Sexual and Reproductive Health of In-Transit Migrant Women in Mexico: A Closer Look at the Role of Migrant Shelters

Larrea-Schiavon Silvana[1], Guendelman Sylvia[1], Graham Jay[1], Auerswald Colette[1], Infante César[2]

[1] School of Public Health, University of California, Berkeley, United States

[2] Health Systems Research Center, National Institute of Public Health, Mexico

Please address all correspondence to:

Silvana Larrea-Schiavon, MD, MPH, DrPH

University of California, Berkeley

School of Public Health

2121 Berkeley Way

Berkeley, CA 94704

silvana.larrea@berkeley.edu

NOTE: This manuscript is a preliminary draft intended for submission to a peer-reviewed journal. We kindly ask that you consider this context when reviewing the content, as some sections may still be under development or refinement.

ABSTRACT

Background: In response to increased in-transit migration, the number of migrant shelters in Mexico has grown. These shelters provide food, water, temporary lodging, basic hygiene, and primary care. However, many are affiliated with religious organizations that may not support the full spectrum of sexual and reproductive health and rights (SRHR), particularly for women at heightened risk of gender-based violence. This study examines the role of migrant shelters in meeting the SRHR needs of undocumented in-transit migrant women (UITMW) and identifies barriers to accessing SRH services for women staying in these shelters.

Methods: From August to November 2023, we conducted 31 in-depth interviews with 36 service providers, migration experts, and federal and local decision-makers in Ciudad Juárez, Chihuahua City, and Mexico City. We used the Guttmacher-Lancet Commission's comprehensive SRHR framework to assess which rights are upheld or restricted in shelters. We also applied Levesque et al.'s patient-centered access to healthcare framework to identify barriers preventing effective access to SRH services.

Results: Participants recognized migrant shelters as essential access points for healthcare for UITMW. However, the religious affiliation of many shelters and the personal beliefs of staff often limit access to key SRH services. While some services—such as menstrual hygiene management, cervical and breast cancer screening, prenatal care, and STI treatment—are generally available, access to contraception (including emergency contraception), abortion care, gender-affirming care, and support for survivors of sexual and gender-based violence is significantly limited or explicitly denied.

Conclusions: Although migrant shelters play a critical role in addressing UITMW's needs, their religious affiliations can restrict access to comprehensive SRH services. In the absence of stronger government oversight and coordination, public health institutions lack the mechanisms to ensure that shelters uphold SRHR for migrant women.

Key words: In-transit migration, Sexual and reproductive health and rights, Migrant shelters, Access to healthcare, Mexico

Background

Since 2010, in-transit migration through Mexico has steadily increased (1). In-transit migrants are individuals who spend an undefined period in a country while en route to a different final destination (2). Between 2011 and 2022, immigration authorities in Mexico recorded a seven-fold increase in detention events involving undocumented in-transit migrants, with 1,230,126 detentions reported in 2024 alone (1). Alongside this rise, the proportion of women and girls in transit has also grown—from 13% in 2011 to 31.3% in 2024 (1). Most are from Central and South America, though increasing numbers come from the Caribbean (e.g., Haiti) and African countries (1).

Due to increasingly restrictive U.S. immigration policies—particularly in 2025—two key trends have emerged: first, undocumented in-transit migrants are staying longer in Mexico. According to the National Survey of Migration, the percentage of migrants who remained in Mexico for over a month rose from 3.8% in 2009 to 31.6% in 2019 (3). Second, there has been a sharp increase in asylum applications in Mexico, from 2,137 in 2014 to 78,975 in 2024, with a peak of over 140,000 in 2023 (4).

These dynamics have led to the expansion of migrant shelters, non-governmental organizations (NGOs), and international agencies across Mexico, which have become key actors in responding to migrants' needs (5). Shelters typically provide food, water, sleeping quarters, and basic hygiene services. Many also support health needs by offering on-site providers and establishing referral protocols to public-sector clinics and hospitals, often in collaboration with NGOs, international agencies, and local health authorities.

Undocumented in-transit migrant women (UITMW) face especially precarious conditions. They experience a range of human rights violations, including arbitrary detention, extortion, and violence from both authorities and organized crime (6). Compared to men, they are more at risk of experiencing sexual violence and of being forced into survival sex to ensure access to food, shelter, and protection (7,8). These experiences directly affect their sexual and reproductive health and rights (SRHR), which the Guttmacher-Lancet Commission defines as the right of all individuals to make decisions about their bodies—free from stigma, discrimination, and coercion—including decisions about sexuality, reproduction, and access to SRH services (9). In this context, UITMW face numerous SRH needs (10,11) and are often unable to exercise their SRHR (12).

Most UITMW stay in migrant shelters during their journey. While shelters are key service providers, many are affiliated with religious congregations whose doctrines oppose comprehensive SRHR, including access to contraception, abortion, and LGBTQ+-inclusive care (13,14). Although Mexico has adopted policies guaranteeing healthcare access to all individuals regardless of migration status (15), structural barriers—such as restrictive

immigration policies, government corruption, and the presence of organized crime—continue to undermine SRH access for UITMW (8,10,12,14,16–20).

Given the central role of shelters in UITMW's daily lives, this study aims to describe how shelters shape access to SRH services and the protection of SRH-related rights for UITMW in Mexico, and to identify barriers faced by those staying in these spaces.

Methods

We conducted an applied qualitative study using semi-structured, in-depth interviews with key stakeholders involved in responding to the health needs of undocumented in-transit migrant women (UITMW). The objective was to understand how migrant shelters influence access to sexual and reproductive health (SRH) services and the exercise of sexual and reproductive health and rights (SRHR) among UITMW.

Study sites

The study was conducted in Ciudad Juárez, a border city in the state of Chihuahua with a longstanding migration history. Since 2018, the city has experienced a significant increase in undocumented in-transit migration. In 2022, two out of every ten undocumented migrants detained in the U.S. had crossed the border through the state of Chihuahua (21). This surge led to a rapid expansion of local support services, with the number of shelters increasing from two to over 30 between 2018 and 2023, alongside a growing presence of NGOs and international agencies. Additional interviews were conducted in Mexico City, where most federal decision-makers are based, and one in Chihuahua City, the state capital.

Participant selection and data collection

We used purposive sampling to recruit key informants with expertise in SRH and migration. The first author (SL) identified potential participants working in Ciudad Juárez, Chihuahua City, or at the federal level. Recruitment began in April 2023 through email invitations explaining the study's goals and the researcher's motivation. A snowball strategy was used to identify additional participants.

Between August and November 2023, SL conducted 31 interviews with 36 informants. Participants included representatives from federal, state, and municipal governments; public health services; shelters; NGOs; and international agencies. Only one invited participant, a federal decision-maker, declined to participate.

Interviews were conducted in Spanish, one-on-one, either via Zoom, by phone, or in person, according to participant preference. Interviews lasted approximately 90 minutes and were audio-recorded. After each interview, SL wrote a post-interview memo. Participants received compensation of $10 USD (~MXN 200) or a keychain of equivalent value. The interview guide covered topics such as SRH needs of UITMW, availability and access to services, barriers to care (individual, institutional, community, structural), and the role of government actors in SRH service provision.

In addition to conducting interviews, SL engaged in participant observation during a one-month stay at a migrant shelter, where she served as a medical volunteer. This experience included providing basic medical care, accompanying women to public health services, and observing day-to-day shelter operations. SL also visited several other shelters across Ciudad Juárez, including religious, secular, and government-run facilities. These immersive experiences offered valuable contextual insight into the diversity of shelter models and the structural and interpersonal dynamics that shape access to SRH services.

Analytic frameworks and data analysis

This study is part of a broader research project on SRH access for UITMW in Mexico. During coding, the prominent role of migrant shelters emerged across interviews, prompting a focused analysis on shelters.

We used the Guttmacher-Lancet Commission's definition of SRHR (9) —the most comprehensive to date—to map which SRH needs and rights were upheld, limited, or denied in shelters. To classify barriers faced by UITMW and shelter staff in accessing or providing SRH services, we applied Levesque et al.'s patient-centered access to healthcare framework, which conceptualizes access as a multi-step process beginning with perceived health needs and continuing through care-seeking, reaching, obtaining, and utilizing care (22). This framework has previously been applied to studies of undocumented migrants in Mexico (23).

We conducted a thematic analysis using a combined deductive-inductive coding approach (24). The initial codebook was based on the conceptual frameworks and interview guide, and was refined iteratively. SL and CI co-coded the first two transcripts; SL coded the remainder. SL, CI, and CA met regularly to discuss emerging themes and resolve coding questions. Data were managed and coded using MAXQDA (VERBI Software, Berlin, Germany) (25).

Preliminary findings were presented to participants during two validation workshops held in Ciudad Juárez in November 2023 and May 2024. Participants endorsed the results,

affirming that they reflected their experiences; no changes were made following this meeting.

Ethical considerations

This study was approved by the Ethics and Research Committees of the National Institute of Public Health in Mexico (Protocol #1861) and the University of California, Berkeley Committee for the Protection of Human Subjects (CPHS #2023-04-16299). Written informed consent was obtained from all participants. To protect confidentiality, participants are identified only by profession, sector, and city. No information is provided on gender, age, or specific institutional affiliation.

Results

Characteristics of interview participants

Participants were mostly women (77.8%), with a median age of 35 years (range: 25 to 62) and diverse professional backgrounds, including physicians, nurses, lawyers, psychologists, anthropologists, social workers, education specialists, sociologists, economists, and political scientists. Of the 31 interviews, 19 were conducted with service providers working in migrant shelters, NGOs, international agencies, and public-sector clinics and hospitals. The remaining interviews included four local decision-makers, four federal decision-makers, and four migration experts. Most participants were based in Ciudad Juárez at the time of the interviews (71.0%), followed by Mexico City (25.8%) and Chihuahua City (3.2%).

Migrant shelters as key facilitators of health services

All participants recognized migrant shelters as critical entry points to health services for undocumented in-transit migrant women (UITMW). As one NGO service provider explained:

> *"Now, I'll tell you another big difference: in shelters, you'll receive help from many sources—organizations, foundations, individuals—because there are local people who go to the shelters and bring things. And for those who are staying in the streets—well, who* [helps] *them?"* **Service provider, NGO, Ciudad Juárez**

Shelters support access to health services in several key ways. Some have on-site medical staff, and a few operate their own clinics or dispensaries. Staff often assist women in scheduling medical appointments and accompany them to public-sector clinics and hospitals. Participants perceived that these practices not only facilitate access but also help reduce denial of care and improve the quality of services received.

In addition, some shelters have established referral pathways for specific SRH needs—particularly for prenatal care, cancer screening and treatment, and sexually transmitted infections (STI) management. To support this work, shelters collaborate closely with NGOs, international agencies, and local health jurisdictions. These partnerships extend beyond clinical services to include educational and resource-based interventions tailored specifically to UITMW. As the director of an international agency in Ciudad Juárez shared:

> *"We have specific work with pregnant women, who may or may not be survivors of sexual violence. We have kits for pregnant women—for their prenatal period. So they're kits with personal hygiene products, but also multivitamins."* **Local director, International Agency, Ciudad Juárez**

These examples illustrate the proactive role shelters can play in addressing the SRH needs of migrant women, particularly when partnerships and referral systems are in place.

Uneven access to SRH services and rights: What is and isn't offered

Table 1 presents our findings using the Guttmacher-Lancet Commission's SRHR framework. Participants consistently described a divide between services that are more readily accessible and those that are restricted or denied. Services that are more accessible tend to be those that are less stigmatized and less likely to conflict with religious doctrine, including menstrual health management, cervical and breast cancer screenings, prenatal care, and sexually transmitted infections testing and treatment. For example, an NGO regularly rotates through shelters to provide prenatal care at least twice a month for pregnant women. Menstrual hygiene products are frequently donated and distributed as needed, and some NGOs conduct workshops on menstrual health and STI prevention. Local health authorities also organize health fairs offering HIV and syphilis testing, with referral support for positive cases. As one NGO provider in Ciudad Juárez explained:

> *"In addition to the monitoring of shelters, we developed dignity kits that contained information on sexual and reproductive health and included what the UN guidelines recommend—menstrual hygiene products, personal hygiene products, etc."* **Service provider, NGO, Ciudad Juárez**

In contrast, services related to contraception, abortion, gender-sensitive care, and sexual violence response are far more restricted—either difficult to provide, discouraged, or explicitly prohibited. Health providers working in shelters or NGOs reported having to deliver information or services related to contraception or abortion "under the table," due to restrictions imposed by shelter leadership or funding partners. For instance, dispensaries inside faith-based shelters often do not include contraceptive methods, besides external condoms, or emergency contraception, as shared by a psychologist working in a faith-based shelter:

"Here at the clinic, in the dispensary, there are no contraceptive methods—not even emergency contraception. They do provide sanitary pads and similar kits, but not that [contraception]."
Psychologist, Faith-based shelter, Ciudad Juárez

Public-sector providers also face restrictions when attempting to distribute contraceptives during outreach. On some occasions, shelter managers have explicitly prohibited the distribution of contraceptives (e.g., male condoms) by public health service providers and NGOs.

"The HIV program, which is here at CAPASITS, they go to the shelters, and they have told us that they struggle a lot to distribute condoms. They only, well, eh, give the talks and do the [HIV] *rapid tests. But they do tell us a lot about that, because, well, because of orders* [to not distribute condoms] *from those in charge* [of the shelters]." **Local decision-maker, Government institution, Ciudad Juárez**

Abortion care is particularly restricted. Several providers from NGOs and the local health jurisdiction, as well as migration experts have experienced barriers to providing information, resources, or accompanienment to abortion services when women are inside faith-based shelters. Even when NGOs have the capacity and resources to offer abortion or post-abortion care, some refrain due to pressure from religiously affiliated donors, who explicitly prohibit funding abortion-related services.

"Abortion is not mentioned openly as such because, in fact, it is not like [NGO] *makes it public, right?* [...] *So, in the workshops, the only thing we do is talk about preventing gender violence, we specify what types of violence there are, and we talk, yes, about sexual violence. Many times, women do not talk about it openly* [about abortion]; *it is only when the workshop is over that they come up and ask* [...]. *But it is not something that* [NGO] *says openly. Precisely because we also work with donors who are Catholic, Christian."* **Service provider, NGO, Ciudad Juárez**

Shelter policies also restrict sexual and gender expression and identity. Participants shared that sexual activity is forbidden inside faith-based shelters, even for married couples, and LGBTQ+ migrants face discrimination and moral judgment from shelter staff.

"There are shelters that are very Christian, and they don't allow them, um, I don't know, for example, certain foods, they don't allow them, uh, anything that has to do with LGBT issues. They make them feel inferior. I've had people say: "No, the manager here [in a faith-based shelter] *tells me I'm going to go to hell if I continue with my ideas."* **Service provider, NGO, Ciudad Juárez**

"I know that there's also a bit of a difficulty in socializing the part of, for example, emergency contraceptive methods or contraceptive methods. I suppose it's because there's like the idea that here it's only women, right? So if they're not with a male partner here, well, they're not, let's say, sexually active. But we also know that it can also happen among women, right? But that's also like another limitation in the sense that not many homosexual couples come here, because this is a religious space." **Psychologist, Faith-based shelter, Ciudad Juárez**

Table 1. Components of sexual and reproductive health and rights of the Guttmacher-Lancet Commission and access or fulfillment of these components in religious migrant shelters.

Sexual and reproductive health components	Access / Fulfillment	Sexual and reproductive rights components	Access / Fulfillment
Counseling and care related to sexuality, sexual, identity, and sexual relationships	**No**	Achieve the highest attainable standard of sexual health, including access to SRH services	**No**
Services for the prevention and management of STIs	**Yes**	Seek, receive, and impart information about sexuality	**No**
Psychosexual counseling and treatment for sexual dysfunction and disorders	**Information not available**	Receive comprehensive, evidence-based, sexuality education	**No**
Prevention and management of reproductive system cancers	**Yes**	Have their bodily integrity respected	**Information not available**
Receive accurate information about the reproductive system and the need to maintain reproductive health	**No**	Choose their sexual partner	**No**
Manage menstruation in a hygienic way, in privacy, and with dignity	**Yes**	Decide whether to be sexually active or not	**No**
Access multisectoral services to prevent and respond to gender-based violence	**No**	Engage in consensual sexual relations	**No**
Access safe, effective, affordable, and acceptable methods of contraception of their choice	**No**	Choose whether, when, and whom to marry, enter into marriage with free and full consent, and equality between spouses in the dissolution of marriage	**Information not available**
Access appropriate health-care services to ensure safe and healthy pregnancy and childbirth	**Yes**	Pursue a satisfying, safe, and pleasurable sexual life, free from stigma and discrimination	**No**
Access safe abortion services, including post-abortion care	**No**	Make free, informed, and voluntary decisions on their sexuality, sexual orientation, and gender identity	**No**
Access services for prevention, management, and treatment of infertility	**Information not available**	The right to make decisions concerning reproduction free of discrimination, coercion, and violence	**No**
		The right to privacy, confidentiality, respect, and informed consent	**No**
		The right to mutually respectful and equitable gender relations	**No**

Ultimately, participants emphasized that core SRHR are not upheld in many faith-based shelters. Migrant women's autonomy in reproductive decision-making, freedom to express sexual orientation and gender identity, and access to gender-sensitive, non-discriminatory care are systematically constrained by internal policies, religious values, and donor influence.

Barriers to accessing or providing SRH services within shelters

Using Levesque et al.'s person-centered access to healthcare framework, we identified three major categories of barriers to SRH access and provision within shelters: (1) cultural and religious barriers, (2) institutional and operational barriers, and (3) absence of government oversight.

1. Cultural and Religious Barriers

Participants described deeply rooted cultural and religious norms within faith-based shelters that limit access to critical SRH services. Certain SRH topics—such as contraception, abortion, and STIs—are often considered taboo by shelter managers, particularly in religiously affiliated shelters. This stigma leads to silence, lack of education, and internalized fear among both service providers and UITMW. One social worker noted:

> *"Also, these, not myths, but challenges of, "Look, she scratches herself a lot here on her parts and then grabs things without washing her hands. She's going to give me this. How am I going to use the bathroom? What if I get infected?"* [...] *There have even been people who haven't wanted to talk about it, "If the* [religious] *sisters find out, they're going to discriminate against me. The other women will start saying not to come near me." The fear of discrimination is very ugly. And even more so with this issue of the place being religious."* **Social worker, Faith-based shelter, Ciudad Juárez**

Even when shelter-based providers (e.g., social workers, nurses, psychologists) are personally committed to SRHR, they may be prohibited from offering related information or services due to religious leadership. Managers—often nuns or priests—determine shelter policies, effectively overriding health professionals' efforts. Although secular and government-led shelters are more permissive, women in those shelters face downstream barriers at public clinics and hospitals, where providers may be untrained or unwilling to provide abortion care. As one government shelter manager shared:

> *"Women who come to us to say, "I don't want to continue with the pregnancy." What we do is channel them, because at the end of the day, we are just a shelter. We channel them to the public health institutions responsible for this, and unfortunately, we have found that the criteria are not*

defined at the hospital. One time they sent her back to us saying she had to be accompanied by a lawyer." **Shelter manager, Government-led shelter, Ciudad Juárez**

2. Institutional and Operational Barriers

A second category of barriers relates to lack of systems and protocols inside shelters. Participants repeatedly highlighted the absence of clear referral pathways for responding to sexual violence, as well as a lack of staff training on how to manage such cases. These gaps result in delayed care, breaches of confidentiality, and heightened anxiety for both providers and survivors. One nurse volunteer shared:

"The case [of sexual violence] *was discovered, and I was the first person to talk to her, and so I had to activate everything, right? And yes, I have felt… Because it has been difficult, many people are involved, many organizations, a lot of ignorance* […]. *So, well, like, who needs to know? Who doesn't? Confidentiality, how far does it go? How many resources do we have to mobilize? Do we give priority to the legal or health? No, we do not know very well. I mean, I feel we are groping in the dark in that sense."* **Nurse volunteer, Faith-based shelter, Ciudad Juárez**

Additionally, shelter policies often restrict women's ability to leave the premises without prior authorization, particularly in shelters with heightened security concerns. In these cases, women must disclose their reasons for leaving—compromising their confidentiality when seeking SRH services unavailable onsite.

3. Absence of Government Oversight

Participants emphasized that government institutions lack mechanisms to monitor or enforce SRHR protections within shelters—even when some shelters receive public funds. The burden of care has largely fallen to civil society organizations and shelters themselves, with minimal coordination or accountability from federal or local authorities. One psychologist explained:

"The Mexican State, from the Federation, must respond because, in reality, all this time, since the MPP [Migration Protection Protocols] *program began, it has been very lukewarm in all aspects of migration. It has been like, "Oh, yes, let them wait here in Mexico, and we totally ignore them", right? We don't know if they have access to health, housing, food, jobs"* […]. *So, I also think that there is irresponsibility on the part of the Mexican State towards migrants."* **Psychologist, NGO, Ciudad Juárez**

Another participant from an NGO working in academia elaborated:

"I mean, there are these shelters that are of religious origin, that do have access to public resources, because ultimately they are addressing the problem and, in that sense, by receiving public resources they should be obliged to respect the minimum legal framework of human rights and everything, but they don't do it. And since the State is not interested, well. I mean, eh, these populations [migrants] *are not of interest* [for the State]. *So then they* [the shelters] *don't do it either."* **Political scientist, NGO and Academia, Chihuahua**

Overall, the lack of government oversight allows shelters to operate with considerable autonomy, which in turn enables the reproduction of religious or moral ideologies that conflict with Mexico's legal commitments to SRHR.

Discussion

This study examined how migrant shelters, especially faith-based ones, shape access to sexual and reproductive health (SRH) services and the exercise of sexual and reproductive health and rights (SRHR) among undocumented in-transit migrant women (UITMW) in Mexico. Interview findings revealed three central insights: (1) shelters serve as critical facilitators of basic SRH care through the distribution of resources, information sharing, service provision, referrals, and partnerships; (2) internal shelter policies and religious beliefs lead to uneven access, with services misaligned with religious doctrine often restricted or denied; and (3) barriers to access operate across cultural, institutional, and systemic levels.

As participants described, shelters—regardless of religious affiliation—often serve as key enablers of access to certain SRH services. Previous research conducted in Mexico supports these findings, identifying migrant shelters as central to connecting undocumented migrants with primary healthcare services (23,26–29). However, this study contributes new insights by documenting how shelters can also act as gatekeepers, particularly when SRH needs and rights conflict with religious doctrine. Llanes-Díaz et al. (2023), in a qualitative study conducted between 2020 and 2022, similarly found that secular shelters were more likely to adopt a rights-based and intersectional approach to SRH, offering a broader menu of services, while faith-based shelters were more limited in scope and referred only to public health facilities when needs exceeded basic care (14).

Given the widespread influence of religious doctrine in humanitarian service provision, this dual role—as both facilitator and barrier—is concerning. This is particularly alarming in a context where UITMW are at heightened risk of sexual violence and may urgently require access to emergency contraception, abortion care, and sexual violence and trauma-informed services. Religion already influences SRH service utilization among women. In the U.S., Stidham et al. (2019) found that women who attended religious services regularly and placed high importance on religion were less likely to use SRH services (30). This

finding is particularly relevant to UITMW in Mexico, as over 80% of women in Central America and 66% in Venezuela—two primary regions of origin for UITMW—consider religion to be a very important part of their lives (31). These dynamics underscore the urgency of guaranteeing comprehensive, rights-based SRH care irrespective of the religious orientation of service providers.

Barriers to SRH access observed in this study cut across Levesque et al.'s five dimensions of access: approachability (limited information), acceptability (religious or moral opposition), availability (restrictions on service delivery), appropriateness (conflicting priorities), and ability to engage (restricted autonomy and mobility of UITMW). One overarching barrier that intersects all five dimensions is the lack of government oversight. Weak governance on migration and health is not unique to Mexico. In various global contexts, scholars have identified the delegation of migrant care to civil society and faith-based actors as both a necessity and a vulnerability in settings where governments do not guarantee universal health coverage for migrants (32–35). Reports from Doctors Without Borders and the International Organization for Migration have similarly called for increased state-led coordination of migrant health responses in humanitarian contexts (34,36). Despite the existence of a favorable legal framework in Mexico that guarantees access to healthcare regardless of migration status (15,37,38), this study shows that insufficient public funding, inadequate staffing, and weak infrastructure hinder the state's ability to respond to UITMW's SRH needs. The outsourcing of health and protection services to shelters and NGOs means that state actors have little ability to enforce rights-based care in privately operated spaces.

Our findings suggest that the Mexican state must adopt a stronger regulatory and service delivery role to guarantee SRHR for UITMW, especially those staying in faith-based shelters. The realization of rights cannot be conditional on the type of shelter where a woman is staying. This is especially important as increasingly restrictive U.S. immigration policies are prolonging migrants' stays in Mexico. Many UITMW may avoid seeking asylum in Mexico in hopes of applying in the U.S., which places them in a legal limbo and reduces access to stable services. In this context, the lack of enforceable standards for shelters has urgent health and human rights consequences. Thus, we recommend the following policy and program actions: (1) Establish oversight mechanisms to enforce minimum standards for rights-based and non-discriminatory SRH care in shelters, regardless of religious orientation; (2) Expand secular and government-led alternatives for temporary shelter and SRH service provision; (3) Develop SRHR-specific outreach services targeting shelter populations; and, (4) Provide mandatory training for shelter staff and public health providers on confidentiality, survivor-centered care, gender-affirming care, abortion rights, and non-discrimination.

As migration through Mexico continues and shelters remain central to humanitarian response, future research should continue to explore the perspectives of religious leaders who manage shelters regarding SRHR, and examine intervention models that could reconcile faith-based service delivery with rights-based approaches to SRHR.

Strengths and Limitations

This study offers a novel perspective on the role of migrant shelters in shaping access to SRH services for UITMW, grounded in multisectoral interviews and participant observation. However, it has several limitations. SL's fieldwork included time as a volunteer in a shelter, which enabled rapport building and contextual understanding. Nevertheless, she did not interview migrant women themselves. Although efforts were made to obtain permissions from shelters to include them, concerns over re-traumatization and "helicopter research" led SL and her co-investigators to prioritize ethical considerations and refrain from direct interviews. Second, the study focused exclusively on cisgender women. While some data on LGBTQ+ populations emerged, this group faces distinct vulnerabilities and may experience even greater discrimination and barriers to SRH services—an area warranting further research. Finally, although the sampling strategy prioritized diversity across institutions and sectors, the findings are not fully transferable to other experiences and settings. Perspectives from private healthcare providers, pharmacy-based clinics, or providers in other states in Mexico were not included, which may have yielded additional insights.

Conclusions

Migrant shelters play a vital role in meeting the immediate needs of UITMW in Mexico. However, their current structure and governance—particularly in faith-based settings—often reproduce exclusionary practices, especially in relation to SRHR. These restrictions disproportionately impact a population already exposed to high levels of trauma and human rights violations. Upholding SRHR for migrant women in transit requires more than goodwill from civil society: it demands political will, robust oversight, and service models that center the autonomy, dignity, and diverse needs of migrant women—above the religious or moral beliefs of the institutions tasked with their care.

Declarations

Availability of data and materials

The qualitative data supporting this study's findings are not publicly available due to confidentiality concerns and ongoing related publications. However, the data may be made available from the first author (SL) upon reasonable request, subject to approval and in accordance with ethical guidelines.

Competing interests
The authors declare no competing interests

Funding
Funding for this study was provided by the Mexican Ministry of Science, Humanities, Technology, and Innovation through the 2021–2025 doctoral scholarship, and by the University of California-Alianza Mexico (Alianza MX) through two grants: the 2023 Seed Funding Opportunity for Mobilities to Mexico and the 2023–2024 Short-Term Research in Mexico for UC Graduate Students.

Acknowledgments

The authors would like to acknowledge all the study participants who agreed to be interviewed. We wish to acknowledge their commitment to improving access to and utilization of SRH services for in-transit migrant women in Mexico. SL would also like to acknowledge her DrPH cohort colleagues, mentors, and professors. Their continuous feedback since the inception of this study was invaluable.

References

1. Unidad de Política Migratoria. Unidad de Política Migratoria, Gobierno de México. [cited 2023 Dec 6]. Boletines Estadísticos. Available from: https://portales.segob.gob.mx/es/PoliticaMigratoria/Boletin_MyH

2. International Organization for Migration. Glossary on Migration [Internet]. Geneva: International Organization for Migration; 2019 p. 217. Available from: https://publications.iom.int/system/files/pdf/iml_34_glossary.pdf

3. El Colegio de la Frontera Norte. Encuesta Sobre Migración en la Frontera Sur de México. Informe Anual de Resultados 2019. Mexico: El Colegio de la Frontera Norte; 2020 p. 1–53.

4. Comisión Mexicana de Ayuda a Refugiados. La COMAR en números [Internet]. 2024. Available from: https://www.gob.mx/comar/articulos/la-comar-en-numeros-387226?idiom=es

5. París MD, Zenteno R, Treviño J, Wolf S. Un análisis de los actores políticos y sociales en el diseño y la implementación de la política y la gestión migratoria en México [Internet]. Tijuana: El Colegio de la Frontera Norte; 2015 [cited 2024 Apr 29] p. 1–103. Available from: https://www.academia.edu/26348849/Wolf_Sonja_with_María_Dolores_Paris_René_Zenteno_and_Javier_Treviño_Rangel_Un_análisis_de_los_actores_políticos_y_sociales_en_el_diseño_y_la_implementación_de_la_política_y_la_gestión_migratoria_en_México

6. United Nations Human Rights. Human rights in transit and at international borders [Internet]. OHCHR and migration. 2022 [cited 2024 May 14]. Available from: https://www.ohchr.org/en/migration/human-rights-transit-and-international-borders#:~:text=Many%20migrants%20in%20transit%20are,never%20reach%20their%20intended%20destination.

7. Infante C, Silván R, Caballero M, Campero L. Sexualidad del migrante: experiencias y derechos sexuales de centroamericanos en tránsito a los Estados Unidos. Salud Publica Mex. 2013 Jan 3;55:58.

8. Infante C, Leyva-Flores R, Gutierrez JP, Quintino-Perez F, Torres-Robles CA, Gomez-Zaldívar M. Rape, transactional sex and related factors among migrants in transit through Mexico to the USA. Culture, Health & Sexuality. 2020 Oct 2;22(10):1145–60.

9. Starrs AM, Ezeh AC, Barker G, Basu A, Bertrand JT, Blum R, et al. Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher– Lancet Commission. The Lancet. 2018 Jun;391(10140):2642–92.

10. Vázquez-Quesada L, Peña J, Vieitez-Martínez I. Necesidades y atención en salud sexual y reproductiva de mujeres migrantes en México. Un estudio desde Ciudad Juárez, Chihuahua. Volumen I. [Internet]. Mexico: Population Council & El Colegio de la Frontera Norte; 2021 Nov. Available from: https://www.colef.mx/wp-content/uploads/2021/12/Reporte_saludsexual_volumen1.pdf

11. Quintino-Pérez F, Montoya A, Gómez-López D, Vázquez-Aguilar E, Cortés Alcalá R, Leyva-Flores R. Dinámica de movilidad y salud de mujeres migrantes en México, en el contexto de la pandemia Covid-19, 2021-2022. Salud Publica Mex. 2024 Jan 26;66(2, mar-abr):137–49.

12. Garbett A, De Oliveira Tavares NC, Riggirozzi P, Neal S. The paradox of choice in the sexual and reproductive health and rights challenges of south-south migrant girls and women in Central America and Mexico: A scoping review of the literature. Journal of Migration and Health. 2023;7:100143.

13. Friedman S, Wegs C, Parra V. CARE Rapid Gender Analysis. Latin America & the Caribbean. Ciudad Juárez, Mexico [Internet]. Ciudad Juárez: CARE International; 2020

[cited 2024 Apr 28] p. 1–18. Available from: https://careevaluations.org/wp-content/uploads/04.27.20-CARE-Border-RGA_FINAL.pdf

14. Llanes-Díaz N, Bojórquez-Chapela I, Odgers-Ortiz O. Oferta de servicios de salud sexual y reproductiva a personas migrantes centroamericanas en Tijuana. Panam Salud Publica. 2023;47:1–9.

15. Cámara de Diputados. Ley General de Salud. May 16, 2022.

16. Quesada LV, Larrea-Schiavon S, Marin TT, García GBM, Basurto-Alcalde E, Ochoa B, et al. Mujeres migrantes en Tapachula, Mexico: barreras y facilitadores para el acceso a la salud sexual y reproductiva en 2020—Resumen de la investigación [Internet]. Population Council; 2021 Nov [cited 2021 Nov 29] p. 44. Available from: https://knowledgecommons.popcouncil.org/cgi/viewcontent.cgi?article=2554&context=departments_sbsr-pgy

17. Vázquez-Quesada L, Peña J, Vieitez-Martinez I. Necesidades y atención en salud sexual y reproductiva de mujeres migrantes en México. Un estudio desde Ciudad Juárez, Chihuahua. Volumen II. Mexico City: Population Council & El Colegio de la Frontera Norte; 2021.

18. Leyva R, Infante C, Quintino-Perez F, Domínguez J, Santos E. Migración y redes sociales para la salud sexual y reproductiva: experiencias del Programa Conjunto de Migrantes en Tránsito por México. Mexico: Instituto Nacional de Salud Pública; 2016.

19. Larrea-Schiavon S, Vázquez-Quesada L, Basurto-Alcalde E, Polgovsky N, Vieitez Martínez I. Atención de la salud sexual y reproductiva de mujeres migrantes: Un mapeo de actores de la sociedad civil en México. Mexico City: Population Council; 2021 Jul p. 1–48.

20. Peña J, Vázquez-Quesada L, Vieitez-Martínez I. Necesidades de Atención en Salud Sexual y Reproductiva de Mujeres Migrantes en México. Un estudio desde Ciudad Juárez, Chihuahua. Volumen III. Mexico: Population Council & El Colegio de la Frontera Norte; 2022 p. 1–57.

21. El Colegio de la Frontera Norte, CONACYT, Secretaría de Relaciones Exteriores, Secretaría de Gobernación, Secretaría del Trabajo y Previsión Social, CONAPO, et al. Encuesta Sobre Migración en la Frontera Sur de México. Informe Anual de Resultados. 2019 [Internet]. Mexico; 2019. Available from: https://www.colef.mx/emif/datasets/informes/sur/2019/Emif%20Sur%20Informe%20Anual%202019.pdf

22. Levesque JF, Harris MF, Russell G. Patient-centered access to health care: conceptualising access at the interface of health systems and populations. Int J Equity Health. 2013;12(1):18.

23. Infante C, Vieitez-Martinez I, Rodríguez-Chávez C, Nápoles G, Larrea-Schiavon S, Bojorquez I. Access to Health Care for Migrants Along the Mexico-United States Border: Applying a Framework to Assess Barriers to Care in Mexico. Frontiers in Public Health [Internet]. 2022 [cited 2022 Oct 26];10. Available from: https://www.frontiersin.org/articles/10.3389/fpubh.2022.921417

24. Quinn Patton M. Qualitative Research and Evaluation Methods. Fourth Edition. United States: SAGE Publications; 2015.

25. VERBI GmbH. MAXQDA. VERBI GmbH;

26. Bojórquez-Chapela I, Infante-Xibille C, Rodríguez-Chávez C, Larrea-Schiavon S, Vieitez-Martínez I. Atención en salud de Covid-19 para migrantes en México: análisis desde la problematización de la política pública. Salud Publica Mex. 2023 Dec 12;1–7.

27. Infante C, Bojorquez I, Vieitez-Martinez I, Larrea-Schiavon S, Nápoles-Méndez G, Rodriguez-Chavez C. Migrant shelters' response to COVID-19: Comparative case study in four cities close to the Mexico-United States border. Journal of Migration and Health. 2022;6:100110.

28. Leyva-Flores R, Infante C, Serván-Mori E, Quintino-Perez F, Silverman-Retana O. Acceso a Servicios de Salud para los Migrantes Centroamericanos en Tránsito por México. Mexico: CANAMID; 2015. (Policy Brief Series Salud). Report No.: 5.

29. Leyva-Flores R, Infante C, Quintino-Perez F. Migrantes en tránsito por México: situación de salud, riesgos y acceso a servicios de salud [Internet]. Mexico: Instituto Nacional de Salud Pública; 2016. Available from: https://www.insp.mx/resources/images/stories/2018/Docs/180724_Migrantes_transito_16may.pdf

30. Hall KS, Moreau C, Trussell J. Lower Use of Sexual and Reproductive Health Services Among Women with Frequent Religious Participation, Regardless of Sexual Experience. Journal of Women's Health. 2012 Jul;21(7):739–47.

31. Pew Research Center. Religious Commitment and Practice [Internet]. United States: Pew Research Center; 2014. (Religion in Latin America). Available from: https://www.pewresearch.org/religion/2014/11/13/chapter-2-religious-commitment-and-practice/

32. Vearey J, Orcutt M, Gostin L, Braham CA, Duigan P. Building alliances for the global governance of migration and health. BMJ. 2019 Sep 16;366:l4143.

33. International Organization for Migration. EMM2.0 Handbook. Migration Governance and Management. [Internet]. Switzerland: International Organization for Migration; 2024. Available from: https://emm.iom.int/handbooks

34. International Organization for Migration. The Migration Governance Indicators. Success Stories 2023 [Internet]. Geneva: International Organization for Migration; 2023 p. 1–25. (The Migration Governance Indicators). Available from: https://publications.iom.int/system/files/pdf/pub2023-074-el-mgi-success-stories-0.pdf

35. Grove N, Zwi A. Our health and theirs: Forced migration, othering, and public health. Social Science & Medicine. 2006;62(8):1931–42.

36. Doctors Without Borders. No Way Out. The humanitarian crisis for migrants and asylum seekers trapped between the United States, Mexico and the Northern Triangle of Central America [Internet]. Mexico: Doctors Without Borders; 2020 Feb. Available from: https://www.doctorswithoutborders.org/sites/default/files/documents/Doctors%20Without%20Borders_No%20Way%20Out%20Report.pdf

37. Cámara de Diputados. Ley de Migración. Apr 29, 2022.

38. Secretaría de Salud. Plan Integral de Atención a la Salud de la Población Migrante. 2020.