

Social inequality, access conditions to public health care and processes of care in bolivian immigrants in Buenos Aires and São Paulo: a comparative inquiry¹

Desigualdad social, condiciones de acceso a la salud pública y procesos de atención en inmigrantes bolivianos de Buenos Aires y São Paulo: una indagación comparativa

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Resumen

Este trabajo es fruto de una incipiente relación de colaboración, intercambio y producción conjunta comenzada en forma reciente entre las instituciones y equipos de docencia e investigación de pertenencia en nuestros países. Parte de las respectivas investigaciones y tareas de intervención que venimos realizando desde hace un tiempo en torno al fenómeno de la inmigración boliviana, tanto en Buenos Aires como en São Paulo, y los procesos de inserción sociolaboral de estos inmigrantes en relación a su situación de salud, focalizando en los procesos de atención que desarrollan frente a los padecimientos que sufren en el contexto sociosanitario de destino. Se presenta una indagación en clave comparativa que busca establecer una primera aproximación al análisis sobre las semejanzas y diferencias entre ambos casos de estudio, como aporte a la necesidad de un abordaje del problema de investigación en toda su complejidad, desde una perspectiva sociocultural y a nivel de la salud pública regional.

Palabras clave: Buenos Aires; São Paulo; Inmigrantes bolivianos; Modos de vida; Vulnerabilidad social; Desigualdades en salud.

Resumo

Este trabalho é o resultado de um intercâmbio, parceria e articulação iniciado recentemente entre as instituições de ensino e equipes de pesquisa de nossos países. Nossas reflexões pautaram-se nas investigações e nas tarefas de intervenção sobre o fenômeno da imigração boliviana observados há algum tempo em Buenos Aires e em São Paulo. Os processos de trabalho e de integração social dos imigrantes foram relacionados ao seu estado de saúde, enfocando os processos de cuidado que se desenvolvem contra as condições que enfrentam nesses contextos sociais. Apresentamos um quadro comparativo com o intuito de estabelecer uma primeira abordagem para a análise das semelhanças e diferenças entre os dois estudos de caso, procurando cercar o problema em boa parte de sua complexidade e circunscrevendo-o dentro de uma perspectiva sociocultural no contexto da saúde pública regional. **Palavras-chave:** Buenos Aires; São Paulo; Imigrantes bolivianos; Estilos de vida; Vulnerabilidade social; Desigualdades de saúde.

Abstract

This work is the result of an emerging partnership, exchange and joint production recently started between institutions, teachings and research teams from Brazil and Argentina. It is part of the respective investigations and intervention tasks that we have been doing for some time around the phenomenon of Bolivian immigration both in Buenos Aires and São Paulo, and the processes of labor integration of these immigrants in relation to their health status, focusing on the care processes that develop against the conditions they suffer in the social context. An inquiry is presented in comparative key aiming to analyze the similarities and differences between the two case studies, as a contribution to the research problem in all its complexity, from a sociocultural perspective, and at the level of regional public health. **Keywords:** Buenos Aires; São Paulo; Bolivian immigrants; lifestyles; social vulnerability; health inequalities.

Introduction

It is proposed in the next lines, a perspective at a regional scale, that will help us investigate, in comparative key, the complexity of the urban context of Ciudad Autónoma de Buenos Aires (CABA) and São Paulo city, in which segmented sectors coexist in terms of social class, rights, market access, to the public health services, as well as the relation to the life conditions, of work and dwelling. Both study cases, particularly addresses a sociocultural group especially vulnerable and damaged, Bolivian immigrants, most of them work and live, in some cases with their families - in clandestine textile workshops located in these two cities.

The migratory process developed by the Bolivians in the CABA and in São Paulo, has from its beginning been marked by obstacles, difficulties, conflicts, stigma and discriminatory social constructions coming from different sectors of the local societies. This is because, among other factors, to the labor-housing introduction and the social integration from immigrants to the sociopolitical territory in each city, it was produced in the framework of contexts under less favorable conditions than those previously existing for the immigrant groups (CABA Europeans, Europeans and Asians in São Paulo) of the late nineteenth and early twentieth centuries.

Based on the above, we inquire into a particular area within the underground sector of the economy of the two cities, characterized by its precariousness: the clandestine textile or sewing workshops (illegal, unreported, in black). These productive units are used by a part of the local entrepreneurs to avoid control, to reduce costs, and to maximize earnings, externalizing the production like this. Most of the workshops are run by Bolivians, ex workers in conditions of semi-slavery that at some point could regularize their immigration status. As it can be seen, in both cases the studies reproduced an exploitative situation in the sector, including as part of this process mechanisms of traffic of people for recruitment and reduced to servitude. Often,

workshops work in small enclosures, being in many cases also the home of the worker and his family. Workers are subjected to long hours of work that reach 16 hours a day (that is twice of the established 8), six days of the week, with a remuneration which most of the times does not reach the minimum wage in each country.

Taking into consideration the analysis of health inequalities, we focus on the dimensions of health/disease/care of these immigrants in the health context of each city, with emphasis on the principal diseases suffered in each case, associated with their lifestyles/jobs/housing, and in the care processes developed according to the particular conditions of access to public health that exist in the CABA and São Paulo.

Finally, a brief analysis of similarities and differences is published between the two case studies, with the purpose of opening future lines of inquiry about the addressed problem.

Anthropological approach to the dimensions of the Bolivian immigration and to the health in the Ciudad Autónoma de Buenos Aires (CABA)

The Medical Anthropology in Argentina starts to get interested in the field of international migration and health just in the last six years. However there is a variety of public health problems linked to the increased presence, mostly from the decade of 1990 until now², of immigrants coming from the close countries. The works originated in other disciplines of social science about the theme, have based their analysis in the border zones and in the migration to them. Specifically in relation to the care processes of the immigrant people in the country, the studies were generally focused in the access barriers to the public health service of these “damaged populations” (Garbus et al., 2009; Comes et al., 2007) and

² Since 1990, attracted by the peso-dollar exchange rate of that decade and inserting mostly in precarious jobs in the field of the economy dipped, we see a gradual increase of Bolivian immigrants in Argentina, although in 2010 represented only the 19.1 % of foreign residents in the country (second only to the Paraguayans). Moreover, according to the Migrant Population Survey Argentina (2008-2009), 53.8% of those born in Bolivia resided in the CABA, reaching by 2010 the number of 76,609 people: INDEC, 2010.

the present obstacles in the intercultural communication between the health professionals and the immigrant users (Jelin, 2007).

One of the limits of this perspective is the lack of analysis over the socioeconomically, political and ideological aspects of the processes of health/disease/care (Menéndez, 2002) as determinants in the access of the subjects to the sanitary services, and as constitutive elements of the fundamentally intercultural concept (Ramírez Hita, 2009). Frequently it is about the focuses that talk about cultural differences without going deeper in the social inequities, and the way these are translated in health inequalities of the subordinates' social groups. At the same time, the context of medical care pluralism is not recognized (Goldeberg, 2010a; 2012).

From the different ethnographic investigations realized from 2006 until now, we started to get closer to the knowledge of the processes of health/disease/care in a specific sociocultural group: Bolivian immigrants in the metropolitan Area of Buenos Aires, speaking about the different diseases they suffer, related with their type of visa/of work, describing and analyzing the principal duties, conceptions, and practices they have around the health/disease/attention. We have researched the therapeutic itineraries of the different suffered diseases in the sanitary context of society.

As part of the empirical results and towards the deepness of the work in the field, we realized how common tuberculosis is in Bolivian immigrants of both sexes, that work and love in underground clandestine textile workshops in the CABA. Because of that, we investigated the risk situations, linked to the emergency of tuberculosis in this group, its infection and transmission, speaking about the therapeutically itineraries of people to diagnose and treat the disease, in the working area, the domestic

unity, and the public health services³. Because of the conditions of semi slavery in which they work and live, including the lack of documents caused by their irregular migration administrative situation, the prohibition of being locked out, and enclosure threat, their sanitary attention right is relatively limited and in many cases is directly infringed (like the rest of their rights). This is enhanced by the migratory paths that often occur in the context of criminal mechanisms, like the traffic of people and the reduction to servitude (Goldberg, 2010a).

At the territorial level, Bolivian immigrants live mainly in the southwestern part of the city, distributed in the poorest neighborhoods, abandoned, suffering the current consequences of disinvestment in public social policies (education, health, housing, services, environment, and job security) from the neoliberal government of CABA. Government constantly recycles, as during the 1990s, the idea of "invasion" of foreigners, supported in the scapegoat theory and on the base of creating fear of "insecurity". With the support of monopoly media, it has tried to build and install on public opinion the figure of the "illegal" immigrant, poor criminal to justify the repression, strengthen the social control and ensure a certain "social hygiene" in the city, so that it does not "deviate" from its tone "European white"⁴.

The access to the public health services, education, justice, promotion and social action that the city of Buenos Aires gives, is an unrestricted character. Any limitation on the exercise may be brought on grounds of origin, nationality, race, language, religion, immigration status or social (Margulies et al., 2003).

This includes the obligation of the State to ensure for free individual and collective actions of promotion, protection, prevention, care and rehabili-

3 We have concentrated the field inquiries in the field of public health, mainly in the Institute-Hospital Vaccarezza F. Muñoz (IVHM) of the CABA, because it is the center which derives the largest part of people diagnosed with tuberculosis of the metropolitan area of the Buenos Aires and in which I could build a sustained link with the personal of health. Also in hospitals and primary care centers neighborhoods in the southwest of the city.

4 In contrast, the reality is that far from registering an "invasion" of immigrants from neighboring countries, the increasing visibility of these groups responds to sociocultural conflicts (including speeches and discriminatory practices, racism and xenophobia against these groups) than reasons that were strictly quantitative. So while weaving a speech to make the society to build and eat a negative and distorted perception of the phenomenon as a "social problem", whereas the reality is that people from neighboring countries and Peru represent only 3% of the total population of our country, who hold nothing more than 5% of registered jobs in the labor market and constitute only 12% of the users of public services (health, education, etc.).

tation with accessibility criteria, fairness, integrity, solidarity, universality and opportunity. However, both access and use of public health services have inherent difficulties in an oversized system with input shortages, insufficient human resources, long delays, etc., all of which negatively impacts the users (Goldberg, 2009).

In case of the Bolivian users, the above may be exacerbated by the triple process of stigmatization to which they are subject by a part of the society of Argentina, for their phenotypic traits (“Indians”); by their subordinate class status in the social structure of destiny (“poor”); and the derogatory meaning attributed to “be Bolivian” with social and cultural connotations implied (“bolitas”). Additionally, a fourth source of stereotype appears as result of the combination of the above, feasible to identify in some areas of public and private health including the medical personnel of the same: to “tuberculosis Bolivian patient”; linked, at the same time with the work in the clandestine textile workshops (Goldberg, 2010a).

Tuberculosis as an indicator of how social inequalities are translated into health inequalities

Tuberculosis is still one of the infectious diseases “of poverty” that causes more deaths in the world: Nowadays, it is the second cause of death among them. According to the latest data provided by the World Health Organization (WHO, 2012), about 2,000 million people are infected with tuberculosis bacillus, representing one third of the world population. Each year, 8 million people get sick with tuberculosis and 2 million die from it, mainly in the until recently called “developing countries” (Goldberg, 2012). However, the situation of the disease in the world is a reflection, not only of the enormous political, economic, social and epidemiological differences persisting globally between the

“central” and the “peripheral” countries; but also of the inequalities that can be identified at a national, regional or local level.

According to the official data of the TBC notified cases in Argentina, CABA and the metropolitan area of Buenos Aires had together, in 2011, more than half of the total cases of the country. In the same way, if CABA is considered as an analysis unity, it appears that Southwest neighborhoods have the highest rates of this disease⁵ (Ministerio de Salud de la Nación, 2011).

Returning to the contributions of various authors, it is possible to analyze how processes of social inequality and the various forms of violence result in health inequalities. In this regard and following Fassin (1996), tuberculosis can be considered the “emblematic disease” that incorporates the existing social and cultural inequality (Goldberg, 2012). In the same way, the concept of Structural Violence (Farmer, 2004) allows to explore the ways in which structural violence penetrates coercively the life of these individuals causing them a particular social suffering (Das et al., 2001; Quaranta, 2006); including, as part of this, the semi-slavery conditions to which they are subject in the workshops, the access limitations to the health system to treat ailments, aches and pains - like tuberculosis, and the impact on their bodies (Csordas, 2001).

The specific context of vulnerability of the clandestine textile workshops in which this sector of Bolivian immigrants of CABA is inserted, after experiencing a migratory process described as “forced”, also, in many cases, by the need to work to pay suffocating debts in their origin, is marked by multiple health risks: from the distress experienced by violence and abuse, passing through the low air flow, confinement and lack of sunlight, dust and moisture in walls, floors and ceilings; to the fact that the work is performed in cramped conditions in unventilated rooms full of scraps of fabric, thread, dust and lint in the environment produced by the machines (that they breath, even when sleeping); that the number

5 In 2011 there were diagnosed in CABA a total of 2,499 new cases of tuberculosis. Of these, 268 patients were treated at the Pinero Hospital, located in the southwest of the city, whose programs in that year recorded 198 cases per 100,000, well above the rate of CABA and outperforming the Argentinean (Network to Care Tuberculosis of CABA). This information is too important, having in mind that within this program area are located many of the clandestine textile workshops of where they work and live CABA Bolivian immigrants and their families.

of hours worked per day is between 14 and 18 with intense rhythms and without interruption; that food is scarce and poor, etc. All these elements, together, can generate a decline in the immune system of these people, making them more vulnerable to infection, contagion and the development of tuberculosis.

While most of the cases reported through 2011 in the CABA remained corresponding with a “native” (Argentinean), the cases corresponding to Bolivian immigrants show a growth, mainly from 2004 onwards. However, rather than associate tuberculosis with Bolivian immigration in terms of disease “imported”, “cultural”, etc. the phenomenon is linked to lifestyles/life/work suffering and experiences by these immigrants in the city.

But some health professionals of public hospitals of the CABA alludes indirectly that Bolivians bring the disease from their country and risk of infecting “native” population. In this regard, studies from molecular biology specialists have shown no scientific evidence of foreign Andean strains transmission to native Argentine patients (“native”) through ill immigrants arriving in Buenos Aires; but in reverse: the strain M, dominant in the metropolitan area of Buenos Aires began spreading among many of the Bolivian immigrants who contracted the disease in the clandestine textile workshops⁶ (Goldberg, 2010b).

With regard to healthcare of tuberculosis, one of the factors hindering the diagnosis, treatment and monitoring of this disease in Bolivian patients is the constant movement that characterizes their migratory processes and ways of life in Argentina. As part of the exposed situations of extreme vulnerability, there is an abandonment of the treatment, mainly because of economic difficulties to take the medicine and make the corresponding controls. In addition it is impossible for them to access existing subsidies because of the lack of documentation caused by their irregular immigration status.

Finally, through the monitoring of the therapeutic itineraries for tuberculosis by the subjects, we could detect that in those discharged from the hospital, after being there for 1 to 6 months, some go back to their country of origin, others return

to the clandestine textile workshops and some are inserted into the textile worker cooperatives with decent working conditions, as part of an awareness process and disruption from the “social suffering” experienced in the workshops. In this case, a determining factor constitutes the condition of a health problem (personal or of their children) and hindrance by the owner of the workshop (the workshop leader) so they go to a medical consultation. The women are the ones that rebel most against the workshop leader, particularly when there are aggressions or abuses to their children.

Briefly, the case study expresses clearly the way in which, in some contexts, the social inequalities are translated into health inequalities, not by the indicators, but by the relation with the access to the public sanitary services, the diagnosis and the treatment of infectious diseases as tuberculosis. Based on the above, it is possible to say that the vulnerability to tuberculosis that Bolivian immigrants of both sexes that work and live in clandestine textile workshops of CABA have, lies mainly in their subaltern class, almost slaves in the Argentinean society, and it is not due to a supposed genetic predisposition, or to their geographic origin or their ethnic identity.

The end of labor exploitation situations and poor housing will reduce the risks of infection, transmission and development of tuberculosis in the study subjects. The successful treatment depends mainly in the fulfillment of the laws that are violated during the entire process (trafficking, smuggling and servitude). In other words, the disappearance of these working and living units, and their transformation into decent legal sewing workshops, with regular security and medical inspections, with all of their worker’s rights guaranteed (including universal access, and a public health care) is essential.

Talking strictly about public health, the coordination and the dynamic link between the welfare levels of the health system constitute central elements, from a preventive perspective, to achieve successful results in fighting tuberculosis. The delay in the diagnosis and in the beginning of the disease treatment impacts both the subject/patient (increase the risk

6 Data from interviews with the doctors, Ambroggi (Tisiología Institute “Prof. Dr. Raul Vaccarezza” UBA-Muñiz Hospital) and Ritacco (National Administration of Laboratories and Health Institutes “Dr. Carlos G. Malbrán”- CONICET).

of mortality and morbidity) as the work and family group (increase the risk of a tuberculosis infection). Modify the conditions associated with this delay and ensure effective treatment; updating and adding complexity to the knowledge and information of health personnel over the most vulnerable society groups to the infection and the disease development, are essential goals. In these actions and tasks, it is really important to strengthen the interdisciplinary health team of the different level attention centers, reducing the internal hierarchies through the revaluation of daily and strategic work of nurses, psychologists, social workers, and doctors.

Bolivians in the city of São Paulo: uncertain inclusion of the invisible?

Although South American immigrants in the city of São Paulo, particularly the Bolivian immigrants, have reached a certain visibility in the media, and in the academic production in South America, the political movement is still slow. Thus the viability of the inclusion processes that will allow to attend the demands and to start solutions that solve the health necessities of these social segments, generally exposed to the most variable situations of vulnerability, is far away.

Such a statement, as exposed, could be considered as one of the many naive complaints that require immediate policies regarding the complex processes that involve dynamic political-administrative conditions, expressed in the formation of conflict camps at the moment of creating and implanting policies

of social inclusion. On the contrary, the reflection on the inclusion processes should always contain the whole conception that orients the success of health policies, making possible specific care practices in the general population, particularly to the Bolivian immigrants. Their frailties, originated in their bad life conditions, can be exemplified in the illegal situation, immersion in intense work routines and precarious and unhealthy housing, that, for many of them, represent also their working places in the manufacturing of clothing, among other inequalities (Silva, 2006).

These are partial results from a set of activities of research and debates, developed on the health conditions of the immigrant groups in downtown São Paulo. There were successive approximations to a social reality that hides, in its underground, accentuated social needs by the poor living and health conditions of the Bolivian immigrants. Oriented by the objective of knowing the inequalities and vulnerabilities to which they are subject, our projects⁷ have allowed to verify the slow incorporation of these groups to the public health system.

Additionally, our contacts with the primary health care network from downtown have allowed observation processes, carried out on a casual way by occasional visits, and relationships with people and organizations involved in assisting immigrants⁸. This approach brought us closer to workers performing interventions with immigrants; we could check new experiences in health care with them. From that learning, we acquired a deeper knowledge about the social processes and illness that are related to the lifestyle of the immigrants. The mentioned workers' team, formed by professionals of assistance organi-

7 Among the works that have been developed in the Department of Social Medicine, Faculty of Medical Sciences of Santa Casa de São Paulo, can be highlighted two: (1) urban social inclusion project: We from the Center: research methodology and inclusion action of vulnerable social groups in the center of the city of São Paulo, funded by the European Union (Office of São Paulo) and coordinated by the researchers Cássio Silveira, Regina M. G. Marsiglia and Nivaldo Carneiro Junior (Silveira et al., 2009) and (2) Social inequalities in health status and access to services for groups with different degrees of vulnerability and social exclusion to live in the center of São Paulo, funded by Conselho Nacional de Pesquisa (CNPq, Brazil), report in the year 2009, under the coordination of the researchers Rita de Cássia Barradas Barata and Manoel Carlos de Almeida Sampaio Ribeiro.

8 Our experience in research and teaching in the central area of the city has accumulated knowledge about immigrants, among other segments of society, in particular the provision of services in the School Health Centre Barra Funda "Professor Alexandre Vranjac" Basic Unit Health associated with the Faculty of Medical Sciences of Santa Casa de São Paulo. Recently we formed a research group, interdisciplinary and inter-institutional health of migratory processes in the city of São Paulo, composed by representatives of the following organizations: Faculty of Medical Sciences of Santa Casa de São Paulo (FCMSCSP), Federal University of São Paulo (Unifesp), Museo Emilio Ribas (Instituto Butantan, SES-SP), Municipal Commission for Human Rights (Special Secretariat for Human Rights, PMSP), Health Institute (SES-SP) and Centre for Studies Augusto Leopoldo Ayrosa Galvão (Cealag - FCMSCSP).

zations, was enriched with the contact experience with the Community Health Agents⁹ from the Bolivian immigrant groups.

Our observation focus is downtown São Paulo, *locus* privileged with attraction and permanence of this group. The social composition of the area was heterogeneous with popular groups, differentiated by their specific foreign origin, and also by their ethnicity. In this context, the social inclusion of the Bolivian immigrants has revealed two interesting aspects: first, that their modes of being conceiving and occupying public and private spaces are their distinctive marks; and, second the inclusion processes are the ones that have captured part of their demands, even if it is still needed to walk a long path to overcome the inequalities they are subject to (Silveira et al., 2009; Barata et al., 2010).

Some of the aspects about the Bolivian immigrants' health in São Paulo

Motivated by the strong attraction of an economy in expansion, the Bolivians began with the process of migration to Brazil in mid-twentieth century. The majority was concentrated in the states of Mato Grosso do Sul and in the metropolitan areas of Rio de Janeiro and São Paulo. The estimates of Bolivian migration and permanence in Brazil are not accurate, they vary a lot depending on the source: the Pastorate of the Migrants (Catholic Church) estimates that there are approximately 60,000 Bolivians; the Demographic Census of IBGE, in 2000 indicated the presence of 20,288, while the Federal Policy counted 32,416 immigrants from that country (Silva 2008).

More recently, the number of Bolivian immigrants living in Brazil was estimated between 80

and 200,000, with almost 40% concentrated in the city of São Paulo. Another demographic characteristic of this group is the number of young adults, around 20 years old, which contrasts with the growing and increasingly obvious parallel phenomenon of aging of the local population (Souchaud, 2010). In São Paulo, recent data from the IBGE¹⁰ indicated the amount of 21,679 Bolivians living there, 17% of them are naturalized Brazilian (IBGE, 2010).

The mentioned numbers do not allow us to say with exactitude how many Bolivian immigrants live in São Paulo. However, it does allow us to verify their considerable presence among the whole population¹¹, and to address the phenomenon of immigration and its impact on the health of this group. In this regard, the appalling living and health conditions of immigrants in the city, in the perspective of a public health problem are within a broader social context of the international migratory processes in a global level (Sassen, 1998; Rizek et al., 2010). In this framework, it is important to mention that textile sector took great proportions in absorbing Bolivians workers, in recent decades, in workshops in São Paulo. It is a model that constitutes a specific territoriality, different from other international migratory attraction poles, similar to the case of the city of Buenos Aires, Argentina (Cymbalista and Xavier, 2007; Rizek et al., 2010). Such a model imposes on migrant workers and their families a confinement situation in sewing workshops within a dynamic sector of the textile production (Silva, 2006; Tambellini et al., 2009).

In the field of health, the expression of that context is manifested in an expansion set of pathologies intimately associated to the living and working conditions of the Bolivians. In the district of Brás, for example, the primary health care service

9 The Program Community Health Workers are an integral part of the Family Health Strategy in the context of primary health care. This are organized into teams of multidisciplinary composition, including at least a family doctor and a community public health nurse, a nursing assistant and four to six communities agents of health care. The work was developed from micro-territories defined as areas with the registration and monitoring of a number of families for each team (between six hundred and a thousand families), with a maximum of 4,500 people registered. Each community agent of health care accompanies a maximum of 150 families or 450 people (CONASS, 2011).

10 Official data from the IBGE (2010) organized and kindly provided by Prof. Dr. Manoel Carlos de A. S. Ribeiro and systems analyst Rodrigo Calado, members of the Centre for Studies Augusto Leopoldo Ayrosa Galvão (Cealag), based in the Department of Social Medicine, Faculty of Medical Sciences of Santa Casa de São Paulo (FCMSCSP).

11 In 2010, the city of São Paulo had 11,244,369 inhabitants. The districts we work are: Santa Cecília, Bela Vista, Liberdade, Barra Funda, Bom Retiro, Cambuci, Consolação Republic and Sé. These represent an expanded center of the city (Source: IBGE, 2010; Seade, 2010).

presented alarming data regarding the tuberculosis: the incidence is higher among these immigrants, which reached 58% of the total patients in treatment. On the other side, the cure rate reached 94% of the treated cases, exceeding the target set by the Ministry of Health which is 80% (REDETB, 2005).

A recent study in the districts of Belém, Bom Retiro, Brás and Pari gave relevance to the Bolivian community regarding the increased incidence of tuberculosis in the urban area. The study found an increase in the number of cases of the disease: while among Brazilians the pathology decreased 45%, among the Bolivians it increased 250% in the last 10 years. The healing rate in this group, however, is 70%, higher than among the Brazilians, that is 62.1%. The access to health services and the continuity of the treatment based on medicines were the reasons pointed for the efficacy of the treatment (Martínez, 2010).

A closer look about the specific ways of life, work, and health of Bolivians in São Paulo shows also particularities in relation to women. The phenomenon of physical and psychological violence, suffered at home, largely affects women, victims of the actions of their peers or from other men. Added to the situation of violence, there are long and intense working days in textile mills, as well as care and maintenance of the domestic space. They also suffer the consequences of their pregnancy: while pregnant, they have to overcome a huge workload and great efforts in subsequent attempts to overcome inequality (Madi et al., 2009; Carneiro Junior et al., 2011).

In a complementary way, we obtained valuable data in the different incursions in the health service. In particular, at the primary health care network organized by the Basic Health Units from the Family Health Strategy, we observed that much of the mediation part with the health services was made by Bolivian women. Mainly in the textile workshops, that also make part of their domestic spaces, these women are responsible for the following tasks with the representative of the health service: to organize

the agenda for query and analysis, to check the health status of people who live and work in the workshops, and to communicate the events and the evolution of the people in treatment. Among other chores and labor, Bolivian women extended their workload, with damaging consequences to their health.

Immigrants and the provision of health services

The Unified Health System in Brazil, since the 1988 Constitution, in its Article 196, guarantees universal and equal access to actions and services for the promotion, protection and recovery of health of the people. This legal framework allowed the development of experiences in the inclusion of immigrants to the system in the last three decades, making feasible the access to services through the creation of new assistance strategies and creating opportunities to maintain health care in this segment of immigrants (Brasil, 2006).

Guided by a conception of human rights based on tolerance and in hospitality, the Unified Health System inaugurated a new phase, wider and graspable, in the fulfillment of these rights. In practice, the immigrant has access to health services without the requirement to present an identification document of permanence in the country. It was a large step, because it allowed the beginning and the expansion of innovative strategies in the incorporation of immigrant groups to the primary health care level and to the assistance actions in the secondary and tertiary levels of health care (Tambellini et al., 2009)¹².

As result, there was an increase in the number of registered immigrants and in the adequacy of a more effective health care system, as it includes Community Health Agents among Bolivian immigrants. The role of them is to act as mediators in the relationship service-user-immigrant, seeking to overcome common difficulties that normal services have. The transposition of language and cultural barriers, and

¹² As we discussed in the previous work, the demand from immigrant group's health services occurs in extreme cases often blocked by barriers imposed by the services themselves. As examples, we can mention the barrier language or the fact of rejecting services to undocumented immigrants, situations that even today can be identified routinely in much of health services (Carneiro Junior and Silveira, 2003; Carneiro Junior et al., 2006; Silveira et al., 2009; Carneiro Junior et al., 2011).

even more, the possibility of direct access to primary health care services, allowed the incorporation of the invisible people to a health system that advocates the principle of universality as essential provision for the formation and constitution of the system (Carneiro Junior and Silveira, 2003; Carneiro Junior et al., 2006; Carneiro Junior et al., 2011; BOLÍVIA CULTURAL NOTÍCIAS, 2012)¹³.

All these developments follow the path towards equity. Nevertheless, there is still a big path to go, so that the inclusion can really recognize the immigrants' illness processes and inequalities in the existing conditions marked by invisibility. In this sense, concretely in the field of hospital care, we have collected stories of professionals who highlighted the problem of language barriers in the access of immigrants to the service. We believe that this problem is not only a linguistic misunderstanding echoed with consequent lack of communication between the parties. In our view conflicts are caused by the polarization between cultural traditions often expressing conceptions and ways of practicing health care very different from the prevailing scientific-technical concepts in the structure of health services.

The difficult equation on the inclusion of immigrants in the city of São Paulo

Just as previously said, even recognizing the progress made in health coverage primary attention for immigrants in São Paulo and that these actions generate positive changes in their health status; it should be noted that they do not meet all of their needs and demands. In this regard, similarly to what happens with the Brazilian population using exclusively public health services, immigrants also suffer the setbacks of a system still in training and with a strong tendency to segment its performances (Marsiglia et al.,

2005). Additionally, due to their specific conditions as immigrants, inequalities are increased.

In summary, what is detected is a slow inclusion process of these groups in the right to social policies (at least, related to health). From the moment they are recognized as immigrants, that the negative consequences of migration on people's health are detected, and that there is a responsibility of the state in relation to the health conditions of this segment of the population, the solution might be under way.

The actions should focus, on one hand, in the multiplicity of cultural and political factors involved in the migration process of these people to São Paulo, that cause them specific health problems, and, on the other side, in the effective capacity of directed intervention to achieve a health benefit, parallel to a denunciation of the extremely precarious living conditions of families and groups of people who suffer the consequences of structural violence organized on the basis of exploitation of labor.

A health aggravating factor affects groups of people whose possibility to remain in anonymity is perpetuated through the formation of relational fields more endogenous and marked by the isolation from their sociocultural contexts. This isolation, along with the restrictions determined by the lack of participative potential and the incapacity of demanding their rights in the country they live, contributes to establish a partial inclusion and a strong tendency to build public actions that transform positive discrimination policies in negative discrimination policies. That is, policies that mark individuals and groups with features that are not chosen for their carriers. According to Castel (2008) when leaning towards a differential treatment, the policies can move away from an equalitarian treatment and walk toward a negative discrimination.

In São Paulo a policy of positive discrimination of Bolivians included a considerable amount of immigrants in the primary health care. However, a supervision is suggested to avoid the risk of the

¹³ This was reflected in the large contingent of Bolivian immigrants recorded in the primary health care services in the downtown of São Paulo. Information from the second half of 2011 show that about 6,500 Bolivians recorded only two Basic Units of Health: School Health Center Barra Funda "Dr. Alexandre Vranjac and Bom Retiro (Bolivia Cultural News, 2011).

development of discriminatory procedures, that intervene in the public services in general, and prejudiced and racist acts.

The challenge to transform the reality described requires changes in several instances of social life, beginning with the critic to the segregation procedure, that does not recognize the groups that occupy urban areas in connection with the logic of a promoter market of their exploitation and permanence in shaded social spaces (Zaluar, 1997). We refer to the fact that, in many cases, the immigrant is not recognized in his deepest needs and his effective incorporation as a person and a citizen of the host society. In this context, the health conditions eventually are one of the most sensitive expressions in the life of Bolivian immigrants.

Final considerations: similarities and differences of the Ciudad Autónoma de Buenos Aires case with São Paulo case

a) The Bolivians form the largest group of recent immigrants in São Paulo, presenting at least three characteristics similar to the general situation of the Bolivian immigrants of CABA: their underground status (administrative and immigration irregularity); inserting them on the low scope of the economy. They get unsafe jobs, that in some cases are close to conditions of slavery. These conditions are shown in the life/lifestyle/work of clandestine textile workshops.

b) As in Argentina¹⁴, the Brazilian Federal Constitution of 1988 guarantees the right to health to all citizens and declares health provision a state duty. In this context, the immigrants, regardless of their administrative and immigration conditions, would have secured the right to entry and free access to public health care. However, many undocumented immigrants face lots of difficulties and obstacles

when trying to made use of this right in public hospitals in the CABA. In São Paulo, the efforts to achieve the recognition of the immigrant populations and their specificities, resulted in a reorganization of the primary health care through the Family Health Strategy and from the Program Community Health Workers. Through this, a significant expansion of the coverage to Bolivian immigrants was achieved, due to the guaranteed entry to the health system, although there are still many illegal immigrants who have no access to health care.

c) In the CABA there is a certain distrust from the Bolivian immigrants without documents, when they visit public hospitals to be cared for their health problems. The feeling of distrust is due to their irregular status. At the same time, the same situation happens with the natives, because the public system now is based on prepaid health care. In São Paulo the primary health care is the entry to other levels of the health system, even though the irregular status of the immigrants hinders the entry to other levels, the ones that are already registered go to other levels of health assistance and the same situation happens with the Brazilians and the immigrants with documents. However, there isnt yet a defined policy and a health service structure that allows to include all the immigrant sector.

d) The main diseases and discomforts associated with lifestyles and ways of work in sewing factories of Bolivian immigrants in São Paulo are equivalent to those described in the CABA clandestine textile workshops: tuberculosis, allergies, postural and articulation problems, alcoholism in men, domestic violence, mental and physical developmental delay of small children, psychological problems of sociability, mood in workers and poor/inadequate nutrition.

e) In both cases, there are usually women who break from the world of the workshops as result of abuse, violence, health problems or awareness of social suffering experienced, personally or by their children.

¹⁴ The National Immigration Law No. 25,871, which came into force in Argentina on July 6, 2010, is a breakthrough in human rights. This law does not conceive of immigrants solely in economic terms (just as labor) but as subjects of law, replacing Law No. 22439, in effect from 1981-versed in the precepts of the “National Security Doctrine” of the military dictatorship, which conceived the phenomenon of migration from a police perspective, restrictive control and surveillance of migrant groups as dangerous potential flashpoints.

References

- BARATA, R. B. et al. Social vulnerability and health status: a household survey in the central area of a Brazilian metropolis. *Cadernos de Saúde Pública*, Rio de Janeiro, v. 27, p. s164-s175, 2011. Suplemento 2. Available from: <http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2011001400005&lng=en&nrm=iso>. Acesso día: 10 Dic. de 2012.
- BOLÍVIA CULTURAL NOTÍCIAS. *UBS Bom Retiro e comunidade boliviana trabalhando pela saúde*. São Paulo, 1 ago. 2011. Disponível em: <http://www.boliviacultural.com.br/ver_noticias.php?id=586>. Acesso em: 07 nov. 2012.
- BRASIL. Ministério Da Saúde. *Carta dos direitos dos usuários da saúde*. Brasília, DF, 2006. Disponível em: <http://portal.saude.gov.br/portal/arquivos/pdf/cartilha_integra_direitos_2006.pdf>. Acesso em: 07 nov. 2012.
- CARNEIRO JUNIOR, N.; SILVEIRA, C. Organização das práticas de atenção primária em saúde no contexto dos processos de exclusão/inclusão social. *Cadernos de Saúde Pública*, Rio de Janeiro, v. 19, n. 6, p. 1827-1835, nov./dez., 2003.
- CARNEIRO JUNIOR, N. et al. Organização de práticas de saúde equânimes em atenção primária em região metropolitana no contexto dos processos de inclusão e exclusão social. *Saúde e Sociedade*, São Paulo, v. 15, n. 3, p. 30-39, set./dez., 2006.
- CARNEIRO JUNIOR, N. et al. Migração, exclusão social e serviços de saúde: o caso da população boliviana no centro da cidade de São Paulo. *Boletim do Instituto de Saúde*, São Paulo, v. 13, n. 3, out. 2011.
- CASTEL, R. *A discriminação negativa: cidadãos ou autóctones*. Petrópolis: Editora Vozes, 2008.
- COMES, Y. et al. El concepto de accesibilidad: la perspectiva relacional entre población y servicios. *Anuario de Investigaciones de la Secretaría de Investigaciones de la Facultad de Psicología-UBA*, Buenos Aires, n. 14, p. 201-210, enero-diciembre, 2007.
- CSORDAS, T. *Embodiment and Experience*. Cambridge: Cambridge University Press, 1994.
- DAS, V. et al. (Ed.). *Remaking the world: violence, social suffering and recovery*. Berkeley: University of California Press, 1994.
- CYMBALISTA, R.; XAVIER, I. R. A comunidade boliviana em São Paulo: definindo padrões de territorialidade. *Cadernos Metrópole*, São Paulo, v. 17, p. 119-133, 2007.
- FARMER, P. An Anthropology of structural violence. *Current Anthropology*, Chicago, n. 45, p. 305-325, 2004.
- FASSIN, D. *L'espace politique de la santé*. Essai de généalogie. Paris: Presses Universitaires de France, 1996.
- GARBUS, P. et al. *Aspectos éticos en investigaciones no clínicas en el campo de la salud*. Algunas consideraciones acerca del consentimiento informado en personas declaradas incapaces. *Anuario de Investigaciones de la Secretaría de Investigaciones de la Facultad de Psicología-UBA*, Buenos Aires, n. 16, p. 329-338, enero/diciembre, 2009.
- GOLDBERG, A. Salud e interculturalidad: aportes de la antropología médica para un abordaje sociosanitario de la población boliviana de la Ciudad Autónoma de Buenos Aires. En: *VVAA. Buenos Aires Boliviana*. Buenos Aires: Comisión para la Preservación del Patrimonio Histórico Cultural de la Ciudad de Bs. As., Ministerio de Cultura, GCABA, 2009. p. 233-246. (Colección Temas de Patrimonio Cultural, v. 24).
- GOLDBERG, A. Tuberculosis en inmigrantes bolivianos del Área Metropolitana de Buenos Aires: narrativas y procesos asistenciales. En: MARTÍNEZ HERNÁEZ, A.; DI GIACOMO, S. (Comp.). *De la evidencia a la narrativa en la atención sanitaria: biopoder y relatos de aflicción*. Tarragona: Publicaciones Universidad Rovira y Virgili, Colección de Antropología Médica, 2010a. En prensa.

- GOLDBERG, A. Análisis de la relevancia de los factores socioculturales en el proceso asistencial de pacientes con tuberculosis, usuarios del Instituto Vaccarezza-Hospital Muñiz. Un abordaje etnográfico desde la Antropología Médica. *Revista Argentina de Salud Pública*, Buenos Aires, v. 1, n. 5, p. 13-21, dic. 2010b.
- GOLDBERG, A. Contextos de vulnerabilidad social y situaciones de riesgo para la salud: tuberculosis en inmigrantes bolivianos que trabajan y viven en talleres textiles clandestinos del AMBA. *Revista Cuadernos de Antropología Social*, Buenos Aires, 2012. En prensa.
- IBGE - Instituto Brasileiro de Geografia e Estatística. *Censo Demográfico Brasileiro de 2010*. Rio de Janeiro: IBGE, 2010.
- JELIN, E. (Dir.). *Salud y migración regional*. Ciudadanía, discriminación y comunicación intercultural. Buenos Aires: IDES, 2007.
- QUARANTA, I. *Corpo, potere, malattia*. Antropologia e Aids nei Grassfields del Camerun. Roma: Meltemi Editore, 2006.
- MADI, M. C. C.; CASSANTI, A. C.; SILVEIRA, C. Estudo das representações sociais sobre gestação em mulheres bolivianas no contexto da atenção básica em saúde na área central da cidade de São Paulo. *Saúde e Sociedade*, São Paulo, v. 18, p. 67-71, 2009. Suplemento 2. Available from: <http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-12902009000600011&lng=en&nrm=iso>. Acesso en: 18 oct. 2012.
- MARGULIES, S. et al. Acceso al sistema público de salud. Buenos Aires: Defensoría del Pueblo de la Ciudad de Buenos Aires-Sección de Antropología social, ICA, FFyL-UBA, 2003.
- MARSIGLIA, R. M. G., SILVEIRA, C., CARNEIRO JUNIOR, N. Políticas sociais: desigualdade, universalidade e focalização na saúde no Brasil. *Saúde e Sociedade*, São Paulo, v. 14, n. 2, p. 69-76, maio-ago., 2005.
- MARTÍNEZ, V. N. *Equidade em saúde: o caso da tuberculose na comunidade de bolivianos na cidade de São Paulo*. 2010. Dissertação (Mestrado em Ciências) - Faculdade de Saúde Pública, Universidade de São Paulo, São Paulo.
- MENÉNDEZ, E. *La parte negada de la cultura*. Relativismo, diferencia y racismo. Barcelona: Ediciones Bellaterra, 2002.
- MENÉNDEZ, E. La enfermedad y la curación. ¿Qué es medicina tradicional? *Revista Alteridades*, México, v. 4, n. 7, p. 71-83, 1994.
- MINISTERIO DE SALUD DE LA NACIÓN. *Programa Nacional de Control de la Tuberculosis*. Buenos Aires: MINSAL, 2011.
- RAMÍREZ HITA, S. *Calidad de atención en salud*. Prácticas y representaciones sociales en las poblaciones quechua y aymará del altiplano boliviano. La Paz: Opas/OMS, 2009.
- REDETB - Rede Brasileira de Pesquisas em Tuberculose. Bolivianos são os mais atingidos pela Tuberculose em São Paulo. Rio de Janeiro: REDETB, 2005. Disponível em: <<http://redetb.org/arquivo-de-noticias/41-noticias2005/124-bolivianos-sao-os-mais-atingidos-pela-tuberculose-em-sao-paulo>>. Acessado em: 06 nov. 2012, 2005.
- RIZEK, C. S.; et al. Trabalho e imigração: uma comparação Brasil-Argentina. *Lua Nova*, São Paulo, n. 79, p. 111-142, 2010.
- SASSEN, S. *As cidades na economia mundial*. São Paulo: Studio Nobel Editora, 1998.
- SILVA, S. A. Bolivianos em São Paulo: entre o sonho e a realidade. *Estudos Avançados*, São Paulo, v. 20, n. 57, p. 157-170, 2006.
- SILVA, S. A. *Faces da latinidade: hispano-americanos em São Paulo*. Campinas, SP: Núcleo de Estudos Populacionais, 2008. v. 1-73.
- SILVEIRA, C.; CARNEIRO JUNIOR, N.; MARSIGLIA, R. M. G. *Projeto inclusão social urbana: nós do centro*. Metodologia de pesquisa e de ação para inclusão social de grupos em situação de vulnerabilidade no centro da cidade de São Paulo. São Paulo: Fundação Arnaldo Vieira de Carvalho, Faculdade de Ciências Médicas da Santa Casa de São Paulo, 2009.
- SOUCHAUD, S. A imigração boliviana em São Paulo. In: FERREIRA, A. P.; et al. (Eds.). *Deslocamentos e reconstruções da experiência migrante*. Rio de Janeiro: Garamond, 2010. p. 72-95.

TAMBELLINI, E.; MASCARO, L.; SILVA, U. V. A inclusão de imigrantes bolivianos na cidade de São Paulo: algumas estratégias e políticas locais. In: SILVEIRA, C.; CARNEIRO JUNIOR, N., MARSIGLIA, R. M. G. *Projeto inclusão social urbana: nós do centro. Metodologia de pesquisa e de ação para inclusão social de grupos em situação de vulnerabilidade no centro da cidade de São Paulo*. São Paulo: Fundação Arnaldo Vieira de Carvalho. Faculdade de Ciências Médicas da Santa Casa de São Paulo, 2009, p. 123-168.

WHO - World Health Organization. *Global tuberculosis report 2012*. Ginebra: WHO, 2012.

ZALUAR, A. Exclusão e políticas públicas: dilemas teóricos e alternativas políticas. *Revista Brasileira de Ciências Sociais*, São Paulo, v. 12, n. 35, 1997. Disponível em: <http://dx.doi.org/10.1590/S0102-69091997000300003>>. Acesso em: 20 nov. 2012.

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