Vulnerabilities and Bolivian immigration in the municipality of São Paulo, Brazil: between public health policies, deaths, and collective resistance

Vulnerabilidades e imigração boliviana na cidade de São Paulo, Brasil: entre políticas públicas de saúde, mortes e resistências coletivas

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Abstract

The insertion of Bolivian immigrants in subcontracting circuits from the clothing industry and their living and working conditions became determining aspects of their visibility in the municipality of São Paulo, marking their entry into local political agendas. Considering the polysemy of the notion of vulnerability, the main objective of this study is to analyze aspects of the "vulnerabilities" of Bolivian immigration, which are visibly inscribed in political-institutional, epidemiological, and relational/procedural contexts. As a method of analysis, this study is based on the systematization of data from multiple sources and shows relations between the incorporation of immigrants in local policies, mortality data, and ethnographic reports on trajectories, presence in the city space, and identity processes, especially based on the action of Bolivian women and their organization in networks and collectives. We found aspects that reinforce and define patterns of vulnerability associated with certain attributes of this population. On the other hand, we observed survival strategies as mechanisms of collective resistance and re-signification of their ways of life in the city.

Keywords: Immigration; Local Health Policies; Work; Identity Re-signification.

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Resumo

A inserção da população de imigrantes bolivianos em circuitos de subcontratação da indústria do vestuário e suas condições de vida e trabalho tornaram-se aspectos determinantes de sua visibilidade na cidade de São Paulo, marcando sua entrada em agendas políticas locais. Considerando a polissemia da noção de vulnerabilidade, o objetivo central do texto é analisar aspectos das "vulnerabilidades" da imigração boliviana, as quais são visivelmente inscritas em contextos político-institucionais, epidemiológicos e relacionais/processuais. Como método de análise, baseia-se na sistematização de dados de múltiplas fontes e apresenta relações entre a incorporação de imigrantes nas políticas locais, dados de mortalidade e relatos etnográficos sobre trajetórias, presença no espaço da cidade e processos identitários, em especial a partir da ação de mulheres bolivianas e sua organização em redes e coletivos. Identificam-se aspectos que reforçam e definem padrões de vulnerabilidade, associados a determinados atributos desta população. Por outro lado, registram-se estratégias de sobrevivência enquanto mecanismos de resistência coletiva e ressignificação de suas formas de vida na cidade.

Palavras-chave: Imigração; Políticas Locais de Saúde; Trabalho; Ressignificação Identitária.

Introduction

Bolivian immigration has been present in the municipality of São Paulo since the 1950s, increasing between the 1980s and 1990s and fundamentally inserting itself in markets subcontracting the clothing industry in this period (Silva, 2006). Despite its marked presence in the municipality, this population has only acquired space in public health agendas in recent decades, after the recognition of its vulnerabilities (Freitas, 2018; Goldberg; Silveira, 2013) as issues related to precarious, unhealthy, and illegal work in sewing workshops become determinant aspects for understanding their living conditions and visibility in the metropolis.

This study belongs to an ethnographic insertion study on Bolivian immigration in the municipality of São Paulo (2018-2019) and begins by describing the assistance practices of a non-governmental organization (NGO) that has traditionally focused on aiding immigrants and refugees in São Paulo. Bolivian immigrants comprise one of the main target audiences of the aforementioned organization. The elements configuring "vulnerability" included demands for Health Care and difficulties in making the deaths of immigrants visible and ritualized by supporting belief systems, performing mourning ceremonies, and transferring dead bodies to their homeland in Bolivia. In our period in the field, we sought to pursue the interwoven circuits of Bolivian immigrants' "vulnerabilities," which begins by recognizing them in institutional contexts based on different markers and approaches to this population. Then, our field research unfolded into non-institutional circuits as it followed a collective of Bolivian women articulated around the support in the face of precarious housing situations, domestic/sexual violence, and the acknowledgement of their deaths.

This study aims by describing the insertion process of Bolivian immigration in local health agendas, its mortality, and actions of participation and collective resistance, to analyze aspects of its "vulnerabilities," which are visibly

inscribed in institutional, epidemiological, and relational/procedural political contexts.

To point out the comprehensive elements in structural contexts and the dynamics of Bolivian immigrants in the municipality of São Paulo, the characterization of their "vulnerabilities" is defined as a polysemic term that has been widely used in health, social work, politics, among other fields. In addition to its polysemy, this research will consider this notion as a classifier of populations and evaluate it in its relational/procedural application, expressed in challenge and leadership social movements around, for example, the policies of the Brazilian National Health System (SUS) (Adorno, 2012). This study will then develop this notion from an institutional, political (insertion in health agendas by a classifying system of populations), and epidemiological marker (expressed in mortality data for this immigrant population) and by its relational/procedural order as it incorporates representatives of a group of Bolivian immigrants as they form collectives and mechanisms of resistance to situations that limit survival.

Thus, we point out that these "vulnerabilities" – as they are characterized based on institutional political elements (Freitas, 2018; Goldberg; Silveira, 2013) – begin to produce contours and visibilities to a discursive field around the "subalternity" that characterizes work as enslaved, diseased, and criminal, determined by racial, ethnic (descendants of original peoples), nationality (Latin Americans), class/work (poor people inserted in subaltern markets), and geographical frameworks (residents of "clandestine" workshops).

We highlight the heterogeneous social composition of Bolivian immigration (Paceños, Aymara, Quechua, among others), bringing it closer to an interethnic mosaic involving several belief systems and characterizing their forms of collective existence. To this extent, we should emphasize that, in addition to whatever "vulnerabilities" it may have in the institutional plan of local health policies, this immigration brings together belief systems, religiosity, and events in spaces of visibility and sociability (such as the occupation of fairs, festivities, and dance groups), mobilizing social negotiations for their insertions in municipal spaces and resignifying identity processes (Silva, 2006, 2012).

As a guiding thread of the thematic and methodological approach of this research, we considered the characterization of a community that suffers intense racial and social discrimination (Silva, 2006) in contexts of repeated inequality of access to health (Aguiar; Neves; Lira, 2015; Goldberg; Silveira, 2013; Silveira et al. 2013) and highlight the intersectionality between gender and racial inequalities.

Thus, deaths in this population (which largely occur due to avoidable causes) highlight their precarious life, housing, and work conditions, ethnic/racial and origin-based discrimination, actions that have sought to respond to unequal access to health and social support by monitoring political and operational changes in health care, and the collective mobilizations around these demands. At their limit, these actions are engendered in political resistance and survival mobilizations in periods marked by extreme precariousness, for example, during the global COVID-19 health emergency, which broadened social inequalities (Medeiros; Hattori, 2020).

Based on ethnographic procedures (Adorno et al., 2018; Biehl, 2011; Epele, 2010), this research is based on producing and systematizing data from multiple qualitative and quantitative sources. Our ethnographic production was based on distance and face-to-face interviews with institutional actors and leaders of a collective of Bolivian immigrants, as well as field reports on visits to São Paulo neighborhoods in which Bolivian immigrants are traditionally inserted. Regarding inclusion in health policies, we interviewed health care professionals based on this population's main demands. Then, we requested quantitative data on the mortality of the Bolivian population in the municipality from the São Paulo Program for the Improvement of Mortality Information (PRO-AIM), which chose data from death certificates. We conducted interviews and field reports with a collective of Bolivian women, focusing on its joint resistance mechanisms as a response to their limit survival situations.

International migration and the municipality of São Paulo: vulnerability and problems in health

The notion of international migration, as it has been called in recent decades, is not given a priori. It is rather a political, social, and discursive construction. From this premise, the notion is rooted in a history of social struggles that has forms of regulating these population groups in normative relations between the State, migration policies, and global-scale processes of productive restructuring as one of its rotation axes (Feldman-Bianco, 2009).

To avod naturalizing a social issue, international migration is considered an effect of the forms of regulating migratory flows in transnational-scale processes of productive restructuring (Shiller; Basch; Blanc-Szanton, 1992). Part of this problem belongs to the construction process of large cities, global-local relations, and the permanent tensions between local migration policies and the incorporation of new immigrants. In this perspective, the phenomenon of migration on a global-local scale crosses the paradoxes underlying ongoing neoliberal projects, which are based on the flexible organization of work, immigration policies that are increasingly restrictive of national security, and the resulting criminalization of immigrants (Feldman-Bianco, 2009).

In this context, considering the new migratory flows – especially European, Latin American, African, and Asian migrations between the 20th and 21st centuries to São Paulo –, we focus on the Bolivian immigration as part of the profile of contemporary migrations, framing it as an object of population government that interdepends on several institutions, local norms, and the political practices regulating flows and insertion and permanence possibilities in the municipality.

São Paulo, more specifically, incorporates families of European immigrants in the 19th century, partially inserting them in industry and commerce and feeding a cheap labor market. With policies to encourage immigration, São Paulo was the target of epidemic control and economy protection practices (Marques; Alfonso; Silveira, 2014). In the late 19th and early 20th centuries, the process of consolidating the ideal of a modern State was engendered together with the reception of European immigration to replace the enslaved labor force. In it, public health supported the development project of the State, facing "the positive confrontation of the control of epidemics and sanitary problems, as well as in authoritarian and coercive actions with the social body" (Marques; Alfonso; Silveira, 2014, p. 83).

The poor sanitary and urban conditions which immigrants endured in rural or urban areas favored unequal forms of work insertion and caused, for example, a high incidence of health problems in mortality frameworks (Bassanezi, 2014). Given the productive restructuring process over the last decades, São Paulo has become a destination for large Latin American migratory flows (Patarra; Baeninger, 2006), inexorably generating new local public management emergencies.

This industrial restructuring process impacts new migratory flows and involves an entire global production chain. Feldman-Bianco (2009), for example, researched global-local interrelations in immigration cycles toward work in the textile and clothing industry and analyzed the processes of incorporating immigrants according to local politics, globalization, and the urban landscape. The author finds a fundamental paradox that includes, on the one hand, an ever more flexible structure of work and an increasing internationalization of financial capital and, on the other, immigration criminalization and restrictive migration policies. Thus, immigration in the late 19th and early 20th centuries presupposed a dividing line between working and land-holding classes or between commercial and manufacturing activities in the traditional context of "classes." Contemporary immigration, on the other hand, establishes groups that, if looked at intersectionally, experience precariousness and ethnic, racial, gender discrimination, among others.

Due to unequal conditions of insertion in the municipality and repeated association with the subalternity of Bolivian immigrants (who partially

establish themselves without documents), they insert themselves in markets subcontracting the clothing industry and are marked by social, historical, and linguistic segregation (Silva, 2012) and unequal access to public health (Goldberg; Silveira, 2013). To this extent, Bolivians in São Paulo can be intersectionally seen (Collins; Bilge, 2020) as an interpretive concept whose articulated issues range from race/ethnicity, class, gender, capacity, and nationality as "attributes" of the social place in which they are exposed to interwoven circuits of their "vulnerabilities."

An assumption of the policy structuring the current Brazilian public health system refers to integrality of care (Brasil, 1990), which, among the meanings attributed to the term, functions as a strategy to reduce population inequalities (Paim; Silva, 2010). In theory, this process is mediated by the recognition of "vulnerable groups'" characteristics linked to race/ethnicity, gender, epidemiological profile, and so-called behavioral aspects. Thus, the Black population, the groups making up the acronym LGBTQIA+, original peoples, and Latin American transnational migrants currently belong to the lens of health policies within this institutional/normative scope defining them as a population in a situation of "vulnerability." The inscription "vulnerable population" in Brazil, for example, has served movements of agglutination and agency to organize demands and resistance to this situation (Adorno, 2012).

The issue is that vulnerability (as highlighted earlier) configures a polysemic notion and, as such, when interpreted and codified in terms of populations, identifies "groups" that come to be characterized and classified by their attributes and, thus, "neutralized" or divided into "social inequalities" (Adorno, 2012). Thus, recognizing certain characteristics inherent to groups then establishes what should or should not be a health problem, becoming intelligible in classifying systems of the body, sexuality, consumption patterns, poverty, and even conditions of access to health.

Bolivian immigration in local health agendas: "vulnerability" as an element of the government

In the 1990s, most Bolivian immigrants were inserted, in the history of the municipality of São Paulo, in traditionally working-class neighborhoods such as Bom Retiro, Brás, and Pari (which currently are large areas of circulation and commercialization of clothing products). Part of this global-local trade is supported by small sewing workshops, in which the organization of domestic life is incorporated into labor dynamics with intense work routines, low payment, and high worker turnover. Domestic life includes a very impoverished diet, confinement in places without air circulation, lack of privacy (rooms are often conjoined), and domestic violence. The domestic dimension intersects with the work and remuneration regime – working hours sometimes exceed 15 hours a day, remuneration is based on the number of produced pieces (which cost about 0.25 to 0.30 R$ cents), and which show aspects of confinement and exploitation.

Among "clandestine" sewing workshops, in which living and working conditions intersect complex social and economic dynamics to support the migratory project (Silva, 2006), intense discussions within the local government were generated around the Bolivian immigration living and working in these places on the one hand, as it constitutes one of the places targeted by reports of labor analogous to slavery; on the other, in the field of public health, as it has become a focus of epidemiological surveillance due to the alarming number of tuberculosis cases (Gaeta, 2005).

Its visibility in urban spaces and the local press and the effects of work restructuring began to be noticed by the local executive power after reports and labor inspection actions as what the International Labor Organization called work "labor analogous to slavery." In parallel to labor inspection actions, the process of inserting Bolivian immigration as an object of local government is fundamentally marked by public health actions as they acknowledge

their "vulnerabilities" and the territories of sewing workshops in São Paulo (Freitas, 2018), which, as places of labor confinement, are understood by the sanitary technical environment as precarious, crowded places with little air ventilation.

Faced with the heterogeneity of population groups in central São Paulo neighborhoods, from the 1990s onward, institutions such as Centro de Saúde Escola Barra Funda (CSEBF), in downtown São Paulo (which had managerial autonomy) began to acknowledge, in addition to other problems such as that of the homeless, the specific needs of undocumented Latin American immigration, which failed to fit traditional programmed routines (Carneiro Jr.; Silveira, 2003). The presence of health care services focused on excluded population segments, (for example, aiding Latin American immigrations) occurred by primary health care technologies such as home visits and therapeutic planning. In an interview with a sanitarian physician working at the Center since the 1980s, aspects of the incorporation of this immigration and health actions emerge:

> *The CSEBF is a department-oriented unit within a larger project, which was an extramural medical project working in a community-based team. […] Together with a Health Center group and people from the department, we began to think about downtown São Paulo […] such as the homeless population and Bolivians, that is, from this perception of Health Center users and the discussion about downtown São Paulo emerged needs to better understand and initiate more specific health actions. Until 2000, a practice of home visits was made for access to public health, it was a nursing staff who, from a case, went in search of […] home visits. They occurred from the event that triggered the epidemiological surveillance of the unit. Then, they went to these homes to actively search for that case. We also began to do some training, especially in 2001, whose mayor was Marta, where the municipalization begins, so we choose to maintain primary care practices such as the PSF* [Family Health Strategy] *and then we started to assemble teams. (Public health physician, 2020)*

Since 2001, the Bolivian immigration has been part of the public health agendas of São Paulo, a process that took place in the ballast of the movement to municipalize the public health system – a tributary to the decentralization of public administration in the State (Keinert; Rosa; Meneguzzo, 2006) – and enabled the restructuring of public health to incorporate SUS principles and guidelines (1990) in the organization of care from 2001 onward, when, according to Keinert, Rosa, and Meneguzzo (2006, p. 100), "the city of São Paulo is qualified according to the rules of SUS for the full management of primary care."

Thus, the distribution of public health services within the municipalization process considered the scope and implementation of primary care services in areas with greater health, education, and income inequalities (Coelho; Szabzon; Dias, 2014). On the other hand, note that the municipalization process, involved in political/partisan negotiations and institutionalized forms of social participation, is established by the decentralized management of sub-prefectures and the strategic implementation of the Family Health Strategy (PSF) and of agreements with private non-profit organizations.

Local health policies (especially after the advance of the municipalization of primary care in the 2000s), taking advantage of the recognition of the "vulnerabilities" of excluded groups to enable the decentralization of health services, signed a specific intersectoral action between the Secretariat of Social Assistance and the Secretariat of Health to study the mapping of areas with greater social exclusion to implement the PSF (Freitas, 2018).

The incorporation of SUS principles and the restructuring of the administrative policy generate conditions to recognize "vulnerable populations" under the backdrop of the scenario of intra-municipal social inequalities, significantly expanding Family Health Units and Teams (ESF) in the areas with the worst socioeconomic indicators (Coelho; Szabzon; Dias, 2014).

As a consequence of the creation of sub-prefectures in regions with great socioeconomic inequality, integrated coordination offices were established to guarantee the political principle of integrality of care. These administrative and operational markers to implement the PSF focus on the wide capillarity of determining its clientele, mapping the territory, and offering home visits as primary health care technologies. From these interventions, the approximation of health teams with the immigrant population has a central importance in the latter's insertion into local agendas as a field of intervention and knowledge and information production on living conditions, sewing workshop location, consumption patterns, illness levels, etc.

The action of these teams (mechanisms of contact with this population) were also strengthened by instruments of social participation and health councils and by hiring Bolivian community agents to work from the Community Health Agent Program (PACS) in regions with significant immigration. In an interview, a Bolivian immigrant working as a community health agent in a health unit in Barra Funda describes the health demands of this population:

> *My life as a health agent, especially with immigrants, begins in 2005, until November 2019. So, back then, there was already talk of a high rate of tuberculosis due to the way of working (closed form) and food was not good. So, all of this was already starting to appear, tuberculosis cases. So, we started to raise awareness in sewing workshops so they would keep their doors open. The demand was practically how to get to the health care of immigrants without documentation because everyone was illegal.* [...] *Another concern was how the health area reached the community to predict the advance of tuberculosis that was taking place in sewing workshops* [...]. *But, at that time, we lived in hiding because we had to wait for amnesty and it was given by the government every 10 years. So, we had to fight a lot, we suffered a lot.* (Community health agent, 2020)

As an effect of the expansion of the care model, the incorporation of actions in primary health care and the presence of technicians, NGOs and managers in spaces of dialogue, the problem was taken to political negotiation instances, giving contours to its visibility both by the sanitary technical look on workshops and, consequently, specific problems, such as the notification of tuberculosis cases in this population. Between 2003 and 2004, for example, care for tuberculosis cases in the population of Latin American immigrants living in the neighborhoods of Mooca, Brás, Pari, and Belém increased by 30%. This epidemic situation was associated with poverty, misery, and certain obstacles to health access, for example, the requirement of a CPF (Natural Persons Register) for care and the dynamics of working hours in workshops (Gaeta, 2005).

At this time, the 31 subprefectures (responsible for the administrative division of the municipality) encompassed regions such as Mooca, Brás, Pari, Belém, and Bom Retiro, which had as part of their audience Latin American immigrants and worked across sectors with the "Somos Hermanos" Project, which formalized articulations with Pastoral do Migrante and the Health Coordination Office, which "defined as work the construction of a network of solidarity valuing cultural diversity and combating the poverty of immigrants, especially Bolivians, Paraguayans, and Peruvians" (Gaeta, 2005, p. 337).

Such issues, involved in the condition of insertion of this population into health agendas and the importance of intersectoral actions, such as those by the "Somos Hermanos Project," also changed access to health, guaranteeing rights such as the obtention of SUS cards and the unenforceability of CPF for access to health equipment by the "Somos Hermanos" Project, becoming important markers in the process of their insertion in the municipality since SUS cards often were undocumented immigrants' first national "identity card" (Aguiar; Mota, 2014).

Thus, note that a central key to understanding the process of insertion of the Bolivian immigrant population into local health agendas were the high notification of "spatialized" tuberculosis cases in clandestine sewing workshops, in which the activities of the network generated visibility to the main problems linked to "urban misery, forced labor, poor diet, and precarious housing conditions.

[...] Diseases, such as tuberculosis, are consequences of poor housing, work, food, and hygiene conditions" (Gaeta, 2005, p. 340).

An evinced question refers to the sanitary understanding of endemic tuberculosis conditions, for example, based on the association of precarious working conditions in workshops and on what this working life implies, indicating the concrete and social determinants of tuberculosis. Based on the normativity of the disease associated with poverty and confinement (Touso et al., 2014), a way of life marked by high turnover in workshops, characteristic of informal sewing markets and exclusion by social, linguistic, and spatial segregation intersect each other (Silva, 2012). Turnover, for example, impacts the continuity of care in health units, especially regarding the mobilization of the PSF to transfer registrations and the long-term follow-up of procedures such as prenatal care or tuberculosis treatment (Aguiar; Mota, 2014).

A first plan of analysis of this problem situates the insertion of immigration as a health management theme to point out that the ties that make this immigration flow visible refer to an "underground" situation and the conditions that circumvent their "vulnerabilities" from certain attributes related to the normativity of the disease and living conditions that associate them with certain marks such as "subalternity."

Mortality: inequalities, violent deaths, and preventable causes

Searching the mortality data that constitute statistical productions linked to municipal health management and indicate the population's health showed the absence of official demographic data on this population, thus making it impossible to obtain a clearer and more objective analysis of its mortality, such as the establishment of mortality rates, for example. However, we describe proportional mortality and the underlying causes of death as spellings of these deaths, representing another element of analysis of their "vulnerabilities" that reflect the failure of health care.

The presence of these data in the composition of this study stemmed from facts NGOs recorded by monitoring Bolivian immigrants' health demands and the need to understand their mortality profile since most deaths occurred to young people and result from preventable causes, such as neoplasms or urban violence. These demands include the community's need to experience grief, an act that consists of mobilizing community resources to maintain beliefs, involving, for example, public mourning events and the transfer of bodies.

From these data, we sought to understand the dynamics of exposure to health problems, characterizing the epidemiological marker of their "vulnerabilities" after establishing a time frame of intense restructuring and wide distribution of public health services in the municipality, especially reaching the regions with the worse socioeconomic indicators (Coelho; Szabzon; Dias, 2014).

Most of this population is characterized as young, with a higher proportion of males, according to the census (IBGE, 2013). The proportional mortality in Table 1 shows that deaths occurred mostly among young people (aged from 15 to 44 years) in comparison with the total mortality of the municipality. We found that 41.3% of deaths referred to men in this age group and 37.8%, to women. Thus, data indicate early deaths for the Bolivian population, occurring to a large extent before the age of 50 years, in comparison with the proportional mortality pattern of the general population of the municipality.

A dialogue with these mortality data shows problems affecting the health of Bolivian immigrants in the age groups associated with workplace insertion. This reality may relate to the high incidence of tuberculosis in workshops, health access barriers, and violence (Goldberg; Silveira, 2013).

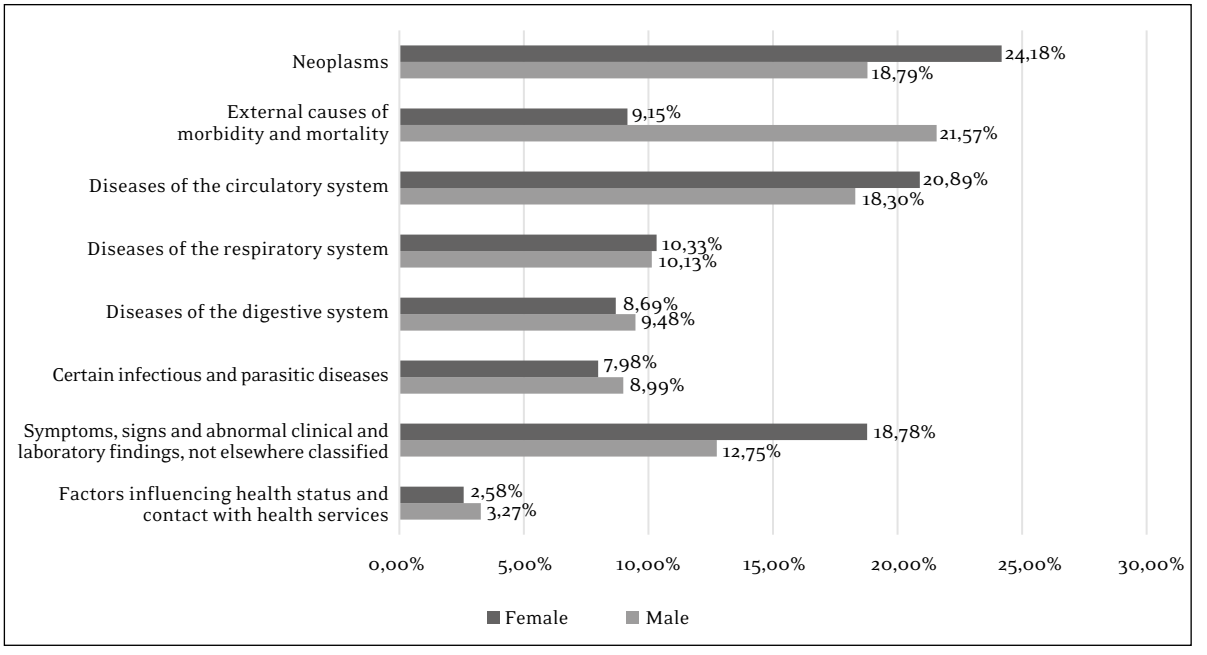
Regarding the distribution of causes of death, figures show that the main underlying causes in this population group generally refer to first, neoplasms (22.41%); second, circulatory system diseases (19.0%); third, external morbidity and mortality causes (15.57%); and fourth, respiratory system diseases (10.35%). The trend among the main causes of death of Bolivian immigrants also differs in comparison with the general population of the municipality of São Paulo (Aguiar, Neves; Lira, 2015).

Table 1 – Proportional mortality by age and gender in Brazilian and Bolivian nationals living in the municipality of São Paulo between 2010 and 2019 (N=1,038)

Age group	Total male pop. (%)	Male Boliv. imi.(%)	Total female pop. (%)	Female Boliv. imi. (%)
Less than 1 year	2.8	1.3	2.5	0.7
1 to 4 years	0.4	2.0	0.4	2.3
5 to 14 years	0.5	2.1	0.4	2.8
15 to 24 years	4.0	10.8	1.2	14.8
25 to 34 years	4.5	17.3	1.9	12.4
35 to 44 years	6.4	13.2	3.6	10.6
45 to 54 years	11.3	8.0	7.2	8.9
55 to 64 years	17.6	10.8	12.4	8.7
65 to 74 years	19.5	14.9	17.2	11.5
75 years or older	33.0	19.6	53.3	27.2
Total	100.0	100.0	100.0	100.0

Source: PRO-AIM (2020).

Graph 1 – Distribution of the main underlying causes of death of Bolivian nationals by chapter of the International Classification of Diseases (ICD-10) in the municipality of São Paulo (2010-2019) (N=1,038)



Source: PRO-AIM (2020).

The distribution of the percentages of the underlying causes also differ according to gender. According to Graph 1, the major cause of Bolivian men's death is associated with external causes, corresponding to 21.6% of the total. In comparison with the number of deaths from external causes in the general population for the same period, this proportion refers to 10.13% of all male deaths in the municipality (Brasil, 2021). In a study on the mortality of Latin American immigrants in São Paulo, Silveira (2018) reiterates that the highest occurrence of deaths among Bolivian immigrants from 2006 to 2015 involves men (57.9%) – 42.1% for women.

The main underlying cause of death among women is neoplasms, whereas chronic non-communicable diseases show 24.18%. The health of Bolivian women usually shows access to health services in cases of pregnancy and sexual or domestic violence (Carneiro Jr. et. al. 2011; Santos; Drezett; Alves, 2015; Santos; Mesquita, 2017). Also note that, in certain contexts, the demand for health services among Bolivian women in São Paulo is higher than among men (Waldman, 2011).

The involvement of advanced cases of neoplasms in women affects in greater proportion those of low socioeconomic level either because of late diagnoses due to detection failures at more primary levels of care or factors involving the non-performance of preventive examinations associated with racial and social inequality (Amorim et al., 2008).

The death of young people (under 50 years of age) due to chronic non-communicable diseases is related to structural inequalities in care since they offer obstacles to access to health. On the other hand, infectious and parasitic diseases represent 8.57% of all deaths, whereas, for the total population of the municipality, 3.75%. Regarding tuberculosis as the underlying cause of death and comprising all clinical forms, 3.94% of all deaths involved the Bolivian population. Evaluating this same indicator for the population of the municipality in the same period shows a 0.41% proportion (Brasil, 2021).

Regarding external causes, men aged from 15 to 44 years represent the highest number of deaths from external causes, of which the most common cause of death refers to homicides (30.3%). Homicides as the underlying cause of death historically affect young Black people living in peripheral regions in a greater proportion (Adorno et al., 2018), which also denotes the racialized issue of this cause.

Among women, 23.08% of deaths occurred due to homicides, thus pointing to broader dimensions such as the absence of documentation boosting urban conflict contexts, including assaults in workshops, violent deaths, accidents, and other factors, such as greater exposure to domestic violence (Santos; Drezett; Alves, 2015).

During 2020 and 2021, note that the PRO-AIM data show 538 total deaths. Of these, 46.01% stemmed from infectious and parasitic causes. Based on this, we show a population that has been highly exposed to the effects of the COVID-19 pandemic either by the impossibility of carrying out sanitary isolation measures or even by pre-existing barriers of access to health.

Thus, the scenario of abbreviation of these lives, i.e., young people dying at a productive age due to external causes or chronic non-communicable diseases, points to sensitive issues related to integrality in health as these immigrants are more exposed to violence and barriers to access to health (Carneiro Jr. et. al., 2011; Santos; Drezett; Alves, 2015; Santos; Mesquita, 2017; Silveira et al., 2013).

The "reverse seam": weaving a collective as a mechanism of resistance

The course of this field research experienced the challenges of the COVID-19 health crisis. Sanitary prevention measures and the daily contact with morbidity and mortality statistics produced numerous effects on lives that already faced obstacles to accessing health and lived in conditions that made social isolation impossible. In this period, the researchers approached a collective of Bolivian women called "Luz e Vida" (Light and Life) as an unfolding of the ethnographic field, getting to know women/mothers' life dynamics and survival strategies during this period that hindered their livelihood through workshops. Field experiences and listening to reports at a distance showed borderline situations (Biehl, 2011; Epele, 2010) for the survival of the collective as guiding threads in coping with everyday barriers in institutional webs (Goldberg;

Silveira, 2013). At this point, the COVID-19 pandemic has highlighted everyday barriers to healthcare access, in which invisibility and increased domestic violence and deaths intersect each other.

The collective began in the Guaianases neighborhood (a peripheral region in the extreme east of São Paulo) in 2014, constituting itself as a group of women who support themselves before domestic, sexual, and labor violence. This collective shares its leadership and shows representation in 14 neighborhoods of Bolivian insertion in São Paulo. One of the interlocutors of this research, a founder of the collective, migrated to São Paulo in 2006. Coming from La Paz, she crossed the border between Puerto Suárez and Corumbá to find better working conditions in Brazil. When she arrived in São Paulo with her son, her daily life was divided between a tenement in downtown São Paulo, domestic care, and the routine of working in a sewing workshop for Bolivian immigrants. To circumvent the onslaught of "criminalization," difficult mobility, and language misunderstanding, her support at the time involved seeking an NGO that aided immigrant women. Inserting herself in the complex institutional and subcontracting fabric of workshops, constant scenes of violence at work were a part of her daily life, which made her join other immigrant women to conquer spaces of voice and protection. A characteristic linked to gender and the working conditions to which they are subjected, Bolivian women/mothers who migrate alone seek to insert themselves into social support networks (Santos; Mesquita, 2017).

The relation between gender and Bolivian immigration in São Paulo relates to a greater exposure to domestic and sexual violence in work environments (Santos; Drezett; Alves, 2015), violence cases, and obstacles to access to health (Goldberg; Silveira, 2013; Waldman, 2011). In addition to work demands, women also face the need to care for their children and difficulties monitoring pregnancy and childbirth (Santos; Mesquita, 2017; Waldman, 2011).

Most women currently in the collective work as seamstresses, migrated alone (or with their relatives and children), and inserted themselves in sewing by subcontracting schemes. Many also do household chores and provide their children with access to vital services, such as public education and medical consultations at primary healthcare units. The collective addresses violence demands against women and children and hold meetings in neighborhoods with a large insertion of the Bolivian population to discuss topics such as domestic violence, communication difficulties with Brazilians, and discrimination in primary healthcare units, for example.

In a life at the center of global economic flows (Feldman-Bianco, 2009), in which remuneration stems from clothing and capital circulation depends on large-scale productions at low prices, the health emergency ceased the activities of wholesale clothing trade. Committed to collective survival, in which, at its limit, the most urgent "immunity" was satiating daily hunger, the collective organized itself to join forces among women to avoid economic bankruptcy given the absence of work due to the suspension of wholesale clothing fairs.

The halt in production due to the interruption of the wholesale clothing trade immediately affected the economic flow sustaining capital mobilization and the sending of remittances to Bolivia. After months without assistance and work, life went on and what they had left to sustain their existence in the municipality depended on sewing masks at pennies a piece, as well as other protective equipment that required greater effort and time (about 14 to 16 hours of daily work).

This difficult management of economic survival was joined by negotiations between the accumulation of overdue bills and the daily threat of eviction from their homes/workshops. In addition to injuries magnified by a population that was mostly unable to socially isolate itself, the collective organized itself to manage situations involving illness by a network of contact with Bolivian healthcare providers and to give visibility to their deaths at a time with widened gaps around death registration and management (Medeiros; Hattori, 2020).

Among unequal forms of access to social security, since the undocumented population lacked access, at least, to emergency income, the lives of hundreds of Bolivian immigrant families oscillated in the

volatile and unstable terrain of daily producing masks to survive, as a leader reports: "*Now that we are in emergency here in Brazil, they have closed the shops again, many people are not being paid* [...]. *For each mask, we were paid 10 cents, we had to manufacture masks by the thousands. We couldn't eat so we could at least pay the bills.*" To escape hunger, the collective organized a "common pot" – or, in the words of the leaders, "olla comunitaria," a strategy to collect food reserves from workshops and distribute meals in groups organized by the women in the collective in insertion neighborhoods.

Under threats of eviction, the silence of the sewing machines was also constant. Nevertheless, the scarce orders of masks and protective gowns were redistributed among the women of the collective to ensure the circulation of income. Threatened by lack of work or eviction from their homes, the only way out in the face of widening social chasms was strengthening support networks to manage situations of greater exposure to risks. According to a leader's report: "*there were many cases of women who were fired from their jobs, were almost on the street with their children* [...] *We had to open a house to welcome those women who were on the street.*"

Throughout the pandemic, leaders also denounced the increase in assaults to sewing workshops, domestic and sexual violence against women and children, threats and fear of going to hospitals due to access barriers imposed by language misunderstandings, criminalization of their absent documentation, and fear of enduring an anonymous death. In addition to all that is "kidnapped" in their lives, these women also experience the threat of anonymity kidnapping their deaths, relegating them into complete opacity, as a leader reports:

> *Hasta the pandemic started, it got very, very complicated for us. Because we know that when an immigrant dies here in Brazil, it is very difficult to be able to make the transfer to Bolivia. Entonces, I've seen a lot of deaths here that just fell there into history, right?* [...] *They buried the bodies, right? but it's like, without a name, because the name of the patient who was dying was not known because they were undocumented.*

By its "reverse seam," the collective leadership's daily life passes as a thread that interweaves the interstices of survival strategies, on the one hand, in the face of the failure of the care network and, on the other, of the extraordinary efforts to sustain the demands of the collective by welcoming women who fall victim of sexual and domestic violence, exhausting work in sowing masks, and avoiding hunger, homelessness, or anonymous deaths.

Managing their needs includes a "line of flight" that resists their daily struggle, strengthens support networks to access health, and seeks the visibility of their deaths. The collective "considers life both in terms of limits and crossroads" (Biehl, 2011, p. 272) in the interstices between restrictive migration policies, normative productions of "vulnerabilities," and insertions into subcontracting markets.

Still between the lines of a common thread: problematizing vulnerabilities

Regarding the polysemic notion of vulnerabilities, which operates both in a classifying, daily, and relational way based on social, ethnic, and linguistic markers, the existence of Bolivian immigration in the spheres of health agendas began to be made visible due to the precariousness of the sewing workshops in which a work system analogous to slavery functioned as a "transmitting focus" of tuberculosis, thus giving rise to complaints against the irregularity of the work and the "risk" of tuberculosis. Added to this "vulnerability" is the "risk" of precariousness and early death from preventable causes, actions of resistance, occupation of public places, and the organization of collectives. In this case (which is also invested with a gender character), the studied women's collective acts and resists to exist as an identity (which includes respecting deaths and avoiding destituted demises) and overcome states of "poverty" in life.

Therefore, its insertion as an object of local health agendas in its classifying notion of "vulnerability" draws attention to what reinforces "identity

marks" (Silva, 2012), juxtaposed with different stigmas: "enslaved," "clandestine," "confined" lives to the frames commonly associated with their ways of living and dying in the metropolis. Thus, the polysemic reference to "vulnerabilities" – a term that has become extremely generalized in public policies and especially in public health – would have to be better and more rigorously treated, based on its plots, contexts, circuits, and movements of segregation and resistance involving its intersectional character (Collins; Bilge, 2020).

The inclusion of Bolivian immigrants in health policies is engendered in a more extreme debate between "fostering life" and "allowing death" both regarding the recognition of their belief systems and their barriers to health access. Bolivians experience living conditions close to that of the Black and peripheral population (Adorno et al., 2018), suffer discrimination, violence, and language barriers (especially women). The organization of resistance collectives is linked, above all, to the resignification of identity (Silva, 2012) so present in the history of this immigration. Thus, ethnic, national, and gender identification, among others – such as the capacity of the women's collective to translate this intersectional web of "vulnerabilities" – configured an action of resistance to the limit of survival and confrontation that exposes them to the non-recognition of their deaths.

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Authors' contribution

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