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Health perceptions and lived vulnerabilities of undocumented migrant women living in settlements in southern Spain: An interpretative phenomenological study

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ABSTRACT

The aim of this study was to explore the experience of residing in a settlement as an undocumented migrant woman from a gender and intersectional perspective, focusing on their health perceptions as well as on living conditions directly related to health. Drawing on an interpretive phenomenological approach, nine semi-structured interviews were conducted in 2023 with African women with undocumented status living in settlements in southern Spain. Participants were recruited through a snowball sampling strategy, and data collection was carried out until discourse saturation was reached. Five superordinate themes were identified: perceptions and beliefs about health; living conditions; insecurity and environmental risks within the settlement; job insecurity and barriers to employment; and difficulties in accessing basic services. This study contributes to advancing health research by incorporating a gender and intersectional perspective that enhances the understanding of migrant women's needs to improve social and healthcare services. It also highlights the urgent need for public policies that address this complex reality through an integrative and gender-sensitive approach.

1. Background

Migration is a complex global phenomenon marked by multiple losses -personal, professional, social, and familial- that deeply affect individual's sense of identity and belonging (Garciandía, 2023). From a health perspective, understanding these losses is crucial, especially considering how health involves both the person and their living conditions, as well as access to resources that determine their capacity to adapt and manage in the face of life's challenges (Huber et al., 2011, Lebano et al., 2020). While migration can open up new opportunities, it often amplifies vulnerabilities, particularly when legal status is lost due to unauthorized entry or prolonged stay (Jiménez-Lasserrotte et al., 2023). In Europe this is a growing phenomenon. In 2020 alone, approximately 125,000 people arrived, many by sea routes (European Parliamentary Research Service, 2024). Spain is currently one of the main points of entry into the continent, presenting a scenario marked by significant social and health repercussions (Fagundo-Rivera et al., 2024).

The need to better understand how these conditions affects the health of migrant populations—both directly (physical and emotional wellbeing), and indirectly (through the living conditions they face)—aligns with recent studies (Napier et al., 2014, European Parliamentary Research Service, 2020) that advocate for analytical approaches capable of capturing the complex interplay of influencing factors. Although Spain settlements appeared in the 1960s, connected to the industrial growth and housing shortages, this situation worsened during the 1990s, with the arrival of migrant agricultural workers, and in 2008, with its economic crisis and a rise in irregular sea migration flows (Cepaim, 2018). The governmental refusal to recognize their right to exist often leads to significant infrastructure challenges, as they are frequently established on precarious and unsuitable land (Azhar et al., 2021; Awuah and Abdulai, 2022), exposing residents to conditions of extreme vulnerability, traversed by social and health risks (Deleu et al., 2022; Eyrich-Garg and Hudson, 2021; Rodríguez-Calles and Estrada-Villaseñor, 2022).

Each year, thousands of migrant women endure infrahumane

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conditions in the marginal spaces of settlements, which reproduce social exclusion and lead to situations of vulnerability and extreme lack of protection (Szocik, 2023, Regata, 2019). In this context, the concept of homelessness is especially relevant. Beyond the mere absence of a physical dwelling, this term encompasses the denial of fundamental human rights, as it refers to the lack of a home that is safe, stable, and appropriate for dignified living (Villa-Rodríguez et al., 2023). Framing the experiences of undocumented women living in settlements as homelessness, in its broadest sense of insecure and inadequate housing, allows for a deeper understanding of the multiple forms of exclusion operating at the intersection of gender, undocumented status, and housing precarity (Villa-Rodríguez et al., 2023).

Huelva, the context of this study, is particularly relevant for examining migrants' health, and more concretely to study how life in settlements can affect the health of migrant women. Located in the region of Andalusia in the south of Spain, it is characterized by a robust agricultural economy that relies heavily on seasonal labour, predominantly carried out by migrant populations. Jobs in the agricultural sector have attracted many migrant women in a process known as the "feminization of migration" (Llácer et al., 2007; Vázquez-Santiago and Peña, 2016; Borrell et al., 2004; European Parliamentary Research Service, 2019). In 2017, 26 settlements were identified in Huelva, housing over 1,600 people; among them, only 30 % of the women had work permits, compared to 70 % of the men (National Institute of Statistics, 2024). After their contracts end, many migrant women remain in Spain without a valid work permit in a situation marked by administrative and legal limitations which affect, among other aspects, their housing options. Settlements emerged as precarious but accessible housing solutions, characterized by structural conditions that seriously threaten health due to unsanitary environments, and multiple barriers to accessing healthcare, employment, and social resources (Cepaim, 2018).

Living conditions in Huelva's settlements are dire, and housing consists of precarious shelters, makeshift camps made from plastic sheets, pallets, and scrap materials. In their work, García-Padilla et al. (García-Padilla et al., 2021) analyzed their impact on health, underlining that water, the most commonly cited necessity, was collected and stored in unsafe ways; waste was accumulated, and plastic was often burned for warmth or cooking, creating toxic smoke; shared toilets, open fires, and overcrowded spaces made daily life a health risk. Life in these settlement is precarious and unhealthy, as it causes health problems related to water and waste, as well as psychological distress connected to living conditions (Gómez-Salgado et al., 2024). Despite the heterogeneity of migrant populations living in them, common characteristics regarding socioeconomic determinants of health point at the scarcity of economic resources resulting from administrative irregularities and their limitations, precarious jobs, unemployment, the impact of socio-environmental and housing conditions, as well as the lack of social support (Gómez-Salgado et al., 2024). For migrant women, living in the settlement becomes a form of homelessness which, as recent studies confirm, represents insalubrity and health hazards that especially affect women's health (Villa-Rodríguez et al., 2023; Gómez-Salgado et al., 2024).

In addition to the conditions described above, life in the settlement makes women face dangers of which men are spared: many live with so-called "security partners" for protection, and some are forced into transactional sex for survival (Fernández and Quiroga, 2023). In this context, gender becomes essential to understand the inequalities permeating the health reality lived by the migrant community (Borrell et al., 2004). Related to roles assumed by men and women within an unequal, historically and socially determined, power structure (Llácer et al., 2007), gender leads to different positions of power and responsibility which affect women's subjectivity (Bacigalupe et al., 2022). As host society, Spain's gender inequality in health reveals how sociocultural dimensions lead to gender inequities both in womens' health (Borrell and Artazcoz, 2008) and in its own healthcare system (Vázquez-Santiago and Peña, 2016). This explains how biological differences are transformed into social health inequalities, leading to discriminatory processes that result in socially organized, unjust, and avoidable health inequities (Borrell et al., 2004). When considering a more individual level, related to women's agency, we find that these historic and cultural normatives, and their social norms, frame and influence social interactions and actions, ways "of doing", which performatively constitute gender identity (Butler, 2002, Butler, 2004).

Adopting a gender perspective becomes essential to properly understand migration from a health perspective. Gender not only influences women's overall health (Manandhar et al., 2018), but also shapes their migration experiences, adaptation processes, and exposure to specific risks such as violence, abuse, rape and human trafficking (Regata, 2019; National Institute of Statistics, 2022). While structural inequalities constrain women's health and well-being, it is also important to consider their agency and capacity to navigate these challenges (Grotti et al., 2018). This study therefore adopts a gender perspective-one that accounts for the compounded effects related to being migrant, devoid of legal and administrative documentation, and living in a settlement.

Although intersectionality has long been acknowledged in health research (Bowleg, 2012), its application remains essential in the field of health inequalities, particularly in relation to space as a key social determinant (Bambra, 2022). Intersectionality recognises that social categories —such as gender, race, social class, and migratory status—do not operate in isolation but, rather, intersect and combine to produce specific experiences of discrimination, vulnerability, or resistance. Since its definitions and uses vary considerably (Abrams et al., 2020), Else-Quest and Hyde (Else-Quest and Hyde 2016), emphasise, intersectional research must attend to the lived experience of occupying multiple, interwoven social positions, consider how these are embedded in power dynamics, and acknowledge their fluid and contextual nature.

This study is grounded in the belief that individuals' situated perspectives shape their understanding and knowledge of the world through their experiences and reflections. It adopts a reflexive and collaborative approach that positions participants as active contributors in the research process (Plano, 2017). Guided by a gendered and intersectional approach, the aim of this study was to explore, from a gendered and intersectional perspective, the experience of residing in a settlement as an undocumented migrant woman, focusing on their perceptions of health as well as on conditions directly related to it. By doing this, it seeks to inform and promote changes in health and social policies—particularly regarding access to healthcare and social services—that address hidden barriers which may exacerbate processes of vulnerabilization.

2. Methods

2.1. Study design

The present study applied a qualitative phenomenological approach to explore the meanings constructed by undocumented migrant women living in Huelva's settlements. The aim of phenomenology is to develop knowledge from the participants' perspectives by describing their lived experiences during specific moments in their lives, allowing interpretations to remain grounded in their viewpoints (Plano, 2017; Yuni and Urbano, 2009).

Semi-structured interviews were selected to perform Interpretative Phenomenological Analysis (IPA) (Eatough and Smith, 2017), which provides a means of exploring new phenomena that exert an influence over the social context. In fact, IPA follows a double hermeneutic when co-creating knowledge: on the one hand, participants actively attribute meaning to their experiences and, on the other hand, the researcher interprets participants' narratives, reflexively seeking to build an in-depth account of the studied phenomenon (Eatough and Smith, 2017). This involves three levels of reflexivity. First, a descriptive account of situated narratives which refers to participants' individual

stories, telling about their experiences. Second, a comprehensive level in which meaningful patterns are considered to explore how participants attribute meaning to their experiences. Third, an interpretative level, in which researchers' need to acknowledge their own positioning as they interpret and co-construct knowledge on the basis of individuals' accounts (Greenhalgh, 2016).

To ensure the rigour of the study, we followed the Consolidated Criteria for Reporting Qualitative Research (COREQ criteria) (Buus and Perron, 2020). In addition to this, we observed the criteria proposed by Guba and Lincoln (Guba and Lincoln, 1994), following its adaptation to qualitative nursing research developed by Speziale, Streubert & Carpenter (Speziale et al., 2011), which includes credibility, transferability, dependability and confirmability. Credibility was addressed through the active involvement of the research team in both data collection and analysis. Interviews were transcribed verbatim, and observational notes were taken regarding non-verbal cues such as gestures and body language. To ground the findings in the participants' own experiences, direct quotations were included. Additionally, participant validation was conducted in follow-up interviews, allowing participants to review and refine the researchers' interpretations and correct any misunderstandings, enhancing both credibility and confirmability. Transferability was supported through rich, contextual descriptions of the study design, including information about the researchers, participants, sampling strategies, settings, and data collection and analysis procedures. Detailed profiles of each participant and their selection process were also provided, allowing readers to assess the applicability of the findings to similar contexts. Dependability was ensured by documenting the research process thoroughly, including methodological decisions and procedural steps. An external researcher reviewed the study design and protocol with particular attention to methodological coherence. This external audit also contributed to verifying the consistency of the findings. Confirmability was strengthened through various strategies such as triangulation, reflective journals that promoted researcher reflexivity, and a clear articulation of the study's rationale and methodological choices. The return of findings to participants also served to minimise researcher bias and enhance the transparency and neutrality of the analysis. By adhering to these established criteria for scientific rigour, the study aimed to produce trustworthy, meaningful and transferable knowledge grounded in the lived experiences of the participants.

The research team consisted of two nursing professionals and a psychologist, all of whom were female. All three researchers are based in Andalusia, with two of them residing in Huelva. All of them have experience conducting research from an intercultural and gender-sensitive perspective, and are familiar with work on social inequalities in health. Throughout the research process, each researcher engaged in critical reflection on their positionality in relation to their specific roles. They ensured that women could participate through a horizontal, collaborative approach, allowing knowledge to be co-constructed jointly. Their clinical and community-based experience shaped their sensitivity to the realities faced by migrant women, allowing them to listen with respect, empathy, and ethical commitment. To minimise researchers' risk of interpreting participants' narratives through an autobiographical lens, spaces for self-reflection were encouraged in order to reduce bias. Participants were actively involved during the process of validation as researchers shared their interpretations with them, seeking their approval and ensuring a respectful and horizontal approach that considered them as generators of knowledge. This reflexive stance aimed to foster critical awareness of the power imbalances inherent in cross-cultural qualitative research.

2.2. Study participants and recruitment

Testimonies were used to understand the lives experienced by undocumented migrant women, thoughts, and emotions, acknowledging the value of their perspectives in shaping understanding. Considering this, we collaborated with the non-governmental organisation Red Cross Huelva, which acted as an intermediate when contacting potential participants and disseminating study information. This organization has a long-standing history of involvement in the settlements where the study was conducted, and maintains strong ties with the migrant communities living there. They assessed the research team regarding the conditions of oppression and structural vulnerability framing participants' living conditions, contributing to their consideration from an intersectional approach (Abrams et al., 2020). As a trusted and respected actor in the area, the Red Cross was an ideal partner that facilitated the recruitment process, ensuring that participants felt safe and supported throughout the research. Their collaboration helped to overcome difficulties in accessing the population and supported the design of a sensitive and appropriate recruitment strategy, which was conducted progressively through snowball sampling.

Inclusion criteria focused on migrant women originating from Africa who lacked regular administrative and legal status, and resided in settlements in the province of Huelva, Spain. Participants were required to provide informed and voluntary consent in the absence of any incentive, and could not have lived in the host country (Spain) for no longer than three years. Women who met these criteria and voluntarily provided explicit consent to participate were recruited for the study, comprising a final sample of nine participants. A small sample size is typically characteristic of this type of methodology, and the number of participants recruited was similar in other studies involving migrant populations (Scott et al., 2022; Ngameni et al., 2022).

2.3. Data collection

Individual interviews were conducted between April and November 2023 by two members of the research team, both experienced in working with vulnerabilized populations and in conducting research on sensitive topics. The interview consisted of several open questions designed from an IPA approach, aiming to explore participants' narratives in depth and allowing for the collection of rich accounts of lived experiences from the participants' own perspectives. Questions were elaborated on the basis of updated literature and discussions with experts in the field of migrant health and intercultural communication. They were used with flexibility, as the researcher openly adapted them to include emerging data.

Bearing on this, interviews included, but were not limited to, the following questions: Could you tell me what your daily life has been like since you arrived here? What does health mean to you in your current situation? Is there anything in your environment that you feel influences your well-being? Have you encountered any particular situations or difficulties while living here? In your day-to-day life here, are there things you do to feel safer or more at ease?

The interviewer adapted her approach according to each participant's responses, using strategies such as silence, reformulation, or exploratory prompts (e.g., "Can you tell me more about that?"). These questions were used flexibly, depending on the pace of the conversation and the emerging content, thus fostering the co-construction of narrative and meaning, as proposed by the hermeneutic logic of IPA.

Once participants had read the information pack and signed the informed consent forms, they were interviewed. A total of nine interviews were conducted, at which point the onset of discourse saturation was observed —that is, no new relevant information or emerging themes were identified in participants' narratives (Fusch and Ness, 2015; Saunders et al., 2018; Chitac, 2022). Interviews were semi-structured and took an average time of 40 minutes (range: 30–50 minutes). Sociodemographic data were collected to describe sample characteristics. All interviews were audio-recorded to ensure minimal loss of data, and were complemented with field notes that registered non-verbal relevant for the analysis. Once the interview transcripts were completed, they were returned to the informants to verify the accuracy of the literal transcription and to provide final feedback. No participant suggested any change.

A team of intercultural mediators supported and mediated communication and translation during the interviews, as well as during the process of sharing researchers' interpretations with participants. This team was also responsible for the adaptation of contents, ensuring their cultural appropriateness. Interviews were conducted using participants' native language. English and French were the official languages of most of the participants' countries of origin. The interviewing researchers had a sufficient level in both, which facilitated direct communication. Additionally, to ensure the authenticity of the answers, and to make participants more at ease, they invited native intercultural mediators with whom they had collaborated before. They assisted and facilitated communication during the entire process, making sure participants felt at ease.

Interviews were transcribed and anonymised, and an official external translator translated them into Spanish. To ensure the fidelity and accuracy of the translated content the transcriptions were reviewed by the intercultural mediators, who confirmed that they preserved the coherence and original meaning of the participants' narratives.

While one researcher conducted the interviews, another was responsible for technical aspects and took field notes. Throughout the data collection process, participants' emotional well-being was a priority. Before beginning their interviews, they were informed that they could stop at any time, choose not to answer questions, and withdraw from the study without needing to provide justification or facing any consequences. During the interviews, two of the intercultural mediators provided emotional, linguistic, and cultural support. Interviews took place in safe, neutral spaces. Researchers ensured that participants felt at ease and remained attentive to any signs of emotional distress or discomfort. When this was the case, participants were offered breaks, the opportunity to receive empathetic listening from researchers, and were reminded of their right to stop the interview at any time. None of the women reported significant distress during or after the interview; on the contrary, several expressed their gratitude for having had a space in which to share their experiences. At the end of each interview, all participants were provided with information about available health and social services in the area.

2.4. Data analysis

2.4.1. Data analysis

This study followed an Interpretative Phenomenological Analysis (IPA) to explore participants' experiences of life in the settlements. Emphasising the importance of understanding participants' lived experiences, IPA examines how they make sense of a situation or experience, and how they interpret and attribute reflective meaning to those experiences (Eatough and Smith, 2017). This is particularly useful when examining complex, ambiguous, and emotionally loaded topics through in-depth descriptions of human experience, connected to health and disease.

The data analysis procedure, which was inductive in nature, was based on the verbatim transcription of information gathered through the interviews. The first author verified data accuracy and stored it for its later analysis, interpretation and categorisation. All files were anonymised and assigned a unique identifier (RE + number of interview).

The coding process was conducted independently by two researchers, who systematically reviewed and interpreted the transcripts to identify subordinate themes and then, superordinate themes. This independent double coding ensured a rigorous and transparent analytical process, allowing for the comparison and discussion of interpretations and discrepancies, which were subsequently resolved through consensus. This approach enhanced the credibility and trustworthiness of the findings.

IPA's iterative analytical approach allows for strong interaction between the researcher and the text. The multi-stage process inherent to IPA was performed on a case wise basis which was later followed by a case comparison between transcripts. Analysis was initiated with an in-depth reading and re-reading of each individual transcript in order to obtain a holistic perspective of each participant's account. Comments and notes were written down and connected to the text based on the researcher's interpretation. This first analytical step gave rise to some subordinate themes.

The connections between emerging subordinated themes led to the development of superordinate themes, which gathered them into wider categories. A reflective analysis of the relationships and connections between the subordinate themes was conducted to identify broader conceptual patterns and categories that could be integrated into coherent and representative superordinate themes reflecting participants' experiences. The development and validation of the superordinate themes, these were generated through the systematic grouping of the subordinate themes identified during the initial coding of the transcripts. The validation of these superordinate themes was carried out through a consensus process among the researchers, who thoroughly reviewed and discussed the interpretations to ensure that the themes accurately and rigorously reflected the meanings expressed in the original data. This procedure included constant comparison with the textual narratives to ensure a strong empirical grounding, thereby enhancing the credibility and reliability of the interpretative analysis.

The qualitative data analysis software Atlas ti v. 23 was used as a support tool to systematically organize and code the interview transcripts. It allowed us to rigorously manage qualitative data, identify patterns, group emerging codes, and facilitate the development of coherent themes, in line with the Interpretive Phenomenological Analysis (IPA) approach. The final interpretation was performed by the research team, as required by the phenomenological approach and the final relation of subordinate and superordinate themes was represented in a table.

3. Findings

With regards to sociodemographic outcomes pertaining to the selected sample, it serves to highlight that nine migrant women were interviewed, all of whom had no schooling or had only been schooled up until 16 years old, they were undocumented and resided in settlements in the province of Huelva (MA). All of them had been living in Spain for less than three years. The average age of the sample was 34.78 years (SD 6.60). With regards to the distribution of nationalities, which is representative of the context itself, the most prevalent belonged to Sub-Saharan Africa (Nigeria, Equatorial Guinea, Libya, Senegal, Ivory Coast and Ghana). With regards to religion, the majority of participating women were Muslim. A total of 55.56 % were married (Table 1).

Based on this information, it is assumed that participants represent an essential resource that allows trustworthy information to be obtained in order to be able to identify and understand the perceptions and lived experiences of migrant women residing in informal settlements and the effect of this condition in relation to their health.

Data analysis produced five study superordinate themes. Once the "emic" of informants was identified, interpretations were made of the

Table 1
Participant profiles.

Participant	Place of origin	Age	Marital status	Number of children	Religion
M1	Nigeria	27	Single	2	Christian
M2	Equatorial Guinea	43	Married	3	Christian
M3	Libya	30	Single	1	Muslim
M4	Nigeria	38	Married	2	Muslim
M5	Ivory Coast	32	Married	2	Christian
M6	Ghana	24	Single	1	Muslim
M7	Algeria	41	Married	3	Muslim
M8	Ghana	35	Married	2	Muslim
M9	Senegal	43	Married	2	Muslim

perspective of informants and the meanings they attributed to the interceding elements of their health perceptions and the role played in their current life as an undocumented migrant woman living in a settlement.

3.1. Perceptions and beliefs attributed to health

The accounts that sculpted the concept of health held by participating women comprised both personal dimensions and sociocultural influences. These are reflected in their decisions and behaviours shaped by gender, which emerged as a transversal factor influencing not only how health was perceived, but also how decisions were made regarding personal wellbeing and the care of others. This reveals a complex crossroads between sociocultural expectations and structural health determinants. The extent to which caregiving was internalised even led some participants to equate health with the ability to continue caring for loved ones:

"For me, health is feeling good, that nothing hurts, that I can keep taking care of my family for many more years" (M5).

Informants defined their health, not only, in terms of the absence of disease but, also, as an essential resource for sustaining family life and maintaining their roles within the household. In several narratives, the ability to care for others appeared not just as a personal value but as an expectation- one that was often difficult to fulfil in the face of limited access to healthcare and social support, particularly in the context of settlements. Participants described tensions between the demand to care for others and their inability to address their own health needs, which led to feelings of guilt, frustration, and emotional exhaustion.

In addition, informants expressed clear concerns regarding their physical and mental health, which were related with work, life in a settlement and lack of resources to be able to take care of oneself. In this sense, participants' experiences reflected the intersections between gender, migratory status, and socioeconomic exclusion, which conditioned their access to care and their capacity to maintain health.

Clear differences existed as a function of gender. This translates into daily activities that entail care responsibilities and lead them, on many occasions, to prioritise the needs of others ahead of their own. The internalisation of these caregiving responsibilities appeared as both a deeply held identity and a structurally imposed role, reinforced by a context in which their own health is often not prioritised—either by themselves or by the systems around them.

Health, or really, the lack of it, is exhibited in maladaptive behaviours that reveal an extreme lack of resources which leads to issues that are heightened in instances in which further conditions conducive to vulnerability within this group are present. One example is problems with addiction:

"A lot of people only want to drink to forget their problems and there is a very big alcohol problem in slums. It wasn't a problem before, people didn't drink as much and people from outside didn't come here. Now, a lot of people come here from outside, sex workers looking for men to work and drug addicts who come selling drugs, because a lot of drugs are taken here too. I think that people do it to escape but in truth it is really horrible here at night, you can't go outside of the slum" (M4).

3.2. Living conditions

As can be seen from the discourse of informants, the challenges expressed by participants reveal that the irregular administrative situation, significantly conditions their health, affecting essential aspects of their life such as housing:

"They promised us a house out there. If you don't have papers, you can't have a house and, even then, it is very difficult to have one. Living in a settlement is not life". (M4).

The absence of legal status not only restricts access to adequate housing and formal employment, but also places women in a position of structural invisibility, where they are deprived of basic rights and live under conditions of systematic neglect.

An irregular administrative situation amplifies the difficulties in accessing support services, including legal counselling for residence or international protection applications, training opportunities, and pathways toward employability and social inclusion. Several participants pointed to the challenges involved in navigating unfamiliar bureaucratic systems or not knowing how to access certain resources—especially when language and cultural differences function as additional barrier.

The need to employ hidden strategies along their migratory route, also illustrates the additional barriers they must face, including the constant risk of detention and deportation. Their actual situation contrasts sharply with their unmet expectations which, far from justifying the challenges they have overcome, puts them on an even more desperate and hopeless trajectory:

"The boat crossing is very hard, four or five days without eating, seven days in the water. I couldn't sleep either. A lot of people died during the journey, another was conned and they left them stranded, but we took it thinking about all the good that would happen when we arrived and look where I'm living…." (M6).

These testimonies expose not only the physical and emotional toll of life in these conditions, but also the systemic nature of the neglect that shapes their everyday environments—where access to health, safety, and dignity remains out of reach.

3.3. Insecurity and risks in the informal settlement setting

Settlements as a living space entail insecurity, whilst the risks of the environment are a constant concern. In this sense, gathered testimony reveals the way in which life in a settlement entails exposure to these aforementioned risks, potentially exacerbating the vulnerability of migrant women. Thus, sexual violence, abuse, exploitation and human trafficking are perceived as real threats with a direct impact on physical, mental and emotional health, perpetuating a cycle of precariousness and risk. This leads these women to call on emergency survival mechanisms in hostile environments, with women potentially ending up feeling forced to depend on others in order to guarantee their basic safety.

"When *I arrived I was at my cousin's house for a time and she, herself, told me to sell my body, that I had to contribute to the house or leave, I was like that for two years, until I met this man and was able to get out of there, but I don't want to talk about that, it pains me, because a lot of us women have to do it out of need, not because we want to. Here in the slums I feel unprotected and afraid, a lot of my female friends get boyfriends in order to have a man, someone to protect you from everyone else, there have been a lot of cases of sex work and rapes. I have been lucky enough to meet a man who truly helps me and loves me, and now we are good" (M1).*

"Besides, here in the slums a lot of men hit their girlfriends or wives, they treat them badly, a lot of women fled their countries of origin for these reasons and when they get here it is the same" (M3).

The testimonies also reveal a profound lack of social support — both from institutions and from within the migrant community itself. Many women feel isolated and unable to rely on formal resources or informal networks that might otherwise offer protection or assistance. The absence of a community fabric based on solidarity, along with institutional inaction, reinforces feelings of abandonment and contributes to the perpetuation of violence and vulnerability.

The conditions outlined by the gathered testimonies illustrate general insecurity which alludes to a lack of protection that impedes basic levels of health from being achieved and, further, go beyond this to reflect dangers that threaten the basic integrity of the individuals

involved:

"Now, people rob you, they hit you, they get into the slums when they are drunk and it is dangerous, you can't trust anybody. The people here don't have money to pay for gas or to have a luxury house, there are a lot of poor people. There is no electricity, nor is there gas and they can't eat, hot water doesn't exist either and, in winter, we have to put up with being very cold. I feel a lot more scared now than I did before, a week ago there was a big fire here in the field and I was next to the fire, I thought that a lot of people were going to die. It is impossible to have quality of life here, you see where we are, surrounded by rubbish and separated from everybody, most of us don't have neither water nor work." (M8).

3.4. Job insecurity and barriers to accessing employment

Job insecurity is a constant in the life of migrant women characterised by unstable work conditions. Poor working conditions often result in occupational disorders, such as back pain and chronic pain. These afflictions are more difficult to treat due to the distance at which migrant women find themselves from main cities.

"Over *time, everything has become more difficult, they only hire men because they say that us women aren't up to those jobs because men are stronger and don't get pregnant. Many women have no way of living." (M5).*

The triple penalisation of being a woman, a migrant, and undocumented severely restricts their participation in the labour market. The intersection of gender and culturally assigned roles reinforces their exclusion from certain types of work, while institutional racism hampers the recognition of foreign qualifications, reducing their chances of achieving economic autonomy.

This structural exclusion is not only linked to limited access to employment, but also impacts their perception of health, which, as previously described, is deeply rooted in their ability to care for others. When they are unable to provide for their families or send money back home, their emotional and mental well-being deteriorates, as they feel they are failing in one of their core social roles.

In addition, domestic and cultural responsibilities, combined with the fact of living in settlements, prevent many migrant women from continuing with their education or professional training. Difficulties in validating qualifications also limits their opportunities for personal and professional development.

3.5. Barriers to accessing basic services

This insecurity is heightened by living on the outskirts where informal settlements tend to spring up. This distances them from society and leaves them without access to, for example, services as essential as social protection and transport which would alleviate social and urban exclusion. Accounts alluded to financial difficulties but, also, to **limited access** to basic services. This prevented them from having certain medications and treatments and, even, stood in the way of them accessing adequate nutrition by reducing the availability of fresh and healthy foods. Lack of electricity and drinking water was outlined in the discourse as one of the most notable unmet basic needs suffered by informants. It was argued that this justified the emergence of diseases associated with malnutrition, obesity and diabetes and, even, maladaptive behaviours such as alcohol abuse. In this sense, reliance on a male figure was also observed:

"It's impossible to have quality of life here, you see where we are, we don't even have water. We have to pay some men so that they bring us water, most of us don't have work, most of all women". (M7).

Here, multiple and overlapping forms of exclusion converge: territorial inequality, due to living in peripheral areas; legal exclusion, due to undocumented status; cultural and linguistic barriers; and gender roles. This accumulation of disadvantages severely limits access to services, resources and protection mechanisms.

The emotional repercussions highlight the experience of loneliness which, together with fear, emerges as one of the main companions in the life of migrant women living in settlements. The distance from family and absence of a support network heightens feelings of vulnerability, in the same way that lack of a partner leaves them without physical protection.

"I feel alone and afraid, I don't have my family close and on top of it I don't have a partner". (M6)

"We seem like animals who live in the woods but we are people." (M6).

The feelings of loneliness and dehumanisation described by the participants are not only the result of poor living conditions, but also reflect a deeper reality of institutional abandonment. The absence of effective public responses to their needs reinforces their marginalisation and contributes to the erosion of their sense of dignity and belonging.

The irregular administrative situation experienced by participants, brought home in an extreme way in the account shared above, leads the present study to consider the potential protective role played by the healthcare system. In Spain, this system provides protection that includes full coverage of emergency services and, at the time of pregnancy, pre- and post-natal services. With regards to access to resources, testimonies provided by participating women reveal that the cultural dimension imposes a barrier that impedes them from taking advantage of such services. Interpreting access based on the nature of the healthcare system in their country of origin, participating women did not consider access to such services to be an option available to them. This lack of cultural competence illustrates the importance of considering resources from a cultural sensibility that facilitates access to them, enables them to be capitalised on and has positive repercussions on the health reality lived by these women.

4. Discussion

The present findings reveal a complex crossroads of social, economic and cultural factors that dynamically influences the health perceptions of these women, as well as their daily life experiences in the settlement. The findings of this study highlight the need to adopt a comprehensive and sensitive approach to the design of public health policies, going beyond the consideration of health as the sheer absence of disease in a person to fully account for the daily challenges faced by undocumented women living in these settlements. In this sense, the findings underline how gender does not operate in isolation but rather intersects with the structural inequalities of living in the settlement with an undocumented migratory status and its impact on employment and women's socioeconomic level. The strategies many women adopt to cope with their reality—such as seeking protection through relationships or accepting precarious jobs—relates to their agency, revealing attempts to adapt and counterbalance structural forces which, connected to intersecting systems of domination, severely constrain their possibilities of action.

These findings align with those reported in previous research highlighting the influence of social determinants over migrant health (Wilkinson and Marmot, 2003). Likewise, they concur with those reported by recent studies such as that conducted by Villa-Rodríguez et al. (Villa-Rodríguez et al., 2023), who examined the life of migrant women residing in settlements and denominated this reality as a type of "hidden homelessness". Their work reveals how living in them influences women's health through social exclusion as well as by severe obstacles which seriously hinder their access to essential health resources, such as employment and social protection. Additionally, barriers to basic health and education services, language barriers and lack of social support networks, appear as factors increasing processes of vulnerabilisation affecting migrant women (Bojorquez, 2015, Ezeh et al., 2017). In line with a study published by Carruth et al. (Carruth et al., 2021), the

present study reveals that these factors, combined with exposure to job insecurity, increase the risk of suffering physical and mental illnesses. The findings show how difficulties such as losing one's job due to attending medical appointments, the absence of public transport, and unaffordable health care cost, act as meaningful barriers to accessing health services. These challenges are directly linked to the precarious living conditions in the settlements, and are closely tied to the structural mechanisms that reproduce social inequalities in health. They underscore the urgent need for social, political, and healthcare responses that are not only sensitive to the complexity of these lived realities, but also attentive to the intersecting power dynamics—including those related to gender and migration status—that shape individuals' interactions with the systems and structures affecting their daily lives.

In the absence of administrative and legal security, the lack of work permits challenges seriously hinders employment possibilities, being negatively related with the development and enjoyment of good health (Flick et al., 2017, Lai et al., 2022). A study conducted by Castañeda et al. (Castañeda, 2022) highlighted that precarious living conditions, food insecurity and lack of access to health services comprise critical factors that affect undocumented migrants.

These challenges—especially in cases where women experienced better living conditions in their countries of origin—draw attention to the losses inherent in the migration process and life in informal settlements. The findings coincide with literature (García-Padilla et al., 2021) that shows how settlements can increase the risk of physical conditions harmful to health –such as the lack of water and extreme temperatures. However, in the present case, findings go a step further to account for ways in which such conditions may pose a threat to women at a social level, with dynamics that are threatening to them in terms of both their integrity and personal security.

In this regard, the concept of migratory mourning developed by Achotegui (Achotegui, 2009) specifically addresses the health impacts associated with the cultural and personal adjustment processes involved in migration. Precarious living conditions in settlements aggravate migratory mourning and complicate the process of cultural adaptation, affecting their dynamics of continuous deculturation and simultaneous acculturation (Ferrer et al., 2014). These circumstances generate feelings of nostalgia, emptiness, and frustration, which can interfere with daily functioning and negatively affect health (Dowling et al., 2019, Cuesta, 2019). Participants' narratives revealed perceptions and experiences tied to significant personal losses—such as separation from children and family, and the absence of basic life stability—which emerged as major contributors to emotional distress. Migration becomes a source of psychological strain when individuals become aware of their inability to meet the demands of their new circumstances, leading to heightened distress and chronic, prolonged anxiety (Niño, 2020). When such conditions persist and intensify, the adaptation process associated with migratory mourning may evolve into a more severe form of psychological suffering, known as Ulysses Syndrome (Achotegui, 2017).

In our study case, the consideration of Ulysses Syndrome requires the consideration of Eguiluz's (Eguiluz, 2021) work. In her work, she emphasises how it should be approached from a gender perspective that contemplates the journeys and losses that specifically shape the situation of vulnerability lived out by these women. The gender perspective is crucial for understanding the experiences of migrant women (Winbush and Selby, 2015). Different studies (Steil et al., 2019, Grycuk, 2020) argue that in research conducted in Western contexts—such as the present study—the mere fact of being a woman constitutes a risk factor for experiencing complicated grief. In addition to the multiple and complex stressors emerging from migration-related discourse and the adjustment of expectations, participants sometimes reported feelings of vulnerability and fear stemming from experiences such as rape or other forms of professional and sexual harassment (Regata, 2019, Tesfaye et al., 2021).

Participants in this study reported feelings of constant fear of abuse and highlighted how some women may be forced to adopt strategies or behaviors that could compromise their dignity and well-being in order to survive in the face of limited employment opportunities and legal insecurity. These testimonies illustrate the specific processes of vulnerabilisation faced by migrant women and underscore how such experiences gender the ability to cope effectively with migratory grief. Supporting this, Morina et al. (Morina et al., 2011) concluded that women are seven times more likely to suffer from complicated grief.

The findings reveal inequities stemming from the intersecting dimensions positioning undocumented migrant women living in settlements, revealing how women's perception of health, as well as their daily life experience living in these settlements, are traversed by intersecting processes of vulnerabilisation. These results underscore the importance of culturally competent healthcare approaches that are sensitive to the structural, gendered and migratory dimensions shaping these women's experiences, and that promote equitable, context-aware care (Cáceres-Titos et al., 2025).

5. Strengths and limitations

This study provides an in-depth understanding of how undocumented migrant women living in informal settlements perceive and experience their health. The qualitative approach, based on individual semi-structured interviews, allowed for the emergence of rich and nuanced narratives that might otherwise remain invisible. The collaboration of intercultural mediators was a key strength, facilitating trust, mutual understanding, and cultural and linguistic accuracy throughout the research process.

However, several limitations should be acknowledged. First, the findings are based on a small, context-specific sample of African undocumented migrant women living in one region of southern Spain, which limits the generalizability of these findings to other migrant populations or geographical settings. Second, given the sensitivity of the topic and the vulnerable situation of participants, it is possible that responses were influenced by social desirability bias, leading some women to withhold information or to frame their experiences in a way they perceived as more acceptable. Third, although great care was taken to ensure the fidelity of translation—including the participation of intercultural mediators and validation of transcripts—some meanings, emotions, or cultural nuances may have been lost or altered in the process, potentially affecting participant engagement and the interpretation of findings.

Despite these limitations, the study provides valuable insights into the lived experiences of a highly underrepresented population and highlights the importance of culturally sensitive and context-aware approaches in health research.

6. Conclusions and recommendations

This study highlights how gender fundamentally shapes health perceptions and wellbeing decisions among undocumented migrant women living in informal settlements. For these women, health transcends the mere absence of disease; it is intimately connected to their capacity to care for family and sustain their households—core aspects of their identity and daily survival.

However, residing in settlements imposes multiple layers of vulnerability. Persistent insecurity, social exclusion, and restricted access to basic services and resources deepen health inequities and hinder social integration. Moreover, the lack of legal and administrative recognition further restricts access to healthcare and employment, perpetuating cycles of marginalization.

These findings underscore the urgent necessity for policies and healthcare interventions that acknowledge and address the intersectional realities of undocumented migrant women. Tailored strategies must focus on dismantling structural barriers and fostering inclusive environments to promote health equity and social justice for this highly vulnerable population.

7. Implications for practice

The findings of this study provide essential insights to guide ethical, equitable, and culturally competent care practices in contexts marked by social vulnerability. Intersectional factors such as gender, irregular migratory status, housing insecurity, and limited support networks significantly shape women's health experiences and perceptions, as well as their access to healthcare services. Therefore, interventions aimed at migrant women living in informal settlements must acknowledge these structural realities, avoid reductionist approaches, and promote person-centered and context-sensitive care.

Healthcare professionals need specific competencies such as active listening, cultural sensitivity, self-reflection on biases, and the ability to build therapeutic relationships based on trust and respect. Adopting a gender-sensitive approach that ensures access to health services and culturally adapted psychosocial support is key, taking into account power inequalities that impact health.

To adequately address these vulnerabilities, health systems must implement structural changes to guarantee universal access to care. This includes regulatory reforms, integration of gender and diversity perspectives, intersectoral coordination, intercultural mediation, ongoing cultural competence training, and the removal of access barriers through mobile units, transportation support, and flexible hours.

These structural measures should be complemented by interventions aimed at strengthening individual and community agency and empowerment, fostering connections with community leaders and neighborhood networks that facilitate trust and continuity of care. This approach moves toward a more inclusive, just, and person-centered health system.

8. Ethical considerations

The present study followed international ethical recommendations established in the Declaration of Helsinki. Participation in the study was entirely free and voluntary. All questionnaire responses were anonymous and all collected personal information was stored in accordance with legal requirements regarding the protection of personal data and guarantee of digital rights (Organic Law 15/1999, of the 13th of December, and Organic Law 3/2018, of the 5th of December 2018). The project was approved by the Ethics Committee of the Junta de Andalucía (reference number: 0426-N/2023 PEIBA).

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CRediT authorship contribution statement

María José Cáceres-Titos: Writing – original draft, Software, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **María Cabillas-Romero:** Writing – review & editing, Writing – original draft, Visualization, Validation, Supervision, Conceptualization. **E. Begoña García-Navarro:** Writing – review & editing, Writing – original draft, Visualization, Validation, Supervision, Software, Methodology, Investigation, Formal analysis, Data curation, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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