OBSERVATORY REPORT ON ACCESS TO RIGHTS AND HEALTHCARE

ON MÉDECINS DU MONDE'S PROGRAMMES IN FRANCE

SUMMARY 2020

LIVING IN PRECARITY DURING THE COVID-19 PANDEMIC

EDITORIAL

The COVID-19 pandemic that spread throughout the world in 2020 has forced us to see health as a common and essential good. In France, the rapid propagation of the virus revealed the limitations of the country's health system and the shortcomings of its public health policies. As for individual people, they were obliged to come to terms with their own vulnerability to the disease, borne out by the lockdowns and restrictions on our freedom.

Yet, although this pandemic has affected all of us wherever we are, it has not had the same impact on everyone. Indeed, after a brief period of stupefaction, Médecins du Monde (MdM) quickly realised that the consequences of the crisis would weigh heaviest on the daily lives and health of those already marginalised and fragile.

As early as March, our teams in France began adapting their reception and outreach activities to take account of the constraints imposed by COVID-19. The challenge was to maintain the strongest links possible with the populations most excluded from rights and healthcare. Through our presence on the ground, we also sought to participate in the collective response to the pandemic whilst constantly reminding institutions and political leaders of their responsibilities towards those in the direst situations.

Based on our experience, and without claiming to have a global vision of the epidemic's impact in France or revisiting all the weaknesses in its management (mask policies, contradictory discourse, etc.), we felt it was important to bear witness to and put into perspective the difficulties experienced by people living in precarity in accessing healthcare and rights.

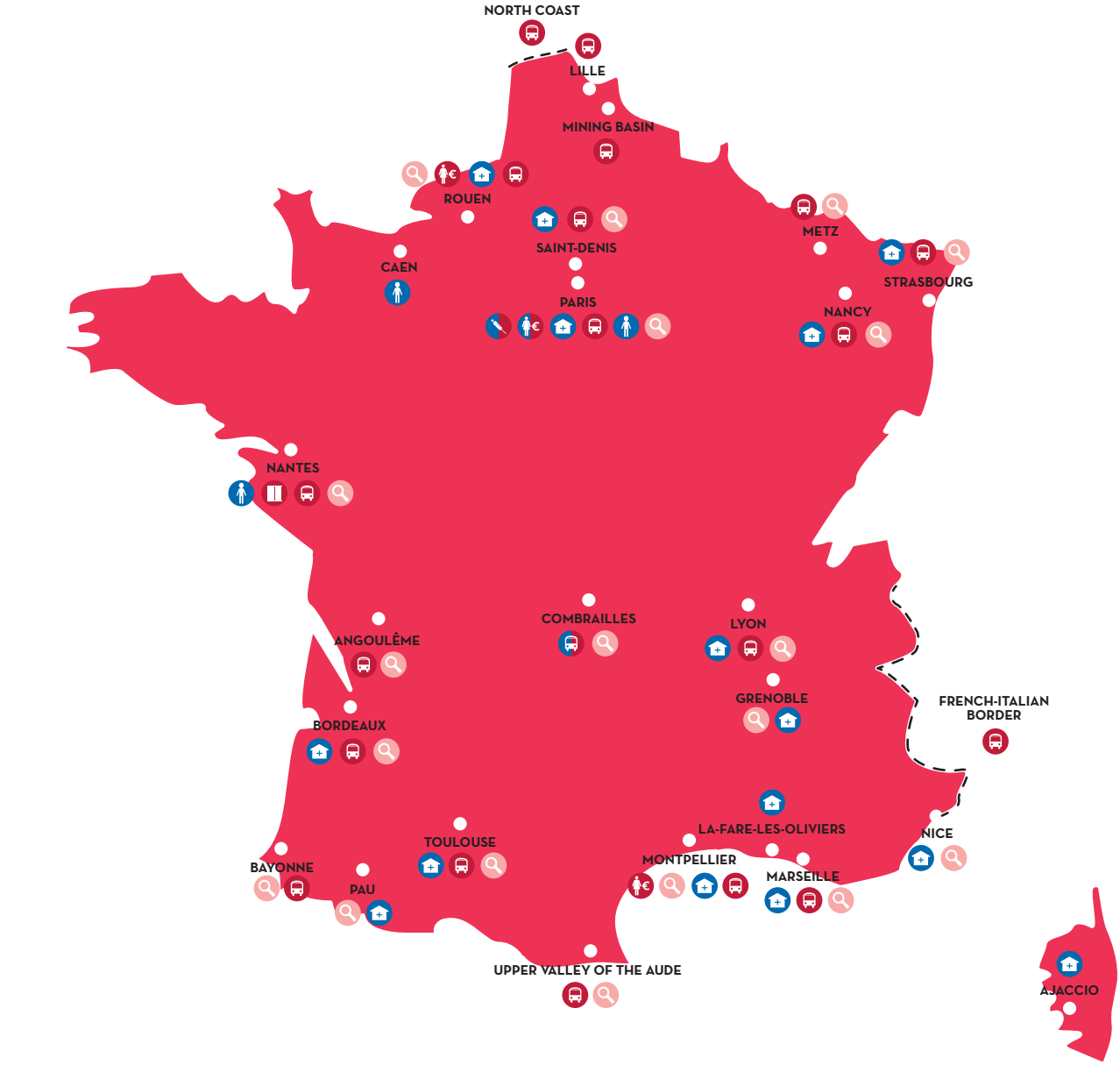
This Observatory report on access to rights and healthcare focus specifically on analysing the first year of the health crisis. It provides an objective and balanced account of our findings on the ground. It describes the consequences of the epidemic on the health of populations living in precarity and shows how access to decent living and hygiene conditions are vital elements of the COVID-19 response. It also illustrates the importance of having appropriate prevention strategies incorporated into curative healthcare and of developing outreach and health mediation for people cut off from the healthcare system – as well as the issue of working hand in hand with them.

It further shows how the public authorities have been able to provide temporary solutions for combatting the virus by increasing the availability of accommodation, reducing prison overcrowding, providing access to water in squats and slums in certain areas, putting mobile health teams in place and adopting measures that facilitate access to rights and healthcare for people living in precarity.

This health crisis is not over yet and it is too early to say what its longer-term consequences will be. But some things are already clear: it is the responsibility of the state to ensure access to healthcare for everyone living within its borders through the organisation of a qualitative, inclusive and supportive health system.

The health crisis has been a powerful reminder of the fact that health is a collective issue. We must waste no time in drawing the necessary conclusions, make permanent the measures and systems that have proved their worth with people living in precarity and place these people at the heart of public health considerations and actions. Not doing so will make us more vulnerable to future crises that could prove even more destructive.

Yannick Le Bihan
Director of French Programmes
Médecins du Monde
June 2021



REUNION

MAYOTTE

FRENCH GUIANA

- Actions in rural environments, on the street or in slums and with migrants
- Healthcare, Advice and Referral Centres (CASO)
- Actions with sex workerst
- Actions with people who use drugs
- Actions with incarcerated people
- Actions with non-French unaccompanied minors
- SRHR prevention

Outreach actions | Actions in MdM medical centres | Cross-cutting programmes

COVID-19: KEY FIGURES FROM MDM'S ACTIVITIES CONDUCTED IN 2020 WITH PEOPLE LIVING IN PRECARITY[1]

CLINIC-BASED ACTIVITY[2]

NUMBER OF HEALTHCARE, ADVICE AND REFERRAL CLINICS (CASOS):

14

PEOPLE ATTENDING THESE CLINICS:

14 348

NUMBER OF CONSULTATIONS (general and specialist medical consultations, dental, paramedical and prevention consultations, social support interviews and physical accompaniment, etc.):

30 635

HELPLINES SET UP DURING THE SUSPENSION OR ADAPTATION OF CLINIC'S ACTIVITIES

AROUND:

1,950 medical sessions

1,700 social support sessions

280 psychological/ psychiatric sessions

1,100 other activities (legal advice, referrals/ information, domiciliation, etc.)

REORIENTATION OF CLINIC-BASED ACTIVITIES TO OUTREACH ACTIVITIES

AROUND:

20 OR SO OUTREACH ACTIVITY SITES (MAINLY SLUMS, CAMPS AND ACCOMMODATION CENTRES)

95 VISITS/OUTREACH PATROLS

450 CONTACTS

300 MEDICAL OR PARAMEDICAL CONSULTATIONS

285 OTHERS (DISTRIBUTION OF COVID-19 HYGIENE KITS, ETC.)

(1) Data provided by MdM's French programmes between March and December 2020 (non-exhaustive). Data collection periods can vary according to activities and programmes. MdM's teams were reorganised to support the different intervention modalities co-existing in any one region.

(2) Data collected from the electronic patient records kept by the 14 clinics.

OUTREACH ACTIVITIES

HELPLINES DURING ADAPTATION OF PROGRAMMES' OUTREACH ACTIVITIES

AROUND:

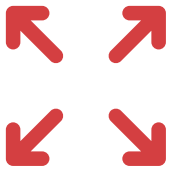
480 medical/social support sessions

70 psychological/psychiatric sessions

720 other activities (mediation, prevention, referrals/information, etc.)

REGULAR MDM ACTIVITIES MAINTAINED WITH ADAPTATIONS

AROUND:



190 OUTREACH ACTIVITY SITES (SLUMS/CAMPS, SQUATS, HOTEL/PSYCHIATRIC HOSPITALS, HOME VISITS, ACCOMMODATION CENTRES/RESIDENCES, PRISONS, WITH PEOPLE SLEEPING ROUGH AND SEX WORKERS)

1,900 VISITS/OUTREACH PATROLS

29,720 CONTACTS

7,700 MEDICAL OR PARAMEDICAL CONSULTATIONS

3,310 OTHER ACTIVITIES (PREVENTION/TRAINING/AWARENESS-RAISING, WELFARE FOLLOW-UP, HEALTH MEDIATION, DISTRIBUTION OF HEALTH KITS, ETC.)

UNACCOMPANIED MINORS PROGRAMME

AROUND:

1,850 MEDICAL, PARAMEDICAL, SOCIAL WELFARE, SOCIO-LEGAL, HEALTHCARE PATHWAY AND PSYCHOSOCIAL SUPPORT HELPLINE SESSIONS

830 PSYCHOLOGICAL/ PSYCHIATRIC HELPLINE SESSIONS

COVID-SPECIFIC ACTIVITIES

MDM'S PARTICIPATION IN AND/OR COORDINATION OF NATIONAL COVID MEASURES, SUCH AS MOBILE HEALTH TEAMS FORMED BY THE REGIONAL HEALTH AGENCIES AND MADE UP OF DOCTORS, NURSES, HEALTH MEDIATORS AND, WHEN NECESSARY, PROFESSIONAL INTERPRETERS.

AROUND:

270 ACTIVITY SITES

1,290 VISITS/OUTREACH PATROLS

11,750 CONTACTS

3,900 MEDICAL OR PARAMEDICAL CONSULTATIONS

1,180 OTHER ACTIVITIES (SOCIAL FOLLOW-UP, COVID-19 PREVENTION INTERVIEWS, ETC.)

TESTING OPERATIONS

NUMBER OF TESTING OPERATIONS:

41

INCLUDING 38 WITH A PARTNER

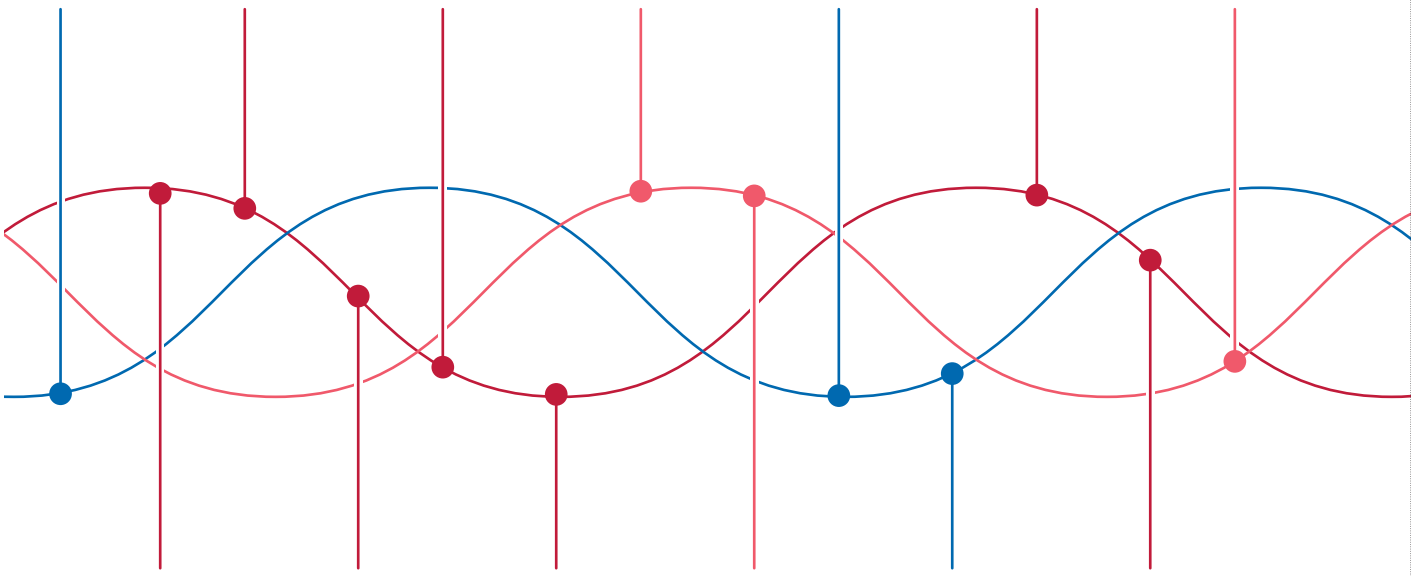
TOTAL NUMBER OF PERSONS TESTED:

1,546

TOTAL NUMBER OF COVID-19 CASES:

372

2020
HIGHLIGHTS



28 DECEMBER 2019
Adoption of reform on the health rights of foreign nationals

30 JANUARY 2020
Epidemic declared a public health emergency by WHO

29 FEBRUARY 2020
Orsan plan stage 2

17 MARCH 2020
National lockdown
Closure of borders in the Schengen zone

25 MARCH 2020
Executive orders organising the extension of social rights and residence documents

MARCH 2020
First COVID-19 cases in Guyana, Mayotte and Reunion Island

11 MAY 2020
Gradual end to lockdown with "increased vigilance" in Mayotte and Guyana

3 JANUARY 2020
First three official cases of COVID-19

23 FEBRUARY 2020
Orsan plan* stage 1

14 MARCH 2020
Orsan plan stage 3

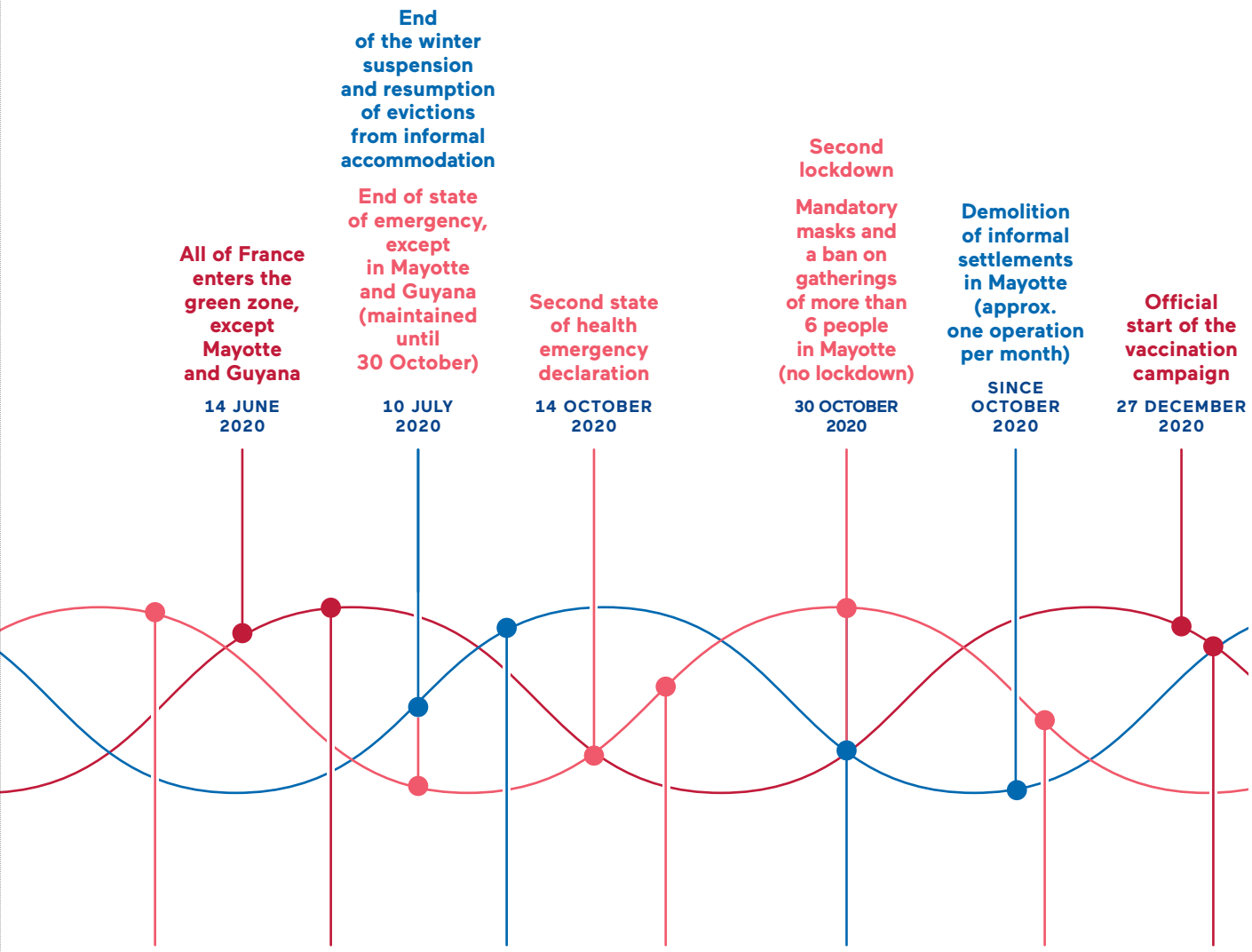
24 MARCH 2020
Entry into force of the state of health emergency

27 MARCH 2020
Instructions to prefects on care and support for vulnerable populations in the context of the COVID-19 epidemic

10 MAY 2020
Almost half of the COVID-19 cases in overseas departments concentrated in Mayotte

- STATE OF HEALTH
- INDIVIDUAL FREEDOMS
- ACCESS TO RIGHTS AND HEALTHCARE

(*) This plan for organising the health system in an exceptional health situation is drawn up by the regional health agencies and made available to prefects. Its purpose is to adapt patients' care pathways and determine the measures necessary for the health system to adapt when an event occurs. In particular, it is based on the mobilisation of health establishments, which can activate their emergency management plan.



10 JUNE 2020

Restrictions with curfew and targeted territorial lockdown in Guyana

14 JUNE 2020

All of France enters the green zone, except Mayotte and Guyana

15 JUNE 2020

Increase in cases of COVID-19, stage 3 of the epidemic in Guyana

10 JULY 2020

End of state of emergency, except in Mayotte and Guyana (maintained until 30 October)

End of the winter suspension and resumption of evictions from informal accommodation

6 AUGUST 2020

Resumption of arrests and deportations from Mayotte to the Comoros, saturation of the Administrative Detention Centre

14 OCTOBER 2020

Second state of health emergency declaration

23 OCTOBER 2020

Introduction of a curfew in 54 departments

30 OCTOBRE 2020

Second lockdown

Mandatory masks and a ban on gatherings of more than 6 people in Mayotte (no lockdown)

Decree on State Medical Aid (AME) implementing the obligation to submit first applications in person to the national social security office (CPAM); introduction of a nine-month waiting period before accessing the full AME care package; reduction of the maintenance of rights to two months for foreigners subject to a *«definitive deportation measure»*

15 DECEMBER 2020

End of second lockdown

SINCE OCTOBER 2020

Demolition of informal settlements in Mayotte (approx. one operation per month)

30 DECEMBER 2020

2,600,498 confirmed COVID-19 cases since January, and 64,078 deaths since 1st March (mainland France and overseas departments)**

27 DECEMBER 2020

Official start of the vaccination campaign

(**) According to Santé Publique France

MÉDECINS DU MONDE'S PROGRAMMES IN FRANCE IN 2020

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 it again 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 30 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 the same or newly-developed programmes offering clinic-based (CASO/CAOA) and outreach activities across the country.

In 2020, MdM France ran 56 programmes on 29 sites in mainland France and in its overseas departments and regions of Reunion, Mayotte and Guyana.

14 CASOS (HEALTHCARE, ADVICE AND REFERRAL CLINICS)[1], INCLUDING ONE CAOA (HEALTHCARE, ADVICE, REFERRAL AND SUPPORT CLINIC) AND 1 HEALTHCARE ACCESS SERVICE (PASS DE VILLE) RUN BY THE CASO IN MARSEILLE

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

CASOs/CAOAs operate as drop-in clinics, offering free consultations without an appointment and without any conditions attached. Patients see different health professionals for a consultation or check-up and are then referred to the appropriate mainstream services as rapidly as possible. They are also empowered to access their rights autonomously. CASOs/CAOAs 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 and because precarious living conditions are particularly harmful to people's mental health, the 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 it over to the city's mainstream services. This pop-up service enables people with no health coverage to receive care without charge. They 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 coverage. In 2020, the CASOs adapted their activities to the different stages in the epidemic and/or introduced outreach activities for people excluded from or out of touch with the healthcare system.

1 CROSSCUTTING PREVENTION PROGRAMME FOCUSING ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR), AND 1 SRHR PROGRAMME IN THE LOIRE REGION (4I PROGRAMME IN FRENCH).[2]

Since 2003, MdM has been running a **crosscutting programme for the prevention of HIV, hepatitis, sexually transmitted infections (STIs) and tuberculosis** focused on strengthening prevention, improving access to testing and facilitating access to healthcare for the programme's beneficiaries. In 2020, MdM adopted the broader definition of sexual and reproductive health and rights proposed by the Guttmacher Lancet Commission[3], which affirms the importance of guaranteeing everyone an autonomous, satisfying and safe sex life, and respect for their rights in this regard. The teams learned more about the gender-based approach to help them more effectively address specific gender-related health issues, **such as screening for gender-based violence. Our programmes also screened for gynaecological cancers, provided information on contraception and monitored pregnancies**. Via a community-based approach involving the people concerned, some missions set up **collective health promotion sessions or actions on selected subjects**. As part of a health promotion approach in the Loire region, a new programme was launched in

(1) To make this report easier to read, the term CASO has been used throughout. However, the data collected concerns the CASO and CAOA in Paris.
(2) Unstable, unhealthy, unfit and/or informal housing includes squats, slums, the street, living in other people's accommodation and emergency accommodation (115 emergency service or emergency accommodation centres).
(3) *« Sexual and reproductive health is a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognise the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing. All individuals have a right to make decisions governing their bodies and to access services that support that right.* » (Report of the Guttmacher-Lancet Commission, Accelerate progress – sexual and reproductive health and rights for all, 2018).

Nantes to strengthen access to and the quality of SRHR services for people living in unstable, unhealthy, unfit and/or informal housing.

4 PROGRAMMES SPECIFICALLY FOCUSED ON MIGRATION, EXILE, RIGHTS AND HEALTH (MERH), AND 1 ADVOCACY PROJECT TO LOBBY THE EUROPEAN INSTITUTIONS IN STRASBOURG

MdM runs **programmes for migrants** on the French-Italian border, in Paris, on the coast between Calais Grande-Synthe and Dunkirk and near Marseille (Fare-les-Oliviers). At the beginning of 2017, a coalition of five associations was created (CAFI[4]) to pool knowledge and tools with a view to strengthening responses to violations of the rights of refugees and migrants at the borders. An advocacy project is underway directed at the European authorities, and more specifically at the Council of Europe in Strasbourg, to promote two priority areas, namely migration and SRHR.

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

On the streets, in homeless shelters or in day centres, MdM's teams offer support with administrative procedures and provide services including health monitoring, medical consultations, psychosocial support and health mediation. These teams also inform and raise the awareness of medical personnel and social workers to the problems caused by insecure or inadequate housing. They explain the effects of homelessness on health and the difficulties encountered by the people concerned in asserting their rights and accessing care. Programmes are also run in **squats and slums** facilitating access to rights and healthcare with the inhabitants and referring them to mainstream health services when necessary. A strong focus is placed on the healthcare needs of women and children. Health mediators are also working with associations and mainstream partners to improve the care management of slum dwellers and empower them to seek healthcare and exercise their rights autonomously. In 2020, several regional offices focused on helping improve the living conditions of people living in squats and slums, as the harmful nature of unfit housing has been exacerbated by the health crisis. Without access to water or decent sanitation conditions, it is difficult for people to respect shielding measures.

5 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 increase people's action capacities and knowledge of harm reduction and sexual and reproductive health (SRH), promote access to mainstream healthcare and rights and (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** (Jasmine programme).

Lastly, MDM continued the gradual transfer of the "XBT" (Xénobiotrope) **programme in 2020**. Created in 1999, the objective of this programme is to develop countrywide a comprehensive drug analysis service as a harm reduction tool. The first regional hubs coordinated by the XBT mission at national level were launched in Île-de-France in 2010. Today, the mission works in collaboration with 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.

The programme was transferred to the Fédération Addiction, the association Charonne-Oppélia, and Sida Paroles at the beginning of 2021.

2 PROGRAMMES WITH PEOPLE 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 is also working in close collaboration with all the ministries concerned to **develop an experimental project in Marseille that offers an alternative to incarceration through housing and intensive follow-up (AILSI). This project, which includes a research component, is also extended to homeless people** with severe psychiatric disorders as alternative to detention.

3 PROGRAMMES WITH UNACCOMPANIED MINORS

In 2015, MdM began running a programme in Paris specifically for unaccompanied minors. In 2016, another two unaccompanied minor programmes were launched in Normandy (Caen/Rouen) and Nantes. In 2020, programmes were maintained in Paris, Caen and Nantes. MdM's teams provide these minors with a safe space where they are listened to, receive healthcare and are helped to obtain recognition of their rights.

3 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 in the Combrailles region in central France, and the other since 2016 in the Haute Vallée de l'Aude in the south-west of the country.

(4) Coordination of Actions at Internal Borders for Migrants, composed of the following associations: Amnesty International France, La Cimade, MSF France, Secours Catholique and MdM France.

In the Combrailles, 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.

In the Haute Vallée de l'Aude, MdM helps empower people living in precarity to access health services. The team runs medical and social support clinics accessible to everyone, as well as outreach activities for the people most out of touch with the health system, all the while adapting them to the health crisis.

In 2015, a programme of access to healthcare and rights in sensitive urban areas was opened in Lille. The programme employs an outreach approach with people who have abandoned their health pathway. This approach includes individual support, working together to overcome the main barriers encountered and mobilising mainstream actors and associations, the aim being to strengthen individual and collective capacities. In 2020, the programme continued its outreach activities, adapting them to the health crisis. In particular, these activities provided social support and medical care designed to maintain contact and continuity, while informing people about the COVID-19 epidemic. The programme was closed in April 2021.

3 PROGRAMMES IN OVERSEAS DEPARTMENTS

MdM runs two programmes in the Indian Ocean, one in Mayotte and the other on Reunion Island.

In Mayotte, the programme works out of a fixed centre and mobile clinics providing medical and nursing consultations and helping people to access their rights. It also carries out preventive health actions in the Kaweni slum, referring people to mainstream services whenever possible. In 2020, in response to the SARS-CoV-2 (COVID-19) pandemic, the team organised rounds in several neighbourhoods and communes of Mayotte to inform about and raise awareness to COVID-19 and carry out tests. Masks were distributed and medical follow-up and advice provided to isolated populations without access to health services.

On Reunion Island, the team launched an exploratory mission in May 2020 to determine the impact of poor housing on health, whilst also introducing COVID prevention and awareness actions.

In French Guiana, MdM's team set up an emergency «COVID-19» project in 2020, involving Mobile Health Teams and the organisation of prevention and information rounds in informal settlements. The team also implemented the Screening, Announcement and Follow-up /Home Visits system for the follow-up and support of people with COVID-19 and their contacts. Another important event on the programme in 2020 was the creation of a team of peer health mediators to work on MdM's activities and those of our operational partners.

SUMMARY

On 31 December 2019, the World Health Organization (WHO) received reports of several cases of pneumonia in the city of Wuhan in China's Hubei province. A week later, on 7 January, Chinese authorities confirmed that they had identified a new coronavirus - a family of viruses that cause the common cold and diseases such as Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS). The sometimes fatal respiratory disease caused by the new SARS-CoV-2 virus[5], named COVID-19, was declared a public health emergency of international concern by the WHO on 30 January 2020.

Since 31 December 2019, there have been nearly 180 million confirmed cases of COVID-19 worldwide, including 5.7 million in France. Almost 4 million deaths from COVID-19 have been recorded in the world, including approximately 111,000 in France[6].

Individual freedoms have been severely restricted in the fight to stop the spread of this virus. France's first lockdown started on 16 March 2020 - stay-at-home orders with authorisation to leave the house for just one hour within a radius of 1 km and with the mandatory certificate, closure of cultural and social venues, etc. - and ended on 11 May 2020 [Légifrance, 2020]. After a period of curfew, the country was locked down for the second time on 30 October until 15 December 2020. A state of health emergency was put in place from 24 March 2020 until 11 July 2020 [Légifrance, 2020]. A second state of health emergency was declared on 14 October 2020 and is still in place at the time of writing. France's overseas territories did not escape the reinforcement of health measures a few weeks after their introduction in mainland France.

RESPONSE TO THE HEALTH CRISIS IN 2020

When France went into lockdown in March 2020, the most excluded members of the country's population were left on the streets or in slums, camps or insecure housing. It was not until the directive of 27 March 2020 was sent to prefects that targeted measures were taken for people living in precarity.

The way the crisis was managed with vulnerable populations varied considerably from place to place and positive results were localised. While outreach and health mediation approaches proved their worth, field teams observed some coordination difficulties and inappropriate responses to people's needs.

The COVID-19 pandemic had a strong impact on solidarity organisations and public bodies supporting people living in precarity in 2020. MdM's teams adapted activities in the healthcare, advice and referral centres (CASOs), setting up telephone helplines and adapting movements and reception and care protocols to the different phases of the epidemic.

But the health crisis caused an exceptionally sharp decline in CASO activity: 14,348 people were seen in 2020 compared to 23,048 in 2019, representing a 38% decrease in the number of patients.

Priority was given to outreach ("aller-vers") activities, including health mediation in order to stay as close as possible to excluded people (rounds and mobile teams in squats and slums) and in contact with the institutions. MdM's teams, who were first-hand witnesses to difficulties in accessing healthcare during the crisis, (re)organised themselves to support the different interventions modalities coexisting in any given region, namely:

- Health mediation activities to support the actions of the Mobile Health Access Units and some hospital teams.
- Outreach activities adapted to the challenges of COVID-19.
- As far as possible and in an appropriate manner, maintaining the continuity of regular activities so as not to neglect other health problems.
- Participation and/or coordination of national measures, such as the mobile health teams formed by the Regional Health Agencies and made up of doctors, nurses, health mediators and, when necessary, professional interpreters.

> **MdM welcomes the recent initiatives taken by the government during the health crisis to strengthen access to healthcare and rights to physical and mental health, as well as its outreach measures to combat inequalities in health and access to healthcare[7].**

(5) *Severe Acute Respiratory Syndrome CoronaVirus 2* (SARS-CoV-2).
(6) *Santé publique France. Coronavirus : chiffres clés et évolution de la COVID-19 en France et dans le Monde* [Internet]. 24 June 2021.
(7) This measure 27 of the *Ségur de la santé*, «Health inequalities», provides additional funding, not all of which is permanent, for the reinforcement of existing services and the creation of new services: LHSS and mobile LHSS (accommodation combined with medical care available for a limited period to homeless/inadequately-housed people), mobile and non-mobile Health Access Units, harm reduction and addiction services (Caarud, Csapa and Elsa), Mobile Psychiatric Teams for people living in precarity, off-site therapeutic coordination flats, mobile health/precarity teams, home nursing services, «participative» health centres and homes.

- However, **organisations and front-line actors should be systematically involved in these initiatives and consulted on their construction** (specifications and implementation) **at local and national level.** Furthermore, it is essential for these measures to become permanent and receive financial support by the state and the Regional Health Agencies.
- MdM is calling for **health mediation to be recognised and supported by public institutions as an essential component of interventions in the field of health and precarity.** The professional skills of health mediators must be recognised at the national level (training leading to qualifications and certification).
- People living in precarity should be **involved in the development, implementation and evaluation of policies that affect them.**

THE IMPACT OF THE HEALTH CRISIS ON PEOPLE LIVING IN PRECARITY

The health crisis and lockdown measures dramatically affected social, individual and economic lives in 2020. Through its work on the ground, MdM witnessed how these measures amplified inequalities and the stigmatisation of certain populations living in precarity.

The **accommodation sector** had been in a particularly poor state for several years when the crisis began. For some time, MdM and its NGO partners have been drawing attention to the state's obligation to provide access to emergency accommodation for all homeless people in distress. These calls seem to have been heard in the first lockdown, as more accommodation places were created and are to be kept open until March 2022. While this large-scale creation of places is to be welcomed, the reception conditions in these facilities have not always been optimal. Moreover, they are always full and it is still difficult to gain access to them today. Lastly, people currently being sheltered must subsequently be given access to permanent accommodation and help with administrative procedures.

The inhabitants of squats and slums have been subjected to a policy of repeated evictions for thirty years. Although MdM's teams can confirm that there were no evictions during the first period of the health crisis, one region remained an exception: Nord-Littoral.

- MdM is calling for an **acceleration in the «housing first» policy** and sufficient resources to ensure integrated support (health, social, etc.) for people in accommodation centres.
- MdM is further calling for a **sufficient number of places in the different types of accommodation facilities to meet the real needs of a given area, regardless of people's administrative status.** All accommodation should also meet the necessary health and safety standards and respect the dignity of the people accommodated (size of individual spaces, movement of persons, sanitation and eating facilities, ventilation of the premises and provision of the necessary protective equipment).
- MdM is continuing its fight for access to decent, stable and appropriate housing for people currently living in slums and squats, and for the effective implementation of the government's slum clearance strategy in accordance with its Instruction of 25 January 2018.
- MdM calls for **health issues to be prioritised** with due respect for individuals and groups, including when an eviction is planned from their living quarters.

The health crisis has significantly worsened the situation of people living below the poverty line. **In 2020, 98.2% of the people seen in the CASOs for the first time declared that they were living below the poverty line, and of these, 48.5% declared that they had no resources.**

Access to food was alarmingly tense in 2020. A large number of actors - volunteers, professionals and citizens' groups - reorganised themselves at the beginning of the crisis to respond to needs as best they could with hot meals, food parcels or service vouchers.

The situation was particularly severe in **French Guiana and Mayotte.** A survey conducted in Guiana in the summer of 2020 found that over 80% of respondents had gone hungry.

The COVID-19 pandemic also highlighted injustices in terms of **access to water and sanitation.** As a result, institutions acknowledged the need, for a time at least, of what had long been demanded by organisations and field operators: basic installations providing free access to water in slums, squats and self-constructed shelters.

Operational solutions that proved successful during the health crisis must be maintained. Access to decent food and clean water in sufficient quantities, waste management and decent hygiene conditions (access to toilets and showers) are essential to protect human health at all times and wherever people live.

ACCESS TO CARE AND PREVENTION FOR PEOPLE LIVING IN PRECARITY

Precarious or crowded living conditions and the presence of chronic diseases aggravated by difficulties in accessing care are all factors increasing vulnerability to the virus and serious forms of the disease. The vast majority of the people seen by MdM live in extremely difficult conditions. They have few or no financial resources and insecure accommodation. **Thus, 91% of the people seen for the first time in the CASOs in 2020 were living in extreme precarity: on the streets, in slums, squats or camps, or in temporary accommodation.**

Teams observed that more than five out of ten people seen in the CASOs in 2020 were suffering from chronic pathologies, raising the question of how to manage their healthcare in a context where most of them have no health coverage. In the current crisis, they are at a greater risk of developing a severe form of COVID-19 due to poor health follow-up, compounded by the presence of one or more comorbidities.

Furthermore, the emphasis given to managing the pandemic within the health system led to delays in seeking care and interruptions to treatments that hit people in administrative or material precarity particularly hard: saturation of emergency services, closure or slow-down of medical and social services (Health Access Units (Pass), free information, screening and diagnosis centres (ceGIDD), Mother and Child protection services, etc.), the development of teleconsultations - a major obstacle for digitally-excluded populations, as well limited movements due to controls or the fear of contracting the virus. **In 2020, MdM's general practitioners estimated that 47.2% of patients seen in the CASOs were behind in their treatment, with this figure reaching 62.9% for patients with at least one chronic disease.** Moreover, in the opinion of the doctors, 82.5% of the patients cared for in the CASOs required follow-up and/or treatment for at least one of their pathologies.

- MdM recommends that decision-makers ensure people living in precarity have **access to protective supplies** (such as masks, soap or hydroalcoholic gel) and COVID-19 tests.
- MdM is calling for **unconditional access to vaccines to be administered via a range of services adapted to people and their living conditions and in agreement with them.** This implies mobile vaccination teams, assistance with making appointments online, by telephone or at the vaccination centre, the systematic provision of professional interpreting services for non-native speakers and a system of vaccino-vigilance for vaccinated people. Conditions must also be in place to obtain people's informed consent prior to vaccination.
- MdM recommends the use of mRNA vaccines for the most stable populations (people who can be reached for a second jab) because of their effectiveness in preventing the transmission of COVID-19.

The crisis and lockdown measures have also increased the anxiety and stress experienced by marginalised populations. For example, the delays in processing applications for health coverage sent before the lockdown, the closure of support structures for obtaining entitlements, and exclusively digital access to rights were all experienced by migrants as forms of administrative or institutional violence. The constant uncertainty in which asylum seekers in particular found themselves was particularly devastating for their mental health in 2020: 13% of them had psychological issues compared to 7% of other foreigners attending the CASOs.

Unaccompanied minors (UAM) have not been spared the consequences of the COVID-19 pandemic. A study carried out in 2020 by MdM's unaccompanied minors programme in Paris showed that 70% of young people expressed feelings of fear or anxiety and 75% had feelings of solitude during the first week of the lockdown. According to psychologists, the lockdown may also have triggered past traumas such as feelings of abandonment.

With regard to the **mental health of unaccompanied minors**, the first priority is to meet the primary needs of all young people who declare themselves to be unaccompanied minors, by guaranteeing:

- Immediate and unconditional provision of shelter to provide them with a period of respite prior to the assessment of their unaccompanied status and age.
- A systematic somatic and psychological health check-up, as well as immediate entitlements to health coverage (and maintenance of entitlements until a definitive judicial decision is made on their admission to child protection services).
- A benevolent and objective assessment[8] of their minority and unaccompanied status: any forensic examination to determine the age of unaccompanied minors should be prohibited.
- The opening of reception centres offering information on rights and a medical and psychological consultation to identify emergency situations.
- The strengthening and adaptation of mainstream mental healthcare services.
- The promotion and funding of professional interpreting as part of mainstream services.

(8) To ensure that a young person presenting him or herself as an unaccompanied minor is covered by the child protection system, departmental services assess his or her situation in order to determine his or her minority and unaccompanied status. Although the law provides for an assessment of the danger faced by the young person, only the assessment of age and unaccompanied status is taken into account.

One of the biggest challenges of the pandemic has been the identification of people with COVID-19 among those most out of touch with the health system and therefore with little or no access to a health professional. To respond to the health crisis in 2020, MdM increased the number of prevention and/or continuity of care interventions in places already known to the organisation and in new sites, such as hostels or emergency accommodation centres. Some of these interventions were incorporated into the mainstream response. Two major measures for people living in precarity were implemented, albeit late in the day, by most of the Regional Health Agencies: **mobile health teams** to identify, assess and refer people with COVID-19 who are living on the streets, in informal settlements or in accommodation centres; and **specialised accommodation centres** for homeless people testing positive to the virus but without complications.

The successive government strategies designed to combat the spread of the virus[9] have run into a number of obstacles hindering the adherence and participation of people living in precarity. In their implementation, and in some areas, they have demonstrated a lack of coherence and anticipation: saturation of testing sites, delays in the delivery of results, mistrust and reluctance on the part of individuals to be tested, under-utilisation of specialised accommodation centres for homeless people testing positive for COVID-19 and, finally, poor integration of general practitioners into the management of the first wave.

ACCESS TO RIGHTS

The first lockdown began just three months after the adoption, at the end of 2019, of a highly regressive reform on the health rights of foreign nationals that introduced, among other things, three-month waiting periods for asylum seekers and people in irregular situations before accessing health coverage. Despite the exceptional context, the government continued to implement this reform in 2020, resulting in an unprecedented loss of access to rights and therefore to healthcare for foreigners in both irregular and regular administrative situations. All these new rules have created a high degree of complexity, not only for the people concerned but also for those helping them with their administrative procedures. **As a reminder, in 2020, 70.1% of the people seen in the CASOs did not have effective health coverage despite being theoretically entitled to it[10] ; and of those theoretically covered by state medical assistance *(AME)*, 81.8% had no health coverage.**

2020 was marked by **three phases (lockdown, a period out of lockdown and a second lockdown), combined with regulations with different orientations in terms of access to rights, not necessarily meeting public health requirements.** Furthermore, although national measures facilitating access to rights were put in place during the initial lockdown, MdM's teams observed unequal information and practices across the country. The results of these measures and their impact on access to rights have been quite contrasting and MdM's teams continued to see difficulties throughout the year (mislaying of health coverage applications submitted before the lockdown, lack of information, difficulties in referring people to mainstream facilities, closure of these facilities or reduced working hours, non-functional email addresses, remote support and an excessive tendency towards dematerialisation). Overall, MdM's teams witnessed greater isolation, greater difficulties in accessing rights and facilities, discouragement and non-use or discontinuation of healthcare and exhaustion.

MdM is demanding:

- **The integration of beneficiaries of state medical assistance *(AME)* into the national social security scheme.**
- Pending this, the repeal of measures concerning AME and more broadly the health rights of foreign nationals adopted in late 2019.
- **The permanence of measures adopted during the health crisis and aimed at facilitating and simplifying people's access to rights** at regulatory or organisational level.
- **Sufficient resources to enable social security offices to properly organise the physical reception** of people submitting their application for entitlements without an appointment, especially in view of the obligation for AME applicants to submit their application to their local office in person, in accordance with the Defender of Rights' recommendations for all public services.
- **Real and total free access[11] to the Social Security telephone line,** 3646, now indispensable for all procedures. Its current cost represents a real barrier to accessing rights for people living in precarity.
- *As a minimum entitlement*, ***a carte vitale*** (card issued by the social security for the reimbursement of doctor or specialist appointments, prescriptions at the pharmacy or hospital visits) **for asylum seekers and AME beneficiaries.**
- **Strengthening of the state's capacity to negotiate fair and transparent drug prices** while ensuring the effective application of the flexibilities provided for in intellectual property law to protect public health, both at the national level (through ex officio licen-

(9) The successive governmental « *test- isolate-trace* » and « *test-alert-protect* » *strategies.*
(10) MdM does not replace mainstream services and when the person has health coverage, MdM refers them to existing mainstream services whenever possible.
(11) Including for calls made using a prepaid telephone card.

sing) and through European and international cooperation.

- **A reform of research and development models to put an end to the abuse of patents and monopolies in the innovation cycle** and better integrate and exploit public research.
- **A reform of the current industrial policy in order to allow the emergence of a new policy based on countries' needs** and the supportability of their public health systems, technology transfer, knowledge-sharing and cooperation between nations.

HEALTH
ABOVE ALL

MÉDECINS DU MONDE:
Direction des Opérations France – Observatoire de l'accès aux droits et aux soins
62 rue Marcadet – 75018 Paris
Tel: 01 44 92 99 92
d-o-f@medecinsdumonde.net
www.medecinsdumonde.org

Graphic design: CommeQuoi?
www.comme-quoi.fr

Coordination and editing
Thomas Flamerion

Cover photo: © Patrick Piro

ISSN: 2425-0945
Legal deposit: September 2021

IN COLLABORATION WITH