Pandemic Lessons for Equitable Maternity Care: Cross-Cultural Perspectives from Immigrant Mothers in Spain

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Article

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Abstract

Background: The COVID-19 pandemic exacerbated pre-existing inequities in maternity care, particularly among culturally diverse and migrant women. Although data were collected during the early pandemic phase, revisiting these experiences offers valuable insights for strengthening equity, cultural safety, and system preparedness in maternal healthcare. Methods: A qualitative phenomenological–hermeneutic study was conducted in a tertiary maternity hospital in Spain. Semi-structured interviews were carried out with six women from diverse cultural backgrounds. Data were analysed inductively through thematic analysis, followed by a secondary interpretive review in 2024 to identify enduring implications for culturally safe, equitable, and crisis-resilient maternity care. Results: Four main themes emerged: (1) heightened fear and uncertainty surrounding hospital care; (2) emotional distress linked to restrictions on companionship and support; (3) disruption of culturally embedded postpartum practices, resulting in isolation; and (4) health literacy barriers and dependence on informal information sources. Despite these challenges, participants demonstrated notable adaptability and resilience. Conclusions: COVID-19 amplified structural inequities in maternity care for culturally diverse mothers. The findings highlight the need to reinforce cultural safety, health literacy support, language mediation, family-centred care, and emotional wellbeing. These lessons offer actionable guidance for strengthening resilient, equitable maternal health systems and improving preparedness for future public health emergencies.

Keywords: childbirth; COVID-19; cultural diversity; health literacy; qualitative study; maternity care

1. Introduction

The COVID-19 pandemic created unprecedented disruptions in maternal healthcare worldwide, intensifying pre-existing inequities and exposing systemic vulnerabilities, particularly among culturally diverse and migrant women. Emerging evidence demonstrates that women from minority ethnic groups experienced higher levels of fear, social isolation, reduced autonomy in childbirth, and barriers to accessing clear and culturally appropriate health information during the pandemic [1–4]. These inequities did not dissipate with the acute crisis; rather, they remain embedded in maternal health systems, underscoring the need to critically examine pandemic experiences to inform more equitable and resilient models of care in the post-pandemic era [5,6]. Spain, like many European countries, has experienced a steady increase in cultural and linguistic diversity among childbearing women. Although the Spanish maternity care model is grounded in universal coverage, immigrant women often face

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structural and communication barriers that limit access to culturally safe and health-literate care [7–9]. These vulnerabilities were amplified during COVID-19 through restricted companionship, reduced face-to-face support, and limited access to interpreters and prenatal education, creating challenges in navigating both healthcare systems and cultural adaptation processes.

International frameworks, including the WHO's roadmap for maternal health equity, emphasise respectful, inclusive, and culturally safe maternity care—particularly for migrant and minority women [10]. Cultural safety theory positions safe care as care defined as such by the recipient, recognising power imbalances, social determinants, and the role of healthcare systems in perpetuating inequities [11]. Complementarily, the universal health literacy precautions approach calls for standardised communication strategies to ensure comprehension for all service users, regardless of language or sociocultural background [12]. Within transcultural nursing, Leininger's model underscores the need to adapt care to people's beliefs, values, and lifeways to promote well-being and equity, a principle directly relevant to perinatal contexts where biomedical routines may conflict with customary practices [13]. Moreover, the pandemic disrupted evidence-based, relationship-centred practices that are foundational to humane care—such as companionship and early skin-to-skin contact—with known benefits for bonding and maternal mental health; restrictions on these practices heightened vulnerability and accentuated inequities for culturally diverse women [14].

Cultural safety theory positions safe care as care defined as such by the recipient, recognising power imbalances, social determinants, and the role of healthcare systems in perpetuating inequities [11]. Complementarily, the universal health literacy precautions approach calls for standardised communication strategies to ensure comprehension for all service users, regardless of language or sociocultural background [12].

While extensive research has documented pregnant women's stress and anxiety during the pandemic, fewer studies have adopted a transcultural and post-pandemic reflective lens, examining how cross-cultural perspectives can inform the redesign of maternal services moving forward. Understanding immigrant women's lived experiences during a health emergency offers unique insight into how health systems may better prepare for future crises while advancing long-term equity, inclusion, and personalised care.

This study aimed to explore childbirth and postpartum experiences among culturally diverse women who gave birth during the COVID-19 pandemic in Spain, and to identify lessons to inform equitable, culturally safe, and resilient maternity care in the post-pandemic era. By drawing on a phenomenological-hermeneutic approach and conducting a secondary interpretive analysis in 2024, this research contributes practice-oriented knowledge relevant for clinicians, health administrators, and policymakers seeking to strengthen maternal care for migrant populations and enhance preparedness for future health system disruptions.

2. Materials and Methods

We conducted a phenomenological–hermeneutic qualitative study at the Hospital Universitario Marqués de Valdecilla (HUMV), Santander, Spain. The study followed COREQ reporting standards and was approved by the Cantabrian Health Service Ethics Committee (code 2021.145). Participants (n=6) represented Spanish, Senegalese, Colombian, Moroccan, and Chinese backgrounds. Semi-structured interviews were performed between March and December 2020, transcribed verbatim, and analyzed inductively. Data were revisited and re-analyzed in 2024 to extract cross-cutting lessons applicable to post-pandemic care frameworks. The study was carried out at the Marqués de Valdecilla University Hospital (HUMV), the reference centre in Cantabria, an autonomous community in northern Spain. This centre attended an average of 2,857 births per year during the pandemic years (data provided by the hospital's admissions service). HUMV is the main provider of maternal care services in the region, especially during the period between March 2020 and June 2021, when it was the only public hospital to deliver babies in the community. In addition, from March 2020 until the end of the pandemic, it was the only hospital in Cantabria, both public and private, that performed deliveries in patients with a positive PCR test for COVID-19 on the day of delivery.

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Target population

The study focused on women of different nationalities and countries of origin who gave birth at the Marqués de Valdecilla University Hospital (HUMV) during the COVID-19 pandemic, specifically between March and December 2020. To participate, women had to be fluent in Spanish and voluntarily sign an informed consent form. Women with significant communication difficulties, mothers of children with congenital diseases or who had developed a serious illness prior to sample selection, and mothers of extremely premature or very premature babies (born before 32 weeks' gestation) were excluded.

Sampling

Non-probability quota sampling was used. This method attempts to select participants who adequately represent the target population based on specific criteria. In this case, the basis for selection was women participating in a cohort study in the same hospital in 2020.

Data collection

The first author of the study conducted in-depth interviews using a script designed by a team of expert researchers. The interviews were individual and semi-structured, allowing an in-depth exploration of the participants' experiences and perceptions.

Subjects

We interviewed six women: one Senegalese, one Colombian, one Moroccan, one Chinese and four Spanish. These nationalities were chosen for the diversity and cultural representativeness they bring to the study. The qualitative methodology of semi-structured interviews allowed us to explore in depth their personal experiences and identify possible patterns and differences related to their cultural backgrounds.

Procedure

Data analysis was carried out using a phenomenological-hermeneutic approach. The interviews were transcribed verbatim and coded following an inductive process to identify emerging categories and themes.

Ethical considerations

The study was conducted in accordance with the ethical principles of the Declaration of Helsinki. Written informed consent was obtained from all participants, who were informed of the aims of the study, the confidentiality of their data and their right to withdraw at any time. Approval was obtained from the Ethics Committee of the Cantabrian Health Service (internal code: 2021.145).

3. Results

This Despite data collection occurring during the pandemic, the re-analysis in 2024 emphasized enduring patterns of inequity and resilience that remain relevant today. Women described how cultural beliefs and social isolation shaped their emotional well-being, revealing the intersection between fear, uncertainty, and health literacy challenges. The women interviewed gave birth between March and November 2020, during the first and second waves of the COVID-19 pandemic. The interviews were conducted within the first six months after delivery. The sample included four women from non-European countries representing different cultures: a Senegalese, a Colombian, a Chinese and a Moroccan woman. Two women of Spanish origin were also interviewed. Details of the characteristics of the participants are given in Table 1. All participants were married or living with a husband of the same nationality.

Table 1. Demographic and Socioeconomic Characteristics of Women at Childbirt.

Age at Childbirth	Nationality	Educational Level	Number of Children	Type of Delivery	Population Type During Pregnancy	Employment Status (if applicable, Type of Job)	Date of Childbirth
39	Spanish	High School	2	Eutocic	Rural	7. Restaurant and retail services	27 March 2020

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31	Spanish	Vocational Training (VT)	1	Eutocic	Rural	7. Restaurant and retail services	23 July 2020
38	Moroccan	Primary Education	2	Eutocic	Urban	0. Inactive/Unemployed	4 June 2020
38	Colombian	High School	1	Eutocic	Urban	2. Teaching professionals	17 November 2020
37	Senegalese	Primary Education	2	Eutocic	Semiurban	3. Student	6 June 2020
39	Chinese	Primary Education	1	Eutocic	Urban	15. Unskilled service workers (excluding transport)	17 September 2020

From interviews with women who gave birth during the COVID-19 pandemic, several key categories emerged that reflect their experiences and perceptions. These categories capture both the emotions and challenges they faced and the cultural differences that influenced their experience of motherhood in this unique context.

Table 2 presents the categories and subcategories in a structured way, with literal examples to illustrate each.

Table 2. Emerging categories and subcategories.

Category	Subcategory
Fear of hospital care	Fear of childbirth during COVID-19
	Fear of hospital admission
	Fear of going to hospital
Perceptions of healthcare	Positive experiences
	Challenges in care
Social and cultural impact of the pandemic	Feelings of loneliness and isolation
	Adapting to a different cultural environment
Access to and use of prenatal information	Reliance on informal sources
	Lack of adequate preparation

A more detailed description of the analysis follows:

1. Fear related to hospital care during the pandemic

- Definition**:** Feelings of fear and anxiety experienced by women when interacting with hospital environments perceived as dangerous due to the pandemic.
- Subcategories:
    - Fear of going to the hospital: Fear of exposure to a source of infection when visiting the hospital, influenced by images of chaos and hospital overcrowding seen in the media.
        - *Example:* "Oh my goodness, really. It was like going to war, no better way to say it." – Informant 2 (Spanish).
    - Fear of giving birth during COVID-19: Anxiety related to hospital restrictions, such as the possibility of being without family support or the risk of separation from the newborn.
        - *Example:* "The anxiety caused by the thought of being separated if I tested positive for COVID during delivery." – Informant 5 (Spanish).
    - Fear during hospital stay: Concerns about the risk of infection for themselves and their babies during hospitalization, leading to extreme precautionary measures.
        - *Example:* "I kept my mask on the whole time, even though it was uncomfortable, to protect myself from the virus." – Informant 17 (Chinese).

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2. Perception of healthcare

- Definition**:** Evaluations of the quality of care received, including interactions with medical staff and perceived support.
- Subcategories:
    - Positive experiences: Appreciation for the care and accessibility of healthcare staff despite restrictions.
        - *Example:* "My primary care pediatrician was more like a friend than a doctor." – Informant 10 (Moroccan).
    - Challenges in healthcare**:** Difficulties arising from safety measures and restrictions on accompanying visitors.
        - *Example:* "I couldn't have anyone accompany me to my appointments, and that made me feel very alone and vulnerable." – Informant 5 (Spanish).

3. Social and Cultural Impact of the Pandemic

- Definition: Changes in traditions and family dynamics due to health restrictions and social isolation.
- Subcategories:
    - Feelings of loneliness and isolation: Loss of postpartum support traditions and limitations on family interactions.
        - *Example:* "In my country, it's a tradition to host a welcome party for the newborn, but they waited until lockdown measures were lifted." – Informant 14 (Senegalese).
    - Adapting to a different cultural environment: Challenges faced by immigrant women in navigating an unfamiliar healthcare system and the absence of cultural family support.
        - *Example:* "My first child was born in Senegal. I had my mother's support. She helped me a lot... But here, I only had my husband, and he had no experience." – Informant 14 (Senegalese).

4. Access and use of prenatal information

- Definition: Access to adequate information and difficulties encountered due to the lack of in-person resources during the pandemic.
- Subcategories:
    - Reliance on informal sources: Use of social media and online platforms to seek information about childbirth and motherhood.
        - *Example:* "I had to watch videos on Facebook, but it was a bit complicated because it's not the same." – Informant 13 (Colombian).
    - Lack of adequate preparation: Lack of knowledge about childbirth and available prenatal resources in the new cultural environment.
        - *Example:* "I didn't know prenatal classes existed here. No one told me." – Informant 14 (Senegalese).

The following categories and specific quotes highlight the cultural differences and ethnographic richness of the shared experiences:

*Layla (Morocco): Layla experienced how COVID-19 restrictions affected the postpartum support and companionship traditions fundamental to her culture.

"In my culture, neighbors and acquaintances come to congratulate you. But they couldn't. I could only receive my parents and my neighbor who lives across from me… But it's for my own good and the baby's and everyone else's, of course."

*Guadalupe (Colombia): Without access to in-person prenatal classes, Guadalupe turned to social media for preparation, finding the experience insufficient.

"I had to watch videos on Facebook, but it was a bit complicated because it's not the same."

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However, she appreciated the care she received at the hospital:

"Everything has been wonderful… Giving birth in Spain is amazing, everything is easy, even with COVID."

*Adji (Senegal): Adji experienced cultural shock giving birth without the presence of her mother, who had been crucial during her first childbirth in Senegal.

"My first child was born in Senegal. I had my mother's support. She helped me a lot... But here, I only had my husband, and he didn't, he had no experience."

The restrictions also impacted her community's traditional celebration:

"They wanted to throw a party... but my husband said, 'No. Now is a very... very difficult time.'"

*Yezi (China): Yezi faced social isolation compounded by a lack of understanding of the healthcare system.

"At first, I didn't know anything, I didn't know what was happening, and I was very worried about the baby because I couldn't get out of bed, I couldn't walk."

Although she was accustomed to solitude, her primary concern was her baby's health:

"To me, it seems normal because before, I also wasn't with people. I don't have many friends; I'm already used to being alone here."

The text continues here.

4. Discussion

This phenomenological–hermeneutic study shows that women's childbirth and postpartum experiences during COVID-19 were shaped not only by fear and uncertainty but also by structural and cultural determinants that influenced perceived safety, autonomy and belonging. Although the data were collected in 2020, the lessons remain pertinent for post-pandemic maternal system redesign focused on equity, cultural safety and health literacy. These findings align with evidence that perinatal anxiety and uncertainty increase in crisis conditions and may be exacerbated among culturally diverse women who face additional barriers to information, support and navigation (1-6).

Cultural safety and cross-cultural vulnerability

Transculturality emerged as a central dimension of maternal experience, consistent with the cultural framework for health (9). Participants—particularly immigrants—described linguistic barriers, difficulty understanding clinical information and the lack of cultural mediation, mirroring reports that language gaps heighten insecurity and disconnection in healthcare encounters (2,10). Leininger's transcultural nursing theory underscores the need for culturally congruent care when family/community scaffolds are disrupted (14). In our sample, the absence of culturally expected postpartum family involvement amplified isolation and hindered re-establishing culturally meaningful practices, echoing prior observations on the protective role of family support during the perinatal period (13).

Emotional and relational support as core safety needs

Restrictions on companionship were experienced as a profound loss of emotional security and advocacy. In line with previous studies, continuous support during labour is associated with better maternal experiences and outcomes (11, 15). The suspension of partner presence and early skin-to-skin-widely reported during the pandemic (12,13)-was not merely a procedural change but a relational rupture with consequences for bonding and mental wellbeing. Our analysis reinforces that policies for future emergencies must preserve humane childbirth practices wherever feasible, explicitly safeguarding the relational components of care (15).

Service disruptions, interventions and unintended consequences

Beyond companionship, women perceived more interventionist routines and fewer supportive services during peak waves, consistent with reports of increased obstetric interventions and reduced supportive care during COVID-19 (16). Such shifts, even when safety-driven, may inadvertently heighten distress and undermine person-centredness. Our findings suggest that preparedness plans should include explicit safeguards to prevent over-medicalisation of routine care in crisis contexts (16).

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Respectful practices and postpartum bonding

The curtailment of evidence-based, relationship-centred practices, especially immediate skin-to-skin, was perceived as de-humanising and avoidable by several participants, aligning with literature stressing its importance for maternal–infant bonding and anxiety reduction (17). Reintegrating and protecting these practices in contingency protocols is essential for humane and culturally responsive maternity care (17).

Health literacy as an equity lever

Health literacy gaps were prominent, particularly among immigrant mothers who missed antenatal education and relied on informal digital sources. This echoes the system-level nature of health literacy (7) and women's decision-making needs in maternity care (18). Implementing universal health-literacy precautions, plain language, teach-back, structured interpreter use and culturally tailored materials, can improve understanding and participation, both in routine and emergency care (18).

Resilience and strengths-based responses

Despite constraints, participants demonstrated adaptability and resourcefulness, resonating with strengths-based perspectives on maternal adaptive capacity (19). Recognising and scaffolding these strengths—through family inclusion, emotional support and culturally meaningful practices—can enhance resilience at patient and system levels (19).

Post-pandemic lessons for system preparedness

Overall, our results illuminate how global crises intensify pre-existing inequities, disproportionately affecting culturally diverse mothers. Post-pandemic maternity system resilience requires embedding cultural safety, language mediation, universal health-literacy precautions and family/partner inclusion into standard pathways, with contingency protocols that preserve the relational core of humane childbirth. These lessons align with contemporary international calls to advance equitable, respectful and culturally responsive maternity care and to integrate these principles into preparedness planning (10-13, 15-19).

Limitations

This study has important limitations. First, although phenomenological research does not aim for statistical generalisation, the small sample size and single-centre design may limit transferability to other settings. Second, interviews were conducted in Spanish, which may have constrained expression among non-native speakers despite culturally sensitive interviewing and opportunities for clarification. Third, given the exceptional and evolving circumstances of the early pandemic, participants' memories and emotions may have been influenced by uncertainty and fear specific to that time. Nevertheless, the re-analysis of data in 2024 strengthens the interpretative depth, allowing contextualisation within current international priorities for equitable and culturally safe maternity care. Future research should explore longitudinal experiences of migrant women, evaluate culturally adapted support pathways, and test health-literacy-sensitive and family-inclusive models of care during crisis and non-crisis conditions.

5. Conclusions

The COVID-19 pandemic magnified existing inequities in maternity care, disproportionately affecting women from culturally diverse backgrounds. Our findings highlight the need to embed cultural safety, emotional and informational support, and universal health-literacy strategies as core pillars of maternity services to ensure equity and resilience. Supporting continuous companionship, culturally meaningful practices, and clear communication pathways is essential to safeguard humane, person-centred care under both ordinary and crisis conditions. These insights provide evidence to guide maternal health systems in strengthening preparedness, enhancing inclusion, and promoting respectful and culturally responsive childbirth care for all women.

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Informed Consent Statement: "Informed consent was obtained from all subjects involved in the study." "Written informed consent has been obtained from the patient(s) to publish this paper".

Data Availability Statement: We encourage all authors of articles published in MDPI journals to share their research data. In this section, please provide details regarding where data supporting reported results can be found, including links to publicly archived datasets analyzed or generated during the study. Where no new data were created, or where data is unavailable due to privacy or ethical restrictions, a statement is still required. Suggested Data Availability Statements are available in section "MDPI Research Data Policies" at https://www.mdpi.com/ethics.

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