Master thesis : "The health-related challenges Brazilian women employed in the cleaning sector in Brussels face, and their health-seeking strategies"

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Mémoire de fin d'études

The health-related challenges Brazilian women employed in the cleaning sector in Brussels face, and their health-seeking strategies

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Abstract

Analyzing domestic workers and cleaners, in particular, offers a rich realm of scientific exploration in the intersection between social sciences and health. Women employed in this sector are vulnerable to extensive working hours, food deprivation, exhaustion, physical and chemical hazards, and deteriorating physical effort. In addition, the private nature of such jobs generates risks concerning social isolation, physical, sexual, and verbal abuse. Despite the existence of a formalization system that grants rights and protection to domestic workers in Belgium, this is only available for people with a regular migration status. As a consequence, undocumented informal workers in the sector are more vulnerable to health disparities and worse living conditions. That does not mean, however, that registered workers are immune to health-related issues, as they still perform low-skilled and poorly remunerated jobs. Adding to the hazardous conditions of this economic sector and its high degree of informality, health-related issues specific to migrant and undocumented populations aggravate this scenario. Considering this context, this master's thesis investigates the health-related challenges Brazilian women employed in the cleaning sector in Brussels face, and their health-seeking strategies. The study has identified **health challenges** related to their **occupation**, **legal status**, **socioeconomic situation**, the **healthcare system organization** and **dynamics**, and **language barriers**. Concomitantly, the study identifies and describes their main **strategies** to overcome (some of) the shortcomings they encounter in contacts with the healthcare system and individual challenges regarding health. Their main strategies are the use of **private services**, **transnational practices**, searching for **Lusophone professionals**, **activating networks,** and **requesting government aid**.

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AMI: Assurance Maladie-Invalidité
AMU: Aide Médicale d'Urgence
C189: Convention No. 189 concerning Decent Work for Domestic Workers
CPAS: Centre public d'action sociale
EU: European Union
ILO: International Labor Organization
TCN: Third Country National
IOM: International Organization for Migration
SPF Emploi: Service Public Fédéral Emploi, Travail et Concertation sociale
WHO: World Health Organization
R201: Domestic Workers Recommendation No. 201

1. Introduction

The “spark” that would originate this research topic was planted when I received the application requirements for the Belgian visa. One of them was a list of health exams, including screening for several sexually transmitted infections. It was an uncomfortable step, as such a requirement seemed to frame me as a dirty and dangerous “third world” subject, putting the health of Belgians at risk. That process opened my eyes to the links between health and migration, which are intertwined in stereotyping communities, in granting or denying access to a territory based on sanitization concerns, denying or providing care, and more.

This personal experience led me to take an interest in and investigate the intersection between migration and health. The group of choice was the Brazilian community, considering the shared cultural background and language between the researcher and interviewees. This choice was also motivated by a research gap regarding the experiences of this group in Belgium, and particularly in Brussels. Within the Brazilian community, women working in the cleaning sector emerged as the target of this research, as this represents a common occupation for Brazilian female migrants in the country.

Furthermore, analyzing domestic workers, cleaners in particular, offers a rich realm of scientific exploration in the intersection between social sciences and health. Women employed in the domestic work sector are vulnerable to extensive working hours, food deprivation, exhaustion, physical and chemical hazards (e.g., chemical cleaning agents), repeated and deteriorating physical effort (repeated bending, reaching, and lifting) (Abubakar et al., 2018). In addition, considering the private nature of such jobs, they are subject to social isolation, physical, sexual, and verbal abuse (Abubakar et al., 2018).

Considering the aforementioned factors, this master's thesis aims to answer the following question: **What are the health-related challenges Brazilian women employed in the cleaning sector in Brussels face, and what are their strategies to overcome such challenges?** Therefore, this study has the goal to document this group’s **health-related challenges** and demonstrate how these women overcome healthcare access barriers by **employing** and **combining different strategies**. From mobilising family and networks to engaging in check-ups in their country of origin, this group's tactics respond to a myriad of

shortcomings, which become even more severe concerning undocumented women's experiences. These strategies' efficiency, nevertheless, varies, encouraging the combination of different tools.

To provide the theoretical basis for this investigation, I start by bringing the literature on migration and health, highlighting historical connections between health and mobility and the recognition that social dimensions affect health (social determinants of health). Following this introduction, care-seeking strategies are discussed. In this section, the literature indicates different ways migrants circumvent healthcare access issues, which may entail transnational movement, healthcare bricolage strategies (Phillimore, 2019), and other arrangements.

This section is followed by an overview of the Belgian scientific production focusing on the intersection between health and migration. That segment brings studies that indicate the country's main weaknesses when providing comprehensive healthcare services for undocumented migrants. Lastly, the theoretical exploration discusses the context in which this target group's migration happens. The domestic work sector, from which cleaners are often part, is mostly female and highly migrantized in the Global North (Marchetti, 2022). Despite the growing demand for their services, domestic work providers are often undocumented, as legal entry pathways rarely consider low-skilled workers eligible for visas. Therefore, this group tends to face a series of challenges due to their vulnerable position.

After the theoretical framework, the Brazilian community in Belgium is contextualized, bringing data and a brief history of Belgium as a destination country for Brazilians. The methodology is addressed next, explaining the choice for a qualitative research design composed of semi-structured in-depth interviews and participant observation. In the same section, there is a brief reflection on the researcher's positionality, which highlights some of the challenges faced when conducting fieldwork. The empirical findings are then separated first concerning the health challenges faced by the group and, secondly, the ways they address such shortcomings. The discussion proposes the analysis of the empirical findings in light of previous research, contextualizing the findings. The conclusion brings a short summary of the most important aspects derived from this study and suggests further research on topics that could not be fully addressed by this master's thesis.

2. Theoretical framework

Health is an essential factor in migration as it affects the selection of who is allowed entry into foreign territories (Vieira, 2016; Morey et al., 2020), the integration of migrants into a new reality (Giannoni et al., 2016), and migrants' well-being (Chiementi et al., 2014). In the context of migration, health as a concept goes beyond the physical or biological human well-being, or the absence of illness, and gains complex social and political nuances.

The intersection between health and migration has attracted attention from various disciplines, such as public health, medical anthropology, political science, and more. When analyzing the importance of countries' healthcare systems in integration, Chiementi et al. (2014: 252) claim that "access to effective healthcare should be seen as no less important than housing and education for the well-being and social inclusion of migrants". They also conclude that health is, possibly, an even more relevant element in the lives of migrants than it is for mainstream society, "[...] because migrants may be less well cushioned against the effect of illness by social protection arrangements, legal safeguards, and social support systems" (Chiementi et al., 2014: 252).

This literature review covers different aspects of migration and health, including historical views on the subject, healthcare transnational living practices, care-seeking strategies employed by migrants, the Belgian scholarship on the theme, domestic workers' health-related challenges, and Brazilian migrant women and their health practices.

2.1 Migration and Health

Migrant populations' health has been examined through different lenses, including the historical association between mobility and transport of pathogens, and migration policy requirements. This community has been portrayed paradoxically both as **healthy** and as **disease carriers**. In the intersection between health and migration, important elements explored by academia are the racialization of migrant groups and their association with public health threats; the social determinants of health that determine these communities' well-being; the healthcare arrangements migrants resort to when overcoming barriers, and more.

2.1.1 The sick and unwanted foreign body

Historically, encounters between locals and foreigners have been marked by introducing new pathogens; this has been thoroughly documented during the colonization of the Americas, with European colonizers introducing new diseases to Native American populations (Kraut, 1994). Epidemic cases linked to mobility were continuously registered throughout the centuries, inspiring countries to apply protocols to mitigate the public health risks associated with welcoming immigrants.

The health inspections conducted at **Ellis Island**, a federal immigration depot in New York where all newcomers to the United States were screened for different illnesses, is a notorious example of such policies (Kraut, 1994: 13). From 1892 to 1954, over twelve million migrants were inspected and interrogated at Ellis Island, where they would be informed whether they were allowed entry or not to the US. The health screenings became gradually more elaborate with the help of new medical technologies; that does not mean that the examinations became less painful, as many testimonies described aggressive and painful practices (Kraut, 1994: 55). Analyzing one's health was used as a selection tool, as it could lead to refusal of entry on the grounds of sanitary concerns. Likewise, public health policies were an assimilation tool in American society (Kraut, 1994: 02). Despite concerns that migrants could represent a danger to public health, the overwhelming majority passed the required medical examinations (Markel and Stern, 2002: 762), challenging the fears of many.

Mobility and migration have been associated with the transmission of diseases. Public health concerns about infectious disease outbreaks and the application of sanitary measures are certainly important. However, socially, certain disease-related episodes in the context of migrant communities have constructed an idea of an “immigrant menace”. According to Kraut (1994: 02), this contributed to the “medicalization of preexisting nativist prejudices”. This happens when excluding members of a particular group is justified by health risks, as they are perceived to endanger their host communities (Kraut, 1994: 02). Consequently, migrant groups faced **stigmatization**, boosting the fear of contamination in the minds of mainstream society members (Kraut, 1994: 02). The **racialization** of migrant groups was also an important factor fueling their portrayal as a threat. During the 20th century, for example, impoverished Jews from Eastern Europe were one of the most stigmatised migrant groups in the United States (Harper and Raman, 2008). Markel and Stern (2002: 757), however,

emphasize that throughout History, “the social perception of the threat of the infected immigrant was typically far greater than the actual danger”.

This portrait of a foreign sick body still influences **contemporary migration policies**. Harper and Raman (2008) highlight the political attention the intersection between health and migration has gathered. In 2005, in the UK, for example, the Conservatives defended stricter immigration control, including medical screenings for HIV, tuberculosis, and hepatitis (Harper and Raman, 2008). This discourse reproduced an idea that migrants, particularly the undocumented ones, were both a threat to locals and a financial burden to the country's healthcare system. This political discourse echoed in other countries, such as Canada and Australia (Harper and Raman, 2008). The authors highlight that the spread of pathogens is frequently associated with racialized bodies; therefore, African, Latin American, or Asian bodies are viewed as disease carriers (Harper and Raman, 2008: 12).

Decades after Ellis Island’s closure, the associations between diseases and migration remain strong (Markel and Stern, 2002: 781). Likewise, medical screenings for migration purposes continue to be enforced. They may come as a condition to grant visas pre-departure (Gushulak and MacPherson 2011; Vieira, 2016; Morey et al., 2020) or be implemented during pandemic contexts, when screening travellers for the presence of a particular pathogen and imposing quarantines upon arrival are recommended by the World Health Organization (WHO, 2016). Such cases were recently observed during the COVID-19 pandemic. Simões (2021) highlights the tension between international mobility and human health protection in the Covid-19 period, which led, in some cases, to travel bans that “breached the rules and principles governing international mobility” (2021: 373). The author defends that the degree of discretion national governments were given led to the adoption of measures inspired by non-scientific considerations, harming Human Rights (Simões, 2021: 431). Therefore, identifying a gap between public health measures and human rights standards’ compliance.

Merkel and Stern corroborate this idea, stating that believing the way to control infectious diseases is by targeting **specific communities** based on their migration journey, nationality, or ethnic background is **antiquated** (Markel and Stern, 2002: 781). Triandafyllidou (2022: 4) acknowledges that health concerns surrounding travelers in that period were legitimate; at the same time, the author emphasizes that border closures did not affect everyone equally, impacting especially those who were non-citizens or non-permanent

residents. When considering public health protection and mobility restrictions, the pandemic, therefore, raised questions about membership, as States adopted an approach that would privilege citizens (Triandafyllidou, 2022). Countries have even put a hierarchy of admissibility in place, dividing people according to legal status and national origin, as was the case in Canada (Macklin, 2022).

Therefore, what was observed during the COVID-19 pandemic was the instrumentalization of the idea of a "sick foreign body" as a policy foundation. The adoption of such measures in the name of public health leads to an important conclusion: anti-immigrant discourses and policies often receive an explicitly medical language frame that blurs the line between perceived and actual threat (Markel and Stern, 2002: 757). This shifts the focus on protecting public health away from actual threats assessed through epidemiological and medical observations and fuels arguments targeting communities based on racialist, nativist, and national security ideas (Markel and Stern, 2002: 781).

2.1.2 The "healthy migrant effect"

In contrast with the idea that migrants are disease vectors, scholarship has also discussed the "**healthy migrant effect**", which suggests migrants are healthier than host, native-born populations. The most common explanation for this theory is that migrants are generally **younger**, as those in poor health and advanced age are unlikely to engage in mobility (Chiementi et al., 2014: 264). Furthermore, considering that many people migrate to perform **manual labour**, physical weakness can lead to the inability to find work; therefore, by **selecting** the most fit for work, the migrant population could be comparatively healthier (Chiementi et al., 2014: 265). However, other elements may also lead to this advantage of the foreign-born population, like pre-migration **socioeconomic status** (Feliciano, 2020; Florian et al., 2021).

Besides the idea that migration would function as a selection tool, other hypotheses that may explain such a phenomenon are related to **cultural aspects**, for instance, when migrants engage in healthier practices and habits, such as **lower alcohol consumption**, **less cigarette smoking,** or less **substance abuse** (Domnich et al,. 2012; Fenelon, 2013). Lastly, another part of the scholarship on this theme considers that the healthy migrant effect could

come as a consequence of biases in data gathering. This would be due to the tendency of unhealthy migrants to return to their origin country (Palloni and Arias, 2004). In addition to these ideas, direct health screening by government authorities before arrival may select relatively healthier immigrants (McDonald and Kennedy, 2004). On the other hand, another factor that may contribute to the "healthy migrant effect" is the under-reporting of health issues among migrants as a result of the under-utilization of healthcare services by this population (McDonald and Kennedy, 2004).

Current literature does not conclude whether the theory that migrants are healthier is accurate. In fact, there is also evidence that migrants may arrive healthy, but experience the **deterioration of their health** during their stay, which can also influence migrants' offspring (Acevedo-Garcia et al., 2012; Ferrara, 2024). Adding to this context, Chiementi et al. (2014) emphasize that the "healthy migrant effect" is not universal, as it varies according to elements such as health status, type of illness, and health profile. Therefore, instead of grouping all migrants into one category and native-born into another and comparing them, the researchers suggest examining illness and unhealthy behavior patterns within groups and sub-groups instead (Chiementi et al., 2014).

An important differentiation is, for instance, between women and men, who may be affected differently due to differing gender roles and the position of women in a society (Marmot et al., 2008). Corroborating this idea, Helgesson et al. (2019: 9) emphasize the importance of stratifying different migrant groups and considering variables such as employment status. Their study found, for instance, that the healthy migrant effect would be true for voluntary Western migrants in Sweden, but less evidence was found of this effect among non-Western migrants, particularly refugees and family reunion migrants (Hegelsson et al., 2019: 9).

In Europe, Moullan and Jusot (2014) built on this literature to show that the "healthy migrant effect" differs among countries. Analyzing four EU countries (Belgium, France, Spain, and Italy), the cross-country comparison demonstrated positive health status results for immigrants in Italy, but negative ones in Belgium and France. The researchers highlight that the heterogeneity of the results may be explained by legal framework differences and the strength of the health selection in migration processes (Moullan and Jusot, 2014: 84).

Differences in migratory history and country of origin may also influence such results (Moullan and Jusot, 2014).

2.1.3 Social Determinants of Health

In 2008, the World Health Organization (WHO) **Commission on Social Determinants of Health** discussed the different factors influencing one's health and the necessary steps to promote health equity (Marmot et. al, 2008). The Commission defended that the "unequal distribution of health-damaging experiences is not a natural phenomenon but a result of poor social policies and programmes, unfair economic arrangements, and bad politics" (Marmot et al., 2008: 1661). The researchers, therefore, understand that health inequity is a result of daily life conditions and the structural determinants in which people are **born, grow, live, work, and age** (Marmot et al., 2008: 1661). In summary, considering the **Social Determinants of Health** (SDH) often leads to the question of who gets the chance to be healthy in a society.

Therefore, **healthy living environments** (including clean water, sanitation, clean air, electricity, paved streets), fair employment and decent work, access to healthcare, and social protection determine one's health outcomes (Marmot et al., 2008). These elements are frequently associated with the concept of **health gradient**, which suggests, in summary, that the higher one's position is on the social ladder, the better this person's health outcomes are. The socioeconomic dimension is central to this discussion, as most diseases are more common in poorer strata of society, and life expectancy is shorter the lower you go on the social ladder (Wilkinson and Marmot, 2003). Other factors, such as stress, early life, social exclusion, work, unemployment, social support, addiction, food, and transport, significantly affect one's health (Wilkinson and Marmot, 2003). It is for these reasons that different environments entail different disease risks.

The **Social Determinants of Health** have been extensively researched by Public Health and Social Medicine scholarship; however, as highlighted by Ingleby (2012), these discussions have heavily relied on **socioeconomic determinants**. Despite the importance of the socioeconomic dimension, other determinants should also be considered, such as **migration** and **ethnicity** (Ingleby, 2012). If the academy once blamed poor health outcomes

on migrants themselves — notably, their alleged negative genes, cultural factors, infections, traumas, etc. —, current literature, on the other hand, suggests that the **social environment** affects this group's health through different factors (Chiementi et al., 2014). These include socio-economic status, gender roles, age, social isolation, poor housing conditions, educational attainment, racial discrimination, unemployment, lifestyle, and more (Chiementi et al., 2014; Viruell-Fuentes et al., 2012; Braveman et al., 2011; Koh et al., 2011; Wilkinson and Marmot, 2003).

Solid evidence that the **environment** cannot be detached from one's health outcomes is, precisely, found in migrant studies in which a group's health is monitored following time trends (Marmot et al, 1975; Marmot & Syme, 1976; Hegelsson et. al, 2019; Ferrara et al., 2024). Certain aspects of one's migration journey, for example, may directly affect their health outcomes. According to Spoel et al. (2019), in three countries (Morocco, Niger, and Tunisia), migrants' exposure to **violence**, **long displacement duration**, and **barriers to healthcare** negatively affected their health. In addition, the study indicates that migrants' health status has a tendency to deteriorate over time.

In this scenario, low-skilled migrants may face worse health outcomes due to their **economic activities**. In the literature, special attention has been given to occupation-related health inequities. Migrant women employed in the domestic work sector face financial difficulties, poor living and working conditions, poor healthcare access, and exploitation (Chen et al, 2022; Hall et al., 2019). Especially in countries where 3D jobs (dirty, dangerous, and demeaning) are migrantized, these factors corroborate the idea that social conditions may disadvantage migrants' health in comparison to native-born people.

An important consideration within this subject is that the promotion of health equity is only possible if policies encompass considerations of social determinants of health. That is because, as Marmot (1999: 3) suggests, **access to medical care alone is not enough to guarantee a population's health**. Therefore, if social conditions in a given area subject large portions of the population to unhealthy environments, universal and free healthcare access will be insufficient to improve health indicators.

Considering the varied social factors affecting migrant health, authors have suggested that an intersectional approach can be fruitful when analyzing migrants' healthcare outcomes.

Viruell-Fuentes et al. (2012) defend that racism should be analyzed as an important intersecting factor with other inequality dimensions. Therefore, authors believe that racism, along with gender and class, has a direct effect on migrant health outcomes (Viruell-Fuentes et al., 2012; Braveman et al., 2011). Krieger (2010) builds on this perspective, highlighting how the embodiment of multiple overlapping social identities coupled with one's occupation influences one's health outcomes. An intersectional approach was already applied to analyze, for instance, migrant mental health (Rocha-Jiménez et al., 2025), the health of migrant sex workers (Mutola et al., 2022), and migrants' health-seeking behaviour (Olajire et al., 2024). These studies aim to highlight how different and overlapping social identities operate, promoting or deteriorating health. This intersectional approach, however, has the potential to go beyond the usual class-gender-race heterogeneity factors, considering markers such as generation, transnational engagement level, and religiosity (Lafleur & Vivas-Romero, 2018).

2.2 Care-seeking strategies employed by migrants

While it is true that the Council of Europe's Resolution 1509 (2006) foresees the provision of emergency medical assistance for undocumented migrants, the application of this right is not homogeneous (Van Ginneken, 2014). In addition, the Resolution also urges the States to provide more global healthcare services for this population; however, only a few provide primary and secondary healthcare to undocumented migrants, such as **Portugal, Belgium, the Netherlands, France, and Switzerland** (Van Ginneken, 2014).

To circumvent potential shortcomings in their access to formal healthcare, migrants develop varied strategies, including **transnational approaches** and **informal social protection** tactics. These strategies are not isolated and involve mixing multiple resources to address health concerns. This attitude is encapsulated by the concept of **Healthcare Bricolage** (Phillimore, 2019). Besides accounting for the use and linkage of multiple resources — simultaneously or consecutively — Healthcare Bricolage also highlights the creativity of these communities in finding alternative ways to fulfill their healthcare needs.

A study conducted with migrants living in four superdiverse European neighborhoods — Birmingham, Bremen, Lisbon, and Uppsala — found that more than half of their interviewees used healthcare bricolage (Phillimore, 2019). The most prevalent type of

healthcare bricolage was found **within the system**, meaning that the use of the regular medical services available was coupled with the help of friends, family, and other information sources. The second most identified type was the **added-to-system bricolage**, which comprises cases where people **added services, treatments, or advice** that were not available or covered by public healthcare systems. That includes, for instance, paying for supplementary services, hiring services from another country, or adhering to alternative or complementary medicine.

Different elements influence the tendency to engage in healthcare bricolage and one's preferred type. Phillimore et al. (2019) highlight migrant background, levels of education, gender, and age as aspects that characterize one's use of healthcare bricolage. Women, for instance, were more likely to engage in bricolage than men, preferring "added to the system bricolage" among the proposed types.

2.2.1 Mobility and New Healthcare Landscapes

With increased mobility, new healthcare landscapes emerged, expanding the possibilities to access healthcare between different countries. The current literature on the theme highlights the **diversification of health-seeking tactics** on a **transnational** scale, simultaneously pointing to material and legislative constraints. Despite increased mobility, scholars claim that healthcare provision remains deeply rooted in the concept of the **Nation-State** and that healthcare systems are, consequently, organized at the national level (Zanini et al., 2013). However, **transnational living practices** (Ormond & Lunt, 2019) and **migration** challenge current healthcare systems and countries' healthcare policies.

This can be observed when non-migrants travel abroad seeking specific healthcare services (e.g., reproductive health and plastic surgery) motivated by financial reasons or the expertise of particular medical destinations (Ormond & Lunt, 2019). On another note, Ormond and Lunt (2019) highlight that non-migrants may also resort to foreign medical services when those of their homeland are insufficient, for instance, when healthcare infrastructure has been damaged by conflict. This phenomenon is described in many ways (e.g., "medical tourism", "medical exiles", "cross-border healthcare", "transnational medical travel", etc) to account for the diversity in each mobility type for health purposes.

Another well-known phenomenon regards migrants who, motivated by, for example, dissatisfaction and difficulties with their host countries' systems (Ormond & Lunt, 2019), travel to their country of origin to obtain treatments that are more familiar to them or that they find better suited for their cases.

Migrants and their networks in their countries of residence also play an important role in contributing to their relatives' healthcare needs from abroad. As the case of Ghanaians in the United Kingdom (Krause, 2008) demonstrates, therapy networks flow both ways. Migrants and their families establish valuable **formal** and **informal** contacts that may provide financial and practical support in cases of sickness (Krause, 2008: 236). These networks also prove necessary when strict migration control and the conditioning of healthcare provision to residency or nationality restrict migrants' access to healthcare services (Mingot & Mazzucato, 2018).

Research shows migrant families combine **different transnational and intersectional approaches** to ensure healthcare access. Lafleur and Vivas-Romero (2018) typified four transnational healthcare arrangements based on different social markers. These can be classified as: (1) Worker's Insurance, (2) Mobility, (3) Individual and Collective Remittances, and (4) Diasporic Health Policies. The first, Worker's Insurance, refers to the purchase of public or private insurance plans by employed migrants in the country of residence (Lafleur and Vivas-Romero, 2018). These can, in some cases, be extended to family members in the country of origin, too. The second type, Mobility, is characterized by a temporary cross-border movement to the migrant's origin country or a third country to receive care (Lafleur and Vivas-Romero, 2018). The same typification applies to the movement of family members to receive care in the migrant's country of residence; therefore, mobility can be used by both migrant and non-migrant people. The third kind, Individual and Collective Remittances, is often employed by migrants who support their family members with cash transfers to allow them to receive healthcare (Lafleur and Vivas-Romero, 2018). These remittances can also be sent through community-based forms of solidarity. Lastly, Diasporic Health policies are seen especially among sending states, which respond to their diaspora healthcare needs (Lafleur and Vivas-Romero, 2018). This is usually aimed at nationals living abroad with limited (or no access) to healthcare in their country of residence. In some cases, such policies may include non-migrant relatives living in the migrant's origin country.

Lafleur and Vivas-Romero (2018) have also identified the use of **sporadic** and **sequential** arrangements. The **sequential** transnational social protection arrangements stem from an exchange of items of equal value at different points in time — "today for you, tomorrow for me" (Lafleur and Vivas-Romero, 2018). This is usually employed by less privileged migrants who provide help to their relatives in their origin country in the expectation that they can count on them in the future, for instance, when they retire and require assistance. The **sporadic** transnational arrangements, on the other hand, are seen, in particular, among more privileged migrants following a logic of "Helping each other, sometimes" (Lafleur and Vivas-Romero, 2018). These often articulate market-based health solutions in the homeland, favorable access to mobility for migrants and non-migrant relatives, and limited use of remittances (Lafleur and Vivas-Romero, 2018). The authors also highlight the female protagonist in shaping and implementing these arrangements.

Therefore, scholarly discussions on the topic point to an emergence of **transnational therapeutic itineraries** (Zanini et al., 2013) and the "(re-)interpretations and (re-)negotiations of conventional forms of attachment and recognition in an ever-more mobile world" (Ormond & Lunt, 2019, p.6). Although these new healthcare landscapes transform the spatiality of service provision, it is important to consider that this phenomenon rests in concrete spaces and is embedded in social stratification and countries' legal distinctions (Zanini et al., 2013: 12).

2.3 Migration and Health Scholarship in Belgium

Concerning the scenario in Belgium, this thesis' main exploration territory, most literature on the intersection between migration and health investigates **migrant mortality rates and causes** (Vandenheede et al., 2015; Lafaut et al, 2019; and Vanthomme & Vandenheede, 2019), **migrant mental health** (Apers et al., 2023; Herroudi et al., 2023; Claerbout et al., 2024; and Molenaar et al., 2024), **undocumented migrants and asylum seekers' healthcare access** (Dauvrin et al. 2018; Lafaut, and Coene, 2020), and lastly, **discrimination in the Belgian healthcare system** (Arrey et al., 2017). In addition, Belgium has literature on the realm of sexual and reproductive health, having extensive research in

pregnant migrant women and newborn health outcomes (Schoenborn et al., 2021; Vanneste et al., 2020; Ceulemans et al., 2020; Keygnaert et al., 2014: 11).

2.3.1 Healthcare access barriers for migrants in Belgium

The contributions of several authors provide an overview of how the Belgian healthcare system can be **inaccessible** to certain migrant groups. Undocumented migrants and asylum seekers are among the most vulnerable migrant populations in Belgium, despite the generous legal framework protecting this community's healthcare rights (Dauvrin et al. 2018). Using the concept of **candidacy** (Chase et al., 2017), Lafaut and Coene (2020) identified several barriers to undocumented migrants' access to healthcare in Belgium and their coping strategies.

These obstacles included administrative constraints linked to obtaining a **medical card**, which ultimately led to delayed or inappropriate treatment, and dismissive or discriminatory attitudes of healthcare professionals. The concept of candidacy refers to the idea that one's candidacy or eligibility for care is **socially constructed**. Therefore, candidacy is dynamic, as the definition of who is an appropriate "object" of medical attention is continuously shaped and reshaped through interactive processes between patients and professionals (Dixon-Woods, 2006).

Among the coping strategies mapped out by Lafaut and Coene (2020) are (1) **abandoning further care-seeking**, (2) **adopting detouring, and dialogical responses,** (3) **enacting performative and discursive coping responses** to plea for understanding their situation and, at the same time, **re-asserting their candidacy**, and, lastly, (4) **confrontational responses**. Their findings suggest that most research participants had engaged in more than one response during their stay in Belgium. The interviewees also often compared their experiences with practices in their country of origin (Lafaut and Coene, 2020: 262).

Healthcare deservingness was another concept that was explored in the literature concerning Belgium and migrant health. In a comparison between Belgium and Spain, Perna and Umpierrez de Reguero (2025: 7) reveal that in both countries, certain individuals, including people with a foreign EU nationality or a migration history, experience penalization intentions when accessing publicly-funded healthcare. In Belgium, effects on deservingness

assessments are fueled by moral ideas of control and reciprocity, as participants believed that there is an individual and collective responsibility towards the cost and funding of healthcare (Perna and Umpierrez de Reguero, 2025: 7). The authors relate this phenomenon to the fact that, in Belgium, social health insurance entitlement is associated with an individual's employment status.

Perceived discriminatory practices in the Belgian healthcare system were also reported in a study focusing on Sub-Saharan African women living with HIV/Aids. Arrey et al. (2016, p. 588) recognize that the negative social perceptions about HIV heavily influence discriminatory and stigmatizing attitudes by healthcare professionals and institutions. Migrant women living with HIV/Aids in Belgium are particularly vulnerable and, as the evidence has shown, this group "may not feel comfortable testing, accessing health services or discussing their social and behavioral risks for HIV with providers where their identity is known" (Arrey et al., 2016, p.589).

2.3.2 Migrants' Reproductive and Sexual Health in Belgium

Concerning healthcare aimed at sexually transmitted illnesses, a study conducted in Belgium and the Netherlands demonstrates that being an undocumented migrant, asylum seeker, or refugee in these countries is a **risk factor for sexual ill-health**. Therefore, the authors claim that **one's migratory status can be considered a health determinant** (Keygnaert et al. 2014: 11). Furthermore, the study results indicate the importance of promoting sexual health through **culturally competent activities** (Keygnaert et al. 2014: 11).

The **reproductive health** has also been studied among migrant women in Belgium, particularly undocumented ones (Schoenborn et al., 2021; Vanneste et al., 2020; Ceulemans et al., 2020). Vanneste et al. (2020) assessed the differences between migrant women following prenatal care through the **Comprehensive Medical Insurance** (Assurance Maladie-Invalidité – AMI), the **Urgent Medical Aid** (Aide Medicale d'Urgence – AMU), or **without any coverage**. The first insurance covers the majority of the Belgian population; however, undocumented migrants may not be entitled to this standard insurance and may qualify for the second option instead, or decide not to adhere to any coverage at all. Not

having access to the healthcare system while pregnant is particularly dangerous, as migrant women face a higher prevalence of adverse pregnancy outcomes (Ceulemans et al., 2020).

The study results confirm that **difficult access to healthcare** and an **unfavorable socioeconomic situation** increase the incidence of low birth weight and premature birth (Vanneste et al., 2020). The said scenario was more common among migrant women who did not have healthcare or social security coverage. Of the uninsured women, 40% were waiting for an answer from the Public Centre for Social Welfare (Centre Public d'Action Sociale – CPAS), demonstrating that delayed procedures may affect the health of women and their newborn children (Vanneste et al., 2020: 311).

In addition, both the pregnant women covered by the AMU and the uninsured ones tended to have their first prenatal appointment at a **late pregnancy stage** (Vanneste et al., 2020: 311). Postponing prenatal care could result from language barriers, financial concerns due to the lack of social security coverage, a low level of education, or their recent arrival in Belgium (Vanneste et al., 2020: 311).

Schoenborn et al. (2021) found similar results, with the relative prevalence of prematurity, perinatal mortality, and low birthweight being higher in **unregistered women**, in comparison to their registered counterparts. The authors highlight that this group's lack of healthcare access stems from bureaucratic barriers, but also a lack of healthcare adaptation to migrants (Schoenborn et al. 2021: 11). Besides, when considering individual elements, pregnant migrant women may be discouraged from seeking healthcare services due to the **fear of being reported to authorities**, **communication barriers**, **shame**, unawareness of their rights, lack of knowledge about how the healthcare system works, or differences in belief systems (Schoenborn et al. 2021: 11).

Data concerning Arabic-speaking pregnant women corroborated the work of Schoenborn et al. (2021), as women reported suffering from communication barriers, hindering their efficient communication with healthcare providers (Ceulemans et al., 2020). The study also found that as a consequence of the language barrier, Arabic-speaking pregnant women would become frustrated or feel negative when their information needs were not fulfilled (Ceulemans et al., 2020).

2.4 Domestic Work Sector and the Feminization of Migration

After analyzing the relationship between migration and health, the care-seeking strategies of migrants, and the Belgian healthcare provision scenario regarding migrants, it is important to explore the literature surrounding migrant domestic workers. This research's target group is part of a global migration chain characterized by women from the Global South providing domestic services in the Global North. International migration with this objective is often **undocumented**, as countries rarely offer regular pathways for low-skilled workers (Marchetti, 2022). However, demand for such tasks is growing due to **welfare service cuts**, an **aging society**, falling **fertility rates,** the increasing **participation of native women in the job market**, and the **marketization of care** in the North (Fudge, 2014; Triandafyllidou, 2016; Marchetti, 2022).

Relying solely on a male breadwinner while the wife handles all the unpaid domestic tasks has become a rare domestic arrangement in both poor and rich countries. Therefore, hiring care services has become the solution for many families, who may resort to different service options (e.g., live-in or live-out employees, registered or unregistered domestic workers, etc). Ungerson (1997) argues that this scenario results in the marketization of intimacy and the commodification of care. As many female migrants step up to provide these services, Hochschild (2002) argues that this trend has boosted the feminization of migration, causing a "care drain" in the Global South. The gendered character of domestic work is undeniable. As stated by the International Labor Organization (ILO), **73.4%** of all migrant domestic workers are women (ILO, 2016). However, linking the increase of female migration to domestic work is criticized by Dumitru (2016), who opposes, in particular, the stereotyped thinking the term "care drain" entails and the overestimation of female migrant workers in the Global North (Dumitru, 2016).

It is also fundamental to consider the peculiar attributes of domestic work, as it blurs the boundaries between the **professional** and **intimate** spheres, which leads to constant negotiations regarding the boundaries between employers and employees (Marchetti, 2022: 14). In addition, as Triandafyllidou (2016) describes, domestic work is performed in other people's homes, a space that is not viewed as a 'formal' workplace, therefore, such an environment **escapes control on the part of labor inspections.** This puts domestic workers

in a vulnerable position, especially in countries that lack legal frameworks to protect this professional class. Likewise, undocumented and, therefore, unregistered workers are unprotected even in contexts where there is legislation on the matter.

The precarious character of work relations in the domestic work field motivated the International Labor Organization to adopt the Convention No. 189 concerning Decent Work for Domestic Workers[1] in 2011. The goal of the document was to extend labor rights to domestic workers worldwide. This was an important step in recognizing that work performed in the household is work like any other (Fudge, 2014). At the same time, the Convention acknowledged domestic workers' participation in the paid labour market and their distinct working conditions (Fudge, 2014).

The document also addresses the important role migrant women play in this market and recommends procedures to promote better working conditions for this group (ILO, 2011: Article 8). Marchetti (2022: 72) observes that the convention connected the fight for the cause of domestic workers' labour rights with wider struggles for the human rights of vulnerable groups, from undocumented migrants to racialized women. This is positive, as domestic workers are not a homogeneous group (Godin, 2016), and paying attention to the different social identities and immigrant trajectories present in this professional category can promote better working conditions in general.

2.4.1. Domestic Work in Belgium

In the European scenario, Belgium offers one of the most comprehensive legal frameworks regarding domestic work. Besides ratifying the C189 Convention, the country has specific legislation for domestic work and a collective agreement with the category (Godin, 2016; Marchetti, 2022: 36). Even before the C189, one of the actions Belgium implemented to formalize work relations in this sector was the creation of a voucher system in 2004. The vouchers — also known as *titres-service*, in French, or *dienstencheques*, in Dutch — allow Belgian households to obtain weekly housework services, excluding care, from authorized agencies.

[1] The convention's full text is available here: https://normlex.ilo.org/dyn/nrmlx_en/f?p=NORMLEXPUB:12100:0::NO::p12100_ILO_CODE:C189

Safuta and Camargo (2019) highlight how the Belgian voucher system created a **two-tier domestic service market**. That is because providing services through the voucher system is only possible if workers have a work permit. Belgium's legal framework allows hiring foreigners to work in a household, which is possible through the Permit B (which includes the *au pair* status) and the status of domestic worker in the diplomatic sector (Godin, 2016). However, despite the possibility in theory, this is made unfeasible in most cases as strict regulations against foreign low-skilled workers restrict such movement (Marchetti, 2022: 36). Interestingly, a phenomenon that has been observed by Lens et al. (2022) is that this system has attracted **highly-skilled migrant women**. Difficulties finding a job in their area despite being qualified and holding a legal status lead them to pursue a steady job in the domestic service sector instead (Lens et al., 2022: 129).

Considering that third-country nationals are offered scarce possibilities to settle in Belgium (particularly those working in low-skilled jobs), many are excluded from this system. This causes the informal domestic service market to be mainly composed of undocumented migrants (Safuta and Camargo, 2019: 06). One of the study's key findings is that formalization **did not considerably improve working conditions in the sector** (remaining still among the most poorly remunerated in the country), and neither did it change the **migrantized and gendered** character of paid domestic work in Belgium (Safuta and Camargo, 2019: 14).

2.4.2. Migrant Domestic Workers and Health

International migrant workers, especially those performing manual labor, face high rates of morbidity, injury, and accidents worldwide (Hargreaves et. al, 2019). Medical scholarship acknowledges that domestic workers are subject to a series of **detrimental health conditions** that could lead to negative health outcomes. The Lancet Commission on Migration and Health conducted a multidisciplinary analysis of the subject, which included concerns about migrant domestic workers. The study indicates that this group is subject to extensive working hours, food deprivation, exhaustion, and physical and chemical hazards (e.g., chemical cleaning agents), as well as repeated and deteriorating physical effort, including bending, reaching, and lifting (Abubakar et al., 2018).

Besides the risks linked to the physical aspects of the job, expectedly, this scenario is aggravated by the private nature of such work environments, which often escape labor inspections and control by the authorities (Triandafyllidou, 2016). Migrant women employed in the sector are, for example, subject to social isolation, physical, sexual, and verbal abuse (Abubakar et al., 2018). This is corroborated by Bauleo et. al (2019), who found that experience with **verbal or physical violence** at the workplace predicts poor general health and mental disorders among domestic workers. In addition, when living in the employer's house and taking care of children, domestic workers' reported general health was worse (Bauleo et. al, 2019).

In addition, Godin (2016) and Triandafyllidou (2016) argue that **undocumented domestic workers still face difficulties accessing healthcare provision.** As mentioned in the segment covering Migrant Care-Seeking Strategies (2.2), undocumented migrants' healthcare access in Europe is highly dependent on national law. Despite the Council of Europe's Resolution 1509 (2006), the application of this right is not homogeneous (Van Ginneken, 2014). Compared to other EU members, Belgium offers undocumented migrants a series of emergency and preventative healthcare services[2].

This population is often affected by the **lack of information regarding healthcare services** in the residence country. This is corroborated by Triandafyllidou (2016), who argues that by working in the household, they have restricted access to information and/or contact with institutions (such as NGOs and trade unions) that could assist them. This dialogues with Chen et al. (2022), who also identify a lack of knowledge or information about the residence country's healthcare system as preventing them from seeking such services in China. In addition, **cultural and language barriers**, and the **lack of time flexibility** when seeking health care services have also been identified as central obstacles (Weng et al., 2021). Issues providing a personal address also limit this group's access to the system (Godin, 2016).

[2] These rights are defined in a 1996 Royal Decree available on this link: https://www.mi-is.be/sites/default/files/documents/ar_1996-12-12.pdf

2.4.3. Brazilian Migrant Women, Healthcare System Use and Health Practices

During the theoretical exploration, the gap in studies about the health practices and healthcare access of domestic migrant workers was clear. Few studies focus on women working in the **cleaning**, **domestic service,** and **care sectors** (Godin, 2016; Lafleur and Vivas Romero, 2018; Safuta and Camargo, 2019). Likewise, studies investigating the Brazilian community residing in Belgium were scarce, and no studies focusing on the intersection between migration and healthcare in this community were found. Specific literature on the theme has been produced in the **United States** (Messias, 2002), **Australia** (Silva and Dawson, 2004), and **Portugal** (Dias et al., 2010a; Dias et al., 2010b), countries that have significantly larger Brazilian communities.

Considering what has been published concerning the health of Brazilian migrant women, these women rely on a **combination of personal and collective transnational resources** (Messias, 2002). The study shows that their **mobile healthcare practices** start before migrating, as some women had engaged in pre-migration healthcare check-ups. On another note, during their stay in the United States, one of the most common cross-border healthcare practices was the use of transnational medications (Messias, 2002). Such medicines would even be stocked, as the interviewees would bring a hefty amount of them upon arrival. For them, this was a strategy to avoid having to seek professional health care in the United States, a crucial issue for the uninsured participants (Messias, 2002).

Another important finding of this study is that **informal social networks** were crucial for the women to access information and formal U.S. healthcare resources. In addition, they would also exchange information, ask and provide advice, and offer or benefit from transportation (e.g., bringing medicines from the origin country). Furthermore, the study demonstrates that the back-and-forth movement between the United States and Brazil allowed some women to continue relying on Brazilian medical coverage and providers.

However, Messias's study (2002) also shows that migrant women may resort to **putting their health on hold**. According to the researcher, this is motivated by “limited time and resources, coupled with a transient mindset (even among long-term residents), which

contributed to the attitude and practice of delaying or postponing the seeking of professional health care" (Messias, 2002: 191). Other factors that contribute to this behavior include migration status, work and employment demands, financial situation, lack of information, knowledge barriers, personal and/or culturally informed practices, and actual and perceived barriers to formal care (Messias, 2002). This delay in healthcare is not exclusive to this demographic, as it was also identified among migrant domestic workers in China (Chen et al., 2022). Other authors, nevertheless, point out that delayed healthcare seeking, diagnoses, and treatment are present in different migrant populations and can be identified concerning different illnesses such as cancer, tuberculosis, and HIV (Ersözlü et al., 2025; Cho et al., 2018; Guillon et al., 2018).

In another study, Silva and Dawson (2004) identified **sociopolitical**, **sociocultural,** and **socioeconomic** barriers affecting Brazilian women's health in Australia. The first category comprises difficulties such as social isolation, language barriers, and a lack of information about the Australian healthcare system. These issues were more compelling during the early stages of their migration trajectory, as they were still unfamiliar with the country's healthcare system and were still dependent on other people to guide them through such processes (Silva and Dawson, 2004).

The sociocultural dimension includes, in particular, issues in the **doctor-patient relationship**. Besides reporting feeling that their needs were not understood and met by healthcare professionals, interviewees mentioned lacking trust in the professionals, and disliking the fact that their access to certain medication was restricted (Silva and Dawson, 2004). Lastly, the socioeconomic barriers mostly refer to the financial impossibility of acquiring health insurance. The study also indicates an underlying power asymmetry between women and health care professionals, leading to women patients' disempowerment (Silva and Dawson, 2004).

The Brazilian community in Portugal is the biggest in Europe, and Brazilian women's healthcare habits were studied by Dias and colleagues (2010a) along with those of other immigrant women. Among the participant groups, Brazilian women were the ones who reported using the Portuguese national healthcare system the least. Brazilian women mostly use health services during emergencies or acute illness (73.8%), for follow-up or routine consultations (65.9%) and for carrying out complementary diagnostic tests (56.5%) (Dias et

al., 2010a: 42). This may be explained by the findings from another study, in which Brazilian women mentioned difficulties in accessing healthcare services, especially among the undocumented ones (Dias et al., 2010a).

Furthermore, Brazilian women described **negative experiences** in health care services (Dias et al., 2010b). Besides expressing their mistrust in the professionals, the participants shared the perception of poor quality of the delivered healthcare. In addition, they expressed having the impression that **preventive medicine** is not valued in Portugal. Regarding the attitudes of health professionals, Brazilian participants claimed they suffered from a set of stereotypes that health professionals would hold about Brazilian women (Dias et al., 2010b). Health professionals would go as far as to imply that Brazilian women have more diseases than native Portuguese (Dias et al., 2010b). Other reported cases included harassment by male health professionals who misinterpreted gestures of gratitude by the patients. Lastly, the study found that after suffering discrimination in healthcare services, participants would avoid the services or use them less frequently.

3. Contextualization and Methodology

The theoretical framework above helps answer this study's main questions: **What are the health-related challenges Brazilian women employed in the cleaning sector in Brussels face, and what are their strategies to overcome such challenges?** At this point, an important distinction must be made. This study is not about occupational health, as it aims to provide a more comprehensive analysis of this group's experiences with health and healthcare. However, during the analysis, mentions of the nature of cleaning and domestic work, as well as incidents connected to their occupation, were present and will be addressed in the coming pages.

In addition, the use of "cleaning sector" instead of "domestic work sector" in the research question acknowledges the fact that not all cleaning work happens in the domestic sphere. Although cleaning the household is the most common activity among the research participants, they also reported performing cleaning services in offices, construction sites, newly-built or renovated places, industrial facilities, schools, stairs, and even post-fire.

This is an important investigation, considering both the lack of studies covering the realities of cleaners and domestic workers in Belgium and the gap in the literature concerning Brazilian migrants in the country. One of the reasons for this gap may be the modest size of this community in comparison to others, invisibilizing it in research, policy-making, and other fields.

3.1. Brazilian migration in Belgium

Until the 1980s, Brazil was essentially an immigration country (Firmeza, 2007). Colonial ties and intense human mobility have shaped Brazil's population diversity and influenced the main destinations of Brazilian emigrants. For instance, Japan hosts the fifth-largest Brazilian community abroad, which is mostly composed of descendants of Japanese who migrated to Brazil (Frizzo & Mascitelli, 2020: 74).

In the absence of colonial ties or a sizable emigrant community in the country, Brazilian migration to Belgium followed a different dynamic. In the 1960s, fleeing the military regime, a small number of political refugees, as well as artists, students, and football players, inaugurated this migration corridor (Schrooten, 2012). However, with the democratic political changes in the 1980s, many of them returned and contributed to Belgium's image as an interesting destination country (Schrooten, 2012).

Since the 1980s, particularly after the fall of the Military Regime (1964-1985), Brazil has become a country of emigration (Firmeza, 2007). After that first politically driven and modest in size migration wave to Belgium, the economic crisis at the end of the 1990s boosted a second wave. The 1990s and the beginning of the 2000s are characterized by a significant economic migration expansion from Latin American countries to Belgium (Godin, 2016). This was also motivated due to stricter migration policies enforced since 9/11, which made traditional destination countries for Brazilians — such as the United States and the United Kingdom — become more difficult to reach (Godin, 2016). As a result, migrants were led to consider other options, elevating Belgium as an attractive option.

According to the Brazilian Foreign Ministry, there are around 50.000 Brazilians living in Belgium (Ministério das Relações Exteriores, 2024)[3]. The data, nevertheless, is only an

[3] The full study can be found here: https://www.gov.br/mre/pt-br/assuntos/portal-consular/BrasileirosnoExterior2023.pdf

estimation, as it is difficult to determine the exact size of the community, for many are undocumented and only a few communicate their stay in Belgium to the consulate. Brussels is notably the city with the largest Brazilian community in Belgium. Despite the lack of official data, the municipality of Saint-Gilles is particularly known for its sizable number of Brazilian residents, which is why most of this research was conducted there.

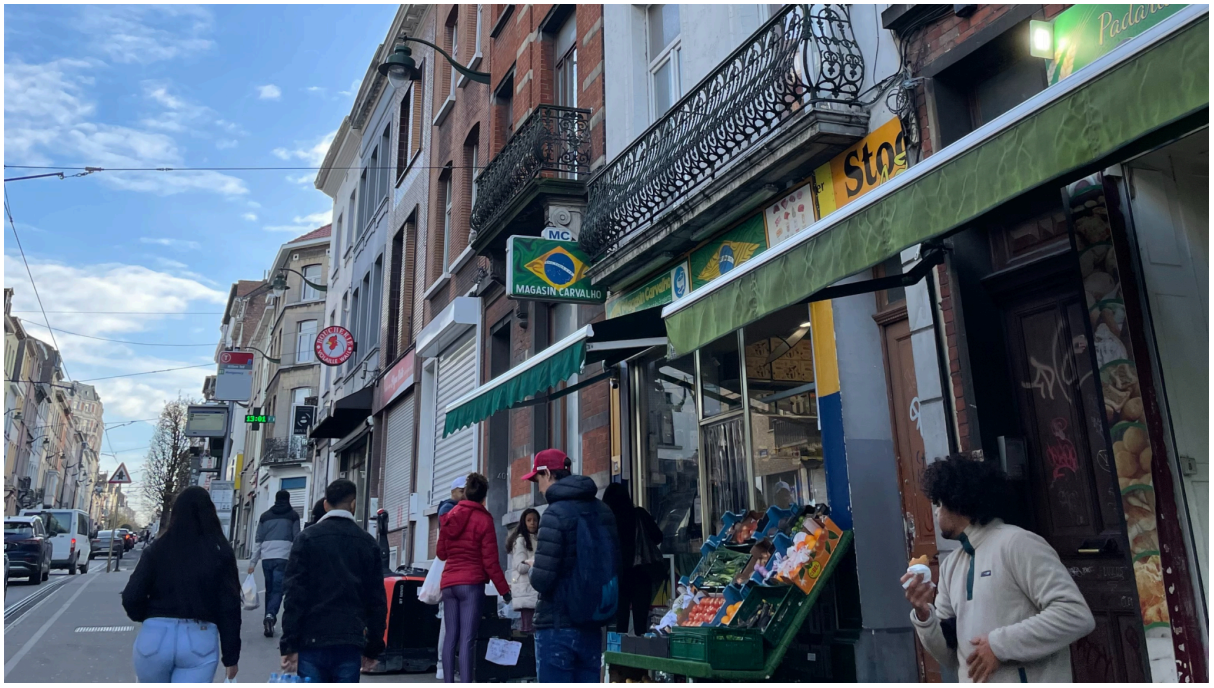

Image 1: A Brazilian Supermarket in the Saint-Gilles Municipality. It is common to see people eating typical Brazilian snacks such as *coxinhas* (a fried chicken croquette) on this region's sidewalks. 01-12-24. Source: author's own archive.

3.2. Brazilian domestic workers

As mentioned before, the domestic work sector is highly migrantized in Belgium; however, data covering the informal sector is scarce. Data concerning service voucher workers, nevertheless, is widely available. According to a recent report[4] out of the 27.911 active service voucher workers that year, **97,8%** had a foreign origin, of which **38%** originate from a country outside of the EU (Idea Consult, 2020). In Brussels, **73,3%** of the service voucher workers are migrants (56,2% from EU countries, and 17,1% from outside the EU). The scenario is very different in Wallonia and Flanders, regions where the majority of the service voucher workers are Belgian (82,9% and 68,1%, respectively).

[4] Full study can be found here: https://www.cgslb.be/sites/default/files/aclvb/05_evaluation_du_systeme_des_titres-services_en_rbc_2019.pdf

There is no specific data about the number of Brazilian service voucher workers in Belgium, but it is known that during the 2000s and 2010s, Latin American and Filipino women have become the two dominant Third Country Nationals (TCNs) groups within the **informal domestic sector** (Godin, 2016). This may explain the smaller numbers of TCNs among service voucher workers, indicating that Brazilian domestic workers could be less protected than their counterparts, both regarding labor conditions and healthcare access. However, the lack of data concerning Brazilian workers in the sector certainly creates a limitation for this study, as it is not possible to confirm this assumption.

3.3 Methodology

This study adopts a qualitative approach, which was deemed the most adequate way to highlight personal experiences and testimonies of Brazilian migrant women working in the cleaning sector. The choice for **interviews** as the main data collection tool for this research takes into account its sensitive and people-oriented character, "as it allows participants to construct their accounts of their experiences by describing and explaining their lives in their own words" (Valentine, 1997: 111). It is important to remember that an interview is useful to understand how individual people experience and make sense of their own lives, without the intention of being representative (Valentine, 1997). Therefore, this research tool is aligned with the aims of this research. In addition, **participant observation** was employed as a complementary method. This is a valuable resource as it allows researchers to participate in a community by engaging in its activities and routines and taking notes, impressions, and documenting the field (Cook, 1997: 167).

The data collection was mostly based on in-depth semi-structured interviews with the aim of obtaining interviewees' perceptions of their health, their struggles accessing and using healthcare in Belgium, as well as their strategies to ensure and preserve their health. The sample was established through contacts with the Group of Brazilian Women in Belgium, the catholic community, and a snowball approach. In addition, participant observation was conducted in the context of activities with the target group and hospital visits.

The main criteria to select the interviewees were: being in Belgium for at least six months, working in the cleaning sector, being over 18 years old, agreeing to collaborate with

the researcher, and providing informed consent. The length of stay requirement had the goal to improve the chances that these women would have spent enough time in the country to face questions regarding health and healthcare service provision. In addition, despite not working in the sector, two other actors in the Brazilian community were also interviewed to provide external insight on this matter, particularly on the role of organizations in providing help and informal networks.

The interviews were semi-structured and covered their experiences with their health pre- and post-migration, care-seeking strategies, and the Belgian healthcare system. The interviews were conducted **in person** or **online,** considering the interviewees' availabilities, as many could only participate in the late hours of the day after their shifts. All of the interactions were held in the community's native language, Portuguese. All the material was recorded for analysis with the interviewee's oral consent, transcribed. To facilitate the data analysis phase, the aTrain software was employed for a first round of transcriptions. This tool automatically transcribes speech recordings without uploading any data online, which motivated its use, to ensure the protection of interviewees' private data. All of the transcriptions were then revised, and incorrect transcriptions were corrected.

Following ethical protocols in social sciences, their names have been anonymized by the creation of pseudonyms, and they were offered the option to refrain from participating at any point in the research. The data was analyzed through codes in search of **common themes** and common experiences that illustrate this community's experiences. The codes were empirically based and grounded in the interview data. They were visually represented in a double coding tree (Chart 1), one regarding the challenges the community faces and the other focusing on their strategies to ensure their health.

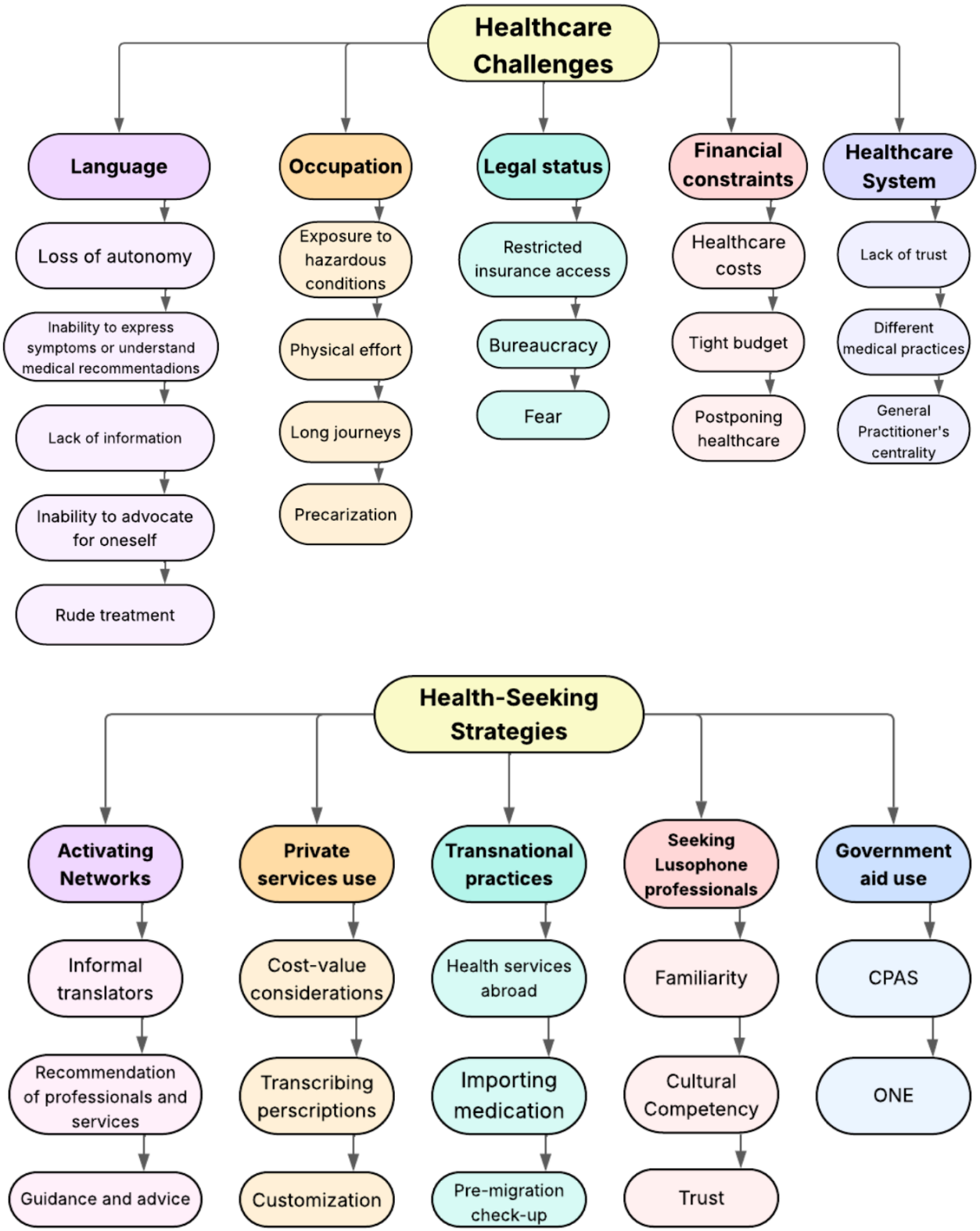

Chart 1: Coding tree separated by the two elements the research question aims to address. Each tree has five nodes followed by its composing elements. Though represented with arrows, that does not mean there is a causal or sequential relationship between them; the choice is purely aesthetic. Source: author's own archive.

The final sample is composed of **17 women**, ranging from **23** to **62** years old, with residency lengths varying from **9 months** to **28 years**. Their formal education levels vary greatly, ranging from incomplete secondary education to complete higher education. Concerning their legal situation, there are documented participants, undocumented ones, and others waiting for the analysis of their files by the Immigration Office. Their reasons to act in the cleaning sector include a lack of diploma recognition, the flexibility the job allows, and the low level of French required to work in the sector.

They are mostly **economic migrants**, motivated by the desire to improve their quality of life. It is common for them to see migration as a family project with particular attention to the future of their children. In many cases, their arrival and settlement in Belgium were made possible through the invitation of family members and friends, who often supported them in their first months or years in the country.

The regions where they originate in Brazil vary, including representatives from all the official macro-regions employed by the Brazilian government (North, Northeast, Central-West, Southeast, and South). Despite the lack of recent information on the Brazilian community in Belgium, a 2009 International Organization for Migration (IOM) report estimated that more than 57% of Brazilians in the country came from the states of Goiás and Minas Gerais (Góis et al, 2009). The sample, though not having the aim of being representative, still mirrors the prevalence of migrants from these states as 7 out of 17 interviewees (41%) originate from Goiás and Minas Gerais. Chart 2 illustrates the geographical variety of the interviewees.

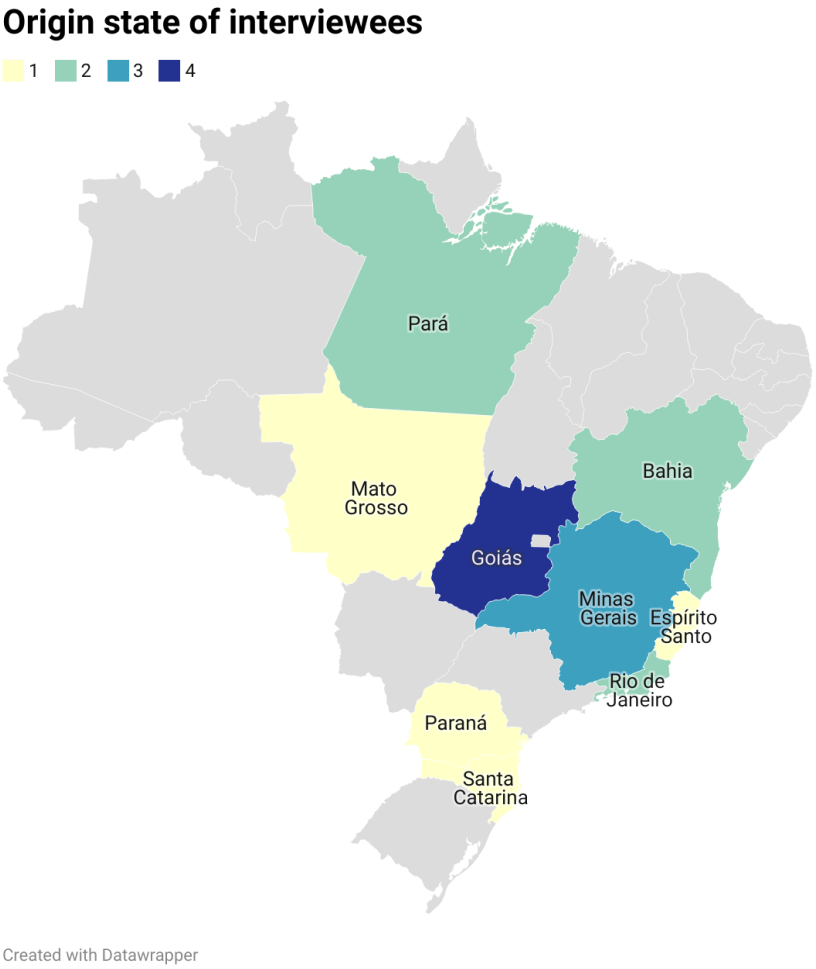

Chart 2: Interviewees' origin states. Source: author's own design created with Datawrapper.

3.4 Positionality and Self-reflexivity

Before following up with the empirical analysis, an important self-reflexivity exercise is needed. It is understood that the social position of the researcher influences their link with the interviewees, affecting, therefore, their access to the field and the information they are provided with in such exchanges (Sánchez-Ayala, 2012). The choice to work with the Brazilian community felt safe, as I, as the researcher, share the same cultural background and language as my research subjects. However, fieldwork was more challenging than expected, in part due to my positionality. Two very different studies resonated with the difficulties I encountered when conducting fieldwork: Takeyuki Tsuda's doctoral research on Brazilian Japanese descendants working in 3D[5] jobs in Japan and Maria Vivas-Romero's doctoral

[5] The three ds mean "Dirty, Dangerous and Demeaning", in Japan, where Tsuda's research was conducted, this concept is known as 3K jobs: *kitanai, kiken, kitsui.*

investigation on global social protection arrangements by Latin-American domestic workers in Brussels.

Despite viewing myself as an insider, during my exchanges with interviewees and other community actors, my "Brazilianness" was questioned. I was asked in different contexts whether I was Portuguese; others would assume that I was of Brazilian origin, but grew up here, and I was once approached by a Brazilian priest in French (as, according to him, I looked European as I was "very white"). These interactions came as a surprise, for being Brazilian is a dear part of my identity. The feeling that I was an insider quickly faded away, as I was not immediately recognized as an equal.

This reminded me of the challenges Vivas-Romero (2017) described in her exchanges with the Latin-American community. Despite recognizing herself as a Venezuelan *mestiza* from a lower middle class (Vivas-Romero, 2017: 165), and as a member of a pan-ethnic Latin-American community (Vivas-Romero, 2017: 167), which did not grant her immediate access to the field. She was perceived as privileged by community members due to her higher education status and "facilitated" migration entryway (family reunification), which restricted her access to the field (Vivas-Romero, 2017: 167).

Upon reflection, I could understand such reactions. I am not a resident of Brussels nor Saint-Gilles (the Brussels commune where most of the fieldwork was conducted); I was an unfamiliar face in the community. Therefore, such interactions taught me that I would have to engage in activities beyond those that would directly benefit my research, to build a bridge with the community I initially considered as my own.

Additionally, social dimensions from Brazil were playing out in my exchanges with interviewees and, at times, distancing us. I too was framed as a privileged girl, being called "chic" for speaking English, following a Master's in a foreign institution, and having parents who were able to afford supporting me in Europe. I understood why distancing me from the community was a common reaction, as I indeed have an upper-middle-class position in Brazil, a different reality from the majority of my research participants. I must recognize, however, that my gender played a great role in granting me access to the field, being a positive influence in my interactions.

It is in this scenario that Tsuda's work resonated with my fieldwork. He highlighted his need to negotiate his identity in the field, being at times a PhD researcher, and at others a *dekasegi* factory worker (Tsuda, 2003). I did not work as a cleaner, but sharing my experiences working at a café in Belgium helped me negotiate my identity in the field. I, too, performed low-skilled work, washing dishes, cleaning floors, handling trash, and enduring challenging moments with my boss. At times, usually on Wednesdays, I would work for eight hours without a break nor food (despite being under a student job contract). After such long shifts, my feet and lower back would hurt. This experience made me closer to their realities, despite one fundamental difference: I do not fully rely on this work to make ends meet. However, when sharing this with interviewees, they expressed surprise and even solidarity, seeming more confident in sharing their stories with me.

In this process, a crucial step was to approach the community through frequent activities. The best way to do so was to interact with a local Brazilian religious community. This also resonates with Vivas-Romero's (2017: 170) fieldwork, as her church engagement granted her more access to her target group. Not all my interviewees came from the religious group, but participating in their activities had a positive effect on making women (and sometimes their husbands) more comfortable with contributing to my research. This would also be crucial for them to indicate people who could fit my criteria. My commitment to the weekly gatherings was seen positively, as people gained trust in me. This was voiced during an encounter, when an interviewee shared that she felt more confident participating after seeing me walking around the neighborhood with Brazilian nuns.

My final evaluation is that despite my initial disappointment with the shortcomings while accessing the field, this was a constructive experience. With time, patience, and negotiation, I was able to obtain the information I aimed to. At the same time, I consider the "natural" distance existing between me and the interviewees was healthy to avoid an emotional attachment towards them on my part, enabling a more balanced analysis.

4. Empirical Analysis and Findings

When directly asking the research participants whether migration had an effect on their health, they would rarely respond "yes". However, as they shared their experiences, there were multiple signs that migrating did affect their health in many ways — in most

cases, negatively. As the coding tree (Chart 1) shows, multiple elements influence these women's health. Concomitantly, they engage in ways to overcome such issues, at times successfully or only partially.

In this section, the different challenges regarding these women's health and their health-seeking strategies will be addressed. Concerning the health challenges, the following paragraphs will discuss the influence of **occupation**, **language**, **legal status**, **financial constraints**, and the **healthcare system's organization** on this group's health. Further on in the text, their health-seeking strategies will be highlighted, considering the activation of **networks**, the use of **private services**, **transnational practices**, the preference for **Lusophone professionals,** and the use of **government aid**. Such factors will be illustrated with direct quotes from their testimonies — Appendix 1 contains short biographical presentations of the interviewees to facilitate reading.

4.1 Health challenges

Before exploring the health-seeking strategies employed by Brazilian women working in the cleaning sector, it is crucial to describe their main difficulties in their country of residence. Their occupation creates a **vulnerability layer**, as prolonged physical effort, contact with contaminating agents, and chemicals can be detrimental to health. However, this sensitive dimension of employment in the cleaning sector overlaps with other circumstances, which will be addressed and exemplified in the following sections.

4.1.1 Occupation(s) and their health challenges

According to the interviewees, cleaning sector services vary by the **type of cleaning** (e.g., deep cleaning, maintenance cleaning), **workplace category** (e.g., private residence, offices), and **how it is provided** (e.g., through vouchers, or “in black”). Work in this sector is rarely organized in a typical nine-to-five routine; employees may work full-time, part-time, or on an hourly basis (Marchetti, 2022: 2). Except for those who live in the home of the employer, cleaners’ workplaces are often dynamic. They may work at a different residence every day, combine residences with other facilities (e.g., offices), or specialize in providing sporadic services (e.g., cleaning construction sites, stairs), therefore not creating a work relationship with an employer.

One of the most important differentiations between these workers is, nevertheless, being employed in the **formal** or **informal** sector. In Belgium, domestic workers in the **voucher scheme system** acquire a set of rights, including access to healthcare in the health agency of their choice (Vivas-Romero, 2017). Healthcare insurance is provided by a mix of their employers' contributions and their own. When working in the formal sector, they also benefit from several **safety norms**, **periodic training**, and the **labor protection regime**[6]. In addition, considering other benefits linked to health, these workers are entitled to paid sick leave related to work accidents (Vivas-Romero, 2017). Therefore, those working in the voucher system are better cushioned regarding healthcare matters, which creates a clear division between domestic workers' health protection and healthcare provision possibilities.

Such measures significantly improve their working conditions. This was clear when interviewing women who have experienced both the declared and undeclared sides of this sector. **Tereza**, a 60-year-old Brazilian woman, has been working in the cleaning sector since she arrived in Belgium 21 years ago. She obtained her documents following the 2009 amnesty for undocumented migrants, and since then, she has worked through the voucher system. Her testimony illustrates that her papers granted her the possibility to prioritize better work conditions and to choose respectful employees.

> *"At first, I took on a lot of difficult work, you know? Then, I got my papers, and now I don't do that anymore. When I didn't have documents, I worked for a woman who didn't have a vacuum cleaner. It was strange, I never understood that. I don't know how many hours I worked there, but she never paid me. And not to mention, we get harassed. I once worked in Braine-l'Alleud, and the man tried to kiss me. I almost pushed him, but I didn't because he was old. He wanted me to dance samba for him. I couldn't speak clearly yet, I didn't have documents, but I said, 'Monsieur Gérard, I'm here to work and not for that.'"*
>
> (Tereza, Brazilian voucher service cleaner, Online, 15-06-2025)

In this short excerpt, we are presented with examples of **exploitative work environments**, **wage theft**, workplace **harassment**, and **language barriers** (Abubakar et al., 2018; Bauleo et. al, 2019). As mentioned in the theoretical framework, these are conditions

[6] Two recent decrees have added more protection mechanisms to service voucher workers in Brussels, guaranteeing, among other things, more training hours and even the exclusion of abusive clients: Arrêté du Gouvernement de la Région de Bruxelles-Capitale du 22 février 2024 modifiant l'arrêté royal du 12 décembre 2001 concernant les titres-services and Arrêté du Gouvernement de la Région de Bruxelles-Capitale du 22 février 2024 modifiant l'arrêté royal du 7 juin 2007 concernant le fonds de formation titres-services.

that a significant part of migrant women employed in the informal sector are subject to. Consequently, as they are excluded from Belgium's labor protection mechanisms, undocumented workers face less favorable working conditions.

Besides being subject to abusive employees, they do not receive training and are fully responsible for any work-related accidents. Furthermore, as they are not guaranteed a minimum wage, participants reported that their working days tend to be longer, and they often accept heavier jobs. A shared feeling among numerous interviewees is that, in this sector, choice is an illusion: you must work regardless of your preferences or personal well-being. Catarina, a 39-year-old Brazilian cleaning lady whose Portuguese papers were under analysis by her municipality at the time of the interview, chose to work informally while she is not able to regularize her situation. She described part of her struggles:

> *"Since we work informally, we don't have any rights. So, if I don't work, I don't earn. Sometimes, we work even when we're sick, you know? I won't deny it. When the situation is really bad, that's when we give up. But that's it, if I don't work, I don't earn. That money is missing at the end of the month, when it's time to pay the bills."*
>
> (Catarina, Brazilian domestic worker, Online, 16-06-2025)

Despite working in the same sector, the conditions voucher system employees and informal market workers face are, obviously, different. This is in line with the findings of Safuta and Camargo (2019), who argue that the system created a **two-tier domestic service market.** I argue that it is also possible to translate this idea to the adverse health conditions that women in this sector face. Though both declared and undeclared workers report work-related health difficulties, it is clear that the registered ones are better cushioned against the short-term and long-term health consequences of their jobs.

Though occupational health is not the main focus of this study, it is not possible to ignore the health risks involved in this activity. In the Belgian context, they were addressed in a 2022 report[7] published by the Federal Public Service Employment, Labor and Social Dialogue (Service Public Fédéral Emploi, Travail et Concertation Sociale). The document lists a series of health concerns linked to domestic work and cleaning tasks, which include: risks associated with **chemical agents**, carrying **heavy weights**, **musculoskeletal** problems

[7] The full report is available on this link

derived from repetitive movements, poor posture, and physical effort (SPF Emploi, 2022). In addition, these workers may suffer from **pain**, especially joint or muscle pain, backache, neck or shoulder pain, wrist or elbow pain (SPF Emploi, 2022). Another common concern is the effects of cleaning products, which can lead to skin problems, irritations, allergies, and even respiratory issues caused by vapors from these products (SPF Emploi, 2022).

During the interviews, several of these issues were reported. Tereza, who developed tendonitis as a result of working as a cleaning lady, is one example. However, despite being protected by labor rights and having heard her doctor's concerns, she could not prioritize her health. Her priority is to support both her daughter and her granddaughter, who also live in Belgium.

> *"With this cleaning job, which I've been doing for a long time, I developed tendonitis. I have tendonitis everywhere, even in my hands. There was a time when I couldn't work anymore. When I lifted my arm, I screamed in pain. So I had to take a break and went to the physiotherapist for a massage. My doctor at the time said, 'For you to get better, you have to quit this job.' So I joked with him, I said, 'But doctor, how am I going to eat?'"*
>
> (Tereza, Brazilian voucher service cleaner, Online, 15-06-2025)

Another typical example of how their occupation challenges their health is the issues with chemical agents. According to the SPF Emploi (2022) report, the system's users can choose the products that the service voucher company's employees must use during cleaning. In practice, interviewees mentioned that some agencies instruct workers and users about products to be avoided. Bleach (*"eau de Javel"*, in French) is a particularly troublesome one that tends to be avoided. Catarina, who works informally, had an experience with this product at the beginning of her career in the sector. She understands this as a consequence of the lack of instruction she was given before working in the area:

> *"Right at the beginning, I mixed anti-lime with bleach. I had no idea I shouldn't do it. It started to burn, my eyes started to sting, my throat burned. I learned as I worked. The type of material, what works, and what doesn't. I learned it all through experience, literally living and learning. The only guidance comes from a friend or two, because working here, especially 'in black', requires a lot of referrals. Whoever worked there first gives you the tips."*
>
> (Catarina, Brazilian domestic worker, Online, 16-06-2025)

Despite being framed as a low-skilled job, cleaning professionally is not intuitive nor just an extension of what is done at home. Training is also crucial for these workers to learn the ideal uses of products, ergonomic postures, and the like. Therefore, promoting specific training for this professional category has been recommended and encouraged by the ILO's C189 and the Domestic Workers Recommendation No. 201 (Liem et. al, 2024). In line with such recommendations, those working for agencies have to fulfill mandatory training before starting on the job and are given the opportunity to update their training every year (A. Gouv. Rég. Brux. nº 2024002252). However, as Catarina's experience highlights, this is far from the reality of informal cleaning workers.

This does not mean, however, that workers employed by agencies are fully protected. The SPF Emploi 2022 report warns that inspections revealed that some agencies were not fulfilling their obligations. Examples of violations include the absence of specific risk analyses, lack of mandatory health monitoring (before starting the job and periodically), and also the verification by company management that the equipment at the user's household is suitable for the work, ensuring workers' safety and health (SPF Emploi, 2022).

Besides the health challenges at work, interviewees acknowledged that their routines also contribute to the deterioration of their health. This is supported by the literature on social determinants of health and the effect of low-skilled migrants' occupation on their health (Chen et al, 2022; Hall et al., 2019; Krieger, 2010; Marmot et al., 2008; Wilkinson and Marmot, 2003). Especially among undocumented participants, **work is the main priority** (also observed by Messias, 2001). The longest workday was reported by Rachel, an interviewer who worked for 16 hours at a construction site during a "big clean-up" job ("*grande limpeza*", in Portuguese). Such long routines demanded planning:

> *"At the time, my daughter was around 5. It was hard because I had to pay for a babysitter and everything. My husband worked construction, and I was cleaning. He came home earlier than me, because in cleaning, you never have an exact time to stop."*
>
> (Rachel, Brazilian cleaning lady, online, 09-06-2025)

Rafaela, a 27-year-old undocumented migrant, works, on average, 9 hours a day from Monday to Saturday. But in reality, she stays away from home for about 14 hours a day, as she must commute from one workplace to another during the day. Taking up such a long routine is necessary as she has no job security.

"Since I'm 'illegal' in every way, I don't know if they'll be able to keep me. My boss called me and said that the situation is complicated. So, I have a deadline of a month or a month and a half. During that time, I have to work as much as I can, so I can make as much money as possible. Because from the moment he lays me off, I'll be out of work, and I need an income to pay my rent. I need to eat. So, we work, work, work to be able to save up so we don't have to go without for two or three months, which has already happened to me."

(Rafaela, undocumented Brazilian cleaning lady, Brussels, 18-05-2025)

Hearing the experiences of cleaning workers is enough to understand that fitting time for personal care is challenging in their routine; a health check-up is among their last priorities. Furthermore, physical exercise is restricted to the effort they put in at work, as exhaustion discourages them from doing sports or going to the gym. In Brazil, Sofia was a pharmacy technician, but in Belgium, she works informally as a cleaning lady while she waits for her regularization process through family reunification to be finalized. Though her main job is cleaning a school, she is also asked to serve lunch for the students and do the dishes. She is accompanied by only one colleague. Though she has always been active, exercise became a hard task since she took on this job.

"I went through a period of extreme fatigue. I've always had a life of physical activity, even in Brazil, working a lot, even in Portugal, I always went to the gym. Always did physical activity. And one thing I can't do here is associate work with it. I've tried several approaches, and the fatigue didn't improve. Why is that happening? The work at school is demanding. They expect us to fit 7 hours' worth of work in 5. It's too demanding, and I end up not having enough energy for physical activity. So I cut it out for now, which is bad."

(Sofia, school cleaner, online 14-05-25)

In addition, healthy meals are often neglected and substituted with snacks on the go. Luzia, a 51-year-old service voucher employee, affirms that she was only able to care for her health after obtaining her documents following the amnesty.

"There was no way [to take care of my health]. Only after the papers. Because, after that, I went to the gym and could 'abandon' the vacuum cleaner. I also went to a nutritionist, because I gained a lot of weight. It was because I used to eat like that: snacks, bread, sandwiches... At night, the stress of work made me very anxious, which would make me hungry and eat even more."

(Luzia, service voucher worker, Brussels, 12-06-25)

Before following with the next section, it is also significant to highlight their multiple occupations **beyond** paid work. Only three women in the sample do not have to engage in direct chores to support their children and husbands. From their testimonies, the division of household chores seems to be uneven and mostly concentrated on the women.

> *"Most of the time, there's not enough time for us. I swear I try, but there are so many things to do throughout the day, then you realize the day is over, and you get that feeling of not having done everything you needed to. It's tough… I try to share it with my husband, but he can't get it done either. Because men leave with one thing on their mind, like, "I go to work, I work, and I come back." Then they don't do anything else. Not us, women juggle a thousand tasks at once. This doesn't just make our bodies tired, but our minds, too, you know?"*
>
> (Catarina, Brazilian domestic worker, Online, 16-06-2025)

> *"I feel like I'm sometimes even more tired when I get home. Because I'll have to do the housework. I'll have to do almost all of that work again. I think that what often tires us out is this double shift. You can see that almost everyone who works in cleaning has to get home and make dinner, and many have to take care of their children. The double shift is what, I think, weighs most heavily on those who work in cleaning. But many of them have children to take care of, and sometimes they don't have a husband."*
>
> (Rosa, service voucher cleaning lady, Online, 15-06-25)

Such testimonies demonstrate that health is, in many cases, the last thing on these workers' minds. Cleaning sector employees face multiple daily challenges concerning their health, as registered in the literature (Chen et al, 2022; Bauleo et. al, 2019; Hall et al., 2019; Abubakar et al., 2018). These challenges are directly associated with their occupation or the arrangements they must make to commute, get to work on time, make sure they save up enough in case they get laid off, and other reasons. In addition, the concentration of household chores on these women also contributes to this scenario.

Both registered and unregistered workers face similar challenges; however, the testimonies indicate that service voucher workers are still more protected against health issues than those who work informally. It could be said that the two-tier domestic service market envisioned by Safuta and Camargo (2019) also operates in the uneven degradation of some workers' health more than others.

4.1.2 Legal status and access to healthcare

As discussed in the previous section, legal status heavily influences one's working conditions in the sector. However, it also affects their access to healthcare. In Belgium, the healthcare system requires **compulsory health insurance**, commonly represented by sickness funds (*mutuelles*, in French and *ziekenfondsen* or *mutualiteiten* in Dutch). Despite its nearly universal coverage (99%), those who do not meet the administrative requirements are left out of the system (OECD/European Union, 2023). This group is often formed by **undocumented migrants**, a part of **asylum seekers** (depending on the status of their application), and **homeless people** (Gerkens et al., 2024), as they often lack a residential address and the necessary documents to register.

The latest report on the Performance of the Belgian Health System (2024) acknowledges the **lack of data concerning the uncovered population** as a barrier to understanding their unmet healthcare needs[8]. This resonates with Krieger's (2004) critical view, who deems data gaps concerning certain populations as a pervasive reality in public health and epidemiology studies. "To the extent we base any of our claims about social injustice in evidence, we must use data — whether of the quantitative or qualitative sort. But data do not simply exist" (2004: 632). The author mentions that studies, especially in epidemiology, often rely on population data categories that are not ideal "precisely because the assumptions of those with the power to shape and accrue the data often differ from those who seek to use these data to illuminate and oppose social inequalities in health" (2004: 632).

This population, nevertheless, is not deemed as completely uninsured, as they can rely on a separate health coverage system offering a restricted set of services, in particular those referring to "**urgent medical assistance**" (in French, "*l'aide médicale urgence"* and "*dringende medische hulp*", in Dutch). Such assistance mechanisms are particularly important for undocumented migrants, as they will be further developed in the health-seeking strategies segment on **government aid**. However, the interviewees highlighted important shortcomings in this coverage. A worrying limbo concerns those who are **attempting regularization**.

[8] This has also been a challenge for this study, as the lack of official data and limited scholarship on the matter limited the possibility to verify if the findings aligned with previous research. The latest report on the Performance of the Belgian Health System can be accessed via: https://kce.fgov.be/sites/default/files/2024-01/KCE376C_HSPA2024__Report.pdf

After living in Portugal for a few years, Sofia arrived in Belgium last year with her husband and son (both Portuguese citizens). She, however, was not able to acquire her Portuguese citizenship by the time her family decided to migrate. To avoid being separated from them, she moved to Belgium and started the regularization process through family reunification. In Portugal, they were entitled to public healthcare, but upon her arrival in Belgium, she did not register for insurance due to her lack of a Belgian residence permit. She was also discouraged from seeking any government aid.

> *"I haven't signed up for any health insurance yet because of the document issue. Though I've been informed that I could still have access, even without documents, since I'm married and my husband works. But I haven't signed up for it because I'm waiting for my documents. I want to get more comprehensive insurance. So, I'm on my own, I can't even get sick. I mean, I can get sick, I know they will check me at the hospital, but the bill will arrive later. Thank God, it's been eight months without getting sick. Because, for example, as the wife of a European citizen, I can't even contact the CPAS. My husband already explained to me that I can't go for a consultation, I can't do anything through the CPAS."*
>
> (Sofia, school cleaner, online 14-05-25)

Sofia and her husband are correct to be cautious about requesting CPAS aid. People holding a residence permit based on family reunification, like her, risk losing their permit in case they are not able to provide for their personal needs. Considering she is the wife of an EU citizen, the Belgian government may interpret the request as a sign that the applicant is an 'unreasonable burden' to the social security system, as described in the EU Directive 2004/38/EC[9] (more in Lafleur and Mescoli, 2018). A few months after the interview, I checked whether she registered with an insurance, and her situation did not change.

Catarina faces a similar reality with her documentation. She arrived with her daughter seven years ago, joining her husband, who was already in Belgium. Her family was quick to request urgent medical assistance through her local CPAS office, and they have used it for the entirety of their time in the country. As regularization through Belgium was unfeasible, they obtained documents from Portugal a year ago[10]. They are undergoing the process of

[9] There are a few exceptions to this rule, for instance being the parent of a Belgian minor who never lived abroad, or being a minor having joined family in Belgium.

[10] For years, the country maintained a welcoming migration policy for citizens coming from Lusophone countries. That is why thousands of Brazilians obtained legal residence and citizenship in Europe through Portugal. According to data from Portugal's 2023 Migration and Asylum Report, published by the Agency for Integration, Migration and Asylum (AIMA), 368.449 Brazilians legally reside in the country.

validating them to live and work in Belgium, and while they wait for a result, they cannot apply for regular insurance.

> *"I'm not entitled to a mutuelle, right? But I would happily pay for insurance. Because I know its cost is reasonable for the service. But I, unfortunately, don't qualify for it, which is why I'm still using the CPAS. That's it. Every six months, I have to go there and prove that I have earned, for example, a thousand euros per month. But I have my rent to pay, I have to pay for food, and my daughter's school meals. In short, I must prove that I don't have the means to pay for my healthcare, especially because my husband has diabetes, a chronic illness."*
>
> (Catarina, Brazilian domestic worker, Online, 16-06-2025)

Both Sofia and Catarina highlight the complicated bureaucracy surrounding both the regularization processes and the obtention of healthcare in Belgium. Bureaucracy also impacts undocumented migrants who have the right to request urgent medical assistance and rely on this policy to care for their health. As mentioned before, this modality of healthcare is protected by both a 1996 Royal Decree and the Council of Europe's Resolution 1509 (2006). Obtaining this aid is not automatic, and migrants living in Brussels must go to their municipality's CPAS office to request this assistance[11]. As mentioned in Catarina's testimony, migrants must prove their inability to ensure healthcare for themselves and/or family members. If the request is approved after the CPAS's investigation, they are given a card (*carte médicale,* in French) that grants them access to a network of licensed professionals. With this card in hand, healthcare costs are covered by the government. Reporting to the CPAS is a crucial step to obtain assistance, with the only exception being in emergency cases or when this process is impossible. In such cases, the hospital can demand payment on behalf of the patient.

Another problem highlighted by interviewees is related to the provision of services by the CPAS offices. Joana is a 24-year-old cleaning lady married to a Belgian national. During the two years they spent in Belgium, she mostly worked informally as a cleaning lady. When requesting the CPAS medical card, she received a paper that did not correspond to the card healthcare services required.

> *"They gave me a card that wasn't a proper card, which is what hospitals and other places usually ask for. They gave me a piece of paper. I faced difficulties because whenever I showed*

[11] This process is explained in this page: https://www.fedasilinfo.be/en/you-are-without-legal-residence-and-need-medical-aid

them my card to get reimbursed for something, or even at the pharmacy, they said it didn't work.

(Joana, cleaning lady, Brussels, 29-05-25)

Ana, a 41-year-old undocumented migrant, faced issues keeping her healthcare coverage when moving from one municipality to another. Despite forming the same region, each municipality has its own CPAS office. As decisions are not unified, when she moved, she had to start the process from scratch; the waiting period left her uncovered.

"We always rely on the CPAS. But now, since we've moved into a new municipality and changed our address, it's difficult. We used to live in a municipality where I used to go and sort things out myself. But we moved to a commune where it's been almost two months, and they haven't given us an answer. So, when we need it, we go to the CPAS. But now, as we moved, there's this bureaucracy. The CPAS in Ixelles leaves a lot to be desired. They're very lazy people."

(Ana, undocumented migrant who works in the cleaning sector, Brussels, 29-05-25)

A few days after the interview, Ana called me to say that the CPAS approved the medical card for her husband and two children, but not for her. Therefore, even if one used the service before, receiving a similar response from the next office to handle one's case is not guaranteed. After a revision of her dossier, she was granted a medical card.

The complex bureaucracy surrounding exchanges with the CPAS and other government offices is not only acknowledged by users, but also by those who volunteer to help with translations. After 28 years living in Belgium, Bárbara became a reference for many in the Brazilian community. It all started when a friend asked her for help with translation during an appointment. As her friend mentioned how helpful Barbara's presence was, people who did not speak French started asking her for help as well. When we met for the first time, in March, she participated in an International Women's Day event organized by Brazilian women. During the event, two panels were held by progressive female Brussels politicians. After a presentation by one of the municipality of Forest, she made sure to express her disappointment at the way migrants were treated during their appointments there. Despite having a job, she still answers many calls for help and observes the struggles to obtain some services.

“For me, it's the same in every municipality. They're very bureaucratic. But that's part of the show. They want to keep people going back and forth until the person gives up and doesn't get

the paper. That's the plan, to make them give up halfway through. But some people don't give up, they go on and get it."

(Bárbara, museum employee, Online, 01-06-25)

Such testimonies focus on negative experiences regarding bureaucracy and the cases where people find themselves in a limbo. Nevertheless, it is important to acknowledge that good experiences with the service also exist. These will be further developed in the section covering Brazilian women's strategies to overcome their health challenges.

On another note, a silent and subjective factor related to their legal status also influences their unmet healthcare needs: **fear**. Living under an irregular status guides many decisions in the lives of undocumented migrants. In the interviewees' testimonies, these decisions include accepting jobs where inspection risks are lower, always paying for public transportation tickets (as inspections in buses, trams, and trains frequently identify undocumented migrants), and even avoiding jaywalking. Though none of the interviewees fear being questioned by the police or being detained when searching for health services, a fearful discourse still lingers in the community. Luzia recalls that this was particularly common when she arrived, 20 years ago.

"I didn't know the country's rules, I didn't know the norms, or anything. The news we would frequently hear was that someone was caught and that he or she was going to be deported. So everyone was afraid to go to the doctor. It was very rare for women to go to a gynecologist, for example. So, it's terrible. It's terrible. When my sister got pregnant, everyone said, 'You're crazy, you'll see, they'll deport you right there in the hospital."

(Luzia, service voucher worker, Brussels, 12-06-25)

The undocumented migrants in the sample express their **stress** under this vulnerable status — a factor that, in itself, constitutes a social determinant of health (Wilkinson and Marmot, 2003). In the context of this community, fear seems to stem from rumors and numerous tragic stories of people who were deported.

Avoiding seeking medical services or the CPAS because of **fear** is, arguably, more of a perceived barrier. This is, however, justified as providing sensitive personal data may discourage migrants who fear being identified by state authorities (Gondin, 2016). Fear as a component hindering migrants from searching for medical care has been documented, especially in the literature concerning Latino and Hispanic migrants in the United States

(Madden and Qeadan, 2017; Maldonado et al., 2013; Cavazos-Rehg et al., 2007; Berk and Schur, 2001). This idea, however, was challenged by López-Cevallos et. al (2014), who did not find a link between fear with medical or dental care use. In the Belgian context, nevertheless, fear as a barrier to health-seeking behaviour has been identified among uninsured pregnant women, mostly undocumented migrants (Schoenborn et al. 2021).

This section highlights how one's legal status determines health insurance possibilities. It is important, nevertheless, to emphasize that this group of migrants suffers from barriers of **accessibility** more than **entitlement**. The legal framework in Belgium includes undocumented migrants in the medical system through the CPAS; nevertheless, migrants face issues accessing this right. Vanneste et al. (2020) concluded that delayed CPAS procedures affect uninsured women and their newborn children in Belgium. One reason that could increase bureaucratic barriers to this population's access is that "'street-level bureaucrats' do not always know the most recent procedure adopted by the decision-makers, due to the frequency of changes" (Geeraert, 2018: 6). The role of bureaucracy in restricting migrant communities' access to healthcare was also observed among newly-arrived migrants in Denmark (Nielsen and Jervelund, 2023) and Ukrainian refugees in Germany (Davitian et al., 2024).

4.1.3 Socioeconomic status, financial constraints, and "survival math"

When asking participants about their financial situation, their concerns were described in great detail. Their testimonies denoted that they put careful thought into their budget, expressing just how fundamental money is in their experience. It was impossible not to think that the very migrants who searched for financial stability and growth overseas were met with considerable financial hardship. Becoming ill certainly did not fit their budget; when that happened, intricate calculations would take place to assess just how risky it would be to go without medical treatment. Though this is, most of the time, a bigger concern for undocumented migrants, ill-health is also a destabilizing factor for migrants with a regular status.

A year and a half after arriving in Belgium, Rafaela noticed her period had not come for six months. After that period, she experienced intense bleeding for three consecutive months. She went to the doctor, where she discovered different gynecological issues. She

paid for that consultation privately, as she does not qualify for insurance, and she does not benefit from the urgent medical aid coverage. For this reason, following up with a treatment would be financially unbearable, as she became unemployed shortly after. In addition to a hectic routine, these factors resulted in her decision to **delay medical treatment.**

> *"The first exam found a clot in my uterus, so I took progesterone for 15 days, and the clot went away. When I returned to the doctor, my uterus was full of cysts, and my Pap smear showed abnormalities. I don't even know what the abnormalities were, whether it was a temporary issue or, I don't know, cancer. God forbid. Because that was in 2023. I haven't been to the doctor since. To follow it up, I would have needed to go privately. I started the treatment in 2023, but I had to stop it because of my work routine at the time. Then I was unemployed for a long period, then I couldn't afford it, because I needed a biopsy and everything. To this day, I couldn't continue with that treatment. My only free time is on Mondays, every two weeks, in the afternoon. So, scheduling an appointment would have to be on that day, because if I schedule it on another day, then I'll have to take time off work, and then I'll have to lose my workday. And that's already 90 euros. I don't know if I'll get back next month."*
>
> (Rafaela, Brazilian cleaning lady, Brussels, 18-05-2025)

Margarida, a 58-year-old undocumented cleaning lady, lived something similar. In her 17 years in Belgium, she tried regularizing her situation twice unsuccessfully and has, therefore, relied on the urgent healthcare assistance provided by the CPAS. She decided to request aid around five years ago, when she started feeling ill due to her thyroid. However, that was not the only issue she'd have to treat. This year, after falling down the church stairs, she had to stop working to treat an elbow fracture. She took the recovery time as an opportunity to use her time off efficiently and undergo different procedures she had postponed for years.

> *"I started to feel a hernia at the same time as my thyroid problem. I just ignored it and went to work. I just worried about working, working, working… and I didn't take care of this hernia. Years ago, I went to the doctor, he ran some tests, and said, 'You need surgery.' I asked if it was serious. He said: 'It's not serious, it's not urgent, but it's a surgical case. This hernia needs to be removed because if it gets worse and explodes inside of you, you'll be rushed to the emergency room, and you'll be in a lot of pain. It's best to have it removed before that happens. And I just ignored it... and now, while I was resting, I've taken care of that part too. The doctor referred me for surgery, and I had the hernia removed. And with that accident, everything came to light. I also acquired some knee problems over the years, especially on the right one that needed [joint] injections. Today, I can't kneel anymore. So, I just bend down to clean underneath the furniture."*
>
> (Margarida, undocumented cleaning lady, Online, 11-06-25)

Both Margarida and Rafaela's **necessity to secure their wage** hindered their chances of treating the issues from the beginning, which reveals a dangerous tendency in this group. As turning down a job or missing a day of work becomes a threat to their financial stability, health is hardly a priority. The delay in seeking medical aid means that issues that were initially simple to treat may evolve to reach severe stages. Therefore, **delaying healthcare** or **neglecting their health** is, unfortunately, a common practice among members of this group. This was equally identified among Brazilian women in the United States (Messias, 2001, 2002). This behavior is recognized by the community and even unadvised by a priest during a homily at a special Pentecost celebration.

> *"The Holy Spirit urges us to take responsibility for our lives. Imagine this… You work, work, work, and leave your health on hold; you will reap the consequences, and your body will become ill. The same can happen to your spirit."*
>
> (Father André, Brussels, 08-06-25)

As previously discussed, sustained physical effort, especially without instruction on ergonomic positions and good practices, can deteriorate one's health. Joana is a 24-year-old cleaning lady married to a Belgian national who was raised in Brazil. During the two years they spent in Belgium pursuing a better quality of life, she worked **informally** as a cleaning lady. Her regularization process was demanding, as her husband did not meet the necessary financial threshold to guarantee her a five-year residence permit. At the moment, she holds a *carte orange*, a provisional permit that must be renewed every six months. Last year, she discovered her first pregnancy, and to financially prepare for the newborn, she decided to **continue working**. However, at five months pregnant, she received concerning news. She was already 5cm dilated, when 10cm are needed for birth. That meant the baby could be born at any moment, a scenario she was not prepared for.

> *"I had 5 hours to clean a 4-story house with a garage, I had to iron clothes, clean the kitchen, 4 bathrooms, and 4 bedrooms. Anyway, I had to rush, and I ran even though I was pregnant. This meant I had to run and squat a lot, and do things very quickly. The weight, the tiredness when I got home… in my head, all of this made it easier for me to get this diagnosis. The doctor even asked: 'Did you make a lot of physical effort?'. I thought, 'I did'. I was afraid of losing the job, or else I wouldn't contribute financially that month. You know? [I needed] to supplement my husband's salary because what he earned wasn't enough to get us through the month. Some bills would be unpaid if I didn't work."*
>
> (Joana, cleaning lady, Brussels, 29-05-25)

As her pregnancy was considered high-risk, she was advised to stop working and avoid physical effort at all costs. Throughout her pregnancy, she experienced three different healthcare regimes. At first, she sought **private care** with a doctor who spoke Portuguese; however, the exams and consultations were costly. She then requested aid from the **CPAS**, which covered her healthcare for a few months. But as she acquired her *carte orange,* she registered for **health insurance**.

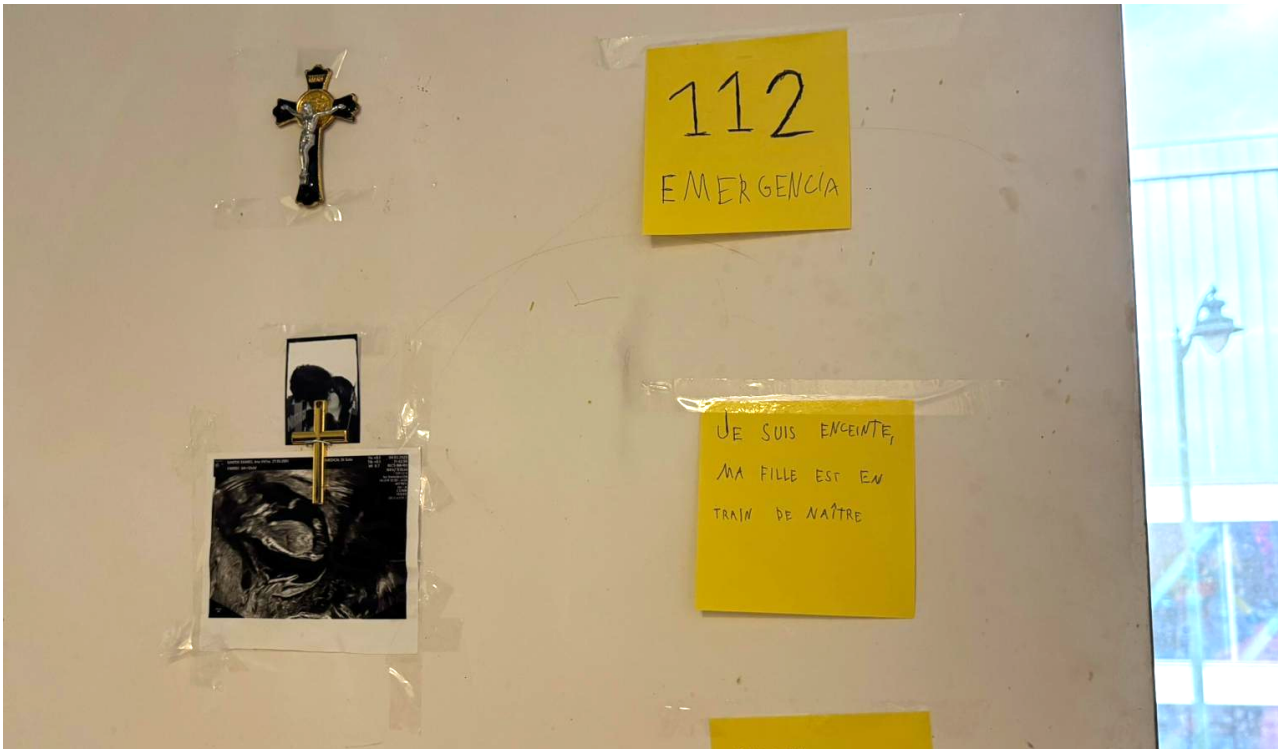

Image 2: The couple glued post-its with the emergency number and the phrase "I am pregnant and my daughter is being born" in French, so Joana would know what to say in the case of an emergency while her husband was absent. Source: personal archive.

Her use of the health insurance was during the most delicate phase of her pregnancy, which translated into multiple exams to assess her and the baby's health. Her experience with the service was positive; however, the **co-payments** started to become heavy on the household budget, especially since she could no longer contribute to it financially. Throughout the research, Joana would send me updates about her situation, frequently expressing concerns about the baby's low weight. Her daughter was born premature via an induced labor, at 33 weeks, after they diagnosed Joana with pre-eclampsia the week before. The hospital bills accumulated, and even with the insurance's reimbursements, all the money they received from their birth premium[12] was used to pay for hospital bills. At the time this

[12] A one-time €1,367.74 contribution from the city of Brussels to support parents during the arrival of a new child.

thesis was being written, her daughter remained in the neonatal intensive care unit, and the total amount they would have to pay for such services was still unknown. On another note, Joana's situation is in line with the findings of Vanneste and colleagues (2020), who found that difficult access to healthcare and an **unfavorable socioeconomic situation** increase the incidence of low birth weight and premature birth.

This is another example of how **financial constraints** affect these women's health. In Joana's case, she carried the guilt of working excessively during the beginning of her pregnancy, which may have contributed to her initial diagnosis. Following her pregnancy, the cost of out-of-pocket payments also became a concern, as they constitute an extra spending in an already tight budget — their rent alone costs nearly 1000 euros, electricity, water, and internet excluded. According to a World Health Organization 2023 report, in 2020, 5.2% of Belgian households endured catastrophic out-of-pocket payments; this represents 1 in 20 households, one of the highest rates of this kind in Western Europe (WHO, 2023)[13]. Though it is not the main focus of this study to discuss co-payment policies, recent evidence from a neighboring country, Germany, suggests that reducing co-payments contributes to decreasing unmet healthcare needs (Klein et al., 2025).

It is possible to assume that, even when covered by health insurance, migrants may be less shielded against **economic hardship**, particularly when working in low-skilled jobs. This section highlights that financial constraints affect both undocumented and documented migrants and that ensuring healthcare can represent a shock to the domestic budget. This situation may be worsened, considering that seeking health treatment is often delayed due to the lack of job security and tight domestic budgets. Therefore, preventative care or early curative care is far from being a priority, which can lead to more complex health conditions in the future. Once again, the negative effect on **nonmedical factors** is central to the discussion. These can be related to the occupation (Chen et al, 2022; Bauleo et. al, 2019; Hall et al., 2019; Abubakar et al., 2018; Braveman et al., 2011; Krieger, 2010), and socioeconomic status (Vanneste et al., 2020; Braveman et al., 2011; Marmot 2008; Marmot et al., 1999; Wilkinson and Marmot, 2003).

[13] The full report can be downloaded via this link:
https://www.who.int/europe/publications/i/item/9789289058599

4.1.4 Healthcare system's organization and medical practices

Differences in the way the healthcare system is organized also lead to confusion and challenges for Brazilians in Belgium. In Brazil, the creation of a public and fully-funded healthcare system was a milestone in democratic history. The Sistema Único de Saúde (Unified Healthcare System, in English) introduced free, public, integral, and universal access to health services for anyone in Brazilian territory — regardless of citizenship status. Full access to its services is indeed undermined by several issues: lack of resources, overwhelmed personnel, insufficient geographical coverage, and more. But even with these shortcomings, if one needs assistance, it will be provided without much bureaucracy, and most importantly, for free. Therefore, acquiring private health insurance is optional.

In Belgium, a free healthcare system is unavailable, and health insurance is compulsory, representing a shift many Brazilians have to navigate upon arrival. As discussed previously, that can be challenging depending on one's legal status. Regardless of the way the interviewees may obtain healthcare services, certain **organizational aspects** and **practices** were frequently mentioned during our conversations. Those who use the healthcare structure in Belgium, particularly in hospitals, compliment the system's infrastructure, technology, and facilities.

Fátima has worked as a cleaning lady since she arrived in Belgium 13 years ago, as an undocumented migrant. Since obtaining her documents, she has used the healthcare system to treat health issues she had been diagnosed with in Brazil (particularly an eye condition caused by toxoplasmosis) and those she acquired later in her migration journey. She has gone through ophthalmological and gastrointestinal procedures, and her experience has been positive so far.

> *"In terms of health, I think Belgium is better than Brazil. Because, well... I don't think what we pay is expensive. I think it's the minimum, and you have access to everything. So, in terms of health, I have nothing to complain about. The times I've needed it, I was always very well supported. The next procedure I'm going through is bariatric surgery. I've always tended to be chubby, and nowadays, because I go up and down to clean houses and such, my knees hurt a lot. So, I went to the doctor here. I had the gastric balloon placed for 9 months, but I didn't lose much weight, so now I'm going through surgery".*
>
> (Fátima, service voucher cleaning lady, Brussels, 18-05-25)

Professional practices, on the other hand, tend to be a target of complaints. From the interviewees' point of view, they differ greatly from what they consider ideal conduct. One of these differences concerns **emergency rooms**; in this regard, the participants[14] often mix their experiences with those of their children. They still reveal, nevertheless, the challenges they may face themselves. Fátima and Catarina have very similar experiences in different hospitals and circumstances.

> *"They don't really use medication here, right? Medication here, an antibiotic or something, is a last resort. They treat everything here with ibuprofen and paracetamol, everything. So, like with my daughter, I've taken her several times to the emergency room when she had a fever and such. They told me to go home and give her ibuprofen and paracetamol for three days."*
>
> (Fátima, service voucher cleaning lady, Brussels, 18-05-25)

> *"I think they wait a lot for things to happen here. It took me a while to get used to it. For example, when my daughter had a fever for a day, I'd go to the hospital. Then the doctor would say: 'What are you doing here? Your daughter only has a fever for 24 hours. She has to have a fever for at least three days for you to bring her here. I'd say: 'What do you mean? She has a fever; I think there's something wrong with her. I need to find out what it is, and I'll only find out by coming here, because you are the experts and all. For me, it has always been a conflict, you know?*
>
> *(Catarina, Brazilian domestic worker, Online, 16-06-2025)*

Professionals' **reluctance to prescribe medication** and **request exams** has also been frequently mentioned as a negative aspect by the interviewees. In the testimonies, requesting exams is often associated with preventative medicine, giving them the perception that the Belgian healthcare system does not privilege prevention. Brazilian women living in Portugal also report the impression that preventative medicine is not valued in their country of residence (Dias et al. 2010b). This may indicate that these impressions are culturally-bound.

This is found both in common cases, like respiratory infections, and more complex ones, for instance, hormonal replacement therapy. This has undermined their **trust in the system,** leading them to insist on receiving medication and exam requests from doctors. In other words, they attempt to advocate for themselves and their children using their previous experiences with health in Brazil as a reference for such requests. In this process, they challenge perceived power dynamics within the healthcare system.

[14] In this section, some women will appear several times, as their use of the system was more frequent than others, and they had more experiences to share.

"When it comes to prescribing medication, sometimes I have to ask them for it. I've worked in the field, and I'm already familiar with several medications. So, I ask them to prescribe the medication I know works for the case. In this field, I think everything is dafalgan for them. Sometimes you have a certain type of pain or something else, and they only know how to prescribe dafalgan."

(Ana, undocumented migrant who works in the cleaning sector, Brussels, 29-05-25)

"If you arrive at a hospital in Brazil with a sore throat, they run a urine test, a blood test… we investigate further. It is not the case here. 'Oh, she has a fever? Oh, okay, take dafalgan'. In Brazil, running tests would be a regular thing, done from time to time. Not here. Only if it's strictly necessary. I remember that during [my daughter's] bronchiolitis, I almost had to beg them to do an X-ray. I kept insisting, saying she had a persistent fever for many days, until the doctor gave in and ended up doing it. She also did a blood test. But since then, she hasn't had a blood test again. So, this is very different to me."

(Catarina, Brazilian domestic worker, Online, 16-06-2025)

"*The [health] system in Brazil may be whatever it is, but for me, the Brazilian system and medicine are unparalleled. I'm 46 years old and I entered early menopause, so I'm already on bioidentical hormone replacement therapy. It's something Brazil is very advanced in: bioidentical hormone modulation, bioidentical supplementation, compounded medication… In my case, I see that Europeans don't care about a woman going through menopause; they don't take care of them, that's the truth. Because I've seen and still see women during menopause who don't take medication, don't take supplements. Women who should be taking calcium, for example, don't do it, because they simply say it's not necessary."*

(Sofia, school cleaner, online 14-05-25)

Regarding the dynamics in which the system operates, another difference is the **centrality of the General Practitioner**. Though making an appointment directly with a specialist is possible in Belgium, it is common practice to centralize one's care with a single doctor. In case more complex care is needed, the professional can refer the patient to a specialist. In Brazil, especially in the private sector, it is common to go to a specialist right away, depending on the problem. Catarina felt that difference.

"I didn't understand at first, because in Brazil, you go straight to a specialist. If I need to go to the gynecologist, I will. But that's not the case here. You have to go to your family doctor first. Nowadays, I have a gynecologist who follows me because of my [uterine] health problem. But it was different for me, because I had to go to a family doctor first. That adjustment was difficult, but we managed. It was a little strange, a little different."

(Catarina, Brazilian domestic worker, Online, 16-06-2025)

The previous points require adaptation that, according to the interviewees, gets easier with time and experience. Other issues, nevertheless, are more difficult to overcome. An important aspect that participants perceive as a challenge is that professionals are distant;

some would go as far as to describe them as cold. This is the impression Ana, who used to work as a lab technician in Brazil, has after accompanying her daughter, who has diabetes, several times to the hospital. She uses strong words, as she perceives **discrimination** when it comes to treating migrants.

> *"I think the system is better here than in Brazil, but I think some doctors leave a lot to be desired in some areas. I don't know if it's just a lack of politeness or because they're discriminatory. They discriminate against immigrants a lot. They are very judgmental, and they end up not providing more effective care. In Brazil, because we already speak the language and we know more about the system, we receive better care. And here, because we do not know much, it creates a barrier. So, we just go there, ask what we need, they answer what they want, we go home, and that's it. In Brazil, I used to work in healthcare too. Here, I think they have more material capacity, but they lack a good touch with people. They're very cold; it's their culture. And since we're in their country, we have to accept it. But the patient is still a human being; they're dealing with a life. So, they could be more human.'*
>
> (Ana, undocumented migrant who works in the cleaning sector, Brussels, 29-05-25)

It is important to mention, nonetheless, that participants would rarely say they suffered discrimination. However, **rude treatment** was a common complaint, and such episodes would frequently revolve around language barriers (as will be further discussed in the next section). On some occasions when Bárbara acted as an *ad hoc* interpreter during medical appointments, she observed rude treatment.

> *"When you open the door and say 'bonjour', you already notice. Even to me, who already speaks the language and understands it. Sometimes the doctor looks at me, even turns his head. There's even been a case when a doctor said to me, 'Why don't you advise them to go back to their country? What are they doing here? There's no future here.' When that happens, I don't translate it. I don't tell them everything because I feel sorry for them. However, I do think Europeans have a discretion of not speaking about it [to the person], maybe they talk among themselves, but they will never speak about it openly."*
>
> (Bárbara, museum employee, Online, 01-06-25)

Bárbara tries, nevertheless, to balance her vision on this topic, trying to understand how the professionals must feel in their daily practices. She reflects, in other words, that they may lack cultural competency, reacting negatively to diversity in their offices.

> *"I think they weren't prepared for all this confusion. All these ethnicities, all these languages, all these people, each acting in their own way. Each one dressed in their traditional attire, different religions, different attitudes. They weren't prepared for this, I think. They should have been prepared to care for people, to heal people. But what's missing is the human side."*
>
> (Bárbara, museum employee, Online, 01-06-25)

These experiences demonstrate that getting used to the system may take some effort and negotiation on the part of patients and professionals. Even those who have frequent access to the healthcare system may face difficulties understanding how it works and adapting to the practices. Language plays a big role in this scenario, creating a barrier and blurring the understanding between patients and professionals. Their negative experiences regarding the **doctor-patient relationship** resonate with the findings of Silva and Dawson (2004), who described that Brazilian women in Australia did not feel their needs were understood and met by healthcare professionals, leading to a lack of trust in the professionals.

According to Yakhlaf et al. (2025), patients with a migration background in Belgium voice preferences and challenges regarding medical decision-making. Their complaints revolve around four elements: exchange of medical information, decision-making agency, patient-provider relationship, and treatment plan (Yakhlaf et al. 2025: 4). These factors seem to also be sensitive to the Brazilian women in the sample, particularly the **patient-provider relationship** and the **treatment plan**.

Improving this relationship is a challenge, as "factors such as views on health, illness and care, religion, taboo and stigma, legal framework, language services, time pressure, medical education and other resources for culturally sensitive healthcare all shape the medical decision-making process" (Yakhlaf et al. 2025: 13). Yakhlaf and colleagues consider, therefore, impossible for healthcare providers to be fully aware of each patient's context during the medical decision-making processes. They can, nevertheless, as the study suggests, "adopt a more culturally sensitive approach in their interactions with patients" (Yakhlaf et al. 2025: 13).

Discrimination in healthcare services has been previously identified in Belgium (Arrey et al., 2017). Regarding the reported perceived discrimination episodes in this study, these were not particularly based on stereotypes linked to the notion that Brazilians would carry more diseases than local women, as is commonly the case in Portugal (Dias et al., 2010b). These episodes seem to stem from professionals' general negative views on migration. Perceived discrimination, nevertheless, is particularly harmful in such spaces as it functions as a barrier to migrants' further use of the system (Lebano et al, 2020).

4.1.5 Language and the loss of autonomy

Throughout all of the fieldwork, language appeared as the most common challenge faced by the interviewees. More than a barrier on its own, language permeated all of the other challenges, adding a layer of complexity to the participants' health-seeking experiences. From all the analysed dimensions, language was the one that affected both **documented** and **undocumented** women in similar ways and intensity. In other words, language is a central challenge, **discouraging health-seeking behaviour** and generating **loss of autonomy**.

As demonstrated by health literacy studies (Nutbeam, 2000, 2008), **explaining symptoms** and **understanding medical recommendations** can be challenging in one's native language already, as the vocabulary may sound inaccessible. This is worsened when health-related appointments happen in a foreign language, as migrants' unfamiliarity with that vocabulary may feel **intimidating**.

During one of my participant observation visits at a hospital, I had to act as an *ad hoc* interpreter for Joana, as a nurse asked her about how she was feeling after giving birth to her daughter. Her husband, her main interpreter in healthcare appointments, had to leave the room for a few minutes, so I stepped in. Joana, then, asked me to tell the nurse she felt pressure on her bladder. Although I had the opportunity to study French for six years in my home city before coming to Belgium, and despite holding a B2 degree issued by the French government, at that moment, I realized my own lack of vocabulary. *"Vessie"* ("bladder" in French) was a word I could not recall learning or even using, so I had to resort to Google Translate. That was an important realization; despite being familiar with the language, I could not fully describe her symptoms.

In addition, Brussels is a bilingual city, and while the communication happened in French, other elements in the room were solely in Flemish. When the bag on her IV-fluid device was empty, for instance, the warning message was: "*Geen druppels*" ("no drops", in English). That warning was accompanied by a scary-sounding alarm, which could worry patients that something serious was happening to them.

I have to acknowledge, nevertheless, the patience and understanding the nurses demonstrated, speaking slowly to her, addressing her, instead of me, focusing on her needs,

and trying to understand what Joana would say in Portuguese. One of the nurses, a Portuguese national, even came for a visit to reassure her in case she had any problems. This understanding attitude is important, as how healthcare providers respond to the communication needs of patients with lower proficiency in the foreign language impacts their satisfaction with the service (Squires, 2018).

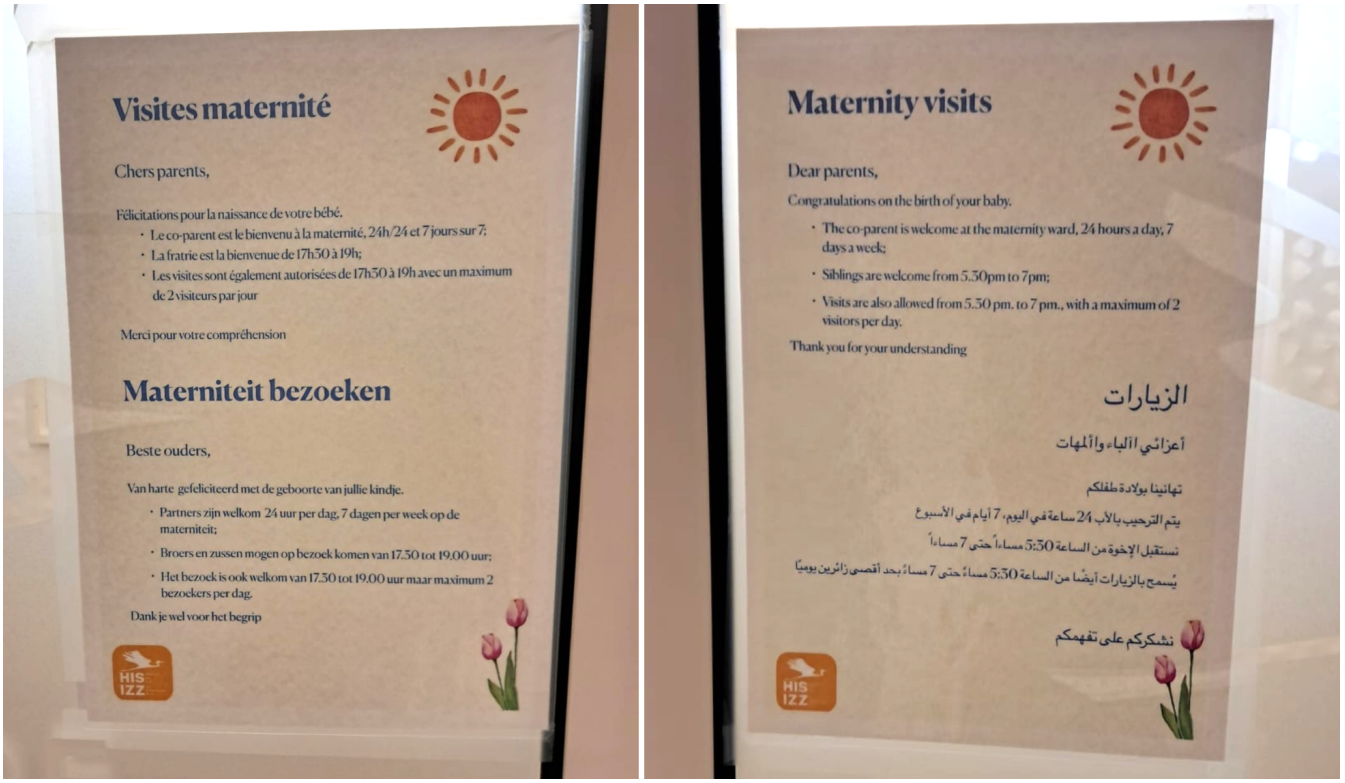

Image 3: Four languages were represented in the signs at a Brussels hospital on 08-06-25. Source: personal archive.

It is evident that for those who have to learn the language in their everyday activities, without any formal instruction, such contexts feel daunting. This was clear in numerous interviews. Ana has been living in Belgium for seven years. She constantly goes to the hospital to accompany her daughter, but she has only been to the doctor for herself once in Belgium, when she noticed a nodule on her breast. Though not fluent, she is immersed in the language, familiar with medical contexts, and still, her experience was not positive due to the language barrier.

> *"[Belgium] is terrible for me, health-wise. I don't like it, let's put it that way, because... It's not that I didn't go after healthcare; it's because of the language. How can I go to a doctor? I went once because I felt a lump in my breast. Since I don't speak the language, my husband always accompanies me. During my appointment, the staff didn't want to let him in. The doctor talked to me, and I didn't understand anything. I said that if she didn't allow him in, I*

wouldn't be able to answer. So she allowed him in order to translate it for me. Because of the language, they don't have much patience with immigrants. On my part, I acknowledge I'm a bit negligent for not looking for medical care. But that's because I still don't know where to look for a professional, because it ends up being like this."

(Ana, undocumented migrant who works in the cleaning sector, Brussels, 29-05-25)

Another element the testimonies emphasize is that the attitudes of health professionals and CPAS workers may change when someone demonstrates difficulty communicating in French. Different interviewees report that, for instance, asking staff to speak more slowly may have the opposite effect. Rita, a 47-year-old service voucher worker, has lived in Belgium for three years. As she has documents, most of her experiences in healthcare have been with health insurance. Despite her secured legal status and insurance coverage, she perceives rude treatment when hospital staff realize she is not fluent in French.

"They don't even care about your documents. You'll always be an immigrant, you're always an intruder. For them, you'll always be no more than a construction worker, a factory worker… You can feel this. It's true. Sometimes in the hospital, right there at the reception, when you arrive, they realize you're an immigrant. Sometimes it's because of something you said… something you didn't understand. When you ask them to repeat it, you see through the tone, the way it's said again, you know? So, you have to be brave. When you decide to migrate, you have to be ready to mentally say 'Je m'en fous' [sic] to them and that's it."

(Rita, service voucher worker, Online, 09-06-25)

Cecília, a 23-year-old undocumented cleaner, experienced something similar. After two years in Belgium, she had her first-ever medical appointment after discovering her pregnancy. Her first experience within the system was negative, improving only after a Brazilian hospital worker offered her help with interpreting the appointments.

"I didn't really like the first appointment. Because it was just me, my husband, and the doctor. Some people don't have much patience to understand us. I understand very little, and they speak very quickly. Sometimes I ask them to speak a little slower, or to repeat something, and they don't like it. In fact, the first doctor was a little rude, so I didn't really like it. I left without understanding much. But then, at the second appointment, I changed doctors, and I even met the girl at the reception who is Brazilian, and she helped me."

(Cecília, undocumented cleaning lady, Online, 26-05-25)

A similar experience was reported concerning the CPAS. When requesting aid to have financial support for perinatal care, Joana visited their office a few times. In such encounters, she felt like her basic language skills became a target depending on who was at the reception.

> *"There were some times when I asked her [the receptionist] to speak a little slower because I didn't understand French very well, and she kept speaking fast. I saw it as a way of stating something like... 'Oh, it's your problem. You don't know French, and I don't know Portuguese to speak with you. So I'm going to keep speaking at my own pace, even though you asked me to speak slowly. I felt that. Then, when I got home, I thought it was a mistake to be in Belgium."*
>
> (Joana, cleaning lady, Brussels, 29-05-25)

What I observed, at least in the maternity area of two hospitals (as those were the only areas I was granted access to as an external visitor), were generous and understanding professionals. These were, nevertheless, very scarce opportunities, which certainly represent a limitation for this study. Interviewees also experienced positive exchanges with health professionals, but it is clear that experiences diverge. On another note, rude treatment could be more present among overworked professionals, as their work environment dynamics could cause stress. Therefore, negative experiences could be context-dependent. This is what Bárbara has observed during her activities as an *ad hoc* interpreter.

> *"In hospitals, with doctors, they're impatient. Because the context is this: 20 minutes in the office, 'blah, blah, blah. De hors.' But then the person wants to talk. You have to translate. The doctor wants to talk. You have to translate. And doctors have no patience. Well, not all of them. You'll find the kind ones, the ones who understand you, doctors who know the person in front of them has a problem, and who want to solve it. But you'll find the ones who just want to charge. There's a huge line outside the office, everyone's late, and they don't have patience during the appointment."*
>
> (Bárbara, museum employee, Online, 01-06-25)

The interviews also emphasize that language constitutes a barrier to obtaining reliable information. This is particularly challenging when dealing with government offices, as information is rarely available in multiple languages. The Brussels CPAS[15] website is only available in French and Dutch. Another government institution, the Office of Birth and Childhood (Office de la Naissance et de l'Enfance — ONE), only has a French website. The latter, nevertheless, made informational brochures available in twelve languages[16]. In a context with inaccessible information, difficulties arise. Beyond the language, Joana reports the lack of information online and workers' unhelpful attitudes. Rafaela, in addition, reported that diverging information hindered her understanding of the system.

[15] https://cpasbxl.brussels/ (the website was lastly accessed on August 10th 2025)
[16] The brochures are available via this link: https://www.one.be/public/cest-quoi-lone/about-us/ours-brochures/ (the website was lastly accessed on August 10th, 2025)

"If we search the internet about something related to the government, like laws, rights, we find nothing. I tried, but I found nothing. I didn't even know how to use the CPAS. I found out through Brazilian WhatsApp groups here. They also told me about another agency, ONE, that I didn't pursue because I already had the CPAS assistance. Then, when I went to the CPAS, the lady responded very curtly, not giving me any clear information on how to proceed with the situation, or how to obtain my medical card."

(Joana, cleaning lady, Brussels, 29-05-25)

"Honestly, after two years, I'm still a little lost. Because there's a lack of information. I didn't know about the CPAS, for example. When I found out about it, some people said, 'Oh, there's no point in trying, because the municipality isn't accepting us'. Then, another person said, 'When the social services visit the house where we live in they won't accept us'. Another person told me, 'You'll go to the emergency room, and after you go there, you have to take that documentation to the CPAS.' So, the lack of information is very detrimental. And because I don't have documents, it's much worse, as I have to know where to go. Because otherwise, any little thing, depending on the situation, they'll say, 'No, you'll have to return to your country.'"

(Rafaela, Brazilian cleaning lady, Brussels, 18-05-2025)

These elements combined create a difficult situation for migrants who do not speak French or Dutch. Therefore, their reliance on companions to speak in their place, their limited understanding of the language, and limited access to information prevent them from solving important matters in their daily lives. Esther, a 46-year-old undocumented cleaning lady, for instance, has not looked for aid as she has not found someone to help her at the CPAS. Since arriving in Belgium around two years ago, she has not been able to study or learn the language.

"The other Brazilians gave me a preview, more or less. They said I have to go there with my passport, with someone who speaks French, to register, to be able to access some minimum benefit. I've considered registering with CPAS, but the only thing holding me back is the language barrier. It can be difficult to find friends or available people to go and say: 'I'll help you.'"

(Esther, undocumented cleaning lady, Online, 24-05–25)

This section has summarized the biggest difficulties concerning language in healthcare contexts, both inside the medical care system and in exchanges with government offices responsible for healthcare aid provision. Discussions regarding difficulties in the patient-doctor communication are not new. In the 70s, Tumulty (1970: 22) affirmed, "We clinicians are better educated and more scientific than ever before, but we have a great failing: we sometimes do not communicate effectively with our patients or with their families".

Ensuring efficient communication between patients and healthcare professionals has been identified as an important aspect of healthcare provision by Nutbeam (2000, 2008), who discusses the concept of **health literacy**. His work demonstrates that issues communicating health are also present within native-born populations. It is evident, however, that health communication in a foreign language adds a layer of complexity to this scenario. The impact of language barriers in migrants' interaction in healthcare contexts has been mostly explored in English-speaking countries (Squires, 2018; Lebrun, 2012; Jacobs et. al, 2006; Ponce et al., 2006). These articles, nevertheless, shed light on important considerations for the European context too.

Language barriers affect migrants' access to healthcare, comprehension and adherence to treatment, quality of care, and satisfaction with the services (Jacobs et. al, 2006). Language-proficient migrants tend to have better health care experiences than those with limited proficiency (Lebrun, 2012). These negative effects, however, may decrease the longer a migrant lives in a receiving country, especially among those living for over ten years (Lebrun, 2012).

In addition, this population is often affected by the lack of information regarding healthcare services in the residence country (Chen et al. 2022; Lebano, 2020; Triandafyllidou, 2016). To overcome these issues, they may combine different sources to obtain information about health, prevention, and treatment (Bernadas and Jiang, 2016). Besides traditional means of communication, the internet and healthcare professionals, domestic workers may seek information from their friends, employers, and family members (Bernadas and Jiang, 2016). At the same time, looking for information within a network may be useful; it can also be confusing, as Rafaela's case illustrates. The combination of low language proficiency and the lack of information (in terms of availability and accessibility) complicates their exchanges with government offices, such as the CPAS, deepening structural and bureaucratic barriers (Schoenborn et al., 2021; Vanneste et al., 2020).

4.2 Health-seeking strategies

After addressing the numerous challenges this group faces, I turn my attention to how they overcome difficulties to ensure they receive the care they need and deem appropriate. The strategies are varied, used in an isolated manner or associated with others. The main health-seeking strategies identified were: the use of **private services**, **activating networks**, **transnational practices**, **seeking Lusophone professionals,** and **requesting government aid**. In addition to describing such strategies, this section will also discuss how they may be problematic or insufficient based on the interviews.

4.2.1 Private services, a double-edged sword

Many interviewees reported the use of **private services** at some point in their migration journey in Belgium. This is, usually, an alternative to the state-sponsored health-insurance-based healthcare system. Rather than a carefully thought strategy, this functions as the staple option for those who are not **insured**, particularly undocumented migrants. The reason to use private services is, precisely, the **inaccessibility of more conventional pathways**. As the problematic aspects of this strategy have been mostly covered in the section regarding financial constraints (4.1.3), this part will be focused on its uses.

Despite these services being, generally, equivalent in efficiency and safety to those available for insured individuals, it is still a problematic practice in the long run, as the cost is often heavy to sustain. Therefore, this strategy is used for **emergencies**, when **symptoms are persistent** and **difficult to ignore**, or when going without care is not an option (for instance, during pregnancy). This was the case for Rachel, a 32-year-old cleaning lady who discovered her second pregnancy in Belgium; her first daughter was born in Brazil. Her pregnancy was the reason she sought medical services for the **first time** after living in the country for six years. Her whole perinatal care was conducted privately in Belgium, but she decided to give birth in Portugal, so her son could obtain documents more easily.

“I didn't have much access to healthcare here. Healthcare for immigrants is very complicated. You can't get there very easily. Then there's the language issue. And everything is paid for. From the moment you don't have the… mutuelle, you have to pay, right? I had my baby's prenatal care here. So, every time I had an appointment, I paid 50 euros. And exams are very expensive too for those who don't have insurance.”

(Rachel, undocumented cleaning lady, Online, 09-06-25)

When one relies solely on private services, it is also common practice to contact different providers and **compare prices** for specific procedures. This has already been observed in Belgium (Cès and Baeten, 2020) and also appeared in the interviews. However, not all cases allow for this possibility, as, depending on the situation, a procedure must be done immediately, not allowing cost-benefit considerations.

Another way using private services can be employed is to **prolong a treatment that has been started in Brazil**. As Brazilian prescriptions are not valid in Belgium, this is particularly useful when the migrant needs to obtain medication to continue chronic disease treatments. This allows them to find an equivalent therapeutic option to the treatment they are already adapted to. Esther has used this service when the stock of blood pressure medication she brought from Brazil was close to running out.

“There was one time I thought I was going to run out of my blood pressure medication, so I went to a doctor here and showed her my original prescription from Brazil. She signed it as a prescription from here so I would be able to buy it at the pharmacy, but I didn't need to, because a friend of mine came and brought it. But we have this option. You pay 30 euros for the consultation, the doctor looks at the prescription and writes it in the local language. She is Portuguese, and she was recommended by a friend whom I used to work with.”

(Esther, undocumented cleaning lady, Online, 24-05–25)

Private services are also an interesting strategy for customizing, in a way, the care to be received. As previously discussed in the section about healthcare organization and medical practices (4.1.4), at first, the centrality of the general practitioner as the primary healthcare provider might not be clear. Private services are more flexible, making it easier, for example, to go directly to a specialist. This was Catarina's case, who decided to make an appointment directly with a gynecologist.

"At that moment, I didn't yet know I should see a family doctor first. So I went straight to the gynecologist. I went there because some people praise his work and recommend him.”

(Catarina, Brazilian domestic worker, Online, 16-06-2025)

Though described as their main strategy to obtain healthcare, when uninsured, this is mainly an **emergency option**. This may explain, in part, the **underuse of primary healthcare** services and **overuse of emergency services** by migrants and refugees in Europe (Lebano, 2020: 8). In summary, private services are an alternative to those who lack more comprehensive healthcare coverage, reflecting, once again, inequities in undocumented migrants' access to healthcare. They may also act as a fast track to obtain prescriptions for continuous medication. Lastly, though this is not their main utility, these services allow some degree of customization. Although efficient, this strategy presents challenges linked to high costs, especially when treating a chronic or complex condition.

4.2.2 Transnational healthcare practices

Documented and undocumented migrants also commonly use transnational connections and mobility to access foreign medication and services. The help of friends, family, and acquaintances is frequently mentioned as a strategy to obtain medication from Brazil. In addition, traveling to the origin country for treatment or undergo procedures was also mentioned, being, nevertheless, rarer — especially among undocumented participants, as traveling in their condition entails risks such as deportation, fines, and restrictions to enter the Schengen area.

During the interviews, a specific practice was repeatedly mentioned: engaging in **pre-migration check-ups** (which could contribute to the "healthy migrant effect"). I must acknowledge the difficulty of fitting this into the coding scheme used for this master's thesis. Inspired by Messias's studies (2001, 2002), I finally considered it as a sign of their **mobile healthcare** practices. Interviewees' experiences also pointed to these health check-ups as part of their international journey and planning, solidifying my choice. They envisioned such check-ups as their last chance to use their origin country's services before departure, using them frequently to delay the need for the receiving country's healthcare services. These medical appointments varied from general health exams to preventative surgeries, revealing this as an important step in the preparation to migrate. The following excerpts exemplify this practice.

"I checked my health, fixed my teeth. I had a whole health checkup to make it two or three years without needing to see a doctor here. I went to the gynecologist, cardiologist, and everything. I even had allergy tests, everything."

(Esther, undocumented cleaning lady, Online, 24-05–25)

"Before coming, I had fibroids in my uterus, and I needed to undergo a full check-up. In the end, my gynecologist said it was necessary to remove my uterus. So before coming here, I had my uterus removed because of the complications; I had been bleeding for months. A few months later, I came to Belgium. [With the surgery] I was already preparing to come."

(Margarida, undocumented cleaning lady, Online, 11-06-25)

"In Brazil, I worked in healthcare, so I had a full check-up, not just for myself, but for the children too. It was the last thing I did before coming. So we came here like this: 'clean'. Because I already imagined that it would take some time until we had a structure here, learned the language…"

(Ana, undocumented migrant who works in the cleaning sector, Brussels, 29-05-25)

These **pre-migration health check-ups** respond to their need to assure a "clean bill of health" (Messias, 2002: 186), representing a safe start to their migration process. In addition, the uncertainty surrounding the possibility of using the healthcare system in Belgium led many interviewees to engage in this practice. This check-up would often be followed by medical prescriptions to guarantee medicine for the journey. Stopping by the pharmacy and buying medication sufficient for months was the "norm". This is a constant practice whenever they have a chance to go to Brazil, as buying prescribed or over-the-counter (OTC)[17] medication is significantly easier there than in Belgium or Europe in general.

With migration, these women's health practices became more dynamic and transnational. **Informally importing medication** is the most common transnational practice employed by these women. This resembles the therapy networks identified by Krause among Ghanaian migrants in the United Kingdom (2008). The reasons include: easier access, familiarity with the medication, and even the belief that the country of origin's medication is more powerful. Another motivation to keep medicine stocks is **self-medication** when Belgian doctors do not prescribe certain medicines (especially antibiotics). This is described in several testimonies.

[17] With the exception of antibiotics and psychoactive substances, which are strictly controlled.

“Whenever someone comes to Belgium, I ask them to bring some amoxicillin for children, some pain killers, flu medicine…. I always have children's amoxicillin because sometimes my girl's throat is infected, but they send her home and give her ibuprofen. So I always have it for when the girl has a fever. But I wait until I see it's been three days.”

(Fátima, service voucher cleaning lady, Brussels, 18-05-25)

“There's no way around it; every time someone comes, I end up asking for something. I don't know if it makes sense, but I have the feeling that some medicines in Brazil are more potent, I don't know, or they work faster, or something like that.”

(Catarina, Brazilian domestic worker, Online, 16-06-2025)

Such cases resonate with literature on the theme, in particular Messia's (2002) findings when studying Brazilian women's health practices in the United States. Just like the Belgian case, antibiotics and pain medications were among the most common “imported” Brazilian medications (Messias, 2002). In addition, having their medicines was also one way immigrants avoided seeking professional healthcare in the United States, an important issue for those who were uninsured. The same is true for the sample of this study.

Cross-border movement also features among their strategies, but it is less common due to the high costs for plane tickets to Brazil, the distance, and participants’ undocumented status. This behavior is, however, still present, particularly encompassing dentistry and aesthetic procedures.

“I only get my teeth treated in Brazil. I only go to the dentist here for cleaning. I like healthcare here, but I prefer Brazilian doctors. The way Brazilian doctors treat us is completely different. I think both our dentists and doctors are better than the ones here. But I don't despise the ones here either, because there are many good ones here too.

(Tereza, Brazilian voucher service cleaner, Online, 15-06-2025)

“I think in Brazil, [doctors] investigate more if you have a health problem. I think that's why a lot of people go to the doctor when they go to Brazil. I go to the dentist, and I go to the doctor for this type of investigation. One of the first things we did the last time we visited was a dental cleaning to check if everything was okay. I did some dental work here, root canal and everything.”

(Catarina, Brazilian domestic worker, Online, 16-06-2025)

“I've had plastic surgery in Brazil. I went there to do it. They say that the specialists in this area here don't do their job well.”

(Luzia, service voucher worker, Brussels, 12-06-25)

One peculiar case of this strategy is part of Rafaela's testimony. She experienced a toothache while in Belgium, but the treatment she would have to pay for privately was too costly. During a trip, she had her documents checked and was deported to Brazil. Despite the negative scenario, she took the opportunity to treat her teeth for a fraction of the cost she would have to pay in Belgium; she returned two weeks later with her teeth fixed.

> *"Last year, I had a terrible toothache, and since I have no insurance or CPAS aid, I had to pay for it privately. It was 160 euros for the treatment, but the dentist couldn't finish it. I went to Brazil at the end of the year, in December, and finished it there. Because here, it would have been absurdly expensive too. Around 300 euros. But my visit to Brazil was a quick one. Because I was deported."*
>
> (Rafaela, undocumented Brazilian cleaning lady, Brussels, 18-05-2025)

During the data collection phase, another pattern of cross-border movement was identified; however, this study will not address it in depth, as the purpose of such practice is not primarily linked to health. This movement concerns pregnant women who travel to other EU countries, notably Spain and Portugal, to give birth. Their main goal is to obtain documents for their children and themselves. This is an uncertain path; however, several interviewees shared that a significant number of Brazilian women have engaged in this practice, as obtaining regularization in Belgium is often impossible.

Transnational practices are, therefore, part of this community's' strategies to look after their health, ranging from informally importing medicines to travelling for procedures, health exams, and treatments. Travelling to obtain treatment or services abroad due to dissatisfaction and difficulties with their host countries' systems is in line with Ormond & Lunt's (2019) findings. In addition, this type of mobility among domestic workers was also identified by Lafleur and Vivas-Romero (2018). When traveling to the country of origin is not an option, looking for Brazilian or Lusophone professionals is a more affordable and easier-to-access option, as will be addressed in the next section.

4.2.3 Lusophone professionals and the search for familiar medical practices

Medical care usually involves intimate aspects of one's health. Trusting professionals may be challenging in a foreign context, with different practices and expectations from the patient-professional dynamics. Besides having the notion that Brazilian doctors are better or more prepared, looking for **familiarity** is one of the main reasons why the participants search

for Brazilian or Lusophone[18] professionals in Belgium. A popular YouTube channel within the community even keeps an updated list of doctors who speak Portuguese[19]. Preferring such professionals is a common practice for both documented and undocumented interviewees.

> *"Regarding medicine, I prefer it in Brazil. It is true for all the professionals I've seen here. I've seen two Brazilian pediatricians for my daughters. The gynecologist I go to is Brazilian, from Minas Gerais, and she's been here for ten years. In my opinion, the doctors and the medicine in Brazil… I don't know if it's the warmth of Brazilians. But I think there's a lack of that doctor-patient involvement with Belgian doctors. Maybe we're just too used to that relationship in Brazil."*
>
> (Rita, service voucher worker, Online, 09-06-25)

Nevertheless, the main aspect to prefer Brazilian or Lusophone professionals is, of course, the language. Mônica, the leader of a group of Brazilian women in Belgium, observes this as a consequence of scarce language skills. That is, indeed, the main reason, as reported by several interviewees. In addition, this is a way for them not to need any help during the appointment, which promotes their autonomy, but also limits their choices.

> *"Unfortunately, we have many people in the community who still don't speak any of the country's languages. They need help with their children at school, they need help going to the doctor… That's why many seek out doctors who speak Portuguese. All Brazilian psychologists in Belgium are overwhelmed, because it's easier to speak in your native language than in another language."*
>
> (Mônica, leader of a group of Brazilian women in Belgium, Online, 13-06-25)

> *"When I arrived, when I still didn't speak French well, I consulted a Portuguese doctor. He was my first doctor here because everyone knew him."*
>
> (Clara, cleaning lady, Online, 15-06-25)

> *"We Brazilians, at least those who come here to Belgium, usually don't speak the language, so we look for professionals who speak Portuguese. We know they are available here. I sought this gynecologist just because he spoke Portuguese, because I didn't speak French well, and because I was afraid of not understanding something they would tell me. Imagine they'd detect a disease in me, but they'd speak in French. I wouldn't understand, so there was no point in going. I think the language is the thing that most discourages migrants here."*
>
> (Joana, cleaning lady, Brussels, 29-05-25)

[18] Lusophone, in the scope of this study, refers to any person who speaks Portuguese, including those who were not born in Portuguese-speaking countries, but who learned the language in other contexts.
[19] The list is kept on the video's description https://www.youtube.com/watch?v=wPddo299jhA (last access on August, 11th, 2025)

This preference, however, is not only seen among migrants with limited language skills. Rosa, a 62-year-old service voucher worker, claims to be well adapted and integrated into the country after living in Belgium for 15 years. From all the participants, she had the most positive experiences and impressions of the Belgian healthcare system. She would frequently criticize compatriots who would complain about cleaning, the healthcare system, and other aspects of life in the country. Her emphasis was mostly on personal responsibility, defending that the system already offers enough possibilities for migrants, but that they must take the initiative to access them. Rosa was, in many ways, an outlier, rarely corresponding to the other participants' views. But, despite understanding French well, on the matter of Lusophone professionals, she was aligned with the others.

> *"I think the medical aspect is very serious. Sometimes, I might misunderstand a small technical word he says to me, so I always look for a doctor who speaks my language, or at least Spanish. If I can't find one and if I feel like I won't be able to understand well enough, I look for someone who speaks French well to go with me. I think that in the medical field, you need to be fluent in the language. My family doctor is Spanish but speaks Portuguese, and I had another doctor who was born in France, but whose mother was Brazilian, so he spoke Portuguese very well. I think that, in healthcare, that is the best approach, even if I understand their language. And here you can find these professionals within the system."*
>
> (Rosa, service voucher cleaning lady, Online, 15-06-25)

On another note, the interviewees describe attitudes that highlight **Lusophone professionals**' **cultural competencies.** Sharing or knowing one's cultural background allows them to develop a closer relationship with the patients. In addition, knowledge of one population's characteristics is appreciated, as it often allows for more personalized care.

> *"Up to these days, I take my daughter to a pediatrician who speaks Portuguese. She's Belgian, but she did a year or two of an internship in Rio de Janeiro. So, I thought it was really cool because she understands Brazilian vaccines. And the communication is much easier for me. Not that I can't do it in French. But I feel more confident in Portuguese. Since it's about health…"*
>
> (Catarina, Brazilian domestic worker, Online, 16-06-2025)

> *"Dr. Bruno was my general practitioner. He no longer works as a family doctor, but since he was Brazilian, he was aware of our struggle here… whenever I got there, he said, 'Joana, you need to rest. I'll give you a medical certificate, but you shouldn't be out on the street. You should rest, because you women really work a lot.'"*
>
> (Luzia, service voucher worker, Brussels, 12-06-25)

> *"I want to see if I can find a doctor here who does bioidentical hormonal modulation, preferably a Brazilian one, and I know I must find one in all of Belgium. It's not possible that I can't find a Brazilian doctor who can do this treatment for me, right?"*
>
> (Sofia, school cleaner, online 14-05-25)

Though ensuring linguistically diverse patients' access to effective communication is essential in providing equitable healthcare (Ahrens and Elias, 2023: 5), when this is not possible, bilingual professionals can contribute to adequate services to migrants' needs (Squires, 2018). Therefore, seeking these professionals is a good strategy.

Nevertheless, it is important to look beyond the language barrier and acknowledge that Brazilian and Lusophone professionals represent a way to **feel closer** to the healthcare provider. The concept of **cultural intimacy** — derived from Herzfeld (2007) — has been articulated by Maffi and colleagues (2023) to explain transnational mobility in the context of reproductive medicine. Though located in different contexts, this articulation can help explain these participants' preference for professionals who share their language and, sometimes, cultural background. It is not always possible, nevertheless, to find professionals who speak the language. In this case, *Ad Hoc* interpreters tend to be a common option. This theme will be addressed in the next section.

4.2.4 Networks as health-seeking spaces and the role of *ad hoc* interpreters

When these women face a barrier or have questions, **activating their networks** becomes an important asset for seeking healthcare. Online communities, particularly on WhatsApp, help women by **providing information**, **recommending professionals**, finding **interpreters**, and even supporting **decision-making processes** regarding their health, for instance, which hospital to avoid when giving birth. As the community is often their main information source, the **lack of social support** creates barriers to migrants facing health problems (Silva and Dawson, 2004: 343).

Online groups are celebrated within the community, as they offer an opportunity to exchange valuable information and obtain quick answers. This is useful especially for those who have just arrived. Clara, a cleaning lady in the informal sector, could not count on such information-sharing spaces when she arrived 12 years ago, and sees them as positive.

"In these groups, you meet more people, you learn things quickly, and you find useful information. You can ask questions, interact… When I arrived here, I didn't have the opportunity to interact with people within a group. I was only in touch with a small group that was very narrow-minded, very closed-minded, and sometimes afraid to speak up. So it's good to interact with these groups when you arrive, gathering knowledge from other people, so you can navigate your migrant situation more smoothly".

(Clara, cleaning lady, Online, 15-06-25)

Since Joana arrived in Belgium in 2023, WhatsApp groups have been her main source of information. She is part of several, some dedicated to finding work, others to (expectant) mothers, and general groups with advertisements and the like. Her testimony exemplifies the topics exchanged in the groups.

"To this day, WhatsApp groups are my main source of information in Belgium. There are questions from everyone, every day, in the groups. When they ask, my own questions are answered just by looking at the messages. I learned about the CPAS through the groups. There are people, for example, who had poor treatment in hospitals here, so there are reports in the groups of people who didn't have a good experience at certain hospitals, at least on the subject of pregnancy, prenatal care, and obstetrics, right? The groups help both by recommending professionals who speak Portuguese to help us when we don't know the language, and by recommending places, facilities, hospitals, and so on, that provide better care".

(Joana, cleaning lady, Brussels, 29-05-25)

Mônica's group, which is dedicated to Brazilian women in the country, maintains a WhatsApp community with over 130 participants. She is the group's main administrator, and despite understanding the importance of such internet communities, she worries about ill-intentioned people spreading false information and illegal services through them.

"I created a WhatsApp group in 2020, at the beginning of the pandemic, for women to support each other. There are almost 150 Brazilian women in this group, and the conversations there cover various subjects. Sometimes it's about work, and others ask for information on doctors who speak Portuguese. Some people are selling products. As soon as I open the messages, I see that people are already helping each other in some way, recommending doctors, saying that this school is easier to register the children… This takes away a bit of our work. But unfortunately, there are a lot of people acting in bad faith who try to take advantage of people who need information. For example, people selling consulate services. When I see this, I block them in the groups I manage."

(Mônica, leader of a group of Brazilian women in Belgium, Online, 13-06-25)

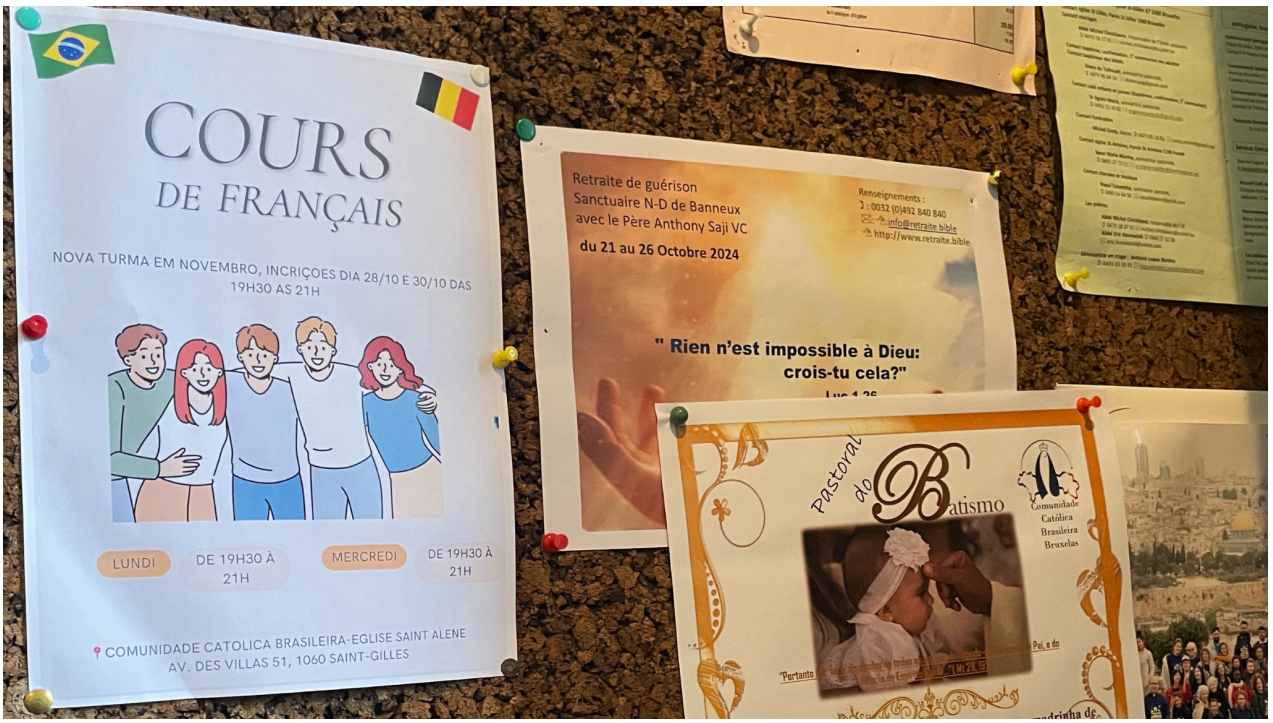

Image 4: Spaces like the Brazilian Catholic Community have projects to address language gaps and promote more autonomy for the community. Source: own archive. 25-12-24.

Despite their popularity, online communities are not the only network people activate in case of need. Reaching out to people who have lived in Belgium for a long time or getting in touch with religious communities are other more traditional ways. Bárbara, for example, who became an *Ad Hoc* interpreter for community members in need, never publicized her work online. The demands would come as people shared her contact with one another. This kind of service can be, however, time-consuming and difficult to fit into one's routine.

> *"It was a spontaneous thing that happened. You go help your neighbor, then your friend, then someone else. This whole Brazilian thing of helping Brazilians, you know? I couldn't avoid it. But then there's that Brazilian thing, too. You help once, and people think you can help another ten times. Then they start to ask me all the time. Then it becomes overwhelming, and you don't have time for yourself anymore."*
>
> (Bárbara, museum employee, Online, 01-06-25)

Ad Hoc interpreters play a big role in this adaptation process, allowing people to understand medical and governmental appointments. In this scenario, there is a tendency to count on **family** and **friends** who have a better command of the language to help, but this can be problematic, especially concerning children. Mônica recalls an episode that alarmed her.

“I'm going to share something really sad with you. It still happens a little. In the past, mothers, especially, would take their children to the doctor for translations. I received a case of a 7-year-old who had to translate a gynecology appointment for his mother. Imagine a child dealing with such an intimate thing of the mother… Since I received cases like that, I always try to work with the parents and tell them that children don't have to carry that responsibility. They don't have to listen to everything, nor know about all the parents' problems, because this has a big impact on the child's mental health.”

(Mônica, leader of a group of Brazilian women in Belgium, Online, 13-06-25)

Bringing children to help with translation was indeed mentioned in the interviews. Rita still relies mostly on her sister, who has lived in Belgium for more than a decade. But when she is not available, her oldest daughter accompanies her.

“Usually, my sister accompanies me. She helps me a lot, especially in the medical field. But now if my sister can't go, and I need to bring a translator, I sometimes take my oldest daughter, who has been studying here for three years already.”

(Rita, service voucher worker, Online, 09-06-25)

Another way of activating networks was described by Catarina, who is insured by the CPAS, but contacts her cousin and her aunt, who are healthcare workers in Brazil, in case she has any doubts regarding her or her family member's health and how to proceed.

“I have a cousin who's a dentist, and I completely trust her. Every time I had any problem here, with myself or my daughter, I'd pick up the phone [and text] ‘help me’. She always supported me, like that. Even my aunt, who's a doctor, whom I'd contact every time I had any trouble here with my daughter: ‘Help me, what do I do?’. Sometimes, with that help, I was able to resolve the issue before going to the hospital, especially because there was a language issue, right? I always felt like I couldn't explain exactly what was going on and so on.”

(Catarina, Brazilian domestic worker, Online, 16-06-2025)

Beyond the family sphere, the Catholic community in Brussels was an important reference point for the participants. I was able to experience the strength of their bonds firsthand. One of my participant observation opportunities was during a hospital visit by one of the sisters and a prayer group. During that occasion, I engaged in prayer with eight churchgoers, and I had the chance to observe how the religious community acts as a support network. During the encounter, Sister Mariana, who is particularly active in providing help and support to migrants in health contexts, shared her own experiences with the health system. I also observed initiatives of the church to raise funds to help community members in need. Fátima, Luzia, and Joana recall the importance of the religious group in this scenario.

"I always recommend Sister Mariana[20] to someone I don't know, and who needs help. I tell them to reach out to the community. Our community is very large now, and there are people, like me, who have been here for years, some for almost 30. These people are already settled."

(Luzia, service voucher worker, Brussels, 12-06-25)

"The church really represents a family. They visit people's homes. When someone has a major problem, they bring it to the sisters, and they take care of it. That's really cool, in terms of assistance."

(Fátima, service voucher cleaning lady, Brussels, 18-05-25)

"The people at the church and in the community, help a lot. Firstly, my source is the community, which we didn't have before, but now we do, right? There are a lot of people here with much more experience, 20 years, 15 years in Belgium already. So these are people who help a lot with their knowledge here."

(Joana, cleaning lady, Brussels, 29-05-25)

Informal social networks are crucial for these women to access information and healthcare resources (Messias, 2002), especially in a context of information scarcity (Chen et al., 2022; Lebano, 2020; Triandafyllidou, 2016). Their information exchanges represented valuable assets to navigate the Belgian healthcare system. Through such interactions, they would search for doctors, find *Ad Hoc* interpreters, learn more about the healthcare system, receive assistance, and even connect with family members who work as healthcare professionals in Brazil and could provide them with some orientation.

Though crucial for these women, some aspects of their use of networks demand further consideration. Interpreters facilitate communication between patients and healthcare providers and can even act as **cultural brokers**, helping manage cultural divides between patients and clinicians (Squires, 2018: 2). However, bilingual healthcare providers and professionally trained interpreters offer the best results and patient satisfaction (Ahrens and Elias, 2023; Squires, 2018; Flores, 2005). From the perspective of healthcare providers, though *Ad Hoc* interpreters can be convenient, they can also be problematic (Yakhlaf et al., 2025). Ad Hoc interpreters, for instance, listen to private details of a patient's life, may filter the communication between the parties, and may be unable to translate technical terms and recommendations accurately. For these reasons, healthcare providers prefer professional language services (interpreters or intercultural mediators (Yakhlaf et al., 2025: 8).

[20] Fictional name

Though professional interpreters are strongly recommended, accessing them is still a challenge for migrants in the country. Such services exist; but they are usually private or do not directly serve individuals, for example, the Brussels Social Translation and Interpreting Service — *Service de Traduction et d'Interprétariat en Milieu Social Bruxelles*[21] (SeTIS), in French.

Lastly, the networks these women rely on are strongly related to their national background. Interviewees never mentioned native Belgians as people they could count on with health-related issues. Therefore, it is possible to identify a strong bonding capital (Putnam, 2000) within this community. They are tightly bound together, helping each other get by. This is valuable, of course, especially for newcomers, but relying on nationality-based networks may, nevertheless, limit their possibilities or even deprive them of valuable connections within the local community.

4.2.5 Government aid

In this last section, the use of government aid is addressed, putting the interviewees' perspectives, once again, in the spotlight. This last strategy is employed only by those lacking a legal status in the country. Considering only those who have utilized aid from the CPAS or the ONE (the only institutions mentioned in the interviews), a pattern became evident. There is a double relationship with these services; they may be sought very **early** on or when private services become **unaffordable**. The experiences vary, as different interviews demonstrate. Ana's first contact with the CPAS was because of her daughter's ill health. After 10 days in the hospital, the bill was 12 thousand euros. Ana and her family could not afford it, and the doctor in charge of the patient decided to help them with the paperwork.

> *"Since my daughter got sick four years ago, we've been receiving help from the CPAS. In fact, it was her pediatrician who helped us. If it weren't for her, I don't even know what would have happened, because she was hospitalized for ten days. And those ten days cost 12,000 euros. And then, she came in, sent a written document, everything organized. She organized everything. So, she already got help from CPAS, thank God!"*
>
> (Ana, undocumented migrant who works in the cleaning sector, Brussels, 29-05-25)

[21] https://www.setisbxl.be/

Tereza originally searched for the CPAS after her daughter became ill with respiratory issues. That first contact also inspired her to request aid for herself.

> *"When I came from Brazil, I had no problems at all. But when I arrived here, I had to get a gallbladder surgery. I had it covered through the CPAS. I was entitled to the hospital and everything for free, but I didn't have access to the medication. But for my daughter, everything was free. I didn't pay a thing. So, I have nothing to complain about. Honestly, I say that Belgium is like a mother, because not every country does this."*
>
> (Tereza, Brazilian voucher service cleaner, Online, 15-06-2025)

In contrast, for a few participants, the visit to request medical aid from the CPAS was scheduled from the beginning. These were rarer, but concerned especially those with family living in the country — highlighting, once again, the importance of networks. Having a reference and someone to accompany them made the difference; that was the case for Catarina, who went to the CPAS office soon after she arrived, as recommended by her husband and his sister, who lived in the country already.

> *"Regarding health, since I arrived here, I've been registered with my neighborhood's CPAS. Since then, we've been protected in that regard. My husband is diabetic, and my daughter has asthma attacks; she's had bronchiolitis and such, so we've always had support. It's a bit of a hassle; you have to constantly claim that you can't afford medical care, but I'm really scared of having to pay out-of-pocket for emergencies."*
>
> (Catarina, Brazilian domestic worker, Online, 16-06-2025)

When preparing for the fieldwork, I expected women would seek Non-Governmental Organizations or free clinics, for example. But only one, Tereza, mentioned using the services of Médecins Sans Frontières (Doctors without Borders, in English). Therefore, governmental organizations are the main source of formal healthcare aid for this community. This is understandable, as, in the European context, Belgium has a rather generous policy for undocumented migrants in comparison with other countries in the region (Van Ginneken, 2014). Despite being denominated "urgent" medical aid, Belgium offers a comprehensive list of procedures under this policy, from **preventative** to **curative** care. Therefore, dentists, blood exams, vaccines, medication, and medical appointments are included. This way, if one obtains coverage by the CPAS, their access to health generally meets their needs.

However, as previously covered in the section on legal status and access to healthcare (4.1.2), obstacles hinder migrants' access to the CPAS. These are varied, ranging from the

lack of information to rude treatment in the offices. Furthermore, information is not always clear, even for users of the urgent medical aid system, who discover its possibilities as they go. Catarina was surprised when she discovered the CPAS could also cover her medication costs, though the process to obtain this coverage is complicated in her opinion.

> *"I didn't know we were entitled to the medication prescribed by the doctor. I had no idea. I found out a while later, when my social worker explained it to me. I said I was paying too much, I mentioned some of my husband's medications, which were very expensive and she said I could request them from the CPAS. I confess that, lately, I haven't requested it, because the medication he is taking costs 6 euros a box. And the process to get the medication is so difficult. You go to the doctor, you take a CPAS form to them to fill out. You go to the CPAS, and then it authorizes you to pick it up at the pharmacy. So, you spend a lot of time on this process. When there's a larger volume of medication, then I resort to it."*
>
> (Catarina, Brazilian domestic worker, Online, 16-06-2025)

Despite all weaknesses, this is still the most comprehensive aid undocumented people in Belgium can receive. Concerning pregnant women, the ONE was also complimented, especially by Cecília, who felt supported throughout her prenatal sessions.

> *"After one year and four months without going to the doctor, I only went now because of my pregnancy. The ONE services are very good, the exams and everything. I'm doing everything for free. Despite my first bad experience, the last three consultations were wonderful, especially after one of them who works in the office offered to come in with me to translate. I thought that was really cool. And I'm really enjoying it. They're very attentive."*
>
> (Cecília, undocumented cleaning lady, Online, 26-05-25)

Although positive experiences can be found, difficulties accessing such services should not be ignored. As emphasized by Schoenborn and colleagues (2021: 11), though services for undocumented migrants are available in Belgium, this system's efficiency is hindered at a structural level by **bureaucratic barriers** (e.g., complex administrative procedures) or a **lack of healthcare adaptation to migrants** (e.g., lack of translation services or cultural competency). An important reflection, nevertheless, is that healthcare access, despite being favorable for migrants' health outcomes, will not, by itself, solve the issues many interviewees reported. This will be further acknowledged in the discussion.

5. Discussion and Conclusion

It was evident through the interviews that most of the participants face obstacles to accessing healthcare and/or have issues caring for their health in Belgium. This group of migrants suffers from barriers of **accessibility** more than **entitlement**. Health inequities are, nevertheless, clear between those who hold a residence permit and those who do not. On one hand, the women working in the formal sector can be **insured** and benefit from **protection norms** regulating the workplace. On the other hand, undocumented migrants are subject to more precarious workplace conditions and must rely on the Urgent Medical Aid system or private services. Though entitled to healthcare provision by law, the latter face issues accessing this right. In consonance with a solid body of literature, the **undocumented participants were the most vulnerable** to having unmet healthcare needs in Belgium (Davitian et al., 2024; Kisa and Kisa, 2024; Nielsen and Jervelund, 2023; Dauvrin et al., 2018; Lafaut and Coene, 2020; Lebano et al., 2020).

The difficulties this group faces are multiple and operate in different overlapping spheres of their experiences with health and healthcare in Belgium. This study has identified **health challenges** encompassing elements related to their **occupation**, **legal status**, **socioeconomic situation**, **healthcare system organization** and **dynamics**, and **language barriers**. Concomitantly, the study identified and described their main **strategies** to overcome (some of) the shortcomings they encounter in contacts with the healthcare system and individual challenges regarding health. Their main strategies are the use of **private services**, **transnational practices**, searching for **Lusophone professionals**, **activating networks,** and **requesting government aid**.

All of the interviewees employed in the cleaning sector **engaged in strategies to overcome challenges and fulfill their healthcare needs**. They employ a combination of **individual** and **collective** resources, blending **local** and **transnational strategies**. This is in line with the concept of Healthcare Bricolage (Phillimore, 2019), through which migrants link multiple resources — simultaneously or consecutively — highlighting the creativity of these communities in finding alternative ways to fulfill their healthcare needs. It is possible to say, for instance, that looking for Lusophone professionals acts as **within the system bricolage**, while traveling for medical procedures fits as **added-to-system bricolage**. Their practices are similar to those of other communities, for instance, informally importing

medication from the home country (Krause, 2008), cross-border mobility (Lafleur and Vivas-Romero, 2018), and pre-migration healthcare check-ups (Messias, 2002). These practices indicate new healthcare landscapes transforming the spatiality of service provision, but such phenomenon still rests in concrete spaces and is embedded in social stratification and countries' legal distinctions (Zanini et al., 2013: 12).

In addition, their strong reliance on networks to fulfill their healthcare needs highlights their dependence on nationality-based communities, indicating a strong bonding capital between its members (Putnam, 2000). Social isolation is, unsurprisingly, harmful for their health-seeking behavior (Silva and Dawson, 2004). Nevertheless, at the same time, these networks can be a valuable asset, they have a harmful potential (e.g., the spread of inaccurate information). Within their networks, the figure of the *ad hoc* interpreter emerges as a protagonist in facilitating communication and bridging cultural differences between patients and healthcare providers. This is expected as language represents an obstacle for documented and undocumented migrants alike. Nevertheless, relying on untrained and non-professional interpreters is not the ideal scenario (Ahrens and Elias, 2023; Squires, 2018; Flores, 2005).

It is a mistake to think that lack of healthcare access is the only problem affecting the participants. It is possible to theorize that even if healthcare in Belgium was universal, fully state-funded, and free for users, this community would still face major health-related issues. In this study, this was best exemplified in the sections on their **occupation** (4.1.1), **legal status** (4.1.2), and **financial constraints** (4.1.3). It is important to think that the women in this sample represent so-called **low-skilled workers**, many of them employed in the **informal sector**, who face precarious work environments daily (Chen et al, 2022; Marchetti, 2022; Hall et al., 2019; Abubakar et al., 2018). As the literature on the social determinants of health emphasizes, a lower economic status directly contributes to ill-health, as it hinders one's possibility to be in a healthy environment and access important resources for their livelihood (Wilkinson and Marmot, 2003; Marmot et al., 1999).

In this regard, I argue that **legal status** plays a determinant role in shaping health-seeking behaviour and health outcomes within this target community. This situation is threefold as undocumented migrants are (1) unprotected in the work environment, (2) do not benefit from job security, and, at the same time, are (3) excluded from obtaining comprehensive health insurance (being restricted to the CPAS services, when they manage to

register). In summary, they are less cushioned against the negative effects linked to this economic activity, and accessing healthcare tends to be harder for this population, creating multiple layers of vulnerability.

Moreover, the stories of these women include **poorly remunerated strenuous work**, relying on a poor **diet** during their working hours, **exhaustion**, and **stress**. They can barely care for their health in their routine, not having the energy, for instance, to engage in physical activity. For those who work in the **formal** sector, the voucher system did, in fact, mean more quality of life and job security **in comparison to working informally**, which is expected on an individual basis. Nevertheless, formalization did not considerably improve working conditions in the sector, and neither did it change the migrantized and gendered character of paid domestic work in Belgium (Safuta and Camargo, 2019: 14). Therefore, most of the healthcare-related issues present in this study "are produced by social injustice and are avoidable and preventable" (Krieger, 2010). Though the participants engage in strategies to overcome them (often, partially), this is not sufficient to change their health-outcomes.

To promote healthcare system practices that address migrants' needs, more effort is needed to ensure effective communication with linguistically diverse patients (Ahrens and Elias, 2023), reducing structural barriers (Schoenborn et al., 2021; Vanneste et al., 2020), and fostering culturally sensitive attitudes among healthcare providers (Yakhlaf et al, 2025). Following Krieger (2004), this engagement must equally include the production of data concerning the uninsured population, as it is impossible to address their needs without diagnosing the main healthcare gaps they are subject to. Governmental engagement is crucial to avoid delayed access to medical care, as it causes economic and public health consequences (Guillon et al, 2018). Therefore, from a policy standpoint, guaranteeing healthcare access to migrants is advantageous, as early interventions cost less to the government budget. However, the current anti-immigrant sentiments and rising public spending on health (linked to a rapidly ageing society) may create barriers to policy changes at the federal level. As demonstrated by Harper and Raman (2008), political attention to the intersection between migration and health still influences contemporary migration policies increasing restrictions.

Moreover, as Messias (2001) would argue, work dominates these women's lives, but that is not their only occupation. **Gender** is also a crucial factor in these testimonies, which

calls for future research with an intersectional approach. Though the interviewees would hardly make direct considerations about how gender would affect their health, they would describe having **multiple journeys**, which increases their workload and, consequently, deepens their exhaustion. Those who have children or who are in stable relationships frequently shape their routine around the household demands. The **flexibility** of the cleaning sector would often attract them for this very reason, as they can work around their children's and husbands' schedules. There is, therefore, more than one working journey in their routine, as they accumulate paid work, household, and childcare chores. They are not in a financial position to privilege paid or unpaid work; they must perform both. This combination has the potential to raise the risk of poor health and reduce their ability to engage in health-seeking behavior (Messias, 2001). Moreover, as they accumulate multiple functions, they cannot engage in other activities that could facilitate their relationship with healthcare services (e.g., language classes).

Though this is a qualitative study with a small, nationality-based sample, which limits its generalisability, it still reveals important health-related challenges migrant domestic workers face and their strategies to fulfill their healthcare needs. These may be present within other migrant communities living in Belgium; therefore, further research on the topic could compare the challenges and strategies other communities use, enriching the discussion. This topic could also benefit from future research on mental health within this community, as the topic was mentioned by participants, but not enough to be further developed in this master's thesis. Regarding the limitations of this study, besides the small sample, it is imperative to mention the short period of time during which it was carried out, from December 2024 to August 2025. This topic could certainly benefit from a longer development period, which could have allowed the organization of focus groups and expansion of interviewees' perspectives (e.g., healthcare providers, union leaders, public servants, etc).

In conclusion, this master's thesis proposed to investigate Brazilian cleaning sector workers' **healthcare-related challenges** and **health-seeking strategies**. It has revealed the complex realities in which these migrants' livelihoods unfold, and how their occupation, socioeconomic status, routines, language skills, legal status, and other dimensions affect their use and access to healthcare. At the same time, their creative arrangements to take care of their health, access medical care, and adapt to the healthcare system were highlighted, demonstrating the variety of strategies and their uses. Beyond discussing the value of

universal healthcare provision, including undocumented migrants in the formal healthcare system, this study aims to highlight that this is not enough to address health inequities concerning this population. Structural change is needed to fulfill their unmet healthcare needs, but political will is needed to advance in this domain.

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Appendix I: Biographical presentation of the interviewees, in their order of appearance

Interviewee	Date of Interview	Description
Tereza	15/06/2025 *Online*	A 60-year-old Brazilian woman who has lived in Belgium for the last 21 years. She has been working in the cleaning sector since she arrived. Before coming to Europe, she worked at the office of an important transportation company in her region. She obtained her documents following the 2009 amnesty for undocumented migrants, and since then, she has worked through the voucher system.
Catarina	16/06/2025 *Online*	The 39-year-old holds a degree in Geography, but started working as a cleaner after moving to Belgium. She migrated with her daughter 7 years ago, following her husband, who migrated upfront. They arrived undocumented, but are attempting to regularize their situation with Portuguese documents.
Rachel	09/06/2025 *Online*	The 32-year-old has been living in Belgium for six years. Since migrating with her husband and daughter (and joining other family members who lived in the country), she has worked as a cleaning lady. She recently had a baby and followed the perinatal care in Belgium.
Rafaela	18/05/2025 *In person*	A 27-year-old cleaning lady who has lived in Belgium for two years. She does not have documents, but is expecting to obtain regularization through Portugal. She migrated alone, though she has acquaintances in Brussels who supported her.
Sofia	14/05/2025 *Online*	A 46-year-old pharmacy technician who has lived in Belgium for about a year and a half. She migrated with her husband and her son (both Portuguese citizens). Her documentation is pending, though she is entitled to it through family reunification with an EU citizen. She works in the cleaning sector as she lacks language skills and the recognition of her diploma to search for a better job.
Luzia	12/06/2025 *In person*	The 51-year-old Brazilian service voucher worker has lived in Belgium for the past 21 years. She migrated after her sister. She obtained her documents following the 2009 amnesty for undocumented migrants.
Joana	29/05/2025 *In person*	A 24-year-old who migrated with her Belgian-Brazilian husband. Her documentation is temporary, though she is attempting to obtain a 5-year residence permit through marriage to a Belgian citizen. Since arriving in Belgium almost 2 years ago, she has worked as a babysitter and cleaning lady. At the time of the interview, she was unable to work due to her high-risk pregnancy.
Ana	29/05/2025 *In person*	She has been living in Belgium for 6 years with her husband and children. She has always worked informally in the cleaning sector, and does not have documents, but seeks regularization through her husband, who obtained a working permit in Portugal.

Rosa	15/06/2025 *Online*	At 62 years old, Rosa is one of the most experienced in migration matters. Before migrating to Belgium, she already had experience in the United States. After her husband acquired European documents, she moved from the US to Belgium 15 years ago. She works as a service voucher cleaner.
Bárbara	01/06/2025 *Online*	She has lived in Belgium for 28 years, the longest length in the sample. Though her main occupation, at the time of the interview, was as a museum worker, she has taken the role of an *Ad Hoc* interpreter several times to aid members of the Brazilian community in healthcare-related contexts. Her long experience in the country has helped her
Margarida	11/06/2025 *Online*	The 58-year-old works informally in the cleaning sector. This has been her occupation since she arrived in Belgium 17 years ago. Despite attempting regularization twice, both her requests were denied. Her dream is to work in the healthcare sector, as she used to be a nursing technician in Brazil.
Fátima	18/05/2025 *In person*	A 43-year-old cleaning lady who has lived in Belgium for 13 years. She is married to a Spanish citizen, with whom she has a daughter. She has documents and works as a cleaner through an agency.
Rita	09/06/2025 *Online*	At 47 years old, she has been living in Belgium for three years with her husband and children. She used to work as a Human Resource Manager in Brazil, but after being laid off, she decided to migrate to Belgium. She has documents and intends to leave the cleaning sector when she receives an opportunity
Cecília	26/05/2025 *Online*	A 23-year-old bachelor of law who migrated to Belgium following her husband. She does not have documents, and since moving to Belgium a year and 6 months ago, she has been working informally in the cleaning sector. At the time of the interviews, she was expecting her first child.
Esther	24/05/2025 *Online*	A 46-year-old accountant who migrated to Belgium a year ago, following her husband, intending to attain financial stability. She does not have documents and works informally in the cleaning sector as she lacks the diploma recognition and language skills necessary to work in her field.
Mônica	13/06/2025 *Online*	After coming to Belgium to pursue her higher education, she settled in the country. Since the beginning of her journey, she has been involved in voluntary projects to address this community's demands. She is currently the leader of a group dedicated to Brazilian women in Belgium.
Clara	15/06/2025 *Online*	The 59-year-old has lived in Belgium for 12 years and has always worked in cleaning; however, she intends to leave the sector and become a masseuse. She is undocumented and employed in the informal sector. She is currently attempting regularization through Portugal.