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VENEZUELAN MIGRATION: REFLECTIONS ON VERBAL COMMUNICATION PRODUCED BY PRIMARY HEALTH CARE NURSES

MIGRAÇÃO VENEZUELANA: REFLEXÕES SOBRE COMUNICAÇÃO VERBAL PRODUZIDA POR ENFERMEIROS DA ATENÇÃO PRIMÁRIA À SAÚDE

MIGRACIÓN VENEZOLANA: REFLEXIONES SOBRE LA COMUNICACIÓN VERBAL PRODUCIDAS POR ENFERMERAS DE ATENCIÓN PRIMARIA DE SALUD

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Objective: to reflect on the verbal communication performed by primary health care nurses in the care directed to Venezuelan migrants. Method: this is a descriptive study of qualitative character. A study conducted with ten nurses distributed in nine basic family health units in the municipality of Boa Vista, Roraima. The data collection technique was the semi-structured interview. The raw data were recorded and their contents transcribed for content analysis. Results: the units of records were organized in the analytical category entitled: “The language as an inducer of verbal communication impaired in the care performed by nurses to Venezuelan migrants in primary health care.” Final considerations: the reflections on verbal communication performed by primary health care nurses in the care directed to Venezuelan migrants pointed to the language as a communication barrier. Speaking slowly, the repetition of messages and the effort to understand the Spanish language were strategies adopted.

Descriptors: Communication. Communication Barriers. Nurses. Primary Health Care. Human Migration.

Objetivo: refletir sobre a comunicação verbal realizada por enfermeiros da atenção primária à saúde no cuidado dirigido ao migrante venezuelano. Método: trata-se de estudo descritivo de caráter qualitativo. Pesquisa realizada com dez enfermeiros distribuídos em nove unidades básicas de saúde da família no município de Boa Vista, Roraima. A técnica de coleta de dados foi a entrevista semiestruturada. Os dados brutos foram gravados e seus conteúdos transcritos para análise de conteúdo. Resultados: as unidades de registros foram organizadas na categoria analítica intitulada: “O idioma como indutor de comunicação verbal prejudicada no cuidado realizado por enfermeiros ao migrante venezuelano na atenção primária à saúde”. Considerações finais: as reflexões sobre a comunicação verbal realizada por enfermeiros da atenção primária à saúde no cuidado dirigido ao migrante venezuelano apontaram o idioma como uma barreira de comunicação. O falar pausadamente, a repetição de mensagens e o esforço para compreensão da língua espanhola foram estratégias adotadas.

Descritores: Comunicação. Barreiras de Comunicação. Enfermeiras e Enfermeiros. Atenção Primária à Saúde. Migração Humana.

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Objetivo: reflexionar sobre la comunicación verbal realizada por las enfermeras de atención primaria de salud en la atención dirigida a migrantes venezolanos. Método: se trata de un estudio descriptivo de carácter cualitativo. Estudio realizado con diez enfermeras distribuidas en nueve unidades básicas de salud familiar en el municipio de Boa Vista, Roraima. La técnica de recogida de datos fue la entrevista semiestructurada. Los datos en bruto fueron registrados y su contenido transcrito para el análisis de contenido. Resultados: las unidades de registros se organizaron en la categoría analítica titulada: "El lenguaje como inductor de la comunicación verbal deteriorada en la atención que realizan las enfermeras a los migrantes venezolanos en atención primaria de salud". Consideraciones finales: las reflexiones sobre la comunicación verbal realizadas por las enfermeras de atención primaria de salud en la atención dirigida a los migrantes venezolanos apuntaron al idioma como barrera de comunicación. Hablando pausadamente, la repetición de mensajes y el esfuerzo por entender el idioma español fueron estrategias adoptadas.

Descriptores: Comunicación. Barreras de Comunicación. Enfermeras y Enfermeros. Atención Primaria de Salud. Migración Humana.

Introduction

The investigative project entitled "Tracking of Knowledge and Care, Management and Educational Practices in the Scope of Primary Health Care (PHC)", registered in the Research Department of the Universidade Federal de Roraima, has been a guide to fruitful scientific diagnoses on know-how-to-manage health in the extreme Northern Brazil. This region, in recent years, has been impacted by migration.

Certainly, the debate around this problem-issue highlights migration as a phenomenon that is not recent and of global magnitude. This is because a little more or less than one seventh of the world's population lives outside their place of origin[1]. In this context, it is estimated that Venezuela's current unprecedented humanitarian scenario has already forced 2 to 3 million people to flee the country. The majority of Venezuelan migrants who enter Brazil seeking adequate living conditions follow different migratory routes in the Amazon region, namely: staying in the state of Roraima itself; head to the state of Amazonas – especially to the capital, Manaus; or seek inner areas, by air, to the rest of the Brazilian states[2].

Specifically, the cities of the state of Roraima, the destination of these Venezuelan migrants, mostly do not have the structure able to receive them. The main municipalities chosen by those migrants are Pacaraima and Boa Vista, which have approximately 16,000 and 300,000 inhabitants, respectively. Therefore, they have difficulties to adequately receive over 30,000 Venezuelan migrants, especially regarding education and health care, the main sectors affected[3].

When thinking about the production of health care, it is necessary to situate the Venezuelan migrant in the meeting with the nurse in the services that make up the Basic Network (BN), understood as "[...] a bet to get health care to the different territories in which life is produced. Contextualized care, which recognizes the singularity of the production of each existence and also the specific circumstances of life in each territory, due to relationships that expand or constrain the power of living"[4:71].

There is talk of singularities understood as practical objects of nurses who operate inclusive ways of managing the production of care in Primary Health Care (PHC) or even in territories where the life of Venezuelan migrants gains existential meanings. The misunderstanding of this migrant about Brazilian health policy, the overload of basic health teams, a reflection of the high demand for basic care, and the overcrowding of physical spaces are challenges experienced daily by nurses in the Basic Health Units (BHU) of the city of Boa Vista. All this attest that Venezuelan migration is a priority phenomenon in the field of public health[5].

The problems related to cultural differences directly influence health know-how, in the context of PHC, with Venezuelan migrants. From this

perspective, social and labor conditions, health customs and beliefs, stigma and discrimination, difficulty accessing health services, the very communication process established between nurses and the migrant person function as social determinants of migratory health[6].

Here, communication is understood as a sharing of sent and received messages that are able to exert behavioral influences on the people involved in care. The messages present in the communication can be transmitted verbally or nonverbally and are located in the environment in which the interaction between the sender and the content receiver occurs[7]. Thus, nurses should create strategies to overcome "distance" in this environment, thus making effective care from the communication point[8].

Regarding this, a reflective basis referring to the verbal communication established between PHC nurses and Venezuelan migrants brings to light knowledge about the production of care based on therapeutic dialogues involving different languages. Thus, verbal communication, when using the words expressed through speech or written language, is the basic instrument of fundamental care, so that nurses know and apply, in their clinical practice, the nursing diagnostic nomenclature appropriate to situations in which verbal communication is impaired[9].

Based on these statements, the present study opens possibilities for the production of reflections on subjectivities that occur through the encounter of Portuguese-Spanish languages in a common space of care. The place of these contents reveals a set of knowledge, skills and relational attitudes seized and led by PHC nurses, which gain new contours when the culture of the Venezuelan people is considered.

With these introductory threads, the following guiding question emerges of this investigation: How is verbal communication perceived by PHC nurses in meetings of care for Venezuelan migrants? Raising other questions implies understanding the complexity involved in the verbal communication process at an intercultural level, especially when considering the relationship of Portuguese-Spanish languages as a knowledge gap to be investigated in the field of nursing care produced in PHC. Thus, the aim of the study was to reflect on the verbal communication performed by PHC nurses in the care directed to Venezuelan migrants.

Method

This is a descriptive study with a qualitative approach. This type of investigation enables the researcher to answer more particular questions, in which the truth of experience is collectively oriented to what is correct, plausible and practical. The choice to select this type of methodological approach is due to its vitality in the health field and the proposition of innovative epistemological responses in the social and health field[10]. The entire search was guided by the criteria listed in the COREQ guide.

The social group involved in this study was represented by ten nurses working in PHC in Boa Vista (RR). The selection followed the following inclusion criteria: time of work in the BHU equal to or greater than three months, having performed 50 or more health care with the Venezuelan migrant population. This study was excluded: foreign nurses, nurses who were licensed or absent from their work activities and nurse-professors linked to higher education institutions that accompanied nursing students in their practical activities of compulsory supervised internship.

The study was carried out in Boa Vista, capital of Roraima, state located in the Legal Amazon. Boa Vista is a city in full development, which has high indicators of human development between the North and Northeast of Brazil. The place chosen for the study was the Psychosocial Care Network (RAPS) of the municipality of Boa Vista (RR), which is divided into eight macroareas with 34 BHU.

The inclusion of the scenarios of the study was carried out by convenience and guided by the proximity of shelters for the reception of Venezuelan refugees and migrants in Roraima. The BHU exclusively for coronavirus care were excluded from this study.

Initially, the investigative proposal, the letter of consent and the memorandum of approval of the Research Ethics Committee (REC) of Universidade Federal de Roraima were presented to the technical leaders of the BHU of Boa Vista. Then, the nurses were invited to participate in the study, through telephone calls and messages by the WhatsApp application. At the time of the invitation, they were informed about the research objectives, methodological procedures for data construction and the need to comply with biosafety measures to prevent Coronavirus disease. After acceptance, the best time and place for the investigative meeting was scheduled individually.

Data construction was guided by a semi-structured interview script, containing three questions that addressed the following themes: care practices performed by nurses in PHC, verbal and nonverbal communication in the Venezuelan migratory context. All interviews were obtained with the aid of a portable voice recorder and saved in MP3 audio format for later transcription and analysis.

All the material produced was transcribed and analyzed according to the theoretical-analytical framework of content arranged in Bardin. This textual analysis technique is characterized by systematic and objective procedures for describing contents present in the messages[11]. The registration units resulting from the analytical process were organized in the category entitled: "Language as an inducer of verbal communication impaired in the care performed by nurses with the Venezuelan migrant in PHC".

The study followed the guidelines provided for in Resolution n. 466/2012 of the National Health Council. The research project was submitted to the Universidade Federal de Roraima's REC and approved by Opinion n. 4.701.055 issued in 2021. The entire production of the data was preceded by the reading and signing of the Informed Consent Form (ICF) and the Voice Recording Authorization Form (VRAF). The anonymity of the participants was guaranteed by the use of the word identifier Participant, followed by an increasing sequential ordinal number, corresponding to the order of conducting the interview.

Results

The contents that deal with the difference in languages, present in the meeting established between the nurse and the Venezuelan migrant in the context of PHC, induce the production of reflections that highlight the impaired verbal communication involved in nursing care. This allowed the inference of the language as a linguistic barrier involved in the production of the care led by the nurse to the Venezuelan migrant in the context of PHC. These linguistic challenges were identified in record units that can be visualized in the following statements:

> *Lack of understanding. It is explicit in the care, and the Venezuelans have difficult to understand.* (Participant 1).

> *The language makes it too hard. They* [Venezuelan migrants] *talk too fast. I have to stop and ask them to speak more slowly.* (Participant 2).

> *It is very hard for me to understand them* [Venezuelan migrants] [...] *many times, we try hard to explain, but they are unable to understand.* (Participant 3).

> *One of the greatest barriers is the language issue. It is not that we cannot work. We manage to do it, but it is difficult.* (Participant 4).

> *We have to wait them* [Venezuelan migrants] *get calmer, speak more slowly, to be able to understand the language.* (Participant 5).

> *The language. We have to keep trying to understand Spanish.* (Participant 6).

> *The language limits the care, it leaves us unable to solve the problems.* (Participant 7).

> *The Venezuelan migrants do not fully understand the guidelines provided in Portuguese.* (Participant 8).

> *The language barrier makes the care slow. I have to keep repeating, to certify that the information was understood.* (Participant 9).

> *Some Venezuelans understand almost nothing of our language; this hinders the nursing care a lot.* (Participant 10).

The challenge of improving the quality of care performed by PHC nurses permeates verbal communication. In it, the orientations, explanations, emotions, doubts and anxieties are expressed in as words, phrases and discourses in the multivariate situations of health and disease. Specifically, the units of records produced by

PHC nurses invite, based on the terms of the order “language barrier” and “language”, to discuss verbal communication impaired by the cultural diversity caused by the Venezuelan migratory flow.

This is evidenced by the rapid articulation of words in speech, the need for repetition of messages, an effort to understand the meaning cores of the information dialogued, Portuguese-Spanish idiomatic shock and partial or total misunderstanding of what is said verbally in the care encounters established between the PHC nurse and the Venezuelan migrant.

Discussion

Bringing up reflections on the mixture of two distinct languages present in the scenes of caring involving nurses and Venezuelan migrants within the scope of PHC is challenging. The discussions have several possibilities of entry, especially when Venezuelan migration is discussed in the light of subjectivity, that is, crossed by political instabilities, conflicts that threaten the public security of National States, racism and xenophobia, social exclusion, risk factors related to working conditions and difficulty in accessing health services[12].

That is because the migrants “[...] carry everything in their body; carry their belongings, physically and/or emotionally carry their family members and children; they also carry their contacts, their dreams; carry their own body and on their own body, the marks of their history. In addition, the body that migrates takes up space, sees, observes and is seen and observed; judges and is judged, is accepted or rejected, often because of its physical appearance, because everything and every part of the body is marked, sometimes culturally stigmatized”[13:9].

The adversities faced at the social, economic, legal, political and cultural level by Venezuelan migrants are not few. Individuals and groups in (trans)formation learn to deal with otherness on different fronts: legislation, customs, beliefs, prejudices, concepts and language[14].

To illustrate this statement, the arrival of thousands of Venezuelans in Boa Vista has been changing the local scenario. When touring the city, it is possible to identify several facades and commercial establishments containing a fragmented set of messages with names and terms in Spanish, in a clear dispute between the Spanish and Portuguese languages[15]. Not knowing the language is a complicating element for integrating this social group. The vast majority of Venezuelan migrants know little Portuguese and do not speak a language other than Spanish. In part, this linguistic difficulty is mitigated by the migratory network that many of them claim to have in the country[16].

All this form of construction of Venezuelan migration points to an urgent need to expand the humanitarian health response in order to ensure access for Venezuelans to health services and the protection of public health in border areas. In Brazil, Venezuelan migrants face difficulties in accessing services due to the marked language barriers[17].

The language barrier hinders the establishment of good communication, which affects the migrant user-health professional relationship and treatment adherence, as well as the good control of the care process. Communication barriers can be present in several ways, however, specifically in the nurse-patient relationship, technical language, language, culture and lack of empathy are identified[16].

Language as an inducer of impaired verbal communication is considered a barrier. This is intensified “[...] when the disease is more severe, due to the greater use by professionals of technical terms to clarify it, in addition to the difficulty of understanding the instructions during the procedures that depend on the collaboration of patients to be performed”[18:126].

In view of this, it is important to think that language is considered an important element of a care barrier, based on which care bonds can be produced. Furthermore, the migrant user’s response to the therapeutic plan can be effectively evaluated. When nurses refuse or are not inclined to adapt to language barriers in the care provided, one of the main strategies for health promotion and disease prevention, which is health education, is seriously compromised.

This weakens not only nursing care, but also global health care[2].

The production of nursing care, represented by the meetings established between Venezuelan nurses and migrants in PHC, is loaded with expectations and mutual interferences, which give an unpredictability character to the product of health work; as the encounter takes place in an act, it is partially uncontrollable[4].

These interferences are represented by domains of language, languages and dialects, which, in the field of health care, (re)build paths articulated with Venezuelan migrants, especially when PHC nurses ask them to speak slowly, expect them to calm down to speak, exhaustively repeat health guidelines and strive to understand the Spanish language.

Due to the linguistic problems that can make verbal communication impaired, it is important, in the interpersonal relationship with the care processes implemented in PHC, that "[...] health professionals have sensitivity to understand the content of the messages sent by patients, in order to provide care more efficient and adequate to their needs"[18:126].

Among the nursing strategies adopted to overcome cultural and linguistic barriers, there is the fulfillment of the emotional and psychological needs of the culturally diverse person. Moreover, cultural conflicts are avoided and adaptations of discourses to language are implemented[19].

For this, it is necessary that nurses have cultural and political competence, understand the values, beliefs, rituals and way of life of Venezuelan migrants and their families, in a perspective of building a new paradigm of care. It should integrate not only a culturally competent approach, but should also aim at health promotion, quality of life and well-being, through the use of recognized linguistic resources of PHC nurses, such as the presence of a companion capable of translating the language and the existence of translators from the respective institution[20-21]. In addition to the proposal to include interpreters in primary health services, it is also considered the team's option of improvement, through the learning of the Spanish language, as well as cultural aspects of the Venezuelan people that can directly interfere in the health of these individuals.

It is unreasonable to demand that Venezuelans who go through the unexpected process of forced migration be penalized, in terms of health care, for not yet dominating the language of the welcoming country. On the contrary, nurses are daily invited to redouble their efforts to achieve efficient communication, or even to charge health services with training to deal with this problem of impaired verbal communication, considering local regional migratory flows[2].

Impaired verbal communication is conceived as a diagnosis present in the taxonomic classification of NANDA I (2018-2020) and defined as "[...] decreased, delayed or absent capacity to receive, process, transmit, and/or use a symbol system"[22:503]. In the migration plan, qualitative clues of their existence were evidenced in the statements of PHC nurses, recording difficulties to speak, form sentences, form words and verbalize.

This discussion is not restricted to NANDA-I Nursing Diagnoses[22]. It is considered necessary to think about the ineffective verbal communication between the Venezuelan migrant and the health professional in the interprofessional field, in which the official language is the International Classification of Primary Care (CIAP)[23]. In this sense, the identification of the reasons for consultation expressed by the migrant user, his/her health problem or procedure performed, promotes a coherent and standardized record by the nurse and, consequently, better comparison of information between health units.

Precisely because of the complexity of the communicative dimension, it seems necessary to consider this nursing diagnosis in the instruments of recording and consolidating data of care from the e-UHS PHC, especially those that use the CIAP in border regions, where migratory flows occur with greater intensity. This is a diagnosis used by nurses in clinical-care practice, still timidly, considering mainly physical aspects, easy to identify, without precise and detailed assessments of the impairment in verbal communication[9].

It is essential to think that PHC nurses, in the interrelationship with the Venezuelan migrant, need to be vigilant about the proper use of interpersonal communication techniques. Only through effective communication can it help patients to conceptualize their problems, face them, visualize their participation in the experience and identify alternative solutions, besides helping them to find new patterns of behavior[24].

In this sense, it is also necessary to reflect on the unsaid verbally by the body of the Venezuelan migrant, that is, on nonverbal communication as essential for speech validation. It is known that PHC is a very broad field for nurses, and it is necessary to master several competencies to perform their work effectively, among which stand out: "[...] management of their work process, clinical and abstract reasoning, planning, communication, time management, technical-scientific knowledge of the area [...]"[25:755] and communication, which includes the verbal and nonverbal dimension[25].

This reasoning is listed, involving the communication process, theoretical contributions of an anthropological nature and practical (trans)cultural inclinations to the interior of the care developed by the nurse with the Venezuelan migrant in PHC. Thus, the modes of communication and language discovered in care need to be incorporated into the social environment in which work and health research are produced.

The limitation of this study is the reduced social group, which occurred due to the unfeasibility of data production in all BHU, motivated by the Coronavirus pandemic. In this sense, it is recognized the need to expand the number of BHU, as well as the consideration, in future investigations, of Haitian and Guyanese migrants. This is because it is believed that the cultural and linguistic matrices of those peoples create singular reliefs in the field of PHC. It is also considered, as a limiting element, its analytical nature to be centered on content units that deal specifically with verbal communication. It is necessary to consider, in future studies, the expressive dimension, represented here by elements of nonverbal communication present in the care produced by nurses with Venezuelan migrants.

Regarding contributions to the nursing area, the study provides reflections in the qualitative field on the strategies and difficulties that nurses present to implement their care with Venezuelan migrants in PHC. It is believed that those working in the extreme north of Brazil and who develop assistance activities in BHU located in border regions can use discussions in educational and managerial processes, as a way to support the improvement of the quality of verbal communication and, consequently, the implementation of safe and problem-solving care actions for migrants.

Final Considerations

This study is based on the existential dimensions involved in the Venezuelan migration process to Brazil, which unveils based on what is communicated verbally. The productions of reflections leave signaling clues that verbal communication, performed by Nurses of PHC in care aimed at the Venezuelan migrant, is traversed by linguistic elements.

The language was considered an element that induces impaired verbal communication in the care that occurred in PHC. The language barrier was evidenced when nurses, within care practices, aimed to create strategies to send and receive messages to Venezuelan migrants. The paused speaking, the repetition of messages and the effort to understand the Spanish language represented the efforts of nurses to care for the Venezuelan migrant in a differentiated cultural matrix.

In this perspective, the reflections placed open up investigative possibilities for nurses to think about impaired verbal communication in the (trans)cultural plane. An investigative object to be explored with other methodological aspects and theoretical references of anthropology, with a view to expanding what is known about Venezuelan migrant peoples located in the Legal Amazon.

It is also important to consider that, in the investigative path, the need for scientific bets involving expressive elements of the Venezuelan migrant body was discovered, that is, the continuity of studies that consider the regime of signs, body expression and what is produced as nonverbal communication in the field of PHC becomes fundamental.

Moreover, the invitation for health managers to think about health care projects or programs aimed at nurses and the Venezuelan migrant population stands out. There is talk of reception microspaces, which present interpreters to enable a complete understanding of what is being sent and received as a care message.

Thus, with the certainty of the unfinished, it is believed that the reflections produced by the discourses of RAPS nurses of Boa Vista (RR), which concern verbal communication, in the meeting with Venezuelan migrants, can contribute to the management, care, educational processes and to the strengthening of the principles and guidelines of the Unified Health System, benefiting the development of (trans) cultural practices capable of considering the migratory specificities in border regions.

Contributions:

The author is responsible for the design of the project, analysis and interpretation of the data, writing of the article, relevant critical review of the intellectual content, final approval of the version to be published and all other aspects, guaranteeing the exactness and integrity of all parts of the study.

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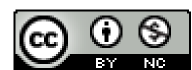

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