Original Article

TEXTO & CONTEXTO ENFERMAGEM
TEXT & CONTEXT NURSING TEXTO & CONTEXTO ENFERMERÍA

CROSS-CULTURAL CARE IN PRIMARY HEALTH CARE NURSES' EXPERIENCE IN BORDER TERRITORIES

Fabiana Paes Nogueira Timoteo[1,2]
Rosane Meire Munhak da Silva[2]
Gisele Cristina Manfrini[3]
Maria Aparecida Baggio[4]

[1]Centro Universitário Descomplica UniAmérica. Foz do Iguaçu, Paraná, Brasil.
[2]Universidade Estadual do Oeste do Paraná, Programa de Pós-Graduação em Saúde Pública em Região de Fronteira. Foz do Iguaçu, Paraná, Brasil.
[3]Universidade Federal de Santa Catarina, Programa de Pós-Graduação em Enfermagem. Florianópolis, Santa Catarina, Brasil.
[4]Universidade Estadual do Oeste do Paraná, Programa de Pós-Graduação em Saúde Pública em Região de Fronteira. Cascavel, Paraná, Brasil.

ABSTRACT

Objective: identify cross-cultural nursing care, based on the Sunrise model, based on primary care nurses' experiences in border territories.
Method: this is qualitative research, carried out in Foz de Iguaçu, Brazil, with 18 nurses through semi-structured interviews, in person and remotely, between January 2020 and January 2021, and data analyzed by thematic analysis.
Results: the factors influencing individuals' care and health were identified, according to their social, cultural structure and worldview, and the decisions and actions of transcultural care by nurses, through consultations or home visits. The Sunrise model components emerged empirically in primary care nurses' practice.
Conclusion: it is recommended that health managers adopt the Transcultural Care Theory to guide culturally efficient nursing care practice, particularly in border territories.

DESCRIPTORS: Nursing. Cross-cultural nursing. Cultural diversity. Primary health care. Border.

HOW CITED: Timoteo FPN, Silva RMM, Manfrini GC, Baggio MA. Cross-cultural care in primary health care nurses' experience in border territories. Texto Contexto Enferm [Internet]. 2023 [cited YEAR MONTH DAY]; 32:e20220250. Available from: https://doi.org/10.1590/1980-265X-TCE-2022-0250en

CUIDADO TRANSCULTURAL NA EXPERIÊNCIA DE ENFERMEIROS DA ATENÇÃO PRIMÁRIA À SAÚDE EM TERRITÓRIO DE FRONTEIRA

RESUMO

Objetivo: identificar o cuidado de enfermagem transcultural, fundamentado no modelo *Sunrise*, a partir de experiências de enfermeiros da atenção primária em território de fronteira.
Método: pesquisa qualitativa, realizada em Foz de Iguaçu, Brasil, com 18 enfermeiros por meio de entrevista semiestruturada, de forma presencial e remota, entre janeiro de 2020 a janeiro de 2021 e dados analisados pela Análise Temática.
Resultados: identificou-se os fatores influenciadores do cuidado e da saúde dos indivíduos, conforme sua estrutura social, cultural e visão de mundo, e as decisões e ações de cuidado transcultural pelos enfermeiros, por meio de consultas ou visitas domiciliares. Os componentes do modelo *Sunrise* surgiram empiricamente na prática dos enfermeiros da atenção primária.
Conclusão: recomenda-se a adoção da Teoria do Cuidado Transcultural por gestores de saúde, para balizar a prática do cuidado de enfermagem culturalmente eficiente, particularmente em território de fronteira.

DESCRITORES: Enfermagem. Enfermagem transcultural. Diversidade cultural. Atenção primária à saúde. Fronteira.

EL CUIDADO TRANSCULTURAL EN LA EXPERIENCIA DE ENFERMERAS DE ATENCIÓN PRIMARIA DE SALUD EN TERRITORIOS FRONTERIZOS

RESUMEN

Objetivo: identificar cuidados de enfermería transcultural, con base en el modelo Sunrise, a partir de las experiencias de enfermeras de atención primaria en territorios fronterizos.
Método: investigación cualitativa, realizada en Foz de Iguaçu, Brasil, con 18 enfermeros a través de entrevistas semiestructuradas, presenciales y a distancia, entre enero de 2020 y enero de 2021 y datos analizados por análisis temático.
Resultados: fueron identificados los factores que influyen en el cuidado y la salud de los individuos, de acuerdo con su estructura social, cultural y cosmovisión, y las decisiones y acciones de cuidado transcultural de los enfermeros, a través de consultas o visitas domiciliarias. Los componentes del modelo Sunrise surgieron empíricamente en la práctica de las enfermeras de atención primaria.
Conclusión: se recomienda la adopción de la Teoría del Cuidado Transcultural por parte de los gestores de salud para orientar la práctica del cuidado de enfermería culturalmente eficiente, particularmente en territorios de frontera.

DESCRIPTORES: Enfermería. Enfermería transcultural. Diversidad cultural. Atención primaria de salud. Frontera.

INTRODUCTION

Culture and care are integrated with each other and, for care to be meaningful and therapeutic, nurses' knowledge needs to be related to individuals' cultural values, beliefs and expectations. The non-congruence of these factors can lead to a lack of cooperation, as individuals from different cultures are generally more susceptible to signs of conflict, such as discontent, mistrust and resentment[1].

Societies are becoming increasingly multicultural with plurality existing within or between countries. There are cultural differences between countries and nations and even unconventional cultures and subcultures within conventional cultures[2]. In this context, the Transcultural Care Theory offers subsidies for the care of culturally diverse and/or vulnerable populations, being frequently used in nursing research[3].

The municipality of Foz de Iguaçu (Brazil), together with Ciudad del Este (Paraguay) and Puerto Iguazú (Argentina), form the triple cities. These, along with the adjacent municipalities, have the specificities of grouping multinational nodes (related to quantity), centralities of flows and strong interaction through cross-border trade, international tourism, energy generation as well as cross-border coexistence between various ethnic groups located there[4].

A territory with populations with multicultural characteristics requires health professionals, especially nurses, to develop a broad vision to identify and understand dimensions inherent to the cultural and social structures of individuals, as well as their worldviews, which involve factors of social structure, ethno-history, genetics, religion, spirituality, ethics, language, environment, politics, family structures, arts and other influencers of human care[5].

Based on these considerations, the provision of competent cultural care by Primary Health Care (PHC) nurses in nursing consultations and home visits are tools that contribute to recovery, knowledge of life situation and creation of bonds with individuals, in addition to favor autonomy promotion. Nurses must develop care adjustment actions that help individuals from a given culture to adapt or to negotiate with other individuals a beneficial or satisfactory health result[6].

On the other hand, lack of knowledge, by nurses, of the cultural universe that permeates individuals' lives, can raise barriers that prevent comprehensive health care for individuals with distinct cultural values and beliefs, made more flexible by interaction with other individuals, whether from other cultures or not. This condition signals the need for advances in nursing for cross-cultural care[1,5].

Thus, the question is: how do nurses experience cross-cultural nursing care during nursing consultations and home visits in PHC of Foz do Iguaçu, Brazil, a municipality located in a border territory? The study aimed to identify cross-cultural nursing care, based on the Sunrise model, based on PHC nurses' experiences in border territories.

METHOD

This is a qualitative, exploratory, descriptive research, carried out with PHC nurses who work in 15 health units belonging to the five health districts of the municipality of Foz do Iguaçu, Brazil. The municipality is located in southern Brazil, on the Triple Frontier, shared with Paraguay and Argentina. Its population consists of 81 ethnic groups, the majority coming from Lebanon, China, Paraguay, Argentina, Japan and South Korea[7].

These health units were intentionally chosen to represent the reality of nurses working in the different health districts of the municipality. It should be noted that the Consolidated criteria for Reporting Qualitative research (COREQ) recommendations were followed.

Nurses who work in user care at PHC in Foz do Iguaçu for a period longer than one year were included. The criterion for involving a minimum performance in the service of one year referred to the need to know the population assigned to the area covered by the health unit. Nurses away from work during the data collection period, due to sick leave or vacations, were excluded.

Nurses were selected for convenience, and they were invited to participate in the study in person or by telephone, when necessary, due to restrictions related to the COVID-19 pandemic. The interviews were scheduled for a later date, depending on nurses' availability, and face-to-face interviews were held in a private room, in the work environment itself. Of the 21 nurses invited, who represented health units eligible for the study, that is, from the five health districts in the municipality, three refused to participate, claiming work overload due to the pandemic. Thus,18 nurses participated.

The interviews were conducted by a master's student, who is a nurse, and was trained by the researcher in charge, who has expertise in the area of qualitative research. The data collection period was between January 2020 and January 2021, through individual interviews, guided by a semi-structured script, initiated by the guiding question: describe the characteristics of the population assisted in the health unit where you work. Nine interviews were conducted face-to-face and nine via WhatsApp voice call, with an average duration of 40 minutes. It should be noted that the pilot interviews (five face-to-face) were included in the study because they reached depth to the subject under study.

The interviews were audio-recorded and later transcribed, faithfully respecting the speeches' integrity. Interview transcription was sent to participating nurses via WhatsApp, providing the opportunity for them to explain any disagreement in the transcribed content. No participant waved any disagreement.

The interviews were closed when the saturation phenomenon was reached, in order to obtain answers to the research's initial questions, allowing to generate a construct of the studied theme.

Data were analyzed using thematic content analysis[8], which is organized in stages: pre-analysis, material exploration, obtained data treatment and interpretation. In pre-analysis, text skimming was performed aiming at constituting the corpus and initial data organization from the proposed objective. In material exploration, the lines were grouped, considering expressions and/or significant words. From the core meanings, it was possible to define categories and subcategories. In data treatment and interpretation, inferences and interpretation of statements' content were made, based on the Sunrise model of the Transcultural Care Theory[9].

The study complied with Resolution 466/2012 of the Brazilian National Council for Health and Research Involving Human Beings. To ensure anonymity, participants were identified by the letter (n), referring to the nurse, followed by Arabic numerals, according to the order of the interview (n1...n18).

RESULTS

The 18 participating nurses are female, with a mean age of 38.2 years, 12.7 years of experience in nursing and 8.4 years in PHC. Of these, 16 have one or more specializations, three hold masters' degrees and ten understand and speak one or more languages, predominantly Spanish. The majority, 15 participants, had never heard of the Transcultural Care Theory and three had heard of it, but did not describe the framework.

The results shown in the interviews allowed the organization of two thematic categories: *Cultural and social dimension: factors that influence care and health*; and *Cross-cultural care in nurses' practice*.

Cultural and social dimension: factors that influence care and health

In the moments dedicated to nursing consultations and/or home visits, nurses are able to identify technological, religious, kinship/partner and social, cultural and lifestyle, political and legal, economic and educational factors, anchored to the language context (language) and environment in which individuals live. These factors mutually interact with the social and cultural structure, as well as with the worldview of individuals, influencing culturally appropriate standards of care for maintaining their health and well-being.

Through nurses' speeches, with regard to technological factors, resistance to vaccines and medications was identified. In particular, resistance to vaccines emerged as a cultural characteristic, not associated with a specific nationality. Incipient information related to the vaccine, fear that vaccines are harmful to the body, mainly due to the number of vaccines in the immunization schedule, influence the view that individuals have about them, regardless of nationality, gender or social class.

Vaccine resistance of some Arabs [...]. *So you have to explain well what the benefits are* [...] *they think they are bad* [...] *they refused to have the vaccine* [...] *Brazilians themselves sometimes refuse* [...] *We have a lot of cultural problems with regard to vaccination. This we have already faced a lot here in the unit* [...] (n8).

[...] *HPV vaccine resistance* [...] *the father claimed that the girl was not going to have sex and was going to marry a virgin, there was no way to convince him* [...] (n13).

Still regarding technological factors, resistance to the use of drugs to treat diseases such as hypertension and diabetes was identified. According to nurses, medicinal teas are frequently used as substitutes for pharmacological treatment. In the culture of some individuals, medication use is not conventional, and the use of teas, herbs, hot compresses, among others, is a custom inherited from ancestors.

There are many patients who do not take medication for hypertension and diabetes because they are already drinking tea [...] (n10).

Argentinians [...] *in health care, they prefer to resort to alternative therapies, they use teas, compresses* [...] (n12).

With regard to religious factors, nurses pointed out individuals' decisions about the health-disease process, based on religious beliefs. According to the worldview of these individuals, faith can heal.

With regard to spirituality [...] *we guide the patient about health measures and treatment and he says that he will not do anything because God will heal* [...]. *The classic example is diabetes and hypertension, where older adults do not want to comply with treatment because in their minds God will heal* [...] (n17).

[...] *a healer, there are a lot of them here, sometimes they exchange medical care for a healer* (n8).

Kinship/partner and social factors were identified, through nurses' speeches, through the cultural manifestation related to gender. Mainly in Arab culture, the figure of the "man" played a central role and superior to that of the woman.

[...] *we have the Lebanese issue related to sexism with women, the way they relate to women* [...]. *So, this issue of sexism is very evident in the relationship of these Lebanese* (n18).

[...] *an Arab, for instance, when a boy is born, there is a type of culture, I know they party a lot* [...] *when it is female it was the opposite, you know, they didn't party anymore, they weren't so happy* [...] *the Arabs had male children and they celebrated a lot* [...] (n13).

Regarding cultural factors and ways of life, the interviewees classified some groups of individuals according to ethnicity/nationality, specifying characteristics related to the pattern of behavior and the way of dressing.

There are people like that from the north and northeast [...], *they have a way of working that is different from ours* [...]. *For instance, with time zone and meeting deadlines* [...] (n18).

We assist several foreigners, refugees, who come to us for assistance. We see the characteristics in the type of clothing [...] *the Paraguayans* [...] *the Arabs* [...] *women who use the scarf, which hides the hair, the body, long dress, with long sleeves* (n13).

In addition to this, regarding cultural factors and ways of life, the relationship of individuals with hygiene habits inserted in the environmental context was noted. Through home visits, carried out by nurses, regarding the pattern of behavior, precarious personal hygiene and home care habits of some individuals or families were identified. This pattern, according to statements, is perceived in Venezuelan and Paraguayan nationalities, and is also related to disadvantaged social structure.

There was a Venezuelan who didn't shower [...], *he didn't have that daily habit, and for him that was fine* [...] (n1).

[...] *some people are poor* [...] *you see the hygiene conditions* [...] *you want to guide them in relation to the bottle of alcohol or an oil can, or washing your hands, or changing positions, bathing and transportation, because they don't understand about it* [hygiene] (n2).

[...] *visiting Paraguayans, I observe the precarious conditions, without sanitation, in addition to not understanding hygiene care* (n13).

Individuals' relationship with the environment is the result of their cultural history. Although accumulating useless objects and living in a dirty environment is a situation to be modified in nurses' perception, they understand that, for individuals who live this pattern of behavior since their ancestors, it is perceived as natural.

A situation that was very complicated is a lady, she lives alone because no one in the family accepts her. She is a hoarder and also works with recycled [...], *but that is hers, it is her culture, she likes to accumulate things, to store* (n8).

There is a lady who is a hoarder, [...] *for her that was normal* [...], *and who was doing very well inside the house* [...] *there was a lot of dirt and a lot of rubble, we went to guide her and she insisted that it was normal, that she was raised that way* (n11).

With regard to political and legal factors, informal work and drug trafficking were identified. The relationship with illegality results in the arrest of individuals from a family. The condition is linked to cultural factors and ways of life, social, economic and educational. This fact was verified by nurses during home visits.

What draws a lot of attention in the visits, in my area, is the very high crime rate, there are drug dealers [...], *their culture, which is part of their lives, which for me is different* (n15).

There is also informal work and, for them, this gain from trafficking is very natural. They live on that income, including, there is always someone in the family who is in prison. This is very common [...] (n10).

Informal work or even drug trafficking, in the study region, is commonly related to foreigners in an illegal situation in the country. Due to the legal status of these individuals, they avoid contact with health professionals. This reflects in the way they relate to the health system. Therefore, the nurse finds it difficult to approach and, consequently, in the ways of caring, due to legal barriers.

Foreigners look like scared little animals, they are afraid of everything, of not being accepted [...]. *What else I have there are Paraguayan pregnant women, Brazilians who live in Paraguay and seek care here because they have family here and use the family address for care* (n10).

[...] *the Chinese are* [...] *suspicious* [...] *they have a lot of difficulty helping people at the door. Sometimes they are at home and hide so they don't see us, I don't know if it's out of fear or if it's something cultural about them* (n8).

With regard to the economic factors of the population that nurses assist, most depend on the public health service due to their income. This is a vulnerable and economically underprivileged population (12 of the 18 interviewees mention this perception in their speech).

[...] *70% to 80% of the population uses the Unified Health System, and most have low socioeconomic conditions where I work* [...] (n16).

Our unit covers a more needy population, unlike other neighborhoods, but this also occurs due to socioeconomic level. But, well, there are some neighborhoods that are extremely poor [...] (n6).

In terms of educational factors, according to nurses' speeches, culturally, individuals are expected to complete high school. However, low education is well accepted. The professionals understand that individuals' insufficient instruction sometimes compromises or favors the relationship with health professionals, however it interferes with individuals' relationship with health care.

[...] *talking to someone who has a different culture, a cultured person, a person who has better knowledge, you can convey the information calmly* [...] (n9).

[...] *culturally, they think they don't need to finish their studies, when they go to high school, they say they've already finished. So, the low level of education for them there is very well accepted* (n10).

Regarding language-related factors, it was identified, through nurses' speeches, difficulties in communicating with foreigners, particularly with Haitians.

[...] *the difficulty with the language* [...] *is greater with French-speaking Haitians* [...]. *As much as they speak Portuguese, there are words that they don't know their meaning, so we feel a little difficult in terms of orientation* (n18).

We have difficulty communicating with language [...]. *As much as we manage to communicate, sometimes a Haitian comes along who speaks more French* [...]. *I make a home visit to a Paraguayan family* [...], *they will communicate in Portuguese, but among them, they speak Guarani, especially if they are the oldest* (n1).

Cross-cultural care in nurses' practice

In this category, it was possible to identify cross-cultural care decisions and actions by PHC nurses, during nursing consultations and/or home visits, which seek to preserve, negotiate or restructure care so that it is culturally congruent. It is important to point out that individuals' world view and social and cultural structure influence health care standards, linked to the constituent factors of this structure.

Nurses, when identifying cultural/popular care/practices, articulate them with technical-scientific-professional knowledge, conforming the Sunrise model. In light of health care preservation/maintenance, it was noted that nurses validate individuals' cultural expressions and sometimes test and incorporate them into their own care. Professionals' actions value cultural care and allow it to be multiplied among them, reinforcing individuals' potential for self-care.

I have already advised on teas, on hygiene with showers [vaginal hygiene], *with calendula and chamomile* [in case of itching and secretion] (n13).

[...] *use of arnica, which they are using for pain* [with topical application in the form of an ointment], *we advise them to continue using it, reinforce use* [...]. [...] *there are women who are in the habit of using a sitz bath with sodium bicarbonate* [perineal hygiene in cases of pruritus]. *They already have this practice, so we reinforce that they keep* [...] (n18).

I think it is possible to value [...] *I try to value everything they bring, for instance, the use of stone breaker tea, when they believe they have stones in their kidneys, liver and spleen. Blackberry leaf for women who are in menopause* [...], *chayote leaf tea to lower blood pressure. Pata de vaca, my mother uses it for diabetes, and there is the guaco leaf that really solves coughs, in the case of herbs for diabetes, I noticed that the blood glucose levels have been reducing. Then I allowed them to multiply this knowledge among themselves. They exchange seedlings between them and grow the herbs. I have another example related to vaginal infection, there is a lady who managed to improve the symptoms with the use of penicillin leaf in a sitz bath* [...], *I allow them to share this knowledge among themselves* (n15).

With regard to health care accommodation/negotiation, negotiation actions were identified by nurses for care, with respect to beliefs, values and customs, according to individuals' expectations and health service resources. It was found that the creativity, flexibility and openness of professionals' minds allowed them to accept, include and adapt the practice of nursing care, valuing the world view and the multiple dimensions of individuals' cultural and social life. Individuals' cultural knowledge was valued and incorporated into scientific knowledge, allowing for culturally congruent care.

There was one time to collect blood, there was an Arab woman, not all of them, but this Arab woman, I think she was Muslim, because she only came with her eyes out, and the others still come with her face showing, but not this one. Then they ask to say a prayer before collecting the blood, but they say their prayer, then we give them that time. Arab women do not like to be exposed, in relation to male care, so we end up offering this care, not leaving men with them, making more appointments with female doctors [...] (n14).

I always give an opinion like, "Wow, I've done that too, it's great! Are you going to take it to bless? He takes it because it's very good, but he also uses the doctor's medication. The two together will leave your child [...] *with iron health"* [...] *so that they feel more confident in us. We do not detract from their belief* [...], *unless, like, it is very harmful* (n8).

Regarding health care repatterning/restructuring, it was possible to observe the approaches by nurses when there is a need to intervene with individuals to restructure health care. Interventions aim at the well-being and improvement of individuals' health. To this end, nurses use negotiation tools and present consequences of practices that cannot be accepted with care so that their cultural values are not disrespected.

[...] *we try to adapt our scientific knowledge to that person's culture, to try to be an agent of change in his life in some way. Everything is guided in the nursing consultation, it is trying to create a bond with the patient so that he understands this idea of self-care* (n18).

DISCUSSION

The results glimpsed the cultural and social dimension that influence care and health and how this process permeates primary care nurses' practice.

Resistance to vaccines and medications, belonging to technological factors available in PHC care practice, were the object of nurses' attention. The lack of compliance with vaccines by parents, although some recognize the importance, may be related to fear, insecurity and lack of knowledge.

Commonly, parents are unaware of the purpose of the vaccine, fear children's suffering due to application as well as the adverse effects and illness caused by the vaccine. With regard to the vaccine in adolescence, such as for the prevention of human papillomavirus, resistance may be due to the fact that, culturally, parents consider it early to approach their children about issues related to sexuality[10–11].

The lack of compliance with drug therapy is linked to the cultural habit of using teas, common in some Brazilian regions to control blood pressure. This conduct, despite not replacing drug therapy, has been widely used by hypertensive individuals. This habit indicates that the population's culture has a strong influence on their health choices[12].

Religiosity can have positive effects on the health/disease process and improves quality of life and mental health, in addition to other benefits, such as reducing disease and increasing the ability to resist illness. Thus, it is important that nurses know the individual's understanding of health, spirituality and religiosity and identify the best ways for them to take care of themselves and, if they need health interventions, provide them with comprehensive care[13].

In order to understand factors related to gender and how this relationship takes place in border territories, nurses, when providing cultural care, need to understand that the entire human experience has divergent impacts for women and men. Immigrant women from the Palestine region, cited as the main example, but also other immigrant women, carry cultural and historical heritages related to the visibility of the female figure in their region of origin, often intertwined with stories of oppression, discrimination and exclusion[14].

In cultural factors and way of life, nurses verify characteristics of clothing, such as Arab women, a significant community in the research region. Using a scarf in Islam by women identifies them and represents their protection. In the Koran, using a scarf is cited as part of women's clothing, representing their culture and religion. Aspects of religiosity and culture, present in the country of these immigrants, may cause strangeness in the local community. In border territory, acceptance and prejudice in relation to habits and customs of immigrants reveal the challenges of those who immigrate[15].

When analyzing environmental factors focused on hygiene habits related to personal care and care for the environment, it is known that notions of cleanliness and dirt are constructed and transformed, and are linked to the historical evolution of the perception of shame and displeasure, inherent in the civilizing process. Thus, it becomes relevant to consider the historical and evolutionary context that a given individual brings to their experience and the way in which this reflects in the interaction with care for the environment and the body, since, in addition to a cultural factor, even if implicitly, through these habits, it influences their relationship with health[16].

In the Triple Frontier, the populations coexist with the legal and the illegal. Illicit activities ensure the livelihood of families in the three countries and are influenced mainly by poverty, unemployment, different legal systems, activities of criminal organizations, corruption of government agencies and police sectors, linked to the strong economic activity of Ciudad del Este, Paraguay[17].

In the situation of illegality, it is known that, although no condition related to migration is a barrier or impediment to access to health, a right that is evidenced by the advances in the Brazilian Migration Law, this access is not always possible. Many are still short of this service, whether due to language barrier, cultural issues or the fear generated by the condition of illegality as an immigrant. Language barriers and cultural differences compromise health treatment compliance, in addition to the lack of information about health and discrimination related to the foreign population[18–19].

Poverty, low economic and educational status and precarious housing are some of the factors that generate social and health inequalities and social vulnerability. Social and health inequalities are an adversity in all countries, to a greater or lesser extent, generated by economic disparities that

produce differences in the opportunities given to individuals, considering factors such as ethnicity, race, social class, gender, educational level, disabilities, sexual orientation and geographic location[20].

Individuals' participation in the construction of their care plan is essential for the success of treatment and basic reading and writing skills are factors that have an important influence in the field of health. The absence of these skills increases the difficulties of individuals to understand the guidelines provided by professionals, particularly in specialized language, with terminologies that are often not understood by them[21].

For nurses who work in culturally diverse environments, such as the one in the study in question, communication and cultural understanding are fundamental pillars for care. Effective communication reduces risk and provides a complete understanding of an individual's needs[22]. Nurses working in PHC need to recognize, in the social determinants, the vulnerabilities and potential for intercultural practices that promote migrant populations' health.

In this sense, language can be considered a visible barrier in the foreign population care, since the individuals' problem may not be understood by the health professional. The difficulty extends to the application of guidance and treatment, which may occur inappropriately. Haitians, specifically, have language characteristics that are particular to them and can increase difficulties in the communication and health care process[23].

Populations, in their conformations, present a diversity of care actions. This means that each one has its own culture and way of understanding and practicing care. Thus, for care that is congruent with a people's culture, nurses must define, together with the person, the care that can be preserved/maintained, what needs to be accommodated/negotiated and restandardized/restructured[24].

There are actions of nurses that allow cultural care maintenance, through practice and/or health education, which helps to preserve relevant aspects of individuals' culture. Thus, nurses, as care facilitators, enhance health promotion and recovery and disease prevention in the assisted population[25]; in this study, considering the cultural multiplicity of a border territory.

It is also important to emphasize that family members' beliefs interact with each other and are influenced by the family environment. Through this family dynamic, it is possible to form family beliefs of a similar nature among the members and, based on these beliefs, the family makes decisions regarding the maintenance and improvement of families' well-being, justifying the importance of knowing how each member expresses their belief in construction of care[26].

Through the negotiation of cultural care, nurses support the use of health practices by individuals, adapting them to obtain a result that benefits their health. However, in some situations, these professionals need to guide health practices that change or restructure care that bring greater benefit or remove the risk of damage to health. Thus, professionals seek congruence of care between popular practices and professional practices, respecting individuals' cultural values and beliefs[9,27].

It is worth remembering that, through the approach between professional and popular/family care cultures, nurses, through actions, implement the actions of several current health policies. In the Brazilian National Health Promotion Policy (PNPS - *Política Nacional de Promoção da Saúde*), for instance, the development of personal skills permeates popular education to develop care autonomy. Reorientation of the care model, training of professionals sensitive to transculturality, creation of public policies and favorable environments, with a view to migratory processes and access to health for populations, they work to mitigate health problems, reducing cultural barriers[28].

As a limitation of this study, we highlighted the fact that the interviews were carried out only with nurses, knowing the perspectives of the population of a cross-border region and entering the home environment could show in greater depth the challenges for care in the cross-cultural context.

CONCLUSION

Health influencing factors and modes of action belonging to the Sunrise model, from Transcultural Care Theory, identified in the results, reflect the decisions and actions in the practice of care for users by nurses, however empirically, as most of them report not knowing the theory. It should be noted that the theory in question is not a theoretical framework that guides the systematization of nursing care in PHC in the studied context.

In light of the specificities of this context, the Transcultural Care Theory is suitable for nurses to be able to perform culturally congruent nursing care in PHC, in particular border territory, where people from a variety of ethnic groups interact with each other.

In this sense, adopting the theory by health managers is recommended, by approaching the theme in continuing education, to guide nursing care practice in border territory, with the understanding of the application methodology by PHC nurses. In practice, the application allows respecting each individual's cultural values regarding the modes of action advocated by the Sunrise model so that, in this way, care is culturally efficient.

REFERENCES

1. Leininger M, Farland MR. Transcultural nursing: concepts, theories, research & pratice. 3th ed. New York, NY(US): Mac Graw-Hill; 2002.
2. Juan L, Bei W, Zhung H, Jiru L, Rong X, Yong L. Investigation for the transcultural self-efficacy of nurses in Guizhou, China. Int J Nurs Sci [Internet]. 2020 [cited 2021 Apr 18];7(2):191-7. Available from: https://doi.org/10.1016/j.ijnss.2020.03.004
3. Alves CL, Lima GS, Albuquerque GA, Gomes EB, Cavalcante EG, Viana MC. Use of nursing theories in brazilian theses: bibliometric study. Cogitare Enferm [Internet]. 2021 [cited 2022 Feb 5];26:e71743. Available from: http://doi.org/10.5380/ce.v26i0.71743
4. Aikes S, Rizzotto MLF. Integração regional em cidades gêmeas do Paraná, Brasil, no âmbito da saúde. Cad Saude Publica [Internet]. 2018 [cited 2022 Nov 10];34(8):e00182117. Available from: http://doi.org/10.1590/0102-311x00182117
5. Leininger M. Culture care theory: a major contribution to advance transcultural nursing knowledge and practices. J Transcult Nurs [Internet]. 2002 [cited 2022 Nov 12];13(3):189-92. Available from: https://doi.org/10.1177/10459602013003005
6. Almeida GM, Nascimento TF, Silva RP, Bello MP, Fontes CMB. Theoretical reflections of Leininger's cross-cultural care in the context of Covid-19. Rev Gaucha Enferm [Internet]. 2021 [cited 2022 Feb 21];42(spe):e20200209. Available from: https://doi.org/10.1590/1983-1447.2021.20200209
7. Foz do Iguaçu. Prefeitura Municipal de Foz do Iguaçu [Internet]. [cited 2021 Sep 6]. Available from: https://www5.pmfi.pr.gov.br/
8. Minayo MC. O desafio do conhecimento. Pesquisa qualitativa em saúde. 14th ed. São Paulo, SP(BR): Hucitec; 2014.
9. Leininger M. Culture Care diversity and universality theory and evolution of the ethnonursing method. In: Leininger M, Mcfarland MR. Culture care diversity and universality: a worldwide nursing theory. 2th ed. Sudbury, MA(US): Jones and Bartlett; 2006. p. 1-46.
10. Carvalho AMC, Andrade EMLR, Nogueira LT, Araújo TME. HPV Vaccine adherence among adolescents: Integrative review. Texto Contexto Enferm [Internet]. 2019 [cited 2021 Apr 11];28:e20180257. Available from: https://doi.org/10.1590/1980-265X-TCE-2018-0257

11. Gomes Araújo MC, Ferreira da Silva L, Stanford Baldoino L, Porto TNRS, de Sousa Martins V, Pereira Carvalho D, et al. Fatores que interferem no cumprimento do calendário vacinal na infância. REAS [Internet]. 2020 [cited 2021 Dec 10];42:e2874. Available from: https://doi.org/10.25248/reas.e2874.2020

12. Panzetti TM, Quaresma MS, Silva JM, Sales FS. Leininger's cross-cultural nursing in mitigating the problems of systemic arterial hypertension. Res Soc Dev [Internet]. 2020 [cited 2022 Nov 10];9(9):e458997408. Available from: https://doi.org/10.33448/rsd-v9i9.7408

13. Brandão JG, Gomes A, Mota DB, Thiengo PC, Fleury ML, Dib RV, et al. Spirituality and Religiosity in the context of comprehensive care: reflections on comprehensive health and nursing care. Res Soc Dev [Internet]. 2020 [cited 2021 Nov 5];9(10):e5499108780. Available from: https://doi.org/10.33448/rsd-v9i10.8780

14. Piñeiro ES, Calazans ME. A migração de mulheres palestinas para a fronteira sul do Brasil. In: Anais eletrônicos do VII Seminário Corpo, Gênero e Sexualidade, do III Seminário Internacional Corpo, Gênero e Sexualidade e do III Luso-Brasileiro Educação em Sexualidade, Gênero, Saúde e Sustentabilidade [Internet]; 2018 Sep 19-21; Rio Grande, RS, Brasil. [cited 2022 Nov 18]. Available from: https://7seminario.furg.br/images/arquivo/201.pdf

15. Dawas DJ, Farinha AB. Memory of Arabs at the Border: Aspects of Culture and Religiosity. RELACult [Internet]. 2018 [cited 2021 Apr 12];4. Available from: https://doi.org/10.23899/relacult.v4i0.718

16. Moreyra C. Material Culture and Daily Hygiene in Córdoba in the Nineteenth Century. Anu Estud Am [Internet]. 2017 [cited 2021 Nov 11];74(1):211-34. Available from: http://doi.org/10.3989/aeamer.2017.1.08

17. Devia CA, Ortega DA. Características y desafíos del crimen organizado transnacional en la Triple Frontera: Argentina-Paraguay-Brasil. Rev Crim [Internet]. 2018 [cited 2021 Oct 18];61(1):9-28. Available from: http://www.scielo.org.co/scielo.php?script=sci_arttext&pid=S1794-31082019000100009

18. Silveira C, Goldberg A, Martin D. Immigration, refuge and health: sociocultural analysis in perspective. Saude Soc [Internet]. 2018 [cited 2021 Oct 2];27(1):26-36. Available from: https://doi.org/10.1590/S0104-12902018170870

19. Carvalho AMC, Andrade EMLR, Nogueira LT, Araújo TME. HPV Vaccine adherence among adolescents: Integrative review. Texto Contexto Enferm [Internet]. 2019 [cited 2021 Nov 11];28:e20180257. Available from: https://doi.org/10.1590/1980-265X-TCE-2018-0257

20. Williams BD, Webb GR. Social vulnerability and disaster: understanding the perspectives of practitioners. Disasters [Internet]. 2021 [cited 2022 Jan 12];45(2):278-95. Available from: http://doi.org/10.1111/disa.12422

21. Maragno CA, Mengue SS, Moraes CG, Rebelo MV, Guimarães AM, Pizzol TS. Test of health literacy for portuguese-speaking adults. Rev Bras Epidemiol [Internet]. 2019 [cited 2021 Oct 18];22:e190025. Available from: https://doi.org/10.1590/1980-549720190025

22. Larsen R, Mandrio E, Persson K. Interpersonal communication in transcultural nursing care in India: a descriptive qualitative study. J Transcult Nurs [Internet]. 2020 [cited 2022 Nov 6];32(4):310–7. Available from: https://doi.org/10.1177/1043659620920693

23. Ferreira W, Oliveira EC, Dutra DD. Imigração haitiana território e direito à saúde: uma contribuição da enfermagem. Cad Saude Desenvol [Internet]. 2018 [cited 2021 Sep 4];12(7). Available from: https://cadernosuninter.com/index.php/saude-e-desenvolvimento/article/view/1030

24. Silva ER, Alencar EB, Dias EA, Rocha LC, Carvalho SC. Transculturality in nursing based on Madeleine Leininger's theory. REAS [Internet]. 2021 [cited 2021 Feb 5];13(2):e5561. Available from: https://doi.org/10.25248/reas.e5561.2021

25. Leininger M. Transcultural Nursing: concepts, theories, research & practices. New York, NY(US): McGraw-Hill; 1995.

26. Hohashi N. A family belief systems theory for transcultural family health care nursing. J Transcult Nurs [Internet]. 2019 [cited 2021 Aug 5];30(5):434–43. Available from: https://doi.org/10.1177/1043659619853017

27. Alves CN, Guilherme LA, Prates LA, Silva SC, Tronco CS, Cremonese L, et al. Care practices performed by nurses during prenatal: basis for cultural care. Res Soc Dev [Internet]. 2020 [cited 2021 Feb 5];9(7):e999975275. Available from: http://doi.org/10.33448/rsd-v9i7.5275

28. Ministério da Saúde (BR). Secretaria de Vigilância em Saúde. Secretaria de Atenção à Saúde Política Nacional de Promoção da Saúde [Internet]. Brasília, DF(BR): Ministério da Saúde; 2018 [cited 2022 Nov 12]. Available from: https://bvsms.saude.gov.br/bvs/publicacoes/politica_nacional_promocao_saude.pdf

NOTES

ORIGIN OF THE ARTICLE

Extracted from a dissertation - *Experiência de enfermeiros no cuidado transcultural na atenção primária à saúde em um município de fronteira*, presented to the Graduate Program in Public Health in Border Region, *Universidade Estadual do Oeste do Paraná*, in 2021.

CONTRIBUTION OF AUTHORITY

Study design: Timoteo FPN, Baggio MA.
Data collection: Timoteo FPN.
Data analysis and interpretation: Timoteo FPN, Baggio MA.
Discussion of results: Timoteo FPN, Baggio MA.
Content writing and/or critical review: Timoteo FPN, Baggio MA, Silva RMM, Manfrini GC.
Review and final approval of the final version: Timoteo FPN, Baggio MA, Silva RMM, Manfrini GC.

APPROVAL OF ETHICS COMMITTEE IN RESEARCH

Approved by the Research Ethics Committee of the *Universidade Estadual do Oeste do Paraná*, under Opinion 3.981.883/2020 and CAAE (*Certificado de Apresentação para Apreciação* Ética - Certificate of Presentation for Ethical Consideration) 25944919.0.0000.0107.

CONFLICT OF INTEREST

There is no conflict of interest.

EDITORS

Associated Editors: Melissa Orlandi Honório Locks, Monica Motta Lino.
Editor-in-chief: Elisiane Lorenzini.

HISTORICAL

Received: October 03, 2022.
Approved: November 22, 2022.

CORRESPONDING AUTHOR

Maria Aparecida Baggio
mariabaggio@yahoo.com.br