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ORIGINAL PAPER

# Immigrant Women's Perspective on Prenatal and Postpartum Care: Systematic Review

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**Abstract** Female migration represents a major public health challenge faced today because its heterogeneity and gender issues placing immigrant women among the most vulnerable and at-risk group. To identify and analyze studies dealing with immigrant women's perspectives with prenatal and postpartum health care. A systematic literature review was conducted to assess studies published between 2000 and 2010 using Cumulative Index to Nursing and Allied Health Literature, EMBASE, PubMed and Cochrane Database of Systematic Reviews. The studies explored the relation between socio-demographic characteristics of immigrant women participants and its impact on the main factors identified as influencing prenatal and postpartum care, characterizing the manifested knowledge and behaviors expressed and describing the women's experience with health care services and the incidence of postpartum depression symptoms. The less favorable socio-economic status of migrant women participants seems to have been influential in the quality of health service in prenatal and postpartum periods. The language barrier was the main negative factor interfering with communication between women and health professionals, followed by health care professionals' lack of cultural sensitivity, leading to women's reluctance in using health services.

**Keywords** Immigrants women · Prenatal care · Postpartum care · Women's health · Systematic review

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## Background

Currently, international mobility is a dynamic phenomenon with over 214 million people migrating from origin to host countries in 2010. According to the International Organization for Migration, every country needs to recognize its responsibility to develop effective and human policies geared towards the well-being of current and future migrants [1].

Regarding the health of the immigrant population, the literature suggests that their health status depends on different determinants present at each phase of the migratory process such as the individual's psychological and social resources, the type of migration and the host society characteristics and host country reception conditions [2]. Thus, focusing on motherhood in the context of migration, immigrant women tend to rely less on prenatal and postpartum care services leading to an increased incidence of complications during pregnancy and the postpartum period [3, 4].

The studies also show that immigrant women present higher incidence of depression and psychosis [3, 4] whose prevalence appears to be related to self-perception of their experiences [5]. In fact, immigrant mothers are often divided between traditional habits acquired in their families (sometimes considered as outdated or inadequate welfare of the child in host country) and practices suggested or imposed by host countries, which does not always make sense to those mothers [3].

Regarding the quality of health services offered to immigrant population in host countries, research has shown that improving the accessibility and use of health services leads to better outcomes for the health of women and children [1], a strategy to reduce vulnerability to these two groups.

Therefore emerge the need to characterize the status and health practices of different immigrant groups and, more specifically, the need to understand the immigrants' perception about health service and care received by healthcare professionals. To meet these needs, there is increased interest in conducting a systematic literature review aimed at identifying studies focused on the immigrant women's perspective on health care services received in prenatal and postpartum in host countries through the following research question: What are the perspectives of immigrant women about health care provided during prenatal and postpartum periods?

## Methods

### Aims

To identify and analyze empirical studies dealing with the immigrant women's perspectives with prenatal and postpartum health care in host countries.

### Research Strategy

The systematic literature review was used to evaluate the data obtained from studies addressing the issue of immigrant women's experience with health care in prenatal and postpartum periods. We present their research evidence and followed the steps described in the Cochrane Database of Systematic Reviews [6, 7]. Using PI[C]OD strategy [8], the following research question was used as the basis for the review: What are the perspectives of immigrant women about health care provided during prenatal and postpartum periods?

Thus, as the first step in this process, the literature review protocol was built and used to organize this work. The following research question was used as the basis for the review: What are the perspectives of immigrant women about health care provided during prenatal and postpartum periods? This question was based on the PI[C]OD strategy in which each acronym is considered a key element of the research question for the literature search, maximizing the recovery of the best available scientific information [8].

### Inclusion and Exclusion Criteria

Taking into consideration the research guiding elements the following inclusion criteria were considered: regarding the types of participants—studies on immigrant women who had experienced a pregnancy and/or postpartum in a foreign country, with health care; studies that focused on women in the period from 18 to 49 years, the reproductive lifespan. Regarding the intervention types—studies that focused in healthcare provided to immigrant women during the prenatal and postpartum periods or that reported on one of these periods; regarding the outcomes—studies that examined the experiences of immigrant women who received health care during pregnancy and postpartum period, however, only from the women's perspective; regarding the study design—qualitative and quantitative studies. Chronological criteria were also used with the inclusion of studies published between January 2000 and 2011.

In addition, the following exclusion criteria were applied: studies of immigrant adolescent women in situations of pregnancy, motherhood or abortion.

The option to exclude studies on adolescent pregnancy is due to the fact that the experience of teenage pregnancy introduces simultaneously two developmental crises that comprises the life cycle of the female gender, where the situational crisis that characterizes pregnancy and motherhood overrides the maturational crisis of the adolescence [9].

### Databases Searched and Keywords

The following scientific research databases were used as the most relevant scientific resources [8, 10]: Cumulative Index to Nursing and Allied Health Literature (CINAHL), Cochrane Database of Systematic Reviews (CDRS), EMBASE and PubMed. The search was conducted on April 27, 2011 using MeSH vocabulary and a combination of the PI[C]OD strategy elements, using the Boolean operators (AND, OR and NOT).

It was used the following search terms: [("immigrant women" OR "immigrant woman") AND (pregnancy OR maternity OR "prenatal care" OR "postpartum care" OR "puerperal care" OR culture OR belief) AND NOT (puberty OR abortion)]. The search was combined in title, subject term or keyword and abstract.

### Search Results

Study selection was conducted in two distinct, consecutive and complementary phases, according to the guidelines used [6, 7, 11, 12] and was conducted by two researchers. From these two phases, the following procedures are highlighted.

In Phase 1, after applying the search expressions, 201 studies were retrieved. Thus, given the previously outlined research question and the inclusion and exclusion criteria, the selection results were refined and 147 studies were directly rejected (Test de Relevancy I) [12].

During Phase 2, the abstracts of the pre-selected 54 studies were read and analyzed. Then, 32 studies were rejected for reasons related to study population (thirteen); to study intervention (nine); targeting immigration policies

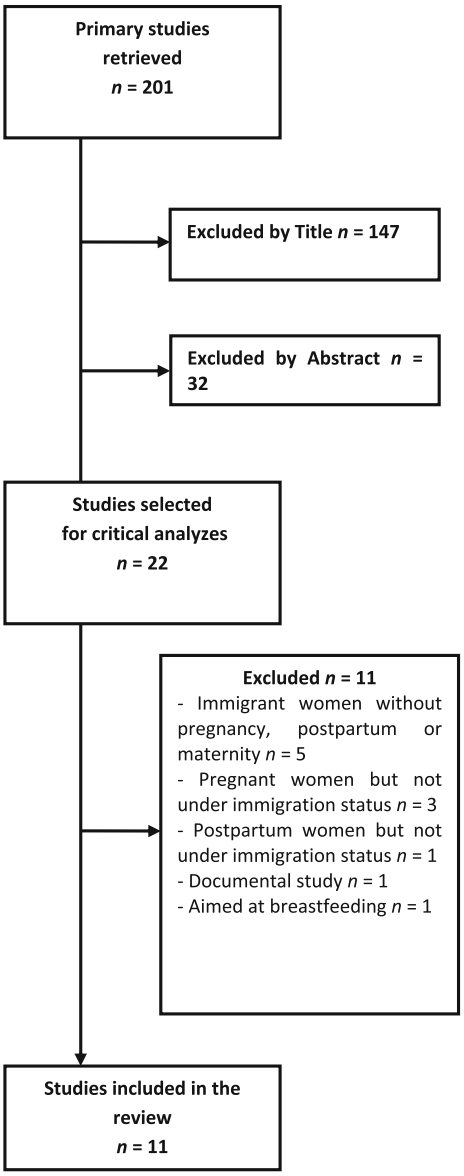


**Fig. 1** Flowchart of selection process

(one); focusing on the perspective of the nursing profession (six); English language comprehension difficult (one), by repeating (two), with the remaining 22 studies kept for further critical evaluation (Test Relevancy II). [12].

During the review of each study, information was extracted that characterized different aspects considered relevant to the research question, using Test Relevancy III as a guideline [12], which proposes the following questions of interest: Is the problem clearly defined? Are the objectives related to the issue being targeted by the systematic review? Is the methodology clearly described? Another question was also added: Do the participants meet the criteria set forth in this systematic review?

After applying Test Relevancy III, 11 studies were excluded for the following reasons: five studies were related to immigrant women, but without the context of pregnancy, postpartum or maternity; three studies focused on non-immigrant pregnant women; one study was related to non-immigrant postpartum women; one was a literature review and another was a breastfeeding study. At the conclusion of this phase of the study selection process, of 201 studies initially selected, only 11 studies were used in this systematic review, as represented by the flowchart diagram in Fig. 1.

## Results and Discussion

[Tags: Immigrant women, prenatal period, host country, pregnancy, prenatal care, health behavior, postpartum period, accessibility, postpartum depression]

Table 1 schematically shows the results analyzed from each of the 11 studies included in this review, regarding: identification of the study, type of study, objectives, participants, method and context of data collection and results. And furthermore, in order to characterize the level of evidence of each study we used the classification of seven levels of evidence namely: Level 1—systematic review and meta-analysis of all relevant RCTs; Level 2—evidence from at least one RCT well delineated; Level 3—well-designed clinical trials without randomization; Level 4—well-designed case–control and/or cohort studies; Level 5—systematic reviews of descriptive and/or qualitative studies; Level 6—derived from a single descriptive or qualitative study; Level 7—opinion of authorities and/or reports of expert committee. [13].

In the established time period of 2000–2011, the majority of studies (six) were conducted from 2006 to 2009 (two in 2006, three in 2008 and one in 2009). The majority of studies were from the USA (six), with two from Canada, two from Taiwan and one from Australia. The majority of the studies (six) fit into an inductive paradigm using a qualitative methodology, four into a deductive paradigm with a quantitative methodology and one adopted a mixed methodology. Among them three studies were cross-sectional, four were exploratory and one was descriptive.

All the studies focused on identifying the health needs of immigrant women during motherhood in the host country, with the majority (six) being restricted to the prenatal period, two to the postpartum and three relating to both periods. The majority of the studies (six) focused their research on immigrant women originating from certain geographic areas. Three studies sought to compare similarities and differences between immigrant and local women and one between different ethnic groups. Among the different data collecting methods, the interview was the most commonly used (six), followed by the questionnaire (five), in which one complemented the interview;

**Table 1** Summary of data relevant for the study analysis

| Study (author, data) country | Type of study | Objectives | Participants | Method | Results | Evidence levels |
|---|---|---|---|---|---|---|
| Lee et al. [18] Taiwan | Quantitative: transversal exploratory | To describe and explore the determinants of prenatal care of Vietnamese immigrant women in Taiwan | Vietnamese immigrant women ($n = 101$) | Vietnamese and Chinese questionnaire<br>*Data collection context*: health institutions and participants' homes | Young participants and early pregnancy in relation to reproductive period<br>Adaptation to life in Taiwan, the perception of the importance of prenatal care and the feeling of loneliness were the main factors influencing prenatal care | Level III |
| Lin et al. [19] Taiwan | Quantitative: transversal | To compare pregnant immigrants from southeast Asia and Taiwan in relation to knowledge and attitudes toward pregnancy, experiences with the health services and prenatal health behavior | *2 groups:*<br>Total $n = 259$<br>Southeast Asian immigrant women ($n = 132$)<br>Taiwanese women ($n = 127$) | Questionnaire structured with 5 scales: DIS, KPS, APS, EMSS, PEBS<br>*Data collection context*: outpatient health services and participants' homes | Vietnamese immigrants with large representation<br>Southeast Asian immigrants' scores were lower than Taiwanese in relation to knowledge and attitudes towards pregnancy and health services experiences (lowest access to services, shorter waiting times for prenatal care consultation and lowest requirements for obtaining insurance coverage)<br>Scores relating to prenatal health behaviors were significantly lower in southeast Asian immigrants who did not have prenatal care in thefirst trimester and who did not have regular prenatal care | Level II |
| Griffiths and Kuppermann [20] USA | Qualitative | To analyze the understanding of rural Latin America (Latin) on prenatal testing, birth defects and risks in the context of alpha-fetoprotein screening decision | Hispanic/Latin immigrant women ($n = 33$) | Semi-structured interviews, in depth, in Spanish and English<br>*Data collection context*: prenatal care clinics | For the majority, alpha-fetoprotein screening was perceived as a routine prenatal care and as important to the "health of the baby"<br>The majority had alpha-fetoprotein screening, one-third understood the result of this test as a risk estimate and one-third believed it was a diagnostic test<br>For most of these women, the personal risk of having a child with a congenital defect was related to destiny, fate or divine influence, but due to the risks, they chose not to undergo amniocentesis or to terminate the pregnancy | Level VI |
| Reitmanova and Gustafson [23] Canada | Qualitative: exploratory | To document and explore maternity health needs and health services accessibility barriers of Muslim immigrant women residing in St. John's, Canada | Muslim women ($n = 6$) | Semi-structured interviews, in depth, in English<br>*Data collection context*: participants' homes | Women had experienced discrimination, insensitivity and lack of knowledge regarding their religion and cultural practices when they received maternal health care | Level VI |
| Sword et al. [15] Canada | Quantitative: transversal | To describe the health of immigrant postpartum women, their needs, access and services received in the first 4 weeks after hospital discharge, compared with women born in Canada | *2 groups*:<br>Total $n = 1250$<br>Immigrant women ($n = 391$)<br>Canadian women ($n = 856$) | Questionnaire in English, French, Spanish and Chinese, with 3 tools: EPDS, DFSSQ and HSSUQ<br>*Data collection context:* by telephone | Immigrant women reported worse general health status, with EPDS scores suggestive of possible postpartum depression, with knowledge needs significantly higher greater difficulty in identifying financial aid, less family support, less social support and financial assistance | Level II |
| | Quantitative: descriptive | To determine the incidence of symptoms of postpartum depression in a sample of immigrant women from India<br>To determine whether cultural factors, such as marriage or newborn gender, are associated with differences in depression scores | Indian immigrant women ($n = 58$) | QuData collection contextestionnaire of the scale (PDSS)<br>*Data collections*: private clinics | Previous history of depression was reported<br>In accordance with other studies concluded that Asian women in India are more prone to postpartum depression than other ethnic groups | Level III |

**Table 1** continued

| Study (author, data) country | Type of study | Objectives | Participants | Method | Results | Evidence levels |
|---|---|---|---|---|---|---|
| Goyal et al. [14] USA<br>Tandon et al. [24] USA | Mix | To verify whether Hispanic mothers are less likely to perceive client-centered prenatal care than non-Hispanic mothers<br>To better understand the perceptions of Hispanic women about this centrality of prenatal care received | Hispanic and non-Hispanic mothers ($n = 427$) | Semi-structured interviews, in Spanish and English<br>*Data collection context*: Hospitals, 24–48 h after childbirth | Hispanic mothers had fewer opportunities than non-Hispanic mothers to perceive whether doctors and nurses treat them with respect during their prenatal care<br>Hispanic mothers were more likely to experience language and communication problems with doctors and nurses during the prenatal care<br>Lack of client-centered prenatal care influenced Hispanic women's desire to continue to perform prenatal care visits. | Level V |
| Rolls and Chamberlain [16] Australia | Qualitative | To gather information about birth and parenting experiences of Nepalese women in their country of origin and in Australia | Women from a Nepalese community ($n = 11$) | Interviews and participant observation<br>*Data collection context*: Homes and worship places | Women appreciated the Australian health system, its facilities, equipment and technology provided in the hospitals, believing that these factors contribute to their and their families' quality of health | Level VI |
| Shaffer [22] USA | Qualitative: exploratory | To explore factors that influence access to health care of pregnant Hispanic women | Pregnant Hispanic women<br>($n = 46$) | Interviews with 5 open questions in Spanish<br>*Data collection context:* Directly or via telephone during the prenatal period | The ability of health care professionals to communicate in Spanish, as well as the availability of culturally-sensitive prenatal care were considered the main factors influencing the willingness of these women to adhere to prenatal care | Level VI |
| Peacock et al. [21] USA | Qualitative: exploratory | To articulate key concepts and issues encountered in this process and qualitatively describe similarities and differences across cultural groups | Women of cultural groups: African-American, Mexican, Puerto Rican and white ($n = 87$) | Eight focus groups<br>(each with 8 to 12 participants)<br>A focus group with Mexican women in Spanish and the others in English<br>*Data collection context*: Within the community | The majority of women reported that pregnancy was not planned<br>Most women Mexican and some women from Puerto Rico were immigrants and in the other cultural groups were women born in USA<br>The main determinants of early versus late prenatal care was late recognition of pregnancy and lack of knowledge about signs and symptoms of pregnancy, with<br>The social support network (friends, family) had a major influence in the coping mechanisms of women to a take positive action toward pregnancy | Level VI |
| Yeo et al. [17] EUA | Qualitative | To describe the role of cultural differences with a child's birth for expatriate Japanese couples in the USA<br>To analyze the implications of culturally-competent care | Japanese couples (11) ($n = 22$) | In depth interviews at 2 different times: once during prenatal care and again during the postnatal period (4 weeks after childbirth) and questionnaires<br>*Data collection context*: Directly or by phone | The majority of women revealed that someone would come from Japan (usually the woman's or spouse's mother) to help during childbirth and in the early postpartum days<br>Major medical and cultural implications emerged including: the language barrier, the need for episiotomy and the use of epidural analgesia because Japanese women were socialized to accept pain during labor and do not feel safe due to possible harm to the baby<br>American doctors are less authoritarian and more humane than Japanese doctors; nurses are friendly, knowledgeable and provide individualized/humane care; women expressed that American health care teams are highly efficient | Level VI |

participant observation (two) in addition to the interview and one study with eight focus groups. The language used by the researchers during data collection was dependent on the participants' background and their competence to communicate in the host country's language, resulting in questionnaires and interviews in different languages. Among the data collection contexts, direct contact (face-to-face) with the participants was predominant, either at their home (four) and health centers (five) or by phone (three). Two studies directed toward the postpartum period used scales as instruments of data collection [14, 15].

## Participants

To obtain a more detailed look at the participants' characteristics across different studies it was noted that only two of the studies focused on a specific ethnic group: the study from Australia, which focused on Nepalese women [16] and one from the USA, which focused on a Japanese community [17]. The authors indicated that the motivation for these studies was the lack of knowledge and research about these cultural groups in the host countries. The majority of the studies related to ethnic groups from certain geographic areas, with two studies from Taiwan reporting on ethnic groups from southeast Asia [18, 19]; four studies from the USA focused on ethnic groups from Latin America [20, 21]. According to these authors, the lack of knowledge, research and the significant influx of these populations into the host countries were the motivation behind their studies.

Regarding the mean age of the participants, the younger women were African-American, with a mean age of 19.5 years [21], and the older women were Japanese, with a mean age of 32.9 years [17]. Among the 11 studies included in this review, three studies had participants who were pregnant, six in postpartum and two studies chose participants in both periods.

Length of residency in the host country among participants ranged from 2 months [22] to 10 years [15]. Participants with the lowest levels of education were among the southeast Asian and Hispanic groups, and the most educated were the Nepalese women [16]. In these studies we find that immigrant women were usually married or cohabiting. Among the participants who became pregnant early during their marriage, the majority belonged to the southeast Asian ethnic group [18, 19]. Employment status varied among women in these studies. It was observed that all Muslim women were stay-at-home mothers [23] and most southeast Asian (Vietnamese) women did not work [18].

## Studies on Immigrant Women During the Prenatal Period

The analysis and comparison of the main results from studies focused on the prenatal period (Table 1) highlighted four main areas of consideration: the sociodemographic characteristics of immigrant women in the host country, previously described; the determining influencing factors in prenatal care; knowledge and behaviors toward pregnancy; and the women's experience during prenatal care.

### *Determining Influencing Factors in Prenatal Care*

The researchers' desire to explore the main influencing factors in prenatal care of different ethnic immigrant women was common to all studies. They used as indicators the moment of the first prenatal consultation and the frequency of prenatal monitoring [18]. It was observed that immigrant women from southeast Asia, especially from Vietnam, began prenatal care in the first trimester of pregnancy and followed the host country recommended prenatal care schedule [18]. Other studies showed less favorable results in terms of proper start and frequency of prenatal care [19, 21].

Immigrant women mentioned the following main factors as influencers of health behaviors during pregnancy in the host country: language barrier, adapting to life in the new country, awareness of prenatal care importance, negative emotions (loneliness), accessibility to health services and lack of information and respect from health professionals toward the customs and cultural practices of immigrant women.

### *Knowledge and Behaviors Toward Pregnancy*

Southeast Asian participants were among the immigrant women who expressed the least knowledge about pregnancy and lack of awareness about the characteristic signs, symptoms and warnings. The lack of knowledge was due to the fact that they were experiencing pregnancy for the first time at the youngest age [18, 19], they have lack of understanding about proper nutrition [19] and they had inadequate experience with self-care and safe use of medication [19, 20]. Another relevant fact, highlighted in some of the studies, was the lack of pregnancy planning among southeast Asian women, who frequently had children soon after marriage [18, 19], and among African-American and white American women, who were often single mothers [21]. The data demonstrated the influence of cultural beliefs in the behaviors of pregnant immigrant women, such as the use of protection pins or amulets by Hispanic or Latin immigrant, and the association of birth defects with destiny, chance, divine influence or natural phenomena [20].

### *Women's Experiences During Prenatal Care*

The main purpose of the studies was to understand how immigrant women express their experiences during

prenatal care. This understanding helps to identify the conditioning and/or satisfaction factors in improving the health quality of the mother and the fetus throughout the pregnancy. The language barrier emerged as the key factor across all reported experiences, especially among immigrants living a short time in the host country [17, 19, 24] or with low levels of acculturation [20, 23]. Factors that negatively influenced adequate prenatal care include consultation waiting time, operation hours, requirements for obtaining health insurance [19, 22, 24], and available information on the different health practices inherent in prenatal care, as exemplified by the screening tests [20] and existing prenatal classes [23]. It is evident that the language barrier not only compromises the abilities of immigrant women with low language skills to understand the information given to them by health care professionals, but also the women's abilities to express their questions, concerns and symptoms. On the other hand, it is clear that these women needs that physicians and nurses understand their beliefs, customs and cultural practices. Muslim and Hispanic immigrant women reported having experienced discrimination, insensitivity and lack of knowledge regarding their religion and cultural practices during prenatal care [22, 23], and the inappropriate comments of health care professionals were considered the main influencing factors in the satisfaction and willingness to continue the prenatal care [22].

In contrast, some studies showed that immigrant women also demonstrated satisfactory and positive experiences during the prenatal care, as in the study of Nepalese women. These women revealed their appreciation for the Australian health care system, its facilities, equipment and technology, believing that these factors contributed to them and their families' health quality [16]. In the view of participant Japanese women, American physicians were less authoritarian and more human than their Japanese counterparts; nurses were friendly and supportive with knowledge and provided individualized and human care [17].

## Studies on Immigrant Women During the Postpartum Period

During the analysis and comparison of studies focused on postpartum and those focused on prenatal periods, two points were prominent: the needs, accessibility and health care received; and the incidence of postpartum depression risk symptoms.

### *Needs, Accessibility and Received Health Care*

Considering that only two of five studies focused on the postpartum period, many aspects previously mentioned in the prenatal period were identified during the postpartum period. However, the data were accurate in the particularities that immigrant women indicated during the postpartum period, such as: the need for social and emotional support from health care professionals, particularly in the first weeks, was often expressed in all studies; the need for knowledge and financial support [21, 23]; the need for sleep, relaxation and child care help during the hospital stay were emphasized, however, the care received from the nursing staff was variable [23]. At home, these needs remained, and women frequently sought support from informal social networks (e.g., immigrant community, friends and neighbors) because of the lack of health care assistance and information about postpartum care and the lack of family support [23], which was considered important for women of different ethnicities [17]. According to the data, cultural issues, beliefs and values becoming even more pronounced during the postpartum period due to the safety of self care and childcare practices performed in the country of origin [23]. The duality of attitudes and behaviors between women's own cultural teachings and the teachings by health care professionals led immigrant women to opt for their customs and to feel less satisfied with the postpartum health care [17, 23].

### *The Incidence of Postpartum Depression Risk Symptoms*

The two studies that reported on the health needs of immigrant women only during the postpartum period showed, through the use of measuring instruments, that these women tended to have a worse general health status with Edinburgh Postnatal Depression Scale (EPDS) scores suggesting possible postpartum depression [23]. As screened for post-natal depression EPDS has proven to be an effective diagnostic tool. However, since the limited positive predictive value of EPDS lies between 44 and 73 %, the National Institute for Clinical Excellence (2007) guidelines advise healthcare professionals to use self-report measures such as EPDS, Hospital Anxiety and Depression Scale [25] or Patient Health Questionnaire [26] for assessing and monitoring outcomes of post-natal depression, instead a particular screening tool [27]. One of the studies reported certain ethnic groups being more susceptible to postpartum depression symptoms, such as the women from India [15]. In fact it would be important to develop a valid and reliable instrument to predict onset of mild, moderate or severe post-natal depression [27].

Both studies are in line with the large number of empirical studies in recent decades that show the presence of higher incidence of postpartum depression factors taking into consideration psychosocial circumstances, such as studies focusing on teenage mothers [28], focused on social adversities [29, 30], or on lack of social support [31], among other factors.

However, postpartum depression sometimes is reported as a distinct psychological state, inherently linked to childbirth, and by others as part of a continuum, multi-layered in terms of definition and aetiology [27].

## Conclusions

[Tags: Immigrant women, systematic review, literature review, health behavior, pregnancy, postpartum period, prenatal care, health services, health care]

This systemic literature review provides a important understanding of certain ethnic groups of concern to researchers from the countries studied, where there are significant influxes of immigrant women to the host countries. By analyzing the factors that influenced the health behavior of immigrant women during the pregnancy and postpartum periods, it was possible to identify socio-economic factors that, when negative, influenced the health quality of immigrant women because of inadequate use of health services. In contrast, more significant cultural issues emerged in women with low levels of acculturation who, because of language barriers and less positive interpersonal relationships with health care professionals, were not satisfied with the health services and did not adhere to the host country's recommended health care during pregnancy and postpartum period.

Data collected allowed the identification of gaps in the established intercultural relations, not only by the frequent lack of cultural competence, but also by the lack of respect for other people's cultural identities. Currently, women's health remains one of the major public health challenges at the regional and global levels. Particularly because of the maternal and family roles they assume in most societies, women continue to be an important pillar in the sustainable development of the societies of which they are a part.

This study show that a multicultural organization of health care should encourage and enhance cultural differences where the communication between healthcare professionals and immigrant women during prenatal and postpartum care had a significantly influence in their relationship with healthcare professionals and in the quality of health results.

The present systematic review evaluates the relationship between how care is given regarding sensitivity to cultural differences and how that sensitivity influences a higher prevalence of health risks in prenatal and postpartum period. Further research should identify the perceptions of healthcare professionals about interpersonal relationships established in intervention contexts.

## Contributions to the Literature

Health care during prenatal and postpartum care should be more proactive in enabling the assessment of potential and real health risks and should focus toward the cultural group to which each immigrant women belongs. Regarding the health care needs expressed, considering the nurse/patient care relation and the multicultural practice, new strategies can be developed at health care level that will respond to the expectations stated by the participants.

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