Healthcare for migrants: rejecting the unacceptable

At the "Prescrire Prize" book awards in October 2016, we held a conference and debate on the theme: "Healthcare for vulnerable migrants. Taking action to ensure access to high quality care for everyone". The following excerpts are from the presentation given by Arnaud Veïsse, the director of the French Committee for the Health of Exiles (Comede: *Comité pour la Santé des Exilés*).

Conceptions about migrant care are varied and have changed over time. For example, one school of thought advocates separate care services for migrants. This is also seen in assertions designed to convince people that migrants have specific health problems, associated with their culture or with torture, and in the whole range of measures put in place for migrants, as if it were not possible to integrate them into our public services and as if dedicated centres to provide health care to migrants were truly necessary.

This is not our experience at Comede, and it really is not compatible with the diversity among the people who come to us. In our opinion, [separate services for migrants] are not necessary; on the contrary, we must first and foremost strive to dispel these conceptions.

Migrants do have specific issues, but what are they?

When we look at the epidemiological data and work with these populations, we see that what sets migrants apart is basically the coexistence of multiple vulnerabilities, and some of these are specific to varying degrees.

Their place in society. Because migrants lack the same rights as everyone else, their integration and access to the law require considerable work on various fronts. We must inform ourselves, or educate ourselves, or at the very least be aware of the health rights afforded to foreigners, rights that depend on their administrative status, on the place the law gives them in society. We must also forge links with a network of professionals and non-profit organisations that can do this work.

Communication difficulties. How can we provide healthcare to people who have recently arrived in France and do not yet speak French? The ability to talk to each other is surely a pretty basic requirement, and yet public healthcare services in this country still all too rarely use professional interpreters. Contrary to what one might assume, the few studies conducted on these issues by the French Ministry of Health, with the participation of Comede and others, have shown that the cost of hiring professional interpreters is neither the only nor the main reason. Instead, it is yet again mainly a matter of conceptions.

In a nutshell, there's an attitude of: "*Well, we don't really need an interpreter, we can do without one, we'll manage with our colleague who speaks a little of the language, we'll manage with the child who speaks a little French because he started school quickly and learned rapidly*". At any rate, you take a certain number of risks when you do this sort of thing. First, because it's inappropriate: this French-speaking child is sometimes placed in the middle of a healthcare situation that will entail discussions about violence or abuse suffered by the mother, father or other relatives, that the child doesn't necessarily have to know about. And second, just because someone can speak a little of the language does not mean that they have mastered the profession of community interpreting.

This is therefore an important aspect of quality healthcare, in all disciplines. In fact, the use of professional interpreters must be expanded, and not just in healthcare and social work more generally: the experience of Comede and others shows that once you start using professional interpreters, you can no longer do without them. In both cases, the difference in the quality of care is plain to see.

Inhospitality and health. These are not specific to migrants, but are more frequent in this population. In brief, it's the whole question of discrimination of various types, and the impact on health of an inhospitable, xenophobic environment. On the other hand, the epidemiological data run counter to a number of widely-held beliefs, since they show that infectious diseases, which are often associated with notions about migrant health, are less frequent than mental health problems.

Psychological trauma. Psychological trauma obviously occurs in this context of exile, violence (including sexual violence) and torture. The annual reports from Comede's monitoring contain some rather enlightening statistics: more than two-thirds of migrants have been subjected to violence (based on the WHO's definition of the term), over one-quarter have been tortured, and over one-third of the women have been subjected to gender-based violence. To give you a rather chilling example: at least one in five of the pregnant women receiving care at the Comede health centre became pregnant as a result of rape. We're referring to violence that occurred in the migrant's country of origin for recent arrivals, but also and increasingly violence that continues to occur in France. This violence is directly related to the vulnerability that we have talked so much about, the fact that people live on the streets and are at the mercy of everything and

everyone. They therefore find themselves in a very precarious and vulnerable situation.

This vulnerability can be shared by other people in the general population, but its cause is quite specific. This brings us back to exclusion at the administrative level: how can people integrate into society when they do not have the right to have rights?

What are the challenges for healthcare professionals?

[…] One of the challenges for everyone involved in healthcare for vulnerable migrants and exiles, under these conditions, is to reconcile two principles. It's certainly not easy, and everyone tries to do the best they can.

Rejecting the unacceptable. The response to this situation is not to devise a form of medical care just for the vulnerable, in which it is accepted that we cannot treat everyone in the same way and that the most vulnerable migrants must therefore do without care considered necessary for the general population. Nor do we respond by practising in France the kind of charity medicine that certain humanitarian workers practised in developing countries 30 years ago. In our opinion, this would be moving in the wrong direction, because the goal is to fight exclusion, not to facilitate exclusion.

Rejecting the unacceptable means continuing to be outraged every time we feel a situation is not compatible with the right to healthcare and access to high quality care for all. Although having said this, such situations are described on a daily basis at the Comede health centre and seen elsewhere by others. These situations are often unbearable, because a highly vulnerable patient is allowed to leave the consultation and go back onto the street. And we know, for example, that Paris's emergency social services (*SAMU Social de Paris*) currently only have accommodations for half of the people who contact them every day.

This means, as you know, that many people are homeless, including disabled people in wheelchairs, pregnant women, unaccompanied minors. Some categories of migrants are even more vulnerable than the rest and have additional vulnerabilities.

A different approach. We often feel powerless to solve the serious problems of the person in front of us. But we must also remember that healthcare for exiles, who have suffered so much trauma, first and foremost means to welcome and listen to the person, and to offer recognition, healing and human interaction.

We've all had the rather strange experience of feeling that we haven't really been able to make any difference at all, and yet of having someone in front of us who thanks us, because we devoted some time to them, because we were able to talk to each other, because we gave them some information, and because our approach to them was different from the way in which they are used to being treated in society. It is a modest reminder of the importance of care even when we don't have all the tools to heal, which is certainly the case when the problem is social exclusion.

This does require us to bear the unbearable, however. Because when you work under these conditions with a population subjected to exclusion and violence, you have to accept a great deal of powerlessness, frustration and outrage.

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