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☑ 35 years of SUS: Nursing in the defense of health as a right

Health care behaviors and needs of migrant university women in an international border region

Comportamentos e necessidades de cuidados em saúde da mulher migrante universitária em região de fronteira internacional

Comportamientos y necesidades de atención de la salud de la mujer migrante universitaria en una región fronteriza internacional

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ABSTRACT

Objective: To understand the behavior and perception of migrant university women regarding the need for health care.

Method: This is an exploratory, descriptive, qualitative study, conducted within the theoretical framework of Symbolic Interactionism. Participants were 19 international migrant women from a public university in Foz do Iguaçu, Brazil. Data collection took place between April and August 2024 through interviews, which were analyzed using Thematic Analysis.

Results: Participants recognize the need to maintain healthy behaviors, including a balanced diet, adapted physical activity, mental health care strategies, and the use of natural plants and herbs. These behaviors, shaped and shaped by their social and cultural interactions, were difficult to achieve due to cultural adaptation, insufficient financial resources, a lack of traditional herbs and plants, and limited time. Sexual and reproductive health was weakened by misinformation, taboos, and barriers to access. The lack of comprehensive and culturally sensitive support in health services compromised the performance of tests for sexually transmitted infections and gynecological follow-up.

Conclusion: Migrant women attending university recognize the need for health care and seek to balance their cultural values with the demands of their new life context. However, misinformation and limited access to services have negatively impacted their sexual and reproductive health care.

Descriptors: Health-Related Behaviors; Health Care; Symbolic Interactionism; International Migration; Women's Health.

RESUMO

Objetivo: Conhecer o comportamento e a percepção da mulher migrante internacional universitária sobre a necessidade de cuidados com sua saúde.

Método: Estudo descritivo exploratório, qualitativo, conduzido à luz do referencial teórico do Interacionismo Simbólico. Foram participantes 19 mulheres migrantes internacionais, de uma universidade pública, em Foz do Iguaçu, Brasil. A coleta de dados ocorreu entre abril-agosto de 2024, por meio de entrevistas, cujos dados foram analisados por Análise Temática.

Resultados: As participantes percebem a necessidade de manter comportamentos saudáveis, que incluem alimentação equilibrada, atividades físicas adaptadas, estratégias de cuidados com saúde mental e uso de plantas. Esses comportamentos, moldados por interações sociais e culturais, enfrentam dificuldades devido adaptação cultural, recursos financeiros, falta de ervas tradicionais e tempo limitado. A saúde sexual e reprodutiva é fragilizada por desinformação, tabus e barreiras de acesso. A falta de suporte integral e culturalmente sensível nos serviços de saúde compromete a realização de testes para infecções sexualmente transmissíveis e acompanhamento ginecológico.

Conclusão: Mulheres migrantes universitárias percebem a necessidade de cuidados com sua saúde e buscam equilibrar valores culturais de origem com as demandas impostas pelo novo contexto de vida. Contudo, desinformação e limitações de acesso aos serviços impactaram negativamente no cuidado à saúde sexual e reprodutiva.

Descritores: Comportamentos Relacionados com a Saúde; Assistência à Saúde; Interacionismo Simbólico; Migração Internacional; Saúde da Mulher.

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RESUMEN

Objetivo: Comprender el comportamiento y las percepciones de las mujeres migrantes internacionales en la universidad respecto a la necesidad de atención médica.

Método: Estudio exploratorio, descriptivo y cualitativo, realizado en el marco teórico del Interaccionismo Simbólico. Participaron 19 mujeres migrantes internacionales de una universidad pública de Foz do Iguaçu, Brasil. La recolección de datos se realizó entre abril y agosto de 2024, a través de entrevistas, cuyos datos fueron analizados mediante Análisis Temático.

Resultados: Los participantes reconocen la necesidad de mantener hábitos saludables, como una dieta equilibrada, actividad física adaptada a sus rutinas, estrategias para el cuidado de la salud mental y el uso de plantas y hierbas naturales. Estos hábitos, moldeados por sus interacciones sociales y culturales, fueron difíciles de lograr debido a la adaptación cultural, la insuficiencia de recursos financieros, la falta de hierbas y plantas tradicionales y la escasez de tiempo. La salud sexual y reproductiva fue un tema clave en la atención, justificado por la desinformación, los tabúes culturales y el acceso limitado a los servicios de salud. La falta de apoyo integral y culturalmente sensible en los servicios de salud contribuyó a la falta de pruebas de detección de infecciones de transmisión sexual y a la falta de seguimiento ginecológico.

Conclusión: Las mujeres migrantes que asisten a la universidad reconocen la necesidad de atención médica y buscan conciliar sus valores culturales con las exigencias de su nuevo contexto de vida. Sin embargo, la desinformación y el acceso limitado a los servicios han afectado negativamente su salud sexual y reproductiva.

Descriptores: Conductas relacionadas con la salud; Atención médica; Interaccionismo simbólico; Migración internacional; Salud femenina.

INTRODUCTION

Migration movements are on the rise across the globe. The number of international migrants has already reached 281 million people worldwide, of which 135 million are women, highlighting the intensification of global mobility and the increasing diversity of migration flows that characterize the 21st century scenario[1].

International migration generates transformations and introduces new dynamics in both origin and destination societies. This phenomenon is complex, as the migrant is an agent in constant transformation, reshaping territories at different levels. Their presence and interaction with new spaces enable the creation of new ways of being, existing, and living, opening paths for perspectives that broaden and enrich cultural and social horizons[2].

The health of migrant women is a topic of global relevance, especially given the increase in female migration and the particularities of this population, such as cultural and linguistic diversity, experiences of discrimination, lack of support networks, economic instability, psychological stress, and difficulties in accessing health services. For young women who migrate in search of educational opportunities, these factors can negatively impact their physical and mental health, leading to changes in behaviors and care practices, such as reduced demand for preventive services, self-medication, dietary changes, adaptation or abandonment of traditional self-care habits, and greater vulnerability to stress, anxiety, and depression[3].

Brazil's Women's Health Care Policy establishes that all women should be considered throughout their life cycles, respecting the particularities of each age group and recognizing the diversity of population groups. This includes Black women, Indigenous women, women living in urban and rural areas, living in hard-to-reach areas, women in vulnerable situations, women deprived of their liberty, women with disabilities, women of different sexual orientations, among others[4].

In the Latin American context, for example in triple-border regions such as Brazil–Paraguay–Argentina, these challenges become more evident, as access to health promotion and disease prevention actions can be limited, requiring differentiated attention to the specific needs of this migrant population[5].

A French study described that changes in the care behaviors of migrant women, precarious living conditions, language barriers, and difficulties understanding the health system have made health care and services significantly deficient, especially in disease prevention actions[6]. Thus, international migration puts women's health at risk, especially their sexual and reproductive health, as indicated by a Canadian study[7] .

Coexistence with different cultures and cross-border dynamics, considering the study setting, makes the migratory experience even more complex for women, as they will need to balance academic and personal demands with the challenges of accessing and adapting to already fragile local healthcare systems[8]. Furthermore, aspects of daily life such as nutrition, physical activity, and sexual and reproductive health will take on new meanings, requiring healthcare professionals and services to adopt specific approaches that consider the sociocultural contexts and life trajectories of these women.

Healthcare professionals need to develop cultural competencies to provide more inclusive care. This involves recognizing and valuing the cultural differences present among patients and colleagues, avoiding judgments, and fostering a collaborative environment. Cultural sensitivity is essential to understanding the diverse forms of expression, beliefs, and health practices, contributing to more humanized care[9,10].

Specifically for nurses, it is fundamental to consider the cultural elements of each patient, respecting their values, norms, and beliefs. This attention allows patients to feel welcomed and more receptive to the care provided. By integrating culture into the care process, the nurse strengthens the bond with the patient and improves the quality of care provided[9,10].

In this context, it is important to understand how young migrant women attribute meaning to their choices and how their social and cultural interactions influence the construction of their healthcare. This debate can contribute to the development of inclusive and culturally sensitive strategies capable of promoting more humane and effective healthcare for migrant women, especially in the context of universities and border regions.

Based on this assumption, the objective of this study was to understand the behavior and perception of international migrant university students regarding the need for healthcare.

METHOD

This is a descriptive, exploratory study with a qualitative approach[11], conducted in light of the theoretical framework of Symbolic Interactionism[12] (SI), with its method outlined according to the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines.

The research setting was the municipality of Foz do Iguaçu, Paraná, located on the triple border area of Brazil, Paraguay, and Argentina. The municipality is marked by the intersection of diverse cultures, where approximately 95 nationalities coexist, coupled with tourist attractions (National Park, Iguaçu Falls, and Itaipu Binacional) that strengthen regional integration and attract a multitude of people from different continents[13]. Additionally, the region has become a destination for young individuals seeking better university opportunities, whether Brazilians studying in the neighboring country (Paraguay) or international migrants, mainly from Latin America, seeking admission to a Brazilian public university.

The research was conducted specifically at a bilingual (Portuguese-Spanish) public higher education institution that enrolls students from Brazil, Mercosur countries, and other Latin American countries.

Through the university's Integrated Academic Activities Management System, 489 non-Brazilian students were identified who met the preliminary inclusion criteria: age over 18, enrolled in undergraduate programs for at least 12 months, and a nationality other than Brazilian. The exclusion criteria were female migrant university students not using the Unified Health System (*Sistema Único de Saúde* – SUS) and those on sick leave. It should be noted that all students declared themselves to be SUS users, therefore, there were no exclusions.

Different recruitment strategies were adopted for eligible students, including in-person approaches at the university, conducted in various circulation and common areas (classrooms, library, hallways, and common areas), invitations sent via institutional email, and advertising in WhatsApp groups. The research objectives were presented, and an invitation to volunteer was formalized. Interviews were then scheduled, based on the participants' availability. Data collection took place in person at the university between April and August 2024.

Students who agreed to participate signed the Informed Consent Form, available in Portuguese and Spanish according to their preference. Individual interviews were then conducted in private rooms within the university, ensuring confidentiality, privacy, and comfort. The in-person strategy proved crucial for establishing a bond and strengthening trust between the researcher and participants, as well as enabling reaching migrant women who might not have been reached by exclusively online invitations.

A total of 19 interviews were conducted by the first author, a nurse, who was previously trained by the other authors, who have experience in qualitative research. To ensure clarity and adequacy of the question guide, as well as to improve the interview process, three pilot interviews were conducted. This stage aimed to identify ambiguities or difficulties in understanding, as well as training the interviewer, increasing the reliability of the collected data. However, no adjustments to the question guide were necessary, and the interviews were conducted appropriately (after content assessment by the main researcher), and therefore, they were included in the study.

With an average duration of 45 minutes, the interviews were audio-recorded and fully transcribed manually, without the use of software. After transcription, the records were emailed individually to the participants for review and validation, without corrections or changes reported. The data collection process ended when theoretical data saturation was reached[11], which was considered achieved when the researcher understood the logic and essential scope of the study group, prioritizing the depth and diversity of the information obtained. Therefore, saturation was monitored throughout the data collection, and the interviews continued until no new themes emerged.

The interviews were supported by a semi-structured question guide developed by the researchers, consisting of seven characterization questions with sociodemographic, academic, and migration data. The remaining questions (18) were conducted based on the following guiding question: How do you take care of your health?

The chosen data analysis method was Thematic Analysis[11], which followed three phases: Pre-analysis, in which transcriptions and repeated readings of the content were performed. The initial data were annotated and grouped by convergence of ideas, identifying relevant aspects, which allowed for the organization of preliminary categories; Material exploration, in which themes were refined, and then an analysis map was organized, enabling the definition of categories with central meaning; and Processing and interpretation of results, in which the essence of each analyzed category was sought, producing a final, concise, coherent, and non-repetitive text, guided by the theoretical framework[12]. No software was used in the analysis stage.

It is important to highlight that higher education institutions can be considered spaces for development that go beyond the technical-professional sphere. Therefore, in the view of SI, by offering opportunities and promoting academic, cultural, affective, relational, sexual and romantic experiences, these institutions contribute significantly to the (trans)formation of individuals[14].

SI refers to an approach in North American sociology that seeks to understand the meanings and logic underlying human actions. As a subjectivist theory, SI considers the individual's perspective and their interpretation of the situation as essential elements for understanding the human being as a social being. This approach relates to the concept of human development adopted in this research, which views it as a process dependent on the social environment and the interactions that arise from this insertion[12,14].

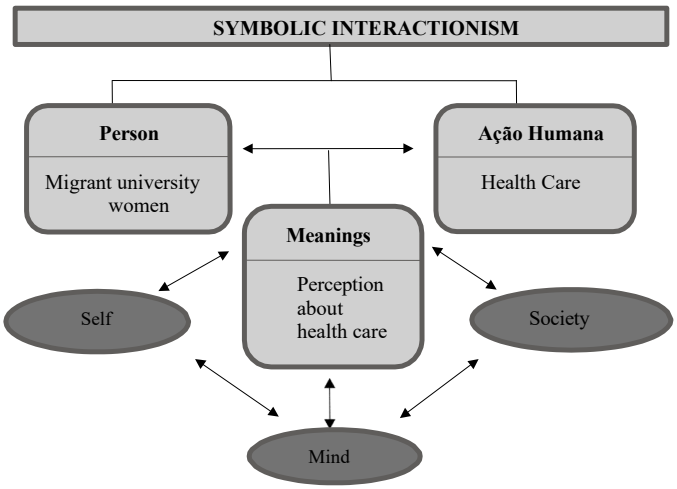
Considering the context of migrant university women students, it was important to understand key concepts of SI , such as symbols, self, mind, human action, society, and human interaction. The symbol is the perception and interpretation of something; the self is a concept common to all, related to interaction with oneself, encompassing self-perception and thought; the mind is the social process of interacting with oneself, through symbols, which assigns meanings and interprets stimuli; human action results from self-interaction, in which the person sets goals, observes and evaluates the actions of others, and directs their behavior[12].

This process involves interactions with others and with the self; social interaction is a dynamic process in which the person, as an actor, communicates, interprets, and relates to others. Through the use of symbols, self-interaction, and decisions, the person becomes a social object, and symbolic interaction is fundamental to understanding the meaning of actions and the dynamics of social relations[12].

Based on the theoretical framework of SI[12], a graphical diagram was developed to represent the behavior and perception of migrant university women regarding the need for health care, as shown in Figure 1.

The study was approved by the Research Ethics Committee of the *Universidade Estadual do Oeste do Paraná* and complied with National Health Council resolution no. 466/2012, under Certificate of Presentation for Ethical Consideration (CAAE) no. 77188224,1,0000,0107 and Opinion no.6,687,085. To ensure the anonymity of the participants, they were identified as PW1 (Participant Woman 1) and PW2 using sequential numerical order.

Figure 1 – Conceptual framework of Symbolic Interactionism applied to the health care practices of migrant university women, Foz do Iguaçu, Paraná, Brazil, 2025.



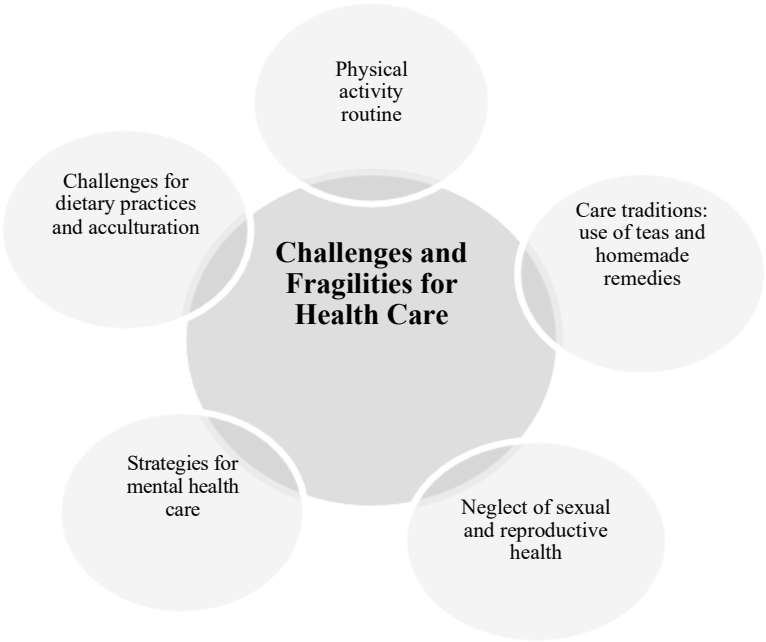
Source: Charon, 2010[12].

RESULTS

Nineteen women participated in the interviews, originating from Colombia (5), Paraguay (4), Peru (3), Haiti (3), Venezuela (2), Nicaragua (1), and Bolivia (1), aged between 21 and 50 years, residing in Brazil for an average of three years, and predominantly enrolled in Language and Medicine programs. Among them, 14 reported receiving some type of financial student aid.

The migrant women participating in the study faced challenges related to cultural, linguistic, and social adaptation, which directly impacted their health care practices. Based on their reports regarding health care, one main analytical category emerged, called Challenges and Fragilities for Health Care, resulting in five subthemes presented in Figure 2.

Figure 2 – Health care behaviors of migrant university women in a border region. Foz do Iguaçu, Paraná, Brazil, 2024.



Source: Authors, 2025

Challenges for dietary practices and acculturation

Participants reported that they base their health care on healthy eating practices, valuing meal preparation with fresh ingredients and, whenever possible, using foods typical of their countries of origin.

> [...] *in my diet, I try to avoid flour and soft drinks.* [...] *I can't eat things with a lot of oil, my stomach can't handle it.* (PW3)

> [...] *I organize myself to eat, like a menu* [...] *I know if I don't eat well, I won't be able to concentrate normally to study, because it's all a cycle. You have to study, but to study, you have to sleep. If you don't sleep well, you won't be able to memorize.* (PW5)

> *The first thing I do to take care of my health is that I don't use many chemical products.* [...] *I don't drink soda, like industrial ones* [...], *for food, I eat natural things, sometimes I eat at restaurants.* (PW9)

Participants recognized healthy diet as a central health care strategy, but described difficulties in maintaining this habit in Brazil, especially when compared to eating habits in their home countries. Among the challenges they highlighted were the high cost of maintaining a balanced diet, the lack of access to typical ingredients, and the need to adapt their meals to the local context.

The adaptation to the consumption of culturally Brazilian foods was mentioned as an obstacle, both due to differences in taste and the perception that many available foods do not meet the expectations of quality or nutritional values based on their cultural traditions. These factors highlighted that healthy eating, while essential, can be hindered by the economic and cultural conditions of the migration process.

[...] *for example, in my country I didn't eat many things that are very common here, like pasta, for example, macaroni is very common here, bread, as well as bread. The food is all root-based,* [...] *beans are very common, rice in smaller amounts, and other cereals like oats, barley, wheat, but not bread, oats, barley, chia, flax, there are many cereals, many grains, potatoes not so much really,* [...] *the cassava, other tubers are also present, very common everywhere* [...] *here we eat a lot of pasta every day, see, there are always pasta in lunch boxes, they have a lot of carbohydrates* [...]. (PW8)

[...] *fruits here are very expensive,* [...] *in Colombia there are oranges in my house, on trees. A potato, in my house there are potatoes in the kitchen,* [...], *here I am scared of this type of food that is all in cans, in packets.* [...] *it was a shock, but I'm adapting, I'm trying to do some things. So, there are many things that I can't say I'm taking care of my health because I don't have access to them.* [...]*I have to adapt.* (PW18)

In terms of food, I try to take care, but it's difficult to have money to take care of the food. [...] *fruits and vegetables, for example, are very expensive. So, I don't know. The only fruit we eat occasionally at home is a banana* [...]. (PW19)

Physical activity routine

The adoption of physical activity practices, such as walking, cycling, and exercising at gyms, was reported by migrant women as a way to promote health and well-being. However, gyms, although valued for offering adequate facilities for different types of exercise, presented barriers such as high costs and a lack of time to attend regularly.

[...] *to get to college I always walk. The only walk I do is to come, but to go back I take the bus* [...]. (PW3)

[...] *I try to do a little exercise about 4 or 5 times a week* [...]. (PW8)

[...] *I always pay attention to what's happening to my body.* [...] *now I'm learning to ride a bike.* (PW9)

I'm taking care of my health, I can say [...], *I'm trying to walk every day. I didn't take the bus to go to my work, to walk every day.* (PW11)

[...] *so I try to take care of my health, with my habits,* [...] *try to do sports* [...], *sometimes I walk a lot, walk a lot because of college, sometimes I have to go to Paraguay too, so I'm walking a lot.* (PW14)

These practices, adapted to individual conditions and preferences, revealed how physical activity is incorporated into the daily lives of migrants, even when faced with cultural, economic, and academic challenges.

[...] *I go to the gym, but I stopped because of money* [...]. (PW5)

Care traditions: use of teas and homemade remedies

The use of natural teas was mentioned by migrant women as a common health care practice, associated with the cultural traditions of their home countries. Reports indicated that teas are used both preventively, to strengthen the immune system, and as a homemade treatment to alleviate symptoms such as pain, colds, and digestive problems. Participants reported that tea preparation is a habit passed down through generations, valuing ancestral knowledge about the medicinal properties of herbs and plants.

[...] *in my family, there's this belief about teas, like for stomach pain, we drink a mint tea, things like that to relieve the pain,* [...] *we are very used to herbs and things like that.* (PW1)

[...] *there's tea for every illness, so for example, there's boldo for stomach pain, there's anise, chamomile, we drink a lot of chamomile. When you have a fever or some pain, we drink mint, so this is also a custom in my family. I'm the person who has a lot of herbs in my house.* (PW3)

[...] *during the Covid period, we drank a lot of tea for colds, like for immunity, colds, those things, we used a lot of it* [...]. (PW4)

When I cook, I use garlic and clove, I do this when I haven't eaten normally and if I get bloated, then before I eat, I make the tea [...]. (PW5)

[...] *right now I'm growing basil and chamomile, I got seeds and I'm growing them,* [...] *and I want to make a medicinal herb garden, because it's something I had back home, I had a lot of things, I had ginger, turmeric, thyme, oregano, boldo, chamomile, there's a flower that*

is used to make tea to sleep, it helps you sleep, it's called valerian. (PW8)

[...] *my mother gave me a cat's claw, it's a tea they give to the elderly.* [...] *as a woman I'm at the 50-year-old stage, I think you have to take care of yourself a little more.* (PW12)

[...] *my family is from Peru* [...] *they have a lot of natural medicine there, like plants, teas* [...]. *I had a lot of mouth ulcers* [...] *couldn't eat properly. And what my mom suggested was to make a tea from guava leaves. Later, she also used vinegar, salt, and water.* (PW14).

However, some women reported difficulties in finding certain herbs typical of their regions, having to replace them with alternatives available in Brazil.

[...] *here are many things that aren't here, but are in Paraguay. For example, I've never found eucalyptus here. So in Paraguay, you can buy eucalyptus as if it were anise, the kind that comes in packets, in the supermarket there's a section for herbs.* (PW3)

These practices highlighted the importance of cultural ties and popular wisdom in the daily health care among migrant women.

Strategies for mental health care

Mental health balance emerged as a concern among migrant women, with reports highlighting the search for psychotherapy as a structured and professional way of dealing with emotional challenges. Some participants mentioned the importance of this support in dealing with issues such as anxiety and stress resulting from cultural adaptation. Additionally, other alternative strategies were also identified, such as listening to podcasts on well-being and personal development, which offer a practical and accessible approach to promote reflection and encourage positive changes in daily life. These practices reflected the search for diverse forms of self-care and resilience, combining formal support and informal resources to preserve mental health.

[...] *I do psychotherapy weekly,* [...] *I try to take care of my health with respect to academics, because there was pressure to be perfect and have everything in order in college, and here at U., it's been very different.* [...] *my disorders influence my academic performance.* (PW6)

[...] *I do therapy, it's self-care* [...]. (PW19)

I'm practicing for my mental health, listening to podcasts with headphones, podcasts about health, taking care of your mental life. I also try to go out at the end of the week, hang out with my friends a little, watch a movie to relax. (PW11)

To maintain mental health, migrant women also described dance, relaxation practices, leisure, and meditation, including those originating from their own cultural context.

[...] *I take good care of my sleep schedule, I take care of my leisure time* [...], *but I don't have a fixed leisure schedule.* (PW5)

I like to dance, [...] *it depends on my anxiety and depression, there are weekends when I don't go outside and other days when I do like to go out and dance. Movement is very good for my health, for my mental and physical health.* (PW6)

[...]*I have a philosophy of life, which is Buddhism. In Buddhism, we have ways of meditating. This meditation for health is very good. So, this meditation helps me a lot, incredibly. It helps me focus on my everyday life, my daily life, you know.* (PW12)

Neglect of sexual and reproductive health

Regarding sexual and reproductive health, most women did not engage in routine preventive practices. This situation resulted from various factors, such as embarrassment, lack of knowledge about available services, absence of welcoming health systems, lack of adequate information about the importance of prevention, and academic routine.

I don't have a sex life. [...] *I haven't had one for a long time. Yeah, I remember the first time I went to the gynecologist,* [...], *I felt embarrassed. Taking off my clothes, showing intimate parts* [...] *I did it, like, two years ago.* (PW9)

*I think I've heard about it, but I don't know***.** [...] *from what you're describing, I think I've heard about it. No, I think I never needed it. I've never needed it. There was a strange condition where my period came, it's very irregular, never consistent. But this month, I remember it came on the 15th, and I felt sick for seven weeks.* (PW13)

No, I know I should do it, but I haven't done it yet. But I think I let time pass and then I don't do it anymore [...] *I know I should do it.* (PW14)

Yes, I do, but I didn't participate. Rather, it's not because I want to do it, but because I didn't think about it, and I became disillusioned with the SUS. (PW16)

No, not me, because I don't know, I'll be honest, the time I have, I use mostly for studying, for Unila, my research, my daily life, and sometimes I neglect my health, honestly. And when something hurts, I buy medicine without a prescription, and I have to be really, really bad to go to the hospital. (PW17)

These attitudes exposed these women to the risk of preventable illnesses and highlighted the need for specific actions that promote access to preventive care services, considering the cultural and social particularities of this group. The statements showed that most women did not undergo cervical cancer screening or rapid testing for sexually transmitted infections (STIs), and they did not always consider them necessary. This situation was aggravated by a lack of knowledge about the importance of these exams, which contributed to low adherence to preventive practices and increased vulnerability to preventable health conditions.

I've never done it. My God, I'm feeling very bad here. Very irresponsible. (MP10)

It's not necessary for me, [...] *because I have only one sexual partner, for me it's not necessary anymore. I'm also thinking about going to the BHU, I need an appointment for that exam. It'll take a while for me, I already know.* (PW11)

The STI test as well, [...] *also no! Yes, it's important, I've never done it.* (PW14)

DISCUSSION

From the perspective of SI, the study made it possible to understand how migrant women assign meaning to their health care practices amid the challenges posed by cultural, linguistic, and social adaptation. According to SI, meanings were constructed and negotiated in social interaction, with these women's actions reflecting not only their individual experiences but also the social and cultural contexts that shaped their experiences upon arriving in a new country[12].

In this sense, the university life goes beyond curricula, programs, and course syllabi, being shaped by the relationships and experiences each student builds within the university and in other spaces, becoming part of a complex network of interactions that impact their academic and personal trajectory[14].

By exploring how they define their health needs through social and cultural interactions, this study identified symbolic strategies that the participants created to respond to these demands, but also to the structural and cultural challenges perceived in their experiences in the host country. These findings were particularly relevant, as they revealed care practices as symbolic constructions influenced by the dynamics of the migratory and academic context, highlighting how these women reconstruct meanings and shape their health choices in an environment of constant interaction and adaptation[12].

From the narratives, perceptions emerged regarding the maintenance of healthy practices, such as balanced diet, physical activities adapted to their routines, strategies for mental health care, and the use of natural plants and herbs, which symbolized the preservation of cultural traditions. These practices were constructed and negotiated through social and cultural interactions, reflecting an effort to balance the self amid the challenges of migration and academic context.

However, general health care contrasted with the apparently limited symbolic interpretation of sexual and reproductive health, marked by gaps in disease prevention and health promotion. From this perspective, there is a clear need to expand access to specific information and promote awareness about this aspect of care, recognizing how the interactions and meanings attributed to this topic influence the overall well-being of these women, which can have repercussions on society.

The eating practices among migrant women revealed a complexity of cultural, social, and structural factors that shaped their choices and habits in the host context. Scientific literature describes that cultural, religious, and socioeconomic disparities often result in distinct dietary patterns between migrants and the local population. These differences are especially challenging for those in vulnerable situations, as limited access to appropriate food and integration difficulties can influence their eating practices[15]. In this context, maintaining traditional and ethnic foods emerges as an important element for promoting health and overall well-being, as it reinforces cultural identity and provides emotional comfort during the adaptation process to the new environment[12,16].

In Australia, Chinese migrants reported changes in eating habits influenced by limited access to traditional ingredients, changes in social meal dynamics, and a curiosity to try new foods. These reports reinforce that, although migration causes dietary adaptations, it also motivates efforts to preserve cultural practices through food[17], corroborating the findings of this study.

By relating diet to physical and mental health, the meanings attributed by the participants to their food choices emerged, which go beyond nutrition and symbolically reflecting their connection to their cultural identity. These choices were continually reinterpreted in social interactions and contexts experienced in the host country, revealing how migratory experiences shape not only their eating habits but also how they perceive and construct their overall well-being.

The regular practice of physical activity plays a fundamental role in promoting health, offering benefits that include improvements in both physical fitness and psychosocial well-being[18]. The research results pointed out that the participants, through individual actions, showed an effort to integrate physical activity into their routines, adjusting it according to their available time within their academic and financial commitments. Despite the challenges related to scheduling, most of them engaged in physical exercise and recognized it as an important action for caring for their physical and mental health.

The effort to integrate physical activity into their routines highlighted a proactive behavior of the participants regarding health care. This stance contrasts with data from a study conducted at Russian universities, which reported an increase in the number of students with health problems[19]. Insufficient exercise levels are linked to a higher risk of weight gain, metabolic syndrome, diabetes, and heart disease[20]. This scenario suggests that university students may develop chronic diseases in the future, generating significant costs for their families and society. In other words, the perception of self-care and the actions taken impact decisions that put overall health at risk[12].

Regarding the use of medicinal plants and herbs, the traditional knowledge and practices brought by migrant women underwent transformations in the host country, being redefined and integrated into new contexts and local influences. In this context, transcultural research is essential to identify culturally specific health needs and expand ethnobotanical knowledge directly in the communities.

This adaptation was evidenced in a study[21] with Haitian migrant women in New York, who demonstrated a strong connection to the use of natural herbs, both in food and in women's health care. These Caribbean practices, adapted to urban life, were widely used in situations such as childbirth, postpartum care, gynecological infections, and ovarian cysts, emphasizing the resilience and the capacity of ancestral knowledge to reinvent itself in new environments.

Among migrant women, these practices, deeply rooted in their cultural traditions, are passed down from generation to generation. The perception of the effectiveness of medicinal plants encourages the continuity of these practices, reinforcing their value as cultural expression and as a health care strategy[22].

In the field of mental health, the study highlighted the importance of strategies aimed at emotional balance and psychological well-being, which are fundamental to dealing with the challenges faced by migrant women. These strategies range from establishing support networks to the use of alternative and traditional therapies, human actions that prove effective in coping with academic, cultural, and social pressures[12].

Mental health problems have become an increasing global concern, exacerbated by changes in lifestyle and academic pressure. Issues such as anxiety and depression are increasingly common, especially among young people and working-age adults who experience a multitude of social interactions. Furthermore, factors such as social isolation, financial insecurity, and global crises, such as pandemics and conflicts worsen this scenario[23].

The academic experience, in turn, is widely recognized as a transitional phase (self), marked by maturation, development of autonomy, the development of emotional bonds, and professional development. However, it is also described as a period of intense stress and vulnerability, which can favor the emergence of different mental disorders[3], particularly when we include international migrant women in this context.

The continuous practice of physical activity plays a significant role in promoting mental health. Thus, it becomes essential to understand it as a central element in care strategies in this area, encouraging its adoption by the general population as a preventive measure against potential psychological disorders[24].

Also, another Brazilian study with university students highlighted that sporadic physical activity proved effective in promoting mental health, reinforcing its benefits at different levels of frequency throughout the analyzed periods[25]. These findings[25] corroborate the effectiveness of the care behaviors adopted by migrant women, which included the integration of traditional health practices and the use of contemporary strategies, such as dance and meditation, to face the mental health challenges in their migratory journey.

Regarding sexual and reproductive health, research has indicated that social and cultural disparities between countries of origin and host countries, combined with women's own perceptions, negatively impact sexual and reproductive health care. These challenges have often been associated with factors such as social stigma, ethnicity, and discrimination related to nationality[26].

In the Brazilian context, the universal healthcare system represents an important facilitator in access to rights and care in sexual and reproductive health. The provision of age- and gender-appropriate information contributes to reducing some of these barriers. However, the lack of knowledge about these rights remains a complex issue, underlining the importance of intersectoral strategies sensitive to the particularities of migrant women and that consider the different contexts in which they live[27].

The lack of knowledge about sexual and reproductive health and the limited availability of appropriate information sources are exacerbated by communication and language barriers. These difficulties have a significant impact, as many migrant women perceive written information as complex and written in the language of the host country, which they often do not speak. Thus, the way information is transmitted plays a fundamental role in women's knowledge and autonomy regarding their rights and sexual and reproductive health services[26].

These communication difficulties directly affect navigation through the healthcare system, which is often unfamiliar and inaccessible to migrant women. A review study highlighted that lack of familiarity leads to low demand for these services, aggravated by ignorance of which services are available, where they are located, and what hours they are available[28]. Therefore, overcoming these challenges, also identified in this research, requires not only inclusive public policies but also efforts to promote cultural integration and the dissemination of accessible and appropriate information to the realities of these women.

A study conducted in China highlighted several obstacles to accessing sexual and reproductive health for migrant women, including a lack of awareness about reproductive health, discriminatory migration policies, dissatisfaction with available healthcare services, and language barriers[29]. Consistent with the literature[26,28,29], this study revealed that many women faced difficulties accessing essential preventive care, such as cervical cancer screening. Nearly half of the participants were referred to a screening test but did not do so. Furthermore, they had never had gynecological exams or STI testing.

Sexual and reproductive health permeates all areas of care and highlights the importance of an approach that goes beyond preventive measures, promoting a perspective of comprehensive and continuous care. It is essential that these issues are addressed by qualified professionals, beyond governmental campaigns, in order to broaden discussions on sexuality, gender, pleasure, desire and reproduction, recognizing them as fundamental aspects of the human condition and contributing to the promotion of more inclusive and effective care[30].

Furthermore, the importance of implementing integrated strategies that address health care in a comprehensive manner, considering the particularities of migrant university women is highlighted. Recognizing the meanings they attribute to their health practices is essential for the development of public policies and institutional initiatives that value their cultures, respect their experiences, and expand access to healthcare services in an inclusive and humanized way[12]. The results suggest the need for actions focused on sexual and reproductive health, promoting education and adequate support so that they can care for their health while balancing academic demands and the challenges of migration.

The selection of participants can be understood as a limitation of the study, given that the focus on a single university in a Brazilian border municipality may have shaped perceptions and favored specific care experiences. However, a deeper understanding of care needs and behaviors with an emphasis on the migratory context can contribute to future research.

FINAL CONSIDERATIONS

This study showed that migrant university women have specific health care needs, which include maintaining healthy behaviors (balanced diet, adapted physical activity, and strategies for mental health care), as well as valuing traditional practices (use of plants and natural herbs). However, a lack of care regarding sexual and reproductive health was a frailty identified in these women's behavior. Misinformation, cultural taboos, and difficulties accessing specific services were mentioned as barriers to preventive care and seeking appropriate assistance.

These needs emerged from a context characterized by university life in a border region, which imposes challenges on migrants such as cultural and linguistic adaptation, limited financial resources, difficulty accessing traditional practices, and time constraints. The lack of comprehensive and culturally sensitive support in healthcare services exacerbates these

conditions, resulting in the failure to perform STI testing and insufficient gynecological follow-up.

The findings indicate that strengthening the cultural competencies of healthcare professionals, especially nurses, is essential to ensure a welcoming, therapeutic bond, and more effective responses to interventions. Furthermore, institutional strategies and public policies are needed to expand access to primary healthcare, considering the specific needs of the migrant university population. The integration between migrant women, healthcare professionals, and universities constitutes an interactive space, based on cultural respect, capable of fostering autonomy, empowerment, and equity in care.

Finally, it is recommended that future research deepen the understanding of the barriers faced by migrant university women in accessing primary care and investigate healthcare professionals' perceptions about care provided to this population. Longitudinal studies could also assess the impact of public policies on improving access and the quality of care offered to these women.

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Data and material availability

Access to the dataset is available upon request from the corresponding author.

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The *Universidade Federal da Integração Latino-Americana* (UNILA) constitutes a privileged space for research, as it fosters investigations that dialogue with cultural diversity, integration, and the trajectories of migrant students.

The possibility of conducting this study with migrant university women within the institution was decisive for its development, allowing their experiences, knowledge, and challenges to gain visibility.

In this way, the importance of UNILA is reaffirmed as a plural, inclusive and socially committed environment, whose mission is strengthened in the promotion of dialogue, the production of critical knowledge and social transformation.

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