



# **OBSERVATORY REPORT ON ACCESS TO RIGHTS AND HEALTHCARE**

FOR MÉDECINS DU MONDE'S PROGRAMMES IN FRANCE



# EDITORIAL

2000...2020, 2021, 2022...

How much longer will we have to wait to see a true and effective right to healthcare being enforced in our societies? In 2021 amongst those who, theoretically, had a right to health insurance, 81.3% of people did not actually benefit from it.

France has one of the worst levels of social inequalities in western Europe despite a good average level of health amongst its population (*Menvielle & Lang, 2021*).

Once a year the Observatory Report on Access to Rights and Healthcare by MdM in France takes the pulse of our health system. And this year, once again, the system's vital signs are not looking good.

There are the people who we see at MdM - those who reach out to us and those we reach out to. There are others, however, who never cross paths with people from the health system or from the voluntary sector. Behind all of the statistics in this report there are people who must fight on a daily basis for many different things: a job, housing, food, medical care, contraception and medication.

This is not one of those struggles that can have a structuring effect. It is a struggle for access to fundamental rights and is it not normal, not acceptable for people to have to go through this. It is a violent, toxic struggle for these people. This fight is also a stain on the image of a society which is supposed to be based on a model of solidarity and whose people believe that its health system is the best in the world.

And yet, year after year in our initiatives we are noticing a degradation of the health of the people we meet. Their health pathways are often marked by periods of breakdowns in access to healthcare.

It is up to the State to guarantee equal access to health and to healthcare for all. And yet the French State has been failing in this task for many years now. The decisions the State has taken have led to a collapse of our health system.

Worst of all politicians are wrongly using the universal, unconditional right to healthcare as a political tool.

Out in the field we have witnessed the devastating impact of the restrictions on access to health insurance that have been placed on foreign nationals in vulnerable situations since 2019.

The recent health crisis revealed the extent of the decay in our health system, although we were already aware that the system was on its knees. Health, which is, of course, an essential common good, is now a key factor in the heightening of social inequalities.

The difficulties faced by vulnerable people in terms of access to healthcare are becoming more and more widespread and an increasingly large proportion of the population are facing similar challenges.

Certain initiatives such as outreach work and health mediation should be encouraged but we need to do more. We must develop more initiatives which are accessible and comprehensible for all and put an end to specific pathways for people in vulnerable situations.

All human beings should be able to make their own decisions on matters related to their health. But this is only possible when access to rights, healthcare and housing are guaranteed.

As stakeholders working out in the field, we are all well aware that there is no miracle solution to these issues. But we also know that we urgently need the implementation of health policies based on two fundamental principles: solidarity and non-discrimination. The public authorities must show strong political will to consider health as a common good and to make solidarity one of the building blocks of their health policies.

Current policies create barriers for certain people in terms of access to the right to healthcare. Therefore, the implementation of health policies and of a truly universal health system must now be a priority.

It is also essential to bring people who have been excluded back on board and to avoid pushing these people into increasingly vulnerable situations. We all live on the same planet, in the same society.

This Observatory Report is a tool to draft proposals, to persuade people and to move towards a future where all obstacles to healthcare have been overcome.

**Doctor Florence Rigal**  
**President of Médecins du Monde**

# OUR PROGRAMMES IN FIGURES

59

PROGRAMMES LED BY 1,530 ACTIVE VOLUNTEERS AND 133 STAFF MEMBERS ACROSS 29 SITES

14

HEALTHCARE, ADVICE AND REFERRAL CENTRES (CASOS), INCLUDING ONE RECEPTION, REFERRAL AND SUPPORT CENTRE (CAOA), AND 2 PERMANENT HEALTHCARE ACCESS OFFICES (PASS CENTRES IN TOWNS AND CITIES)

18

PROGRAMMES FOR PEOPLE SUFFERING FROM POOR HOUSING OR FROM A LACK OF HOUSING (ISOLATED PEOPLE IN STREET SITUATIONS AND/OR PEOPLE LIVING IN POOR HOUSING, PEOPLE LIVING IN SQUATS OR SLUMS)

5

HARM REDUCTION PROGRAMMES FOR PEOPLE WHO USE DRUGS (1 PROGRAMME) AND FOR SEX WORKERS (4 PROGRAMMES)

4

PROGRAMMES FOR MIGRANTS ALONG THE COAST IN THE CALAIS REGION, ALONG THE BORDER BETWEEN FRANCE AND ITALY AS WELL AS IN PARIS AND NEAR MARSEILLE. AN ADVOCACY PROJECT IS ALSO BEING LED TO LOBBY THE EUROPEAN INSTITUTIONS IN STRASBOURG

3

PROGRAMMES FOR UNACCOMPANIED MINORS IN PARIS, NANTES AND CAEN

5

PROGRAMMES IN THE FRENCH OVERSEAS DEPARTMENTS AND REGIONS OF MAYOTTE, LA REUNION AND FRENCH GUIANA

3

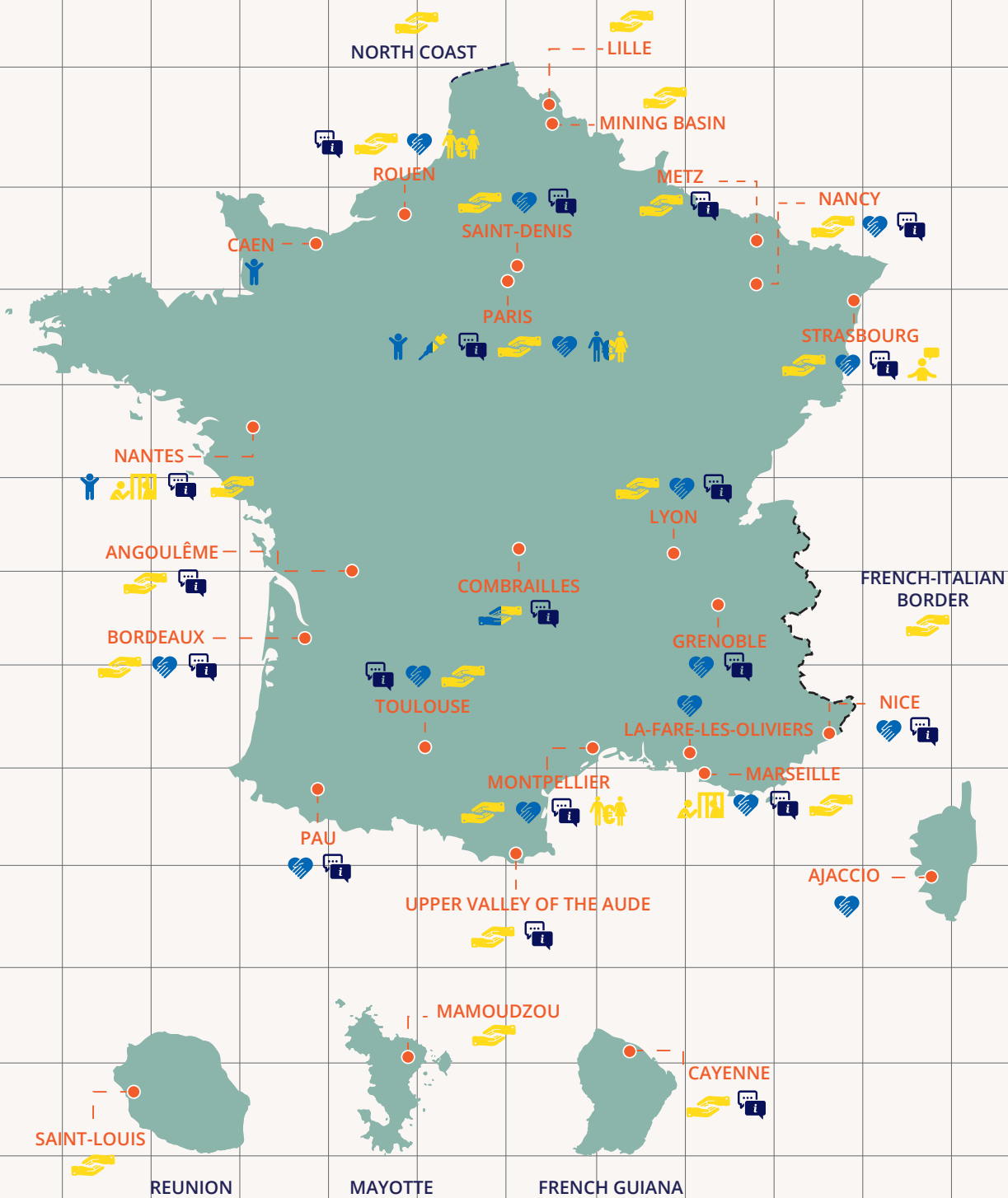
PROGRAMMES FOR ISOLATED PERSONS IN URBAN AND IN RURAL AREAS IN THE UPPER AUDE VALLEY AND IN THE HAUTS-DE FRANCE REGION (LILLE AND LENS-HENIN)

2

PROGRAMMES FOR PEOPLE PLACED UNDER JUDICIAL SUPERVISION IN NANTES AND MARSEILLE

1

CROSS-CUTTING PREVENTION PROGRAMME ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AND 1 SPECIFIC PROJECT IN THE LOIRE REGION FOR PEOPLE LIVING IN UNSTABLE, INSALUBRIOUS, UNDIGNIFIED AND/OR INFORMAL HOUSING



	Actions with unaccompanied minors		Healthcare, Advice and Referral Centres (CASO)		Outreach actions
	Actions in rural environments, on the street or in slums and with migrants		Actions with sex workers		Actions in MDM's medical centres
	Actions with incarcerated people		Actions with people who use drugs		Crosscutting programmes
	HIV/Hepatitis/STIs/Tuberculosis prevention		Advocacy directed at European institutions		

# MÉDECINS DU MONDE'S PROGRAMMES IN FRANCE IN 2021

Médecins du Monde (Mdm) has been working in France since 1986 when it opened its first free health centre in Paris to address the healthcare needs of the capital's poorest populations. The intention was to close the centre within 6 months after alerting the authorities to the situation of people living in precarity and/or exclusion with a view to obtaining unconditional access to healthcare for all.

More than 35 years on, despite the introduction of numerous public schemes for vulnerable populations, there are still many barriers to healthcare and rights and Mdm is still running some of the same programmes as well as newly-developed programmes offering clinic-based (CASO/CAOA) and outreach activities across the country.

**In 2021, Médecins du Monde France ran 59 programmes across 29 sites in mainland France and in its overseas departments and regions of La Reunion Island, Mayotte and French Guiana.**

**14 CASOS (HEALTHCARE, ADVICE AND REFERRAL CENTERS), INCLUDING ONE CAO A (RECEPTION, REFERRAL AND SUPPORT CENTRE) AND 2 HEALTHCARE ACCESS OFFICES (PASS), ONE IN MARSEILLE AND THE OTHER IN CAYENNE**

The CASOs/CAOA offer primary medical care and health and social counselling to people having difficulties accessing their rights or health prevention and care in France. These facilities act as support centres for people living in precarity or exclusion who are either unaware of their rights or are unable to exercise them.

CASOs/CAOA operate as drop-in clinics, offering free consultations, mainly without an appointment, and without any conditions attached. Patients see different health professionals for a consultation or a check-up and are then referred to the appropriate mainstream services as quickly as possible. They are also empowered so that they can access their rights autonomously. The CASO/CAOA centres provide nursing care, medical consultations, information on the prevention of infectious diseases and/or specific screening for certain pathologies. Also, because the road into exile can cause not only physical but also psychological suffering for people undertaking migrations and because precarious living conditions are particularly harmful to people's mental health, these clinics also offer psychosocial support and mental healthcare.

In 2019, Mdm's CASO in Marseille launched a **Healthcare Access (PASS de Ville)** service, with a view to eventually handing this service over to the city's mainstream system. This pop-up service enables people with no health insurance to receive care without charge after an initial socio-medical assessment. This is done thanks to a system whereby the invoicing of the services is delayed until their rights to health insurance have been activated. Patients are seen by local doctors and are able to follow a free and comprehensive care pathway (medication, bloodwork, radiology, etc.) while they endeavour to obtain health insurance. This initiative will be handed over to a new, local organisation in mid-2022.

In 2021 the team in Cayenne worked to prepare a Healthcare Access project (PASS de Ville), but the launch of this service was delayed due to the Covid crisis and due to the reform of State medical aid. The operational launch and the first uses of this service are expected in early 2022.

**ONE CROSS-CUTTING PREVENTION PROGRAMME ON SEXUAL AND REPRODUCTIVE HEALTH RIGHTS (SRHR) FOR 29 PROJECTS AND 1 SRHR PROGRAMME IN THE LOIRE REGION (KNOWN AS THE '4I' PROGRAMME IN FRENCH - FOR UNSTABLE, INSALUBRIOUS, UNDIGNIFIED AND/OR INFORMAL LIVING CONDITIONS)**

Mdm's initiatives adopt a **complementary approach focusing on strengthening public health, promoting human rights and fighting against gender inequalities** in order to overcome the obstacles in access to sexual and reproductive healthcare and to better meet the specific needs of different population groups. In 2021 Mdm outlined its inclusive vision of gender so that all people - no matter their sex, their gender identity or their sexual orientation - can make their own decisions regarding their bodies, can have an independent, satisfactory and risk-free sex life and can access sexual and reproductive health services which are adapted to their needs. Depending on the programme or the region in question, the Mdm teams implement different activities and services in order to reach our goals in terms of strengthening access to SRHR:

- **One-on-one prevention interviews** on the topic of SRHR.

- . A **screening offer** (rapid orientation and screening tests for HIV, syphilis, hepatitis B and hepatitis C) that is adapted to the needs of the target groups and is led in partnership with the public authorities and the local laboratories.
- . **Collective initiatives on SRHR**: prevention sessions, community mobilisation initiatives, self-help groups to debate SRHR and to deliver SRHR messages.
- . **Making sure prevention equipment is available** (condoms, contraception, self-tests, etc.).
- . **Guiding and/or supporting people on their journeys towards the public health system** for better SRHR treatment pathways (family planning and education centres, mother and child protection centres, etc.).
- . Helping **the target populations to get involved in their own care** via health mediation initiatives, the use of interpreters and counselling techniques
- . **Documenting the status of people's sexual and reproductive health and of the stumbling blocks** in terms of access to SRHR.
- . **Advocacy initiatives** to protect the SRHR of vulnerable people.

To make these goals a reality a specific programme was launched in 2020 in the Loire region with the objective of strengthening the offer of SRHR services and improving access to these services for people living in unstable, insalubrious, undignified and/or informal housing (the 4i initiative). This initiative adopted a community approach and was led in both Nantes and Angers.

## FOUR PROGRAMMES SPECIFICALLY FOCUSED ON MIGRATION, EXILE, RIGHTS AND HEALTH AND 1 ADVOCACY PROJECT TO LOBBY THE EUROPEAN INSTITUTIONS IN STRASBOURG

MdM works with migrants for the majority of its programmes in France; 97.1% of the people we see in the CASO centres are vulnerable foreign nationals. Our organisation also leads specific programmes for migrants on the French-Italian border in Briançon and Ventimiglia, in Paris, on the coast in Calais, Grande-Synthe and Dunkirk as well as in the Marseille region (in La Fare-lès-Oliviers).

At the beginning of 2017, a coalition of several organisations (CAFI) was created to pool knowledge and tools with a view to putting an end to violations of the rights of refugees and migrants at borders thanks to observations on the borders, via litigation against illegal refoulements as well as mobilisation and advocacy initiatives. In 2021 CAFI notably took action to create a parliamentary commission on migration.

An advocacy project is underway in order to lobby the European authorities, specifically at the Council of Europe in Strasbourg, and to promote two priority areas, namely migration and SRHR.

## 18 ENVIRONMENTAL

## HEALTH PROGRAMMES (WITH ISOLATED, HOMELESS AND POORLY-HOUSED PEOPLE)

The topic of environmental health within MdM in France has been developed through programmes in squats, slums and on the streets which focus on the impact of living conditions on health.

On the streets, in the housing centres and in the day centres our mobile teams carry out various actions: supporting people with admin tasks, helping them to get access to health insurance, health monitoring, medical consultations, psychosocial support, health mediation, information and awareness raising amongst medical and social stakeholders on the topic of housing and poverty. Through our initiatives MdM explains the difficulties homeless people face when they wish to assert their rights and access healthcare. In addition to our field interventions, and to ensure that we are not replacing the institutions, our organisation leads lobbying initiatives to promote adapted, long-term housing solutions as well as deploying mobile units to establish medico-psychosocial contact and to provide effective access to healthcare for the most excluded.

We also intervene in squats and slums to propose access to rights and healthcare for the populations and to direct people towards health structures - a strong focus is placed on the health of women and children.

Our health mediation initiatives are highly adapted to the populations we work with. Our health mediators work with partner organisations and with the public system to improve the care provided to the inhabitants of slums and to empower them to seek healthcare and to exercise their rights autonomously.

Being in favour of a slum clearance policy, as long as the residents are involved in the discussions, MdM insists on the importance of solutions which stem from joint decisions and of how the proposals for rehousing must be designed for the long-term and adapted to the needs of the populations. Whilst waiting for dignified proposals to be drafted in collaboration with the residents, MdM calls for stability for the people in the meanwhile and for greater health security within slums.

## FIVE HARM REDUCTION PROGRAMMES LINKED TO DRUG USE AND/OR SEX WORK

MdM's teams run four programmes with sex workers in three cities (Montpellier, Paris, and Rouen). Working out of mobile units and day centres, these programmes are designed to build capacities and knowledge of harm reduction and sexual and reproductive health (SRH), to promote access to mainstream healthcare and rights and to foster community involvement. A national prevention programme is also being run to promote access to legal and healthcare services for sex workers who are victims of violence (the Jasmine programme).

In early 2021 MdM completed the handover of the XBT

(Xenobiotrope) programme to Fédération Addiction, Charonne-Oppélia and Sida Paroles. Created in 1999, the objective of this programme is to develop countrywide a comprehensive drug analysis service as a harm reduction tool and it now has more than 50 partners throughout the Paris region. It offers people who use psychotropic drugs the opportunity to have their products analysed before and/or after use as part of a harm reduction approach.

In the last quarter of 2021 MdM decided to return to the field to tackle the increasingly worrying situation amongst people taking drugs in public spaces in the north-east of Paris.

## TWO PROGRAMMES WITH PEOPLE PLACED UNDER JUDICIAL SUPERVISION

Since 2014, MdM has been working with people incarcerated in Nantes prison to promote their health and improve their access to healthcare, through a community-based approach.

MdM also worked in close collaboration with all the ministries concerned and with other operational partners to finalise the design in October 2021 of an experimental project in Marseille that offers an alternative to incarceration through housing and intensive monitoring (AISI). This project, which includes a research component, will also be extended to homeless people with severe psychiatric disorders as an alternative to detention. The project will be launched in early 2022.

## THREE PROGRAMMES WITH UNACCOMPANIED MINORS

In 2015, MdM began running a programme in Paris specifically for unaccompanied minors, helping them to undertake the various procedures they need to go through. In 2016, another two programmes for unaccompanied minors were launched in Normandy (Caen/Rouen) and in Nantes. In 2021, the programmes were maintained in Paris, Caen and Nantes. MdM's teams provide these minors with a safe space where they are listened to, where they can receive healthcare and where they are given support in order to exercise their rights.

## THREE PROGRAMMES WORKING WITH ISOLATED PEOPLE IN RURAL AND URBAN AREAS

MdM runs two programmes aimed at improving access to rights and healthcare for people living in precarity in rural environments, one has been underway since 2013 in the Combrailles region in central France, and the other since 2016 in the Upper Aude Valley in the south-west of the country.

In the Combrailles region the programme uses health mediation as a means of promoting and facilitating access to rights and healthcare. Mediation provides a bridge between populations having difficulty accessing healthcare

and local medical and social services. In 2020, the programme transferred part of its activities to local health providers and this handover continued in early 2021. This project has now been closed.

In the Upper Aude Valley, MdM helps empower people living in precarity so that they can access health services. The team runs medical and social support clinics which are open to all, as well as outreach activities for those who are most out of touch with the health system. These activities also had to be adapted to the restrictions linked to the Covid crisis.

In urban areas two programmes are led across two sites in northern France.

In the south of Lille the project for access to rights and healthcare in urban areas, launched in 2016, was defined as an experimental operational project. From the design phase the idea was to capitalise on a medico-social method of intervention. Launched in 2020 the capitalisation work on this 4-year project was aimed at outlining the experience gained, the practices used and the know-how collected during the implementation of the project in order to identify the lessons learned. Thus we will be able to repeat certain aspects of this initiative for other MdM projects or transfer parts of it to other stakeholders (institutional partners or other organisations). This capitalisation work was completed in 2021 and an educational guide was created, in several instalments, each with their own documents and tools and providing several links to health mediation information. The project was officially closed in April 2021.

In Lens-Henin the objective of our work is to promote health amongst the residents of 5 local communes. By trying to understand the residents' point of view, by working together to launch actions with active partners and by immediately integrating new partners we have been able to strengthen the relationships and to create new relationships amongst local stakeholders in order to take action for and alongside the local people. MdM's teams help people to build up their individual and collective capacities for action by sharing our knowledge and practices on the topic of health prevention initiatives.

## FIVE PROGRAMMES IN OVERSEAS DEPARTMENTS/REGIONS

In the Indian Ocean region MdM has a presence in Mayotte and on Reunion Island.

On Reunion Island, the team launched an exploratory mission in May 2020 to determine the impact of poor housing on health. The results outlined that vulnerable people living in poor housing or who were geographically isolated have worse health than the rest of the population. This was due to a lack of use of healthcare services and due to living conditions and or environments.

Based on these results the MdM team on Reunion Island launched a project in November 2021. The objective of this project is to promote the use of healthcare services and to enrol isolated and poorly-housed persons living in the south and west of the island in the public health system.



This will be achieved thanks to the use of health mediation approaches which are adapted to the local area and to the needs of these populations. The project is aimed at promoting interactions between the health sector (which replicates the model used in mainland France) and the diverse population of Reunion Island.

In Mayotte in a context of an increasing number of decrees to evacuate and demolish slums MdM continued its advocacy work in order to push for rehousing solutions which are adapted to these people's needs and to clear the insalubrious housing. In December 2021, whilst the Prefect of Mayotte was getting ready to execute his 12th decree to evacuate and demolish a slum the local people, supported by several organisations, including MdM, fought against this decree in court. The judge ordered that the evacuation and demolition be suspended.

The activities linked to the second wave of Covid-19 continued in 2021 with information and awareness raising work done during the team's rounds. Vaccines were also administered using permanent and mobile units - between February and July 2021, 949 people were vaccinated against Covid-19.

In French Guiana, 2021 was marked by an ongoing crisis with the arrival of asylum seekers and social tensions on the topic of migrations. Also, due to the continued impact of the Covid-19 crisis the MdM team provided - in addition to its health mediation work - an emergency response thanks to the launch of mobile health units and teams doing the rounds in areas of informal housing providing information on preventative measures.

# SUMMARY

## THE PEOPLE MDM MEETS AT ITS CASO CENTRES

Health inequalities affect the entire population, across the social gradient. Socio-environmental and economic aspects also have an influence on inequalities. The cumulative effect of these obstacles worsens the physical and moral well-being of the populations.

**In 2021 15,355 people were welcomed into Mdm's CASO centres.** In over 75% of cases the people were coming to the CASOs for the first time for health needs whilst more than 2 in 5 people came to Mdm for social, legal or administrative support.

Just under 70% of the people we met were male. The population was quite young (51% of them were aged 18-34) and the overwhelming majority were foreign nationals (97%). The people who came to the CASO centres were from a wide variety of countries, our teams met people from 134 different nationalities. The people hosted were mainly from sub-Saharan Africa (41%), from North Africa (just under 30%) and from the EU (10%).

In 2020 the Covid crisis had a major impact on the quality of life of the most vulnerable (98% of the people who came to the CASO centres declared that they were living below the poverty line). In 2021 the financial resources available to these people were, again, practically non-existent and just under 96% of them were living under the monetary poverty threshold<sup>1</sup>. 43% of these people had no financial resources available to them at all.

**Just over 53% of the people who came into the CASO centres had an irregular immigration status.** Just under 70% of these people were provided with accommodation. GPs outlined that **just under 52% of these people with irregular immigration statuses should have been given care earlier and that 40% required urgent or quite urgent care.**

**Asylum seekers represented over 12% of the total people welcomed to the CASO centres.** Due to the return to power of the Taliban in Kabul in 2021 the number of Afghan asylum seekers tripled. Afghans, Nigerians and Guineans were the most widely represented nationalities. According to the law people should be provided with certain conditions whilst their asylum requests are being processed. And yet the situation of the asylum seekers that we see in the CASO centres shows how difficult it is for these people to find dignified housing

given that 2 out of every 5 people are homeless. **GPs outlined that 48% of these asylum seekers should have been given care earlier and that over 46% of them required urgent or quite urgent care.**

The proportion of minors present in the CASO centres had decreased prior to 2020 but the figures remained stable in 2021. The Mdm teams welcomed 1,340 minors (representing almost 9% of the total number of people seen), including 332 **unaccompanied minors (representing 38% of the total number of minors). Unaccompanied minors aged between 6 and 15 years of age rarely had access to education (81% of them were not in school). GPs outlined that over half of these unaccompanied minors (51%) should have been given care earlier and that over 59% of them required urgent or quite urgent care.**

**In 2021 only 8% of the people we met at the CASO centres had individual housing. Almost 3 out of 10 people were living in highly precarious conditions:** in slums, squats, on the streets or in emergency, short-term accommodation. Poor housing has significant consequences on health and access to care for these people. It makes it difficult for people to be able to declare an official address, it hinders access to rights, it creates breakdowns in the continuity of care and it also makes it difficult for people to look after themselves and to implement preventative behaviours.

In 2020 43,000 accommodation spots were opened up. The same number of places will be provided again in 2021 following requests made by several organisations. And yet several needs are still unmet notably because the treatment pathways are often interrupted and inadequate: a lack of care at the required times and a lack of medical and social follow-up provided after a visit to a health structure.

The perspectives for housing moving forward are not very encouraging: the government is planning on deleting 14,000 of the existing accommodation spots in late 2023. As regards the clearance of slums, the existence of a national framework represents significant progress but when such frameworks are non-binding and do not cover all of the people and all of the regions concerned they are insufficient. This framework also needs sufficient budget in order to be truly effective.

<sup>1</sup> An index led by Insee which is set at 60% of the median level of resources

MdM is fighting for:

- A ban on evictions whenever there is no adapted, long-term solution for rehousing.
- A guarantee of access to dignified housing, to dignified living conditions and to support which is adapted to different people's lives and backgrounds.
- The implementation of a binding legal framework on the topic of the clearance of informal housing, an increase of the budget for these initiatives, a widening of the non-European groups covered and working on this topic in France's overseas departments and regions.

## HEALTH PROBLEMS RELATED TO THE LIVING AND WELCOME CONDITIONS IN FRANCE

### PRECARIOUS SITUATIONS HAVING A NEGATIVE IMPACT ON HEALTH

In 2021 13,345 GP appointments were held with 9,090 patients, giving us an average of 1.5 appointments per patient. During these appointments digestive issues were diagnosed for over 1 in 5 patients (23%), osteoarticular issues were diagnosed for just under 21% of patients, dermatological issues for 15%, respiratory issues for just under 15%, and psychological issues for 9% of patients.

According to our doctors **at least 85% of the patients they saw during appointments in 2021 required follow-up or treatment for at least one pathology.** Almost half of these people were not being given care or follow-up before they came to the CASO centres.

According to our doctors **over half of the people they saw during appointments in the CASO centres should have been given care earlier and 44% of them required urgent or quite urgent care.**

Almost 6 out of 10 patients (56%) were suffering from chronic diseases, according to our doctors. Precarious living conditions help such chronic diseases to emerge and to become more severe. An even more worrying figure was that **almost 2 out of 5 of these chronic diseases which required follow-up or treatment had not been given follow-up before the appointment** in the CASO centres. Of the people with chronic diseases welcomed to these centres in 2021, 67% should have been given care earlier and 56% of these people required urgent or quite urgent care.

People in vulnerable situations are notably exposed to environments which can lead to health problems and their health status can, in turn, have an impact on their means of subsistence. Furthermore, the living conditions they face can also lead them to prioritising other needs over health-related needs. These people are, therefore, more exposed to difficulties in access to healthcare and in exercising their

right to health. Public policies can either reduce or heighten these inequalities in living conditions and in access to health and healthcare.

The teams at MdM meet adults, children and teenagers who are poor, lost and who have been shaken by their journeys in life, by their migration routes and by the conditions of welcome here in France. In 2021 psychological and psychiatric disorders were identified amongst 9% of patients seen by our GPs<sup>2</sup>. Patients showed signs of anxiety disorders and depression in addition to other social stresses (due to their immigration status, their precarious economic situations, their housing situations, etc). Whether these people have health insurance or not their **severe psychosocial distress must be treated by professionals** during GP appointments or via psychosocial, psychological or psychiatric support initiatives.

- Unstable housing, physical and psychological violence, complex immigration situations and the lack of visibility of people in vulnerable situations can lead to the emergence of physical disorders, psychosomatic disorders and even psychiatric pathologies. These situations tend to be due to multiple factors and they heighten the vulnerability of these groups and have a negative impact on their health.
- Preventative measures and a continuous provision of care are urgently required for populations living in precarious situations.

### COVID PREVENTION AND VACCINATION: CHAPTER 2

For the second year in a row in 2021 the world struggled with the impact of the Covid-19 pandemic. **Social distancing, testing, quarantine for people who had symptoms, self-isolation for those who tested positive and being fully vaccinated were, once again, key preventative measures which helped to limit the spread of the virus. And yet these measures were not accessible to all in the same way.**

The requirement of a health pass in hospitals and for medical appointments had a very negative impact on MdM's patients. **Access to this pass was difficult or even impossible for people living in highly vulnerable situations. The cumulative effect of medical comorbidities and social vulnerabilities meant that things could get very difficult for these people if they caught the virus, notably for those who suffer from chronic diseases and who do not have regular access to healthcare.**

The overwhelming majority of the people that the MdM teams meet live in very difficult living conditions. Organisations and grassroots stakeholders have been sounding the alarm bell for many years on the effects a person's environment can have on their health. Access to safe drinking water, sanitation, waste management and good hygiene conditions are essential in order to protect health during periods of epidemics such as

<sup>2</sup> This figure is likely underestimated because these patients only go to 1.5 appointments with our GPs on average and it is difficult to identify such disorders at just one appointment.

Covid-19. Furthermore, precarious living conditions are also quite incompatible with preventative measures, treatment and continuity of care. **Preventative measures and screening are essential when working with people living in precarious housing conditions. Such people require special attention.**

Access to Covid vaccines became a source of tension due to the need to get vaccinated quickly. The obstacles to Covid vaccination were the same as for access to primary health-care: **language barriers, trust issues, a feeling of not needing the vaccines or a feeling of not having a right to these vaccines.** In order to strengthen the vaccination drive among our target populations the MdM teams adopted several different strategies: guiding people towards mainstream vaccination centres, working to solve administrative issues, vaccinating people in the CASO centres and vaccinating people elsewhere.

**The launch of vaccination for unaccompanied minors in June 2021 was complicated and confusing,** notably in terms of understanding the conditions required to access different health services. The lack of vaccination and the impossibility to get a health pass made it even more difficult for these unaccompanied minors to access mainstream health structures. Once again the lack of recognition provided to these young people left them isolated and without protection.

The first Covid-19 vaccines were given emergency approval in December 2020. The spread of the virus meant that it was necessary for vaccines and key products to be made available to all, equally, no matter a person's country of residence or their economic or administrative situation. In 2021 MdM led, alongside various French and international organisations, advocacy initiatives for effective access to the new health technologies developed in response to the Covid-19 pandemic. **In a context of mass public investment into the development and launch of vaccines, the main messages we sent out highlighted the need for States to limit abuses by pharmaceutical companies who were monopolising the market, instead promoting cooperation in order to ensure that intellectual property rights, vaccines and anti-pandemic treatment is, truly, a global common good that is accessible to all.**

#### RECOMMENDATIONS

The Covid-19 pandemic once again highlighted the importance of identifying people who are excluded from the mainstream system and of adapting prevention, information and vaccination programmes to their needs, no matter the communicable disease in question. MdM recommends that:

- Information campaigns should be clear, accessible and personalised. They should be co-produced and passed on by reliable sources within the communities of vulnerable, marginalised people.
- Young people who say they are minors should be given equal access to care, no matter their official status (whether or not they have been recognised as minors).
- Public health strategies should not be used as a means to hinder freedom of movement.

#### SEXUAL AND REPRODUCTIVE HEALTH RIGHTS (SRHR): PRECARIETY HAS A SERIOUS IMPACT

SRHR means that throughout life all people - no matter their sex, gender, sexual orientation or living conditions - should **have access to all essential information, prevention and treatment services in order to be able to enjoy and understand their sexuality, to be given support for the choices they take and to have their needs met.**

In 2021 9,221 patients, 60.1% of the total number of active patients at the CASO centres, discussed SRHR with our staff during at least one of the appointments they attended.

**In 2021 the majority of people we asked - due to the fact that they were distant from prevention and care services - did not know their status for various diseases when they first came to the CASO centres: almost 75% were unaware of their HIV status, almost 83% for hepatitis B and almost 78% for hepatitis C.** This lack of knowledge of their status was influenced by different variables - it was higher amongst foreign nationals, amongst people aged 29 and under as well as amongst people who had been in France for less than a year.

2,869 women took appointments with a GP, the average number of appointments per woman was 1.5. During appointments at the CASO centres a third of women aged 15 to 49 and who were impacted by contraception talked to our doctors about this topic. **9 out of 10 of these women stated that they did not use contraception.** There is, therefore, a high risk of unplanned and unwanted pregnancies amongst these women.

Cervical cancer can be avoided thanks to HPV vaccination and a pap test. The French health authority recommends performing this test once every 3 years but over 80% of the women we met in the CASO centres in 2021 had never had a smear test before or were unsure whether they had ever had one or not. There are several factors which hinder access to such testing, including access to health insurance. Amongst the women who did have health insurance almost 39% of them had had a smear test before whilst amongst those who did not have insurance the figure was just over 15%.

**In 2021 33% of pregnant women were behind in terms of prenatal care and 58% of the pregnant women seen by our GPs required urgent or quite urgent care.** Furthermore, many of these pregnant women were living in unstable conditions and over 23% of them were homeless. Pregnant women and new mothers who live in unstable, undignified, informal and insalubrious housing will be affected by these conditions, it will have an impact on their health, on their pregnancy and on their perception of the role of their entourage during the pregnancy and during the postpartum period. **Mental health, food insecurity, physical suffering and fatigue, complications during pregnancy, the risk of infection and a worsening of pre-existing chronic diseases are amongst the factors which are linked to the living conditions these women face.**

In addition to the terrible conditions is the issue of a lack of health insurance - almost **94% of the pregnant women we met in the CASO centres in 2021 did not have health insurance.**

In order to guarantee fair and effective SRHR for all, including for people who do not have health insurance, MdM recommends:

- Developing various scenarios for simplified screening and treatment for STIs and for genital cancers.
- Widening the offer of free screening without prescription in laboratories to cover all STIs.
- Guaranteeing free and effective access to all forms of contraception to provide people with a free choice which they can base on the knowledge that they have acquired.
- Providing better, more adapted support for vulnerable pregnant women and for new mothers in order to reduce the risks related to pathological pregnancies.
- Adding the right to abortion and to SRHR to the French Constitution.

## LACK OF ACCESS TO THE MAINSTREAM SYSTEM AND RESORTING TO MECHANISMS WHICH ARE FOCUSED ON PEOPLE IN VULNERABLE SITUATIONS

### NO HEALTH WITHOUT RIGHTS

State medical assistance (AME), universal health protection (PUMa), the solidarity health scheme (C2S)... there are many options for health insurance but understanding the criteria to be eligible for them is difficult, especially when you are not used to the French system. Different departments share the responsibility for sharing information and managing these schemes. Furthermore, the **right to healthcare, a key stepping stone to accessing the system, is not widely understood by people who have this right, both amongst the general public and amongst vulnerable groups. These rules surrounding the right to healthcare are often complex and end up closing the door in the face of those who they would like to welcome inside.**

**In fact, in 2021 during the welcome interviews we identified that over three quarters of the people seen at the CASO centres were eligible for health insurance but 81% of them did not have it.** Amongst those eligible for state medical assistance 82% did not have health insurance in France. Amongst asylum seekers almost 77% were eligible for health insurance but almost 70% of them did not have it. Of all the people we met at the CASO centres almost 28% outlined a need for an official address during their first visit (without an address you cannot be granted coverage).

A reform in 2019 brought in several new restrictive measures which hindered access to health rights. In June 2021 a 3-month waiting period was implemented before a first request for state medical assistance can be made by people with irregular immigration statuses. Furthermore, people now have to drop off their first state medical assistance request in person after having booked an appointment

over the phone. When you realise how busy the phone lines are, when you notice the lack of training given to the staff, the isolation from the structures, the difficulties in accessing interpreters, the fear these people face when having to travel and their lack of knowledge about their rights, you soon realise just how grotesque the situation is. **Another obstacle in access to health rights is administrative issues (not having access to required documents, the complexity of the admin required, a lack of proof of the date of arrival in France, etc.) and this was something which 36% of our patients in the CASO centres were struggling with.**

The digitalisation of admin tasks is an obstacle which many population groups, including the people we meet in the CASO centres, find it difficult to overcome. They find themselves forced to seek help from social workers, meaning that they lose their independence, become distanced from the mainstream system and have to resort to using special structures and systems for people in vulnerable situations.

Allegations of suspicion and fraud were amplified by the 2019 reform, leading to increasingly rigid and heterogeneous practices in the processing of state medical assistance requests. **Whenever a document is refused it takes several extra weeks or months for the request to be processed, for the insurance to kick in and for the medical assistance card to be sent to the person. Meanwhile people wait, avoiding visits to the doctor or to the hospital out of fear of receiving a hefty bill.**

**Instead of allowing these people to use mainstream health services they have to resort to using mechanisms for people in vulnerable situations, making it more difficult for them to have continuity and coordination in their health pathways in the long term.**

In order to guarantee equal access to the public system and to fight against non-use of health services MdM recommends:

- Developing tools, information campaigns and communication about people's rights and about the health system which are accessible and have been developed by the CNAM in coordination with the users before being adapted to the user's needs and translated into different languages.
- Increasing the resources provided to the CPAM for hosting people. Increasing the number of appointments available and making these appointments longer. Providing training to the staff who are also suffering from the impact of the 2019 reform.
- Guaranteeing access to an official address for all people all across France and providing the same social support no matter the person's immigration status.

MdM demands that:

- The beneficiaries of the state medical assistance scheme be brought into the general health insurance scheme in order to provide truly universal health insurance all throughout France, including in the overseas departments and regions.
- Without truly universal health insurance we should at least bring an end to the waiting period before asylum seekers can have health insurance as well as an end to all the restrictive measures implemented in 2019 (having to drop off the first request for state medical assistance in person, the 3-month waiting period, the 9-month waiting period before having access to the full range of care, and coverage being provided for just 6 months instead of 12 months).
- Providing insurance to all people who claim to be unaccompanied minors from the emergency temporary welcome phase. This insurance should then be maintained throughout the process of the person being recognised as a minor and until the final legal decision has been taken, thus applying the principles of the best interests of the child and of the presumption of minority.

### NO HEALTH WITHOUT ACCESS TO CARE IN THE MAINSTREAM HEALTH SYSTEM

In addition to the obstacles to rights and healthcare mentioned above, the language barrier remains significant given that almost 22% of the people we see in the CASO centres mention this issue, including almost 35% of asylum seekers. **Both the scientific documentation and the opinions of people working in the field outline that the quality of interpretation has an impact on the quality of the care provided (leading to delayed or incorrect diagnoses and having an impact on the relationship between the patients and the healthcare staff).** In 2021 interpreters were present at almost 81% of the appointments and interviews held in the CASO centres. There are various options for providing interpretation in the health system but they are limited to certain structures and certain population groups. These limits create inequality in terms of access to healthcare for vulnerable, non French-speaking groups and push these patients towards special structures for vulnerable populations, making it more difficult for them to have continuity and coordination in their health pathways in the long term.

MdM demands that the necessary resources be made available throughout France in order to implement a system for providing professional interpreters for appointments both with local health professionals and at hospitals

Due to the degradation of the health system, people in vulnerable situations are faced with extra obstacles in access to healthcare and prevention. Public hospitals, which were already "in a crisis situation" prior to 2020, were heavily impacted by the Covid pandemic. And since, for different reasons, the same policies are still being implemented - grouping hospitals together, funding via a pricing system per activity, getting rid of hospital beds, etc.

A&E, both before Covid and even more so now, is saturated and struggling (a lack of emergency doctors on the front line and then a lack of beds further down the line to be able to keep these patients in our hospitals). The price of emergency care may heighten inequalities by affecting patients who have no or limited health coverage and who are already isolated from the healthcare system.

Just like our hospitals the PASS schemes have also been affected by staff departures and a lack of social and medical staff. Despite the commitment of many healthcare professionals the waiting time to get an appointment may well double. **The number of active patients is increasing, a consequence of the loss of health coverage for many vulnerable foreign nationals who are now unable to pay for healthcare.** The MdM teams have outlined that in the 12 months before the first visit to the CASO centres 13% of people declared that they had to refuse care, and for 83.1% of these people they did so for financial reasons. Because they are unable to pay for care they either refuse to go back to hospital or they delay their care and, of course, this has a negative impact on their health.

Some of the PASS schemes welcome mainly people with highly complex medical and social situations whereas other people who have no health coverage can only turn to the few rare health structures that are free of charge, such as MdM. Some of the PASS schemes have not yet relaunched the walk-in service. Patients must, therefore, get an appointment and this is not easy - you can wait a long time with no guarantee of success either in person or over the phone and once they do speak to someone these people are then often confronted with a language barrier. Some people are directed towards MdM to get an appointment more easily. **Vulnerable people then struggle to be re-integrated into the mainstream health system.**

**A lack of political will to promote access to healthcare and a continuity of care for all people in France, no matter their status, gender or economic situation, leads to people having to give up on care and delays in care which will have a significant human and economic cost further down the line.**

In 2021 there were significant changes made to the health systems for vulnerable people and to the framework which governs these systems. These changes were quickly adopted following the Covid crisis. **The measures and funding under the Health Ségur system help to strengthen the existing system and to create new systems, notably new outreach structures.** The mobile health teams for vulnerable people were recognised during these changes and several organisations have welcomed this recognition. **But outreach should also be about bringing people back into the picture.** These systems should not be there to paper over the cracks of the public health system or to replace it in any way. **The medical, psychological and social network that we direct people towards needs to be in good health in order to be able to properly welcome its patients.**

Another measure under the Ségur system is **the promotion of health mediation in medico-social services.** This practice includes the possibility of outreach work and support, it encourages capacity building for the target populations and it is a great example of democracy in the health system.

MdM must, however, sound the alert and outline the limits of this institutionalisation of health mediation in the absence of proper recognition of the role of mediators (who must be trained, paid, given support, governed by an ethical charter, etc.). **Furthermore, mediators cannot make up for the failures due to a lack of resources and/or due to poor strategic choices for our public health system.** Mediators alone cannot solve all of the obstacles faced by people in vulnerable situations: a lack of care, terrible living conditions, discrimination, various forms of violence, poor housing, etc. Recommendations

RECOMMENDATIONS

MdMs demands that:

- **The public structures for healthcare and prevention are provided with the needs required to function correctly and to meet the populations' health needs.**
- **Funding for the PASS schemes should be tailored to the needs in the different regions of France. Funding for the PASS schemes should enable access to healthcare - appointments, technical facilities and treatment - for all vulnerable groups no matter their immigration status, in accordance with a hospital's duty to serve the public interest.**

# MÉDECINS DU MONDE

The French Operations Directorate and the Health and Advocacy Directorate –  
Observatory Report on Access to Rights and Healthcare  
84 avenue du Président Wilson  
93210 La Plaine-Saint-Denis  
Phone: +33 1 44 92 15 15  
pole-ope.dof@medecinsdumonde.net  
et PoleRechercheApprentissages@medecinsdumonde.net  
www.medecinsdumonde.org

**Graphic Design:**

CommeQuoi ? [www.comme-quoi.fr](http://www.comme-quoi.fr)

**Coordination**

Valérie Brunel

**Translation:**

Michael Walne

**Photo :**

Thomas Flamerion

**With support from the French Department of Health (DGS) and from the  
Inter-Ministerial Delegation on Accommodation and Access to Housing  
(DIHAL)**

**IN COLLABORATION WITH**



**ALSO TREATING  
INJUSTICE**