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Articles

Primary Health Care for Bolivian immigrants in Brazil

Atenção Primária em Saúde para imigrantes bolivianos no Brasil (resumo: p. 14)

Atención Primaria de Salud para inmigrantes bolivianos en Brasil (resumen: p. 14)

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This is a qualitative research that used semi-structured interviews, conducted with thirty Bolivians seeking healthcare services and with 49 healthcare professionals who treat them in the Basic Health Unit of *Bom Retiro*, a neighborhood located in *São Paulo*, Brazil. These interviews were analyzed according to five thematic categories, using the content analysis method. The results showed that access guarantee is not enough for the immigrant population to actually receive health care. Political actors and social subjects must be involved, organized, and prepared for this service to actually take place.

Keywords: Migration and health. Primary Health Care. Bolivian migration.

Introduction

In recent decades, there have been a change in the characteristics of Brazilian migration international flows and an increase in its volume[1]. These processes are related to changes in the social division of labor at a global level, which end up reconfiguring the forms of organization of the metropolis, assigning new economic functions and changing the profile of its international immigrants[1].

The presence of people from other countries in the Southern hemisphere, such as Bolivia, Senegal, Congo, among others, is increasingly growing in Brazil[2]. Through the data from the National System of Registration of the Federal Police and the Brazilian Ministry of Justice, 833,682 records were granted to foreigners in 2015[3]. Bolivians were those who had a higher volume of permanent records granted, 50,357, demonstrating a significant increase since the Bolivian immigration data from the 2010 census[3]. Therefore, we can observe changes in the dynamics of international migration and a new position of Brazil as a receiver of immigrants. This makes it necessary to discuss the insertion of this population into Primary Health Care Services offered in the country and how public policy works in this sense.

In this article, based on an understanding of the dynamics of international migration and the insertion of Brazil in the current international division of labor[1], we analyze this integration of the migrant population from the perspective of the Bolivian population residing in *Bom Retiro*, a neighborhood of *São Paulo*, Brazil. This immigration began in the 1950s, was intensified in the 1980s, and has presented a growth trend since then, especially with the arrival of young people, mostly coming from the Andean region and seeking placement in the manufacturing industries that are concentrated in the central region of *São Paulo*[4,5].

Therefore, with this increased migration flow, the population also starts demanding services that are offered by the Brazilian public sector, understood as universal rights, such as health care, for example. In the context of healthcare services, despite the guidelines of global organizations stablishing that health is a universal right and that everyone should have access to it, some obstacles may exist for this immigrant population to actually access these services[6].

This situation has multiple determinants, especially cultural-related, linked to the dynamic and complex process of the concept of the health-disease process, considering that each population has its own beliefs, behaviors, and characteristics. Another decisive factor is the social context in which the group of immigrants is inserted in the country of destination, in addition to the legal status of their stay in the country, since they may find themselves in a condition of greater vulnerability, hindering their real access to healthcare services[6].

Therefore, our aim was to verify, from the perspective of Bolivians living in Brazil and healthcare professionals, if the guaranteed access to services for immigrants indeed means that the Bolivian population can be inserted into Primary Healthcare services offered by the health system, which is ensured by the guidelines of the constitution of the Brazilian National Health System (SUS). We chose this level of health care due to its specific

involvement with healthcare professionals and patients, specificities that will be explained later in the study. In a study on health facilities in the municipality of *São Paulo* that serve immigrants and refugees, 77.2% of these establishments were basic health units. In addition, with regard to the nationality of the immigrants served, 81% were Bolivians[7].

The term "insertion" is used in the sense of being something beyond the simple access and integration into the healthcare services, but as a process linked to the recognition of and respect for cultural specificities.

Primary Health Care in Brazil

Among the Brazilian studies and even official texts of government, there is a difficulty in precision concerning the use of the terms "primary health care" and "basic health care," which are often used as synonyms[8]. The Primary Health Care[9] is intertwined with the national prioritization policy on primary care network and with the family health strategy, which are inserted into the Brazilian health system services[8].

According to the hierarchy of SUS services, the attendance begins at the Basic Health Unit (UBS), which is the unit of the Primary Health Care located in the municipal scope. The UBS is operated by a georeferenced system, i.e., each UBS serves the population of a certain coverage area; and some healthcare professionals who work on these units, such as Community Health Workers, must live in this same area[10]. This means that healthcare professionals share living experiences with the population and thus become closer to them.

Thus, the proposal of the UBS is the continuous monitoring of the population of its coverage area, and its main guidelines are the promotion and prevention of health, i.e., health integrality, a concept included in the constitution of SUS[10]. In addition, the concept of universality is one of the main principles of SUS, which means that any person within the Brazilian territory has the right to use its health care services[10].

Thinking of immigrants who live in Brazil and their rights to use the national healthcare services guaranteed by the universality principle, it is important for healthcare professionals who will serve them to consider their current situation. After all, these professionals shall deal with different cultures, customs, and perspectives, which may influence in how patients will be received and cared for. Cultural competence, which is the ability to recognize specificities of each population group, considering their cultural characteristics and ethnic or racial differences, is considered in primary care services[8]. In addition, one possibility for promoting the articulation between different perspectives of the health and disease process is to considering the interculturality in health, aiming at a greater dialogue between biomedicine and traditional medicine without subordinating one to the other[11].

Indeed, it is necessary to consider that each person faces the disease situation differently depending on several factors, including their habits and cultural customs[6]. This is one of the reasons that can influence or hinder the work of healthcare professionals and serve as a barrier for the provision of care to effectively occur.

Materials and methods

The neighborhood chosen for this study was Bom Retiro and this choice is justified for being a neighborhood that has historically been an immigrant's territory and for currently being the residence of many Bolivians[12,13].

A qualitative study[14] was carried out to understand the reality of the UBS belonging to *Bom Retiro*. Semi-structured interviews were conducted with triggering questions[14] divided into two groups, one for health professionals and another for Bolivian users of this UBS.

The following questions were asked to healthcare professionals: are Bolivian immigrants treated at this Basic Health Unit? How often? What is the profile of the Bolivian immigrant who seeks assistance at this UBS (women, men, children, older people)? Have you attended any Bolivians? What are the greater difficulties or facilities in this service? What do you think is still missing to overcome these difficulties?

For Bolivian immigrants who use the healthcare services of the studied UBS, the following triggering questions were asked: is it the first time you seek assistance in this Basic Health Unit? If not, what are the main reasons for using the UBS of *Bom Retiro* services? Why did you choose this unit? What are the facilities and difficulties you find in the service? What do you think is still missing for these difficulties to be overcome?

The interviews were conducted from January to March 2015, with 49 healthcare professionals and thirty Bolivians who were users of the UBS services. The snowball sampling[15] was the method used to select the interviewees, for being the most suitable strategy for populations with difficult access[15], and the amount of revealed contents was delimited by saturation. No exclusion criteria were used.

Among healthcare professionals there were physicians, nurses, nursing assistants, psychologists, community health workers, administrative assistants, physical education professionals, environmental protection agents, psychiatrists, and physiotherapists. These professionals were identified with the letter “P” followed by an Arabic number, from P1 to P49, and the Bolivians, with the letter “B” followed by an Arabic number, from B1 to B30.

The study was approved by the Ethics Committee through processes no. 34589614.1.0000.5404 and 34589614.1.3001.0086, the interviews were digitally recorded, and the participants signed an Informed Consent Form. Interviews were carried out in Brazilian Portuguese because respondents indicated they spoke the language; then, interviews were transcribed in their entirety in such a way they could be analyzed according to the content analysis method[16].

After performing the first analysis of the content of the interviews and defining thematic categories, the main interviews that could concurrently relate to these issues were selected in order to potentially compare them. For the selection, the participation of the various healthcare teams that compose the Primary Care at the UBS was considered. Then, representatives of each group that is part of the unit service were chosen. Finally, twenty interviews with healthcare professionals and 21 with Bolivian immigrants were selected by reading and rereading the answers, in order to establish a dialogue with the categories created, namely:

Frame 1. Systematized categories created according to the interviews

Category 1	Mutual perception of the Bolivian migrants and the health professionals team – How do I see them?
Category 2	Demand for health services – What does he need? / What do I seek in them?
Category 3	Difficulties found – What are the barriers that exist to deal with them?
Category 4	Strategies built – How do I overcome the barriers?
Category 5	Personal perspectives and/or professionals – How do I see myself?

Source: authors analysis.

Results and discussion

The empirical survey conducted through the interviews was essential for us to begin understanding the complexity involved in the insertion process of the Bolivian community into the Brazilian Primary Care service. The speeches organized into the listed categories allow us to perceive there are aspects beyond the legal protection for providing care to these immigrants.

The results presented next for each category are shown from the perspective of both the professionals and the Bolivian immigrants. Excerpts of the speeches were translated into English when writing this article.

In “Category 1”, we sought to find in the reports an understanding about the perception of healthcare professionals working in this healthcare unit about the Bolivian immigrants, and whether this perception contributes to guarantee and ensure the insertion of the community.

We investigated how healthcare professionals see the Bolivians, which of their characteristics are noticed when providing health care, and what are the differences between meeting the Bolivians and the rest of the population. According to data from the management sector of their own healthcare unit, among the 15,000 patients served at the UBS *Bom Retiro*, it is estimated that 5,000 are Bolivians. We also sought to verify these professional’s perception regarding how the Bolivian populations live and what is implied in this condition for promoting prevention, health, and recovery.

Based on the analysis of the interviews, we can state that, for these professionals, Bolivians who use healthcare services are perceived as humble, modest, shy people, who suffer from stigmas and who live in a situation of vulnerability because they are going through processes of migration and immigration. This double migration process is due to the fact that most Bolivians who migrate to São Paulo come from rural areas in the Andean Altiplano[4]. Therefore, in addition to immigrating to another country, they also undergo a change to the urban area[4].

Moreover, from the perception of healthcare professionals, Bolivians living in the city of São Paulo face adverse living conditions, mostly working in sewing shops, which are often their residences as well, thus blurring the line between working time and leisure time[17]. The living conditions of most Bolivian immigrants in São Paulo are closely

associated with the access to healthcare services. Researchers show that the precarious work they perform and the time of residence in the country are factors that will influence the demand for healthcare services, especially those of the primary care services[17].

Healthcare professionals are aware that the living conditions encountered by Bolivians in São Paulo favor the incidence of diseases, as we can observe in the following excerpt:

> [...] regarding their living conditions, everything is very close, there are very narrow environments, and large agglomerations certainly allow the spread of infections [...] (P17)

The relationship between place of residence and the influence on the population's health supports the idea that, in more degraded areas, people tend to get sick more often than those living in places with more infrastructure[16]. Hence, it is necessary for healthcare professionals to realize that their everyday practice must go beyond the biomedical content, also incorporating a practice aimed at the users, identifying their specific needs, focusing on the subject, and recognizing them as carriers of subjective and sociocultural singularities with specific interests and needs[18].

The UBS *Bom Retiro* works with a dynamic that is distinguished from other health units. Due to the formation of primary care in the Brazilian health system, according to which the municipal projects assume varied settings in order to focus on the health needs of each location[17], there was the possibility of hiring Bolivians as community health agents. With the presence of these agents in the unit since 2005, the first contact between UBS and the resident population in its territorial scope was facilitated. This was a local strategy to favor the provision of care, considering that many Bolivians were afraid to receive healthcare professionals in their residence, probably due to the undocumented condition in which many of them live.

The hiring of Bolivian community agents was only enabled due to the perception of a difficulty and the action of public agencies to overcome it. Actions such as these were raised by the 1st Municipal Conference on Migrant Policies, which took place in São Paulo through the Municipal Secretariat of Human Rights and Citizenship at the end of 2013, proposals were formulated in order to meet the demands of migrant communities living in the city[18]. This Conference served as a basis for other policies to be implemented for including immigrants in public services[19].

In this sense, we can consider that this was a great facilitator for including the Bolivian population in the services. Thus, immigrants may feel more accepted by the healthcare system, since it allows the proximity between users and healthcare team, because in order for care to exist there must be the continuity of affinity and actions[20].

With "Category 2", the intention was to know the Bolivian's reasons for seeking healthcare services, understanding the moment they seek care and the major causes for doing so. In addition, we also sought to understand the repressed demands of this population regarding the UBS services.

A very intriguing fact we perceived in the reports of the UBS team was the use of healthcare services as a strategy of the Bolivian population to prove their residence in the country of destination. This occurs due to the Brazilian migration legislation (Law 6,815, August 19, 1980 also known as “Foreigner’s Statute”). In most cases, Bolivians who immigrate to the country do not meet the categories for legal staying. Considering that the registration to healthcare services, due to the principle of universality, does not require a very strict documentation, it also serves as a proof of the length of stay in the country, since an identification card is issued for all users. For undocumented immigrants, the importance of having proof of the date of arrival in the destination country lies in the fact that it may aid a possible amnesty for residence in the country, which has already been observed in Brazil[2].

Another point raised by professionals regarding the demands for the use of the services related to health recovery is linked either to living conditions or to working conditions experienced by the Bolivian community resident in *São Paulo*. According to professionals, the diseases that most affect the Bolivian population attended at the unit are tuberculosis and syphilis. This fact is also mentioned in other studies on migration and health, whose authors establish a link between the vulnerability to infectious diseases, such as tuberculosis and sexually transmitted diseases, and the conditions faced by the migrant population in the country of destination[20].

From the point of view of Bolivian immigrants, complaints regarding the delay in making appointments with the UBS due to frequent absence of physicians consisted in the main demand. However, this is not limited to the immigrant population; it actually consists in one of the major problems of the SUS, which is unable to meet the demand[21].

Most of the interviewed Bolivians stated that the most common reason to seek treatment in the UBS is the care for women and children’s health, with women seeking examinations for gynecologic cancer prevention, and many of them confirmed having prenatal follow-up on this unit. After the birth of the children, many women continue to bring the children to the unit at least during the first year after birth for continued healthcare.

Conditions faced by immigrants in the countries of destination, especially those in situations of stigma, may often lead them to avoid healthcare services, using self-medication or alternative medicine instead[20]. Another important issue is the working situation faced by many of them, since production per hour of gainful labor represses the absence at work. Furthermore, many would be reprimanded by their employers. As a result, those who seek healthcare services do so because they have more serious problems or diseases in advanced states[20].

With “Category 3”, we seek the answers of the professionals for their main difficulties in providing care to the Bolivian immigrant population. The issue of language (mainly the population coming from the Bolivian countryside, due to the use of different languages such as Aymara and Quechua) is one of the main barriers reported by healthcare professionals, which is something also reported by other researchers regarding the care of an immigrant population[7,17,20].

Bolivians reported that communication difficulties occur more frequently with newcomers:

> Yeah, sometimes when there's a new person [newcomer] they don't understand well, so it's better to speak [Spanish] with them [...] but we go along [...] (B1)

In this speech we can observe there is cooperation within the immigrant community, which assists newcomers in the process of insertion into the healthcare services. These are strategies created by Bolivian immigrants who have been in Brazil or in São Paulo for a while, as a result of surviving the immigration process[22].

In the answers of healthcare professionals of the studied UBS, we also found great difficulty in dealing with some Bolivian cultural aspects, which, according to them, are very different from the Brazilian healthcare habits. An example mentioned by these professionals was the large consumption of potatoes on the part of the Bolivian population, which can cause problems of malnutrition and obesity when consumed in excess and without the accompaniment of other foods sources of varied vitamins and nutrients. In Bolivia there is a huge variety of tubers, making this one of the main components of the population's diet. However, when this population migrates to Brazil, the economic conditions in which they find themselves do not give them access to a more varied diet.

This example is sufficient to explain how immigrants carry the memories and identity of their homeland, which often challenge the existing medical knowledge[23]. When the cultural diversity shock is exposed, healthcare professionals need time and space to add new perspectives in their clinical practice, which is often not possible due to the hierarchical structure and the low flexibility of the institution[23]. Thus, cultural differences can become deep barriers to access health care, which is complex and requires great subjective mobilization in the relationship between these differences and health care[9,11], which is often not possible due to the structure and organization of healthcare workers.

During the analysis of "Category 4", we noticed that one of the main factors that can really ensure the insertion of the Bolivian population into healthcare services are the strategies created to overcome the possible difficulties that hamper health care. Professionals of the UBS *Bom Retiro* have somehow organized themselves in order to overcome barriers during the performance of their work activities.

Here, when we use the term "work activity," the emphasis is on the person who is perceived as an "intelligent" agent and not only as one of the components of the organizational system[24]. The workers have a set of skills and shared practices, based on their work experience with others, which allows them the ability to control (i.e., to regulate and coordinate) and to regulate their conduct in order to achieve a certain goal. This regulation and coordination, performed by the professional, are not isolated. The activity is located in a given material, social and historical context, which provides resources, but also defines restrictions, which in turn carry a cost for the subjects. At the same time, this context is affected by the life experience of the subject, and is, therefore, constantly reviewed and reinvented[25].

Continuously, subjects who work must address problems in their activities, which are never fully defined by the formal statement of the tasks to be performed, which means they need to do the "constitution" of the problems, and that the work activity entails an original response, which integrates and reconstructs in the action, a broad set of determinants. Some of these determinants are external to the workers – such as the working instruments (environment, materials, tools, the collective of workers), the rules, the quality determinations, and the customer's requirements –; others are linked to their personal characteristics (history, experience, projects) and internal state (fatigue, pleasure, suffering, expectations, motivations, for instance)[26].

In this perspective, we understand that the team of professionals needed to perform various activities that were not effectively part of their duties as healthcare professionals, but which were fundamental for health care to be exercised. One of them was participating in radio programs run by the Bolivian community, in order to disseminate the work accomplished by the UBS *Bom Retiro*, taking advantage of a mean of communication that can actually reach this population.

Community radio stations are historically used by the Bolivians since the old mining radios of Sucre[27]. In São Paulo, they serve as a way to communicate with the Bolivian population, produced by the community itself. Using this channel allowed the UBS to become even closer to the population it sought to communicate. This initiative was easily carried out because one of the Bolivian health community agents is a public radio broadcaster. He uses this channel aiming to bring information and entertainment to the Bolivian community living in the city. Uniting the knowledge acquired by his professional work, the radio also started being used as a communication channel with the community, disseminating information about care, prevention, and health promotion.

Another initiative consisted of carrying out health campaigns in typical parties of the Bolivian community, bringing the professionals closer to the population, which is essential for Primary Care to take place considering that creating a bond and continuity of care are required. All these strategies are designed to create a closer rapport between healthcare professionals and the served population. The bond is necessary for providing care, and is expressed in everyday experiences[9].

The purpose of "Category 5" was to know how professionals see their work, what they expect with the development of care, and which role, as social actors, they assume in the relationship with the Bolivian community. We infer that professionals consider that, based on the developed strategies, they can insert the Bolivian population into the Primary Care services of the UBS *Bom Retiro*, as we can observe in the following statement:

> There was an improvement because we started showing them our interest, and that our focus is on health care. [...] We've been to radio interviews and that way we became known, and this UBS ended up being a reference for them [...] (P17)

However, during the interviews, we perceived that there are still many difficulties, and the immigrant population still suffered a lot of prejudice linked to the adversity of the situation they face in the country, which stands out in the following statement:

> [...] I don't know if it's discrimination against foreign people, but the doctor [says]: 'You work in sewing, right?' and already fills up the complete diagnosis, but he doesn't question what you have [...], it's the same with most foreigners who go there, it's frequent [...] You have to check the professional ethics of the doctors, they should take a training course to examine, right, because sometimes there's a foreigner to be attended and health is for everyone, internationally, by law, regardless of race, color, or nationality and still there's prejudice [...] (B16)

This speech shows that the Bolivian man sees himself as suffering prejudice in the service, and this makes it necessary to train healthcare professionals to understand they should equally care for all the users. However, we can infer that the very way the work is organized often fails to favor professionals in adopting a better attitude towards users of the service who need more attention, considering that physicians are subjected to time constraints, being constantly required by goals and service numbers[28], not to mention that, often, the number of professionals is insufficient to meet the care demands.

Moreover, we consider that understanding the personal perspectives of Bolivians is essential to comprehend how this population perceives healthcare needs, including their cultural representations of the processes of health and disease.

Indeed, a theme addressed in this study was the perception of Bolivian immigrants regarding the different ways they relate with the environment around them, with nature. This fact is linked to cultural beliefs and reinventions of cultural and symbolic heritage. When one of the Bolivian health workers was asked about the relationship of Bolivians with nature, called *PachaMama*, the response was as follows:

> That's the answer, it's connected to nature. [...] it's the culture, it's the root, when we have to talk of Bolivia, Bolivia is a mystic and ancient country. That is the way it is connected to nature. Nature, we call it PachaMama. [...] We have the so-called healers, or yatiris. There is disease, which is not disease, it's a nature thing, there's someone who got a strong shiver, [who] was paralyzed. [The person] Goes to the doctor, the doctor will not find anything, because it's not a normal disease, it's a natural disease. [...] (P9)

The aspects related to cultural determinants, such as customs and beliefs, influence in health behaviors and in the perceived need of healthcare services[21].

The health-disease process needs to be differently understood, making health care for immigrants more complex. Therefore, it is necessary to consider intercultural health care[11].

This very significant speech demonstrates the great need for the healthcare team being able to develop actions that are culturally sensitive and to understand the specificities of these subjects. Hence, we can state that legislation alone is insufficient to ensure the access to Primary Care services for the immigrant population. More should be done. In other words, there is need to invest in material and organizational working conditions of the UBS.

In a systematic review of the literature about health and migration previously conducted in UBS *Bom Retiro*, we noticed an increase in the importance given to the theme of health and international migration over the last five years, which shows a growing concern about this theme within the academy. Reflection is necessary to know the problems and to act on them.

Final considerations

Through the interviews, their analysis and discussion with the literature, we can consider that the insertion into health care is not only a matter of guaranteed access, but also of activities of daily living within the unit offering this service. Without the immigrant community being in a position to hold rights and make their presence known, it will not be respected. Without the insight and the awareness of the daily practice of healthcare professionals, there would be no possibility of understanding the reality of the immigrant subject. In addition, the management sector of services must develop strategies and resolutions in order to overcome the encountered difficulties and barriers, not only guaranteeing access, but also the actual insertion into healthcare services. There are strategies created by healthcare professionals and Bolivian immigrants themselves that enable health care to take place. In other words, the social and political actors must be committed for integration to really occur.

In the case of the UBS *Bom Retiro* and the Bolivian immigrants, we can consider that this insertion did occur, as a result of specific actions that took place in that area, which is an area already historically known as frequented by immigrants of different nationalities. Without these actions undertaken through the engagement of healthcare professionals, it is difficult for the Bolivian population living in the neighborhood to enjoy their rights related to access to public health services. Cultural differences and different characteristics of care must be recognized and accepted, and these professionals somehow act in this regard.

Lastly, some questions were raised and deserve further studies, for it is necessary to better understand what kind of service this population is being inserted into. Does the clinical practice of the professionals really aim to care for the subject in need of its services? How much do healthcare professionals change their clinical practice due to the characteristics of the Bolivians being cared for? Are the cultural aspects really considered? Are professionals trained and prepared to take care of people with different cultures and identities?

Moreover, considering the local actions developed in the context of a single health unit, we mention the need for a public policy to be a State policy, especially considering the new moment Brazil experiences nowadays, as a receiver of new immigration flows. This makes the following question necessary: to which extent is the concept of universality in health care responsible for people choosing to immigrate to Brazil?

Even though this is an exploratory study on the insertion of a certain group into healthcare services, some aspects proved to be cross-sectional regarding the “health” and “migration” relationship, and more research is necessary to demonstrate the complex facets of this process, which definitely marks our contemporary world.

Authors' contributions

Both authors actively participated in all stages of preparing the manuscript.

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Conflict of interest

Both authors have no conflict of interest to declare.

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Trata-se de uma pesquisa qualitativa que utilizou entrevistas semiestruturadas, realizadas com trinta bolivianos e com 49 profissionais de saúde que os atendem na Unidade Básica de Saúde do Bom Retiro, bairro de São Paulo, Brasil. Essas entrevistas foram analisadas por meio de cinco categorias temáticas, utilizando o método de análise de conteúdo. Os resultados mostraram que a garantia do acesso não é o bastante para que o cuidado em saúde à população imigrante aconteça. Os atores políticos e os sujeitos sociais precisam estar envolvidos, organizados e preparados para que esse serviço realmente ocorra.

Palavras-chave: Migração e saúde. Atenção Primária à Saúde. Migração boliviana.

Se trata de una investigación cualitativa que utilizó entrevistas semiestructuradas, realizadas con treinta bolivianos y con 49 profesionales de salud que los atienden en la Unidad Básica de Salud de Bom Retiro, barrio de São Paulo, Brasil. Esas entrevistas fueron analizadas por medio de cinco categorías temáticas, utilizando el método de análisis de contenidos. Los resultados mostraron que la garantía del acceso no es suficiente para que se realice el cuidado de salud a la población inmigrantes. Los actores políticos y los sujetos sociales precisan estar envueltos, organizados y preparados para que ese servicio ocurra realmente.

Palabras clave: Migración y salud. Atención Primaria de la Salud. Migración boliviana.