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Stigma and unmet sexual and reproductive health needs among international migrant sex workers at the Mexico–Guatemala border

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Abstract

Objective—To explore international migrant sex workers' experiences and narratives pertaining to the unmet need for and access to sexual and reproductive health (SRH) at the Mexico–Guatemala border.

Methods—An inductive qualitative analysis was conducted based on ethnographic fieldwork (2012–2015) including participant observation and audio-recorded in-depth interviews. The participants were female sex workers aged 18 years or older and international migrants working at the Mexico–Guatemala border.

Results—In total, 31 women were included. The greatest areas of unmet need included accessible, affordable, and nonstigmatizing access to contraception and treatment of sexually transmitted infections. On both sides of the border, poor information about the health systems, services affordability, and perceived stigma resulted in barriers to access SRH services, with women preferring to access private doctors in their destination country or delaying uptake of until

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Author contributions

TR-J contributed to data collection, data analysis and interpretation, and manuscript writing and revision. SM-M contributed to interpretation of the analyses, and manuscript revision. CF-C contributed to interpretation of the analyses, and manuscript revision. KB contributed to interpretation of the analyses, and manuscript revision. SMG contributed to the design of the study, data collection, data analysis and interpretation, and manuscript revision. All authors provided final approval of the submitted manuscript and agreed to be accountable for all aspects of the work.

Conflicts of interest

The authors have no conflicts of interest.

their next trip home. Financial barriers prevented women from accessing needed services, with most only receiving SRH services in their destination country through public health regulations surrounding sex work or as urgent care.

Conclusions—There is a crucial need to avoid prioritizing vertical disease-specific services and to promote access to rights-based SRH services for migrant sex workers in both home and destination settings.

Keywords

Guatemala; Mexico; Migrants; Sex workers; Sexual and reproductive health; Stigma

1 INTRODUCTION

The WHO defines sexual and reproductive health (SRH) as “a state of complete physical, mental and social well-being related to the reproductive system, not merely the absence of disease but a positive and respectful approach to sexuality and sexual relationships, as well as having safe sexual experiences, free of coercion, discrimination and violence”[1]. Worldwide, high levels of unmet need for SRH services confer serious health consequences for women. In 2015, 300 000 women died owing to pregnancy or childbirth-related complications and approximately 200 million women experienced an unmet need for contraception[2].

Additionally, considerable gaps remain globally in preventive SRH services such as cervical cancer screening, particularly in low- and middle-income regions like Central and South America and Sub-Saharan Africa, where more than 80% of global cervical cancer cases occurred in 2012[3]. Latin America and the Caribbean experience among the highest rates of adolescent pregnancies in the world (72 per 1000 adolescents). In Mexico and Guatemala, 10–19% of women aged 15–49 years are estimated to face unmet family planning needs[4,5].

Globally, key populations of marginalized women such as female sex workers face considerable health and social inequities, including those related to HIV and sexually transmitted infections (STIs)[6]. In particular, migrant sex workers have been identified as an important population facing serious gaps in healthcare access and a number of unique health and social vulnerabilities related to stigma, across diverse destination settings; yet, little is known about their broader SRH, including patterns of unmet need and access to SRH services[7].

Previous research has documented poor access to SRH services and rights (for example, limited access to contraceptives or safe abortion) among sex workers across diverse settings including the Mexico–USA border[8,9], Canada[10,11], and Sub-Saharan Africa[12]. However, there remains a critical research gap in understanding migrant sex workers’ access and unmet need for SRH services.

Stigma toward both sex workers and international migrants is an issue present around the world including in Latin America, with previous research showing that migrant sex workers

frequently experience stigma influenced by factors such as their occupation, their ethnicity, and stereotypes of their links to the transmission of diseases such as HIV[7,13]. In both Guatemala and Mexico, the prevalence of HIV/STIs is considerably higher among marginalized populations. The prevalence of HIV among sex workers is estimated at 4.5% in Guatemala and the prevalence syphilis, chlamydia, and gonorrhea has been measured at 9%, 14%, and 12%, respectively, along the Mexico–Guatemala border[14,15]. The Mexico–Guatemala border region represents a key destination and transit region for migrants moving from southern countries destined for Mexico and the USA[16,17]. This region hosts a thriving sex work scene, and previous work indicates that the majority of sex workers in this border region are either internal or international migrants from Mexico, Guatemala, or other Central American countries[17].

Given gaps in our understanding of SRH access and rights among migrant sex workers within the Mexico–Guatemala border context, the aim of the present analysis was to explore international migrant sex workers' experiences and narratives pertaining to the unmet need for and access to SRH services at the Mexico–Guatemala border.

2 MATERIALS AND METHODS

A qualitative analysis of data drawn from ethnographic fieldwork (May 1, 2012, to June 30, 2015) including in-depth interviews was conducted with international migrant sex workers in two cities in Guatemala (Tecún Umán and Quetzaltenango) and one city in Mexico (Tapachula). Eligible participants were women aged 18 years or older who had exchanged sex for money in the past month, were international migrants (residing in a different country from where they were born), and gave informed consent. Mexican women living in Guatemala were not interviewed because the direction of international migration in this region is predominately from south to north.

The ethnographic fieldwork performed specifically for the purposes of the present study entailed seven visits to the study settings, and included participant observation and informal conversations with key actors such as community members and local clinic staff to gather contextual information on the locally available SRH services. The insights gained from the ethnographic fieldwork (for example, understanding local sex work regulations) informed the design of the interview guide used for the in-depth interviews, the participant recruitment strategy, and the data analysis.

In all three study communities, public health guidelines require that sex workers in certain sex work environments (for example, formal venues/bars) undergo regular HIV/STI tests at local clinics to maintain a health card to engage in sex work[18]. Women who exchange sex in informal venues (for example, street/hotels) often do not maintain a health card[18]. In Tecún Umán and Quetzaltenango, health permits are provided free of charge through community health clinics. In Tapachula, obtaining a health card involves out-of-pocket fees and requires transportation to a clinic located in an isolated outlying area (Las Huacas).

The recruitment for the in-depth interviews involved unobtrusively inviting women during community-led outreach to diverse sex work venues. The participants were selected using a purposive sampling approach.

The interviews followed loosely structured interview guides, which were iteratively revised by the research team as data analysis and collection progressed. The data collection was led by researchers from the University of California, San Diego (UCSD; La Jolla, CA, USA) and Simon Fraser University (Burnaby, Canada) in close partnership with representatives of community-based HIV prevention and sex work organizations in Mexico and Guatemala. All interviews were audio-recorded, and transcribed and translated by trained bilingual staff at UCSD. Any personal identifiers were removed and substituted by pseudonyms.

NVivo version 10 (QSR International, Melbourne, Australia) was used to manage data coding. Interviews and field notes were initially organized and coded according to the major themes that emerged in the transcripts, such as key health concerns and access to healthcare. Given the paucity of literature pertaining to the experiences of migrant sex workers with regard to access to SRH services in the study sites[7,13,18], a primarily inductive analysis approach guided by the participants' own narratives was adopted[19].

The study activities were approved by the ethics committees at UCSD; the Universidad del Valle de Guatemala (Guatemala City) and the Ministry of Health in Guatemala; and El Colegio de la Frontera Sur (Campeche) and Centro Nacional para la Prevención y el Control del VIH y el SIDA in Mexico.

3 RESULTS

All of the participants (n=31) except one had at least one child, and child support was one of the main reasons cited for sex work involvement. Most participants were single and reported working mainly in informal venues (Table 1). More participants interviewed in Tecún Umán and Quetzaltenango reported owning a health card compared with participants interviewed in Tapachula.

The primary unmet needs for SRH described by the study participants included contraception, which was linked to frequent experiences of unintended pregnancy; lack of sexual health education; and absence of timely and accessible prevention, care, and treatment services (Table 2). Lack of information, perceived stigma, and unaffordable costs often resulted in barriers to access to SRH services in the destination country, with numerous women (n=17) preferring private doctors or delaying uptake of SRH services until their next trip home. When participants did receive SRH services in their destination country, this was typically related to sex work regulation practices or to a need for urgent health care (for example, childbirth), or the services were taken up whenever women could afford it, as opposed to using SRH services in a preventive context.

Most participants (n=22) reported not having access to contraception information when needed. Although condom promotion was more frequent, information on non-barrier contraceptive methods was notably limited and often failed to address broader contraception

needs. One participant (Josefina in Table 3) explained how she had learned about methods of preventing unplanned pregnancies when she started working in her home country.

Despite the efforts of local and nongovernmental agencies to improve knowledge about SRH and access to SRH information in the participants' countries of origin and destination, the majority of the participants reported never having received information regarding non-barrier contraceptive methods or information surrounding pregnancy (see for example Gabriela in Table 3). Instead, the participants' testimonials highlighted how their knowledge of contraceptive methods was restricted to condom use for the purpose of HIV/STI prevention within the context of sex work and did not address the potential for pregnancy within the context of nonpaying partnerships (see for example Pia in Table 3).

The participants' experiences regarding access to and use of SRH services varied depending on how much information they had about the health system in their country of destination, their migration status, the healthcare resources available, the affordability of such services, and health providers' willingness to offer certain services.

Owing to restrictions on Central American migrants' ability to live or work without a visa in Mexico, access to services was frequently restricted because of the women's legal immigration status. Luciana's testimony (Table 3) portrays how access to health care for marginalized migrant women in Mexico is inextricably linked to their legal status. Because she could not access SRH services at her local health center, Luciana went to a low-cost pharmacy service in the destination country to fulfill her needs, exemplifying the barriers posed by the affordability of services in the destination country—a notion shared by other participants (see Cecilia in Table 3).

Some participants (n=16) felt that they were forced to delay healthcare access until their next trip back to their home country because of such barriers to healthcare services in their destination country. Many circular migrants shared narratives of having avoided or delayed much-needed SRH care in their destination countries owing to unaffordable costs, impolite or inconsistent treatment by providers, and concerns regarding their immigration status. These experiences together posed powerful barriers to women's ability to successfully interact with health providers in the destination country. Cecilia (Table 3) explained that although she was able to give birth in Mexico without cost, she had a hard time accessing other necessary and closely related SRH services for herself and her newborn following the delivery, mainly because of affordability issues. The affordability issue was clearer on the Mexican side of the border, where women have to pay out of pocket to maintain a health card to engage in sex work, compared with the practices surrounding sex work in Guatemala, where a health permit is available free of charge.

Participants also frequently attributed barriers to accessing SRH services to the perceived stigma related to sex work and their immigration status. In one case, a Salvadoran-born participant explained that although she received HIV/STI information and testing free of charge at Quetzaltenango's local health clinic, she preferred to pay for a private doctor because of the increased privacy and safety she felt this afforded, and because of her concern that being seen accessing care at the health clinic could be perceived by her clients as

meaning that she was HIV- or STI-positive. Several women (see for example Veronica in Table 3) also shared serious concerns about perceived stigmatization by the community not only for being sex workers but also for being international migrants, and reported that these intersecting sources of stigma together posed notable barriers to SRH services access.

Although perceived stigmatization toward sex workers was common in both countries, international migrants described themselves as feeling particularly targeted for being sex workers in a foreign country. This was identified as a major barrier preventing women from interacting with healthcare institutions providing SRH and other needed health services within destination settings.

4 DISCUSSION

In the present study, key unmet SRH needs identified by migrant sex workers at the Mexico–Guatemala border included limited access to contraception information and other SRH services. The analysis found gaps in SRH access largely related to women's migration status and experiences of perceived stigma in the destination settings. As a result of these gaps, many women avoided health services or delayed uptake of preventive or urgent SRH services until the next trip to their home country. Where participants could afford them, many noted private doctors or clinics requiring payment to be preferable because of the reduced stigma and increased privacy this was perceived to confer.

When migrant sex workers were able to successfully access SRH services in their destination setting, this was typically facilitated through sex work venues or third parties, a finding in agreement with previous studies[13]. However, these sources of information and services primarily focused on workplace-related health risks such as HIV/STIs, and typically did not recognize sex workers' broader SRH needs (for example, contraception) outside the context of the workplace. These findings indicate that workplaces could be potential supportive environments in which broader SRH interventions could be delivered, including the provision of SRH information and efforts to link sex workers with nonstigmatizing services offered within the community, where available[20–23]. Further efforts to scale up access to nonjudgmental and community-based SRH services for migrant sex workers—especially those who do not access municipal clinics—are recommended as part of a comprehensive approach to improve sex workers' health that addresses broader SRH needs, rather than exclusively focusing on HIV/STI prevention[13].

Access to certain SRH services, including treatment for STIs, in the destination country (mainly in Mexico) sometimes involved out-of-pocket fees that not all participants could afford, illustrating that—in addition to the need for comprehensive SRH services—there remains a critical need to ensure that these services are available at low or no cost to populations most in need, including migrant sex workers.

The present analysis highlights the critical importance of privacy and fear of perceived stigma in shaping women's decision to access care in their home country and destination settings[7,13]. International migrants frequently described concerns regarding their legal status as among the most important reasons they did not receive the SRH care they needed.

These findings complement previous research conducted with migrant sex workers[7,11,24], which has found that they frequently face enhanced barriers to healthcare access compared with native-born populations, for reasons that include a lack of financial resources, experiences of stigma, and their legal status, which jointly contribute to limited access to and seeking of care.

Based on these findings, efforts to integrate SRH services into broader health services for sex workers are recommended. Currently, severe gaps remain in community-based services within the Mexico–Guatemala border region, and future efforts are essential to engage with the community and policymakers to develop such services in collaboration with local sex workers. Although many local organizations (Médicos del Mundo; Una Mano Amiga in Tapachula, Mexico; and Educación para la Vida [EDUCAVIDA] in Guatemala) have advocated the inclusion of SRH services (for example, Pap smears) as part of sex workers' regular visits to municipal clinics, barriers to such integration persist, including limited resources and funding models that continue to prioritize vertical, disease-specific interventions[24]. A shift to a rights-based approach emphasizing the protection of sex workers' human rights and broader social well-being is critically needed[7,18].

The present study has several limitations. Our qualitative research does not represent the experiences of all migrant sex workers in the Mexico–Guatemala border region or elsewhere, and future studies exploring other experiences that may be relevant to migrant sex workers' SRH needs and access are recommended[13,25].

In conclusion, the testimonies obtained in the present study provide important insights regarding structural barriers and facilitators of migrant sex workers' unmet SRH needs near the Mexico–Guatemala border. The findings may be relevant to similar populations working in other contexts. Further epidemiologic and mixed-methods research is needed that addresses the complexity of migration patterns and experiences (for example, unsafe transit journeys, trauma, and stigma) in relation to SRH outcomes and access to SRH services among migrant sex workers in the present setting and others[13,25].

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Synopsis

There is a crucial need to avoid prioritizing disease-specific services and to promote access to broader sexual and reproductive health services for migrant sex workers.

Table 1

Sociodemographic characteristics of international migrant sex workers interviewed in Tecún Umán, Quetzaltenango, and Tapachula (n=31).

Characteristic	Tecún Umán (n=11)	Quetzaltenango (n=7)	Tapachula (n=13)
Age, y[a]	30 (22–39)	37 (31–47)	33 (20–44)
Civil status			
Single	7 (23)	6 (19)	9 (29)
Married/partnership	2 (7)	0	3 (10)
Widowed	1 (3)	1 (3)	0
Divorced	1 (3)	0	1 (3)
Country of origin			
El Salvador	3 (10)	5 (16)	1 (3)
Honduras	5 (16)	2 (7)	4 (13)
Guatemala	0	0	8 (25)
Nicaragua	3 (10)	0	0
Level of education			
None	1 (3)	1 (3)	3 (10)
Some primary school	3 (10)	2 (7)	7 (21)
Finished primary school	5 (16)	2 (7)	1 (3)
More than primary school	2 (6)	2 (7)	2 (7)
Sex work environment			
Entertainment venues (bar, nightclub)	6 (19)	2 (7)	1 (3)
Informal venues (cantinas, hotel/motel, rented room, trailer)	5 (16)	5 (16)	12 (39)
Health permit			
Yes	8 (26)	5 (16)	4 (13)
No	3 (10)	2 (7)	9 (28)

[a]Values are given as mean (range) or number (percentage).

Table 2

Unmet sexual and reproductive health needs among female sex workers in Tecún Umán, Quetzaltenango, and Tapachula (n=31).

Type of service	Details
Contraception information and related services	Sexual education
	Safe delivery/childbirth
	Information about and access to barrier and nonbarrier contraception
Prevention and treatment of STIs	Access to condoms
	Treatment for STIs such as syphilis, chlamydia, gonorrhea, and HIV
Early diagnosis and treatment of reproductive health issues	Screening for cervical cancer (Pap smear)

Abbreviation: STI, sexually transmitted infection.

Table 3

Narratives of barriers to accessing sexual and reproductive services among female sex workers in Tecún Umán, Quetzaltenango, and Tapachula (n=31).[a]

Identified themes	Pseudonym	Origin	Destination	Quote
Access to family planning and contraceptives	Josefina	Honduras	Quetzaltenango, Guatemala	A long time ago when my children were young, I worked at a table dance [strip club] in San Pedro Sula [Honduras], so the lady [manager] showed me how to use a condom with clients, and what to take [pills] if I didn't want to get pregnant again. She also showed me how to negotiate condoms use with clients … She taught me a lot of things.
	Gabriela	Honduras	Tapachula, Mexico	Q: Did you also receive information about abortions, about pregnancies? Did someone inform you? A: Nobody talked to me about my pregnancy, not even my family, not even my mother … I barely got information about my pregnancy and how to avoid getting pregnant … When I got pregnant for the first time, I never thought it was painful to have a child.
	Pia	Guatemala	Tapachula, Mexico	Q: Do you know about birth control methods, where did you learn this? A: Well, yes I know about condoms … I always use condoms; since I started to working in this [sex work] at the beginning I didn't know but … the manager of the bar where I started working told me that I needed to use condoms always with the clients. Then, at the clinic, they told me that we [sex workers] needed to use them because of the diseases … I do use it when I work but not with my [nonpaying] partners.
Access to and use of SRH services (STI treatment and testing)	Luciana	Guatemala	Tapachula, Mexico	Q: Could you tell me if you get sick here in Tapachula, can you receive medical attention in the local health center? A: No, I go to see a private doctor, because they don't give me attention there, as I'm not from here [Mexico] and I don't have any documents so they do not offer help to us. I rather go to the Similares [public pharmacy offering low-cost medical appointments] … I feel bad because I was born in Guatemala but migrated here when I was really young … However, I don't have any identification so I only go to those pharmacies.
	Cecilia	Honduras	Tapachula, Mexico	I got pregnant and had my baby here in Mexico, I didn't pay anything, but after he was born I found out that I had syphilis … They told me over there [in the municipal health clinic]. The baby has it too … I haven't been able to get treatment here as I'm not from here, and every time I go to the clinic they tell me different things, that I have to pay for a test or something like that … and I don't have the money, so I'm going back to Honduras to get the treatment for me and my son … but I don't… [know] when that's going to be.
	Veronica	El Salvador	Quetzaltenango, Guatemala	Sometimes I go to the clinic, the only thing is that sometimes I feel bad because the housewives see us [sex workers] and you know that for society we are not very well looked upon. They [housewives] can tell we're not from over here [Guatemala] … and many people see us [migrant sex workers] as unequal, they discriminate upon us, some of them are housewives, they discriminate against us … That's why I avoid the clinic sometimes.

Abbreviations: A, answer; Q, question; SRH, sexual and reproductive health; STI, sexually transmitted infection.

[a]The women's testimonies included in this table were chosen as exemplars based on their value for demonstrating primary themes identified by the present study participants, as well as to ensure representation of experiences from each study site.