


# Access and right to health for Bolivian migrants in a Brazilian metropolis<sup>1</sup>


## Acesso e direito à saúde para migrantes bolivianos em uma metrópole brasileira

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### Abstract

This paper analyzes the health care accessibility conditions afforded to Bolivian immigrants in the Brazilian health system and their perception of the right to health. This was a cross-sectional, quantitative and qualitative study carried out from 2013 to 2015. Data were collected by a questionnaire with closed questions answered by 633 Bolivian individuals; questions regarding access to health were answered by 472 immigrants over 18 years old. Semi-structured interviews conducted with 55 subjects (Bolivians, health professionals, representatives of Health Departments, Consulate of Bolivia, Public Defender's Office, Federal Public Prosecutor's Office and Non-Governmental Organizations) underwent content analysis. Most Bolivian immigrants know the Brazilian National Health System (SUS) and often use Primary Health Care; however, they described structural and systemic barriers to health accessibility, such as lack of documentation, working conditions, medium and high complexity procedures, language barriers, among others. The National Health Card (CNS) is an important gateway to access health care, playing a role of social integration. Interviewees recognize health as a social right, pointing it out as a human and solidary value. Ensuring this recognition, when not based on the consolidation of social policies aimed at strengthening universal social protection, is threatened.

**Keywords:** Bolivian migration; Right to health; Access to health.

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## Resumo

Este artigo analisa as condições de acesso do imigrante boliviano ao sistema de saúde brasileiro e a percepção do direito à saúde. É um estudo transversal de metodologia quantitativa e qualitativa, realizado de 2013 a 2015. Foi elaborado um questionário com perguntas fechadas respondidas por 633 bolivianos, e em relação ao acesso à saúde por 472 indivíduos bolivianos maiores de 18 anos. A abordagem qualitativa foi feita por meio da análise de conteúdo de entrevistas semiestruturadas com 55 sujeitos (bolivianos, profissionais de saúde, representantes de Secretarias de Saúde, Consulado da Bolívia, Defensoria Pública da União, Ministério Público Federal e Organizações Não Governamentais). Os bolivianos conhecem o Sistema Único de Saúde (SUS) e utilizam com frequência a Atenção Primária à Saúde (APS). Todavia, barreiras de acesso são descritas, como falta de documentação, condições de trabalho, procedimentos de média e/ou alta complexidades, dificuldades para entenderem o que é dito assim como para serem compreendidos, entre outras. Sobressai-se a obtenção do Cartão Nacional de Saúde (CNS) como porta de entrada para o acesso à saúde, desempenhando papel de integração social. O reconhecimento da Saúde como direito social destaca-se entre os entrevistados, apontado como valor humano e solidário. A garantia desse reconhecimento fica ameaçada quando não se apoia na consolidação de políticas sociais que visem o fortalecimento da proteção social universal.

**Palavras-chave:** Migração Boliviana; Direito à Saúde; Acesso à Saúde.

## Introduction

The inter-country population movements have generated constant challenges for the territories that receive these populations, regardless of the economic, political, cultural or environmental issues that motivated them. In the Americas, immigration has been associated with economic aspects, notably the precarious living conditions of population groups that move in search of better social insertion and well-being (Goldberg; Martin; Silveira, 2015).

Bolivian immigration to Brazil began notably in the 1950s with the arrival of students stimulated for scientific-cultural exchange (Silva, S., 2012). The characteristics of this flow have changed dramatically in profile since the 1980s, when young people who were single and had mid-level education, in search of better wages, as well as family groups, in increasing numbers, have been precariously incorporated into the textile production process, within the informal labor market, in situations of social vulnerability, determining health risks (Silva, S., 2012; Melo; Campinas, 2010).

The state of São Paulo, due to its prominence in Latin American socioeconomic development, has a strong attraction for Bolivian migration. It is estimated that 350 thousand Bolivians live in the Metropolitan Region of São Paulo, about 70% of the contingent present in Brazil, with concentration in the city of São Paulo, the state capital (Silva, S., 2006).

Implications on the epidemiological profile, particularly in relation to communicable diseases, emerge in this context. A study in Bolivian immigrants in the city of São Paulo observed a prevalence of infection by *Trypanosoma cruzi* of 4.4%, being 6.1% in women of reproductive age, both higher than that found in the Brazilian population (Luna *et al.*, 2017).

On the other hand, the lack of knowledge on the part of health professionals about epidemiological profiles in this population limits assistance and, thus, contributes to their vulnerability in health care (Carneiro Junior *et al.*, 2018).

Studies that analyze macro- and micro-structural dimensions involved in contemporary international migration contribute to the qualification of social

protection systems, with particular power to those who understand these issues from the subjects involved. In this perspective, this article brings an empirical research with results of high relevance for understanding the current situation of the vulnerability of Bolivian immigrants in accessing the Brazilian health system. The results point to evidence about the perceptions of the immigrants themselves and of representatives of public agencies and civil society in relation to the right to health.

## Methods

This was a cross-sectional study with quantitative and qualitative approaches, conducted from 2013 to 2015. A sample of 633 Bolivian individuals was previously sized to meet the objectives of a larger study (Luna *et al.*, 2017), with 111 children under 10 years of age selected from the enrollment register of a primary health care service, located in the central region of the city of São Paulo, a reference in the medical and health care of this population (Silva, R. *et al.*, 2020). Those selected or their guardians signed the Informed Consent Form (ICF), translated into Spanish, and answered a structured questionnaire applied in Spanish by an interviewer, addressing: date of birth, place (rural or urban), marital status, education, occupation and family salary; migration and length of stay in the city of São Paulo; access to health care, including language comprehension by the immigrant and health worker. Sociodemographic characteristics, such as gender, age group, length of residence in the city of São Paulo and family income, had their simple frequencies previously described (Luna *et al.*, 2017; Silva, R. *et al.*, 2020), being analyzed here together with other variables. To describe the access to health care of this population according to aspects such as occupation, family income and language comprehension, 472 individuals over 18 years of age were included. However, to describe access to health according to the place of care and other variables applicable to people of any age group, all 633 subjects in the sample were used.

The qualitative approach results from semi-structured, individual, recorded and later transcribed interviews, addressing questions about migratory aspects, health care and social rights. A total of 55 subjects participated, among them 27 Bolivian adults, 20 women and 7 men (randomly selected from 472 Bolivians and interviewed in Spanish); 19 health professionals - physicians, social workers, pharmacists, nurses and administrators. These professionals were invited from the indications of the managers of the respective health services, having as criteria those who addressed issues on care for Bolivian immigrants in the meetings of the unit issues on care for Bolivian immigrants; nine representatives of the following institutions with actions and/or care related to Bolivians: Consulate of Bolivia in São Paulo, state secretariat (SES) and the Municipal Health Secretariat of São Paulo (SMS), two primary care clinics located in the central region of the city of São Paulo, Pastoral do Migrante de São Paulo (Catholic church migrants' pastoral), Association of Bolivian residents, the Public Defender of the Union and the Federal Public Ministry. All have signed the ICF; in the case of Bolivians, Spanish language version. The analytical treatment of this material was carried out through content analysis.

This study is part of the research "Chagas disease in a population of Bolivian migrants in the city of São Paulo: an analysis of the prevalence of *Trypanosoma cruzi* infection and morbidity of Chagas disease; the population's knowledge about the disease and access to different levels of health care", approved by the Research Ethics Committee of the Hospital das Clínicas of the Faculty of Medicine of the University of São Paulo.

## Results

### Migration process, living and working conditions

In the migration circuit, only one Bolivian interviewee out of 472 over 18 years of age reported having passed through Argentina before arriving in Brazil. The rest came directly from Bolivia to the city of São Paulo.

In relation to the migratory flow, the interviewees point out economic, political, family and human trafficking aspects:

*We are working with the Secretariat of Citizenship and Human Rights, Ministry of Justice on human trafficking. (Consulate of Bolivia)*

*Many of them [Bolivians] come not so much for the political issues, but mostly for the economic ones. (Public Defender of the Union)*

*It is a group [Bolivians] very attached to sewing workshops, but not only that. You can already find several realities. Those who have been here longer, have families who already have children born here. There are those who have gone to college, who are doing well and those who still continue to arrive and who still are still quite strong on the sewing industry. (Pastoral do Imigrante)*

*Our community [Bolivians] works a lot in the field of sewing, eighteen, twenty hours, we are working together with the Ministry of Labor [...] (Association of Bolivian residents)*

We can observe that having a secondary or higher level of schooling does not interfere with the family salary range, mostly up to two minimum wages. Another characteristic is that most of them work in sewing workshops (90.9%), regardless of schooling level (89.7% among those with primary education, 91.6% among those with secondary education and 81.0% among those with higher education). At the same time, this occupation is predominant in all monthly family income groups, 74.5%, when the family income is less than 1 minimum wage; 94.9%, with income between 1 and 2 minimum wages; 90.4%, between 2 and 3 minimum wages and 75% with family income greater than 3 minimum wages (Table 1).

### Access to health care

Regarding access to health services, of the total of 633 immigrants interviewed, 96.5% use the public health system. As can be seen in the Table 2, 37.9% of women aged 20 to 39 years reported frequent visits to health services, while among men of the same age group it was 20.0%. Among children aged 1 to 9 years, this rate rose to 77.1%.

**Table 1 – Distribution of Bolivian immigrants according to schooling level, occupation and family income.**

Schooling level	Occupation	Family income (minimum wage)				Total*	
		<1	1-<2	2 <3	≥3	No.	%
Primary education	Sewing	11	35	14	1	61	12.95
	Other	02	02	03	0	07	1.49
Secondary education	Sewing	28	236	76	10	350	74.31
	Other	11	11	7	03	32	6.79
Higher education	Sewing	02	10	04	01	17	3.61
	Other	01	02	0	01	4	0.85
Total		55	296	104	16	471	100.0

\* We excluded those under the age of 18 and one individual who refused to report its salary.

Regarding the use of hospital services, 38.9% used and 61.1% sought a primary care clinic (UBS). It should

be noted that in hospital care women in the age group of 20 to 45 years represent the majority (Table 3).

**Table 2 - Distribution of Bolivian immigrants in relation to access to health services according to age group and sex**

Age group	Went to health services	Male		Female		Total	
		No.	%	No.	%	No.	%
1 to 9	Yes	44	54.3	37	45.7	81	100.0
	No	10	41.7	14	58.3	24	100.0
10 to 19	Yes	11	44.0	14	56.0	25	100.0
	No	22	36.7	38	63.3	60	100.0
20 to 29	Yes	20	32.8	41	67.2	61	100.0
	No	84	52.2	77	47.8	161	100.0
30 to 39	Yes	14	27.5	37	72.5	51	100.0
	No	52	50.5	51	49.5	103	100.0
40 and over	Yes	12	42.9	16	57.1	28	100.0
	No	24	61.5	15	38.5	39	100.0
Total	Yes	101	41.1	145	58.9	246	100.0
	No	192	49.6	195	50.4	387	100.0

Among the 633 Bolivians interviewed, 1.7% had access to private health plans or insurance, being mostly women aged 20 to 29 years, with a medium schooling level, working in sewing, with a family income of less than 1 minimum wage and living in São Paulo for up to 2 years. The Unified Health System (SUS) was the most likely destination for 96.5% when they had health problems. It is noteworthy that 86.4% reported knowledge about their constitutional principle of universality.

From health professionals to representatives of government institutions and civil society, many emphasize the importance of primary care services as a “gateway” to the health care network and the recognition of the public health system, identifying some access strategies, such as the presence of Bolivian community health agents:

*[...] Women are coming a lot for the prenatal examination and the Pap [Papanicolau] smear. Pediatrics are also sought after quite often... [...]*  
(Health professional)

*Health [health services] is where most often the first contact with this population occurs.* (SMS)

*From the point of view of attention or care for this migrant, I think that the thing that we treat with priority is pregnant women, today fifty percent of our pregnant women are Bolivian [...]*  
(Health Unit Manager)

*Community workers [Family Health Strategy] have differentials because they are Bolivians, both for the contact in the families, and for knowing their reality, so in the team itself they may be bringing up the issue of customs, of their culture, to be trying this approach in the language.* (Pastoral do Imigrante)

### Difficulties in access

The lack of regular documentation in Brazil and working conditions are issues that affect health care:

*The reason [for no outpatient follow-up] is usually because they [Bolivians] work in the sewing workshops, their bosses don't let them leave [...]. We [health professionals] try to make it easier for them [Bolivian], see which schedule is more flexible [...], we work to find quick schedule for them to help them [...], because the number of*

*absences [in routine consultations] is too big.*  
(Health professional)

*It is very common for the foreigner to go to the DPU [Public Defender of the Union] office He/she was known in the health unit that he could not receive health care because he did not have the document ready that is the RNE [National Registry of foreigners] [...]*  
(Public Defender's Office of the Union)

*Some difficulties that happened on the way, or a person alone who is admitted to the hospital and needs follow-up, more attention, or some basic attention, or if referred to the specialties, they sometimes need some help to understand why it is taking so long.* (Pastoral do Imigrante)

Another limitation of access is the omission of the place of residence by immigrants:

*In fact, what limits [the health service] is not knowing where he [Bolivian] lives, because*

*they often do not give the correct address.*  
(Health professional)

*Often the Bolivian informs an address that is not his, for fear that this information could be used against him by immigration authorities.* (Public defender of the Union)

Communication is also also considered among the difficulties:

The language barrier represents an important limit in the use of health services by Bolivian immigrants (Table 4). Of the 472 Bolivians over the age of 18, 41.5% said that health professionals understood them well. However, 42.6% of respondents stated that they could not adequately understand the guidance of professionals (Table 4).

Finally, 282 individuals (59.7%) reported needing help due to difficulty in understanding the guidelines during care. Of these, 92.1% (312/339) reported not being understood by health professionals.

**Table 3 - Place of care of Bolivian immigrants in the health service, according to age group and sex**

Age group	Hospital						UBS						Total					
	Male		Female		Total		Male		Female		Total		Male		Female		General	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
1 to 9	44	81.5	37	72.5	81	77.1	10	18.5	14	27.5	24	22.9	54	18.4	51	15.0	105	16.6
10 to 19	11	33.3	14	26.9	25	29.4	22	66.7	38	73.1	60	70.6	33	11.3	52	15.3	85	13.4
20 to 29	20	19.2	41	34.7	61	27.4	84	80.8	77	65.3	161	72.6	104	35.5	118	34.7	222	35.1
30 to 39	14	21.2	37	42.0	51	33.1	52	78.8	51	58.0	103	66.9	66	22.5	88	25.9	154	24.3
40 and over	12	33.3	16	51.6	28	41.8	24	72.7	15	48.4	39	58.2	36	12.3	31	9.1	67	10.6
Total	101	34.4	145	42.6	246	38.9	192	65.6	195	57.4	387	61.1	293	100.0	340	100.0	633	100.0

**Table 4 - Understanding of health professionals in relation to the speech of Bolivians (A) and understanding of Bolivians in relation to the speech of health professionals (B) according to age group**

Age group	Variable	Yes		No		No information		Total	
		No.	%	No.	%	No.	%	No.	%
18 to 19	A	12	41.3	14	48.3	3	10.4	29	100.0
	B	11	37.9	15	51.7	3	10.4		

continue...

**Table 4 – Continuation**

Age group	Variable	Yes		No		No information		Total	
		No.	%	No.	%	No.	%	No.	%
20 to 29	A	83	37.4	126	56.7	13	5.9	222	100.0
	B	86	38.7	127	57.2	9	4.1		
30 to 39	A	62	40.2	88	57.1	4	2.7	154	100.0
	B	65	42.2	85	55.1	4	2.7		
40 and over	A	39	58.2	24	35.8	4	6.0	67	100.0
	B	39	58.2	24	35.8	4	6.0		
Total	A	196	41.5	252	53.4	24	5.1	472	100.0
	B	201	42.6	251	53.1	20	4.3		

Barriers to communication were identified in the interviews:

*What happens is that many Bolivians come from rural areas and sometimes do not speak well, including Spanish. They speak indigenous dialects [...]* (Health professional)

*Yo vine cuando estaba embarazada. Fue muy difícil porque no comprendía la lengua, no sabía hablar. Fue muy difícil la comunicación [...]* (Bolivian immigrant)

*Because the language is Spanish, but we also have more than two, three languages within the Bolivian community. We have the Aymara, which most come from the highland region of Bolivia [...]. We have Quechua and we have a minimum of Guarani, but the real strength is Spanish [...]* (Consulate of Bolivia)

### Right to health

The perception of the right to health is expressed in the statements of Bolivians:

*Si, conozco [SUS]. El atendimento es universal, para todos y es gratuito. Es muy bueno.* (Bolivian immigrant)

*Por el SUS se consigue atendimento medico, hospitales y emergencias sin tener que pagar nada.* (Bolivian immigrant)

The absence of a visa to stay in Brazil is not an impediment for immigrants to have access to the public health system, according to institutional representatives:

*[...] [The Public Defender Office] receives many requests for judicial protection of health; high-cost drugs and hospitalizations are leaders of this [migrant population in general]. But here in São Paulo we have a very peculiar situation, in the unit we receive very few health demands, compared to our national scenario.* (Public defender of the Union)

*Es un derecho por lo menos aquí en Brasil, es uno de los pocos países que tiene establecido, está en la constitución por lo menos que es un derecho a la salud, esta garantizado, no dice que no tiene que ser inmigrante, cualquier persona tiene que ser atendida.* (Association of Bolivian Migrants)

*[...] It is important to emphasize that it is not due to the absence of specific policies or actions that this population is not being served. On the contrary, it enters into the bosom of the same rights as the general population, regardless of nationality or status here.* (SES)

*I think our country is a very supportive country, although we have a lot of difficulty, I think SUS is a very important public policy, both for us Brazilians and for the people who come here. And those who live here [...]. (Health Unit Manager)*

The issue of documentation is central to the perception and guarantee of the right. In this sense, all interviewees emphasize the National Health Card (CNS) as the first document that many of these immigrants obtained in the country, seen as a condition of social insertion:

*Te dan un cartón [National Health Card] que con él puede ser atendida en el puesto o en hospital. Es muy bueno. (Bolivian immigrant)*

*[...] From the moment they [Bolivian] get their SUS card, they feel Brazilian. (Health professional)*

*Many immigrants have told me that the only official document from Brazil they have is the SUS card. (Consulate of Bolivia)*

*The National Health Card can be an important means of citizenship for this vulnerable group, which are immigrants in an irregular situation. Receiving from the state a document giving them access to a right means a lot in terms of citizenship. (Federal Prosecutor)*

## Discussion

The results expose a precarious social insertion of Latin American immigrants in Brazilian society, in the case of Bolivians in the city of São Paulo, evidenced by the working conditions to which most of them are subjected in the “sewing workshops” - part of the textile production chain -, driven by unregulated migration (Freitas, 2011; Silva, S., 2006).

This work situation is strongly denounced by the interviewed health professionals, who relate it to vulnerabilities in health status and to the limits on access to services, noted in studies that show determinants of health inequities in the processes

of social exclusion of this population determinants of inequities in health (Silveira *et al.*, 2013).

The presented schooling and income indicators demonstrate a segment of socially disadvantaged social classes, expressing well the profile of social inequality of contemporary migratory flows (Cucunuba *et al.*, 2017; Forsyth *et al.*, 2018; Manne-Goehler; Reich; Wirtz, 2015; Martini, 2005). It is also noteworthy that Bolivian immigrants correspond to 1/3 of the total number of immigrants admitted to hospitals in the municipality of São Paulo and that, 75% of Bolivians correspond to pregnancy, childbirth and postpartum (Aguiar; Neves; Lira, 2015).

The lack of opportunity for professional practice in the period of arrival in the country from 2008 onwards, with 75.5% receiving up to 2 or 3 minimum wages, as well as the predominance of work in sewing workshops have been previously pointed out (Silva, R. *et al.*, 2020). Therefore, they are individuals without social or economic resources requiring support of intersectoral policies and programs.

A question worthy of better understanding refers to the uniqueness of the Bolivian migratory circuit in São Paulo. This refers to the length of residence in São Paulo, which shows a period of less than five years among most young immigrants (81.9% in those aged 20 to 29 years and 69.1% in those aged 20 to 39 years). Freitas (2011) calls attention to this particularity, calling it “circulatory territory”, characterized by constant movement of comings and goings Bolivia/Brazil, associated with the seasonality of textile production. This aspect appears in the statements of health professionals as obstacles in the control of diseases. Shikanai-Yasuda *et al.* (2017) analyzed the implications of such periodic returns of this population to Bolivia in the lack of adherence to treatment and medical follow-up for Chagas disease.

In addition to these, other dimensions related to the characteristics of the population group in focus are implied and constitute challenges for health care, that is, when we have 59.2% origin from rural areas (Silva, R. *et al.*, 2020), influencing the perception of the health-disease care process (Martes; Faleiros, 2013).

In the results, we highlight the communication as an obstacle towards care and health services. The non-mastery of the Portuguese language



by Bolivians, as well as of Spanish by professionals, hinders care, a limiting factor in the performance of Public Health Services, demanding, therefore, training of public agents (Aith; Forsyth; Shikanai-Yasuda, 2020; Aguiar; Neves; Lira, 2015; Martes; Faleiros, 2013). In this scenario, other aspects are also added, such as the lack of knowledge of health problems of the Bolivian population, for example Chagas disease (which is endemic in Bolivia), not only by health professionals in Brazil, but also in countries such as the United States (Carneiro Junior *et al.*, 2018; Manner-Goehler; Reich; Wirz, 2015; Manne *et al.*, 2013).

The described information contributes to the debate on the potential and limits of the SUS when it is observed that public health services are expressly referenced by this population. About 40% of Bolivian immigrants reported frequent visits to such services, with the UBS being the most used service (61.2%), mainly by children and women. The reports of health professionals and immigrants themselves ratify these results, mentioning welcoming attitudes in care. Thus, the service fulfills one of its main attributes in the organization of the health system: being preferential access in Brazil (Brasil, 2017) and in other countries (Stafield; Shi, 2015).

Noteworthy, in this context, are technical-managerial arrangement initiatives that promote the guarantee of Bolivian immigrants' access to health actions; that is, flexibility of schedules, insertion of health professionals of Bolivian origin, acceptance of spontaneous demands, communication strategies, among others (Steffens; Martins, 2016; Martes; Faleiros, 2013; Silva, E., 2009). This organization of work processes oriented to the specificities of a certain population group points to the principle of equity in health (Campos, 2006).

On the other hand, these potentialities observed in the SUS are stressed by internal and external conditions of the health sector, as well as by the particularities involved in Bolivian migration, which impose limits and compromise the guarantee of the right to health.

In recent years, the Brazilian state has been adopting non-redistributive social policies, which greatly affect the financing of the SUS, and making changes in its management, thus causing

weaknesses in the integrality of health care (Mendes; Carnut, 2018).

The discussion on contemporary migratory flows in countries with universal social policies is necessary, enabling qualification and strengthening of them, in a scenario of increasing restrictive conceptions of immigrants' access to social services (Fortes; Carvalho; Louvison, 2015).

In this context, it should be highlighted important local initiatives for the formulation and implementation of policies and programs in public administration, particularly in the municipality of São Paulo, aimed at the social inclusion of immigrant populations, such as the creation in 2013 of the Coordination of Policies for Immigrants and Promotion of Decent Work/Municipal Secretariat for Human Rights and Citizenship to promote intersectoral actions, the Municipal Law no. 16,478/2016 that instituted the Municipal Policy for the Immigrant Population, the Municipal Health Policy for Immigrants and Refugees in 2015, among others (Carneiro Junior *et al.*, 2018; Otero; Lotta, 2020).

As part of the approved Municipal Policy, the City Hall of the municipality of São Paulo, implementing the law, organized in 2019 the 2nd Municipal Conference of policies for immigrants, of São Paulo, with expressive participation of immigrant groups. As a result of the conference, the 1st Municipal Policy Plan for Immigrants 2021-2024 was prepared, which was an instrument for planning, implementing, monitoring and evaluating municipal policies for the population of other nationalities living in the city (São Paulo, 2020).

Although the 1988 Constitution expressly recognizes health as a fundamental right in Brazil, including for immigrants, and even with the efforts of municipal bodies to welcome them in the city of São Paulo, the vulnerability of immigrants in Brazil is still present, either due to their lack of knowledge of their rights, or due to possible irregularities in the documents necessary to stay in the country, with consequences including in health care by the SUS (Aith; Forsyth; Shikanai-Yasuda, 2020; Baeninger; Demetrius; Domeniconi, 2019).

Still, it is noteworthy that for immigrants the SUS represents a possibility of social insertion,

a policy of guaranteeing social rights, expressly in opposition to the reality in their country (Martes; Faleiros, 2013). In this sense, the reports of immigrants and authorities that highlight the right to health in Brazil embodied in obtaining the National Health Card stand out.

Indeed, many immigrants use the “SUS card”, provided they present some identification document, even from their country of origin. This card represented one of the main forms of integration with society, being sometimes the only Brazilian document they had. According to an institutional representative, the National Health Card can be an **important mean for the exercise of citizenship for this vulnerable group**. As recorded in the present study and pointed out by Xavier (2010), immigrants use the SUS and expressed perceptions of the same right to health as natural-born or naturalized citizens.

Finally, it is worth noting the lack of therapeutic routes for Chagas disease (Aith; Forsyth; Shikanai-Yasuda, 2020), as well as the need for training for doctors in primary care, implementing strategies such as Chagas disease care manuals, as well as guidance applications, via cell phone, with specificities for Bolivian immigrants (Shikanai-Yasuda et al., 2017). The approval of a protocol of guidelines for diagnosis and therapy for Chagas disease opens the possibility of qualifying the care of this disease in Brazil for infected individuals, mostly asymptomatic, particularly women of childbearing age and young adults (Shikanai-Yasuda et al., 2017).

This study, despite a considerable sample of 633 individuals, has limitations. The sample of Bolivians studied lives in a restricted area of the city of São Paulo, being users of a health service. A greater number of qualitative interviews, including social care services, would also be desirable.

## Final Considerations

The lack of documentation, working conditions and low wages, associated with the difficulty in communication point out as important barriers to access to health, requiring different political and programmatic interventions, such as having

professionals and/or cultural mediators who speak the Spanish language to resolve such difficulties.

The data in this article point out the fundamental role of obtaining the National Health Card, not only as a gateway to health, but as a means of social integration of the immigrant.

The results add knowledge to the existing literature on the subject, discussed throughout the text, especially with regard to the need to organize new forms of care aimed at these specific communities.

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