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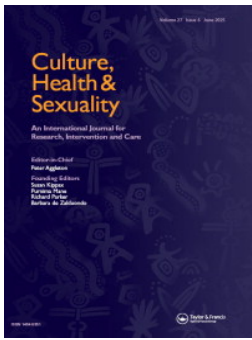
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Invisible survivors: sexual and reproductive health and rights of migrant women in French Guiana

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ABSTRACT

French Guiana faces significant sexual health challenges, notably a high prevalence of HIV. Migrant women are particularly vulnerable, and are impacted by socio-economic factors such as poverty, food insecurity, and precarious living conditions, which affect their sexual and reproductive health and rights. Previous research has primarily utilised quantitative data, neglecting qualitative insights into the factors shaping women's health and rights. The aim of this study was to explore the factors and phenomena liable to have an impact on the sexual and reproductive health and rights (SRHR) of migrant women in French Guiana. Between 2021 and 2022, semi-structured interviews were conducted with health and social professionals. Data triangulation against evidence from two existing surveys on mental health and healthcare access reinforced the findings. The results highlight some of the socio-economic environment factors affecting SRHR, with transactional relationships and gender-based violence exacerbating physical and mental health risks. Addressing these issues requires a systemic approach sensitive to women's lives and the context, prioritising efforts to tackle gender-based violence. The study's findings provide support to local health stakeholders and policymakers in enhancing services and policies to better care for migrant women in French Guiana.

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Introduction

According to the World Health Organisation (WHO), sexual health may be defined as 'a state of physical, emotional, mental and social well-being in relation to sexuality, and not simply the absence of disease, dysfunction or infirmity' (WHO 2023). A similar definition applies to reproductive health as it connects to 'all aspects related to the

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reproductive system and its functions and processes' (Starrs et al. 2018). Established in 2016, the Guttmacher-Lancet Commission proposed a definition of sexual and reproductive health and rights (SRHR), which directed attention to the links between sexual health, reproductive health, and sexual and reproductive rights. Priorities in the field of SRHR have since been established, (Starrs et al. 2018).

French Guiana is a region of France in South America which faces major sexual health issues (Agence Régionale de Santé de Guyane 2022). It is the region of France that has the highest prevalence of HIV (over 1%) (Nacher et al. 2010). In addition, the prevalence of sexually transmitted infections (STI) is substantial (Santé Publique France 2023). A worrying recent increase has been in the number of cases of syphilis, with several cases of congenital syphilis being documented in the western part of the region (Agence Régionale de Santé de Guyane 2022). Contraceptive use is low, mainly due to the cultural and religious context and associated beliefs (Santé Publique France 2023). Moreover, recourse to abortion is high (four times higher than in hexagonal France) (Agence Régionale de Santé de Guyane 2022). High and widespread levels of sexual violence in French Guiana are deeply concerning (30% of Guianese women report not wanting sex the first time it took place). Professionals across the field unanimously warn about the prevalence of gender-based violence (GBV), especially sexual violence, in all populations (Agence Régionale de Santé de Guyane 2022). All of these factors occur in a particularly precarious environment. Half of all French Guianese people were reported to be living below the poverty line and one third were living in extreme poverty in 2018 (Institut National de la Statistique et des Etudes Economiques 2023). In 2020, 80% of households consulting the mobile health teams in French Guiana had suffered from hunger in the last month (Basurko et al. 2023).

French Guiana is rich in cultural diversity, and blends together traditional and modern healthcare practices, with various languages and knowledges coexisting alongside one another (Renault-Lescure and Goury 2009). Additionally, due to its geographical location and history, it is a land of migration (Piantoni 2011). In 2020, 30.8% percent of the inhabitants of French Guiana were born in another country (Institut National de la Statistique et des Etudes Economiques 2023). Previous studies in the country have shown that the vast majority of people living with HIV were born abroad (Nacher et al. 2010). More than half of them had contracted the infection after their arrival in French Guiana (Nacher, Adriouch, Van Melle, et al. 2018). Among women living with HIV in French Guiana, 10.7% of cases are attributable to transactional sex (Nacher et al. 2010). A study conducted in 2021 in French Red Cross prevention and health centres among foreign-born women highlighted the high exposure of women with a migrant background to sexual violence (20% of women reported having been raped in the course of their lifetime), transactional relationships (30% of women had already exchanged sex for something in the course of their lifetime), and sexual practices exposing them to the risk of acquiring sexually transmitted infections, such as unprotected sex with occasional partners (Alcouffe et al. 2022).

Based on the available information, migrant women are identified as being particularly exposed to sexual and reproductive health problems, exacerbated by the high prevalence of STIs (including HIV), prevalent sexual violence, and the precarious environment in which they live after arriving in French Guiana.

Over the past 10 years, research on sexual health in French Guiana has focused on HIV (particularly phylogenetic approaches) and access to care, while work addressing SRHR more broadly has targeted illegal minors, the partners of sex workers, and urban migrants. Practically all the work carried out on these topics has been quantitative in nature (see, for example, Valmy et al. 2016; Van Melle et al. 2019; Arantes et al. 2021; Nacher, Adenis, et al. 2018; Eubanks et al. 2018; Bello et al. 2020; Mosnier et al. 2019; Nacher, Adriouch, Huber, et al. 2018; Mutricy-Hureau et al. 2022; Bello et al. 2018; Parriault et al. 2016; Brun-Rambaud et al. 2023). There is a lack of close focus qualitative research on this topic. To our knowledge, only one study focusing specifically on the SRHR of migrant women has been conducted in French Guiana in the course of the past decade (Alcouffe et al. 2022). Against this background, the aim of this study was to explore factors likely to have an impact on the SRHR of migrant women in French Guiana in recent years.

Material and methods

Study design

The GUYASSEREMIG (GUYAne, Santé SExuelle, REproductive et femmes MIgrantes) study, which we focus on here, was a qualitative investigation conducted in 2021 among healthcare professionals and social workers. Sexual health themes explored were informed by The Lancet Guttmacher Commission's definition of SRHR, and included: HIV and other STIs; contraception; maternal and neonatal health; reproductive cancers; and GBV. To enhance the validity of study findings, data were triangulated against already available survey material from two qualitative studies conducted in 2022.

Given the challenges of accessing migrant women in French Guiana, our work focused on the perspectives of healthcare professionals and social workers. This approach aimed to guarantee feasibility, limit the language barriers, and provide an expert view on the issues through the prism of wellbeing and health. Our work took place in the main municipalities of French Guiana, including local health centres in isolated areas.

Eligible healthcare professionals and social workers included doctors, midwives, pharmacists, paramedics, psychologists, health facilitators and facilitators working with migrant people. The sample was selected on the basis of representativeness, feasibility and diversity. The main institutions providing care for migrants were first targeted and contacted. They included primary care centres, non-governmental organisations working in informal settlements and in the field of sexual health, and hospital services (e.g. in dermatology, HIV care, and mental health). To mobilise a larger group of healthcare professionals and social workers in French Guiana, the mailing lists and address books of surveyed professionals were used.

A considerable amount of time was spent familiarising ourselves with networks and building relationships. Participants who were contacted *via* email, in-person solicitation, or by phone were offered the opportunity to participate in the study. Those who agreed were scheduled for an interview in a confidential environment.

Recruitment to the study ceased when data saturation was reached. All participants received detailed information about the study, and in line with French legislation, the investigator assigned each participant a pseudonymisation number. They gave their consent to the recording of the interview. The GUYASSEREMIG survey and the Parcours d'Haïti survey (which we also draw on) were reviewed by the Île-de-France VII and the Sud-Est I Ethics Committees for the Protection of Individuals (on 16 June 2021, Reference 2021-A01311-40 and on 12 October 2021, Reference 2021-A02185-36) respectively.

Data were collected by means of semi-structured face-to-face interviews. Participant characteristics (occupation, gender and practice location) were recorded. In the interview guide, topics focused upon included the sexual health problems encountered by women, access to contraception and abortion, quality of care, and possible improvements to service provision.

Participants' characteristics were analysed in terms of numbers and percentages using Stata 15[®] software. Interviews were transcribed and analysed with the aid of MAXQDA 2022[®] software. An exploratory inductive thematic analysis was carried out (Costa et al. 2016). The interviews were listened to and transcribed. Segments were coded, then particularly salient and redundant themes were grouped together. The decision was made to conduct the analysis from a public health perspective.

Data from two additional qualitative studies conducted in 2022 were made available to us by Gabriel Brun-Rambaud and Anaïs Selvelian and were analysed in order to situate the primary data collected as part of this study within a broader context.

Use of secondary source material

Mental health is closely tied to sexual health, especially in relation to sexual violence, as it can impact SRHR behaviours and decision making. Access to care highlights systemic issues with both availability and utilisation, directly affecting SRHR. To address this, existing survey data were used to enhance the validity of the results collected through the interviews described above, and provide a more comprehensive overview of SRHR in the study context.

The first set of materials came from a qualitative survey of migrants' access to healthcare conducted between April and June 2022 (Brun-Rambaud et al. 2023). Semi-structured face-to-face interviews were conducted with healthcare professionals, social workers, and members of local NGOs. Topics covered included professionals' perceptions of migrants' access to healthcare, SRHR facilities on offer, and support practices. The interviews were conducted by Gabriel Brun-Rambaud, a master's degree student in public health with a background in political science.

The second data set came from a qualitative study of mental health conducted in 2022 based on semi-structured interviews, supplemented by focus groups, this time with a focus on access to care, mental health, and mental health problems, as well as violence (including sexual violence). This study was conducted by Anaïs Selvelian, a master's degree student in demography with a background in sociology. Both of these surveys took place as part of the Projet Parcours d'Haïti and utilised similar recruitment methods to those described above.

Data triangulation

To triangulate the data, a deductive thematic analysis was conducted on the secondary interview data with a focus on access to care and mental health. The interviews were first read to ensure familiarisation. Each theme and sub-theme developed during the initial phase of the analysis (based on interviews from the first survey) was systematically searched for in the content of secondary interview data. These themes are further explored in the findings below. Each interview segment was coded before being qualitatively analysed. The coded verbatim extracts were then extracted and added to the previously defined analytical themes. If new themes related to sexual and reproductive health and associated rights emerged, they were incorporated into the analysis.

Findings

Participants

Bringing together the different sources, [Table 1](#) identifies the participants involved in the different studies and their socio-demographic characteristics. In total, data from 89 interviews were analysed. Three individuals had taken part in more than one study. Interviews varied between 15 and 80min in length. The number of interviews conducted per survey, and the socio-demographic data of the participants, are presented in [Table 1](#).

Thematic analysis

From our analysis of the interview data, nine themes and eight sub-themes were identified. Their overall structure is presented in [Figure 1](#).

Table 1. Socio-demographic characteristics of participants surveyed ($n=86$).

	GUYASSEREMIG		Parcours d'Haïti			
	Survey of SRH among migrant women		Study of access to and use of healthcare among migrants		Study of mental health among migrants	
			<i>n</i>	%	<i>n</i>	%
Socio-professional category	30	100	25	100	31	100
Nurses, psychologists and healthcare managers	13	43.3	6	24.0	26	83.9
Physicians and midwives	10	33.3	12	48.0	3	9.7
Social workers and health facilitators	7	23.4	7	28.0	2	6.4
Gender	30	100	25	100	31	100
Women	23	76.7	17	68.0	25	80.6
Men	7	23.3	8	32.0	6	19.4
Work locations	30	100	25	100	31	100
Cayenne (main city)	12	40.0	13	52.0	29	93.5
Saint Laurent du Maroni (Western city)	15	50.0	4	16.0	2	6.5
Saint Georges de l'Oyapock (Eastern city)	0	0	3	12.0	0	0
Kourou (Central city)	0	0	5	20.0	0	0
Maripasoula (Inland city)	3	10.0	0	0	0	0

Note: The bolded values are the total lines.

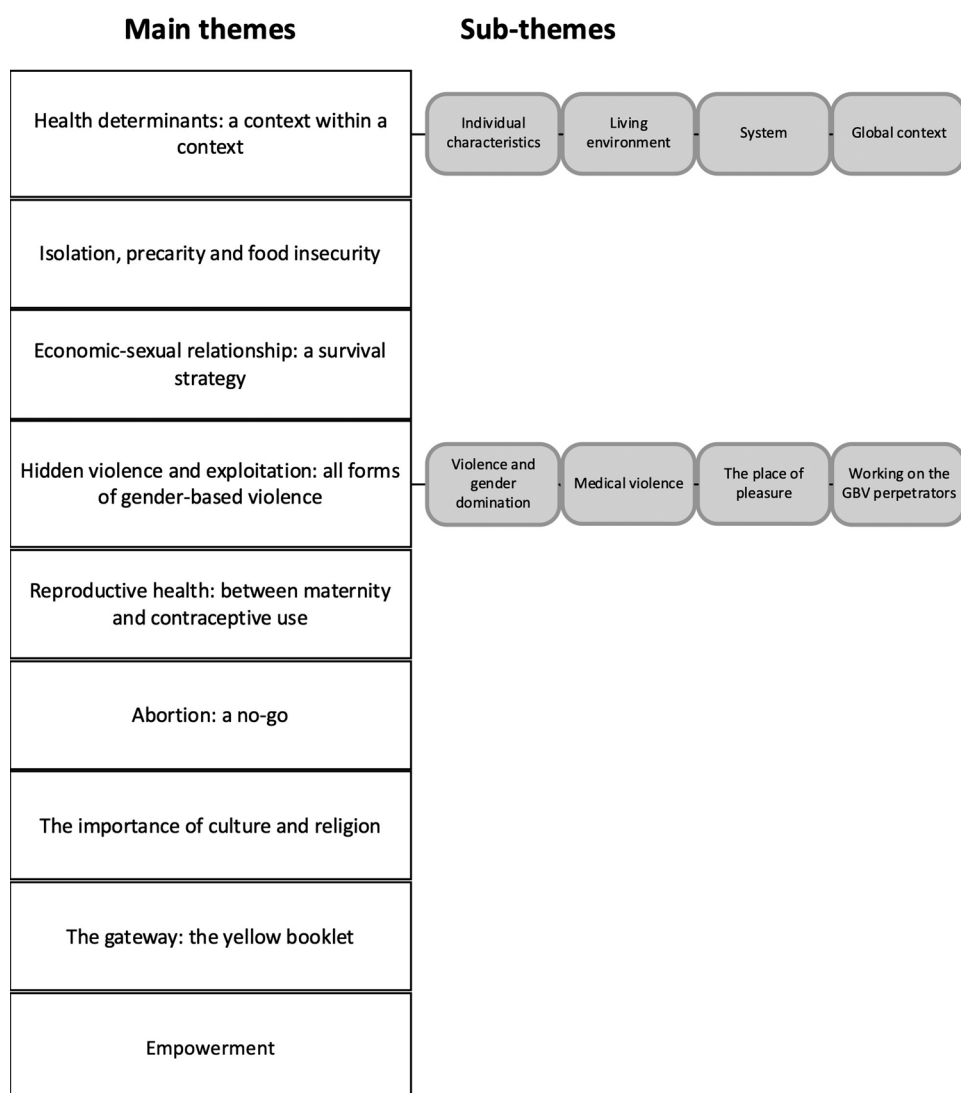


Figure 1. Structure of the themes and sub-themes that emerged from the analysis.

Participants reported encountering different profiles among the women they provided services to, who they felt had different needs in terms of SRHR. In their patient files, health care providers reported encountering Haitian, Dominican, Surinamese, Brazilian, Cuban, and Syrian women with differences in spoken languages, backgrounds and cultures. Mention was also made of the Businenge, an Afro-descendant community encompassing various groups and languages. Emerging from the process of marronage, and the escape of enslaved people from the plantations, the Businenge traditionally live in remote forest areas.

Health determinants: a context within a context

The points of importance raised during the interviews could be contextualised and organised according to the conceptual framework in [Figure 2](#).

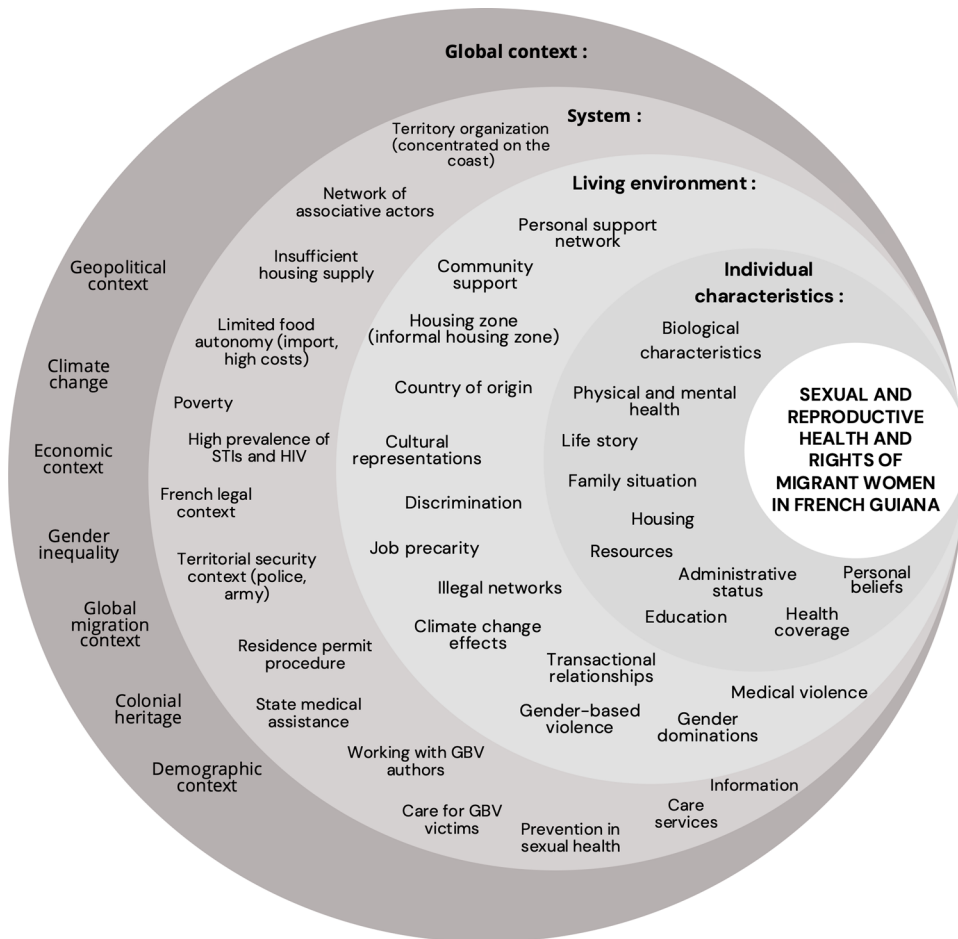


Figure 2. Determinants of SRHR of women with a migratory history in French Guiana, as mentioned by participants during interviews.

Notes: GBV (Gender Based Violence), STIs (Sexual Transmitted Infections), HIV (Human Immunodeficiency Virus), SRHR (Sexual and Reproductive Health and Rights).

Isolation, precarity and food insecurity

Caregivers linked women's SRHR issues to their socio-economic environment, citing the lack of social cohesion and community support. For many women, health was not a priority, especially when it concerned prevention. Housing and food insecurity were more major concerns. Women (including pregnant women), were often isolated, faced language barriers place with an unfamiliar health system. Widespread insecurity led some to pursue to livelihood strategies that created relationships of dependency between women and the men who housed them or who provided them with money.

There are women who are staying with someone but who are not in prostitution networks [they] have a man who comes over, they only have one, but he comes over in exchange for sex, which generally gives them enough to live on. [...] The man demands that there be no condom. So these women quickly find themselves pregnant or with illnesses, because their men generally have multiple relationships. (GUYA009 – Woman, midwife)

Economic-sexual relationships: a survival strategy

Caregivers described meeting women who defined themselves as *trabajando en la calle* [working in/on the street]. As regular or occasional sex workers they were exposed to violence, mental health risks, social stigma, and even death threats.

I come with a SW [sex worker] with me, there's a little kid who said to the SW "Look she's a daddy stealer". I saw that and it put me on my ass! It's a child, you can't argue with a child! If he talks, he's listening to an adult. (GUYA010 – Woman, facilitator).

According to caregivers, transactional relationships were omnipresent among the women they encountered in their practice. They could have damaging consequences for women, such as sexually transmitted infections, threats to physical and mental health and unwanted pregnancy. Sexual exchanges were often kept quiet, and difficult to shed light on during medical consultations.

There are those who are under pressure, particularly when it comes to housing. I had one with "every time I have sex with my boyfriend, he leaves me money and I can pay for my housing or food". (GUYA006 - Man, nurse).

Faced with this phenomenon and its frequency, health and social care teams highlighted the importance of addressing all women and not just named 'sex workers' as a key population to be provided for through their work.

Hidden violence and exploitation: all forms of gender-based violence

In the GUYASSEREMIG survey, despite no direct questions being asked about violence, respondents frequently highlighted violence as a key issue affecting migrant women's sexual and reproductive health. Similarly, the Parcours d'Haïti survey, which focused on healthcare access, did not explicitly enquire into gender-based violence, yet interviewees also often raised this theme.

Violence and gender domination

Various forms of violence were reported by migrant women, often complicating their healthcare experience. Intimate partner violence was particularly difficult for women to talk about during consultations, even when questions were asked about it directly.

[A patient encountered during a consultation] said "it's my husband who brings in the money, so I'm not going to go to the police" [...] This concerns all women, and the more precarious you are, the harder it is to defend yourself. (ACCES022 - Man, doctor).

Stories of rape were frequently reported by women, with serious psychological consequences. According to caregivers, sexual violence is subject to code of silence: even when it is revealed by women, it is passed over in silence by those around them.

I've advised Haitian women, especially those who have been raped in Haiti. Because when a woman is raped, especially here, it always holds them back. Even when they walk down the street, it's as if the men are walking behind them. Even here in French Guiana, they don't feel safe. (GUYA022 – Woman, facilitator).

Networks of traffickers, between a country of origin (for example the Dominican Republic) and French Guiana promise women a job when they leave their country,

but when they arrive, they become caught up in a prostitution network of which they had no idea at the beginning. The women become dehumanised objects for the people who house them.

We have a significant number of women who belong in some way [...] to people who have their papers, who are in order administratively, and who take them in, give them a little money for food, and in return they possess them [...]. (ACCES017 - Man, midwife).

Some women face gender-based control over contraception. Caregivers reported low rates of condom use, with some men removing condoms (stealth) or perforating them out of comfort or the desire for paternity. Additionally, many women said during clinical consultation that their partners refuse to get tested for STIs and other sexual health problems. In situations where partners opposed contraception, caregivers sometimes offered 'invisible' methods, such as three-monthly progestin injections.

I met 3 or 4 cases of minor girls, pregnant and with syphilis, who returned after treatment who were still positive, because they didn't talk [...] if the girl doesn't have the freedom to express her rights in the couple relationship, it sucks, and it creates problems in sexual health at all level. (GUYA015 - Woman, doctor).

[They] come to me and say, "You've got to take my implant out, because he really wants me to take the implant out, but can you give me an injection so he won't see anything and then it'll work". (ACCES017 - Man, midwife).

Medical violence

Caregivers described encountering women with contraceptive implants or intra-uterine devices without being aware of them. Whatever the reason, such as lack of time or comprehension difficulties, this raises questions about the practices of their colleagues.

I recently met a Haitian woman who had an intra-uterine device and didn't know what it was. She told me they hadn't explained it to her, so they put it in. A midwife, after giving birth [...] to have something put in and you don't know what it means, what it does, it's a bit ... (GUYA021 - Woman, facilitator).

The place of pleasure

Caregivers reported that consent and women's sexual pleasure were frequently neglected. They felt compelled to satisfy their partners regardless of their own desires, with little opportunity to communicate about sex.

Consent too, and the woman's pleasure. And I have the impression that this is the case in all communities too, where women's pleasure is somewhat put aside, if it pleases her man that's fine. [...] in the end, does she want to, does she not want to? Most of the time when we ask them, it's more to please the husband. (GUYA014 - Woman, nurse).

Working with the perpetrators of gender-based violence

In interview, some caregivers stressed the importance of working with both victims and perpetrators to reduce GBV, through prevention, education and legal sanctions. In Cayenne, several organisations and institutions specialise in working with men as perpetrators, whether they have committed specific acts or not.

We're dealing with a machismo that's really basic, and to fight against it we really need information and education. (GUYA002 – Woman, doctor).

Reproductive health: between maternity and contraceptive use

Caregivers identified a strong, long-term desire for pregnancy and motherhood among the women they saw, emphasising the importance of supporting women in their wishes. However, although women recognised the need for contraception, many refused to use the methods offered. These refusals were often influenced by religious beliefs and preconceived ideas (for example, that contraception can cause infertility). Among the Businenge in particular, cultural views on contraception are especially important, with children being seen as indicative of a woman's wealth and independence.

Haitian women often believe that the flow of blood during menstruation should not be disturbed. Other women express fears about the side effects of contraceptive use, infertility and the belief that the use of contraception is equivalent to killing a baby. Caregivers highlighted how proactively providing information and education is essential to help women make informed contraceptive choices.

There are women who say "no, I'm not going to use contraception, because I don't feel good when people say it's going to give me cancer, it's going to give me other diseases, I don't even prefer to use condoms, I prefer to stay like this". (GUYA022 – Woman, facilitator).

Abortion: a no-go

In French Guiana, abortion is legal before the end of the 14th week of pregnancy. Caregivers reported that access to abortion services is generally good, with midwives being key gatekeepers to services. However, many women, influenced by societal and/or legal time constraints for completion, do not see abortion as an option, even in the case of an unwanted pregnancy. Some women, particularly Businenge women, use traditional plant-based remedies to terminate a pregnancy, while others buy abortion drugs on the black market (particularly drugs imported from neighbouring Suriname).

In general, they refuse, abortion is a subject that doesn't come to mind when a pregnancy is discovered, even if it's unwanted, they don't even consider it. (GUYA004 – Man, nurse).

Despite a generally efficient system for supporting women wishing to end their pregnancy, difficulties of access have recently been encountered, notably due to the refusal of many gynaecologists in Cayenne to perform abortions.

Doctors were against it with the "let them live" movements, or I don't know what. Very Catholic movements, ... [...] at that time, when the hospital was no longer doing anything, and we didn't know where to turn to do it. GUYA028 – Man, doctor.

The importance of culture and religion

Caregivers emphasised the significant impact of religion and culture on women's decision making about abortion and contraception. The refusal of contraception was reported even by members of healthcare teams, with some nurses stating that they did not use contraception for religious reasons. However, some healthcare providers reported that religious leaders in French Guiana, particularly in certain Catholic

churches, do offer support in terms of prevention and health (for example, in screening for breast cancer).

Even if I want to have a child or not, I couldn't take contraception, for personal reasons, but otherwise I totally respect people who take contraception, it's their choice [...] It's religious reasons. We won't use contraception in our home. (GUYA003 – Woman, nurse)

There's also religion, which means you can't use a condom, you can't have an abortion... (GUYA012 - Woman, facilitator).

Caregivers stressed the importance of developing greater cultural awareness in order to better care for patients and respect their choices. Some caregivers stressed the need to be vigilant in an intercultural context, where cultural overdetermination can mask mental health pathologies.

That's why you have to be very vigilant about the cultural aspect, and not overdetermine the cultural [...] All my colleagues were obsessed by the fact that this was a difficult patient, and he was a patient of Haitian origin [...]. This gentleman emphasised, the whole universe of persecutory experiences, experiences of possession, witchcraft etc. [...] At the conclusion, he said "yes, yes to the doctor" [...]. [...] in the end, on a psychopathological level, the man had started a serious depression, to the point of death. (001LC – Woman, psychologist).

A key gateway: the Yellow Booklet

A key moment in health care for migrant women in French Guiana is the receipt of an international vaccination card (Yellow Booklet), after a mandatory yellow fever vaccination. This document serves to prove their arrival date and initiates a variety of administrative processes (including residence permits or health coverage applications). Accredited by the French Red Cross, these consultations also provide a gateway to healthcare and an opportunity for check-ups.

We take this opportunity [the request for the international vaccination booklet] to offer blood screening, contraception, cervical cancer screening, these are services we offer following the request for a Yellow Booklet (ACCES003 - Woman, doctor).

Empowerment

The importance of empowering women to become custodians of their own SRHR, as well as active participants in the care offered to them, was frequently highlighted.

[We need] to build up this partnership so that they're more listened to, more valued, more in the spotlight. And then tell them that they have a choice, and I keep telling them that: they have the right to say no, they have the choice to choose what they want as a contraceptive method, and what they want for their life, and not just sex and love, but their future life. Let them have the choice. (GUYA024 - Woman, nurse).

Discussion

Health determinants in context: isolation, precarity and food insecurity

Living environments have a significant impact on health, shaping individuals' choices and opportunities to improve their well-being. The Lancet-Guttmacher Commission,

which redefined the concept of SRHR in 2018, highlights the important role of social and environmental factors in determining health outcomes: level of education, wealth, and place of residence are related to morbidity -and mortality- linked to sexual and reproductive health (Starrs et al. 2018). A 2012 study of sub-Saharan women in France found that lack of a residence permit or stable housing access increases the likelihood of involvement in transactional sex, multiple partnerships, and forced sex, raising the risk of HIV (Desgrees-Du-Lou et al. 2016; Pannetier et al. 2023; Gosselin et al. 2020). In French Guiana, food insecurity is high and is associated with a lack of residence permit, lack of social support, water insecurity, and cramped housing (Basurko et al. 2023). A study conducted with women displaced after the earthquake in Haiti found that food security increased the likelihood of 'consistent' condom use (Logie, Daniel, and Wang 2016). These examples illustrate the interdependence of determinants, such as isolation and hunger, transactional relationships and the risk of HIV, or food insecurity and condom use. Environmental precarity also shapes women's health priorities, causing them to focus on day-to-day survival rather than prevention.

Transactions for survival: a wide range of situations

This study provides insight into the high prevalence of transactional sex among migrant women in French Guiana. Transactional sexual exchanges can take many forms. Whether they are occasional, undertaken as a professional activity, hidden or forced, they concern a significant proportion of the women. A quantitative survey conducted in French Guiana in 2021 found transactional sexual intercourse was more frequent among women who had been living in the country for more than two years, which supports the hypothesis that these exchanges take place in a survival context. In addition, according to this same survey, transactional sex was associated with alcohol abuse, a history of threats of any kind, and a history of rape and depressive disorders, highlighting the cumulative effects of the violence suffered by women and its damaging consequences (Alcouffe et al. 2022).

Violence, a lifelong reality for women

Globally, an estimated 30% of women over 15 years of age have experienced physical or sexual violence by a partner, with notable regional differences (Starrs et al. 2018). In Latin America and the Caribbean, violence against women, especially migrants, is highly prevalent. The literature illustrates the many forms that this violence can take: before departure (often one of the reasons for leaving), during transit, and on arrival (where violence turns into rejection and difficulties in accessing employment) (Asakura 2016; Baranowski et al. 2019; Díaz-Rincón, Enamorado-Estrada, and Almanza-Iglesias 2021). For some women in this study, racism and sexism intersect to reinforce each other in experiences of violence, contributing to intersectionality (Crenshaw and Bonis 2005; Keller, Mendes, and Ringrose 2018), with the interdependence of determinants highlighting the importance of taking a systemic view of gender-based violence and the factors contributing to it (Hanmer 1977).

Women's right to control over their bodies

Information to contraception is crucial to understanding the available services, entitlements, and needs (Starrs et al. 2018). In the results of this study, beyond the desire for motherhood, refusals of contraception were often linked to a lack of information as well as the influence of religion over reproductive decision making (Perković et al. 2019). In addition, studies in France have highlighted the medical violence women may face during contraceptive consultations, including lack of consent, withheld information, and imposition of social norms and moral judgements (Fonquerne 2022).

Abortion is a complex and often debated issue, however, worldwide, 55–57 million abortions are performed each year (Ganatra et al. 2017). The work described in this paper highlights the significant refusal of women to resort to abortion. Many women in the studies cited came from countries where abortion is illegal and influenced by strong social and cultural factors. Moreover, in French Guiana, many doctors still refuse to perform abortions (Ministère de la Santé 2023). This barrier to abortion access also limits access to SRHR more generally (Starrs et al. 2018).

Links between biomedical medicine and personal beliefs

French Guiana is characterised by major cultural and linguistic diversity, creating gaps in perception and understanding between caregivers and patients. Traditional therapeutic approaches in French Guiana are shaped by a variety of cultural heritages, many of which combine traditional knowledge and spiritual practices. Haitian Vodou medicine, Obia among the Bushinenge, and Amerindian plant-based remedies blend together different healthcare practices (Tareau et al. 2022). It is crucial to avoid taking an essentialist and reductive view of local cultures and take these factors into account to ensure good quality care (Jolivet 2013). Successful examples of linking traditional medicine and biomedicine have been reported, such as the case of a woman living with HIV in French Guiana who refused her diagnosis, where facilitators played a key role in encouraging discussion and facilitated her return to biomedical treatment and care (Tareau et al. 2024).

An environment that affects access to healthcare

A range of environment factors pose obstacles to women's access to healthcare including lack of transport, administrative complexity and language barriers (Brun-Rambaud et al. 2023). One of the challenges for healthcare and social work professionals is to reach women at key moments on their health journey. However, this is not always possible, and underline the importance of 'outreach' actions in informal settlement areas in French Guiana, by trained facilitators.

Strengths and limitations

This study has a number of strengths. Firstly, it is the first investigation to provide a reasonably comprehensive overview of sexual and reproductive health and right as they apply to migrant women in French Guiana. While several quantitative studies

have been carried out, none of these studies have focused in on the social and cultural factors influencing the challenges and problems identified. The analysis has certain limitations, however. Foremost among them must be the fact that members of the target population (i.e. women with a migration history) were not directly interviewed. In addition, most of the interviews were conducted in major cities in French Guiana, and remote areas being less well covered. Finally, the secondary data we analysed did not directly focus on SRHR but on related concerns.

Conclusion

This study has presented an analysis of issues around the SRHR of migrant women in French Guiana, highlighting the importance of the socio-economic and environmental context in which women live. The results show that isolation, precarity and food insecurity are factors influencing not only access to care, but also decision-making on health matters. Study findings highlight the importance and extent of transactional sexual exchanges, often established as survival strategies, as well as the multiple forms of violence, whether sexual, domestic or institutional, faced by women. This violence, combined with cultural, religious and administrative barriers, limits women's access to healthcare and support, particularly in respect of contraception and abortion. Moving forwards, action is needed to address women's vulnerability in a precarious environment, with the creation of emergency health and food support structures to combat inequalities. A systematic evaluation of women's mental health needs within the context of transactional relationships and violence, is also required. The fight against gender-based violence must be a priority on the regional agenda in French Guiana, addressing it both as a social and a health issue. In moving forwards, it will be important to reinforce local actions, particularly in respect of empowerment, in order to improve the overall health and rights of migrant women and girls in French Guiana.

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