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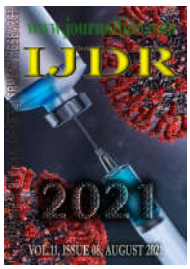

RESEARCH ARTICLE OPEN ACCESS

HEALTH ACCESS OF CAPE VERDEANS IN LISBON-PORTUGAL

***Janaína Alvarenga Aragão, Luciano Silva Figueiredo, Elvis Gomes Marques Filho, Evandro Alberto de Sousa, Maria Vieira de Lima Saintrain, Virna Rodrigues Leal Moura, Yana de Moura Gonçalves, Ígor Alcenor Granja de Moura, Vitória Martins Granja de Moura, Carla Ledi Korndorfer, Rita de Kássia Leal e Silva, Patrícia Maria Santos Batista, Verônica Lourdes Lima Batista Maia and Joyce Mesquita Nogueira**

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****Corresponding author:***
Janaína Alvarenga Aragão,

ABSTRACT

Social exclusion and inequalities have been discussed for years. Human migration occurs because people seek advanced and structured societies in technologies. Fact due to inequalities in economic development between countries. Among social inequalities, we have health access. Ageing grows in different parts of the world, and it implies increasing public health expenditures. This article seeks to understand the relationship between immigration, health and aging of Cape Verdean elderly residents in Lisbon-Portugal. This exploratory, qualitative study was carried out with Cape Verdeans in July 2013 through interviews with a semi-structured questionnaire and participant observation, the data being processed by content analysis. Social inequalities affected the health access of Cape Verdeans, with the scarcity of materials and physicians, the low income that impaired the purchase of medications and/or reach to health care. Therefore, it is necessary to reduce social inequalities, to change this situation of absence or ineffectiveness of public policies (health access). Urgent for immigrants and viable by embracing the existing welcoming policies, and the creation of new ones with goals for the near future.

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INTRODUCTION

Exclusion and inequalities in developed countries have been discussed since the 1970's, products of the disarticulation between economy and politics due to the interruption of the post-war expansionist cycle and the new and last structures of capitalism, reducing citizenship rights and impoverishing living conditions of people, in some situations driving the abandonment of the homeland (CARNEIRO, 2006). Human immigration, being it forced or voluntary, is a natural and ancient phenomenon, today occurs due to globalization, where people look for societies developed in technologies (transport, education, communication, health, safety,...) and well-structured. It also occurs due to inequalities in economic development between countries, in addition to political and armed conflicts (GRANADA *et al.,* 2017). Among the social inequalities, access to health has associated determinants, causing the actions of programs and policies for access to health to be reorganized to serve the most vulnerable individuals and regions. These are regions where it is necessary to rethink the redistribution of financial resources, education, life expectancy and other problems to reduce social distances (GOMES et al., 2016). The number of elderly people grows worldwide, and implies an increase in health expenditures, so governments must focus investments in health promotion for the elderly population to live longer and better (NUNES, 2017). The Portuguese population decreases among young people and people of working age, and increases among elderly people in the total population, with a probable trend until 2080, due to low birth rates, increased longevity and negative migration balances in general (INSTITUTO NACIONAL DE STATÍSTICA, 2016). The last factor is related to strict immigration control policies, usually based on security reasons. Therefore, in this scenario, the article seeks to understand the relationship between immigration, health and aging of elderly Cape Verdeans residing in Lisbon-Portugal.

METHODOLOGY

The survey was conducted in Lisbon-Portugal, which in 2016 had an estimated resident population of 10,309,573 – of which 4,882,456 men and 5,427,117 women. The Portuguese population continues to decline, a fact verified since 2010, and continues to age (INSTITUTO

NACIONAL DE STATÍSTICA, 2016). The number of participants was obtained by accessibility, the least rigorous among the types of sampling, devoid of any statistical rigor. The researcher selected the participants he had access to, assuming that they could represent the appropriate context for the research. This sampling is widely used in exploratory or qualitative studies, where a high level of precision is not required (GIL, 2007). With observation, a lot of knowledge is acquired, through the senses to assimilate messages from the external world. Therefore, participant observation was used to verify the actual participation of the group's knowledge, the elderly Cape Verdeans, where the observer assumes, to a certain extent, the role of a member of the group. Through this technique it is possible to get to know the life of a group from within itself (GIL, 2007). For data collection, a semi-structured interview with open questions was chosen (GIL, 2007; BELL, 2008), carried out with eleven elderly Cape Verdeans at the Cape Verdean Solidarity Association of Friends of the MargemSul do Tejo, in Largo dos Cravos, Vale da Amoreira, in July 2013 through pre-scheduled meetings. We assume as elderly those aged 60 years and over (for developing countries, e.g. Brazil), and those aged 65 and over (developed countries, e.g. Portugal). Carried out with Cape Verdeans, the 2nd largest immigrant community in Lisbon according to a study by the Institute of Preventive Medicine and Public Health/Faculty of Medicine, University of Lisbon on Access to Health Care and Health Level of African and Brazilian Immigrant Communities in Portugal (GOULÃO et al. 2015). The interviews were digitally recorded, transcribed in full for content analysis, category identification, coding, among other interests (BELL, 2008). Content analysis (BARDIN, 1977) performed, is a set of communication techniques that uses systematic and objective rules for the description of the content of messages and comprises the phases: A) pre-analysis - the documents to be analyzed, the formulation of hypotheses and objectives are chosen, and the elaboration of indicators that support the final interpretation; B) exploration of the collected material - consists of coding, discounting or enumeration operations, based on previously formulated rules; C) treatment of results, based on the results, it is possible to propose inferences and anticipate interpretations regarding the foreseen objectives or unexpected discoveries. The results, shown by the interviewees' statements and respecting the interviewees' anonymity, are cited by the letter I and the number of the respondent in order, I1, I2, and I3.

RESULTS AND DISCUSSION

Based on socio-demographic data, we could conclude that the majority of respondents were female (eight), aged between 60 and 80 years (nine); mostly married (six), separated/single (three) and two widowed. Regarding the number of children that respondents had, most had more than five children (seven respondents), one child (two respondents) of the respondents and two to four children (two respondents).

The majority's level of education was low, eight knew how to read, write a little and do math, and the other part were illiterate (three). Verified in the following statements:

> *I1: I can't read... At that time there was no support to study. It was work to survive, it wasn't state work, it was on land.*
> *I3: I didn't have school. I didn't work... because my husband was an emigrant and I stayed at home taking care of the children.*
> *I4: A little bit, I did the first and second grade.*
> *I8: ..., I never studied. It was just work, I was born on January 30, 1940 and on that day my father died and in June 1947 my mother died. I was left without anyone at the age of six. I was raised by my grandfather. When I was 15 years old my grandfather died and I stayed in the house working in agriculture because there was no one to support me.*

The good educational level of immigrants from Portugal is important, as studies show that the higher the educational level, the better the assimilation of information, including health information, to promote better prevention and quality of life, especially among the elderly who maintain at this stage of life an intense relationship with health services (LOUVISON et al., 2008; BORIM et al., 2012; LINS et al., 2013). All born in the Republic of Cape Verde, emigrated to Portugal for various reasons: for their own health/and family members (five), war/politics (three), as confirmed in the lines below. They had Portuguese nationality (eight), two did not and one respondent had a residence permit.

> *I5: I came to Portugal in 1979, I came to stay here for two months and then I went to France... Because of the cancer in my left breast, I refused treatment in France and came to Portugal for it... They said I was stubborn, it's true I was stubborn because I know what I want… I wasn't satisfied and so I came to Portugal. I came and I was glad I came, I didn't find doctors, I found angels.*
> *I4: I came in 2000, because my husband had been here for 17 years, he was a bus driver, a truck driver and then there was an accident... He didn't die at the time, he was crippled, in one foot, in the hand, he died about nine years ago... I came later because he had other health problems and the doctor sent a letter to us to come and take care of him because he was in the hospital and there was no one to take care of him. So I came, I arrived here and after seven months he passed away.*
> *I2: The reason that brought me to Portugal was to flee from PIDE (International State Defense Police). I worked at the Magisterium of Tomário, I saw things I couldn't see, I was poor and we had a social canteen there, we had a law that in the canteen what was left was thrown away. There were children who arrived with a small bottle and said, Mr Teacher, my mother said that instead of me drinking milk here so I can take it home, she put a little bit of water and sugar to share with my brother. This was expressly prohibited, and I was caught doing it several times and then I was called to the school inspector and I said I did it and I would do it again.*

There are motivations that accelerate migration processes, such as the level of industrialization, with Europe being the preferred destination, especially for people coming from Africa. “The dimension and structure of immigration is linked to the colonial history of the target countries” (CASIMIRO, 2008). Another reason would be the constant increase in the picture of inequalities between immigration countries within each geographical area. And for Cape Verdeans, emigration was, and continues to be, a driving force and a universal link, which made the diaspora a multicultural and interactive community (CASIMIRO, 2008). These factors have determined an acceleration of migrations that have been experienced in Europe over the last twenty years. The main repulsive factors are economic (unemployment, drought, hunger, natural disasters) and political (wars, dictatorships) and others such as the attractive alternative of urban life in contrast to the 'stagnation' of rural life (RAVENSTEIN, 1885).

Theoretical analysis of migratory phenomena that were studied by Ravenstein (RAVENSTEIN, 1885), who said that the Laws of migration try to explain migrations through flows conditioned by variables, called repulsion and attraction (push-pull). According to Lee(1969), most migrants move for short distances, and only do so far away, in search of large industrialized centers such as Cape Verdeans who emigrated to Lisbon and Rotterdam. Nowadays there are several types of migration, and for this reason the protection of specific groups, such as refugees, has been harmed, as in some situations they are not granted the possibility of requesting refuge. The attitude that most characterizes this action of central countries in relation to immigrants is an attempt to increase barriers and deconstruction of certain rights, such as that of refugees. This lack of understanding on the part of States about mixed flows leads them to act inversely to the commitments assumed in international documents. In this sense, there has recently been a political interest in mixed migration flows for a better approach by academia, and by institutions that produce norms and propagate good practices, in terms of protecting migrants (SILVA et al., 2017). The financial situation of the interviewees was that of

two non-retired people, four in a pre-retirement/retired situation and five receiving disability pensions, health problems and compensation, that is, they lived with few financial resources. Checked in the lines below:

> *I1: No, I have a pension because of the health problem, I worked and lived my life. My doctor gave me the paper for the pension and that's how I support myself.*
> *I3: No, because I never worked. Yes, I receive a pension of a hundred and a few euros. It used to be two hundred, but then there were cuts. It's to pay the house rent… Very difficult, especially for medicines, which are expensive, those for the heart, cholesterol… It's a bit difficult, but we fight, my son and I. We eat a cookie with a cup of waterand keep walking. I can't leave my son because he doesn't see. He had a tumor on his head, had an operation and went blind… I did everything, I got so tired, so tired, we had to lift him, wash him, sometimes he fell... my God... Now he does it alone, he showers alone, he gets dressed...*

It was also investigated how access to health occurs among those surveyed, the health network offered to elderly Cape Verdeans. How is your health? It was the 1st question asked, most answered that it is bad, not good, and three claimed to be good, as we see in the speeches:

> *I1: I don't think so, because a person who doesn't move normally with everyone doesn't have such good health. My health, look... I have bone problems, even today with this crutch I couldn't walk.*
> *I12: I'm not healthy. I have back problems, high blood pressure, diabetes, cholesterol, everything… On the outside it looks like I'm fine but on the inside…*
> *I5: I have two friends, younger than me, I'm already 75 years old, but people my age and also younger than me who don't even walk anymore, I thank God, despite the age I am, I survived cancer and thank God I'm healthy today, I don't have what to complain about. I don't see very clearly because I have cataracts, but the doctor told me that he doesn't know if I'm going to be operated on for cataracts...*

Factors determining access to health include the acceptability of the health system by users, the relationship with health professionals, the adequacy of the number of professionals to provide services, secondary care/reference, financing of the health system, among others (VIEGAS *et al.,* 2015). In the aging phase, the challenges are varied, as the importance of social support for the health of people can be highlighted, not only when they are in health services, but also in the community, as a transforming instrument in the health and disease process of the elderly, which should be carried out by various social actors, including the elderly and other members of society (family, friends, neighbors, religious groups, health and social service professionals, students, among others) (GUEDES et al., 2017). The health, and access to it, of Brazilian quilombola communities is still poorly studied and there is still much to be debated; where there is a great disparity in health care, it is important to unite all health professions to change this situation, an action of great challenge, but necessary to correct a sad passage from our past and present, as these groups are still excluded from the current development process. Studies show that there is a need for constant assessment and analysis of the health conditions of quilombolas of all age groups and genders, in order to create intervention strategies and thus obtain improvements in the quality of life of these groups (LEITE et al., 2016; CARDOSO et al., 2018; FREITAS et al., 2011).

Enabling health and access to health for these groups is difficult due to their specificities, as territory and identity are closely related as a lifestyle, a way of seeing, doing and feeling the world. Sociocultural specificities and differences must be highlighted, valued and prioritized when managing a sustainable development model for quilombola communities, together with the integration of five other dimensions: environmental, social, cultural, economic and political sustainability. Only from this perspective will it be possible to ward off the threats that surround these communities, such as: titling, to ensure land ownership and ownership, ensuring viable alternatives for their survival with dignity, recovering and renewing their culture; environmental legislation that does not recognize the rights of traditional populations, and often favors tensions and conflicts in the areas, which make their permanence on the land and education impracticable, where schools operating in communities do not have guaranteed maintenance nor do they value the culture location (BRAZIL, 2004). The majority participated in social support groups (nine of those interviewed), the most cited support groups were the church (nine times) and the Cape Verdean Solidarity Association of the Friends of MargemSul do Tejo (five times interviewed). Of the elderly people interviewed, four lived alone and seven with their families. The lack of social and community support networks in the destination society, the disruption of social and family relationships resulting from immigration without family, isolation, nostalgia, fear of deportation in the case of undocumented immigrants, and the consequences of trauma, fears in the case of refugees, increase their vulnerability (STAMPINO, 2007). Stressful situations that can lead these groups to aggravate the situation, triggering the emergence of mental health problems (PADILLA, 2013).

Social support networks are difficult to implement in practice, it is a challenge for people's health and for health services, and the community (family, friends, neighbors, religious groups, health and social service professionals, students, among others, and the elderly themselves) a transforming instrument in the health-disease process of the elderly (LEITE et al., 2016). Social support for caregivers of the elderly is also important to prevent health implications, overload, bio-psychosocial wear and to provide favorable conditions for their quality of life, by allowing greater freedom to develop their daily activities (ANJOS et al., 2015). Social support increases the well-being of the elderly, leading them to evaluate their lives in a more positive way, to experience more pleasant affections than unpleasant ones (ROCHA et al., 2017). Living among family members is very important to strengthen the health of older people. In relation to health services and access to them in Portugal, some questions were asked such as what they thought of the medical appointments; to this question, the majority (ten of the interviewees) answered that they thought it was good, as we can see in the following statements:

> *I2: Good. In principle they work well, it is already known that there is a shortage of materials.*
> *I10: Good. Yes, when I got there I make my file and I wait there sometimes 20, 30 minutes. In the mud it takes longer, sometimes a whole morning.*

The respondents' answers do not corroborate with what Padilla (2013) says when stressing that hunger, lack of access to medicines, treatments, diagnostics, difficulties in making appointments, are everyday situations in health centers and associations that assist the immigrants, concentrated on the outskirts of Lisbon.

As for the health service they use the most when they get sick, the majority responded that they seek the Vale da Amoreira Medical Center (ten of the interviewees), as shown in the following statements:

> *I1: It's a medical post. There, every agent makes an appointment and, if necessary, goes to the hospital. The post is open every day except Saturday and Sunday. If we feel the need to go to the hospital we can go.*
> *I9: It's the Vale da Amoreira center, because it's close and people go on foot, there's often no money for transportation, and when I have to go to the hospital if I don't have money, I make an effort and walk. It's at night that if you give me anything, it's that I'm afraid it has to be either an ambulance or a taxi.*
> *I10: It is the health center in Vale da Amoreira. Yes, it used to be in Baixa da Bath, but then I asked the family doctor to move me here because it was closer.*

Basic health care is important. In Brazil, several advances were consolidated with the Family Health Strategy (ESF), mainly in the expansion of access to home care, especially in the care of the elderly and chronic diseases. However, there is still a strong influence of the hegemonic biomedical model in care practices, despite the actions to combat it in the daily life of health services (FERTONANI et al. 2015). Two main points can still be added for the harmony and effectiveness of the service in primary care: first the teamwork that reorients the health care model through collective actions and sharing of information; second the notion that continuity of care will only be guaranteed when the perception of the need for the work of the other is valued (SANTOS et al., 2016). The treatments most offered and sought after by them in the health services in Lisbon were, closer to where the interviewees lived, to get medication (pills, injections, vaccines) (seven), consultation (seven), dressings (two) and to measure the blood pressure (two):

I4: There are appointments, and there are many things. The nurses gave injections and when I had high blood pressure the doctor told the nurse to give me a pill under my tongue and when I got better I came home.
I5: When I have high blood pressure, I go to the Medical Center and ask the doctor if I can measure the blood pressure. I don't like being around doctors, always bugging them. It was a short time ago, I went before going to São Tomé now. She went to the doctor about the vaccines for dengue and malaria.
I8: I went there once to get a vaccine... And I went there because my... told me to get a tetanus shot and I went...

Aragon's research (2014) found that the distance between the residence and the Basic Health Unit greater than 5km was a significantly important factor for the lower chance of preferring non-traditional health knowledge. In the study, geographic distance interfered in the access to health of the quilombola communities studied in the rural interior of the State of Piauí - Brazil. Also, for the same author, the rural communities surveyed were located in areas that are difficult to reach, which is geographically why they needed the feasibility and organization of assistance from health professionals and the administration of managers sensitive to their historical context. In Lisbon, in the studied community, a reality close to the Brazilian rural quilombola communities was also verified, with the factor of social inequalities being the one that most affected the access to health of Cape Verdean families, the first reason reported was the shortage of materials and doctors, necessary for professionals to provide adequate health care, then the low income was verified, which hindered the acquisition of some medicines to continue treatments and/or to reach the nearest health establishment for consultations, as explained below, in the testimonials:

I2: Good. In principle they work well, it is already known that there is a shortage of materials... not easy because doctors always have to make an appointment beforehand, or go there early in the morning and wait in line. Well, not even the doctors who are working can give an answer. It is not about arriving at the clinic at the time and being treated immediately, there is a shortage of doctors. It is necessary to arrive early and find vacancies. It's by order, it's already scheduled, my doctor is simple, she's a young girl and she's assiduous, now not all doctors are like that, there are doctors who show up late.
E3: I receive a pension of a hundred and a few euros. It used to be *two hundred, but then there were cuts. It's to pay the rent for the house… Very difficult, especially for medicines, which are expensive, those for the heart, cholesterol…*
E8: You have to be there at 5:00 in the morning to make an appointment.
E9: It's the Vale da Amoreira center, because it's close and people go on foot, there's often no money for transportation, and when I have to go to the hospital if I don't have money, I make an effort and walk. It's at night that if you give me anything, it's that I'm afraid it has to be either an ambulance or a taxi.

About the health professionals who work at the medical post, 10 of the respondents said they have a doctor, nine responded that they have nurses, seven responded that they have other professionals such as: counter staff, secretaries, employees, employees, attendants, and the staff who fill the records and the secretariat staff. As for medical care in the last year, the majority (nine respondents) consult regularly. And about the time it took to make an appointment and wait for an appointment at the clinic, the majority (eight) said it was easy to make an appointment and that they did not wait long for an appointment, and three replied that it was difficult.

I1: Yes, you get there and make an appointment on the same day. Don't delay.
I2: Not easy because doctors always have to make an appointment beforehand, or go there early in the morning and wait in line. Well, not even the doctors who are working can give an answer. It is not about arriving at the clinic at the time and being treated immediately, there is a shortage of doctors. It is necessary to arrive early and find vacancies. It's by order, it's already scheduled, my doctor is simple, she's a young girl and she's assiduous, now not all doctors are like that, there are doctors who show up late.
I8: You have to be there at 5:00 in the morning to make an appointment.
I12: Yes, but sometimes it's very crowded and it's difficult to schedule. When there was no family doctor it was more difficult.
I1: I have to take medication every day, my life has been like this, that medication I have to do. For all the problems I have, I have a lot of health problems. So the doctor gave the prescription for six months, instead of going there all the time. I already have those prescriptions and as I live next to the pharmacy, my granddaughter goes to pick them up when the medication finishes.
I3: Last month. That I had the controls to do and the tests to deliver, which I had at the hospital last month. For 7 days, I was connected to machines and that, because of the tension, I felt very bad.
E5: It was a short time ago, I went before going to São Tomé. I went to the doctor about the vaccines for dengue and malaria.

In Brazil, the "More Doctors Program" (PMM) alleviated the shortage of doctors in primary care by expanding access to health, but on the other hand it made some municipalities dependent on the program, especially those that already lived in time with situations of shortage and deprivation of health services. The PMM was launched in 07/2013 by Provisional Measure No. 621, later converted into Law No. 12871, on 10/2013 (GIRARDI, 2016). Studies are currently being carried out to assess the impact of this program on the SUS and the health of the Brazilian population with the departure of Cuban doctors from Brazil. In Portugal there was no program (PMM), but the launch of a similar program could help reduce the shortage of doctors in Lisbon. Based on the Brazilian experience, Portugal could launch the program with actions that anticipate and minimize possible negative consequences and predict future ones, as occurred in Brazil. In the last consultation, the majority received a prescription with a prescription for medication (eight), where the majority (seven of the interviewees) claimed to have to buy all the medications and four claimed to be able to buy only a part of the medications.

I1: I have to buy them all. As there are many medications, I sometimes buy some in a month and in the next month I buy the rest.
I2: I have to take one every day, the doctor writes the prescription and I buy it.
I3: Sometimes I can't buy. I didn't buy it, sometimes the recipes are there because the money doesn't pay.
I5: No. No, I don't have an abundance of wealth
I9: Yes, it's with his retirement that we buy the medicines for both of us, because he has a lot of sleeping problems, because he had many years in the army in Africa and he suffered a lot and today he's retired because of that, because where he worked he didn't he slept because he worked in shifts.

I10: Yes, but I have a discount because I have a user card and I have a discount. There was a time I almost couldn't pay, but now I pay.

In Portugal, being a woman, being divorced, unemployed, having a chronic illness, having a limitation in ADL, a lower level of education or belonging to a lower quintile are risk factors for having unmet health care needs (NNSCS). There is regional variation among NNSCS that needs further investigation. The NNSCS study makes it possible to identify barriers to accessing health services such as financial reasons, waiting time and distance. Identifying these access inequalities is the first step towards reducing them. That is why a cross-cutting policy intervention aimed at reducing health inequities and socioeconomic inequalities is important (MARTINS, 2017). Since the creation of the NHS, and in recent decades, the health of the Portuguese population has improved a lot, reflecting a political commitment to health and an economic growth that has allowed for better living conditions, with Portugal having achieved results that are close to the best values recorded in the countries of the European Union (DGS, 2012; BARROS et al., 2011). The situation of health and social well-being in Portugal declined only with the 2008 crisis, where the phenomena of social exclusion and inequalities emerged, impoverishing the population as a result of the reduction in the offer of employment and the precariousness of the labor market . And only in the future will it be possible to analyze in detail the impact of this crisis on the health of the Portuguese (MOREIRA, 2016; CORTES, 2016).

In this sense, the PNS 2012-2016 of the Portuguese NHS was complemented by nine priority national health programs, as they cover the main causes of death for both sexes in 2013. The programs are: National Program for Diabetes; National Program for HIV/AIDS Infection; National Program for the Prevention and Control of Tobacco Use; National Program for the Promotion of Healthy Eating; National Program for Mental Health; National Program for Oncological Diseases; National Program for Respiratory Diseases; National Program for Cerebro-Cardiovascular Diseases; Prevention and Control of Infections and Antimicrobial Resistance Program (DGS, 2012). It is noteworthy that the priority programs are not accompanied by an evaluation process (DGS, 2012; CORTES, 2016). And the absence of evaluation makes it difficult to know the reality, having a negative impact on the reorganization of actions in search of results, making it difficult to evaluate the results of implemented health measures (such as: the PNS and priority health programs). Therefore, it is important that public policies are studied, monitored and evaluated, so that they can be continually adapted according to the results achieved (CORTES, 2016). For the SNS, the current challenges today are: financial constraints and significant cuts in State budgets (as in the Portuguese case, with the Troika); the aging of the population and current health professionals and insufficient/difficulties in recruiting new professionals; the reduction of births; problems in the establishment of health professionals due to working conditions and low wages in some of the occupations, leading, in part, to "brain drain"/migration in a global market; emergence of new standards of care given the chronic conditions of population aging; importance of new technologies in health that require other/new skills and future professions and, finally, the increase in chronic diseases and the costs of illness/health (CORTES, 2016; MARQUES and MACEDO, 2018).

It can also be seen through some indicators of performance of services or hospital production, a decrease or stabilization in health outcomes. Facts perhaps associated with a reduction in access to care and an overload of services. In terms of health gains and results, the impact of the measures will only be fully visible in the medium and long term (CORTES, 2016). The lack of family doctors and of doctors in the countryside are topics that are much debated and need quick answers in order not to exclude citizens from services that should cover everyone (MOREIRA, 2016). Today, accessibility to health services has reduced for everyone, and more for immigrants. Of concern are the external, internal and self-exclusion barriers that have increased (socioeconomic inequalities typical of poverty, low command of the language, even affecting populations from the PALOPs who do not always speak or understand Portuguese, facts that affect access or their journey through the system health, and discrimination and social exclusion, both in the country of origin and in the destination (PADILLA, 2013). Legally all immigrants have "guaranteed" access to health care, but in practice there has been an increase in limitations. Portugal, in recent years, has moved away from the good practices and immigrant-friendly policies that it has defended so much, while at the same time deepening the path of increasing inequalities. Possibly in a short time, this change in strategy will result in worse health indicators for Portuguese and immigrants, in a setback in health literacy (PADILLA, 2013).

CONCLUSIONS

The historical context of immigration of these communities must be considered, paying attention to the local structure where they live today - residence levels; financial income; retirement status; Existing health services - as the majority of elderly immigrants have many health problems and few financial resources, it is impossible to provide them with health care, and for them to take care of their health and education. Factors that are important for health professionals, as a well-educated immigrant will better and more quickly absorb the learning of health actions that protect the human being; also the regularization of nationality is beneficial to facilitate daily access to the health system. Only from this recognition will it be possible to strengthen existing public policies for social support and health in these areas, and to foster a targeted organization of health professionals to meet their specific needs, from the Cape Verdean community residing in Portugal, especially the elderly. Access conditions reflect the characteristics of the provision of services, which can facilitate or hinder the ability of individuals in a given population to use health services according to their needs. Furthermore, they are influenced by sociodemographic characteristics and the health profile of users. As we have seen in this article, in the results, through the interviewees' testimonies, there are obstacles to the acquisition of adequate access to health by Cape Verdean communities in Lisbon - Portugal. To the detriment of this fact, the real need would be to reduce social inequalities, to reverse any situation of absence or ineffectiveness of public policies (access to health) of a State to its compatriots and people from other countries. It is urgent for immigrants to embrace existing reception policies and create new ones.

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REFERENCES

Anjos KF, Boery, NSO, Pereira R, Pedreira LC, Vilela ABA, Santos VC, Rosa DOS. Associação entre apoio social e qualidade de vida de cuidadores familiares de idosos dependentes. *Cien Saude Colet* 2015; 20 (5): 1321-1330.

Aragão J A. *Acesso de saúde na atenção básica prestada aos quilombolas, Piauí* [tese]. Porto Alegre: Pontifícia Universidade Católica do Rio Grande do Sul; 2014.

Bardin, L. Análise de conteúdo. Lisboa: Edições 70, 1977.

Barros PP, Machado SR, Simões J. Portugal: health system review. *Health Systems in Transition* 2011; 13 (4): 1-156.

Bell, J. *Projeto de pesquisa: guia para pesquisadores iniciantes em educação, saúde e ciências sociais*. 4ª edição. Porto Alegre: Artmed; 2008.

Borim FSA, Barros MBA, Neri AL. Autoavaliação da saúde em idosos: pesquisa de base populacional no Município de

Campinas, São Paulo, Brasil**.** *Cad* Saude Publica 2012; 28 (4): 769-780.

Cardoso CS, Melo LO, Freitas DA. Condições de saúde nas comunidades quilombolas. *Revista de enfermagem UFPE*2018; 12 (4): 1037-1045.

Carneiro R. Reflexões em torno de uma nova agenda para o enfrentamento da pobreza e das desigualdades sociais. *Ser Social* 2006; n.18: 15-46.

Casimiro EMV. *Percursos escolares de descendentes de imigrantes de origem cabo-verdiana em Lisboa e Roterdão.* Lisboa: Editorial do Ministério da Educação, 2008.

Cortes M. Breve olhar sobre o estado da saúde em Portugal. SOCIOLOGIA, PROBLEMAS E PRÁTICAS 2016; n. 80, p. 117-143.

Direção-Geral da Saúde (DGS). *Plano Nacional de Saúde 2012-2016.* Lisboa: DGS/DGS; 2012.

Fertonani HP, Pires DEP, Biff D, Scherer MDA. Modelo assistencial em saúde: conceitos e desafios para a atenção básica brasileira. *Cien Saude Colet* 2015; 20 (6): 1869-1878.

Freitas DA, Caballero AD, Marques AS, Hernández CIV, Antunes SLNO. Saúde e comunidades quilombolas: uma revisão da literatura. *Revista CEFAC* 2011; 13 (5): 937-943.

Gil AC. *Métodos e técnicas de pesquisa social.* 5. ed. São Paulo: Atlas, 2007.

Girardi SN, Stralen ACSV, Cella JN, Maas LWD, Carvalho CL, Faria EO. Impacto do Programa Mais Médicos na redução da escassez de médicos em Atenção Primária à Saúde. *Cien Saude Colet* 2016; 21 (9): 2675-2684.

Gomes DR, Gomes DR, Mattos MP. Desigualdades em saúde e a estratificação social no acesso aos serviços de saúde. *Revista das Ciências da Saúde do OesteBaiano – Higia* 2016; 1 (2): 19-33.

Goulão B, Santos O, Alarcão V, Portugal R, Carreira M, Carmo I. Prevalência de excesso de peso nos imigrantes brasileiros e africanos residentes em Portugal. *Revista Portuguesa de Saúde Pública* 2015; 33 (1): 24–32.

Granada D, Carreno I, Ramos N, Ramos MCP. Debating health and migrations in a context of intense human mobility. *Interface (Botucatu)* 2017; 21 (61): 285-96.

Guedes MBOG, Lima KC, Caldas CP, Veras RP. Apoio social e o cuidado integral: à saúde do idoso. *Physis* 2017; 27 (4): 1185-1204.

Instituto Nacional De Estatística (INE). *Estatísticas Demográficas 2016*. Lisboa-Portugal: INE; 2017.

Lee E. *A Theory of Migration*. Cambridge: Cambridge University Press; 1969.

Leite DS, Martins ALF, Ferreira JF; Batista KNM, Rosário MJA. Racismo, saúde e comunidades remanescentes de quilombos: reflexões da fisioterapia. *Revista Conexões de Saberes/UFPA* 2016; 01 (1): 111-116.

Lins APM, Sichieri R, Coutinho WF, Ramos EG, Peixoto MVM, Fonseca VM. Alimentação saudável, escolaridade e excesso de peso entre mulheres de baixa renda.*Cien Saude Colet* 2013; 18 (2): 357-366.

Louvison MCP, Lebrão ML, Duarte YAO, Santos JLF, Malik AM, Almeida ES. Desigualdades no uso e acesso aos serviços de saúde entre idosos do município de São Paulo. Rev Saude Publica2008; 42 (4): 733-40.

Marques APP, Macedo APMC. Políticas de saúde do Sul da Europa e desregulação das relações de trabalho: um olhar sobre Portugal. *CienSaude Colet* 2018; 23 (7): 2253-2263.

Martins JLV. Necessidades não satisfeitas de cuidados de saúde dos portugueses em 2014 [dissertação]. Lisboa: Universidade Nova de Lisboa /Escola Nacional de Saúde Pública; 2017.

Moreira ILB. O impacto da crise económica, financeira e social no acesso aos cuidados de saúde em Portugal [dissertação]. Coimbra: Faculdade de Economia e à Faculdade de Psicologia e Ciências da Educação – Universidade de Coimbra; 2016.

Nunes AM. Demografia, envelhecimento e saúde: uma análise ao interior de Portugal.*Rev Kairos*2017; 20 (1): 133-154.

Padilla B. Saúde dos imigrantes: multidimensionalidade, desigualdades e acessibilidade em Portugal. *REMHU-Revista Interdisciplinar da Mobilidade Humana* 2013; 21 (40): 49-68.

Ravenstein, EG. (1885). As leis da migração. *Jornal da sociedade estatística de Londres* 1885, *48* (2): 167-235.

Rocha LFD; Oliveira ER, Mota MMPE. Relação entre apoio social e bem-estar subjetivo em idosos: revisão sistemática. *Revista Brasileira em Promoção da Saúde* 2017; 30 (4): 1-13.

Santos RR, Lima EFA, Freitas PSS, Galavote HS, Rocha SEM, Lima RCD. Ainfluência do trabalho em equipe na Atenção Primária à Saúde. *Rer. Bras. Pesq. Saúde* 2016; 18 (1): 130-139.

Silva JCJ, Bógus LMM, SILVA SAGJ. Os fluxos migratórios mistos e os entraves à proteção aos refugiados. *Rev Bras EstudPopul* 2017; 34 (1): 15-30.

Stampino VG. Improving access to multilingual health information for newcomers to Canada. *J pode* saúde *Libr Assoc* 2007; 28 (1): 15-18.

Viegas APB, Carmo RF, Luz ZMP. Fatores que influenciam o acesso aos serviços de saúde na visão de profissionais e usuários de uma unidade básica de referência. *Saúde e Sociedade* 2015; 24 (1): 100-112.

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