KRAAMZORG AS CARE AND BEYOND: INTERNATIONAL MOTHERS' PERCEPTIONS OF MATERNITY CARE ASSISTANTS IN THE NETHERLANDS

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by

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ABSTRACT

The postnatal period is an important and transitional time for new mothers, and more complex for mothers in a migration context. In the Netherlands, maternity care assistants (MCAs) provide postnatal care at home. Past research has identified numerous challenges to migrant maternal and postnatal care, including language and communication barriers, cultural needs and misunderstandings, and the importance of social support at home and abroad. Existing research examines non-Western and displaced populations, while less is known about other migrant groups. This study qualitatively examines international women's perceptions and experiences of MCA care through a framework examining the role of expectations, culture and communication in experience. In-depth semi-structured interviews were conducted with 11 international mothers from diverse countries of origin, and 2 Dutch mothers. Thematic analysis found that MCA care expectations form along thematic lines which did not positively or negatively relate to experiences. Respondents had positive experiences of MCA care overall: care and cultural traditions mutually accommodated each other, English-language care removed most language barriers and communication challenges, when resolved, yielded positive experiences. Findings suggest that respondents' multicultural background helped them to shape expectations and contextualize their Dutch postnatal experience. This illustrates the diversity of experience across migrant groups and highlights the effectiveness of client-centered approaches using a common language to provide effective and participatory cross-cultural care. Additional research is needed to better understand the diverse needs and experiences of international families in the Dutch postnatal care context.

1. INTRODUCTION

The journey from pregnancy to motherhood is a period marked by transitions in health, family and personal identity. The postnatal period in particular, typically recognized as the first six weeks after a baby's birth (World Health Organization, 2022), is a vulnerable time for mother and baby, bearing the highest burden of mortality and morbidity for both (Langlois et al., 2023). A "positive postnatal experience" has been identified by WHO as a significant end point for all women giving birth and their newborns, in line with UN Sustainable Development Goals (World Health Organization, 2022). Yet provision, costs and delivery of prenatal (pregnancy), intrapartum (childbirth) and postnatal (newborn) care services vary widely across the EU (Fair et al., 2020).

New motherhood is made more complex in a migration context, which puts additional pressure on health equity and outcomes among mothers and babies before, during and after birth (Verschuuren, 2024). Migration also brings additional burdens of socioeconomic challenges, discrimination, social exclusion, and stress (p. 2). Mothers are challenged to navigate social and cultural differences in care even as they attempt to find and rebuild social networks in their host locale (Shan et al., 2023). Studies show that non-Western migrant women often receive delayed care and struggle with expressing themselves, with having needs acknowledged and met, and with stereotyping by their caregivers (p. 1-2). In international research and practice postpartum care is less of a priority (Rudman & Waldenström, 2007), and care in this period is left out of basic health services in many countries (Langlois et al., 2023). When services are provided, guidelines and recommendations are rarely informed by the stated needs of those receiving postnatal care (Finlayson et al., 2020). One noteworthy exception is the Netherlands, where postnatal care is available to all mothers in the home as part of basic health care.

This thesis will present the postnatal care context in the Netherlands (Section 2) and the research question, literature and theoretical framework in which the current research has been conducted (Section 3). This will be followed by a description of the study methods (Section 4) followed by the research findings (Section 5). These findings are then discussion within the context of the state of the art and theoretical framework, and limitations are addressed (Section 6). Finally, conclusions are made and future research avenues are suggested (Section 7).

2. CONTEXT

Postnatal Care in the Netherlands: *Kraamzorg*

In the Netherlands standard postnatal care is provided in two forms. While midwives provide primary maternity care throughout the pregnancy and postnatal period as part of basic healthcare, maternity care assistance or *kraamzorg* is a secondary, partially-subsidized healthcare service (ActiZ et al., 2008, p. 6). *Kraamzorg* caregivers or Maternity Care Assistants (MCAs) serve as the "eyes and ears" of the midwife who is medically responsible for the mother and baby (Lambermon et al., 2021, p. 2). Care typically takes place in the home of the mother, which already serves as the location of uncomplicated labor and the site of delivery in approximately 13% of all births (RTL Nieuws, 2023). MCAs provide care within the first 8-10 consecutive days following birth. New mothers are entitled to 24 hours minimum and 80 hours maximum, with 49 hours as the standard allocation of MCA care (de Verloskundige, n.d.). Hour calculations are dynamic and factor in additional days in hospital and the needs of the family (Baas et al., 2017, p. 129; ActiZ et al., 2008, pp. 23-24). Registration to receive MCA care is voluntary and basic health insurance, for which all Dutch residents are eligible, pays most costs. Mothers contribute a co-pay of €5.10 per hour (in 2024, Zorg Instituut Nederland, n.d.).

MCA care is provided by professionals trained at a secondary vocational educational level for up to 3 years (Baas et al., 2017, p. 129). They can be employed or operate independently, and support midwives in primary and secondary care settings to assist in the birth or to support women with basic needs in the postnatal period (Cronie et al., 2018, p. 23). MCAs operate independently of each other and use varying means of communicating their services, information and instruction to (potential) clients prior to the birth, including online, print and in-person information. Mothers select from a number of organizations or freelancers

and, although voluntary, it is estimated that 90% of mothers access postnatal home care (Baas et al., 2017, p. 129).

Home-based care includes a number of care activities that are provided in three packages: minimum, basic and customized care. Table 1. includes information about the basic and minimum packages of care provided over eight days. All packages involve physical care and monitoring of mother and baby (1,2,4), providing guidance and instruction in the care and hygiene of their baby (3), maintaining hygiene (5) and lending support with household tasks (Zorg Instituut Nederland, n.d.). Customized care involves additional care in all categories as indicated, including products 6 and 7a, to a maximum 80 hours over 10 days (ActiZ et al., 2008, p. 20) or beyond in exceptional cases (in 2024; Rijksoverheid, n.d.).

Table 1. *Nature and Scope of MCA Care – Basic and Minimum Packages*

Products	Hours per product maternity care, Basic package First child	Additional	Hours per product maternity care, Minimum package
1. Maternity care and monitoring	9	9	4
2. Care and monitoring of child	7	7	6
3. a) Information and instruction *e.g. breastfeeding, mobility, planning, hygiene; bathing, changing, sleep rhythms, crying behavior*	12	8	10
b) Integration of child into family	-	4	-
4. Observing, signaling and reporting	5	5	4
5. Ensuring hygiene *clean bathroom/toilet daily, change mother/baby bedding frequently, sanitize bottles/pumps*	8	8	-
6. Care and minding housemates *e.g. older children*	Custom	Custom	-
7 a) Basic household tasks *clean mother/baby rooms and laundry; prepare lunch*	8	8	-
7 b) Extra household tasks *warm meals, clean other rooms/ laundry, receive guests, errands*	Custom	Custom	-
Total hours	49	49	24

Adapted from: National MCA care Indication Protocol, March 2008 (ActiZ et al., 2008, pp. 16-22)

Research on postpartum care in the Netherlands, which is not provided in a clinical setting, receives less attention than clinical prenatal and intrapartum care, and even less attention paid to women's ratings of MCA care experiences (Baas et al., 2017, p. 129). Research on the efficiency and client-centeredness of MCA care has also been found lacking, prompting the Dutch National Health Care Institute to urgently call for research on MCA care to provide an evidence base for its position in Dutch maternity care (Lambermon et al., 2021, p. 2). Research exploring Dutch mothers' perspectives and experiences of MCA care finds that mothers experience challenges in communicating their needs to MCAs, and that practical and emotional support are critical to their needs being addressed (Lambermon et al., 2021). In a migration context, where language barriers and cultural differences arise, such communication and support needs can be urgent (Boerleider et al., 2014, pp. 1-2). This is directly relevant to the 15% of Dutch residents who were born in another country and migrated (Centraal Bureau voor de Statistiek, 2023), many of whom will experience Dutch maternity care.

Migrant mothers' experiences are diverse, yet touch upon themes of communication and connection, expectations and the lived experience. In the unique postnatal MCA care context, the expectations of mothers may shape how they experience their care and their interactions with MCAs. An exploration of mothers' perceptions may better illuminate the range of expectations new mothers have entering MCA care, the cultural and contextual factors that influence their interactions, and how these contribute to their lived experiences.

3. RESEARCH QUESTION, LITERATURE AND THEORETICAL FRAMEWORK

3.1 Research Question

To address this challenge, the proposed research will address the following research question:

How do international migrant mothers perceive home maternity care assistance in the Netherlands?

These will be further examined through four subquestions:

- Which factors contribute to the shaping of individuals' expectations?
- How do these expectations manifest themselves in their lived experiences with MCAs?
- What role does culture play in defining these expectations and interpreting their experiences?
- How are language and communication experienced during MCA care?

3.2 Literature

Migrants and Dutch Postnatal Care

Past research has addressed various aspects of migrant motherhood in the Dutch postnatal care context, examining migrant mother and caregiver perspectives at times in comparison with Dutch mothers. Cultural differences between MCAs and non-Western migrant women have received much attention (Fakiri et al., 1999; Korfker et al., 2011; Boerleider et al., 2014; Shan et al., 2023), including representative migrant populations such as Turkish and Moroccan (Fakiri et al., 1999) or Chinese mothers (Shan et al., 2023). Others have examined a broader range of ethnic and national backgrounds in migrant postnatal (Baas et al., 2017) and general maternity care (Jonkers et al., 2011; Schouten et al., 2021) including refugee, asylum-seeking and undocumented mothers (Verschuuren, 2024).

Communication barriers were nearly universal findings. Language barriers were perceived to limit usage and understanding of care (Fakiri et al., 1999; Korfker et al., 2011;

Schouten et al., 2021; Verschuuren, 2024), and some MCAs were critical of other languages being spoken during care (Fakiri, 1999, p. 132). Studies noted broader miscommunication and lack of sufficient, clear and accessible information (Fakiri et al., 1999, Korfker et al., 2011; Jonkers et al., 2011, Baas et al., 2017; Boerleider et al., 2014; Schouten et al., 2021). MCAs cited misinformation and misunderstandings about their care role: housekeeping expectations of MCAs was a sensitive point for caregivers and led to disappointed expectations for mothers (Fakiri et al., 1999, Korfker et al. 2011, Lambermon et al., 2020). Multiple caregivers per family was a problematic issue for mothers (Korfker et al., 2011; Baas et al., 2017) and MCAs (Lambermon et al., 2020), as were insufficient care hours assigned (Korfker et al., 2011; Baas et al., 2017). Mothers and caregivers also found cultural differences impacting care (Schouten et al., 2021) including less direct communication styles than Dutch people (Korfker et al., 2011), reluctance to report medical problems (Jonkers et al., 2011) and lack of understanding of migrant mothers' practices (Boerleider et al., 2014) and preferences for culturally-sensitive care (Shan et al., 2023).

There were findings that all mothers saw MCA care as beneficial (Fakiri et al., 1999), satisfactory (Baas et al., 2017) or worth doing again (Korfker et al., 2011). Some rated postnatal care higher than pre- or intrapartum care, ratings which deviate from international literature (Baas et al., 2017; Ellberg et al., 2010, p. 467; Lambermon et al., 2021). Flexible and creative approaches were called for (Boerleider et al., 2014; Lambermon et al., 2020) to promote client-centeredness at both organizational and individual levels (Lambermon et al., 2021) and to limit dissatisfaction (Baas et al., 2017). Findings call for care focused on the needs of migrants (Lambermon et al., 2020, Shan et al., 2023; Verschuuren, 2024) to build trusting relationships between MCAs and mothers (Shan et al., 2023; Boerleider et al., 2014). Recommendations emphasize the need to expand the focus of research on women's own experiences with MCAs, allowing a betting and more nuanced understanding of these

interactions, particularly in non-Western migrants (Boerleider et al., 2014). Key practical recommendations for MCA providing organizations included clear explanation of main tasks and discussion of expectations at intake (Baas et al., 2017, p. 136).

Although studies have addressed different migrant groups, limited research addresses expatriate, middle-class or higher-educated mothers' perspectives in midwife and MCA care. One study explores the relationships of Chinese migrant mothers with their midwife and MCA caregivers in the Netherlands with a goal to add to research on middle-class migrant mothers: an understudied group whose preferences were not understood by maternity caregivers despite fewer language barriers and more effective communication (Shan et al. 2023, p. 5). Perspectives of higher-educated mothers and recent first-generation migrants were examined in a Dutch migrant maternal morbidity study (Jonkers et al., 2011). Respondents filled perceived gaps in information through social contacts, book research and the internet, which did not prevent challenges in communicating with caregivers about problems or decision-making. These contrasted with Dutch women's "more engaged, proactive" attitude and better understanding of healthcare interactions (p. 149). Findings attribute lower risk of severe maternal morbidity to migrants with social support from an extensive ethnic network (p. 151). Authors call for more research into cultural and gendered expectations of care, fear of care exclusion due to discrimination in mothers (Jonkers et al., 2011, p. 151), as well as nuanced approaches to culturally-sensitive care and a proactive MCA role in addressing the individual (Shan et al., 2023, pp. 1,6).

Beyond Dutch Postnatal Care

Postnatal care is not always offered in other countries (Langlois et al., 2023), and usually occurs in hospital settings. Studies in Sweden and Finland examine hospital-based postnatal care in migrant and non-migrant parents. Communication barriers and informed care remain issues across these studies (Barimani et al., 2015, Ellberg et al., 2010, Rudman &

Waldenström, 2007, Wikberg & Bondas, 2010; Wikberg et al., 2012) even in the face of heterogenous linguistic repertoires: the most integrated mothers found maternity care different or unknown (Wikberg et al., 2012). Two studies highlighted family dissatisfaction with postnatal caregivers' exclusion of fathers as caregivers in the new family (Ellberg et al., 2010; Rudman & Waldenström, 2007). Other negative experiences were nuanced: lack of staff continuity caused dissatisfaction for some (Barimani et al., 2015, p. 815; Rudman & Waldenström, 2007, p. 6) while for others, continuity was disadvantageous if there were language or relational barriers (Wikberg et al., 2012, p. 644). Culture was just one factor contributing to respondents' unique care wishes and needs (Wikberg & Bondas, 2010, p. 10) and negative experiences were sometimes communicated within a positive rating of overall care (Rudman & Waldenström, 2007, p. 4). Findings emphasize informational continuity, relational trust, safety, communicative agency and communication with kindness as important dimensions of satisfaction and effective self-management (Barimani et al., 2015, Wikberg & Bondas, 2010; Wikberg et al., 2012).

Women's perceived postnatal needs and expectations were found to be similar across context, culture, organization and care delivery (Beake et al., 2010). Mothers seek experiences which allow adaptation, confidence and competence as new mothers in their own cultural contexts (Finlayson et al., 2020). Care, trust, consistent information and flexibility from a continuous provider are seen as good quality care (p. 16), and difficulties arise when they lack access to supportive families and communities (p. 17). Authors argue that health systems are essentially malfunctioning if maternity care is not founded on support, communication and effective clinical input centered around mothers' and babies' needs (p. 17). Interestingly, findings from a study of Saudi women's hospital-based postnatal care satisfaction found a positive association between high midwife ratings and high postnatal care

ratings (Al-Hussainy et al., 2021), aligning with similar unexplained findings in the Netherlands (Baas et al., 2017, p.134).

Migrants and Maternity Care

Several European reviews have more broadly explored migrant maternity care experience. Studies identified themes in migrant women's perspectives: complex systems, organizational barriers and effective, graspable communication (Fair et al., 2020; Balaam et al., 2013; Sellevold et al., 2022); awareness of linguistic and cultural barriers and needs (Fair et al., 2020; Sellevold et al., 2022; Balaam et al., 2013; Higgenbottom et al., 2016); and the importance of caring support from staff, spouses and family (Almeida et al., 2023; Balaam et al., 2013; Sellevold et al., 2022; Higgenbottom et al., 2016). Family support is identified as a well-known protective element of postpartum mental wellbeing which migrants often lack, contributing to exhaustion and helplessness (Almeida et al., 2023). Family judgement, social and gender roles, and expectations of maternal self-sacrifice interact in complex ways (p. 216). One study suggests that resilience, adjustment and changing their cultural beliefs yield better outcomes for migrant women (Balaam et al., 2013, p. 1926). Two additional noteworthy findings are that 1) that migrant expectations for care were determined by past experiences--of negative events, cultural background, beliefs about procedures, or their preferences for communication; and 2) that these past experiences can influence their choices for future use of care (Fair et al., 2020, pp. 11-13).

Individual studies in Canada and Switzerland explore migrant women's broader maternity care experiences similarly show communication and language barriers, system-wide and individual care information deficiency, isolation and loneliness, and cultural conflict or incompetence (Higginbottom et al., 2016; Sami et al., 2019). Information should made available "in the patient's 'first or any familiar language'" to equalize access, availability of trained interpreters, and cultural competence training for caregivers (Sami et

al., 2019, p. 7). Notably, home postpartum care was seen as positive by women who had previously given birth in countries without such care (p. 6).

Two studies examine expatriate mothers in maternity and postnatal care. Expat mothers' experiences in Geneva are found to be unique in their approach to citizenship (Wallace, 2018): instead of an "imagined community" based on nationality, these mothers strategically used citizenship to expand their options as individuals and families (p. 127). This group, despite its privilege, experienced maternity and postnatal transitions as complex and "full of friction" (p. 4-5). Respondents faced communication barriers, loneliness, dependence and adjustment in a shifting mobility context which required "vast amounts" of time and resources to manage (p. 5, p. 28). A shared language was important for relating to caregivers (p. 28), and communication barriers limited their ability to advocate for themselves (p. 127). Aligning with Dutch maternity research (Jonkers et al., 2011), respondents used digital tools not only to maintain long-distance ties, but to create "local" support spaces for and in the expat community (Wallace, 2018, p. 128). In the UK, lower levels of perceived social support were associated with postpartum depression in immigrants (Collins et al., 2010), and postnatal depression measured higher in a returned group of expatriate mothers than non-expats (Banbury et al. 2023, p. 329). Expatriate women may face unique barriers to support due to language and cultural differences, and less access to support services such as pregnancy groups (p. 329).

Also similar to Dutch findings, a UK review found few actual interventions focusing on improving maternity care for migrant women (Higginbottom et al. 2020). Findings in a US study of healthcare language barriers also call out scientific stagnation on already-established issues: evidence is needed for interventions that limit language barriers "rather than continuing to document how they negatively impact care" (Schwei et al., 2016, p. 43).

3.3 Theoretical Framework

The proposed research will be structured using three theoretical frameworks: Expectation of healthcare (Lakin & Kane, 2022), cultural scripts (Goddard & Wierzbicka, 2004), and communication accommodation theory (Giles, 1972; Ylänne, 2008).

Lakin and Kane (2022) developed an integrative analytical framework to examine individuals' expectations of healthcare. This framework was designed to be intersectional, translocation and relational, to identify how individuals' expectations of healthcare interactions can be shaped by multiple factors: social location (which may be temporal or special), relational dynamics within these locations, and interpretation of past experiences of care. These may include their own first-hand experiences and the experiences of trusted friends or family whose experiences are familiar to them. This framework has multiple theoretical bases in organizational management, social psychology, sociology and health care, including (but not limited to) belief formation, expectation states theory, social systems theory, habitus, and health systems responsiveness (pp. 2-3). It is specifically designed to capture the migrant experience in their expectations and experience of care, which is called for in past literature examining postnatal care experiences (Boerleider et al., 2014). This framework is applied in the proposed research to explore the expectations that mothers bring into MCA care, the factors that contribute to these expectations, and their experiences of interactions with MCAs during their care. This builds on past research establishing links between past experiences, expectations and future care (Fair et al., 2020, pp. 11-13).

Two theories address the interplay of communication and culture, which are consistently recurring themes in past research on postnatal care in a migration context. Goddard and Wierzbicka (2004) developed cultural scripts as a technique for articulating cultural norms, values, and practices in terms which are clear, precise, and accessible to cultural insiders and outsiders (p. 153). Cultural scripts can identify norms and practices of

social interactions: “Cultural scripts exist at different levels of generality, and may relate to different aspects of thinking, speaking, and behaviour” (p. 154). The proposed research will explore the possible relevance of cultural scripts as a component which contributes to or informs expectation development in mothers. Communication accommodation theory was developed by Howard Giles and posits that speakers are motivated to reduce language or communication differences in particular circumstances to optimize communication (Ylänne, 2008). This can involve convergence, where interlocutors attempt to limit the distance in communication repertoires, or divergence, where they resist accommodation or even accentuate differences to maintain distance (p. 164). Further, these strategies can be engaged symmetrically or asymmetrically and can reflect power dynamics (p. 168). The proposed research will explore whether CAT is identifiable in interactions between MCAs and migrant mothers.

3.4 Definitions: Migrant, Expatriate, International

Definitions to classify people crossing international borders vary (Fair et al., 2020). Research examines not only the people identified but the categories themselves. Use of terms such as “migrant” or “expatriate” invokes conscious or unconscious association with class, race and value (Kunz, 2020). and conveys “widespread social hierarchization of migrants” (Klekowski van Koppenfels, 2014, p. 139). “Expatriate” conveys privilege, education, skill and higher (moral) value, often with Global North origins (Wallace, 2018; Kunz, 2020; Cranston, 2017; Klekowski van Koppenfels, 2014, p. 139). It also implies self-segregation and a temporary stay, with a negative undertone that raises questions of how one relates to either host or homeland (Klekowski van Koppenfels, 2014, p. 23). Conversely, “migrant” or “immigrant” is associated with illegality, lower class, less educated, non-Western and non-white Otherness (Wallace, 2018; Kunz, 2020; Cranston, 2017), yet also permanence and successful integration (Klekowski van Koppenfels, 2014, p. 139). People self-identify with either or both terms

interchangeably (pp. 138-140), and current research acknowledges these terms as contested, shifting (Kunz, 2020, p. 2148) and insufficiently problematized (Klekowski van Koppenfels, 2014, p. 133).

Given this contested landscape, the current study begins with the IOM definition of "international migrant" as a person who relocates outside of their country of citizenship or nationality, or for stateless people, outside of their birthplace or habitual residence (International Organization for Migration, 2019, pp. 132-133). This definition allows a nuanced exploration of the diversity in this target population across differences in circumstances of migration, length of stay, and documentation or residency status (Fair et al., 2020, p. 2). Migrants in this study are identified as "internationals", to maintain a broad common thread of migration experience and also to subvert class- and race-based migrant or expat "prototypes" even while acknowledging that avoidance risks reproducing these politicized uses and social meanings (Klekowski van Koppenfels, 2014, p. 139; Kunz, 2020, p. 2157). Dutch mothers are defined as those whose country of citizenship is the Netherlands and do not have a migration background.

4. METHOD

4.1 Research Method and Operationalization

Design

This research was conducted using a qualitative, descriptive ethnographic analysis of the expectations and lived experiences of mothers who received home postnatal care from an MCA in the 10-day period following the birth of their child. The design allows for the full exploration of and rich detailing of unique backgrounds, expectations and experiences that comprise these stories. In-depth semi-structured interviews were chosen to allow respondents to share personal and vulnerable experiences in their own voice and in a manner that best fit the story they wished to tell.

Study Population and Inclusion Criteria

The study population includes international and Dutch mothers (See Section 3.4, Definitions, p. 14) in the Netherlands who received maternity care assistance in their places of residence in the postnatal period. Inclusion criteria were age 18 and older, international or Dutch mother, participation in home maternity care assistance approximately 6 months to 2 years prior to study inclusion, and who received care at home from a Maternity Care Assistant. This timeframe allowed for sufficient recall to convey accurate information, yet also allowed for sufficient distance to reflect on their experiences. Ultimately a sample group of 13 women participated in the study: 11 international and 2 Dutch respondents (See Section 5, Findings, p. 22 for sample group characteristics).

One maternity care assistant (MCA) provided context to the respondent findings. Criteria were past/current experience as MCA and Dutch and English-language proficiency.

Ethics

Several ethical issues required consideration in the planning and conduct of this research. These include the rights of respondents to informed consent, privacy and safety; and the

collection, storage and security of the research data and analysis. Participation was voluntary and carried out only with the signed informed consent of each respondent (See Appendices 1 and 2). Data collected in this study included recorded (audio) interviews, transcripts of interviews, their coded analysis and researcher notes.[1]

Sampling and Recruitment

Respondents were actively recruited and included over the course of 4 weeks using purposive sampling (criterion sampling and deviant case response) as well as snowball sampling techniques. The sample size was determined when saturation of information was achieved in the respondents with a migration background. Dutch sample size was determined by positive response: recruitment was insufficient to provide full sample comparison but allows for reflection on themes. Several recruitment methods were used within a compressed four-week timeframe:

- **Study advertisements** were placed in physical locations where new mothers tend to congregate, including infant and toddler childcare clinics (consultatiebureau's) in central neighborhoods within the cities of Utrecht, Amersfoort and Zwolle. These cities were chosen for access to (international) mothers, comparability of urban environments, and variation in the overall size and presence of international communities. Paper flyers which indicated the inclusion criteria for participation were posted and handed to healthcare clinic staff for individual distribution. Flyers were also distributed to one pre/postnatal maternity care clinic in the city of Zwolle (at the suggestion of childcare clinic staff).
- **Social media messages** were posted on three Facebook groups where new mothers connect, which also indicated the inclusion criteria for participation. Groups included a

[1] In limited circumstances (n=3), respondents communicated follow-up data points via email which was subsequently added to the researcher's notes for that respondent.

local English-language group for mothers based in the region of Utrecht, two Dutch-language groups for mothers (unsuccessfully), and an expat/internationals group in Amersfoort.

- **Mobile telephone applications** were used to recruit respondents. Two recruitment posts were sent via the NextDoor mobile phone app, which distributes locally-relevant messages to members in nearby neighborhoods (in this case, Amersfoort). Messages were distributed using the Whatsapp mobile phone app via the personal and professional networks of the researcher.
- **Study respondents** who indicated knowledge of potential respondents and who voluntarily offered to assist in recruiting other moms were provided with mobile messages and/or paper flyers for further distribution.
- **Deviant case response recruitment** was engaged to recruit 1 respondent midway through data collection via social media (a Facebook group not specific to mothers).

Flyers and postings referred to an online contact form, generated using Google Forms, which was accessible through QR-code or web link. Through this form interested mothers could indicate their contact information, which inclusion criteria applied to them and whether they were Dutch or international. Flyers and forms were distributed in Dutch and English languages. In some cases, mothers made initial contact with the researcher directly via mobile phone or email without use of the contact form. After contact information was provided to the researcher, additional information about the study, including the study Information Sheet, was provided electronically to potential respondents and their eligibility was verified. Upon verification and verbal agreement to participate, the researcher and respondent planned an interview at a time and location of the respondent’s choosing.

During respondent data collection, an MCA perspective became necessary to provide context to the experiences of the respondents. The researcher used professional contacts to contact an experienced MCA who gave verbal consent for her participation.

Inclusion and Informed Consent

Participation in this project was voluntary and data was collected with the informed, written and signed consent of each respondent. Information about the purpose of the research and the rights of respondents was provided to respondents via an information sheet written in accessible language, in Dutch or in English. Respondents were informed that they could withdraw from the study at any time, without explanation. Respondents were also informed that those who wish to withdraw consent after participation may do so, however the researcher will not be required to undo the processing of any data that occurs prior to withdrawal. The research data obtained prior to withdrawal would in that case be erased. Consent for the MCA interview was obtained verbally prior to start of the interview.

4.2 Data Collection and Analysis

Interviews

In-depth semi-structured interviews were conducted in Dutch or English, using an interview guide. This consisted of pre-determined, open-ended topics and questions to which the respondent could freely respond, elaborate and be guided where necessary (Dörnyei, 2007, p.136). The interview guide was developed based on the theoretical framework, nature of the maternity and postnatal care system, and the research question and subquestions. The guide was further adapted during data collection in an iterative process as new insights emerged. Respondents were informed that the interview was expected to last from 30-60 minutes, and that they could pause or stop at any time. The MCA interview guide was developed based on questions that arose in respondent data collection and analysis.

All but two interviews were conducted in person, in either public or private setting, at the convenience and preference of the respondent. One online meeting was conducted at the request of the respondent (Respondent 1), and the other was conducted via telephone with the MCA. Respondent interviews were conducted with the mother as the source of information, but in limited circumstances, the father was also present and was asked by the respondent for verification of events as she remembered them.

Interviews were organized around key areas: demographic information, overall maternity and delivery context, general expectations for postnatal period, specific expectations of MCA care, and actual experience of MCA care. Each was introduced broadly to encourage the mother to define her own narrative, such as "tell me about your actual experience of *kraamzorg*" or "How would you summarize your pregnancy and birth experience?" Follow-up questions were asked to specify details, to move into specific areas of inquiry relevant to the theoretical framework of the study, or to explore topics that arose during the interview. Upon completion of the interview, the respondent was thanked for her participation, and was given a small token of appreciation (chocolates valued at less than €10). When interviews took place in a café, costs were paid by the researcher to limit financial burden of participation.

Data Processing and Analysis

Interviews were recorded using Apple iPhone audio software. Audio files were transcribed using Amberscript automatic transcription software. Transcription files were visually reviewed against the audio recording and edited for accuracy and context where needed. During transcription editing, interview data was pre-coded (Dörnyei, 2007, p. 250). Basic demographic data and other information were summarized in an MS Excel spreadsheet to provide preliminary organization and comparison. First impressions of the data were noted in a preliminary analysis outline. MCA interview was transcribed using MS Teams.

Transcription text was further analyzed and coded using MAXQDA 2022 software. A secondary edit was made during coding for any remaining textual corrections or clarifications. Data was analyzed using inductive thematic analysis (Braun & Clarke, 2006). Open coding was used to make sense of the data as it was received and transcribed. Meaningful textual elements were categorized according to the key areas of inquiry developed in the interview guide (See above). From this basis, a multilevel working coding system was developed according to emergent themes within the data. This system was modified iteratively as each new interview was incorporated into the analysis and new aspects of data were identified. When all transcription data was coded, the codes were cross-checked by reviewing each linked transcript quotation. This inductive approach yielded a final coding scheme upon completion of the final interview transcription and analysis (See 9.3, Appendix: Coding Tree, pp. 64-66). This was examined against the theoretical framework and the existing literature, which led to the following findings.

5. FINDINGS

This study explored the diverse expectations and experiences of *kraamzorg* or MCA among international mothers in the Netherlands. Overall, the findings suggest that the expectations of international mothers in the Netherlands develop out of past experiences with non-Dutch health care systems and/or traditions, past experiences with Dutch health care and maternity care, and both informal and formal sources of information. Their experiences, in contrast, appear to be shaped by the variable care received, communication experiences, and familial support.

5.1 Respondent Characteristics

In total 11 international mothers and 2 Dutch mothers participated in this study. Interviews ranged from 32 to 102 minutes, with a mean duration of 60 minutes. At the time of study participation, respondent (n=13) ages ranged from 30 to 39 with a mean age of 34.3. Demographic characteristics of respondents are included in Table 2. Table 3 documents the summary details of self-reported MCA care provision, ranging in duration from 5-10 days, and per day between full-time (typically 7-8 hours) and part-time (less than 7 hours) care.

At the time of MCA experience, respondent (n=13) ages are approximated from 29 to 37 with a mean age of 33.4. Most respondents were first-time mothers (n=11); two had children in other countries prior to arrival in the Netherlands. One mother (Respondent 12) gave birth at home, 12 mothers gave birth in the hospital due to personal choice, medical indication or emergency. Some mothers received MCA care during delivery or in recovery at the hospital, yet findings address the MCA care that all received at home. In the sample, 8 respondents received care in the region of Utrecht and 5 respondents in other regions of the country.

Table 2. *Respondent Demographic Information*

Respondent	Age[2]	Professional background	Country of origin *Past country context*	Years in NL	Reason for migrating to NL	Parity NL birth
1	35	Dutch government (Ministry), business consultant	Turkey *Georgia*	4.5	Political asylum	1
2	39	Corporate communications, public affairs	US *Belgium* *Luxembourg*	2.5	Spouse career	2
3	33	Biomedical research	Chile	8	Education> career	1
4	30	Clinical trials management	Pakistan *US*	5	Career	1
5	35	Biomedical research, nonprofit management	UK *Australia*	5	Proximity to spousal family	1
6	31	Psychology, Homemaker[3]	US *Turkey* *UK*	5	Education	1
7	38	Export management (freelance)	Spain *Japan* *Germany* *China*	1	Proximity to spousal family	3
8	37	Data management	Romania	14	Education> career	1
9	37	Government veterinary inspection	NL	N/A	N/A	1
10	30	Personal training, fitness (freelance)	US	5	Spousal reunification	1
11	32	Corporate/ nonprofit management	Malaysia *Australia* *Singapore*	5	Spousal reunification	1
12	32	Media and culture (academic)	Germany *Austria* *Scotland* *Denmark*	1.5	Career	1
13	37	Higher education, art design (freelance)	NL	N/A	N/A	1

[2] Self-reported age at time of study participation.
[3] Respondent 6 had an educational background in Psychology and was a homemaker at the time of this study.

Table 3. *Respondent MCA Characteristics*

Respondent	Month/ year MCA	Location MCA	Days	Full time/ part time	No. MCAs[4]	Expectations of MCA care	Experience of MCA care
1	Jan-Feb 23	Bussum	6-7	FT	2	Negative: *impression that the Dutch kraamzorg are very harsh*	Positive: *love this kind of support…professional, caring*
2	Feb 22	Utrecht	5	FT	1	None: *didn't have expectations, you just kind of hope that it fits*	Positive: *overall very positive… exceeded my expectations*
3	Aug 22	Amsterdam	7	PT	2	None/Positive: *Blurry…no idea, no expectations…sort of had positive expectations*	Very positive: *amazing… everything was positive*
4	Jul 23	Utrecht	6	FT (1 day e-consult)	3	None/concerned: *didn't have many…what if they don't understand our culture?*	Positive: *really felt cared for… received more than I expected*
5	Apr 22	Vianen	8	FT>PT	2	Cautious: *expected a moderate amount of care*	Very positive: *amazing service…so pleasantly surprised*
6	Sep 22	Utrecht	9	FT	3	Low/cautious: *had pretty low expectations…ridiculous*	Very positive: *thrilled… far beyond my expectations*
7	Feb-Mar 23	Enschede	5 of 7	FT>PT, family ended early	2	Positive/cautious: *not big…we can have a nice experience*	Negative: *useless…didn't really get anything*
8	Jan-Feb 22	Utrecht	5	FT	2	None: *quite open…didn't have very strong/clear expectations*	Negative: *horrible experience… disappointed*

[4] Includes hospital-based MCA care, home care and trainees as applicable.

Respondent	Month/ year MCA	Location MCA	Days	Full time/ part time	No. MCAs[4]	Expectations of MCA care	Experience of MCA care
9 NL	May 22	Veenendaal	6-7	FT	1	Few: *wist dat dat gebruikelijk was…niet heel hoog [knew that it was standard…not too high]*	Good: *goed in haar werk…over het algemeen goed [good at her job…good in general]*
10	Aug 23	Utrecht	6	half days	1	Negative/cautious: *already annoyed…didn't exactly know*	Very positive: *got close…in general it is an amazing service*
11	Nov-Dec 22	Zaandam	7 of 10	FT, doctors ended early	2	Few/none: *simple…didn't have many…quite a new notion*	Positive: *invaluable help… a good system…professional*
12	May-Jun 23	Utrecht	10	FT and PT	4	Low/cautious: *really low or basic…not investing hopes*	Very positive: *amazing...it was the most beautiful time*
13 NL	Apr 22	Wageningen	8	FT	1	Negative: *Terughoudend…wil niemand in huis…struis tante [reluctant…didn't want anyone at home…overbearing lady]*	Very positive: *echt top [really great]*

Respondents shared their maternity and postnatal care stories covering a broad range of experiences, perceptions and reflections. For the purposes of this analysis, findings reported will be limited to the themes of MCA care expectations and experiences that were identified in the many stories that moms shared. Although the number of Dutch respondents is not sufficient for a full comparison, the experiences of these mothers are included to provide context to and contrast with the international experience.

5.2 Expectations of MCA Care

Expectations of MCA care varied among respondents. On the whole, most respondents did not articulate clear expectations prior to MCA care. Mothers accessed experiential, knowledge and support resources from multiple locations, cultural contexts and time points prior to MCA care. These did not always align. The quality of past experiences, including Dutch maternity care, did not necessarily lead to similar expectations for MCA care. Many respondents formed low or cautious expectations, as this mother explains:

I didn't really have much expectations. I think that's why I don't think I was disappointed much.[5] [Respondent 4]

Some respondents had "blurry" (Respondents 3, 8) impressions of MCA care. In the face of so much information, one mother was "prepared to be completely unprepared" (Respondent 5). Or as this mother explained, she had an unclear sense of the details but was generally negative about the prospect of home care.

So when I was pregnant, I was already annoyed at our kraamzorg *and I didn't even know her.* […] *I don't want people in my house doing stuff that they don't know what they're doing, and telling me what to do.* [Respondent 10]

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[5] Personally identifiable information, fillers and vocal pauses ("um", "like"), redundant/repeated words, and researcher backchanneling have been removed.

One respondent who initially expressed having no expectations, described several different factors that ultimately shaped them:

I don't know, because the health care system here is very much different from what we have home. So that was like that would have been a negative influence in the kraamzorg*. But I think the midwife care I got was so good* […] *I think I was expecting a very good treatment because I think in the Netherlands they care so much for the baby that I think that's why I sort of had positive expectations.* [Respondent 3]

As mothers talked about their experiences, three main factors emerged which appeared to inform their expectations of MCA care: 1) knowledge of healthcare and maternity practices in other countries, 2) experiences with Dutch health and maternity care, and 3) MCA care information provided by local sources, formal and informal.

Knowledge of Non-Dutch Health Care and Maternity Practices

Respondents described knowledge of maternity care and broader healthcare approaches in other countries as well as familial, cultural or religious traditions or practices which relate to the postnatal period. Mothers brought multiple experiential and cultural contexts to their MCA care experiences.

This British mother explained how her knowledge of the Australian health care system helped her draw parallels with Dutch MCA care, shaping her expectations.

And through my [self-]education, I'd heard about postpartum doulas that you have in quite popular in Australia, for example, and that this is something people can do. So not necessarily a birth doula, but actually a postpartum doula specifically. And then I started [...] reading more about it and learning more about what the kraamzorg *would do. I was like, okay, this is actually kind of a postpartum doula.* [Respondent 5]

Similarly, a Romanian respondent described healthcare in her home country as "having more preventive medicine to the extreme."

10, 15 years ago, you could just walk into a pharmacy and get antibiotics without or without a prescription, right? […] *That's the extreme of self-medication and asking a cousin of a cousin of a cousin to give you a prescription for something.* [Respondent 8]

She and other mothers also talked about cultural traditions from their home country. This mom summarized her impression of postnatal care in Turkey.

So in Turkey there's no kraamzorg *or* kraamzorg-*like [system] here, but, almost always your mother or your mother-in-law comes to stay with you for etern—for several months, at least one month. But I mean, long. [Laughing.] And so they help you, I don't know, they tell you what to do.* [Respondent 1]

Respondents from different countries cited a 40-day period in which mothers receive extensive support from family, including special food or tea, limited visits with the mother, and the mother's confinement to bed. This Pakistani-American mother summarizes her tradition.

So in our culture, there's the 40-day period where you're supposed to take care of the mother. […] *And also kind of the baby as well, but mostly for the mother where you get fed a lot of fatty, warm stuff. I think it's across a lot of Asian cultures.* [Respondent 4]

Other respondents from the US perceived maternal caretaking practices as familial or community-based, rather than as cultural or religious. One talked about the help expected from her mother's Jewish community in the US.

I think if I was to have had her at home in the US, at least my mom's community and I guess our community, they would have brought over food every single day. They would have […] come over and offered to go grocery shopping or offered to do the laundry. […] I don't know if it's tradition, but I know that's what they would have done. [Respondent 10]

Some found other health and maternity care systems more medicalized and regimented than in the Netherlands. One positively contrasted her experience of care from Dutch midwives with the German standard care from a doctor (Respondent 12), while another noted that mothers spend more time in UK and Australian hospitals after birth (Respondent 5). One respondent was surprised at the lack of "basic" annual gynecological checkups and testing that she received in Romania (Respondent 8) while an American mother had a previous birth in Luxembourg which tested regularly.

I thought there was less kind of intervention here than there was in Luxembourg where I was doing all the blood tests and the urine tests every other week. Whereas here I just think they were just like, yeah, you're gonna have a baby at some point. [Laughing.] [Respondent 2]

Another Spanish mother contrasted the "hippyish" approach to birth in the Netherlands with the high level of medicalized care in China, where she described feeling very well cared-for during two previous births.

When I left the hospital in China, which, by the way, you had to stay 2 or 3 nights […] *In the last day, they ask you, do you have any pains? And if you say yes [you get] everything you want. Like painkillers also, there's something you can put in the water to heal your private parts.* […] *So they also give you those medicines. You basically go home with a lot more stuff with your birth certificate already in place.* [Respondent 7]

Dutch respondents created or borrowed traditions to make meaning in their postnatal experience. One involved care: the respondent's father was interested in Ayurvedic medicine, and made her special cookies (Respondent 13). She also kept a journal during pregnancy, as her mother did. The other respondent revived a centuries-old Dutch tradition of drinking *kandeel*, an alcoholic egg punch (Respondent 9). Both referred to the Dutch postnatal hosting tradition of serving visitors *beschuit met muisjes*, round toasts with candied anise seeds.

Past Experiences with Dutch Health and Maternity Care

A second factor shaping respondent experiences of MCA care was personal experience with Dutch health and maternity care. When respondents were asked to summarize their birth experience, some reported medical indications requiring additional clinical care during pregnancy, while others talked about unplanned interventions during their labor and delivery. Mothers were critical of the Dutch system in three areas similar to MCA care: home-based care, variable staffing, and a perceived low-intervention approach. Nonetheless, there appeared to be no direct linear relationships between maternity/health care experiences and MCA expectations in this sample.

Almost all respondents experienced a hospital birth. Some mothers were skeptical about maternity care at home, a common Dutch practice.

So I had to give birth in a hospital, […] which, to be honest, felt comforting in a way, because the whole giving birth at home on the couch and then ordering pizza and stuff, I was a little bit skeptical about […] maybe it's a good idea that there's someone around that knows what they're doing because I probably don't. [Respondent 8]

One respondent talked about the variability of midwifery staffing and lack of proactive care during a critical moment in her delivery, which appeared to align with other respondents' prior experiences with Dutch healthcare in general. Although generally positive, they perceived a minimally-interventionist approach to care.

I feel like the Dutch system is like "take a paracetamol." They're not, they're not going to do much. […] It needs to be like, it's almost the house needs to be on fire. [Respondent 2]

Several respondents shared a belief about the Dutch medical system's reliance on paracetamol as a cure-all, conveying perceptions of low-intervention and low-pain management in the Netherlands. One mother summarized this.

So that's the other extreme of not having any sort of preventive medicine, but just with paracetamol, the recurrent joke, if you're really feeling horrible, you're going to get one. If you're dying, you get two. [Respondent 8]

One Spanish respondent bitterly described her lack of pain relief during birth:

I thought maybe they would change their mind after they see me, in how much pain I am. But they didn't. […] And I was so angry, so angry because I was so spoiled from China. [Respondent 7]

One Dutch respondent learned from her studies that Dutch MCA care was "special" and "valuable" (Respondent 13) while another was not aware that Dutch MCA care was different.

Iets wat niet-algemeen bekend was, is dat het iets typisch Nederlands is, dat wist ik niet, inmiddels wel. Ik begrijp ook niet hoe dat dan in andere landen gaat. [Respondent 9]

Formal and Informal Sources of MCA Information

A third factor shaping mothers' expectations of MCA care is the sources of information about care in the Netherlands, formal and informal. Taken together, information from these sources did not always lead to clear positive or negative expectations.

Major formal sources of MCA care information were midwives providing prenatal care and intake meetings with the MCA provider. Intakes were inconsistently planned by providers: some mothers had face-to-face home intakes, while others had online meetings.

During pregnancy, most respondents met with an organizational representative instead of their (potential) caregiver. One mother had a phone call. Respondent 3 had an in-person meeting which did little to change her care expectations during pregnancy.

So we met not with the ladies that actually came, but with a representative of the kraamzorg *I chose, and they explained a little bit. […] But it was very general. So my expectation was the same as before because I didn't know anything. It was like very general of what would happen.* [Respondent 3]

One mother described her intake as emphasizing the limitations on the care that she would otherwise have received.

I knew what was going to happen, that they were gonna come and they were gonna stay for some time. I think I was told that I wouldn't get a full day, so I had half days on most days. […] I think just the shortage of personnel. And they also told me that it could be multiple people as well. And I told them I really preferred just one person. [Respondent 4]

Another learned about MCA care during pregnancy and found it too good to be true.

My expectation was that they're going to like teach us basically how to take care of a newborn. […] Midwives had said that they also can help with some like laundry stuff or like disinfecting the bathroom. And I was like, they say this, but there's no way someone's going to come and do laundry for me. That's ridiculous. [Respondent 6]

One mother felt that her intake was useful and gave her “simple” expectations of help beyond care for mother and baby.

Kraamzorg *came to discuss what they would do before. So yeah, even the hours and how hours would taper off. I think it's well structured. I was also quite happy to hear that they would help a little bit with chores like empty the dishwasher. […] Not too much. A little bit. They'll prepare breakfast for you.* [Respondent 11]

Other mothers, despite the intake, simply did not have specific details on what to expect their MCA would do. One mother recalls her impression of MCA care.

So I didn't have a very strong, very clear expectations of what exactly she was going to do. […] If not necessarily physically help us with stuff, that she would give us information that helped us later on. But that's one of the two things that I think I imagined. It's either like just doing stuff around the house, or helping me do things.
[…]
I think I would make it more clear of what the expectations should be, at least for non-Dutch people or people who tell them, I don't know anything about kraamzorg*, please inform me.*
[Respondent 8]

Respondents supplemented information from providers with the experiences of others around them. This information came from both Dutch and non-Dutch friends and family. It could be positive or negative, and sometimes made strong impressions which served as cautionary tales. Several respondents were concerned about MCAs being overbearing or controlling. One was told by non-Dutch friends in the Netherlands that MCAs would be helpful but rigid (Respondent 1), while another felt that the “help” friends described would be overbearing (Respondent 10). Some respondents combined their intake information with the negative stories from friends and family, which prompted them to limit their expectations.

I've always heard stories, so I have two sister-in-laws who obviously also had kraamzorg *in the Netherlands. But I didn't really hear positive things from them. It was more like ‘they were always in the way, or like ‘they wanted me to do things a certain way’, so I didn't really know what to expect. But also, […] I understand that everyone has their own experience. So I think I took it as, you know, just another experience in the Netherlands, you know, don't come with expectations. Just see how it is and just take it from there.* [Respondent 4]

Another respondent had positive input from her mother-in-law, but was cautious in forming strong positive expectations given her excellent postnatal care in Shanghai.

So they could do some of the house chores like laundry, and making coffee for visitors. Clean the house, or at least vacuum, clean the bathrooms also, and generally just help out, also with the older children when you have older children. […] And also take care of the mother, as in do checkups, because you also check your temperature and general health of the mother to see if there's a potential sign of any other conditions. […] And, um, so actually I had not big expectations, but I said, oh, if it's so great, at least for a week, you know, we can have a nice experience. [Respondent 7]

Dutch respondents also expressed concerns about MCAs being unfriendly (Respondent 9) or overbearing (Respondent 13). One mother had a firm knowledge of MCA care, nonetheless “worried about in particular, if I have a dominating caregiver who wants to chatter and is overbearing […]; whether I can do enough of my own thing and get some rest and say that I’d rather not chat.”

Waar ik me zeg maar zorgen over maakte, was vooral dat ik dacht oh, ja, als ik dan zo'n struis tante die wil babbelen en die iets aanwezig is […]of ik dan genoeg mijn eigen ding of zo ook genoeg mijn rust ontpakken en kan aangeven dat ik liever even niet wil kletsen. [Respondent 13]

The study MCA expressed frustration about providers creating false expectations for mothers.

It's no longer possible to give a family the whole package anymore. Everybody else has 2 or 3 or even 4 different people. And that's the complaint, you know, the disgruntlement with clients. And that's because the organizations […] promote something they cannot deliver. Yeah, they promote care, individual care. For the whole week, the same person and then people sign up to that organization thinking they're going to get that. And the reality is it's not possible. [MCA]

5.3 MCA Care Experience

Experiences of MCA care were generally positive. Many respondents expressed transformative experiences and two gained professional inspiration: one expressed a desire to become a postpartum doula in the UK when she moves back, and another plans to advocate for better MCA access and conditions. Two mothers had a negative experience but still acknowledged MCA care as a good concept. Several mothers would request the same MCA again in future. Respondents experienced few language barriers or cultural conflict, and many brought family to their Dutch homes for support during and after the birth. When communication challenges did arise, respondents sometimes attributed these to differing culture and communication norms. When challenges were addressed, they were minimized and did not negate the overall positive experience of MCA care. While some themes in respondent expectations resurfaced in experiences, no direct positive or negative relationship between expectation and experience was found.

On the whole, respondents felt cared for and appreciated the help.

It was amazing. Yeah, I'm gonna tear up because it was the most beautiful time. Yeah, I'm really fond of the people who looked after us. [Respondent 12]

Another summarized her care and the kindness in her MCA's approach:

Overall positive. She was good. You have to do so many things when you're a kraamzorg *nurse. And I think she performed well in that sense professionally. And also her manner was, you know, 'I'm there to help you, I'm there to help you.' She even made pancakes for me.* [Respondent 11]

Two respondents had negative experiences. One described it as “horrible” and felt the MCA acted as a guest instead of caregiver (Respondent 8). Nonetheless, even dissatisfied mothers felt MCA care was a worthwhile concept.

I think the idea itself is great. […] I think their job is actually greater in our eyes as mothers than what they think maybe it is. But if you're not delivering, then I think it's useless. [Respondent 7]

Three themes were identified which contributed to their varied experiences even despite overall satisfaction: variation in the care respondents received, communication barriers and resources, and familial support.

Variation in Care Received

Respondents described a variety of care activities which often contrasted with their expectations and the information they received before birth. Where some anticipated lots of support and received it, others had experiences which did not live up to the information they received. Most were surprised by their care, and some mothers received a level of emotional support, caring and listening which went far beyond what they thought would be available.

Basic care of baby and mother, and instruction for new parents were shared by all respondents, including physical checks and measurements. Instruction was provided to fathers as well as mothers. Care did not always seem to match the needs of the family: mothers with older children were given unnecessary instructions, such as understanding babies’ cries, which one mother attributes to a protocol-driven approach.

You know, she did it in a way like, ‘listen, I need to, I need to share this information with you.’ […] She also wasn't like selling it too hard. She was sort of like, […] ‘it could be interesting, it could be not, but I'm going to tell you.’ [Respondent 2]

Some respondents were surprised at the care they received. Household activities received the most attention in mothers’ stories: cooking, tidying, mopping, laundry and cleaning the bathroom were often unexpected. Many described these as positive “extras”. One

mother had just a second child and received cleaning support that she later learned was standard.

I think one, the fact that she cleaned the toilet, for example, […] I knew there was like light housework, but I didn't know that that was standard. I know now that it's standard because I sort of saw it with the second one. […] they're instructed to do that. And we didn't expect it because we didn't know about it, but it felt like, oh, that's something. [Respondent 8]

The majority of respondents received care from multiple caregivers, either sequentially or simultaneously. Care sometimes varied among MCAs within the same household. One mother was surprised to receive housekeeping support from her second MCA, given that providers told her not to expect it.

…They [MCA providers during intake] had sort of said that they would not do any house care, that this was in the past, and that now they focus more on the person and on the baby. […] And so the first one [MCA] didn't. No they didn't do anything basically. I mean she helped a lot, but not in the house. And the second one [MCA] did actually. Yeah, she did bathrooms every day and then she did laundry. [Respondent 3]

Many respondents described a level of emotional support in MCA care that exceeded their expectations. MCAs gave the mothers reassurance and listened without prejudice. Respondents felt comfortable recounting birth experiences and bonded over shared motherhood. Some respondents shared difficult experiences, such as the death of a parent (Respondent 11). One mother described how her MCA helped her process a difficult birth.

At first we butted heads, but then we became quite close. And I did open to her about my experience with the midwife and about the panic attacks […] And then when the midwife even came to ask about how things went, she sat here with us and she said, 'I'll just sit here with you in case [respondent] wants to tell what happened.' And it was nice having her kind of there as a backup because I was able to share with the midwife about what I didn't like. [Respondent 10]

Many respondents felt cared for and listened to. Mothers received support that built trust and helped them feel confident in their own parenting. One summarized her experience as far exceeding her expectations.

I think that my expectations were really low or basic. […] I then got to be super surprised with how, how it felt being cared for and nourished and looked after, also spiritually or emotionally […] she gave me this confidence that I'm this baby's mom and I can do it. [Respondent 12]

One Dutch respondent expressed surprise at the care she received versus the care she anticipated, despite being well-informed about MCA care: “the extent to which I talked with her, that I didn’t expect. That I also got a lot of support from that, in giving some space to how the birth had gone…very intense and intimate and so really as if someone is kindof part of your family.”

De mate waarin ik ook met haar gepraat heb, dat had ik niet verwacht. Dat ik daar ook wel veel steun uit had of zo in het aan de ene kant een beetje de plek geven van hoe die bevalling was verlopen… Echt heel intens en heel intiem en dus echt [als]of iemand ongeveer onderdeel van je gezin is. [Respondent 13]

Communication

When asked about their communication, respondents described effective communication and minimal language barriers. Respondents received care from MCAs who spoke English with variable proficiency, and all made efforts to accommodate each other. Communication barriers were identified when respondents had unmet expectations or negative experiences with care. Some respondents were unable to confront MCAs directly, and engaged their Dutch partner. When mothers addressed the issue directly or indirectly, their experience improved.

Respondents identified their need for English-language MCA care during intake. Nearly all mothers felt English-language communication with their MCA was effective, even when proficiency varied. One mother describes her experience with two MCAs:

Her English was really good. The intern [was] not as confident, but she was really great in English and I really felt I could just ask her anything. [Respondent 5]

Trainee MCAs paired with main caregivers were sometimes less proficient in English. Yet because main support was provided by a more proficient MCA, respondents did not perceive it as a problem. When differences in English proficiency arose, respondents used mobile phone apps, switched to the Dutch they knew, or engaged Dutch partners as informal translators, as this mother describes.

She spoke English just fine. But if she didn't know something or if there was something in Dutch, my husband just told her or helped translate. [Respondent 10]

One mother experienced a language barrier with her MCA, who spoke English with effort. Instead, the MCA spoke to the father in Dutch in another room, leaving the respondent feeling alone.

After the first two days, I became aware of a sense of isolation because she and my husband would speak Dutch and I could hear them. We were in a small apartment, so I could hear them and it sounded so cozy. And I was alone, suffering, in pain. And I just felt like crying. And it wasn't the blues, but it was like. Talk to me! Talk to me! Speak English to me, please. I belong in this home too. I don't want to be isolated in my own home. [...] Then once she found out, she did start to try and speak more English to me. So I appreciated that. [Respondent 11]

When negative experiences arose, respondents used different approaches. A few communicated their dissatisfaction to MCAs directly or enlisted their Dutch partners. For some, communication norms limited their ability to confront their MCAs directly because it would be impolite or cost too much effort. They perceived Dutch people to be direct or straightforward in communication. Regardless of who communicated, addressing their issues improved respondent's experience. This is illustrated by a respondent from the US:

We only had one point of very strong disagreement where my husband and I put our foot down. [...] the next day we talked to the kraamzorg and [said] "look there's things that you can advise us on and tell us, like what you think is best, but when it's going to come to our health like you don't tell us what to do." [...] And my husband did that speaking, being a sort of Dutch man. [...] And then since then, our work was amazing and we got along really well, and she respected our boundaries and listened to everything we said. [Respondent 10]

Dissatisfied respondents recognized that being direct might have helped them, but could not do it themselves. One mother explains:

It's very difficult to tell someone, 'Hey, you're doing a crappy job. We don't like you.' [...] To call someone to say it's not a good match, because you're basically giving feedback when somebody is a person. Well they're a professional service as well. But also the match. [Respondent 8]

Dutch respondents did not express concerns about addressing potential dissatisfaction, even with unusual interactions (Respondent 9). Another mother explains: "If someone came

in with whom I felt absolutely no click, we would have said something, we would have taken action. We did agree, however, that he [husband] would take the lead in doing something.”

Als er iemand binnen was gestapt waar ik echt totaal geen klik mee had gevoeld, dan hadden we daar wel wat van gezegd, denk ik, dan hadden we daar wel actie op ondernomen. […] We hadden wel afgesproken dat hij [man] dan ook in de lead was om daar iets mee te doen. [Respondent 13]

This study’s MCA indicated that Dutch MCA providers have increased English-language accommodations for non-Dutch speaking international mothers over the past 10-15 years. To reduce other communication barriers, her organization instructs MCAs to invite ongoing feedback from mothers—a practice not reported in this sample. She explains:

It could be that they'd rather you didn't do something. Or they'd rather you did something else. But they're too tired and too involved in their new baby to have the energy to actually bring the subject up, so it's up to us as kraamverzorgsters [MCAs] to ask everyday: Are you OK with the way I was working? Would you rather I did it differently? Is there something I'm missing? So you check in with them every single day just to make sure that they're happy with what you're doing. [MCA]

Familial Support

Many respondents brought their mothers, parents or parents-in-law from their home country to stay with them during the postnatal period. This occurred for most throughout the delivery and MCA care period, while others planned the support after MCA care. This served as social-emotional support, connection to cultural tradition and practical support that could supplement MCA care. Interactions between familial support and MCA care were positive, and no conflict arose. Some respondents expressed concerns beforehand, but these experiences were generally positive. For one respondent, her mother’s six-week visit provided both practical support and connection her to Pakistani cultural tradition.

My mom brought certain seeds and ingredients where she wanted to make little snacks for me, so we did that a bit beforehand. [Respondent 4]

Traditions were not necessarily set in stone, and expectations for this respondent’s experience of tradition was made more complex by the migration background of her visiting mother, who migrated from Pakistan to the US. She continues:

I think because I'm also her first child, she didn't really know how to go about it. I know she wanted to do it because it's a cultural norm, but she didn't really, she also didn't watch anyone go through it, because we lived in America. We don't have family in America. So she had this expectation that she needs to do something, but she didn't really know how to do it. So it was very interesting to navigate. [Respondent 4]

Some respondents chose not to have family involved, while others were limited by circumstance. One mother was happy to have an alternative to family coming to stay.

...It's also not very simple if your mother, your own mother comes and tries to help. There are too many emotions playing there, so I don't like that too. So I'm really happy that we were able to do this without our mothers being involved, with a professional who was also caring. [Respondent 1]

Respondents reported no problems or negative interactions between the MCA and the family visiting the household. Respondents and their visiting families worked with MCAs in and around their cultural traditions: family care and support for mother and baby worked with and around MCA care. MCAs expressed interest in cultural traditions, and families appreciated caregivers' professional knowledge and practice. Some expressed initial concerns about the interactions, such as one respondent, whose mother-in-law flew in from Turkey for the birth and postnatal period. This concern did not materialize: her mother-in-law expressed strong approval of the MCA's approach to caring for mother and baby.

... but it turned out to be incredible. And [father]'s mother was just like, "Apparently I know nothing. This woman knows everything, and I am learning everything from this woman for the first time." So she was she was just completely impressed and amazed by her as well. [Respondent 6]

Dutch respondents also navigated the role of parental support during their birth and MCA care. One respondent had a short visit from her parents during MCA care, while another had friends make meals for them and could rely on nearby family: "My parents live fairly close by, so I thought they would check in regularly, and if we need help we can ask."

Mijn ouders wonen best dichtbij, dus ik dacht inderdaad wel, ja, die komen, denk ik, wel regelmatig even kijken en als er iets is, kunnen we wel een om hulp vragen. [Respondent 13]

All respondents whose brought their parents to the Netherlands also perceived their MCA care as positive. This may be due to not relying solely on MCA care and having additional sources of practical and emotional support in a challenging time for new mothers.

Respondent expectations and experiences do not clearly align with theoretical expectations. Moreover, the link between new mothers' expectations and experiences is unclear, suggesting a gap in theories linking expectation and experience. These topics are discussed below.

6. DISCUSSION

This qualitative examined the Dutch postnatal home care experiences of international mothers with diverse sociocultural backgrounds and maternity experiences. Findings indicate what shapes respondents' expectations for Dutch postnatal home care and important themes in lived experiences of mothers. This study also illustrates the role of culture, language and communication in respondent expectations and experiences.

The study adopts the Lakin and Kane (2022) model to frame inquiry around factors which shape migrant healthcare expectations: (temporal and spatial) social location, relational dynamics, and interpretation of past care experiences. In this study the social location of respondents is varied, translocational and dynamic. Mothers accessed experiential, knowledge and support resources from multiple locations, past and present. This moves beyond past research identifying the lack of social support due to distance or migration circumstances (Jonkers et al., 2011; Sami et al., 2019; Almeida et al., 2023; Sellevold et al., 2022; Higginbottom et al. 2016; Finlayson et al., 2020). Social contexts were not limited to the Netherlands and home country, but transnational: mothers brought multiple cultural reference points and resources to their new Dutch experiences. Social support shifted across borders: respondents brought familial support to their Dutch location during and after the birth. They incorporated experiences of "intermediate others" (Lakin & Kane, 2022, p. 3) including local care providers, friends and family to manage expectations and fill information gaps. This aligns with past research identifying friends and relatives in the new country as important access points to a new health system (Fair et al., 2020; Wallace, 2018) as well as local-international social media groups for knowledge and support (Wallace, 2018, p. 128).

This study also adds to the understudied influence of past healthcare experiences on people's expectations of future health care (Lakin & Kane, 2022; Fair et al., 2020). Findings confirm past healthcare experiences as a relevant source of information for mothers preparing

for MCA care. Although findings may reflect previous conclusions that duration, new roles and new social contexts can variably influence healthcare-related expectations (Lakin & Kane, 2022, p. 3), this study found no clear positive or negative relationship between past healthcare experiences and MCA care expectations, deviating from past research (Lakin & Kane, 2022; Fair et al., 2020). Respondents with a range of past experiences predominantly approached MCA care with few or cautious expectations. This may be attributed to the relative lack of comparable postnatal care systems in other countries, and divergent or incomplete sources of information about Dutch MCA care. Findings suggest that respondents consciously say to manage or limit expectations even when absorbing multiple factors from past experiences or current information.

Findings in this study suggest that migrant healthcare expectations are important but nuanced in their relationship with future experience. Generally aligning with past research, most respondents in this study found home based MCA care beneficial (Fakiri et al., 1999) and a satisfactory or positive experience overall (Baas et al., 2017; Korfker et al, 2011; Sami et al., 2019) even when negative isolated interactions occurred (Rudman and Waldenström, 2007). Yet respondents' expectations varied within and across positive and negative care experiences, and both evaluations contain complex individual interactions. This makes a unique contribution to the discussion of expectations and experiences, in which past findings indicate a reciprocal relationship where past healthcare experiences can "broaden or limit one's 'horizon of expectations'" in care experiences (Lakin & Kane, 2022 p.7) and home country or maternity experiences determine expectations of maternity care (Fair et al., 2020; Baas et al., 2017; Al-Hussainy et al., 2021). Findings suggest that other aspects of experience override or intertwine with expectations. This could be due to high education level, few language or communication barriers and/or familiarity with multiple sociocultural contexts.

Additional research is needed to better articulate how expectations and experiences connect in multicultural and complex migration contexts.

Findings in this study add to the discussion of language and communication barriers in migrant maternity and healthcare. Respondents in this study were women with post-secondary education, medically literate and utilized a variety of resources to inform themselves about their care. All respondents had MCA providers who spoke English, and MCAs and respondents communicated predominantly in English instead of Dutch. Proficiency varied, but communication was wholly seen to have been effective. Only one respondent in this study identified a language barrier, a low occurrence deviating from most past research but consistent with findings in a middle-class migrant sample in the Netherlands (Shan et al., 2023). Language barriers were mitigated by accommodation behaviors of both caregivers and mothers (Ylänne, 2008). When language skill levels mismatched, respondents and their MCAs used mobile phone apps to translate and engaged fathers or MCA colleagues with different linguistic repertoires to ensure successful communication. Findings show that Dutch MCA providers have increased accommodations for non-Dutch speaking international mothers: this can be seen as an organizational-level convergence to increase and improve MCA care systemwide. Establishing a common language is a practical approach by care providers which aligns with past research recommendations about language (Sami et al., 2019; Wikberg et al., 2012; Wallace, 2018), flexibility and client-centeredness in care (Boerleider et al., 2014; Lambermon et al., 2020; Baas et al., 2017).

This study found insufficient and inconsistent information about MCA care in expectations and lived experiences of mothers. Findings align with past research citing challenges in information about and understanding of healthcare systems (Korfker et al., 2011; Higgenbottom et al., 2016; Fair et al., 2020; Sellevold et al., 2022; Sami et al., 2019) and detailed information accessible to migrant mothers (Boerleider et al., 2014; Barimani et

al., 2015; Higgenbottom et al., 2016). Formal and informal communication channels did not yield clear knowledge and understanding of what care would specifically entail. This aligns with past research citing lack of information as limiting women's care options and rights, their ability to advocate for themselves, and their full partnership in care decisions (Fair et al., 2020; Wallace, 2018; Shan et al., 2023). Additionally, inconsistent MCA information may not only be a "migrant" problem: Dutch respondents lacked information even with common language and culture. Additional research is needed to compare the real-world provision of MCA information with care received, across all backgrounds.

The findings of this study suggest a more nuanced role of culture in this sample than reported in past research (Fakiri et al., 1999; Wikberg et al., 2012; Korfker et al., 2011; Boerleider et al., 2014; Schouten et al., 2021; Sami et al., 2019; Banbury et al., 2023; Higgenbottom et al., 2020, Shan et al., 2023). Postnatal cultural traditions were identified by several mothers and manifested in support by family or community. Despite concerns, respondents identified no cultural barriers or clashing norms in their care experience: MCA care was accommodated around their cultural traditions, literally and figuratively occupying a shared space. Some MCAs expressed interest in cultural traditions, and families appreciated caregivers' professional practices. This aligns with one study's finding that resilience, adjustment and changing cultural beliefs yields better care outcomes (Balaam et al., 2013, p. 1926). Notably, the majority of respondents came from two or more geographical or cultural locales prior to the Netherlands. These past multinational migration contexts may combine with the new one to form a "transformed *habitus*" in place of there-versus-here normative cultural experiences (Lakin & Kane, 2022, p. 3). Findings indicate that through learning and navigating multiple migration contexts, respondents develop intercultural competence skills in assessing, reflecting, integrating multiple knowledge sources before making a judgment.

Study findings point to a possible cultural role in communication barriers arising from respondents' reluctance to confront MCAs with negative experiences or dissatisfaction, aligning with past research (Korfker et al., 2011; Sellevold et al., 2022). Cultural scripts (Goddard & Wierzbicka, 2004) may play a role in some communication challenges between respondents and MCAs. Some respondents who couldn't confront their MCAs indicated that their own cultural scripts characterized such direct communication as inappropriate, at times even when recognizing it might be more effective. Dutch partners were engaged as co-parents in postnatal care, contrasting with Swedish studies (Ellberg et al., 2010; Rudman & Waldenström, 2007) and as communicators. This was apparently due to the contrasting cultural script of Dutch communicative directness, shared between MCAs and partners without internal conflict. However, Dutch respondents also delegated communication to fathers, indicating multiple possible motivations.

Cultural misunderstanding, conflict and "othering" of non-Dutch mothers and their visiting families are well-cited in past research (Shan et al., 2023; Fair et al., 2020; Higgenbottom et al., 2020; Korfker et al., 2011) but were not found. This may be due to common language usage between patients and caregivers or a general accommodation of cultural traditions and respondent needs, reflecting an existing theme of flexibility in MCA care (Boerleider et al., 2014).

Findings contribute important narratives to an ongoing discussion of the migrant and expatriate maternity experience (Verschuuren, 2024; Shan et al., 2023; Wallace, 2018). This study provides insights into the experiences of new mothers, the majority of whom migrated for career, family or relationship reasons. This categorizes them by some definitions as expatriates ("expats") or internationals (Middendorp et al., 2020; Kunz, 2020; Cranston et al., 2017) and identifies them in the increasing group of mobile humans driven to relocate by choice, affluence or self-actualization (Robertson and Roberts, 2022). Additional research is

needed on identity and identifiers in migration research, to better understand individual motivations, sociopolitical implications and collective impact on all migrant subgroups.

The sample is homogenous in its higher education level and professional status, relatively higher median age of first-time moms, and gender-normative family compositions. Yet it is heterogenous in respondent national origin and diversity of cultural experiences and influences. Respondents were recruited independent of migration route or socioeconomic status; these can be inferred but were only occasionally made explicit in data. Findings deviate from those of broader migrant studies exploring cultural or racial discrimination, exclusion, and socioeconomic pressure (Fair et al., 2020, p. 2) or those addressing the needs of migrants who experience trauma through migration (Fair et al., 2020; Almeida et al., 2023). Research in these areas is fundamental to understand, identify and ultimately address migration challenges for those most affected and least empowered. Additionally, findings suggest exploring postnatal care comparatively across migrants rather than with local populations, in keeping with research recommendations (Cranston et al., 2017). Further examination across migrant, international and expatriate experiences can broaden existing knowledge of emergent subgroups, including the growing "middle-class cultures of mobility" who increasingly access global education, professional or life experiences (Robertson & Roberts, 2022, p. 2). This can yield better understanding of commonalities, differences, challenges and opportunities across the spectrum of migrant life experiences.

Limitations

The present study is descriptive research on a small sample of respondents, which yields no correlational or causal inferences and is not statistically generalizable to the target population. Nonetheless, the rich description of current mothers' experiences in the Dutch MCA care setting yields insights into international mothers' expectations of home maternity care assistance, the interplay of those expectations with their lived experience, and the role of

culture in both. Themes identified here were also identified in and build on past research findings in both supporting and contrasting ways.

A number of biases may have impacted study results, the most important involving recruitment. The sample was recruited in a short timeframe, limiting access to intended target groups and prohibiting a representative or broad sample, impacting the heterogeneity of findings. Numerous recruitment approaches were used to find a broad sample, including deviant case response sampling. Dutch respondents were also underrepresented due to lack of response, despite these attempts. Recruitment time was extended and additional measures taken to increase and broaden participation as much as possible. Most respondents reacted to a single Facebook group, which may have biased results towards older mothers and limited the comparability of respondents. Other social media (NextDoor) and printed flyers were used to access a wider age and educational range, but were unsuccessful given the study timeframe.

Data was collected through semi-structured interviews. Phrasing of questions, tone, and body language could impact the responses of respondents through interviewer bias or the interviewer's inexperience (Gibson & Hua, 2016, p. 186). Interview guides were reviewed iteratively to ensure responses remained in relative alignment, and the interviewer reflected on their role on an ongoing basis. Interviewee bias is possible given respondent knowledge of the interview as a non-Dutch mother, potentially increasing social desirability or a socially-constructed narrative (Ladegaard, 2018, p. 696). Recall bias may occur: expectations of MCA care changed over time and were challenging to articulate retrospectively. Respondent views may have also been positively influenced by the significant event of giving birth. Multiple and sometimes overlapping questions were incorporated into the interview guide to elicit information from multiple angles. Interviews were conducted in person for typically an hour, which may have prevented some mothers from participating given lack of available time or

interest. Interviews were arranged as conveniently as possible for respondents at times, days and locations of their choosing.

Finally, this study collected the significant life events of 12 individual women, whose full experiences are impossible to share in this limited space and whose representation in this study is a small fraction of the rich stories they told. The author is deeply indebted to them for their patience, humor and generosity.

Reflection

This study was conducted with a personal and academic curiosity about Dutch MCA care. Assumptions about possible findings, were challenged during the research. Personal MCA experiences and informal stories of other mothers led to expectations (mostly supported by literature) of Dutch-language challenges and unpredictable MCA interactions. The lack of similar findings here was unexpected, as was the contrast between easy recruitment of international mothers, and unsuccessful recruitment of Dutch mothers. Social media access and social networks play a role: the researcher had ready access to groups where other international moms connect. Attempts to recruit through Dutch language social networks failed, despite multiple avenues and attempts, largely due to study time constraints. A fuller examination of reasons for this failure would benefit future expansions on this research.

The researcher was challenged by terminology. Usage of the terms “voluntary migrant”, “expat” and “international” were interchanged throughout the interview process. As an American living in the Netherlands for 15 years, the term “expat” was perceived to be heavily loaded and conflicted with the researcher’s personal acculturation experience perspective. The present study led to new awareness of the complexity of this positioning and the need to continue examining these categories.

The researcher was privileged to hear women's deeply personal stories, and sometimes the figurative space between interviewer and interviewee was very narrow. It cost

effort to refrain from sharing personal experiences. It has been important to continuously reflect on the researcher role, while acknowledging that it is human to connect and relate.

7. CONCLUSION AND SUGGESTIONS FOR FURTHER RESEARCH

This qualitative descriptive study explored the perceptions of international women regarding postnatal care from Dutch maternity care assistants. This inquiry was framed around expectations and experience, and examined the role of culture and language in MCA care. Study findings challenged common understandings of the migrant postnatal and maternity experience. Language barriers and cultural friction are known findings of migrant healthcare research yet were minimized here through a common language and mutual accommodation between MCAs and mothers. A systemic approach to English-language MCA care allowed respondents to participate in care and form trusting relationships with caregivers, while access to family brought support and links to cultural traditions which worked with and around MCA care. Findings indicate that migrant mothers' expectations did not overtly shape their experiences, yet the multiple sociocultural backgrounds of the sample contributed to tempered expectations and helped them to contextualize their experience of postnatal care.

Further research is recommended to build and expand on findings from the present study. The need remains for additional research into the experience of non-Dutch mothers in Dutch postnatal care. A closer and comparative look at populations of multiple migration backgrounds, motivations and socioeconomic status can yield more nuanced insights into the experience of mothers giving birth outside of their home country. In the Netherlands, MCA care and maternity care delivered to those living in asylum centers may yield very different expectations and experiences of postnatal care, given stressful or traumatic migration and living conditions that can deviate sharply from Dutch norms (Verschuuren, 2024).

Additional research is needed to better articulate the role that expectations play in shaping experiences, and the factors that contribute to those expectations. A focus on

migrants with multicultural backgrounds across migration contexts can explore new facets of the collective migration experience. Future research in postnatal care expectations would likely benefit from a longitudinal approach, to capture how expectations shift across time points during pregnancy, birth and new motherhood. A mixed methods approach would allow for more detailed analysis of care delivery, care activities and migrant mothers' satisfaction levels. In a larger sample findings could be generalizable to the population. Direct observation of MCA care interactions may yield insights into (intercultural) communication which cannot be identified through self-reporting alone. Recruiting migrant mothers from more rural locales in the Netherlands may yield insights into the variation in language accommodation throughout the care system. Additional research into common language approaches in cross-cultural MCA care delivery could yield practical new insights for postnatal care and beyond.

Findings indicate that fathers were actively incorporated into postnatal care, as co-caregivers and care recipients. Dutch partners of non-Dutch mothers also served a critical role as communicator on behalf of mothers. Additional research into the evolving role of fathers in postnatal care can shed light on ways in which their own experiences contribute to and deviate from mothers' experiences. Comparing Dutch and non-Dutch fathers' experiences in migrant mothers' postnatal care could yield unique insights into how their roles are shaped in cross-cultural care contexts.

Finally, the present study yields findings which have practical implications for maternity care assistance in the Netherlands. Recommendations for practice center along three principal findings.

Common language met mothers' linguistic needs. Respondents' linguistic and cultural needs in this study appear to have been met successfully on the whole, in large part due to the implementation of English-speaking MCAs in standard postnatal care practice. Availability of

and demand for English-speaking caregivers is likely to be greater in the Utrecht region, where 21.6% of residents were born outside of the Netherlands and the migrant community is diversifying (Utrecht Monitor, 2023). However, the growing number of migrants in smaller Dutch towns and the dominant position of English as a global lingua franca (Jenkins, 2011) call for a system-wide examination of the potential benefits of care offered in English, Arabic or other common languages.

Communication of dissatisfaction was not always possible. While findings in this sample indicate that difficulties with confronting MCAs were at least partially grounded in culture, other factors may prevent mothers from having hard conversations during care moments. Implementing a low-threshold manner for mothers to approach difficult topics may increase effective communication: this may include online feedback systems throughout care periods, regular telephone check-ins with provider representatives, or ongoing inquiries by MCAs to increase opportunities for mothers to express their needs. Such systems can account for and ideally circumvent mothers' (cultural) barriers to difficult conversations.

Informational resources were often insufficient. Despite intake meetings, print and online materials, mothers did not have a clear sense of the care they would receive. During caregiving, care activities were not always consistent across caregivers or in line with the information given. MCA providers can provide a clearer and more detailed explanation of care activities during intake, distinguishing between standard versus special care and providing specific examples. Changes to the plan of care can be discussed dynamically with families. This will allow all mothers a greater sense of trust and informed participation in their postnatal care, and more accurately inform their expectations for MCA care.

In examining the perceptions of international mothers in MCA care, this study aims to shed light on the diversity of expectations and experience across a relatively understudied migrant group. Findings show the complex connection between expectations and experience,

the multiple factors that influence expectations, and the themes of care, communication and family support which characterize their lived experiences. These findings provide unique insights and suggest promising future research directions into maternal perceptions of the unique Dutch postnatal care context, through the stories of international migrant women within it.

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9 Appendices

9.1 Appendix: Consent forms

DECLARATION OF CONSENT for participation in:

Maternity care assistance in the Netherlands:
The expectations and experiences of new moms

I hereby confirm:

- that I have been satisfactorily informed about the study through the information letter;
- that I have been given the opportunity to ask questions about the study and that any questions I asked have been satisfactorily answered;
- that I have had the opportunity to carefully consider participation in this study;
- that I voluntarily consent to participating.

I consent to the following:

- the data collected will be obtained for educational purposes and retained as stated in the information letter;
- audio recordings will be made for educational purposes.

I understand that:

- I have the right to withdraw my consent to the use of data, as stated in the information letter.

Name of participant: ________________________

Signature: ________________________ Date (d/m/y): ___ / ___ / ___

Town/city: ________________

To be completed by the researcher carrying out the study:

I declare that I have explained to the above-mentioned participant what participation in the study entails.

Name: ________________________

Signature: ________________________

Date: ___ / ___ / ____, ________________

DoC_adults 16+_20211210

Universiteit Utrecht

TOESTEMMINGSVERKLARING voor deelname aan:

Kraamzorg in Nederland:
de verwachtingen en ervaringen van nieuwe mama's

Ik bevestig:
- ☐ dat ik via de informatiebrief naar tevredenheid over het onderzoek ben ingelicht;
- ☐ dat ik in de gelegenheid ben gesteld om vragen over het onderzoek te stellen en dat mijn eventuele vragen naar tevredenheid zijn beantwoord;
- ☐ dat ik gelegenheid heb gehad om grondig over deelname aan het onderzoek na te denken;
- ☐ dat ik uit vrije wil deelneem.

Ik stem ermee in dat:
- ☐ de verzamelde gegevens voor educatieve doelen worden verkregen en bewaard zoals in de informatiebrief vermeld staat;
- ☐ er voor educatieve doeleinden geluidsopnamen worden gemaakt.

Ik begrijp dat:
- ☐ ik het recht heb om mijn toestemming voor het gebruik van data in te trekken, zoals vermeld staat in de informatiebrief.

Naam deelnemer: ________________________________

Handtekening: __________________________________ Datum, plaats: ___ / ___ / ____, ___________

In te vullen door de uitvoerend onderzoeker:

Ik verklaar dat ik bovengenoemde deelnemer heb uitgelegd wat deelname aan het onderzoek inhoudt.

Naam: _________________________

Handtekening: _________________________

Datum: ___ / ___ / _____

9.2 Appendix: Information Sheets

Information about participation in

Maternity care assistance in the Netherlands:
The expectations and experiences of new moms

1. Introduction

You are being asked to take part in scientific research. The study will be conducted in person at a convenient time and location for you.

2. What is the background and purpose of the study?

In this Masters research project, we would like to learn about the expectations and experiences of new mothers during their time at home with a Maternal Care Assistant (*kraamzorg*). This is an educational research project.

3. Who will be carrying out the study?

Elizabeth Groom, Master's student of Intercultural Communication at Utrecht University will be conducting the research. She can be reached at e.a.groom@students.uu.nl. The data controller and research supervisor for this project is Dr. Rena Zendedel, she can be reached at r.zendedel@uu.nl.

4. How will the study be carried out?

For this study 12-16 people will be interviewed and asked to talk about their experiences. These interviews will take between 30-60 minutes.

5. What will we do with your data?

We will make a recording and transcription of our interview, for educational purposes only.
This audio and transcription text will only be shared with our data controller and supervisor, Dr. Zendedel. The transcription data will also be anonymised and your name will only be known to us.

6. What are your rights?

Participation is voluntary. We are only allowed to collect your data for our study if you consent to this. If you decide not to participate, you do not have to take any further action. You do not need to sign anything. Nor are you required to explain why you do not want to participate. If you decide to participate, you can always change your mind and stop participating at any time, including during the study. You will even be able to withdraw your consent after you have participated. However, if you choose to do so, we will not be required to undo the processing of your data that has taken place up until that time. The research data we have obtained from you up until the time when you withdraw your consent will be erased.

7. Approval of this study

If you have any complaints or questions about the processing of personal data, please send an email to the Data Protection Officer of Utrecht University: privacy@uu.nl). The Data Protection Officer will also be able to assist you in exercising the rights you have under the European General Data Protection Regulation (GDPR). Please also be advised that you have the right to submit a complaint with the Dutch Data Protection Authority (https://www.autoriteitpersoonsgegevens.nl/en).

8. More information about this study?

Supervisor: Dr. Rena Zendedel, r.zendedel@uu.nl

Elizabeth Groom: e.a.groom@students.uu.nl

9. Appendix:

Informed Consent Form

Informatie over deelname aan

Kraamzorg in Nederland: de verwachtingen en ervaringen van nieuwe mama's

1. Inleiding

Je wordt gevraagd om deel te nemen in wetenschappelijk onderzoek. Deze studie wordt uitgevoerd in persoon op een tijdstip en plaats die jou uitkomen.

2. Wat is de achtergrond en het doel van het onderzoek?

In dit Master onderzoeksproject willen we meer te weten komen over de verwachtingen en ervaringen van nieuwe moeders tijdens hun tijd thuis met kraamzorg. Dit is een educatief onderzoeksproject.

3. Door wie wordt het onderzoek uitgevoerd?

Elizabeth Groom, masterstudente Interculturele Communicatie aan de Universiteit Utrecht, zal het onderzoek uitvoeren. Zij is te bereiken op e.a.groom@students.uu.nl. De databeheerder en onderzoeksbegeleider voor dit project is Dr. Rena Zendedel, zij is te bereiken op r.zendedel@uu.nl.

4. Hoe wordt het onderzoek uitgevoerd?

Voor dit onderzoek worden 12-16 mensen geïnterviewd en gevraagd om over hun ervaringen te praten. Deze interviews duren 30-60 minuten.

5. Wat gebeurt er met jouw gegevens?

We maken een opname en transcriptie van ons interview, alleen voor educatieve doeleinden.

Deze audio- en transcriptietekst wordt alleen gedeeld met onze databeheerder en supervisor, Dr. Zendedel. De transcriptiegegevens worden ook geanonimiseerd en jouw naam is alleen bij ons bekend.

6. Wat zijn jouw rechten?

Deelname is vrijwillig. Jouw gegevens mogen alleen voor ons onderzoek verzameld worden als je hier toestemming voor geeft. Als je toch besluit niet mee te doen, hoef je verder niets te doen. Je hoeft niets te tekenen. Je hoeft ook niet te zeggen waarom je niet wilt meedoen. Als je wel meedoet, kun je je altijd bedenken en op ieder gewenst moment stoppen — ook tijdens het onderzoek. En ook nadat je hebt meegedaan kun je je toestemming nog intrekken. Als je daarvoor kiest, hoeft de verwerking van jouw gegevens tot dat moment overigens niet te worden teruggedraaid. De onderzoeksgegevens die wij op dat moment nog van je hebben, zullen worden gewist.

7. Goedkeuring van dit onderzoek

Heb je een klacht of een vraag over de verwerking van persoonsgegevens, dan kun je terecht bij de functionaris voor gegevensbescherming van de Universiteit Utrecht (privacy@uu.nl). Deze kan je ook helpen bij het uitoefenen van de rechten die je onder de AVG hebt. Verder wijzen we je erop dat je het recht hebt om een klacht in te dienen bij de Autoriteit Persoonsgegevens (www.autoriteitpersoonsgegevens.nl).

8. Meer informatie over dit onderzoek?

Supervisor: Dr. Rena Zendedel, r.zendedel@uu.nl

Elizabeth Groom: e.a.groom@students.uu.nl

9. Bijlagen:

Toestemmingsverklaring

9.3 Appendix: Coding Tree

MAXQDA 2022 15/04/2024

Code System

Code System
Code System
MCA interview
Autocode - ANY: expat
Autocode - ANY: bossy
Autocode - ANY: paracetamol
Autocode - ANY: Cocoon+bubble
Autocode - ANY: Trauma
Expat search
Luck
Motivation to participate
Introduction
Feeling as migrant general
Study general
Study general\blurry vague search
Study general\Online sources
Study general\Paracetamol
Experience
Experience\Expectations + experience connect?
Experience\Expectations + experience connect?\inspiration professionally
Experience\Future changes
Experience\Future changes\would you do it differently?
Experience\Future changes\Wish list KZ
Experience\Future changes\same person again!
Experience\Relating with KZ
Experience\Relating with KZ\beyond tasks - emotional support
Experience\Relating with KZ\"Typically" NL
Experience\communication
Experience\communication\directness
Experience\communication\SID12 confusion two kzs
Experience\communication\English
Experience\unexpected care given

Experience\unexpected care given\things expected that DIDN'T happen
Experience\Care given
Experience\Care given\comparing to second KZ exp-SID8
Experience\Household interactions
Experience\Household interactions\Dad involvement
Experience\Household interactions\Dad involvement\Dad as communicator search 1-6
Experience\Household interactions\Deferring to knowledge of KZ
Experience\Household interactions\Culture-care intersections
Experience\Household interactions\Culture-care intersections\modifying culture/traditions
Experience\Other support actual
Experience\Month/year kraamzorg
Experience\Number of MCAs
Experience\Days and hours kraamzorg
Expectations
Expectations\Other support expected
Expectations\Sources of info KZ
Expectations\Sources of info KZ\English request
Expectations\Sources of info KZ\Intake KZ
Expectations\Expectations KZ
Expectations\Expectations KZ\Negative image NL healthcare
Expectations\Past experiences (e.g. HC)
Expectations\Past experiences (e.g. HC)\Other countries
Expectations\Social media
Expectations\Other moms elsewhere
Expectations\Other moms NL
Expectations\Traditions customs norms
Maternity
Maternity\Other care+support
Maternity\Other care+support\self-education maternity/PNC
Maternity\Delivery
Maternity\Delivery\how long hospital stay
Maternity\Delivery\complications?
Maternity\Birth location
Maternity\Circumstances maternity time

Maternity\Circumstances maternity time\Health status-complications
Demographics
Demographics\spouse/partner
Demographics\City/town of kraamzorg
Demographics\City/town in NL now
Demographics\Education background
Demographics\Professional background
Demographics\Reason to come to NL
Demographics\Child # NL KZ
Demographics\Length of stay in NL
Demographics\Place of Origin
Demographics\Age