National Consultative Ethics Committee for Health and Life Sciences

35, rue Saint-Dominique
75700 Paris
Tél. 01 42 75 66 42
www.ccne-ethique.fr

CCNE's Opinion n° 127
MIGRANTS' HEALTH AND ETHICAL IMPERATIVES

Composition of the Working Group

Christiane BASSET
Carine CAMBY
Jean-Marie DELARUE (rapporteur)
Anne Marie DICKÉLÉ
Pierre-Henri DUÉE
Martine LE FRIANT
Patrick GAUDRAY
Florence GRUAT
Francis PUECH
Bertrand WEIL (rapporteur)

Opinion published on 16 October 2017

Personalities auditioned
Dr Amine Trouve Baghdouche, Doctors of the World (Calaisis and Dunkerquois)
Dr Françoise Fromageot and Mme Stéphanie Giron (French Red Cross)
Dr Marie-Elisabeth Ingres and Dr Frédérique Drogoul (Doctors Without Borders)
Mme Lise Faron (CIMADE) (French NGO for assistance to refugees).
Dr Paul Bouvier, M. Ali Saradi, M. Régis Saviot, Mme Ghislaine Doucet (International Committee of the Red Cross)
Dr Claude Rosenthal, President of Gynaecology Without Borders
Dr Pascal Ravaut (COMEDE) (French NGO addressing the health and rights of exiles)
M. Didier Leschi, préfet, Director General of OFII (French Office of Immigration and Integration) and Dr Thanh Le Luong, Head of OFII's medical department
Prof. Alfred Spira, member of the *Académie de médecine*
M. Samuel Pratmarty, Deputy Director of the department for the regulation of healthcare delivery), (*Direction générale de l'offre de soins*)
Dr Sylvie Germain and Mme Magali Guégan (*Direction générale de la santé*) (General Directorate for Health).
M. Jérôme Antonini, Head of the AP-HP Director General's Office (*Assistance Publique-Hopitaux de Paris*)
Dr Luc Ginot, Director for the promotion of health and reducing inequalities and M. Bernard Kerchen, Inspector for health and social affairs des affaires sanitaires et sociales (*Agence régionale de santé d'Île-de-France*)
Mme Rose Ngekueng, association Ikambere (French NGO addressing women infected with HIV)

On 9 February 2017, the Working Group visited the Calais hospital centre (visit organised by Mme Richoux, Deputy Director, head of General Affairs). The Group met a number of people present in the PASS hospital unit (Permanence d'accès aux soins de santé – walk-in healthcare clinic) located close to the Calais "jungle". They met the nursing staff (Mme Hennicaux in particular), staff involved in financing of operations (the deputy director of financing). They visited the emergency response unit (Dr Battist, Head of Unit), the department in charge of migrant social services (Mme Legrand) and PASS staff and management, Dr El Mouden and Mme Andrieux, healthcare manager.

SUMMARY OF THE OPINION

For decades, France has been host to immigration for political, economic or cultural reasons. Today, the word "migrants" has come to refer to a moment in time in the lives of men and women who have decided to leave their country of origin. They reside on French soil for very diverse periods of time but their situation is unfailingly precarious as regards access to health care. Most of them prefer to keep out of sight to avoid being escorted back to the frontier and therefore choose to give pride of place to their plans for migrating over any health problems they may be suffering from, which is the cause of a number of unsolved public health problems. The healthcare institutions (hospitals in particular), unlike humanitarian organisations, are not organised to offer their services to migrants without visible government support.

At this point, it is difficult to estimate the number of people already present in this country and the numbers of migrants entering and leaving, but there is every indication that altogether they do not exceed 0.5 % of the population of France. They do not in any way constitute a threat either to our healthcare system or to our social fabric. However, we must all be well aware that geopolitical developments (climate, etc.) are bound to augment migrational flows so that forward planning is required involving the creation of official and durable structures to shelter new arrivals in acceptable conditions. There is also a need to organise the integration of those who may be entitled to claim rights of asylum or refugee status. In any event, it is unacceptable to consider that not providing elementary hygiene for these men, women and (often unaccompanied) children is an instrument of choice to regulate migrant flows.

Despite the factual reality of violence and the major assaults on their mental and psychological health during migration, the physical health of these people who have received varying degrees of care cannot, on the whole, be described as poor. The "good physical health" assessment, however, cannot conceal some cases where circumstances are not optimal, in particular as regards mental health and the trauma inflicted — in France itself also — on women and unaccompanied juveniles.

The French constitution, laws and regulations take into account the ethical imperatives applying to people undergoing the vicissitudes of migration; these rules comply with international agreements. Administratively speaking, the instruments for giving migrants a decent welcome already exist. But political utterances and public resources are such that these instruments are lacking in effectiveness, as indisputable authorities on such matters have recently warned us of, time and time again.
Although the welcome given migrants in the *"centres d'accueil et d'orientation (CAO)"* (reception and guidance centres) seems to be satisfactory, this phase is either preceded or followed (for those who have left the centres) by long periods of time during which the most elementary rules of hygiene are not adequately complied with. Women and unaccompanied juveniles, in particular, may be exposed to danger. In such circumstances, for far too long, the sole measures taken were those initiated by local or national associations and public agents acting individually. There was no coherence between their efforts and those of the CAOs.

As regards the general public health system, there are a number of conflictual situations surrounding the welcome given to migrants and the everyday running of the health

institutions: hostile reactions to migrants from patients also waiting to receive care and, in some hospital departments, selective choices that need to be made because their resources are limited between the usual patient population and an inflow of people from abroad whose needs for healthcare enter into competition with the day-to-day running of the hospital's services. There is also no effective follow-up of migrant health and they frequently experience difficulty in communicating with care providers.

There is no policy for harmonising the operations of the walk-in health care clinics (*Permanence d'accès aux soins de santé* - PASS) so that they differ greatly in the way they discharge their legal duties.
Finally, the implementation of the State aided medical assistance (*aide médicale d'Etat* - AME), which only represents a minute portion of the total French healthcare budget, raises a number of issues due to unrealistic and inefficient procedural constraints.

These findings inspired the following list of ethical imperatives.

(1) CCNE has deliberately chosen to give priority to respect for human dignity, which is measured in concrete terms by the way in which each individual's material life is provided for.
(2) It is the healthcare system's responsibility (hospitals in particular) to be capable of acting with understanding and enlist the trust of people whose priority is the need for concealment rather than the need to obtain medical help.
(3) There is a need to enable "one-to-one communication" between doctor and patient by dialogue made comprehensible in both linguistic and cultural terms.
(4) Members of the medical professions must be willing to prioritise actions specifically intended to ensure migrant wellbeing.
(5) Equity, i.e. equality of access to healthcare and to physical, mental and social wellbeing.
(6) Solidarity, an essential consideration, expressed here in terms of fraternity and hospitality, is a condition and also the outcome of all that is described above; everyone must feel individually responsible for the welcome extended to migrants.

In addressing the subject of migrants' health, CCNE had no wish to take sides in the political dimensions of the issue. The Committee noted, however, that we were facing a complex situation for which the solutions implemented by public agencies were not, on the whole, responding adequately to today's and tomorrow's challenges. CCNE considers that, as matters stands at present, there is no insurmountable reason why migrants' healthcare needs cannot be met honourably and decently. One prerequisite, however, would be to make convincingly truthful, trustworthy and, later, encouraging public statements on the subject, as a corollary of more fit-for-purpose public policies. CCNE states categorically that, as regards migrants, as is true of any person in distress, health in the meaning defined by WHO, cannot ever be instrumentalised, in particular by perpetuating insanitary conditions as an instrument of rejection. In choosing to give prominence to respect for human dignity, CCNE emphasises that the ethical imperative of solidarity is expressed by a spirit of fraternity, in particular as it is extended to those entering French territory and in the duty of hospitality which is owed to them.

TEXT OF THE OPINION

In conformity with the first sub-paragraph of the Preamble to the 1946 Constitution, reiterated in the 1958 Constitution, all individuals residing on French soil are entitled to the safeguarding of their personal dignity against all forms of subjugation and degradation[1]. Moreover, the World Health Organization's (WHO)[2] original Charter states that health is a fundamental right for everyone, regardless of their position in the world. This means, above all, "a state of complete physical, mental and social well-being"[3]. When someone is affected by physical or mental illness, freedom of access to healthcare on the same footing as anyone else on French territory must be provided.

Solidarity and fraternity must prevail without reference to origins, ethnicity, religious belief, mode of entry and conditions of residence on French territory in particular for those who have had to resign themselves to exile and grapple with the severe constraints and assaults of travel, to which are added clandestinity and subjugation to people-smugglers. International agreements, for juveniles in particular, have defined and developed these imperative principles. French law and regulations take full account of them. But political expression and public funding do not provide the support required for their implementation to become reality.

The National Consultative Ethics Committee wishes to make a public statement on the theme of migrants' health, in the broadest meaning of the word. Although the Committee recognises that the problem is a complex one, it observes that healthcare for migrants involves legislative standards, various resources and views that are frequently strongly held and controversial and that it is furthermore a topic which has recently been under scrutiny and the object of cautionary statements, but that it also raised public health and sanitation problems and, more to the point, some ethical issues on which the Committee therefore feels it would be appropriate for it to formulate an opinion.

---

[1] Cf *Conseil constitutionnel*, decision n° 94-343/344 DC of 27 July 1994, § 2; decision n° 2010-14/22 QPC 30 July 2010, § 19; decision n° 2015-517 QPC of 22 January 2016, § 4, etc.

[2] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference held in New York, from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States and entering into force on 7 April 1948. Official records of the World Health Organization, n° 2, p. 100: ***"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".***

[3] This state implies access to adequate protection from poor weather, access to suitable food, access to water and to installations permitting personal hygiene, access to latrines built so that evacuation of waste water complies with international standards.

I – CCNE findings

Migrant presence and precariousness as regards access to healthcare
The word "migrant[4]" is used here for people of non-French nationality — wherever they may come from, for whatever reason they decided to move from home and however they entered France — who are currently on French territory without a residence permit.
The word however is far from covering the full range of actual circumstances of the people it designates. "Migrant" refers to a factual phase of their existence, corresponding to a decision which is forced upon them, and possibly upon their families, to go into exile without any hope of return. It is however sufficient to indicate that people who are "migrating" may well find that their health is seriously endangered by the loss of physical, mental and social wellbeing even though they may be cared for with empathy in the country they currently reside in. For these reasons, migrants' health is a primary and fundamental fact calling into question manifestations of fraternity and solidarity in the country of destination, even though they may not be intending to live there permanently.

Their presence may be temporary:
- because the migrants had set out, on their own initiative or forcibly, on a journey for which France was not the final destination (transit in Calais);
- because they were stopped and readmitted (into another European country) or sent away (towards a more remote third country).

Their presence may be durable:
- because some migrants remain in France for many years, without a residence permit, and they are sometimes designated by the name "undocumented".
- because they manage to survive by working without a contract or regular social protection, living in the hope that they may at some point be given legal residence authorisation to stay in France, which does not happen in most cases.

Precariousness in access to healthcare may be temporary:
- when migrants are granted a permit of some kind to reside legally in the country as may mostly be the case of non-French nationals authorised to request asylum so that they themselves and their dependents gain the right to "sickness, maternity and death" benefits (combined articles L. 161-25-1 et 2 et D. 161-15 of the Code of Social Security).
- This may also be the case for non-French nationals who have been granted refugee status[5].

[4] The concept "migrant" as used here should not be confused with the following concepts: foreigner (person who is not a French national); immigrant (person residing in France but born a foreigner outside France); refugee (a foreign person suffering persecution in his or her home country, to whom a State grants protection by virtue of the 28 July 1951 Geneva Convention); "undocumented" person (in particular a foreigner residing temporarily or for a long time in France without the official legal permit to do so as provided by law).

[5] In 2016, out of 85,726 applications (including rare cases of stateless people and mostly juveniles whose fate is linked to that of their parents), 26,428 adults and, as a direct consequence, 10,125 children were provided with protection (either as refugees, or "subsidiary protection"). In other words, 42.6% of requests were received favourably, which is a particularly high proportion not reflecting traditional acceptance figures that vary between 20% and 35% from year to year (the previous highest figure was for 2008, 35%). With time, the percentage of the cohort protected on a given year tends to shrink. For people who requested protection in 2012 (latest figures known), 23.5% are under protection in 2017, according to data provided by OFPRA. (French Office for the Protection of Refugees and Stateless people).

But this extension of rights is also reversible: an asylum seeker loses any rights to social protection and residence if the request for asylum is refused. Temporary presence and precariousness are the correlative characteristics of this population: this is for example the case of "unaccompanied minors" in Calais who have not gained admittance to the United Kingdom.
These distinctive characteristics raise so far unsolved issues for healthcare providers.
- How to identify pathologies requiring treatment?
- How to ensure continuity of preventive healthcare along the length of an international journey (vaccination)?
- How to achieve continuity for treatment prescribed in one migrant admission centre from which the migrant subsequently disappears?
- How to ensure traceability of data concerning the safety, follow-up and effectiveness of healthcare so as to protect the person concerned and those in contact with that person?

Invisibility and uncertainty about numbers of migrants
Migrant invisibility and its consequences
The characteristics we have just described describe furthermore an invisible, or almost invisible population, which means that despite the very striking images of columns marching along the south east frontiers of Europe or of survivors of overcrowded boats, most of the time migrants into our country prefer not to draw the attention of government institutions — unless they want to request asylum — for fear of being stopped and escorted back to their country of origin.

As happens from time to time, the Syrian crisis and the Calais "*jungle*" have simply brought into the limelight a situation which is usually invisible and obviously of greater amplitude than is immediately apparent.
This "invisibility" applies to the system for providing healthcare which is poorly organised to look out for people who are afraid of being brought to the notice of the authorities.

Migrant flows
These are not new arrivals. There have been constant flows of migrants for years attempting to reach the more prosperous European countries. Past examples abound as evidenced by several recent episodes in France, for instance the *manu militari* evacuation of the Saint-Bernard church in Paris in 1996, or international events, for instance the "siege" of Ceuta and Melilla where African migrants were trying to force their way in from Morocco into Spain and therefore into Europe.

The crisis that erupted in the Middle East in 2015 simply intensified and above all gave more visibility for a while to these flows.
But there is no likelihood that the flows will subside. We must be well aware that geopolitical developments and the fast-moving environmental degradation that follows on from human activity, as evidenced by the Opinion published by CCNE on the subject of the Paris COP 21 in 2015, will be amplifying North/South population migration for several decades[6]. Furthermore, a change of scale is to be expected.

[6] See also the review by the International Organization for Migration: O. Brown (2008). Migration and Climate Change. N° 31. IOM Migration Research series. French translation: M. Tessier and P. Nicolas. 56p.

It is true that many of these population shifts are for immediate escape over short distances: the Syrian crisis, like many others before: Afghanistan, the Congo, etc., have shown that it is neighbouring countries that take in the greatest number of exiles in wartime.
The long treks — controlled by the people smugglers — are however the preserve of those who can afford the thousands of dollars they are asked to pay. But, in any event, short-term measures and speeches must not conceal from public opinion that migrant flows, far from subsiding, are going to increase.

At the same time, we should assess the current dimensions of the development in relation to the size of our population and our prosperity.

The United Nations evaluate at 65.3 million the number of displaced persons worldwide, of which 39% were allowed entry in the Middle-East, 29% in Africa, 14% in the Asia-Pacific region, 12% on the American continent and 6% in Europe.
The main host countries for refugees, in increasing order of numbers, in absolute terms and, therefore, increasing material constraint, are[7]:
- Jordan (where they account for nearly 7% of the population),
- Ethiopia (where they account for nearly 0.8% of the population),
- Iran (where they account for nearly 1.2% of the population),
- Lebanon (where they account for nearly 29.1% of the population,
- Pakistan (where they account for nearly 0.8% of the population),
- Turkey (where they account for nearly 3.2% of the population) which is taking in the most.

In migrant resettlement in Europe, members of the European Union are very unequally represented so that countries in the south (Spain, Greece and Italy) bear the heaviest burden. It could be mentioned in passing that these countries are dismayed by a European Union that seems to be lending a deaf ear to their appeals for help.

Numbers of foreigners residing durably in France

It is impossible to make a precise count of migrants in France. Unlike other countries, there are no plans for providing them with lasting shelter and at least minimal standards of sanitation. As a result, taking a full census is out of the question and extrapolations — all disputable — are the only alternative[8].

Some 200,000 to 400,000 illegal aliens residing on French soil at any one time is an often quoted figure. The actual numbers as a result of incoming and outgoing flows, non-measurable over a lengthy period of time, is therefore totally unverifiable. Supposing it

[7] In fact, illegal resident undocumented exiles in France, residing temporarily and/or permanently represent less than five per thousand of the entire population.

[8] Based in particular on State medical aid, the number of arrests of illegal foreign residents, the number of children in school or the number of asylum seekers. None of these accounting systems are satisfactory since neither the number of those entering nor the number of those leaving can be ascertained (those gaining entry into the United Kingdom via Calais or elsewhere, those who decide to try for entry into another country, etc.). There is nevertheless abundant literature on the subject (see for example reports to the French Senate n° 470 (1997-1998) and n° 300 (2005-2006). See also François Héran, "*Cinq idées reçues sur l'immigration*" (Five popular misconceptions about immigration), INED, *Population et sociétés*, n° 397, January 2004.

to be exact, the proportion of illegal aliens residing in France would therefore be somewhere between 0.3% and 0.6% of the population at large.
The 30,000 foreigners that the authorities agreed to allow into France because of the "Syrian crisis" represent 0.04% of the French population.

Measured in flows, the same variance appear in the estimates. It seems likely, as evidenced by increased claims for asylum in recent years (+ 29.4% since 2013[9]) that flows have built up between 2015 and now, but by how much nobody can evaluate reliably and reproducibly[10]).

All of this points to the fact that foreigners residing illegally on French territory do not in any way constitute a "threat", either on the management of the healthcare system or on its finances or, *a fortiori*, on our social structures[11].

But the concentration of a great many of them in a geographically restricted area may well lead, as has already been the case, to difficulty in organising their assistance and even to episodes of resentment on the part of the local population, despite an initially welcoming attitude, for reasons as explained below.

Apart from Calais and other townships along the Channel coastline where there are ferry departures for the United Kingdom, there is also a critical situation in Mayotte due to persistent and repeated migration so that many youngsters are left to their own devices for lack of the resources that the administrative authorities in charge of social services for children (ASE) would need to cope with the situation and also to the well-known shortage of social and healthcare facilities for the permanent indigenous population. This is also true of Guyana where the river borders are totally "porous" and cannot be monitored, guarded or made reliably secure. This French territory, furthermore, suffers from severe overcrowding of its hospitals, as was evidenced by social unrest in the spring of 2017.

These specific cases should not give rise to unsubstantiated generalisation, nor should much credence be given to inconsequent discourses on the risk of insecurity and terrorism incurred by the French population because of the arrival or residence of migrants. The very few terrorists infiltrating the large flows of migrants in south-east Europe are in no way representative of the vast numbers whose aspirations are centred on finding a safe haven. Generally speaking, migrant populations are more likely to be the victims of violence than the vectors of possible insecurity or acts of terrorism. It would therefore be more pertinent if the media and the educational system were to address public opinion, particularly the young, to provide authentic information on migrants and put across the empathy which their circumstances deserve.

[9] A fraction of this build up is due to government encouragement to claim asylum, in particular aimed at foreigners concentrated in Calais and transferred to the centres for reception and guidance, as well as to foreigners whose requests for asylum were rejected in other European countries (Germany for instance) and who try their luck in France. This double effect is continuing in 2017.
[10] Paul Valéry, in his acceptance speech at the Académie Française, said: "the truth is verifiable".
[11] Nor, for that matter on security, according to testimony given during the hearings. But conversely, does not closing down the frontiers to those who hope for protection by European countries put them at grave risk?

Neither the systems for temporary shelter — if they are to provide adequate sanitation and food— nor those providing medical services are prepared for a situation where so much need is concentrated in so small a space and, above all, in so short a time. They are even less well prepared for the long term.

As a result, the centres for the reception of asylum seekers (CADAs), as stipulated by the Code for social and family affairs, are regularly challenged by a rise in the number of asylum seekers. The CADA facilities for reception are chronically inadequate and regularly augmented, but with a time gap which is so large that the shortage, and its consequences, persist. The need to house asylum seekers who cannot be accommodated in the CADAs, means that they are sent to emergency shelters that are already overcrowded. As a result, the management of such shelters are obliged to make difficult choices between people who are all in as much need as each other and should all be given suitable lodging.

Certain migrant populations, such as unaccompanied minors, pose difficult problems for those in charge of educating youngsters with special needs, aggravated by the fact that they are geographically unevenly distributed. These are mainly due to cultural and linguistic barriers in the social housing centres for children (*Maisons d'enfants à caractère social - MECS*) where the ASE administrative authorities try to house[12] them, as is the case in the Ile-de-France region.

Social and healthcare institutions need to prepare for the long term in order to receive, take charge of and take care of these people, and also possibly to provide medical services for them. Their specific and original cultural characteristics require efforts to adapt to communication difficulties, linguistic primarily.

Higher education and research authorities are now aware of these problems, as evidenced by the fact that the *Agence Nationale pour la Recherche - ANAR,* in the context of its "investments for the future" and the setting up of multidisciplinary teaching and research institutions, created a "convergence institute" on migration in April 2017. This institute will be grouping in the same place (in Seine-Saint-Denis) multidisciplinary research units in human and social sciences, life and health sciences as well as economics and other disciplines with resources drawn from research institutions and universities. Their substantial annual budget will be renewed for a period of ten years so that a number of employment opportunities will be created for researchers and teaching staff from France or abroad.

Reception and shelter of migrants

There are already instruments dedicated to the reception of migrants, some of them are quite long-standing and others were created at the time of the migration crisis in 2015. We shall be returning to these more recent creations below.

[12] On this subject, see the report by the Senate's social affairs commission on the social services provided for unaccompanied minors (28 June 2017, Elisabeth Doineau and Jean-Pierre Godefroy, rapporteurs).

The hearings CCNE initiated have convinced us that, in the main, efforts were reliant for quite some time on the good will of charitable organisations, those already in existence and those that were created for the occasion ("*La vie active*" in Calais, in particular); mostly, they spontaneously got themselves organised specially for that purpose. These associations are funded through popular solidarity and charity and a little official but rather precarious assistance from the government *via* non revolving lines of credit.

Except in some temporary specific cases in Calais or in Ile-de-France, the effort has not been much of a burden on the ordinary healthcare system. As already mentioned, the issue is to decide whether those concerned:
- should be in a special system relying essentially on associations defending human rights (this was described as a "humanisation[13]" of migrant reception based on a model already being used for other precarious populations);
- or should be integrated as well as they possibly can be in view of their specific characteristics, into the public health and social services system.

While not underestimating the work of associations whose efforts to seek out those in need, gain their trust and provide physical and moral support is extremely valuable, clearly the involvement of national solidarity dictates the second alternative as the only possible choice. For that matter, many people — including some in international institutions — were, to say the least, astonished at the French authorities' inability to organise the reception of migrants in Calais, other than by closing down a Red Cross centre created in 2000 and then allowing "squats" to develop in the town, and finally by an authoritarian move of migrants to an uninhabited moor devoid of any facilities, which became known as "*the jungle*"[14].

The Calais *jungle's* features until its attempted elimination in 2016 were the results of the migrants' own efforts and those of local helpers who did what they could with the often limited means available to them. This camp was far more disastrous, in particular as regards sanitation but also for everything else, than the refugee camps organised on the tried principles of the United Nations for initial countries of reception.

It must be clearly understood that, whenever distressed people are involved ethically speaking, health in terms of the provision of elementary hygiene and care must not — for any reason — be instrumentalised. For migrants, poor sanitation must absolutely not be sought or perpetuated as an instrument to implement a policy for discouragement and subsequently expulsion.

Furthermore, what France takes exception to in the Calais situation (a population surge as a result of a diplomatic agreement signed in 2004[15], considered to be too favourable to the United Kingdom, it is creating simultaneously today in Ventimiglia in Italy, by the

[13] This expression is used to mean a theoretically public policy put into the hands of associations whose purpose is to implement the various aspects of human rights instead of the usual institutional players.
[14] Opinions differ as to where the name came from: thought by some to be of Afghan origin signifying "small wood", but obviously not a flattering term in the meaning generally given currently.
[15] The treaty between the French and British governments on the implementation of border controls in the maritime ports of the Channel and North sea of both countries. Signed on 4 April 2003 and entered into force on 1 February 2004, this "Touquet agreement" reproduces the principles of the "Sangatte Protocol" of 1991 and its additional protocol in 2000.

lockdowns on foreign migrants who have arrived in Italy after a dramatic journey and wish to enter France illegally through the border at Menton or surroundings to continue their migration to countries in northern Europe.

The action of charitable institutions and municipal authorities

Associations, and some townships[16], in so far as they were entitled and their resources allowed them to, took action to assist migrants, at least in providing for their more essential needs. However, migrants settled not just in towns such as Calais and Grande-Synthe, but also in small camps (frequently regrouped according to geographic origins) along the Channel and North Sea coastlines.

Anonymous individual action as well as charity workers from some associations coordinated their efforts to maintain a degree of effective sanitation within the camps where the representatives of authority (firefighters and law enforcement) dared not enter because of the climate of unrelenting tension, not to say hostility, they met with.

Some initiatives, individual at first, led to enabling the Calais hospital walk-in healthcare unit (PASS) to open up a clinic in the "*jungle"* with the initial objective of taking over the Doctors of the World clinic and later to launch a unit to take on patients just out of hospital whose frail state of health prevented them from going back to the discomfort of the camp. The healthcare providers from the hospital who participated in this effort spoke of their experience with professional enthusiasm and commitment.

However, all the hospitals in the region did not follow the same path and not all the Calais Hospital professionals sustained or propagated the effort; nor did the public institutions (departmental authorities and regional health agencies) provide much support.

The situation changed when the "*jungle*" was about to be dismantled or when, elsewhere and in the Paris area in particular, it was decided to close down the camps on the streets and provide lasting accommodation and significant assistance (at least for the time required for processing a claim for asylum).

At this point, institutions — other than police and "*gendarmerie*" forces who were already substantially involved and had been for quite a while — mobilised without the provision of any additional human resources. The institutions concerned were those dealing with reception of foreigners *(Office français de l'immigration et de l'intégration – OFII)* and those concerned with general law following voluntary specific decisions (Paris town hall, the Ile-de-France Health Agency). The institutions enlisted the assistance of tried and trusted associations (Emmaüs, Doctors of the World). It was nevertheless reported that the follow up of what had been achieved in Calais and its relevance to what might be achieved in the future in the *"centres d'accueil et d'orientation (CAO*)" (reception and guidance centres) might be compromised by the difficulty of coordinating the efforts of the various players.

It appears that the two phases, associative and then institutional, functioned separately and independently without any attempt at effective coherent action.

---

[16] This refers in particular to the action of the mayor of Grande-Synthe.

II – Migrants' state of health

Despite the very real assaults and trauma to the psyche and mental health inflicted on migrants during their journey, the physical condition of those given various forms of protection cannot be described as globally bad[17]. Most often they are young men, in good health when they left home, who did not embark on such an adventure on a whim and who have developed some measure of physical and mental stamina.
They are also driven by eagerness to arrive at the goal they have set for themselves in view of all the sacrifices in both material and social terms they made before they reached France. Another motivation is that these are people who do not entertain any hope of returning home, because "*migration is essentially renunciation*". There is also the objective impossibility of reintegrating, professionally and socially, their home town or village. Such a return would be experienced as a resounding failure and an economic disaster and, above all, as a loss of dignity in the eyes of loved ones who had contributed financially to the attempted migration.
This general statement "good physical health" does cover, however, some rather less satisfactory situations[18]. In 2017, the Ministry of Health referred to "Santé Publique France" on the subject of migrant health, already considered previously by IPSES[19]. A series of articles on this same subject and migrants' access to healthcare was published recently in the "*Bulletin épidémiologique hebdomadaire*[20]".

One example of this is to be found in the fact that when a number of people who do not have access to sanitation for their basic toilet needs are thrown together, this is a breeding ground for Sarcoptes, mites causing scabies, which is passed from person to person. This is also true of other more serious contagious diseases. In such circumstances, the authorities are implicated because migrants may be infected by the simple fact of their presence on French soil.
Another example involves the more complex problem of mental health, either because of post-traumatic phenomena, partly of an acquired and potentially reversible neurotic nature due to the conditions endured while travelling, in particular countries where torture or abuse is commonplace (Libya for instance), or else as a result of pre-existing organic psychoses without visible clinical symptoms and/or symptoms that were not revealed during the journey.
A complication is that healthcare structures (community psychiatry) are ill-equipped to cope with this situation.

The mobile psychiatry and insecurity units (EMPP – *équipes mobiles psychiatrie-précarité*) are not as mobile as their name suggests. Furthermore, coordination of medical management is difficult.

[17] For more information on the epidemiology of migrants received in various points of access in Seine-Saint-Denis, for example, see issue n° 52 (December 2016) of the COMEDE newsletter, *Maux d'exil*, page 7.
[18] An enquiry by Doctors without Borders in November and December 2015 in the Calais camps pointed out that two thirds of the people they had interviewed had experienced at least one episode of ill health (during the journey or in Calais) with upper respiratory tract pathologies predominating.
[19] Bulletin épidémiologique hebdomadaire n° 2-3-4, 2012, thematic issue, *Santé et recours aux soins des migrants.*
[20] *La santé et l'accès aux soins des migrants : un enjeu de santé publique »* (2017) *Coordination scientifique* : F. Lot et S. Quelet. Bull. Épidémiol. Hebd. (19-20), 371-436.

Some post-traumatic mental conditions are caused by abuse, rape for instance (which has also been perpetrated in France itself). Nor can it be over-emphasised that care for mental health needs to be integrated, with the participation of specialists, in primary healthcare structures.

On another subject, *Gynécologie sans frontières* (GSF – Gynaecology without borders), with massive amount support from all the midwives in the region, managed to provide clinical monitoring of more or less wanted pregnancies, including the use of ultrasound scans, and organised hospital supported childbirths. GSF also satisfied requests for elective terminations but were unable to set up any guarantee of continuity for sustainable and effective contraception. More recently and without any direct financial assistance from public sources, GSF opened up a flat for the temporary accommodation of young postpartum migrants and their babies.

Gaps in migrant health monitoring

Without any documented evidence of care in the country of origin or during the journey, or of any international health record document[21], due to difficulties specific to migrants, health status cannot be reliably monitored with the required degree of confidentiality.
The current system allows for clinical examination and possibly treatment at a given point in time. There is no document, even one carried by the person concerned, that can ensure the follow-up and treatment of a diagnosed pathology.

The most sensitive issue — in psychiatry particularly — is the one-to-one dialogue between patient and healthcare provider and therefore, that of the mutual understanding between them. Complete linguistic translation comprises three radically different levels:
- literal word-for-word translation;
- interpretation of what the other person is expressing or is willing to say or wishes to impart;
- interpersonal, but also intercultural, mediation (the example of Sudanese using sign language… but only in English).

These three levels of translation required different skills and do not fulfil the same healthcare purpose.

Associations have often worked with translators who are relatives or friends of the people they were providing healthcare to, but all of the translations levels were not covered. In the Paris area, although the translation of more common languages (Arabic, Persian, etc.) is not a problem, there are some less accessible languages which require the help by telephone of *ISM-Interprétariat*, a service supplied by the *Institut Supérieur d'Interprétariat (ISM[22])* so that the "one-to-one" nature of the dialogue is questionable, to say the least.
In fact, translation raises two very different issues: on the one hand access to the migrant's language and to what he or she is able or wishes to express and, on the other hand, the

[21] In this respect, what about a Nansen health passport? Who is going to invent one? Fridtjof Nansen, the League of Nations' first High Commissioner for Refugees, invented this document in 1922. It was issued to refugees without identity documents or whose country of origin had stripped them of their nationality. Thanks to the Nansen passport, Russians, Assyrians, Armenians and other victims of World War I were able to cross borders and gain asylum in countries where they would otherwise not have been admitted.

[22] Not to be confused with the CIMADE (French NGO for help to people uprooted by war) "inter service migrants".

introduction of a third party into this healthcaring dialogue and the exact role of this third party: should translators give priority to making available the essential cultural elements to enable an understanding of the disability? Should translators translate everything ? Should translators give the substance of what was said taking into account people's privacy and shared cultural backgrounds? Should they act as mediators?

The reception and health management of migrants.

While some remarkable initiatives are worthy of note and major public institutions have duly supported the organisation of migrant reception and guidance in the specialised centres (CAOs) as mentioned above, reports in general indicate that the reception and health management of migrants fall far short of achieving integration into the general scheme of public healthcare and access to social services.

It cannot be denied that there are circumstances where relations between migrant reception and the usual administration of public health operations become conflictual: hostile attitudes from patients awaiting their turn alongside "migrants" in so-called emergency[23] services, allegations of refusal to provide treatment for any extra patients in some departments where, because of various constraints and limited resources, selective choices must be made between the usual patient population and an inflow of people arriving from abroad for various reasons and who represent an extra patient load which sometimes competes for the attention of already almost saturated hospital services.
Sadly, community based private networks are not involved to any great extent since they are only marginally called upon for the treatment of people living in precarious circumstances[24] who do not benefit from State medical assistance (*AME – aide médicale de l'Etat*) and are unable to pay for the price of a visit to the doctor.
In the event of requests addressed to ambulatory healthcare (private non hospital-based treatment), some testimonies mention refusals to treat on the part of healthcare providers.

The vast majority of people in precarious circumstances — and not just foreigners — go to a hospital in the full expectation that they will be taken in and that treatment does not primarily depend on the production of certain documents. Hospitals, actually, except in certain very specific circumstances, which the "grapevine" reports on (the Parisian Robert Debré Hospital paediatric department, the Saint-Denis hospital who organised their services specially to cope with an inflow of foreigners,) are not disorganised by a sudden inflow of people from abroad (including for example the Calais hospital's emergency department who managed very well). Furthermore, the issue of who would pick up the financial burden for such patients is not new.
And yet, as previously mentioned, it is often alleged that hospital practitioners have refused to treat such patients, flying thus into the face of medical ethics, on the grounds that budgetary constraints on hospital expenditure were too weighty to permit an extension of already problematic demands, potentially generating "bad debts".

The vicissitudes of State medical assistance ((AME)

[23] That have now mostly been given the name of "reception and guidance services".
[24] Probably, efforts to recruit their participation were insufficient, in particular in the form of walk-in clinics under the aegis of the medical associations, as was done for assistance from the legal professions.

And yet instruments do exist already to provide essential medical care. They came into being when certain public health institutions became aware of the need for them, quite a while ago. *"The public health system"*, it was noted, *"via its personnel, its associations for assistance to non-nationals, associations promoting health, has worked assiduously against all odds… It is this current of opinion that has represented the "the rule of law" to which we must refer to avoid collective momentum being trapped into the single defensive definition that has been represented by the French authorities…"*[25]

The law sets out the principle that all non-nationals residing in France but not satisfying the conditions of regular admission are entitled to AME (Article L. 251-1 of the *Code de l'action sociale et des familles*, following on a 27 July 1999 law), subject to means testing, on the condition that they can provide evidence of residence on French territory "*without interruption for a period exceeding three months*". The AME guarantees the payment of medical expenses (less extensively than for sickness insurance) for foreign nationals and their dependents (spouse, under-age or student children). Expenses are met by the State (Article L. 253-2 of the same Code as above) out of a special budget not included in the national objective for sickness insurance (ONDAM – *objectif national de dépenses d'assurance-maladie*) which is drawn up every year as part of the process of adoption of the social security budget.

Furthermore, circular DHOS/DSS/DGAS/2005/141 of 16 March 2005 guarantees for any foreigners, even those not covered by AME, urgent care by hospitals, as part of a "limited" financial budget heading, i.e. "urgent care the absence of which would be life-threatening or could give rise to serious and sustained impairment of health" or urgent action to "avoid the propagation of disease to next of kin or the community" (TB and the Human Immunodeficiency Virus — HIV — that may cause AIDS).
Any medical care required for an under-age child is classified as "urgent" for the meaning of the circular".

As a result, according to the AME circular of 27 September 2005, "when the patient's condition requires it", hospitals "are bound to provide the care required in the name of "equal access to medical care for all".
The system has enabled 316,314 foreign nationals eligible for AME to receive medical care in 2015 for the cost of the "ordinary" component alone (urgent medical care not included) of 722 million Euros, i.e. 0.16% of total healthcare expenditure[26] (progressing more steeply than expenditure for sickness insurance).

Periodically, there are requests to revoke AME, less because of its impact on the budget than by virtue of the "theory" of over-indulgent generosity that acts as a magnet for an inrush of new foreigners arriving in the country, i.e. the classic rhetoric against immigration.

---

[25] In *Parcours de vie et santé des Africains immigrés en France*, directed by Annabel Desgrées du Lou and France Lert, Paris, la Découverte, July 2017, 359 p., page 336.
[26] Percentage still lower than the proportion (estimated) of migrant population residing in France as mentioned above.

Yet the testimonies we heard and previous reports[27] point out that revoking AME would have no real financial consequence since emergency care would have to be dispensed later on for diseases diagnosed very tardily at a cost which *a priori* would appear to be much greater and complicated by increased risks to public health, not just for the people directly concerned, but also for the population as a whole.

As for the "magnet effect" phraseology which boils down to a cynical statement that if you treat migrants "too well", even more of them will flock to your country, it has inspired many a legislative change and government decision for over twenty years. Apart from the fact that it betrays a serious lack of understanding of the motives and conditions of departure from the country of origin, the assumption has never been verified and is, for that matter, unverifiable. As far as anyone knows, it is totally wrong: except in the last few years, inflow figures remained relatively stable. Similarly, it is also wrong in terms of healthcare as long as health as a reason for immigration is not in excess of 8% to 9% of HIV[28] carriers, often mothers doomed to certain death in their country of origin due to a lack of effective antiretroviral drugs[29].

Walk-in healthcare clinics (PASS - *permanences d'accès aux soins de santé*)
Hospitals themselves have a specific reception structure to implement the fight against social exclusion in which they are required to participate (article L. 6112-1 of the *Code de la santé publique*). This takes the form of the PASS walk-in clinics already mentioned above in the context of the Calais situation.

These clinics, a creation of the 29 July 1998 law, article L. 6112-6 of the Code of Public Health, are intended "to facilitate access to healthcare" for people in precarious circumstances and "to assist them in applying for a recognition of their rights". This combination of "medical" and "social" assistance is financed through funds provided for the hospital's "general interest missions" (MIG) by the *Agence Régionale de Santé* (ARS) from dedicated funds set aside by the Ministry of Health's general directorate for healthcare (*direction générale de l'offre de* soins - DGOS).

The PASS are tasked with assisting patients in their health-related procedures and also with raising the level of awareness of hospital staff to the needs of people in precarious circumstances. They coordinate their activities with sickness insurance funding authorities, community centres for social services, child welfare services, etc.

There were some 410 PASS structures in existence in 2013 (according to circular DGOS/R4/2013/246 of 18 June 2013) who very appropriately played a major role in the reception of migrants in hospitals. However, there are major differences from one PASS to the other as regards their effectiveness and their presence in the hospital and their vitality. In practice, it would seem that the allocation to them of human, material and financial resources depends greatly on the goodwill and implication available in the hospital to which they are attached, and hospital management everywhere is not always convinced that the PASS is part of their core business…

---

[27] Such as the report written by Alain Cordier and Frédéric Salas – *Inspection générale des finances et inspection générale des affaires sociales* – in 2010, under the title *"Analyse de l'évolution des dépenses au titre de l'aide médicale d'Etat" (*Analysis of trends in expenditure for State medical assistance).
[28] *Parcours…* op. cit., page 344.
[29] Audition of the Ikambere association (French NGO addressing women infected with HIV).

III – Ethical issues and imperatives

These findings call into question a number of ethical imperatives for which implementation is difficult in the specific case of migrant foreign nationals in exile, residing illegally in France. At the same time, the situation generates a public health problem which is currently underrated as a societal priority. CCNE has deliberately chosen to give pride of place to respect for human dignity as an expression of the fraternity and solidarity of which hospitality is the consequence. It is this ethical imperative that we shall seek to emphasise in closing as a token of the importance we attach to it.

The **first ethical imperative** is **respect for human dignity.**

The principle may give rise to various general definitions. A distinction must be made, in particular, between the ontological dignity to which each human being is entitled from birth to death, and even after death, and on the other hand the feeling of being dealt with in a dignified (or undignified) way, in this case personal dignity. Personal dignity is connected to the social and cultural values of a population; it is subjective and can be challenged by the lack of respect people experience in the various circumstances of their social life as a migrant.

But respect for ethical imperatives is measured by the concrete manner in which people's material living conditions conform to their quality as a human being. Only the "visible" migrants can be addressed here, but the "invisibles" whose circumstances may be even worse because of the lack of mobilisation on their behalf, must not be forgotten. This could be described as a form of leaving the most vulnerable to fall by the wayside, precisely because of their "invisibility".

Very obviously, in this respect, the circumstances of people living in Calais, at Grande-Synthe (before the La Linière camp was rehabilitated to conform with UNHCR standards at the request of the local authorities, a camp which was destroyed in April 2017 following an inter-ethnic conflict terminating in a fire), or at Steenvoorde or elsewhere, did not meet anyone's minimum standards of either personal or ontological dignity.

People living in a sea of mud, with stagnant water under their tents, without access to latrines preserving women's privacy in particular, without waste collection and removal, are examples of the conditions which prevailed for a long time despite the efforts of volunteers and associations. They were contrary to the most elementary concept of human dignity as was often pointed out[30], but failed to elicit any major effort on the part of authorities to cope with this miserable situation.

[30] The official independent French Defender of Human Rights has made numerous public representations to the authorities on the subject of disregard for the fundamental rights of people inhabiting the *jungle*: *Rapport général sur la situation des exilés de Calais* (General report on the situation of the Calais exiles) (October 2015), decisions n^os^ MDE-2016-113 of 20 April 2016, n° MSP-2016-198 of 22 July 2016, of 14 October 2016, *Rapport d'observation, démantèlement des campements et prise en charge des exilés Calais-Stalingrad (Paris)* (Report on observation of dismantling of the camps and management of Calais-Stalingrad (Paris) exiles, December 2016, decision n° 2017-206 of 21 January 2017. The *Commission nationale consultative des droits de l'homme* (French governmental consultative committee on human rights)

A vast number of testimonies and reports have underlined the particular lack of dignity pervading material arrangements provided for women — who are in the minority — as well as the violence to which they have been exposed. The same was true for "unaccompanied" minors who have often become the instruments of all kinds of trafficking. Such violence has not ceased despite the strong presence of law enforcement since the object of their presence did not aim to putting an end to these indignities and forms of violence and they did not enter the camps, as was reported.

The authorities were not only, as we have read, indifferent to this situation: their specific objective for quite some time was to render "invisible" what was not already invisible enough. To this end, as mentioned above, they began by closing the French Red Cross "centre" in Sangatte and then proceeded to repel migrants from "squats" in Calais to the coastal moor area, after which they ignored them except to repress illegal immigration.
In this regard, law enforcement personnel confronted with a trying and even frustrating task without any perceptible outcome, according to convergent sources, were inclined to behave in a manner which was seen as merciless and sometimes intimidating and brutal, including in their dealings with those healthcarers and volunteers who were present.

Respect for human dignity would demand, for example, when the authorities consider they have legitimate reason to oppose migrant movements, that they simultaneously propose an alternative which can guarantee for the wellbeing of all concerned a minimum physical, mental and social environment in conditions which are not regulated by the constraints of the policies governing illegal foreigners.
When, as has been witnessed, there is a forcible interruption of the distribution of water or food, which is in itself a particularly severe violence in view of the circumstances of the people concerned, and even unacceptable as far as those who gave such orders are concerned, such action is only conceivable if credible and immediately available facilities for washing, meeting bodily needs in privacy and eating are simultaneously provided by the authorities.
To simply oppose any resettlement in Calais may well be seen by the local population as a comprehensible public policy, but it certainly is not a policy which can be described as mindful of all the people concerned, both local residents and migrants. There were cases where inhumanity was a deliberate choice: as a result, respect for human beings and their dignity was flouted.

Dignity is also measured by the way in which sick people are admitted to hospitals and taken care of when they need medical attention. In this respect, healthcarers and social workers have, on the whole, acted professionally and with empathy, thus meeting the demands of medical ethics.

---

published an Opinion on the situation of migrants in Grande-Synthe on 26 May 2016 and an Opinion on the situation of migrants in Calais, published 7 July 2016. The Commission was also asked for an administrative report (*Rapport aux ministres du logement et de l'intérieur* – Report to Minister for housing and Minister for internal affairs) by J. Aribaud – former "*préfet*" for the region and by J. Vignon, President of the *Observatoire national de la pauvreté et de l'exclusion sociale* - (national observatory of poverty and social exclusion). June 2015). It was only once a decision had been taken by the *Conseil d'Etat* (Council of State) and failed appeals by the regional authorities and the Minister for internal affairs (6ème ch., 31 July 2017, n° 412 125, F. Dieu, published report) that the latter ordered the installation, as the Lille administrative court had already ordered, of a few water points in Calais where migrants returned after the autumn 2016 evacuation.

Care must be taken, however, to resist the temptation to create a separate and different admission process from the common rule, with the object of not "disturbing" normal operations. This would be a clear case of discrimination.
The **second ethical imperative** is the **reception and inclusion of migrants —** who have been described as "**invisibles**" **— by the healthcare system**, hospitals in particular [31].

"Invisibles" indeed, because although ordinary patients do not experience any particular difficulty in addressing the healthcare system when they are sick (leaving aside the possibility of different individual behaviours when people are stressed by ill health), the same is not true for migrants. In his report "*Pauvreté, précarité et santé*" (Poverty, precariousness and health) referred to in footnote 31 (rapporteur: Professor Alfred Spira), the *Académie de Médecine* points out in clear terms that existing legal and regulatory instruments already recognise the rule of healthcare access for all. They observe, however, that this access is far from being all inclusive because of the extreme complexity of administrative procedures, particularly as regards migrants. Many of those who are entitled to healthcare either have not been informed of the fact or do not dare to make themselves known to people who could help them.

For recent arrivals particularly, crucial issues arise in the form of the need for information, needing to choose between continuing their journey or receiving medical assistance and, above all, the fear of being identified and stopped by enforcement agencies for being at fault regarding their presence on French territory.

There are also the special difficulties experienced by women and underage juveniles, particular those who are unaccompanied, for reasons mainly related to the constraints and aggressions to which they fall victim.

As a result, although morbidity is no different in migrant and resident populations, apart from fractures and trauma caused by dangerous attempts at getting aboard lorries to cross the Channel, for example, or else transmissible diseases because of deplorable hygiene, access to healthcare is differs considerably. Migrants not getting care because of giving absolute priority, whatever the cost to them, to crossing the Channel into the United Kingdom therefore introduces a risk of diverging morbid developments.

Furthermore, despite the existence of special agencies for the reception of people in precarious circumstances, the healthcare response may be far from fully effective in practical terms. Although the PASS may be fully integrated into the hospital structure, it

---

[31] Regarding this principle — and the next one — see:
- articles by C. Berchet and F. Jusot, "*Etat de santé et recours aux soins des immigrés : une synthèse des travaux français*", *Questions d'économie de la santé*, n° 172, January 2012 and by C. Hamel and M. Moisy, "Immigrés et descendants d'immigrés face à la santé", *Documents INED*, Paris, 2013 ;
- the report adopted on 20 June 2017 by the *Académie de médecine*, "*Pauvreté, précarité et santé"*, by Professor Alfred Spira ;
- collective book directed by Annabel Desgrées du Loû and France Lert, *Parcours*… op.cit. ;
- acta Rencontres Santé – Société Georges Canguilhem, 7 and 8 October 2016, "*Migrations : enjeux pour la santé"* (Euro Cos & Humanisme et santé, Paris, Éditions de santé, 2017, 228 p.) ;
- and also various publications by the *Comité pour la santé des exilés* (COMEDE) already mentioned, in particular their report "*La santé des exilés",* Paris, éd. COMEDE, 2014, and their *"Guide pratique pour les professionnels pour les migrants en situation précaire"*, Paris, éd. COMEDE, October 2015, 543 p., as well as the activity reports of the "mission France" of Médecins du monde.

can also in some cases be set apart by the absence or deficiency of signing, separate sites, mediocre functionality, etc. and also as regards the services it renders because of a lack of suitable staff or an absence of operational connectivity, etc. The few visits by CCNE rather confirmed these findings. The duty staff is often very actively "dedicated", but mostly is not sufficiently taken into account as regards the institution's operations and full attribution of material resources allocated by the authorities. Regional public health authorities must encourage hospitals to allow the "PASS to get out and about" and be given the wherewithal to seek out "invisible" migrants in their camps and provide for their health and social needs, with a guarantee that they will not be reported to enforcement agencies.

The necessary complementarity between the PASS and migrant associations (which must be encouraged) plays a very useful mediation role, but this must not lead to absolving the PASS of its social responsibilities.

As for the welcome given to migrants in hospital departments, it tends to vary, both on the part of "ordinary" patients and members of the medical professions.

The dual effects of demand and supply of healthcare generates discrepancies which, in some cases, may be the cause of failings in patient management. This is rarely the case for emergencies but more frequent for everyday care.

One of the components of a solution to the problem is the way in which a hospital, or other static establishment or structure is able to "mobilise" its action (in particular literally become mobile) to go and meet the healthcare needs of people who express them sparingly.

Game-changing developments in Calais were first and foremost due to the presence there of various associations (*Médecins du Monde* — Doctors of the World, *Médecins sans Frontières* — Doctors without Borders, *Gynécologie sans frontières* — Gynaecology without Borders, *la Vie active*, and others), and subsequently the arrival on the scene of a hospital nurse followed by more personnel specially recruited by PASS.

In Paris, the *Agence Régionale de Santé* (ARS) says that it has rendered the mobile psychiatry and insecurity units (EMPP) "really" mobile so that they are able to reach out and offer assistance to migrants.

There is also a need to achieve a degree of coherence in hospitals between care focusing on morbidity which is generally adequate, and care providing a minimum of social and mental wellbeing for migrants for which most medical establishments are ill equipped to cope (except those who have specialised in this branch of care and are therefore at risk of being overwhelmed).
Since migrant flows are not about to cease, lessons learned in recent years must not be wasted. Increasingly, mobile units, or if they cannot be provided, nearby resources, possibly in the form of outposts providing information to people about available care and advising them to call on these resources if needed, must be planned and increased in numbers compared to today's offering. There must also be an effort to establish coordination between care in hospitals and the various street-patrolling schemes organised by NGOs so that particularly vulnerable people can be made more "visible".

The approach of "visible" migrants — whose presence in number in the Calais "jungle" or the Parisian pavements on the Boulevard de la Chapelle made them more noticeable — must be extended to those who are far less visible, by means of research on the finer details of migrant flows. A closer relationship with organisations whose experience is similar and complementary (the "street patrols[32] ") is a necessity and should lead to a more effective performance in approaching the sick.
Further thought must also be given to the social role of hospitals so that measures taken coincide with the extended meaning of good health that should apply.

The **third ethical imperative** is for the implementation of a **pertinent mode of linguistic and cultural communication with those concerned** so as to gain a **better understanding of their expectations** in the context of their admission into healthcare.

Understanding begins with language. "*Medicine cannot exist without narrative*". Treatment cannot exist in the absence of interchange between patients and healthcare providers.

The budget allocations to hospitals for the PASS include all their estimated expenditures, including those for interpretation (in accordance with circular DGOS/R4/2013/246 of 18 June 2013). But there can be significant stumbling blocks . The multiplicity of migrant inflows brings to France nationals from countries whose languages are rare (for instance the *Tigre* or *Nara* languages of Eritrea). Ethnic antagonisms or the frailty born of past, shared and distressing life experience are reasons to exercise caution when recruiting individuals from the same geographical area as "translators", "interpreters" or "mediators".

But understanding also means understanding the cultural context. As mentioned above, although medical matters may require a literal translation, for instance to identify clinical signs, above all cultural mediators are needed in order to understand patients' concerns and feelings regarding the state of their own bodies and the treatment they are receiving. This is a particularly crying need in psychiatry.

The solutions found to these problems by associations and the authorities are diverse; some of them work very well, such as the French Red Cross system calling on a pool of responsible volunteers, while other charitable institutions with very meagre resources are not nearly so fortunate. The use of telephone services such as *ISM-interprétariat* cannot be considered as satisfactory except in special circumstances for a short time.

So it must be reported that testimonies converge to the effect that budgetary allocations for the purpose of communicating with migrants are frequently too small. It is also generally recognised that the procedure for selecting participants is not satisfactory. General guidelines on this subject should be laid down in the light of experience and be applied. Trust between doctors and patients can only be established with the implementation of strict and concrete solutions.

[32] Lost in the midst of the "homeless" are many still "invisible" migrants.

The **fourth ethical imperative** lies in **the determination to establish priorities in the actions intended to ensure the welfare of migrants.**

The ICRC delegates who were heard by CCNE spoke of their experience when giving emergency relief following natural disasters, violent conflict or murderous attacks and vast numbers of injured people were in need of their help. They learned how to sort out on the spot the wounded who needed to be given first aid and evacuated immediately, without further delay, so as to improve their chances of survival and others, either because their chances of survival were nil or they were less severely injured. Allocation of priorities when engaged in rescue work is a necessity, not forgetting of course the need for care and sedation to provide relief for all casualties, be they lightly injured or dying.

The same is true for situations affecting migrants.
Recent experience of assistance to migrants has shown that emergency action needs to be ranked and that the first priority is giving shelter (including to families) to people exposed to poor weather, hunger, negligence, lack of hygiene, squalor and the resulting dirtiness, all of which cause suffering and humiliation.
After which, in a new environment, can in-depth health assessments and investigation of administrative status be undertaken (this was the object of a centre opened Porte de la Chapelle in Paris and in Ivry to take care of families, but experience has shown that the resources made available were unequal to the task of coping with the inflows of migrants).

Similarly, GSF (Gynaecology without Borders) worked in the Calais region at providing contraception training for women. But however essential this may be (in a context of almost commonplace sexual abuse) such educational efforts must be ranked after the immediate need for coping with pregnancy and childbirth, together with a transferable follow-up document for every woman concerned, to be also handed over to her for keeping.

As a corollary, this same regard for vital urgency must be an integral part of day-to-day hospital practice. When a person is about to be discharged from hospital after surgery or childbirth, for example, it is a deontological and ethical concern for all involved to consider the conditions awaiting their patients once they have left the medical environment so as to be sure that convalescence and return to health will not be severely compromised. For this reason, as already mentioned, a "post-care" centre was set up immediately adjacent to the *jungle* for the follow-up and accommodation by GSF of newly-delivered mothers once they leave hospital.

Generally speaking, what may be designated as the *a minima* objective for such priorities is to make certain that there are no circumstances which could lead to any aggravation of the physical, and also mental, health of migrants while they reside on French soil, originating in the neglect, or even discrimination which is not all that rare, of our reception and care system.

From an ethical viewpoint, the health issue in the meaning of providing elementary hygiene for people in distress, must not ever become a policy instrument. In the case of migrants, it must not be used as part of a determent and rejection policy.

The **fifth ethical imperative** is one of **equity**, meaning in particular **equality of treatment for access to healthcare and to physical, mental and social wellbeing.**

This demand for equity is included in the principles mentioned above favoured by AME and PASS. Equality of treatment for all is set out as such in the constitutional[33] instruments as well as in those setting up specialist healthcare instruments.

Today, in France, observable reality does not conform to this principle.

On this subject, three points are deserving of discussion, leaving aside the recurrent, obviously risky and costly enticement of eliminating AME some political leaders demand, as has already been mentioned.

The first point is matching budget allocations to the needs generated by the inflow of migrants. The situation of the Calais hospital, in a fragile financial position because of large recent investments (fixed assets for reconstruction and the purchase of new equipment) is revealing. Setting up of the PASS unit close to the "*jungle*" was achieved by more or less willingly consented "donations" of various items of furniture and instruments from other hospital services and detached personnel.

The funding of the MIG (general interest missions) by the Ministry of Health's DGOS (general directorate for healthcare), via ARS (regional health agency or agencies), does not seem to have taken place at the required level for meeting supplementary needs at a time when the number of people dependent on the PASS is building up (this number being the determinant for the amount of MIG funding); there has never been a time when extra funding matched expenditure.
In this respect also CCNE considers that poor administrative practices are above all the outcome of a disregard for deontology, or even an absence of ethical consideration on the part of their originators.
The only national contribution was made in the form of two on-site missions in October 2015 and September 2016, in response to local criticism of PASS commitment. As a matter of fact, the second mission validated the commitment and efficiency of the PASS.
Were the ARS to pay more attention to events which are frequently unlike each other, are difficult to quantify and to manage qualitatively, they would be better able to respond to the demands of the unexpected. Local assessment of needs, their analysis on a regional level and national public coordination — apparently poorly developed[34] — are now an absolute necessity.

The second point relates to conditions in which migrants are allowed to access care for themselves and their dependents. These are ill-matched to requirements.

The *Code de l'action sociale et des familles* (Code of social action and families) sets out in detail the procedures allowing people concerned to benefit fully from AME (State aided medical assistance). It lists for instance the supporting documents — only very rarely available to migrants and social services — to certifying the three months' presence on French soil required to access services: e.g. lease agreement, rent receipts or bills for electricity and water more than three months old, tax notifications, hotel bills dating back

[33] Article 6 of the 1789 Declaration of Human Rights and Artile 1 of the 1958 French Constitution.
[34] There is an association of practitioners operating in the PASS units.

to over three months, confirmation of over three months of residence delivered by a centre for accommodation and social rehabilitation, document recording applicants' resources (2° of Article 4, decree of 28 July 2005). Such documents may sometimes be produced by particularly fortunate migrants, that is those who happened to be registered in the system for assistance to people in precarious circumstances.

This is absolutely not the case of the vast majority for whom such demands are totally unrealistic. The outcome is a considerable administrative burden put on the shoulders of hospital social workers who are obliged to search for elusive solutions with a haphazard rate of success, depending on the response of the local unit of the national health insurance scheme.
The Calais hospital is a striking case in point: until the end of 2014, people admitted to hospital without any AME or CMU support were accepted with a waiver for "*the delivery of urgent medical care*" financed as such by the competent health insurance unit with the usual costing scale (codified as T2A). But as of January 1, 2015, the health insurance scheme demanded the creation of a personal file allowing (or disallowing) the provision of healthcare for migrants admitted to hospital by AME. Funding for urgent care therefore ceased. As a result, it became almost impossible to respond to these requests from the health insurance scheme since very few of the migrants were able to produce a document certifying their presence in France for more than 90 days or reliable identity documents (out of 660 cases under consideration in 2015, only 23 had a favourable outcome). As a result, the hospital was overwhelmed with a multitude of unpaid debts and a financial imbalance more or less compensated by non-renewable credits from ARS.

There was then a temporary slackening in the health insurance unit's demands, but this did not carry over to the following budgetary exercise. To the lack of relevance to reality of the regulatory requirements is added the unpredictable behaviour of the various players concerned which frustrates any attempt at implementing a sustainable policy.

This local situation is corroborated by an enquiry organised by ANRS-Parcours in 2012-2013, confirming that refusal of CMU or AME support or other difficulties to obtain "sickness insurance" cover are the main reason for migrants being turned down from obtaining healthcare after their arrival in France[35]. Such difficulties, and this is also true for enrolment to supplementary health insurance schemes, explains the high level of failure to seek healthcare and consequently the high level of migrant health deterioration once they have arrived in France. The degree of such deterioration is, by its very nature, difficult to quantify.

The question therefore arises, and this is our third point, of the possibility of an unconditional entitlement of the right to AME once it has been found in good faith that a migrant's situation conforms to the criteria set by law, if necessary with the assistance of a third party in the form of a representative of an association. In any event, the situation as it is today simply adds considerably to the workload of hospital social workers in order to help a handful of patients. The time spent on this task, which is therefore not available to assist other patients, is a significant factor in the resentment some French people — the most deprived in particular — feel about what they see as the harmful effects of the presence of migrants in their country.

---

[35] Cf. *Parcours…*op.cit. p. 131.

The fact that a large proportion of the material living conditions of migrants (food, housing, hygiene, healthcare etc.) is managed solely by local and national associations leads to fragile funding procedures as there is no or only partial official commitment[36].

In fine, the **sixth ethical imperative**, which is an essential one, is that of **solidarity** which, since we are referring here to the elementary needs of human beings, can be given the name of **fraternity**. And, since these human beings come from afar, that of **hospitality**.

There have been any number of unconditional, prolonged and inventive commitments to come to the assistance of migrants, in particular and perhaps mainly, on the part of associations, but also by members of the medical professions, social workers and administrative personnel, in hospitals but not only in hospitals. They have followed the example of the Mayor of Palermo in Sicily, declaring that every migrant is an "inhabitant of Palermo". There have also been examples, and this is probably unavoidable, of indifference and hostility. The same pattern emerged with local populations developing experimental and original forms of hospitality based on respect for "otherness" and the protection of individual dignity although there were also some examples of rejection.

It is also true that the public discourse has not for a long time shown any evidence of favouring solidarity, nor of realism in the face of inevitable population movements. It has above all sought to diminish their effects.

At the same time, purely technical events (such as the evacuation of gathering points) are eagerly played up, in circumstances which only too frequently display failures of public policies (lack of prior warning, poor follow-up of existing conditions, disruption of fragile established social relationships, traumatic events of an emotional — and sometimes physical — nature inflicted on the individuals concerned, etc.).

The testimonies we heard reported that human beings, who were hopeful of the reception they would be receiving from a country such as our own, have often and quite justifiably expressed their astonishment or anger at being "welcomed" in conditions of such precariousness, harshness and even sometimes inhumanity in a country as rich as ours when compared with the poverty of their own countries. To call on some of them to be willing to work at integration into the French environment supposes also that this society of ours will be forthcoming in expressing its willingness and capacity to assert and put into practice the values for sharing and equity it already believes in.

---

[36] As an example, the Gynaecology without Borders Association, for its operating costs, i.e. around €8,000 per month (maintenance and heating of examination rooms, logistics for "street patrols", transport logistics — over 5,000 km per month for the van they use — and supplies for examinations) has received no grant from ARS. The Association makes do with the proceeds of appeals for charity and for financial help contributed, for instance, by the *Conseil départemental du Nord*, from the Delegation for Women's Rights for the Pas-de-Calais region and the Ministry of...Culture! Such conditions, obviously less strenuous for larger associations, remain precarious for smaller ones so that the continuity of efforts to continue their action becomes less plausible.

Administrative authorities and care providers must become aware of the dimensions of the problem. The entire French population must be must be informed in good faith and come to terms with its responsibility for the treatment handed out to people who are in exile, who are migrants, who are here illegally, but who are also highly vulnerable.

Some structures may be momentarily in some difficulty (accommodation, care) because of unexpected inflows, but overload cannot be accepted as the default setting. Such effects will be all the more frequent when they are concentrated in a given area or areas instead of being spread out. *A contrario*, the centres for reception and guidance distributed over the whole country have turned out to be a positive step and have fostered the appearance of many diverse expressions of solidarity, more than expected.

In addressing the subject of migrants' health, CCNE had no wish to take sides in the political dimensions of the issue (size of flows, etc.). The Committee noted, however, that we were facing a complex situation for which the solutions implemented by public agencies were not, on the whole, responding adequately to today's and tomorrow's challenges. CCNE considers that, as matters stands at present, there is no insurmountable reason why migrants' healthcare needs cannot be met honourably and decently. One prerequisite, however, would be to make convincingly truthful, trustworthy and, later, encouraging public statements on the subject, as a corollary of more fit-for-purpose public policies. CCNE states categorically that, as regards migrants, as is the case for any person in distress, health in the meaning defined by WHO, cannot ever be instrumentalised, in particular by perpetuating insanitary conditions as an instrument of rejection. In choosing to give prominence to respect for human dignity, CCNE emphasises that the ethical imperative of solidarity is expressed by a spirit of fraternity, in particular as it is extended to those entering French territory and the duty of hospitality which is owed to them.

Opinion adopted unanimously by the members of CCNE on 7 September 2017.