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Migration, Quality of Life and Health of Brazilian Immigrants in Portugal

ORIGINAL

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Abstract

Background: Immigrants face many challenges when settling in a foreign country, numerous factors influence this immigrant experience including the resources they bring with them and those they find in the host society. The literature has indicated that a significant number of individuals migrate in search of a better quality of life. In this context, the objective of the study was to analyze the quality of life and health of Brazilian immigrants living in Portugal, using the"Medical Outcomes Study: 36-Item Short Form Survey" (SF-36).

Methods and Results: A cross-sectional study with a quantitative approach developed under the project titled: Health status and quality of life of Brazilian immigrants in Portugal conducted in the first half of 2016, with 682 Brazilian immigrant women over 18 living in Portugal. This study adopted as reference SF-36, a generic instrument for the evaluation of Quality of Life. It can be affirmed that the quality of life and health of Brazilian immigrants living in Portugal is good, since all dimensions presented values above 50%. It was evidenced that Brazilian immigrants who live alone have lower levels of quality of life and health than those who live with someone and, that Brazilian immigrants who are unemployed, have low levels of quality of life and health compared to those who are in another employment situation, and Brazilian immigrants entering the labor market with a workload of more than 40 hours per week present similar levels of quality of life and health compared to those who work fewer hours.

Conclusion: In general, one can affirm that the quality of life and health of Brazilian immigrants living in Portugal is good, but due to

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the particularities of the migration process in the current political and international context, a systematic monitoring of living conditions and health of this population is necessary.

Keywords
Emigrants and Immigrants; Quality of life; Women, Mental health.

Introduction

Migratory flows are part of the history of humanity, as natural catastrophes, conquest, domination of peoples and colonization of new lands stimulate the movement of people. Migration can be understood as a global and multidimensional phenomenon that requires profound changes. Understanding the migratory issue implies objectifying what is meant by multicultural and intercultural, considering interculturality a challenge capable of recognizing and valuing difference [1]. It is not enough that different cultures achieve a coexistence based on mutual respect and solidarity, a significant interaction between them is necessary.

The literature on migratory processes has indicated that a significant number of individuals migrate in search of a better life with a view of a quality of life (QoL) often unreachable in their countries of origin [2-5]. In this paper, searching for research developed in France, Portugal, Italy and other countries, both European and North American, the complex and varied set of socioeconomic, psychosocial and family factors observed in the migratory contexts, stands out. These factors effectively affect health, stress levels, development and QoL of migrant people and families, especially those from developing countries [6-7].

The concept of 'quality of life' is recent and has been used very often by both the population and the scientific community. This is a central theme in planning and management policies and analyses in the health sector. A number of currents propose a definition for this concept. For QV it implies three reference forums [8]:

1. *historical,* that is, at a certain moment the economic, social and technological development of a society presents a parameter of QV different from the same society at another time;
2. *cultural,* that is, values and needs are constructed and hierarchized differently by peoples, revealing their traditions; and
3. stratification, or social classes.

Bring the debate about QoL in relation to these broader polysemic characteristics that involve development, democracy and the way of life and lifestyle, associating the socioeconomic evaluation with the health of the populations [8]. It is considered that the conception of QoL refers to historical and cultural aspects and social classes, since societies in different stages of economic, social and technological development present different values and needs in cultural terms and the different social stratifications also have different perceptions of QoL [8].

The World Health Organization [9] defines 'quality of life' as a holistic phenomenon that brings together the social, individual and physical resources necessary for the individual to achieve their goals and aspirations, as well as for the satisfaction of their demands at different levels.

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Though there are numerous definitions of QoL, none of them are widely accepted [1]. What is increasingly evident is that one cannot only consider health-related factors such as physical, functional, emotional and mental well-being; other important elements in people's lives, such as work, family, friends and everyday circumstances are also relevant and personal perception is always paramount.

It warns that the theme of QoL and immigration should be studied and discussed in all current societies, since the great population flows change with the emergence of a new, generally active and autonomous group formed by immigrants [10]. It points out that there are multiple obstacles that ethnic minorities face in integrating into a society and a sociocultural universe different from their own [11]. These are difficulties of a material, legal and cultural nature that the immigrant experiences in their constant search for a better QoL. This intensifies the movement of people and creates new forms of mobility, new directions and new trajectories of migration.

Among the new migratory movements are those that involve people with necessary conditions for their economic reproduction. In their places of origin, they no longer play the role of direct producers of goods and yet migrate in search of a better life. Brazilian immigration in Portugal is part of this scenario, which is increasingly present and widespread in all regions of the country and has an impact on the socio-cultural fabric of the host country.

Based on this contextualization, we question how the aspects of quality of life and health of Brazilian immigrant women living in Portugal are presented. This study presents four questions: Q1: Brazilian immigrants living alone have lower levels of quality of life and health? Q2: Brazilian immigrants who are unemployed have low levels of quality of life and health? Q3: Do Brazilian immigrants with more time in the country have more adequate levels of quality of life and health? Q4: Do Brazilian immigrants entering the labor market with a workload of more than 40 hours a week have low levels of quality of life and health?

To answer the questions of the study the objective of this article is to analyze the quality of life and health of Brazilian immigrants living in Portugal, having as parameter"Medical Outcomes Study: 36-Item Short Form Survey" (SF-36).

Method

We selected 682 Brazilian women over 18 years of age who lived in Portugal for at least 3 months. In relation to the age group, they present the following proportions: 22.1% were 18 to 29 years old; 38.4% were 30 to 39 years old; 23.1% were 40 to 49 years old; and 15.5% were 50 to 76 years old. As for the time of residence in Portugal, 20.0% lived in the country for 1 year; 25.0% between 2 and 5 years; 29.0% between 6 and 10 years; and 26.0% for more than 10 years.

With regard to marital status, 27.0% were single; 48% were married; 13% lived in union; 2.0% were separated; 8.0% were divorced; and 2.0% were widows. The analysis of the nationality of the spouses of the Brazilian women with husbands or partners in Portugal raised the following data: 57.0% are Portuguese; 37.0% are Brazilian; 2.0% are Portuguese-Brazilian; and 4.0% are from other nationalities, such as French, Angolans, Cape Verdeans, Spaniards, Germans, Britons, Dutch or Senegalese.

Regarding maternity, 58.4% had children and 41.6% did not have children. Among the mothers, 45% had 1 child; 40.0% had 2; 12.0% had 3; 2% had 4; and 1% had 5 children.

Considering the educational level, it was verified that: 5.0% had incomplete Elementary School and 5.0% had complete Elementary School; 8.0% had incomplete High School and 25.0% had complete High School; 15.0% had incomplete Higher Education and 15.0% had complete Higher Education; and 27.0% had postgraduate degrees.

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In terms of housing situation in Portugal, 69.0% lived with their own family; 15.0% lived alone; 6.0% lived with Brazilian friends; And 10.0% lived with a Portuguese family.

Finally, the analysis of the sample raised the following picture in the labor market: 21.0% were unemployed; 44% were employed; 17.0% were students; 5.0% were both students and workers; and 13.0% were domestic or housewives.

Instruments

This study adopted as a reference SF-36, a generic instrument for the evaluation of QoL that is easy to administer and understand. It consists of one question of comparative evaluation between current health conditions and those of one year ago and 35 items, encompassed in eight scales (or components): a) functional capacity (ten items); B) physical aspects (four items); C) pain (two items); D) general health status (five items); E) vitality (four items); F) social aspects (two items); G) emotional aspects (three items), and h) mental health (five items). It evaluates both the negative aspects (illness or disease) and positive aspects of health (well-being or QoL), [12] and validated for Portuguese [13]. In the evaluation of the results, after its application, a score is assigned for each question, which is later converted into a scale from zero to 100, where zero corresponds to the worst health condition and 100 to the best, with isolated analysis of each dimension. Purposely, there is not a single value that sums up the whole evaluation, which translates into a better or worse general health state, so that, in an average of values, avoid the error of not identifying the real problems related to QoL and the health of the interviewee or even to underestimate them [13].

For the characterization of the sample, a sociodemographic questionnaire was adopted with the following items: a) age; B) civil status; C) schooling; (D) child (ren); E) labor market situation; F) length of residence in Portugal; and g) housing situation.

These studies have shown that the scores for the SF-36 domains obtained in adult populations present satisfactory reliability and validity when compared to other instruments of evaluation of the QoL. It was verified that the SF-36 meets the required psychometric standards regarding data quality, scheduling assumptions, reliability and validity as an instrument; their scales reproduce hypothetical physical and mental dimensions; and the patterns of relationships between factors and scales are predictive of their associations to external criteria of physical and mental health. All this is relevant in the context of this research, because health status is a social construct and its evaluation involves a specific cultural understanding of the person [14].

Procedures

This research was presented to the Brazilian Consulate General (in the city of Porto, in Lisbon and in Faro), to the Brazilian Embassy in Lisbon and to the Associação Brasil (AMB). These bodies have significantly supported the identification and approach of Brazilians living in Portugal.

Data collection took place from July to September 2016 and two modalities were instituted: online, through the LimeSurvey Platform, and face-to-face, at the Consulate General of Brazil (in the city of Porto and in Lisbon) and AMB. To complement the online approach, a Facebook group was created: "Brazilians living in Portugal". The link to the study survey was made available on the official social networking pages of AMB, the Brazilian Consulate General in Faro and the Brazilian Embassy in Lisbon and the Facebook group"Brazilian people living in Portugal". The approach and face-to-face identification were developed at the Consulate General of Brazil (in the city of Porto and in Lisbon) and in the AMB, presenting the research regarding the objectives, method adopted and its social importance. Subsequently, there was an invitation for voluntary participation in order to complete

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the survey. It is worth mentioning that in both modalities (on-line and face-to-face), participation was formalized through the signing of a free and informed consent form.

The inclusion criteria adopted were: a) being a Brazilian women; B) to live in Portugal for more than three months; and c) to be over 18 years of age. It is worth mentioning that this study was developed within a broader research entitled"State of health and quality of life of Brazilian immigrants in Portugal", which obtained a favorable opinion from the Research Ethics Committee of the Vale do Acaraú State University (UVA), Under Protocol n. 1,692,063

The data was compiled in the LimeSurvey Platform and processed in the Statistical Package for the Social Sciences (SPSS) program, version 24.0. Descriptive statistics were used to identify the way answers are distributed [15] and the internal consistency analysis of the scale was based on [16-17] and analysis of variance to examine the influence of socio-demographic variables in SF-36 dimensions.

Results

Table 1 presents the mean of each SF-36 dimension. Which can be interpreted as follows: the higher the percentage obtained by the participant, the better is its Quality of Life. One can identify that change of health over time, vitality, mental health and emotional aspects are the dimensions with the lower means, are functional capacity, physical aspects, social aspects, pain, general health state are the dimensions with higher means.

Table 2 shows the distribution of SF-36 dimensions in relation to who Brazilian immigrants live in Portugal. It was verified that the dimensions of physical aspects, general health status, social aspects, emotional aspects and mental health, present statistically significant differences, suggesting that Brazilian immigrants living alone have less quality of life than those who live with them.

Table 1. Distribution of SF-36 dimensions in Brazilian immigrant women living in Portugal.

		N	Mean	Standard deviation	Coef. Variation	Minimum	Maximum
			n	n	%		
SF36		621	70.9	17.3	24	8	100
1	Functional capacity	670	83.6	18.8	22	0	100
2	Physical aspects	671	80.6	32.3	40		
3	Pain	673	73.3	23.4	32		
4	General health state	665	71.1	21.0	30		
5	Vitality	676	60.6	22.8	38		
6	Social aspects	676	74.3	26.1	35		
7	Emocional aspects	670	68.8	40.2	58		
8	Mental health	667	66.3	21.7	33		
9	Change of health over time	679	56.1	22.7	40		

The indicated values refer to the measurement scale, between 0% and 100%.

Table 2. Distribution of SF-36 dimensions in relation to those who live with Brazilian immigrants in Portugal.

			N	Mean	Standard Deviation	T	p
SF36		Alone	93	67.3	17.0	-2.186	0.029*
		Acompanied	521	71.5	17.2		
1	Functional capacity	Alone	97	80.8	21.5	-1.607	0.108
		Acompanied	566	84.1	18.3		
2	Physical aspects	Alone	98	72.4	38.1	-2.702	0.007**
		Acompanied	566	82.0	31.1		
3	Pain	Alone	97	71.2	25.1	-.913	0.361
		Acompanied	569	73.6	23.1		
4	General health state	Alone	98	66.9	21.8	-2.087	0.037*
		Acompanied	560	71.7	20.8		
5	Vitality	Alone	98	57.9	23.0	-1.333	0.183
		Acompanied	571	61.2	22.6		
6	Social aspects	Alone	98	67.9	27.3	-2.704	0.007**
		Acompanied	571	75.5	25.6		
7	Emocional aspects	Alone	98	59.9	42.8	-2.388	0.017*
		Acompanied	565	70.3	39.5		

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			N	Mean	Standard Deviation	T	p
8	Mental health	Alone	95	61.2	20.8	-2.509	0.012*
		Acompanied	565	67.2	21.7		
9	Change of health over time	Alone	98	52.0	21.4	-1.888	0.059
		Acompanied	574	56.7	22.8		
*: significant difference in p < 0.05; **: significant difference in p < 0.01							

The data of **Table 3** shows the dimensions of the SF-36 and its relation with the work situation of Brazilian immigrants living in Portugal. It can be seen that for functional capacity, emotional aspects, mental health, and health change over time, there are statistically significant differences between the classes of the Work Situation, where the unemployed condition proves to be the most affected.

Table 3. Distribution of the dimensions of the SF-36 and its relation with the work situation of Brazilian immigrant women in Portugal.

			N	Mean	Standard deviation	F	p
	SF36	Unemployed	132	68.1	19.0	1.957	0.099
		Employed	271	72.8	16.4		
		Student	106	70.5	17.6		
		Student and worker	29	72.0	13.8		
		Maid/House wife	76	69.0	17.1		
1	Functional capacity	Unemployed	142	81.7	19.4	5.970	0.000**
		Employed	294	83.5	19.0		
		Student	111	88.4	12.8		
		Student and worker	30	93.0	8.2		
		Maid/House wife	85	78.4	22.8		
2	Physical aspects	Unemployed	143	75.9	36.6	1.715	0.145
		Employed	293	83.7	29.9		
		Student	114	78.7	32.6		
		Student and worker	30	85.0	25.1		
		Maid/House wife	83	79.5	32.9		
3	Pain	Unemployed	143	72.5	24.0	.848	0.495
		Employed	296	72.7	24.3		
		Student	114	75.7	21.1		
		Student and worker	29	78.2	18.9		
		Maid/House wife	83	71.4	24.1		
4	General health state	Unemployed	138	69.9	21.6	1.857	0.116
		Employed	291	72.9	20.5		
		Student	113	70.5	22.0		
		Student and worker	30	73.3	17.9		
		Maid/House wife	86	66.4	21.1		
5	Vitality	Unemployed	144	57.3	23.5	2.084	0.081
		Employed	296	62.6	21.2		
		Student	112	59.5	24.8		
		Student and worker	30	54.3	23.8		
		Maid/House wife	86	62.5	23.3		
6	Social aspects	Unemployed	144	71.3	28.0	1.292	0.272
		Employed	294	76.7	24.2		
		Student	114	72.8	26.8		
		Student and worker	30	71.3	25.7		
		Maid/House wife	86	74.0	27.8		
7	Emotional aspects	Unemployed	143	63.2	42.4	6.577	0.000**
		Employed	291	76.4	36.5		
		Student	114	60.5	41.5		
		Student and worker	30	48.9	44.4		
		Maid/House wife	85	69.4	39.9		
8	Mental health	Unemployed	143	61.7	23.3	2.939	0.020**
		Employed	292	68.7	20.3		
		Student	110	64.1	24.0		
		Student and worker	30	65.1	18.2		
		Maid/House wife	84	67.5	20.8		

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			N	Mean	Standard deviation	F	p
9	Change in health over time	Unemployed	143	53.7	23.9	2.657	0.032**
		Employed	298	55.9	22.0		
		Student	114	58.8	23.7		
		Student and worker	30	65.8	21.3		
		Maid/House wife	86	52.9	20.4		

*: significant difference in p < 0,05; **: significant difference in p < 0,01

Table 4 shows the SF-36 dimensions and its relation with the length of time Brazilian immigrants live in Portugal. It is identified that the emotional aspects present statistically significant differences for the Brazilian women living for at least one year there. It suggests that this group may present limitations in their quality of life regarding the emotional aspects.

Table 4. Distribution of the SF-36 dimensions of Brazilian immigrant women in Portugal and the relation with length of residence in the country.

			N	Mean	Standard deviation	F	p
SF36		1 year	128	70.6	17.3	0.700	0.552
		2 to 5 years	158	69.6	17.4		
		6 to 10 years	168	70.6	17.5		
		More than 10 years	160	72.4	17.1		
1	Functional capacity	1 year	134	85.1	17.0	1.530	0.206
		2 to 5 years	165	85.2	19.0		
		6 to 10 years	189	83.0	18.6		
		More than 10 years	173	81.4	19.9		
2	Physical aspects	1 year	134	78.9	33.4	0.210	0.889
		2 to 5 years	165	80.8	32.2		
		6 to 10 years	189	80.6	32.5		
		More than 10 years	175	81.9	31.5		
3	Pain	1 year	135	74.0	22.1	0.315	0.815
		2 to 5 years	166	74.1	23.4		
		6 to 10 years	187	72.0	23.8		
		More than 10 years	176	73.8	23.8		
4	General health state	1 year	133	72.2	20.6	1.259	0.287
		2 to 5 years	164	68.7	21.3		
		6 to 10 years	188	70.4	22.1		
		More than 10 years	172	72.8	20.0		
5	Vitality	1 year	135	59.7	23.7	1.505	0.212
		2 to 5 years	164	58.4	22.7		
		6 to 10 years	193	60.3	23.2		
		More than 10 years	175	63.5	21.4		
6	Social aspects	1 year	135	74.3	26.2	1.495	0.215
		2 to 5 years	166	71.0	28.0		
		6 to 10 years	190	74.2	25.2		
		More than 10 years	176	77.0	25.1		
7	Emotional aspects	1 year	134	64.2	40.4	3.536	0.015*
		2 to 5 years	166	62.9	42.1		
		6 to 10 years	189	70.9	40.3		
		More than 10 years	173	75.3	37.1		
8	Mental health	1 year	133	63.9	23.6	1.465	0.223
		2 to 5 years	163	65.0	20.6		
		6 to 10 years	192	66.6	21.2		
		More than 10 years	170	68.8	22.0		
9	Change in health over time	1 year	135	57.2	22.6	0.397	0.755
		2 to 5 years	166	55.1	23.4		
		6 to 10 years	192	54.9	20.8		
		More than 10 years	177	56.6	23.6		

*: significant difference in p < 0,05; **: significant difference in p < 0,01

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The information in **Table 5** demonstrates the dimensions of the SF-36 relative to the number of weekly work hours. It is verified that there are no statistically significant differences between the classes of number of weekly working hours.

Table 5. Distribution of the SF-36 dimensions in Brazilian immigrant women in Portugal and the relation with the number of weekly working hours.

			N	Mean	Standard deviation	F	p
	SF36	Less than 20 hours	19	71.6	15.6	1.645	0.179
		20 to 39 hours	42	77.1	14.2		
		40 hours	172	72.7	15.9		
		More than 40 hours	66	70.0	17.9		
1	Functional capacity	Less than 20 hours	20	86.8	16.4	0.778	0.507
		20 to 39 hours	45	87.8	17.7		
		40 hours	187	84.0	17.7		
		More than 40 hours	70	83.0	21.0		
2	Physical aspects	Less than 20 hours	21	82.1	28.7	0.076	0.973
		20 to 39 hours	44	84.1	28.6		
		40 hours	186	83.3	30.6		
		More than 40 hours	70	85.0	28.0		
3	Pain	Less than 20 hours	22	73.2	22.4	0.134	0.940
		20 to 39 hours	46	74.9	23.8		
		40 hours	185	73.5	24.0		
		More than 40 hours	70	72.1	23.9		
4	General health state	Less than 20 hours	22	70.2	21.6	1.603	0.189
		20 to 39 hours	46	78.7	18.6		
		40 hours	184	72.6	20.5		
		More than 40 hours	68	71.0	20.3		
5	Vitality	Less than 20 hours	22	54.3	19.3	2.111	0.099
		20 to 39 hours	46	65.7	20.1		
		40 hours	187	63.0	21.4		
		More than 40 hours	69	58.6	23.1		
6	Social aspects	Less than 20 hours	22	74.4	25.1	0.471	0.702
		20 to 39 hours	46	78.8	24.8		
		40 hours	186	76.7	23.8		
		More than 40 hours	68	73.7	25.7		
7	Emotional aspects	Less than 20 hours	21	69.8	39.3	0.357	0.784
		20 to 39 hours	43	72.1	41.1		
		40 hours	186	73.5	38.0		
		More than 40 hours	69	77.8	36.0		
8	Mental health	Less than 20 hours	21	66.1	19.5	0.827	0.480
		20 to 39 hours	45	71.9	19.1		
		40 hours	185	68.6	19.8		
		More than 40 hours	69	66.2	21.9		
9	Change in health over time	Less than 20 hours	22	54.5	21.3	2.457	0.063
		20 to 39 hours	46	60.9	22.8		
		40 hours	188	58.2	22.4		
		More than 40 hours	70	51.1	20.6		

Discussion

The evaluation of the quality of life and health of Brazilian immigrant women in Portugal using the SF-36 as shown in **Table 1** presented an average value of 70.9%, with a dispersion of 24%. The minimum and maximum values are, respectively, zero and 100%. It can be inferred that the quality of life of this group is good since all dimensions presented

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values above 50%. The lowest percentages were detected in the dimensions of health change over time 56%, vitality 61%, mental health 66% and emotional aspects 69%, suggesting that these may contribute to a reduction in the quality of life of the studied group.

Research with people immigrant [18] showed that despite the difficulties encountered in the migratory process, the results showed good quality of life. The research results [19:548]"showed a current growing profile of the Brazilian immigrant in Portugal and their inclusion in a social risk group, reflected in their precarious psychological, social and, more specifically, in the field of health".

A study [20:287] with immigrants in Portugal, the case of Brazilians, Ukrainians and Guineans revealed aspects related to quality of life."In the classification - good quality of life, the immigrants who present the best profile of affections, always positive, are also, mostly, Guineans and Brazilians, live in Northern Portugal and when they entered Portugal they brought between 1500 and 2000 euros. These immigrants chose Portugal as a destination country because of their language, because they understood, wrote and read Portuguese very well. Although they have created friendships, they are not satisfied with the bonds of friendship they have made and do not participate in any group in their community of origin.".

Table 2 shows the results of the first study question. Brazilian immigrants living alone have lower levels of quality of life and health than those who live with them. Living alone seems to be a condition that is growing among women who migrate in search of better living conditions. Offers some trails to analyze this situation of vulnerability of dimensions physical aspects, general health status, social aspects, emotional aspects and mental health presented by Brazilian immigrants living alone [21]. For this author, immigrant women accumulate employment discrimination while being affected as women, and workers, by the triple disadvantage by sex, nationality and social class.

In identifying the level of mental health in the Brazilian community in Lisbon, Viana found that women presented more cases of probable psychological distress than men [22].

A survey conducted in Porto [23] found 43% of Brazilian immigrants living alone, 51% living with relatives. In a large study of experience and integration in 15 European cities, living in a family center helps immigrants improve family life, strengthens the sense of belonging and facilitates integration [24].

Some studies have demonstrated the presence of psychological distress and mental illness in the immigrant population, and women in general are affected by these studies [5, 25-27] to a greater extent than men.

The second question of study can be understood from the results of **Table 3**, Brazilian immigrants who are unemployed have low levels of quality of life and health compared to those who are in another employment situation.

Regarding unemployment [20], the study found that immigrants of"Brazilian nationality spend less time unemployed, most of whom are unemployed (65%) up to three months (only 3% are unemployed for more than one year) in the case of the Ukrainians, 31.5% were unemployed for up to one month, but 13% of respondents with longer unemployment, more than one year. (30%) are unemployed between six months and one year, with 19% of them who have been unemployed for more than one year."The author concludes that the vulnerability of immigrants to unemployment is greater in Guineans.

According to [28: 213] "The concentration of migrant workers in work that does not take into account their qualifications, where social protection is inadequate or omits in law or practice, is a manifestation of discrimination. When working conditions are lower than those of the national population".

A survey carried out in several cities in Europe found that immigrants had a difficult employment

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situation, few legal contracts, and discrimination and mistrust are very present, causing fear and insecurity [24].

Some studies relate unemployment to suffering and mental illness. Individuals suffering from unemployment suffer more frequently and intensely from sufferings related to low self-esteem, reduced morale and mood, stress, anxiety, shameless feelings, humiliation and sleep disturbances [29]. The absence of formal work is an important factor related to the degradation of individual self-esteem, deterioration of social relations and, possibly, psychopathological problems [30]. Unemployed workers feel stigmatized and face prejudice and social discrimination.

For the adverse consequences of unemployment can lead to the de-structuring of social and affective ties, restriction of rights, socioeconomic insecurity, reduction of self-esteem, feelings of loneliness and failure, development of mental disorders, as well as increased drug use or dependence [31].

In the text"Une souffrance qu'on ne peut plus cacher" [32] the authors comment on the situation of long-term unemployed women, draw attention to the psychological suffering influenced by unemployment, and the poor working conditions and emphasize that this group may have a more severe number of pathologies due to late diagnosis and treatment, psychosocial deficiency, and clandestine and discriminatory situations.

Neto suggests that there are innumerable changes that can occur both socially and individually, among them: "physical, biological, cultural, social, political and economic changes, involving psychological conflicts, social disintegration and/or even decline in mental health" [33: 43].

Table 4 shows the answer to the third study question, Brazilian immigrants with more time in the country have more adequate levels of quality of life and health. The emotional dimension aspect has been altered reducing the quality of life and health of the women who have been in Portugal for at least a year. This suggests that the first few months and the period of adaptation may cause some emotional instability.

Research carried out evidenced the initial and adaptation difficulties that immigrant women find in Portugal for insertion and permanence in the labor market. This can influence their emotional aspects [34].

For example, the migration process is associated with feelings of mourning, sadness, nostalgia for what has been left behind (friends, relatives, the land) [5] with less migration time and still in the adaptation phase. In which they were born); painful emotional issues in the early days of the process of acculturation

Table 5 presents the information on the fourth issue of study, Brazilian immigrants entering the labor market with a workload exceeding 40 hours per week present low levels of quality of life and health. The results did not show statistically significant differences between women working more than 40 hours per week and women working less hours. It can be assumed that, with the majority of young adults being of reproductive age, the weight of the workload is still not compromising the physical and mental aspects, this may change with increasing age.

In a study conducted with Brazilians in Portugal the results revealed that 16% work from 41 to 45 hours a week and 32.3% work more than 46 hours a week. It seems to be a reality in the Brazilian community in Portugal the insertion in the labor market with weekly workload greater than 40 hours. [35]

In making the relation between workload and quality of work suggests that"rather than establishing objectives about the amount of employment, the debate about reducing work hours needs to be focused on its quality."What can be applied in the case of some immigrants, the number of weekly work hours above the standards established by the labor market seems to be offset by other benefits that are optimizing the quality of life and health of this group [36:117]

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It is recommended in the host countries' migratory context that mental health devices be prepared to deal with people who are struggling to adapt and integrate into the new country, as these people generally have different demands when compared to natives [32]. In this scenario it is fundamental to have a public health policy directed specifically to the immigrant population that can offer care in order to promote mental health and to prevent diseases related to psychic disorders.

Conclusions

In general, it can be affirmed that the quality of life and health of Brazilian immigrants living in Portugal is good, since all dimensions presented values above 50%. The lowest results were detected in the dimensions of health change over time 56%, vitality 61%, mental health 66% and emotional aspects 69%.

The study questions were answered as follows: Brazilian immigrants living alone have lower levels of quality of life and health compared to those living with them. Brazilian immigrants who are unemployed have low levels of quality of life and health compared to those who are in another employment situation. Brazilian immigrants with more time to stay in the country have more adequate levels of quality of life and health, compared to those that have been there less time. Brazilian immigrants entering the labor market with a workload greater than 40 hours per week present similar levels of quality of life and health compared to those who work fewer hours.

The limitations of this study are the fact that it does not resort to a qualitative deepening, where the context and the conditions of life could be presented in a subjective way, enriching the presented diagnosis. This research offers insights on the domains for the measurement of the quality of life and health of Brazilian immigrants in Portugal, since smaller values were detected in the dimensions related to emotional aspects, mental health, vitality and change of health status over time, although there is a need for a deepening of the social context and the way of life.

We suggest other researches whose object is to study the dimensions where we detect the lowest percentages of quality of life, because they are exactly the ones that deserve an accurate investigation.

It is believed to be important to create a policy that aims at transforming actions aimed at strengthening the citizen and collective conscience of these Brazilian immigrants, generating better conditions for the full exercise of citizenship.

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