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Immigrant women's satisfaction with childbirth care in Brazil

Satisfação das mulheres imigrantes com a assistência ao parto no Brasil

Satisfacción de las mujeres inmigrantes con la atención durante el parto en Brasil

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ABSTRACT

Objective: to evaluate immigrant women's satisfaction with childbirth care in Brazil. **Method:** this qualitative study was guided by Donabedian's theoretical framework. Interviews were conducted with 14 immigrant women, and their statements were analyzed using the Collective Subject Discourse method. The research protocol was approved by the Research Ethics Committee. **Results:** five core ideas were identified and grouped into two themes. Theme 1, satisfaction with healthcare services, included the following core ideas: evidence-based practices and the role of the healthcare team; comparisons to previous experiences in other countries; the assurance of respectful reception and accessible healthcare for immigrant women. Theme 2, dissatisfaction during childbirth, included the following core ideas: dissatisfaction with medical interventions and inadequate infrastructure. **Final considerations:** the women expressed satisfaction with certain aspects of the childbirth experience; however, they also identified significant shortcomings that impact the quality of obstetric care.
Descriptors: Obstetric Nursing; Hospitals, Maternity; Quality of Health Care; Patient Satisfaction; Emigration and Immigration.

RESUMO

Objetivo: avaliar a satisfação de mulheres imigrantes acerca da assistência ao parto no Brasil. **Método:** estudo qualitativo, sob o referencial teórico de Donabedian. Foram realizadas entrevistas com 14 mulheres imigrantes, submetidas à análise Discurso do Sujeito Coletivo. O protocolo de pesquisa foi aprovado pelo Comitê de Ética em Pesquisa. **Resultados:** obteve-se cinco ideias centrais agrupadas em dois temas. O tema 1, satisfação com o atendimento dos serviços de saúde, teve como ideias centrais: práticas baseadas em evidências científicas e o papel da equipe de saúde; comparação entre vivências anteriores em outros países; e acolhimento e garantia da assistência em saúde à mulher imigrante. O tema 2, insatisfações durante o processo de nascimento, teve como ideias centrais: descontentamentos em relação às intervenções; e espaço físico inadequado. **Considerações finais:** as mulheres mostraram-se satisfeitas com alguns aspectos do nascimento, porém, pontuaram fragilidades importantes que apresentam impacto na qualidade da assistência obstétrica.
Descritores: Enfermagem Obstétrica; Maternidades; Qualidade da Assistência à Saúde; Satisfação do Paciente; Emigração e Imigração.

RESUMEN

Objetivo: evaluar la satisfacción de las mujeres inmigrantes con respecto a la atención durante el parto en Brasil. **Método:** estudio cualitativo, basado en el marco teórico de Donabedian. Se realizaron entrevistas a 14 mujeres inmigrantes, sometidas al análisis del Discurso del Sujeto Colectivo. El protocolo de investigación fue aprobado por el Comité de Ética en Investigación. **Resultados:** se obtuvieron cinco ideas centrales, agrupadas en dos temas. El tema 1, satisfacción con la atención de los servicios de salud, tuvo como ejes centrales: prácticas basadas en evidencia científica y el rol del equipo de salud; comparación con experiencias previas en otros países; y acogida y garantías de atención sanitaria a las mujeres inmigrantes. El tema 2, insatisfacción durante el proceso de parto, tuvo como ideas centrales: insatisfacción con relación a las intervenciones; y espacio físico inadecuado. **Consideraciones finales:** las mujeres se mostraron satisfechas con algunos aspectos del parto, sin embargo, resaltaron debilidades importantes que impactan en la calidad de la atención obstétrica.
Descriptores: Enfermería Obstétrica; Maternidades; Calidad de la Atención de Salud; Satisfacción del Paciente; Emigración e Inmigración.

INTRODUCTION

Childbirth is a profoundly meaningful experience for women, as it involves physical, emotional, and psychological dimensions. As such, women in labor should be recognized by healthcare professionals as the protagonists of this deeply personal process of bonding with their baby, while healthcare services must provide humanized, woman-centered care that responds to their unique needs[1].

In this context, cultural aspects should also be considered during childbirth, as pregnancy and birth are experiences deeply rooted in traditions and values that carry profound personal significance for women. Therefore, it is crucial to acknowledge and respect cultural diversity while delivering high-quality, evidence-based care that protects women's autonomy and fosters a positive, fulfilling birth experience for every woman in labor[2,3].

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The migration phenomenon has been on the rise in many countries, mainly driven by environmental disasters as well as political and economic crises[4]. After restrictive immigration measures were implemented in the United States and France, Brazil has become a refuge for many immigrants in recent years. Moreover, the new Brazilian migration policy ensures an expansion of immigrants' rights, thereby making the prospect of living in the country more appealing. According to data from the International Migration Observatory, approximately 1,085,673 immigrants were registered in Brazil between 2011 and 2019, predominantly individuals from Latin America, with notable numbers of Haitians and Venezuelans[5].

The 1988 Brazilian Federal Constitution establishes health as a right for all and a duty of the state, guaranteeing universal access to the Unified Health System (SUS) for all individuals, including migrants and refugees. However, cultural differences, communication barriers, lack of documentation, along with racism and xenophobia, pose significant challenges to immigrants' access to healthcare services in Brazil[6].

Given this context, it is essential to explore the childbirth experiences of immigrant women in Brazil to identify their sources of satisfaction and needs, thereby informing the development of strategies that provide quality care grounded in ethical, cultural, and moral principles.

Therefore, this study aimed to assess immigrant women's satisfaction with childbirth care in Brazil.

THEORETICAL FRAMEWORK

This study's theoretical framework draws on the foundational work of Avedis Donabedian, who conceptualizes healthcare quality through three key components: structure, process, and outcome[8].

To evaluate the framework known as the "Donabedian triad", it is essential to carefully consider the distinct aspects of each item. Regarding structure, the assessment focuses on the physical environment, human resources, available equipment, information systems, and organizational elements of the healthcare service that affect the quality of care. As for process, it encompasses all activities and interactions between the healthcare service and the patient, including communication, clinical practices, and adherence to protocols and guidelines. Finally, the outcome is assessed through clinical evaluation, encompassing both improvements in the patient's health and non-clinical aspects, such as patient satisfaction with the care provided. Each element inevitably influences the others; in other words, the quality of the structure shapes the process, which in turn affects the outcomes[8].

The seven pillars of quality proposed by Avedis Donabedian are essential elements for evaluating and promoting the continuous improvement of healthcare services. These pillars provide a foundation for understanding and improving healthcare quality, encompassing not only clinical outcomes but also patient experience and the overall efficiency of the healthcare system[9].

The first pillar is efficacy, which refers to the healthcare services' ability to achieve desired outcomes based on available scientific and technological advances and interventions proven beneficial to patients. The second pillar, effectiveness, refers to the practical application of efficacy in real-world contexts, considering the conditions and limitations of both the healthcare system and the patients, with the aim of achieving the best possible outcomes within the available constraints and resources. Efficiency, the third pillar, relates to the rational and economical use of resources, aiming to maximize benefits at the lowest possible cost without compromising the quality of care. The fourth pillar, optimization, refers to achieving the best balance among quality of care, costs, and outcomes, striving for maximum efficiency and effectiveness in healthcare delivery. Acceptability, the fifth pillar, refers to the alignment of healthcare services with patients' expectations and values, encompassing factors such as accessibility, respect for dignity and privacy, and active patient involvement in care, all aimed at ensuring a positive experience for those receiving treatment. The sixth pillar, legitimacy, reflects how healthcare services consistently align with established norms, regulations, and ethical standards. Finally, the seventh pillar is equity, which ensures equal access for all to healthcare services without discrimination. It also involves the fair distribution of resources and services, taking into account the specific needs of different population groups and ensuring that all patients receive care appropriate to their individual circumstances[9].

These seven pillars provide a robust framework for assessing the quality of healthcare, with the aim of delivering patient-centered care. This approach allows general principles to be adapted to the unique needs and circumstances of each individual, ensuring that interventions not only promote health but also respect and uphold each patient's individuality. Such a personalized approach maximizes the efficacy of care in promoting health, while also ensuring that patients receive high-quality, humanized experience within the healthcare system[8,9].

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METHOD

This is a qualitative study conducted in accordance with the *Consolidated Criteria for Reporting Qualitative Research* (COREQ) checklist[7].

The study was conducted in three maternity hospitals affiliated to the Brazilian Unified Health System (SUS) network, located in the southern region of Brazil—two classified as low-risk facilities and one as a referral center for high-risk pregnancies. One of the low-risk maternity hospitals is equipped with nine rooming-in beds and three LDRP beds (labor, delivery, recovery, and postpartum). The other offers 11 rooming-in beds and three LDRP beds (labor, delivery, recovery, and postpartum). The referral maternity hospital had 17 rooming-in beds and three LDRP beds (labor, delivery, recovery, and postpartum) at the time of data collection. However, this facility has recently moved to new premises, expanding its capacity to 30 rooming-in beds and nine LDRP beds (labor, delivery, recovery, and postpartum). It is important to note that all three facilities included in the study have obstetric nurses on their staff.

The participants in this study were immigrant women in the immediate postpartum period who were hospitalized at the time of data collection. The study included immigrant women who gave birth in the aforementioned maternity hospitals and had received prenatal and childbirth care in northern Paraná. Women with communication difficulties were excluded from the study.

Data collection was carried out between June and December 2023, with participants recruited using consecutive and convenience sampling methods. Immigrant women who had recently given birth at one of the selected healthcare facilities were recruited as they accessed these services, which served as the main inclusion criterion. To streamline communication, a *WhatsApp®* group was created by one of the researchers, with the participation of maternity ward nurses. The group served as a channel to inform the research team about the presence of immigrant women in the facilities.

From that point on, the researcher would visit the facility to approach potential participants in person, providing them with all necessary information and subsequently inviting them to take part in the study. Upon agreeing to participate, the women signed a Free and Informed Consent Form (*Termo de Consentimento Livre e Esclarecido* – TCLE). In the case of minors, a Free and Informed Assent Form (*Termo de Assentimento Livre e Esclarecido* – TALE) was also completed.

Data were collected through individual interviews using a semi-structured script composed of two sections: the first addressed the sociodemographic characteristics of the immigrant women, and the second contained guiding questions related study's subject-matter, namely: *"Tell me how you felt when the team informed you about your type of delivery",* and *"Tell me about your childbirth experience"*.

The interviews were conducted in a private setting to ensure participant confidentiality and were carried out by an obstetric nurse trained in interview techniques, who was not involved in the care provided at the healthcare facilities under study. Most interviews were conducted with the presence of both the researcher and the woman participant; however, three women had limited proficiency in Portuguese and were therefore accompanied by their partners, who assisted with communication. This arrangement facilitated communication without affecting the authenticity of the information shared during data collection.

It is worth noting that all interviews were recorded on a mobile phone and had an average duration of 38 minutes. At the end of each interview, the participant listened to the recording and was given the opportunity to request any necessary changes to her statements. After transcription, the participants' speech was edited for conformity with formal Portuguese grammar, without altering the meaning of their statements.

It is important to highlight that a pilot test was conducted with three women who were not included in the study given the need to make minor adjustments to the questions. Data collection concluded upon reaching theoretical saturation, defined as the point when repetition or redundancy related to the study's subject-matter emerged[10].

For data analysis, the methodological framework of Collective Subject Discourse (CSD)[11] was adopted. The process involved repeatedly reading each discourse to gain familiarity with the content and identify key expressions (KEs), which were then used to extract core ideas (CIs). To formulate the CSD, the KEs were grouped to form a coherent discourse. Connectors were employed to ensure the CSD's coherence without changing the original sentence structure as expressed by the participants.

This study is part of a larger research project entitled "Representations of Immigrant Women Regarding Obstetric Care in Northern Paraná", approved by the Research Ethics Committee. Ethical principles governing research with human subjects were strictly observed, and anonymity was maintained by assigning participants the initials "IW" (for Immigrant Woman), followed by their participant number, to prevent them from being identified and consequently exposed.

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RESULTS

A total of fourteen immigrant women participated in the study, with four receiving care at the tertiary hospital and ten at the low-risk maternity facilities. Five women were excluded due to childbirth outside the hospital setting. Additionally, two women were excluded due to communication difficulties in Portuguese and the absence of a companion during the interview, while two others declined to participate.

Among the participants, eight were Venezuelan, five Haitian, and one Cuban, with ages ranging from 13 to 40 years old. Among them, eight have resided in Brazil for more than two years, and nine have lived in the state of Paraná for over one year. Most participants had completed eight or more years of schooling and reported having a steady partner (n=13). Concerning occupation and family income, eight women reported being employed in paid work, holding positions such as production assistant, kitchen assistant, and self-employed saleswoman, with family incomes ranging from two to four times the minimum wage.

Regarding obstetric history, ten participants had two or more previous pregnancies, seven had previously experienced vaginal delivery, while four were experiencing childbirth for the first time. As for the current type of delivery, eight women had vaginal deliveries, while the remaining underwent surgical births due to the following indications: fetal distress, previous cesarean delivery, cephalopelvic disproportion, and failed induction. Only one case had no recorded justification.

From the analytical process, core ideas (CIs) emerged, which were grouped to create the Collective Subject Discourse (CSD). At the end of the analysis, two main themes were identified. The first, "Satisfaction with healthcare services", encompassed "CI 1 - Evidence-based practices and the role of the healthcare team"; "CI 2 - Comparisons to previous experiences in other countries"; and "CI 3 - Assurance of respectful reception and accessible healthcare for immigrant women". The second theme, "Dissatisfaction during childbirth", involved "CI 4 – Dissatisfaction with medical interventions"; and "CI 5 – Inadequate infrastructure".

Theme 1: Satisfaction with healthcare services

CI 1 – Evidence-based practices and the role of the healthcare team

Participants reported positive experiences with the care provided at the maternity facilities during childbirth. They highlighted the attentiveness of the healthcare team, who provided guidance and support, including communication in their native language.

> *CSD 1 – It was so different! I used the birthing ball and the tub to help relax my body. The shower helped a lot! It relieves the pain and helps the baby descend... Then I sat on that other piece of equipment. The baby dropped really quickly. I was very happy with the care I received! It was very good, it went smoothly... Everything turned out well, thank God! (IW2, IW4, IW5, IW7)*

> *CSD 2 – The team that assisted with my delivery was excellent in every way, very attentive. The nurses were kind; every fifteen minutes they would ask if everything was okay with me and the baby. They helped me and never left me alone, not even for a moment. The doctor offered me the birthing ball. They explained everything to me. They said it would be fine. The doctor spoke Spanish and talked to me. That made me feel more confident! I liked the care I received. They looked after me well. They spoke to me kindly. Everything turned out fine. (IW1, IW2, IW3, IW4, IW5, IW6, IW7, IW9, IW10)*

CI 2 – Comparisons to previous experiences in other countries

Some of the women had previously experienced childbirth in their countries of origin. Accordingly, their reports highlighted evident comparisons between obstetric care in Brazil and other countries. Certain practices stood out as positive aspects of giving birth in Brazil, such as the presence of a companion during labor, the use of non-pharmacological methods for pain relief, and the freedom to choose birthing positions. These elements contributed to a more positive and empowering labor and childbirth experience.

> *CSD 3 - Everything is different! I used the birthing ball and the tub… Here, the baby was born in the shower. I had a companion. The staff was attentive! That didn't happen in my country. I really liked the care I received! (IW2, IW3, IW4, IW8).*

> *CSD 4 - It was really good! Very quick. My previous cesarean was in my country. It took a long time and was a very bad experience! The care here is much better, unlike there, where resources are scarce now. (IW11, IW12, IW13)*

CI 3 - Assurance of respectful reception and accessible healthcare for immigrant women

Immigrant women reported feeling genuinely welcomed and respected throughout their care in Brazilian healthcare services. Some women expressed a sense of satisfaction in not encountering prejudice or discrimination during their care.

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CSD 5 - They took very good care of me. Here, we experience a much warmer reception! There's no such thing as being treated differently because I'm a foreigner. That doesn't happen. In other countries, there's more discrimination. I felt like a Brazilian; I didn't feel any prejudice at all. I'm very happy! (IW1, IW4, IW7, IW10)

CSD 6 – They treated me with great care and respect. The staff was attentive and never left me alone; they talked to me the entire time. Brazil has been very supportive! Welcoming us warmly, unlike other countries where discrimination is common. (IW1, IW2, IW3, IW5, IW7)

Theme 2: Dissatisfaction during labor and childbirth

CI 4 - Dissatisfaction with medical interventions

For some women, their experience with obstetric care in Brazil was negative, with these perceptions associated with pain caused by interventions such as labor induction and frequent vaginal examinations. Among participants who had previously experienced a "natural" vaginal birth, these factors stood out distinctly and evoked feelings of fear and distress.

CSD 7 – This specific labor was induced, and the dilation process was prolonged. It was more painful. I was scared. My first birth was natural. It was different! The contractions were very painful! (IW2, IW3, IW4)

CSD 8 - This labor was especially painful. I really tried to have a natural birth, but I couldn't — I was in a lot of distress. When they did frequent vaginal exams or used the fetal monitor, I just couldn't take it anymore. It was very distressing, you know? (IW4, IW8, IW14)

CI 5 – Inadequate infrastructure

Some women expressed dissatisfaction with the maternity facilities' infrastructure, highlighting issues such as inadequate hygiene and lack of accommodation for companions.

CSD 9 - The infrastructure was poor. It was very dirty! Filled with dust. My husband, who was my companion, arrived and there wasn't even a chair for him. He ended up sleeping in the car because there was nowhere for him to stay. It's complicated! (IW6, IW8, IW9, IW10)

DISCUSSION

The narratives of immigrant women reveal satisfaction with the obstetric care they received in Brazil. It is important to clarify that satisfaction in this context can be defined as the positive personal perception of care received during childbirth[12]; however, this concept goes far beyond that. It encompasses elements related to accessibility, infrastructure, cleanliness, reliable access to medications, supplies and human resources, privacy, confidentiality, promptness, appropriate emotional support, type of delivery, skin-to-skin contact with the newborn, continuous support throughout the process, performed procedures, and information received during labor[12-14].

From Donabedian's perspective, satisfaction is connected to the "structure, process, and outcome" triad, key aspects that directly influence the quality of care. It is important to highlight that the quality of the structure shapes the healthcare service process, which in turn affects the outcomes[7]. To provide excellent care, healthcare services rely on the seven pillars of quality: efficacy, effectiveness, efficiency, optimization, acceptability, legitimacy, and equity[11].

This study revealed several key aspects related to the process of delivering quality care, including healthcare professionals' attentiveness, effective communication, emotional support, and the use of non-pharmacological methods for pain relief during labor. These actions align with the pillar of efficacy, as they comply with the National Guidelines for Normal Childbirth, which recommend the adoption of evidence-based best practices aimed at reducing unnecessary cesarean sections and ensuring qualified and safe obstetric care[3].

Communication stands out as one of the major challenges in providing care to immigrants, as many struggle to learn Portuguese, while healthcare professionals often lack fluency in other languages, ultimately creating barriers to understanding and addressing the desires and preferences of this population. Accordingly, it is essential to implement strategies that address communication barriers, thereby ensuring access to healthcare services and facilitating the understanding of clinical information[15]. In the context of this study, the efficiency and effectiveness of the healthcare process were evident, as none of the immigrant women reported communication problems during their interactions with professionals. On the contrary, they expressed appreciation for the professionals' efforts to use knowledge of another language to facilitate clear and effective communication.

As highlighted in the participants' accounts, a welcoming approach, emotional connection, and the continuous presence of healthcare professionals are essential for ensuring quality care and facilitating the physiological progression of labor. The relationship between healthcare providers and birthing women must go beyond the mere transmission of clinical information;

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it should also encompass emotional and psychological aspects that foster mutual trust. In a study conducted in public maternity hospitals in Salvador, women reported that attentive care, words of encouragement, the professional's constant presence, and individualized treatment based on their subjective needs contributed to their overall satisfaction[16].

In this study, immigrant women reported favorable experiences with maternity ward care, emphasizing that the support received during childbirth was perceived as free from prejudice and discrimination. This suggests that equity was present in the healthcare services. However, this issue warrants further examination, as the aforementioned forms of bias and exclusion continue to persist in Brazilian society, adversely affecting many individuals. Furthermore, considering that the quality of reception is one of the key parameters used to assess user satisfaction, it is essential that healthcare professionals develop the competencies needed to provide humanized and respectful care[17].

While the principle of universality underpinning SUS ensures access to healthcare services for all Brazilian citizens, it likewise encompasses the immigrant population. Therefore, all individuals, without any form of discrimination, are entitled to access healthcare services[18]. However, it is necessary to raise awareness and train healthcare professionals at all levels of care throughout Brazil[6].

Despite this, a study conducted with Black immigrant women in the states of Pernambuco and Rio de Janeiro identified reports of discrimination experienced within healthcare services, where professionals made prejudiced remarks concerning physical and religious aspects. These findings revealed instances of obstetric racism, which dehumanizes women and renders them vulnerable to obstetric violence. Specifically, aversion to Black aesthetics, the racist stereotype regarding the supposed biological predisposition of Black women to pain resistance, and religious racism were all prevalent in the childbirth care experiences of Black immigrant women[19]. However, in the present study, no reports of discriminatory or racist experiences were recorded.

Regarding non-pharmacological methods for pain relief, it is important to highlight their valuable role, as they represent a non-medicated and effective approach to reducing pain intensity, offering women a more active and autonomous role during labor[20]. In this sense, as also evidenced in another study[12], immigrant women reported feeling comforted using such methods, resulting in positive childbirth experiences. They also noted that these practices are not available in their countries of origin. This specific aspect observed in maternity wards, along with reports of respect for patients' dignity and privacy, exemplifies the principle of legitimacy, as both the adoption of these practices and the conduct of healthcare professionals in obstetric care are grounded in public policy recommendations, clinical guidelines, and universal human rights standards.

Although most participants reported satisfaction with childbirth care in Brazil, some accounts reflected dissatisfaction with certain aspects of the healthcare process. These concerns were related to the use of certain clinical interventions and perceived shortcomings in the infrastructure during hospitalization, both of which contributed to feelings of dissatisfaction. These perceptions align with users' assessments of key structural components of care[7], including the physical environment, available equipment, human resources, and information systems.

Most of the women in this study progressed to vaginal delivery; however, there were expressions of dissatisfaction related to the experience of labor induction and the performance of multiple vaginal examinations. This was particularly evident among participants who had previously given birth in their countries of origin, as they reported fear and intense pain in comparison to their current experience.

In line with the findings of this study, scientific evidence indicates that vaginal examinations and the use of oxytocin, when not performed rationally, offer no benefit and may, in fact, be harmful[21], potentially constituting obstetric violence. This phenomenon has gained increasing attention in recent years, as many practices violate women's rights during childbirth, birth, and the postpartum period. These include lack of information and informed consent; unnecessary interventions such as episiotomies, unwarranted cesarean sections, and excessive use of medication; disrespectful, humiliating, or discriminatory behavior by healthcare professionals; negligence; and ineffective communication. Viewed through this lens, a dehumanized model of care becomes evident, perpetuating a systemic cycle of oppression toward women in healthcare settings[22]. It is therefore essential to ensure humanized care free from harm or mistreatment for all women, upholding their dignity, privacy, and confidentiality, while guaranteeing access to information and continuous support[23].

The humanized care model is an approach that prioritizes safety, respect, and female empowerment. It emphasizes vaginal delivery and centers care on women, respecting their choices while avoiding unnecessary interventions and routine or potentially harmful practices, such as the indiscriminate use of synthetic oxytocin, episiotomies, or surgical deliveries without medical indication[3].

A study conducted in Spain comparing the humanized childbirth care model with the biomedical model revealed numerous advantages of the former. These included a higher rate of spontaneous labor onset, shorter labor duration,

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increased use of alternative pain relief methods, a greater incidence of uncomplicated vaginal deliveries, intact perineum and first-degree tears, as well as lower episiotomy rates[24]. Supporting these findings, a study carried out in a public maternity hospital in Uruguay that evaluated the outcomes of implementing the Maternal Health Humanization Program demonstrated increased encouragement of vaginal delivery, non-supine birthing positions, and skin-to-skin contact, along with improvements in perineal integrity management[25].

It is important to clarify that humanizing obstetric services also involves aspects related to the environment, which in healthcare is defined as the physical, social, professional, and interpersonal space that should permeate respectful, effective, and compassionate care[26]. Thus, the adequacy of the physical space is a crucial element in promoting the health and well-being of laboring and postpartum women, aiming to provide an environment that ensures privacy, safety, comfort, necessary equipment, and accommodations for their companions, thereby fostering a positive childbirth experience[1]. However, it was noted that some immigrant women expressed dissatisfaction with inadequate hygiene and the lack of accommodations for their companions, which hindered their companions' continuous presence throughout hospitalization. These issues contributed to dissatisfaction with the healthcare service infrastructure, consistent with findings from other studies[27].

Study limitations

This study faced limitations, particularly due to the limited availability of scientific literature exploring the topic from the perspective of immigrant women, which constrained the ability to conduct broader comparisons with the findings. The geographic scope of the data collection site, along with language barriers, limit the potential to generate data with broad applicability.

FINAL CONSIDERATIONS

The results demonstrated immigrant women's satisfaction with the obstetric care received in Brazil. The importance of respectful reception, culturally sensitive and prejudice-free care for immigrant populations, effective communication, and the adoption of evidence-based best practices in childbirth was underscored. These aspects relate to the healthcare service delivery process, which is fundamental to attaining the core pillars of quality, including efficacy, effectiveness, efficiency, optimization, acceptability, legitimacy, and equity.

Conversely, some women reported negative experiences within healthcare services, particularly expressing dissatisfaction with certain clinical interventions and inadequacies in the physical environment. Therefore, the influence of healthcare service infrastructure on the care process is highligted, given its significant impact on outcomes.

This study aims to contribute to the evaluation and development of public policies in response to the increasing immigrant population in Brazil. It is noteworthy that research on satisfaction with childbirth care provides valuable insights for improving the quality of care offered to women.

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Conceptualization, P.P.S.O. and K.R.T.F.P.; methodology, P.P.S.O. and K.R.T.F.P.; validation, P.P.S.O. and K.R.T.F.P.; formal analysis, P.P.S.O. and K.R.T.F.P.; investigation, P.P.S.O. and K.R.T.F.P.; data curation, P.P.S.O., E.M.A., M.P.C. and K.R.T.F.P.; manuscript writing, P.P.S.O. and K.R.T.F.P.; review and editing, P.P.S.O., A.V.Z., C.C.F.B., E.M.A., M.P.C., S.C. and K.R.T.F.P.; supervision, A.V.Z., C.C.F.B., S.C. and K.R.T.F.P; project administration, A.V.Z., C.C.F.B., S.C., K.R.T.F.P. All authors read and agreed with the published version of the manuscript.

Use of artificial intelligence tools

Authors declare that no artificial intelligence tools were used in the composition of the manuscript "*Immigrant women's satisfaction with childbirth care in Brazil*".