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Health care access and migration experiences among Venezuelan female sex workers living in the Dominican Republic

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ABSTRACT

Objective. To identify sexual risk behaviors and barriers to sexual and reproductive health care (SRH) among Venezuelan female sex workers living in the Dominican Republic.

Methods. This was a mixed-methods study using four focus group discussions (FGDs) and a cross-sectional quantitative survey with Venezuelan migrant female sex workers. The study was conducted from September through October 2021 in two urban areas (Santo Domingo and Puerto Plata) in the Dominican Republic. Information collected from the FGDs was analyzed using thematic content analysis, and quantitative data were analyzed using univariate descriptive statistics. Data analysis was conducted from 30 November 2021 to 20 February 2022.

Results. In all, 40 Venezuelan migrant female sex workers with a median (range) age of 33 (19-49) years participated in the FGDs and survey. The FDGs identified barriers to SRH services, including immigration status and its implications for formal employment and health access, mental wellbeing, quality-of-life in the Dominican Republic, navigating sex work, perceptions of sex work, SRH knowledge, and limited social support. Findings of the quantitative analysis indicated that most participants reported feeling depressed (78%), lonely/isolated (75%), and having difficulty sleeping (88%). Participants reported an average of 10 sexual partners in the past 30 days; 55% had engaged in sexual practices while under the influence of alcohol; and only 39% had used a condom when performing oral sex in the past 30 days. Regarding AIDS/HIV, 79% had taken an HIV test in the past 6 months, and 74% knew where to seek HIV services.

Conclusions. This mixed-methods study found that nationality and social exclusion have a multilayered influence on migrant female sex workers, sexual risk behaviors, and access to health care. Recommendations for effective evidence-based interventions to address sexual health knowledge need to be implemented to address risky sexual behaviors, improve access to SRH, and reduce affordability barriers.

Keywords Dominican Republic, Venezuela, migrant, sexual health, reproductive health, access to health services, social discrimination.

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Migration is a multidimensional phenomenon of social, cultural, economic, and political confluences. It is often associated with sociopolitical situations and can have a profound effect on the socioeconomic development of the sending countries as well as the receiving countries (1). According to the International Organization for Migration, patterns of migration are associated with various factors such as economic opportunities, poverty, political instability, human right violations, natural disasters, and more recently, climate change (1).

Migration is a well-recognized social determinant of health (2), influenced by structural factors determined by inequity and socioeconomic policies. Often considered as a pathway to better living conditions, prosperity, and opportunities, migration has been associated with increased risks to health for several groups of people. Immigration studies reveal that most migrants are formal and informal workers of reproductive age with a range of health concerns (3). An estimated 281 million migrants are living in low- and middle-income countries, such as the Dominican Republic (DR) (4). Migrants often experience mood distress related to their immigration status, which affects employment, living conditions, and health care access (5, 6).

For two decades (2000-2020), political, economic and health security have affected the people of Venezuela, a phenomenon that has been associated with long-term political instability. This instability has exacerbated the existing poverty, hyperinflation, and scarcity of resources (e.g., food, medication). These issues have eroded the foundation of the health service delivery system, prevention programs, and access to health services, and consequently, has altered all health indicators, not only locally but also those of neighboring countries in South America and the Caribbean (7, 8).

Recently, the United Nations Refugee Agency (UNRA) reported that the Venezuelan exodus ranks as the second largest displacement crisis worldwide (9). As of March 2022, the number of Venezuelan refugees and migrants was estimated at 6 million, with more than 80% relocating to other countries in Latin America and the Caribbean (9). The DR ranks 10th among the receiving countries, with an estimated 115 000 Venezuelan immigrants as of June 2021 (10).

Venezuelan migrants in the DR have settled primarily in four large urban areas of the country: the Santo Domingo province (30.6%); the Santo Domingo capital city (28.3%); La Altagracia (12.9%); and Santiago (9.4%) (11). The urban pattern of residence (10), in which 97.1% of Venezuelan migrants live, has been associated with the economic dynamism, as well as immigrant perceptions of more employment opportunities (10). Data from the DR National Migration Institute (2018) showed few differences in gender distribution, with slightly more men (51.8%) than women (48.2%) (11).

Most migration studies that address the health care utilization issues faced by women migrants are focused on sexual and reproductive health care (SRH) usage. To our knowledge, few studies have considered other health determinants, such as drug abuse, mental health, and commercial and transactional sexual work. Migration health analyses of other migrant populations in the DR suggest that female migration has been largely associated with exclusion, increased incidence of HIV and other sexually transmitted infections (STIs), mental health issues, violence, and alcohol and drug abuse as social contributing factors to the AIDS epidemic (12, 13).

Acknowledging that a significant number of Venezuelan migrant women in the DR are of reproductive age, it is important to consider the health and safety risks that migration poses, including and not limited to sexual and physical violence, human trafficking, robbery, and exposure to STIs via transactional sex in exchange for money, housing, or food (14). The aims of this study were to understand the associations between health care seeking, sexual risk behaviors, and mental and physical wellbeing, and to identify sexual risk behaviors and barriers to accessing SRH services among Venezuelan female sex workers living in the DR.

MATERIALS AND METHODS

Study design and data collection

This study used a mix-methods design consisting of focus group discussions (FGDs) and a cross-sectional survey. Two study sites were selected for data collection, the capital city of Santo Domingo and Puerto Plata (a tourist destination and the country's third largest city). These sites were selected because of their large populations of Venezuelan migrants and female sex workers. We recruited participants using systematic sampling through two civil society organizations, the *Centro de Orientación e Investigación Integral* (COIN) in Santo Domingo and the *Centro de Promoción y Solidaridad Humana* (CEPROSH) in Puerto Plata. Both organizations provide integrated health services, including HIV/STIs services, and have a long history of working with female sex workers, including migrants. Peer navigators and outreach workers at each organization contacted potential participants, explained the study objectives, and connected those who were interested with research staff.

Eligibility criteria were to be an adult woman (≥18 years); a migrant from Venezuela; to have exchanged sex for money, drugs, food, or a place to sleep during the previous 6 months; and to provide written and verbal informed consent.

Data were collected from September through October 2021. At both study sites, FGDs were conducted in a counseling room by a trained member of the study team. Surveys were administered on paper. All FGDs were audio-recorded with permission from participants and conducted in Spanish. Participants did not mention their names while being recorded; to maintain confidentiality, we assigned a numeric code to each participant during the FGD and an alphanumeric code for the paper-based survey. Participants who fully agreed to participate in the interviews were also invited to the FGDs. The discussions had a duration of approximately 60 minutes, and participants were compensated for participating (US$ 10).

Surveys were administered by a research team member in Spanish, took approximately 45 minutes to complete, and had closed-ended questions. The survey included sections on sociodemographics, migration experiences, sexual history, sexual risk behaviors, health care seeking behavior, psychosocial and mental health wellbeing, health care access, social services access, social support, and violence. The survey instrument was piloted with 10 participants who were not included in the final analysis. The instrument has been used in previous local serological and epidemiological studies (15-17).

In total, four FGDs were conducted with two to seven participants per group (two FGDs at each study site); 40 surveys were administered (20 at each study site). The FGDs were used

to further explore personal experiences with navigating health services, the migratory process to the DR, access to SRH services, state of health and mood, substance abuse, violence, educational level, and knowledge of HIV/STI transmission. Because we could not estimate the population of Venezuelan female sex workers in the DR, a power calculation could not be made; therefore, the sample obtained was based on peer-to-peer invitation at study sites.

Data analysis

A content analysis approach was used to analyze the information from the FGDs. The audio-recorded FGD sessions were transcribed verbatim. Transcripts were imported into a textual analysis software (NVivo, version 12, QSR International) and coded using line-by-line coding. Codes were generated *a priori* based on the specific research objectives, and adjusted as new themes emerged through the coding process. Themes were identified throughout the iterative coding process using an applied thematic approach, and relevant data were extracted and categorized based on the thematic content. Three researchers (E.F.K., A.H.C., and R.P.R.) coded the data and fixed discrepancies. Lastly, summaries of the key themes were developed along with representative quotes. Data from the paper-based surveys were extracted to MS Excel (Microsoft), cleaned up, and checked for errors. Analysis of quantitative data was performed using STATA, version 12 (StataCorp). Univariate descriptive statistics were used to summarize sociodemographic characteristics, sexual risk behaviors, perceived mental health and wellbeing, and health care seeking behaviors. Data analyses were conducted from 30 November 2021 to 20 February 2022.

Ethics approval

The study was reviewed and approved by the Universidad Iberoamericana (No. CEI2020-15) and the Pan American Health Organization Ethics Review Committee (No. PAHO-ERC.0235.02). All participants provided voluntary oral and written consent to participate in this study.

RESULTS

Sociodemographic characteristics

Table 1 presents the sociodemographic characteristics of the participants. The median (range) age of sex workers was 33 (19-49) years, and 33% had a secondary or university (28%) education. More than half (57%) of the participants reported earning between RD$ 5001 to 10 000 (US$ 1 = RD$ 55) per month, and 75% reported having a secondary source of income in addition to sex work. Sixty-five percent were single, 20% had a steady partner, and 15% were divorced. Most (73%) of the female sex workers surveyed were heterosexual.

In the FGDs, participants discussed their experiences with migrating to the DR. Reasons for migration fell into several categories, with the political and economic instability in Venezuela being the driving factor. As one participant stated,

> I left Venezuela because of the economic crisis. [Prior to the crisis], in Venezuela I had not lacked anything, but then circumstances of life changed. With the crisis and the economy…my mom and I and my kids had to spend 4 to 5 hours a day in a line for a single packet of flour…Although we didn't have to pay rent or anything like that, taking everything into consideration, I told my mom, "I am going even if for one month just to see."—Participant, Puerto Plata, CEPROSH.

TABLE 1. Sociodemographic characteristics of Venezuelan female sex workers (n=40), Dominican Republic, 2021

Characteristic	No.	Percentage
Age, median (range), years	40	33 (19-49)
Level of schooling		
Primary	2	5
Secondary	13	33
Technical school	14	35
University	11	28
Employment		
Sex worker	30	75
Stylist	9	23
Cosmetologist	5	13
Business woman	2	5
Unemployed	2	5
Professional	1	3
Other	13	33
Monthly income from sex work, RD$[a]		
0-1000	2	5
1001-5000	4	10
5001-10 000	10	58
>10 001	23	3
Additional income source		
Yes	30	75
No	10	25
Sexual orientation		
Heterosexual	29	73
Bisexual	8	20
Homosexual	3	8
Cohabitation status		
Single/not married	26	65
Married/cohabitating	8	20
Divorced	6	15

Source: Prepared by the authors from the study results.
[a]US$ 1 = RD$ 55

The economic crisis in Venezuela made it difficult for study participants to provide for their families, which eventually pushed them to migrate in search of better economic opportunities.

Access to health care and social services

Most study participants reported having sought health care services for sexual and/or reproductive health during the 12 months prior to the survey: 55% within 1 to 6 months of the survey and 25% within 6 to 12 months; 20% had not sought health care services during the previous 12 months. Other services that participants reported seeking included nutrition services (44%), counseling (45%), and emergency health care (43%).

For health care services, the main source of care was the public sector (65%). As shown in Table 2, multiple factors were associated with the location at which participants sought care. The most important were the provision of integrated care (100%), confidentiality (97.5%), previous experience with the health facility staff (97.5%), cost (95%), no sexual harassment by staff (95%), and the expertise of the medical professionals (95%).

Findings from the FGDs reflected the survey findings. Most of the participants reported little difficulty in accessing health services and were satisfied with the services they received; they were also satisfied with their overall health status (65%). Participants stated that they primarily sought care at a public hospital because it was cheaper and because they would not need to present proof of medical insurance. Lack of medical insurance limited where participants could seek services, and the private sector was reported to be too expensive without insurance.

Most of the participants had learned about where to seek care from social media groups. The Internet and social media were also the main sources for health education. Interestingly, knowledge on where to seek SRH services was limited. As one participant stated, "Normally one is in WhatsApp groups, and the girls share things they find… Also, several social networks publish things, such as where to look for services and get tested."—Participant, Santo Domingo, COIN.

TABLE 2. Access to health and social services among Venezuelan female sex workers (n=40) in the Dominican Republic, 2021

Measure of access	No.	Percentage
Time since seeking health care services		
<1-6 months	22	55
6-12 months	10	25
>12 months	8	20
Type of institution of most recent visit		
Public	27	68
Private	8	20
Combination of both types	5	13
Factors influencing where to seek care		
Integrated services available	40	100
Confidentiality	39	98
Previous experience with staff	39	98
Cost	38	95
Expertise of the medical professionals	38	95
Lack of sexual harassment by staff	38	95
Available information and orientation	35	88
Wait time	37	93
Sexual abuse by staff	37	93
Comfort to discuss sexuality	35	88
Discrimination by staff	34	85
Previous bad experience	32	80
Insecurity and social violence	31	80
Hours of service	28	72
Distance	26	65
Required to reveal sex/gender	15	18
Was offered/received condoms in past 3 months	21	53
Utilization of Government programs in past 6 months[a]		
Nutrition services, applied for	17	44
Nutrition services, received	15	88
Counseling services, applied for	17	45
Emergency services in hospital/health center, applied for	17	43
Emergency services in hospital/health center, received	15	88
Satisfied with one's health in past 6 months	26	65

Source: Prepared by the authors from the study results.
[a]Missing values were not considered in the calculation of percentages.

Sex work, risk behaviors, and HIV knowledge

Participants were asked a series of HIV-related knowledge questions. As shown in Table 3, 30% of the participants reported that someone can become infected with HIV by kissing, 50% reported that a positive HIV test result means the person has AIDS, and 75% knew where to seek HIV-related services. All participants (100%) had received an HIV test at least once in their lifetime, and 79% had been tested for HIV during the 12 months before the survey.

Of the participants, 84% had performed oral sex during the past 30 days, and only 37.5% had used a condom at all times. Almost half (46%) had engaged in anal sex in the past 6 months, and 55% (alcohol) and 32% (drugs) had been involved in sexual practices while under the influence of a substance.

The female sex workers who participated in the FGDs talked about entry into sex work and perceptions of sex work. Most of these migrant women did not come to the DR with the goal of working in the sex industry. Rather, they turned to sex work as a way to support themselves and their families back in Venezuela after having attempted work in another informal industry (e.g., street vendor or waitress). Entry into sex work was typically through a bar or cafe where they were first employed to sell drinks to customers; over time, they learned from others that they could make more money by providing sexual services to customers. One woman explained,

> When I started with sex work, I started in a bar. I arrived here to the DR with no money. Nothing, nothing, nothing. I looked in newspapers and I saw, "Looking for a waitress to work in a café bar." I didn't know that it was something sexual, a café bar in Venezuela doesn't have you do anything like that…When we arrived, they told us, "You are not obligated to go with people. But if you don't go, you don't make money." My family in Venezuela was waiting for me to send money. —Participant, Santo Domingo, COIN.

Some participants perceived sex work to be a service job for the purpose of making money to support their families. They discussed the risks that came with the job, such as sexual health risks, violence, and the possibility of being killed. Despite these risks, most of the participants reported that their clients and the Dominicans, in general, had treated them well.

Participants in the FGDs also described the different types of sex work that they engaged in (virtual and in-person), and each sex worker had her own protocol of what sex acts she would engage in with clients; in general, kissing was not permitted. Virtual sex work consisted of exchanging images and video calls with clients whom participants met through online platforms.

Psychosocial health and wellbeing

Table 4 presents findings on psychosocial health, life satisfaction, and wellbeing. Feelings of depression and isolation were

TABLE 3. HIV knowledge and sexual health behaviors among Venezuelan female sex workers (n=40) in the Dominican Republic, 2021

Measures	No.	Percentage
Knowledge		
Can someone become infected with HIV by kissing someone who has HIV?		
No	28	70
Yes	12	30
If someone has a positive HIV result, do they have AIDS?		
No	20	50
Yes	20	50
Know someone with HIV?		
No	16	40
Yes	24	60
Know where to receive HIV-related services?		
No	10	25
Yes	30	75
Behavior		
Ever had HIV test	40	100
Had HIV test in past 12 months	30	79
Average (range) number of times performed oral sex in past 30 days	38 (1-65)	9
Performed oral sex in past 30 days	32	84
Frequency of condom use in past 30 when performing oral sex (male partners)		
All the time	15	38
Sometimes	3	8
Never	22	55
Received oral sex in the past	12	39
Engaged in anal sex in past 6 months (received)	16	46
Frequency of condom use during each sexual contact	16	46
Average (range) number of partners in past 30 days	38 (1-75)	10
Substance use in past 6 months		
Alcohol	32	84
Marijuana	12	32
Cocaine	5	13
Sexual practices performed while under the influence		
Alcohol	22	55
Marijuana	13	32

Source: Prepared by the authors from the study results.

TABLE 4. Psychosocial health, satisfaction, and quality-of-life among Venezuelan female sex workers (n=40) in the Dominican Republic, 2021

Measure	No.	Percentage
Psychosocial health in the past 6 months		
Felt happy	38	95
Difficulty sleeping	35	88
Felt nervous after a fear-induced situation	34	85
Felt depressed	31	78
Felt everything required effort	31	78
Felt isolated	29	75
Felt part of sex worker community	14	35
Felt discriminated by other sex workers	14	35
Quality of life in past 6 months		
Satisfied with accessibility of public/private health services	36	90
Received support from family and friends	33	83
Satisfied with living conditions	31	78
Satisfied with health	26	65
Experienced verbal abuse (ever)	14	36
Experienced physical abuse (ever)	12	31

Source: Prepared by the authors from the study results.

prevalent. Slightly more than three-fourths (78%) of participants reported feeling depressed in the past 6 months, 88% had difficulty sleeping, 75% felt isolated, and 85% felt nervous after a fear-induced situation. Most women were satisfied with their health (65%); 78% were satisfied with their living conditions; and 90% were satisfied with the available health services. More than one-third (36%) had ever experienced verbal abuse, and 31%, physical abuse.

Undocumented status

In the FGDs, participants discussed being undocumented (not having proof of legal work status). To obtain legal status in the DR, one must fulfill the immigration requirements and pay the related expenses, which presents a barrier for those who are unemployed or have limited income. Participants expressed how being undocumented had posed challenges, such as not having access to certain social services; being discriminated against, which could be traumatic; and feeling lonely when first arriving in the DR. Some participants talked about how their undocumented status made it easier for others to take advantage of them, and that they could not file legal complaints because of their status. "Many times, because we don't have documents in this country, some men believe that they can abuse or not pay us; sometimes maybe they even beat us up," stated one of the participants (Santo Domingo, COIN). Another participant said, "When you are with someone, you are afraid that since you don't have citizenship documents or are illegal, they could attack you; many of the men with us don't abuse us, but it could happen" (Santo Domingo, COIN).

Not having documents was also an issue for securing a more formal job. Participants who were professionals in Venezuela could not practice their profession in the DR without first obtaining legal status. "It hasn't been easy…[it's] hard staying quiet, humble, while they yell at you calling you criminal. And you stay quiet because this Dominican person knows you need work," explained one of the participants (Puerto Plata, CEPROSH).

Despite these difficulties, however, there were few negative comments about life in the DR, in general. Participants reported being thankful to the DR for accepting them and allowing them to make a life in the country. Dominicans were generally viewed as friendly toward Venezuelans. One participant described how she considers herself to be Dominican now and has no desire to return to Venezuela because the Venezuela she knew no longer exists:

> Venezuela is my country, but now it has become a nightmare …At least here, I have food, and I don't have to think about whether I'll be able to fill the gas cylinder, or whether

there will be chicken in the supermarket. —Participant, Santo Domingo, COIN.

Another participant agreed:

…In the Dominican Republic I have found a second home, people are very similar to Venezuelans, sometimes they don't realize it, but we have so many things in common. We have had to fight a lot to have things, but here at least I have the option that mine is mine and not of a dictatorship. —Participant, Santo Domingo, COIN.

DISCUSSION

Migration is a complex phenomenon that is influenced by economic, social, and political factors. The third Sustainable Development Goal refers to the health of migrants and advocates for healthy lives and wellbeing for all at all ages (18). However, in the DR, undocumented migrants have limited access to government financial and social support (19).

Acknowledging that a significant number of Venezuelan migrant women are of reproductive age (Table 1) and that many travel alone, it is important to consider the risks that migration poses to their health and safety, including and not limited to sexual and physical violence, human trafficking, robbery, and exposure to sexual diseases via transactional sex in exchange for money, housing, or food.

The findings of this study reveal that there are elements of mental health that influence the quality-of-life of migrant women. Often, these are not addressed by the health services available in the country. These services focus on the provision of packages to prevent unwanted pregnancies and STIs; however, they leave aside their primary prevention tools. This situation is not exclusive to the experiences reported by the study participants; rather, they reflect an incomplete health care model.

The health services most frequented by the participants were public, in part because they had very low income (Table 2). In the DR, access to hospital services and primary care are free of charge, and therefore, they are the gateway to the health system for most migrants with low or no income.

The COVID-19 pandemic directly affected health care provision not just for migrants but for Dominicans. A study by Wang and colleagues (20) evaluated the structural and psychological experiences among female sexual workers during the COVID-19 pandemic. Substance abuse, partner abuse, and mental health challenges were among the most reported effects, especially for those with declining or no income during the study period. Other studies found that mental health issues were the most robust predictor of HIV care, stress, anxiety, and depression among female sex worker living with HIV (21, 22). Similarly, the participants in the present study reported similar experiences (Table 4). This suggests that perhaps the COVID-19 pandemic and immigration status could be synergistic elements in the mood disorders of the participants.

During the early pandemic lockdown measures, there was an increase in the vulnerability and loss of income among migrants because their work, including sex work, was considered to be non-essential. This was compounded by limited access to mental health services, an increase in wait times to obtain official documents, and flight disruptions between the DR and Venezuela (23). The response of the DR did not allocate specific resources to migrants, and irregular migration conditions did not allow them to have access to the social security system. However, Venezuelan migrants did receive access to the health system, which emerged as a positive aspect of the COVID-19 response by the DR.

Most of the study participants reported negative mental health effects. The findings of many researchers (24, 25) concur that individuals who are unemployed experience the worst mental health and psychological distress; this association is also influenced by differences in social groups, life situations, countries, and aging. Several psychological approaches, such as the helplessness theory and the expectancy-value theory, also support this association (26). A future study should further evaluate this theoretical approach and the interaction between mental health status and the effects of migration (27).

Notably, the study participants reported a high level of formal education (high school, 33%; university degree, 28%). This suggests that before the economic crisis in Venezuela, these participants had a stable financial situation. This possibility was reflected by the aforementioned statement, "In Venezuela I had not lacked anything, but then circumstances of life changed."

Despite being able to receive health care services through the public sector, comprehensive services that would include SRH packages, STI/HIV prevention, substance abuse counseling, and mental health therapy were often not available or were not of high quality. Improving access to health insurance for undocumented migrants could encourage higher rates of health care utilization and improved health outcomes. Numerous studies have shown that health insurance can be a countermeasure (28, 29, 30) that increases health care access, facilitates follow-up, and ensures continued monitoring of SRH programming. Health services should be tailored to the characteristics and needs of migrants taking into consideration their demographic profiles and the epidemiology of communicable diseases in their country of origin.

Even though most participants reported little difficulty in accessing health services and were satisfied overall with the services they received, many of them reported engaging in sexual behaviors that pose a risk to their health. In addition, the HIV knowledge and sexual health behaviors indicated some educational gaps to be addressed. Educational interventions with a peer-to-peer educators' approach, educational material distribution, and culturally competent media campaigns are needed.

Limitations

The main limitation of this study was the cross-sectional nature of the quantitative survey, which limited the ability to draw conclusions about causality. Quantitative data were based on self-report and were subject to social desirability bias, which can lead to over- or underreporting of specific behaviors. The small sample size limited our ability to conduct robust statistical analysis, and these findings are not generalizable to other contexts or populations. Because of time constraints, the quantitative and qualitative data were collected at the same time; therefore, the qualitative field guides were not developed to address gaps identified in the quantitative data. Because FGDs were conducted during the height of COVID-19 cases, conducting large or homogenized groups was not permitted and many

potential participants wanted to avoid being in large groups where the risk of infection would be greater.

Conclusions

This mixed-methods study provides an approximation of the migratory phenomenon taking place between Venezuela and the DR, from a health perspective. These findings may help define the public health policies and actions that are necessary for a more comprehensive and integrated approach toward the female migrant who seeks to access and use health services and to exercise her reproductive rights.

These findings reveal the layered influence of migratory status and social exclusion on migrant female sex workers, their sexual risk behaviors, and their access to health care. The observations made offer key insights for researchers, advocates, and policymakers who work with migrant populations; more structural and behavioral interventions are needed.

Notably, many of the health issues identified were associated with mental health status. We propose considering a programmatic model with behavioral interventions to address sleep and anxiety disorders and to screen for depressive disorders. These interventions could be embedded with primary care services and offered during a first visit or when SRH services are sought.

On-the-ground grassroots collaborations between health care services and nonprofit organizations that provide support during the migration process will facilitate connections with care. These organizations would benefit from economic aid policies by government agencies and international collaboration to provide a truly community-engaging intervention with a comprehensive perspective.

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Experiencias en materia de migración y acceso a la atención de salud en trabajadoras sexuales venezolanas residentes en República Dominicana

Resumen

Objetivo. Determinar los comportamientos sexuales de riesgo y los obstáculos para acceder a los servicios de salud sexual y reproductiva (SSR) en trabajadoras sexuales venezolanas residentes en República Dominicana.

Métodos: En este estudio se empleó una metodología mixta con cuatro debates en grupos de opinión y una encuesta cuantitativa transversal en trabajadoras sexuales migrantes venezolanas. El estudio se llevó a cabo entre septiembre y octubre del 2021 en dos zonas urbanas (Puerto Plata y Santo Domingo) de República Dominicana. La información recopilada a partir de los grupos de opinión se analizó mediante análisis de contenido temático, y los datos cuantitativos se analizaron mediante estadísticas descriptivas univariadas. El análisis de los datos se realizó del 30 de noviembre del 2021 al 20 de febrero del 2022.

Resultados: Un total de 40 trabajadoras sexuales migrantes venezolanas con una mediana (rango) de edad de 33 años (entre 19 y 49) participaron en los grupos de opinión y la encuesta. Los grupos de opinión permitieron determinar los obstáculos para acceder a los servicios de SSR, como la situación migratoria y sus implicaciones para el acceso al empleo formal y a los servicios de salud, el bienestar mental, la calidad de vida en República Dominicana, el trabajo sexual y la manera de transitarlo, las percepciones sobre el trabajo sexual, los conocimientos sobre la SSR y el escaso apoyo social. Los resultados del análisis cuantitativo indicaron que la mayoría de las participantes manifestaron que se sentían deprimidas (78%), solas o aisladas (75%), y que tenían dificultades para dormir (88%). Las participantes también indicaron que habían tenido un promedio de 10 parejas sexuales en los últimos 30 días, el 55% había mantenido relaciones sexuales bajo los efectos del alcohol y solo el 39% había utilizado preservativo al practicar sexo oral en los últimos 30 días. En cuanto a la infección por el VIH/sida, el 79% se había sometido a una prueba del VIH en los últimos 6 meses y el 74% sabía dónde buscar servicios relacionados con el VIH.

Conclusiones. En este estudio basado en metodologías mixtas, se observó que la nacionalidad y la exclusión social afectan de diversas formas a las trabajadoras sexuales inmigrantes, sus comportamientos sexuales de riesgo y su acceso a la atención de salud. Es necesario poner en práctica las recomendaciones para la realización de intervenciones eficaces basadas en la evidencia para atender los conocimientos sobre salud sexual con el fin de abordar los comportamientos sexuales de riesgo, mejorar el acceso a la SSR y reducir los obstáculos relacionados con la asequibilidad.

Palabras clave República Dominicana, Venezuela, migrantes, salud sexual, salud reproductiva, accesibilidad a los servicios de salud, discriminación social.

Acesso à atenção à saúde e experiências de migração entre trabalhadoras do sexo venezuelanas que vivem na República Dominicana

RESUMO

Objetivo. Identificar comportamentos sexuais de risco e barreiras aos cuidados de saúde sexual e reprodutiva (SSR) entre trabalhadoras do sexo venezuelanas que vivem na República Dominicana.

Métodos. Estudo de métodos mistos. Foram realizadas quatro discussões com grupos focais e uma pesquisa quantitativa transversal com trabalhadoras do sexo migrantes venezuelanas. O estudo foi realizado de setembro a outubro de 2021 em dois áreas urbanas (Santo Domingo e Puerto Plata) da República Dominicana. As informações coletadas dos grupos focais foram analisadas por meio de análise temática de conteúdo, e os dados quantitativos foram analisados por meio de estatísticas descritivas univariadas. A análise dos dados foi realizada de 30 de novembro de 2021 a 20 de fevereiro de 2022.

Resultados. No total, 40 trabalhadoras do sexo migrantes venezuelanas, com mediana de idade de 33 anos (mínimo, 19; máximo, 49), participaram dos grupos focais e da pesquisa. Os grupos focais identificaram barreiras aos serviços de SSR, incluindo status de imigração e suas repercussões para o emprego formal e o acesso à saúde, bem-estar mental, qualidade de vida na República Dominicana, navegação do trabalho sexual, percepções do trabalho sexual, conhecimento de SSR e apoio social limitado. Conforme a análise quantitativa, a maioria das participantes relatou sentir-se deprimida (78%), solitária/isolada (75%) e com dificuldade para dormir (88%). As participantes relataram uma média de 10 parceiros sexuais nos últimos 30 dias; 55% praticaram sexo sob efeito de álcool; e apenas 39% usaram preservativo na prática de sexo oral nos últimos 30 dias. Em relação ao HIV/aids, 79% fizeram teste de HIV nos últimos 6 meses e 74% sabiam onde procurar serviços de HIV.

Conclusões. Este estudo de métodos mistos constatou que a nacionalidade e a exclusão social têm uma influência multifacetada nas trabalhadoras do sexo migrantes, nos comportamentos sexuais de risco e no acesso à atenção à saúde. É preciso implementar recomendações para intervenções eficazes e baseadas em evidências para abordar o conhecimento da saúde sexual, visando a abordar comportamentos sexuais de risco, melhorar o acesso aos serviços de SSR e reduzir as barreiras de acessibilidade.

Palavras-chave Republica Dominicana, Venezuela, migrantes, saúde sexual saúde reprodutiva acesso aos serviços de saúde, discriminação social.