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trabalhadores de saúde

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The Family Health Program in the Bom Retiro district, São Paulo, Brazil: communication between Bolivians and healthcare workers

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This paper presents the analysis of the interaction between the Family Health Program (PSF) and Bolivian immigrants in the Bom Retiro district of São Paulo, Brazil, through specific experience. To this goal, semi-structured interviews were conducted with Bolivians and healthcare workers at the Bom Retiro PSF, with the particular aim of ascertaining the dimensions of the worlds of work and housing and the great migratory spatial mobility, thereby requiring flexibility within the cartographic logic of the PSF, with broadening of the concept of family and communicative strategies – hiring of a Bolivian healthcare agent, production of educational material in Spanish and use of Bolivian radio stations –, which would have the capacity to be translated into improved healthcare services.

Keywords: Healthcare communication. Ethnicity and health. Bolivian immigrants. Family Health Program. Bom Retiro district.

Introduction

The *Programa de Saúde da Família* (PSF – Family Health Program), currently defined as Family Health Strategy, was instituted by the *Política Nacional de Atenção Básica* (PNAB – National Primary Care Policy) as a strategy to reorganize Primary Care, replacing the traditional care model¹. In January 2013, it reached a national coverage of 105 million inhabitants (54%)². Merhy³ and Paim⁴ discuss the difficulty of a single model responding to the diversified and complex health situations that exist in Brazil.

With the expansion of the Family Health Program in large urban centers, in 2001 the municipalization of health occurred in the city of São Paulo, and this model was implemented in the neighborhood of Bom Retiro, located in the central region of the city. This neighborhood

constitutes a unique landscape, a social microcosm that has been marked, since its origin, in the end of the 19th century, by the presence of diverse ethnicities: it has received, throughout its history, large amounts of immigrants with very peculiar cultural characteristics⁵. Today, the Koreans and Bolivians have become the two groups of immigrants with a remarkable presence in the neighborhood. Both are included in the material basis of the clothing industry, as textile production is one of the structuring economic axes of Bom Retiro^{5,6,7,8,9}.

The inclusion of the *Unidade de Saúde da Família* (USF – Family Health Unit) in the neighborhood of Bom Retiro triggers reflections on the potentialities and difficulties of the Family Health Program in large urban centers^{10,11} and also raises questions related to the presence of these immigrants, requiring diverse analyses on the theme of the interaction between healthcare professionals and these users.

Methodology

This is a qualitative research carried out in the capital city of the State of São Paulo, at the Family Health Unit of Bom Retiro, with four Family Health Teams. The Unit is managed by the Municipal Health Department in partnership with the hospital and institution *Irmandade da Santa Casa de Misericórdia de São Paulo*.

In qualitative research, saturation sampling is used to define sample size. The number of participants was considered sufficient when the research data reflected the totality of the multiple dimensions of the object of this study and became repetitive¹². Concerning sample composition among users, we used “snowball” sampling, in which one participant nominates another and so on. Among healthcare professionals, the criterion was “length of service”.

For data collection, we utilized the semi-structured interview. Nine subjects were interviewed: three Bolivian users and six healthcare professionals from the Unit (the manager, one doctor, one nurse, one nursing technician and two community health agents, one of whom was Bolivian). The interviews were recorded and transcribed, and the participants were identified by the letters: HP – Healthcare Professional; BU – Bolivian User; thus, their anonymity was guaranteed.

The interviews lasted an average of 34 minutes and followed a script containing open questions. To the healthcare professionals, they approached the neighborhood of Bom Retiro and its ethnical composition, and allowed them to analyze: the Bolivian immigrants; acceptance of enrolment by the Community Health Agent; adherence and bond with the Unit; users' needs and demands; facilities and difficulties in the interaction with them and strategies used to overcome the difficulties; and the activities developed with these groups of users. The script for the Bolivian users approached their inclusion in the neighborhood, mainly in sewing workshops, and their settlement there; their health needs and demands; and the utilization of the Family Health Unit of Bom Retiro, mainly the aspects of access, bond, adherence and communication with the team.

Results and discussion

The neighborhood of Bom Retiro - a palimpsest

The neighborhood of Bom Retiro forms a unique landscape that has been constituted, over time, by the permanence and circulation of groups from several origins; and by additions, substitutions and inclusions, configuring one landscape written over another, in a confluence of sociocultural layers defined as a palimpsest, in the words of Milton Santos¹³.

This conformation started with Italian immigrants, the first ones that arrived at the neighborhood, at the end of the 19th century – as a result of the subsidization of immigration by the government of the Province -, intended to form the labor force in the coffee plantations located in the Western region of the State of São Paulo. The process of constitution of the neighborhood continued when, from the World War I onwards, countless foreigners coming from Eastern Europe, the majority of them of Jewish origin, arrived at Bom Retiro. There, they generated the first clothing manufactures and shops, and the neighborhood started to have a commercial function. From 1970 onwards, the Koreans arrived, running away from a war situation in their country, and entered into this sector. From 1980 onwards, Bom Retiro started to receive droves of Latin Americans, mainly Bolivians who, motivated by the economic crisis in their country¹⁴, were also introduced into the clothing production chain. It is important to highlight that all these immigrants arrived at São Paulo searching for work and, in the case of Bom Retiro, they concentrated on the clothing sector, which has become an economic activity niche for immigrants in this neighborhood.

Located in the city center, Bom Retiro is perceived by the Bolivians as a place with attractive qualities: the proximity to sociability spaces and, mainly, to work contacts; the possibility of constructing neighborhood relationships; and the accessibility to public transportation. The neighborhood constitutes a scenario of transition in which inclusion is more viable when the immigrant arrives at the city with few resources and little autonomy, which facilitates placement at a sewing workshop⁷.

Interviewer: How does the flow of Bolivians to Bom retiro occur?

BU1 [owner of the sewing workshop]: The majority of them don't have opportunities in Bolivia, and if someone here has been doing well, he comments on it, and then everybody wants to come. All of them are searching for a better life. Most of them come here with no intention of staying in Brazil; they just want to work here for a while and then they want to go back.

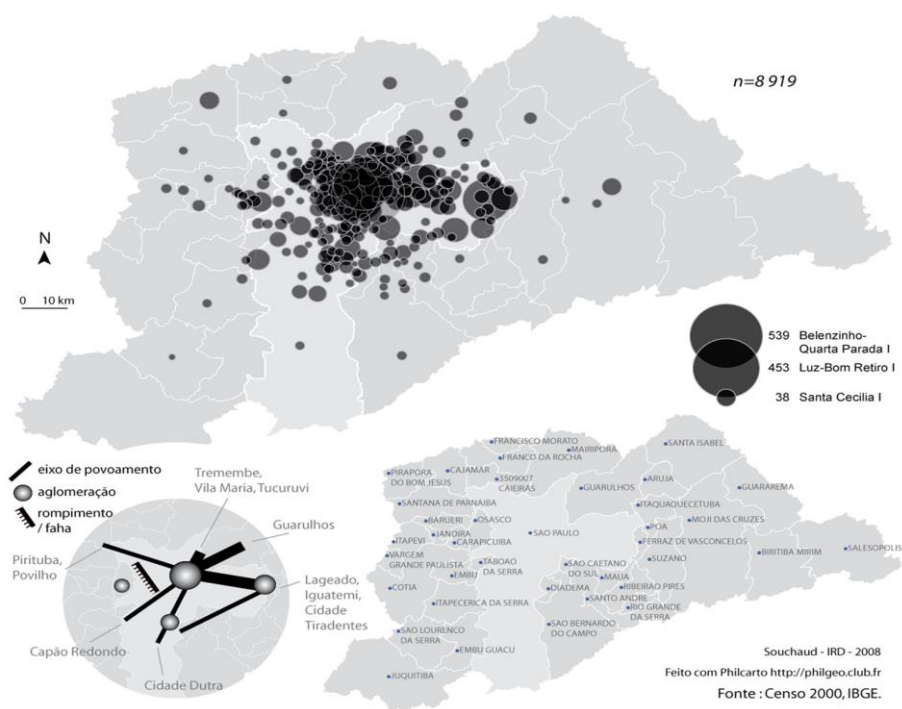
It is important to highlight that there has been a circularity of experiences among these groups that have started, historically, to co-exist in the neighborhood of Bom Retiro. These experiences allow us to understand how what is particular and what is general have come to

intertwine, forming a social tissue whose complexity is very interesting in this area of the city of São Paulo. These cultures have been absorbed by the daily routine of the social practices, in a process in which these cultural marks were identified, but never “encysted”, in such a way that the Bolivians have related to the Italians’ “Bonra” (the way in which the Italians referred to Bom Retiro); to the Jewish culture, identified in churches and synagogues, in markets and restaurants; and also to the Koreans: their shops, restaurants, schools, and their cultural, sports and religious institutions, which are identified by plates in Portuguese and in Hangul, the Korean alphabet.

From the Bolivian plateau to Bom Retiro

From 1980 onwards, there has been an intense immigration of Bolivians to the city of São Paulo, in search for better job opportunities, as a result of the poor economic conditions of their country. These immigrants are predominantly single youths of rural origin, of both sexes, with an intermediate level of schooling¹⁴.

From the spatial point of view, they concentrated on neighborhoods like Bom Retiro, Brás and Pari in the 1990s, where they worked in the clothing industry¹⁴. Today they are spread across the central and peripheral areas of the city; however, they still concentrate on those neighborhoods, which shelter 19.5% of the Bolivians who live in the city. This reiterates the central neighborhoods’ vocation for being the immigrants’ entrance door into the city of São Paulo¹⁵, which can be observed in the map below.



Map 1. Distribution of the population born in Bolivia, residing in the Metropolitan Region of São Paulo, in 2000.

Source: Souchaud, 2008

The presence of relatives and countrymen settled in Bom Retiro has become a motivation for Bolivians to immigrate. In addition, they maintain strong bonds with their country of origin, which results in a tendency to perform a circular movement, with comings and goings between São Paulo and Bolivia and a true desire of going back there one day¹⁴.

I arrived here, downtown São Paulo, at Parque Dom Pedro [...]. The first time it was through a colleague that had worked here in Brazil for almost two years. He arrived at Bolivia and commented about here, and I wanted to come because there are jobs here, and I worked in the sewing area in Bolivia. [...] Then, in the middle of the year, I moved to the neighborhood of Paraíso, there was a Korean working there. I worked with the Korean until the end of the year. Then I came back and worked at Bela Vista for four years. Then I started working only as an employee, a tailor, and after four years, almost five years, in 2000 I started to build a workshop with my younger brother and began working on my own [...]. I rented an apartment in Bom Retiro, at José Paulino street, and then I started to work in my own business. (BU1)

Concerning the estimates of the size of the Bolivian community in São Paulo, there is a large variation that ranges from 10 to 30 thousand non-regularized Bolivians, according to the

Ministry of Work and Employment, to 200 thousand (regular and irregular), according to the Public Ministry. The most recent datum provided by the 2000 Census¹⁶ indicates the presence of 8,909 Bolivians registered in the metropolitan region of São Paulo¹⁷. The consensus among these estimates is the fact that São Paulo shelters the largest number of immigrants in Brazil, but the imprecision of the data about this community poses methodological challenges to the construction of scientific knowledge about it.

The sewing workshop (combination between home and work) and the Family Health Program

At the beginning of the 20th century, the neighborhood of Bom Retiro was marked by the presence of small factories where goods were handmade. Many of them were installed in the same space of the home or in a space next to it, where family members worked or a few employees who lived in the same neighborhood. This was the industrial characteristic that predominated in the city in the first half of the 20th century and it marked the landscape in its territory, where the association between home and work on the same piece of land or in the same building seemed to be the rule, not the exception, in the neighborhood⁶.

The maximum expression of this combination, nowadays, is represented by the countless sewing workshops that exist there, where Bolivian immigrants work and live. The formation of sewing workshops with their current characteristics had its origin in 1970, with the arrival of the Koreans at Bom Retiro. At that moment, in view of the need to compete with the producers that had come to São Paulo from the Northeast region of Brazil and worked with low-price, low-quality clothes, accumulating production and wholesale, the Koreans organized themselves to work at home, with the participation of relatives and countrymen, during long working hours, so as to reduce production costs¹⁸.

The arrival of Bolivians at Bom Retiro occurred from 1980 onwards, in a moment marked by the Koreans' economic rise. The Koreans were distancing themselves from the production segment and were starting to play another role in the clothing industry, creating their own brands, which would be sold in their wholesale shops¹⁹. Another relevant aspect was the fact that, at that moment, the national labor force – essentially female and coming from other Brazilian states – that predominated in the sewing sector migrated to the services sector, and this opened space to Bolivian workers in the production segment²⁰. The background of these changes that occurred in Bom Retiro was the restructuring of São Paulo's clothing industry, with the aim of reducing costs: it was convenient, then, to consolidate the emergence and diffusion of small and medium-sized, subcontracted, sewing workshops⁹.

Thus, the Bolivians were initially hired by the Koreans to work in the workshops and, subsequently, they started to be the owners of the workshops, and the Koreans became the main buyers of their productions. A peculiar aspect is the fact that – as we argued above – these

workshops started to combine the working and living space to the Bolivian immigrants, who had just arrived at the neighborhood with little money, in an underground situation; and working and living in the same place was a way to solve the housing issue, not to mention that it was profitable to the employers, as they could maintain their workforce close to them¹⁴.

They [the Bolivians] live in the same place where they work. (HP5)

[...] if we think about the workshops, which today are places where it's very difficult to go, because people live, work and interact there, with their children, etc. [...]. (HP1)

The sewing workshops in Bom Retiro constituted places of inclusion and social ascension. The informality and flexibilization of these organizations facilitated integration into the job market and the completion of the migratory project of people who, frequently "unregistered", without knowledge of the job market, and with a poor command of the language and habits of the society of the destination country, would have little chance of staying in São Paulo²⁰.

[...] The Koreans are the owners of power here in the shops of Bom Retiro. The other part belongs to the Bolivians, who have also come to this region because there is a large market, due to the shops and to the sewing activity. They work to the Koreans. [...] The ones who are becoming great owners of workshops and who have been bringing many Bolivians to work in the region are the Bolivians themselves. Bolivians who used to have only one function, that of sewing, today have become owners of workshops and employ other people to work for them, producing goods to the shops. [...]. (HP3)

These sewing workshops, with this configuration, have provided a singularity to this neighborhood, which has required that the Family Health Unit understands it from a multi-territorial perspective, leaving aside a partial understanding, under a legal-political line in which the definition of territories based only on the size of the population, with no proposal for the typification of such territories, limits the efficacy of the actions²¹.

Considering the Family Health Unit's need to adapt its regulations when it interacts with Bom Retiro, an issue to be discussed is how this model, whose object of action is the family, has come to understand the sewing workshops, a space that combines home and work to the Bolivian immigrants. Analyzing the main official documents of the Family Health Program^{22,23,24}, we noticed an imprecision concerning the concept of family: they define it based on the space in which people live, the space-domicile, which is the point-of-departure to the logic of domiciliary enrolment used in this organization proposal.

The choice of the family as the main factor determining the population's health, the central intervention nucleus to change the morbidity and mortality profile, and the absolute center to

approach social problems, means a reduction and a regression in the conception of social production of the health-disease process²⁵. Undoubtedly, it will be positive to look at an “individual in relationship with” in opposition to the “biological individual”; and, where there are traditional families, the understanding of the dynamics of this nucleus will enrich the healthcare work. However, sometimes this nucleus is not present; sometimes, it is not the predominant relationship space, not even the place of synthesis of people’s way of conducting life²⁶.

In light of such considerations, let’s go back to the reality of Bom Retiro, where the Bolivians’ enrolment is performed at the sewing workshops, a fact that has brought the inevitable need of broadening the concept of family. In this context, we have a set of immigrants who work at these workshops and also live there. Nevertheless, sometimes the relationships among them are not close and, sometimes, they are not fulfilled²⁷. Furthermore, the fact that these immigrants are workers who live at the workplace puts them in a risk situation and is related to the Family Health Unit’s need to take into account the local production processes and to identify their relation to the workers’ and dwellers’ health^{28,29}.

The Bolivian’s “visibility” by means of the Family Health Program

According to Cymbalista and Xavier³⁰, this community has low visibility in São Paulo, as it is a group that is practically absent from the public statistics. These authors argue that the sewing workshops are a space of “collective privacy” and mention the internalization of the community, with hypertrophy of the workplace, which would determine the group’s invisibility and its low utilization of public equipment, commerce and services. However, the healthcare workers’ discourses suggest that the Family Health Unit of Bom Retiro may have another meaning to this immigrant, who searches for an “identity” there.

The Bolivians come here saying: “I came to have my SUS* card made”. It’s the first identification that they want, “I’ve just arrived and I need the SUS card”. And they have a very unique, very articulated network. I think that, when they come here, they do so to require an identity at this Healthcare Unit, which, in this case, is the SUS card. Sometime ago we used to make more than one hundred SUS cards per week [...]. (HP1)

On the other hand, Xavier⁷ has reiterated that the Bolivian immigrants’ relation to the Family Health Unit assumes a fundamental meaning in the process of their inclusion in the city, mainly regarding their identity, as the SUS card starts working as an identification – many times,

* SUS = *Sistema Único de Saúde* (Brazil’s National Health System).

the first one that they receive in Brazil. In addition, according to Silva³¹ and Silva and Ramos³², the Bolivians have a remarkable presence in the Family Health Unit of Bom Retiro, recognized as a conviviality space, as it is one of the few spaces that they attend.

Sometime ago, whenever I got sick, as I was single and had the workshop, I used to attend the [hospital] *Beneficência Portuguesa* and I paid for the consultation. Now the consultation is too expensive, [...] I started using the unit with my son and my wife, who got pregnant, and then she started attending prenatal consultations at the healthcare unit. It was then that I started to use the healthcare unit of Bom Retiro. (BU1)

The Bolivian immigrants' mobility in bom retiro and the cartography of the Family Health Program

The operational principle of the Family Health Program is based on clientele enrolment, which allows the establishment of bonds between the Family Health Unit and the population, and theoretically enables to rescue the commitment to co-responsibility between healthcare professionals and service users. It has become clear that, when we deal with a neighborhood like Bom Retiro, it is necessary to flexibilize regulations, so that the bond between professionals and users, mainly the Bolivians, is preserved, as the latter have an intense mobility across the territory that results from their inclusion as workers in the sewing workshops. If the norms are not adapted to the reality, we run the risk of imposing organizational barriers to the access to the service. Thus, the highly prescriptive nature of the Family Health Program may negatively affect the potential of its proposal²⁶.

According to Pereira and Barcellos²¹, the delimitation of areas and micro-areas for operation, which is essential to the implementation and evaluation of the program, is generally performed based only on the size of the population, without considering the social and political dynamics that is inherent in the territories. The Bolivian immigrants circulate across many spaces of the city, with a strong concentration on the central region¹⁵. This constant movement is due to the search of new jobs at sewing workshops. This aspect emerges from the workers' discourses.

[...] today, they [the Bolivians] are spread, so they stay here and after a while they go to another workshop [...] They move a lot, from one team to another. The Bolivian Healthcare Agent only deals with Bolivian enrolments, and she performs an average of fifty, one hundred enrolments per month. She circulates, so they move all the time. I don't know if it's because of better working conditions or what, because they live together in some workshops, so I think that it's when they get a better space, I don't know. (HP1)

The adaptation of the Family Health Program to the bolivians' "circulative" movement

Territorialization and the bond of a given population with the Family Health Teams are nuclear ideas to the Family Health Program's proposal, whose theoretical framework is mainly circumscribed to the field of health surveillance. In view of the characteristics of Bom Retiro as a "circulative" territory, with Bolivians included in sewing workshops, with a high turnover and always searching for better opportunities, we agree with Franco and Merhy²⁶ when they argue that the Family Health Program runs the risk of disarticulating its transforming power, imprisoned in defined norms, according to the ideal of health surveillance.

When the Family Strategy was conceived, it was not conceived to this or to that type, at least I can't see differences, and I don't think there should be any. It's exactly the same thing: you'll take care of families. The only great difficulty is that this group of immigrants [Bolivians] has a very large mobility. In one month they live in an address and then they move. This, to the organization of the service, is very complicated. (HP2)

An exemplary case of this flexible understanding required by the Bolivians' frequent changes of address within the neighborhood is the adaptation that has been made to this Unit's enrollment logic: usually, when one user moves from one micro-area to another, the Community Health Agents transfer the user's enrolment among themselves. When this occurs among Agents who belong to different teams, this includes changing the doctor and the nurse who are responsible for the care that is provided for that user. This situation has negatively affected the continuity of prenatal assistance and the treatment of Bolivian immigrants who have tuberculosis, a very common disease due to their unhealthy living and working conditions³³. In light of this, the team agreed internally that, when there was a change between the catchment areas of the Family Health Teams, the initial enrolment would be maintained, ensuring the conclusion of the assistance with the same team with which a bond had already been established.

[...] a large part of the Bolivians has health problems, it's tuberculosis. So, I think there should be differentiated care [...] the conditions in which they live are precarious, they don't have a space to sleep when they are tired, after having worked during the whole day [...]. (HP5)

Many times, they don't attend the prenatal consultations, they begin the assistance, but don't conclude it, much because of their mobility, as they are always moving from one workshop to another. She begins receiving prenatal assistance here and all of a sudden she moves to another neighborhood and so on, it's a very big change, sometimes they move not only to another street, but

to another neighborhood. So, we have to go after them, searching for them, to know where they are. [...] Even when she changes areas and goes from the blue [micro-area] to the red one, she keeps receiving prenatal assistance from the [doctor] who started it until the end. The same happens in the case of tuberculosis. (HP5)

Some studies^{31,34,35} have discussed the importance of approaching cultural issues – mainly related to childbirth – during the Bolivian woman's prenatal assistance, as there are many reports on the difficulty in performing their deliveries at public hospitals in the city of São Paulo: they are against procedures like the Cesarean section, which has a pejorative meaning among them. Thus, it will only be possible to discuss these themes with Bolivian pregnant women if the continuity of their prenatal assistance is guaranteed and if such issues are considered.

The communication between the Bolivian immigrants and the Family Health Team

When we approach the interaction between Bolivians and healthcare professionals at Bom Retiro, the issue of communication emerges. However, it is important to underline the polysemy of this object, and it is necessary to delimit the aspect that interests us, that is, the conversation network involved in the interaction between them, either inside the Family Health Unit or in the territory. According to Teixeira³⁶, the nature of the healthcare processes that occur in the encounter between worker and user is eminently conversational.

In this sense, there are many difficulties related to the understanding of the spoken language, as the Bolivians do not constitute a homogeneous group from the ethnic point of view: Bolivia is a multiethnic and multicultural society, with 26 different languages that are subdivided into 127 dialects³⁷, as the narrative presented below reveals:

[...] the Bolivians come from different places in Bolivia [...] they speak different native languages. I myself don't understand them. [...] for example, I speak Spanish and another native language, and other people speak other native languages, too. (BU3).

On the other hand, the healthcare service workers mention difficulties in understanding what the Bolivians say to them, and also identify the Bolivians' difficulty in understanding our language.

[...] I think that the Bolivians have difficulties in understanding Portuguese [...]. (HP4)

[...] it's the language, because Spanish we can... how can I say it... it's hard, but we can understand something [...]. (HP5)

Therefore, it is possible to notice that this encounter can be marked by “misunderstandings”, which negatively affect adherence to the proposed instructions and treatment. The Bolivians think that their complaints may not be understood, and the healthcare professionals are surprised by the lack of understanding of their message.

[...] He [the doctor] doesn't understand well. I was a little afraid... sometimes they speak differently, then they give us medicines, I don't know. [...]. (BU3)

[...] I think that the difficulties are these barriers to understand. For example, some days ago we were having an activity about dengue, so we were talking about the care that must be taken, the question of vases, still water, and then one of these Bolivians said: “No, I won't catch the disease because I'm not from this country”, [...] (HP1)

Some strategies were proposed by the Family Health Teams to amplify and improve the “conversation” between Bolivians and the healthcare professionals of the Family Health Unit of Bom Retiro. One of them was the hiring of Bolivian Community Health Agents from 2003 onwards, which has facilitated the access to the sewing workshops and has enabled a better understanding of the inclusion of these immigrants in the territory and of their cultural characteristics.

Working at the workshops imposes challenges to the utilization of the Family Health Unit, as the payment of the workers depends on production and, therefore, interruptions are approved neither by the workshops' owners nor by the workers. In addition, the Community Health Agents have difficulties in performing, at the workshops, the enrolments, their monthly home visits or any other activity. In view of this, the Bolivian Health Agents have started to raise the owners' awareness concerning the need to facilitate these types of interruption, so as to enable the healthcare professionals' access and to fight the fear derived from the underground situation of the workshop workers.

[...] They [the Bolivians] are afraid of opening their house's door to receive us. They think that we're not there because of healthcare, but for another reason, and then we really have difficulties. They don't allow us to enter [...] if the owner isn't present, the worker can't open the door so that we can go in, meet them, talk to them, right? [...]. (HP5)

The incorporation of Bolivian Community Health Agents into the Family Health Team has enabled to better understand the reality experienced in these workshops and the complaints that are frequently made by the Bolivians, mainly muscle pain, which results from long working hours using sewing machines. To alleviate these complaints, the Family Health Team has developed stretching exercises at the workshops.

Today, the most frequent disease is low back pain, arm pain. This is the disease that most of them report when they arrive at the Unit [...]. These complaints are related to the Bolivians' way of life, because they work for 14/15 hours uninterruptedly, in the same positions, and they stop exclusively to eat. [...] there are many repetitive exercises. [...]. (HP3)

In fact, we have been trying to do at least some labor work so that they leave the machines for a while, but it's not easy, I think it's a very hard and complex task, because how can you combine profit and this need? How is it possible to combine these two things? (HP1)

Other actions to improve communication are related to the creation of an educational material in Spanish and also to the participation of these Community Health Agents in educational activities, which often take place at the workshops themselves. Furthermore, a handbook has been written to the Family Health Team containing expressions to be used in the daily routine, aiming to enable a better interaction between the professionals and the Bolivians.

[...] the medical team has been working to create a handbook, a kind of vocabulary, a short dictionary containing basic words: "Good morning!", "Good afternoon!", "What are you feeling?", "What do you need?", "How are you feeling today?", "Where do you live?". This dictionary was written in the three languages: Portuguese, Spanish and Korean, and it has helped us a lot to at least establish some understanding with the two cultures. (HP6)

In relation to the Bolivians, we [the healthcare professionals] have also developed some handbooks with instructions to pregnant women, instructions about hypertension and diabetes, the issue of tuberculosis, some handbooks and leaflets that could really help us [...]. (HP1)

Another vehicle used by the Family Health Teams to improve communication are the Bolivian radio stations, which are related to the symbolic role of the central areas as a space of urban resources: only in the city center can one listen to these stations, for it is not possible to tune to them outside a determined and limited perimeter. In the sewing workshops, it is very common to see a radio that remains turned on all the time, a vehicle that broadcasts all pieces of information, gives instructions about procedures to regularize the stay in Brazil and job offers, helps to locate relatives and friends, and also serves as a friendly, comforting voice that prevents the Bolivian from feeling alone in the city⁷. These radio stations also approach the issue of health - they mainly warn of the danger of tuberculosis -, and advertise ointments and creams for backache and cramps, which are frequent among them.

Thus, the Family Health Team recognizes the relevance of this vehicle and uses it as a communication channel with this community. In addition, it recognizes the importance of participating in spaces located in the city center, to which the Bolivians go in search of conviviality and group identities, such as the Kantuta fair, which happens on Sundays in a neighborhood that is near Bom Retiro. There, commercial, gastronomic and artistic relationships are established; jobs and services are offered, such as haircuts, photographs, among others¹⁴.

[...] Now the teams have been participating in many feasts, like the Kantuta feast, which is for immigrants only. There are other feasts and fairs, other places where we have been always present, talking to them. There is a community radio station that is specific to the Bolivians, to immigrant communities, [...] the professionals have been there to give interviews and talk about health [...].
(HP1)

Although the implementation of the Family Health Program and its organization are highly regulated by the Ministry of Health, it is in the daily routine that the Family Health Team faces diverse realities in its territories and can identify that such regulation is insufficient, using knowledge that has been generated by an integral view and proposing varied strategies to improve the interaction between the services and the users.

According to Mendes-Gonçalves³⁸, this knowledge, as (immaterial) technology, is utilized in the production of healthcare services. We understand technology as the set of knowledge and actions applied to the production of something. Merhy³⁹, in his proposal of typology, has called "soft technology" the working technology used to produce health. Moreover, Ayres⁴⁰ highlights the central place of care in the health practices and underlines that practical knowledge supported by technology is useful to health, but health interventions cannot be reduced to it.

Final remarks

In spite of the regulations, when the Family Health Teams of Bom Retiro established a bond with the community, they promoted the flexibilization of the cartographic logic of the Family Health program, as they adapted themselves to the territoriality that is typical of these immigrants in the neighborhood. Therefore, the incorporation of the Bolivian Community Health Agent has been very important to reduce the distance between the service and the users, as it has facilitated the access to the sewing workshops, improved the understanding of their routine and broadened the comprehension of the social production of the health-disease process.

Although the nature of the Family Health Program is strongly prescriptive, with intense "surveillance" in a given territory, we must be careful not to, in spite of its origin, dogmatize it a

priori. This attitude may prevent the recognition of the potentialities of this program, when the reality of the territory overcomes the Ministry's regulations and reveals creative experiences.

This study suggests that the Family Health Program can enhance the knowledge about the Bolivian immigrants in the city of São Paulo and can promote greater visibility and recognition in their relation to the service, as a means to build other identities. In this way, the Family Health Unit of Bom Retiro has started to be part of the conversation network that this community has built in its daily life.

Collaborators

The authors worked together in all the stages of development of the paper.

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