Original Article
Arruda-Barbosa L, Santos AAA, Rodrigues SS, Lima GM, Fonseca BC, Santos ECM, et al. Perspective of health professionals on the cross-cultural challenges in prenatal care for pregnant Venezuelan immigrant women.
Rev Gaúcha Enferm. 2026;47:e20250183.
https://doi.org/10.1590/1983-1447.2026.20250183.en

Perspective of health professionals on the cross-cultural challenges in prenatal care for pregnant Venezuelan immigrant women

Perspectiva dos profissionais de saúde sobre os desafios transculturais no cuidado pré-natal às gestantes imigrantes venezuelanas

Perspectiva de profesionales de la salud sobre los desafíos transculturales en la atención prenatal de mujeres embarazadas inmigrantes venezolanas

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How to cite this article:
Arruda-Barbosa L, Santos AAA, Rodrigues SS, Lima GM, Fonseca BC, Santos ECM, et al. Perspective of health professionals on the cross-cultural challenges in prenatal care for pregnant Venezuelan immigrant women. Rev Gaúcha Enferm. 2026;47:e20250183.
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ABSTRACT

Objective: To identify the challenges faced by healthcare professionals in prenatal care for pregnant Venezuelan immigrant women from a cross-cultural perspective.

Method: This was an exploratory, qualitative study that employed snowball sampling. Data collection (March-April 2024) was conducted via interviews and subjected to Bardin's content analysis..

Results: Interviewees' experiences with pregnant immigrant women ranged from 1 to 10 years; five had specialized in Primary Care. Two categories emerged: 1) Challenges in cross-cultural communication - language as an obstacle, especially for less experienced

professionals; 2) Cross-cultural challenges in prenatal care - culture and behaviors: preference for cesarean section, low adherence to prenatal care, and resistance to practices such as family planning, partner monitoring, vaccination, and prevention of sexually transmitted infections. Dietary differences and a lack of knowledge about the Brazilian healthcare system were also mentioned.
Final Considerations: The conclusion is that the quality of care is compromised by linguistic and cultural barriers, which also contribute to an elevated clinical risk. To overcome these barriers, the adoption of transcultural competencies and cultural mediation of care is required. Therefore, investing in professional training for cultural negotiation will positively impact patient care and the organizational structure of health services.
Descriptors: Host Society of Migrants; Transcultural Nursing; Primary Health Care; Culturally Competent Care; Prenatal Care.

RESUMO

Objetivo: identificar os desafios enfrentados pelos profissionais de saúde no cuidado pré-natal a gestantes venezuelanas, sob uma perspectiva transcultural.
Método: pesquisa exploratória, qualitativa, que empregou amostragem por bola de neve. Coleta de dados (março-abril/2024) via entrevistas, submetidas à Análise de Conteúdo de Bardin.
Resultados: as experiências dos entrevistados com gestantes imigrantes variaram de 1 a 10 anos; cinco possuíam especialização em Atenção Primária. Emergiram duas categorias: 1) Desafios na comunicação transcultural: idioma como obstáculo, especialmente para profissionais menos experientes; 2) Desafios transculturais no pré-natal: cultura e comportamentos: preferência por parto cesárea, baixa adesão ao pré-natal e resistência às práticas como planejamento familiar, acompanhamento do companheiro, vacinação e prevenção de infecções sexualmente transmissíveis. Também foram citados as diferenças alimentares e o desconhecimento do sistema de saúde brasileiro.
Considerações Finais: conclui-se que a qualidade do cuidado é comprometida por barreiras linguístico-culturais, que interferem também na elevação do risco clínico. Para sua superação, é exigida a adoção das competências transculturais. Sendo assim, investir na formação profissional para negociação cultural impactará positivamente no cuidado e na estrutura assistencial dos serviços de saúde.
Descritores: Sociedade Receptora de Migrante; Enfermagem Transcultural; Atenção Primária à Saúde; Assistência à Saúde Culturalmente Competente; Pré-Natal.

RESUMEN

Objetivo: Identificar los desafíos que enfrentan los profesionales de la salud en la atención prenatal de mujeres embarazadas inmigrantes venezolanas desde una perspectiva transcultural.
Método: Este fue un estudio exploratorio cualitativo que empleó un muestreo de bola de nieve. La recopilación de datos (marzo-abril de 2024) se realizó mediante entrevistas y se sometió al análisis de contenido de Bardin..
Resultados: La experiencia de las entrevistadas con mujeres embarazadas inmigrantes osciló entre 1 y 10 años; cinco se especializaron en Atención Primaria. El idioma es una barrera, especialmente para los profesionales con menos experiencia. Existe una preferencia por las cesáreas, baja adherencia a la atención prenatal y resistencia a prácticas como la planificación familiar, el seguimiento de la pareja, la vacunación y la prevención de infecciones de transmisión sexual. También se mencionaron: diferencias dietéticas; desconocimiento del sistema de salud brasileño.

Consideraciones finales: Se concluye que las barreras lingüísticas y culturales comprometen la calidad de la atención e incrementan el riesgo clínico. Superarlas requiere adoptar competencias transculturales y la mediación cultural del cuidado. Por ende, invertir en la formación profesional para la negociación cultural impactará positivamente en la calidad asistencial y la estructura de los servicios de salud.
Descriptores: Sociedad Receptora de Migrantes; Enfermería Transcultural; Atención Primaria de Salud; Asistencia Sanitaria Culturalmente Competente; Atención Prenatal.

INTRODUCTION

Care is a phenomenon in the provision of assistance, support, or facilitation to people with expected or evident needs, to improve their condition or lifestyle[1-3]. It is the primary goal of nursing, though secondary in other health professions. In mother's health, this concept of care is realized exemplarily during the follow-up of the gestational process. Pregnancy follow-up allows the early identification and appropriate clinical management of conditions of risk. This is why it is essential to reduce mother-child morbidity and mortality. At least six consultations, alternating between nurse and physician, are recommended to ensure continuous and interdisciplinary care[4].

Ensuring quality and humane pregnancy care is even more complex when dealing with immigrant pregnant women. Their experience with displacement may involve not only socioeconomic difficulties, but also differences in language, culture, and care-related values. This is the context experienced by many Venezuelan women who arrive in Roraima seeking better conditions of life. From 2023 to 2024 alone, 82,364 Venezuelan people entered the state[5,6].

Many of them deal with significant difficulties in their health-disease-care processes, due to their poor living conditions. Several of them live in spontaneous shelters, or those maintained by support institutions, such as Operação Acolhida, created by the Federal Government. This situation overloads the local health system, increasing both the demand for health services and the costs associated with it[7-10].

In this context, pregnant Venezuelan women are particularly susceptible to the lack or discontinuity of care during pregnancy. This may be the result of difficulty access, lack of knowledge about the health system of the receiving country, or cultural barriers. In this study, "culture" is understood as the set of beliefs, values, behavioral norms, and practices related to lifestyle. These elements are learned, transmitted, and shared by a specific group, guiding thought, decisions, and the actions of their members[1-3].

Literature discusses the main difficulties that may harm the quality of prenatal care, from the perspective of physicians and nurses in primary care, in studies carried out with Brazilian pregnant women. Among the main obstacles, stand out: delays in delivering exam results; lack of resources; and the inadequacy of space in health units. Furthermore, pregnant women are brought in late in their pregnancy to start receiving care. Additionally, their partners are often missing in consultations, even when needed to treat Sexually Transmitted Infections (STI), such as syphilis[11,13].

However, the care for the pregnancy of Venezuelan immigrants involves challenges that go beyond the clinical aspect, especially in regard to cultural differences that change perception, adherence, and the reception of care. Understanding these practices, beliefs and expectations is essential for the effectiveness of care and the strengthening of the relationship between health workers and patients. Thus, this study aims to recognize challenges to care and cultural and behavioral barriers to the gestational attention provided to these women in the Northern end of Brazil, from the perspective of health workers.

Literature on this topic, although scarce, indicated a low adherence to prenatal in Venezuelan immigrants in the puerperium. Reports indicate that the supplements recommended in pregnancy start to be taken late, there are high levels of urinary infection, complications at delivery, and health issues in the newborn. A study in the main maternity of Boa Vista, capital of Roraima, found that most Venezuelan pregnant women do not undergo prenatal properly, if at all. However, the revision carried out for this manuscript could not find studies that addressed this topic from a transcultural perspective of care. This is a relevant gap, especially in the context of a border, in which cultural plurality can have a direct influence on the care provided.[13,14]

Considering the above, the goal of this study was to identify the challenges faced by the health workers in the prenatal care provided to Venezuelan pregnant women, from a transcultural perspective. The justification of this study is the fact it analyzes how cultural, linguistic, and behavioral differences influence the prenatal care of Venezuelan pregnant women in the context of a border. The results are particularly relevant for physicians and nurses.

METHOD

Qualitative study with an exploratory approach. The role of qualitative research is in investigating the experiences of people and obtaining a deeper understanding of the meaning of their experiences[15]. The theoretical framework we used was Leininger's Theory of Culture

Care Diversity and Universality. This theory refers to a set of inter-relations between concepts and hypotheses that consider values, beliefs, and behaviors of individuals and groups in the practice of care. Therefore, to recognize the cultural aspects of human needs means considering the particularities of the way of life of each person[1,2].

Therefore, this theory selected and integrated nursing's own constructs with those of anthropology. Both are integrated and form an indivisible whole, representing a humanistic guidance of life and being. Thus, care is understood to be culturally constituted, and each culture has its ways, standards, expressions, and structures to understand, explain, and predict the state of wellbeing, as well as the behaviors related to the health-disease-care process and the social and cultural contexts in which these take place[3].

Thus, this Theory guided all stages of this investigation. Its adoption is justified seeing as prenatal care, in this context, is a potential intercultural meeting between health workers and users. This is an appropriate theoretical framework to interpret how physicians and nurses recognize, incorporate,or deal with these differences in daily care. Thus, it was pertinent to sustain the analysis of the professional perceptions about the care provided in a the context of a country's border.

The study was conducted in the city of Boa Vista, the capital of Roraima, Brazil, whose population is 413,486, with a population density of 72.71 people per square kilometer. According to data from the Municipal Health Secretariat, local primary care is made up of 37 Basic Health Units (UBS)[16,17]. The research was developed in five of these units, all located in the capital.

The participants were selected according to the following inclusion criteria: being a physician or nurse; having at least six months of experience, self-reported, in prenatal care for Venezuelan immigrants; being Brazilian. Participants of double nationality were excluded, give that interviewees who had another nationality in addition to being Brazilian could have a different cultural perspective. Professionals on leave or vacation were also excluded.

The number of participants was determined considering data saturation. For this approach, from six to seven interviews are generally sufficient to address most themes of interest in homogeneous groups. To ensure a more consistent saturation, this limit can be expanded, to capture a larger diversity of perspectives and experiences relevant to the study. However, saturation goes beyond the number of participants. It must reach a point in which new information on a phenomenon cannot be obtained, even after new participants are included[18].

Data saturation was reached gradually during the interviews. After the eighth, we found that information became repetitive and there were no new elements that were relevant to the object of our study. As a result, we chose to conduct two other interviews, in order to make sure that the content found was consistent and guarantee that the data collected was sufficient.

Interviewees were selected using a sample technique guided by participants, known as "snowball". This technique is a non-probabilistic sampling, based on chains of referrals. In this non-probabilistic method, a chain of samples, based on referrals, is used, facilitating recruiting. The method is supported by "key informants", who suggest new potential participants, thus contributing to forming the group that will be part of the study. It is worth highlighting that the referred individuals have the option of not participating in the research[19].

The first participant, a health worker who was in accordance with inclusion criteria and had collaborated with other university activities, was invited in person. At the end of this interview, he was asked to indicate one or two colleagues (physicians or nurses) who had experience in conducting the prenatal of Venezuelan women, preferably those who worked in UBSs that were close to immigrant shelters. The same procedure of referral was repeated in later interviews, until data saturation was reached. The referred participants were contacted in person or through WhatsApp messages.

Data collection took place from March to April 2024, in the waiting rooms of the health workers, at a time previously scheduled by them. To conduct the interviews, we used a semistructured script, developed by the authors. The script, guided by the assumptions from the Transcultural Nursing Theory, was elaborated according to the following guiding questions: Describe your experience in providing care for pregnant Venezuelan women. In your practice, how do issues related to language and culture influence prenatal care?

These questions were formulated to understand how the cultural and linguistic dimensions of pregnant Venezuelan women manifest in the practice of care reported by these professionals.

All interviews were recorded in audio and later transcribed by the researchers. It is worth noting that, after the statements of the participants were transcribed, in the process of skimming, expressions that sought the confirmation of the listener (such as "right?", "you know?") were suppressed, as they did not give support to the analysis carried out here. The data collection instrument was validated externally through a pilot interview, conducted respecting the same inclusion criteria. This interview was not a part of the final data set.

Data was analyzed using the Thematic Content Analysis technique. This technique has been a robust methodological tool, widely accepted in qualitative research to interpret complex data. It has three main stages: 1) pre-analysis, in which the materials are organized; 2) exploration, in which information is grouped in thematic/symbolic categories; and 3) analysis of results, followed by their interpretation, in order to propose inferences[20]. As a support, we used the software Qualitative Data Analysis (WebQDA).

After skimming the interviews[20], we found and highlighted significant extracts related to the topic of intercultural care. These excerpts originated initial codes, which are later organized around axes of meaning, resulting in the thematic categories that form the results. The process of categorization was carried out independently by two PhD authors, who, after the analysis were separated, gathered to discuss, compare, and consolidate the categories that emerged. The other authors reviewed and validated collectively the end-product of the categorization, ensuring the analytical process was rigorous and reliable.

Data analysis was also guided by the theoretical framework, which offered conceptual references to interpret the meanings attributed by professionals to the experience of care. The theory guided the reading process, the organization of statements, and the building of the categories, highlighting elements such as cultural values, beliefs, practices, and ways of interacting that go beyond prenatal care. Thus, it allowed identifying how these dimensions influence the perceptions and conducts of physicians and nurses when attending Venezuelan pregnant women.

The study was authorized by the Municipal Health Secretariat of Boa Vista, which produced an agreement letter for the approval by the Research Ethics Committee of the State University of Roraima (UERR), under opinion 3.898.659 and CAAE: 19076819.2.0000.5621. The anonymity of interviewees was ensured and all signed an informed consent, in accordance with the directives of Resolution No. 466/12, in addition to receiving a copy of the signed documents. The interviews were coded using the letter "E", followed by a number indicative of sequence.

RESULTS

This study included 10 health workers, five nurses and five physicians. Two of them were generalist professionals, while eight had some specialization or residency. From those with a post-graduation, six were specialists in the field of Family Health (four nurses and two physicians). Total professional experience varied from 1 to 26 years. Interviewees had from 1 to 10 years of experience in assisting pregnant Venezuelan immigrants. The results were the

same for the statements of physicians and nurses. Based on the statements of the interviewees, the following categories were elaborated.

Transcultural communication challenges

The statements consistently highlighted that the language barrier is always a significant challenge, especially for those who are less experienced in providing pregnancy care to this population. For those with longer experience working with immigrants, the language is not such a relevant issue.

Two interviewees highlighted that the greatest communication issue is associated with the inability of immigrants to understand Portuguese, not with the inability of workers to understand Spanish. They reported that inefficient communication has a direct impact on the quality of care. This manifests in mistaken interpretation of health guidance, trouble scheduling consultations and exams, and frustration on the part of both health workers and patients, as they attempt to reach clear communication. Below are some statements on this issue:

> *The first barrier to accessibility is language. They have this issue with the language. Sometimes, they don't understand what we say, they misunderstand it. We schedule a date for the consultation, they show up another day.* (E2)
>
> *The main barrier, I think, is communication on their side.* (E5)
>
> *They don't understand fully all that we say.* (E9)
>
> *One of the main challenges we face is related with the language. Communicating with them is quite difficult. They don't understand what we say, our guidance.* (E1)
>
> *First, the language, in the beginning. But today there's no more trouble with that. For me, there's no longer trouble, no.* (E3)
>
> *The language barrier makes it harder for them to understand where they should collect, for example. We take them outside, explain how it works, what she has to do, and they can't access the service. Sometimes we think they are understanding, but they aren't.* (E4)
>
> *A great challenge is communication. Communicating is hard, both understanding Spanish and getting Portuguese to be understood. This part, explaining, providing guidance, it's a bit tricky.* (E8)

Transcultural communication transcends the language barrier. It shows that difficulties ensuring mutual understanding not only hinders adherence to prenatal care (as shown in scheduling mistakes, for instance), as it also harms the credibility of the health worker, from the perspective of the pregnant immigrant.

Transcutural challenges in the prenatal: culture and behavior

The ideas expressed in the statements of the participants showed cultural and behavioral challenges in care during the pregnancy of these women. Differences stood out in their expectations about how delivery would take place. Almost all Venezuelan women strongly reject physiologic delivery and want the physicians and nurses to ensure that their labor will be conducted with a cesarean section.

> *The issue of labor also makes things more difficult, because they come wanting to choose the form of delivery. They arrive already asking if labor "will be a cesarean". When we say that here in Brazil it's different, they get afraid. In Venezuela, they strongly favor the operation. So they arrive here with this experience.* (E5)

> *Pregnant Venezuelans want a cesarean delivery. They bring this from Venezuela as something trivial and routine. They want us to give them a referral, ensure that they will get a cesarean delivery.* (E1)

Reports also highlighted that this pregnant population often shows low adherence to routine consultations during pregnancy, in addition to difficulties in understanding the decentralized nature and the protocols of Brazilian health services. Furthermore, many of them do not adhere to practices of family planning and STI prevention strategies.

> *They have a lot of children, one after another. There is no such thing as family planning in Venezuela. So, that's why we see that so many women, even in a difficult situation, are still getting pregnant*(E4).

> *The follow-up, the monitoring in the prenatal. [Which is hard with them.] Carefully minding monthly consultations [...]. Later, when the gestational ages reach the middle of pregnancy, every 15 days, then every week. They think they don't have to come back, to follow up. Just because everything is fine with the child, that doesn't mean you don't have to come.* (E10)

> *Health care, before the crisis in Venezuela, was a bit different from ours. If they went to a clinic, they did everything there - ultrasound, exams, all of it. Sometimes, this makes it more difficult, because they don't understand that our services are decentralized.* (E5).

> *In Brazilian patients, I noticed more care in the follow-up. Knew they were doing everything as it should. But they [Venezuelan] did not. (E10)*

> *They do not care for themselves as a habit, and thus they have a lot of STIs.* (E2)

> *Their culture of following on the prenatal is also different. Here, there are protocols established by the Ministry of Health which we have to see through. This also hinders their care.*(E5)

Three interviewees highlighted the frequent resistance of Venezuelan women to adhere to the vaccination schedule, attributing it to a cultural perception of devaluing vaccination. As for their diets, two professionals highlighted that the diet of these women is culturally different from a Brazilian diet, with high intake of caloric foods with low nutritional value, such as arepas and fried foods. However, they also mentioned that their poor socioeconomic conditions limit their access to healthy foods. Thus, the dieting issue may be more related to financial restrictions than to cultural preferences. This duality suggests that it is necessary to consider both cultural barriers and structural inequality when caring for these pregnant women.

> *We also highlight the element of vaccination. Many Venezuelan pregnant women have trouble vaccinating, because they think it's not necessary, they don't think it's important.* (E6)
>
> *It's the type of culture, so that also hinders care. One thing I noted is regarding vaccination. They are kinda, against the vaccine. They also have more children, younger children*. (E8)
>
> *Culturally, for example, they don't have the habit of eating vegetables. It's always that food based on arepa and rice. So, when the doctor gives orientation to the woman with gestational diabetes, you see they don't have the habit of eating healthily. But, many of them, it's because they just have the dietary habits from there, really*.(E7)
>
> *The cultural issue - we could say, the diet - the Venezuelan patients, many of them have issues such as anemia, they have a really poor diet, actually. Maybe due to cultural issues, financial issues, but their diet is not good.*(E6)
>
> *They have to struggle for food all the time, it's hard. Some women with gestational diabetes are in shelters now. They have to eat what's provided there, which is usually richer in carbohydrates than protein. Some of them will tell you that the issue is that they will not be able to buy it, because we know it's more expensive. Buying fruit, vegetables, and having a healthier diet is more expensive*. (E7)

This category shows a dissonance between the Brazilian health care model and the value system of these Venezuelan women, manifested in resistance to the physiologic delivery and generating a demand for cesarean sections. The low adherence to Brazilian routine protocols (periodic consultations and vaccination) is compounded by difficulties decoding the decentralized nature of SUS. Finally, the issue of dieting exposes the intersectionality of these barriers, as being poor and having limited access limit their ability to follow nutritional advice.

DISCUSSION

It is remarkable that, although 60% of interviewees are post-graduate in primary care, emphasizing their connection with the topic, sociocultural adaptation, and longitudinal care, difficulties receiving Venezuelan pregnant women remained. This suggests that, even with a specialized formation, the most noteworthy sociocultural idiosyncrasies impose challenges that go beyond technical competence and humanized approaches. Data show the complexity of cultural congruence in practice, suggesting that formal education in primary care, despite being necessary and relevant, can require specific tools in order to improve transcultural care.

This type of care shows the relevance of understanding the sociopolitical and cultural context of the individual and groups. This understanding is the basis to identify practices of care and their association with health systems, both in the scope of traditional popular knowledge and in the field of professional knowledge, which encompasses nursing and the other health professions. This approach allows health workers to establish three types of relationship with cultural care: preservation, accommodation, and restructuring[1-3].

In this context, cultural preservation in care is related to a practice of care that values and improves the traditional knowledge of the user, encouraging the continuity of health practices that are rooted in culture. Cultural accommodation involves the process of mediating between popular and scientific knowledge. It allows adjustments in health habits that respect each individual's beliefs and values. Finally, cultural restructuring represents the collaborative construction of new meanings in health, according to which professionals and users rebuild forms of care that are more effective and culturally relevant[1,3].

In this study, language was broadly recognized as a barrier by almost all health workers, especially those who had less experience attending Venezuelan immigrants. Similar findings were found in previous studies in Roraima[8,14,21,22].

As they reported that the language makes it more difficult to attend to immigrant women, some interviewees did not consider that communication presupposes the active participation of both parties, including the professionals themselves, who, in general, do not speak Spanish. Curiously, it has also been shown that Venezuelan immigrants do not see the language as a significant challenge in health services in Roraima. This apparent divergence may reflect a power asymmetry in the professional-patient relationship and in the immediate need to access services[8,23].

While professionals see the language as a technical obstacle, the immigrants, in a more vulnerable condition, may minimize or relativize this issue, prioritizing access to the service to the detriment of other demands. This dynamic shows the need for a more critical approach about the management of language differences in daily care. This approach must

also go beyond the technical obstacle represented by language, also considering cultural and social aspects that permeate communication in health services.

The transcultural theory of Madeleine Leininger highlights the relevance of a cultural congruence between health workers and the patient, so care is effective and significant[1-2]. In this context, the lack of effective communication may lead to mistaken interpretations, reducing the efficacy of care and the establishment of a therapeutic bond. An interesting transcultural strategy to adopt would be the implementation of translators or bilingual culture mediators. This measure could follow the successful example of the Boa Vista Municipal Pediatric Hospital, which has Yanomami interpreters to help provide care to the indigenous population.

Complementarily, municipal management could place professionals who can speak Spanish in the primary health units with the highest number of Venezuelan users. This strategy could be improved by elaborating bilingual educational materials and training the health teams in basic language competencies in Spanish, as well as in cultural sensitivity, to increase the effectiveness of communication and the therapeutic bond.

Cultural variations have a significant influence on the follow-up of these pregnant women, from their high expectations regarding cesarean sections to their lack of understanding about the Brazilian health system. These differences reiterate the need for a transcultural approach to care, in which communication and negotiation of codes and meanings are central for effective and humanized care.

Studies point out that, in the last few years, the number of cesarean sections has increased around the world, and Latin America shows the highest rates of these surgeries[24,25]. Recent articles found that Venezuelan women prefer cesarean sections, corroborating the perception that this practice could be associated with cultural influences[14,26]. This expectation is often in conflict with Brazilian protocol, which prioritizes and encourages physiologic delivery whenever possible[27].

The low adherence to vaccination during the prenatal was also mentioned. This may reflect a biomedical view that is excessively focused on cure, in which the prevention of health issues is not as valued as a central part of care. Furthermore, this could be intrinsically connected to the condition of mobility and instability of the migrant population. In this context, prevention can be relegated as a second concern when compared with the immediate needs of survival, displacement, and resettlement.

A study carried out in Roraima found that the rates of abandonment of the vaccination schedule in the Venezuelan population are "higher than what is considered high-risk", and

quite superior to the abandonment rates among Roraima-born citizens[28]. Equally challenging is convincing partners to participate in prenatal consultations or adhere to family planning, strategies that are still not often employed in their original cultural context.

Access to immunization in Venezuela is poor, with low vaccine coverage rates. This situation is made worse by the economic and political crises, which have led to a shortage of vaccines and low coverage in risk areas and borders. The main logistical challenges to implement a broad immunization program include the access of indigenous populations and remote areas (accessible via rivers and the air), and others[29].

In this setting, the cultural accommodation of care, as proposed by Leininger[1-2], is appropriate. In practice, it means: negotiating the importance of vaccination, relating it to the protection of the baby and not only as a bureaucratic measure; gradually encouraging the participation of the partners in consultations, and respecting the gender roles established in the culture of the pregnant women. This also implies family planning as a strategy to ensure better conditions for the family, with no imposition.

In more challenging situations, such as the cultural preference for cesareans, the cultural restructuring of care may be necessary. This involves explaining, with sensibility, the differences between the Brazilian and the Venezuelan health systems. It also requires explaining, using culturally-adapted scientific evidence, the benefits of vaginal delivery when it is the clinical recommendation. Furthermore, progressive precautions about the labor plan must be established, respecting the fears and beliefs of the pregnant woman.

Another issue raised at first, as being associated with the culture of the participants, involves their dietary habits. These are mostly unhealthy, based on fried foods, especially arepas, and associated with a low intake of proteins of high biological value, fruit, and vegetables. It was found that, in general, the dietary variety of the Venezuelan women studied was quite limited, and the foods they ate the most were white bread, arepas, coffee, and cheese. However, this study was conducted at the highest point of the Venezuelan crisis, when food was scarce in many regions of the country[30].

However, it is worth highlighting that culture is not hegemonic, and participants also recognized that the main barrier to a balanced diet is not cultural, but financial fragility. Even though cultural aspects influence dietary habits, choosing hyper-caloric foods of low nutritional value, which are, consequently, cheaper, is more associated with lack of resources than with cultural resistance.

The main limitation of this study was methodological, as it only considered the perspective of health workers and did not incorporate the pregnant women. This restricts a

broader, bilateral understanding of transcultural challenges in the prenatal. The lack of demographic data from participants, such as gender, race/color, and age, limited the exploration of potential variations in the perception reported.

Still, our findings provide relevant contributions to the practice of care and to the field of Collective Health, as they demonstrate the need for culturally adapted care. From the perspective of training, it is important to include competences that involve intercultural communication when training physicians and nurses who work, mainly, in the context of borders.

FINAL CONSIDERATIONS

Through the Lens of Leininger's Theory of Culture Care Diversity and Universality, this study identified challenges for health workers that go beyond language. These include a culturally ingrained inclination for cesarean sections, in direct conflict with Brazilian protocols; a low adherence to prenatal, associated with trouble understanding the decentralized structure of SUS; a cultural resistance to vaccination and preventive practices; trouble implementing family planning; and the participation of partners. The linguistic barrier was an expected challenge. It was found to have complex negative repercussions, that lead to mistakes in scheduling exams and the mistaken perception that information was understood during health education. This work showed the profound cultural and behavioral challenges that hinder the congruence of care.

These findings show that the crux of the challenge is not verbal communication, but the necessary mutual understanding of meanings that are profoundly ingrained, and the modulation of expectations between professionals and pregnant women. This reiterates the imperative need for practices that use cultural preservation, accommodation, and cultural restructuring. Training in intercultural competences is also a direct and necessary response for the specific difficulties identified. Finally, this study paves the way for further investigation, be it concerned with listening to Venezuelan pregnant women themselves, or exploring the reality of other groups of immigrants in the Northernmost region of the country, or in other regions.

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Data and material availability
Access to the set of data can be made via request to the corresponding author.

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The authors declare there is no conflict of interest.

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Received: 06.21.2025
Approved: 01.03.2026

Associate editor:
Elen Ferraz Teston