Original Article

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

CANADIAN-BRAZILIAN INSIGHTS FOR TRANSCULTURAL NURSING: AN EXPLORATION OF COMMUNITY HEALTH NURSING CONTEXTS

Margareth Santos Zanchetta[1]
Rafaella Queiroga Souto[2]
Kateryna Metersky[1]
Alana Ferguson[3]
Gleicy Karine Nascimento de Araújo Monteiro[2]
Bianka Nóbrega Fernandes[2]

[1]Toronto Metropolitan University, Faculty of Community Services, Daphne Cockwell School of Nursing. Toronto, Ontario, Canada.
[2]Universidade Federal da Paraíba, Programa de Pós-Graduação em Enfermagem. João Pessoa, Paraíba, Brasil.
[3]University of Toronto, Sick Kids Hospital. Toronto, Ontario, Canada.

ABSTRACT

Objective: to analyze the distinct features, incongruencies, and harmony between the features of Canadian-Brazilian community health nursing as well their practices.
Method: ethnographic research conducted in primary healthcare clinics (city of João Pessoa, Brazil). Data collection unfolded from July to September 2018 and included direct, unstructured participant observation of collective social and professional-clientele interactions, with a structured personal digital log and reports of the researcher's observations, as well as social immersion in community settings. The fieldwork log was thematically analyzed to build the meaning of the comparative nursing practice.
Results: analysis of observations' reports identified challenges and opportunities to promote sustainable changes and create a supportive environment. Nurses' competencies to promote health are in consonance with conceptual, political, and ethical sounding perspectives. Among the distinctive practices observed was that in Brazil, the prescribing practice has been well-established because legally the registered nurses are allowed to prescribe within the primary healthcare programs. In Canada, registered nurses have been granted authority to do so, upon receipt of specific training and under certain scope of advanced practice. Thematic analysis revealed uniqueness of the grasped information, incongruence between community health nursing practices and harmony between contextual practices of Brazil-Canada community health nursing composed the empirical evidence.
Conclusions: this research uncovered the compatibility between Canadian and Brazilian practice as well as intricate features of Brazilian community health nurses. Unquestionably, the evidence sums up to the consolidation of the well-established Brazil-Canada cooperation in the field of primary health care. This evidence addresses the political perspective of cooperation for global health.

DESCRIPTORS: Brazil. Canada. Community health nursing. Ethnography. Health promotion. Primary health care. Social determinants of health. Transcultural nursing.

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INTROSPECÇÕES CANADENSES-BRASILEIRAS PARA A ENFERMAGEM TRANSCULTURAL: UMA EXPLORAÇÃO DOS CONTEXTOS DA ENFERMAGEM EM SAÚDE COMUNITÁRIA

RESUMO

Objetivo: analisar as características distintas, as incongruências e a harmonia entre as características da Enfermagem em saúde comunitária canadense e brasileira bem como suas respectivas práticas.
Método: pesquisa etnográfica realizada em unidades básicas de saúde (cidade de João Pessoa, Brasil). A coleta de dados ocorreu no período de julho a setembro de 2018 e incluiu observação participante direta, não estruturada de interações sociais coletivas e entre profissionais e clientela. Houve registro digital estruturado de relatos das observações de campo pela pesquisadora, assim como imersão social em ambientes comunitários. O diário de campo foi analisado tematicamente para construir o significado da prática comparativa de Enfermagem.
Resultados: a análise dos relatos das observações identificou desafios e oportunidades para promover mudanças sustentáveis e criar um ambiente de apoio. As competências dos enfermeiros para a promoção da saúde estão em consonância com perspectivas conceituais, políticas e éticas. Entre as práticas diferenciadas observadas destaca-se que, no Brasil, a prática de prescrição tem sido bem estabelecida, pois, legalmente, os enfermeiros estão autorizados a prescrever dentro dos programas de atenção primária à saúde. No Canadá, os enfermeiros receberam autorização para fazê-lo, após um treinamento específico e sob certo escopo da prática avançada. A análise temática revelou singularidades nas informações apreendidas, incongruência entre as práticas de Enfermagem em saúde comunitária Brasil-Canadá e harmonia entre tais práticas contextuais que compuseram as evidências empíricas.
Conclusões: esta pesquisa revelou a compatibilidade entre a prática canadense e brasileira, assim como características próprias dos enfermeiros brasileiros nessa prática. Inquestionavelmente, as evidências resumem-se à consolidação da bem estabelecida cooperação Brasil-Canadá no campo da atenção primária à saúde. Essas evidências abordam a perspectiva política de cooperação para a saúde global.

DESCRITORES: Assistência Primária de Saúde. Brasil. Canadá. Enfermagem em saúde comunitária. Enfermagem transcultural. Etnografia. Determinantes sociais da saúde. Promoção da saúde.

PERSPECTIVAS CANADIENSE-BRASILEÑAS PARA LA ENFERMERÍA TRANSCULTURAL: UNA EXPLORACIÓN DE LOS CONTEXTOS DE ENFERMERÍA EM SALUD COMUNITARIA

RESUMEN

Objetivo: analizar las características distintivas, incongruencias y armonía entre las características de los enfermeros en salud comunitaria canadiense-brasileños y sus prácticas.
Método: estudio etnográfico realizado en centros de atención primaria (ciudad de João Pessoa, Brasil). La recolección de datos se desarrolló de julio a septiembre de 2018 e incluyó la observación participante directa y no estructurada de las interacciones sociales colectivas y profesional-clientela, con un registro digital personal estructurado e informes de las observaciones del investigador, así como la inmersión social en entornos comunitarios. El registro de trabajo de campo se analizó temáticamente para construir el significado de la práctica de enfermería comparada.
Resultados: el análisis de los informes de observaciones identificó desafíos y oportunidades para promover cambios sostenibles y crear un entorno de apoyo. Las competencias de los enfermeros para promover la salud están en consonancia con las perspectivas conceptuales, políticas y éticas. Entre las prácticas distintivas observadas, la práctica de prescripción ha sido bien establecida en Brasil porque legalmente las enfermeras están autorizadas a prescribir dentro de los programas de atención primaria de salud. En Canadá, a las enfermeras se les ha otorgado autoridad para hacerlo al recibir capacitación específica y bajo cierto alcance de práctica avanzada. El análisis temático reveló singularidad de la información captada, incongruencia entre las prácticas de enfermería en salud comunitaria y armonía entre las prácticas contextuales de enfermería en salud comunitaria Brasil-Canadá que compusieron la evidencia empírica.
Conclusiones: esta investigación demostró que existe compatibilidad entre las prácticas canadiense y brasileña, así como las características de la enfermería comunitaria brasileña. Incuestionablemente, la evidencia resume la consolidación de la cooperación bien establecida entre Brasil y Canadá en el campo de la salud primaria. Esta evidencia aborda la perspectiva política de la cooperación para la salud global.

DESCRIPTORES: Brasil. Canadá. Enfermería en salud comunitaria. Etnografía. Promoción de la salud. Atención primaria de salud. Determinantes sociales de la salud. Enfermería transcultural.

INTRODUCTION

The increasing shift in perspectives regarding health promotion (HP) as applied to nations and populations, from international to global contexts has been imprinting community health nurses' (CHNs) perceptions of their social commitment. Globally, these nurses are called to contribute to the all-encompassing agenda to protect and promote health of individuals, living entities and the planet[1]. Embracing the political commitment towards the achievement of the Sustainable Development Goals[2] requires new strategies for nurses to sum-up efforts and mobilize their professional potential. One of the most feasible strategies is the dialogue among mainly CHNs in different countries to design a transcultural and global nursing agenda. Gaining knowledge about the role of CHNs on a global level is important, as it will allow for both empowerment of nurses and promotion of global health.

Two partners in HP are Canada and Brazil, whose Framework Agreement for Cooperation on Science, Technology, and Innovation guides joint actions in the field of research and development[3]. As both members of the Pan American Health Organization, Canadians' partnership and involvement with Brazil is key, and Canada and Brazil share a strong academic and cultural connection which they hope to continue to strengthen. The similarities in their healthcare systems are notable. The Canadian healthcare system possesses pillars for a universal, accessible, and portable system including the provision of care "sensitive to race, color, gender, sexual orientation, ability, disability, ethnic origin, language, place of residence, social or economic status, and religion"[4:50]. The Brazilian Unified Health System (SUS) equally aims to promote population health based on three conceptual pillars: integrality, universality, and equity[5].

In the Canadian healthcare system, CHNs work according to the Canadian Community Health Nursing Standards of Practice[6]. The Canadian CHNs' role focuses on eight different standards of practice: health promotion; prevention and health protection; health maintenance, restoration, and palliation; professional relationships; capacity building; health equity; evidence informed practice; and professional responsibility and accountability. More specifically, this role concerns the promotive, protective, and preserving aspects of care. It is also heavily concentrated on how the social determinants of health (SDH) impact the health of individuals, families, groups, populations, communities, and systems wherever individuals live, work, learn, play, and practice their religion. CHNs are educated through a lens of specialized nursing, social and public health science being combined with experiential knowledge. According to the Ministry of Health's policies and protocols, Brazilian CHNs provide integral assistance to the clientele through activities of health promotion, prevention, and rehabilitation, such as: assistance to the individual in all phases of development (e.g., prenatal care, childcare, etc.); nursing consultations; delivery of educational activities; attentive listening; reduction of injuries; home visits; and prescription of medications[7–8].

This research aligned with the Canadian-Brazilian existing cooperation in Primary Health Care (PHC) and is a second initiative of a scientific collaboration officially established between the Brazilian and the Canadian universities expanding their nursing research agenda[9]. This research aimed to promote dialogue and joint reflection about the CHNs' practices framed by legal frameworks to enforce existing collaborations between Canada and Brazil in the areas of CHN, HP and internationalization of initiatives in transcultural nursing. Despite the clear conceptual similarities, any potential incongruences, differences and even harmony in the respective contexts of CHNs' practice remain unexplored. This research addresses these gaps in knowledge.

The following question guided the research: Within the perspective of transcultural nursing, what are the contextual features, incongruencies, differences, and harmonies between Canadian

and Brazilian CHN? The main objective was to analyze the distinct features, incongruencies, and harmony between the outstanding features in the context of practices of Canadian-Brazilian CHNs.

Conceptual framework

To offer the lens to grasp the surrounding reality and select relevant contents for the understanding of the unique dimensions of CHNs practice in PHC, the Population Health Promotion Model (PHPM) framed this research. The model displays the features to improve health based on what (should we work to achieve), how (should we achieve this) and who (should we achieve this with)[10]. The model guided the analysis about ways the SDH impact on nursing practice. Furthermore, the PHPM was used to outline how variations in the scope of nursing practice determine community action, the building of health policy, and the development of supportive environments for clients and CHNs. This conceptual framework inspired the research project's conception, its fieldwork including collection of data, as well as the description, analysis and interpretation of the findings using the same Canadian HP lens. Three co-authors who are Canadian nurses extensively worked within this framework. The first author's professional subjectivity guided her direct and indirect scholarly work with the Brazilian nurses who, as co-authors, equally conducted the fieldwork.

METHOD

For the specific set of evidence reported in this manuscript regarding the fourth author's immersion in the Brazilian professional and social settings with participant observations, the second author additionally contacted the local PHC clinic, and the local Municipal Secretary of Health obtained their administrative authorization for the research team to observe and interact, as well as interview the health professionals. All professionals and other individuals were verbally informed about the observations' goals (e.g., understanding the cultural underpinning of Brazilian CHNs practice) and the research review/approval by the Canadian and Brazilian universities' research ethic boards.

This section focuses on reporting on the procedures and strategies undertaken through the observer's fieldwork log to document the multiple aspects of the ethnographic research. Information on procedures that took place simultaneously, before, or afterward the production of the log, are not reported on in this article.

An ethnographic research was implemented to examine the ways Brazilian CHNs behave, think, speak, and act in their professional practice. This design allows an investigation of a cultural group in a natural setting over a long period of time[11]. The research setting was the PHC organizations affiliated to the Brazilian SUS and the local community settings where the researcher was culturally immersed with the inhabitants. The research was implemented in the urban settings of the city of João Pessoa (state of Paraíba-Brazil). The research ran from July to September 2018 with a sample composed of a nursing team (i.e., university educated, technician and auxiliary nurses) working in the PHC organizations assisting the population enrolled in the Family Health Strategy (FHS). The recruitment was done by nurse managers of the PHC teams who communicated to their members the presence of the research team in the organizations, explained the research fieldwork and, the team's integration in daily activities, as well as the nature of participation in the data collection activities.

Data gathering was conducted by the fourth author (the observer), at that time a Canadian female senior undergraduate nursing student and a research trainee, supported by the second author, a female Portuguese-English bilingual nursing faculty and two female undergraduate nursing students (the fifth and sixth authors) who acted as interpreters and translators to the fourth author. The used

strategies included the direct, unstructured participant observation, individual interviews, structured personal digital log with reports of the observer's observations, interactions, deeds, and reflections, as well as long stay social immersion in community settings of social practice. A stay such as this, as a fieldwork method, is recommended for studying processes, relationships and organization of individuals and events over time, and can also be used to study sociocultural contexts[11]. The stay allowed the unstructured direct participant observation focusing on meetings with professionals and the clientele, as well as consultation with nurses and managers. The observer's reflections based on the daily observations were documented in a digital log format. Once in the research field, the observer decided the occasion, frequency, and content appropriateness when it came to logging the daily observations. The observer produced a log containing the observations and daily reflections that were inspired by a set of questions defined by the first author (who acted as the observer's home research supervisor) (see Chart 1).

Chart 1 - Observation and reflection focused questions.

Observation-focused questions	**Reflection-focused questions**
What happened?	Did the observation involve learning something new?
What did I observe?	How was the experience in the community setting different from what I expected?
What was my role in the community setting?	What did I learn about the individuals and/or community?
What issue is being addressed and/ or what population is being served?	How did this experience relate to my nursing experiences in Canada?
What were my initial expectations and thoughts?	How have the environment and social conditions affected the individuals at the community site?
What did I hear, smell, see or feel?	Did anything about my experience with the community surprise me?
What impacts the way I can view the situation/ experience?	What are the root causes of any issues present?
What skills do the nurses use in the community site?	What personal learning occurred through this experience?
	What information can I share with my peers or the community

Over a 10-week period, the observation occurred during cultural immersion in numerous social, collective events unfolded, with 14 days spent on clinic observations. Observations approximately entailed three intermittent hours per day. These observations were primarily of PHC visits with a CHN at the local clinic, well-child check ups by an interdisciplinary team at the local school, and of home visits by the clinic's Community Health Agents (CHAs) and CHNs. Observations included the interactions among clientele and health professionals (PHC nurses, CHAs, physiotherapists, etc.), as well teachers and students, in non-private moments. It was done during educational sessions, visits to vaccination clinics, school, and home. Observations focused on the interactions between professionals, politicians, policymakers, managers, nurses and the population in public settings and events. Importantly, no direct observation was done during medical or nursing consultations where

an invasive procedure would be performed. The observer recorded the observations in a daily log/journal, voice recordings and photos. The observer reported findings and impressions at the end of the daily fieldwork shift.

The raw narratives composed a total set of 64 typed single-spaced pages. Narratives were mostly produced using a free, informal writing style of the familiar approach of being a reflective practitioner, as this is a common practice for the observer as part of her Canadian home School of Nursing clinical and community practice-related reflection written assignments. The research fieldwork was guided by the observer's consolidated personal knowledge grounded from previous international work-learning experiences in five countries on two different continents. Knowledge in the areas of community resilience, importance of social relationships, religious power in health, societal influence, and political power was instrumental to the observer to have insights, lead reflections and further analyze the experiential findings. The narratives were anonymized protecting the identity of professionals and lay individuals during the many daily interactions and conversations in community health centres, nursing stations and diverse social settings in the city.

The data analysis & interpretation used the observer's log as the only raw material subjected to analysis to build the meaning of the comparative nursing practice. The method of thematic analysis[12] inspired the analysis and involved the following procedures: (i) identification of themes after intensive and repeated readings of raw material; (ii) creation of a thematic index with reflections about the content of the discussions and attempts to re-group the themes; (iii) refinement of the theme titles; and (iv) answering the research question using the final theme titles. The analysis was led by the first author, a Brazilian born and now a Canadian nursing faculty who explored congruence between the observer's narrative with the Brazilian's view of CHNs, as compared with the narrative interpretation by the second, fifth and sixth authors (who are Brazilian nurses). These authors identified the appealing narratives' contents and together with the first and third authors identified the congruency between the Canadian and Brazilian CHNs' perspectives. Finally, the observer (the fourth author) reviewed the team members' understanding of the narratives through a Brazilian lens and refined with them the findings' final interpretation. This last procedure was used as a strategy for the verification of verisimilitude in qualitative research[11].

The COREQ checklist was partially applied to this research report considering only the applicable items for the contents reported here. The next section presents the report entries regarding observation and reflection by the observer that were guided by an experiential perspective framed by the Canadian HP guidelines[13].

RESULTS

This section presents evidence gathered through observation using the Canadian HP lens. It was done targeting the compromised SDH and their consequent impact on Brazilian CHNs practice. By using such a lens, the observer could have seen the reality as stimulated by areas that could require community action, health policy design, and the development of supportive environments for CHNs and their clientele. Importantly, the observer was quite familiar with the reality of the overall community health conditions in many low-income countries (i.e., poor sanitation, malnutrition, inadequate public transportation, restricted access to healthcare).

The partial findings presented in this section were based on the original written narratives in the log produced according to the observer's educational background about the practice of Canadian CHNs. Narratives also present an interesting portrayal of the discovery of Brazilian wide ways of socializing, individuals' amalgamation, and leisure, religious and food practices that altogether indicate scope of

interest for health promotion actions by CHNs. The upcoming paragraphs summarize and analyse the key evidence within these perspectives and describe the three analytical themes: 1) Uniqueness of the grasped information; 2) Incongruence between community health nursing practices; and 3) Harmony between contextual practices of Brazil-Canada community health nursing. Noteworthy to say that the comparative analysis was based on the observer's immersion in the field witnessing the local CHN practice through the lens of HP and the post-observation debriefing with the local research team. Some of the SDH that most likely caught the observer's attention included access to health services, health practices, healthy childhood development, health literacy, social support network, geographical location, and work conditions.

Uniqueness of the grasped information

All verbatim refer to the observer's original personal notes on the fieldwork log. Entries were broad and extensive to individuals' behaviors, spatial organization of public spaces, natural resources, availability of air system in closed, high temperature environment, types of food (red meat, fried meat) and beverages (free alcohol consumption in public spaces) consumed in dining establishments, self-preventive practices (e.g. use of sunscreen, outdoor exercises with martial arts, soccer, jogging, etc.), way of enjoying the natural resources, food vendors at the beaches and streets, individuals' reliance on public transit, and free access to post-secondary education for low-income individuals are among others features that called the attention of the non-cultural insider (the observer wrote):

The environment and social conditions have affected the populations' access to healthcare, beliefs on healthcare/primary health prevention, etc... because of limited resources and poor funding models there is limited access to services → extending beyond the initial primary healthcare visit (specialized testing and services). There is an evident downstream approach to seeking healthcare services in Joao Pessoa.

The experience in the community setting was different than what I expected because it was VERY hot in the immunization room. Due to lack of funding, they cannot afford an air conditioner unit, and are not able to have a fan for sanitary purposes.

Many unpredictable and surprising experiences occurred. Once in PHC facilities, one of the first impressions was how welcoming the local community was to have a foreign student among them. In other locations, a lack of office computer, unstable internet connection and individuals who are highly computer-skilled even the holistic approach to promote health (the observer wrote):

The community setting was different than what I expected because I was unaware of the different public services available to community members. For example, at the specialized centre there was free access to healthy cooking classes, medication classes, art therapy, etc.

Another feature worth attention was the wait times for specialized care, the high number of individuals waiting to be served, as well as the existing difficulties to access PHC resulting in neglect of preventative self-care (the observer wrote):

Although healthcare in Brazil is free, the wait times to get specialized medical services, and immunizations for travel can be months.

People of poor education and low socioeconomic status have to take time off work to seek medical care, and this is not always something that can happen. Therefore, people allow problems to progress before seeking help, instead of proactively advocating for their health.

Regarding the CHNs' practice, one of the most common activities was health education since in the Brazilian FHS, nurses' educative actions are extremely efficient despite some socio-cultural features, such as religion, use of natural remedies, and neglect of preventative care (the observer wrote):

Nurses... use health promotion skills → encourage individuals to lead healthier and more active lives.

Community nurses utilize many local's desires to partake in physical activity as prevention methods for the development of diseases in which physical inactivity is a risk factor... Nurses... must be knowledgeable about the different religious practices of the people of the community and how they affect their health and health practices.

People appear to believe strongly in alternative/holistic medicine → could be difficult for community nurses to impose scientific medicine.

This experience is related to my nursing experiences in Canada because many times in the community setting clients identify with a specific religion and it affects their process with illness and health.

Importantly, CHNs are the point of entry into PHC services, which is a highlight of the CHNs' role (the observer wrote):

The nurses... use assessment skills, such as critical thinking skills to determine if it is best for the client to be seen by the nurses or the doctor.

It is important to highlight that CHNs in the FHS frequently prescribe medication for common health problems in the community (e.g., medicines for birth control, tuberculosis, hypertension, diabetes, etc.) (the observer wrote):

Nurses... have more authority and autonomy as they are able to prescribe medications, manage their own staff, etc.

The closeness between CHNs and the community allows nurses to identify the population's needs and determine the appropriate strategies to guide them towards possible solutions (the observer wrote):

I learnt that many women in this community (pretty much all) come to maternal health appointments alone. I have not seen a man and woman come in for appointments together to this date.

My initial expectations and thoughts were surprised that the nurses went into the family homes to conduct assessments. This was especially surprising because this family's home was so close to the clinic. The nurse said that there is low compliance when asking the families to come to the clinic for assessments - this is part of the reason that they go to the homes.

Nurses... often travel to home visits together due to safety concerns, however, the community health nurses have reported having a feeling of personal safety due to their occupations (they are often highly respected).

CHNs' problem-solving skills were emphasized through a scenario of a woman's lack of financial resources to purchase a breast milk pump where a CHN was able to teach the woman alternative strategies for breast milk extraction. CHNs also focus on high efficacy of action plans to solve clients' problems. CHNs' adaptation skills in the work environment are considered as being highly responsive to the needs of the community and individuals they care for. As an example, they can conduct home visits for individuals who face barriers to access the PHC unit due to their mobility or caregiver support statuses.

Visits were also extended to schools with CHAs coming in to monitor the children's vaccination rates and offering opportunities to receive vaccinations, if needed. Adolescent health issues and students' safety due to community violence were equally addressed (the observer wrote):

I learnt that many of the students engage in drug use and sexual activity at a young age. Furthermore, there is a huge issue of lack of attendance in schools in this area, as it is very low

income... students... are subject to very adverse life conditions, and that it is common for continuous generations to be affected by lack of education and low socioeconomic status.

... learn that there would be highly reduced access to health care if the HCPs [health care professionals] relied on the community members to come to them. In turn, there would be less points of access to implement a prevention-based model to health care.

I was surprised about the precautions that schools have to take to promote a safe environment (bars on doors, locked areas, high walls, security checks, etc.).

... surprised at the number of children who are not vaccinated and remain in school. I noticed that some of these students were particularly older than the typical age in which children get their early years vaccinations (6/7 years old). . . I earnt that the people in this community have very ambivalent feelings towards vaccinations, and that many children in school are unvaccinated.

Visits to a private school allowed the identification of a social impact of economic disparity within the school system and children's ability to access to good education and PHC services (the observer wrote):

The contrast between this private school... and the public school I visited today is significant in terms of socioeconomic status, safety of location, population of students who attend, infrastructure, etc. These students feel comfortable with these CHAs as they are members of their community and have been following them in the healthcare system over the years.

The active search for PHC clients who could benefit from receiving care is an essential task to prevent interruption of treatment and the implementation of planned care (the observer wrote):

My initial thoughts were that people will come all the way to the clinic to monitor their blood pressure. I was surprised by the number of people who have diabetes or high blood pressure, and also the number of people who are concerned about developing it.

... many people in this community live alone and coming to these visits with the nurse is a means of communicating and having a social interaction with someone else (especially for the elderly).

The regular home visits by CHNs usually occurred in cases of postnatal care, complex dressing changes, and follow-up of clinical cases for individuals with mobility issues. CHNs also use their skills for clients' referrals to ensure that the clientele could access the required services (e.g., lab tests, imagery diagnosis, assessment by specialists, etc.). The equitable access to PHC services is a constant concern due to the population work-related barriers, such as no free time to attend consultations (the observer wrote):

... many people in the community have to take time off work to come into the clinic due to the hours, and that they are required by their employers to show proof of the appointment, or medical notice with reason for absence. Without this, clients can be penalized by their employers. This often prevents people from coming to the clinic, as they cannot afford to miss working hours and are usually not granted time off to come to the clinic.

The environment and social conditions affected the people at the community site because many of them were forced to wait in long lines to access various healthcare services, particularly those who are not wealthy enough to pay for services.

To allow the continuity of care, whenever possible, the CHNs refer clients to undergo additional lab tests in community-based services external to the SUS as per the integration of public and private services. Despite such coordinated efforts, the clientele tends to not comply with these tests. In fact, CHNs consider, as plausible reasons, the difficulty to pay other commuting fares, and concerns with being welcome in a private health care organization. Such non-compliance may undermine efforts and act as a barrier to CHNs' work resoluteness (the observer wrote):

... people and the community are generally not compliant with medical care. This is for several reasons. For example: lack of support, low socioeconomic status, societal norms, etc.

Finally, the observation was also extended to the context of the Regional Council of Nursing (COREN) office to learn about nursing practice's regulations (the observer wrote):

. . . during the presentations everyone sat in a circle to watch (this is not the normal form of presentation for students in Canada). At COREN, I was surprised to see it was like the CNO/RNAO offices in Canada. . . and felt welcomed again.

Incongruence between community health nursing practices

A key reported incongruence is not per se specific to the context of CHNs but to the overwhelming environment of practice in the SUS facilities. The increasing number of individuals looking for PHC services, the inadequate physical installations, and need of rapid pace actions may justify what was overtly unacceptable through the lens of a foreign nursing student. Repeated notes were made about breaches to clients' confidentiality and privacy. An example of this occurred when an individual was called by their full name in the waiting room prior to entering a consultation/exam room potentially threatening one's privacy. Moreover, the lack of adequate facilities to offer privacy during patient consultations and exams was a concern (the observer wrote):

... the nurse conducts consultations in her office where her desk is and where she does paperwork. In addition to this, the nurse shares her office with another nurse and sometimes two patients are being seen at the same time, in the same room.

The observation setting was different than what I expected because norms of privacy are very different in this clinic than in Canada. This is primarily due to lack of space and funding.

... health assessments being taken at a local school. The assessments were taken in a very unclean tech room at a high security school... I observed the health assessments being conducted in front of many HCPs and students (lack of privacy seems to be a common theme).

Moreover, the rapid pace of work could jeopardize patient safety (the observer wrote):

I was also surprised that patients are allowed to leave immediately after getting 2-4 vaccinations and do not have to sit to be monitored for adverse effects.

However, the identification of deviation of some tasks and the deprivation of equipment of individual protection was noted (the observer wrote):

I noticed that the nurse was responsible for clerical and managerial tasks. It was evident that the nurse was overwhelmed with being responsible for all the paperwork.

I was surprised by the lack of safety measures put in place for the nurses. The community site cannot afford gloves, needles with safety, non-penetration needle disposal boxes, medical tape, etc.

Another issue concerns the educational interventions regarding healthy food. Regarding educational practices, understanding and adapting how to guide individuals about their diet is a factor that CHNs should consider. When creating plans of care, information about food should be compatible with financial means to balance food preferences to not aggravate possible risks for food insecurity. New food trends in Brazil such as veganism were identified since (the observer wrote):

... there is only one vegan restaurant in João Pessoa. Traditionally, it is evident that meat consumption in Brazil is abundant.

Equity in access to PHC services for LGBTQIA+ individuals seemed to be limited requiring CHNs to expand their knowledge in areas such as gender orientation and sexual health due to the visible presence of non-cis individuals in the visited cities. CHNs engaged in a non-judgemental, socially inclusive practice that could protect the human rights of their diverse clientele (the observer wrote):

Nurses... use awareness strategies and open/non judgemental dialogue... For example: education related to risk of STI's/STD's and allowing clients to present/express whatever gender they identify as.

CHNs may be in a privileged position to influence some internal policies due to their acknowledged leadership and managerial skills. However, management within the SUS structure by CHNs is characterized by many skills (e.g., planning, evaluating, budgeting). CHNs are asked to be responsible for managing the CHAs' and nursing team's work hours, delegate specific tasks and monitor the FHS team-focused actions.

Ultimately, CHNs in the explored field perform significant leadership functions as related to their administrative positions and practice. The final comment relates to underfunded FHS that do not provide to CHNs the needed, relevant HP educational materials. Therefore, health education interventions are mostly carried out verbally, unless they are a part of a specific aspect of a government public health campaign, in which the Ministry of Health, the State of Municipal Secretary of Health would provide the FHS with materials for public distribution.

Harmony between contextual practices of Brazil-Canada community health nursing

Overall, CHN practice in Brazil and Canada is responsive to the economically vulnerable populations, community violence, underfunded PHC system, nursing overload in PHC facilities, low levels of health literacy and compromised determinants of health particularly for those living in rural and less urbanized areas (the observer wrote):

Root causes: FUNDING and resource allocation = huge issues

I learnt more about the places the people and community can access healthcare services and witness some of the barriers to seeking care - wait times, inconvenient hours, far locations, etc. This related to my experiences in Canada because similar concerns are seen within the primary healthcare system in Canada.

I was surprised with how comfortable the locals were at living in the middle of nowhere. Additionally, it was interesting to see how self-sustaining these people are. The food they eat is locally grown, the children play with hand made toys, etc. The root cause to access health care is due to rural areas with limited health care facilities.

Throughout the observation and field immersion, the observer noted a few similarities between the PHC systems in Brazil and Canada, influencing how PHC services are delivered to their respective populations. The observer learned that legal frameworks that govern the work of CHNs, collaboration and collaborative practices between local populations and CHNs, financial allocation and government budgets for healthcare services, and social and cultural contexts that impact on healthcare delivery are some examples of such similarities. In addition to this, in both Brazilian and Canadian PHC systems, the CHN role engages in multidisciplinary and interprofessional collaboration as well as places emphasis on the SDH ability to strengthen community action to promote health and reorient health services to empower populations and individuals.

The observer also identified notable differences between the CHN roles as part of the Brazilian and Canadian PHC systems. These differences can be classified into three areas: scope of practice, barriers to care, and location of work. In Brazil, CHNs can make referrals for diagnostics and laboratory testing, and prescribe routine drugs, which for Canadian CHNs is beyond the scope of their practice. In relation to barriers to care, in Canada these include limited resources and public funding to provide care to older adults in the community, insufficient rural and remote access to PHC services, extensive wait times for referrals leading to significant service gaps, and the work-life balance is challenging due

to extended work hours. In Brazil, to contract, CHNs' primary challenges include poor financial allocation of government funding which leads to diminishing access to infrastructure and basic materials for the provision of care, political corruption and political issues, and complex societal culture of community members exacerbated by high levels of non-adherence to medical advice and treatment as well as low levels of education and general literacy. Finally, in relation to location of work, in Canada, CHNs provide nursing care through public health in the client's home, while in Brazil, the CHNs provide care through assigned geographically stratified areas within a community through mainly their assigned CHAs and FHS team' members.

Therefore, from the perspective of transcultural nursing, evidence assembling what was observed, perceived, and possibly understood as being similar, different or a gap in perspectives, even as a complex issue, the CHNs actions remain congruent with the paradigm of HP. The core of such practice either in Brazil or Canada addresses structurally compromised SDH as lived by socially excluded populations. The fieldwork uncovered that both countries distinctively express the barriers CHNs encounter to advocate, defend, and protect these populations. Immersion in other CHNs' reality of practice by undergraduate nursing students is unquestionably a unique opportunity to learn that there exists a transcultural, transnational, exponential problem for CHNs to tackle the systemic impact of the deprivation of opportunities to improve health.

DISCUSSION

Among the distinctive practice noted by the observer was that in Brazil, the prescribing practice has been well-established because legally CHNs are allowed to prescribe within the PHC programs[14]. Recently, authority has been granted to Canadian CHN and Nurse Practitioner (NP), upon completion of specific training, to prescribe opioids in the province of Ontario[15] bringing this expansion of the CHN role to align more with the Brazilian CHN role.

Brazilian CHNs, who mostly hold a post-certificate in community health and correlated areas, are the entry point to the FHS intertwining actions into the public and private health sector. They use a multidisciplinary and interprofessional healthcare approach to address PHC issues: poor education, lack of compliance and treatment non-adherence, lack of funding, and long wait times for specialized care. The interface of their work with that of Canadian CHNs regards its focus on health promotion, prevention, protection, and maintenance. Differently, in the Canadian PHC system, entry point into the system is either through a Family Physician or a NP. The healthcare approach tends to be quite specialized. The PHC issues include the long wait times to access PHC, only one issue per visit can be addressed, multiple access points, funding, and poor rural access to health care. Despite private health care in Canada being very limited, it may imply a more equitable system for the population, while contributing to the oversaturation and long waiting times health users face. In both health systems the funding deficits lead to limited access to healthcare resulting in overcrowding and CHNs' declining levels of work satisfaction due to the primary issues that remain unsolved and insurmountable.

Another point for discussion revolves around the difference in approaches to ethical practice and incorporation of ethical principles in practice. In the Brazilian PHC system it is culturally appropriate and acceptable to call clients using their full names or even start conversations with them in a physical space without offering total visual and auditory privacy while discussing their personal and clinical information. Culturally, the informality of personal interactions among individuals placed at distinctive social ranks (teachers, physicians, dentists, nurses, etc.) is acceptable. From a Canadian PHC system perspective, these types of actions equate to a breach of privacy/confidentiality and not aligning with

the delivery of ethical practice. Hence, the observation of such interactions within this research further underlines the intensity of the experience about this matter.

It is necessary to ponder on the multidimensional issues that root events/facts/deeds as perceived by the observer, a Canadian nursing student. First, amendments to the Brazilian Constitution weakened the public services financing resulting in lesser capacity to respond to the increasing demands for services[16]. Second, the SUS weakening and negative impact on PHC services due to the economic, social and political crisis lead professionals to purchase work-related material[16–17]. Third, the shortage of PHC staff caused most of them to engage in task overload, deviation of regular tasks (from clinical to bureaucratic), and increased need for supervision[18]. Despite the unfavourable working conditions, CHNs, due to their established bonds with the clientele, remain able to provide nursing care and advocate for the clientele's, families', and community's rights to quality PHC[19].

Challenges faced and opportunities encountered by Brazilian CHNs are numerous. In promoting health, nurses may deal with the intermittent engagement for instance by parents' attempts to bring effective change to family health habits[20]. Other concern regards to the less effectiveness of HP actions to create a supportive environment for the emotional protection of socially vulnerable subgroups like school-age children suffering from bullying due to obesity[21]. Competences to address HP major issues were corroborated by CHNs' education in the field of HP that is in consonance with conceptual, political and ethics soundful perspectives[22]. The protection of such Brazilian socially vulnerable individuals has been the focus of Canadian and Brazilian teams of scholars targeting PHC research, professional development, and community social development projects. These knowledge transfer projects[23] were framed by the notion that knowledge transfer is an interactive and dynamic process to synthesize, exchange, disseminate, and apply knowledge[23]. Unsolved issues regarding the CHNs work with socially vulnerable populations are present in both PHC contexts. Some issues may be emergent and contingent on asking for transformational solutions[24] to revolutionize professional in-service education focusing on real-world problems and experiences. Moreover, solutions should focus on developing strong leadership in PHC to transform its commitment to service and action to shorten the gap between care providers' interventions and the clientele reach-out[24].

Having the goal of improving population health and health care delivery to strengthen the healthcare system, knowledge transfer involved Canadian experts (nurses, midwives, and social workers) who transferred knowledge to Brazilian social leaders (mainly nurses, physicians, psychologists, physical educators, dentists, and CHAs) in their healthcare organizations. For instance, empirical evidence about the multidimensional violence against women's obstetric rights as per the adequacy in the implementation of Brazil's Program of Humanization of Prenatal and Labor generated recommendations for nursing advocacy[25]. A public consultation about community actions to tackle the interpersonal violence against women uncovered the invisibility of CHNs and other nurses in the hospital as key social actors to intervene and protect this population[26]. Research on immigrant and refugee's health allowed the dialogue between Canadian students, Brazilian researchers and social leaders sharing the Canadian philosophical grounds of human rights and population protection[27].

In yet another example, research with Portuguese-speaking men about alcohol drinking and cancer prevention explored issues of SDH (sex, masculinity, family practice, alcohol culture, age, etc.) revealing an extensive need of mass health education about risk of cancer for men[28]. Evidence about knowledge incorporation to practice reinforced the appropriateness of educational professional development projects for Brazilian CHNs in the area of promotion of individual and community health literacy[29] including recommendations of concrete action for incorporation of both concepts in the CHNs

in their practice in the SUS[30]. Notably is the longstanding difficulty of CHNs to intervene on matters of street drugs and overdose prevention. Such experiential knowledge was explored with Toronto-street nurses foreseeing knowledge transfer for the development of Brazilian leadership in this area[31].

Reported experiences during the pandemic identified noticeable, promising areas for renewed global CHNs' social leadership. As the world is transitioning into post-pandemic living, growing use of alcohol, licit and illicit drugs (mainly opioids and their unsafe use) is emerging revealing major community mental health needs affecting all ethnic groups, for instance in the North America region[32]. Ineffective response to such a crisis can be potentially further aggregated by a pandemic-related shortage of PHC professionals and in particular, of nurses who have been exiting the profession in exponential numbers[33]. In Brazil, the worsening of the PHC services was experienced during the pandemic by inhabitants of major shantytowns while facing a multifaceted crisis (health, economic and social)[34]. The lack of government's responsiveness led to communities being left to organize themselves in insurgent citizenship, claiming the protection of rights and response to the population's needs[34]. In such a context, CHNs' work on community frontlines was likely compromised due to the delayed vaccination launch. The federal government's poor coordination and logistics caused serious delays in a country whose history of successful government policies for mass vaccination, effective communication strategies, free availability of doses, and the SUS responsiveness were unquestionable.

On the other hand, Canadian CHNs faced challenges posed by Covid-19 vaccine hesitation specially by socially marginalized populations[35]. CHNs encountered initial non-compliance to public health preventative measures and under-vaccination within a context of polarizing social and political debate about vaccine literacy, PHC system history, and human rights ideology[35]. Differently from the Brazilian colleagues, Canadian CHNs dealt with uncommon compensation incentives for vaccination contrary to the key principles of community health education, outreach, and reduction of access barriers to PHC services[36].

Currently, Brazilian CHNs are dealing with the unprecedented effects of the economic and social matters potentializing the following critical PHC situations widely disseminated by the official, professional and popular media: (a) hunger and food insecurity; (b) recrudescence of childhood infectious diseases (e.g., measles, polio) and population' vaccines hesitancy; (c) increased school shootings; (d) worsening of the opioid crisis among homeless populations; and, (e) increased rates of domestic violence, sexual assaults, homicides and suicides. Today, the nursing shortage is a wide problem approached by professional and political stakeholders to secure the Canadian public health system multi level operation[37] to respond to community health crises exacerbated by economic and social issues.

In sum, the pillars of PHC philosophy will illuminate ways to build on recent lessons for innovative collaboration and exchanges between Brazilian and Canadian CHNs. The uniqueness of their experiences entails avenues to enhance such actions aiming high-quality PHC systems while strengthening their professional development, evidence-based practice and showcase their unquestionable social leadership.

One limitation is related to the Canadian observer's lack of mastery of conversational Portuguese language, which could have limited her understanding of lived experiences due to the immediate inability to explore further explanations. The observer's short stay in the research field limited an in-depth immersion in the Brazilian popular health culture. It limited a wide grasp of the actual and hidden issues related to the implementation and delivery of PHC in the SUS administrative and political structure. Both limitations were addressed by the Canadian-Brazilian principal investigator who, prior to the observer's trip to Brazil, offered information sessions about potential expected and

unexpected issues that could be met once in the research field. Brazilian collaborators acting as interpreters, cultural insiders and gatekeepers significantly reduced linguistic and cultural obstacles.

A key contribution to the advanced dialogue between Canadian and Brazilian CHNs relies on the expansion of their mutual understanding of major contextual issues that undermine the high efficacy of their PHC work. Moreover, other CHNs could learn how the practice in middle- and high-income countries could be equally affected and distorted. The discussion of convergences and divergences between Brazilian and Canadian realities, inspires a critical reflection of the practices of CHNs as transformative leaders. Unquestionably, there is some convergence in CHNs' practice and areas for improvement for Brazilian CHNs as well as Canadian CHNs. Canadian CHNs may learn with Brazilian CHNs about the specificity of PHC in a cultural, creative, and context of understanding health. This mutual learning project can be an object for further collaboration.

There is a special role for undergraduate and graduate nursing students interested in global nursing, who are expected to seek out learning opportunities in many foreign contexts. The observer, a Canadian undergraduate student possessing prior international experiential knowledge was instrumental to the prevention of cultural clashes. As evidenced by the successful completion of this research, students once offered opportunities to participate in experiences of global and transcultural nursing can contribute to bridge nursing research programs between international researchers.

CONCLUSION

This research uncovered the compatibility between Canadian and Brazilian primary care practice as well as some features in the Brazilian CHNs' practice. Unquestionably, the evidence sums up to the consolidation of the well-established Brazil-Canada cooperation in the field of PHC uncovering the issues faced by one of the most relevant social actors in the implementation of PHC policies and programs: the contingent of CHNs. Such eloquent evidence addresses the political perspective of collaboration for global health. For that, a periodic, critical review of performance and underpinning factors can be beneficial to help Brazilian CHNs to appraise the quality and efficacy of their actions according to a global agenda of promoting equity in health. The CHNs' empowerment could redesign the work engineering, shaping health policy, and furthering the commitment of the CHNs' role on a global level.

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NOTES

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Study design: Zanchetta MS, Ferguson A, Souto RQ.
Data collection: Ferguson A
Data analysis and interpretation: Zanchetta MS, Ferguson A, Monteiro GKNA, Fernandes BN.
Results discussion: Zanchetta MS, Souto RQ, Ferguson A, Monteiro GKNA, Fernandes BN.
Manuscript writing/critical review: Zanchetta MS, Metersky K, Souto RQ, Ferguson A, Monteiro GKNA, Fernandes BN.
Revision and approval manuscript final version: Zanchetta MS, Metersky K, Ferguson A.

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CORRESPONDING AUTHOR
Margareth Santos Zanchetta
mzanchet@torontomu.ca