Female migration and health in different prostitution scenarios in the province of Almeria, Spain

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Abstract

The objective of this paper is to present the social inequalities in health faced by foreign migrant women in prostitution and the social exclusion of this group in the province of Almeria, Spain. Ethnographic research focused on participatory observation and discourse analysis of foreign migrant women in harm reduction and health promotion program of Doctors of the World, Almeria. Foreign migrant prostitute women have a higher risk of getting sick, given their living and working conditions, the health inequalities they face, the lack of social support networks and the difficulties they have to access the health and social services offered in the province.

Keywords: Social inequalities, Gender, Migration, Health, Prostitution;

1. Introduction

According to the report by the Permanent Observatory of immigration, of the Spanish Ministry of Employment and Social Security, on Spain, the number of foreign people with a valid registration certificate or residence card as of March 03, 2013 was 5,467,955, of which 2,854,579 (52.20%) are males and 2,613,376 (47.79%) are women.

The "feminization of poverty" is one of the effects of economic globalization, which results in negative consequences in the areas of health, development, and personal autonomy of women; it has boosted the displacement of people abroad, seeking to improve the quality of life for themselves and their families (Oso, 2005).
It follows that many single women "heads of household" see in migration an out to the precarious situation of the households for which they are responsible, looking for an opportunity that takes them, usually, to developed countries to enter the transnational labor market (Sassen, 2003). The demand for labor in jobs considered ‘feminine’ is the constant claim that link different migratory networks, domestic, institutional, or illegal, such as networks of human trafficking for purposes of sexual exploitation. In the case of the sex industry there is a demand for "exotic" women from Western countries, making this industry to be an avenue in which many migrant women earn money (Ordóñez, 2006).

There are groups, such as the group of sex workers that require a more global assessment of their health situation within the immigration contexts. This research, through ethnographic methodology allows for a closer and deeper look to the reality of these people, through the experiences of everyday life, and the specificity of the exercise of prostitution. I present here the results of four years of work and study with women that stimulate the sex market in the province of Almería, Spain. Describing the social inequalities faced by these women, and its effects on their health and social integration that prevents a satisfactory migratory processes. The work is illustrated by the discourses of women participating in this research, and the professionals who work in this area.

Qualitative Research opens a space in the analysis of health problems from a social and cultural perspective, adopting for this purpose various procedures, such as content analysis or the analysis of the discourse, which allows an approach to forms of communication and squints in the ideology that is behind the language (Amezcua and Galvez, 2002).

Within the biomedical paradigm the main factors that cause a disease are organic, the weight of Genetics and the Constitution of the individual become fundamental. The disease is seen as a clinical experience defined by the physician; the socio-cultural context is not valued as an important element to clarify the causality of diseases. As an alternative to the biomedical approach emerges the bio-psycho-social model posed by George Engel in 1977. This model emerged as a critique of the dehumanization of medicine that looked at the patient as an object, without taking into account their word, or their experience; without observing what happens with the individual’s body and their health. The disease is seeing more from the experience of getting sick than from the pathological physiology of the disorder. The bio-psycho-social model is defined not only by the disorders but also by the discomfort or problems perceived by the patient, there is an understanding that the cause of the disease is a combination of multiple factors. The static and reductionist concept of health that limits the vision of the disease to a biological cause has evolved historically towards a broader concept in which it is possible to think of the biological, psychological, and social dimensions that affect not only the health of an individual but that of the collective.

The theory of Social Inequalities in health and the bio-psycho-social model, have been the theoretical framework for this research. Both allow the analysis, since it includes different aspects of the lifestyles, social, economic, and global circumstances of societies and their influence on the health of individuals and their communities. To the structural determinants-social position, race, ethnicity, education, age, gender, and territory – are tied secondary social determinants, generating inequalities in health: styles of life, stress, work, unemployment, social support, nutrition, addiction, transportation, and social exclusion (Wilkinson and Michell, 2003).

2. Field Work

The biggest difficulty to reach this group is the high geographical mobility of the women in the program of Doctors of the World. This mobility limited the follow-up of cases, however this data is significant in itself, as it tells us the instability in the scenes of prostitution, the difficulty of people to acquire and maintain healthy lifestyle habits, and the stress generated by being in constant geographical mobility.

In this ethnographic investigation, the information was gathered using qualitative techniques such as participant observation, semi-structure and informal interviews with key informants.

The participant observation technique was carried out in two areas: the scenarios of prostitution-buildings, streets, settlements of immigrants, and side road clubs-, and the different public and private institutions that provide social, and/or health services to this population. The opportunity for participant observation came through my role as a health mediator, while working with the Organization Doctors of the World; as such, I was able to accompany these women to their appointments. The information obtained is recorded in the field journal.
Through in-depth and informal interviews with women of diverse backgrounds, as well as semi-structured interviews to social agents that work with this group, I have deepened my knowledge of the social inequalities faced by women which source of income is stigmatized by their profession, prostitution. The women who work in different scenarios gave me their trust, which allowed us to have an open dialogue. Therefore, our discussions were extensive and covered different areas of their lives such as, the migration process, the practice of prostitution, their emotional status, the conditions for their work, and the difficulties to have a "normal daytime life". We also discussed their health situation, and the difficulties to access health centers, their relationships with their partners, their customers, their family members, and friends; their psychological suffering, their troubles, their loneliness, etc.

Recordings of all interviews with the women and the social partners, have been transcribed and categorized for further qualitative analysis, carried out through a procedure of coding and manual categorization, which has allowed the interpretation and compression of the material produced in the field work. This process has been a back and forth between field work and theory, which is characteristic of ethnography studies (Vallès, 2009).

3. Population

Foreign migrant women constitute a very heterogeneous group, age, marital status, region and country of origin, social class, religious beliefs, educational levels, time spent in Spain, and overall health status, varies within this group. These women are considered “eternal immigrants” as they constantly relocate inside and outside of Spain; making the follow up of complex cases difficult. The selection criteria for the preparation of the in-depth interviews have been:

- Region and Country of Origin, with the most representative groups in the provincial areas;
- Language Competence and;
- Length of Stay in the province (one year).

Every year Doctors of the World Almería, serves approximately 700 people in prostitution, of which 80% are foreign migrant women. In-depth interviews were carried out to seven women from the following countries: Brazil, Colombia, Spain, Equatorial Guinea, Morocco, Nigeria, and Romania.

4. Results

4.1. Socio-demographic data

The fieldwork revealed that within the program Doctors of the World, the women of Romanian origin represent the group with the largest presence in the province, followed by the group of Sub-Saharan women, in which stands out the presence of Nigerian and Guinean women. The third group with the largest presence is that of Brazilian and Colombian women, and last group is comprised of Moroccan women. Although, services were provided to transsexuals, and men who have sex with men, the ratio of their presence in the province is lower than that of females, and the conditions of their prostitution practice is different. The presence of women from Spain engaging in prostitution is minimal (Institute Andalusian Women's, 2011). Other important socio-demographic data are presented below:

- **Marital Status:** Sub-Saharan women represent the largest group of single women, with the exception of Romanian women; the predominant marital status of Colombian and Magrebies women is married and divorced. Women from all nationalities continue to have family responsibilities in their countries of origin.
- **Educational level:** The level of education is high between the Romanian and Latin women, they have acquired secondary, technical, and/or professional studies. The Sub-Saharan women have a high level of literacy with the exception of Magrebies women who are mostly illiterate (mainly from rural areas of Morocco.) As described by Roxana: “in my village, in Romania, women stay home to take care of the children, some that are able to work
go to work, some stay with friends, I wanted to continue studying, go to College because I finished High School but there was no money for College’. (Roxana, Romanian, 29 years)

- **Age:** Younger women, between 20 to 30 years of age, are of Romanian and Sub-Saharan origin; Latinas are at an average of 25 to 40 years of age, as well as Moroccan women.

- **In relation to their Legal Immigration Status**, with the exception of the Rumanians, who are part of the community, the rest of the Group – Sub-Saharan and Moroccan-, have an illegal immigration status (without residence or work permits). We find in these scenarios Latin women with work permits, but because of the economic crisis, they cannot find jobs that allow them to sustain a high social security.

- **Residence:** In relation to residential status, African women, Sub-Saharan and Moroccan - reside in areas of settlement of immigrants, some of them in depressed areas, known as “housing ghettos” (Checa, 2007). The Romanian and Latin American women reside mainly in clubs and apartment buildings where they work, characteristic that they share with women from the other groups. Usually these scenarios of prostitution are located in rural areas, away from health centers and social services agencies, presenting significant difficulties of access to urban centers.

### 4.2. The bio-psycho-social health of foreign migrant women in prostitution

#### 4.2.1 In relation to sexual and reproductive health, the following outcomes are highlighted:

*Free delivery of safe sex material* is a critical factor for persons in prostitution and the perfect excuse to open communication with this group. The proper use of safe sex material has been an ongoing task of associations working with people in prostitution. Harm Reduction programs have positive outcomes on the control of sexually transmitted infections. This distribution is guided by health policies that tend more and more to delegate these functions to non-for profit agencies (Belda et al. 2003). However, ways to prevent sexually transmitted diseases (STD’s/HIV), cannot be reduced to the free delivery of safe sex material, constant sexual health education from a gender perspective is needed, an education that takes into account the heterogeneity of women working in prostitution.

Foreign migrant women focus their physical care in sexual and reproductive health. They are usually meticulous with the care of their body and their client’s body. Sometimes, they lower their guard with their emotional partners, so frequently sexually transmitted diseases come from their relationships with a stable partner instead than from their clients. Chincha, explains it this way: "In so many years working on this, and never any client has giving me anything because I always work with a condom, and it is your boyfriend, your husband, or the one that you live with, the one that gives you diseases... Ah! because I, at home, prior to working on this, I have loss a child, he was born dead eaten by syphilis, there in Romania, because of my husband who had syphilis, my baby girl received the disease and was born with deformities! (Chincha, Romanian, 30 years).

Women, who have several years of experience in prostitution, are clearly aware of the effects on their body and mind. Their sexual hygiene behaviors are so constant and regular, that they become excessive. For them, the task of health care workers is to dismantle the excessive cleansing rituals, as they end up damaging the vaginal flora and increase vaginal dryness.

These women’s health status does not escape the commercialization of the sex industry, insofar as it is an element of control used by the entrepreneurs, who engage in discriminatory practices when selecting new workers for their clubs. Alina describes the abuse of power and control exercised by health professionals, which lack ethics and scruples, at a club in Seville. "I think I'm doing well, a month ago I came from Seville, and there each month we have analytical and PAP smears done, within the same club". (Alina, Romania, 29 years.)

Women are aware of this, but the fear of losing their place of work, forced them to undergo such impositions. Empowerment of foreign migrant women in prostitution starts with informing them clearly and objectively about the risks on their overall health, which gives the possibility to make informed decisions when facing the sanitary and social control that others exercise over their work conditions in prostitution.

*Social inequality* and the difficulties involved in being an immigrant directly influence self-care and availability of contraception measures to prevent unwanted pregnancies (Barroso, Lucena and Parron, 2005). The most popular method, used by sex workers is the male condom. The relationship body-contraception is greatly influenced by
women’s religious values, their conception of motherhood, their awareness of self-care, possible infections, and unwanted pregnancies.

*Cultural Heritage and Health Beliefs* are different in each ethnic group and in each member within that group. (Rodriguez and Martínez, 2011), each group of women who have participated in this research has different beliefs and attitudes toward the ideas of disease and health. Within the Group of Latin American women, the promotion of health and prevention of disease has greater effects, since the language enables better communication with health professionals. Supported by the preventive culture developed in some Latin America countries, they know methods of contraception and have capacity for personal agency in relation to the use and care of their body. Women of Sub-Saharan origin and North Africans, largely use the male condom. Although, they are knowledgeable of methods of contraception, they do not possess economic resources to pay each month for a different method. The work done with this group focuses, in raising awareness of existing resources to have access to sexual and reproductive health, and to other health programs for women. In the same way, individual and collective sex education work was completed with this population; through the implementation of a system of follow-up gynecological consultation. These follow-up appointments have been instrumental in strengthening the relationship with women from Muslim religion, as it facilitates trust and communication of their experience of sexuality within their culture and religion.

Women of Romanian origin are the group with the highest rates of abortions performed within the program of Doctors of the World. During my research, I interviewed a few Romanian women, 28 years of age, with a personal history of ten or more carried out abortions. This fact hinders the promotion of sexual and reproductive health, because these women interpret that a different method of contraception is not needed if they can abort. “Watch, this is my fourth abortion, I know that here they are free, but I feel safer in my country, even though I have to pay, you know?” (Ioana, Romania, 35 years)

4.2.2 Mental Health in prostitution

*The economic, social, and working conditions* that cross the lives of women in prostitution create stressors that are slowly undermining their emotional stability (Villarroya, 2007). Foreign migrant women have to face with fortitude situations that violate their rights and the social inequalities that impede the realization of their migration projects, sharpening the migratory grief (Sayed Ahmad, 2008). Within this group of women, there is a vast heterogeneity, of rich cultural, linguistic, and life experiences; however, the practice of prostitution homogenizes the experiences of these women, as their life styles and conditions is unfavorable towards their health and happiness. They face stressful and frustrating situations, incidents of violence, constant strings of labor exploitation, economic, emotional, etc. (Fernandez, 2011).

Non-Governmental Organizations (NGOs) highlighted the psychological suffering that foreign migrant women practicing prostitution experienced: “The situations that generate more psychological stress for immigrant women are the irregularity of their situation and the long process needed to acquire residence and work. They are objects of stigmatization and social exclusion and they face extreme loneliness as they are away from their families. This situation would not be as detrimental, if there was recognition of their rights as autonomous workers”. (Social Agent APDHA).

*Mood Disorders -Anxiety and Depression disorders -, linked to the consumption of psychoactive substances* are those that appear most frequently in this collective. As Irina tells us: "once here in Almeria, I stared using drugs. When you are on drugs, you feel so supremely evil, you feel like crap! What I had was a strong anxiety crisis, but of course, with the aggravating circumstance that I was using drugs. Then it was worse." (Irina, Romanian, 29 years) With the exception of Maghrebi women in settlement areas, the consumption of legal and illegal substances is frequent in the scenes of prostitution; most women consume alcohol, because of the characteristics and conditions in which prostitution is exercised. Alcohol consumption spreads rapidly and widely among Sub-Saharan women, mainly between the Nigerian and Guinean, but not consumption of other substances such as tobacco or other illegal substances is frequent. In the contrary, Romanian and Latin American women consume tobacco, marijuana, and cocaine, etc. more frequently.

Relations of emotional dependence with their emotional partners. Many would be the stories, which would
exemplify these situations, in which the loneliness of foreign migrant women, their social vulnerability, and the lack of social networks, become the fertile soil to plant affective relationships of dependence, whose gateway is the so-called romantic love and whose output, sometimes, is gender-based violence. In repeated cases, acts of aggression and violence against them by their customers is not considered gender violence, because the aggressor is not an "emotional partner", they are marginalized from any economic and even social aid. And in Spain the Gender Violence Law defines this violence as violence perpetrated by a partner.

Isolation, loneliness and lack of social support, is one of the main psychosocial factors that affect both the mental and physical health of foreign migrant women. It is important, that stakeholders working with this group in the identification of victims of trafficking and sexual exploitation, know how they manage their free time, their links with social networks aside from the scenes of prostitution, since the greater the isolation, the greater the chance of being a victim of sexual and labor exploitation. The exercise of prostitution under conditions of pressure increases the risk of mental and physical diseases in women, mainly to people trapped on networks of human trafficking and sexual exploitation, young people without any or with minimal sexual experience.

4.2.3 Social Health
The main result of this research in relation to the social health is the visibility of the violation of the human rights of this group. Individuals, who work as prostitutes, are not seeing as subjects of rights, as evidenced by the social inequalities that they face, and that become barriers to the access of health and social integration.

- **Difficulties in obtaining a permit of residence and work in Spain**, which would allow them access to other sources of employment, and to pursue strategies of social integration that are not marginal, as it is the exercise of prostitution.
- **Lack of knowledge of the functioning of the Spanish Health System.**
- **Difficulties in accessing adequate housing**: the conditions of housing and sanitation where they reside and exercise prostitution, are a health risk factor. In addition, they reside away from urban areas, where health facilities and social services are, they face difficulties to access transportation to continually attend and participate in health treatment.
- **Language barriers present** difficulties for access to health and social services: except for the women of Latin American origin. The implementation of socio-sanitary mediators will enable the relationship of African and Romanian women with social supports, in the mean time they will learn the Spanish language, which then will give them independence and opportunities for proper participation in the social integration process.
- **Fear of deportation and complaints**: aspect that makes difficult the search for social support and approach to health centers, because women are afraid of being arrested by the police and deported to their countries of origin.
- **Discrimination in care by health professionals and social service agents** occurs when they learn of the exercise of prostitution of women attending public services, sometimes denying care to health programs and social support that could alleviate the situation of vulnerability of these people.

They are increasingly aware of the risks of the work within the sex industry, but this is not enough to combat social inequalities that threaten their well-being. "Every day I have asked the Government, like last Wednesday, I was in trial for ill-treatment. I said to the judge: Why don't you hear me a little? why do you forget me? I have been living here since 1999, my three children were born here, I am here sick, I can't go to my country, I need papers, I need help to obtain work".(Angue, Guinean, 32 years)

5. Conclusions
This study sought to describe the various health problems of a collective of woman challenged by social exclusion, the results are not generalizable, but illustrate the impact on the health of individuals living in conditions of social inequality which coincides with other studies (Fernandez, 2011; Brabant and Raynault, 2012). This study can guide future lines of research in health in other groups at risk of social exclusion, which do not have access to
health services or equal social services. This study highlights the inequalities in health of a collective stigmatized by their triple status: women, migrants, and prostitutes. This collective receives health care from a biomedical approach, focusing on sexual health and control of infectious or contagious diseases, without taking into account other important elements of the health of the people in migratory contexts, such as those highlighted in this article, the hope is that this article brings attention no only to the service gap for this collective but also to the need of the scientific literature in this field to speak about this group and their health inequalities. Shifting attention to knowledge of the social, economic, and legal context, can provide professionals working in the areas of health and psychosocial service programs, with valuable information about obstacles or advantages, faced by this collective. This information is vital when working with collectives at risk of social exclusion, as it can represent adherence or non-compliance of the patient to treatment. Diagnosis, treatment and treatment evaluation are significantly link to this information. Finally, the challenge for the health and social sciences is to create a new paradigm in health an integrative approach, which broadens the reductionist look of the biomedical model, in relation to the process of disease/health/care. This research provides a perspective of integrative social inequalities in health that affect the bio-psycho-social health of this group, analyzing social determinants that must be taken into account for the design of future public health policies, new research proposals and best health education programs.

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