

# Cross-cultural nursing care for immigrant women during pregnancy and childbirth: experiences and vulnerabilities


*Cuidado transcultural de enfermagem à mulher imigrante na gestação e parto: experiências e vulnerabilidades*

*Cuidado transcultural de enfermería para la mujer inmigrante durante el embarazo y el parto: experiencias y vulnerabilidades*

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## How to cite this article:

Zarth MD, Fernández PA, Baggio MA, Zilly A, Gamarra CJ, Silva RMM. Cuidado transcultural de enfermagem à mulher imigrante na gestação e parto: experiências e vulnerabilidades. Rev Gaúcha Enferm. 2024;45:e20230161. doi: <https://doi.org/10.1590/1983-1447.2024.20230161.en>

## ABSTRACT

**Objective:** To understand the experiences and vulnerabilities for cross-cultural nursing care for immigrant women during pregnancy and delivery.

**Method:** Exploratory, qualitative research, in the light of the Theory of Diversity and Universality of Cultural Care, in Foz do Iguaçu, Brazil, through interviews with eight postpartum woman and 18 nurses, between February and September 2022. The interpretation of meanings was adopted for analysis.

**Results:** The categories of analysis emerged: Experiences, vulnerabilities and acculturation of immigrant women during pregnancy and delivery; Cross-cultural care and vulnerabilities experienced by immigrants in Brazilian health services. Vulnerabilities were identified in Cultural and Social Structure Dimensions expressed in access to work, low socioeconomic conditions, lack of family and social support and specific services for this population. The potentialities experienced included good care provided by health services, quality of the multidisciplinary team and appreciation of professional knowledge, however, the understanding of expectations and cultural aspects needs to be deepened.

**Final considerations:** Understand that immigrant women experience situations of vulnerability in pregnancy and childbirth, in the Brazilian context, mainly related to social and programmatic dimensions. However, potentialities were also experienced, evidenced by positive aspects in cross-cultural nursing care in Brazil.

**Descriptors:** Emigrants and immigrants. Social vulnerability. Pregnancy. Parturition. Empathy. Culture.

## RESUMO

**Objetivo:** Compreender as experiências e as vulnerabilidades para o cuidado transcultural de enfermagem à mulher imigrante na gestação e parto.

**Método:** Pesquisa exploratória, qualitativa, à luz da Teoria da Diversidade e Universalidade do Cuidado Cultural, realizada em Foz do Iguaçu, Brasil, mediante entrevistas com oito puérperas e 18 enfermeiros, entre fevereiro e setembro de 2022. Adotou-se, para análise, a interpretação de sentidos.

**Resultados:** Emergiram as categorias: Experiências, vulnerabilidades e aculturação da mulher imigrante na gestação e parto; Cuidado transcultural e vulnerabilidades experienciadas pela imigrante em serviços de saúde brasileiros. Vulnerabilidades foram identificadas nas Dimensões Culturais e de Estrutura Social expressas no acesso ao trabalho, baixas condições socioeconômicas, falta de suporte familiar, social e serviços específicos para essa população. As potencialidades experienciadas incluíram: bom atendimento nos serviços de saúde, qualidade da equipe multiprofissional e valorização do saber profissional; entretanto a compreensão das expectativas e dos aspectos culturais precisam ser aprofundados.

**Considerações finais:** Compreendeu-se que as mulheres imigrantes experienciaram situações de vulnerabilidade na gestação e parto, no contexto brasileiro, principalmente relacionadas às dimensões sociais e programáticas. Contudo, potencialidades também foram experienciadas, evidenciadas pelos aspectos positivos no cuidado transcultural de enfermagem no Brasil.

**Descritores:** Emigrantes e imigrantes. Vulnerabilidade social. Gravidez. Parto. Empatia. Cultura.

## RESUMEN

**Objetivo:** Comprender las experiencias y vulnerabilidades de la atención de enfermería transcultural a mujeres inmigrantes durante el embarazo y parto.

**Método:** Investigación cualitativa, exploratoria, basada en la Teoría de la Diversidad y Universalidad del Cuidado Cultural, realizada en Foz do Iguaçu, Brasil, a través de entrevistas con ocho madres y 18 enfermeras, entre febrero/septiembre de 2022. Se adoptó la interpretación de significados para el análisis.

**Resultados:** Emergieron las categorías de análisis: Experiencias, vulnerabilidades y aculturación de mujeres inmigrantes durante el embarazo y parto; Atención transcultural y vulnerabilidades vividas por inmigrantes en los servicios de salud brasileños. Se identificaron vulnerabilidades en las Dimensiones de Estructura Cultural y Social expresadas en acceso al trabajo, bajas condiciones socioeconómicas, falta de apoyo familiar y social y de servicios específicos para esta población. Las potencialidades vividas incluyeron: buena atención en los servicios de salud, calidad del equipo multidisciplinario y valoración del conocimiento profesional, sin embargo, es necesario profundizar la comprensión de las expectativas y los aspectos culturales.

**Consideraciones finales:** Se entendió que las mujeres inmigrantes vivieron situaciones de vulnerabilidad durante el embarazo y el parto, en el contexto brasileño, principalmente relacionadas con dimensiones sociales y programáticas. Sin embargo, también se experimentaron potencialidades, evidenciadas por aspectos positivos en la atención de enfermería transcultural en Brasil.

**Descritores:** Emigrantes e imigrantes. Vulnerabilidad social. Embarazo. Parto. Empatia. Cultura.

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## INTRODUCTION

Human mobility is a historical phenomenon of societies. Today's growing immigration flow, justified by political and economic conflicts and environmental disasters, is a global challenge, especially in developing countries. Brazil, a country that faces its own weaknesses in the health system, needs to ensure that the immigrant population has access to public services, revealing a complex scenario for its political and social organization<sup>(1,2)</sup>.

Currently, more than half of the world immigrant population is female, and has the worst health indicators, especially in sexual and reproductive health<sup>(1,2)</sup>. Studies show that, for immigrant women, pregnancy is a period of greater vulnerability, considering the unfavorable outcomes regarding morbidity and mortality<sup>(3)</sup>.

Given this scenario, the Pan American Health Organization (PAHO) warned that reproductive planning and prenatal care are among the biggest challenges faced by immigrant women in the Americas. PAHO also emphasized the need for recipient countries to carry out long-term planning for the demand for care for these women, which tends to be growing and continuous<sup>(4)</sup>.

The cultural aspects of immigrant women, related to the processes of pregnancy and childbirth, since motherhood often involves beliefs, myths, values and practices, translate into cultural patterns, which are inherited and marked by the characteristics of each population<sup>(5)</sup>.

Regarding the vulnerabilities of immigrant women during pregnancy and childbirth, those related to communication, culture and understanding the functioning of the country's health system stand out<sup>(5,6)</sup>. Therefore, knowing the experiences of immigrant women is a key element in ensuring adequate care from a cultural and operational point of view<sup>(7)</sup>.

Cultural care, proposed by the Theory of Diversity and Universality of Cultural Care (TDUCC), by Madeleine Leininger, considers the habits, beliefs, values, environments and ways of life of each population<sup>(8)</sup>. In light of this Theory, nurses can structure their care practice by proposing actions that encompass cultural aspects appropriate to each woman's way of life, providing effective, meaningful, humanized and culturally competent care<sup>(9)</sup>.

The concept of vulnerability is based on the understanding of the individual, social and programmatic components<sup>(10)</sup>, which together with TDUCC<sup>(8)</sup>, seek to expand the understanding of the situations that determine health outcomes in unequal scenarios, resulting from injustices, inequities, exclusion social and cultural differences.

The dimensions of vulnerability can be considered as: individual, which deals with susceptibility associated with

biological, behavioral, emotional factors, access to information in quantity and quality, added to the ability to understand and insert this knowledge into practice and transform it into actions; social, which refers to sociocultural and economic aspects that determine the possibilities of access to goods and services; and programmatic, related to resources, promotion, protection and conservation of individuals' health<sup>(10)</sup>.

Considering the diverse cultural contexts in the study scenario and the TDUCC theoretical framework, the following research questions were formulated: What are the care experiences and vulnerabilities of immigrant women during pregnancy and childbirth? And what about the experience of nursing care for immigrant women from different cultures? The present study aimed to gain insight on the experiences and vulnerabilities for transcultural nursing care for immigrant women during pregnancy and childbirth.

## METHOD

Exploratory qualitative research, in the light of Madeleine Leininger's Theory of Diversity and Universality of Cultural Care (TDUCC)<sup>(7)</sup>, conducted in the municipality of Foz do Iguaçu, Brazil, on the border with Cidade do Leste (Paraguay) and Porto Iguaçu (Argentina). The aspects listed in the Consolidated Criteria for Reporting Qualitative Research (COREQ) were observed and adopted<sup>(11)</sup>.

The assumption of TDUCC is the understanding of the Cultural and Social Structure Dimension, which includes technological, religious, philosophical, family, social, cultural (ways of life), political, legal, economic and educational factors. Such factors help to understand the reality experienced by the individual/community and must guide care actions<sup>(7,8)</sup>.

Regarding the study scenario, there are more than 80 ethnicities in the municipality of Foz do Iguaçu, mostly made up of individuals from Paraguay, Lebanon, China, Argentina and Japan<sup>(12)</sup>, formed throughout history with the arrival of diverse peoples from multiple cultures. Among the main factors in the immigration movement the construction of the Itaipu Hydroelectric Plant, tourist attractions, such as the Iguaçu National Park, the strong trade in the region and the implementation of the Federal University of Latin American Integration, which gets students from Latin America and the Caribbean deserve mention<sup>(13)</sup>.

Eight postpartum women, immigrants from four different countries (Paraguay, Haiti, Venezuela and Lebanon) and 18 nurses (13 from Basic Health Units (UBS) and five from a hospital institution, participated in the study. The participation of postpartum women was driven by the need to understand the experiences related to receiving care, and the participation of nurses aimed to provide understanding

about the experiences of caring for postpartum women from different cultures. TDUCC assumptions for care practices during pregnancy and childbirth were considered in the interviews.

The inclusion criteria were immigrant postpartum women, up to one year postpartum, with prenatal follow-up carried out at a UBS and who gave birth in Foz do Iguaçu, Brazil; nurses working in the UBS and in the hospital, who provided care to women of another nationality (other than Brazilian) in the pregnancy-puerperal cycle. Postpartum women who did not understand the Portuguese language and nurses who were away from work during the data collection period were excluded from the study.

The postpartum women were selected intentionally; initially, by searching the UBS when accessing the service for childcare and/or immunization of their children. Due to the difficulty of finding postpartum women in the UBS during the COVID-19 pandemic, telephone contact was made with them, based on the registration available in the units, to invite them to participate in the study. In total, 26 postpartum women were invited: 15 did not call back and three did not speak Portuguese. Of the eight postpartum women who agreed to participate in the study, six were interviewed in person, at the UBS, with the use of protective measures, and two digitally, by call via Google Meet®.

The UBS nurses were intentionally selected, and those who worked at the hospital were selected through the snowball technique<sup>(14)</sup>. The first contact was made by telephone, and interviews were subsequently scheduled. Interviews with UBS nurses were carried out in person, at the health unit itself, and interviews with hospital nurses took place both in person and digitally. Among the latter, three nurses were interviewed in person, in a private room, at the hospital itself, and two via digital means (Google Meet®). Of a total of 24 nurses invited to participate in the study (13 from UBS and 11 from the hospital), six from the hospital area did not call back.

In-depth interviews were carried out, based on a semi-structured guide, starting with the following guiding question for the postpartum women: "Tell me about your experience during pregnancy and childbirth in Brazil"; and for nurses: "Tell me about your experience providing care during pregnancy and childbirth for immigrant women."

Data were generated from February to September 2022. The interviews, which lasted an average of 45 minutes, were audio recorded and transcribed in full, and were carried out by the first author, who is a nurse, master's student, and previously trained for this activity. It should be noted that three pilot interviews were carried out, one with a postpartum

woman and two with nurses, included in the study, as there was no need to change the semi-structured guide, and the data obtained covered information relevant to answering the study questions. The interviews were discontinued when the data obtained contained sufficient elements to generate empirical knowledge, capable of responding to the initial research objectives and reflecting the internal logic of the object of study<sup>(15)</sup>.

Data analysis was carried out through the interpretation of meanings<sup>(16)</sup>, based on a socio-anthropological perspective and focusing on the cultural phenomenon. For this purpose, the analysis was organized into three stages: i) Comprehensive, in-depth and repeated reading of the material, establishing an interrogative relationship between the theoretical framework and the proposed objective; ii) Exploration of the material through analysis and interpretation of the participants' statements, linked to the TDUCC, which allowed understanding broader meanings, in common situations, the difficulties and singularities of immigrant women during pregnancy and childbirth, as well as the experiences of nurses in their service; iii) Elaboration of an interpretive synthesis, through analysis and reinterpretation of cultural diversity and individual, social and programmatic vulnerabilities, culminating in the organization of two categories of analysis: experiences, vulnerabilities and acculturation of immigrant women during pregnancy and childbirth; Transcultural care and vulnerabilities experienced by immigrants in Brazilian health services.

The study was developed in accordance with the standards of the Research Ethics Committee and was approved by Protocol No.5,216,517, CAAE 5325722.4.0000.0107. To maintain confidentiality and anonymity, participants were identified by alphanumeric codes with letters (P) for postpartum women, (EUBS) for UBS nurses, and (EH) for hospital nurses, followed by the interview order numbers.

All participants were informed about the objectives of the study, and upon agreeing to participate, they signed the Free and Informed Consent Form (TCLE) in two copies. This document was also made available in Spanish for immigrant women, as it is the official language spoken in Latin American border countries.

## ■ RESULTS

The immigrant women were aged between 18 and 34 years old, had steady partners, and came from Paraguay, Venezuela, Lebanon and Haiti. The length of residence in Foz do Iguaçu varied from one to six years. The nurses were predominantly women, aged 31-50, with an average length

of time working in the health service of nine years and had at least one specialization.

### Experiences, vulnerabilities and acculturation of immigrant women during pregnancy and childbirth

The immigrant women left their countries in search of better living and working conditions in Brazil. However, pregnancy, specific symptoms during this period or work overload during pregnancy interfered with maintaining or entering the job market. The women who continued working during pregnancy, particularly in food industries in the region, faced obstacles in receiving prenatal care.

*I was working, but I had to stop because it was too hard, I worked in the [food industry], when I got home, I had pain in my stomach, in my back, it was difficult. (P8)*

*[...] one patient needed to find a job. She got a job even though she was pregnant, it was on the production line, very hard, very tiring work [...] We can't do the ultrasound scan because we have to work, the clinic where the exam is carried out provides a certificate, but since the patient was not seen by us, we were unable to give her a certificate. So you can see that this is really an economic issue. [...] people's education level is low, at least around here... the issue of employment is what we call underemployment. (EUBS12)*

Many women who started the migration process did not plan their pregnancies, and this may have made it difficult for them to adapt to the new country and receive prenatal care.

*No, I didn't want to have a child, maybe later, but it wasn't supposed to be now. (P5)*

*The first thing we ask is: did you want to have this baby? "No, no" [...] Most people say "I'm not accepting it yet", "I cry every night". It happens a lot around here, unplanned and unwanted pregnancies. I always take note, [...] because this changes the approach during prenatal care. (EUBS13)*

Communication with immigrant women was also perceived as a complicating factor for nurses, a priori, when contacting Haitian women.

*We found it difficult to understand the Haitian women, because they speak in a very different way... In turn, communication with other pregnant women, from Paraguay*

*and Argentina, was much easier [...]. We managed to understand each other well. (EUBS1)*

The situations of social and programmatic vulnerability of immigrant women were maximized in the experience of pregnancy, especially during the COVID-19 pandemic.

*We arrived during the pandemic and everyone was at home, we had no friends [...] we didn't speak the language well [...] all this happened because of the pandemic, if you want to speak a language you have to talk with people who speak that language, but we only stayed at home [...] we only spoke French and Creole. (P7)*

*[...] when I caught COVID-19 [during pregnancy] I wanted someone to guide me. I went to the health unit and the receptionist told me that I was very irresponsible: "you will contaminate everyone". They didn't treat me very well! (P8)*

Being far from family and friends and having established few bonds were also unfavorable aspects mentioned. The lack of structure and support made it difficult to adapt to changes in the new country and the birth of children, highlighting the social vulnerability of this population.

*After my mother left, I started to feel bad, I cried a lot, I wasn't enjoying motherhood, I didn't like anything, I didn't feel good. (P5)*

*It's very hard to talk to your parents only on the phone, staying in a country that isn't ours. (P7)*

*[...] my mother and my sisters were not around, only him [my husband], but he worked a lot. (P2)*

*If these pregnant women do not have family support, support from someone who understands the real importance of all guidance during pregnancy, nothing will be done, because pregnant women cannot do much on their own. (EUBS6)*

In their country of origin, the immigrants lived in precarious socioeconomic conditions. Nurses from the UBS and the hospital said that, despite living in Brazil, these women maintained their condition of social vulnerability.

*When I had my first child we were starving, so I didn't eat well [...], here [in Brazil] I can eat better. (P8)*

*The economic issue seems silly, but it is not. From admission to the ward, during the postpartum period... sometimes the lack of a companion, because no one*

*can afford to have a companion, as that person needs to work.*(EH17)

*When you come from another country, the situation is precarious from an economic point of view, and then everything becomes even more complicated, you know? [...] Some women take prenatal care because they are afraid of not being assisted at the time of birth. So that's why they feel obligated to do prenatal care and don't really understand the importance of it.* (EUBS1)

The immigrant women brought with them habits, customs and knowledge from their country and their original culture, and upon arriving in a different country, they went through new experiences and needed to adapt to this new situation, and they did so, whether or not they adopted the way of life from the local population. For Latin American immigrants, reports of these experiences showed less cultural divergence. The acculturation process seemed more intense for immigrants from more distant regions, such as Lebanon and Haiti.

*It's normal here to breastfeed babies in public, very normal. In Lebanon, this is not allowed, so breastfeeding is more difficult for women. For this reason, babies are weaned earlier. Here I was able to breastfeed in public, normally!* (P6)

*In Haiti it's complicated, [...] parents say that babies should sit from three months onwards, they help babies to sit. Not here, here it's only after six months [laughs]. Haitians sit earlier than Brazilians.* (P7)

*It's very difficult [...] because Arab women have a completely different culture, a completely different way of thinking when it comes to childbirth, birth [...] The family is very involved.* (EH10)

*Arab women always wear scarves, even when they are giving birth they wear scarves, veils [...] no one can see anything of their bodies. And this is characteristic of them, it is not up to us to judge whether it is wrong, whether it is right, it is only up to us to understand, accept and make women feel comfortable with the situation.* (EH18)

### **Cross-cultural care and vulnerabilities experienced by immigrants in health services in Brazil**

Immigrant women suggested ease of access to health services and even made comparisons between the different

health realities of their country of origin and Brazil, both in terms of primary care (UBS) and hospitalization.

*[...] In our medicine [Brazil], if we have a health problem, we can go to the health center and there [Venezuela], if my children got sick, the use of natural medicine, plants, was recommended, or something like this.* (P8)

*I started my treatment in Paraguay, I did all the analyzes [exams, but I missed some, in Paraguay the situation is a little more precarious [...]. Then I came here [UBS] and did prenatal care again, I was 3 months [pregnant].* (P3)

*They [Paraguayans] come here [Brazil] with this intention, they leave their country to live here in order to receive prenatal care, as there is no such assistance there.* (EUBS5)

*The organization here is much better than there [Paraguay], I was impressed with the participation of nurses, because I didn't know that nurses could do everything they do [regarding the care at the UBS and the hospital], compared to Paraguay, since we are only assisted by doctors there.* (P3)

The proximity between Brazil and Paraguay, with a border that allows easy mobility, provided peculiar health care scenarios, as individuals use both services, depending on their needs and location. However, there is no communication between services, and prenatal care may be compromised. According to reports, Paraguayan women seek this care because of the free and high quality of public services offered in Brazil.

*I used to come here at the health center for consultation, it was great, they always treated me very well, even though I'm Paraguayan, I still didn't have the necessary papers, but they treated me very well, they never denied me anything [...] and there in Paraguay everything is paid for, although healthcare is public.* (P4)

Brazilian health professionals played an important role in the care decisions of the participants, who valued professional knowledge, even when this knowledge differed from the knowledge and customs of their culture of origin.

*There is a difference between what the family says and what professionals say; It's best to listen to the professionals.* (P7)

*So they don't always do what their mothers recommend to them [...]. I have never had this type of difficulty [...] of them not accepting my guidance.* (EUBS7)

*In Paraguay there are beliefs about some foods that can be harmful to babies, I asked health professionals and they said that I could eat these foods without any problems, and so I ate them. (P3)*

*During my pregnancy, I took an iron-based supplement and there [in Haiti] they say you shouldn't take these supplements. I found this confusing, but took the supplement, the doctor said this is necessary! (P7)*

*First we have to listen to patients, know what their expectations and those of their partners are [...] and then we can adapt to their culture, to what they want at such a special moment in women's lives.(EH15)*

The nurses understood that immigrant women tend to comply with or not question the guidelines due to the vulnerable condition in which they find themselves.

*I don't know if they are afraid because they are not from here [...]. But we realize that they don't ask questions, they don't talk [...] they say amen to everything you say [...]It seems that they are afraid to speak, afraid of being reprimanded and losing their rights [...]. (EUBS16)*

*They have difficulties, I perceive insecurity on their part [...] I feel this difference, they feel more afraid [...] because they are in a foreign country, because of the language, imagine not being able to express yourself the way you would like. (EH14)*

*I try to talk and explain, according to science [...] without dismissing what they say [...] And normally this works, they understand, they respect it. (EH15)*

The comparison between health services in Brazil and the immigrant's country of origin was naturally made by the women. The nurses reported that they did not attempt to understand the health reality of the country and the culture of immigrants.

*In Venezuela, health professionals investigate more about what patients feel [...], because during my pregnancy I felt pain and when I came here the professionals said that everything was normal. Not there, there they wanted to know the reason for the pain, the cause of this pain. During the nine months of pregnancy they get ultrasounds. (P2)*

*I was never interested in asking what the health system is like in their country, what the prenatal process is like. I never had that curiosity. (EUBS3)*

*Trying to understand the culture, the patients' thoughts, have empathy, put yourself in their shoes, even though*

*sometimes it seems like it's something that doesn't make sense to you, but it makes perfect sense to the patients and you have to respect this. (EH15)*

Care was compromised during the parturition process, according to reports of insufficient guidance and difficulties in adjusting pregnant women's expectations with the need for professional interventions.

*I hoped to have some time to prepare for the cesarean section because I was not psychologically prepared, I always wanted to have natural childbirth [...] the doctor was very direct and said that the birth would be by cesarean section and now! (P3)*

*Sometimes it is very difficult to deal with the situation, because the woman's mind is totally prepared for a natural birth, and she wants to deliver the baby at any cost, regardless of how the baby is doing, or how she is doing. Trying to convince her, talk to her and tell her that it is necessary to have a cesarean section to guarantee her and the baby's well-being, sometimes it is really difficult. (EH10)*

*I didn't know much about the laceration, I wish I had had more information about the fact that when the water breaks, it does not necessarily mean that birth will soon follow, as this takes some time. I wish I had had more information about the birth itself. (P5)*

## DISCUSSION

Brazil has been the destination for many immigrants, who find it relatively easy to enter the country and who, for the most part, are looking for work opportunities and better living conditions<sup>(1)</sup>. However, upon arriving in another country, these individuals, such as the immigrant women who participated in this study, are more likely to obtain low-paying jobs, corroborating the findings of a North American study, in which the working conditions of Mexican immigrant women were unfavorable, and they were more susceptible to the risk of occupational diseases related to long working hours that prevent them from taking care of their own health<sup>(17)</sup>. In this regard, the challenges faced in the immigration process impact health as a whole, highlighting social and programmatic vulnerabilities, as they compromise prenatal care<sup>(10,17)</sup>.

Although Brazil has immigration laws that are considered welcoming compared to other countries, expressed by the guarantee of access to public services for immigrants, in practice, the real integration of this population still remains far from satisfactory<sup>(18,19)</sup>.

The scientific literature describes that immigrant women may be more vulnerable to unwanted pregnancies. A Brazilian study conducted with Venezuelan immigrant women showed that reproductive planning has been insufficient and many are unable to access a contraceptive method<sup>(19)</sup>. Another study, developed in a triple border region, reported that the low sociodemographic conditions in the border region, a peculiar scenario due to the high number of immigrants and which is similar to the setting of this study, interfere with actions and adherence to reproductive planning<sup>(20)</sup>. It should be emphasized that unplanned pregnancy has a negative impact on the health of mothers and children, with implications related to low adherence to prenatal care, increase in complications during the gestational period and a greater chance of postpartum depressive symptoms<sup>(21)</sup>.

Communication, or lack thereof, is the first and most obvious barrier to health care for immigrant women. A study carried out in the United States showed that immigrants seek preventive health services, such as prenatal care, less often and end up resorting more to urgent and emergency services, data also confirmed by a Brazilian study. The absence of these women in prenatal care is intensified by the lack of understanding of the local language and the lack of knowledge about the functioning of the health system in general, and this interferes with and compromises the care of these women during the gestational period<sup>(1,21)</sup>.

By recognizing the social structure of immigrant women, nurses direct the practice of care to their reality. Thus, TDUCC provides theoretical support for the exercise of this practice, such as the concept of cultural dimension and social structure (which encompasses technological, religious, family, political, economic and educational factors) and the understanding of the significant forces that affect and influence the health care<sup>(6,8)</sup>.

Another relevant aspect that affected health care for the population in general, especially for pregnant women, was COVID-19, as despite the undeniable importance of prenatal care, pregnant women faced difficulties in carrying out consultations during the pandemic period. This situation was even more serious for pregnant women diagnosed with COVID-19 because monitoring should be intensified given the risks of the virus for the mother-baby dyad<sup>(22)</sup>, a fact that contrasts with what was described by a participant in this study.

Especially in pandemics, access to healthcare for immigrants should be facilitated and preventive campaigns should be disseminated in several languages through communication channels, as recommended by researchers from the Department of Psychology in China and the United States<sup>(22)</sup>.

In the absence of these strategies, the pandemic may have accentuated inequalities in health care for immigrants<sup>(2,18)</sup>.

When they left their countries, the women participating in this study left part of their family and moved away from their support network. This distance was perceived with greater intensity during the gestational process, given that this period is culturally conceived by different beliefs and practices that intensify family traditions, values and habits. Families generally provide support in care, and their relationships influence the way individuals perceive and experience this moment. The absence of this support weakened and increased the vulnerabilities of immigrant women<sup>(23)</sup>.

A systematic review conducted by North American and Canadian researchers reported that healthcare professionals must understand the singularities involving habits, customs and cultures. Nurses, in particular, must provide effective and culturally competent care, seeking to prevent and be alert to the culture shock that may be experienced. It is important to recognize that the acculturation process can become a stress factor and impact immigrants' physical and mental health<sup>(24)</sup>.

Regarding Brazil's healthcare system, the participants compared this system with the care provided in their country of origin. Positive evaluations were made about the quality of the services that are free<sup>(2,25)</sup>, an experience that for many immigrants seemed very far from what happens in their country of origin. One of the reports revealed that in the immigrants' country of origin, more routine exams were carried out in case of complaints, a fact that may be related to the cultural way of understanding the pregnancy and birth process, as shown in the study carried out in Norway with immigrants from southern Europe. In the referred study, it was found that the view of pregnancy as a health problem requires more interventionist assistance, which does not occur in Norway, as there this process is treated as something natural, which focuses on the body's ability to self-adjust, directly reflecting on the organization of services and the performance of health professionals<sup>(5)</sup>.

In addition to the functioning of the health system, there is the work process of nurses, which despite having similarities with other countries, is influenced by historical, economic, political, legal, health care model and work organization. Understanding the expectations and vision of immigrant women about nursing work favors care<sup>(26)</sup>.

The study setting, Foz do Iguaçu, brought specific components expressed by cross-border mobility, resulting in the overload of Brazil's health service, due to its universal and free nature, which in a certain way may have compromised the comprehensive care provided to immigrant pregnant women and women in labor<sup>(27)</sup>.

The results addressed the indication that women consider the guidance of health professionals to be relevant compared to that of their family members. Even so, health professionals need to validate the role of the family as a basic unit of cultural care, consisting of standardized and learned values, beliefs and ways of life<sup>(28)</sup>. Furthermore, it is necessary to value women's prior knowledge in care practices, avoiding the imposition of professional knowledge, as highlighted in the Dutch study<sup>(29)</sup>. The greatest cultural differences were observed between immigrants from Haiti and Lebanon in the present study.

In the municipality where the study was carried out, a significant portion of the population also comes from Arab Muslim countries. Religion is conceptualized by Leininger as a structuring factor in each individual's worldview. Thus, nurses must be aware of the cultural and religious factors involved in this segment to provide culturally competent and appropriate health care<sup>(7,8)</sup>.

For culturally competent care, it is not necessary to have in-depth knowledge of all cultures or to always accept the beliefs of a patient or a group. Culturally competent care emphasizes respect for cultural differences and provides support to understand how this interferes with care standards, allowing us to admit that there are many ways of living and seeing the world, and that no way is the best or correct way<sup>(7)</sup>.

The results of this study reinforced the need for nurses to know the customs, cultures and beliefs that can interfere with the gestational process and birth. In this sense, cultural preservation, accommodation and restructuring measures become promising strategies, consolidating culturally congruent care<sup>(7,30)</sup>. The study conducted in the Netherlands highlighted the relevance of giving a voice to those in need of care, listening to their experiences to understand their expectations, especially during pregnancy and childbirth, as this can guide nurses' conduct and define an effective and culturally competent care plan<sup>(29)</sup>.

Understanding the theoretical framework of TDUCC, where care is defined by the understanding of diversity (inequality) and universality (equality) between cultures, in addition to situations of vulnerability common to immigrant women, made it possible to identify the singularities of each experience and their cultural background<sup>(7,9)</sup>. It is important to emphasize that cultural factors related to care influence human expressions regarding health, illness and well-being. In this context, TDUCC is a fruitful path, as it provides harmonious care with individual or collective beliefs, practices and values<sup>(7)</sup> to achieve practical success in health actions.

Cross-cultural care constituted an important care tool and stood out in moments such as birth, considering the need to adopt healthier habits to protect newborns<sup>(9)</sup>. The

TDUCC favors its understanding as a natural process and supports nurses in helping immigrant women through all the transformations experienced at this singular moment in their lives.

A limitation of the study was conducting interviews with nurses only, since knowing the experiences of other health professionals from a border region could reveal in greater depth the challenges for care in the cross-cultural context. In this regard, new investigations are suggested with the inclusion of other health professionals, in other regions of the country or the world, given that sociocultural conditions may be different. Another limitation is that the investigation concerned only the pregnancy and childbirth period, since the postpartum period could provide additional insights.

## ■ FINAL CONSIDERATIONS

The results of this study revealed the Social and Cultural dimension that influences care and health, expressed by economic difficulties, precarious work, language, religious customs, cultural differences and lack of knowledge of the Brazilian health system, helping to understand experiences and vulnerabilities of immigrant women during pregnancy and childbirth and their impact on care. Potentialities were also experienced, evidenced by the positive aspects in transcultural nursing care in Brazil during the pregnancy-puerperal cycle.

The COVID-19 pandemic has intensified difficulties, especially in creating social bonds and a support network, situations aggravated by the distance from family in this critical period for humanity, as well as hindering access to health services.

The use of TDUCC made it possible to understand the multicultural scenario of the study and support the establishment of common points (universalities) experienced by immigrant women during pregnancy and childbirth, as well as the diversity (difference) peculiar to each culture, in addition to the acculturation process they experienced.

Madeleine Leininger's TDUCC contributed to identifying the cultural factors considered by nurses, highlighting the need to enhancing cultural understanding.

Culturally training health professionals, directing specific health education actions to the immigrant population and developing health protocols and policies that consider this population and its cultural aspect can improve maternal health care and reflect in better morbidity and mortality indicators.

As suggested by Leininger, cultural aspects and patterns of care must first be discovered so that a body of cross-cultural knowledge can then be established. In this process of



discovery, both similarities and differences were identified, as highlighted by the present study, strengthening care from a multicultural perspective during pregnancy and childbirth of immigrant women.

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The authors declare that there is no conflict of interest.

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Received: 07.29.2023

Approved: 11.27.2023

**Associate editor:**

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