


The “Venezuelan migrant” in Brazil: conceptions of coordinators of the Brazilian National Health System


O “sujeito migrante venezuelano” no Brasil: concepções de gestoras de serviços de saúde do SUS

Pedro Henrique Conte Gil^a

 <https://orcid.org/0000-0003-1158-8199>


E-mail: pedrohcontegil@gmail.com

Georgius Cardoso Esswein^b

 <https://orcid.org/0000-0002-6757-1954>

E-mail: georgius.esswein@gmail.com

João Luís Almeida Weber^c

 <https://orcid.org/0000-0002-7434-2359>


E-mail: jlweber27@gmail.com

Marina Basotti^c

 <https://orcid.org/0009-0003-2085-7503>

E-mail: mbasottii@gmail.com

Adolfo Pizzinato^d

 <https://orcid.org/0000-0002-1777-5860>

E-mail: adolfopizzinato@hotmail.com

^a Universidade Federal do Rio Grande do Sul. Programa de Pós-Graduação em Psicologia. Porto Alegre, RS, Brasil.

^b Universidade Federal de Ciências da Saúde de Porto Alegre. Programa de Pós-Graduação em Psicologia e Saúde. Porto Alegre, Rio Grande do Sul, Brasil. Universidade La Salle. Curso de Graduação em Psicologia. Canoas, Rio Grande do Sul, Brasil.

^c Centro Universitário da Serra Gaúcha. Curso de Graduação em Psicologia. Caxias do Sul, RS, Brasil.

^d Universidade Federal do Rio Grande do Sul. Programa de Pós-Graduação em Psicologia e Programa de Pós-Graduação em Política Social e Serviço Social. Porto Alegre, RS, Brasil.

Abstract

This study aims to analyze the conceptions of coordinators of the Brazilian National Health System services regarding the Venezuelan individual, as well as the health care practices of their respective teams of professionals with the Venezuelan population, in a municipality in South Brazil. This is a qualitative study that involved focus groups with coordinators of health services in the region. The results were analyzed via an inductive Thematic Analysis and organized into two main themes: (1) conceptions about the “Venezuelan migrant individual” in Brazil; and (2) health care policies, strategies, and practices for the Venezuelan population. We identified that the conceptions of coordinators point toward the vulnerabilization of Venezuelans in different spheres, while indicating a non-difference in relation to Brazilians and questioning the health rights of the migrant population in Brazil. Furthermore, there are no specific public health policies for Venezuelan migrants, instead there are actions at an interpersonal level by health service professionals. Getting to know the specificities of migrant populations, such as Venezuelans, provides an opportunity to develop consistent public health policies, especially for proposing more culturally sensitive health practices. **Keywords:** Brazilian National Health System; Primary Health Care; Human Migration; Venezuela; Focal groups.

Correspondence

Pedro Henrique Gil
pedrohcontegil@gmail.com.

R. Ramiro Barcelos, 2600 — Porto Alegre, RS, Brazil. CEP 90035-003

Resumo

O objetivo deste estudo é analisar as concepções de gestoras dos serviços de saúde do Sistema Único de Saúde (SUS) sobre o sujeito venezuelano, bem como as práticas de saúde de suas respectivas equipes de profissionais com a população venezuelana, em um município do interior do Rio Grande do Sul (RS). Trata-se de um estudo qualitativo, que operacionalizou grupos focais com gestoras dos serviços de saúde da região. Os resultados foram submetidos à análise temática indutiva e organizados em dois principais temas: (1) concepções sobre o “sujeito migrante venezuelano” no Brasil; e (2) políticas, estratégias e práticas de saúde e cuidado com a população venezuelana. Identificou-se que as concepções das gestoras apontam para uma vulnerabilização da população venezuelana em diferentes esferas concomitante a uma não diferença em relação aos brasileiros e questionamento dos direitos à saúde da população migrante no Brasil. Além disso, não há políticas públicas de saúde específicas para os migrantes venezuelanos, mas ações em nível interpessoal dos profissionais dos serviços de saúde. Conhecer as especificidades das populações migrantes, como dos venezuelanos, oportuniza o desenvolvimento de políticas públicas de saúde consistentes, sobretudo para a proposição de práticas em saúde mais culturalmente sensíveis.

Palavras-chave: SUS; Atenção Básica; Migração Humana; Venezuela; Grupos focais.

Introduction

According to the International Organization for Migration (IOM), the official agency of the United Nations (UN) for people in conditions of mobility, the Venezuelan migratory flow is already considered the largest exodus in the contemporary history of Latin America (IOM, 2024). Due to the complex conjuncture of historical, geopolitical, and socioeconomic factors, Venezuela faces a humanitarian crisis and human rights violations that have led more than seven million Venezuelans to leave the country.

Brazil, since it is a bordering country, has become an important destination for the Venezuelan population. Data from the Federal Police show that, since 2018, more than 640 thousand Venezuelans have entered the Brazilian territory, and this number increases daily (IOM, 2024). In terms of health, due to the frailty of human resources and scarcity of supplies for Venezuela's health facilities, most of the country's health centers have collapsed and are unable to offer basic care to the population (Mazuera-Arias *et al.*, 2019). Therefore, in addition to geographical proximity, the universality and free services of the Brazilian National Health System (SUS) has proven to be a determinant factor in choosing Brazil as a destination country, as it consists of a possible alternative for health treatments and care (Gil *et al.*, 2024).

In this context, the Venezuelan population becomes a significant portion of SUS users, especially in Primary Health Care, which is the gateway and organizer of care in health services (Brasil, 2017). The doctrinal and organizational principles of the SUS and Primary Health Care, as well as the branching public policies, are aligned with the paradigm of comprehensive health care, which advances from a strictly organic logic and encompasses the physical, psychosocial, cultural, environmental, and contextual dimensions of its users, when providing health care (Brasil, 2017; Scliar, 2007). Specifically in the care of migrant populations, healthcare providers need to orient their health practices in a culturally sensitive way, respecting markers beyond biological and socioeconomic ones, attending to subjective references, such as historical, political, linguistic, ethnic-racial, and symbolic (Amarante; Costa, 2012).

The relation between SUS and migratory processes has been the subject of current research. Literature reviews point to the challenges of the migrant population in accessing health services and care in these devices. Some of the challenges include communication difficulties, different conceptions of health and disease, cultural and religious intolerance, lack of consistent public policies, as well as resistance and discriminatory attitudes of healthcare providers (Faqueti; Grisotti; Risson, 2020; Araújo et al., 2021). Regarding Primary Health Care, a systematic review involving studies from different countries concluded that the challenges of providing care to migrants refer to the professionals' work overload, to the lack of training and preparation to deal with the specificities of these populations, and to the precariousness and insufficiency of service resources (Lima Junior et al., 2022). There is also regionalized and qualitative evidence that points to the obstacles in achieving universal access for migrants in the Brazilian territory, due to a lack of knowledge among healthcare providers about the population's right to access health (Delamuta et al., 2020).

However, the specific literature on Venezuelan migration in SUS health devices is still limited, especially because it is a recent phenomenon (Barreto et al., 2018). In any case, the available evidence also denotes frailties in the offer for comprehensive health care for the Venezuelan population, especially when we consider the obstacles that have already been documented regarding other migratory processes, which include linguistic disparities, discriminatory conceptions and practices of health services and healthcare providers, and the lack of knowledge of the inner workings of the SUS. These are issues that compromise the length of a population's care and, therefore, its effectiveness (Arruda-Barbosa; Sales; Souza, 2020; Barreto et al., 2018; Silva; Arruda-Barbosa, 2020; Neto; Oliveira, 2021). However, it has been thought that Venezuelan migration to Brazil has specific connotations, when compared to other large migratory flows that have already occurred in the country, such as that of Haitians (Gil; Pizzinato, 2023; Gil; Lopes, 2024). Such conceptions, in addition to the ethnic and mostly economic sieve, also permeate the political and social dimensions attributed to Venezuela,

that the country would have been destroyed by the ideology and practice of "communism" (Chagas; Modesto; Magalhães, 2019). Although it is something with less ballast, this reading seems to elicit ambivalent responses in Brazilians, sometimes being of inclusion, via a savior way (Gil et al., 2024), and at others, of exclusion, which seem to be associated with the intertwining between racism and xenophobia (Faustino; Oliveira, 2021).

This scope of representations, among professionals, invariably has consequences in the population's health, whether at the level of more verticalized practices or in the professional-user relationship itself, since both can mutually affect adherence and length of care (Caprara; Rodrigues, 2004). In this sense, a better understanding of these conceptions about the Venezuelan migrant individual is crucial to materialize the offer of comprehensive health care for migrant populations, contributing to the development of consistent public policies that, in addition to promoting better quality of life indexes, also mitigate xenophobic and discriminatory practices in health facilities (Amarante; Costa, 2012). In view of this problem, associated with the gaps in the literature on this recent and emerging phenomenon in Brazil, this study aims to analyze the conceptions of SUS health service coordinators regarding Venezuelan individuals, as well as the health and care practices of their respective teams of professionals with the Venezuelan population, in a municipality in the countryside of Rio Grande do Sul (RS).

Methods

Design and procedures

This manuscript refers to a cross-sectional, exploratory, and descriptive study (Creswell, 2021), which sought to understand the effects of a formative intervention operationalized by the research group, based on focus groups with health service coordinators. The theoretical perspectives used for data analysis involved the articulation between theoretical productions of Psychology, Social Sciences, Collective Health, and empirical studies on the Venezuelan migrant population, with attention to the specificities of this migratory

process in the investigated territory. The reading of the analyzed phenomena was based on the concept that the participants reproduce the hegemonic understandings of their territory, they are not the absolute origin of their discourse (Caregnato; Mutti, 2006). For this reason, specific elements of the territory, the migratory flow, and the characteristics of the services were also considered in the analysis process, so that our objective was not to offer absolute and generalizable data, but a territorialized and historical perspective (Haraway, 1995) that contributes to thinking about the relation of the coordinators with their conceptions and practices of health care for the Venezuelan population.

Therefore, the data in this study come from a larger research project, called “*Indicadores de saúde e apoio social de migrantes venezuelanos: um estudo longitudinal*” (Health and social support indicators of Venezuelan migrants: a longitudinal study), in which one of the integrated studies consisted of the elaboration and execution of a training for SUS healthcare providers in the highlands of Rio Grande do Sul (RS) on ethnic relations, migratory processes, and sexual and gender diversity in health. This training consisted of intervention research, of a formative nature, with moments of theoretical explanation, collective debate, and subsequent qualitative evaluation with focus groups. The study arises as a request from the 5^a *Coordenadoria de Saúde do Rio Grande do Sul* (5^a CRS - Regional Health Coordination) and the *Secretaria Municipal de Saúde* (SMS - Municipal Health Department) of a medium-sized municipality in the state of Rio Grande do Sul (RS) directly to our research group.

In general, the training aimed to sensitize the participating healthcare providers to the specificities and psychosocial care of Black, migrant, and LGBTQIAPN+ populations in public health devices. The methodology used was expository-dialogued lectures with specialists in studies and research with the respective populations, which took place in the months of May and June 2023. Therefore, four modules were organized: humanization and listening; LGBTQIAPN+ population; Black population; and migrant population. The modules lasted two hours each, totaling eight hours of training for the healthcare providers. In addition,

one last module was offered only for health service coordinators, via the focus group technique, with the purpose of understanding their perceptions about training and possible impacts on their health teams and practices. This module also lasted an average of two hours, which was conducted in July 2023.

This article derives from the qualitative analysis of the processes and data collected specifically in the last module of the intervention—the focus groups with the coordinators, which discussed the migratory issue and the ethnic scope in health care. Considering that the salient theme of these focus groups was the migratory processes into Brazil, especially of Venezuelan people, we analyzed the participants’ speeches that elucidate conceptions, stereotypes, discourses, and representations that organize a collective notion of “Venezuelan migrant individual,” as well as the health and care practices developed by their respective teams of professionals in the *Unidades Básicas de Saúde* (UBS - Basic Health Units) towards this population.

In terms of the operationalization of this last module and meeting, it began with the explanation of the focus group offer and, afterwards, the participants were divided into two groups, whose egalitarian compositions were randomly drawn (six participants per focus group). This alternative was chosen for a better deepening of the discussions, considering the number of participants. When the groups were already composed, a sociodemographic questionnaire was applied to the participants, and then the focus groups were conducted simultaneously, in separate and reserved rooms, by the researchers who compose the authorship of this article. Each group was recorded for later transcription and analysis.

This study integrates the results of the doctoral dissertation of the first author, made in the Psychology Graduate Program of the Universidade Federal do Rio Grande do Sul (UFRGS), under the guidance of the last author. The study was approved by the Research Ethics Committee of the Institute of Psychology, Social Work, Health, and Human Communication (IPSSCH) at UFRGS (CAAE No. 59079522.3.0000.5534), as well as by the Municipal Health Department of the city where the research was conducted (protocol No. 599/2022). The research adopted all the ethical

principles recommended by Resolution No. 466/2012 and Resolution No. 510/2016 of the Brazilian National Health Council, with all participants signing the Informed Consent Form before participating. To ensure the confidentiality of the participants, only the focus group in which the statements were originated is mentioned, without reference to the professionals.

Participants

The study included 12 coordinators of SUS health services in a medium-sized municipality in the interior of Rio Grande do Sul (RS). All of them identify themselves as cisgender women, most identified as White (n = 11), had a degree in nursing (n = 9), and had a postgraduate degree (n = 9). In addition, most were responsible for the management of Basic Health Units in Primary Health Care (n = 10) in the city, with the time of work in the respective services ranging from three to 26 years (mean age of 14 years).

Therefore, the participants were invited by convenience (Creswell, 2021), since the number of participants was conditioned to the interest of the coordinators themselves and referral from the 5^a CRS and the municipality's SMS. The only inclusion criterion for the participants was to be responsible for some SUS health service and related care in the mountain municipalities covered by the 5^a CRS, at the time of training. No exclusion criteria were established to cover a diversity of participants.

In terms of contextualization of the territory, the city in which the study was conducted has strong hegemonic cultural traditions, especially in terms of the importance of work, family configurations, and gender roles (Manfio; Pierozan, 2019). In addition to the resistance that the local community shows regarding ways of existence that are not aligned with the prerogatives of the hegemonic knowledge of the territory, it was found that non-European migrants are placed in subordinate positions in relation to migrants of Italian descent (Gil et al., 2024; Gil; Lopes, 2024). Therefore, the Venezuelan population is generally marginalized, either in the way "the Venezuelan individual" is interpreted, or in the social reality, via their work occupations that commonly involve manual activities with different

levels of unhealthiness and dangerousness, such as work in slaughterhouses and industrial production.

Instruments

Sociodemographic questionnaire. The following data from the participants were accessed: age, profession, nationality, place of birth, ethnicity, gender identity, marital status, education, function, and length of care in the SUS, in Primary Health Care, and in the current territory/UBS.

Focus group script. Focus groups are research tools used when interested in data interaction, which provide insights, and are less accessible without the interaction of a group (Creswell, 2021). Group discussions can elicit how opinions are created and, above all, how they are altered, defended, and eliminated in social-group exchange. The script of the study's focus groups followed the offer of questions, in which the participants were able to freely talk about perceptions about ethnic relations and migratory processes, as well as their interactions with work practices in their activity fields.

Data analysis

The transcripts of the focus groups were submitted to thematic analysis, an analysis format that has been widely used in qualitative studies (Braun; Clarke, 2022). This method consists of identifying, analyzing, and reporting patterns, called themes, which represent the grouping of these patterns, which synthesize relevant content from that data set. To conduct the thematic analysis, six stages are used: (1) familiarization of researchers with the data, by the processes of transcription, exhaustive readings, and interaction with the analyzed material; (2) generation of the initial codes, in which a first coding of the material is performed, assigning codes based on relevant and interesting characteristics of the data for the study's aims; (3) search by themes, in which the codes are grouped to identify possible consistent and relevant themes for the study; (4) review of the themes, a stage that consists of evaluating the coherence and how the themes that were identified so far operate in relation to the coded extracts and in relation to the other

themes; (5) definition and naming of the themes, in which the specificities of the themes are reviewed, seeking to find a representative name of the codes and meanings that it assembles; and (6) production of the manuscript of the analysis, which involves the description of the themes and contents analyzed, choosing the best and most representative examples of the speeches that characterize each theme.

Note that the thematic analysis that was conducted in this study is from an inductive perspective, that is, it does not start with any pre-defined theme. Thus, all the themes identified were organized based on the data, aiming to respond to the study's goal (Braun; Clarke, 2022).

Results and discussion

The results were organized into two themes of analysis: (1) conceptions of the “Venezuelan migrant individual” in Brazil; and (2) policies, strategies, and practices of health and care toward the Venezuelan population.

Conceptions about the “Venezuelan migrant individual” in Brazil

Conceptions about the Venezuelan individual are categorically associated with vulnerability markers. Initially, the precarious socioeconomic dimension is the main migratory motivation attributed, since the Venezuelan population would be in a situation of extreme poverty. In fact, this classist conception is not linked only to this population's new condition in Brazil, but that, even in Venezuela, they would already be in situations of severe scarcity, to the point of migrating to a context like the Brazilian one, which was also criticized by the participants. In this sense, Venezuelan migrants would be: “*Fleeing a country at war [...] with no papers, nothing but the clothes on their backs*” (GF2). Such condition seems to exemplify the coordinators' conceptions about the conditions experienced by Venezuelans in their own country, but this perspective is maintained in relation to those who are already in Brazil: “[at] every traffic light, [there is] a Venezuelan beggar holding a sign: ‘I’m Venezuelan I need to buy diapers for my daughter’” (GF2.). Therefore, they are surprised when they come across an individual who disagrees with this conception, not marked by so much

vulnerability. It is as if there were no other possible condition, other than of poverty, to be attributed to this migrant population: “*A beautiful Venezuelan came here [at the UBS]. You could see that she was a different person. She wasn’t a poor person, no. She was a person who probably had a better condition there*” (GF1).

Regarding the choice of the country, destination, and territory, the professionals attribute the arrival of Venezuelans to two main motivations: job opportunities and health conditions. Both seem to have mutual implications, since when migrants move to a city, they start to access health facilities and “fill” the services available: “*One [Venezuelan] tells the others: ‘In [study city] there’s this, there’s that, there’s that’. Then they come here from afar and end up filling the Municipal Public System*” (GF1). On this aspect, there is an emphasis on the impossibility of welcoming migrants, considering a supposed lack of job offers, something that would reinforce their vulnerability condition: “*They come, and we don’t have an adequate job offers or an expansion of job offers. Not just talking about health, education, social work. They come, perhaps, with the idea that they are going to have a job. Then, they arrive, and they don’t have a qualified workforce. What will happen? Go to the streets to ask*” (GF2). Nonetheless, some participants also recognize that the arrival of migrants has impacts on the Brazilian economy, attributing to them some participation in the advancement of the region: “*But they also make the economy turn, they increase it too, right?*” (GF2).

Migratory processes can imply staggered and overlapping vulnerabilities, of physical, psychic, socioeconomic, environmental, political, and symbolic orders (Prado; Araújo, 2019). This is enhanced when migration is configured in an involuntary dimension, that is, a type of displacement more associated with the survival field, than with planning and will to migrate. However, when it comes to the Venezuelan migratory process to Brazil, some important specificities of this phenomenon are considered. Although there is a lack of studies in the area, the study by Chagas, Modesto, and Magalhães (2019) analyzed the discursiveness shared in several far-right WhatsApp groups and identified a conception that is also associated with

an extreme scarcity of resources for Venezuelans, which is used as a political maneuver of social panic under the aegis “Brazil will become a Venezuela,” if the country came to be led by left-wing parties at the time (in the 2018 and 2022 elections). Therefore, while the savior discourse that Venezuelans need to “be rescued from communism” is produced, a conception of impoverished people is also nurtured, which will negatively affect the Brazilian economy. The effects of this discourse can be observed in the statements of the service coordinators, suggesting that Venezuelan migrants would come to Brazil to “steal our jobs” or to live on the streets and survive on donations (Chagas; Modesto; Magalhães, 2019). This phenomenon clashes with another intense migratory process to the region, referring to the Haitian population. In addition to not carrying this supposedly communist political-party connotation, Haitian migrants moved to Brazil for reasons related to the effects of natural disasters and/or civil conflicts that occurred in their country (Gil; Pizzinato, 2023). In this aspect, the impacts of racism and xenophobia in the territory are outstanding in the community integration of the Haitian population, since, because they have phenotypically Black characteristics, they are easily recognized by the community and, consequently, segregated by this ethnic marker.

In the health field, in the aspect that migrants access the services of the territory, there are findings about the health conditions of the Venezuelan population, which, again, converges to a vulnerable conception: “*They are coming with very poor health condition*” (GF1). The reports describe health conditions that were aggravated by a lack of care at the primary health care level, as well as situations of illness due to negligence that require care at the tertiary level. Although there are no official health indicators available on the Venezuelan population (Barreto et al., 2018), one can think about how the migratory process is implicated with their health conditions. Venezuelan migrants are a collective who had their health rights denied by the collapse of their home country’s health system and services (Mazuera-Arias et al., 2019). This condition, associated with the risks and vulnerabilities involved in the characteristics of their involuntary migratory

process, has created a population that arrives in the country with significant health vulnerabilities. There is some evidence from epidemiological and qualitative studies that reiterate these propositions (Arruda-Barbosa; Sales; Souza, 2020; Barreto et al., 2018; Silva & Arruda-Barbosa, 2020), pointing out that Venezuelan migrants seek care and treatment for health conditions that are not treated in their country, and that they demand practices and techniques of technological density at the secondary and tertiary levels of the SUS. These data corroborate our findings, as it is found that health care is an important factor in choosing Brazil as a destination country for the population, to the detriment of other countries that have identity, geographic, and linguistic characteristics that are more similar to Venezuelans, such as Colombia.

Health care was the first space in which professionals had the opportunity to have contact with the Venezuelan population. Such question has given rise to different conceptions about the Venezuelan individual, which seems to constitute an ambivalent paradox: sometimes they are the same, sometimes they are different from the native Brazilian population, or even from other migrant populations. This argument of non-difference, of not looking at these social markers, already configures a form of differentiation, since it absolutizes differences and prevents characteristics of this population from being considered both at the level of social conceptions and health practices, even contradicting the principle of equity of the SUS (Barros; Souza, 2016). Simultaneously, there are reports of professionals who seem to approach a logic of affirmation of differences, which are associated with a recognition and valuation of specific characteristics: “*The narrative that people are the same will never exist, because people are different, and they will always be different. And we must respect*” (GF1).

However, when it comes to the interactions between the Brazilian community and Venezuelans, the perception that this migrant population must adapt is identified, in an assimilationist and non-integrative logic: “*I think we need to work in the sense that they need to adapt to our country*” (GF2). Or even, sometimes, the presence of Venezuelans is perceived as a threat, because they would be enjoying a service or place that does not belong to them: “*If*

you taught a child to read and write in their native language and then you want them to arrive where our children are” (GF1). This is a differentiation also made in relation to migrants of other nationalities, such as Haitians and Senegalese, in which these migrants do not seem to generate so much discomfort, as they demonstrate themselves: *“most thankful”* (GF2) or *“try to understand how our system worked”* (GF2).

In addition, there is a significant lack of knowledge among professionals about the rights and duties of people in migratory situations: *“I have a question about this, when these people come, are they under the same Brazilian legislation?”* (GF1). This lack of knowledge, in addition to the judgment about the conditions of the population, can lead to negative perceptions about their migratory process: *“I don’t know if Brazil has opened the door too much, in a way that they arrive thinking they have more rights than everyone else”* (GF2). This phenomenon can have critical consequences, especially when there is no clarity about the right of universal access to the SUS for any person in the national territory, regardless of whether they are migrants or not. Such lack of knowledge of rights can constitute barriers in the provision of health services, as well as potentialize verticalized and/or discriminatory practices with the population (Delamuta et al., 2020), who, from the perspective of the participants in this study, supposedly would not have the right to health services. In the same way, the migrants themselves, also in a condition of ignorance, can place themselves in a subordinated position due to fantasies of being “reported” or “deported” when they question the figure of authority projected onto the healthcare provider, thus having their rights violated (Gil; Lopes, 2024). In view of this, we find that there is a current conception of a Venezuelan individual who *“might not be a citizen with rights”* in Brazil.

In this sense, even though it does not involve the Venezuelan nationality per se, but because it shows parallels in the violations of the rights of people in migratory situations, the study by Delamuta et al. (2020), when qualitatively investigating the experiences of healthcare providers from Primary Health Care with Bangladeshis, found similar results. In addition to vertical practices and discriminatory attitudes, the professionals questioned the

obligation of the SUS to serve the refugee population (Delamuta et al., 2020). On another occasion, via a case report regarding the influx of Venezuelans to the same countryside municipality of Rio Grande do Sul, we observed other important obstacles of health services in serving the population (Gil et al., 2024). Due to a technical bureaucratization in updating the address of the SUS card, Venezuelan migrants were prevented from accessing Primary Health Care for about four months, making it impossible to withdraw controlled medication and have follow-up appointments at this level of care. In this sense, it is worth questioning that, in addition to the asymmetrical relations between people in migratory conditions and healthcare providers, such doubts about rights or inflexible attitudes towards the population mark a serious attack on the principle of universality of the SUS.

In addition to the conceptions of vulnerability, of (not) being different people or of rights, an interesting conception still emerges in the discursive narrative of the focus groups: the assumption that Venezuelan migrants have the will to return to their country: *“Although they are welcomed, cared for in the country [Brazil], if you ask about their dream, it is to change this situation so they can go back”* (GF1). It is not a matter of invalidating the experience of the professionals with the population, however, the discursive formation of the groups points to a generalization of the interests of a large migratory group, which seems to relate to a fantasy built on common sense (Chagas; Modesto; Magalhães, 2019). It is as if, in the conception of coordinators and professionals, the Venezuelan population could not want to remain and even belong to the country they decided to migrate. Such assignment may even reveal a relativization of the need for adaptation and training of health services and practices for the migrant population, since the phenomenon is considered, even if partially, transitory, by the discursive formations of the focus groups.

Health policies, strategies, and practices with the Venezuelan population

The conceptions of the Venezuelan individual invariably impact the policies, strategies, and

practices of health and care of coordinators and professionals towards the Venezuelan population, either directly or indirectly. The description of this theme begins with the presentation of some challenges reported by the coordinators who are participating in the focus groups that sometimes occur in health care, as well as strategies used by the participants to deal with such challenges.

An outstanding challenge is configured as another facet of the absolutization of differences, a conception showed in the previous thematic axis. Even if considered different and vulnerable, Venezuelans, as users of health devices, are still considered “equal” to any other user of the SUS. This is something that would not imply specific health policies or practices for the population: “*I see some, at least in, in the team I work with, I don’t see differentiation*” (GF1). It seems that a possible differentiation in treatment sounds to professionals with a connotation of preferentialism, and not of equity in health. Moreover, while it is important to not discriminate against a population based on differences, denying the differences inherent to a migratory process can call into question the principle of equity of the SUS, compromising the integrality of care (Barros; Souza, 2016). And Venezuelan migrants, due to the migratory conditions discussed above, are already configured as a group that requires an equitable look at these specificities.

The coordinators reproduce this paradox by recognizing that, even if starting from the old assumption of equality, there are differences in the care provided to the Venezuelan population. The main challenges reported are justified by language and communication between Venezuelans and professionals: “*And in health it is even more difficult, because how are you going to explain that you have a stomachache. This hurts, that hurts. It’s tough*” (GF1). On the one hand, some considerations were learned about these differences in languages, which were aligned with a more solidary perspective and awareness of the difficulties faced in the context: “*We [Brazilians] are the only Portuguese speakers in all South and Central America. We are used to hearing Spanish. But they don’t listen to Portuguese*” (GF1). At the same time, there is another layer of reports that describe the resistance of professionals in the

care of migrants, again under the prerogative of communication, but that, by refusing to serve the population, explain different levels of discrimination and xenophobia. In these cases, the unilateral responsibility was even imputed to the migrants in learning to speak Portuguese, to the detriment of the professionals also being instrumentalized in the language: “*Professionals often refused to attend because they did not understand the language [...] They say ‘Why did you come here? Why don’t you learn Portuguese?’*” (GF1).

The challenges of communication between healthcare providers and the migrant population are understandable and frequently referred to in the literature (Faqueti; Grisotti; Risson, 2020; Araújo et al., 2021). However, note that the responsibility for this communication is attributed, above all, to the inability of a population known to be marked, according to the perspective of the interviewees, by vulnerabilities. These contradictions highlight the defensive position from which health teams act, blaming migrants for their condition, as well as for their unilateral overcoming. Consequently, the responsibility of the State, represented by the services and professionals, is omitted. Examples like this reiterate the need for a health care perspective, in which only a few have guarantees (Paim, 2009), which must still be overcome and replaced by a rights perspective.

Another important challenge was in terms of knowledge regarding the processed within the health services. Because this is a population that, upon arriving in the country, was unaware of the services and levels of care of the SUS, the professionals need a greater investment of time to explain issues that they do not need to occupy themselves with when dealing with native Brazilians—combined with the bureaucratic difficulties of having the SUS card for access to the Primary Health Care level: “*They had back pain and went to the urgency and emergency service. Because they were just arriving, they didn’t have the SUS card, so there were several situations that prevented access to the UBS*” (GF1). There is, also, reference to not understanding queues or order of service, which can create several conflicts: “*But they arrived, and they wanted to pass in front of everyone, because they had one of their people there*

and it ended up creating the biggest uproar [...]. We had to call the municipal guard” (GF2).

These issues were described as exhausting emotional demands for healthcare providers, as participants report a detachment of energy and greater time for mutual understanding: *“So you must have more patience than we are used to, with migrants even more so, because they often don’t understand” (GF1).* The lack of knowledge of migrants about the processes of the SUS, as well as the respective impacts both on access to health services accessibility and on the professional-user relationship, are phenomena found in the literature (Martin; Inoue; Silveira, 2022). This issue, in fact, exposes the insufficiency of public policies for the integration of the migrant population, which would facilitate access to the SUS and the dissemination of information about the processes and possible referrals to specialty services or services with higher technological densities.

Still, the coordinators reiterate that the presence of Venezuelans overloads services: *“Then it seems that it is filling up a service that was already difficult before” (GF2),* thus generating disputes between migrants and Brazilians: *“It’s dividing the little that we had or the nothing that was being offered, right? So it is obvious that these lines ‘These people came here to take our spots” (GF2).* Therefore, the service, which was already perceived as insufficient, has become even more overloaded. Note that a question that echoed in the groups does not refer to the improvement of services, but to the lack of conditions to receive migrants: *“Are we able to receive people with so many needs?” (GF2).* In other words, for professionals, it seems to make more sense to evaluate the possibility of not aiding migrants, than to seek strategies to expand health services.

Another challenge highlighted by the coordinators refers to what was called *“the way they [Venezuelans] arrived at the health service” (GF2),* referred to as boastful. According to some participants, when the migrants made demands for care and reportedly ignored the service procedures, it caused a rejection within the health teams: *“They want everything quickly. This makes our work process very difficult as well. Because it ends up creating conflict within the unit. It’s exhausting for the team” (GF2).* The

coordinators also consider a challenge having to deal with the resistance on the part of the teams, created by these conflicts, which stigmatize these Venezuelan migrants: *“This ends up creating a preconception. Then it is difficult for us to demystify this within the team, because their behavior ends up making the process difficult” (GF2).* Although a professional acknowledged during the focus group that some Brazilians also have similar attitudes: *“They are like us, Brazilians... We have very arrogant Brazilians too” (GF2),* there seems to be a shared understanding that it is more challenging to deal with the supposed arrogance of Venezuelans than with native Brazilians. Because those who are being helped, from a condition of vulnerability, are quickly understood as arrogant, if they do not have the attitudes expected by the team: *“At first it seems that there was empathy on the part of the team, to receive them. ‘They’re coming with difficulty, let’s help, etc.’ And after they, you know that line, you give them a hand, they want the arm?” (GF2).*

Evidently, different cultures have particular ways of existence and, therefore, have behaviors and practices that resonate with their cultural scope, regarding interpersonal relationships and also their health processes (Laraia, 2020). However, note the disparity in the reactions of professionals when they are faced with some behaviors of migrants that, as they consciously point out, tacitly resemble the behaviors of Brazilians. Such strangeness of the coordinators marks a differentiation that does not occur at the level of the action itself, but of the people who practice it. That is, a discriminatory conception of the migrant individual, in this case, the Venezuelan individual, which can be thought of from the logic of racialized xenophobia (Faustino; Oliveira, 2021). In turn, the concept refers to the intertwining and intersection between xenophobia and racism against migrants considered non-White by the territory’s population, something that reverberates in a selective and unequally distributed aversion of foreigners in Brazil. Such a prerogative goes beyond a sieve of purely class discrimination or intellectual prejudice but is based on the ethnic and identity markers of the migrants assisted in the health devices.

Given these challenges, some coping strategies and health and care practices were identified in the narratives of the focus groups, which we categorized at the public-political and interpersonal levels. At the level of public policy, the coordinators describe some necessary actions. The first one concerns the increase in structure and resources for health services: “*We need this increase in the services offering, because we do, there are too many people that need, right?*” (GF2). They also refer to the need to evaluate the municipalities’ conditions to accept migrants: “*A support network that acts before they come, to see if there are conditions to accept them, right?*” (GF2). This statement contains a suggestion to evaluate the structure of the municipality to serve migrants and not accepting them is a possible outcome. This is, therefore, a strategy of an exclusionary rather than an integrative nature, even if it is not explicitly expressed with this content.

Another issue that emerged in the data is the importance of intercultural mediators, even if they do not work in the city’s territory. Such strategy consists of hiring, via public services, people from the same ethnicity-nationalities as the population served, to assist in the communication between health professionals and migrants: “*Cultural mediators help with the health issue, to make this connection, in language issues*” (GF1). The coordinators also identify that having professionals from other countries could also be an interesting strategy, since it facilitates communication with Venezuelan users: “*To have people of other nationalities for care, including doctors who communicate in Spanish, they love it*” (GF2). Note that, in addition to the language issue, there are still other symbolic-cultural resources that are facilitated by the presence of cultural mediators and professionals who speak the migrants’ language, such as, for example, the different conceptions and modes of existence that are facilitated at the time of care, and which are directly related to the expanded notion of health and well-being of the population via culturally competent and sensitive care (Coutinho et al., 2022). Therefore, it is believed that the inclusion of intercultural mediators in health services can ensure greater cultural sensitivity in the interventions developed in the community, expanding the health promotion of migrant populations. However, the

coordinators did not mention the need for other public policies that are more consistent and specific for the population, which may suggest a lack of recognition of their importance.

On an interpersonal level, there are multiple strategies. The participants showed a preference for choosing a reference professional to serve a certain population, being, in the case of Venezuelans, a person who communicates in Spanish: “*We will direct service [of Venezuelans] for So-and-so [Spanish-speaking professional] and then they communicate*” (GF1). The possible effects of this strategy are considered: although it makes it easier for some teams that have these professionals, it is not a solution for health services that do not have an alternative. Still, it is questioned to what extent this position can be linked to a resistance of coordinators and staff to deal with populations that challenge them in different ways, such as migrants (Gil; Lopes, 2024). Therefore, the logic of referring to a specific professional could be at the service of a mechanism that is more avoidant for professionals (Onocko-Campos, 2014) than inclusive for the Venezuelan population.

Other small health practices are salient in the focus groups. From adapting communication, in terms of avoiding the use of technical terms so the population can understand, to a movement to make sure that migrants understand the guidelines and information showed: “*Sometimes if you ask, ‘Did you understand?’, he will say yes, but in fact he didn’t understand*” (GF1). To overcome these language barriers, the coordinator says: “[I’m] taking a Spanish course to understand a little more” (GF2). However, it is not possible to know if all professionals would be willing to do the same. One way to mitigate these communication disparities is to use possible internal and external resources, such as the use of signs, drawings, and posters displayed in health services, which would show information both in Portuguese and Spanish. Something that was even pointed out as an effect of the training described in this material, which was provided to the participating healthcare providers: “*But I think it was also a reflection of the participation in the training. They also made a poster at the door with guidelines for dental care patients, in Portuguese and Spanish*” (GF1). Although such strategies at the interpersonal level may seem simplistic and mundane, the coordinators say that

such small adaptations in care have a positive impact on Venezuelans: “So I said 2, 3 words there in the Spanish context, and he said, ‘Gracias, muchas gracias por hablar conmigo.’ He understood that there was a space where he felt welcomed” (GF1).

This adaptive movement towards more culturally sensitive practices, that is, practices that consider and validate the different knowledge and processes in health, as well as the modes of existence of migrant populations, has a direct impact on the professional-user relationship, to the extent that it respects, validates, and integrates different cultures of the target population in their process of health promotion and recovery (Amarante; Costa, 2012). A symmetrical relationship between the professional and the user promotes the construction of bonds between services and the community, an essential element when thinking about the integrality and continuity of care in the SUS (Caprara; Rodrigues, 2004). Therefore, since Primary Health Care is a level of care that works with simplified “backyard” technologies, as they are light and at the same time complex (Scliar, 2007), it is essential that professionals can pay attention to an adaptation of both their health practices and their relational techniques with migrant populations. This does not exempt the importance of consistent public policies that, in fact, contemplate the specific needs of these marginalized groups. However, the onslaught of these orders that are more interpersonal can promote a sense of presence and affective availability of these professionals towards Venezuelan migrants (Gil et al., 2024), elements that, in addition to being important in the construction of the professional-user bond, can also provide different forms of reception and community belonging.

Final considerations

This study aimed to analyze the conceptions of the SUS health service coordinators about the Venezuelan individual, as well as the health and care practices of their respective teams of professionals with the Venezuelan population, in a municipality in the countryside of Rio Grande do Sul (RS). We identified the conceptions that the coordinators pointed to processes of vulnerability of the Venezuelan population in different spheres, while indicating a non-difference in relation to

Brazilians in health services. Additionally, it was found that there are no specific public health policies for Venezuelan migrants in the region, but only actions at the interpersonal level of health service professionals that, because they are not systematized, can compromise the population’s care.

The study has some limitations, since most coordinators were from Primary Health Care, as well as the restriction to a specific region of the country, a municipality in the countryside of Rio Grande do Sul, which requires the results to be interpreted with caution. We suggest for future studies to investigate these conceptions with coordinators from other levels of care of the SUS and from more organizational sectors of the municipalities. Such studies can shed light on the conceptions that place the Venezuelan migrant individual in a position of vulnerability and marginalization, while enabling the construction of knowledge that supports the elaboration of more consistent public health policies to mitigate disparities in the migrant populations’ health.

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