Health Policy

Intersections between gender approaches, migration and health in Latin America and the Caribbean: a discussion based on a scoping review

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Summary

Gender is a sociocultural construct that assigns forms of behaviour, power, and roles to individuals based on their sexual differentiation. There are multiple gender approaches that help distinguish risks, health conditions and behaviours related to the body, health-disease processes, and differential opportunities to access health care. Based on a scoping review of scientific and grey literature in LAC, we discuss existing understandings of international migrants' health in LAC with a focus on gender approaches. Our discussion covers the following seven dimensions: gender-based violence, sexual and reproductive health, sexually transmitted diseases, mental health, barriers to healthcare services, and emerging patterns of health and healthcare among men and LGBTIQA+. The evidence indicates the urgent need to adopt gender approaches when addressing migrant and refugee health in LAC. Including gender approaches into ongoing strategies for promoting and protecting the health and rights of migrants and refugees is a pending challenge in the region.

Keywords: Gender; Migration; Health; Latin America and the Caribbean

Introduction

Gender is fundamental to understanding and resolving health inequities. It is a complex concept, often defined as a sociocultural construct that assigns forms of behaviour, power, and roles to people based on their sexual differentiation. However, it goes beyond its biological dimension to include self-identifications, social expressions and legal recognitions.[1] Gender approaches are set in a continuum, from exploitative to transformative: the gender-unequal and gender-blind impede promoting gender equality approaches (gender-exploitative), while the gender-sensitive approach acknowledges gender without taking action (part gender-exploitative, part gender-accommodative), and gender-specific (part gender-accommodative, part gender-transformative) and gender-transformative approaches actively promote gender equality through the transformation of gendered social structures.[2] The three approaches on the continuum's accommodative and transformative sides are concerned with individuals' roles, responsibilities, limitations, and opportunities in societies, fundamentally focusing on power relations.[3] They recognise the sociocultural construction of pre-defined social norms in a system of social relations and that a hierarchical social valuation of the functions assigned to women, men, non-heterosexual and non-binary people is established throughout their lives, where feminine, non-heterosexual and non-binary expressions are given lesser value than the masculine and heterosexual.[4] Care must be taken in order not to conflate gender identity and sexual orientation, however, some challenges might be shared between diverse gender expressions and sexualities.

From a gender-transformative perspective, gender is recognised as a social determinant of health.[5] For example, it has been documented that women tend to use available health services more than men throughout their lives, albeit with a marked emphasis on sexual and

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reproductive health.[6] Conversely, men tend to consult late, i.e., once the health conditions have been manifesting for a long time and already present complications.[7] Finally, little is known about LGBTIQA + groups' access to healthcare and specified healthcare needs and rights.[8] Since gender significantly impacts population health, transforming gendered social structures to achieve gender equality is a global health priority.

In the Americas, the Pan American Health Organization (PAHO) adopted its Gender Equality Policy in 2005 based on the existing World Health Organization (WHO) policy. The goal was to contribute to achieving gender equality in health through research, policies, and programs focusing on gender differences in health and their determinants while actively promoting equality between women, men, and LGBTIQA + groups. Most of the existing evidence around this topic in the region is focused on women; however, there is emerging evidence related to men and the LGBTIQA + community.

Evidence around migration and health in Latin America and the Caribbean (LAC) generally recognises the value of adopting gender approaches when looking at migrant and refugee health. Additionally, in the context of LAC, intersectionality is relevant. Intersectionality was initially coined by Kimberlé Crenshaw in her work drawing on black feminism, establishing that the mechanisms that persistently exclude black women are situated at the intersection of gender and race, allowing to describe the experience of black women not only in terms either of gender or race and beyond simply the sum of both.[9] Intersectionality has developed into a theoretical framework that focuses on interweaving power relations considering the complexity of multiple structures, including gender, race, sexuality, class, age, and disability, among others.[10–14] It recognises that power acts not only on sexual oppression but also on racial, class, and other types of oppression.[15] It also strives to provide the methodological framework to study the interrelationships of these categories and to understand their meaning and significance.[11–13]

The increasing feminization of human mobility has required the inclusion of intersectionality in the study of migration[16] to dismantle the apparent homogeneity of the migrant woman category and recognise the vulnerability they may experience and their constant contributions to transforming societies with a long tradition of immigration.[17] It seeks to make visible the multiplicity of experiences of migrant women and the impact that class and ethnicity have on the migratory experience. It reveals the historical continuity between the current mobility processes and their relationship with the colonial order under which the globalization of capitalism was inaugurated.[18–20] Integrating intersectionality theory in research on migration and health is necessary to shift from an individual, culturally based approach to models that reveal how place, racialization processes, the media, and immigration policies impact immigrant health.[21–23] Generally, evidence suggests that there might be differential migration experiences based on gender identities and sexual orientations. Also, the sociocultural, legal, political and economic circumstances in which people migrate define different health risks for each of them.[24] For example, while men migrating for economic reasons experience the stress of providing for their families, women who act as primary caregivers can experience the double burden of caring for children and securing work and other resources during the migration process.[25,26]

This policy paper aims to discuss the current understandings of migrants' health in LAC with a focus on gender approaches based on a scoping review of the existing scientific and grey literature.

Methodology

We carried out a scoping review of scientific and grey literature on gender, international migration, and health in LAC.[27] We aimed for a broad consideration of all papers explicitly addressing any gender approach in the region that were related to the health of international migrants, including refugees, and avoided reducing our search to a single gender perspective or theory.

Search strategy and selection criteria

We followed two different strategies: (i) Search in *PubMed* with a list of both MeSH and string terms related to "health", "international migration", "gender", and "Latin America and the Caribbean" in November 2022. Filters were applied to exclude articles including non-human subjects and older than 10 years. Articles were also identified through searches of the authors' own files. All papers published in the past 10 years and focused on the health of migrants with any gender consideration and in any language were reviewed. (ii) Regional search using *Google Scholar* with the same search terms as above in English, Spanish and Portuguese. The same criteria from strategy (i) were used and a filter was applied to exclude publications older than 10 years. We also added manuscripts based on a detailed hand-search of selected papers' references. Flowchart and checklist appear in Supplementary files S1 and S2.

The final reference list was generated based on the following inclusion criteria: (i) Focus on migration and health in Latin America with an explicit gender dimension. (ii) Published in the last 10 years. (iii) Available in English, Spanish or Portuguese. Exclusion criteria: non-human migration topics. Finally, we included 52 relevant manuscripts in our review. Qualitative thematic data analysis was conducted allowing for main common themes to emerge from the existing literature.

Gender approaches and impact on regional health

From all documents included, after data analysis was conducted the most prominent themes observed were related to the health of migrants in the following seven dimensions: gender-based violence, sexual and reproductive health, sexually transmitted diseases, mental health, barriers to health care services, and emerging patterns of health and healthcare among men and LGBTIQA + communities. We discuss each of them with a particular interest in their connection to gender approaches and their potential impact on regional health.

1. Gender-based violence (GBV) among migrants in LAC

An important risk during migration is gender-based violence (GBV). The UNHCR defines GBV as harmful acts directed at an individual based on gender and indicates that it violates human rights and is a life-threatening health issue.[28] In LAC, the literature identifies different forms of GBV along the three stages of the migratory path (departure, transit, and destination).[29] Additionally, women and LGBTIQA + people are at higher risk of sexual violence than men, and women of reproductive age have health needs that can be difficult to address while on the move.[30–33] In some cases, the GVB violence people experience in their country of origin is the reason they migrate.[34]

We found relevant evidence connecting GBV with migration in LAC. For example, in Colombia, women are forced to flee due to the use of sexual violence as a war weapon in the armed conflicts affecting the country.[35] In addition, Hiroko Asakura[36] points out that the migratory process of Central American women to the United States is characterised by a high degree of violence due in part to the unequal distribution of power between the sexes, economic inequalities, and the feminisation of poverty in the region. Furthermore, significant risk factors in the destination country increase GBV against migrant women, such as criminalization, stigmatization, precarious employment, and the lack of legal protection.[37] For instance, Romero analyses the experience of Bolivian migrant women living in Tarapacá, Chile, and emphasizes that gender violence is primarily experienced by irregular migrant women.[38] Also, some migrant women experience violence throughout their lives, carrying the mental load implied in being a woman, a mother, and someone else in an unknown place. The multiple forms of violence leading to emotions such as anguish, fear, and disempowerment push them to carry on their migratory path.[36]

There is also evidence of the trafficking and smuggling of migrant women in the region. This phenomenon is attributed to several factors contributing to its spread, such as poverty, lack of education, and other challenges in the countries of origin. External trafficking aims to cover a broader demand in the international market and is related to networks in the United States, Europe, and Asia that base their operations and recruitment in our region. One relevant trafficking path in the region starts in Brazil, Suriname, Colombia, the Dominican Republic, and the Antilles, where the most active centres are located.[39] The literature also reaffirms the regional trajectories of woman trafficking and smuggling from Central American countries to the United States.[40]

In 2021, the Inter-American Development Bank published the "Feminization of Migration", which specifically points out that most migrant women perform tasks that do not reflect their skills and academic training.[41] These conditions of vulnerability associated with the woman's country of origin have also been reviewed in the scientific literature.[42] For example, Venezuelan women, who constitute 48% of the migrant population in Colombia, are especially at risk of sexual exploitation and having to engage in sex work to make ends meet.[43] Evidence in the region also indicates that there is a need for a better understanding of the underlying mechanisms that explain what leads migrant women, men, or LGBTIQA + people to accept fraudulent labour offers or the differences in the context associated with the countries involved in their migration flows that make these irregular practices possible.[44]

GBV among migrants in LAC is a crucial dimension of health in these populations, and evidence in the region suggests the urgent need for structural and transformative actions to eliminate it. These actions should be based on the concrete recognition and protection of gender identity and health needs throughout the migration process, especially when experiencing socioeconomic vulnerability and irregular migratory status. Furthermore, the voices of gender-diverse migrants should be heard as they must play a crucial role in the design and implementation of any solution concerning the health of migrants, promoting gender-transformative approaches.

2. Sexual and reproductive health among migrants in LAC

Sexual and reproductive health in the context of human mobility is a prominent area of research and public health action in the region. We identified several papers on this topic, most of them exploring intersections between migration and different forms of vulnerability. For instance, we found studies about migrant Venezuelan women in Colombia,[45] Peruvian migrant women in Argentina,[46] and Nicaraguan migrant women in Costa Rica.[47] Migrant women in LAC often experience: a) difficulties and barriers to accessing

health services in destination countries, b) increased risk of complications during pregnancy and childbirth compared to locals, c) disadvantages in accessing timely gynaecological and obstetric care compared to locals, which increased during the pandemic, d) some of them tend to initiate prenatal care later than local pregnant women and more of them require emergency care during childbirth.

It is worth noting that multiple studies focusing on Venezuelan migrant women have been conducted in recent years. For example, one study found that access to primary healthcare was not guaranteed to Venezuelan pregnant migrants, but 25.9% of them declared having been able to access emergency healthcare assistance.[48] Another similar case study reported that some pregnant migrant women decide to migrate due to the several obstacles to accessing basic maternal care in countries of origin.[31] Undocumented migrants, instead, can only access emergency care or be included in only a few public health initiatives (for example, prenatal check-ups, childbirth, and postnatal care). These investigations indicate that migrant pregnant women who want to regularize their migratory status and affiliate with the healthcare system might go through burdensome, unclear, and complicated bureaucratic procedures without sufficient information. Consequently, some migrant women rely on emergency care only.[31]

Continuing with the underutilisation of reproductive health services by migrant women in LAC, Aizenberg et al. analysed the factors that influence the access and use of health systems by Bolivian and Peruvian women in Argentina during pregnancy and delivery.[49] They found that migrant women with low educational levels, precarious migratory situations, and entry into informal jobs without social security had higher risks of reporting obstacles to access healthcare services. Likewise, women from rural sectors arrive with traditional knowledge, practices, and values that are in tension with the modern health system of the city, which affects the ties of trust between them and the doctor. Another relevant factor is the use of contraceptives among the migrant population. As found in this review, unwanted pregnancies can exacerbate the already vulnerable situation of migrant women leading to major health issues such as unsafe abortions, increased maternal mortality and morbidity, and worsening mental health.[50]

From both gender and intersectional approaches, unequal opportunities for reproductive health among migrant women have been extensively documented, showing a profound impact on population health. Pregnant irregular migrant women experience the highest degree of health risk and yet continue to be unprotected. This is an urgent political, legal and health global issue that proves the need for more decisive transformative-gender action in LAC. This is especially urgent when these women experience the intersections between gender, migration status, poverty, and racial discrimination, as has been historically the case for indigenous migrant women and many migrant women today in our region.

3. Sexually transmitted diseases among migrants in LAC

Regional evidence indicates that most studies around sexually transmitted diseases have been dedicated to HIV. Some cases are, for example, related to Haitians in the Dominican Republic, Central Americans in southern Mexico, Venezuelans in Colombia, international migrants in Chile, migrants from El Salvador, and the Dominican population emigrating to Puerto Rico. This evidence proposes that differences in HIV prevalence could be related to insufficient knowledge of HIV, stigmatization, cultural background, infection in the country of origin, and access to screening. It also suggests that irregular migrants living with HIV face human rights violations, discrimination in health services, and social rejection due to negative social representations around migration.

López and De Moya, for example, found that migrants living with HIV face stigmatisation due to their nationality and their seropositive status, even facing ostracism and denial of medical care.[51] A study carried out in the border community of Tapachula, in Mexico, found that mobile populations are perceived to be linked to social issues such as violence, insecurity, prostitution, and the spread of HIV/AIDS, exacerbating social rejection and discrimination attitudes against undocumented migrants, sex workers, homosexuals, truck drivers, and soldiers.[52] In Chile, a policy analysis from 2020 showed five predisposing factors for vertical transmission of HIV in the mother-child relationship: 1) demographic factors (e.g., irregular status), 2) socioeconomic factors (e.g., low education level), 3) health and social policies in the receiving country (i.e., restrictive ones), 4) risks during the migratory process and 5) specific disease-related conditions like cell counts and adherence to medication during pregnancy.[53] Hernández, Alas, and Gómez found a relationship between space and the social life of Salvadoran migrants with HIV requiring access to treatment and control of the disease during transit across borders despite restrictive policies and other obstacles.[54] Rivera Díaz, Álamo and Rapale found that irregular migrants living with HIV are less likely to seek and receive healthcare and face multiple social barriers when seeking healthcare services, such as stigma, shame, rejection, discrimination, or fear of deportation.[55]

Given the amount of relevant evidence on HIV in LAC, we have synthesized some recommendations in Box 1. This list of seven recommendations is concerned with preventing, diagnosing, and treating HIV by formally including gender approaches in their design, implementation, and evaluation. As we observe from

Box 1.

Evidence-based proposals to promote gender approaches for effective prevention and treatment of migrants and refugees living with HIV and AIDS in LAC.

- Culturally adapting health programs with an explicit gender-aware and gender-responsive perspective, especially for women but also including diverse gender identities and men.[51–53]
- Creating gender-informed confidential information systems that disaggregate information on the health profile of migrants in their country of origin, during transit, and at destination; capable of providing continuity of care for a person with a chronic condition like HIV.[54]
- Promoting the inclusion of gender approaches to guidelines established at the national level to guarantee care for all, including migrants living with HIV and AIDS, especially in relation to tackling the lack of control and prevention of infectious diseases in these populations.[56]
- Continuing gender-based transformative and intersectional research on risk factors for migrants' health related to infectious diseases, including HIV, and taking into account their historical and social context, as well as their long-term unequal power relations between migrants and locals and between people living with HIV/AIDS and health systems.[51]
- Improving gender-aware and gender-responsive communication between international migrants and healthcare workers by integrating an intercultural health approach.[57]
- Designing health programs and HIV prevention strategies that entail gender-responsive and gender-transformative approaches to health, as well as culturally appropriate actions, particularly to reduce stigma and rejection towards mobile populations, combating segregation and social distancing of people discriminated against.[58]
- Developing unique and novel strategies to formally include gender approaches in designing and implementing HIV prevention and treatment. These actions should help reduce gaps in the effective use of available health services, including existing programs to prevent vertical transmission of HIV in pregnant migrant women.[53,54]

existing evidence, the only way to shorten persistent and structural unequal gaps in access to HIV/AIDS prevention and treatment strategies among migrants in LAC is by producing solutions based on gender-transformative and intersectional approaches, shedding light on the historical reproduction of power imbalance between migrants and locals and between people living with HIV and healthcare systems.

4. Mental health among migrants in LAC

Migration and poor mental health are not directly related, but migration can negatively affect mental health when challenging or risky circumstances occur during the migration process. There is relevant evidence related to the mental health of general migrant populations in LAC around general migrants and subgroups like refugees, undocumented people, and historically stigmatised migrant communities, focussing on acculturation processes, traumatic experiences and, more recently, COVID-19.[59–62] However, there are fewer studies explicitly considering gender or intersectional approaches. In this review, we found one study on indigenous Andean migrant women entering the labour market, which showed that greater public participation increased dependency and gender domestic violence, deepening the deterioration of mental health and other disorders among these women.[63] Hence, from an intersectional perspective, the international migration of indigenous women in LAC raises the challenge of better understanding the cultural dynamics of indigenous migrant women and their impact on mental health while migrating and integrating into host societies, as well as narratives from locals that reproduce unfair opportunities, visibility, and recognition.[49]

Indigenous migrant women in LAC are affected by stigma and discrimination in terms of class, gender, and ethnicity, and this triple discrimination is worsened when they migrate. A case study in Mexico showed how indigenous migrant women suffer the worst living and working conditions, including physical and sexual abuse.[64] Literature about Bolivian migrant women in Argentina shows how these discriminations are also mirrored in the healthcare setting that ignores, marginalizes, and abuses them.[65,66] Furthermore, there are gender and indigenous perspectives on the environmental migrations caused by climate change. In Chile, natural disasters and the shortage of natural resources are significant obstacles for Mapuche and Peheunche indigenous women who oversee agricultural activities to feed their communities. Therefore, these women are forced to migrate to seek other modes of subsistence, leading to threats to their health.[67] Additionally, as Albornoz-Arias et al.[45] pointed out, Venezuelan migrant women face xenophobic cultural pressures in Colombia, including prostitution, stigma, family separations, and couple relationship reconfigurations, all of which lead to mental health problems.

Overall, intersectional dimensions of mental health among migrants in LAC are being increasingly acknowledged and studied, but further theoretical development, research priority, and public health considerations are urgently needed in the region. There is relevant evidence around risks and poor mental health of migrants, yet gender and intersectional approaches concerning the health of ethnic migrant minority

women, for example, have been less visible in the scientific literature. Something similar occurs with migrant men and those self-identifying as gender diverse. Grey literature, especially discussions from the social sciences in the global south,[68] including LAC, have raised great awareness about the historical neglect of inclusive gender approaches to health. This historical neglect has reproduced stigma, discrimination, and xenophobia against these groups in general social scenarios and within the healthcare settings, with powerful adverse mental health effects. A positive transformation of this reality goes far beyond healthcare systems. It requires a paradigm shift under which the person's value remains equal to others irrespective of their country of origin, migration status, gender, socioeconomic status, and ethnic belonging. In times of great inequity and global human challenges, the rich sociocultural diversity in LAC might be its greater strength, yet it needs favourable consideration in political, legal, social, and cultural domains.

5. Barriers to health care services and experiences among migrants in LAC

The literature classifies the barriers migrants face to accessing healthcare along several dimensions, among which socioeconomic, cultural, communication, health system, knowledge, and personal barriers.[69–75] Many of these barriers are experienced or perceived differently based on gender, but others are common for gender-diverse migrants. For example, some of the common barriers in the Latin American region are migration status and lack of culturally and linguistically relevant information, leading to difficulties in navigating the health care system, discrimination, abuse, racism, mistrust in health care providers, and systemic inefficiencies of the health care system, including the lack of cross-cultural healthcare.[76–81] Language emerged as a significant barrier to health care in LAC, especially among migrant women, as some studies suggest they have fewer opportunities to learn the local language than migrant men.[77,82,83] Other papers indicate symbolic barriers to accessing health care services among migrant women from an indigenous ethnic group (i.e., Quechua women living in Argentina).[84] In these cases, differences between the functioning of the health system of origin and destination (Bolivia/Argentina) and language differences (Quechua-Spanish) cause communication difficulties and distrust that affect the healthcare experience and the adherence to available health services.

The types of healthcare services that migrants underutilize in LAC are diverse. For example, Albornoz-Arias et al.[45] identified the main difficulties of migrant and refugee women from Venezuela to access, in times of COVID-19, essential health services, medical diagnosis, treatments for cancer and non-communicable diseases, emergency obstetric care, and care for newborns. Many mechanisms might be involved in producing and reproducing such barriers; some may come from the individual, others from the health system, and others from previous interactions between the two parties. A study on the discourses of health professionals (doctors and nurses) from Costa Rica about prenatal care and childbirth to Nicaraguan migrant women also informs about exclusion mechanisms for maternal healthcare.[47] Authors indicated that pregnant migrant women navigate between health institutions, bureaucracies, and different values and prejudices that emerge from society and healthcare workers, facing moral regimes and new forms of exclusion.

Additionally, there is literature in LAC on culturally relevant, pertinent, or sensible healthcare (also framed as intercultural health), which observes explicitly the cultural, labour, and gender intersectionality that crosses the life and health trajectories of migrants in this region. For example, a study of Bolivian migrant women in Argentina recognised the need to foster intercultural dialogue with them to reduce barriers to health care.[84] This is particularly relevant because migrant women respond to cultural patterns of origin that must be accurately understood to provide appropriate medical care, including preventive medicine. Following this idea, a study carried out by Biondini in 2020[46] reported that Peruvian migrant women in Argentina make strategic use of public and private health services and institutions, depending on the urgency, working conditions, and economic capacity at the time, as well as based on their understanding of the local healthcare system.

In all, gender, class, nationality, and ethnicity are parts of a complex system of intersectional inequalities that produce distinctive barriers to care among migrant populations in LAC and other regions. These barriers include legal impediments, administrative blockages, waiting times, power relations, language, lack of information, and fear of deportation. In addition, the health professional-patient relationship can impede access to quality care due to the discriminatory behaviour some health professionals may show against migrants. In many ways, barriers to health services are what we can see as gaps in care between migrants and locals in the region. However, they might be explained mainly by more structural, regional, historical, and systematic differences in the implementation of countries' visions around human rights, mobility, ethnic diversity, and power. These current theoretical de-colonization gender perspectives are highly relevant to understanding how health policies might not only ignore the primary roots of unjust differences in the health of migrants compared to locals in LAC but also ignore how they replicate them.[85] As stated by Rao et al., in 2019, health

systems reflect and reinforce gender inequalities and restrictive gender norms in healthcare delivery and the division of labour among the health workforce globally.[3]

6. Emerging patterns of health and healthcare among men

There is less prominent, yet relevant literature on the health of migrant men in LAC. In terms of occupational risks, a specific analysis of occupational accidents among males is observed, especially in the cases of male migrant workers who are hired (formally or informally) to work moving heavy loads or in jobs that require high physical strength and therefore result in the deterioration of their physical health.[86] Migrant men must often accept jobs requiring greater physical wear and tear and even precarious conditions. These include living in workplaces to respond to long working hours, resulting in the spreading of infectious diseases,[87] or working in agricultural activities far from their families.[88] In this sense, it is suggested that health systems should monitor the differentiated health needs of migrant men and women, hence adding gender lenses to healthcare provision and including the health needs of men.[24]

Men seek less health care than women, only seeking medical attention if they suffer an accident or face a severe health problem. Men do not seek medical care mainly for three reasons: the little importance they give to health issues, not stopping work, and the expensive costs of medicine.[89] We found that Venezuelan male migrants in Peru[71] and Haitian migrants in Brazil[86] underutilize healthcare services. In Chile, the literature indicates that male migrants perceive more problems accessing health care than women.[90] Additionally, a study with Cuban, Central and South American adult men in the USA examined how cultural stressors coupled with traditional Latino male gender norms (machismo -strong or aggressive masculine pride- and caballerismo -masculine gentleness-) influence the severity of alcohol use. This study found that higher levels of machismo strengthened the association with cultural stress and higher risks of alcoholism, accidents and HIV/AIDS.[91] Finally, limited evidence is available around GVB directed towards men in LAC, which can take the form of sexual violence and forced incorporation into criminal groups or trafficking for sexual or labour exploitation.[92]

Multiple progressive masculinities among migrant men could emerge in LAC. As shown by limited evidence in the region, increased awareness of gender inequities in men facilitates the emergence of values (respect and responsibility) and behaviour (thoughtful action) that increase their critical thinking and agency at individual, social, and political levels.[93] As seen through the lens of Homan's concept of structural sexism that mirrors contemporary theories of gender as a multilevel social system, migrants face systematic gender inequalities at the macro level (societal/state), meso level (marital dyad), and micro level (individual). All these dimensions influence how migrant men, for example, relate to their body, their health and disease processes and the use of healthcare services. Furthermore, the emerging literature on structural intersectionality focusing on structural sexism and structural racism could also inform novel, distinctive perspectives on migrant men's health in the region.[94] Multiple gender approaches exist for gender-focused research and action around migrant men's health in LAC.

7. *Emerging patterns of health and healthcare among* LGBTIQA+

Regarding gender diversity and sexual orientation, few studies were identified, highlighting little research on migrants belonging to the migrant LGBTIQA + community in LAC. However, it is recognised that gender and sexual orientation can shape the migratory experience and that LGBTIQA + migrants have been historically discriminated against and excluded. In addition, they have suffered specific violence throughout their lives, which often increases during migration.[95,96] In LAC, studies have been carried out on the mental health of LGBTIQA + displaced people,[97] the rights of these migrant communities,[95] social and health-related experiences of LGBTIQA + refugees and migrants,[98,99] the situation of trans people in migratory transit,[96,100] and the impact of the COVID-19 pandemic on LGBTIQA + asylum seekers.[101]

Despite the existence of international legal bodies that aim to protect the LGBTIQA + community, LGBTIQA + migrants denounce a series of violence and barriers to accessing their rights, including the right to life, identity, and health.[95,96,99,100] They face violence in multiple spheres, including institutional, health, and public security scenarios. They are exposed to risks differently, according to their gender expression and depending on the stage of the migration cycle. In that sense, LGBTIQA + people may migrate because of GVB, to which they are more exposed than heterosexual and cisgender people.[18] In transit, lesbian, bisexual, and trans women are more exposed to harassment, sexual violence, and human trafficking than gay, bisexual, and trans men.[95] It has also been reported that LAC is the region with the most homophobic and transphobic crimes that remain unpunished. Being trans in the region represents a danger of experiencing sexual violence sometimes resulting in death. Thus, members of the LGBTIQA + community may migrate to protect themselves from hostile realities and degrading treatment. Nevertheless, they walk with latent feelings of insecurity and fear of being attacked.[96]

A pull factor for those who suffer discrimination in their countries of origin due to their gender identity

and sexual orientation is the recognition of the rights of LGBTIQA+. Argentina is a country that attracts migrants, given the rights that the LGBTIQA + movement has secured, such as the laws guaranteeing equal marriage, gender identity, and comprehensive health care for trans people.[102] Some authors in LAC even use the term "sexile" to discuss forced migration based on gender, sexual orientation, gender identification, or gender expression.[95,99] Sexile occurs for several reasons, including the lack of implementation of policies with a differential health approach towards LGBTIQA + people, the lack of attention to HIV and the prejudice for carrying the virus, the unguaranteed access to medication for sexually transmitted infections and chronic diseases, the increase in deaths, and the feeling of expulsion.[95] In addition, trans people usually experience transphobia from their family, society, and institutions, violation of their rights, limited job opportunities and precariousness, leading them to sex work as a survival strategy.[96] LGBTIQA + migrant people also face prejudice in destination countries as they are seen as responsible for spreading HIV[95] and COVID-19.[101] Consequently, the LGBTIQA + migrant population in the region tend to live in secrecy and isolation[96,101] for fear of being discriminated against or abused. Dealing with loneliness and social rejection usually brings mental health conditions such as anxiety, depression, and suicidal thoughts.[96,98,100]

Additionally, LGTBIQA + migrants in LAC face barriers to accessing health services such as medicine for chronic patients, antiretroviral treatments for people living with HIV/AIDS, financing for treatments or hormonal therapies, and lack of physical and psychological care for sexual abuse survivors. Furthermore, mental health disorders and STDs, including HIV/AIDS, have been documented in LGBTIQA + migrants, as well as interruption of their hormonal process or treatment, difficulty in accessing medications, lack of trained medical supervision, and a poor quality of care for people with surgical modifications.[96] Therefore, studying the mobility of LGBTIQA + people is critical to achieving an inclusive and accurate understanding of gendered global migration. Evidence-based recommendations to improve the situation of LGBTIQA + migrants and refugees appear in Box 2 and include training health professionals and conducting more research around gender perspectives of migrants' health in the region, as well as generating and adapting health policies towards practical gender-transformative approaches to the health of mobile populations in LAC.

Discussion

Latin America and the Caribbean is a cultural concept for a subregion in the Americas where languages derived from Latin are predominantly spoken. The region covers an area that stretches from Mexico to Tierra del Fuego and includes much of the Caribbean. It encompasses twenty countries and seven territories with great bio and sociocultural diversity, including multiple indigenous communities with their own cosmovision and languages. The region is also characterised by deep inequalities between and within countries regarding rurality, economic and human development, indigenous

Box 2.

Evidence-based proposals to improve the situation of LGBTIQA + migrants and refugees in LAC.

- Carry out more gender-focused studies on LGBTIQA + migration, specifically on trans people, to find out their needs and expectations, guarantee their rights, and provide them with services, protection and assistance differentiated by gender identity from human rights and transformative gender approaches.
- Recognize, measure and take action on the exacerbated and differentiated violence experienced by LGBTIQA + migrants,[95,99,100] recognizing hate crimes as a valid reason to grant political asylum,[100] and including all types of gender-based violence (GBV) as a cause of refuge.
- Mental health providers can help document and prevent the psychological impact of persecution experienced by LGBTIQA + people to ensure refugee status with the explicit inclusion of gender-informed and gender-transformative approaches.[97]
- Psychosocial support and support systems for LGBTIQA + migrants and refugees, guaranteeing their access to health and other social rights using a formal gender perspective that addresses structural sexism, racism and intersectionality.[99,100]
- Avoid re-victimizing LGBTIQA + asylum seekers during transit, arrival, or settlement.
- Adjust regularization processes and gender identity health and social policies to provide gender-sensitive encounters and care, particularly from public institutions.
- Create regulatory frameworks to protect transgender migrant children and adolescents.
- Raise awareness that migrants are not a threat to recipient countries and promote gender-inclusive societies that help eliminate social prejudices, violence, and homophobia.
- Train civil servants and migration officials on gender perspectives and intersectionality approaches, including adequate training against discrimination and stigmatization to care for LGBTIQA + people adequately.
- Make alliances between the government and non-profit organizations, civil society, and shelters to provide gender-transformative, dignified, and respectful spaces for migrants.
- Thematize sexuality and queer studies, such as asylum applications due to sexual orientation, emigration caused by homophobia and transphobia, heteronormativity as an integral feature of migratory legislation, sex work and HIV-AIDS, the migratory experience of LGBTIQA + populations,[102] how COVID-19 impacts these populations, and others.[101]

communities' recognition and protection, demographic and epidemiological profiles, and types of health systems. Human mobility is an ancestral part of the region's dynamic, and current migration flows largely follow the south–south migration pattern, in which most international migrants come from other countries within LAC.[103] More recently, a political and social crisis pushed millions of Venezuelans out of their country, and today, seven million Venezuelans are living abroad. The exodus of Venezuelans is considered the largest in Latin America in the last 50 years, and some consider it a humanitarian emergency.[104,105]

This health policy review discussed existing scientific and grey literature around migrant and refugee health in the LAC region from gender perspectives. This analysis identified seven major areas of published research from scientific and grey literature evidence. There most prominent areas of evidence were related to gender-based violence, sexual and reproductive health, sexually transmitted diseases, mental health, barriers to healthcare services, and emerging patterns of health and healthcare among men and LGBTIQA+. Evidence related to these themes was presented and discussed using different gender perspectives available from contemporary theories, including intersectional approaches. Intersections between migration status and ethnicity, employment, living standards, and social integration are also discussed. These dimensions have a powerful impact on stigma and discrimination, human trafficking, violence and death among migrant women, men and LGBTIQA + migrants. Limitations of this scoping review are around language and date filters, yet we included additional grey literature to expand our analysis and synthesis of relevant evidence in the region. The need for more research and visibility of gender dimensions, including sexual orientation, when studying and reporting the health of migrants in LAC becomes evident, as well as a stronger, more theory-informed and more explicit connection between health policies and actions adopting gender perspectives.

From this review, we can synthesize some urgent challenges to integrate gender approaches in the protection of the health of migrants in LAC like: (i) facilitating the formal enrolment in the health system in transit and destination countries regardless of migratory status, (ii) guaranteeing equal access to health care, regardless of migratory status, gender, ethnic origin, social class, religion, or age (iii) providing culturally and linguistically relevant information and services, (iv) providing access to health services relevant to them, including culturally appropriate and gender-responsive mental health care, as well as adequate care for LGBTIQA + migrants, (v) training health professionals on contemporary gender approaches including structural and intersectional perspectives, (vi) revising and adapting health policies in terms of their explicit recognition of gender approaches and related meaningful strategies and actions for the health of migrants in the region, (vii) conducting more research in the subject of gender related to the health of migrants in LAC. In all, more research and policy action are urgently required to achieve health for all migrants in LAC effectively.

Contributors

BC—writing (original draft), review, editing.
BV—bibliographic review, editing.
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Declaration of interests

We declare no competing interests.

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Appendix A. Supplementary data

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References

1 Lindqvist A, Sendén MG, Renström EA. What is gender, anyway: a review of the options for operationalising gender. *Psychol Sex*. 2021;12:332–344.
2 Pastrana NA, Somerville C, Suggs LS. Integrating gender into social marketing programmes. *J Market Manag*. 2022. https://doi.org/10.1080/0267257X.2022.2071964.
3 Gupta GR, Oomman N, Grown C, et al. Gender equality and gender norms: framing the opportunities for health. *Lancet*. 2019;393:2550–2562.
4 Heise L, Greene ME, Opper N, et al. Gender inequality and restrictive gender norms: framing the challenges to health. *Lancet*. 2019;393:2440–2454.
5 Pederson A, Greaves L, Poole N. Gender-transformative health promotion for women: a framework for action. *Health Promot Int*. 2015;30:140–150.
6 Tecco H, Cheek J. *Women's health is more than female anatomy and our reproductive system- it's about unraveling centuries of inequities due to living in a patriarchal healthcare system*. Harvard Business School Health Supplement; 2022. published online Jan 18. https://www.hbs.edu/healthcare/blog/post/defining-womens-health-womens-health-is-more-than-female-anatomy-and-our-reproductive-systemits-about-unraveling-centuries-of-inequities-due-to-living-in-a-patriarchal-healthcare-system. Accessed December 20, 2022.
7 Lefkowich M, Richardson N, Robertson S. "If we want to get men in, then we need to ask men what they want": pathways to effective health programing for men. *Am J Mens Health*. 2017;11:1512–1524.
8 Position Statement. *Recognising and addressing the mental health needs of the LGBTIQ+ population*. The Royal Australian and New Zealand College of Psychiatrists; 2021. published online Aug. https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/mental-health-needs-lgbtiq. Accessed December 20, 2022.
9 Crenshaw K. *Demarginalizing the intersection of race and sex: a black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics*. University of Chicago Legal Forum; 1989;1989:139–167.
10 McCall L. The complexity of intersectionality. *Signs*. 2005;30:1771–1800.
11 Collins PH. Intersectionality's definitional dilemmas. *Annu Rev Sociol*. 2015;41:1–20.

12 Yuval-Davis N. Intersectionality and feminist politics. *Eur J Womens Stud*. 2006;13:193–209.
13 Cole ER. Intersectionality and research in psychology. *Am Psychol*. 2009;64:170–180.
14 Vigoya MV. La interseccionalidad: una aproximación situada a la dominación. *Debate Fem*. 2016;52. https://doi.org/10.1016/j.df.2016.09.005.
15 Curiel O. Crítica poscolonial desde las prácticas políticas del feminismo antirracista (en Nómadas, 2007). In: *Mujeres intelectuales*. CLACSO; 2017:149–164.
16 Pinto Baleisan C, Cisternas Collao N. Reflexiones sobre el uso de la interseccionalidad en los estudios migratorios en Chile. *Revista Punto Género*. 2020;14:49–70.
17 Kastoryano R. Être Turc en France et en Allemagne. *Cah Mediterr Orient Monde Turco Iran*. 1992;13:5–17.
18 Said EW. *Orientalism*. Knopf Doubleday Publishing Group; 2014.
19 Bois WEBD. *W. E. B. Du Bois: selections from his writings*. Courier Corporation; 2013.
20 Fanon F. *Black skin, white masks*. Grove Press; 2008.
21 Fernández-Sánchez H. Transnational migration and Mexican women who remain behind: an intersectional approach. *PLoS One*. 2020;15:e0238525.
22 Viruell-Fuentes EA, Miranda PY, Abdulrahim S. More than culture: structural racism, intersectionality theory, and immigrant health. *Soc Sci Med*. 2012;75:2099–2106.
23 Gadson A, Akpovi E, Mehta PK. Exploring the social determinants of racial/ethnic disparities in prenatal care utilization and maternal outcome. *Semin Perinatol*. 2017;41:308–317.
24 Llácer A, Zunzunegui MV, del Amo J, Mazarrasa L, Bolůmar F. The contribution of a gender perspective to the understanding of migrants' health. *J Epidemiol Community Health*. 2007;61:ii4–10.
25 Hennebry J, Hari K, Piper N. Not without them: realising the sustainable development goals for women migrant workers. *J Ethn Migr Stud*. 2019;45:2621–2637.
26 Villares-Varela M. Negotiating class, femininity and career: Latin American migrant women entrepreneurs in Spain. *Int Migr*. 2018;56:109–124.
27 Tricco AC, Lillie E, Zarin W, et al. A scoping review on the conduct and reporting of scoping reviews. *BMC Med Res Methodol*. 2016;16:15.
28 UNHCR. Gender-based violence. UNHCR. https://www.unhcr.org/gender-based-violence.html. Accessed December 7, 2022.
29 Cambronero MPL. Mujeres migrantes centroamericanas y el reto de la violencia de género. *Estudios*. 2021;42:669–692.
30 Bahamondes L, Laporte M, Margatho D, et al. Maternal health among Venezuelan women migrants at the border of Brazil. *BMC Public Health*. 2020;20:1771.
31 Giraldo V, Sobczyk R, Fernández-Niño JA, Rojas-Botero ML, Bojorquez I. Prenatal care of Venezuelans in Colombia: migrants navigating the healthcare system. *Rev Saude Publica*. 2021;55:49.
32 Leighton CS, Báez CL, Maldonado NG, Carimoney AÁ. Barreras interaccionales en la atención materno-infantil a inmigrantes peruanas. *Revista Sociedad y Equidad*. 2014. https://doi.org/10.5354/rse.v0i6.27213. published online Jan 1.
33 Rangel Sandoval MP, Cruz-Manjarrez García A. "La verdad no me gustaría regresar a ese lugar de donde salí, muchos malos recuerdos, muchas cosas feas". Violencia de género y migración forzada en personas homosexuales de Centroamérica a México. *GénEroos Revista de investigación y divulgación sobre los estudios de género*. 2020;27:9–32.
34 Willers S. Migración y violencia: las experiencias de mujeres migrantes centroamericanas en tránsito por México. *Sociologica*. 2016;31:163–195.
35 Posada-Zapata IC, Orozco-Giraldo IC, Mendoza-Rios A, Restrepo-Correa C, Cano-Bedoya SM. Perception of health/illness associated with gender roles displaced women located in Medellín, Colombia, 2013-2014. *Cad Saude Publica*. 2019;35. https://doi.org/10.1590/0102-311X00088618.
36 Asakura H. Articulando la violencia y las emociones: las experiencias de las mujeres migrantes centroamericanas residentes en Houston, Texas. *Sociologica*. 2016;31:197–228.
37 SICA. *Factores de Riesgo y Necesidades de Atención para las Mujeres Migrantes en Centroamérica, Estudio de actualización sobre la situación de la violencia contra las mujeres migrantes en la ruta migratoria en Centroamérica*. El Salvador: SICA; 2016.
38 Romero M. Experiencias de violencia de género en mujeres migrantes bolivianas residentes en Tarapacá, Chile. *Estud Front*. 2022;23. https://doi.org/10.21670/ref.2201085.
39 Chiarotti S. *La trata de mujeres: sus conexiones y desconexiones con la migración y los derechos humanos*. Santiago de Chile: BID-NU. CEPAL. CELADE; 2003.
40 Izcara Palacios SP, Moral de la Rubia J, Andrade Rubio KL, Izcara Palacios SP, Moral de la Rubia J, Andrade Rubio KL. Mujeres migrantes víctimas de esclavitud sexual, prostitución involuntaria y prostitución no forzada. *Papeles Población*. 2019;25:145–173.
41 Granada I, Ortiz P, Muñoz F, Saldarriaga Jiménez A, Pombo C, Tamayo L. *La migración desde una perspectiva de género: ideas operativas para su integración en proyectos de desarrollo*. Washington, DC: Inter-American Development Bank; 2021.
42 Palacios Valencia Y. Perspectiva de género en los fenómenos migratorios. *Revista CES Derecho*. 2016;7:145–162.
43 Mesa Melgarejo L, Espinel M. *Condiciones socio-sanitarias de las mujeres migrantes en situación de prostitución en el espacio fronterizo de Colombia-Venezuela*. Buenos Aires: IDEP Salud.FLACSO República Dominicana; 2020.
44 Mattar M. *Trata de personas, en especial mujeres y niños en los países de América. Un informe regional sobre el alcance del problema y la respuesta gubernamental y no gubernamental*. Santiago de Chile: CEPAL; 2003.
45 Albornoz-Arias N, Mazuera-Arias R, Ramírez-Martínez C, Carreño-Paredes M-T, Morffe Peraza MÁ. *Derechos sexuales y reproductivos en mujeres migrantes venezolanas en tiempos de COVID-19. Desafíos para su implementación*. San Cristóbal, Venezuela: Observatorio de Investigaciones Sociales en Frontera (ODISEF); 2021.
46 Biondini V. Entre barreras y estrategias: experiencias de acceso a servicios de salud pública de mujeres migrantes peruanas. *Pacha Revista de Estudios Contemporáneos del Sur Global*. 2020;1:56–67.
47 Spesny Dos Santos SL. Undeserving mothers? Shifting rationalities in the maternal healthcare of undocumented Nicaraguan migrants in Costa Rica. *Anthropol Med*. 2015;22:191–201.
48 Fernández-Niño JA, Cubillos A, Bojórquez I, Rodríguez M. Recommendations for the response against COVID-19 in migratory contexts under a closed border: the case of ColombiaRecommendations for the response against COVID-19 in migratory contexts under a closed border: the case of Colombia. *Biomedica*. 2020;40. https://doi.org/10.7705/biomedica.5512.
49 Aizenberg L, Rodríguez ML, Carbonetti A. Percepciones de los equipos de salud en torno a las mujeres migrantes bolivianas y peruanas en la ciudad de Córdoba. *Migr Int*. 2015;8:65–94.
50 Flórez-García VA, Gartner VG, Chapela IB, et al. Utilización de anticonceptivos en población migrante: el caso de las gestantes migrantes venezolanas en dos ciudades receptoras de la costa norte de Colombia. *Rev Fac Nac Salud Publica*. 2020;38:1–10.
51 López-Severino I, de Moya A. Migratory routes from Haiti to the Dominican Republic: implications for the epidemic and the human rights of people living with HIV/AIDS. *Int J Psychol*. 2007;41:7–16.
52 Infante Xibile C, Leyva Flores R, Caballero M, Guerrero C, Cuadra SM, Bronfman M. VIH/SIDA y rechazo a migrantes en contextos fronterizos. *Migración y Desarrollo*. 2004;3:45–53.
53 Cabieses B, Sepúlveda C, Obach A. Prevention of vertical transmission of HIV in international migrant women: current scenario and challenges. *Rev Chil Pediatr*. 2020;91:672–683.
54 Hernández A, Ales F, Gómez S. VIH y migración en El Salvador: apuntes desde la salud internacional. In: *VIH, migraciones y derechos humanos: perspectivas internacionales*. Buenos Aires: CLACSO; 2019. http://www.sidastudi.org/es/registro/a53b7fb37256b87c01737b13e77703ed. Accessed December 7, 2022.
55 Rivera Díaz M, Álamo N, Rapale M. Fronteras de salud y derechos humanos: mujeres inmigrantes viviendo con VIH en Puerto Rico. In: *VIH, migraciones y derechos humanos: perspectivas internacionales*. Buenos Aires: CLACSO; 2019:77.
56 Ariza-Abril JS, Rivillas-García JC, Cifuentes ÁM, Calderón-Jaramillo M, Rivera D. Uso de servicios de salud y enfermedades transmisibles de la población migrante y refugiada venezolana. *Salud UIS*. 2020;52:392–401.
57 Cabieses B, Libuy M, Dabanch J. *Hacia una comprensión integral de la relación entre migración internacional y enfermedades infecciosas. De la creencia a la evidencia para la acción sanitaria en Chile*. Santiago, Chile: Universidad del Desarrollo. Sociedad Chilena de Infectología y Colegio Médico de Chile; 2019. http://hdl.handle.net/11447/2813.
58 Díaz F, Erazo J, Sandoval C. Actuales políticas públicas para la desinstitucionalización y rehabilitación de personas psicóticas en Chile. Experiencia de la comunidad terapéutica de Peñalolén. *Revista de Psicología*. 2008;17:ág. 9–37.

59 Urzúa MA, Heredia BO, Caqueo-Urízar A. Salud mental y estrés por aculturación en inmigrantes sudamericanos en el norte de Chile. *Rev Med Chile*. 2016;144:563–570.
60 Carreño A, Blukacz A, Cabieses B, Jazanovich D. "Nadie está preparado para escuchar lo que vi": atención de salud mental de refugiados y solicitantes de asilo en Chile. *Salud Colect*. 2020;16:e3035.
61 Blukacz A, Cabieses B, Obach A, et al. "If I get sick here, I will never see my children again": the mental health of international migrants during the COVID-19 pandemic in Chile. *PLoS One*. 2022;17:e0277517.
62 Mendoza W, Miranda JJ. La inmigración venezolana en el Perú: desafíos y oportunidades desde la perspectiva de la salud. *Rev Peru Med Exp Salud Pública*. 2019;36:497–503.
63 Aizenberg L, Maure G. Migración, salud y género: abordajes de proveedores de salud en la atención de mujeres migrantes bolivianas en la provincia de Mendoza, Argentina. *Rev Interdiscip Mobil Hum*. 2017;25:149–164.
64 Lara Flores SM. Violencia y contrapoder: una ventana al mundo de las mujeres indígenas migrantes, en México. *Rev Estud Fem*. 2003;11:381–397.
65 Baeza B. La memoria migrante y la escucha de los silencios en la experiencia del parto en mujeres migrantes bolivianas en Comodoro Rivadavia (Chubut, Argentina). *Anuario Americanista Europeo*. 2013;11:11.
66 Cantore A, Bertoni MB. Mujeres indígenas mbyá-Guaraní y migrantes bolivianas en Argentina: comparaciones etnográficas sobre sus partos y atenciones sanitarias. *Antropol Exp*. 2021;21:469–484.
67 Ulloa A, Escobar M, Donato LM, Escobar P. *Mujeres indígenas y cambio climático. Perspectivas latinoamericanas*. Bogotá, Colombia: UNAL-Fundación Natura de Colombia-UNODC; 2008.
68 Pratt B, de Vries J. Where is knowledge from the global South? An account of epistemic justice for a global bioethics. *J Med Ethics*. 2023;49:325. medethics-2022-108291.
69 Blukacz A, Cabieses B, Markkula N. Inequities in mental health and mental healthcare between international immigrants and locals in Chile: a narrative review. *Int J Equity Health*. 2020;19:197.
70 Cabieses B, Oyarte M, Pedrero V, Markkula N, Flaño J. Problems of Access to health care in Chile: comparative analysis between international migrants and local population. *Medwave*. 2016;16:e6777.
71 Hernández-Vásquez A, Vargas-Fernández R, Rojas-Roque C, Bendezu-Quispe G. Factores asociados a la no utilización de servicios de salud en inmigrantes venezolanos en Perú. *Rev Peru Med Exp Salud Publica*. 2019;36:583–591.
72 García YEL, Ghys T. Barriers to access healthcare for Middle American Migrants during transit in Mexico. *Política, Globalidad Ciudadanía*. 2021;7:182–204.
73 Bojorquez-Chapela I, Flórez-García V, Calderón-Villarreal A, Fernández-Niño JA. Health policies for international migrants: a comparison between Mexico and Colombia. *Health Policy OPEN*. 2020;1:100003.
74 Arrieta JDR. Banca, salud y estímulo del empleo: servicios públicos desde la óptica de los refugiados y solicitantes en Costa Rica. *Rev de Cienc Soc*. 2017;155:111–129.
75 Fouratt CE, Voorend K. Esquivando al Estado. Prácticas privadas en el uso de los servicios de salud entre inmigrantes nicaragüenses en Costa Rica. *Anu Estud Centroam*. 2019;45:373–403.
76 Quesada L, Larrea-Schiavon S, Marin T, et al. *Mujeres migrantes en Tapachula: barreras y facilitadores para el acceso a la salud sexual y reproductiva en 2020—informe de la investigación*. Mexico: Centro Nacional de Equidad de Género y Salud Reproductiva, Ipas CAM, Médicos del Mundo, y Population Council; 2021.
77 Linardelli MF, Anzorena C. Cuidar, gestionar, esperar. Estrategias de mujeres migrantes ante contextos restrictivos de acceso a la atención sanitaria. *Jangwa Pana*. 2021;20:206–224.
78 Leal-Jofré E, Alonso-Karle M, Espinoza-Fabri F, et al. Salud sexual y reproductiva en mujeres migrantes latinoamericanas: una revisión narrativa. *MUSAS Revista de Investigación en Mujer, Salud y Sociedad*. 2022;7:104–126.
79 Irons R. Percepción de mujeres venezolanas sobre los servicios de salud sexual y reproductiva en Lima, Perú. *Rev Peru Med Exp Salud Publica*. 2021;38:248–253.
80 Buzzi P, Sy A. Itinerarios terapéuticos de mujeres migrantes de origen boliviano en la ciudad de Buenos Aires. *Anthropologica*. 2020;38:187–208.
81 Blukacz A, Carreño Calderon A, Obach A, Cabieses B, Peroncini J, Oliva A. Perceptions of health needs among Venezuelan women crossing the border in Northern Chile during the COVID-19 pandemic. *Int J Environ Res Public Health*. 2022;19:15175.
82 Bernhard S, Bernhard S. Gender differences in second language proficiency—evidence from recent humanitarian migrants in Germany. *J Refug Stud*. 2022;35:282–309.
83 Carreño A, Cabieses B, Obach A, Gálvez P, Correa ME. Maternidad y salud mental de mujeres haitianas migrantes en Santiago de Chile: un estudio cualitativo. *Castalia - Revista de Psicología de la Academia*. 2022;1:79–97.
84 Linardelli MF. Among the farm, the factory, and home: productive and reproductive work of female migrant farmworkers in Mendoza (Argentina) and its impact in the health-disease process. *Salud Colect*. 2018;14:757–777.
85 Lutz H, Amelina A. Gender in migration studies: from feminist legacies to intersectional, post- and decolonial prospects. *Zeitschrift für Migrationsforschung*. 2021;1:55–73.
86 Leão LHDC, Muraro AP, Borges FT, et al. La salud de trabajadores inmigrantes haitianos en Mato Grosso, Brasil: vulnerabilidades y riesgos. *Salud Colect*. 2018;14:779–795.
87 Goldberg A. Contextos de vulnerabilidad social y situaciones de riesgo para la salud: tuberculosis en inmigrantes bolivianos que trabajan y viven en talleres textiles clandestinos de Buenos Aires. *Cuad Antropol Soc*. 2014;39:91–114.
88 Ro A, Goldberg RE. Post-migration employment changes and health: a dyadic spousal analysis. *Soc Sci Med*. 2017;191:202–211.
89 Marco Conca L. Barreras en el acceso a la salud de los hombres y mujeres migrantes en situación irregular que viven en Panamá. *Societas Rev Soc Humanist Panamá*. 2015;17:75–93.
90 Yáñez S, Cárdenas Castro M. Estrategias de Aculturación, Indicadores de Salud Mental y Bienestar Psicológico en un grupo de inmigrantes sudamericanos en Chile. *Salud Sociedad*. 2010;1:51–70.
91 Balagopal G, Davidson S, Gill S, Barengo N, De La Rosa M, Sanchez M. The impact of cultural stress and gender norms on alcohol use severity among Latino immigrant men. *Ethn Health*. 2022;27:1271–1289.
92 Chynoweth SK, Freccero J, Touquet H. Sexual violence against men and boys in conflict and forced displacement: implications for the health sector. *Reprod Health Matters*. 2017;25:90–94.
93 Torres VMS, Goicolea I, Edin K, Ohman A. 'Expanding your mind': the process of constructing gender-equitable masculinities in young Nicaraguan men participating in reproductive health or gender training programs. *Glob Health Action*. 2012;5. https://doi.org/10.3402/gha.v5i0.17262.
94 Homan P, Brown TH, King B. Structural intersectionality as a new direction for health disparities research. *J Health Soc Behav*. 2021;62:350–370.
95 Bula Beleño AA, Cuello Santana VF, Bula Beleño AA, Cuello Santana VF. Sujetos en tránsito y sexualidades fronterizas. Derechos de migrantes venezolanos LGBT en el Caribe colombiano. *Trab Soc*. 2019;21:169–195.
96 Gutiérrez Albertos VH. La 72 como espacio intercultural de emancipación y resistencia trans en la frontera sur de México. *Península*. 2017;12:69–94.
97 Shidlo A, Ahola J. *Los retos relacionados con la salud mental de los migrantes forzados LGBT*; 2013. published online May. http://rua.ua.es/dspace/handle/10045/28642. Accessed December 7, 2022.
98 Corporación Caribe Afirmativo. *Sentir que se nos va la vida: personas LGBTI+ refugiadas y migrantes de Venezuela en Colombia, Ecuador y Chile*. Barranquilla, Colombia: Sentir que se nos va la vida. Personas LGBTI+ refugiadas y migrantes de Venezuela en Colombia, Ecuador y Chile; 2020.
99 Galaz C, Menares R. Migrantes/refugiadas trans en Chile: sexilio, transfobia y solidaridad política. *Nómadas*. 2021;54:205–221.
100 Cano-Collado LA, Priego-Alvarez HR. El oscuro panorama en la migración de las personas trans: ¿Qué hacer para mejorar la situación en México? *Salud Tabasco*. 2020;26:126–130.
101 Cowper-Smith Y, Su Y, Valiquette T. Masks are for sissies: the story of LGBTQI+ asylum seekers in Brazil during COVID-19. *J Gend Stud*. 2022;31:755–769.
102 Stang F. *Aflojando el corsé. Los estudios sobre migraciones internacionales y géneros en la Argentina*. Santiago de Chile; 2013.
103 IDB. *Migration flows in Latin America and the Caribbean*. Washington DC: IDB, OECD; 2021.

104 Cabieses B, Darrigrandi F, Blukacz A, Obach A, Silva C. Migrantes venezolanos frente a la pandemia de COVID-19 en Chile: factores asociados a la percepción de sentirse preparado para enfrentarla. *Notas Poblacion*. 2020;111:43–62.

105 United Nations High Commissioner for Refugees. *Joint declaration of the vi international technical meeting on human mobility of venezuelan citizen in the region*. Geneva, Switzerland: United Nations High Commissioner for Refugees; 2018.