

Venezuelan migrants and the right to health: perceptions of nursing technicians at a general hospital

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Abstract: **Objective:** To understand the perceptions of nursing technicians at a general hospital regarding Venezuelan immigration and the right to health. **Method:** Qualitative research with an exploratory and descriptive approach using participant observation and semi-structured interviews with 15 technicians. Bardin's framework was used to analyze the data. **Results:** Most interviewees associated immigrants with a worsening quality of local life and an overload of health services. Only four considered immigration and its consequences to be a humanitarian issue, showing empathy with immigrants. Many were aware of the principle of universality that characterizes the Brazilian health system but disagreed with the immigrant's right to free access to health services. There was a strong depreciation of public health. **Conclusion:** Most of the interviewees opposed the immigration of Venezuelans and their speeches contained traces of xenophobia, prejudice, and discrimination. The study allowed us to broaden our understanding of the care processes of health professionals in the context of migratory crises.

► **Keywords:** Collective Health. Nursing. Emigration and Immigration. Right to Health.

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Introduction

Since 2015, a growing number of Venezuelans have entered Brazil due to the serious political and socio-economic crisis in Venezuela. In general, they are looking for better living conditions and, in many cases, are migrating forcibly to avoid starvation (Arias, 2018). The vast majority entered Brazil through the dry border with the state of Roraima and have remained there, without moving to other units of the federation, profoundly altering the routines, especially in the cities of Pacaraima, on the border with Venezuela, and Boa Vista, the state capital (Leal *et al.*, 2021). Thus, the state has made efforts to welcome and accommodate a significant part of this contingent of Venezuelan migrants and integrate them into local society.

The crisis in Venezuela has also affected its health system (Roa, 2018; The Lancet, 2018) and a substantial proportion of Venezuelans arrived in Roraima in search of health care. Together with those already settled there, they constitute an additional demand for the services of the local health system (Almeida-Silva *et al.*, 2019; Roraima, 2019; Arruda-Barbosa; Sales; Souza, 2020; Silva; Arruda-Barbosa, 2020).

The phenomenon of immigration represents an important challenge for public health, with an impact on the dynamics of health services in host countries (Dias *et al.*, 2010). This challenge is being experienced in Roraima, with repercussions on the health system and the services offered, as well as increasing the workload for health professionals. Aggravating this scenario is the fact that Boa Vista has an old hospital network that has long been unable to supply the population adequately. Within the hospital network, the General Hospital of Roraima (GHR) stands out as the state's main hospital (Arruda-Barbosa *et al.*, 2023; Arruda-Barbosa; Sales; Torres, 2020). Thus, one of the services that has seen the greatest increase in demand is this hospital. Among the health professionals who work at the GHR, the ones who have suffered the most impact on their work routines are the nursing technicians, professionals who are part of the nursing teams and make up the front line of health care.

It is believed that the work of nursing technicians and, consequently, the care given to Venezuelan migrants can be influenced by their perception of the migratory context and the right to health, as well as their level of empathy towards migrants.

Thus, the aim of this study was to find out the perceptions of nursing technicians at the GHR regarding Venezuelan immigration and migrants' right to health.

Its purpose is to contribute to the development of public policies aimed at the immigration and health crisis, since the relationship between public health and immigration increases the concerns of political managers around the world (Fonseca, 2007). Brazil, and especially Roraima, needs to find ways to deal with this situation efficiently and with respect for human rights, which is why this study was carried out.

Method

This is a qualitative, exploratory, and descriptive investigation, guided by the Consolidated Criteria for Reporting Qualitative Research (COREQ), recommended for research reports that collect data through interviews or focus groups (Tong; Sainsbury; Craig, 2007).

The GHR is the state's main hospital. Although it was built on a single plan and has a very old physical structure, it is a reference in medium and high-complexity care for the state's interior and even for neighboring countries. It has a 24-hour clinical and surgical emergency service but does not include obstetrics, which is the responsibility of the local Maternity Hospital (Silva, 2017; Roraima, 2021). It has 221 beds, divided between an intensive care unit (ICU) and an inpatient block, an emergency room, and an emergency department. Construction is underway on Block E, which will increase the hospitalization capacity by 120 beds (40 clinical and 80 surgical) and 10 operating rooms (Roraima, 2020).

Between 2019 and 2020, the GHR provided 188,373 healthcare services, 5% more than in 2015 and 2016, the years preceding the peak of Venezuelan immigration to the state (Roraima, 2017; 2021).

This study's sample was made up of nursing technicians from different sectors of the GHR. The inclusion criteria were: being permanent and working at the hospital for more than three years since Venezuelan immigration has intensified in recent years, so the participant would also have previous experience of the peak of Venezuelan migration. The exclusion criteria were: being a foreigner, being on probation, or having higher education, since in Roraima it is common for nursing technicians to be studying or have completed a degree in Nursing, but

remain working as technicians. This exclusion criterion was chosen because higher education provides a more in-depth study of the SUS and the right to health than technical education, which could represent a possible bias.

Initially, contact was made with the nurses in the sectors where the nursing technicians work, namely: the emergency department, major trauma, and the two ICUs. They were shown the letter of consent and told that the research had been authorized by the hospital management, the university, and the ethics committee. The objectives of the research and its methodology, the dynamics of the interviews, and a period of participant observation were also explained to the nurses, who gathered the technicians and passed on the information about the study. The nurses in each sector were asked to nominate the first nursing technician to take part in the research, and the following participants were nominated by the first. The technicians were then invited to take part in the interviews and the first to accept the invitations were chosen for the interviews, observing the inclusion criteria.

Of the 15 interviewees, four worked in a major trauma department, four in emergency care, four in ICU I, and three in ICU II. Within each sector, the aim was to interview one technician per work team (there are usually four teams per sector) to ensure a greater diversity of experiences and less interference from experiences lived collectively by a given nursing team.

A semi-structured interview was used, prepared, and recorded by the authors, with guiding questions about the impacts of the immigration of Venezuelans in Roraima, especially on the health system, and questions about the right to health. The interviews took place in private places inside the hospital and lasted approximately 20 minutes. It should be noted that the authors have no employment relationship with the GHR.

When a given interview script is suitable, the saturation point is usually reached in a maximum of 15 interviews (Nascimento *et al.*, 2018). In this study, the data was already saturated at the fifteenth interview, so this was the sample limit.

The use of multiple data collection methods increases the results' credibility (Figueiredo *et al.*, 2003). Thus, in order to help interpret the data captured by the interview script, we also opted for participant observation, a technique characterized by the immersion of the researcher in the respondent's reality to promote interactivity between the researcher, the subjects observed, and the context in which they

live. This requires a certain amount of interaction and exchange of experiences (Fernandes; Moreira, 2013).

As an auxiliary tool in the process of participant observation, as recommended in the literature, a field script was used with the aspects to be explored during the observation according to the research objectives, but without the concern of following them with absolute rigidity, leaving room for unexpected situations and the perceptions of the observer (Fernandes; Moreira, 2013; Malinowski, 1984). In this study, participant observation was carried out by two of the authors over a one-week period, individually, in different shifts and in all the hospital sectors where the interviewees' teams worked. Care was taken to ensure that the observer did not interfere in the work activities of the health professionals or in the interactions between them and the patients, or make any comments or judgments about the attitudes and conditions of care in the observed environment.

To process the data, content analysis was used which, according to Bardin (2011), comprises three phases: 1) pre-analysis, in which the material is organized, followed by 2) exploration, in which the information is aggregated into symbolic or thematic categories and, finally, 3) treatment of the raw results and their interpretation, in order to then propose inferences. The statements made up units of meaning and were then grouped into empirical categories.

The research was submitted to the Research Ethics Committee (CEP) of the State University of Roraima and was approved under opinion 3.357.346 and CAAE 12031518.5.0000.5621. The authors immersed themselves in the field after approval by the CEP and with the consent of the institution where the study was carried out. All the participants signed an informed consent form before the interviews. In honor of the nations that receive Venezuelan migrants, names of Latin American countries have been attributed to the statements *sic erat scriptum*.

Results

Fifteen nursing technicians took part in the study, seven men and eight women, four from the major trauma department, four from the emergency department and seven from the two ICUs. Their experience at the GHR ranged from three to 15 years. After analyzing the raw data, the results were organized into three categories as follows.

Category 1: Aversion to migrants

This first category expresses the opposition to Venezuelan migration on the part of most interviewees. In the speeches and between the lines, it was possible to perceive aversion simply because it was a migrant. There were also associations with the compromised quality of life in the city of Boa Vista and the worsening of services due to the presence of Venezuelan migrants. Some interviewees even verbalized their discomfort with requests for help from migrants in situations of poverty or social vulnerability, while voicing expressions that resemble “hate speech”, which is composed of words that tend to insult, harass, or intimidate people because of their color, race, ethnicity, gender, nationality, religion, or sex, with the potential to encourage violence, hatred, or discrimination against such individuals (Brugger, 2007).

Their coming here is awful, terrible, they should stay there, they're too lazy (Chile).

[Before] the city was peaceful, education and security functioned. Health was okay, and there weren't many thieves. It got worse with them! I see them in the street, but I don't give them a real (Brazilian currency) (Brazil).

I feel like I'm in Venezuela: squares, supermarkets, pharmacies, there's always someone speaking Spanish, asking for help, lots of *curumins* [boys] surrounding us, asking: “can you pay for me?”. I say: “No! I can't!” (Chile).

There's a lot of xenophobia and it's been worse. Brazilians once rioted and burned everything they owned in Pacaraima [a municipality in Roraima]. This is creating a rivalry (Brazil).

As far as I'm concerned, the most they can get is food in jail, without doing anything (Colombia).

If I had the means, I'd take them all and set off a bomb to blow them all up. And anyone who says that like me is criticized; on Globo, they said that we are xenophobic towards Venezuelans (Chile).

There was also the perception that Venezuelan migrants compete for services with people from Roraima, especially the poorer ones.

Everyone here knows that they [the Venezuelans] are the priority and that's very unfair because it's our country and we should be the priority. The day I go to the health center and they're the priority, there's going to be a riot. This is unacceptable (Chile).

As a Brazilian, I thought it was bad. Our country wasn't prepared! So our education system became very overloaded (Panama).

We pay a lot of taxes and they pay nothing and have a lot more privileges, it's ridiculous (Chile).

I know that the resources that would be used to help Brazilians who need them, who pay taxes, have to be given back, and they're not. The priority is the Venezuelans (Paraguay).

[Venezuelans] already receive Bolsa Família (social welfare program of the Government of Brazil), they receive all kinds of assistance from the government, they should also pay tax! They're worse than Indians, you know? Indians just suck on the government's tit! The Venezuelans came to wipe out a budget that we had been preparing for all this time to have this resource (Colombia).

The hospital should charge a fee. We pay taxes, they're benefiting from it and they don't contribute anything (Ecuador).

In other countries, when immigrants come, they're put in a different sector, far away, you know? And they're there getting medicine and everything, but it's there! Not in the middle of the population, getting in the way and complicating the lives of those who are here (Colombia).

Category 2: The Humanitarian Outlook

This category presents ideas that are favorable to migration, with a humanitarian outlook. Three of the four interviewees considered the migration process and its consequences to be a human rights issue, important for preserving the essential rights to life and showing empathy towards the migrants. Even so, one interviewee (Paraguay) was critical of Venezuelans, which was also represented in the previous category.

They're running from hunger, I don't see it [migration] as a bad thing, because it could be us too (Paraguay)

They have the right to seek refuge in order to get their daily bread (Uruguay)

We can't solve this situation, but we can help in any way we can (Mexico).

Category 3: Healthcare as a right

This category brings together ideas about health as a right of the individual and a duty of the state. Most of the interviewees are aware of the universality of Brazil's Unified Health System (UHS) but disagree with the Venezuelan migrant's right to free access to local health services. Others even disagree with the existence of the UHS and justify their position by the fact that migrants don't pay taxes.

That's the problem, as the UHS is for everyone! I think they can be treated by the UHS but without priority (Bolivia).

They have the right to health under the Constitution, but we should have priority, they should contribute to the UHS. Brazilians are working hard to pay for it, they use it and we lack it (Argentina).

Unfortunately, it [UHS] is everyone's right! (Peru).

I don't agree with the UHS! It should be health insurance, if you don't pay, you don't get it! I work and it's taken from me to support someone else. How can someone who has never paid a penny in taxes in Brazil have the same rights? I know it's inhumane, but I don't agree (Brazil).

They should be charged a fee to have the right to health, we're contributing and they're just using it (Ecuador).

Only four of the interviewees said they supported UHS care for Venezuelan migrants, but stressed the need for management planning so that the services provided are more effective and of higher quality.

[The UHS] is universal... They [Venezuelans] have the right... It's just that the state should be prepared because there's no point in offering quality healthcare when there isn't any (Nicaragua).

Well, it's the right of every citizen, it's in the Constitution. I have nothing against them being treated for free. Especially since they're already in a critical financial situation, it's not even logical to tell them to start paying, right? I think everyone has the right to be cared for as a citizen (México).

Somehow, it has a very big [financial] burden, right? I think it should be better organized so that the federal government can help more. We have to organize ourselves more, there's money, we just have to manage it better. That's all (Paraguay).

I agree, health has to be for everyone! You can't deny health to human beings (Panama).

Participant observation revealed less willingness for professional-patient interaction when the patient was of Venezuelan origin. In these cases, the technicians solved the demands more objectively, without adding any further explanations, except on request. The professionals seemed to expect the foreign migrant to automatically understand the workings of the hospital and the service in general and to be passive about what was being offered. When it came to Brazilians, there was a longer exchange of information, mainly due to the understanding of speech.

Discriminatory attitudes towards migrants were observed, albeit quite veiled. The nursing technicians provided the necessary care, generally carrying out procedures related to technical assistance. There were differences, however, when it came to the humanization of care: for the Brazilians, there was greater welcome and clarification, while for the Venezuelans, care was shorter and less friendly and interactive.

Discussion

Most interviewees (11 out of 15) expressed xenophobic ideas for different reasons. One of them even acknowledged that there is xenophobia in the state of Roraima, mentioning an episode of violence that took place at the border, in which Venezuelans were beaten and their belongings burned in a demonstration by Brazilians against these migrants (Veja, 2018). Xenophobia is a common feature of various types of discrimination which, depending on the stigmatized group, include racism and religious intolerance (Farah, 2017). It is not only related to physical or verbal violence, but can also be a silent process that hurts, oppresses, silences, and can interrupt an individual's development due to the psychological impacts that can accompany them for a long time.

Allied to xenophobia is a socio-economic component, since most Venezuelan migrants live in extreme poverty. Most depend on shelters set up by *Operação Acolhida* and, without this assistance, would live on the streets and with extreme food insecurity (Arruda-Barbosa *et al.*, 2020). Therefore, there also seems to be aporophobia, an aversion to the poor (Cortina, 2017), a behavior not expected for health professionals who work, above all, in public hospitals, where a significant part of the demand is from people who are more socioeconomically vulnerable.

One of the biggest barriers to the integration of international immigrants into Brazilian society is overcoming xenophobia and prejudice (Silva; Fernandes, 2017), which not only affect Venezuelans, but also those of other nationalities, who have to deal with these and other difficulties: having a different language, suffering constant racist attacks and religious persecution, among other forms of exclusion and discrimination of which they are frequent targets (Ca; Mendes, 2020).

The literature shows that there are Venezuelan migrants who have chosen to come to Brazil for the possibility of free access to education and other public services (Arruda-Barbosa *et al.*, 2020). This has intensified demands for housing, security, health services, work, and food, among others (Silva; Arruda-Barbosa, 2020).

The interviewees' statements reveal that there is no willingness to accommodate these demands, whether in the use of health care or other public services in the city, but rather segregation. The needs of the Venezuelan migrant population, which is in a situation of great social vulnerability, are given little consideration. In the view of those interviewed, foreigners living in Brazil don't pay taxes, so they shouldn't have

access to free public services. Although there is no charge for health services in public institutions, they believe that these services should be charged to Venezuelans. It is not taken into account that all people within the current Western urban-capitalist conformation - even when marginalized - make tax contributions since most taxes are paid indirectly, embedded in the prices of goods and services.

The first barrier to be overcome by the immigrants in Brazil is the lack of hospitality (Silva, 2017), which is absent in the interviewees' accounts of Venezuelan migrants since the nursing technicians see them as the ones responsible for Roraima's social ills and their needs are undervalued in the face of an ethnocentric view, in which social rights are restricted to Brazilians.

Participant observation corroborates this data, as it was possible to notice prejudice among the interviewees who, in general, associate Venezuelan migrants' access and right to health care with a loss of rights for Roraima residents. In informal conversations between these technicians or between them and the observer, there were frequent statements such as: "Look how many Venezuelans there are in this sector, more than Brazilians"; "A bed occupied by a Venezuelan takes away the chance for a Brazilian to be treated"; "While a Venezuelan is here in the ICU, there's a Brazilian in the trauma waiting for an opening".

There were also comments associating the lack of hospital resources (e.g., lack of beds, medicines, or staff) with the use of Venezuelan patients. There was no interpretation that any patient in the same condition would use the same resources and could empty the stocks, which would be consumed in the same way. Venezuelans were always seen as the cause of the problems faced by the service, even though, when questioned, the technicians claimed that the limitation of resources and supplies was a problem that predated the increase in immigration. There was a clear intention to hold Venezuelans exclusively responsible for the various problems experienced in Roraima, many of which have structural causes and were already present even before the current migration situation (Milesi; Coury; Roverly, 2018).

From the political-administrative point of view in Roraima, it is known that discrimination against Venezuelans has been encouraged by local political leaders, for whom xenophobia may represent a way of alienating the population from the structural causes of the various problems faced by Roraima residents, especially in the run-up to the election period. On the other hand, if this discourse is working and being so widely adopted, it may be an indication that it is, in a way, aligned with

the voters' desires (Milesi; Coury; Rovey, 2018). This whole situation is reflected in the health system.

Another important barrier is language, as it is one of the factors that amplifies the stigma against a subjugated group (migrants) by the dominant group (locals). Language is one of the important cultural manifestations that underpin and strengthen a people's identity, and also one of the essential elements in the process of integration and interaction, especially in contact with others (Ca; Mendes, 2020). The language barrier can increase discrimination against a group, facilitating and enhancing domination (Diehl, 2015). A foreign language speaker or even a Portuguese speaker with a foreign accent can become the object of automatic discrimination, just as skin color leads to racism.

Based on the observations regarding language, it was clear that language is a stigmatizing factor. However, one fact drew attention: language seems to be a greater obstacle for the health professional than for the Venezuelan, and this could open up a range of possibilities for future research into the impact of cultural and linguistic differences on care for Venezuelan migrants.

The language barrier, together with the positions against forced immigration, creates a social stigma that has already been described (Arias, 2018): the loss of appreciation for dialogue and democracy is exacerbated by the political contrast between extreme right-wing Brazil (Bolsonaro government) and extreme left-wing Venezuela (Maduro government), which overvalues the state to the detriment of private initiative and free trade. It is therefore conjectured that the Brazilian population runs the risk of venting its frustrations against Venezuelan migrants who have become the target of their own migration and also by the social judgment that since they bring with them the socio-economic ills of their country.

Some interviewees take a broader view of the problem, based on an understanding of the forced causes of the migration process, cultural competencies, and equitable health care. This view is in line with the welcoming position that the Brazilian state has traditionally shown the world over the years, through public policies and international agreements related to human rights and immigration. Brazil was the first country to ratify the United Nations Convention relating to the Status of Refugees; to sanction a National Refugee Law; to have a National Committee for Refugees, as well as be a member of the Executive Committee of the United Nations Refugee Agency (Brasil, 2017; Dominguez; Baeninger, 2016; Brasil, 1997).

In 2019 the Bolsonaro government withdrew Brazil from the Global Compact for Safe, Orderly, and Regular Migration and recently the Lula government returned to it (Brazil, 2023).

It also opens up the possibility of future more comprehensive quantitative health research aimed at the degree of awareness and the impact of educational actions for professionals who deal directly with migrants, such as the health professionals studied here. In this respect, examples can be found in the Portuguese Immigrant Integration Policy, which provides for the training of public service professionals working in the immigration sector (Costa, 2016).

Cultural competency education, which is based on bringing the learner closer to the culture and customs of a given social group, is an important strategy for addressing health inequalities and should be directed at health professionals to ensure that all adults and children can receive equitable and effective healthcare, particularly those who are culturally and linguistically diverse (Masland; Kang; Ma, 2011; Goulart; Levey; Rech, 2018).

The universal right to health has been a banner of struggle for the Brazilian social movement since the 1970s and is now a constitutional guarantee (Cebes, 2014; Brasil, 1988). It is regrettable that, after all these years of struggle and more than 35 years of efforts to strengthen the UHS, there are still health professionals, and statutory workers of the UHS, who devalue it, disagree with its existence, or wish to restrict access to health. It is believed that this position is strongly influenced not only by the xenophobic ideas presented here but also by a strong lack of historical knowledge of the healthcare system evolution in Brazil, which was once based on the restrictive, hospital-centric, and biomedical care that characterized the national healthcare model prior to the 1988 Constitution.

The depreciation of the UHS is based on the discourse of the pseudo-efficiency of private health services, especially in the United States. However, in studies on the health systems of 11 developed countries, the restrictive and privatized health system in the United States was classified as the worst. It had the highest health expenditure, reduced administrative efficiency, and the worst results in terms of equity, access, quality, life expectancy, and infant mortality. It is also a segmented and fragmented system in its organization, supply, financing, eligibility rules, and range of covered services. In order to expand access to health care, the Obama administration proposed the Obamacare program, which expanded coverage

through subsidies to private insurance and inclusion in public segmented schemes, but without achieving the universality already achieved in Brazil by the UHS (Schneider *et al.*, 2017; Birn; Hellander, 2016).

Thus, it is clear how strong the influences of the dissemination of ideas of the supremacy of private health care in relation to the UHS are, whether national or international, which, combined with the other influences already discussed, contribute to discourses of undervaluing the UHS and encouraging the social exclusion of poor migrants rather than inclusion, reception, equity and humanization of the care, as one expects from a health professional.

It is well known that access to national health systems and the achievement of good results in the health status of individuals have become key indicators of the integration of migrants because health is an essential aspect of their social inclusion. The denial of access to healthcare to migrants may also be linked to the lack of preparedness and sensitivity of the healthcare professional (Fonseca *et al.*, 2007). Thus, more than training to deal with migrants, it is necessary to exercise empathy and humanization of health care in Roraima, given only a minority of participants have outlined a more humanized and inclusive look towards foreigners.

Finally, it is described that there is agreement on the part of the authors with the perception of the four respondents who were the only ones to consider that Venezuelan migrants are not only relieved from hunger in Brazil but also of their need to be accepted and included as subjects of rights in the receiving society.

It is warned that everything else is using their suffering as a vile and unworthy currency of ideological cunning with political purposes, as has already been used in these issues nowadays around the world (Arias, 2018), and in Roraima has not been different. It is understood that this awareness-raising is necessary for the plural society, especially for health professionals who deal with the most fragile side of human life: the breaches in quality of life and health in emergencies that often destabilize the health-sickness process in the direction of disease.

It should also be considered that the schooling of the respondents at the technical level, coupled with the possible lack of skills related to the UHS and its structure, may have influenced the reports presented, since they did not have the opportunity for more in-depth studies on health ethics, anthropology and philosophy applied to health, as well as a baggage of disciplines related to UHS, and the right to health present in most of the degree courses in health. On this issue, Rodrigues and

Andrade (2017) say that there are obvious weaknesses in the process of training nursing technicians in Brazil. Reflecting in unintegrated care resulting from rapid vocational training and questionable quality. This helps to ensure that they are trained only with technical content and that discussions aimed at the multiple dimensions of care are not addressed.

Final considerations

This study allowed us to know the perceptions of nursing technicians about Venezuelan migrants, having found that most see them as responsible for many of the current social messes in Boa Vista, Roraima, in addition to exposing xenophobic and prejudiced ideas. Behavior and ideas of a segregationist base were perceived, including criticism of the universalization of the right to health by the UHS. It also enabled to broaden the understanding of the processes of caring for health professionals who are situated in migratory crisis environments, as well as raising the reflection on the impact that educational processes on cultural diversity and the right to health could have on the humanization of care and reception in health services.

Future studies could be developed to broaden the understanding of the right to health of migrants, involving nurses in order to compare the results with those obtained in this study and to analyze whether the baggage of knowledge acquired in higher education influences the understanding of the immigration process and the rights to health.¹

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Note

¹ L. de A. Barbosa: research project orientation; observation participant analysis of results and article writing. A. F. G. Sales: project writing; data collection and analysis; article writing and approval. A. S. Cavalcante Neto participated in the writing and final approval of the article. M. A. of C. Oliveira: writing and approval of the article.

Resumo

Migrantes venezuelanos e direito à saúde: percepções de técnicos de enfermagem de um hospital geral

Objetivo: Conhecer as percepções de técnicos de enfermagem de um hospital geral relativas à imigração venezuelana e ao direito à saúde. **Método:** Pesquisa qualitativa com abordagem exploratória e descritiva que utilizou a observação participante e entrevistas semiestruturadas com 15 técnicos. Para análise dos dados, lançou-se mão do referencial de Bardin. **Resultados:** A maioria dos entrevistados associou o imigrante à piora da qualidade de vida local e à sobrecarga dos serviços de saúde. Apenas quatro consideraram a imigração e suas consequências como uma questão humanitária, demonstrando empatia com os imigrantes. Muitos manifestaram ciência do princípio da universalidade que caracteriza o sistema de saúde brasileiro, mas discordaram do direito do imigrante ao acesso gratuito aos serviços de saúde. Houve forte depreciação da saúde pública. **Conclusão:** A maioria dos entrevistados opôs-se à imigração dos venezuelanos e seus discursos continham traços de xenofobia, preconceito e discriminação. O estudo permitiu ampliar a compreensão sobre os processos de cuidar dos profissionais de saúde em um contexto de crises migratórias.

► **Palavras-chave:** Saúde Coletiva. Enfermagem. Emigração e Imigração. Direito à Saúde.

