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RESEARCH

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Interaction between health professionals and international migrants: perceptions of care in an emergency unit

Interação entre profissionais da saúde e migrantes internacionais: percepções do atendimento em unidade de emergência

Interacción entre profesionales sanitarios y migrantes internacionales: percepciones de atención en unidad de urgencia

Lorena Franco Buzzerio[1]
Nathalie Campana de Souza[1]
Sonia Silva Marcon[1]
Gabriel Zanin Sanguino[1]
Anderson Reis de Sousa[2]
Mayckel da Silva Barreto[1]

1. Universidade Estadual de Maringá. Maringá, PR, Brasil.

2. Universidade Federal da Bahia. Salvador, BA, Brasil.

ABSTRACT

Objective: to understand how health professionals and international migrants perceive care in an emergency unit. **Method**: This is a descriptive, qualitative study conducted in the emergency department of a teaching hospital in southern Brazil. Nine health professionals and six international migrants participated. Data were collected between August and October 2023 through semi-structured, audio-recorded interviews. After transcription, the data were analyzed based on Symbolic Interactionism, using thematic analysis as proposed by Braun and Clarke, with the support of ATLAS.ti software. **Results**: three main themes were identified: "Positive aspects perceived during care," "Difficulties perceived during care," and "Strategies used to support social interaction and care delivery." **Final considerations and implications for practice**: the interactions between health professionals and migrants in emergency settings carry both positive and negative meanings. These interactions take place in a context that often hinders communication, connection, and cultural respect. Even so, both professionals and migrants use different strategies to make care possible and more effective.

Keywords: Emergency Medical Services; Health Professionals; Immigrants; Qualitative Research; Symbolic Interactionism.

RESUMO

Objetivo: compreender como profissionais da saúde e migrantes internacionais percebem o atendimento em uma unidade de emergência. **Método**: estudo descritivo, com abordagem qualitativa, realizado no setor de pronto atendimento de um hospital escola localizado no Sul do Brasil. Participaram nove profissionais da saúde e seis migrantes internacionais. A coleta de dados ocorreu entre agosto e outubro de 2023, por meio de entrevistas semiestruturadas gravadas em áudio. Após a transcrição, os dados foram analisados com base no referencial do Interacionismo Simbólico, utilizando a análise temática proposta por Braun e Clarke, com o apoio do software ATLAS.ti. **Resultados**: três temas foram identificados: "Aspectos positivos percebidos durante o atendimento", "Dificuldades percebidas durante o atendimento" e "Estratégias utilizadas para efetivar a interação social e o atendimento". **Considerações finais e implicações para a prática**: as interações estabelecidas entre os participantes, no contexto do pronto atendimento, são simbolicamente construídas por meio de percepções positivas e negativas. Essas interações ocorrem em um ambiente que frequentemente dificulta a comunicação, a interação e o respeito à cultura do outro. Ainda assim, tanto migrantes quanto profissionais adotam estratégias que viabilizam e fortalecem o atendimento.

Palavras-chave: Imigrantes; Interacionismo Simbólico; Pesquisa Qualitativa; Profissionais da Saúde; Serviços Médicos de Emergência.

RESUMEN

Objetivo: comprender cómo los profesionales de la salud y los migrantes internacionales perciben la atención en una unidad de emergencia. **Método**: estudio cualitativo, de tipo descriptivo, realizado en el servicio de emergencias de un hospital universitario en el sur de Brasil. Participaron nueve profesionales de la salud y seis migrantes internacionales. Los datos se recolectaron entre agosto y octubre de 2023 mediante entrevistas semiestructuradas grabadas en audio. Tras la transcripción, los datos se analizaron con base en el Interaccionismo Simbólico, utilizando el análisis temático propuesto por Braun y Clarke, con el apoyo del software ATLAS.ti. **Resultados**: se identificaron tres temas principales: "Aspectos positivos percibidos durante la atención", "Dificultades percibidas durante la atención" y "Estrategias utilizadas para favorecer la interacción social y la prestación del cuidado". **Consideraciones finales e implicaciones para la práctica**: las interacciones entre profesionales de la salud y migrantes en contextos de emergencia presentan tanto significados positivos como negativos. Estas interacciones ocurren en un entorno que, a menudo, dificulta la comunicación, la conexión y el respeto cultural. Aun así, tanto profesionales como migrantes emplean distintas estrategias para hacer posible y más efectiva la atención.

Palabras clave: Inmigrantes; Interaccionismo Simbólico; Investigación Cualitativa; Profesionales de la Salud; Servicios Medical de Urgencia.

Corresponding author:
Lorena Franco Buzzerio.
E-mail: lorenabuzzerio@yahoo.com.br

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INTRODUCTION

In 2022, global migration flows reached around 400 million displaced people, according to data from the International Organization for Migration (IOM). This means that one in every 30 people that year was a migrant either within their own country or internationally.[1] An *international migrant* is someone who crosses their country's borders, regardless of the reason. This group includes immigrants, refugees, and stateless individuals, all of whom are recognized as having rights. Migration is therefore a complex human and social phenomenon that can create different forms of vulnerability.[2]

In recent decades, several factors have intensified global migration. These include natural disasters, climate change, serious political and economic crises, religious persecution, the search for better access to education, health care, and safety, the social effects of the COVID-19 pandemic, and war.[3] A current example is the war between Russia and Ukraine, which has led to about 6.5 million people still seeking international protection as refugees.[4] In addition, there has been a rise in violence against migrant populations and growing challenges throughout the migration process. In 2023, at least 8,565 people died while traveling on migration routes worldwide — the highest number ever recorded.[1]

In this global context, Brazil has become an important destination for migrants, especially those coming from Latin America. According to the Federal Police, around 1.2 million residency applications were submitted in the past ten years — a number ten times higher than in 2013.[5] In 2023 alone, nearly 25,000 requests were made across the country for the National Migration Registry (NMR). That same year, in the state of Paraná — the fourth Brazilian state with the highest number of international migrants — there were about 6,000 applications for refugee status.[6]

International migrant populations are known to be more exposed to both past and present risk factors that can affect their physical and mental health. This is mainly due to the social vulnerability they face in the host country. Common challenges include poor housing conditions, unemployment or underemployment, food insecurity, limited access to healthcare services, psychological stress, family disruption, language barriers, difficulty adapting to the climate, cultural shock, and experiences of prejudice or xenophobia.[7] Such factors contribute to a higher demand for health care among international migrants.

In Brazil, health care is provided mainly through the Unified Health System (SUS). SUS offers free, universal, and comprehensive care to the entire population, including non-Brazilian residents and visitors.[8] Access to services happens through different entry points, which are organized into Health Care Networks (RAS). For various reasons — such as more flexible service hours, the need for immediate care, work-related injuries, or a preference for the biomedical model — international migrants often seek care through the Urgent Care Network (RAU).[9] The RAU includes services such as Emergency Care Units (UPAs), entry-point and referral hospitals, the emergency ambulance service (SAMU 192), and in some cases, Basic Health Units (UBS).[8] Across all these services, symbolic interactions occur between health professionals and migrants during the care process.

Qualitative studies[9-11] and literature reviews[12,13] show that in both Latin America and Europe the experiences of health professionals and migrants during health care encounters are influenced by factors at multiple levels. At a broader level, these factors include the specific vulnerabilities of migrant populations and the health care model in place. At a more practical level, key issues include the lack of professional training in cultural competence, communication barriers, and the presence of xenophobia. As a result, positive social interaction between professionals and migrants rarely occurs. There is also a lack of critical reflection on the individual, cultural, and socioeconomic needs of migrant patients. This often leads to a relationship marked by conflict, imbalance, and limited effectiveness in addressing health needs.[13]

In emergency care settings, the wide variety of cases and the high-stress environment in which professionals work can negatively affect the quality of care. In this context, migrants often face teams that are not prepared to provide linguistically and culturally competent care. This makes it harder to properly address their health needs, increasing their vulnerability.[9] A common example is ineffective communication caused by language barriers. This can prevent a full understanding of the patient's complaint and compromise the ability to provide complete and effective care.

However, it is important to note that research on this topic in emergency care settings is still limited. When studies do exist, they usually focus either on health professionals[9,14] or on migrants.[10] There is still a lack of broader and deeper analysis of how the relationship between these two groups is built, and how their interaction shapes the meaning they assign to healthcare in emergency contexts. This study contributes to scientific knowledge by offering a comparative and complementary analysis from the perspective of both social actors involved in emergency care.

This study aimed to understand how health professionals and international migrants perceive care in emergency units.

METHOD

This is a qualitative study with a descriptive, exploratory design. The main methodological aspects were reported using the Consolidated Criteria for Reporting Qualitative Research (COREQ).[15]

The theoretical framework adopted was symbolic interactionism (SI), which helps explain how individuals interpret the objects and people they interact with. This interpretation process shapes individual behavior in specific situations.[16]

This framework focuses on studying social interaction between people, aiming to understand subjective meanings and individual interpretation. It is based on four central concepts: i) symbol: something that represents meaning and is shaped by personal interpretation and interaction with others; ii) self: the ego or the individual identity, which allows a person to act socially; iii) mind: the tool for interpreting others' behaviors in social relationships,

enabling reflection and planning; iv) society: made up of individuals who interact with one another.[16]

The choice of SI as the theoretical framework benefited this study, given the sociocultural diversity among participants. This approach made it possible to symbolically understand how social interaction between individuals was shaped by both personal and shared concepts related to healthcare in the emergency setting.

The study was conducted at a medium-sized university hospital located in southern Brazil. This hospital functions both as a referral center and as a direct entry point for patients. In the emergency department, patients are first received and then triaged based on risk level before receiving care or being referred elsewhere. The hospital is located in the headquarters of Paraná's 15th Regional Health Division, which serves 30 cities. The emergency department specifically includes 132 health professionals. Of these, 103 are on-call physicians — including general practitioners, surgeons, pediatricians, obstetricians, and gynecologists — most of whom work limited shifts (up to 36 hours per month). In addition, 29 nurses also work in the unit. The department has 24 observation beds, 8 inpatient beds, 4 semi-intensive care beds, and 6 emergency beds.

The inclusion criteria for professionals were being a physician or nurse; working in the emergency department; and reporting previous experience attending to international migrants in that setting. For migrants, the inclusion criteria were: i) having non-Brazilian nationality; ii) being over 18 years of age; iii) residing in Brazil; and iv) having received care at the health unit where the study was conducted. Migrants who did not speak Portuguese, Spanish, or English — the languages spoken by the lead researcher — were excluded.

In addition to the participants included in the study, ten other professionals — eight physicians and two nurses — were invited but declined to participate. The main reason given was a lack of familiarity with the topic, even though all of them had experience attending to migrant patients. Another five professionals initially expressed interest but did not follow up with the researcher after the first contact. Regarding migrants, nine individuals who met the inclusion criteria were approached but also declined to participate without providing a reason.

Sampling was based on convenience and access. The lead researcher invited healthcare professionals and migrants who were present in the department during different shifts — morning, afternoon, and night. Through daily active search, professionals were approached during their work shifts. Migrants were invited to participate after receiving medical care and once their clinical condition had stabilized.

Although the lead researcher was familiar with the setting — having previously worked there as a nursing resident in emergency care — she had no prior relationship with the participants interviewed. She also had previous experience in collecting and analyzing qualitative data in emergency settings and was directly supervised by a senior researcher from the group.

The interviews were conducted in person between August and October 2023, with each participant interviewed only once. They took place in a private room within the hospital department. All interviews were fully audio-recorded, transcribed, and translated into Portuguese when necessary. Each interview lasted approximately 25 min on average.

A semi-structured interview guide was used, consisting of two parts. The first focused on collecting participant background information, while the second included guiding questions related to the study topic. For health professionals, the questions addressed care provided to migrants, including possible difficulties in delivering care and the strategies used to improve it. For migrants, the questions focused on their perception of the care received in the emergency unit, including doubts, challenges, and the strategies they used to make the interaction possible.

Interviews were transcribed and analyzed by the lead researcher using ATLAS.ti software and based on the thematic analysis (TA) approach proposed by Braun and Clarke.[17] The analysis followed six phases, organized in a non-linear process: i) familiarization with the data – carried out through repeated and in-depth reading; ii) generation of initial codes – the main ideas of the study were revisited, and meaningful elements in participants' statements were identified and assigned codes; iii) searching for themes – the codes were grouped based on semantic similarities and organized by color, leading to the creation of initial themes; iv) reviewing themes – the themes were reanalyzed to identify similarities and possible combinations; v) defining and naming the themes; and vi) producing the final report. A total of 22 initial codes were generated, which appeared 364 times across the dataset. Such codes were then organized into three main themes.

Interviews were conducted until data saturation was reached. Using SI as the analytical framework, it was possible to identify similarities across the experiences reported. After nine interviews with health professionals and six with migrants, the responses began to repeat, the themes were well developed, and the research objectives had been met.[18]

The study was approved by the Permanent Human Research Ethics Committee at the State University of Maringá under approval no. 6.014.601 in accordance with Resolution No. 466/12 of the Brazilian National Health Council. To ensure participant anonymity, health professionals were identified using the code "Professional E" followed by a randomly assigned number. Migrants were coded as "Migrant I," also followed by randomly assigned numbers. All participants signed an informed consent form, provided in two identical copies.

RESULTS

A total of 15 participants were interviewed: nine healthcare professionals and six migrants. Among the professionals, eight were nurses and one was a physician. There were two men and six women, with ages ranging from 25 to 59 years. Professional experience ranged from 2 to 35 years, and experience in emergency care ranged from 2 to 10 years.

Among the migrants, there were three women aged 22, 35, and 54, and three men aged 23, 25, and 34. Their nationalities were as follows: two from Venezuela, one from Haiti, one from Equatorial

Guinea, one from Paraguay, and one from the Democratic Republic of the Congo. Four interviews were conducted in Portuguese and two in Spanish. All interviews were fully transcribed and translated into Portuguese when necessary.

Two migrants were formally employed: one worked as a machine operator in the food industry, and the other as a mechanic. A third migrant worked as a delivery app rider but was on medical leave due to health issues. Two participants were university students, and one migrant had no employment or educational ties in Brazil. Length of residence in the country ranged from 2 weeks to 7 years. Half of the participants reported coming to Brazil with their families. All of them stated that they chose Brazil in search of better living conditions.

Positive aspects perceived during care

In emergency healthcare services, social interaction between professionals and migrants takes place during the care process. Overall, migrants viewed the care they received as adequate, especially when they perceived a closer, more attentive approach, effective communication, and efforts by professionals to address their individual needs. This perception involved the interaction between *mind* and *self* throughout the care experience.

> *The care is good. They let my friend come in with me to help with communication, since I'm still learning Portuguese. I thought that was great—it helped me talk better and understand more of what they were saying* (Migrant I6).

> *The care here at the hospital is good. I can understand what they say to me. Well, I kind of understand the doctor, and the other people who come in. What I don't get, I just ask* (Migrant I2).

> *There's always a nurse around, people come talk to me all the time—everything's fine, everything's good* (Migrant I1).

> *The care isn't bad. In my country, we don't have a place that's completely free like this, where you can go and get all the things I got. But of course, no one likes being sick, especially in a different country where you don't know anyone. Arriving and already being sick is really hard* (Migrant I5).

Some professionals also reported trying to adopt a more empathetic attitude during their interactions with migrants. This was reflected in more humanized care practices. This perspective was confirmed by the migrants themselves, who, by comparing their past experiences with those they had in Brazil, gave new meaning to the health care they received.

> *This immigrant thing, sometimes it really gets to you. You feel like helping them. I try to put myself in their shoes, like, 'what's it like to be in another country?' I imagine adapting must be really hard. So, I try to see things from their side and give them the best care I can* (Professional E6).

> *He had to stay with her, even though it's not allowed for companions to be in the emergency room at her age. But we let him stay, so we could give more humanized care* (Professional E5).

> *One time in Colombia, I needed medical care and forgot my ID. They yelled at me, like 'how do you leave the house without ID?' Then they asked my name to treat me. Here, it was different—they just asked for my name and birth date, that's it. They even told me to relax. Here, you can tell the care is more humane* (Migrant I3).

Difficulties perceived during care

In addition to positive experiences, the study also revealed a certain ambiguity — or even a paradox — in the meanings and social relationships formed between health professionals and migrants in emergency settings. Many professionals, influenced by their personal and cultural values shaped by their own social environments, ended up stigmatizing migrants and the reasons they sought care. In some cases, they linked the frequency of emergency visits to the migrant status itself.

> *When they show up here, they're usually seen as the ones coming just to get a sick note. So sometimes I notice a bit of neglect, from both doctors and nurses, because they kind of have this 'same old story' reputation. People say immigrants only come here for medical leave* (Professional E4).

> *There are a lot of them* [migrants]*—really, a lot. They always come to the emergency room. Work accidents and pregnant women are the most common. And later, once the migrant moms get to know our service, they bring their kids too. Since the moms already come here for prenatal care, after the baby is born, they bring the child here too—for emergency checkups. It's just easier for them* (Professional E1).

Among the factors that affected social interaction, communication difficulties stood out. Language differences were frequently mentioned as the main barrier to providing effective and welcoming care. In this context, migrants felt the need for more attention from professionals and often required repeated explanations during care.

> *The hardest part is really just talking. Some of them understand what we say, but others don't. Then we're stuck—we don't know what they're saying, and we're not sure they understood what we said either. And usually, they come alone, no family with them, so that just makes it harder* (Professional E2).

> *There were lots of times when I couldn't really understand what they* [the health professionals] *were saying. They talked too fast, and some didn't have much patience, so*

> *I ended up not really getting what they were trying to tell me* (Migrant I).

In addition, health professionals noticed that cultural differences — shaped by the migrants' diverse societies of origin — influenced the process of social interaction. These differences negatively affected the way emergency care was delivered and also impacted how international migrants interpreted the guidance and instructions given to them.

> *And when kids are involved, it gets even more complicated, because Haitian moms have different customs than Brazilians. So sometimes, the way they act or take care of their kids might be misunderstood by the staff here* (Professional E7).

> [Migrant patients] *don't really like being touched. We try to talk, to get a little closer. Talking is key, but there's this thing—before you even touch the patient, you have to talk to them, because you can tell they don't like it when you just reach out and touch them* (Professional E6).

> *There are cultural things with them* [migrants] *that are hard to explain sometimes—like when we need to insert an IV or give medication, and it has to be done a certain way (...) And even when we use a translator or gestures, it's really hard to make them understand. I think the care suffers a bit because of that* (Professional E8).

Another factor that made interaction more difficult, as pointed out by the healthcare professionals, was the lack of continuing education on immigration-related topics. In addition to the inherent characteristics of emergency services, which limit the possibility of active listening, participants reported that there were no training activities focused on this issue. According to them, educational initiatives could help shape the professionals' *self* and directly influence the way interactions and care are delivered.

> *The emergency room is always a challenge—so many things happen at once. It's hard to stop and really listen to any patient with full attention* (Professional E9).

> *As far as I remember, there's never been any training on this topic. I've never had anything specifically about immigration, so we just go with what we think works* (Professional E5).

Another issue raised by some health professionals was the difficulty migrants had in understanding preventive health care and how the Brazilian health system works. This limitation often placed them in a more vulnerable position.

> *(...) most pregnant women who are immigrants are considered high-risk, and many of them come in already in labor, without any prenatal care—and that's really worrying. They don't know what the health system offers* (Professional E7).

> *(...) it's really hard to explain the referral and counter-referral system. It's already confusing for people who've lived here their whole lives—they don't know how SUS works. So, for them* [migrants], *I think it's even harder* (Professional E8).

> *I think most of them don't really know what's going on. They just go with the flow. They go through reception, then the appointment and everything, but they don't actually understand how it works—they just follow along* (Professional E5).

Strategies used to support social interaction and care delivery

Professionals reported using different strategies during care delivery in an effort to offer higher quality care to migrants. However, when reflecting on their own actions (*self*), they symbolically recognized uncertainty about the effectiveness of the techniques they used. This perception often led to feelings of frustration.

> *There are times when you just keep explaining, using gestures so the person understands, and sometimes you're repeating things over and over to see if it gets through. But I feel like they leave here without fully understanding what we said. That's frustrating* (Professional E1).

> *We go ahead with the care anyway. We check with the social worker, see if there's a family member who understands what they're saying, and that's it. If there's no one, we just try to figure it out ourselves—use gestures, try to understand* (Professional E2).

Professionals frequently sought strategies to support communication and interaction with migrants. Such efforts often included involving another staff member who spoke the language, allowing a family member or companion to be present, and confirming the information provided to the patient. However, these strategies did not always produce the expected results. In some cases, for example, family members were unable to clearly express the patient's experience of illness, which limited the effectiveness of care.

> *The biggest issue we have is the language barrier, because sometimes they come alone, and other times they come with someone—but the person with them doesn't really know how to explain what the patient is feeling* (Professional E4).

> *There were two times when I asked them to call my friend. Then the doctor spoke to him in Portuguese, and he translated it for me in French over the phone. That's the only way I understood that I'd been discharged and could go home, because my tests had already improved* (Migrant I6).

> *They only understand the basics. These are patients we really need to pay extra attention to. We have to check and confirm the instructions to make sure they actually understood what we said* (Professional E5).

Despite the language barrier, professionals reported having an easier time performing physical examinations and interpreting nonverbal communication during care. Similarly, migrants, in their attempts to be understood, used slower speech and gestures, symbolically attributing meaning to these strategies.

> *During the physical exam, it's a bit easier. We can use gestures to show how we're going to touch or do something different, and you can read the person's facial expression* (Professional E3).

> *I speak slowly, I use gestures. For example, when I want to say 'I need,' I just point to myself, and the person understands me* (Migrant I3).

Health professionals also reported that having family members present during care helps with communication, as in many cases someone in the family understands or speaks Portuguese. From the migrants' perspective, the presence of family members was seen as a positive aspect — both during medical care and in their personal lives in the host country.

> *They always ask, and we let in the companion who speaks more Portuguese, someone who can help make communication easier* (Professional E7).

> *(...) she* [my daughter] *understands and speaks, but I can't speak myself. She works with people, so it's easier for her* (Migrante I2).

The use of symbols and additional tools during care was described by health professionals as a strategy to help establish more effective social interaction with migrants.

> *So, to be able to help, we had to turn to the internet, show videos, use a mannequin, write things down, and even act things out* (Professional E8).

> *There was this app they used to talk, and it would translate what they were saying* (Professional E2).

> *Whenever I needed to talk to someone from Haiti or Africa, I'd call a colleague who spoke several languages. I'd ask him to ask a few questions — just over the phone — and he'd do it. That really made the conversation easier* (Professional E3).

DISCUSSION

The findings of this study help to show that perceptions of care and interaction between social actors in emergency settings are shaped by both positive and negative aspects. These interactions often take place in environments that hinder communication, symbolic exchange, and cultural respect. Even so, both migrants and professionals develop and use strategies that not only make care possible but — in many cases — help strengthen it.

A study with migrant women in the postpartum period found that they described their experiences with health services as generally positive.[19] Humanized care plays an important role in bringing users and professionals closer together, strengthening the relationship and improving care during and after the service. On the other hand, other studies have shown that international migrants often report fear, insecurity, and a lack of support. These factors create barriers to accessing and staying connected to health services.[13,19,20]

Migrants and health professionals often have different symbolic and socially constructed perceptions regarding how welcoming the health system is. Some care experiences are marked by empathy and support, while others involve prejudice, neglect, or xenophobia. This dual perception of care among migrants was also identified in a literature review that examined studies from 14 European countries.[13] The way migrants are treated during care can directly influence their health and illness experience. In many cases, they only seek healthcare services when experiencing acute situations, even if those situations are not necessarily emergencies.[9] This pattern contributes to their disconnection from the healthcare system and shows how easily users can bypass the main entry point of Brazil's Unified Health System (SUS): Primary Health Care (PHC).[21]

Regarding stereotyping, migrants who seek healthcare services face different forms of prejudice at all levels of care[15] — a finding that is not unique to this study. Differences in physical appearance, culture, and language act as sociocultural barriers that directly affect migrants' access to and continuity in health care. For this reason, it is essential to implement educational actions aimed at training health professionals to provide qualified care to this population. Professionals often respond only to the immediate complaint, without deepening the care process. This approach is largely shaped by the barriers already identified.[15] Such practices reinforce the dominant biomedical model, which focuses on treating disease rather than understanding its causes. As a result, care fails to address the biopsychosocial and symbolic dimensions of the individual within their broader context.

Among the contextual aspects addressed in this study, healthcare professionals highlighted the lack of continuing education as a significant gap. Academic training for health professionals be broad and include content related to migration and the specific characteristics of the migratory process. This training should cover the health-disease process, as well as strategies for prevention and health promotion tailored to this population. One study points to the effectiveness of remote learning as a viable option for developing skills among health professionals.[22] Active learning methods and team-based learning, even in non-face-to-face formats, can be used to support this type of training. Such tools help raise awareness among professionals

and promote the adoption of culturally competent care practices. These actions not only increase safety in migrant care but also improve patient satisfaction.

The results of this study highlight several challenges in the relationship between health professionals and migrant patients. At the same time, they reveal a range of strategies used by both groups to make care possible. Communication difficulties were identified as one of the main obstacles, and they were understood as a factor that triggers other issues in the interaction between individuals. Researchers have shown that ineffective communication with Japanese migrants during hospitalization negatively impacted their understanding of treatment, their perception of the health-disease process, and their relationship with the health care team.[20] Another more recent study supports the findings of this research, showing that the use of technical language and language differences make communication difficult between health professionals and migrant women during childbirth.[19]

Alarmingly, communication challenges between professionals and international migrants are common and occur across various sectors. For example, a study conducted in the Brazilian judicial system showed that professionals often relied on third parties who spoke the required language, used automatic translation tools, or asked migrants to return later with a family member, friend, or interpreter to enable the service.[23] Both national[24] and international[25] studies confirm that poor communication between professionals and migrants creates a major gap in the interaction between the social actors involved in care. This failure compromises the comprehensiveness of the health care system and puts migrants' access to care at risk.

Cultural differences between natives and migrants, which are socially constructed and embedded in individuals' *self*, are seen as barriers in the care process. Many migrants report feeling afraid that their customs will not be respected during healthcare encounters.[13,19,25] Around the world, different cultures hold deep meaning for the people who live by them. Therefore, their beliefs should be recognized and respected. Maintaining certain cultural traits can help strengthen migrants as they adapt and settle in a new country. This process can support their connection with and integration into the new culture.[12]

Family serves as a consistent support network and, in this study, was identified as an important strategy for migrant care — both from the perspective of professionals and of the migrants themselves. One study supports these findings, showing that migrants who go through the migration process with family support feel more empowered by a sense of belonging.[12] In addition, family members often act as interpreters, helping to translate or at least make communication easier for those who do not speak or understand Portuguese.[22] However, as noted in a previous study,[7] the challenges professionals face in providing adequate care to migrants go beyond communication alone.

Care and social interaction also involve symbolic elements. One example is physical touch, which is essential for medical examinations but can become a limiting factor in the relationship between professionals and migrants. Still, the effort to communicate and the use of alternative tools have become the path chosen by both professionals and migrants to build interaction and provide care. Translation apps, protocols, gestures, and miming are commonly used when verbal communication is not possible.[7,9,15] Even within the scope of PHC, placing professionals within migrant communities — bringing this population closer to health-related topics and sharing knowledge about how the Brazilian health system works — can help bridge the gap between healthcare services and migrants' cultural backgrounds and lived experiences.[26]

FINAL CONSIDERATIONS AND IMPLICATIONS FOR PRACTICE

The findings of this study revealed ambiguity in the meanings assigned to the social relationships between healthcare professionals and migrants during emergency care. Most migrants perceived the care as adequate, close, and humanized. However, in some situations, professionals tend to stigmatize migrants and the reasons behind their use of health services. The recurrence of emergency visits was often linked to the migrant condition itself. In addition, professionals highlighted elements of the emergency care setting that made it harder to provide attentive and meaningful communication, such as the lack of continuing education on migration and persistent language barriers.

To establish effective interaction between professionals and migrants, various strategies were used. These included involving another staff member who spoke the required language, allowing a family member to be present during care, validating the information provided to the migrant, and using additional tools such as online translators. However, these strategies did not always achieve the desired outcome. In some cases, for instance, family members were unable to accurately describe the patient's illness experience, which raised concerns among professionals.

Strategies must be developed to improve social interaction and the relationship between healthcare professionals and migrants. Emergency services should adopt institutional policies aimed at ensuring proper support for this population — for example, by allowing the continued presence of family members during care. In addition, educational intervention studies could help raise awareness among health students and professionals, promoting the development of skills and competencies needed to provide culturally competent care in emergency settings.

This study has some limitations. One limitation concerns the fact that interviews with migrants were conducted while they were still in the health care setting, which may have contributed to low participation rates. Another potential limitation is related to the context of the interviews with professionals which took place during their work shifts. This may have caused concern about returning to their duties, affecting their level of engagement during the interviews. Even so, considering that data saturation was reached and the goal was to include a broader number

of participants, the decision to conduct data collection in the emergency setting proved to be appropriate.

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DATA AVAILABILITY RESEARCH

The contents underlying the research text are included in the article.

CONFLICT OF INTEREST

None.

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AUTHOR'S CONTRIBUTIONS

Study design. Lorena Franco Buzzerio. Nathalie Campana de Souza. Sonia Silva Marcon. Mayckel da Silva Barreto.

Data collection. Lorena Franco Buzzerio. Sonia Silva Marcon. Mayckel da Silva Barreto.

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Manuscript writing and critical review. Lorena Franco Buzzerio. Nathalie Campana de Souza. Sonia Silva Marcon. Gabriel Zanin Sanguino. Anderson Reis De Sousa. Mayckel da Silva Barreto.

Final approval of the article. Lorena Franco Buzzerio. Nathalie Campana de Souza. Sonia Silva Marcon. Gabriel Zanin Sanguino. Anderson Reis De Sousa. Mayckel da Silva Barreto.

Responsibility for all aspects of the content and integrity of the published article. Lorena Franco Buzzerio. Nathalie Campana de Souza. Sonia Silva Marcon. Gabriel Zanin Sanguino. Anderson Reis De Sousa. Mayckel da Silva Barreto.

ASSOCIATED EDITOR

Rafael Silva

SCIENTIFIC EDITOR

Marcelle Miranda da Silva