



The health of asylum seekers and refugees housed in CADA (Reception and Accommodation Centre for Asylum Seekers) and CPH (Temporary Accommodation Centre) IN 2008



STUDY BASED ON MEDICAL EXAMINATION FORMS

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I - INTRODUCTION and METHODOLOGY:

As in previous years, the survey took place with a slight lag, from 15 February 2008 to 15 February 2009 so as to take into account the inevitable delay between the OFPRA (French Office for the protection of Refugees and Stateless Persons) decision and the actual medical examination.

The target public are asylum seekers processed by the Dispositif National d'Accueil (DNA - National Reception System) for which the OFII (French Office for Immigration and Integration) has been managing the health component since 1 January 2003, and the accommodation part since 1 January 2004.

This system is composed of CADA (Centre d'Accueil d'hébergement pour Demandeurs d'Asile - Reception and Accommodation Centre for Asylum Seekers), CPH (Centre d'Hébergement Provisoire - Temporary Accommodation Centre) and provisional or transient structures linked to this system (e.g.: AUDA (Emergency Reception for Asylum Seekers). It should be noted that since 2003, many transient structures have become CADA. The system included 217 structures in 2004, 245 on 1 January 2006 and 271 on 31 December 2008 (with a total of 20 410 places).

The number of asylum seekers has grown by 16.7% relative to 2007¹. In 2008, entries grew by 7.7% at a constant capacity:

12 402 entries

The method of managing the structures is almost always associative. Of the "hostel" type structures, the ADOMA and AFTAM are the two main operators. France Terre d'Asile, the traditional operator, is also present among the expanded structures and throughout the Ile-de-France. The associative group "Forum Réfugiés" (Refugee forum) occupies a comparable position in terms of legitimacy in the Rhône-Alpes region.

The people concerned by this survey are essentially those who were admitted to a DNA-dependent establishment in 2008, called "incomers", and those who left these same establishments *having obtained refugee status, called "out goes" (i.e. looked after under the Geneva Convention and not by the 1945 order²)*.

The basic forms used for the survey have been available since 2003. They are filled in by referring physicians for *asylum seekers on their arrival at*

¹State of the National reception system for asylum seekers and refugees in 2008-OFII- April 2009.

² People who have been *regularized* or awarded an APS (Temporary Residence permit) for medical treatment are not included among the "outgoes"

the CADA (Reception and Accommodation Centre for Asylum Seekers)³ (so-called incomers "blue" form). Similarly, the referring physicians fill in a second form once the asylum seekers obtain *refugee status* (so-called *out goers* "yellow" form).

Asylum seekers and those obtaining refugee status and their families are concerned by the survey. The first medical visit gives the asylum seeker and family access to the treatment system by choosing a referring physician and this constitutes the first health examination. The outgoing consultation leads to a medical summary and evaluation of the individual impact of the health measures instigated on the basis of the entry visit. The study consists of a reflection on the demographic and health situations at both these times, from admission on requesting asylum until refugee status is acquired. Some files (incoming/outgoing) may concern the same person.

For both forms, the items to fill in are identical and the declaring physicians are the same⁴, so that optimal comparability is ensured between both series of data.

The length of stay in a CADA is highly variable and the decision, even if taken rapidly by the OFPRA (French Office for the Protection of Refugees and Stateless Persons) or CNDA (National Health Insurance Fund), has no direct influence on reception centre *turnover*. Indeed, administrative, employment and, above all, social housing problems later on can delay the transfer of new statutory refugees from CADA centres, although it is desirable for the managers as well as those concerned.⁵

The growing number of rejections by the OFPRA since 2006 has had the unexpected consequence of making it harder to leave the CADA: claims are more frequent although these establishments are designed to be transition zones. Furthermore, statutory refugees cannot be asked to prolong their stay at a CADA and even less be forced to remain there.

Therefore, on receiving their certificate, some leave the CADA very quickly without having the exit medical examination and without going via the nearest OFII (French Office for Immigration and Integration) or signing the CAI (Reception and Integration Contract). Part of this problem could be improved by having closer, and above all, institutionalized contact between the OFII Management, the Prefectures and the CADA centres.

³ As far as possible within a maximum of eight days!

⁴ as a general rule

⁵ And the public authorities, of course.

With this in mind, transferring the medical examination for statutory refugees to the regional OFII platforms is being evaluated in several regions.⁶

II - EVOLUTION OVER 4 YEARS:

Comparison of the number of medical examination forms per year relative to the number of "incomers" and "out goers" provided by the DAI (Director of Reception and Integration) and the OFII:

YEAR	2005	2006	2007	2008
Incomers	10161	11810	11509	12402
Outgoers	9142	10302	10724	11817
	Medical forms	Medical forms	Medical forms	Medical forms
Incomers	5796 (57 %)	6626 (56,1 %)	5476 (47,5 %)	8849 (71.35%)
Outgoers	4719 (52,6 %)	2669 (25,9 %)	3196 (29,8 %)	4143 (82,9%)

In 2008 the analysis concerned almost all those transiting via CADA centres.

III - Survey objectives:

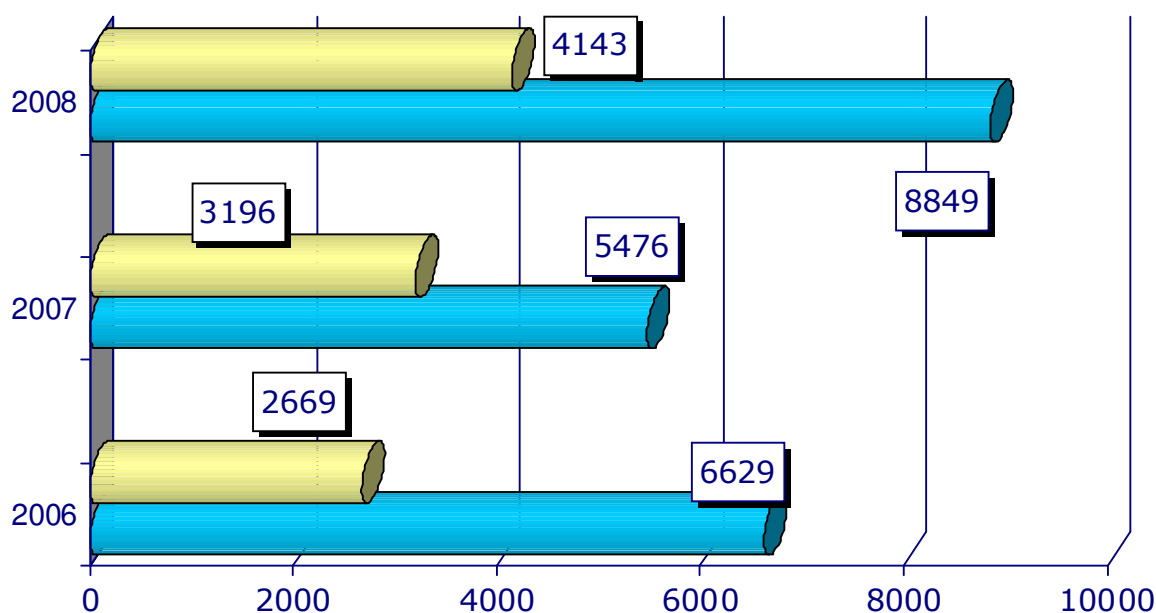
- Analyze and compare the state of health of asylum seekers on arrival at the CADA and on obtaining refugee status.
- Evaluate the benefits to their health of treatment in a CADA.
- Specify the main health problems faced by asylum seekers as a population exposed to specific risks and envisage general or specific solutions to their situation.
- Demonstrate the strong points and the weak points of the French health system relative to asylum seekers' health problems.

IV - DEMOGRAPHIC RESULTS: STRUCTURE OF THE STUDY POPULATION.

IV - 1 - Global distribution:

The secretariat of the National Admission Commission (CNA) listed 12 402 actual entries representing asylum seekers and 11 817 exits, of which 4 999 were refugees and 2 600 people whose status `was being examined.

⁶ PACA (Provence-Alpes-Côte d'Azur), Languedoc Roussillon, Auvergne, Limousin, Poitou-Charentes, Nord-Pas-de-Calais, Upper and Lower Normandy.



CADA INCOMERS: The 2008 analysis concerned **8 849 forms** for asylum seekers entering CADA centres (so-called blue forms), versus 5 472 in 2007, i.e. an increase of 61.7% in the number of medical examinations of entries filled in.

For all the CADA centres, the entry medical forms listed for this study constituted 71.3% of the total number of asylum seekers at CADA centres (and for whom the results were sent to the DSP (Public health department)).

This increase in the number of dossiers listed (+61.7%) is distinctly greater than would be caused by the simple increase in numbers of entries observed over the year (+7%). It could be due to better access to medical consultations because of greater awareness of associative partners with referring and hospital physicians, as well as the work done by social referral agents to ensure that health cover access is provided within a reasonable time. This authorization of social rights still poses problems with certain local funds however.

CADA OUTGOERS⁷: The study concerns **4143** so-called yellow forms, used for refugees' medical examinations (of the 4 999 who obtained this status), versus 3 196 in 2007. The observed increase of 29.6% also reflects an improvement in the number taking the medical examination⁸.

⁷By "CADA out goers", we include only people leaving a CADA centre with refugee status or subsidiary protection. Those regularized one way or another, and those dismissed, are not included in this field

⁸Under strong pressure from the department, and better communication about the objectives of the forms produced by the DSP and its zone coordinating physicians.

These dossiers represent 82.9% of the total number of out goers received for medical examination, and whose results were sent to the DSP. This is very close to the actual number of refugees and is more representative. Like the increase in incomers, it testifies to a higher number of people having their medical examination at these key moments in the refugee process. They should have better health as a result: any prevention or follow-up actions must go through these examinations and eventually improved treatment will lower the number of curable pathologies.

IV - 2 - Distribution by zone

5 Zones were defined in 2002 for mainland France (the only area so far concerned by this device).

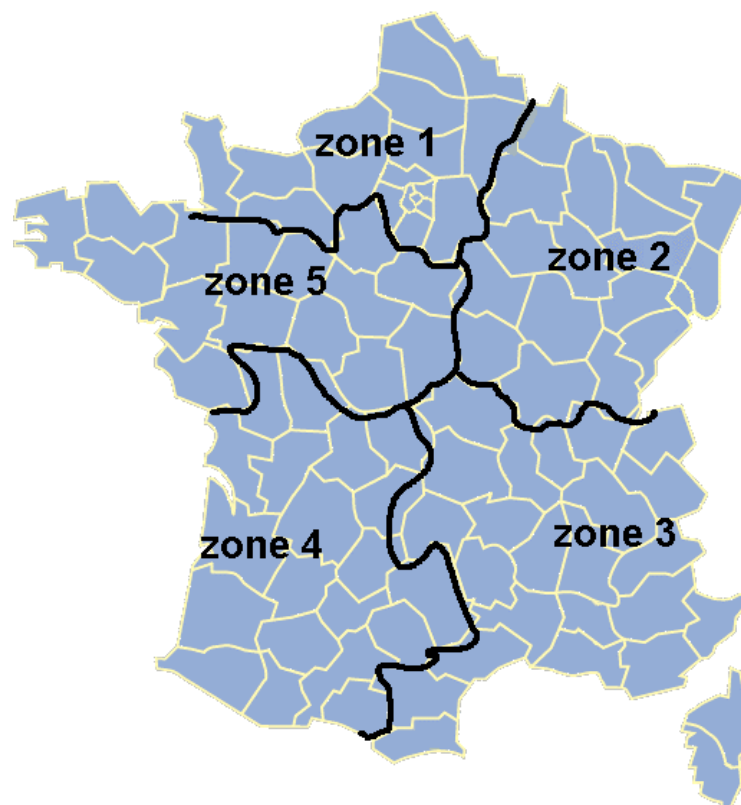
Zone 1 : This zone includes the Ile-de-France, Nord-Pas-de-Calais, Upper Normandy, Lower Normandy and Picardy regions. Total 6098 places (**29.8% of the total number of places**) .

Zone 2 : This zone includes Alsace, Champagne-Ardennes, Bourgognes, Franche-Comté and Lorraine regions Total: 4239 places (**20.7% of the total**).

Zone 3 : This zone includes Auvergne, Languedoc-Roussillon, Provence-Alpes-Côte d'Azur and Rhône-Alpes regions. Total : 4691 places (**24% of the total**).

Zone 4 : This zone includes Aquitaine, Limousin, Midi-Pyrenees and Poitou-Charentes regions. Total : 2145 places (**10.5% of the total**).

Zone 5 : This zone includes Brittany, Centre and Pays de la Loire regions. Total : 3237 places (**15% of the total**).



Total admissions:

Zone 1 : 3807 persons-
Zone 2 : 2323
Zone 3 : 3341
Zone 4 : 948
Zone 5 : 1813.

The pyramid of nationalities within the CADA varies from one zone to the next and this influences the types and frequency of pathologies detected.

Thus, zone 1 had more than half of the people of Asian and African origin admitted into CADA centres. Zone 3 has mostly asylum seekers from Eastern Europe (28.3%).

It is difficult to give more details because other parameters are involved in the study: family structure, singles or minors for example.

Asylum seekers.

In general admission data, and from the number of medical examination files received, zone 1 predominates over the others with the greatest capacity for reception in the country. Zone 3 logically follows, also because of its reception capacity but the number of incoming files is lower than expected because turnover is less in the CADA centres.

In addition to the differences in reception capacity, the number of files returned to the DSP varies from one zone to the next, particularly for zones 3, 4 and 5:⁹

Zone 1 : 30.7% of total admissions and 30.7% of total medical files;

Zone 2 : 18.7% of total admissions and 18.7% of total medical files;

Zone 3 : 26.9 % of total admissions and 22.6% of total medical files;

Zone 4 : 7.6% of total admissions and 11.1% of total medical files;

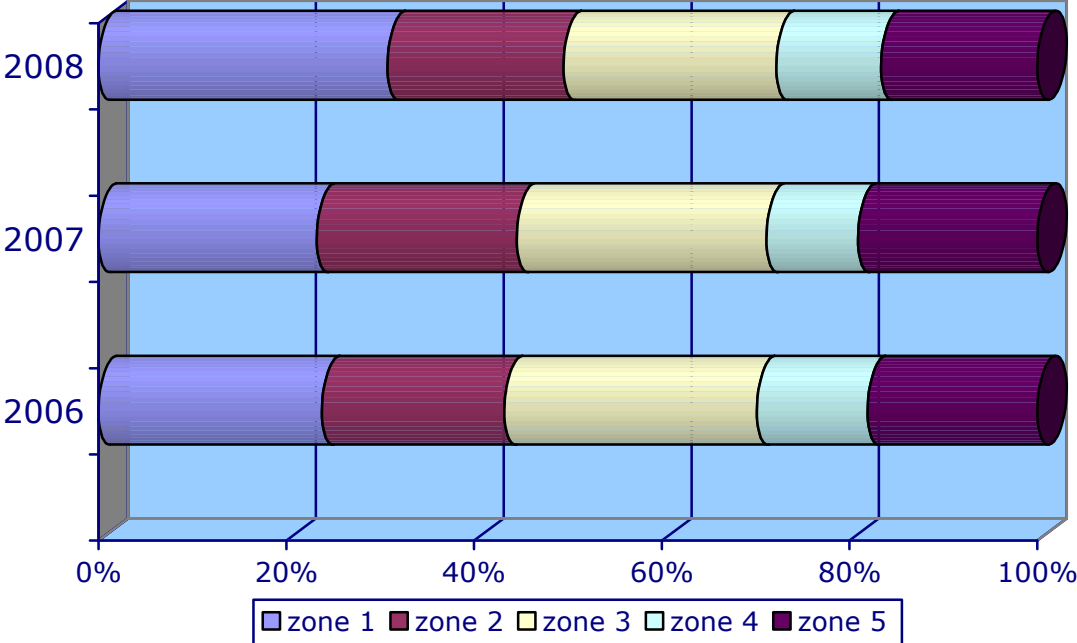
Zone 5 : 14.6% of total admissions and 16.6% of total medical files;

DISTRIBUTION OF MEDICAL FILES PER ZONE:

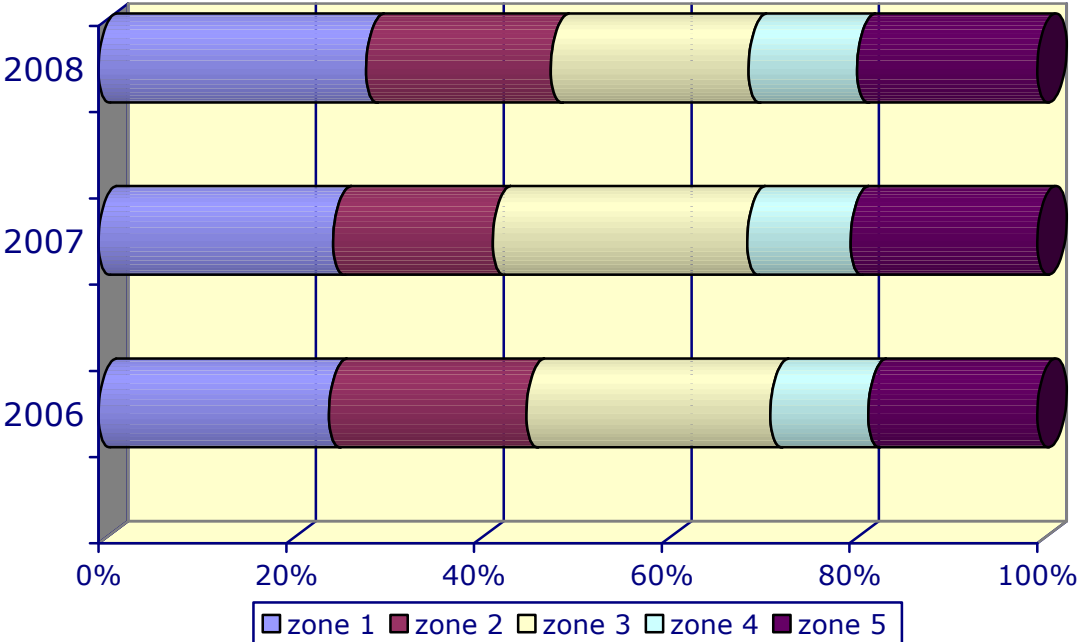
FOR ASYLUM SEEKERS (INCOMERS) In terms of information feedback, relative to the volumes of files per zone, zones 1 and 4 show distinct progress with 114% and 85% more respectively for this year. However,

⁹ There is no plausible explanation for these variations, particularly in zone 4, except that this zone was without an appointed medical coordinator for quite a long time...

the increase concerns all the zones: for zone 2 it was 42.2%, for zone 3 37.9% and for zone 5 40.9%.



FOR REFUGEES (OUT GOERS) zone 1 is also predominant with nearly a third of refugees in number as well as in the number of medical files received.



This zone did not record the highest increase in the number of files returned to the DSP (47.8%) but zone 2 did (+50%). In zone 3, the increase was only 0.8%, in zone 4 it was 36% and in zone 5 25%.

IV 3 - GENDER-RATIO:

The gender-ratio of both populations (asylum seekers and refugees) having medical examinations is balanced.

	Asylum seekers (N: 8849)	Refugees (N: 4143)
Men	4696	2090
Women	4153	2053
Gender-ratio	1.1	1

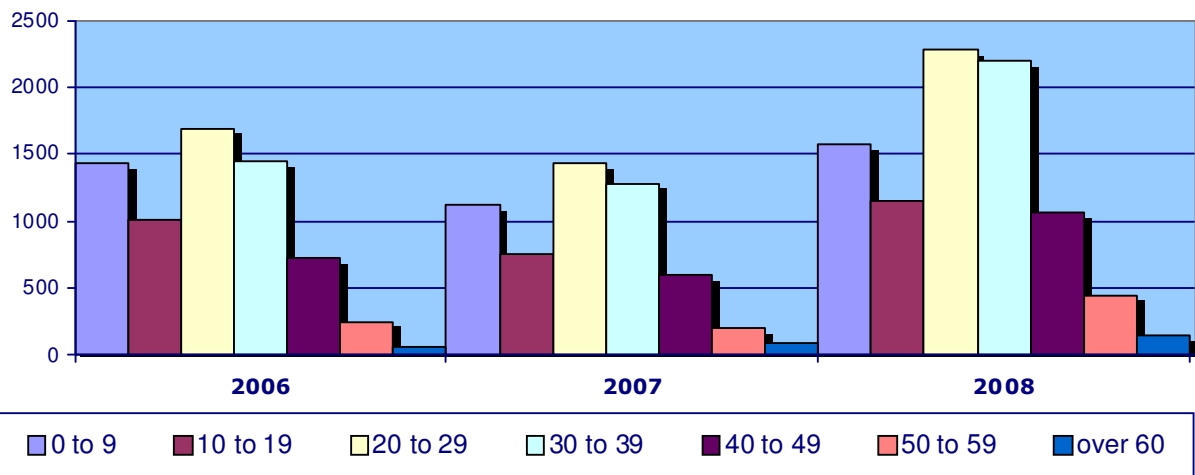
IV 4 - DISTRIBUTION BY AGE CATEGORY AND GENDER:

Asylum seekers:

The two predominant age categories from one year to the next are 20-29 and 30-39 years old. These are also the ones which do not vary much in percentage (25.8% and 24.8% respectively).

On the other hand, the 0-9 and 10-19 categories have been falling steadily since 2006: the 0-9 range fell by 3.9 points and the 10-19 by 2.1 points: they are at 17.7% and 13% respectively of all age categories this year.

The number of "incomers" files is increasing and the characteristics of age

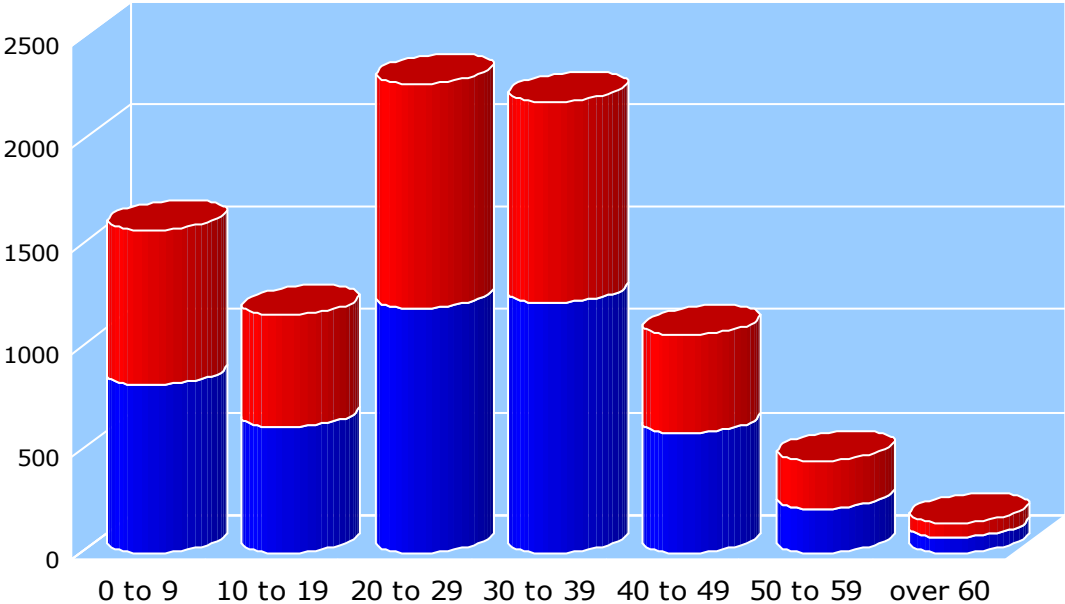


distribution are being confirmed.

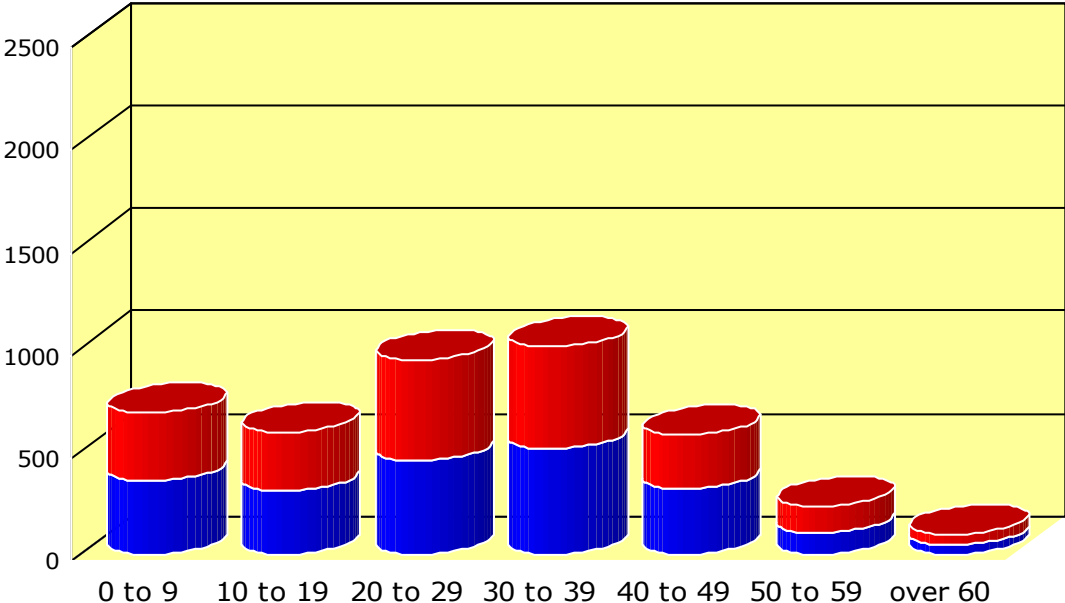
FOR 2008:

FOR ASYLUM SEEKERS, as a percentage the 20-29 year olds represent 25.8% of incomers of all ages, the 30-39 year olds 24.8%, then the 0-9 year olds at 17.7% and the 10-19 year olds at 13%.

There is no preponderance of one gender over the other for any age category.



FOR REFUGEES here also the age categories which have been falling over the past two year are the 0-9 year olds (-5.9%) and the 10-



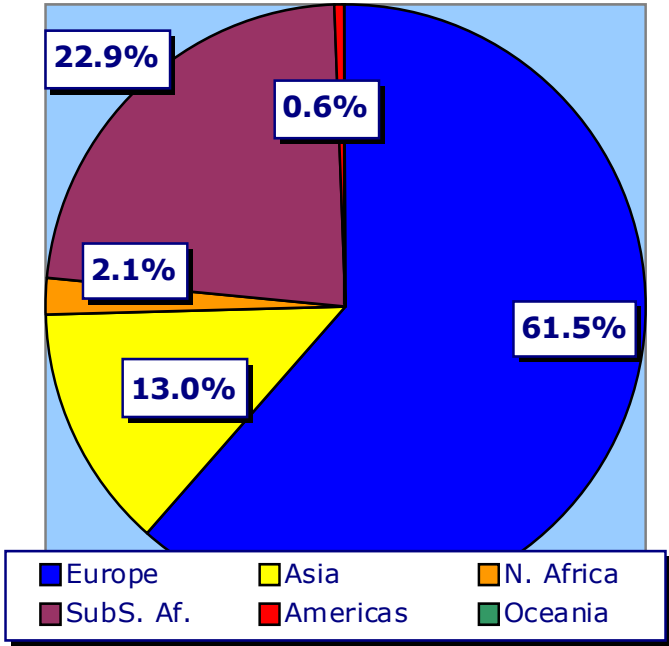
19 year olds (-2.6%). This drop is connected to the fall in these age categories observed on entry.

For both populations, the 0-9 and 10-19 age categories still represent one third of the total. On the other hand, the variation in age categories from 20 to 39 years old is not significant enough to affect health.

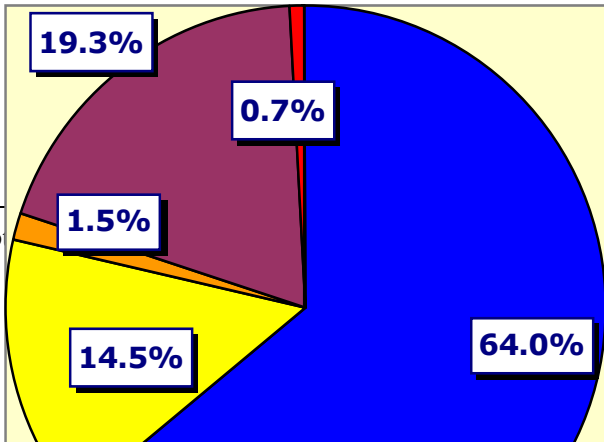
IV - 6 - CONTINENTS OF ORIGIN:

For asylum seekers, the number of people of Asian origin (13%) has been growing steadily every year and is nearly twice that of last year (7.8%). One of the reasons is the reception of Iraqi nationals belonging to minority groups which are extremely vulnerable¹⁰.

- Europe's share (61%) is still largely in the majority this year: it consists essentially of people from 4 countries: Russia (mainly Chechens), Armenia, Serbia and Kosovo, 95% of whom are families with children.
- For North Africa (2%) they are mainly from Algeria.
- From Africa (23%), they are mainly from the Congo Brazzaville, then Guinea Conakry and Angola. Numbers have fallen by nearly 3% in one year (with the overall number of asylum seekers increasing). Colombia is the main American country (1%) represented by asylum seekers.



Concerning refugees, the distribution per continent of origin is not much different from that of the incomers, except for people from Sub-Saharan Africa (- 4 points relative to African asylum seekers).

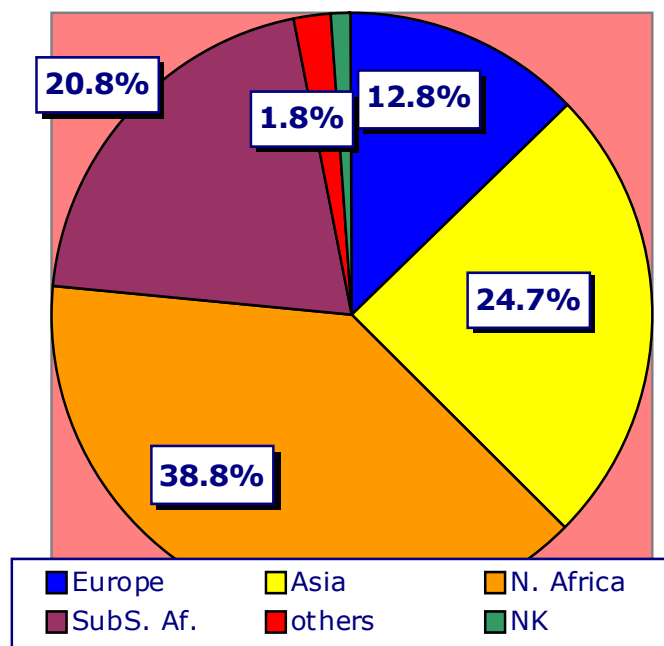


¹⁰State of the National recep

II- April 2009.

Comparison with the geographic origin of primary migrants (2008):

The "data-week" survey of 2008 concerning analysis of the medical examinations undergone by primary migrants can be used, with all relativity maintained, to highlight **highly significant differences**¹¹ in migration zones and thus define specific objectives (see the 2008 Health report on primary migrants).



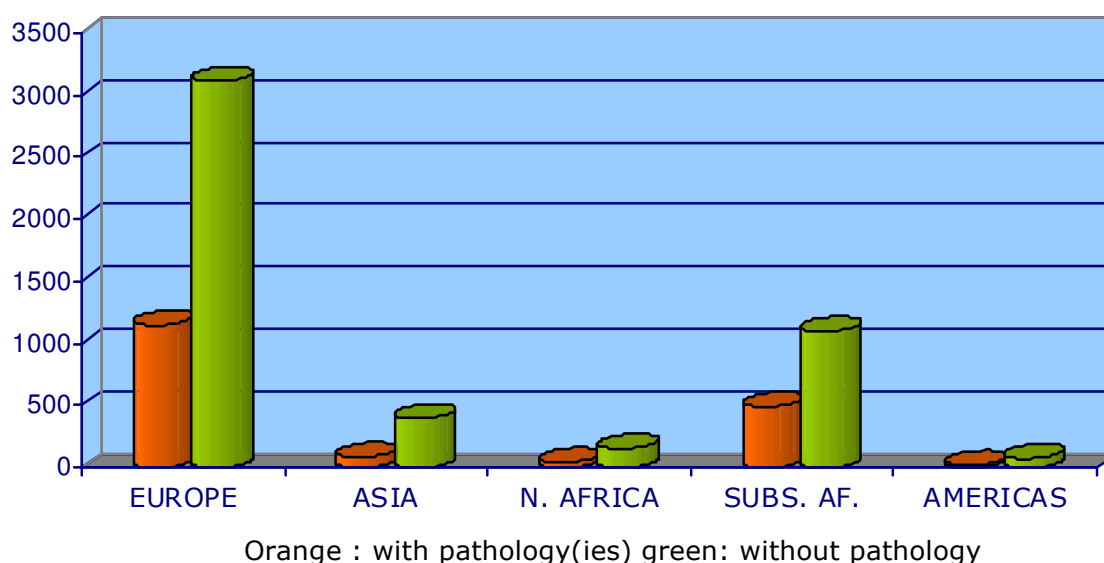
Source: The health of primary migrants in 2008 - Study based on "given week" surveys (M. WLUCZKA & Thierry KERN, OFII-DSP, 2009)

¹¹ Except for Sub-Sahara Africans apparently (around 20% in all cases). But it does not involve the same countries. Primary migrants are almost all from North Africa (39%). Asia is increasing this year as it did last year.

V - ANALYSIS OF MORBIDITIES IN CADA AND CPH (Temporary Accommodation Centres):

V - 1 ASYLUM SEEKERS:

This table takes the number of medical files notifying the presence of one or more pathologies, for all diseases (see later "pathology data" for details). It gives a general assessment of the state of health, is used to compare with previous years and evaluate the measures to be taken in priority.



Files with at least one pathology in 2008: Comparison with 2007 data:

	Europe		Asia		North Africa		Subs Africa		Americas	
	2008	2007	2008	2007	2008	2007	2008	2007	2008	2007
WITH PATH. N and %	1148 27%	585 17%	88 18%	63 15 %	45 22,4%	20 18%	493 31%	328 23,4%	22 2%	7 11%
WITHOUT PATH. (N)	3107	2873	396	360	156	92	1097	1073	77	48

As in previous years, people from Sub-Saharan Africa have the most pathologies (previous or current history), following European asylum seekers.

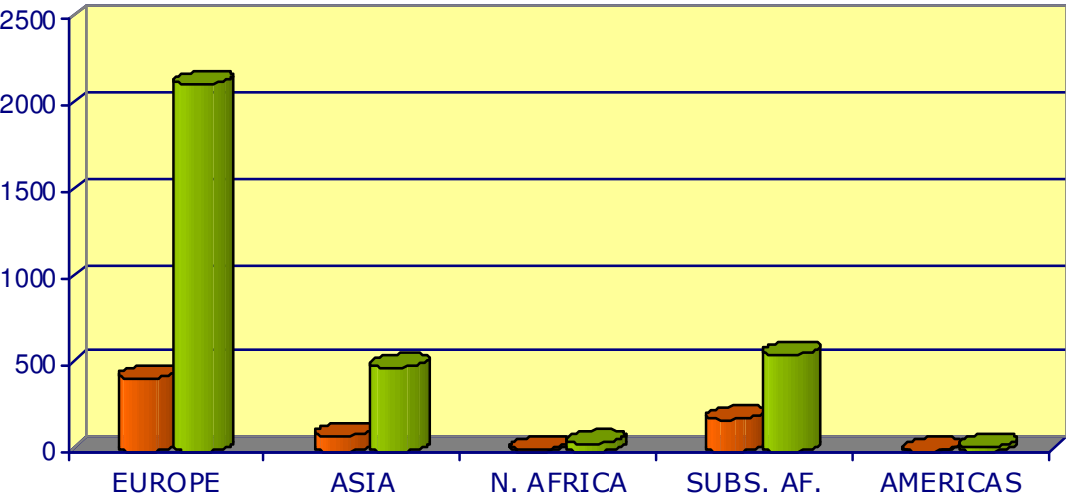
Comparison between 2007 and 2008 shows **marked differences**: unlike 2007 where a fall in the number of medical files *with* pathology/pathologies was noted (-10.6% for all continents), this year the

percentages are higher (+3.3% on average), apart from the Americas but its low numbers make the results insignificant.

Distribution is not uniform because the increase in the number of files for asylum seekers essentially concerns Europe, where those for Africa are falling. However, for those, the number of files *with* pathology/pathologies compared with the total number of files for people from this continent has increased by nearly 8%: doubtless the quality of returned files has improved for certain points, but we cannot exclude the hypothesis of a significant drop in the state of health of African asylum seekers¹²

Another observation between 2006-2007 and 2007-2008, the size of variations in the numbers of files within each geographic zone is comparable¹³

V - 2 - REFUGEES:



The greatest prevalence of pathologies noted on leaving CADA centres, not surprisingly concerns people of African origin, but with an improved state of health: a 6% fall in files *with at least one pathology was noted on departure*.

Overall, all cases with pathologies, no matter what the continent of origin, are falling. *The steepest drop in out goes from CADA centres concerns people of European origin (-10.4%) and the smallest was Asia (-2.8%).*

¹² analyzed later in the chapter on "files per geographic zone"

¹³ this may indicate a certain consistency in the quality of information provided on the incoming/outgoing forms

Files with at least one pathology in 2008. Comparison with 2007 data:

	Europe		Asia		North Africa		Subs Africa		Americas	
	2008	2007	2008	2007	2008	2007	2008	2007	2008	2007
WITH PATH. N and %	422 16,6%	234 11,9%	89 15,4%	34 10%	11 19%	9 10,6%	187 25%	95 12,7%	3 11%	3 7,9%
WITH OUT PATH. (N:	2123	1736	488	303	47	76	560	652	25	35

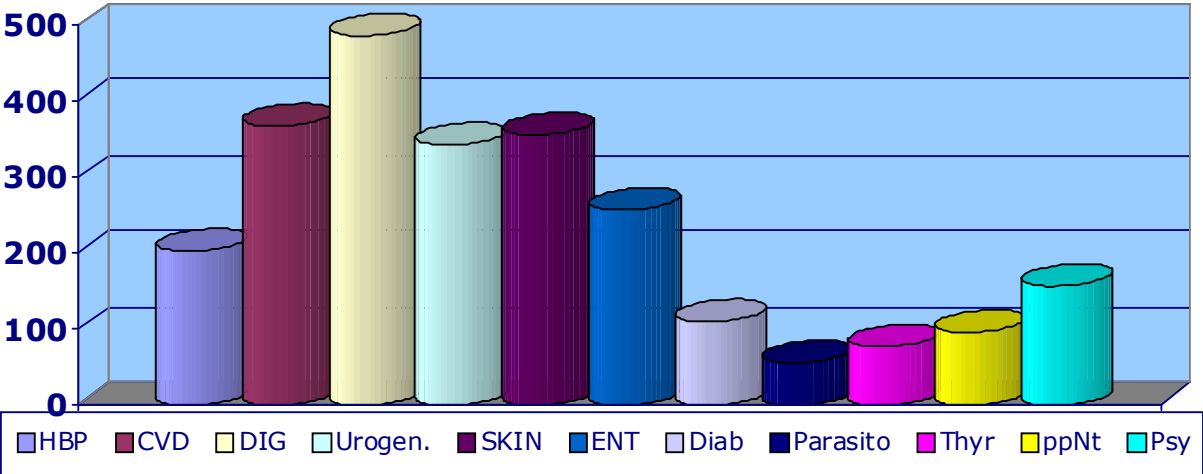
Compared with 2007 the number of files with at least one pathology leaving CADA centres **rose by 6.7%**. This figure must, however, be related to the 29.6% increase in outgoing examinations in 2008 (and with more than 8 refugees out of 10 who have this examination).

VI - MAIN PATHOLOGIES OBSERVED

Certain people may be suffering from several pathologies. The following therefore concerns the number of pathologies (classified by category), not the number of people. The pathologies most commonly observed are the least specific (CVD, digestive tract, ENT, dermatosis... etc.) and sometimes chronic.

Early screening at arrival will allow enforcing targeted treatment which will logically lead to reduction in prevalence of non-chronic diseases at the outgoing examination.

VI - 1 Pathologies noted on entry of asylum seekers:



Compared with 2007, the total number of cases in each category of pathologies is increasing, which is in line with the growing number of files in 2008. On the other hand, their value as a percentage is stable in the population examined from one year to the next.

Distribution of pathologies in asylum seekers on arrival at a CADA centre:

For example, the level of HBP detected was 2.4% (134 cases) in 2007 and 2.3% (203 cases) in 2008; that of diabetes was 1% (55 cases) in 2007 and 1.2% (110 cases) this year.

This applies to virtually all pathologies except for the 3 following ones for which significantly more cases per file were detected in 2008:

- Thyroid diseases, with a frequency which was 57% higher than expected: 77 cases of dysthyroidism noted with 49 expected (in volume of medical files)
- Pulmonary pathologies with 96 cases and 50 expected: + 92%.

- And notably, because this screening is very complex, a 33% increase in psychological/psychiatric disorders with 157 cases out of the 118 expected.

In practice, and concerning this last point, 2008 saw the start of a study of psychiatric disorders, mainly related to the difficulty of treating people housed in CADA centres.

These results must, above all, lead to a more systematized approach to the state of health of asylum seekers, particularly through the efforts made by the CADA centres. This is specifically why a study of this question has been started, so that we can improve detection of isolated or recurrent psychiatric diseases in the migrant population.

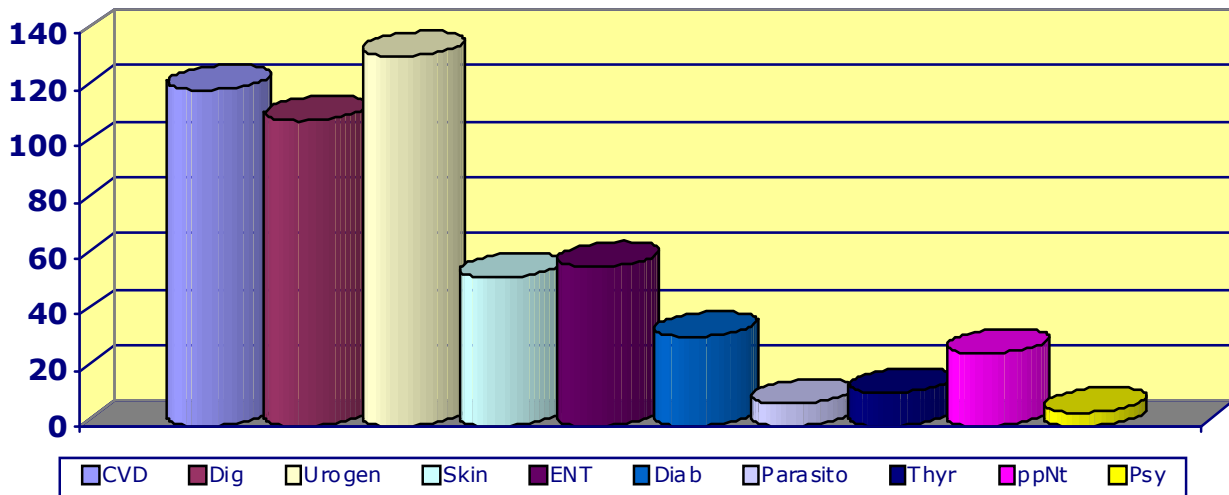
On this subject, we must unfortunately add that "better screening" does not generally mean that treatment is easier to follow-up. The analyses of practices in this field are therefore continuing.

In detail for incomers:

People of African origin suffer from more cardiovascular disease (4.7% of them), digestive pathologies (7.9%), pulmonary disease (1.5%), skin diseases (5.6%) and parasitosis (1.9%) than asylum seekers from other continents.

On the other hand they suffer less from dysthyroidism, HBP or diabetes than people of Asian origin.

VI - 2 - Distribution of pathologies suffered by refugees, noted on leaving the CADA centres



At the end of a stay in a CADA centre, the fall in the number of files with pathology/pathologies compared with those noted on arrival, is general and concerns all categories of curable diseases equally.

The number of chronic pathologies, better detected over time and therefore increasing, counterbalances the raw results (except for psychological/psychiatric pathologies). All this is linked to registration over time of asylum seeker and refugee access to health care as well as to the social protection provided and medical orientation.

This fall is particularly marked for psychological/psychiatric pathologies which fell from 157 files on arrival to 5 on departure (for an average stay of 580 days). The reason is not given.¹⁴

In detail for out goers:

The differences observed between the incoming and outgoing examinations concerns:

- a fall in the number of curable diseases such as urogenital (-3.2%), dermatological (-6.2%), ENT (-2.1%), parasitological pathologies (-1%) and dysthyroidisms (-1.5%).

¹⁴ For information, analysis of the 2007 files emphasized the deficit in diagnosis of psychological disorders on arrival at the CADA centre, which led the DSP to launch a study of this question in 2008.

- but an increase in chronic diseases detected and treated: cardiovascular diseases (+2%), High Blood Pressure (+4.5%) and diabetes (+1.5%).

VI - 3 - PREGNANCIES:

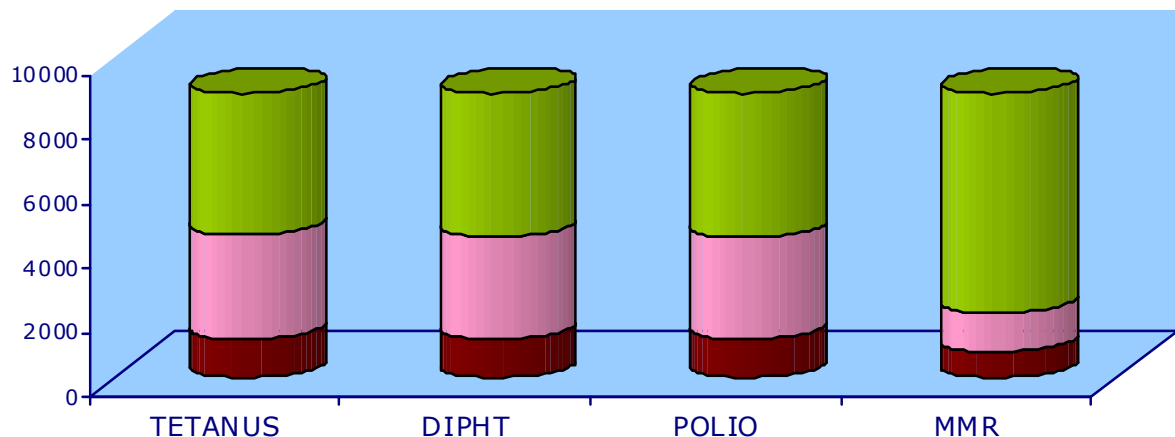
On *entering* a CADA, out of 2850 women aged 15 to 50, of child-bearing age **9.5%** (270) were pregnant, of whom:

- 29.2% in the first three months, 35.5% in second three months and 27.4% in the last three months (7.7% for whom term was not given).
- 28.5% were African, 7% Asian and 62.2% European.

On *leaving* the CADA, out of 2053 women of child-bearing age **4.6%** (95) were pregnant. These pregnancies included 32.6% in the first three months, 43.1% in the second three months, 20% in the last three months and 4.2% not specified.

VI - 4 - VACCINATIONS

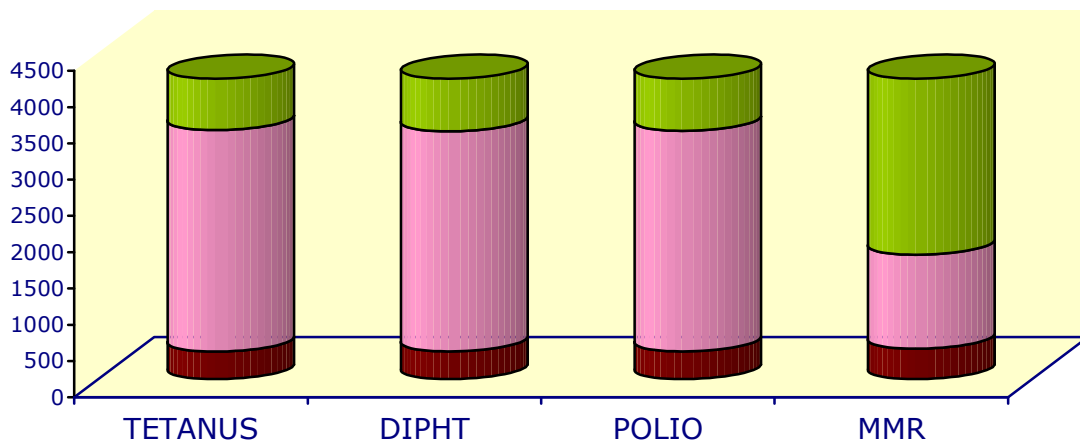
VI - 4 - 1 - Vaccine status of asylum seekers:



Vaccine boosters are easier to perform on children because of the requirement for school and this is therefore systematic for them. However, the situation on arriving at the CADA centre is rather poor for both adults and children, as shown in the table:

However, this information is extremely inadequately filled in by some doctors in the asylum seekers' files (with, on average, barely one case in two) and cannot be used to report development between incoming and outgoing, but reflects a lack of interest in this question of preventive health.

VI - 4 - 2 - Vaccine status of refugees:



The results for this year show a significant fall in the level of vaccination cover, for any vaccine. Traditionally, and for previous years, the difference between vaccine status on arrival and departure was very small so that levels reached more than 80% cover on leaving. Similarly, the "don't know" are usually in the majority, which is not the case here (apart from the MMR) where the "not up to date" predominate. We therefore have more data with a serious deficit in vaccine cover.

VII - BCG, Tubertest and chest X-ray.

VII - 1 - TUBERTEST¹⁵

Recommendations for screening for infections and tuberculosis in migrants concerns the systematic chest X-ray taken on arrival (then regularly) and the Tubertest in children aged under 15 and their BCG vaccination according to their previous status and the test results.

The number of children aged under 15 was 2 295 among asylum seekers: **only 845 children had a Tubertest, which is barely more than a third of those who should be screened.**

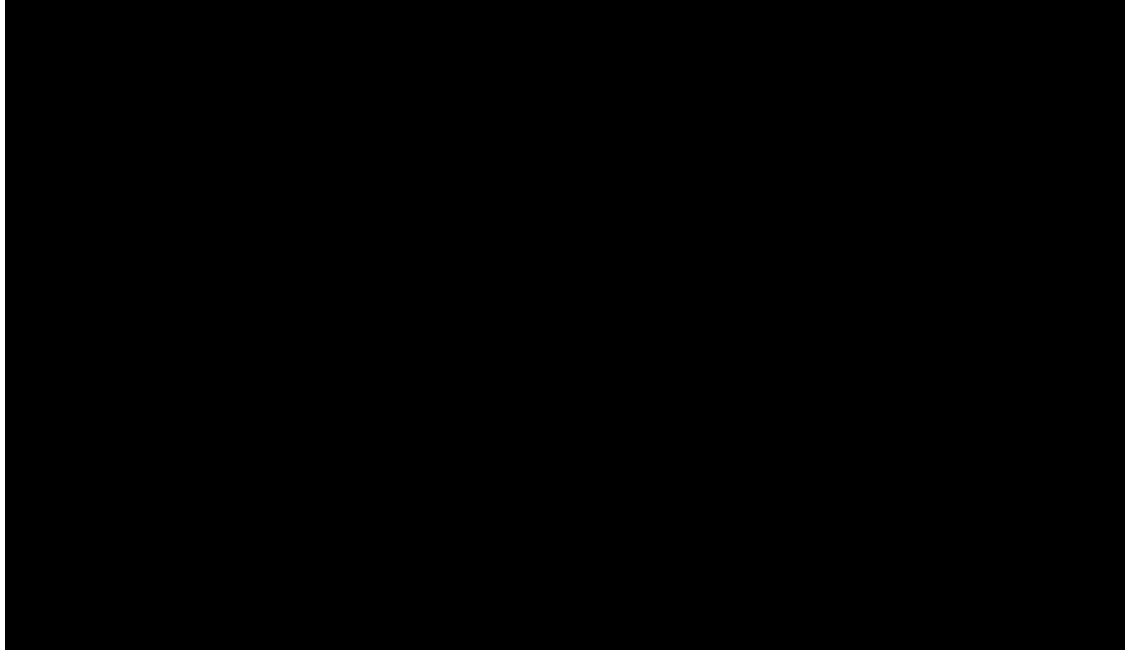
Here are the results for children in asylum seekers' families¹⁶:

Considering the prevalence figures and rates of incidence of tuberculosis in migrant populations, as well as the recommendations¹⁷ repeated in the 2007 National Plan, this lack of screening at CADA centres is a real problem.

¹⁵ = IDR, skin test, "Mantoux"

¹⁶ The positive cases include Latent Tuberculosis Infections.

¹⁷ DGS (General Health Directorate). Working group on tuberculosis and migrants: "Recommendations relative to the fight against tuberculosis in migrants in France" 07/06/2005



Most children are treated by the town physician and/or PMI (Mother and child protection centre), so this is where work needs to be done, but also with health referral agents in the CADA centres.

Level of BCG cover (relative to the number of files properly filled in) :

The data on BCG vaccine cover suffers from the fact that **a large number of files do not include this information. Not including these files (which include cases where the BCG has been done and others where it has not), the level is evaluated at 31.6% in asylum seekers of all ages, and 49.4% in those aged under 15.**

There is no idea of systematic vaccine "boosters" for these cases.

Chest X-ray screening:

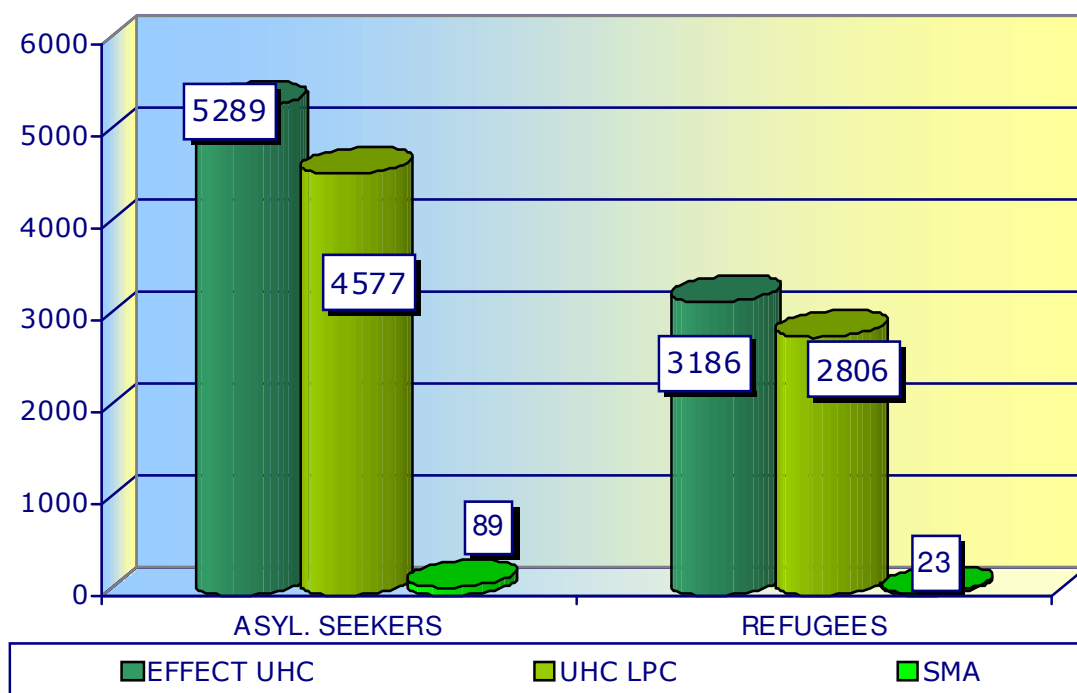
It must be systematic on arrival at the CADA, except in children aged under ten who have the BCG vaccination and show no clinical respiratory signs. Booster shots provided between arrival and departure is done properly if you take into account children aged under 10 who represent 16% of refugees.

Chest X-ray	Done	Not filled in
Asylum seeker	6462 (73%)	2387
Refugees	3483 (84%)	660

VIII - SOCIAL PROTECTION:

The DNA (National Reception System) objectives include promoting access to health care for asylum seekers.

However, the difficulty in obtaining access to health cover in certain departments¹⁸, often linked to particularities and local CPAM (Primary Health Insurance Fund) practices sometimes complicates the medical situation of asylum seekers even more.



Many asylum seekers do not arrive directly at a CADA centre and therefore already have social cover.

On admission 59.8% had Universal cover (CMU) (**5% fewer than in 2007**) and 51.7% CMU-C (Free Health Insurance) (**7% fewer than in 2007**). About a third of the files are not filled in.

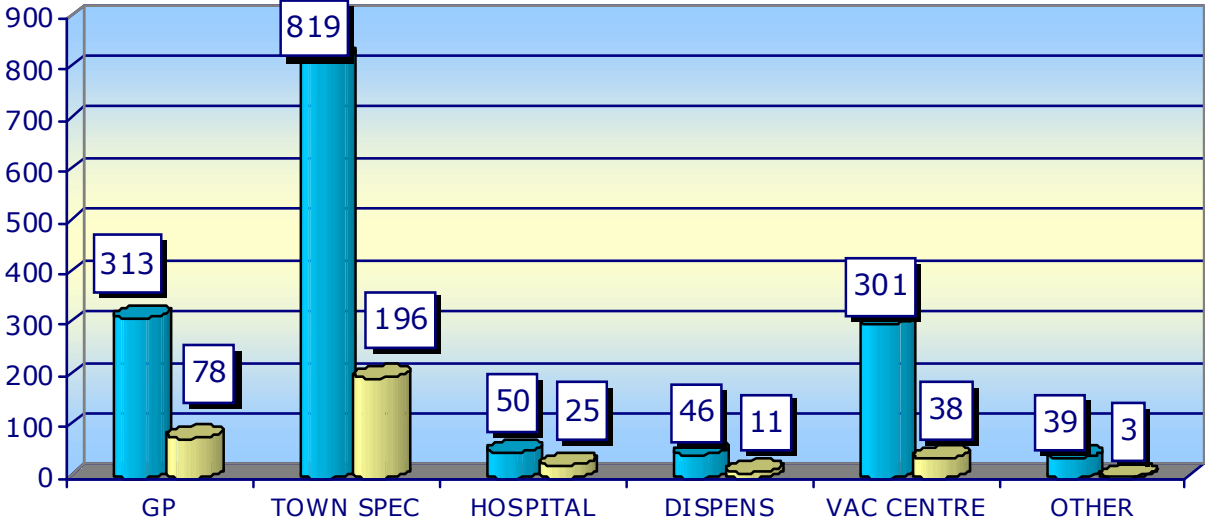
This social protection improves with treatment in a CADA centre: the social provisions often make it easier to pass certain stages. Levels on departure are 76.9% CMU, of which 67.7% are CMU-C, **2 points lower in both cases than in 2007, with improved exhaustiveness.**

IX - ORIENTATIONS

The arrival and departure examinations are reflected in both cases by a proposed orientation for health care. This was heavily reinforced in 2005

¹⁸Access to CMU (Universal Health Cover) and treatment for asylum seekers with the DNA. Flash survey of a national sample of CADA centres. Dr C. FORTIN and Dr M. WLUCZKA. OFII DSP. May 2009

with the application to asylum seekers of legal provisions concerning the choice of referring physician.¹⁹

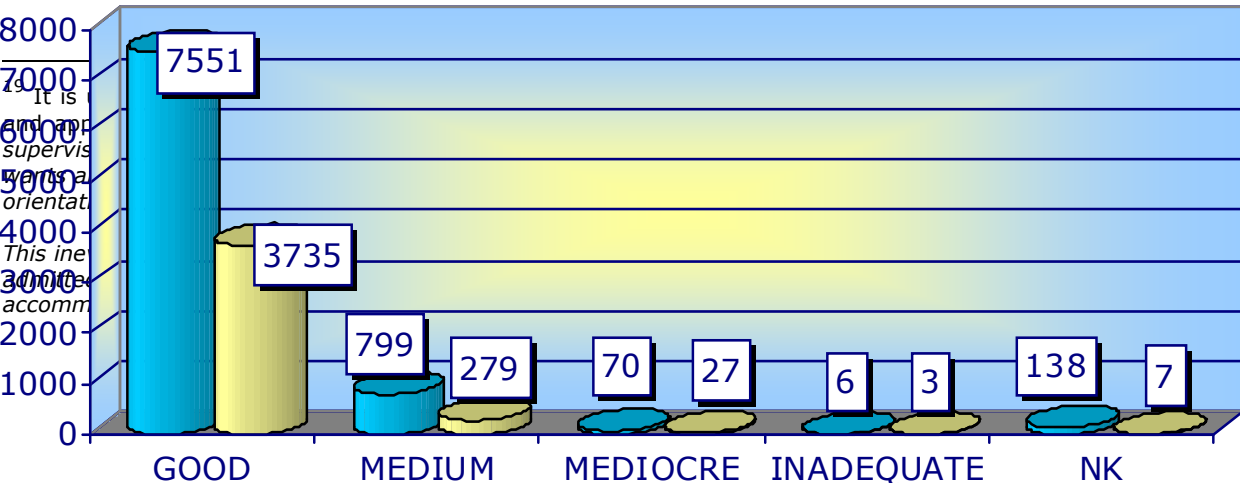


Asylum seekers who have just been admitted to a CADA centre are seen by the referring physician they choose or a health centre doctor, or any other means of having a medical examination with a chest X-ray. The children are sent to PIM centres, particularly for vaccine updates. Preferably to specialists (819 people, i.e. 9.2% of asylum seekers) for the chronic pathologies described above. These transfers fall rapidly because on departure, the level has fallen by half (4.7%). Same remark concerning visits to the referring physician, for which orientations on departure also fell by half.

In spite of the small number of files filled in, these results are good indicators of a certain degree of health improvement. The problem mentioned above concerning the level of vaccine cover cannot be solved here, because orientation to a Vaccination Centre on departure totals less than 1%.

X - SUBJECTIVE ASSESSMENTS OF STATE OF HEALTH

Although both question and answer can be subjective and perhaps because of this subjectivity, it is interesting to have a general assessment



made by referring physicians on this population which most of them know fairly well.

The state of health of incomers was considered good for 85.3% of them, average for 9% and mediocre or poor for less than 1%. These percentages were 90%, 6.7% and 0.7% respectively at the outgoing examination. This item is one of the rare ones to be well filled in... 95.3% of the files filled in on arrival and 97.6% on departure.

CONCLUSION :

In 2008 there were 271 accommodation structures in the DNA, all in mainland France. Asylum seekers all transit via these structures while awaiting their status.

12 992 medical files were included in this study, for which the items are noted every year by doctors during examinations on arrival at a CADA centre and again on departure. These 12 992 files can be split into 68% concerning asylum seekers and 32% refugees.

The study's exhaustiveness has continued to increase regularly for asylum seekers since 2003, but it recorded a steep rise for refugees in 2008. This notable improvement is due to the high rate of file collection in 2008: more than 71% of information feedback for asylum seekers and **more than 82% for refugees, levels never previously reached.**

The analysis of demographic data (evolutions of entries per zone, per continent of origin and age category...) shows that the geographic zones of origin of people housed in CADA centres are the same from one year to the next *in order of importance*²⁰. However, it confirms an upward trend from Asia and a falling trend from Africa.

Age categories did not change much, the 20-29 and 30-39 year olds still accounting for slightly more than half the total. There is just a slight fall in 0-9 and 10-19 year olds noted in the incoming and outgoing medical files.

Concerning these minors, the data points to inadequate vaccination in CADA centres, inadequate orientation towards vaccination centres and too many files not properly filled in on this subject...

Similarly, screening for Latent Tuberculosis is **very far** from the results required in the context of communal living in a CADA environment. Particularly because this population has a very high rate of prevalence of tuberculosis: does the fault lie in less knowledge and/or application of the recommendations? To practices which vary a great deal according to physicians? To reluctance? The study cannot give an answer.

This problem noted in this report, like BCG cover in children, must be a target action implemented in the context of the combat against tuberculosis.

The analysis of pathologies also generates the question of **psychiatric treatment, with a strongly increasing rate this year and an**

²⁰ Europe, Sub-Saharan Africa, Asia, North Africa then the Americas

apparently positive result on departure. The problems they raise were already noted in the previous report and raised at meetings. In 2008, they were the subject of a CADA study backed by the DSP (Public Health Department) which is ongoing at the present time. Psychiatric pathologies remain complex, particularly in a context of emigration for asylum and multiculturalism. **This situation is one of the DSP's main concerns.**

In this study, other specific points concerning pathologies have been emphasized; they lead to the conclusion that health treatment in CADA centres does have a real impact on reducing disease.

However, we must be able to count on medical cover for treatment: the 2008 results seem to confirm that this access is difficult in a certain number of cases - even with the support and assistance of CADA qualified personnel - because nearly 20% still do not have social security on their departure, and some people (a minority) have only AME (State Medical Aid), whereas their status gives them the right to CMU (Universal Health Care).

The answer to these problems is also one of the priorities of a doubtless long-term working process!

Paris, 24 July 2009