

# Immigration and health: women immigrants' (in)ability to access health care

## Imigração e saúde: a (in)acessibilidade das mulheres imigrantes aos cuidados de saúde

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### Resumo

A utilização dos serviços de saúde pelas populações imigrantes tem vindo a ser considerado um dos mais importantes indicadores da sua integração nas sociedades receptoras (Dias e col., 2009). No entanto, o conhecimento em torno da qualidade e da eficácia do acesso dos/as imigrantes aos cuidados de saúde, especialmente no que respeita às mulheres imigrantes, é ainda escasso em Portugal (Fonseca e col., 2005). Embora os estudos nacionais tenham vindo, nas últimas décadas, a procurar traçar os diferentes perfis sociais das mulheres imigrantes em Portugal, sobretudo no que concerne às suas relações familiares ou laborais (Wall e col., 2005), a investigação no domínio da saúde é ainda parca e exclusora de uma análise centrada no género ou interseccional. Neste texto apresenta-se uma reflexão sobre os determinantes que condicionam a (in)acessibilidade das mulheres imigrantes aos cuidados de saúde, enfatizando-se os fatores que poderão estar a agir no sentido contrário à sua integração neste setor.

**Palavras-chave:** Mulheres imigrantes; Acessibilidade aos cuidados de saúde.

## Abstract

The use of health services by immigrant populations has been considered one of the most important indicators of the integration of these communities (Dias et al., 2009). However, knowledge about the quality and efficacy of this access to care, especially for immigrant women, is still scarce in Portugal (Fonseca et al., 2009). Although domestic studies have, in recent decades, sought to trace the different social profiles of immigrant women in Portugal, especially with regard to family or work relationships (Wall et al., 2005), research on health is still sparse. Gender-centered or intersectorial analysis has not yet been done. This paper presents a reflection on the determinants that influence immigrant women's (in)ability to access health care, emphasizing the factors that may be acting to block integration in this sector.

**Keywords:** Immigrant Women; Accessibility to Health Care.

## Immigration in Portugal: a brief socio-historical portrait

Transit of people is presently, and globally, indicated as one of humanity's greatest challenges (Alvarenga, 2002). Such a challenge requires constant efforts towards internal, political and social reorganization on the part of both origin and host countries, in order to respond to the needs and expectations of migrant populations. Portugal has not been immune to such efforts, relying on the development of regulatory policies (due to the strength of transformation of migratory realities) which have oscillated between a "zero immigration" paradigm and other less radical approaches (Baganha, 2005). A proof of this reliance is the assessment conducted in the area of the Migrant Integration Policy Index (MIPEX III)<sup>1</sup>, which placed Portugal in second place with regards to integration of immigrants.

Despite the fact that the number of foreigners residing in the country has been restricted since the 1960s, starting with the 1974 Carnation Revolution a substantial increase in the flow of migrants especially from former colonies, namely Angola, Mozambique and Guinea has been seen. According to Pires (2002), the number of immigrants in Portugal has been rising steadily since 1975, at an annual rate of above 7%. From an emigrant country, with Portuguese citizens in practically all corners of the globe, Portugal has recently come to be a country of immigrants (Lages et al., 2006; Peixoto, 2004).

Between the 1970s and the 1990s, the majority of immigrants came from the Portuguese-speaking world, especially from the Portuguese-speaking African countries (Países Africanos de Língua Oficial Portuguesa: PALOPs) and from Brazil (Peixoto, 2004). In the 1980s and 1990s, greater diversification was seen with respect to the origin of immigrants, with Europe, India and China also playing a role on the same order as Brazil and the PALOPs on the list of countries of origin (D'Almeida and Silva, 2007). According to the Superior Council of Statistics, the Permanent Section on Demographic and Social Statistics, Families, the Environment, and the Working Group on Demographic Statistics (2006), in

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<sup>1</sup> Cf. [http://www.acidi.gov.pt/\\_cfn/4d6b77b1c7065/live/Ver+relat%C3%B3rio+MIPEX+III](http://www.acidi.gov.pt/_cfn/4d6b77b1c7065/live/Ver+relat%C3%B3rio+MIPEX+III)

the 1990s in particular immigration from Africa and the Maghreb increased significantly, with an equal surge of a new group coming from Eastern Europe.

Currently, around 4% of the population residing in Portugal is foreign (PORDATA, 2012), with the total number of foreign citizens living in Portuguese territory being, in December 2011, 436,822; of these, 217,685 were women and 219,137 were men (Serviço de Estrangeiros e Fronteiras, 2012). Around half of the immigrants in Portugal come from Portuguese-speaking countries (47.9%), namely Brazil (25.5%), Cape Verde (10.1%), Angola (4.9%) and Guinea-Bissau (4.2%). A very significant percentage of the female immigrants came from the Americas, especially South America, the only case in which the population of women was greater than men. In the population coming from Africa, gender parity was observed for immigration.

## Female Immigration and Health: from explanatory theories to empirical evidence

In Portugal, as in the rest of the world, the presence of female immigrants has grown in recent decades. The *feminization* (Castles and Miller, 2003) or *genderization* of migrations (Yamanaka and Piper, 2006) today is an internationally recognized trend, although it is not always duly respected in migratory studies (Hondagneu-Sotelo, 1999; Morokvasic, 1984; Nolin, 2006; Omelaniuk, 2005).

Although investigation of the social profiles of immigrants in Portugal today is still under development, especially in the areas of the family and work activity (Wall et al., 2005), studies conducted from a gender perspective are scarce (Miranda, 2009). Studies seeking to analyze health issues related to female immigration are not only few in number, but also very recent in the country; according to Machado and Azevedo (2009), between 2000 and 2008 there were only 45 specifically concerning illness and health. In the view of Fonseca et al., in 2007, Portugal lacked epidemiological studies about the “state of health” of the immigrant populations, as well as information about the (in)accessibility of health care for these groups in general. On the other

hand, the existing data are scattered throughout different bodies or scientific areas, which makes a rigorous, systematic, and integrated analysis of this reality impossible (Dias and Gonçalves, 2007; Peixoto et al., 2006).

The scarce scientific production in this area is more obvious with regards to studies done within an intersectorial matrix, which are almost nonexistent. The investigations of women immigrants in Portugal tend to favor a homogenization of their experiences, hiding specifics of their identities that generate different forms of oppression. In reality, although the immigrant women are, in general, particularly vulnerable to discrimination (Crenshaw, 1991), when compared to the immigrant men, some immigrant women are more vulnerable than others. Affiliations of gender, along with ethnic affiliation and affiliations of class and nationality, among others, create conditions for different forms of discrimination (Correia and Neves, 2011; Miranda, 2009; Neves, 2010a, 2010b), and also affect the health of immigrant women differently (Castaño-López et al., 2006; Pusseti et al., 2009).

### Explanatory theories

Analysis of the questions related to the health of migrants depends on the characteristics of the person who migrates, where they migrate from, when they migrate, where they migrate to, and what is the health concept that is to be evaluated (Carballo, 2007). The idiosyncrasy of migratory experiences causes its impact on individual health to be sometimes positive, sometimes negative, and sometimes neutral.

According to Im and Yang (2006), there are three groups of theory that allow us to understand the relationship between issues of female immigration and health. The first group, called selective migration and health, maintains that immigration is a type of natural selection, and that immigrants tend to be healthy and resilient women, capable of responding to the challenges posed by the migratory experience. The “healthy migrant” effect (Abraído-Lanza et al., 1999; Razum et al., 2000 apud Dias and Gonçalves, 2007) fits into the sphere of these perspectives, with migrations understood to be opportunities for personal and social development. This phenomenon

indicates the immigrants whose health is revealed to be better than that of the natives, with the migratory experience seen as a factor protecting health.

The second group of theories, known as the negative effect of immigration on health, assumes that immigration is an experience that generates stress, which can provoke health risks. At the heart of these perspectives, the factors that most contribute to a higher prevalence of physical and psychological diseases are the living conditions and the diseases endemic to the country of origin, the social, political, and environmental conditions underlying the migratory process, social isolation, cultural conflicts, poor integration and social assimilation, changes in roles performed and identity crises, as well as reduced socio-economic status and racial discrimination.

The third and last group of theories is called acculturation and health. Acculturation has been indicated as an expected result of the migratory process, strongly related to health. In this way, it is expected that the women integrate into the receiving cultures, adapting to their norms and values as well as their health practices. The greater the immigrants' capacity to adapt to the receiving cultures, the fewer difficulties they may have from the point of view of health care accessibility. This adaptation does not suppose, however, the abandonment of the values and norms of the cultures of origin.

It is essential to remember, according to Huijts and Kraaykampque (2012), the characteristics of the immigrants' countries of origin also have a definite influence on the health that they will have in the countries they migrate to. If the health of the immigrants in their countries of origin is marked by conditions of vulnerability, the same tendency will probably be manifested in the receiving countries. On the other hand, socialization in terms of health habits during childhood affects living standards throughout development, which is naturally reflected in the level of health. The habits acquired in childhood, molded by social, cultural, and religious norms, accompany the migrants on their migratory experiences, and manifest in their daily practices. Finally, the level of political oppression existent in the counties of origin affects the health of fellow citizens abroad. This fact seems to be confirmed in the case of second-generation immigrants (e.g.

children descended from Holocaust survivors show elevated rates of psychological vulnerability) (Major, 1996 apud Huijts and Kraaykampque, 2012).

### **Empirical evidence**

Despite the fact that they do not necessarily pose a threat to health, as we have seen, migrations and the conditions in which they take place can increase the vulnerability of immigrants to physical and psychological illness (Ramos, 2008; United Nations Population Fund, 2006). Factors such as type of migration, the policies to which the migrants are subjected in the host countries, conditions of access to education and employment, the type of contact maintained with the country of origin, possibility of return and reintegration, regular or irregular status (International Organization for Migration, 2010), and family, affective, linguistic and symbolic ruptures, as well as the accumulation of contradictory cultural references and experiences (Miranda, 2009; Topa et al., 2010) can greatly affect the migrants' quality of life, interfering with their health. Therefore, structural issues (social, cultural, and political) associated with notions of identity play a central role in the immigrants' health status and the way they use (or do not use) health services (Fonseca et al., 2007).

In some cases, the migrant workers have a greater risk of developing pathologies, registering a higher incidence of accidents and diseases related to work activities (International Organization for Migration, 2005). Some studies show that some immigrant populations are also at a greater risk of developing cardiovascular diseases, of having diabetes, of showing a higher mortality rate associated with cancer, of contracting infectious diseases (e.g., tuberculosis, HIV/AIDS and hepatitis) and of suffering from mental illness (e.g., depression, schizophrenia, and post-traumatic stress disorder) (Dias et al., 2009; Rocha et al., 2012).

A study conducted by Godinho et al. (2008) on 2,485 immigrants concluded that there was psychological suffering in 31% of the cases analyzed, with women more affected by this problem. This suffering seems to be due, in large part, to the differences felt in adapting to the host country and the breaking of significant emotional ties. The immigrants, especially the women, face countless changes which can

involve psychological conflict, social disintegration, and/or even a decline in mental health (Neto, 2008; Topa et al., 2010).

When compared with non-immigrant residents of the countries, female immigrants tend to show worse health indicators (Dias et al., 2009), especially in the area of sexual and reproductive health (Rademakers et al., 2005). In the case of pregnant women that face, among the generality of immigrant women, very particular difficulties in terms of health and of violence (International Organization for Migration, 2004), studies have concluded that this group shows higher rates of maternal, perinatal and child mortality (Fonseca et al., 2007), a higher number of complications during pregnancy and in the post-partum period, a greater tendency towards risk behaviors, and a lower predisposition to adopting preventative behaviors (Machado et al., 2009; Ramos, 2008; United Nations Population Fund, 2006).

Factors such as social precariousness, unemployment, absence of social support, different access to rights and opportunities and exposure to violence have been indicated as determining factors in the development of physical and psychological illness in pregnant immigrant women (International Organization for Migration, 2004; Peixoto et al., 2006; Ramos, 2008; Sopa, 2009). When these women belong to socially or ethnically disadvantaged groups, there is a lesser probability of their receiving the monitoring required during pregnancy, birth, and the post-partum period (Alderliesten et al., 2007 apud Dias et al., 2009).

The results of a study by Machado et al. (2009) warn us that pregnant immigrant women receive care later in their pregnancies than Portuguese women. On the other hand, rates of fetal neonatal mortality are higher in immigrant populations and the mothers suffer from a greater number of pathologies during pregnancy, namely infectious diseases, a fact which could justify a later start for prenatal appointments (Bragg, 2008). The same thing happens with undocumented pregnant immigrant women, who tend to begin medical treatment at a very advanced stage of pregnancy (Wolff et al., 2008), afraid they will be reported to the authorities.

The loss or reduction of social assistance and support networks (e.g., friends, family), due to the migratory experience often causes isolation of

immigrant women, which can become intensified during pregnancy and after childbirth, accentuating levels of stress and suffering (Estrela, 2009; Franks and Faux, 1990; Sword et al., 2006 apud Dias et al., 2009), as well as anxiety levels (Peer et al., 2010). A study by Fung and Dennis (2010) shows that in the post-partum period, the risk of depression is more elevated, given the complexity of the issues that immigrant women face.

Immigrant women are also more vulnerable to sexual victimization (Neves, 2010a). In the case of human trafficking for sexual exploitation, immigrant women are preferred victims. The effects of trafficking on health are devastating, sometimes irreversibly impacting mental, physical, sexual, reproductive, and social health (Neves, 2012).

In the face of these issues, and keeping in mind that for a considerable group of immigrants, health is in fact affected by the migratory experience, it is absolutely vital to evaluate the way that they utilize health services. Below we present some data about immigrant women's (lack of) access to health care.

## **Women immigrants' (in)ability to access health care**

In European Union countries, health coverage for the native population and immigrants has changed significantly since the 1960s in accordance with the principle of universality (Romero-Ortuño, 2004).

Portugal took an important step in 2001 towards promoting universal access to health care for immigrant populations with the publication of Order n.º 25.360/2001 (Diário da República, II Série, n.º 286, December 12, 2001). This measure guaranteed migrant populations the right to use the services available at health centers and hospitals in the National Health Service (Serviço Nacional de Saúde: SNS), regardless of nationality, economic and/or legal status (Alto Comissariado para a Imigração e o Diálogo Intercultural, 2007). In the case of immigrants in irregular situations, this Order mentions the right to access SNS services and establishments by presenting proof of their presence in Portugal for a period of greater than ninety days to the health services in the area where the person resides (Bäckström et al., 2009).

According to Fonseca et al in 2007, access to health care should be viewed from a multidimensional concept that integrates, on the one hand, the rights to health care consecrated by law and, on the other hand, the immigrants' capacity to make use of these rights. Now in Portugal, as unfortunately occurs in other countries, there seems to be a gap between that which is the legal dimension of the immigrants' rights in the health sector and the real capacity to demand care. Actually, despite the legal advances in recent years, access to health care is not the same for native inhabitants and immigrants; additionally, with respect to this latter group, access is not the same for legal and illegal immigrants. In this case, access varies in practice as a function of legal status, time of residence in the country, and each person's nationality, among other aspects (Baleizão, 2010).

The immigrants, especially those without legal status, seem to avoid using health services, frequently opting to self-medicate (Committee on Community Health Services, 1997) or, when they do use the health services, they seek them at a very advanced stage of their illnesses (World Health Organization, 2003). This reluctance to use services is due to fear of deportation, as immigrants are poorly or insufficiently informed about the rights they have.

Some studies have reinforced this evidence that illegal immigrants use health services in host countries less than the rest of the population does. Torres and Sanz (1997), for example, conclude that there is a strong barrier between access by sick illegal immigrants to health care in Spain, a situation which puts them in a position of great social vulnerability (apud Romero-Ortuño, 2004).

Some studies also show that the immigrants with a higher level of literacy and who lived for a longer period in their countries of origin seek health services more than those with lower levels of education and less time abroad (Rocha et al., 2012).

Although there is a plurality of factors that contribute to the (in)accessibility of health care for immigrants in general, in 1989 Aday indicated the characteristics of the population, of the health system, and of the environment as the main indicators of potential immigrant access to health services (Marshall et al., 2005). From these individual aspects

and aspects of a structural nature, there are many factors that determine the use and non-use of the health services by migrants. Organizational, economic, linguistic and cultural, as well as human barriers (Fonseca et al., 2007; Reijneveld, 1998) seem to condition quality and efficacy of access to health services, leaving the migrants not infrequently in situations of risk.

A study conducted of 1513 immigrants in Portugal concluded that 3.6% of them did not know where to go if they had a health problem. Around 20% stated they had never used the SNS. Among users, 35.6% utilized Health Centers, 12% used hospitals, and 54.4% used both. Of these, 22.4% reported being unsatisfied or very unsatisfied with the services. Use of services was significantly associated, in the case of male immigrants, with waiting time, legal status, and country of origin. As for female immigrants, the use of services was significantly connected to wait time and country of origin (Dias et al., 2008).

The behavior of health professionals has similarly been indicated as one of the two factors that most determine the use or non-use of health services by immigrant communities. Studies suggest that these professionals frequently present a limited knowledge of legislation and/or its applicability and act in accordance with social stereotypes (Wolffers et al., 2003 apud Dias et al., 2009), not responding to the effective needs of the users. Conversely, they tend to not have the cultural competencies necessary to relate to users of other nationalities, and do not know their specific characteristics (Pusseti et al., 2009).

Lopes (2007) for example, verified in his work with a group of HIV-positive migrants utilizing obstetrics services in a hospital in the Lisbon area that the health professionals were not very supportive in their contact with the users, providing them with very little information about HIV.

According Dias et al. (2010), lack of information on the part of health technicians about cultural aspects related to sexual and reproductive behavior of immigrants also conditions utilization of health care and the way in which many women experience pregnancy, childbirth, and motherhood. A study published by Manuel (2007) about family planning issues in female Timorese immigrants to Portugal

showed that the cultural dimension, as well as the circumstances in which the Timorese women found themselves after having arrived in Portugal, influenced their attitudes about fertility.

Another study conducted on Hindu mothers concluded that the culture of origin is reproduced in Portugal, specifically the cultural practices related to maternity (Monteiro, 2007).

Another study conducted with immigrants from Sao Tome who used maternal/child health services indicated complaints against administrative professionals, who seem to be poorly informed about the rights of pregnant female immigrants in Portugal (Almeida and Caldas, 2012).

In reality, cultural and societal factors associated with the social roles of gender, of customs, the language, and standards of communication can restrict the use of health services on the part of women, and pregnant women in particular (Dias et al., 2009), causing formal care to often be substituted by traditional practices (Gonçalves et al., 2003).

Non-mastery of the host country's language is also indicated as one of the major blocks to accessing health care (Ponce et al., 2006), discouraging immigrant woman from soliciting help in case of illness or pregnancy. Not uncommonly, interpreters are absent from the health services, or ignorance of their existence forces women to use services accompanied by their husbands or other male family members, which inhibits them from openly expressing their most intimate concerns (United Nations Population Fund, 2006). From another angle, in domestic violence situations, this dependence can impede victims from reporting the situation to the authorities. It is important to stress that pregnant women who are victims of violence present more health complications than non-victims, especially during the second trimester of pregnancy (Morewitz, 2004).

On the other hand, some female immigrants, due to the cultural norms of their countries of origin which are deeply rooted in conservatism and the patriarchy, feel uncomfortable and even disrespected by the practice of certain medical acts, namely care from male doctors, or the need to show private body parts during clinical observation (Mestheneos et al., 1999 apud Dias et al., 2009).

In some cases, the westernization of health, ignorance or insensitivity regarding traditions, preferences and conventions, of specific diets, and of the rules of interaction between men and women, are factors that limit women's access to health contexts.

Women's representations of the concept of health and health services interfere in their life habits and, more concretely, in their health care (Madi et al., 2009). The particular beliefs of each culture about health and illness, often associated with the supernatural, can be barriers to seeking formal health services.

In many cultures, for example, the western concept of mental health does not exist, and as a result immigrants will only take advantage of mental health services if they are informed about their utility, and educated about their benefits (United Nations, 2006).

A study conducted by Velho (2012) in Portugal, with 21 immigrant women of various nationalities who were pregnant or mothers, observed indicators of psychological, physical, and sexual/reproductive health which were quite concerning, such as elevated levels of exposure to violence and discrimination, with a recurring pattern of not recognizing the symptoms they experienced, and a consequent lack of medical assistance. In this investigation, it was possible to identify a negative association between low literacy in the participants and the presence of elevated rates of psychopathological symptoms, such as somatization and interpersonal sensitivity. This fact, combined with the others, suggests that higher educational levels seem to function as factors protecting the health of these women.

Cultural issues also are reflected in prevention practices, namely the level of preventative vaccinations, of regular checkups, and of oral care, just to cite a few examples (Fonseca and Malheiros, 2005). Some studies indicate, for example, that Afro-American women tend to seek medical care at advanced stages of breast cancer, when compared with white women who tend to seek care at earlier stages, which is reflected in the higher rates of mortality in the former group (Brown et al., 2000).

Gender also has a strong, indirect influence on many health determinants. At a macro level, for example, allocation of resources in the health sector

is made based on cultural presuppositions related to gender and social representations about women's capacity to make decisions (Albrecht et al., 2000 apud Marshall et al., 2005).

Precariousness of work, instability or absence of social protection and the costs associated with health care can also be barriers to utilization of services by immigrant populations (Fonseca et al., 2007), increasing these populations' vulnerability to disease. Siddiqi et al. (2009) that in the USA and Canada, health insurance is one of the differentials in access to health care between immigrants and non-immigrants.

The economic and social background is, along similar lines, one of the factors that most condition accessibility to health, as it is known that immigrants with fewer socio-economic resources are those who least use medical care (Derose et al., 2007). This fact is particularly relevant in considering that an elevated percentage of immigrants decide to immigrate for economic reasons when experiencing financial problems in their countries of origin. A 2012 study by Coutinho et al., which questioned 499 hospitalized women immigrants 24 hours after giving birth, indicated the main reasons they immigrated to Portugal were improved living conditions, lack of employment and money in their country of origin, closer proximity to family members, and positive references with regard to Portugal.

## Final Reflections

Portugal has, in recent decades, begun to follow the trend of other European countries with respect to the feminization of migrations (Castles and Miller, 2003). The number of female immigrants in the country has grown, today being similar to that of men. Although studies about migration favor an androcentric approach to the phenomenon (Assis, 2003), the more visible presence of women in migratory scenes has made their characteristics and trajectories more and more evident; they are described in the literature, although rarely from a gender or intersectoral perspective.

Among the myriad of questions related to immigrant communities, questions of health have special interest for investigators, as health is often one of the most important indicators of non-native

community integration. In line with this supposition, the European Union stresses that each member state should provide quality medical care that is adapted to the needs of different population groups, including migrants, meeting the specific conditions of each national health system (European Commission, 2006).

From analysis of the impact of migrations on the migrant populations' level of health, criteria can be established that are personal, but also social, economic, and political. As it is untrue that migrations alone are processes generating vulnerability to illness, it must be considered that, for some migrants, migratory experiences are effectively risk experiences, whether referring to health status or use of health services.

Studies have come to conclude that female migrants tend to be more vulnerable to physical and psychological illness than male migrants and native women, although different degrees of vulnerability are found in different groups of migrant women. These findings reinforce the need to consider migrants as a heterogeneous universe, with specific and not always coinciding needs, which should be observed as a function of the particularities which are present (e.g. age, occupation, nationality, sexual orientation). Young, old, lesbian, disabled, or refugee women are some of the groups of migrants who tend to be neglected in migratory studies, or hidden by identity groupings considered to be dominant (European Commission, 2010).

The studies actually suggest that migrant women contend with enormous challenges with regard to the issue of accessibility to health care. The difficulties seem to intensify in the domains of sexual and reproductive health, with pregnancy and maternity being the periods of greater vulnerability to illness and to risk, for the women and for their children.

The results of studies carried out in this area point in the direction that health professionals are not adequately prepared to work with migrant populations, often contributing to reinforce the difficulties these populations experience. They denote acute gaps or total absence of training at the level of multicultural competencies, which could contribute to minimizing some of the difficulties most often reported by the immigrants, especially with respect to the language. Truly, the existence of



language assistance and cultural competency training diminishes barriers between the professionals and the immigrants, increases access to services and, lastly, improves the health of the most vulnerable people (Ponce et al., 2006). Scarcity or absence of information about cultural specificities, and the tendency to adopt an ethnocentric vision of health, often causes immigrant women to feel inhibited and discriminated against in seeking support, staying invisible and isolated. The lack of social and family support frequently felt by these women, connected with conditions of poverty and economic precariousness, places them in a situation of great social fragility which, as is known, encourages the development of psychological disturbances such as depressive states and, at worst, suicidal ideation.

Limited or lack of access to health care for immigrants can reflect the failure of a health system which claims to be democratic and for everyone. More than reevaluating health policies, the mode in which these are applied must also be reevaluated, with the participation of the migrant populations who deal with them on a daily basis. As we are reminded by Bäckström (2009), health professionals also are confronted with new concepts of health and illness every day in their professional practice, and interventions in these concepts are not always linear or simple. Beyond investigating the needs of the immigrants, it is equally necessary to listen to the health professionals and support them in this learning process which is mutual: between who arrives and who is already there. The challenges faced by the immigrants often collide with the challenges of the system and of the people who embody it, which is why it is so important that the work of reorganizing health services, in the sense of equality and inclusion, be shared by all.

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