WomenHealthASU93 Project

South Asian women's experiences in the healthcare system in Seine-Saint-Denis

Institut Convergences Migrations

Introduction

Understanding South Asian women's experiences in the healthcare system in Seine-Saint-Denis

Context and key issue

The WomenHealthASU93 project examines the sexual and reproductive health (SRH) practices and perceptions of South Asian women (from Bangladesh, India, Pakistan and Sri Lanka) who have recently arrived in Seine-Saint-Denis, an area with a high concentration of South Asian migrants (84% of the total in the Île-de-France region). These women, rendered invisibile by both their gender and their origin, face structural barriers to accessing healthcare: language barriers, cultural misunderstandings, family disruptions and power imbalances in healthcare interactions.

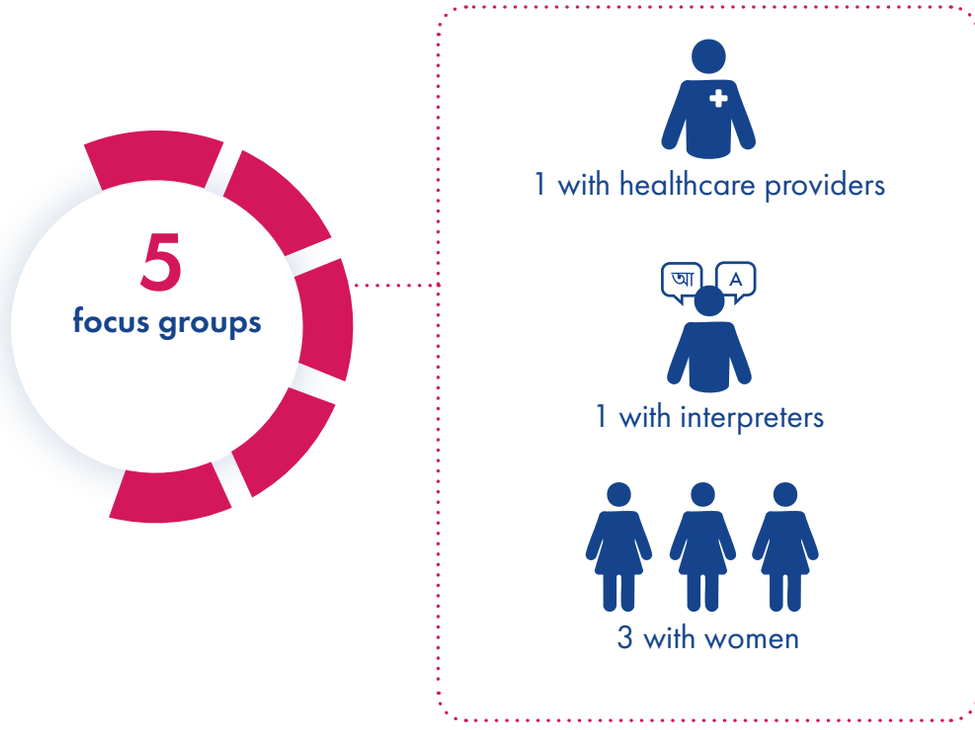
Data collected, October 2024–December 2025

The WomenHealthASU93 study adopts a qualitative, comprehensive and exploratory design, combining non-participant observation, semi-structured interviews and focus groups with three groups: first-generation migrant women from India, Pakistan, Bangladesh and Sri Lanka living in the Île-de-France region; professionals from the medical, social and voluntary sectors; and professional interpreters/mediators. Participants were recruited through cultural associations, healthcare settings and communities. The sample was constructed using a multiple-case approach, standardised according to language, experience of motherhood and geographical area, and supplemented by snowball sampling.

26
interviews with healthcare providers

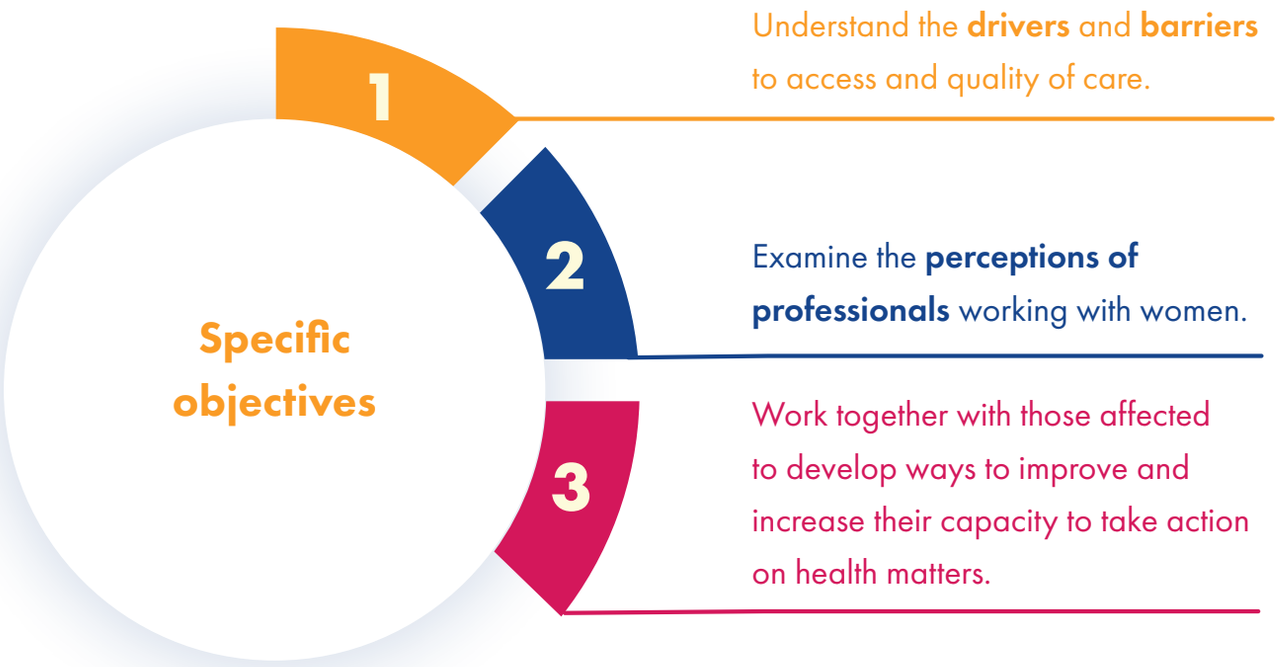
30
interviews with women

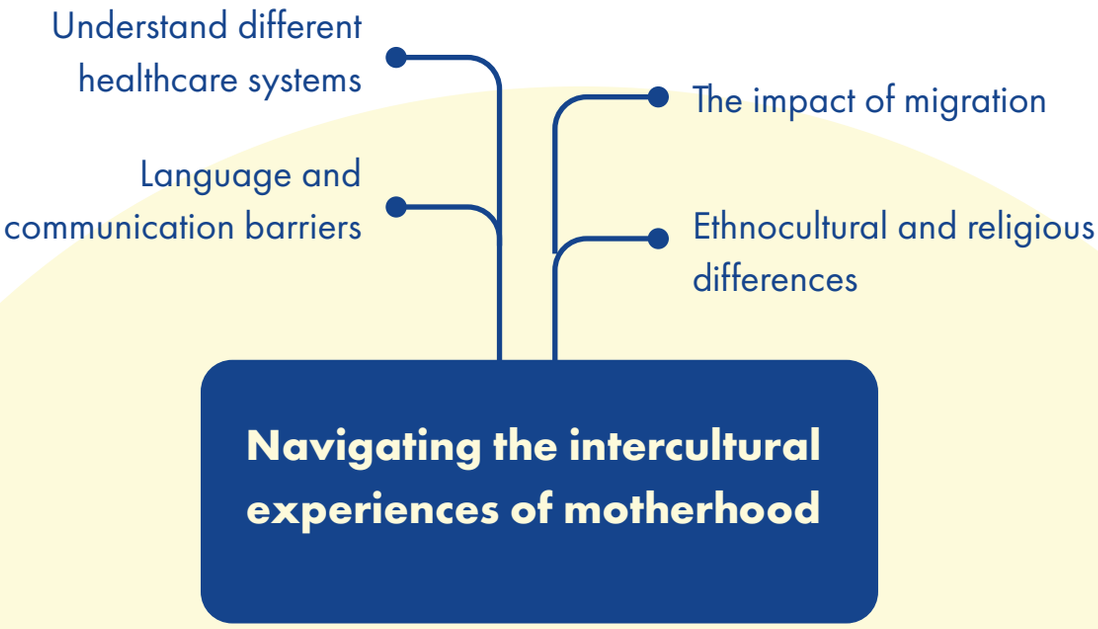
12
days of non-participant observation



Main objective

To analyse the experiences and health needs (sexual and reproductive health, mental health and general health) of South Asian women living in Seine-Saint-Denis.





Themes

Language

Overarching theme

Perinatal care

Perinatal care refers to the experiences of pregnancy, childbirth and the postnatal period, which involve a high level of medical expertise, physical anxieties and a sense of isolation within an individualistic healthcare system.

Cultural representations

Cultural representations encompass the perceptions and stereotypes that women and healthcare professionals hold of one another regarding gender, modesty, suffering and 'good motherhood', and demonstrate how these frames of reference shape interactions in healthcare settings.

Strategies employed

The ***strategies employed*** refer to the range of resources, tactics and makeshift solutions – linguistic, relational, digital and community-based – used by women and care teams to overcome obstacles and try to make the healthcare system a little more accessible.

Language is the common thread because it determines whether a woman can express her pain, explain her fatigue or understand medical instructions. It is not just a matter of words, it is what enables her to feel heard and validated by healthcare professionals, from the delivery room through to postnatal consultations.

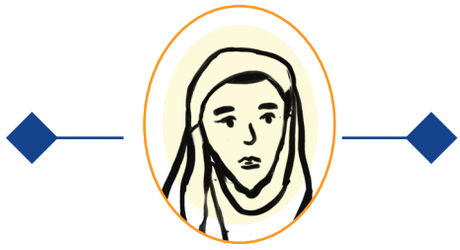
Parenting and mental health

Parenting and ***mental health*** shed light on how educational responsibilities, mental load and changing family structures in the context of migration undermine mental well-being, while making it difficult to openly ask for help.

1

Language

The "overarching theme" of the study



"For the other pregnancy, I could see that there were tests being done on me, but I didn't understand what kind. Maybe they did explain, but I didn't know, I didn't understand(...)"

—Mayilai

Language, confidence and personal transformation

In the women's accounts, language emerges as a marker of both continuity and rupture in their sense of identity. One participant directly describes the impact of the language barrier on her sense of competence and self-worth:"And there, yes, actually, I feel that, in the end, this language barrier is still a problem. But not being able to follow along, asking myself loads of questions – as time went on, that really started to chip away at my self-confidence. So yes, if I compare myself to the woman I was in India and the woman I am today, for me, there is still a difference, yes." The comparison between 'the woman I used to be' and 'the woman I am today' shows that language is not merely a functional tool, it shapes the way we see ourselves as individuals capable of acting, questioning, challenging or consenting. Whereas the mother tongue allows for a "natural" expression of symptoms and emotions, the French language requires prior preparation, self-censorship and selection.

From the language barrier to feeling discriminated against

During consultations, it has become clear that the language barrier is sometimes compounded by racism or rejection. One woman said: "No, at first I never felt I was treated any differently, but later on, when I was living in Paris, I did sense a bit of racism. (...) Some people pretended not to understand English, even though they understood it perfectly well. They acted as if they couldn't speak, intentionally. That sort of behaviour gave the impression that it wasn't a language problem, but rather an attitude of rejection. " Others mention irritated reactions to their requests for clarification: "I know I won't understand, so I'll say to them: 'Could you rephrase that?' And they do that; they take the time. But I still had two or three doctors who were a bit irritated when I asked them that. Once, I was even told: 'Bring someone who can speak, then.' Here, the reasonable request for understanding is shifted onto the patient's shoulders, which reinforces the feeling of not being entitled to accessible information. Healthcare professionals indirectly confirm this shift when they report that some colleagues say, 'I'm not going to take her on', or that 'some groups of people give birth more easily than others'. The language barrier then becomes one of the factors contributing to implicit discrimination in the treatment of patients.

Language, obstetrics and misconceptions about the body

In the field of obstetrics, language plays a particularly significant role. One professional describes how a failure to understand instructions on how to push is interpreted as a lack of competence on the part of the patients: "Now, because there's a language barrier, we end up thinking

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—Phushpa

it's the patients who aren't pushing properly, they don't know how to push. So often, because they don't know how to push—since they don't understand—it ends up with the doctor coming in, using instruments, and the patient, who doesn't understand."

For the women, the end result is a sense of being powerless: "With my other pregnancy, I saw that I'd had tests done, but I didn't understand what sort. Maybe they did them, but I didn't know, I didn't understand. (...) The first piece of advice would really be to be kind; if we could at least share our health problems with all our intentions, all our feelings. If we could explain, in fact, the aim is to have passed the information on to the doctor so that they can treat us according to our problems. (...) Because otherwise, I think that when we leave a doctor's office, we leave with the problems still in our bodies, in our heads, because we haven't been able to explain them."

2

Perinatal care

Challenges of the perinatal period in an individualistic society

The pitfalls of breastfeeding and post-partum isolation

The postnatal period highlights the limitations of a healthcare system centred on the individual, whereas for many migrant families, it is the extended family as a whole that normally plays a key role in supporting the new mother. For women from South Asia, breastfeeding often becomes a source of tension: on the one hand, healthcare professionals recommend exclusive breastfeeding, in line with French guidelines, on the other, the family – often contacted from afar – encourages different practices, such as giving supplements or traditional remedies from the very first days. Caught between these two conflicting demands, young mothers find themselves in a difficult position, unable to truly rely on either side, which reinforces their sense of isolation and confusion in the days following the birth. This isolation is further exacerbated by the urban environment. In Seine-Saint-Denis, women give birth in the hospital and then return home, a transition that is often difficult to cope with both practically and emotionally. Many describe childbirth as a difficult, even traumatic, experience. Many are wary of an epidural, either for fear of long-lasting back pain or because those around them value giving birth 'naturally'. In their home countries, the in-laws would have been there to look after the mother and baby. Here, they find themselves alone in a hospital where healthcare professionals become their only points of reference, without the support of friends and family. When they return home – often to cramped accommodation – they must both recover physically and care for their newborn, without outside help. This lack of communal support creates a profound sense of isolation, a far different experience from what they would have had in their home country.

Unspoken depression and the clash of healthcare systems

Postpartum depression is a common reality for these women, yet it often goes unspoken. The language barrier makes it difficult for them to put into words what they are feeling, both emotionally and physically. Added to this is a significant difference between two cultural models: in their home countries, the extended family naturally takes on a large part of the care of the newborn, allowing the mother to recover. In France, the women believed this was the role of healthcare professionals. One participant sums up the situation plainly: in her country of origin, the care of mother and newborn falls primarily to the family, whereas in France it is provided by healthcare professionals. This shift does not only concern the organisation of postpartum support, it also alters the relational framework within which the maternal experience is expressed. In the absence of close family members, the young mother bears a significant part of her emotional burden alone, particularly as the expression of this experience is limited by the language barrier.

This silence —imposed both by the language barrier and the absence of family —becomes a major risk factor. It prevents these women from seeking help and accessing existing support services in time, such as counselling or support groups. Healthcare professionals sometimes perceive them as distant or unresponsive, without always understanding that this reserve is linked to their practices and living conditions in France. Postpartum depression remains under-identified by healthcare professionals. Due to the language barrier, referral to a psychologist is not systematically offered. Some healthcare providers point out that, even when psychological support should be recommended following a traumatic birth, this approach is still too rarely implemented. Furthermore, this withdrawal is linked to the fact that women believe it is the role of healthcare professionals to care for the newborn in the early stages.

“It’s because it was my first baby. I didn’t have much experience. But I had my family around me, and in our culture, as we say, parents always have advice, tips and tricks to help us look after the children, especially when you’re just starting out.”

—Adya

Burnout and opportunities for collaborative development

From the perspective of healthcare professionals, deliveries involving these patients are often more complicated, with more frequent use of instruments or caesarean sections. This is sometimes attributed to assumed physical factors — a narrow pelvis, fragile skin, difficulty pushing — but the language barrier also plays an important role: when instructions are not understood, labour does not go as well. Faced with these recurring difficulties, some professionals eventually burn out. This exhaustion can manifest in blunt ways, for example in reactions like “oh no, not the Tamil women again”, revealing a kind of weariness at facing the same obstacles over and over. In the postnatal ward, these mothers are often perceived as insufficiently attentive to their babies, which can lead to suspicions of mother-infant bonding difficulties. Many professionals also regret that adapting post-partum classes to their patients’ languages is too complicated to manage. And when gestational diabetes is diagnosed, it is often attributed straight away to diet — rice, oil, sugar — without any attempt to understand the social or economic reasons behind these habits.

3

Parenting and mental health

Invisible burdens

"Mental health = madness"

For the women, the idea of seeking help for mental health issues is closely associated with madness and social stigma. One participant explains the gap between these two ways of thinking: "But you know, in our country, seeing a psychologist really means there are problems with madness, that there's someone who's completely unwell. It's not like here. Since I've been here, I've come to understand that it's not necessarily like that." This statement captures a gradually shifting perspective: migration exposes women to different definitions of psychological distress, but acceptance of these new categories is neither immediate nor universal. It conflicts with another central element of the accounts: the fear of intervention by social services. As another woman puts it, "There's this rumour in the community that if you say you're not well psychologically or mentally, they'll split up families." Parenthood becomes the focal point of two anxieties: protecting the children and preserving family unity, whilst managing psychological distress that is difficult to name and treat within medical terms.

"There's a rumour going around the community that if you say you're not doing well psychologically or mentally, they'll split up families."

—Sarah

Changes in family structures and loss of support

Healthcare providers have a long-standing understanding of this transformation. One of them highlights the protective role of extended families in their countries of origin: 'After giving birth, you're surrounded by a family of ten people. You're bound to talk to at least one of them about it. What's more, these are families you grew up with, so if you're not feeling well, people will notice. They'll sort of act as a family support network, which helps prevent you from developing a psychiatric or psychological condition. The same participant emphasises the disruption caused by migration: 'But the problem is that once they arrived in France, family structures changed. It's no longer large extended families living together; it's single-parent families, and that's where the problem lies." The shift towards more nuclear and isolated family structures, combined with the living conditions in Seine-Saint-Denis, undermines these informal systems of mutual support. This analysis aligns with the experiences of women who describe the mental load as centred on their children's academic success and safety, in an environment where educational benchmarks, the languages of society and institutional expectations are numerous and sometimes contradictory.

Silence, stigma and unspoken aspects of the care relationship

Healthcare providers acknowledge that mental health is rarely addressed directly. A midwife points out that the 'language barrier' makes it difficult to put these

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—Inaya

issues into words: ‘Honestly, I can’t really say much, because with this language barrier, personally, I don’t really... These aren’t things you can easily bring up, you can’t really communicate them.” In practice, women turn to family, religious or community resources, while healthcare providers mainly highlight breastfeeding, isolation or obstetric trauma. Between the two, a gap in communication persists: women describe their sadness or distress in their own words during the perinatal period and indicate that little psychological support was offered to them.

4

Cultural representations

The body, the family and secularism in encounters with the healthcare system

Modesty, "shame" and cultural displacement

The accounts of South Asian women reveal a way of thinking about the female body centred on modesty, restraint and the protection of privacy. This modesty is not experienced as a negative sense of shame, but as a form of dignity and self-respect. From childhood, they are taught that a woman protects herself, covers herself, and does not readily discuss her body with strangers.

"At the same time, I was also worried that I'd be coming to a different culture, to a country I didn't know"

—Inaya

Perceptions and stereotypes

Healthcare providers interpret these attitudes through their own frames of reference, which are shaped by a Western conception of female autonomy and by implicit biases. Some describe parents as having "endless patience" with their children's behaviour, attributing this trait to the families' "background": "I get the impression there's a kind of boundless patience with what the children do and the impact that has in terms of acceptance... parents who are endlessly patient. ' In the context of motherhood, the bodies of South Asian women are sometimes interpreted through predetermined scripts, contrasting, for example, supposed 'syndromes' with reactions deemed exaggerated or detached.

One professional notes: "Just as we often talk about the 'Mediterranean syndrome' in North Africa, with Sri Lankan, Indian and Pakistani women, one gets the impression that they're putting on a bit of a show with their husbands. Afterwards, the men are doting on them." ' Another goes further in trivialising women's supposed 'resilience': 'They've adopted this mindset of telling themselves that, anyway, back home, that's just how it is; they've already given birth without electricity, without a hospital. So, in fact, nothing shocks them... There's a medical error, she doesn't care; she's not being looked after, she doesn't care; I get the impression that nothing gets to them." These accounts illustrate how complex experiences (often marked by violence, structural inequalities and difficult migration journeys) are simplified and reinterpreted as uniform cultural traits. They contribute to what the study describes as an 'embodiment of inequality', where gender, 'race' and geographical origin combine to legitimise differentiated standards of care.

Family, cultural traditions and resources

However, these same accounts show that women's cultures of origin serve as a source of support, particularly when it comes to parenting and caregiving. One participant highlighted the importance of family support when her first child was born: "It was because it was my first baby. I didn't have much experience. But I was surrounded by my family, and in our culture, as they say, parents always have advice, tips and tools to help us look after the children, especially when we're just starting out." The extended family and

"We come from a culture where women are taught to show restraint and modesty." We use the words "shame" and "curtain", but not in the negative sense of the word "shame". It is a kind of modesty, a sense of discretion. And in this culture, a woman's body falls within that framework."

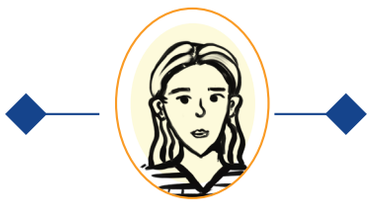
—Jiya

social networks play a role here in providing emotional and practical support. This aspect is often overlooked in professional literature, yet it constitutes a major point of tension when moving to a French environment where intergenerational cohabitation is rarer and where parenting models differ. It is precisely at this point that the themes of parenting and mental health emerge.

5

Strategies employed

Resources and coping mechanisms



"When I speak to a Tamil doctor, I can explain things naturally, in my own language. I feel more at ease because I can find the right words straight away; it's easier for me. But when I have to see a French doctor, I often prepare for the appointment in advance."

—Jiya

Resources for women: navigating and improvising

Women employ a range of strategies to mitigate the effects of linguistic, cultural and institutional barriers. They use Doctolib to find practitioners who speak their language, attend OFII courses despite transport constraints, join activity groups (physical, cultural, culinary) and use social media to find information on pregnancy and children's health. These practices illustrate a form of autonomous 'navigation' within a healthcare system perceived as lacking transparency.

Adaptations on the part of healthcare providers

For their part, professionals rely on colleagues who speak the same language, whilst women call upon interpreters, associations and community networks. However, they recognise the limitations of these arrangements.

In psychiatry in particular, one care worker points out that psychologists often do not call on interpreters', which makes referral to psychological support 'complicated' for Tamil families or those speaking other South Asian languages.

This lack of systematic integration of interpreting in mental health care reinforces the marginalisation of these individuals within the care relationship. More generally, one professional points out that "lots of things they don't talk about" remain unaddressed, "because there is the language barrier, but also because they don't want to cause a fuss".

Tool 1:

Migration & Health Training (Intercultural Understanding: India / South Asia)

A six-hour training course for hospital-based healthcare professionals, focusing on intercultural understanding when working with patients from India and South Asia, to better understand their family, religious and cultural backgrounds in the context of patient care.

Tool 2:

Arokiyam booklet in Tamil

A booklet in Tamil produced by the Arokiyam association, containing tailored health information and a list of useful contacts. It serves as a tool to facilitate communication between women, families and healthcare institutions, and helps navigate the system.

Tool 3:

INALCO training course: 'South Asian immigration: family, health and cultural perceptions'

A training course designed to help professionals better understand the specific characteristics of families with a South Asian immigrant background, their attitudes towards health and their cultural perceptions, in order to adapt support and communication practices.

Tool 4:

Women's Health Picture Book – Fable-Lab

A visual resource offering an illustrated vocabulary on women's health, designed for contexts where French language skills are limited, to support consultations, health education and communication with patients who speak little or no French.

Tool 5:

Musafir health education website

A website featuring information in the form of videos in two languages, Urdu and French, on mental health, sexual health and access to healthcare rights. An Urdu-French glossary is also included.

Interpreting at the heart of patient care

The importance of interpretation for women navigating maternity care

Why prioritise people over apps?

The findings of the WomenHealthASU93 project remind us that access to reliable information is a fundamental right for every patient. An interpreter is much more than a mere translator of words, they act as an advocator of the woman's safety and dignity throughout her healthcare journey. This role of protection and human support is carried out on a daily basis by the expertise of the interpreter-mediators Farjana Hossin, Anamiga Joseph and Nohmana Khalid, the interpreters who supported us throughout our project. Unlike digital tools, their presence enables the decoding of non-verbal language, adaptation to cultural taboos, and confirmation that the patient has truly understood the implications for her health. For migrant women, this personalised support reduces isolation and alleviates anxiety related to healthcare, thereby establishing the trust essential for a peaceful pregnancy. The systematic use of interpreter-mediators also helps prevent major clinical risks that technological tools cannot rule out. As the use of translation apps in a medical setting has high error rates.

These online tools can generate "hallucinations" or completely fabricated text which, when it comes to prescribing medication, could prove fatal. By prioritising the use of interpreters, informed consent is safeguarded and medical confidentiality is respected, whereas apps often store sensitive data on third-party servers. In a hospital setting, where a single misunderstood nuance can turn a routine diagnosis into a serious error, interpreting mediators are an essential safeguard for patient safety.

Translation apps (AI)	vs	Professional interpreter
Risk of serious errors and technical omissions		Technical accuracy and explanations of diagnoses
May increase anxiety if the meaning is misinterpreted		Reduces isolation and builds the necessary trust
Unable to guarantee informed consent		Ensures the patient truly understands
Literal translation only		Interpretation of non-verbal cues and cultural sensitivities

Optimising patient care

Although turning to a relative, a friend or even a minor is a common practice to address urgent language barriers, this solution raises serious ethical concerns. As well as breaching medical confidentiality, relying on family and friends exposes the patient to the risk of sensitive information being withheld or of harmful diagnostic errors. Similarly, while translation apps may be appealing due to their ease of access, tools that have not been technically validated compromise the reliability of care and the confidentiality of data. It is essential to understand that calling on a professional interpreter is not a waste of time, but an investment in the patient's safety. By ensuring accurate and fluid communication from the very first contact, we guarantee a higher quality of care, avoiding complications caused by misunderstandings.

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Johann OMIYA (CAILHOL)
Paige GASKINS
Lucia GENTILE
Sabah JAROOF
Clémence JULLIEN
Sofia MEISTER
Noélie NDIAYE
Valéry RIDDE
Marie-Caroline SAGLIO-YATZIMIRSKY

Designed by: Paige Gaskins