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# **Sex Work and Social Inequalities in the Health of Foreign Migrant Women in Almeria, Spain**

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## **Abstract**

This paper is part of a broader study about prostitution among foreign migrant women in the province of Almeria, Spain. The specific aim of the paper is to analyse the different profiles of women working in the sex industry and interpret the social determinants that generate social inequalities in their health. The ethnographic research was conducted in different settings involved in the sex industry (clubs, private apartments, bars, immigrant settlements, and street prostitution) between 2009 and 2012 as part of the “Damage Reduction and Health Promotion” programme run by the NGO Medicos del Mundo. The research tools used were standardised and in-depth interviews conducted with sex workers, and observation in their working environments. Findings show that the main markers for major inequalities in terms of the health of women and the use of healthcare services available are: gender (being a woman), status as an immigrant, social class, level of education, and geographical area. This study argues the need to design programmes in local contexts of bio-psycho-social healthcare aimed at women who work as prostitutes with low earnings and very limited social support networks with a view to impacting on their safety, education and living conditions, as well as their lifestyles, and their physical and psychological health.

*Keywords:* health, social inequalities, migration, sex work.

## **Migration, sex work, and health: conditions and conditioning factors**

Since the 1990s, global economic inequality has contributed to the emergence of migratory processes bringing men and women to Spain from different countries, principally Africa, Latin America, and Eastern Europe. From this global economic perspective, some authors have highlighted the link between migration and the sex industry, characterised as an ‘alternative cross-border circuit’ towards inequality, impoverishment of life for people from the most underprivileged sectors,

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and democratic rigidity in contrast to the freedoms of private capital (Sassen, 2003). Studies into migration and prostitution in Spain describe conditions of poverty and gender inequalities as interpretative factors of that activity (Rios, 2015). Sassen (2003) argues that this highlights how women become a new global class of 'underprivileged workers', characterised fundamentally by a lack of social mobility, numerous inequalities, and an absence of effective mechanisms for social participation.

Much of the literature that deals with international migration and sex work still focuses on Sexually Transmitted Diseases (STD), sexual victimisation, and the social stigmas affecting women working in this industry, rather than on the concept of health. In fact, health programmes designed with this collective in mind are mainly geared towards 'health control', as a by-product of efforts to protect the community in general from the possible spread of STDs, rather than other dimensions of the health of these individuals, such as social and economic position and gender inequality, among others (Ross, Crisp, Mansson & Hawkes, 2012). The analytical consideration of these dimensions stems largely from feminist, theoretical, and activist discourse, driven by the political struggles of women working as prostitutes in the 1970s in Europe. Their stance is linked to demands for social rights and tackling their social invisibility as a strategy against violence, marginalisation, and the vulnerability of their rights (Holgado, 2013).

One particularly productive line of research promotes studies that allow us to understand the place of women as social subjects (Maquieira, 2001). Hence the interest displayed by feminist researchers in understanding the reality and consequences of sex work, an interest that grounds this present study, which aims to analyse the concept of health, based on the understanding that it is impacted by discrimination and social exclusion faced by the immigrant population in general, and particularly for people working in prostitution (OIM, 2013; MDM, 2014).

The analytical potential of the concept of health from this perspective has enabled us to overcome the health/illness binomial linked exclusively to natural causes and biological factors, giving great importance instead to the social conditions in which individuals move. From this position, the Theory of Social Health Inequalities emerged (Wilkinson & Marmot, 2003), according to which there are relationships of interdependence between health and social and economic position, assessing the environment in which people live and work, and determining its implications in the social structure where their health is manifested.

In spite of the analytical advances made since the work of Marmot and Wilkinson (1999), which became a global reference for the public health policies of the World Health Organisation (WHO, 2011), very little empirical research has analysed the physical, psychological, and social health conditions of female sex workers. Theory distinguishes between structural determinants defined by social stratification and its mechanisms of maintenance (social position, race, ethnic

background, education, age, gender, and geographical area) and intermediate determinants related with the specific factors and circumstances of a population (lifestyles, stress, work, unemployment, social support, diet, addictions, transport, and social exclusion) (Wilkinson & Marmot, 2003). The aim here is to identify and analyse a specific case study of foreign women working as prostitutes in Almeria, Spain, looking at different structural and intermediate determinants to understand how they affect health inequality in these specific contexts.

## Methodology

The research uses a qualitative methodology (Lincoln & Denzin, 2000) and makes use of the ethnographic method, which makes it possible to describe and interpret the discourses of sex workers about health. We used an inductive design, conceptualising the information produced in the field; hence we are not interested in generalising our findings but in endowing them with explanatory depth. The research was conducted over four years (2009 to 2012). We accessed the field through one of our researchers, recruited by the NGO *Medicos del Mundo* to work on the programme *Damage reduction and health promotion for people in situations of prostitution*<sup>3</sup>, in the province of Almeria. According to the organisation's latest figures, in 2014 it reached 10,356 people in situations of prostitution<sup>4</sup> throughout Spain, from 88 different nationalities (MDM, 2014). In Almeria, in 2015, this programme reached 387 foreign migrant women, very close to the figure recorded during the period this research was conducted.

The research techniques used were participatory observation in the different working contexts of these women, and interviews (standardised and in-depth) with foreign immigrant women working as sex workers in the province. Participatory observation was carried out in different settings of the sex industry: indoor (private apartments, clubs, and bars) and outdoor (migrant settlements, commercial greenhouses, and in the street), as well as different public and private institutions that support women when requesting or accessing social and/or health provisions and services in the province. The information produced was recorded in a field journal.

The purpose of the standardised interviews was to define the sociodemographic profile of female sex workers in the province, offering a point of entry into the

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<sup>3</sup> The programme *Damage reduction and health promotion for people in situations of prostitution* has been operating in Spain since 1993. It was launched in Almeria in 2008. It is funded by the organisation itself and by regional health authorities

<sup>4</sup> The organisation *Médicos del Mundo España* is working ultimately to abolish the phenomenon of prostitution. Therefore, in its reports, it refers to people who are working as prostitutes as "people in situations of prostitution".

field. We followed the protocol designed by *Medicos del Mundo* interviewing a total of 895 women during the four years of research. The data obtained through these interviews were analysed, mainly for frequencies, providing us with the subjects' sociodemographic information, administrative status, and health conditions.

The fundamental aim of the in-depth interviews was to access through language the way in which these women describe their processes of health/illness and the social determinants that condition them. One of the virtues of interviews is their openness (Kvale, 1996), enabling us to 'follow the clues' leading to the different themes explored by these women and go into selective detail with each of the informants regarding the different dimensions of their life experiences. We interviewed 7 women, carrying out a total of 44 sessions at different times (*Table 1*). We selected the informants on the basis of the following criteria: (a) women whose origins (country or region) were largely outside the province of Almeria; (b) competency in the language, allowing for fluid communication in Spanish or English; and (c) they should be living in the province for at least six months, allowing a bond and contact to be established for the research. All the interviews were recorded and then transcribed literally.

*Table 1.* Interviews conducted

Informant (fictitious name)	Region/country of origin	Language of interview	Time living in the province	Number of interview sessions
Angue	Africa/Equatorial Guinea	Spanish	10 years	10
S2	Eastern Europe/Romania	Spanish	4 years	5
S3	Latin America/Brazil	Spanish	3 years	7
S4	Africa/Morocco	Spanish	4 years	3
S5	Sub-Saharan Africa/Nigeria	English	1 year	10
S6	Latin America/Colombia	Spanish	8 years	5
S7	Europe/Spain	Spanish	6 months	2
Total				44 sessions

*Source:* Authors' own

This research encountered the same difficulties as other studies in relation to accessing the field and the women studied (Sanchis & Serra, 2011). In order to process the data, we had to guarantee a series of conditions to the women taking part: (a) anonymity; hence the names used are fictitious; (b) informed consent from the women to process the information provided exclusively for academic purposes; and (c) the option to leave the study should they choose to do so.

The analytical processing of the information produced by means of the different strategies followed the Grounded Theory approach (Glasser & Strauss, 1967). Specifically, using the qualitative analysis programme Atlas ti. v. 7, we began by open coding (*in vivo codes*) the information produced in the field. Secondly, we created categories and subcategories, which enabled us to structure and organise the information (*axial coding*). And thirdly, we interpreted selective categories in accordance with the theory. This last stage of analysis is presented in this article.

## Research findings

### *Profiles of sex workers in the province of Almeria*

Sex work in Almeria is carried out to a greater extent by foreign immigrant women than by Spanish nationals. According to the data used in this research, provided by different non-governmental organisations, for the period studied (2009-2012), an estimated 895 foreign women were in a 'situation of prostitution' in the province (Rios & Hernandez, 2015). Public administrations have no estimations of these figures. In order to report on the profiles of foreign migrant sex workers in the province of Almeria, we analysed the standardised interviews conducted as part of the programme run by *Medicos del Mundo* in Almeria.

The following characterisations were found with regard to the participants:

- *Youngest sex workers*: mainly Romanian in origin (making up 35.8% of the young group), followed by Sub-Saharan (27.03%) and Maghreb (7.59%), in the 18-35 age bracket. Those aged 35 to 45 are mostly from Latin America (13.40%) and Africa (10.05%).

- *Level of education*: Romanian and Latin American women have the highest level of education: compulsory secondary education and vocational training. African women, on the other hand, mostly have a Primary education only. Greater levels of illiteracy were noted for women from rural backgrounds, mainly in Morocco.

- *Marital status*: the single women interviewed were mostly from Romania and Sub-Saharan Africa. In the other cases, there was a great deal of variability with regard to marital status (married, common-law partners, separated) in all the groups of women, with a minority of widows, chiefly from Romania and Latin America.

- *Legal status in Spain*: Women from Africa (53.63%) were largely living in irregular situations, hoping to obtain a residency permit and work permit through social ties, unlike the Romanian women, who are citizens of the EU and are therefore free to move and seek employment in any member of the EEC. The legal status that protects them allows them to remain and work without having to be

granted a residency or work permit, as women from other countries have to, including Latin Americans, 5.2% of whom had a residency and work permit during this research.

### ***Social determinants of the health of sex workers***

Analysis reveals the different nature of the factors that determine the health of sex workers in the different contexts in which they move. Schematically (see Figure 1), we have identified the most relevant factors and we will describe their study subsequently. The most relevant factors uncovered by this study are presented below.

*1. Status as immigrant linked to administrative situation.* Our research reveals that these women feel part of a collective that faces difficulties in terms of social integration, and they express the ways in which they are discriminated against by the local population, and by public and healthcare institutions. This element is expressed in relation to two factors: on the one hand, the stigmatisation and marginalisation they perceive as members of a minority racial or ethnic group that is different from the national majority; and secondly, the exclusion they experience with regard to certain social/healthcare resources owing to their illegal status. S1 stated: *“I’ve been in Spain for ten years, I have a ruling because of domestic violence, and they still won’t give me my papers!”* (S1, Equatorial Guinea, 32 years old).

*2. Geographical area and scenarios of commerce as sex workers.* The sex industry in the province of Almeria is structured according to the characteristics of the geographical area and the most important production sectors where immigrant and national men are employed, as the potential clients of sex workers. According to the latest report about the economic forecast for Andalusia (2016), in the province of Almeria, there has been a generalised increase in the sectors of industry (40,7%) and polytunnel and greenhouse farming (22.7%), higher than the average for Andalusia, and a more moderate increase in construction (7.5%) and in services (1.4%). The absence of working opportunities for immigrant women in the province makes it hard for them to find work in the services or farming sector, for example in warehouses or greenhouses. These sectors, although they do employ many women, they are still male dominant (Acien, 2010). Sex workers living in the province of Almeria live in two different types of housing situation corresponding to the description provided by Checa (2007): firstly, in rural hamlets or farmsteads, settlement of immigrants, and depressed neighbourhoods, which is mostly where the African women interviewed – Sub-Saharan and Moroccan – work; secondly, in indoor settings such as clubs or apartments shared with other women, found more commonly in our research among women of Romanian and Latin American origin. In both cases, these settings are far from health centres and social services located in urban centres. These data reveal,

therefore, how sex workers are segregated spatially according to their countries of origin, their social class, and the gender relations they establish with males from their own countries and from Spain. We found that the possibilities offered to women in terms of accessing social and healthcare resources as well as the possibility of establishing a relationship with the rest of the population, are different if the women live in the city as opposed to in the greenhouses where the migrant population is located: surrounded by pesticides, with no access to drinking water, or energy, and far from public transport to access nearby socio-healthcare resources.

3. *Social class and socioeconomic inequalities.* There are significant differences between the collectives described in this study with regard to their social position and the generation of income through sex work. Higher earnings were found among Latin American and Romanian women, which allows them to have a better quality of life, reflected in the family and personal projects they spend their earnings on, either back home or in Spain. The lowest earnings were observed for women from Africa. We interpret this difference as being linked with the contexts in which they work, as explained previously: outdoor or indoor. For those in a more favourable situation, their earnings allow them to rent a property, affording them the possibility of privacy and a real distinction between their rest time and the time they dedicate to providing sex for money. They have greater control over their free time and the distribution of their economic resources, including taking care of their health. In contrast, women with lower earnings, such as the Nigerian women interviewed, explain how they no longer invest in other personal or family projects, and have to dedicated a large amount of the money they earn to repay their debts for their journey to Spain, which affects their health and becomes clear in the deficient care they take of their own diet. This was expressed by Beuty, when talking about the habits of a group of Nigerian women living in a farmstead in Almeria: *“Eat? We share out rice among the girls who live in the house, and fish. We don’t buy a lot of food. We save money for boss, if we don’t pay not good for us, we get moved somewhere else”* (S5, Nigerian, 27 years old). Economic responsibilities to their families back home and in Spain are a constant feature among all the women interviewed. Through their earnings, they care and provide for their families back home. As S4 describes: *“I have a deaf daughter in Morroco, my parents take care of her, they are very poor, so I send what I earn so they can pay for the treatments she needs”* (S4, Maghreb, 30 years old).

4. *Language barrier and social support.* Language difference makes it difficult to access healthcare and social services. This barrier is much stronger for African groups than for people from Latin America or Romania, making it hard for them to integrate into the local fabric of society since they interact mainly with their compatriots and do not have the time to attend Spanish classes. Hence, the situation of immigrant women is one of immense vulnerability, and they express



feelings of loneliness and a lack of social support networks. Vera expressed this as follows: *“I got used to crying alone at the house”* (Vera, Equatorial Guinea, 26 years old). We identified these feelings of loneliness and lack of social support as the main psycho-social factor that impacts on the physical, mental, and social health of this collective.

5. *Access to public health and social service systems in the host country.* The right to health has been recognised as a human right by various international bodies and ratified by various European countries (Bjorngren, 2010). In Spain, healthcare was no longer available free of charge to all foreigners following Royal Decree-Act 16/2012. This fundamental change in Spain’s healthcare legislation has been a great setback to illegal foreign immigrants, since they cannot access the healthcare system and are excluded from health services (except for emergency services, minors, and pregnant women). Immigration support associations are the main instrument through which they can gain access to healthcare and social services. Women like S2 express their disregard for the public healthcare service as follows: *“I want you to change my doctor, that man treats me badly, he makes me feel bad, he says I should be grateful he sees me, because in September my free ride is over. As a person I deserve respect, even if I’m a whore”* (S2, Romanian, 30 years old). Some of the difficulties accessing resources we identified here in the province of Almeria are linked to factors such as: (a) restricted timetables for routine or specialist appointments. Because care is only available during the day, they have difficulty attending, either due to physical exhaustion or because they forget; (b) fear about their illegal status; (c) their idea that health services are only for the wealthy who can afford private healthcare; (d) ignorance regarding their right to receive health services and fear that they will be rejected by healthcare staff when they find out what they do for a living; (e) self-care practices, to avoid unwanted pregnancies or the spread of disease, for example, which leads them to perceive themselves as autonomous and without the need for physical or psychological healthcare professionals.

## Discussion

Analysis of the discourses of foreign immigrant women working as prostitutes in Almeria reveals the inequality they experience in health processes. Below we highlight three main factors that have emerged, which we have contextualised with regard to other research on this subject.

1) *The importance of analysing social determinants of health in contexts of migration and sex work.* The social determinants highlighted in our analysis of the interviews conducted have been studied by different national and international research projects; these studies also show how *status as an immigrant and administrative situation* within a host country conditions the health of people, owing to

the stigmatisation they suffer and their need to live in the margins of visibility, but also how it prevents them from accessing healthcare resources provided by government (Brabant & Raynault, 2012; Fernandez & Agoff, 2012; Gaines *et al.*, 2013; Bianchi *et al.*, 2013; Mc Grath *et al.*, 2014).

The spatial situation of women within the territory, and the way in which the settings of sex work are distributed make a particularly relevant contribution to health. This social determinant of health has been tackled by other international studies and is particularly important in this research. The migrant population who work in this industry usually reside in more underprivileged territories (lower economic cost, isolated from resources and the possibility to establish frequent social relations), and in the case of women, this becomes a deciding factor that generates different relational patterns, characterised by: being grouped in terms of housing by nationality; working in prostitution, particularly close to the workplaces of male immigrants from their country of origin; and isolation with regard to access to healthcare services and social resources. Territory and the way it is configured are mediated by gender relations established between clients and sex workers, a finding that coincides with the research developed by Bianchi *et al.*, (2013), with regard to immigrant farm labourers and sex workers in the US. In this study, this element is particularly salient with regard to the African migrant population – Sub-Saharan and Maghreb – employed in commercial glasshouse farming in the province, and sex workers originally from these countries. Spatial segregation could, therefore, be interpreted as one of the determining social elements in the health of migrant women in the area of Almeria studied, coinciding with studies such as that of Malmusi *et al.*, (2014) who stress the difficulties women working as prostitutes face, particularly in terms of upward social mobility in times of economic crisis.

Even bearing in mind these residential patterns, self-care behaviours have proven to be particularly significant in our research with regard to certain health determinants (Rios 2015). Their significant presence and importance in the population studied has also been highlighted in the research conducted by Gaines *et al.*, (2013). Other research projects also point to an aspect that has proven to be particularly relevant in this study: care practices towards stable partners and families in the context of their residence or back in their home country, to whom they send material or economic resources to meet their needs (Fernandez & Agoff, 2012; Wong, *et al.*, 2012; Weine *et al.*, 2013).

Our analyses indicate that *social class*, *socioeconomic situation* and scarce social mobility are factors that unbalance health and the social integration process of the immigrant collective. This evidence has been pointed out by other research, such as the study conducted in Spain by Malmusi *et al.* (2014).

When configuring the social determinants of health in our ethnographic study, a lack of knowledge of the Spanish language among certain women has emerged

as a significant factor, as has a lack of social support in the places where they live. Both elements can constitute psychosocial risks associated with their health, contributing to low self-image both physically and mentally. Another study that points in this same direction is the research conducted by Sanchis *et al.*, (2013), regarding migrants in Spain. In contrast, the availability of social support, education, and access to healthcare services were signalled by Nielsen and Krasnik, (2010), and Salinero *et al.*, (2011), as crucial factors for inclusion and strengthening social ties with the host society among migrant women. A lack of social support can influence wellbeing and state of health, a fundamental aspect set out in the findings of this research. This lack of support also makes migrant sex workers in Spain more vulnerable to abusive behaviour from clients and pimps, as found in the study conducted by Muftic and Finn, (2013), in which sex workers from ethnic minorities in the US presented difficulties accessing healthcare services owing to their lower level of education, lack of medical insurance, social isolation and more frequent exposure to potentially violent situations and sexual exploitation. In our research, violence, one of the most widespread risks for sex workers at a global level, is linked particularly to the absence of social support networks. We interpret the stigma of the activity they carry out and social discrimination as elements that perpetuate a culture of violence. Other authors who have conducted studies in Spain have also reflected this finding (Roos *et al.*, (2012); Bungay *et al.*, (2012), and Holgado, (2013)).

The fact that migrant sex workers often do not have a strong grasp of the vehicular language can be interpreted as a determining factor in their social isolation and anxiety, since they cannot communicate their health needs, aspects that were also highlighted in the studies conducted by Wong, *et al.*, (2012); Weine, *et al.*, (2013) and Rios, (2015).

*2. Sex workers, migration, and health rights.* The new class of underprivileged workers (Sassen, 2003) has not been widely studied with regard to health conditions. However, various studies show how they face harmful living conditions and multiple obstacles to accessing healthcare and other social resources in Spain and Europe (MDM, 2014; Rios & Hernandez, 2015). Our research has shown how their irregular/illegal immigration status situates this collective as second-class citizens, making this one of the primary factors in their vulnerability (Bjorngren, 2010). Our findings agree with those of Juliano (2004) and Holgado (2013), who posit the multiple reasons for the vulnerability of sex workers: lack of familiarity and contact with legal systems, ignorance of their health rights, and exclusion from prevention and medical care programmes.

*3. The importance of social networks in health processes.* The literature about migration indicates that social position and social support networks are fundamental elements to support upward social mobility and bio-psycho-social wellbeing (Wilkinson & Marmot, 2003). In the case of sex workers in the province of Almeria, we have provided evidence of the social inequalities they face, showing

in turn how these social inequalities become barriers to accessing healthcare and social services. As proposed by Garaizabal: “the conditions under which women work in the sex industry are closely linked to the subordinate position of women in our societies” (2007: 26). Their conditions limit the level of control and empowerment women have over their life circumstances. The bio-psycho-social health of sex workers is closely related with questions of power, and in the prostitution trade, the position of the women we have studied is one of vulnerability (Ross *et al.*, 2012). They are increasingly aware of the health risks of working in the sex industry, but this is not enough to combat the social inequalities that threaten their wellbeing. Along these lines, some research conducted in this area recognises the self-care strategies of women in relation to their health, how they deal with the social inequalities that threaten their wellbeing, and how they are excluded from comprehensive healthcare services in different European countries (Mc Grath *et al.*, 2014; Rios, 2015).

## Conclusions

This paper contributes to the body of research conducted into the impact of different conditioning factors that have become structural and intermediate determining factors to explain social inequalities in the health of migrant women working in prostitution. In particular, the conditioning factors affecting women have been studied over four years in the context of Almeria.

The research conducted here indicates that the most relevant factors in shaping their position of social exclusion directly impact the health processes of migrant women working in prostitution. Specifically: their status as migrants and their irregular administrative situation, settlement strategies and location in the territory in different settings for sex work; the lack of economic resources; difficulties in terms of mobility and social ascent; lack of knowledge of the language spoken in the context where they work, and the scarcity or lack of social support; and difficulties accessing the public healthcare systems and/or social services of their surroundings. Analysis of the discourse generated by these women reveals the effect of said factors on their physical and mental health.

This analysis coincides with the latest studies that recommend the application of public health programmes that take into account the needs of this collective, in turn recognising cultural difference and adapting programmes to the needs of immigrant sex workers (Wong *et al.* 2012; Muftic & Finn, 2013). Studies carried out from a qualitative perspective provide an understanding of said factors, examining in depth the causes and effects on the health of women.

The lifestyles and conditions in which they live and work have a major impact on their health, even more so when the social significance of poverty is linked

with the social stigma of working in the sex trade. According to the Theory of Social Determinants, in order to improve the lifestyles of people and communities, actions to promote health must take into account the creation of healthy public policies, capable of affecting security and safety, education, and housing; creating favourable environments for the promotion of lifestyles that integrate physical and recreational activity, reinforcing community actions and refocusing healthcare services.

This study highlights the need to develop bio-psycho-social health programmes aimed at sex workers of diverse origins, along with the importance of creating public policies and programmes aimed at the migrant population, particularly the female community with limited economic resources and scarce social support networks, as crucial strategies in the promotion of health behaviours.

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