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Women's health in migrant populations: a qualitative study in France

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Background: In 2019, there are 6.5 million migrants living in France. Numerous quantitative studies show inequalities in access and quality of care, in particular in women's health. This study aimed to explore migrant women's experience of gynaecological care. **Methods:** We conducted 17 semi-structured in-depth interviews with migrant women in Toulouse (France). We used a Grounded Theory approach to perform the analysis. **Results:** Although migrant women were generally satisfied with the gynaecological care received, they also reported dysfunctions. Positive elements were the French health insurance system, the human qualities of the healthcare providers and the performance of the health system. Although reassuring, the structured framework was perceived to have little flexibility. This was sometimes felt as oppressive, paternalistic or discriminatory. These obstacles, amplified by the women's lifestyle instability and precariousness, the language barrier and the difficulty to understand a totally new healthcare system, made women's health care and, especially, preventive care, a difficult-to-achieve and low-priority objective for the women. **Conclusions:** Migrant women's overall satisfaction with the healthcare system contrasted with the known health inequalities in these populations. This is a good example of the concept of acculturation. Healthcare professionals need to make an introspective effort to prevent the emergence of stereotypes and of discriminatory and paternalistic behaviours. A better understanding and respect of the other person's culture is an indispensable condition for intercultural medicine, and thus for reducing the health inequalities that migrant women experience.

Introduction

To date, France has 6.5 million immigrants in its population. With 276 576 residence permits issued in 2019, including 36 512 asylum grants, France has a vocation to be a welcoming land for migrant populations.[1,2]

The word 'migrant' has a multitude of definitions in health studies but none is universally agreed.[3] In our study, the word 'migrant' refers to a foreign-born, non-French woman who has no residence permit, and entered France with a view to settling there (i.e. mainly asylum seekers or migrant workers). A variety of profiles can be included in this definition, depending on the country of origin, the cause of migration or the length of stay in France.

Since 2005, there has been a marked increase in the number of migrant persons arriving in France, as in many European countries.[4] Migrant health has thus become a priority social and political concern.[5] Large health disparities remain between the migrant and the native French populations, notably in terms of access to health care and prevention.[6,7]

For women's health, several studies have reported inequalities in Europe and North America, notably in terms of access to gynaecological cancer screening.[8–10] Regarding Sexually Transmitted Infections (STIs), migrant populations (mostly sub-Saharan and Caribbean populations but also other migrant populations) have a higher rate of seropositivity for human immunodeficiency virus and viral hepatitis than the national rates.[11–14] Studies on the perinatal period have also shown an increased risk of perinatal complications and maternal morbidity and mortality in migrant populations, partly explained by inadequate prenatal follow-up and delayed care.[15–17]

Qualitative studies have looked at the representations and experience of migrant women, but these have been limited to the study of perinatal health inequalities.[15,18–20] The women's own view of gynaecological follow-up care, their motives for seeking care and their experience of the French healthcare system, remain unexplored.

Women's health is a complex, intimate area, often rich in beliefs, taboos and representations. For these reasons, we decided to explore the experience of gynaecological care by migrant women using a qualitative method.

Methods

We selected women over 18 years (to ensure a minimal experience of gynaecological care). Participants were required to have an official administrative status and be in a stable housing situation, to try and maximize their adherence to the study and basic knowledge of the French health system. Nationality was not considered in the selection process.

To recruit participants, the researchers collaborated with social workers of the Mairie de Toulouse (southern France), the town's administrative centre which liaises with migrant families housed in individual units (apartments, mobile homes) in various neighbourhoods of the city. Convenience sampling was used initially, via face-to-face with social workers who were informed of the exclusion criteria and the main objectives of the study. The sampling later

became more targeted, asking social workers to look for specific characteristics, to maximize diversity in the participants' profiles. The number of interviews was not set in advance, as we aimed to achieve data saturation.

The individual semi-structured interviews were conducted by one of two general practitioners (GPs), female, Caucasian, aged 27 and 28 (L.O. and P.A.). They had not conducted qualitative study before but had been trained in qualitative research ahead of and during this study. They were supervised by a GP experienced in health research and several experts in qualitative research were consulted throughout the study. An interview guide was developed following an initial literature review, with the help of an expert in qualitative research (L.G.). It consisted of five open questions and several potential follow-ups (Supplementary appendix S1). The guide was revised following two test interviews with young French women and the first three interviews.

The interviews took place at the participants' home or in the social workers' office, according to the preference of the participants. Participants were asked to be alone for the interview. The presence of a professional interpreter specialized in health, previously prepared for the interview, was almost systematic (absent during one of the interviews at the request of the participant). The interviews were entirely recorded on digital audio device, after written consent was obtained. Field notes of non-verbal reactions were taken. The participants didn't know the researchers and no information was given about their medical profession.

In order to explore the social process of encounter between migrant women and the French health care system, an inductive analysis of the empirical data (transcriptions, audio recording, field notes) was conducted, following the specific steps of Grounded Theory.[21] The first step consisted of an exhaustive transcription of the recordings by the researcher undertaking the interview. Using Microsoft Excel®, the two researchers independently performed an open analysis followed by an axial analysis (mapping) to articulate the categories around the most meaningful axes, before concertation.

The researchers then undertook an integrative analysis in order to develop an explanatory model integrating the different axes. Continuous comparison between the empirical and theoretical results allowed to test emerging theories. Building on the findings, the theorization was performed via a diagram in Microsoft Word®. Each stage was discussed with and supervised by a third researcher (M.-E.R.-B.), for investigator triangulation purposes. The anonymity of the participants was preserved throughout the transcription and data analysis process.

Results

The researchers conducted 17 interviews, lasting between 30 min and 2 h. Data saturation was achieved in the 15th interview, confirmed by two additional interviews. Participants were of six different nationalities and had been living in France for more than 6 months (table 1). The language barrier, the economic precarity of the participants and the male gender of some recruiters, seem to have been the main obstacles to recruitment.

Representations in women's health

Cultural influences

The interviews revealed major cultural influences on women's behaviours and beliefs with regard to women's health. Many participants explained that they must adhere to a strict traditional family framework, and follow community rules (especially in the Romani community, regardless of the participant's age). The place of God seemed all-encompassing, at the origin of all diseases and all births, particularly for Syrian and Romani women. Marriage was described as a change in status, transforming a young virgin woman into a childbearing woman, having therefore access to gynaecological care. 'Yes if a young girl who is unmarried goes to a gynaecologist, they're going to wonder if she may be pregnant, people will talk. That's the culture, it's going to make some noise (laughter)' *Astrid*. Many, especially among Syrian women, described a strong intrafamilial solidarity, even a mother–daughter companionship, as well as a sharing of knowledge between sisters, female cousins and friends, on questions, such as pregnancy, childbirth or contraception. Some expressed taboo and modesty towards other family members (mostly in Romani community) and healthcare providers, specifically around gynaecological examination. 'We don't talk because our people, they are ashamed. We don't talk about those things! [. . .] but even if we are among three or four girls, we don't talk about this'. *Mathilde*.

The gynaecological consultation

When the topic of gynaecological consultation was mentioned in the interviews, most participants associated it first with pregnancy: many deemed a rigorous follow-up necessary, until the delivery, when they could finally be fully reassured. 'It's the most beautiful thing in the world, we forget everything, as soon as we hold the child'. *Brigitte*. They rarely cited prevention as a motive to consult, or in very vague terms. 'Would you go and see her for other reasons besides pain? – Yes, to examine me, to see if I don't have any problems. – What kind of problems are you thinking about? I don't know, in case I have something'. *Hélène*. Participants seemed to be knowledgeable about artificial contraception, but many described them as not very reliable, harmful, and unnatural. 'I prefer to let nature take its course. I have a body, if God wants me to have a baby, then I will have one'. *Sylvette*. Regardless of their age or origin, the majority preferred to use natural methods, such as the pull-out method, and, for many, abortion remained an option if needed.

Definition of a good healthcare provider

A good healthcare provider for women's health was described as both competent and having human qualities. 'For me, a good gynaecologist, [. . .] it's the one who will take the time to examine, to talk, to make one feel at ease, not just spread your legs to examine you, but who will be careful to take the time to talk and to examine you. [. . .] A good gynaecologist, it's the one who will examine you from A to Z, who will take care of the blood group, who will take care of many many many details'. *Sarah*. Some expressed their preference for a women healthcare provider. Many insisted on the importance of having a trusting relationship with their doctor.

The 'status of migrant woman' in health

Life changes and lifestyle

The participants all described a life characterized by great instability and precarity, with several and repeated changes in housing conditions and locations, including rough sleeping, several precarious and short-term jobs, which resulted in sometimes chaotic healthcare. 'But I lost my vaccination booklet. Because they got us out of the squat and everything stayed behind' *Floriane*. Participants reported being often too preoccupied by their daily problems to be able to project themselves in an uncertain future. They did not prioritize healthcare. 'I had to struggle to survive. This wasn't my priority'. *Catherine*.

Unfamiliarity with the health system and language barrier

Administrative procedures and language barrier seemed to be real obstacles to understanding the healthcare system and therefore to accessing care '(Sigh and uneasy smile) Honestly . . . Since I'm in France I've never been to consult a gynaecologist. I don't even know where to go'. *Catherine*. Many participants expressed also great frustration at the impossibility to express themselves and understand the doctor. This compounded the suffering and anxiety that are often inherent to a healthcare situation. '(interpreter) She is pretty stressed

Table 1 Demographic characteristics of the interviewees ($N = 17$)

Participant (anonymized name)	Interview date	Age (years)	Country of origin	Family situation	Children	Other pregnancies	Education level	Profession France/country of origin	General practitioner (GP)/ other healthcare providers
Eliane	29 November 2018	29	Sudan	Married	2	Current pregnancy	Up to 15 years old	0/childcare worker in Sudan	GP
Sarah	12 December 2018	49	Bulgaria	Married	1	1 voluntary termination	SAT + 3rd level education in economics	Maid/Consultant	GP, others (pneumologist)
Estelle	21 February 2019	47	Bulgaria	Single, divorced	3	1 stillbirth	2 years of Elementary School	Maid/construction worker, agricultural worker	GP and 2/3 emergency hospital treatments
Mathilde	26 March 2019	23	Bulgaria	Married	3	3 voluntary terminations	No schooling, illiterate	0/agricultural worker	No GP
Paule	28 February 2019	38	Syria	Married	5	0	Up to 10 years old	0/0 (husband salesman in Syria)	GP
Catherine	20 March 2019	41	Bulgaria	Cohabiting	1	0	0	Maid + agricultural worker in France/maid in Bulgaria	GP, others
Françoise	26 March 2019	31	Syria	Married	3	2 stillbirths	Up to Middle School, can read and write	0/0	GP
Ikram	06 May 2019	19	Rumania	Cohabiting	0	0	Up to the end of Middle School	Was janitor, doesn't currently work (partner working)	GP, gynecologist, ob-gyn during pregnancy
Claire	06 May 2019	28	Rumania	Cohabiting	0	Current pregnancy	Up to 9th grade, can read and write	Never	Ob-gyn for pregnancy
Imane	06 May 2019	23	Rumania	Cohabiting	1 (+3 of the partner)	0	Up to the end of High School in Rumania	Currently registered as a job-seeker (partner self-employed)/Self-employed in sales	GP and gynecologist
Maud	06 May 2019	32	Rumania	Cohabiting	2	1 voluntary termination	Some schooling in Rumania, can read and write	Self-employed in second-hand clothes sales/Not working in Rumania	GP and gynecologist
Floriane	01 July 2019	25	Bulgaria	Cohabiting	1	Current pregnancy, 1 voluntary termination	Up to Middle School in Rumania	Maid/grape picking in France	GP and gynecologist
Hélène	01 July 2019	55	Bulgaria	Cohabiting	6	2 voluntary terminations, 1 child deceased	Up to 7th grade, can read and write	Not working in France/agricultural worker in Bulgaria	GP and occasionally gynecologist
Sylvette	17 September 2019	20	Rumania	Cohabiting	3	0	1st grade in Rumania	0/0 (partner job-seeker)	Hospital unit (for people without health insurance)
Brigitte	16 July 2019	44	Bulgaria	Cohabiting; Divorced from another man	4	1 late stillbirth, 1 voluntary termination	Up to 15 years old, can read and write	Agricultural worker, then homecare assistant in Italy for 6 years	No information
Séverine	07 January 2019	24	Kosovo	Cohabiting	1	Current pregnancy	Up to High School	Never. Volunteering in France.	GP and neurologist
Astrid	07 January 2019	36	Albania	Cohabiting	4	0	Up to 18	Never. Volunteering in France	GP

out at the moment. She goes to the health checks but she doesn't get a response, she can't ask about all her concerns. So she stresses out'. *Sarah*.

Gynaecological care provision in France: a mixed overview

A satisfactory system

Participants expressed overall great satisfaction towards the French gynaecological healthcare system, described as efficient and easy to access thanks to the social security system. It also offers a great freedom of choice. 'There is no better, really! (laughs) – But are there things that she would like to see improved? – (interpreter) She said that she has never been taken care of so well!' *Paule*. Healthcare providers possessed great human qualities and tried their best to overcome the language barrier to better communicate with them. This was in marked contrast with their experience in their country of origin. 'Here it's like if for example, the doctor, you are something for him. Not just business. He gives the heart like that. He works with the heart'. Imane. 'They bring an interpreter. Every time. – Is it good? – Yes because I understand them better. I do understand, I speak a little, but there are words that I don't understand'. *Floriane*. They also understood and appreciated that GPs could be competent in women's health or could direct them to the right person. 'I'm going to ask this to the GP, he will explain and tell me why. I will ask the GP who will make an appointment for me'. *Hélène*.

Over-medicalization, paternalism and discrimination

Participants however felt that the system was over-medicalized, with too extensive follow-ups. 'She couldn't stand it anymore, every 15 days, she couldn't stand it [...] They were too involved, she was too closely followed. [...] In Syria, it was her who would go there, and every month. Here it was imposed every two weeks. [...] This annoyed her because she also had to take care of her other children'. *Françoise*. The women did not appreciate being imposed the French way of thinking. 'They wanted to insert an implant. But she doesn't want contraception. They wanted to insert an implant, but she refused'. *Paule*. The greatest source of frustration was the behaviour of some healthcare providers, which they felt was actively or passively discriminating, or paternalistic. 'When they see that I don't speak well, that I don't express myself well, they say: Don't worry Madam, take your treatment and all will go well'. *Sarah*.

Unsatisfactory preventive care

We noted a quasi-absence of preventive healthcare in the group (cancer screening, STIs, birth control). Preventive examinations, if they took place, were done systematically, without being understood by patients. '(About the pap smear test) They did it there, during the pregnancy. But I didn't understand, they told me it was for a cancer or ... [...] – and the aim, do you find it good? – well it's good, it's good for the baby'. *Floriane*.

Some participants seemed to have little interest in gynaecological questions, or were content with basic empirical knowledge. 'And do you know what is the cervical smear?—I don't feel like it, I'm scared! [...] Is it mandatory?—Nothing is mandatory. – If that's the case, I don't feel like it (laughter)'. *Mathilde*.

Good information tended to modify passive or defiant behaviours. 'Who can talk to me about this? How am supposed to find out? Is it not the job of the GP?!' *Catherine*.

Discussion

By using a qualitative method, we highlighted a marked contrast between the satisfaction expressed by migrant women with the French health system, described as efficient and human, and the numerous obstacles to access and quality of health care. These could be inherent to the difficult life courses of the migrant women, but also sometimes linked to over-medicalization and discrimination.

One of the strengths of the study was the diversity of the sample in terms of age, country of origin, and culture. The diversity was limited however in terms of the participants' education level, and their location, which was essentially urban. Data saturation and investigator triangulation improved the internal validity of the study. The presence of an interpreter was an essential prerequisite to the exchanges, but it could be an obstacle to the quality of data collection (data loss, wrong interpretation, presence of a third party). The lack of a proper theoretical sample is a weakness of the study, which could be explained by the multiple difficulties of recruiting migrant women for health studies in France. The two researchers reflected on their role in the study, being young, Caucasian female physician. They attempted to eliminate their preconceived notions, through continuous bibliographical research, annotations in the notebook and conversations within the research team as the interviews progressed.

The results obtained allowed to theorize the different processes involved in the provision of gynaecological care to migrant women populations (model in figure 1). We approached the theorization of this encounter between migrant women and the French gynaecological healthcare system through the prism of the socio-psychological theories of acculturation.[22] According to Meryers Herskowits 1938,[23] 'acculturation comprehends those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original culture patterns of either or both groups'. Looking at the care of migrant women in France through the prism of acculturation therefore allows to reflect on the cultures involved, their relationships with each other, and the vectors of change.

The first phenomenon resulting from the encounter between these two entities was the contrast between very satisfactory hyper-medicalization, and an expressed feeling of over-medicalization. Unofficial recommendations and national statistics seem to confirm a rather rigid French system imposing quasi-mandatory annual examinations,[24] very structured pregnancy follow-up, and a systematic contraceptive scheme based on the patient's age.[25] This critique of an over-medicalized system, described as oppressive, brought us to reflect more widely on the reality of the satisfaction that was expressed. A study conducted by Nina Gabai[20] suggested that such a very performant and organized system could in fact falsely reassure both patients and healthcare providers, and hide the loss of cultural markers for migrant women.

The second phenomenon observed was unsuitable provision of preventive care. This could be explained by misunderstanding and lack of interest for these questions, sometimes very removed from their immediate concerns. However, we observed that some women expressed behaviours of active opposition towards certain ideas that caregivers seem to want to impose, which clashed with their cultural beliefs. This contrasted with the great freedom of choice in other care situations, which was appreciated by the participants. This paradox is supported by the literature, in particular with the example of African mothers confronted with a health system both emancipating and normative on the question of prenatal diagnosis of sickle cell disease.[19] In the context of screening, we also found classical resistance behaviours such as test results anxiety.[26,27] The question can be raised about the usefulness and ethics of conducting systematic tests that are not understood and sometimes even unwanted, and whose diagnostic and therapeutic consequences are often ignored.

Healthcare providers were often described reverently, but situations of discrimination and paternalism were reported. These stigmatizations and categorizations of migrant women in a health care context have also been described in some French maternity hospitals.[18] In his study about transcultural psychiatry in primary care, Sanchis Zozaya[28] explains that poor listening and information sharing, distancing or avoiding, are sometimes used as defence mechanisms by healthcare providers. These defence mechanisms are described as 'counter-attitudes' towards the zone of discomfort

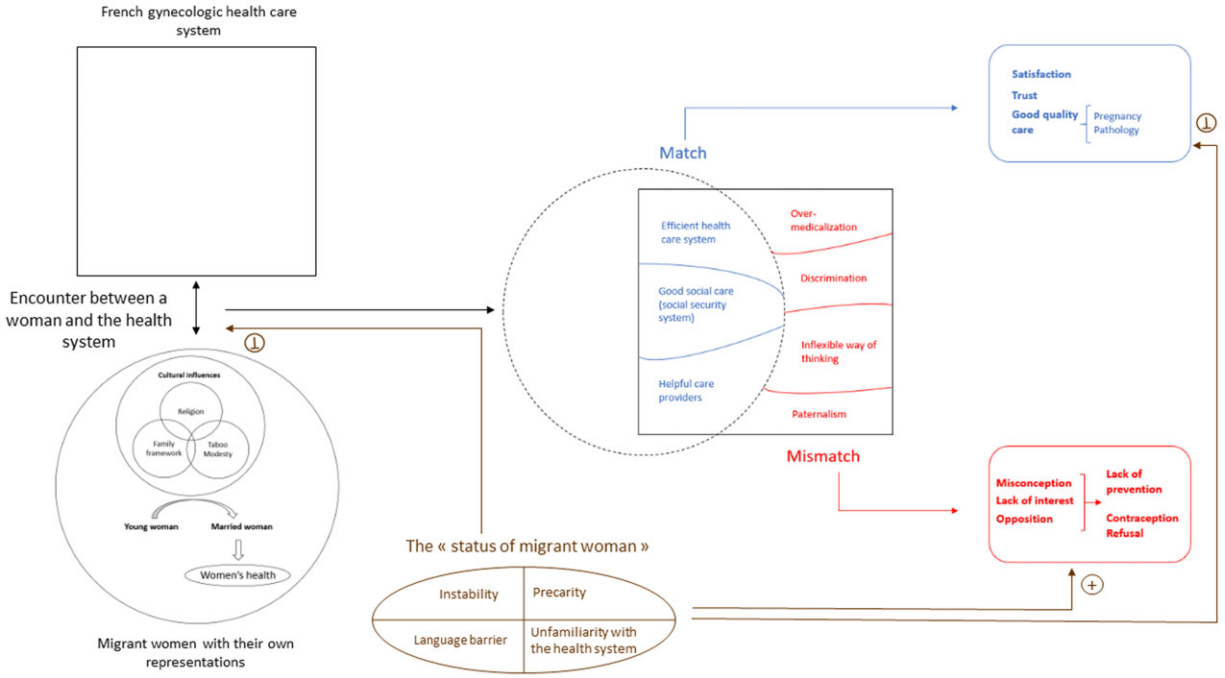

Figure 1 Gynaecological care for migrant women: modelling

represented by consultations with migrant population. Discomfort could be explained by the difficulty in managing cultural and linguistic barriers, the inherent complexity of following up women in situation of precarity, and by the resulting feeling of impotency.[29,30]

In our study, many women had never had the opportunity to see a gynaecologist in France. Studies conducted in France and other European and North American countries have identified several factors that could explain this insufficient access to healthcare, often linked to social vulnerability due to migration: a misunderstanding of the healthcare system, linguistic and financial barriers and phenomenon of prioritization.[7,8,31–35]

Overall, our study puts into perspective the encounter between two groups of individuals from different cultures, the migrant women and the French healthcare professionals. A domination emerges, pushing women to forget their culture of origin, but also their reference points, in order to better adhere to the norms of the French system, and encouraging carers to over-medicalize their care or to propose paternalistic or even discriminatory care, for lack of mastering this encounter with otherness. The highlighted deficiency in the provision and quality of healthcare reinforces and complements the results of other studies, often quantitative, conducted in Europe and North America, which reveal inequalities in health.[17,33,36]

New qualitative and quantitative studies on migrant populations, using community-based participatory research,[37–39] could enable the emergence of culturally and experientially appropriate interventions, so as to reduce current inequalities in healthcare.

Implications for practice

Although some study participants had not visited a gynaecologist, they had all had at least one contact with a doctor or other healthcare professional. Each caregiver could thus play a major role in the reduction of gynaecological risks in migrant women (cancers, STDs, abortion and their complications). We propose here an application of our findings to current medical practice (Supplementary appendix S2).

The prerequisite is to understand the obstacles limiting access to and quality of healthcare for each woman, and to adapt the framework of consultations. Health professionals should express patience and flexibility towards instability and medical nomadism. They need to build a competent network, train in the care for socially disadvantaged, and thus direct as well as possible women needing to enter the social security system. They could propose translation methods. Finally, it seems very important to inform women on the services available and the functioning of the system.

Caregivers then need to try to fight discriminating and paternalistic attitudes. For this, it is necessary to undertake introspective analysis, identify one's fears faced with a patient of a different culture, attempt to understand their cultural prerequisites, and, if necessary, train in transcultural medicine.

The next major objective is to make these women 'stick' to healthcare, taking advantage of the times when they consult doctors spontaneously (for paediatrics, pregnancy, pathology). One then needs to dissociate the woman from the mother, by proposing a consultation dedicated to prevention in women's health. This consultation could in a first phase include an exploration of the woman's prior knowledge and representations. In a second phase, it would aim to inform them about risks and to propose a preventive follow-up schedule adapted to each patient, in the respect of free and informed consent. This step could be more specifically the GP's mission, in accordance with his accessibility and his follow-up and prevention role.

Finally, this whole process could result in reinforcing the link between doctor and patient, thus improving adherence to healthcare, while respecting their refusals of certain procedures and treatments.

Supplementary data

Supplementary data are available at *EURPUB* online.

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Ethical approval

This study was approved as in accordance with the French law by the Collège National des Généralistes Enseignants (CNGE) Ethics Research Committee (reference: n°IRB IRB00010804).

Key points

- By exploring migrant women's experience of gynaecological care, this qualitative study showed a global satisfaction of migrant women with the French healthcare system.
- Many obstacles to access and quality of gynaecological care were identified, related to their difficult life courses, but also sometimes to over-medicalization and discrimination.
- The identification by healthcare providers of their difficulties in caring for migrant women and a better training in transcultural medicine are the first step in improving the gynaecological follow-up of these women.
- Using community-based participatory research could enable the emergence of culturally and experientially appropriate interventions to reduce current inequalities in healthcare.

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