is harder than preventing opening." (...) Now we have greater legal means, but it's true that we are in a state of law and therefore there are a certain number of subjects to respect. But I say it to the Mayor of Mulhouse as to any mayor of France: "We are at your side in this kind of approach. "So no one can say that national education today would be lax on this subject. That's not true. We have taken the necessary legal measures and we are in action. You have in each rectorate in France a team "Laïcité valeur de la République" (Secularism, value of the Republic) which deals with these subjects and any mayor can call upon the inspector of the academy and the rector to come in support for the necessary steps. We obviously work in close liaison with the prefects for all these steps."[13]

The relevant provisions of the GATEL law mentioned by the Minister are set out in Article L.441-1.-II of the Education Code. They are as follows:

"II- The competent authority of the State in matters of education, the mayor, the representative of the State in the department and the public prosecutor may oppose the opening of the school:

"1° In the interest of public order or the protection of children and young people;

"2° If the person opening the establishment does not meet the conditions provided for in I of this article;

"3° if the person who will be running the establishment does not meet the conditions set out in article L. 914-3;

"4° If it emerges from the school project that the school does not have the character of an educational or, as the case may be, technical school.

"In the absence of opposition, the establishment shall be opened on the expiry of a period of three months".

Thus, certain authorities will have the possibility of opposing the opening of a private establishment on the basis of the interest of public order. However, the concept of public order in French law suffers from insufficient conceptualization, which leads to the possibility of a broad interpretation. Disturbance of public order may at one and the same time constitute a disturbance of good order, security, public health and tranquillity, public morality or the dignity of the human person.

The systematic nature of refusals to open independent Muslim private school, as established by the abnormally high number of refusals (27), indicates that the Ministry of National Education is exploiting this legal broadness to prevent the establishment of educational establishments by Muslims.

However, these ministerial decisions constitute a violation of the second point of Article 29 of the Convention, which provides that:

"Nothing in this article or in Article 28 shall be construed so as to interfere with the liberty of individuals or bodies corporate to establish and direct educational institutions, subject always to the observance of the principles set forth in paragraph 1 of this article and to the requirement that the education given in such institutions shall conform to such minimum standards as may be laid down by the State".

[13] https://www.vie-publique.fr/discours/273820-jean-michel-blanquer-19022020-separatisme-islamiste-nouveau-bac

By systematically preventing the opening of Muslim private schools to natural or legal persons who have not been found to be in breach of the requirements of the first item of Article 29 or to constitute potential dangers to public order, the Ministry of Education is undermining the right of Muslim citizens to establish educational institutions.

C. REST, PLAY, LEISURE, RECREATIONAL, CULTURAL AND ARTISTIC ACTIVITIES

We question France's compliance with Article 31 of the International Convention on the Rights of the Child. Indeed, "the right to rest and leisure, to engage in recreational activities appropriate to his or her age and to participate freely in the cultural and artistic life" of the child, as well as access to these rights under conditions of equality, as provided for in paragraph 2 of the same article, is sometimes disregarded by France, since young Muslim girls are treated differently in terms of access to certain sports.

As a human rights association, we would also like to bring to the Committee's attention the cases of discrimination in access to sport that have been brought to our attention. Indeed, many young girls are denied access to sports clubs, particularly football and basketball clubs.

As an example, the French Basketball Federation (FFBB) opposes the International Basketball Federation (FIBA) which itself authorizes the wearing of headscarves by Muslim players during international competitions and explains it in these precise terms: "The central board has approved the proposal submitted by the Technical Commission which authorises the wearing of headscarves by players, said the FIBA in a statement. The new rule has been developed to minimise the risk of injury and to maintain colour uniformity with the rest of the clothing".

When we ask the FFBB about the ban on headscarves, we will be hearing totally different things: "Concerned with the protection of principles that prevail in terms of secularism within the French Republic and in public establishments welcoming the public, particularly in sport, and considering head covering accessories as "inappropriate for the game", the federal authorities therefore definitively stated last December that this FIBA provision could not be applied. »

A ban on the wearing of headscarves is therefore imposed on female Muslim minor players under the FFBB's rules of procedure, which prohibit the wearing of any accessory covering the head, without specifying that the ban applies to the wearing of headscarves for religious reasons. It is important to recall that the ban on the wearing of religious symbols, since this is a religious symbol, is not legally justified since the establishment is a sports club and not a primary or secondary public educational establishment in which the ban on the wearing of symbols showing religious affiliation applies to pupils and staff.

Consequently, the principles of secularism and neutrality are in no way relevant since they apply only in the previously mentioned case or in respect of public service employees. The prohibition on the wearing of religious symbols cannot therefore be invoked against girls on grounds of secularism, as mentioned in the above-mentioned comments, especially since the FFBB regulations do not contain any neutrality clause.

The same applies to the French Football Federation (FFF), which, like the FFBB, runs counter to the International Football Federation (FIFA).

The consequence of these two divergences between French law and international law is the exclusion of these young children from sport, which is a vector of integration and social inclusion.

D. OBSERVATORY REMARKS

The ADDH-CCIF recommends to the Ministry of National Education to teach secularism as defined by the law of 1905.

The ADDH-CCIF recommends that applications for the opening of independent Muslim private schools should no longer be met with quasi-systematic refusals.

The ADDH-CCIF recommends that France comply with international provisions applicable to sports leisure activities.

Appendix : RECOMMENDATIONS

1-The ADDH-CCIF recommends that the Prime Minister should propose to the President of the Republic that the 1958 Constitution be revised, as permitted under Article 89, to recognise the concept of minorities and to restrict the principle of indivisibility to the national territory alone. Failing that, and still in accordance with article 89 of the Constitution, the CCIF recommends that a parliamentary group be set up to work on a draft constitutional revision covering the same measures.

2.- .The ADDH-CCIF requests that the study group on the rights of the child and youth protection should hear at least once a year from NGOs working to combat discrimination, and not only from NGOs specializing in the defence of children's rights.

3.- The ADDH-CCIF recommends the creation of a compulsory module in the initial training of public officials dealing with minors (such as teachers, police or gendarmerie services, etc.) on combating Islamophobia, discrimination and related prejudices. In a complementary way, we encourage public authorities to review the definition of radicalisation and the so-called weak signal clusters accompanying it.

4.-. The ADDH-CCIF recommends that a link be created between organisations fighting against discrimination and public services in contact with minors, such as the police or gendarmerie services, primary and secondary public schools, etc.

5.-. The ADDH-CCIF advocates a more homogeneous distribution of police territory, autonomous, broadened investigative measures and sanctions commensurate with the seriousness of the facts. It is necessary that, in the case of instructions for insult or rebellion against agents of public authority, the investigation should be systematically relocated so that it cannot be conducted by police officers belonging to the same police or gendarmerie service as the perpetrators of the proceedings.

6.- The ADDH-CCIF would like the study group on the Rights of the Child and Youth Protection to work on a more precise definition of the concept of the best interests of the child. In this case, we believe it is essential to recognise as an indicator of the child's best interests the quality of life of the child as defined by the World Health Organisation. Quality of life is how individuals perceive their position in life, in the context of the culture and value system in which they live and in relation to their goals, expectations, norms and concerns. It is a broad concept that incorporates in a complex way a person's physical health, psychological state, degree of independence, social relationships, personal beliefs and relationship to important elements of the environment. WHO recognizes that personal beliefs and personal spirituality form a central area of an individual's quality of life. The concept of spiritual well-being, recognised by the Convention in Article 17, must be at the core of public policy concerns if the general principles of the Convention are to be respected.

7.- The ADDH-CCIF recommends that France be questioned about its practices of withholding official documents (national identity card, passport) and that the parental administrative flagging should not infringe the civil rights and freedoms of the child.

8.- The ADDH-CCIF recommends an assessment of the law of 15 March 2004 in the light of the study carried out by Stanford researchers.

9.- The ADDH-CCIF urges public authorities to define scientifically and academically the terms "communautariasm", "radicalization" and "separatism".

10.- The ADDH-CCIF urges the Audio-visual Council to apply binding effect sanctions.

11- . The ADDH-CCIF recommends that initial training should be provided for judges on religious practice, discrimination and on child's best interests.

12.- The ADDH-CCIF recommends that the Medical Association should impose penalties commensurate with the seriousness of the discriminatory acts experienced by parents and their children in accessing health care. The CCIF recommends the establishment of regular meetings between anti-discrimination associations and the National Order of Physicians, as proposed by the Commission in charge of assessing healthcare refusals to the National Council of the Order of Physicians on 20 September 2018.

13.-The ADDH-CCIF recommends to the Ministry of National Education to teach secularism as defined by the law of 1905.

14.- The ADDH-CCIF recommends that applications for the opening of independent Muslim private schools should no longer be met with quasi-systematic refusals based on a poorly conceptualized legal concept such as public order.

15.- The ADDH-CCIF recommends that France comply with international provisions applicable to sports leisure activities.

Political Secularism and Muslim Integration in the West: Assessing the Effects of the French Headscarf Ban*

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Abstract

In response to rising immigration flows and the fear of Islamic radicalization, several Western countries have enacted policies to restrict religious expression and emphasize secularism and western values. Despite intense public debate, there is little systematic evidence on how such policies influence the behavior of the religious minorities they target. In this paper, we use rich quantitative and qualitative data to evaluate the effects of the 2004 French headscarf ban on the socioeconomic integration of French Muslim women. We find that the law reduces the secondary educational attainment of Muslim girls, and impacts their trajectory in the labor market and family composition in the long run. We provide evidence that the ban operates through increased perceptions of discrimination and that it reduces assimilation by casting religion and national identities as incompatible.

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1 Introduction

Concerns about rising immigration and homegrown radicalization have dominated both European and US politics in recent years, fueling populist far-right parties and driving policy choices of elected political leaders. At the confluence of these two issues lies the large and growing group of Muslim immigrants which has been increasingly perceived as less desirable than other cultural and religious groups (Bansak, Hainmueller, and Hangartner 2016), difficult to assimilate (Bisin et al. 2008), and a threat to Western values (Sniderman, Hagendoorn, and Prior 2004). Either as a direct response to terrorism, or as a means of reaffirming the secular character of the state and society in view of a new and salient religious minority, several governments have enacted policies that regulate Islamic dress, especially the various types of head and face covering worn by Muslim women. As can be seen in Figure 1, about one third of European countries have either a local or national ban on some form of veiling. The type of veiling banned ranges from full-face covers, like the niqab or burqa, to partial ones that cover hair and sometimes neck, like the headscarf. The scope of application also varies, from bans on veiling in all public spaces, to restrictions in specific state or state-funded institutions only (like public services, courts or schools).

[Figure 1 about here.]

Such policies have on various occasions been upheld by the European Court of Justice and survey data indicates that they are supported by a majority of the public in countries where they are debated or enacted.[1] While their intended goal often is to

[1] A poll by Pew Research Center in 2010 showed that 62% of people in the UK, 82% in France, 71% in Germany and 59% in Spain support a ban on full-face veiling. http://www.pewglobal.org/2010/07/08/widespread-support-for-banning-full-islamic-veil-in-western-europe/

reduce the visibility of religion in the public sphere, policies of secularity may inadvertently have other effects on the behavior and choices of the religious minorities they target. Despite the increasing prevalence of these laws in Europe and the widespread public debate on their normative implications, there has been little systematic investigation on their broader effects. And yet this question should be of paramount importance, not only to social scientists, but also to policymakers and Western societies that grapple with achieving both immigrant integration and the preservation of Western culture. To what extent are religious bans contributing towards these goals?

Recent research suggests reasons to doubt the efficacy of bans. Despite approval from native populations, veiling bans targeting Muslim women are perceived as discriminatory by Muslims and many non-Muslims alike.[2] A growing theoretical literature suggests that both discrimination and cultural prohibitions can intensify a minority's sense of identity and, under certain conditions, encourage radicalization (Bisin et al. 2011; Battu, Mwale, and Zenou 2007; Battu and Zenou 2010). Empirically, it has been shown that perceptions of discriminatory treatment among Muslims in the US positively correlate with feelings of sympathy for radical Islam (Lyons-Padilla et al. 2015) and European countries like Belgium or France, which have enacted national veiling bans, have among the greatest flows of foreign fighters to ISIS (Benmelech and Klor 2016). While such correlations do not necessarily imply a causal relationship, they do suggest that the effects of cultural and religious bans may not be innocuous.

This paper is the first attempt to empirically identify the effect of veiling bans on a large range of behavioral and attitudinal outcomes of Muslims. We do so in the context of the most famous of veiling laws, the 2004 French law on secularity and conspicuous religious symbols. The law banned the use of religious signs in primary and secondary public schools in France, and though it did not explicitly single out any particular sym-

[2]Institut Montaigne (2016) survey a representative sample of French Muslims. They find that 60% support wearing the headscarf in schools and in other public institutions.

bol or religion (large Christian crosses, as well as Sikh turbans and Jewish kippahs were included in the ban), it aimed to and de facto mostly affected veiled Muslim schoolgirls. Using rich individual-level data from the French Labor Force Survey, the French census, and a representative survey of immigrants in France, we employ a difference-in-differences strategy to isolate the impact of the law on educational and labor market outcomes, as well as on attitudes of Muslim women. We measure educational and socioeconomic outcomes of French-born women with parents from Muslim-majority countries who were just old enough to have been at school when the law was enacted, and compare them to older cohorts who did not experience the ban, and to a variety of control groups, including non-Muslim immigrants and Muslim men.

Our first finding is that exposure to the ban significantly reduces the likelihood of completing secondary education. Part of this effect appears to be driven by a negative impact on enrollment rates in secondary school for Muslim women aged 16 and above – the cohorts that, by French compulsory schooling law, were legally allowed to drop out. We also find that Muslim women affected by the ban took longer to complete secondary education, conditional on their pre-existing age-educational profiles. These higher dropout rates and longer completion times indicate that the ban disrupted the educational progress of Muslim girls. This negative educational shock carries over to a number of longer term outcomes, such as labor force participation, employment rates, and fertility patterns.

We show that these longer run effects of the ban work through two hypothesized pathways: a *discrimination* channel, and an *identity* channel. First, women affected by the ban report increased perceptions of discrimination at school and a lower trust in the French school system. A set of interviews conducted in Paris with religious Muslim women who shared their personal experiences on the 2004 ban corroborates the role of discrimination. As the accounts of interviewees suggest, discriminatory treatment in the public school, as well as outside of it, negatively impacted educational performance, and sometimes even led girls to leave the public school. Second, both survey and

interview evidence highlight the importance of identity channels as potential drivers of our findings. Muslim women were forced to choose between a secular French identity and attachment to their religious practices, a conflict that often led to alienation from the French society. In the data, Muslim women affected by the ban increase their identification with the nationality of their father relatively more than their identification with France. Interestingly however, identification increases both for French and for foreign identities on average. This latter result indicates that the salience of identity and belonging in general increased for affected cohorts. It also points to a potential polarization of identities, as the incompatibility of French and foreign identities was highlighted by the ban.

The rest of the paper is organized as follows. In Section 2, we review the tension between increasing Muslim presence and secular values in France, which led to the passage of the 2004 ban against conspicuous religious symbols. We then synthesize a body of theoretical work on the effects of assimilationist policies and discrimination on minority identity, and highlight two distinct mechanisms through which bans on veiling can negatively impact the behavior and attitudes of Muslim women: discrimination and identity (Section 3). In Section 4 we outline the empirical strategy and data that we use to evaluate the impact of the headscarf ban on French-born women of Maghrebi and Middle Eastern origin. In Sections 5 and 6 we investigate the short and long-term effects of the ban on secondary educational attainment and other outcomes, and present evidence that the effects are driven by the hypothesized discrimination and identity channels. In Section 7 we present additional qualitative support for these mechanisms through a set of interviews with French Muslim women. Section 8 concludes with a discussion of the broader significance of our findings for integration policies and of avenues for future research.

2 Context

2.1 Islam and laicité in France

Approximately 6 million Muslims live in France (Mattei and Aguilar 2016). The history of their integration has been fraught with difficulties.[3] Current tensions over the assimilability of Muslims can be traced to the 1980s. A religious consciousness arose among third generation French of Muslim origins. Their increased religiosity was a radical deviation from prior generations that maintained only a cultural connection to their Islamic heritage. The reorientation of third generation Muslims to Islam percipitated public anxiety for two reasons. First, Islam was associated with fanaticism and retrogradeness.[4] In the 1980s, fundamentalist Islam was on the rise globally, with restrictions on women's dress in theocratic Iran, religious war against the Soviets in Afghanistan, and Islamist terrorism in Algeria's civil war (Piscatoi 1990; Appignanesi and Maitland 1989; Bowen 2007).

Public anxiety over Islam was also rooted in the French approach to religion. French laws, enacted in the late 1800s as part of the anti-clericalism of post-Revolutionary France, relegate faith to the private sphere and strongly regulate organized religion to maintain public order (Mattei and Aguilar 2016). The state's policies are enshrined in the principle of laicité (loosely translated as "secularism"). Embodied by several laws, laicité is meant to ensure freedom of conscience, equality of religious expression, and religious neutrality of government institutions (Messner et al. 2003) – to avoid religious conflict and maintain social order.

Laicité was importantly enacted through the education system. Public schools were established to combat the influence of the church, replacing religious fealty with nationalism (Kepel 2012). Schools were and remain an important vehicle through which

[3]For more information, consult Fredette (2014) and Cesari (2009).

[4]For more on French media representation of Islam, see Bowen (2007).

the state creates citizens, instilling in all children republican values (Lorcerie 2012). As Fredette (2014) explains, "Part of France's *jus soli* [birthright citizenship] tradition is the belief that one is not born French; one becomes French. That process of becoming French is carried out in public schools. It is there that students learn what it means to be French and how to be a good French citizen." Within this context, the increasing religiosity of Muslims – translated into pupils in headscarves, praying in public settings, requests for halal food (meals prepared as prescribed by Muslim law), and refusal to engage in certain activities (like swimming in mixed gender environments or studying classical art with pictures of nudes) – was perceived as an assault on the very institution instilling republican values (Bowen 2007).

2.2 The headscarf ban

Latent anxieties culminated in public crisis. In 1989, three veiled girls attended Gabriel-Havez Middle School. The principal asked them to unveil because headscarves infringed on the neutrality of public schools. When the girls refused, the school expelled them. The students filed suit against the school, and the case reached the Conseil d'Etat (French Supreme Court of administrative law). Ultimately, it ruled that the girls had the right to veil unless their headscarves were disruptive, and it instructed schools to determine disruptiveness on a case by case basis (Mattei and Aguilar 2016). The government also created a ministerial office to help mediate between schools and pupils.

When cases of headscarf expulsion persisted, the government convened a parliamentary commission in 2002 to find a definitive solution. The Stasi Commission – a group of public intellectuals and politicians – consulted relevant stakeholders. Educators reported that headscarves jeopardized the liberating mission of schools "to give citizens-in-the-making the means to free themselves from social, cultural, ethnic or gendered determinism" (Bowen 2007). Headscarves, they argued, impinged on the liberty of conscience of other pupils, and represented the triumph of communitarian pressures (Bowen 2007). Ultimately, the Stasi Report (2004) advocated state intervention – in-

cluding a school ban.

In 2004, the National Assembly passed a bill banning conspicuous religious symbols in schools. The bill broadly refers to ostentatious religious symbols, including large crosses and kippahs. However, headscarves not only motivated the enactment of the law, but also, due to their prevalence among students as compared to other religious symbols, they were the main symbol affected by the law in practice (Paul 2004). The bill went into effect in September 2004 in primary and secondary public schools. It preserved the mediation infrastructure of the prior decades and instructed schools to pursue mediation efforts before imposing penalties on students (Tebbakh 2007).

While no systematic study of the ban exists, there are a few lessons about its impact. The French government sponsored a study of four public schools, culminating in the 2005 Chérifi Report. It painted a positive picture of the ban's implementation, citing a decrease in veiling and expulsions. At the start of the school year in 2004, only 639 out of 10 million students showed up wearing ostentatious religious symbols, 626 of whom were Muslims (Mattei and Aguilar 2016).[5] Of the 639, 143 students switched from public to private schools and 50 enrolled in long-distance courses (Mattei and Aguilar 2016). There is also evidence the ban was applied broadly. Castel and Saby (2011) find that some schools used the ban to bar veiled parents from schools, university professors sometimes adopted the ban (though it only applies to public primary and secondary schools), and young interns were expected not to veil.

[5]This compares to 3000 cases of wearing religious symbols in 1994-1995, and 1465 cases in 2003-2004 (Mattei and Aguilar 2016; Tebbakh 2007).

3 Conceptually linking religious bans to minority outcomes

How would we expect the 2004 ban on religious symbols to affect the behavior and outcomes of French Muslim women? We anticipate that the ban depressed the educational performance and attainment of French Muslim girls enrolled in secondary school during and after its implementation in 2004. We furthermore expect that this had downstream effects on longer-term socioeconomic outcomes of affected cohorts. We combine insights from a rich interdisciplinary literature to identify two classes of mechanisms through which cultural bans can impact a minority group's integration.

The first and more direct one is the de facto discriminatory nature of the law. The law was discriminatory in a specific sense: it singled out Muslim schoolgirls who chose to veil and subjected them to differential treatment because of their mode of dress. During the first phase of the law's implementation, girls who persisted in wearing the headscarf were removed from their classes to discuss alternatives to veiling with school administrators (Mattei and Aguilar 2016). If this failed, girls were expelled. Girls then had several options: they could leave the education system (if 16 or older), switch to private school, opt into distance learning, or leave the country.[6] The process of switching and the period of mediation away from class could have directly impaired school performance.[7]

Besides the direct changes that girls experienced in their everyday school life, the ban's passage was accompanied by a national debate that singled out veiled girls – and predominantly cast their veiling as incompatible with French ideals. This broader

[6]There are many reasons for lack of compliance with the law. One could be marriage market considerations (Blaydes and Linzer 2008). Prior to the ban, in communities that value pious brides, girls could veil at school without jeopardizing their marriage prospects. If returns to marriage were high enough compared to returns to education, some girls may have left the public school after the ban to avoid removing the veil.

[7]Even the optimistic evaluation of the law in the Chérifi report expressed concerns that the transitional mediation period may have been too long.

public discussion, and the associated anti-Islamic sentiment expressed by segments of the French population, likely reinforced Muslims' difference. A significant literature demonstrates that perceived racism is negatively associated with educational performance (Levy et al. 2016; Chavous et al. 2008). While Islamophobia spurred by the ban might have broadly affected all Muslims, we expect that this effect should be most acute in school-age Muslims because they were in their formative and most impressionable years when the ban was implemented (Wong and Sameroff 2003; Sanders-Phillips 2009; Adam et al. 2015; Brondolo et al. 2009; Dahl 2004). School-age Muslim boys may have also experienced a drop in educational outcomes, but we expect that the effect of the ban was most felt by school-age Muslim girls because the 2004 law pertained directly to them.

The second potential mechanism linking the 2004 ban to lower educational outcomes relates to social and group identity. The 2004 law defined the Muslim headscarf as a "violation of French secularism, and by implication, a sign of the inherent non-Frenchness of anyone who practiced Islam, in whatever form" (Scott 2009). French Muslim girls that could until that point readily identify as members both of their religious community (by wearing the headscarf) and of their country of birth, received the signal that their two identities were incompatible and that one could not be French without embracing the principle of secularity as enshrined in the law. Both theoretical and empirical work on the formation of oppositional identities (Bisin et al. 2011; Fouka 2018) indicate that assimilationist attempts on the part of a majority may strengthen the identity of minority members. In this case, we contend that the headscarf ban led some Muslim girls to resolve this identity conflict by retreating into their religious and ethnic communities. Practically, we expect this retreat to alter behavior in the short- and long-run, for example through reduced participation in the educational system and the labor force.

In sum, we hypothesize that the headscarf ban depressed educational performance and attainment through two pathways: a *discrimination channel*, and an *identity chan-*

nel. Under the label discrimination we bundle both the direct consequences of the implementation of the law in the classrooms, and the associated differential treatment either inside the school or outside of it. Discrimination of girls wearing the headscarf may have disrupted their ability or willingness to attend school thereby delaying school completion and worsening educational performance. We also hypothesize that the ban impaired educational and labor market outcomes in the long run. This could have occured as a direct result of the ban's negative effect on Muslim girls' educational attainment. Additionally, the emphasis the law placed on the incompatibility of a religious Muslim identity with being French could have increased some Muslim girls' identification with the Muslim community and reduced their participation in the education system and the labor market. Finally, based on both the discrimination and the identity channel, we expect Muslim girls from families with two Muslim parents to have been more acutely affected by the ban because these girls are doubly implicated in the public debate, and being part of a family with a unified Muslim identity likely intensifies the conflict between family background and belonging to the French society.

4 Data and empirical strategy

4.1 Data

We utilize two datasets in our main empirical analysis of the ban's effect on educational attainment and long-term labor and social outcomes. We describe the data in detail below.

French Labor Force Survey. Our main data source is the French Labor Force Survey (Enquête Emploi, and henceforth LFS). The LFS is a comprehensive survey of socioeconomic and labor market characteristics conducted in a representative sample of the French population. It has a rolling panel structure, with each household remaining in the survey for six consecutive quarters. All household members over 15 years of age are interviewed every quarter. For most of our analysis, we keep only the first

quarterly observation of an individual, thus treating the survey as a repeated cross-section. We take advantage of the panel structure of the data in Section 5 in order to better understand the mechanisms behind our observed effects. We restrict the sample to the French born, so as to ensure that we are only examining the behavior of people who went to school in France. We focus on respondents interviewed 2003 to 2012, the range of years in which we can identify the country of birth of both the individual and of the father, and thus the origin of second-generation immigrants. We also restrict attention to individuals who were 20 or older in each survey year, so that we can examine completed education and labor market characteristics.

One limitation for our exercise is lack of information on religion and veiling behavior. French statistics do not collect data on religion and religious practices, and thus we rely on the father's country of birth to identify Muslim women.[8] This information is highly aggregated in the LFS. The variable coding father's origin takes one out of ten values (excluding a code for missing values): France, Northern Europe, Southern Europe, Eastern Europe, Maghreb, Rest of Africa, Middle East, Laos/Vietnam/Cambodia, Rest of the World. We drop from the sample the categories Rest of Africa and Rest of the World, which contain both countries with and without a significant Muslim population. We then code the Maghreb and the Middle East as "Muslim" and all other countries as our "non-Muslim" control group. Our final cross-sectional sample consists of 52,201 observations, out of which 4,163 are Muslim. Our main results are based on the sample of women, but we use men as an additional control group for a number of our analyses.

To verify the robustness of results produced using the LFS, we use information from the 2011 1% sample of the French census microdata, which is part of the International Integrated Public Use Microdata Series (IPUMS International), collected and distributed by the University of Minnesota. More details on this data source are

[8]We use the father to identify second-generation Muslims because Islam is patrilineal, passed on through the male line. If we use the mother, LFS results are only slightly attenuated.

provided in the Appendix.

Survey *Trajectories and Origins*. To assess the long-run effects of the headscarf ban on the social attitudes of Muslim women, we take advantage of a survey uniquely designed to record the characteristics and attitudes of immigrant populations in France, the survey Trajectories and Origins (Trajectoires et Origines, henceforth TeO). TeO was conducted in 2008-2009 on a sample of 21,000 people and included representative samples of immigrants, descendants of immigrants, as well as French without an immigrant background, born in France or in overseas departments. The survey includes religious adherence, which allows us to improve on our earlier identification, by focusing on self-reported Muslim women, without needing to indirectly identify them using the father's country of birth.[9] We restrict attention to women born in France, or those who moved to France before age 6, so as to ensure that everyone in the sample attended school in France.

Tables B.1 and B.2 in the Appendix provide summary statistics on our main outcome variables for women and men, respectively. A complete description of all variables is provided in Appendix Section C.

4.2 Identification strategy

To evaluate the effects of the school veiling ban, we employ a difference-in-differences analysis. Our source of cross-sectional variation is Muslim origin. Depending on the outcome of interest, we use two sources of time variation: birth cohorts and survey years. Birth cohort variation (i.e. comparing outcomes of cohorts in school during the ban to those who completed school before the ban) allows us to examine the long-run effect of the law. Yearly variation (i.e. comparing outcomes of everyone before and after the ban's passage in 2004) allows us to identify its immediate impact. We explain

[9]The TeO thus also allows us to verify that our approach for identifying Muslims in the LFS and IPUMS is valid: the correlation between self-reported Islamic religion and an indicator for father born in a Muslim-majority country in the TeO sample is 0.7403.

each of these strategies in detail below.

Cohort variation. When examining the ban's effect on educational attainment, as well as other long-term socioeconomic characteristics, we assess how the difference in outcomes between women of Muslim and non-Muslim origin changes for cohorts of school age at the time of the law's enactment as compared to cohorts just old enough to have left school at the time of the ban. Students in France attend secondary education between the ages of 11 and 18. While attendance is compulsory by law only until the age of 16, the second stage of secondary education (*lycée*) which prepares students for a high school degree, or *baccalauréat*, lasts until the age of 18. Based on this structure of the educational system, we assume that women born in 1985 or earlier, who were 19 years old in 2004, were likely to have already left secondary education and would thus be unaffected by the law. Any cohort born in 1986 or later would instead have had at least one year of education under the new law.[10] These younger cohorts of Muslim girls constitute our treatment group. The distinction between treatment and control group is not sharp – some girls born 1986 or later may have not actually been in school when the ban was implemented – but this only introduces measurement error which would bias any estimated effect towards zero. We always restrict our focus to cohorts born 1980 or later, to ensure a roughly equal amount of observations on either side of the 1986 cutoff.

Our simplest specification takes the form:

$$Y_{icg} = \alpha_1 + \alpha_2 T_{cg} + g_g + c_c + \epsilon_{icg} \tag{1}$$

where i indexes individuals, c indexes birth cohorts, and g indexes groups based on the father's region (LFS) or country of birth (IPUMS), or the individual's religion (TeO). T_{cg} is an indicator for individuals identified as Muslim and who were 18 or

[10] Figure B.1 in the Appendix shows that close to 100% of women born 1986 or later were enrolled in secondary education in 2003, the year before the implementation of the ban. This share drops to less than 80% for those born in 1985 and to 40% or less for older cohorts.

younger in 2004 (born 1986 or later). g_g and c_c are group and birth cohort fixed effects, respectively, and ϵ_{icg} is an idiosyncratic error term. The coefficient of interest is α_2, the differential treatment effect of the ban on schooling age cohorts of Muslim women. When using the LFS, the repeated cross-section structure of the data allows us to simultaneously control for birth year, survey year and age fixed effects, since we observe the same birth cohorts at multiple points in time. Our preferred specification then includes a full set of father's region of origin by age fixed effects. This is particularly important, since most of our educational and labor force outcomes of interest follow a different age profile for Muslim vs non-Muslim women.

Yearly variation. When analyzing the immediate effect of the ban on secondary school enrollment, we use an alternative time dimension as a source of variation. We assess how the difference in the change of student status between fall and spring quarter of the same year for Muslims and non-Muslims varies before and after the ban. We exploit the fact that the LFS has a panel structure, which allows us to observe the same individual in six consecutive quarters, and we track the same person right before and right after the implementation of the law. We run a regression of the form:

$$\Delta Y_{isg} = \beta_1 + \beta_2 T_{sg} + g_g + s_s + \epsilon_{isg} \tag{2}$$

where i and g index individuals and groups, as before, and s indexes survey years. T_{sg} is an indicator that equals one for Muslim individuals observed in a survey year when the law is already in place. The outcome of interest ΔY_{isg} in this case is the change in student status (in secondary education) from the second to the fourth quarter of survey year s. As before, we are interested in the direction and magnitude of the coefficient β_2, the differential treatment effect on student enrollment for Muslim women.

Threats to identification. The validity of the difference-in-differences approach relies on two identifying assumptions. First, outcomes of Muslim and non-Muslim women would have been following parallel trends in the absence of the law. While this assumption cannot be tested directly, availability of data for older cohorts of women

allows us to demonstrate the absence of any differential pre-trends in outcomes prior to the passage of the law. This rules out the possibility that behavior was already changing for younger cohorts of Muslim women for reasons unrelated to the headscarf ban. Second, there can be no time-variant unobservable factors that coincide temporally with the headscarf ban and differentially affect women of Muslim origin. This assumption is also unlikely to be violated given the nature of the variation we are exploiting: the time dimension for most of our analysis is not years, but birth cohorts. It would have to be the case that any time-variant confounder that differentially affects Muslim girls does so only, or disproportionately, for the younger cohorts. We are not aware of other changes in legislation or rules relating to the educational system that could be correlated with the 2004 ban. It is plausible that general discrimination against Muslims, particularly against veiled Muslim women, either preceded or was a direct consequence of the ban and the associated public discussion. We consider such anti-Muslim sentiment part of the bundle of factors that constituted the "effect" of the law, and not a confounder. To the extent that anti-Muslim sentiment extended to older Muslim women and did not only single out young Muslim women, this will bias downward our estimate of the differential effect of the law on the directly affected group of school-aged Muslim women. We will present evidence of such spillovers of the law on Muslim men in Section 5.

A more concrete threat to identification is a source of discrimination unrelated to the law, such as Islamophobia, initially spurred by the 9/11 attacks in 2001 and still prevalent in later years. There are two reasons why such a concern is unlikely to be important. First, even if such discrimination differentially affected school-age cohorts – an unlikely hypothesis a priori – it would not have manifested with a sharp break in the educational attainment of cohorts just old enough to be in school in 2004. In Appendix Section A.1, we demonstrate with a set of placebo exercises that no cohort born before 1986 displays a significant drop in secondary educational attainment, as we would expect if other sources of discrimination, and not the ban, were the drivers of our findings. Second, part of our difference-in-differences design exploits an entirely

different source of time variation (survey years instead of birth cohorts). It is unlikely that generalized Islamophobia can explain both educational attainment of cohorts born 1986 and later and the change in rates of secondary enrollment of Muslim women between 2003 and 2004.

Finally, it is worth emphasizing at this point that we lack information on who was wearing a headscarf in 2004 and was thus *treated* by the law in the strictest sense. What we are identifying is the effect of the law on women of schooling age who either report being Muslim (TeO) or whose father was born in an identifiable Muslim-majority region or country (LFS, IPUMS). To the extent that schooling-age Muslim women who did not wear a headscarf did not respond at all to the 2004 ban, we would expect an additional downward bias in our estimates. In short, both the potential spillover effects of the law, as well as the lack of precise information on veiling practices, should contribute to estimated treatment effects being a lower bound of actual effects.[11]

5 Effects on educational attainment

As discussed in Section 3, the first order effect of the 2004 law should be traceable in educational attainment. Figure 2 separately plots the likelihood of having completed secondary education for Muslim and non-Muslim women in the LFS, conditioning on age and survey year fixed effects. Secondary attainment of Muslim women is generally lower, but follows a parallel trend to non-Muslim women for older cohorts, thus providing support to the main identifying assumption of the difference-in-differences strategy. This pattern ends abruptly with the group born in 1986, precisely the first cohort of women old enough to be affected by the ban while at school. The gap between

[11] It is also worth pointing out here that prior to the law, regulation of headscarves was decided school by school. A ministry of education circular had established this discretion prior to 2004. Therefore, not all schools were affected equally by the law; some implemented anew the regulations against veiling whereas others maintained the status quo. That some schools did not accommodate veiling prior to 2004 should be an additional factor biasing our estimated effects downwards.

Muslim and non-Muslim women more than doubles with this cohort, and remains large thereafter.

[Figure 2 about here.]

Table 1 clarifies the magnitude and demonstrates the robustness of this result. Column (1) reports the interaction coefficient from equation 1 which suggests that the difference in the likelihood of completing secondary education between Muslim and non-Muslim women becomes almost three percentage points larger for school age cohorts. The effect remains unchanged when controlling for survey year fixed effects in column (2). In column (3) we control flexibly for age by father's birthplace fixed effects, effectively allowing women from different origins to have different age profiles in terms of when they complete secondary education. This increases the magnitude of the estimated coefficient. In column (4), we include a linear Muslim-specific trend in birth year. The coefficient remains robust and further increases in magnitude. This increase likely captures a fact that can be observed in Figure 2: Muslim women born before 1986 were catching up with their non-Muslim counterparts in terms of secondary educational attainment.

The estimated effects are large. The magnitudes imply that the difference between Muslim and non-Muslim women in secondary attainment more than doubles. Our preferred specification reported in column (3) implies that we can attribute to the veiling law a differential increase in the share of Muslim women who fail to finish secondary education of 3.9 percentage points, which corresponds to 20% of the overall share of women without secondary education in our sample (19.1%).

[Table 1 about here.]

Finally, column (5) investigates one important source of the effect's heterogeneity: the origins of the parents. The drop in secondary educational attainment is double in magnitude for women with both parents born in Muslim-majority regions, compared to those with a Muslim father and a non-Muslim mother. Parental origin may proxy for

two things. The first is the intensity of the treatment – girls born in Muslim families are perhaps more likely to wear the headscarf and thus to have been directly affected by the ban. The second relates to the strength of the identity channel in driving responses to the ban. Conditional on having worn the headscarf, women from Muslim families would have faced more of a conflict between their family background and French secular identity compared to their counterparts with parents in mixed marriages.

We perform a wide set of robustness checks to verify the validity of the estimated effect of the ban on the likelihood of completing secondary school. We show that the effect is not driven by other changes coinciding temporally with the headscarf ban, such as general xenophobia and Islamophobia spurred by the 9/11 attacks, or by imbalances across the sample of Muslims and non-Muslims. A detailed description of robustness checks can be found in Section A.1 of the Appendix.

5.1 How does the ban reduce educational outcomes?

Through which pathway does the law have such a negative impact on the educational outcomes of Muslim women? In what follows, we further unpack the process that leads cohorts affected by the ban to attain lower levels of secondary education, and identify two additional effects of the law.

First, Muslim women in affected cohorts are likely to require more time than their counterparts in the control group to complete secondary education. Figure 3 plots the differential treatment effect of the ban, estimated from a flexible version of the specification in equation 1, which interacts Muslim origin with two-year birth cohort dummies. The dependent variable is the likelihood of being enrolled in (but not having completed) secondary education, conditional on a full set of age by father's birthplace fixed effects. The pattern suggests that cohorts born after 1986 are more likely to be students in high school at any given age. Conditional on differential age trends, Muslim women are on average somewhat more likely to stay in secondary education longer than non-Muslims, but this gap widens for affected cohorts. One reason this may happen,

which would be consistent with observations made in the official evaluations of the ban's effects, is the ban led girls to repeat a class. This could be because of time lost during the mediation period, switches from public to private education, or simply the pernicious effects of discrimination at school on girls' effort and grades.

[Figure 3 about here.]

The increase in enrollment rates in secondary education conditional on age is substantial in magnitude. Muslim women's enrollment rates increase by up to 4 percentage points. Note that among 20 year old non-Muslims, only around 7.9% are still attending secondary education. For Muslims this share is 13.3% – a difference that is largely explained by the estimated effect of the veiling law.

Second, we find evidence that Muslim girls drop out of school in direct response to the law's implementation. The panel nature of the French LFS allows us to examine how the student status of Muslim women changed after 2004. We restrict attention to women enrolled in secondary school in the spring quarter of each school year and who were older than 16 (and thus could have legally dropped out of school if they wanted to). We then compute a proxy for dropping out of school, as the difference in student status between spring quarter and fall quarter of the next school year. This variable takes on the value -1 for individuals who were students in secondary education in the spring quarter, but are not students anymore (in any degree of education) in the fall of the same academic year. We examine how this average difference changes for Muslim girls after 2004, by estimating the specification in equation 2. The results are plotted in Figure 4 for all survey years in our sample. While we only have information on one calendar year before 2004 (the change between spring 2003 and fall 2003), it is clear that this difference is zero and increases by around 6 percentage points in 2004–2005. With the exception of 2006 and 2009, all years after 2004 see an increased dropout rate for Muslim women compared to their non-Muslim counterparts.

[Figure 4 about here.]

Figure B.2 in the Appendix examines the effects of the ban on men's likelihood of dropping out of secondary school, plotted alongside those of women. For men, as for women, there is an increase in the dropout rate in the two years directly following the implementation of the ban. For later years, the difference in the dropout rate returns to pre-2004 levels or even decreases for men. Table 2 demonstrates the robustness of this result to a number of specifications and successive inclusion of fixed effects, both for men and for women. Once again, estimated magnitudes for women are large. The average rate of leaving secondary education in our data is 11.8 percent. Estimates in Table 2 indicate an increase in dropout rates for Muslim women exposed to the law of up to 60 percent of this long run average, a sizable effect.

[Table 2 about here.]

There are two possible explanations for the differential drop in student status for Muslim women after 2004. One possibility is that they complete secondary education, but do not follow their classmates to university. Alternatively, they drop out earlier, before completing secondary education in the first place. Arbitrating between these two scenarios allows us to further test if the observed effect indeed results from the 2004 law: since the ban did not legally pertain to universities, we should not see an immediate reduction in university attendance rates between 2003 and 2004. Instead, the short-run effect should come from drop outs in secondary education.

Table 3 demonstrates that this is indeed the case. Columns (1) and (2) display the differential change in the dropout rate from secondary education for Muslim women in the short (column 1) and long run (column 2). Specifically, column 1 presents the estimated effect of the ban on dropout rates between 2003 and 2004, i.e. during the first year of implementation. Though imprecisely estimated, the effect is negative and larger in the short-run. Columns (3) and (4) present the same differential effect for the dropout rate out of university. Unlike with those in high school, Muslim women enrolled in university are not more likely to drop out in 2004. They do, however, become more likely to drop out in the longer run. Conditional on a full set of parent

birthplace-specific age effects, this finding is consistent with the immediate effects of the law on high school dropout rate carrying on to university in later years. It is also consistent with accounts of Muslim women that discrimination against those who veil was also present in the university in the years following the ban's implementation, even though the official law did not apply to higher education.

[Table 3 about here.]

In sum, our results so far indicate that the 2004 headscarf ban negatively impacted the secondary educational attainment of Muslim women. It also had two additional effects. It led affected cohorts of Muslim women to spend more time completing secondary education. As Tables 2 and 3 show, it also made Muslim women more likely to drop out of secondary school upon implementation of the law, but also in subsequent years. The effect spilled over to Muslim men, though this was limited in magnitude and duration.

To what extent were these facts the result of discrimination faced by these cohorts in school? While we cannot precisely test how much of the effect is due to discrimination, we can show that affected cohorts faced more intense discrimination at school than the control group. To this purpose, we apply our difference-in-differences specification to the TeO survey. Figure 5 plots the interaction coefficient from equation 1 in the sample of French-born women born 1980-1994. Columns 1–2 of Table B.3 in the Appendix report the magnitudes associated with these effects, as well as a comparison of the differential effect between men and women, in a triple differences specification. Affected cohorts are significantly more likely to say that they have experienced racism (in the form of insults or harassment) in school. They are also more likely to report lower trust in the French school. These results show that Muslim girls were differentially treated in schools, and thus work as evidence for a discrimination channel driving results on educational outcomes.

[Figure 5 about here.]

6 Effects on long-run socioeconomic integration

We next proceed to examine how the headscarf ban affected a larger set of longer term outcomes. We are unable to precisely distinguish what part of these effects is the direct result of lower educational attainment, and what part was independently produced through the mechanisms highlighted in Section 3. Our analysis of the TeO does, however, provide suggestive quantitative evidence for both the role of discrimination and that of identity. We complement and further strengthen this evidence with qualitative data from interviews in Section 7.

Our analysis here mirrors that presented in Table 1, using as dependent variables a number of different outcomes: labor force participation, employment, co-habitation with one's parents, the likelihood of being married, and number of children. In Table 4, we estimate our preferred specification of equation 1, which includes a full set of survey and age fixed effects interacted with father's region or country of birth. Affected cohorts of Muslim women are almost 3 percentage points more likely to be out of the labor force and 3.7 percentage points less likely to be employed. They are also 2.4 percentage points more likely to live with their parents. Finally, while we find a small (negative) difference in the likelihood of marriage, affected cohorts are almost 4 percentage points more likely to have children.

[Table 4 about here.]

Both the labor market and social effects are substantial. When comparing them to the difference between Muslim and non-Muslim women among untreated cohorts, the estimated magnitudes indicate that the veiling law widens the gap with respect to employment by more than a third (initial gap of 10.9%) and the gap with respect to labor force participation by more than half (initial gap of 5.3%). The gap between Muslims and non-Muslims in cohabitation with parents increases by a similar amount (more than a third of the initial gap of 6.9%). Reassuringly, we find similar patterns when we replicate our results in the 2011 1% sample of the French census. These are

discussed in Section A.2 of the Appendix.

Finally, we use the TeO data to provide evidence that the 2004 ban had an impact on social identity. Figure 6 reports differential effects on various self-reported measures of identity for school age cohorts of Muslim women.[12] Affected cohorts are less likely (though not significantly so) to report higher levels of agreement with the statement "I am seen as French," but not less likely to say that they feel at home in France. Surprisingly, treated cohorts are more likely to identify both as French, and with their father's country of origin, though on average, identification tends to increase more with the father's origin than with France. This indicates that identity, whether French or foreign, became a more salient issue for cohorts affected by the law. Models of oppositional identity formation (Bisin et al. 2011) would suggest that attempts at assimilation have a polarizing effect, by forcing individuals to identify with one of two incompatible identities. While we find some indication of this effect here – since Muslim women identify relatively more with their father's background on average – our results do not fully support the predictions of such models. The headscarf ban may have cast Muslim identity as incompatible with French ideals, but the TeO results suggest that Muslim women respond to this by reaffirming their belonging to both France and their ethnic and religious communities.

[Figure 6 about here.]

7 Qualitative evidence on mechanisms

To complement our empirical analysis, as well as provide evidence particularly on the mechanisms driving our long-term estimated effects, we leverage qualitative interviews.

[12] Columns 3–7 of Table B.3 in the Appendix report the magnitudes associated with these effects, as well as a comparison of the differential effect between men and women, in a triple differences specification.

The experiences of young Muslim respondents show how the discriminatory environment present after the 2004 ban impaired women's educational and career trajectories. Interviews also reveal a split in the attitudes and behaviors of young Muslim women. The incompatibility of the Muslim and French identities, signaled by the ban and reinforced by the media, drove some respondents to withdraw from French society while others reasserted their belonging to both French and Muslim communities.

This section draws on interviews with 20 Muslim women conducted by one of the authors in Paris in July-August 2011. Information about sampling strategy and data collection is provided in Appendix Section D. Importantly, the respondent pool is diverse in terms of age, ranging from 18 to 47, as well as immigrant origins, including sub-Saharan Africa, North Africa, Turkey, and Pakistan. Because we anticipate the headscarf ban to have negatively affected younger cohorts who were in the education system in 2004, the age distribution of respondents enables us to corroborates that older cohorts were unaffected by the ban. Summary statistics on the characteristics of interviewees are provided in Table D.2 in the Appendix.[13]

7.1 Discrimination channel

Interviews indicate that the ban generated differential treatment of Muslim women in educational institutions and the labor market, thereby impeding Muslim women's advancement. First the law instituted a de facto discriminatory regime in primary and secondary education, wherein veiled girls were the primary targets of the new regulations. Twenty-eight-year-old Nadia shared her own experience of expulsion.[14] Nadia started veiling at 13. When she veiled at school, her teachers were dismayed but failed to convince her to unveil. The school ultimately expelled her and engaged a govern-

[13]These interviews were approved by Yale University's Human Subjects Committee under IRB procotol 1005006869.

[14]Names have been changed to preserve anonymity. Her expulsion occurred prior to the 2004 ban, when an education circular enabled schools to adopt their own regulations. She attended a school where veils were not allowed.

ment mediator to resolve the impasse. Her parents, concerned about her education, convinced her to unveil in school.[15] That process took a significant amount of time and led her to fall behind relative to her peers. Her experience illustrates how the law directly altered the lives of veiled Muslim girls, with the potential to undermine their academic performance.

Even for girls who obeyed school veiling regulations or did not veil at all, the 2004 law contributed to an environment more hostile to Muslim girls more broadly. An anti-islamophobia lawyer reported, "For those who remained, there was an enormous psychological effect. They are made to feel like culprits but they have done nothing. Despite that, they are humiliated, and [they] do not understand why they are insulted or made to feel like outsiders."[16] Interviewees who were in the education system in 2004 recall an environment of scrutiny and suspicion after the passage of the ban. Respondents in schools with predominantly French-origin peers were asked to serve as representatives of the Muslim community; they were challenged to disprove the benefits of the ban: its preservation of secularism, its liberation of Muslim women from religious pressure, and its assimilation of a community that claimed to be French but preserves its difference.[17] The stereotypes and interrogations placed Muslim girls, particularly highly religious ones, under considerable stress, and "the more discussion [of the ban], the more one is alienated".[18]

7.2 Identity channel

The law also signaled that veiling was not compatible with the French identity. The narrative of the inconsistency of the Islamic and French identities was reinforced by the national media as well as enacted through the formal enforcement of the law in

[15] Author interview, July 2011.

[16] Author interview, July 2011

[17] Author interview, July 2011

[18] Author interview, July 2011

schools and its unauthorized application in higher education. Respondents were all keenly aware of the alleged incompatibility of their Muslim and French identities, but they differed in their reactions. Some rejected the false choice between identities and reasserted their right to be both French and Muslim. One respondent proclaimed that she was born in France, she speaks the language, and she respects the laws, and therefore she was as French as any other citizen. She, and others, insisted on integrating on their terms, maintaining their veils and French values. A few interviewees used activism at university or through civic associations to affirm their dual identities.[19] One such activist explained, "But for me, I think that it [retreating, giving up] is not the solution at all. I think it is necessary to cling on... when you hang on, you make advancements."[20] In contrast, other respondents chose to retreat into their Muslim identity. This retreat took many forms, such as attending a school where children of immigrants predominate, applying to work in Muslim-owned businesses, and moving to immigrant-dominated suburbs.[21] One woman interviewed left work altogether and began wearing the burqa. She explains her decision, "you can do what you want without limitations if you have bad intentions. But there is persecution [of those who want to do good]. It is the hypocrisy of France. They teach in schools [that we are free] but then they close off all of your options; they do not accept you at all [if you do not conform]."[22]

The dynamics described here were reported by Muslim women born between 1983 and 1990. Respondents born in the 1960s and 1970s were not personally impacted by the ban, neither were those born after 1990. Rokhaya, a French-Senegalese woman born in 1976, describes an adolescence without a relentless focus on Islam and veiling. When she started working in 1998, she experienced no pushback against her religious practice

[19] Author interviews with three respondents, July 2011.

[20] Author interview, July 2011.

[21] One respondent in particular reported that the persecution she felt pushed her to become much more insular and closer to her family. (Author interview, July 2011.)

[22] Author interview, July 2011.

at work, including covering her hair and praying.[23] These cohort differences provide evidence that Muslim girls in school in 2004 were most affected by the headscarf law relative to older cohorts.

8 Discussion and conclusion

Do bans on religious expression affect minority integration? In this paper we systematically investigate the effects of the 2004 French headscarf ban and show that the integration of Muslim women was negatively impacted by the law along a number of dimensions. Affected cohorts of Muslim women are less likely to complete secondary education, more likely to drop out of secondary school after the law's enactment, and more likely to take longer to complete secondary education. Long-term socioeconomic outcomes and attitudes are also affected. Treated cohorts have lower rates of labor force participation and employment, and are more likely to have more children. A combination of quantitative and qualitative evidence suggests that these results are primarily driven by two mechanisms. The first one is discrimination, either through the policy itself or through negative attitudes surrounding and accompanying its implementation. This manifested in school, with direct consequences for educational performance and enrollment, but also in university and in the labor market. The second mechanism is the strengthening of Muslim identity and the weakening of ties with France, which led women affected by the ban to retreat into their communities and avoid interaction with the broader society.

We emphasize these two mechanisms, as the mediators of observed effects most supported by our evidence. They do not, however, exhaust the set of potential channels at work. The headscarf ban may affect outcomes by interfering with other functions that veiling performs for women who use it, such as signaling adherence to the norms

[23] Author interview, July 2011.

of the religious community. Studies such as Carvalho (2012), Patel (2012), and Aksoy and Gambetta (2016) suggest that pious Islamic dress is used by Muslim women as a commitment device which, by affirming their religiosity to the community, allows them to work and otherwise participate in the broader society. By removing this signaling mechanism, veiling bans can thus have the perverse effect of increasing religiosity and decreasing integration. There are a few different reasons to think that school-age girls may substitute away from veiling to other signals of religious commitment. As the third generation is more religious than prior generations, signaling religious piety, in general or to peers, is more important than in prior generations. Moreover, parents, who are particularly religious could have played a role in these substitution decisions. Some of the documented effects of the law involved girls switching from public to private schools or to distance learning so that they would not have to remove their head covers (Mattei and Aguilar 2016). For students or parents who did not have the means to switch in that way, substitution could have manifested with increased monitoring of behavior and increased emphasis on religious behavior outside the school. Such behaviors could have a lasting impact on girls' religiosity, and associated attitudes towards female education or labor force participation in the long run.[24] These behaviors would also be consistent with the identity channel we document above, though we lack the data to identify whether signaling considerations played an additional role in Muslim women's decisions.

Our paper makes four main contributions. First, we are the first to causally assess the impact of veiling laws in general and of the French 2004 law in particular. Given the increasing prevalence of these laws, the support they garner both from native populations and European courts, as well as the intense debate surrounding them, a systematic positive evaluation of their effects was prominently absent. Second, we contribute to a

[24]The work of Meyersson (2014) in Turkey provides an interesting test of a similar hypothesis in the reverse setup. In Turkey, female educational outcomes improved in municipalities with higher Islamic representation in the local government, consistent with the interpretation that an education more aligned with religious norms may increase educational investment of both parents and schoolchildren.

growing theoretical and empirical literature on the effects of assimilationist policies on minority outcomes and identity, which so far has produced conflicting results. Though some theoretical studies suggest the likelihood of a minority reaction to assimilationist attempts (Bisin et al. 2011; Carvalho 2012), others discount such a possibility (Alesina and Reich 2013), and empirical work has produced conflicting evidence. Feir (2016) and Gregg (2018) suggest that even the legacy of assimilationist Native American boarding schools in the US and Canada can be positive for individuals and communities in terms of economic indicators. At the same time, Fouka (2018) finds that forced monolingualism intensifies minority self-identification, but that such effects are characterized by substantial heterogeneity in responses depending on the initial degree of assimilation and minority identity. Our study shows that religious bans can have a similar negative effect on integration, but makes substantial progress compared to existing literature in identifying the mechanisms behind this effect.

Third, we provide new evidence on the effects that discrimination has for immigrant behavior and integration outcomes. Theoretically, one potential effect of discrimination is that it induces minority group members to disassociate themselves from the minority group and assimilate into the majority in order to avoid being singled out. Fouka (2017) finds evidence for such effects in the behavior of German immigrants in the US during the period of heightened anti-Germanism that followed World War I. At the same time, it is also theoretically possible that discrimination can lead to alienation or radicalization. Adida, Laitin, and Valfort (2014) use behavioral games to show that discrimination against Muslims and alienation of the latter coexist in a "discriminatory" equilibrium in France. Gould and Klor (2015) show that the integration of Muslim immigrants in the US was substantially hindered after 9/11, and more so in states that saw a higher rise in hate crime. Mitts (2018) shows that online Islamic radicalization correlates with patterns of right-wing voting in Europe. In the absence of exogenous variation in discrimination none of these studies identifies a causal effect of discrimination on immigrant behavior. Our study contributes to this literature by isolating a

causal effect of the veiling ban on Muslim outcomes and providing multiple pieces of evidence that indicate that the effect is driven by discrimination of Muslim women at school.

Finally, our study contributes to a broader debate on the success of multiculturalist policies. Wright and Bloemraad (2012) and Bloemraad and Wright (2014) have attempted to place countries on a spectrum of multiculturalism and assess the impact of multiculturalist policies on immigrant integration. Their findings suggest that multiculturalism has modest positive effects for the first generation and no discernible effects for the second generation. By moving beyond cross-country correlations and focusing on the evaluation of a specific policy, our study informs the debate on the merits of multiculturalism by providing causal evidence that policies with an assimilationist character can hinder integration. Evaluating the impacts of specific integration policies can be a useful complementary approach to broader overviews of country policy packages, and a fruitful avenue for future research on immigration and integration.

It is worth emphasizing at this point, that important potential effects of the ban are not easy to assess with existing data. Theoretical work on cultural transmission (Bisin and Verdier 2001; Bisin et al. 2011) suggests that assimilationist policies, cultural bans and native discrimination have long-run multi-generational implications for the dynamics of minority identity. One of the potential impacts of veiling bans highlighted by Carvalho (2012) is their potential to increase religiosity and minority identification among younger generations. To what extent policies like the headscarf ban affect the incentives of second-generation immigrants to acculturate their children, and the implications this may have for minority identity in the long-run are important questions that remain unanswered. We leave such questions to future research.

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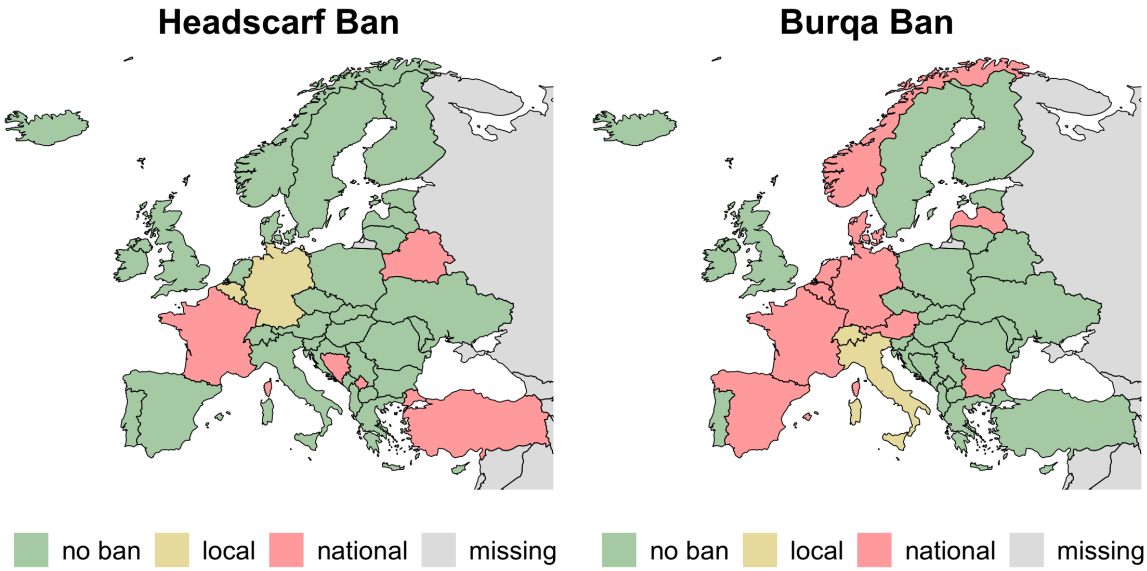
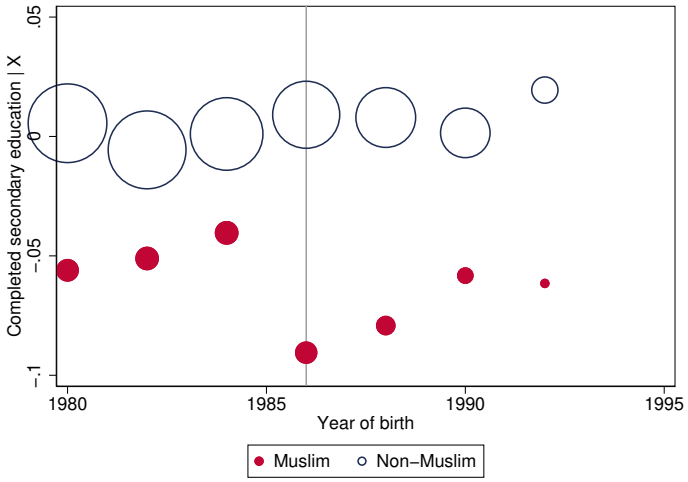
Figure 1. Prevalence of laws regulating veiling across Europe



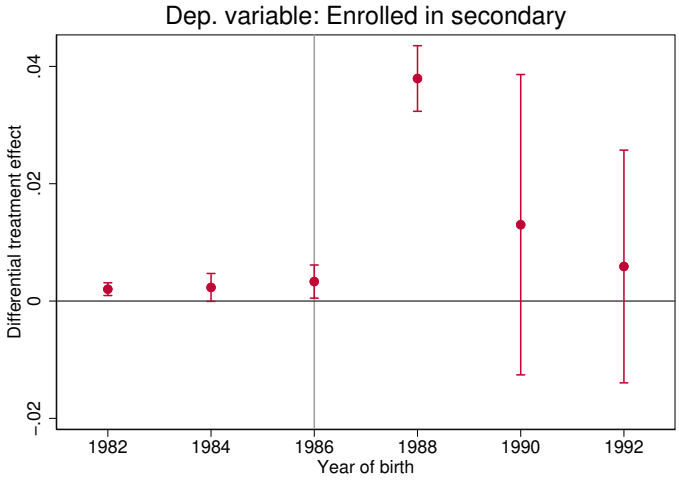
Source: European Commission (2017) and Open Society Foundations (2018). On the left, the map visualizes the status of headscarf bans. National or local laws refer to bans implemented broadly in the public sphere or specific contexts such as schools or courts. On the right, the map visualizes the status of national bans on the full-face veil (burqa or niqab).

Figure 2. Probability of having completed secondary education by birth cohort for French-born women



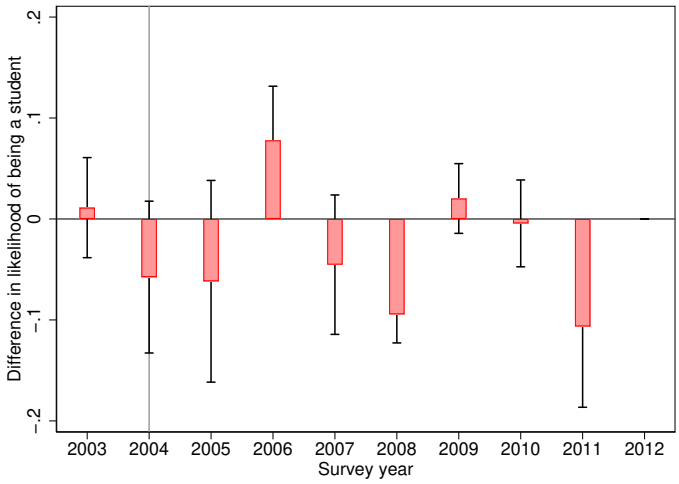
The figure plots residuals, aggregated over two-year cohorts, from a regression of an indicator for completed secondary education on age and survey year fixed effects. The sample consists of French-born women born after 1980 and who were at least 20 years old at survey year. Data is from the 2004 to 2012 waves of the LFS. Circle size is proportional to sample size. The vertical line corresponds to 1986, the first birth cohort impacted by the ban.

Figure 3. Likelihood of being a student in secondary education, conditional on age



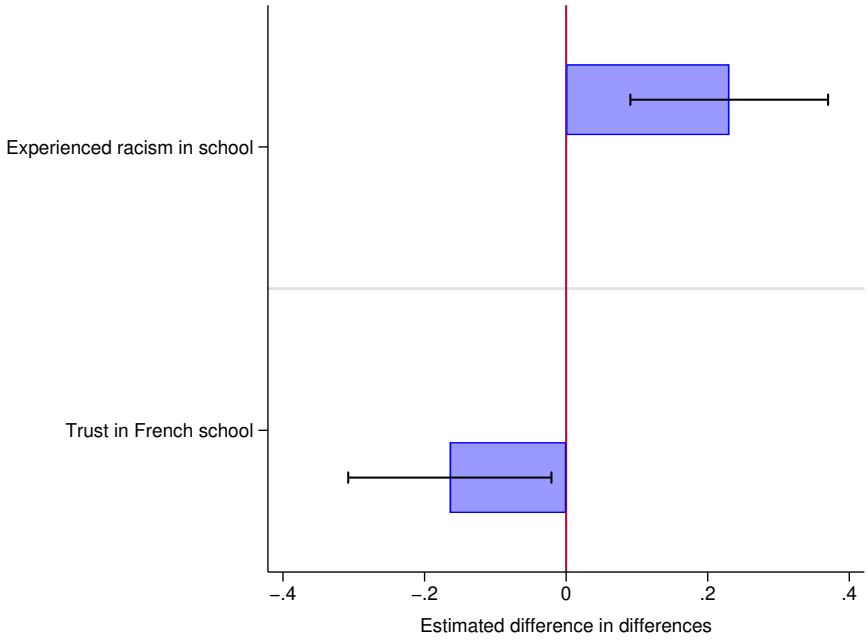
The figure plots estimates of the interaction coefficient between Muslim origin and 2-year birth cohorts from a regression of an indicator for being in secondary school, that additionally controls for survey year and father's birthplace by age fixed effects. Vertical lines denote 90% confidence intervals. The sample consists of French-born women born after 1980 and who were at least 20 years old at survey year. Data is from the 2004–2012 waves of the LFS.

Figure 4. Change in student status between spring and fall quarter, difference Muslim women vs others



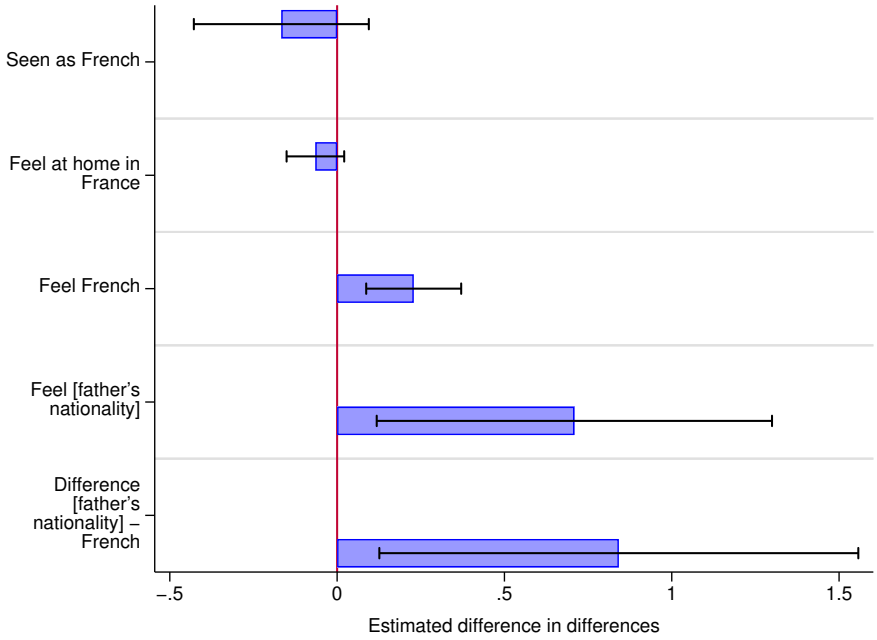
The figure plots estimates of the interaction coefficient between Muslim origin and survey year fixed effects from a regression of an indicator for changed student status between fall and spring quarter of the same school year, that also controls for survey year, birth cohort and father's birthplace by age fixed effects. Vertical lines denote 90% confidence intervals. The sample consists of French-born women aged 16 or above at survey year, who were enrolled in secondary education in the spring quarter of the previous year. Data is from the 2004–2012 LFS.

Figure 5. Effects on self-reported attitudes related to school



The figure plots coefficient estimates and 90% confidence intervals from the interaction between Muslim religion and an indicator for individuals born after 1986. The regression controls for birth cohort and religion fixed effects, as well as for a linear Muslim-specific age trend. The sample consists of French-born women born after 1980. Outcomes are standardized and estimated effects can be interpreted in terms of standard deviations. Data is from the Trajectories and Origins survey.

Figure 6. Effects on self-reported attitudes related to identity



The figure plots coefficient estimates and 90% confidence intervals from the interaction between Muslim religion and an indicator for individuals born after 1986. The regression controls for birth cohort and religion fixed effects, as well as for a linear Muslim-specific age trend. The sample consists of French-born women born after 1980. Outcomes are standardized and estimated effects can be interpreted in terms of standard deviations. Data is from the Trajectories and Origins survey.

Table 1. Effect on the probability of having completed secondary education

	(1)	(2)	(3)	(4)	(5)
Dep. Variable	Completed secondary education				
Muslim × Born after 1986	-0.0295***	-0.0291***	-0.0386***	-0.0712***	
	(0.00776)	(0.00771)	(0.00343)	(0.00805)	
Muslim father only × Born after 1986					-0.0233***
					(0.00298)
Muslim father and mother × Born after 1986					-0.0488***
					(0.00776)
Observations	45265	45265	45265	45265	45265
R-squared	0.00456	0.00548	0.00985	0.00994	0.0117
Birth year FE	✓	✓	✓	✓	✓
Father's birthplace FE	✓	✓	✓	✓	✓
Survey year FE		✓	✓	✓	✓
Age × Father's birthplace FE			✓	✓	✓
Muslim-specific linear trend				✓	✓

Notes: The sample consists of French-born women born after 1980 and who were at least 20 years old at survey year. Data is from the 2004–2012 waves of the LFS. "Muslim" refers to women whose father was born in the Maghreb or the Middle East. Standard errors are clustered at the father's birthplace level. *** p< 0.01, ** p< 0.05, * p< 0.1.

Table 2. Change in student status between spring and fall quarter

	(1)	(2)	(3)	(4)	(5)
Dep. Variable	Change in student status				
	Panel A: Women				
Muslim × 2004 or later	-0.0268	-0.0701*	-0.0662**	-0.0542***	-0.0561***
	(0.0278)	(0.0365)	(0.0302)	(0.0163)	(0.0178)
Observations	8667	8667	8667	8667	1387
R-squared	0.00383	0.0984	0.100	0.107	0.136
	Panel B: Men				
Muslim × 2004 or later	-0.00333	-0.00932	-0.00774	-0.0142	0.0315
	(0.0343)	(0.0329)	(0.0332)	(0.0471)	(0.0303)
Observations	8462	8462	8462	8462	1479
R-squared	0.00453	0.0943	0.0974	0.104	0.160
Survey year FE	✓	✓	✓	✓	✓
Father's birthplace FE	✓	✓	✓	✓	✓
Age FE		✓	✓	✓	✓
Birth year FE			✓	✓	✓
Age × Father's birthplace FE				✓	✓
Sample 2003-2004					✓

Notes: The dependent variable is student status in quarter 4, difference from quarter 2. The sample is restricted to French-born individuals older than 16, who were in secondary education 2 quarters before. Data is from the 2003–2012 LFS. Standard errors clustered at the father's birthplace level. *** p< 0.01, ** p< 0.05, * p< 0.1.

Table 3. Likelihood of being in secondary or tertiary education, conditional on age

	(1)	(2)	(3)	(4)
Dep. Variable	In secondary		In university	
Muslim × 2004 or later	-0.0496	-0.0114	0.00766	-0.0342
	(0.232)	(0.0525)	(0.209)	(0.0410)
Observations	1387	8667	1387	8667
R-squared	0.230	0.201	0.169	0.172
Survey year FE	✓	✓	✓	✓
Birth year FE	✓	✓	✓	✓
Age × Father's birthplace FE	✓	✓	✓	✓
Sample 2003-2004	✓		✓	

Notes: The sample is restricted to French-born women older than 16, who were in secondary education 2 quarters before. Data is from the 2003–2012 LFS. Standard errors clustered at the father's birthplace level. *** p< 0.01, ** p< 0.05, * p< 0.1.

Table 4. Effect on long-term outcomes

Dep. Variable	Out of labor force	Employed	Lives with parents	Has children	Married
	(1)	(2)	(3)	(4)	(5)
Muslim × Born after 1986	0.0288**	-0.0370***	0.0242**	0.0398***	-0.00912**
	(0.00875)	(0.00461)	(0.00655)	(0.00993)	(0.00285)
Observations	45289	45289	45289	9836	45286
R-squared	0.183	0.174	0.244	0.0347	0.132
Birth year FE	✓	✓	✓	✓	✓
Father's birthplace FE	✓	✓	✓	✓	✓
Father's birthplace × Age FE	✓	✓	✓	✓	✓

Notes: The sample consists of French-born women born after 1980 and who were at least 20 years old at survey year. Data is from the 2004–2012 waves of the LFS. "Muslim" refers to women whose father was born in the Maghreb or the Middle East. Standard errors are clustered at the father's birthplace level. *** p< 0.01, ** p< 0.05, * p< 0.1.

Appendix (Not for publication)

Table of Contents

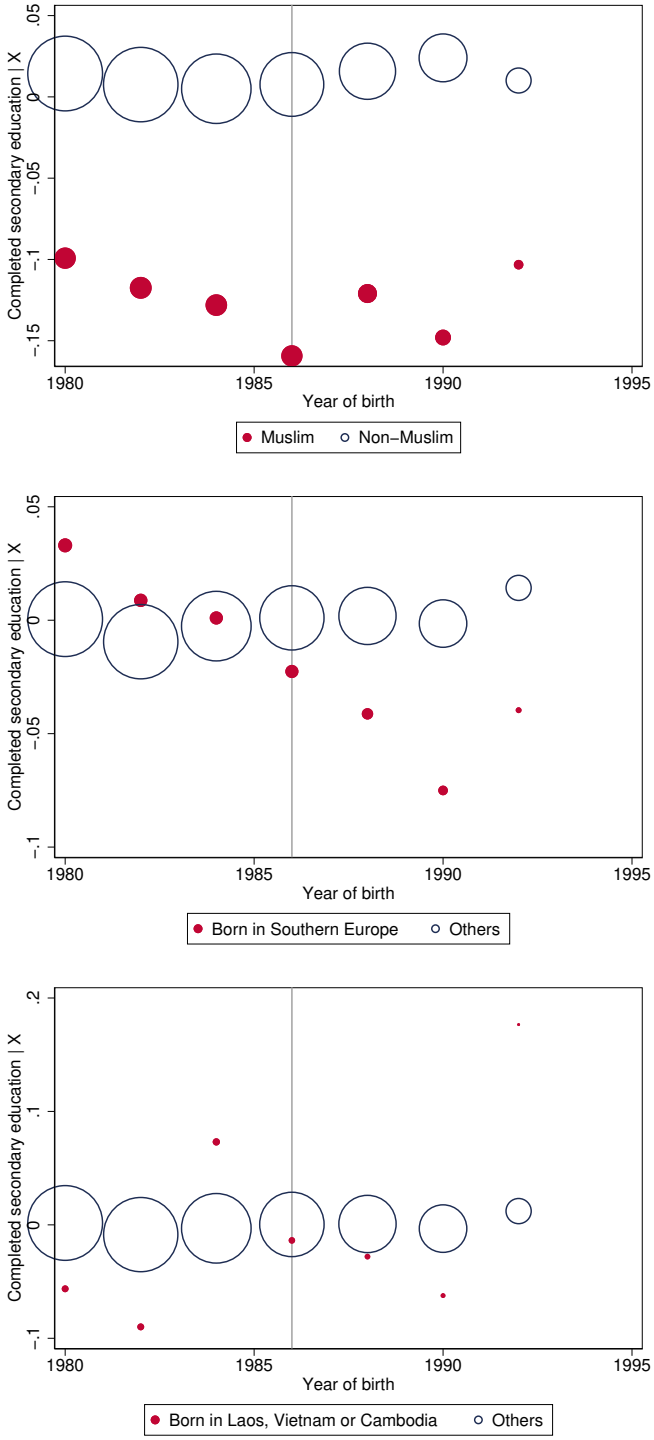
A Robustness checks

A.1 Ruling out alternative explanations for effects on educational attainment

We perform a wide set of checks to verify the validity of the estimated effect of the ban on the likelihood of completing secondary school. Figure A.1 is a replication of Figure 2 for a set of different comparisons that constitute plausible placebo checks. If the effect estimated in the previous section is indeed resulting from the veiling ban, rather than from general discrimination or other events, then it should be more pronounced for Muslim women, as compared to Muslim men. This is indeed what we observe. The upper panel of Figure 2 plots the conditional likelihood of completing secondary education in the sample of men, comparing Muslims to non-Muslims. There is somewhat of a dip in educational attainment for cohorts born in 1986 or 1987, but the drop is not as pronounced as for women. Though the trend for Muslim men is more of a continuation of an earlier trend and rebounds for younger cohorts, it is still potentially reflective of an indirect effect of the law.

Similarly, if the estimated effect is resulting from a general increase in xenophobia, potentially targeting women more directly, we should observe a similar drop in educational attainment of cohorts born 1986 or later for all immigrant groups. This is not what we find. The middle and lower panels of Figure A.1 focus on the sample of women, but define as treated two groups of second-generation immigrant women that should not have been affected by the ban: Southern Europeans (the largest group of second generation immigrants in France after those from the Maghreb) and those born in Laos, Vietnam or Cambodia. Despite smaller sample sizes, there is no pattern that mirrors that for Muslim women and that would indicate that confounding factors are affecting the educational profiles of younger cohorts of second generation immigrants in general.

Figure A.1. Placebo results for men and non-Muslim second generation immigrant women



The figure plots residuals, aggregated over two-year cohorts, from a regression of an indicator for completed secondary education on age and survey year fixed effects. The sample consists of French-born men (upper panel) or women (middle and lower panel) born after 1980 and who were at least 20 years old at survey year. Data is from the 2004 to 2012 waves of the LFS. Circle size is proportional to sample size.

To address any concerns that the drop in completed secondary education for younger cohorts reflects discrimination spurred by 9/11, we run additional placebo regressions. Table A.1 reports the interaction coefficient of our preferred specification (that reported in Column (3) of Table 1) when using each cohort in our sample as an alternative cutoff for treatment. Only 1986 corresponds to a large and significant negative effect on educational attainment. Importantly, almost all coefficients for cohorts born before 1986 are near zero, indicating that our findings are not merely the continuation of a trend that started in 2001.

Our difference-in-differences design does not require that Muslims and non-Muslims are balanced in terms of their characteristics in order to deliver estimates of causal effects. The validity of the design only requires that any difference between the two groups would have remained constant in the absence of the headscarf ban. Figure 2 and the robustness of our results to controlling for pre-trends and alternative cutoffs indicate the absence of differential pre-trends in secondary educational attainment between Muslims and non-Muslims. Nonetheless, to further ensure that any differential effect is not driven by a time-varying change in other characteristics of the sample, we combine difference-in-differences with a balancing exercise in the spirit of Ladd and Lenz (2009). We use entropy balancing (Hainmueller 2012) to balance Muslims and non-Muslims in terms of pre-treatment covariates. The method generates a set of weights, that, when applied to the original sample, balance selected moments of the treatment and control group. We match the means of the following pre-treatment characteristics available in the LFS: a full set of age dummies, a set of indicators for different categories of urbanization, and an indicator for individuals living in *sensitive urban zones* (Zones urbaines sensibles, ZUS), urban areas with high unemployment, a low percentage of high school graduates and a high percentage of public housing, which are specifically targets for state policy in France. Table A.2 in the Appendix presents characteristics of the balanced and unbalanced samples, and Table A.3 replicates our main results after applying entropy balance weights. Both the size and the significance of the coefficients

Table A.1. Effect on the probability of completing secondary education - Placebo cohorts

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
Dep. Variable	Completed secondary education											
Muslim × Born after 1981	-0.00903											
	(0.0226)											
Muslim × Born after 1982		0.0148										
		(0.0158)										
Muslim × Born after 1983			0.00183									
			(0.0174)									
Muslim × Born after 1984				-0.00303								
				(0.00667)								
Muslim × Born after 1985					0.00176							
					(0.00278)							
Muslim × Born after 1986						-0.0386***						
						(0.00343)						
Muslim × Born after 1987							-0.0198					
							(0.0104)					
Muslim × Born after 1988								-0.00262				
								(0.00527)				
Muslim × Born after 1989									0.0306***			
									(0.00303)			
Muslim × Born after 1990										0.0181**		
										(0.00539)		
Muslim × Born after 1991											0.000504	
											(0.00225)	
Muslim × Born after 1992												0.00961
												(0.0178)
Observations	45265	45265	45265	45265	45265	45265	45265	45265	45265	45265	45265	45265
R-squared	0.00972	0.00973	0.00972	0.00972	0.00972	0.00985	0.00975	0.00972	0.00978	0.00974	0.00972	0.00972

Notes: The sample consists of French-born women born after 1980 and who were at least 20 years old at survey year. Data is from the 2004–2012 waves of the LFS. "Muslim" refers to women whose father was born in the Maghreb or the Middle East. All regressions control for survey, cohort and age by father's region of origin fixed effects. Standard errors are clustered at the father's birthplace level. *** p< 0.01, ** p< 0.05, * p< 0.1.

remain largely unaffected.

Table A.2. Covariate balance before and after applying entropy balance weights

Variables	Muslim	Non-Muslim (unweighted)	Non-Muslim (weighted)
Age 21	0.102	0.120	0.102
Age 22	0.092	0.118	0.093
Age 23	0.098	0.112	0.098
Age 24	0.089	0.091	0.089
Age 25	0.097	0.076	0.097
Age 26	0.084	0.067	0.084
Age 27	0.075	0.058	0.075
Age 28	0.063	0.048	0.063
Age 29	0.047	0.040	0.047
Age 30	0.037	0.031	0.037
Age 31	0.023	0.022	0.023
Age 32	0.012	0.010	0.012
Rural	0.033	0.045	0.033
Less than 15,000 inhabitants	0.007	0.014	0.007
15,000 – 19,999 inhabitants	0.004	0.008	0.004
20,000 – 24,999 inhabitants	0.010	0.022	0.010
25,000 – 34,999 inhabitants	0.011	0.022	0.011
35,000 – 44,999 inhabitants	0.011	0.024	0.011
50,000 – 99,999 inhabitants	0.060	0.073	0.060
100,000 – 199,999 inhabitants	0.087	0.097	0.087
200,000 – 499,999 inhabitants	0.145	0.191	0.145
500,000 – 9,999,999 inhabitants	0.339	0.253	0.339
Paris	0.266	0.158	0.266
ZUS	0.225	0.061	0.225

Notes: The sample consists of French-born women born after 1980 and who were at least 20 years old at survey year. Data is from the 2004–2012 waves of the LFS. "Muslim" refers to women whose father was born in the Maghreb or the Middle East.

Table A.3. Robustness: Effect on the probability of completing secondary education, entropy balance weights

	(1)	(2)	(3)	(4)
Dep. Variable	Completed secondary education			
Muslim × Born after 1986	-0.0276**	-0.0280**	-0.0429***	-0.0662***
	(0.00882)	(0.00832)	(0.00209)	(0.0111)
Observations	45255	45255	45255	45255
R-squared	0.0102	0.0115	0.0197	0.0199
Birth year FE	✓	✓	✓	✓
Father's birthplace FE	✓	✓	✓	✓
Survey year FE		✓	✓	✓
Age × Father's birthplace FE			✓	✓
Muslim-specific linear trend				✓

Notes: The sample consists of French-born women born after 1980 and who were at least 20 years old at survey year. Entropy balance weights applied, matching the mean of a set of age indicators, eleven indicators for levels of urbanizations and an indicator for residence in ZUS areas. Data is from the 2004–2012 waves of the LFS. "Muslim" refers to women whose father was born in the Maghreb or the Middle East. Standard errors are clustered at the father's birthplace level. *** p< 0.01, ** p< 0.05, * p< 0.1.

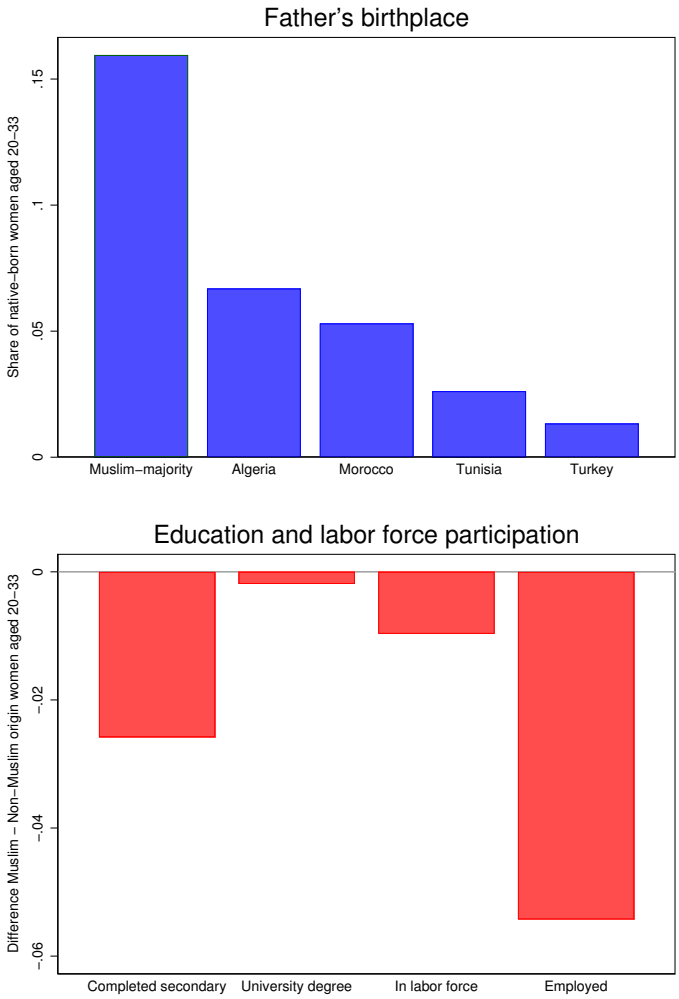
A.2 Replicating LFS results using census microdata

To verify the robustness of the results in LFS, we use information from the 2011 1% sample of the French census microdata, which is part of the International Integrated Public Use Microdata Series (IPUMS International), collected and distributed by the University of Minnesota.[25] This dataset records parents' country of origin only for individuals whose parents are observed to live with them in the same household. While this is an unrepresentative sample of all individuals in our age range of interest, differences between this subsample and the broader population are not very large.[26] In any case, our empirical estimates of the ban's effect remain internally valid within this subsample. As in the LFS, we restrict our attention to the native born and code as "Muslim" women whose father was born in Algeria, Morocco, Tunisia, or Turkey and as "non-Muslim" those with fathers born in Italy, Portugal, Spain, France, or the European Union. We drop from the sample those with fathers born in non-specified parts of Europe, of Africa, or the rest of the world, which cannot be identified as predominantly Muslim. Figure A.2 shows the distribution of second-generation Muslim women by father's country of origin (upper panel), and plots differences in key variables between Muslim and non-Muslim French-born women (lower panel) in the IPUMS dataset. Second generation Muslim women are about 2 percentage points less likely to have completed secondary education than other French-born women, and about 6 percentage points less likely to be employed. Our empirical analysis demonstrates that these cross-sectional differences were amplified for cohorts affected by the 2004 ban.

[25] The 2011 1% French IPUMS sample combines data from 2009 to 2013. The 2006 sample combines data from 2004 to 2008. Since the precise year of data collection is not specified, we cannot identify and exclude those observations that were collected before the passage of the 2004 ban (the first half of 2004). We thus chose not to use the 2006 sample.

[26] Compared to the full sample of women aged 20–33 in 2011, those living with their parents were 2 percentage points less likely to have completed secondary education and 1 percentage point less likely to be in the labor force.

Figure A.2. Second generation French women with father from Muslim-majority country



Source: 2011 IPUMS France. The sample consists of women aged 20–33 at census time. "Muslim" refers to women whose father was born in Algeria, Morocco, Tunisia or Turkey. The upper panel shows the distribution of second-generation Muslim women by father's country of origin. The lower panel plots differences in key variables between Muslim and non-Muslim Frenhc-born women.

Table A.4 replicates the specification in equation 1 in the IPUMS sample. Results are consistent with those from the LFS not just in direction, but also in magnitude. Column (1) replicates our main finding in the LFS on secondary educational attainment. The estimated (negative) impact of the law on secondary education completion for affected cohorts is 2.9 percentage points, essentially identical to that estimated in the LFS. Women are 0.5 p.p. more likely to be out of the labor force and 2.1 p.p. less likely to be employed. As before, we estimate near zero effects for the likelihood of marriage,

but we do find a near-significant positive effect on the likelihood of marrying someone from the same country of origin as the father for those women who are married. We estimate an identical increase in the likelihood of having children as in the LFS.

Given that in the IPUMS analysis we can only use data from one census year, we are unable to control for differential age profiles of women by their father's birthplace. The comparability of the estimates to those of the LFS suggests this matters little. In any case, to increase confidence in our findings, in Panel B of Table A.4 we repeat our analysis with a sample of Muslim men in the same age range. As in the LFS, we find a small negative effect of the law on secondary attainment of school age cohorts of Muslim men. This is additional evidence of the presence of a spillover effect of the law on Muslim school aged boys. However, with the exception of a lower likelihood of marriage for younger cohorts of Muslim men, no other outcome responds to the law. There are two, non-mutually exclusive ways to interpret this finding. First, lower educational attainment is more likely to affect later outcomes for women, rather than for men, especially given the larger magnitude of the estimated effect. Second, while the law impacted Muslim boys through mechanisms related to school and school performance, the effect on women also worked through additional channels related to identity choices, as discussed in Section 3.

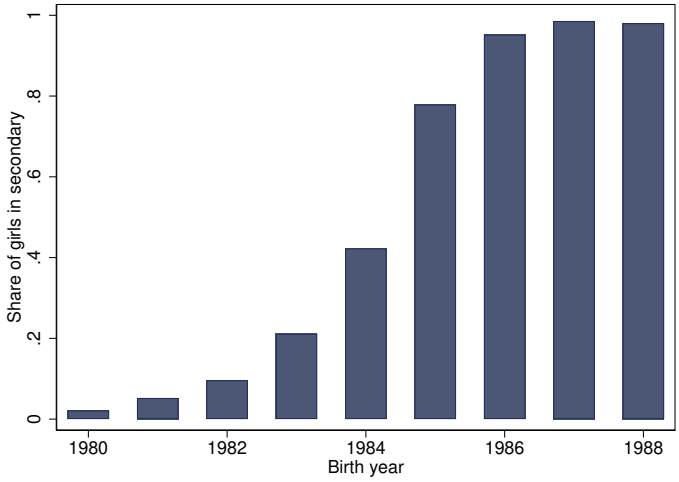
Table A.4. Robustness: Effect on long-term outcomes in census microdata

Dep. Variable	(1) Completed secondary	(2) Out of labor force	(3) Employed	(4) Married	(5) Endogamous marriage	(6) Has children
	Panel A: Women					
Muslim × Born after 1986	-0.0287***	0.00500**	-0.0214**	0.00344	0.122	0.0284***
	(0.00358)	(0.00213)	(0.00678)	(0.00280)	(0.0910)	(0.00331)
Observations	203724	203724	203724	203724	872	203724
R-squared	0.00413	0.00281	0.0532	0.00775	0.288	0.0223
	Panel B: Men					
Muslim × Born 1986 or later	-0.0187***	-0.00124	-0.00555	-0.0282**	-0.0362	-0.00690
	(0.00449)	(0.00233)	(0.00608)	(0.0101)	(0.0459)	(0.00814)
Observations	310370	310370	310370	310370	1878	310370
R-squared	0.00955	0.00383	0.0449	0.0181	0.198	0.0137
Birth year FE	✓	✓	✓	✓	✓	✓
Father's birthplace FE	✓	✓	✓	✓	✓	✓
Age × Father's birthplace FE	✓	✓	✓	✓	✓	✓

Notes: The sample consists of French-born individuals born after 1980 and who were at least 20 years old at census year. Data is from the 2011 1% census microsample. "Muslim" refers to individuals whose father was born in Algeria, Tunisia, Morocco or Turkey. *Endogamous marriage* takes on the value one if the spouse is born in the same country as the individual's father. The sample in column (6) is restricted to married individuals with a spouse present in the household. Standard errors are clustered at the father's birthplace level. *** p< 0.01, ** p< 0.05, * p< 0.1.

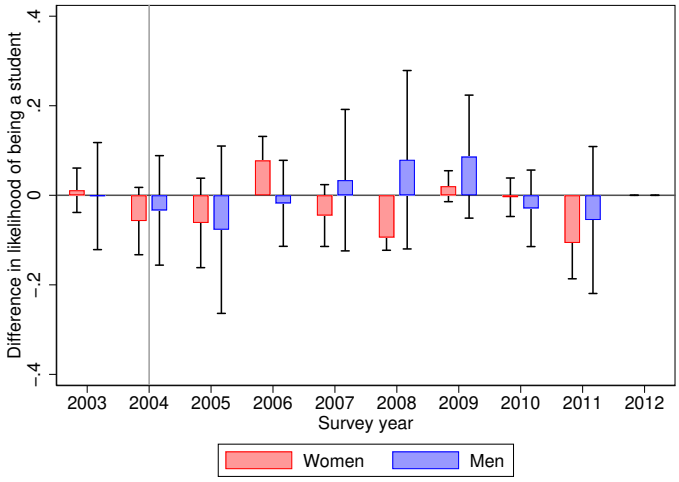
B Additional Figures and Tables

Figure B.1. Share of girls enrolled in secondary education by birth cohort



Data is from the 2003 wave of the LFS. The sample consists of French-born women.

Figure B.2. Change in student status between spring and fall quarter, difference Muslim vs others



The figure plots estimates of the interaction coefficient between Muslim origin and survey year fixed effects from a regression of an indicator for changed student status between fall and spring quarter of the same school year, that also controls for survey year, birth cohort and father's birthplace by age fixed effects. Vertical lines denote 90% confidence intervals. The sample consists of French-born individuals aged 16 or above at survey year, who were enrolled in secondary education in the spring quarter of the previous year. Data is from the 2004–2012 LFS.

Table B.1. Summary statistics - Women

Variables	Mean	S.D.	Min	Max	N
LFS Repeated cross-section					
Age	23.72	3.225	20	32	52201
Muslim origin	0.080	0.271	0	1	52201
Completed secondary	0.855	0.352	0	1	52155
Out of labor force	0.374	0.484	0	1	52201
Employed	0.514	0.500	0	1	52201
Lives with parents	0.355	0.478	0	1	52201
Housework	0.050	0.218	0	1	48357
Married	0.098	0.297	0	1	52198
Has children	0.195	0.396	0	1	52201
IPUMS					
Age	22.896	2.704	20	33	203724
Muslim origin	0.159	0.366	0	1	203724
Completed secondary	0.899	0.300	0	1	203724
Out of labor force	0.0398	0.195	0	1	203724
Employed	0.490	0.500	0	1	203724
Housework	0.00641	0.080	0	1	203724
Married	0.0167	0.128	0	1	203724
Endogamous marriage	0.720	0.449	0	1	872
Has children	0.0268	0.161	0	1	203724
TeO					
Age	22.376	3.181	17	29	2642
Muslim	0.332	0.471	0	1	2608
Experienced racism in school	0.210	0.407	0	1	2642
Trust in French school	3.225	0.683	1	4	2626
Seen as French	3.0620	1.046	1	4	2566
Feel at home in France	3.630	0.650	1	4	2622
Feel French	3.559	0.743	1	4	2624
Feel [father's nationality]	2.40	1.136	1	4	664

Notes: Data consists of French-born women born after 1980 who were aged 20 or older at survey year. The LFS data pools survey years 2004-2012. IPUMS data is from the 2011 1% French census microsample. "Muslim" refers to women whose father was born in the Maghreb or the Middle East (LFS), in Algeria, Tunisia, Morocco or Turkey (IPUMS) and to religious identification (TeO).

Table B.2. Summary statistics - Men

Variables	Mean	S.D.	Min	Max	N
LFS					
Age	23.71	3.226	20	32	50852
Muslim origin	0.077	0.267	0	1	50852
Completed secondary	0.809	0.393	0	1	50768
Out of labor force	0.291	0.454	0	1	50852
Employed	0.587	0.492	0	1	50852
Lives with parents	0.475	0.499	0	1	50852
Housework	0.00164	0.0405	0	1	46840
Married	0.0569	0.232	0	1	50851
Has children	0.098	0.297	0	1	50852
IPUMS					
Age	23.371	2.896	20	33	310370
Muslim origin	0.140	0.347	0	1	310370
Completed secondary	0.835	0.371	0	1	310370
Out of labor force	0.043	0.202	0	1	310370
Employed	0.557	0.497	0	1	310370
Housework	0.000351	0.0187	0	1	310370
Married	0.0136	0.116	0	1	310370
Endogamous marriage	0.744	0.436	0	1	1878
Has children	0.00762	0.0869	0	1	310370
TeO					
Age	22.281	3.265	17	29	2597
Muslim	0.282	0.450	0	1	2556
Experienced racism in school	0.236	0.424	0	1	2597
Trust in French school	3.114	0.753	1	4	2579
Seen as French	3.064	1.056	1	4	2496
Feel at home in France	3.593	0.668	1	4	2564
Feel French	3.595	0.716	1	4	2567
Feel [father's nationality]	2.466	1.148	1	4	686

Notes: Data consists of French-born men born after 1980 who were aged 20 or older at survey year. The LFS data pools survey years 2004-2012. IPUMS data is from the 2011 1% French census microsample. "Muslim" refers to men whose father was born in the Maghreb or the Middle East (LFS), in Algeria, Tunisia, Morocco or Turkey (IPUMS) and to religious identification (TeO).

Table B.3. Self-reported attitudes, difference-in-differences and triple differences

Dep. Variable	(1) Experienced racism in school	(2) Trust in French school	(3) Seen as French	(4) Feel at home in France	(5) Feel French	(6) Feel [father's nationality]	(7) Feel more [father's nationality] than French
	Panel A: Women only						
Muslim × Born after 1986	0.230**	-0.164*	-0.167	-0.0649	0.229**	0.709*	0.842*
	(0.0789)	(0.0811)	(0.147)	(0.0483)	(0.0796)	(0.318)	(0.385)
Observations	2608	2594	1407	1455	1454	200	199
R-squared	0.0141	0.0113	0.0890	0.0401	0.0525	0.146	0.175
Birth year FE	✓	✓	✓	✓	✓	✓	
Religion FE	✓	✓	✓	✓	✓	✓	
Linear Muslim–specific trend	✓	✓	✓	✓	✓	✓	
	Panel A: Entire sample						
Muslim × Born after 1986	-0.155*	0.391***	0.185	0.0575	-0.215*	0.277	0.372
	(0.0759)	(0.0757)	(0.172)	(0.0905)	(0.104)	(0.297)	(0.223)
Muslim × Born after 1986	0.386**	-0.555***	-0.352	-0.122	0.443***	0.432*	0.470
× Female	(0.147)	(0.0482)	(0.205)	(0.0918)	(0.117)	(0.205)	(0.378)
Observations	5164	5133	2723	2824	2824	404	401
R-squared	0.0146	0.0197	0.0933	0.0422	0.0446	0.200	0.212
Birth year × Female FE	✓	✓	✓	✓	✓	✓	✓
Religion × Female FE	✓	✓	✓	✓	✓	✓	✓
Linear Muslim–female–specific trend	✓	✓	✓	✓	✓	✓	✓

Notes: The sample consists of French-born individuals born after 1980. Outcomes are standardized and estimated effects can be interpreted in terms of standard deviations. Data is from the Trajectories and Origins survey. Standard errors are clustered at the religion level. *** p< 0.01, ** p< 0.05, * p< 0.1.

C Variable description

Variable	Description
LFS	
Muslim	Indicator for father born in Maghreb or Middle East. Father's country of birth based on variable PAIPERC.
Completed secondary education	Indicator for having at least a professional secondary degree (CAP, BEP, or equivalent). Coded based on variable DIP11.
Enrolled in secondary	Indicator for currently enrolled in secondary professional (CAP, BEP) or general/technological secondary education. Coded based on variable FORNIV.
In university	Indicator for currently studying for Bachelor's degree or higher (including Grande École, Master's, PhD). Coded based on variable FORNIV.
Change in student status	Student status coded based on the variables ACTEU6 and FORNIV, taking on the value one for those who are currently students enrolled in secondary education. Change computed between quarter 4 (fall quarter) and quarter 2 (spring quarter of previous year), for individuals who were enrolled in secondary education in quarter 2.
Out of labor force	Indicator for individuals coded as "inactive", based on variable ACTEU.
Employed	Indicator for individuals coded as "actively employed", based on variable ACTEU.
Lives with parents	Indicator for individuals coded as "child of reference person" in the household, based on variable LPR.
Has children	Indicator for individuals with children present in the household, based on variable EM1.
Married	Indicator for married individuals, based on variable MATRI.
IPUMS	
Completed secondary	Indicator based on variable EDATTAIN.
Out of labor force	Indicator for inactive, based on variable EMPSTATD.
Employed	Indicator based on variable EMPSTAT.
Married	Indicator based on variable MARST.
Endogamous marriage	Indicator for individuals whose spouse (present in the household) was born in the same country as their father.
Has children	Indicator based on variable NCHILD.

Variable	Description
TeO	
Experienced racism in school	Indicator for individuals who mentioned they experienced insults or racist attitudes at school. Variable D_OURACI_C.
Trust in French school	Trust of the respondent in the French school. Variable I_ECOLE. Coded on a 4-point Likert scale (1=Trust very much, 4=Do not trust at all), and recoded, so that higher values indicate more trust.
Seen as French	Opinion of respondent on the statement: "I am seen as French." Variable X_VUFRI. Coded on a 4-point Likert scale (1=Completely agree, 4=Completely disagree) and recoded, so that higher values indicate higher agreement.
Feel at home in France	Opinion of respondent on the statement: "I feel at home in France." Variable X_MOIFR. Coded on a 4-point Likert scale (1=Completely agree, 4=Completely disagree) and recoded, so that higher values indicate higher agreement.
Feel French	Opinion of respondent on the statement: "I feel French." Variable X_APPARF. Coded on a 4-point Likert scale (1=Completely agree, 4=Completely disagree) and recoded, so that higher values indicate higher agreement.
Feel [father's nationality]	Opinion of respondent on the statement: "I feel [father's nationality]." Variable X_APPARP. Coded on a 4-point Likert scale (1=Completely agree, 4=Completely disagree) and recoded, so that higher values indicate higher agreement.
Feel more [father's nationality] than French	Difference between *Feel [father's nationality]* and *Feel French*.

D Interview protocol

D.1 Sampling

Subjects were identified through snowball sampling. The author visited Muslim institutions (e.g. civic associations and religious classes) to recruit practicing Muslim women; in turn, they provided access to other women in their social network. The benefit of this sampling strategy is that it enables recruitment of the population most likely to be affected by government religious bans – Muslim women who self-identified as Muslim and enact this identity through their public behavior.[27] At the same time, the results are not representative of the experiences of all Muslim women, particularly those who identify as cultural Muslims or practice their religious identity privately. However, insights provided by this non-representative sample are consistent with the quantitative evidence provided, and can help interpret our empirical findings for the broader sample of all Muslim women.

D.2 Mode of data collection

The mode of data collection was semi-structured interviews, with prepared questions regarding several categories: background, religious practice, evolution of (religious) identity, effects of the headscarf ban, effects of the burqa ban, and Muslim experience in France. A list of structured questions is provided below. Interviews took place in cafes, restaurants, or homes of respondents, as per respondent preferences. Five interviews occurred with another person present, often a friend who also came to be interviewed and once a significant other. Interviews lasted between thirty minutes to

[27]The objective of the study in 2011 was to identify the effect of the burqa ban, which went into effect in 2010. As a result, women who strongly identified as Muslim were selected in order to better understand how the ban would affect their lives. While the project sought to understand the effect of the burqa ban, respondents were also asked about the 2004 ban, their experience in France as Muslims, and the evolution of their religious and political identities. The expansiveness of the interviews enables us to use them for this study.

two hours.

List of Relevant Questions	
Q.1	In your opinion, what unleashed the public discourse on the identity of Muslims?
Q.2	What were the general consequences of the 2004 headscarf ban on the Muslim community?
Q.3	What were the specific consequences of the 2004 law for your life, in terms of school, employment, housing, and personal interactions?
Q.4	How do you think the 2004 law affected the religious pracices of Muslim women?
Q.5	Describe your own religious trajectory. When did you start veiling and why? How was your decision to veil received by educators, employers, friends, and family?
Q.6	What were the religious practices of your parents and family? How did these shape your own religious practices?
Q.7	Where did you grow up and go to school? What was the demography of those in your school and neighborhood?
Q.8	What does Islam signify in your life?
Q.9	Have you experienced discrimination directly? In what domain?
Q.10	Describe your family's cultural/national background.
Q.11	Describe your parents' professional and educational background.
Q.12	Age.
Q.13	Employment.
Q.14	Educational attainment.
Q.15	Civic involvement and involvement in Muslim organizations.

Table D.2. Interviewee characteristics

Variable	Mean	SD	Min	Max	Obs
Age	27.3	6.9	18	47	20
Born before 1986	0.52	0.51	0	1	19
Attained BA	0.65	0.51	0	1	20
Attained MA	0.35	0.48	0	1	20
Attained Bac	0.95	0.22	0	1	20
Sub-Saharan Africa origin	0.25	0.44	0	1	20
Maghreb origin	0.65	0.42	0	1	20
Turkey origin	0.05	0.22	0	1	20

Réouverture

Coronavirus et risque de replis communautaristes

Aujourd'hui, la violence de la pandémie causée par un nouveau virus nous confronte à l'incertitude sur de multiples plans (en matière, médicale, sociale, économique, culturelle…). La crise du Covid-19 peut être utilisée par certains pour démontrer l'incapacité des Etats à protéger la population et tenter de déstabiliser les individus fragilisés. Divers groupes radicaux exploitent cette situation dramatique dans le but de rallier à leur cause de nouveaux membres et de troubler l'ordre public. Leur projet politique peut être anti-démocratique et antirépublicain. Ces contre-projets de société peuvent être communautaires, autoritaires et inégalitaires.

En conséquence, certaines questions et réactions d'élèves peuvent être abruptes et empreintes d'hostilité et de défiance: remise en question radicale de notre société et des valeurs républicaines, méfiance envers les discours scientifiques, fronde contre les mesures gouvernementales, etc. Or, plus que jamais, nous avons besoin de bâtir une société de la confiance, solidaire porteuse de sens et offrant aux élèves des chemins vers une socialisation positive.

1. Enjeux

- Lutter contre les replis communautaristes qui portent atteintes aux valeurs du pacte républicain et contre toute manifestation de séparatisme ;
- Lutter contre la désinformation, les théories complotistes, les rumeurs et les *fake news* sur le Covid-19 utilisées à des fins mercantiles et politiques ;
- Accompagner les personnels en établissement face aux réactions de repli des élèves.

2. Conduites à tenir

L'Ecole est le lieu par excellence de la **transmission des idéaux républicains**. Le rôle de l'École a été réaffirmé dans le plan national de prévention de la radicalisation (PNPR), **« Prévenir pour protéger »**, présenté par le premier ministre le 23 février 2018 ; dix mesures y associent pleinement les acteurs de l'éducation nationale.

Identifier les discours ou les signes de replis communautaristes

- **Prendre en compte l'intégralité du spectre des idées radicales du communautarisme** (ethnique, religieuse, culturelle, sociale, politique, mystique…).
- **Repérer les glissements sémantiques** fréquents entre « communauté » et « communautarisme ». Le terme de « communautarisme » est utilisé pour signifier une dérive opposée à l'idéal républicain, **qui donne la primauté des règles du groupe**

sur la loi républicaine française universaliste et intégratrice. Le communautarisme peut être alors considéré comme **une menace pour la cohésion sociale en France**. A l'inverse, « les communautés » en France sont anciennes et expriment le lien social. L'appartenance à une communauté, voire à plusieurs communautés, est un lien positif, voire essentiel pour la **construction de l'identité** de la personne et le développement des valeurs de l'individu.

- **Être attentif aux atteintes** à la République qui doivent être identifiées et sanctionnées.
- **Mobiliser la vigilance de tous :** les enseignants en cours, les CPE et assistants d'éducation dans les couloirs et la cour pour repérer des propos hors de la sphère républicaine en rupture avec les valeurs de l'Ecole et qui s'attaquent à la cohésion sociale.

Identifier les techniques de communication des groupes radicaux qui reposent sur diverses manières de procéder :

- **Attiser les peurs** comme par exemple en qualifiant l'émergence du Covid-19 de « *châtiment envoyé par Dieu sur qui Il veut* » Le coronavirus est interprété comme une punition céleste ;
- **Exploiter la satisfaction vengeresse :** certains groupes extrémistes se félicitent de ce désastre sanitaire en exploitant le déroulement et les effets sur le mode coutumier de la vengeance ;
- **Exploiter la pandémie comme un présage apocalyptique** ;
- **Participer à une vision manichéenne** du monde (les bons scientifiques et les mauvais, les croyants et les impies etc.) ;
- **Engendrer volontairement des confusions et des antagonismes** (islam/islamisme, communauté/communautarisme, identité/nationalité, religion/laïcité…) ;
- **Critiquer tous les discours d'autorité**, notamment scientifiques, et en même temps de s'en servir pour discréditer les discours qui sont hostiles à leurs thèses.

Alerter

- Alerter l'équipe de direction afin qu'elle puisse :
  - Effectuer un signalement dans l'application « Faits établissement » ;
  - Informer l'IA-DASEN en lien avec la cellule départementale des services de l'État dédiée à cette action et mise en place par le préfet.

3. Proposition d'activités pédagogiques

- **Aborder les questions sur la nouvelle situation géopolitique** en lien avec la pandémie, en montrant à la fois la complexité des relations internationales et la place de la France.
- **Etayer un débat dans le cadre d'une séance d'enseignement moral et civique (EMC)** qui pose progressivement, de l'école primaire au collège, les règles de vie fondamentales dans un Etat de droit. Evoquer les spécificités des lois françaises et ses valeurs : **l'indivisibilité de la République** à l'article 1 de la Constitution ou de l'unicité du peuple français, reconnue dans la jurisprudence du Conseil constitutionnel, **la laïcité** présente, elle aussi, à l'article 1er de la Constitution et **l'égalité entre les femmes et les hommes**, reconnue dans le préambule de la Constitution de 1946 et donc intégrée à notre bloc de constitutionnalité.
- **Organiser une intervention des équipes académiques Valeurs de la République**, sur les principes de liberté, l'égalité, fraternité et laïcité, pour une action d'accompagnement, voire une formation locale, notamment lorsque l'établissement est situé dans l'un des quartiers particulièrement sensibles identifiés dans le plan mis en place depuis février 2018.
- **Animer un débat**, par exemple autour de l'émission de France culture intitulée « A propos des origines animales du virus » » avec l'infectiologue Didier Sicard qui

peut faire l'objet d'une écoute par les élèves et d'une demande de synthèse. Cf. l'intervention sur France Culture.

- **Renforcer l'esprit critique des élèves avec l'éducation aux médias et à l'information (l'EMI)** qui participe à la prévention du complotisme à l'école, afin qu'ils réussissent à résister à la tentation d'une lecture du monde simplificatrice et aux vidéos de propagande qui circulent sur internet.

Les préconisations qui précèdent sont appliquées dans les établissements sous contrat dans le respect de leur caractère propre.

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Glossaire de la promotion de la santé

Organisation mondiale de la santé
Genève

Division de la Promotion, de l'éducation et de la communication pour la santé
Service Éducation sanitaire et promotion de la santé

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Glossaire de la promotion de la santé

Organisation mondiale de la santé
Genève

Le présent Glossaire de la promotion de la santé a été élaboré pour l'OMS par Don Nutbeam, du Centre collaborateur OMS pour la promotion de la santé du Department of Public Health and Community Medicine de l'Université de Sydney (Australie). Une version préliminaire du glossaire a été établie en tant que document de travail pour la Quatrième conférence internationale sur la promotion de la santé (*À ère nouvelle, acteurs nouveaux : adapter la promotion de la santé au XXIe siècle*), qui a eu lieu à Jakarta (Indonésie), du 21 au 25 juillet 1997. Cette version a ensuite été révisée compte tenu des résultats de cette conférence, et en particulier de la Déclaration de Jakarta sur la promotion de la santé au XXIe siècle.

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Sommaire

Avant-propos : Vers une nouvelle santé publique

La première édition de ce glossaire de la promotion de la santé a été publiée par l'OMS en 1986, afin de faciliter la compréhension des documents et publications de l'OMS. Elle clarifiait le sens d'un grand nombre de termes et expressions peu courants à l'époque et indiquait les relations qui existaient entre eux. Cette première édition du glossaire a été traduite dans plusieurs langues (français, espagnol, russe, japonais et italien), et les termes et expressions définis ont été largement utilisés à l'OMS et en dehors de l'Organisation. Le glossaire a été adapté et publié en allemand en 1990.

Beaucoup de choses se sont passées depuis la publication du glossaire il y a une dizaine d'années. En particulier, en octobre 1986, la Première conférence internationale pour la promotion de la santé a eu lieu à Ottawa (Canada) et a produit la **Charte d'Ottawa pour la promotion de la santé**. Cette conférence a été suivie d'autres, au cours desquelles les participants ont étudié les grands thèmes de la **Charte d'Ottawa** ; ces conférences ont porté sur la politique des pouvoirs publics favorables à la santé (Adélaïde, 1988) et sur les milieux favorables à la santé (Sundsvall, 1991). Elles nous ont permis de beaucoup mieux comprendre les stratégies de promotion de la santé et leur application pratique, ainsi que de mieux expliquer les questions présentant de l'intérêt pour les pays en développement. En juillet 1997, un nouveau pas en avant a été accompli grâce à la Quatrième conférence internationale sur la promotion de la santé (*À ère nouvelle, acteurs nouveaux : adapter la promotion de la santé au XXIe siècle*) qui a eu lieu à Jakarta (Indonésie).

L'OMS a élaboré et mis en œuvre plusieurs programmes et projets dont l'objet était de traduire les concepts et stratégies de promotion de la santé en mesures concrètes. Il s'agit notamment des programmes **Villes-santé**, **Villages-santé**, **Municipalités-santé** et **Îles-santé**, des réseaux d'**Écoles-santé** et d'**Hôpitaux-santé**, des programmes **Marchés-santé** et **Lieux de travail favorables à la santé**, ainsi que des plans d'action de l'OMS sur l'alcool et le tabac, la vie active et le vieillissement en bonne santé.

Des évolutions récentes concernant les systèmes de santé dans le monde entier ont donné une importance nouvelle aux méthodes de la promotion de la santé. L'intérêt de plus en plus marqué pour les résultats en matière de santé confirme qu'il est justifié d'accorder un degré de priorité élevé à l'investissement dans les déterminants de la santé grâce à la promotion de la santé. La question « Où la santé est-elle créée ? », posée systématiquement, établit un lien entre la promotion de la santé et deux grands débats sur des réformes : l'élaboration de nouvelles stratégies en matière de santé publique et la nécessité de réorienter les services de santé. La démarche résolument tournée vers l'avenir qui imprègne la **Charte d'Ottawa** a été adoptée par un grand nombre de pays et d'organisations dans le monde entier et ce processus a été encore renforcé grâce à la Quatrième conférence internationale sur la promotion de la santé, qui s'est tenue à Jakarta en juillet 1997. Au cours de cette conférence, les participants ont adopté la **Déclaration de Jakarta** sur la promotion de la santé au XXIe siècle. Un certain nombre de mots et expressions essentiels de la **Déclaration de Jakarta** ont donc été repris dans cette nouvelle version du glossaire de la promotion de la santé.

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Janvier 1998

Introduction

Grâce à une dizaine d'années d'expérience et à l'évolution continue des idées depuis l'élaboration de la première édition de ce glossaire, la présente révision offre une vue d'ensemble actualisée sur les nombreuses idées et notions qui occupent une place essentielle dans la promotion de la santé moderne. Le but fondamental du glossaire est resté inchangé : faciliter la communication entre pays et dans les pays, et entre les différentes organisations et personnes qui travaillent dans ce domaine. Comme précédemment les définitions n'ont rien d'immuable. À mesure que l'expérience s'accumule et que les idées évoluent, les mots et expressions devront être réévalués, sur les plans de leur signification et de leur pertinence.

Cette version du glossaire est sensiblement différente de la première. Des mots et expressions ont été omis, un grand nombre de définitions ont été modifiées compte tenu de l'expérience et de l'évolution des concepts, et l'on a ajouté 19 mots et expressions. La liste des mots et expressions repris n'est ni exhaustive ni exclusive ; elle concerne les disciplines très diverses sur lesquelles repose la promotion de la santé. Dans un certain nombre de cas, la définition adoptée correspond à l'utilisation du terme ou de l'expression dans le contexte de la promotion de la santé, et cela est indiqué dans la définition.

Comme dans la première version, les définitions sont brèves et ne visent pas à offrir des interprétations plus complètes qui peuvent se trouver dans d'autres publications. Là où cela se justifie, des notes explicatives ont été ajoutées.

De même, l'utilisation des mots et expressions est souvent liée à un contexte particulier et déterminée par une situation sociale, culturelle et économique donnée. Certaines des notions et définitions qui figurent dans le glossaire reflètent la façon de s'exprimer et les particularités culturelles de l'auteur principal. Par leur nature même, les définitions sont restrictives, car elles représentent des résumés d'idées et d'actions complexes. L'existence de telles restrictions est implicitement reconnue dans le libellé des définitions.

Malgré ces restrictions évidentes, on a élaboré le glossaire pour permettre à un public aussi large que possible de comprendre les idées et notions fondamentales pour la conception de stratégies et de mesures concrètes en matière de promotion de la santé. Comme le présent glossaire clarifie la terminologie essentielle, il fait partie intégrante de la démarche qui consiste à associer autant de personnes que possible à des actions visant à promouvoir la santé et à prévenir la maladie.

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Janvier 1998

Note

Ce glossaire comprend deux parties. La première contient sept définitions de mots et expressions fondamentaux pour les notions et les principes de la promotion de la santé ; en outre, des explications plus détaillées sont présentées à leur sujet. La deuxième partie comprend une liste de 54 mots et expressions couramment utilisés dans le domaine de la promotion de la santé. Cette liste est présentée dans l'ordre alphabétique.

Dans la mesure du possible, les définitions ont été reprises ou adaptées de publications de l'OMS, en particulier dans le cas des notions essentielles. La plupart des définitions sont suivies d'une note donnant des explications complémentaires ou des précisions. Lorsque cela se justifie, la source des différents mots et expressions figurant dans la deuxième partie du glossaire a été indiquée dans le texte. Certaines des définitions sont propres au présent glossaire ou font la synthèse de définitions qui correspondent à différentes conceptions à l'égard du mot ou de l'expression en question. La bibliographie mentionne toutes les sources indiquées dans le texte. Des versions préliminaires de la présente révision du glossaire ont été diffusées dans tous les bureaux régionaux de l'OMS en vue de recueillir des observations. Cela a permis d'apporter d'importantes modifications à plusieurs définitions.

Un grand nombre de définitions sont reprises intégralement ou en partie de la première version du glossaire, publiée en 1986. Certaines d'entre elles restent identiques à ce qu'elles étaient dans cette version (**Glossaire de la promotion de la santé, 1986**), mais l'on a modifié un grand nombre d'entre elles compte tenu de l'évolution de l'utilisation et des notions (on indique alors qu'il s'agit d'une **définition modifiée**).

Certains mots faisant partie des définitions et des notes sont imprimés en *italiques*, ce qui renvoie l'utilisateur à d'autres définitions. L'objet de ces renvois est de mieux faire comprendre les relations réciproques qui existent entre les différents mots, expressions et concepts.

Glossaire de la promotion de la santé
Partie 1 : Liste de mots et expressions essentiels

Santé

Dans la Constitution de l'OMS, adoptée en 1948, la santé est définie comme suit :

> La santé est un état complet de bien-être physique, mental et social, et ne consiste pas seulement en une absence de maladie ou d'invalidité.
>
> Dans le contexte de la promotion de la santé, on a considéré que la santé n'était pas un état abstrait, mais plutôt un moyen d'atteindre un but ; sur le plan fonctionnel, il s'agit d'une ressource qui permet de mener une vie productive sur les plans individuel, social et économique.
>
> La santé est une ressource de la vie quotidienne, et non le but de la vie ; il s'agit d'un concept positif mettant en valeur les ressources sociales et individuelles, ainsi que les capacités physiques.

Référence : Charte d'Ottawa pour la promotion de la santé, OMS, Genève, 1986.

La santé étant conçue comme un droit fondamental de la personne humaine, la **Charte d'Ottawa** mentionne certaines conditions préalables à la santé, qui sont la paix, des ressources économiques suffisantes, des aliments et un logement appropriés, un écosystème stable et une utilisation viable des ressources. La prise en compte de ces conditions préalables met en évidence les liens inextricables qui existent entre la situation sociale et économique, l'environnement physique, les modes de vie individuels et la santé. Ces liens sont la clé d'une compréhension globale de la santé, qui est un élément essentiel de la définition de la promotion de la santé.

Aujourd'hui, la dimension spirituelle de la santé est de plus en plus reconnue. L'OMS considère que la santé est un droit fondamental de la personne humaine, de sorte que tous devraient avoir accès aux ressources fondamentales indispensables à la santé.

Conformément à une conception globale de la santé, l'ensemble des systèmes et des structures qui régissent la situation sociale et économique et l'environnement physique doivent tenir compte des incidences de leurs activités sur la santé et le bien-être individuels et collectifs.

Voir également *responsabilité sociale en matière de santé*

Promotion de la santé

> La promotion de la santé est le processus qui confère aux populations les moyens d'assurer un plus grand contrôle sur leur propre santé, et d'améliorer celle-ci.

Référence : Charte d'Ottawa pour la promotion de la santé, OMS, Genève, 1986

La promotion de la santé représente un processus social et politique global, qui comprend non seulement des actions visant à renforcer les aptitudes et les capacités des individus mais également des mesures visant à changer la situation sociale, environnementale et économique, de façon à réduire ses effets négatifs sur la santé publique et sur la santé des personnes. La promotion de la santé est le processus qui consiste à permettre aux individus de mieux maîtriser les

déterminants de la santé et d'améliorer ainsi leur *santé*. La participation de la population est essentielle dans toute action de promotion de la santé.

La **Charte d'Ottawa** définit trois stratégies fondamentales pour la promotion de la santé. Il faut *sensibiliser* à la santé pour créer les conditions essentielles à la santé indiquées plus haut ; *conférer* à tous des moyens de réaliser pleinement leur potentiel de santé ; et *servir de médiateur* entre les différents intérêts présents dans la société en vue d'atteindre la santé.

Ces stratégies sont soutenues par cinq domaines d'action prioritaires énoncés dans la **Charte d'Ottawa** pour la promotion de la santé :

Élaborer une *politique publique saine*

Créer des *milieux favorables à la santé*

Renforcer l'*action communautaire pour la santé*

Acquérir des *aptitudes individuelles*, et

Réorienter les services de santé

Le glossaire définit ces stratégies et domaines d'action.

La **Déclaration de Jakarta** sur la promotion de la santé au XXIe siècle (juillet 1997) a confirmé que ces stratégies et domaines d'action sont valables pour tous les pays. En outre, on dispose de données qui indiquent clairement que :

Les approches globales du développement sanitaire sont les plus efficaces. Celles qui combinent les cinq stratégies susmentionnées sont plus efficaces que celles qui reposent sur une seule d'entre elles ;

Les *cadres pour la santé* offrent des possibilités concrètes de mise en œuvre de stratégies globales ;

La participation est essentielle pour que les efforts accomplis soient inscrits dans la durée. Les individus doivent être au centre de l'action de promotion de la santé et des processus de prise de décision pour que ceux-ci soient efficaces ;

La possession et l'acquisition de *connaissances en matière de santé* favorisent la participation. La possibilité de bénéficier d'une action éducative et de recevoir des informations est essentielle si l'on veut obtenir une participation effective des individus et des communautés et leur donner des *moyens d'agir*.

Pour la promotion de la santé au XXIe siècle, la **Déclaration de Jakarta** énonce cinq priorités :

Promouvoir la *responsabilité sociale pour la santé*

Augmenter les *investissements pour le développement sanitaire*

Développer les *partenariats pour la promotion de la santé*

Accroître les capacités des communautés et donner des *moyens d'agir* aux individus

Mettre en place une *infrastructure de promotion de la santé*

Chacune de ces priorités est définie dans le glossaire. La notion de développement des capacités des communautés est abordée dans la définition de l'*action sanitaire auprès des communautés*. La notion d'octroi de *moyens d'agir en faveur de la santé* est définie dans le glossaire.

Santé pour tous

> L'accession de tous les habitants du monde à un niveau de santé qui leur permette de mener une vie socialement et économiquement productive.

Référence : Glossaire de la série « Santé pour tous ». OMS, Genève, 1984

Depuis près de 20 ans, la Santé pour tous est une référence importante pour la stratégie de santé de l'OMS et de ses États membres. Bien que cette notion ait été interprétée de différentes façons dans les pays, compte tenu du contexte social et économique, de leur situation sanitaire, des caractéristiques de leurs populations en matière de morbidité et de l'état de développement de leur système de santé, elle constitue un objectif ambitieux, qui repose sur l'*équité en matière de santé*. On procède actuellement à une révision de la stratégie de la Santé pour tous pour faire en sorte qu'elle conserve toute sa validité au cours du siècle prochain. Une nouvelle politique est en cours d'élaboration et elle doit être adoptée par l'Assemblée mondiale de la santé en 1998.

Santé publique

> Science et art de favoriser la santé, de prévenir la maladie et de prolonger la vie grâce aux efforts organisés de la société.

Référence : adapté de l'« Acheson Report », Londres, 1988.

La santé publique est une notion sociale et politique. Elle vise à améliorer la santé, à prolonger la vie et à donner une meilleure *qualité de vie* à des populations entières, par la *promotion de la santé*, la *prévention de la maladie* et d'autres types d'intervention sanitaire. Dans la littérature sur la *promotion de la santé*, on établit une distinction entre la *santé publique* et une nouvelle santé publique, afin de mettre l'accent sur des démarches nettement différentes à l'égard de la description et de l'analyse des *déterminants de la santé*, et des méthodes utilisées pour résoudre les problèmes de santé publique. Cette **nouvelle santé publique** se caractérise par le fait qu'elle repose sur une compréhension globale des façons dont les *modes de vie* et les *conditions de vie* déterminent l'état de santé, et sur une prise de conscience de la nécessité de dégager des ressources et de faire de bons investissements dans des politiques, des programmes et des services qui créent, maintiennent et protègent la santé en favorisant des *modes de vie* sains et en créant des *environnements favorables à la santé*. Il se peut qu'à l'avenir cette distinction entre une santé publique ancienne et nouvelle ne soit plus nécessaire, si la notion générale de santé publique se développe et s'élargit.

La notion de **santé publique écologique** a également fait son apparition dans la littérature. Elle vise à tenir compte de l'évolution des questions sanitaires et de leur interaction avec de nouveaux problèmes mondiaux d'environnement. Ces derniers comprennent des risques écologiques mondiaux tels que la destruction de la couche d'ozone, une pollution sauvage et effrénée de l'air et de l'eau, et le réchauffement de la planète. Ces évolutions nouvelles ont des effets considérables sur la santé, qui se dérobent souvent aux modèles simples de causalité et d'intervention.

La santé publique écologique met l'accent sur les moyens d'action communs qui permettent d'assurer la *santé* et un *développement durable*. Elle est axée sur les *déterminants* économiques et environnementaux *de la santé*, et sur les moyens par lesquels on devrait orienter les investissements économiques pour obtenir les *meilleurs résultats en matière de santé* de la population, une plus grande *équité en matière de santé* et une utilisation viable des ressources.

Soins de santé primaires

> Les soins de santé primaires sont des soins essentiels reposant sur des méthodes et des techniques pratiques, scientifiquement valables et socialement acceptables, accessibles à un coût que la communauté et le pays peuvent supporter.

Référence : Déclaration d'Alma Ata, OMS, Genève, 1978

La Déclaration d'Alma Ata souligne également que chacun devrait avoir accès aux soins de santé primaires et y participer. La démarche des soins de santé primaires comprend les éléments essentiels suivants : équité, participation de la *communauté*, intersectorialité, caractère approprié des technologies et accessibilité économique.

Ensemble d'activités, les soins de santé primaires doivent comprendre au minimum une éducation sanitaire pour les individus et la communauté tout entière portant sur la nature et l'ampleur des problèmes de santé et sur les méthodes permettant de prévenir et de maîtriser ces problèmes. Les autres activités essentielles sont la promotion d'un approvisionnement suffisant en aliments et d'une bonne nutrition ; la distribution d'une quantité suffisante d'eau potable et un assainissement de base ; les soins de santé maternelle et infantile, y compris le planning familial ; la vaccination ; un traitement approprié des maladies et lésions courantes ; et la fourniture de médicaments essentiels.

Les soins de santé primaires, tels qu'ils viennent d'être définis, contribuent dans une large mesure à créer les conditions préalables à la *santé* mentionnées plus haut. En outre, de façon très concrète, ils offrent des possibilités considérables de mener une action de *promotion de la santé* tant planifiée qu'opportuniste, grâce au contact quotidien entre le personnel de soins primaires et les individus dans leur localité. Grâce à l'action *d'éducation pour la santé* que les agents de soins primaires mènent auprès de leurs patients et à la *sensibilisation* qu'ils assurent au nom de la communauté locale, ils sont bien placés pour répondre aux besoins individuels et pour influencer les politiques et programmes qui ont des effets sur la *santé* de la *population*.

La notion de soins de santé primaires et les thèmes qu'elle met en jeu font actuellement l'objet d'un réexamen de la part de l'OMS.

Prévention de la maladie

> La prévention de la maladie comprend des mesures qui visent non seulement à empêcher l'apparition de la maladie, telle que la lutte contre les *facteurs de risque*, mais également à en arrêter les progrès et à en réduire les conséquences.

Référence : adapté du Glossaire de la série « Santé pour tous ». OMS, Genève, 1984

La prévention primaire vise à empêcher l'apparition d'une maladie. La prévention secondaire et tertiaire vise à stopper ou à retarder l'évolution d'une maladie et ses effets par le dépistage précoce et un traitement approprié ; ou à réduire le risque de rechute et de chronicité, au moyen d'une réadaptation efficace, par exemple.

Les expressions « prévention de la maladie » et « *promotion de la santé* » sont parfois utilisées de façon complémentaire. Bien que le contenu et les stratégies de ces deux notions se recouvrent souvent partiellement, la prévention de la maladie est définie séparément. Dans ce contexte, la prévention de la maladie est considérée comme l'action qui provient généralement du *secteur sanitaire* et porte sur des personnes et des populations qui présentent des *facteurs de risque* identifiables, souvent associés à des *comportements à risque* différents.

Éducation pour la santé

> L'éducation pour la santé comprend la création délibérée de possibilités d'apprendre grâce à une forme de communication visant à améliorer les *compétences en matière de santé*, ce qui comprend l'amélioration des connaissances et la transmission d'*aptitudes* utiles *dans la vie*, qui favorisent la *santé* des individus et *des communautés*.

Référence : définition modifiée

L'éducation pour la santé concerne non seulement la communication d'informations, mais également le développement de la motivation, des compétences et de la confiance en soi nécessaires pour agir en vue d'améliorer sa santé. L'éducation pour la santé comprend la communication d'informations concernant les conditions sociales, économiques et environnementales de base qui ont des effets sur la *santé*, ainsi que sur les différents *facteurs de risque* et *comportements à risque*, et sur l'utilisation du système de santé. En conséquence, l'éducation pour la santé peut consister à communiquer des informations et à transmettre des aptitudes, ce qui démontre la faisabilité politique et les possibilités organisationnelles de différentes formes d'action visant à agir sur les *déterminants* sociaux, économiques et environnementaux *de la santé*.

Dans le passé, l'expression « éducation pour la santé » englobait une gamme plus large d'actions, qui comprenait notamment la mobilisation sociale et la *sensibilisation*. Ces méthodes relèvent maintenant de la *promotion de la santé*, de sorte qu'une définition plus étroite de l'éducation pour la santé est proposée ici pour souligner cette distinction.

Sensibilisation aux questions de santé

Ensemble d'actions individuelles et sociales visant à obtenir un engagement politique, le soutien d'une politique, l'acceptation sociale et un appui de systèmes pour un but ou un programme relatif à la santé.

Référence : Report of the Inter-Agency Meeting on Advocacy Strategies for Health and Development: Development Communication in Action. WHO, Geneva, 1995

La sensibilisation doit être assurée par des individus et des groupes ou en leur nom pour créer des *conditions de vie* favorables à la *santé* et à l'adoption de *modes de vie* sains. Elle est l'une des trois grandes stratégies de *promotion de la santé* et peut prendre de nombreuses formes, y compris l'utilisation des médias et du multimédia, une action d'influence politique directe et la mobilisation de la *communauté*, par exemple grâce à des coalitions d'intérêts autour de certaines questions. Les professionnels de la santé ont une importante responsabilité en matière de sensibilisation aux questions de *santé* à tous les niveaux de la société.

Alliance

Une alliance pour la promotion de la santé est un *partenariat* entre plusieurs parties qui s'efforcent d'atteindre un ensemble de buts dans le domaine de la *promotion de la santé*.

Référence : nouvelle définition

La constitution d'alliances comporte souvent une *médiation* entre les différents partenaires pour la définition de buts, de règles éthiques de base et de domaines d'action commune, et la réalisation d'un accord sur la forme de coopération propre à l'alliance.

Communauté

Groupe de personnes, qui vivent souvent dans une zone géographique bien définie, partagent une culture, des valeurs et des normes, et ont une place dans une structure sociale qui est conforme à des relations que la communauté a créées au cours d'une certaine période. Les membres d'une communauté acquièrent leur identité personnelle et sociale en partageant des convictions, des valeurs et des normes qui ont été conçues par la communauté dans le passé et pourront évoluer à l'avenir. Ils sont dans une certaine mesure conscients de leur identité de groupe, ont des besoins communs et souhaitent les satisfaire.

Référence : définition modifiée

Dans de nombreuses sociétés, en particulier celles des pays développés, les individus n'appartiennent pas à une communauté unique, mais sont membres de diverses communautés reposant sur des variables telles que la géographie, la profession, la place sociale et les loisirs.

Action communautaire pour la santé

L'*action communautaire pour la santé* désigne les efforts collectifs déployés par les communautés en vue d'accroître leur maîtrise des *déterminants de la santé* et d'améliorer ainsi cette dernière.

Référence : nouvelle définition

La *Charte d'Ottawa* souligne l'importance d'une action *communautaire* concrète et efficace pour la fixation de priorités pour la *santé*, la prise de décision, l'élaboration de stratégies et la mise en œuvre de celles-ci en vue d'améliorer la santé. La notion d'octroi de *moyens d'agir* à la communauté est étroitement liée à la définition de l'action communautaire pour la santé qui se trouve dans la Charte d'Ottawa. Selon la première de ces deux notions, dans une communauté à laquelle on a donné des *moyens d'agir*, les individus et les organisations utilisent leurs aptitudes et leurs ressources de façon collective pour répondre à des priorités sanitaires et à leurs besoins respectifs en matière de santé. Grâce à cette participation, l'individu et les organisations d'une communauté dotée de *moyens d'agir* fournissent un *soutien social pour la santé*, font face aux conflits au sein de la *communauté* et obtiennent une influence et une maîtrise accrues sur les *déterminants de la santé* dans la *communauté*.

Déterminants de la santé

Facteurs personnels, sociaux, économiques et environnementaux qui déterminent l'*état de santé* des individus ou des populations.

Référence : nouvelle définition

Les facteurs qui influent sur la santé sont multiples et agissent les uns sur les autres. La *promotion de la santé* porte fondamentalement sur l'action et la *sensibilisation* nécessaires pour prendre des mesures à l'égard de l'ensemble des déterminants de la santé potentiellement modifiables, non seulement vis-à-vis de ceux qui sont liés aux actions des individus, tels que les *comportements en matière de santé* et les *modes de vie*, mais également de facteurs tels que le revenu et le statut social, l'instruction, l'emploi et les conditions de travail, l'accès à des services sanitaires appropriés et les environnements physiques. Combinés, ces éléments créent différentes *conditions de vie* qui ont des effets sur la santé. La réalisation d'un changement de ces *modes de vie* et *conditions de vie*, qui déterminent l'*état de santé*, est considérée comme un *résultat intermédiaire en matière de santé*.

Octroi de moyens d'agir en matière de santé

Dans le domaine de la promotion de la santé, l'octroi de *moyens d'agir* est un processus par lequel les individus maîtrisent mieux les décisions et les actions qui influent sur leur santé.

Référence : nouvelle définition

L'octroi de *moyens d'agir* peut être un processus social, culturel, psychologique ou politique qui permet aux individus et aux groupes sociaux d'exprimer leurs besoins, d'indiquer leurs préoccupations, de concevoir des stratégies en vue d'une participation à la prise de décision, et de mener une action politique, sociale et culturelle en vue de satisfaire ces besoins. Grâce à ce processus, les individus constatent une meilleure correspondance entre leurs buts dans la vie et une idée de la façon de les atteindre, ainsi qu'un lien entre leurs efforts et les résultats obtenus dans l'existence. La *promotion de la santé* comprend des actions visant non seulement à renforcer les *aptitudes* fondamentales utiles *dans la vie* et les capacités des individus, mais également à influencer les conditions sociales et économiques de base et les environnements physiques qui ont des effets sur la *santé*. Dans ce sens, la *promotion de la santé* vise à créer des conditions plus favorables à l'existence d'une relation entre les efforts des individus et des groupes et les *résultats* ultérieurs *en matière de santé* de la façon décrite plus haut.

On établit une distinction entre l'octroi de **moyens d'agir** à un individu et à une **communauté**. En ce qui concerne l'individu, les moyens d'agir désignent avant tout l'aptitude à prendre des décisions sur sa vie personnelle et à maîtriser celle-ci. Une communauté dispose de moyens d'agir lorsque les individus agissent collectivement pour obtenir une plus grande influence et une maîtrise accrue sur les *déterminants de la santé* et la *qualité de la vie* dans leur *communauté* ; l'obtention de moyens d'agir par une communauté est un important but de l'*action communautaire pour la santé*.

Libération du potentiel

> En matière de promotion de la santé, la libération du potentiel consiste à mener une action en *partenariat* avec des individus ou des groupes afin de les doter des moyens d'agir qui leur permettent, par la mobilisation de ressources humaines et matérielles, de promouvoir et de protéger leur *santé*.

Référence : nouvelle définition

Dans cette définition, l'importance accordée à l'octroi de *moyens d'agir* grâce à des *partenariats* et à la mobilisation de ressources attire l'attention sur le rôle important des professionnels de la santé et des autres militants de la santé qui agissent comme des catalyseurs pour une action de promotion de la santé, par exemple en donnant accès à des informations sur la santé, en facilitant l'acquisition de compétences et en soutenant l'accès aux processus politiques qui façonnent les politiques des pouvoirs publics influant sur la *santé*.

Épidémiologie

> Étude de la distribution et des déterminants des états ou des événements de santé dans des populations déterminées, et application de cette étude à la lutte contre les problèmes de santé.

Référence : Last, JM. Dictionary of Epidemiology. Royaume-Uni, 1988

L'information épidémiologique, notamment celle qui définit les risques relatifs à l'individu, à une population ou à l'environnement physique, est au cœur de la *santé publique* et constitue la base des activités de *prévention de la maladie*. Les études épidémiologiques utilisent les classifications sociales (telles que la catégorie socioéconomique) pour l'étude de la maladie dans les populations mais ne se sert généralement pas de façon optimale des sciences sociales, en particulier des informations économiques et relatives à la politique des pouvoirs publics pour l'étude et la compréhension de la maladie et de la *santé* dans les populations.

L'épidémiologie sociale s'est constituée en discipline au cours des deux dernières décennies. Elle est l'étude de la *santé* et de la maladie dans les populations ; elle repose sur des informations sociales, psychologiques, économiques et relatives à la politique des pouvoirs publics et utilise ces informations pour définir les problèmes de *santé publique* et des propositions de solutions. À l'avenir, à mesure que l'épidémiologie se développera et s'étendra, de telles distinctions perdront de leur importance.

Équité en matière de santé

> Qui dit équité dit justice. Pour qu'il y ait équité en matière de santé, il faut que les besoins des personnes guident la répartition des possibilités de bien-être.

Référence : Equity in health and health care. WHO, Geneva, 1996

La stratégie mondiale de la *Santé pour tous* de l'OMS vise fondamentalement à réaliser la plus grande équité en matière de santé entre populations, au sein de populations et entre pays. Cela signifie que tous les individus doivent avoir une possibilité égale d'être et de rester en bonne *santé*, grâce à un accès juste et équitable aux ressources de santé. L'équité en matière de santé n'est pas synonyme d'égalité d'*état de santé*. Les inégalités d'*état de santé* entre individus et entre populations sont des conséquences inévitables de différences génétiques, d'écarts entre situations sociales et économiques ou de choix personnels de *mode de vie*. Un manque d'équité existe à la suite de différences de possibilités offertes, qui entraînent par exemple un accès inégal aux services de santé, à des aliments nourrissants, à un logement approprié, etc. Dans ces cas, les inégalités d'*état de santé* résultent de manque d'équité dans les possibilités offertes aux individus.

Comportement en matière de santé

> Toute activité entreprise par une personne, quel que soit son *état de santé* objectif ou subjectif, en vue de promouvoir, de protéger ou de maintenir la *santé*, que ce comportement soit ou non objectivement efficace dans la perspective de ce but.

Référence : Health Promotion Glossary, 1986

On peut soutenir que presque tous les comportements ou toutes les activités d'un individu ont des effets sur son *état de santé*. Dans ce contexte, il est utile d'établir une distinction entre les comportements adoptés délibérément pour promouvoir ou protéger la *santé* (comme indiqué dans la définition qui précède) et ceux qui sont adoptés indépendamment des conséquences pour la *santé*. Une distinction est établie entre les comportements en matière de santé et les *comportements à risque*, qui sont des comportements liés à une vulnérabilité accrue à l'égard d'une cause déterminée de mauvaise santé.

Les comportements en matière de santé et les *comportements à risque* sont souvent liés entre eux dans un ensemble plus complexe de comportements appelés « *modes de vie* ».

Communication en matière de santé

> La communication en matière de santé est une stratégie essentielle visant à informer le public au sujet de problèmes de santé et à faire en sorte que d'importantes questions de santé intéressent la population. L'utilisation des médias, du multimédia et d'autres innovations technologiques pour diffuser d'utiles informations en matière de santé augmente la prise en conscience de certains aspects de la santé individuelle et collective, ainsi que de l'importance de la santé dans le développement.

Référence : adapté de Communication, Education and Participation : A Framework and Guide to Action, WHO (AMRO/PAHO), Washington, 1996

La communication en matière de santé vise à améliorer l'*état de santé* des individus et des populations. Une grande partie de la culture moderne est transmise par les médias et le multimédia, ce qui a des conséquences positives et négatives pour la *santé*. Les travaux de recherche montrent que des programmes de *promotion de la santé* reposant sur une théorie particulière peuvent susciter l'intérêt du public pour la *santé*, renforcer les messages de santé, inciter les individus à obtenir plus d'informations et, dans certains cas, favoriser des *modes de vie* sains de façon durable.

La communication en matière de santé englobe plusieurs domaines : divertissement éducatif, journalisme axé sur la santé, communication interpersonnelle, action de sensibilisation dans les médias, communication organisationnelle, communication sur les risques, communication sociale et marketing social. Elle peut revêtir de nombreuses formes, depuis les communications par les médias et le multimédia jusqu'à la communication traditionnelle et propre à la culture locale, telle que le récit oral, les représentations de théâtre de marionnettes et les chansons. Elle peut prendre la forme de messages de santé discrets ou être incorporée dans des supports de communication tels que les feuilletons radiophoniques ou télévisés.

Les progrès accomplis dans le domaine des supports de communication, en particulier le multimédia et les nouvelles technologies de l'information, continuent d'améliorer l'accès à l'information en matière de santé. À cet égard, la communication sur la santé devient un élément de plus en plus important lorsqu'il s'agit de donner plus de *moyens d'agir* aux individus et aux *communautés*.

Développement sanitaire

> Le développement sanitaire est le processus d'amélioration progressive et continue de l'*état de santé* des individus et des groupes d'une population.

Référence : Terminology Information System. WHO, Geneva, 1997

Selon la **Déclaration de Jakarta**, la *promotion de la santé* est un élément essentiel du développement sanitaire.

Espérance de santé

> L'espérance de santé est une mesure basée sur une population de la proportion de la durée d'existence prévue dont on estime qu'elle se caractérise par une bonne santé et est gratifiante ou est exempte de maladie et d'invalidité selon les normes et perceptions sociales et les critères professionnels.

Référence : nouvelle définition

L'espérance de santé appartient à une nouvelle génération ou à un nouveau type d'indicateurs de santé en cours d'élaboration. Ces indicateurs visent à créer des mesures qui soient plus sensibles à la dynamique et aux *déterminants* de la santé. Les indicateurs d'espérance de santé combinent des informations provenant de tables de mortalité et d'enquêtes sur la santé dans la population. Ils doivent reposer sur l'espérance de vie au niveau du pays ou d'une zone géographique similaire.

Parmi les indicateurs d'espérance de santé actuellement utilisés, on peut citer les années de vie sans invalidité et les années de vie corrigées de la qualité. Ils sont essentiellement axés sur la mesure dans laquelle les individus ont une existence exempte d'invalidités, de troubles ou de maladies chroniques. La *promotion de la santé* vise à élargir la compréhension de la notion d'espérance de santé au-delà de l'absence de maladies, de troubles et d'invalidités pour obtenir des mesures positives de la création, du maintien et de la protection de la santé, en mettant l'accent sur une durée de vie en bonne santé.

Progrès de la santé

> Le progrès de la santé est un moyen d'exprimer une amélioration des *résultats en matière de santé*. On peut utiliser cette notion pour rendre compte de l'avantage d'une intervention de santé par rapport à une autre parce que la première engendre un plus grand progrès de la santé.

Référence : nouvelle définition

Selon la Déclaration de Jakarta, en menant une action de promotion de la santé, « on agit sur les *déterminants de la santé* et on contribue aux progrès de la santé ».

Voir également *résultats en matière de santé* et *résultats intermédiaires en matière de santé*

But sanitaire

> Les buts sanitaires résument les *résultats en matière de santé* qu'un pays ou une *communauté* pourrait espérer obtenir dans un laps de temps déterminé, compte tenu des connaissances et des ressources disponibles.

Référence : nouvelle définition

Les buts sanitaires sont des énoncés généraux exprimant une intention et une aspiration, qui visent à être le reflet des valeurs de la *communauté* en général et du *secteur sanitaire* en particulier en ce qui concerne une société saine. De nombreux pays ont adopté une méthode de fixation de buts et de *cibles sanitaires* indiquant une orientation et une intention concernant leurs *investissements pour la santé*. L'OMS a soutenu cette évolution et a favorisé l'utilisation de buts et de cibles sanitaires aux niveaux mondial, régional, national et local.

Indicateur de santé

> Caractéristique d'un individu, d'une population ou d'un environnement qui se prête à des mesures (directement ou indirectement) et peut être utilisée pour décrire un ou plusieurs aspects de la santé d'un individu ou d'une population (qualité, quantité et temps).

Référence : définition modifiée

Il est possible d'utiliser des indicateurs de santé pour définir des problèmes de *santé publique* à un moment donné, mettre en évidence une évolution dans le temps de la santé d'une population ou d'un individu, définir des différences de santé entre populations et évaluer la mesure dans laquelle les objectifs d'un programme sont en vue d'être atteints.

Les indicateurs de santé peuvent comprendre des mesures relatives à des maladies qui sont plus fréquemment utilisées pour mesurer les *résultats en matière de santé*, à des aspects positifs de la santé (tels que la *qualité de la vie*, les *aptitudes* utiles *dans la vie* ou *l'espérance de santé*) ou à des comportements et des actions d'individus qui sont liés à la santé. Ils peuvent aussi englober des indicateurs qui mesurent la situation sociale et économique et l'environnement physique dans la mesure où il est lié à la santé, et des mesures concernant les *compétences en matière de santé* et les *politiques des pouvoirs publics favorables à la santé*. On peut utiliser les indicateurs faisant partie de ce dernier groupe pour mesurer des *résultats intermédiaires en matière de santé* et des *résultats de l'action de promotion de la santé*.

Compétences en matière de santé

> Aptitudes cognitives et sociales qui déterminent la motivation et la capacité des individus à obtenir, comprendre et utiliser des informations d'une façon qui favorise et maintienne une bonne *santé*.

Référence : nouvelle définition

Pour posséder des compétences en matière de santé, il faut atteindre le niveau de connaissances, d'aptitudes personnelles et de confiance nécessaire pour prendre les mesures requises pour améliorer sa santé et celle de la communauté en modifiant ses *modes de vie* et les *conditions de vie*. En conséquence, les compétences en matière de santé vont au-delà de l'aptitude à lire des brochures et à prendre des rendez-vous. Étant donné que les compétences en matière de santé améliorent l'accès des individus à des informations sur la santé et leur capacité à les utiliser efficacement, elles sont essentielles pour l'obtention de *moyens d'agir*. Les compétences en matière de santé dépendent d'un niveau d'instruction plus général. Un niveau d'instruction médiocre peut nuire directement à la *santé*, en limitant l'épanouissement personnel, social et culturel des individus, et entraver l'acquisition de compétences en matière de santé.

Résultats en matière de santé

> Changement de l'*état de santé* d'un individu, d'un groupe ou d'une population qui est attribuable à une intervention planifiée ou à une série planifiée d'interventions, que ces interventions visent ou non à modifier l'*état de santé*.

Référence : nouvelle définition

Cette définition met l'accent sur le résultat d'interventions planifiées (par opposition à une exposition fortuite à des risques, par exemple) ; elle souligne également que les résultats peuvent concerner des individus, des groupes ou des populations tout entières. Les interventions peuvent comprendre des politiques gouvernementales et les programmes et dispositions législatives et réglementaires adoptés en conséquence, ou des services et des programmes sanitaires, notamment des programmes de *promotion de la santé*. La définition englobe également les résultats en matière de santé intentionnels ou non intentionnels des politiques des pouvoirs publics relatifs à des secteurs autres que celui de la santé. Normalement, on évalue les résultats

en matière de santé en utilisant des *indicateurs de santé*. Voir également les rubriques *résultats intermédiaires en matière de santé* et *résultats des actions de promotion de la santé*.

Politique sanitaire

> Énoncé ou processus relevant d'institutions (en particulier le gouvernement), qui définit des priorités et les paramètres d'action compte tenu des besoins sanitaires, des ressources disponibles et d'autres pressions politiques.

Référence : définition modifiée

La politique sanitaire est souvent adoptée sous la forme d'une législation ou d'autres normes qui définissent des dispositions réglementaires et des incitations permettant d'assurer des services et de mettre en œuvre des programmes sanitaires, et garantissant l'accès à ces services et programmes. La politique sanitaire se distingue actuellement de la *politique des pouvoirs publics favorable à la santé* du fait qu'elle concerne avant tout les services et les programmes sanitaires. Les progrès qu'accompliront à l'avenir les politiques sanitaires seront mis en évidence par la mesure dans laquelle elles peuvent également être définies comme des *politiques des pouvoirs publics favorables à la santé*.

Comme c'est le cas de la plupart des politiques, les politiques sanitaires résultent d'un processus systématique d'obtention d'un appui pour des actions de *santé publique* inspirées de données disponibles complétées par les préférences des communautés, les réalités politiques et la disponibilité de ressources.

Hôpital-santé

> Un hôpital-santé offre des services médicaux et infirmiers complets de haute qualité, mais crée également une image de marque englobant les buts de la *promotion de la santé*, met en place une structure et une culture organisationnelles favorables à la santé (notamment en donnant des rôles actifs et participatifs aux patients et à tous les membres du personnel), devient un environnement physique favorable à la santé et coopère activement avec sa *communauté*.

Référence : adapté de la Déclaration de Budapest sur les Hôpitaux-santé. OMS, Bureau régional de l'Europe, Copenhague, 1991

Les Hôpitaux-santé agissent pour promouvoir la *santé* de leurs patients, de leur personnel et de la population de la localité dans laquelle ils sont implantés. Ils s'emploient activement à devenir des « organisations saines ». L'initiative « Hôpitaux-santé » est mise en œuvre depuis 1988. Il existe un réseau international chargé de promouvoir l'adoption plus large de cette notion dans les hôpitaux et d'autres cadres de soins.

École-santé

> École qui renforce constamment son aptitude à être un cadre sain de vie, d'apprentissage et de travail.

Référence : Promoting health through schools. Report of a WHO Expert Committee on Comprehensive School Health Education and Promotion. WHO Technical Report Series N°870. WHO, Geneva, 1997

Pour atteindre le but énoncé dans cette définition, une école-santé incite les fonctionnaires responsables de la *santé* et de l'enseignement, les enseignants, les élèves, les parents et les notables locaux à déployer des efforts pour promouvoir la santé. Elle favorise la *santé* et l'apprentissage par tous les moyens qui sont à sa disposition et s'efforce d'offrir un *cadre favorable à la santé* et un ensemble de programmes et de services scolaires essentiels

d'*éducation pour la santé* et de promotion de la santé. Une école-santé met en œuvre des politiques, des pratiques et d'autres mesures propices à l'estime de soi des individus, offre de multiples possibilités de succès et tient dûment compte des efforts et des bonnes intentions, ainsi que des réalisations personnelles. Elle s'emploie à améliorer non seulement la santé des élèves mais aussi celle du personnel scolaire, des familles et des membres de la communauté, et coopère avec les notables locaux pour les aider à comprendre comment la *communauté* contribue à la *santé* et à l'instruction.

L'initiative mondiale Écoles-santé de l'OMS vise à aider toutes les écoles à devenir des écoles-santé, par exemple en encourageant et en soutenant des réseaux internationaux, nationaux et sous-nationaux d'écoles-santé et en contribuant à renforcer les capacités nationales de *promotion de la santé* à l'école.

Évaluation de la promotion de la santé

> L'évaluation de la promotion de la santé vise à déterminer la mesure dans laquelle les actions de *promotion de la santé* obtiennent un résultat auquel une « valeur » est attribuée.

Référence : nouvelle définition

La mesure dans laquelle les actions de *promotion de la santé permettent* aux individus ou aux communautés de maîtriser leur *santé* représente un élément essentiel de l'évaluation de la promotion de la santé.

Dans de nombreux cas, il est difficile de déterminer les processus qui lient certaines activités de promotion de la santé à des *résultats en matière de santé*. Cela peut être dû à diverses raisons, par exemple la difficulté technique de séparer cause et effet dans des situations concrètes complexes. En conséquence, la plupart des modèles récents relatifs aux résultats en matière de *promotion de la santé* établissent une distinction entre différents types de résultats et proposent une hiérarchie entre eux. Les *résultats en matière de promotion de la santé* représentent le premier point d'évaluation et traduisent des modifications des facteurs personnels, sociaux et environnementaux qui constituent un moyen d'améliorer la maîtrise que les individus ont sur leur *santé*. Les modifications des *déterminants de la santé* sont définies comme des *résultats intermédiaires en matière de santé*. Les changements d'*état de santé* représentent des *résultats en matière de santé*.

Dans la plupart des cas, une « valeur » est attribuée au processus par lequel différents résultats sont obtenus. Dans l'optique de processus valorisés, les évaluations des activités de promotion de la santé peuvent être **participatives**, c'est-à-dire associant tous ceux qui ont intérêt à ce que l'initiative aboutisse ; **interdisciplinaires**, c'est-à-dire faisant intervenir diverses perspectives disciplinaires ; et **intégrées** dans tous les stades de conception et de mise en œuvre d'une initiative de promotion de la santé. Elles peuvent aussi contribuer à permettre aux individus, aux *communautés*, aux organisations et aux pouvoirs publics de faire face à d'importants problèmes de santé.

Résultats de l'action de promotion de la santé

> Les résultats en matière de promotion de la santé sont les changements des caractéristiques et aptitudes personnelles, des normes et actions sociales ou des pratiques organisationnelles et des politiques des pouvoirs publics qui sont attribuables à une activité de *promotion de la santé*.

Référence : nouvelle définition

Les résultats de l'action de promotion de la santé représentent les effets les plus immédiats des activités de *promotion de la santé* et sont généralement orientés vers une modification des *déterminants de la santé* susceptibles d'être changés. Les résultats de l'action de promotion de la santé se situent dans les domaines des *compétences en matière de santé*, des *politiques des*

pouvoirs publics favorables à la santé et de l'*action communautaire pour la santé*. Voir aussi *résultats en matière de santé* et *résultats intermédiaires en matière de santé*.

Secteur sanitaire

Le secteur sanitaire comprend les services de santé publics et privés organisés (y compris la *promotion de la santé*, la *prévention de la maladie*, le diagnostic, le traitement et les soins), les politiques et les activités des services sanitaires et des ministères de la santé, les organisations non gouvernementales et les *groupes communautaires* s'intéressant à la santé, et les associations professionnelles.

Référence : adapté du Glossary of Terms used in Health for All series N°9. WHO, Geneva, 1984

État de santé

Description ou mesure de la *santé* d'un individu ou d'une population à un moment donné en fonction de normes définies, généralement par référence à des *indicateurs de santé*.

Référence : adapté du Glossary of Terms used in Health for All series N°9. WHO, Geneva, 1984

Cible sanitaire

Les cibles sanitaires énoncent, pour une population donnée, l'ampleur du changement (exprimé à l'aide d'un *indicateur de santé*) qu'on peut raisonnablement attendre dans un laps de temps défini. Elles reposent généralement sur des changements spécifiques et mesurables des *résultats en matière de santé* ou des *résultats intermédiaires en matière de santé*.

Référence : nouvelle définition

Les cibles sanitaires définissent les mesures concrètes qui peuvent être prises pour atteindre des *buts sanitaires*. L'adoption de cibles constitue aussi une méthode d'évaluation des progrès accomplis dans l'optique d'une *politique* ou d'un programme *sanitaire* déterminé, car elle fixe des points de repère par rapport auxquels il est possible de mesurer ces progrès. L'adoption d'une cible nécessite l'existence d'un *indicateur de santé* approprié et d'informations sur la distribution de cet indicateur dans la population considérée. Elle exige également une estimation des tendances actuelles et futures probables en ce qui concerne la modification de la distribution de cet indicateur, ainsi qu'une compréhension des possibilités de modifier la distribution de cet indicateur dans la population considérée.

Ville-santé

Ville qui crée et améliore en permanence les environnements physiques et sociaux et développe les ressources communautaires qui permettent aux individus de se soutenir mutuellement pour accomplir toutes les fonctions de la vie et réaliser pleinement leur potentiel.

Référence : Terminology for the European Conference on Health, Society and Alcohol : A glossary with equivalents in French, German and Russian. WHO (EURO), Copenhagen, 1995

Le programme Villes-santé de l'OMS est un programme de développement à long terme qui vise à mettre la *santé* en bonne place parmi les préoccupations des villes du monde entier et à constituer un mouvement en faveur de la *santé publique* au niveau local. L'idée de ville-santé s'élargit à d'autres formes d'habitat, en particulier les villages-santé et les municipalités-santé.

Île-santé

> Île qui a engagé résolument un processus d'amélioration de la santé et de la *qualité de la vie* de ses habitants et de création d'environnements physiques et sociaux plus sains dans le contexte du *développement durable*.

Référence : adapté de la Déclaration de Yanuca, Bureau régional de l'OMS pour le Pacifique occidental, Manille, 1995

Selon la **Déclaration de Yanuca**, les îles-santé sont des lieux où le corps et l'esprit des enfants sont protégés ; où les environnements favorisent l'apprentissage et les loisirs ; où les habitants travaillent et vieillissent dans la dignité ; et où l'équilibre écologique est une source de fierté. Cette déclaration a été ratifiée par les ministres de la santé de 14 États insulaires du Pacifique en 1995 et est devenue une référence interrégionale pour des programmes Îles-santé mis sur pied dans le monde entier.

Politique des pouvoirs publics favorable à la santé

> Une politique des pouvoirs publics favorable à la santé se caractérise par une préoccupation pour la *santé* et l'équité dans tous les domaines et par une responsabilité pour les effets sur la santé. Le but principal d'une politique des pouvoirs publics favorable à la santé est de créer un *environnement qui permette* aux individus de mener une vie saine. Grâce à une telle politique, il est possible ou plus facile pour les citoyens de faire des choix sains. Elle a pour effet que les environnements sociaux et physiques améliorent la santé.

Référence : Politiques pour la santé : les recommandations d'Adélaïde. OMS, Genève, 1988

La **Charte d'Ottawa** a mis en évidence le fait que l'action de *promotion de la santé* va au-delà du secteur des soins de santé, en soulignant que la santé doit constituer un sujet de préoccupation dans tous les secteurs et à tous les niveaux des pouvoirs publics. Dans l'optique d'une politique des pouvoirs publics favorable à la santé, la notion de responsabilité en matière de *santé* est importante. Les gouvernements sont en définitive responsables devant les citoyens des conséquences sanitaires de leurs politiques ou de leur absence de politique. Un gouvernement soucieux de mettre en œuvre des politiques favorables à la santé doit mesurer ses *investissements pour la santé*, les *résultats* de ces derniers *en matière de santé* et les *résultats intermédiaires en matière de santé* de ces investissements et politiques ; il doit également faire rapport à ce sujet sous une forme que tous les groupes de la société comprennent aisément. La stratégie d'*investissement pour la santé* est étroitement liée à la notion de politique des pouvoirs publics favorable à la santé, qui relève du domaine de la promotion de la santé. L'investissement pour la santé constitue une stratégie permettant d'optimiser les effets de promotion de la santé des politiques des pouvoirs publics.

Infrastructure pour la promotion de la santé

> Ressources humaines et matérielles, structures organisationnelles et administratives, politiques, réglementations et incitations qui facilitent une action organisée de promotion de la santé en vue de faire face à des questions et défis de *santé publique*.

Référence : nouvelle définition

Ces infrastructures peuvent résider dans des structures organisationnelles très diverses, dont des organismes de *soins de santé primaires*, des pouvoirs publics, du secteur privé et du secteur non gouvernemental, des organisations d'*entraide* et des organismes et fondations spécialisés dans la promotion de la santé. Bien que de nombreux pays aient un personnel spécialisé dans la *promotion de la santé*, la principale ressource humaine est constituée par le personnel de santé en général, les travailleurs d'autres secteurs que la *santé* (par exemple l'enseignement, la protection sociale, etc.) et des non-professionnels qui agissent au sein des *communautés*. L'infrastructure pour la promotion de la santé prend non seulement la forme de ressources et de

structures tangibles mais également celles de la sensibilisation publique et politique aux questions de santé et de la participation aux mesures visant à faire face à ces questions.

Résultats intermédiaires en matière de santé

Modifications des *déterminants de la santé*, en particulier des *modes de vie*, et des *conditions de vie* qui sont attribuables à une ou plusieurs interventions planifiées, notamment des actions de *promotion de la santé*, de *prévention de la maladie* et de dispensation de *soins de santé primaires*.

Référence : nouvelle définition

Voir aussi *déterminants de la santé, résultats en matière de santé*

Coopération intersectorielle

Relation entre des éléments de différents secteurs de la société qui a été établie en vue d'agir sur une question de façon à atteindre des *résultats en matière de santé* ou des *résultats intermédiaires en matière de santé* d'une façon qui soit plus efficace, plus rationnelle ou plus durable que si le *secteur sanitaire* avait agi seul.

Référence : adapté de Intersectoral Action for Health: A Cornerstone for Health for All in the 21st Century. WHO, Geneva, 1997

L'action intersectorielle pour la santé est considérée comme essentielle pour l'obtention d'une plus grande *équité en matière de santé*, en particulier là où l'accomplissement de progrès dépend de décisions et d'actions relevant d'autres secteurs, tels que l'agriculture, l'enseignement et les finances. Un but important de l'action intersectorielle est de sensibiliser davantage aux conséquences sanitaires de décisions et de pratiques organisationnelles dans différents secteurs et, de cette façon, de provoquer un mouvement dans la direction de *politiques* et de pratiques *des pouvoirs publics favorables à la santé*. Certaines actions intersectorielles pour la santé ne nécessitent pas la participation du *secteur sanitaire*. Par exemple, dans certains pays, la police et le secteur des transports pourraient s'associer pour prendre des mesures visant à réduire les dommages corporels résultant des accidents de la circulation. De telles mesures, bien qu'elles visent à réduire le nombre de traumatismes, peuvent dans certains cas être prises sans la participation du *secteur sanitaire*. On considère de plus en plus que la coopération intersectorielle s'effectue entre les grands secteurs de la société, tels que le secteur public, la société civile et le secteur privé.

Investissement pour la santé

L'investissement pour la santé désigne des ressources qui sont affectées spécifiquement à l'obtention de la *santé* et de *progrès en matière de santé*. Ces ressources peuvent être investies par des organismes publics et privés, ainsi que par des individus et des groupes. Les stratégies d'investissement pour la santé reposent sur des connaissances relatives aux *déterminants de la santé* et visent à obtenir un engagement politique en faveur de *politiques des pouvoirs publics favorables à la santé*.

Référence : nouvelle définition

L'investissement pour la santé ne se limite pas à des ressources consacrées à la prestation et à l'utilisation de services de santé, et peut comprendre, par exemple, des investissements réalisés par des individus et des groupes dans les domaines de l'enseignement, du logement, de l'attribution de moyens d'agir aux femmes ou de l'épanouissement des enfants. Un plus grand investissement pour la santé suppose également une réaffectation des ressources au sein du *secteur sanitaire* en direction de la *promotion de la santé* et de la *prévention de la maladie*. Une proportion importante des investissements pour la santé est réalisée par des personnes dans

le contexte de leur vie quotidienne et relève de stratégies de maintien de la santé personnelle et familiale.

Voir aussi *politique des pouvoirs publics favorable à la santé* et *environnements favorables à la santé*

Déclaration de Jakarta sur la promotion de la santé au XXIe siècle

Voir *promotion de la santé* (section I)

Aptitudes utiles dans la vie

> Aptitudes à adopter un comportement adaptatif et positif, qui permet aux individus de faire face efficacement aux exigences et aux difficultés de la vie quotidienne.

Référence : Life skills education in schools. WHO, Geneva, 1993

Les aptitudes utiles dans la vie sont des compétences personnelles, interpersonnelles, cognitives et physiques qui permettent aux individus de maîtriser et de diriger leur existence et d'acquérir la capacité à vivre dans leur environnement et à modifier celui-ci. Voici des exemples d'aptitudes utiles dans la vie : capacité à prendre des décisions et à résoudre des problèmes, raisonnement créatif et réflexion critique, conscience de soi et empathie, compétences en matière de communication et de relations interpersonnelles, capacité à faire face à ses émotions et à maîtriser le stress. Les aptitudes utiles dans la vie mentionnées plus haut sont fondamentales pour l'acquisition de *compétences personnelles en matière de promotion de la santé*, qui constituent selon la **Charte d'Ottawa** l'un des domaines d'action essentiels.

Mode de vie (favorable à la santé)

> Façon de vivre qui repose sur des types définissables de comportement qui sont déterminés par les relations réciproques entre les caractéristiques personnelles d'un individu, les relations sociales et les *conditions de vie* socioéconomiques et environnementales.

Référence : définition modifiée

Ces types de comportement sont en permanence interprétés et mis à l'épreuve dans différentes situations sociales et ne sont donc pas immuables. Les modes de vie individuels, caractérisés par des types de comportement définissables, peuvent avoir des effets importants sur la santé d'un individu et la santé des autres. Pour améliorer la *santé* en permettant aux individus de modifier leur mode de vie, les mesures prises doivent être orientées non seulement vers l'individu mais également vers la situation sociale et les *conditions de vie*, qui s'influencent mutuellement pour produire et maintenir ces types de comportement.

Cependant, il importe de se rendre compte qu'il n'existe pas de mode de vie « optimal » qu'il faille recommander à tous. La culture, le revenu, la structure familiale, l'âge, les aptitudes physiques, le foyer et l'environnement professionnel rendent certaines façons de vivre et conditions de vie plus intéressantes, plus réalisables et plus appropriées.

Conditions de vie

> Les conditions de vie sont constituées par l'environnement quotidien des individus, là où ils vivent, se distraient et travaillent. Elles sont un produit de circonstances sociales et économiques et de l'environnement physique – qui peuvent tous avoir des effets sur la *santé* – et dans une large mesure ne peuvent être influencées de façon immédiate par l'individu.

Référence : définition modifiée

L'action de création de *milieux favorables à la santé* prévue par la *Charte d'Ottawa* porte en grande partie sur la nécessité d'améliorer et de changer les conditions de vie pour favoriser la santé.

Médiation

> Dans le domaine de la *promotion de la santé*, la médiation est un processus par lequel les différents intérêts (personnels, sociaux et économiques) des individus et des *communautés* et des différents secteurs (public et privé) sont conciliés d'une façon qui assure la promotion et la protection de la santé.

Référence : nouvelle définition

La modification des *modes de vie* et des *conditions de vie* des individus entraîne inévitablement des conflits entre les différents secteurs et intérêts d'une population. De tels conflits peuvent par exemple résulter de préoccupations concernant l'obtention, l'utilisation et la répartition de ressources, ou de contraintes pesant sur des pratiques individuelles ou organisationnelles. Pour éliminer ces conflits d'une façon qui favorise la santé, il peut être nécessaire que les praticiens de la promotion de la santé déploient des efforts considérables, notamment en utilisant leurs aptitudes à mener une action de *sensibilisation de la santé*.

Réseau

> Groupement d'individus, d'organisations et d'organismes structuré de façon non hiérarchique autour de questions ou de préoccupations communes, qui font l'objet d'une action préventive et systématique reposant sur une volonté d'agir et la confiance.

Référence : nouvelle définition

L'OMS a procédé au lancement et assure le fonctionnement de plusieurs réseaux de *promotion de la santé* axés sur des *cadres de vie* et des questions essentiels. Il s'agit par exemple du réseau intersectoriel *Villes-santé*, des réseaux d'*Écoles-santé* et des réseaux de pays de l'OMS pour la promotion de la santé tels que l'initiative megapays de l'OMS. Des réseaux de réseaux sont également en cours de création. À cet égard, on peut mentionner l'initiative « Travail en réseau des réseaux » du Bureau régional de l'OMS pour l'Europe et des initiatives mondiales d'activités en réseau pour la promotion de la santé, qui visent à mettre en place une *alliance mondiale pour la promotion de la santé*.

Charte d'Ottawa pour la promotion de la santé

Voir *promotion de la santé* (section I)

Partenariat pour la promotion de la santé

> Accord entre partenaires désireux de travailler en coopération en vue d'obtenir un ensemble commun de *résultats en matière de santé*.

Référence : nouvelle définition

Un partenariat de ce type peut constituer un élément d'une *coopération intersectorielle* pour la santé ou reposer sur des *alliances* pour la promotion de la santé. Le partenariat peut se limiter à viser la réalisation d'un but clairement défini – tel que l'élaboration et la mise en vigueur de dispositions législatives – ou avoir un caractère permanent et porter sur une large gamme de questions et d'initiatives. De plus en plus, les acteurs de la *promotion de la santé* étudient la possibilité de mettre en place des partenariats entre le secteur public, la société civile et le secteur privé.

Voir également *responsabilité sociale pour la santé* et *soins de santé primaires* (section I)

Aptitudes personnelles

Voir *aptitudes utiles dans la vie*

Qualité de la vie

> La qualité de la vie est la façon dont les individus perçoivent leur position dans la vie, dans le contexte de la culture et du système de valeurs dans lesquels ils vivent et en relation avec leurs buts, attentes, normes et préoccupations. Il s'agit d'un concept large, qui incorpore de façon complexe la santé physique d'une personne, son état psychologique, son degré d'indépendance, ses relations sociales, ses convictions personnelles et sa relation avec des éléments importants de l'environnement.

Référence : Quality of Life Assessment. The WHOQOL Group, 1994. What Quality of Life? The WHOQOL Group. In: World Health Forum. WHO, Geneva, 1996

Cette définition met en évidence l'idée que la qualité de la vie relève d'une évaluation subjective, qui a des dimensions à la fois positives et négatives et est enracinée dans un contexte culturel, social et environnemental. L'OMS a défini six grands domaines qui décrivent les aspects essentiels de la qualité de la vie dans une perspective transculturelle : un domaine physique (énergie et fatigue, par exemple), un domaine psychologique (sentiments positifs, par exemple), un degré d'indépendance (mobilité, par exemple), des relations sociales (soutien social concret, par exemple), l'environnement (la possibilité d'obtenir des soins de santé, par exemple) et les convictions et la spiritualité personnelles (sens de l'existence, par exemple). Le domaine de la *santé* et celui de la qualité de la vie sont complémentaires et se recouvrent partiellement.

Il y a qualité de la vie lorsque les individus estiment que leurs besoins sont satisfaits et qu'ils ne sont pas privés de possibilités d'être heureux et comblés, quel que soit leur *état de santé* physique ou la situation sociale et économique. Le but d'amélioration de la qualité de la vie, à côté de celui-ci relatif à la prévention des problèmes de santé évitables, a pris une importance accrue dans le domaine de la *promotion de la santé*. Cela revêt une importance particulière lorsqu'on s'efforce de répondre aux besoins des personnes âgées, des malades chroniques, des patients en phase terminale et des handicapés.

Réorientation des services de santé

> La réorientation des services de santé se caractérise par une préoccupation plus nette pour l'obtention de *résultats en matière de santé* de la population grâce à la façon dont le système de santé est organisé et financé. Cela doit provoquer un changement d'attitude et d'organisation des services de santé, axé sur les besoins de l'individu considéré comme un tout complet, mis en balance avec les besoins des groupes de la population.

Référence : adapté de la Charte d'Ottawa pour la promotion de la santé. OMS, Genève, 1986

La **Charte d'Ottawa** souligne également qu'il importe que le *secteur sanitaire* participe aux efforts en faveur de la santé. L'obtention de ce résultat incombe à l'ensemble des professions de santé, aux institutions du service de santé et aux pouvoirs publics, dont l'action est complétée par la contribution des individus et des communautés desservis par le *secteur sanitaire*. Dans la plupart des cas, cela nécessite une expansion de l'action de *promotion de la santé* et de *prévention de la maladie*, afin d'obtenir un équilibre optimal entre les investissements dans la promotion de la santé, la prévention de la maladie, le diagnostic, le traitement, les soins et les services de réadaptation. L'élargissement de ce rôle ne nécessite pas toujours une augmentation de l'activité directe du système de santé. Il se peut que l'action menée par des secteurs autres que le *secteur sanitaire* permette d'atteindre plus efficacement de meilleurs *résultats en matière de santé*. Les pouvoirs publics doivent reconnaître le rôle essentiel que le *secteur de la santé* joue dans le soutien de cette action intersectorielle pour la santé.

Voir également *Hôpital-santé*

Comportement à risque

Comportement dont on a constaté qu'il est lié à une vulnérabilité accrue à l'égard d'une maladie déterminée ou de certains problèmes de santé.

Référence : définition modifiée

On définit généralement les comportements à risque sur la base de données épidémiologiques ou d'autres données sociales. La modification des comportements à risque représente un but important de la *prévention de la maladie* et, traditionnellement, on utilise l'*éducation pour la santé* à cette fin. Dans le cadre plus large de la *promotion de la santé*, on peut considérer que le comportement à risque est une réaction à de mauvaises *conditions de vie* ou un mécanisme visant à faire face à ces dernières. Les stratégies permettant de contrer cette réaction comprennent la transmission d'*aptitudes* utiles *dans la vie* et la création d'*environnements plus favorables à la santé*.

Facteur de risque

Situation sociale ou économique, état biologique, comportement ou environnement qui est lié, éventuellement par une relation de cause à effet, à une vulnérabilité accrue à une maladie, à des problèmes de santé ou à des traumatismes déterminés.

Référence : définition modifiée

Comme dans le cas des *comportements à risque*, une fois que des facteurs de risque ont été repérés, ils peuvent devenir le point de départ ou l'axe de stratégies et d'actions de *promotion de la santé*.

Auto-assistance

Dans le contexte de la *promotion de la santé*, actions menées par des personnes qui ne font pas partie professionnellement du secteur de la santé en vue d'obtenir les ressources nécessaires pour promouvoir, maintenir ou rétablir la santé des individus ou des communautés.

Référence : définition modifiée

Bien que l'on comprenne généralement la notion d'« auto-assistance » comme une action menée par des individus ou des *communautés* qui en bénéficient directement, elle peut également englober une entraide entre individus et groupes. L'auto-assistance peut même inclure l'auto-prise en charge, qui comprend notamment l'auto-médication et les premiers soins dans le contexte social normal de la vie quotidienne des individus.

Cadre de vie

Lieu ou contexte social dans lequel les individus vaquent à leurs activités quotidiennes et où les facteurs environnementaux, organisationnels et personnels influent les uns sur les autres et ont ainsi des effets sur la santé et le bien-être.

Référence : nouvelle définition

Un cadre de vie est aussi un lieu où des personnes utilisent activement ou façonnent l'environnement et ainsi créent ou résolvent des problèmes relatifs à la *santé*. Normalement, les cadres de vie se caractérisent par des frontières physiques, diverses personnes ayant des rôles définis et une structure organisationnelle.

Les actions menées pour promouvoir la santé dans différents cadres de vie peuvent revêtir des formes très variées, souvent via un mode de développement organisationnel particulier, y

compris la modification d'environnements physiques, de la structure organisationnelle, de l'administration et de la gestion. On peut également utiliser les cadres de vie pour mener une action de promotion de la *santé* en atteignant les gens qui y travaillent ou en les utilisant pour obtenir un accès à des services et via l'interaction de différents cadres de vie avec la *communauté* dans son ensemble. Les cadres de vie sont par exemple l'école, le lieu de travail, l'hôpital, le village et la ville.

Capital social

> Le capital social représente le degré de cohésion sociale qui existe dans les *communautés*. Il désigne les processus interpersonnels qui établissent des *réseaux*, des normes et la confiance sociale, et facilitent la coordination et la coopération dans l'intérêt des différentes parties.

Référence : nouvelle définition

Le capital social est créé à partir de la myriade de relations quotidiennes entre les individus et prend la forme de structures telles que des associations de citoyens, des groupes religieux, la famille et les *réseaux* communautaires informels, et de normes (le volontarisme, l'altruisme et la confiance). Plus ces réseaux et ces liens sont solides, plus il est probable que les membres d'une *communauté* coopèrent dans l'intérêt de tous. De cette façon, le capital social crée la santé et peut renforcer les avantages découlant de l'*investissement dans la santé*.

Réseaux sociaux

> Relations et liens d'ordre social entre les individus qui permettent d'obtenir un *soutien social* favorable à la *santé*.

Référence : définition modifiée

Une société stable a généralement mis en place des réseaux sociaux qui permettent de bénéficier d'un *soutien social*. Des influences déstabilisatrices, telles qu'un taux de chômage élevé, des programmes de relogement et une urbanisation rapide, peuvent entraîner des perturbations considérables des réseaux sociaux. Dans ce cas, l'action de promotion de la santé peut être axée sur des mesures contribuant au rétablissement des réseaux sociaux.

Responsabilité sociale en faveur de la santé

> La responsabilité sociale en faveur de la santé trouve son expression dans les mesures que les décideurs des secteurs public et privé prennent pour mettre en œuvre des politiques et des pratiques qui assurent la promotion et la protection de la *santé*.

Référence : Déclaration de Jakarta sur la promotion de la santé au XXIe siècle. OMS, Genève, 1997

Les politiques et les pratiques mises en œuvre par les secteurs public et privé devraient éviter de nuire à la *santé* des individus ; protéger l'environnement et assurer l'utilisation viable des ressources ; restreindre la production et la commercialisation de produits et substances intrinsèquement nocifs, et décourager les pratiques malsaines de commercialisation ; protéger le citoyen sur le marché et l'individu sur le lieu de travail, et procéder à des évaluations d'impacts sur la santé axés sur l'*équité* en tant que partie intégrante des politiques.

Voir aussi *politique des pouvoirs publics favorable à la santé*

Soutien social

Assistance dont les individus et les groupes peuvent bénéficier au sein de *communautés* et qui peut atténuer les effets négatifs d'événements de la vie et de *conditions de vie*, et constituer une ressource positive pour l'amélioration de la *qualité de la vie*.

Référence : définition modifiée

Le soutien social peut comprendre le soutien affectif, le partage d'informations et la fourniture de ressources matérielles et de services. On reconnaît maintenant largement que le soutien social est un important *déterminant de la santé* et un élément essentiel du *capital social*.

Milieux favorables à la santé

Les milieux favorables à la santé offrent aux individus une protection contre les menaces pesant sur la *santé* ; ils leur permettent de développer leurs capacités et leur autonomie en matière de santé. Ils comprennent les lieux où les individus vivent, leur *communauté* locale, leur foyer, et les endroits où ils travaillent et se divertissent, et englobent l'accès des individus à des ressources pour la santé ainsi que des possibilités d'acquérir des *moyens d'agir*.

Référence : adapté de la Déclaration de Sundsvall sur les milieux favorables à la santé. OMS, Genève, 1991

L'action visant à créer des milieux favorables à la santé comporte de nombreuses dimensions et peut inclure des mesures politiques directes visant à élaborer et à mettre en œuvre des politiques et des réglementations qui contribuent à mettre en place des milieux favorables à la santé ; des mesures économiques, en particulier en vue de favoriser un développement économique durable ; et une action sociale.

Développement durable

Développement qui répond aux besoins de la génération actuelle sans compromettre l'aptitude des générations futures à répondre à leurs propres besoins (Commission mondiale pour l'environnement et le développement 1987). Il comprend de nombreux éléments et l'ensemble des secteurs, y compris le *secteur de la santé*, qui doit contribuer à réaliser ce type de développement.

Référence : Notre avenir à tous : Rapport de la Commission mondiale pour l'environnement et le développement, 1987. Santé et environnement dans le cadre d'un développement durable. Cinq années après le Sommet Planète Terre. OMS, Genève, 1997

Les êtres humains sont au centre du développement durable. Celui-ci désigne une utilisation des ressources, une orientation des investissements et du progrès technologique, et un développement institutionnel tels que l'exploitation et l'utilisation actuelles des ressources ne compromettant pas la *santé* et le bien-être des générations futures.

Il n'existe pas une seule façon optimale d'organiser la relation complexe développement-environnement-santé, qui révèle toutes les interactions importantes et les points de départ possibles d'interventions en matière de *santé publique*. En ce qui concerne la *promotion de la santé*, le développement durable revêt une importance particulière dans l'optique de l'élaboration de *politiques des pouvoirs publics favorables à la santé* et la mise en place de *milieux favorables à la santé* d'une façon qui améliore les *conditions de vie*, favorise les *modes de vie* sains et réalise une plus grande *équité en matière de santé* tant maintenant qu'à l'avenir.

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* La plupart des ouvrages mentionnés ont été publiés par l'OMS. Pour des renseignements complémentaires concernant des publications, veuillez consulter : Health Promotion Bibliography. WHO/HPR/HEP/41CHP/RS/97.2. WHO, Geneva, 1997.

« La possession du meilleur état de santé qu'il est capable d'atteindre constitue l'un des droits fondamentaux de tout être humain, quelles que soient sa race, sa religion, ses opinions politiques et sa condition économique ou sociale. »

L'OMS est une institution spécialisée aux termes de la Charte des Nations Unies. Elle a été créée en 1948 par 61 gouvernements désireux de coopérer entre eux et avec d'autres pour favoriser la santé de tous. Le nombre d'États membres s'élève maintenant à 191.

L'OMS représente l'aboutissement d'efforts de coopération internationale en matière de santé qui ont commencé il y a près de 150 ans. En 1851, on a organisé la première conférence sanitaire internationale, qui a examiné des mesures visant à empêcher l'importation de la peste en Europe. Plus tard, des pays se sont associés pour lutter contre des menaces communes telles que la fièvre jaune, le choléra, la variole et le typhus. Il faut également mentionner la création du Bureau sanitaire panaméricain en 1902, de l'*Office international d'hygiène publique* en 1907 et de l'Organisation sanitaire de la Société des Nations en 1919. En 1945, le Brésil et la Chine ont proposé de créer une organisation internationale de la santé, ce qui a débouché sur l'élaboration de la Constitution de l'OMS, adoptée en 1946. La Constitution est entrée en vigueur le 7 avril 1948, lorsque le 26ème des 61 États membres signataires a procédé à la ratification.

Les fonctions principales de l'OMS sont les suivantes :

- donner des conseils dans le domaine sanitaire à l'échelle du monde entier ;
- coopérer avec les gouvernements pour renforcer la planification, la gestion et l'évaluation de programmes sanitaires nationaux ;
- concevoir et transférer des technologies, des informations et des normes sanitaires appropriées.

Depuis la création de l'OMS, des résultats très importants ont été obtenus sur le plan de la santé dans le monde. En particulier, l'Organisation :

- lutte contre les maladies infectieuses. C'est ainsi que, chaque année, des millions d'enfants évitent de contracter des maladies mortelles et invalidantes, notamment grâce à des programmes mondiaux de vaccination ;
- fournit des services sanitaires ;
- réduit la mortalité ;
- fournit des médicaments essentiels ; et
- accroît la salubrité des villes.

L'OMS a éradiqué la variole en 1980 et, aujourd'hui, nous pouvons nous attendre à l'élimination d'autres graves maladies, telles que la poliomyélite, la dracunculose et la lèpre, au cours des prochaines années.

L'OMS doit encore s'acquitter de tâches difficiles :

- réaliser la Santé pour tous ;
- maîtriser des maladies anciennes et nouvelles ;
- assurer la santé reproductive pour tous ;
- constituer des partenariats pour la santé ; et
- assurer la promotion de modes de vie et d'environnements sains.

Les publications de l'Organisation contiennent des informations plus détaillées sur de nombreux aspects des activités de l'OMS.

TRIBUNAL DE GRANDE INSTANCE D'AUCH

MINUTE JAF N°

AFFAIRE N° RG 19/00702 - N° Portalis DBX5-W-B7D-CKG5

M.
c/
Mme

JUGEMENT

Le dix sept décembre deux mil dix neuf,

Monsieur , Juge aux Affaires Familiales, assisté de Madame , Greffière,

a rendu le jugement dont la teneur suit, après que la cause a été débattue à l'audience du 19 novembre 2019, date à laquelle le Juge aux Affaires Familiales a indiqué que la décision serait rendue à la date de ce jour ;

PARTIE DEMANDERESSE :

assisté de Me, avocat au barreau de GERS

PARTIE DÉFENDERESSE :

assistée de Me, avocat au barreau de AIX EN PROVENCE

CCCFE Le
Me
Me

De l'union de M. et de Mme, qui l'ont tous deux reconnu, est né un enfant :

- né le 12 Juillet 2012.

Selon le dernier état des décisions de la juridiction des affaires familiales rendues entre les parties (Jaf Auch 7 mai 2013, 3 décembre 2013 et 27 janvier 2015) :

- l'exercice de l'autorité parentale a été confié conjointement aux deux parents,
- la résidence de l'enfant a été fixée au domicile de la mère,
- le droit de visite et d'hébergement du père a été réglementé,
- la contribution alimentaire du père a été fixée à la somme mensuelle de 130 €.

M. ayant formé une demande tendant au transfert de la résidence de l'enfant, par jugement du 17 septembre 2019 cette juridiction a :

- sursis à statuer au fond,
- ordonné l'audition de l'enfant,
- dans l'attente, provisoirement, reconduit les mesures arrêtées par les précédents jugements.

Après audition de l'enfant, l'affaire a été appelée à l'audience du 19 novembre 2019.

A cette date :

- M. a réitéré sa demande,

- Mme a conclu au rejet des prétentions adverses.

SUR QUOI :

Attendu qu'il n'y a pas lieu d'avoir égard aux attestations versées aux débats, celles émanant du clan paternel faisant de M. le portrait d'un père attentionné et celle émanant du clan maternel le décrivant comme un personnage irresponsable ;

Attendu qu'il est constant que suite à son admission dans la fonction publique Mme (qui s'est récemment convertie à l'Islam), courant septembre 2019, s'est installée avec l'enfant à Gardanne (13) ;

Attendu que, s'il ne peut être attendu de lui des réponses raisonnées, un enfant de 7 ans est tout à fait en mesure d'exprimer un ressenti et de répondre à des questions purement factuelles ;

Attendu que lors de son audition l'enfant a clairement exprimé le souhait de vivre chez son père chez lequel il se sent mieux ;

Attendu que, sur interpellation, l'enfant a notamment indiqué :

- "chez ma mère, je ne mange pas de porc. Ma mère m'a dit que je n'avais pas le droit d'en manger",
- "j'aimerai prendre des cours d'arabe",
- "ma mère a des copains qui viennent la voir. Des fois l'un, des fois l''autre. Ils sont musulmans" ;

Attendu que prises isolément, chacune de ces réponses est anecdotique ;

Que leur conjonction, dans le contexte actuel ne peut qu'interpeller, voir inquiéter ;

Attendu que, par ailleurs :

- l'enfant a toujours vécu dans le Gers où il a ses habitudes et ses amis et où réside la famille paternelle (la famille maternelle réside à proximité dans le département de l'Ariège) ;
- la mère n'a pas respecté l'exercice conjoint de l'autorité parentale en imposant unilatéralement à l'enfant des pratiques alimentaires dictées par des considérations purement religieuses ;

Attendu qu'en considération de l'ensemble de ces éléments, il apparaît qu'il est de l'intérêt de l'enfant que sa résidence soit fixée au domicile de son père ;

Attendu qu'il n'est pas contesté qu'il y a lieu d'attribuer à la mère un droit d'accueil adapté à la distance séparant le domicile des 2 parents ;

Attendu qu'au vu des pièces financières versées aux débats, et par référence au barème indicatif du Ministère de la Justice, il y a lieu d'arbitrer à 130 € le montant mensuel de la contribution alimentaire de la mère ;

Attendu qu'aucun élément objectif ne justifie qu'il soit fait droit à la mesure d'interdiction de sortie du territoire national sollicitée par le père ;

P A R C E S M O T I F S

Le Juge aux Affaires Familiales,

Statuant en Chambre du Conseil, par décision contradictoire et en premier ressort, après débats hors la présence du public, et après en avoir délibéré conformément à la Loi,

Vu les jugements précités,

Vu le jugement du 17 septembre 2019 et le procès-verbal d'audition de l'enfant ;

‣ Fixe, à compter de la fin du 1er trimestre scolaire 2019-2020, la résidence de l'enfant mineur au domicile du père,

‣ Dit que la mère disposera sur la personne de son enfant mineur d'un droit de visite et d'hébergement s'exerçant, sauf meilleur accord :

- pendant l'intégralité des vacances scolaires à l'exception de celles d'été et de Noël qui seront partagées par moitié avec alternance,

‣ Dit qu'il appartiendra à la mère d'aller chercher l'enfant et de le ramener,

‣ Supprime la pension alimentaire précédemment mise à la charge de M. du chef de l'enfant,

‣ Condamne Mme à payer à M. , d'avance et sans frais, entre le 1er et le 5 de chaque mois, une pension alimentaire mensuelle de 130€ pour contribuer aux frais d'entretien et d'éducation de l'enfant mineur,

‣ Dit que cette contribution sera indexée sur l'indice mensuel des prix à la consommation des ménages urbains, dont le chef est employé ou ouvrier, série "France entière", ensemble “hors tabac” publié mensuellement par l'INSEE, (Tél. 08 92 68 07 60 ou internet : www.indices.insee.fr ; site permettant le calcul de l’indexation :

www.service-public.fr/calcul-pension/index.html) ; révisable au 1er janvier de chaque année et pour la première fois le 1er janvier 2020, sur l'indice du mois de novembre précédent, selon la formule :

$$\text{pension revalorisée} = \frac{\text{(montant initial pension) x (nouvel indice)}}{\text{indice de référence : décembre 2019}}$$

‣ Rappelle que cette pension sera due y compris au-delà de la majorité si l'enfant demeure à la charge du parent gardien,

‣ Déboute les parties de leurs prétentions plus amples ou contraires,

‣ Ordonne l'exécution provisoire de la présente décision,

‣ Dit que la présente décision sera signifiée par voie d'huissier à la diligence des parties conformément aux dispositions des articles 651 et suivants et 1142 du code de procédure civile,

‣ Dit que chaque partie supportera la charge de ses propres dépens.

LA GREFFIÈRE LE JUGE AUX AFFAIRES FAMILIALES

Pour satisfaire aux prescriptions de l'article 9 de la loi n° 84-1171 du 22 décembre 1984, il est rappelé qu'en cas de défaillance dans le règlement des sommes dues au titre de la contribution alimentaire:

(1) le créancier peut en obtenir le règlement forcé en utilisant à son choix une ou plusieurs des voies d'exécution suivantes : saisie-attribution entres les mains d'un tiers, autres saisies, paiement direct entre les mains de l'employeur, recouvrement public par l'intermédiaire du Procureur de la République,

(2) le débiteur qui manque à ses obligations encourt les peines des articles 227-3 et 227-9 du Code Pénal : 2 ans d'emprisonnement et 15 000 €uros d'amende, interdiction des droits civiques, civils et de famille, suspension du permis de conduire, interdiction de quitter le territoire de la République.,

(3) Si le débiteur organise volontairement son insolvabilité pour éviter de payer la pension qu'il doit, le créancier peut porter plainte à ce titre. Le débiteur peut être puni de trois ans d'emprisonnement et de 45 000 €uros d'amende.

Tant que la pension n'est pas révisée, elle est intégralement due par le débiteur.