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Research Article

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# Navigating Maternity as an Expatriate: A Qualitative Inquiry into Maternal Experiences in the Netherlands

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**Abstract**

*This study explores the personal experiences of expatriate women during pregnancy, childbirth, and the postpartum period in the Netherlands. The expatriate women's population continues to grow globally, but their experiences in navigating the maternal healthcare system are underexplored and often are lumped into general immigrant data. This research aimed to understand how healthcare practices, language differences, and lack of social connection significantly shaped their maternity care experiences. Semi structured interviews were conducted with a diverse sample of 12 expatriate mothers from 5 different countries of origin, and the data was analyzed using Braun and Clarke's six-phase thematic analysis. Five major themes emerged: navigating the healthcare system, encountering care through voice and relationship, living between cultures, navigating body and mind, and the lived experience of breastfeeding. Many participants highlighted the significance of autonomy, trust, and communication in shaping their perceptions of care quality. The findings underscore the importance of culturally responsive maternity care that supports diverse needs and enhances the well-being of birthing individuals in cross-cultural contexts. This research contributes to the growing body of knowledge on global maternal health and calls for healthcare systems to adopt more inclusive and adaptable practices for expatriate populations.*

**Keywords:** Expatriate, The Netherlands, Maternal, Postpartum, Birth, Breastfeeding

## 1. Introduction

Globally, the rise of expatriate women starting families in unfamiliar healthcare systems is increasing [1]. The Netherlands ranks among the leading countries in Europe for the growth of expatriates due to its excellent health care system, attractive work-life balance, robust job market, growing tech industry, efficient public transport system, and safety [2]. In 2022, the Netherlands had a foreign-born population of 2.8 million, 52% women, and the largest population came from Ukraine, Poland, and Syria [2]. The Netherlands is known for its midwife-led maternity care model, which emphasizes home births and provides *kraamzorgs*, home-based postpartum care, during the first week after childbirth. Midwives primarily provide maternity care during pregnancy, labor, and childbirth, with obstetricians being utilized in high-risk medical deliveries such as cesareans [3]. Kraamzorgs, also known as postpartum doulas, provide in-home care for the immediate postpartum mother and the newborn baby for up to 10 days [4]. Women in the Netherlands can choose if they would like to have a home birth, a birth center delivery, or a hospital delivery. The Netherlands is the only country in the EU registered for home births with an average of 16% compared to other countries in the EU with an average of 1% in 2019 [5]. The community midwives are the first point of contact for most pregnant

women, and the midwife will refer medium- to high-risk patients to a specialist or hospital-based obstetric care professionals when needed, with an average of up to 70% needing this referral. This referral uses a national multidisciplinary evidence-based list of medical indications [6].

Some medical indications for referral include advanced maternal age, underweight or overweight, education level, history of sexual abuse, and smoking [7]. Approximately two-thirds of midwives in the Dutch system are considered community-based, with the remaining one-third employed by a hospital [6]. The existing literature and research are primarily based on Dutch nationals, migrants, asylum, and refugee women. A study in the Netherlands examined women's natural and medical birth beliefs. Natural birth beliefs were higher in educated women who attended an antenatal class and had a previous positive birth experience. Women living in the Netherlands generally had a stronger belief that pregnancy and birth are natural experiences rather than medical experiences. This same study also found that a woman's previous medical experience was often a predictor of their current medical beliefs in pregnancy. The Netherlands has a perinatal system that believes that pregnancy and childbirth are a natural experience, unlike other Western countries that believe it needs to be a medical experience. With the growing immigrant population in the Netherlands, the Dutch perinatal system is trending towards being more medicalized [8].

The Dutch have their own unique postpartum home care with the kraamzorgs. The kraamzorgs provide care during the first 8-10 days, for approximately 7 hours a day for the first half of the week and decrease to about 4 hours during the last few days. The total hours received ranged from 24 hours to 80 hours, with an average of 49 hours for breastfeeding mothers and 45 hours for formula-fed mothers. The main responsibilities of the kraamzorg include the health promotion of mother and baby, identifying risks or complications, and supporting parents during this transition. There is limited evidence-based research on kraamzorgs since the Dutch are the only country worldwide to include this service for all mothers [9]. Expatriates are defined by being highly educated, associated with a work organization, and having no plans for permanent residence in the host country [10]. Expatriate women have been overlooked and under-researched [11]. Previous expatriate research has focused on men in the workforce, with little research on expatriate women and families [10]. This lack of research includes the Dutch maternity system related to expatriate women's experiences. Understanding this growing population is crucial for informing culturally sensitive maternity care practices and supporting the population's well-being. This study aims to describe expatriate women's personal experiences of pregnancy, childbirth, and postpartum in the Netherlands. It will present the thematic findings, providing insights into how expatriate women experience care, adapt culturally, and navigate healthcare encounters in the Netherlands.

## 2. Methods

### 2.1. Study Design

This study employed a qualitative research design, drawing on Braun and Clarke's foundations of reflexive thematic analysis to explore and engage deeply with participants' experiences as expatriate women in the Netherlands [12]. This qualitative design was utilized to understand and describe the lived experiences of expatriate women during pregnancy, childbirth, and the postpartum period in the Netherlands. The researcher used the 6-step thematic analysis by Braun and Clarke, a flexible method for identifying patterns in the subjective data experiences of the expatriate women in the Netherlands [12].

### 2.2. Recruitment, Participants, and Setting

The study participants were recruited using a purposive sampling technique with the assistance of Hogeschool Rotterdam University in Rotterdam, Netherlands, social media platforms Facebook, Instagram, Meetup, and in-person recruitment at a pediatric clinic at CJG Rijnmond, Rotterdam. Recruitment strategies included reaching out to social media group moderators for permission to post a recruitment picture, networking in person with birth specialists in the Netherlands, receiving referrals from participants, and setting up a table outside of a pediatric clinic to talk to mothers and share a flyer with them about the study. The recruitment and interviews were completed from October 2024 to December 2024. The selection of participants was based on the following criteria: a woman at least 18 years old, a baby under the age of 12 months, who gave birth in the Netherlands, lived in the Netherlands for less than 36 months, was not a Dutch citizen, and could speak and read English. The potential participants completed a survey on Google Forms to screen for recruitment.

Twelve expatriate mothers participated in this study. The interviews were conducted virtually via WhatsApp Video and recorded with an audio recorder. Participants were encouraged to choose a private, comfortable setting for the interviews, enabling them to speak openly and reflectively about their experiences. Creating a safe, relaxed environment supports the authenticity and depth of the collected data, which is essential for meaningful qualitative analysis using Braun and Clarke's thematic approach [12]. Participants' characteristics were collected verbally at the beginning of the interview and entered into a Google Form. The participant characteristics represented in Table 1 include a median age of 35 years, with origin countries of the United States (42%), Brazil (17%), the United Kingdom (17%), Taiwan (8%), Greece (8%), and Spain (8%). The average length of living in the Netherlands was 24 months, with seven living in an apartment and the remaining five living in a house. Nine of the participants were married, two had a partner, and one was single at the time of the interview. Half of the women worked over 30 hours a week, a third worked under 30 hours a week, and the remaining 16% were currently unemployed. All the women were educated and had at least a bachelor's degree. Seventy-five percent of the women had a medical vaginal delivery, 16% had a nonmedical vaginal delivery, and 9% had a cesarean delivery. A medical vaginal delivery is defined as a delivery that requires medical interventions during labor and delivery. This included induction of labor, meconium-stained amniotic fluid, breech presentation, and multiple gestations [13]. The baby's median age was 5 months at the time of the interview.

| Demographic characteristics | *N* = 12 |
|---|---|
| **Age (years)** | 35 (30-39) |
| **Origin country** | |
| United States | 5 |
| Brazil | 2 |
| United Kingdom | 2 |
| Taiwan | 1 |
| Greece | 1 |
| Spain | 1 |
| **How long in the Netherlands (months)** | 24 (6-35) |
| **Living arrangements** | |
| Apartment | 7 |
| House | 5 |
| **Relationship status** | |
| Legally Married | 9 |
| Not married but has a partner | 2 |
| Single | 1 |
| **Age of child (months)** | 5 (1-11) |
| **Highest education** | |
| University | 12 |
| **Current employment status** | |
| Employed over 30 hours a week | 6 |
| Employed under 30 hours a week | 4 |
| Unemployed | 2 |
| **Mode of birth** | |
| Vaginal birth medical | 9 |
| Vaginal birth nonmedical | 2 |
| Cesarean Birth | 1 |

**Table 1: Participant Characteristics**

### 2.3. Data Collection

A semi structured interview guide with probing questions was used to interview the participants. This method encouraged the researcher and the participant to have unscripted dialogue and to explore the participant's thoughts, feelings, and beliefs [14]. Interviews were conducted privately and recorded. A pilot study was completed with three participants virtually in the spring of 2024. These participants are not represented in this study, but were considered useful for improving the interview questions and adjusting participant characteristics parameters. The pilot data was reviewed with experienced qualitative researchers, and adjustments were made to improve the semi structured interview questions. The potential participants completed a prescreening Google form online and included their preferred contact information. The potential participant was notified either by email or WhatsApp messaging if they qualified for the study. When a participant qualified, an informed consent link for Google Forms was provided, and an interview time was scheduled. At the scheduled interview, the researcher confirmed the informed consent form was complete and asked if the participant had any questions before beginning the interview. The researcher announced that the WhatsApp Video would be recorded as an audio recording and asked for a verbal agreement, in addition to the written agreement in the informed consent. Most participants were in their homes alone with their infants for the interview. One participant felt more comfortable walking in the park. The participant characteristics questions were asked during the interview before starting the semi structured interview. This helped to build rapport with the researcher and the participant and encouraged an unscripted dialogue. The objective was to have the participant share her pregnancy, childbirth, and postpartum experiences. The initial question in the interview guide asked how it felt to be pregnant in the Netherlands. The questions initially were about pregnancy, then moved to childbirth, and finished with postpartum. This helped guide the participant from discovering her pregnancy to her current stage as a mother. The interviews lasted 45 to 75 minutes and were audio recorded and transcribed by the researcher. Microsoft Transcribe was a tool used to help with the initial written transcription. The audio recordings were replayed, and the written transcription was reviewed for accuracy and completeness.

### 2.4. Data Analysis

Thematic analysis (TA) was developed to support researchers in examining qualitative data by identifying meaningful codes and overarching themes. Reflexive thematic analysis was used in this study. Qualitative research is inherently flexible; TA supported this adaptability throughout the study. Key aspects of TA include understanding your research questions and the study's purpose. The data analyzed were from the participant characteristic questions and the semi-structured interview translation. The data was analyzed ethically with the purpose of the answers provided [12]. The data analysis aimed to condense a large amount of data to make meaningful categories and themes [12]. Thematic Analysis, a six-step approach, was used to evaluate and analyze the data. The steps included immersion in the dataset, coding the segments, identifying initial themes, developing and reviewing themes, redefining themes, and putting them together into conclusions) [12].

- **Step 1:** Involved transcribing and becoming familiar with the data, selecting quotes, and doing a deep dive into the transcription. This step required immersion into the data, listening to the recordings as often as needed, writing notes, rereading the data, and becoming familiar with it [12].
- **Step 2:** Revisiting the data by identifying recurring patterns and terms by selecting keywords was crucial in this step. The keywords are based on the participants' common perceptions and experiences. During this phase, the researcher identified segments that were relevant and meaningful. Code labels were assigned that were meaningful for the analyzed data [12].
- **Step 3:** This step involved coding the keywords and segments of data that captured the message and significance, reorganizing the codes into categories and subsets, and generating the coded data into meaningful clusters [12].
- **Step 4:** The researcher reviewed the developed themes and data set. This included listening to the data again and examining the themes and how they were coded. The researcher revised codes and themes in this phase, modifying and revisiting the initial codes and categories [12].
- **Step 5:** The researcher continued to refine and redefine the data set by conceptualizing and interpreting themes, keywords, and codes. This guided the researcher in understanding the concepts of the emerging data and removing any redundancies in the categories and subcategories [12].
- **Step 6:** The final step was developing the conceptual model by identifying key concepts or themes from the data. Five themes and nine subthemes were identified [12].

### 2.5. Study Rigor

Qualitative research requires trustworthiness in data to ensure scientific rigor [15]. A holistic approach with a participant's experiences and in-depth data that can be interpreted is essential [16]. The Lincoln and Guba framework for trustworthiness is credibility, dependability, confirmability, and transferability [17]. For this study, the researcher ensured that the participant was a credible source of information and that the interpretation from the researcher was utilized in its transferability with detailed field experiences. Credibility was essential for establishing confidence and believability in findings [18]. Dependability was established using the same interview guide and characteristic questions for each participant. Having dependable and reliable data that can be replicated with the participants was the second criterion [18]. Conformability was established using triangulation and a journal of research logistics, inquiries, and reasons. This third criterion was established by using the participants' viewpoints, and interpretations of the data were not invented [18]. The transferability of this research was established with a detailed account of the research process. Transferability was the last criterion and was important to evaluate the data for relevance [18].

## 3. Results

This study is based on interviews with 12 expatriate women conducted individually in the Netherlands. The analysis generated five main themes related to the participants' pregnancy, birth, and postpartum experience in the Netherlands. These themes are (1) navigating the healthcare system, (2) experiencing care through connection, (3) living between cultures, (4) navigating body and mind, and (5) the lived experience of feeding. Table 2 gives an overview of themes and subthemes.

| Theme | Subthemes | Participants (P) |
|---|---|---|
| Navigating the healthcare system | • Feeling lost and alone in the system<br>• Leaning on others for guidance | P1, P2, P3, P4, P5, P6, P8, P9, P10, P11, P12, |
| Encountering care through voice and relationship | • Meaningful communication<br>• Embodying choice in care | P1, P2, P3, P4, P7, P11 |
| Living between cultures | • Speaking across worlds<br>• Seeking familiarity in an unfamiliar place | P1, P2, P10 |
| Navigating body and mind | | P1, P2, P3, P5, P7, P10, P11, |
| The lived experience of breastfeeding | • When breastfeeding does not flow<br>• Negotiating the breastfeeding journey<br>• Relational grounding in moments of need | P3, P4, P5, P6, P9, P10, P12 |

**Table 2: Themes, Subthemes, and Participants**

### 3.1. Theme 1: Navigating the Healthcare System

This theme relates to how the expatriate women navigated the healthcare system in the Netherlands. Two subthemes are identified: feeling lost and alone in the system and leaning on others for guidance. The expatriate women in the Netherlands experienced pregnancy as a navigation process shaped by initial uncertainty, the influence of social connections, and the strategic use of digital resources. Their narratives highlight the unique challenges of pregnancy in a new country, where standard care pathways were unfamiliar and support systems were often limited or newly forming.

#### 3.1.1. Feeling Lost and Alone in the System

Some participants felt confused and unsure about navigating the system, questioning whether they needed a referral from their general practitioner (GP), if they should make an appointment with a midwife, and when the ideal time to make that appointment was. Participant 6 called her GP office for a referral, and they responded that no referral is needed to call a midwife practice. Participant 11 shares, "I didn't know how it worked, so I went to my doctor at the health center, and they told me, 'Okay, you've been here, so you have to go to this midwife center,' and I made an appointment." Participant 12 also made an appointment with her GP, "I was a bit lost at first because when I found out I was pregnant, it was really quick. So, I booked a GP appointment, and then the GP said, 'Congratulations, but it is not here you need to be, but you need to see the midwife.'" Participant 10 shares about her experience of confusion and loneliness. "I was a bit confused at first because I didn't really know what to do. It sounds a bit silly, but because you find your midwife yourself, I wasn't sure when you're supposed to contact them. I guess I felt a little alone, because I don't have any family here. I have a few friends, one of whom recently gave birth, but it is also isolating, being here, and not knowing other people going through that experience."

#### 3.1.2. Leaning on Others for Guidance

Participants highlighted how important it is to have social networks to help guide them through the healthcare system and pregnancy. These networks provided some practical advice but also gave some security. Participant 1 shares, "I was 100% dependent on the stories of other women; I knew a gal who had gone through the experience and delivered her son the year prior, and so I ended up becoming friends with her, and it was really helpful." For some participants, it was how they figured out how to navigate finding a midwife. Participant 3 shares how her friend guides her, "Oh, how did you find a midwife? She said, Well, I used these people, and then I looked online and found a practice near me." Work peers were also helpful in guiding some of the participants. Participant 5 shares, "I had a coworker in the Netherlands and asked her for advice on finding prenatal care." Participant 9 was not working, but her partner was: "My partner did most of the work in finding out where to go by asking peers." Some participants relied on online communities to guide them on this journey. Participant 2 shares her experience using these online communities to search for her birth doula and midwife, "I started asking around for doula recommendations, and then my doula recommended this midwife practice. I found them through a Facebook group; they were very expat-friendly, which is why they were recommended." Online search engines, such as Google, websites, and online reviews, were powerful tools for the participants navigating the healthcare system. These platforms provided essential information to help guide the women in making educated choices for their healthcare. Participant 4 shares the use of Google, "I googled, tried to find reviews, and found those who had a website... and then I emailed two or three, depending on the website content." Participant 5 moved to the Netherlands after finding out she was pregnant and attempted to find care before arriving: "Initially, I was very stressed and daunted by it, especially since I was conducting research from the U.S. and trying to navigate the website and figure it out." Even after research, the participants were more likely to choose a midwife close to them. Participant 8 shares, "I used Google. I searched via social media, but I ended up going to someone close. There isn't a hospital near me, but there was a midwife practice nearby."

### 3.2. Theme 2: Encountering Care Through Voice and Relationship

The participants valued experiencing an interpersonal and emotional quality of care in healthcare relationships. Relationship experience was often related to these subthemes: meaningful communication and embodying choice in care. These elements are crucial for building trust and fostering positive relationships between care providers and patients.

#### 3.2.1. Meaningful Communication

Communication is a fundamental component in healthcare settings, particularly in the relationship between care providers and patients. Effective communication from the healthcare provider involves consideration of language preferences and a commitment to ensuring patients feel informed and comfortable. Participants shared how care providers frequently checked in with them, asked questions, and ensured their comfort. This proactive approach helped the participants feel supported and cared for, reducing anxiety and fostering a positive relationship. For example, Participant 1 shares, "The midwife practice always asked a lot of questions, tried to make sure I was comfortable, and encouraged me to ask any questions I might have." Participant 3 adds: The midwives have been communicative, clear about what's happening, made expectations clear, and allowed me to ask questions at the midwife practice. We talked about what the process would look like and how it would be with this practice, and she gave me a folder with many different things in it, including a schedule for the 9 months. The schedule included the appointments that we're going to have, and the tests that they needed to do along the way. The whole process, I have felt so well informed. The importance of using a language that the patient understands cannot be overstated, and was critical to the expatriate women's healthcare experience. Participant 2 shares, "I was really explicit with them, please don't speak Dutch around me. If you're speaking about me, please speak in English or translate so I know what's happening. And they were over-communicative in English because of that." Participants noted that the care providers would use translation tools like Google to

bridge language gaps if needed. Participant 4 states, "All of them were good English speakers. If they didn't know all the terms, they used Google to describe something they did not know; they were eager to explain everything."

### 3.2.2. Embodying Choice in Care

Autonomy in decision-making is a crucial aspect of the relationship between care providers and patients. It involves empowerment, respect for personal preferences, assertiveness, informed choices, consistency, and a hands-off approach [19]. These elements are crucial for building trust and fostering positive relationships between care providers and patients. Participant 1 shares how she felt she was able to make her own decision and listen to her body during pregnancy, "I kept asking my midwife if I needed to stop working? Do I need to stop riding the bike? Their philosophy was that if you feel good doing it, do it. It's good for your body." Participant 2 was able to feel in control of who delivered her baby: "I wanted the midwives to deliver, and then the gynecologist came in at the end after I delivered the baby to make sure that the placenta was delivered fine." Participant 3 was able to voice when she felt she needed pain relief in labor; I said, "We are going to the hospital to get an epidural now, I'm in charge. This is my birth."

Making informed choices during pregnancy and labor is essential for a woman to feel in control. The participants did not feel pressured to have an induction when postdates, but were educated by the provider and made their own decision. For instance, Participant 4 shares, "They never tell you how long to wait, but at a 41-week pregnancy, it means a higher risk-wise. At 42 weeks, you decide on the induction appointment. And then the moment you are induced, you're no longer with your midwife, but then you are a hospital client now, medical." Participant 7 shares that consistent familiarity with a care provider with a hands-off approach was important, "I went with an independent midwife who, you know, is going to be at your birth, rather than a midwife collective of six or seven, you never know who will be there or be on call. I felt more in control this time than I did the first time. And they were very hands-off. It was more like a free birth." Participant 11 emphasized the importance of being listened to when advocating for less invasive care when starting oxytocin. "I wanted to wait, and in the end, they said okay and allowed me to wait. I had to take it at the end, but at that moment they allowed me. I had to surrender and let them carry me and help me."

## 3.3. Theme 3: Living Between Cultures

Expatriate women's experiences of pregnancy, childbirth, and postpartum life in the Netherlands are deeply influenced by the process of cultural adaptation. This theme reflects how they adjust to an unfamiliar sociocultural and linguistic environment while seeking to preserve a sense of security, comfort, and familiarity.

### 3.3.1. Speaking Across Worlds

Language adaptation was a recurring focus for participants, influencing their sense of autonomy, security, and inclusion in healthcare settings. Many participants expressed relief and gratitude for the widespread English fluency among Dutch medical professionals. For example, Participant 1 shares, "Everyone in the office speaks wonderful English. They were open to me trying my Dutch, but never pushed that." Prioritizing clear and accessible communication fostered a sense of respect and empowerment. However, language remained a challenge for some. Participant 10, for instance, struggled to find childbirth classes conducted in English, "Finding classes that they had in English, as there was a limited number, was limited, and then when I realized the dates didn't match up, so I didn't go, I wish I had."

### 3.3.2. Seeking Familiarity in an Unfamiliar Place

To navigate cultural differences and the emotional demands of giving birth in a foreign country, participants sought ways to maintain a sense of home by recreating familiar comforts. For some, being in a specific environment offered a reassuring sense of stability. For example, Participant 1 shares her experience and feelings about the midwife practice: "Their office felt very homey, and it was comforting." Many participants recreated rituals or meals tied to their home cultures as a coping mechanism. Participant 2 noted: "I made a bunch of soups and made a bunch of like home comforts. For Thanksgiving, we recreated them, like we had mac and cheese, we made Thanksgiving food." Participant 2 adds, "We had Five Guys delivered, and we were like, will it be drastically different? It's exactly the same." The availability of home visits from midwives also helped bridge the comfort gap, providing care in a familiar domestic setting. P1 shares, "The midwives started coming to my house when I was in labor and to check if my waters "amniotic sac" had broken. It's nice that they come to check, and I'm still in my comfort area and not getting sent home."

## 3.4. Theme 4: Navigating Body and Mind

Navigating body and mind explores the deeply connected journey of physical recovery and mental adjustment that expatriate women go through during pregnancy, childbirth, and postpartum life in the Netherlands. It highlights how their bodies and minds are intertwined throughout this transformative experience, often reshaping their expectations and emphasizing the need for support, autonomy, and validation. The two key aspects physical and mental offer deeper insight into how expatriate women process their bodily and emotional shifts outside their home country. Emotional processing was a significant part of the women's journey, often marked by vulnerability, unmet expectations, and the search for psychological reassurance. Several participants described feelings of fear, sadness, and helplessness, especially in the labor and the immediate postpartum period. One woman recalled her emotional breakdown when the kraamzorg arrived after a stressful first night: Participant 1 shares, "The kraamzorg came on day two, and the first night was so stressful. When she arrived the next morning, she asked, 'How did it go?' I just broke down crying; the baby is this tiny little thing. All night, we didn't know what to do, and we were so stressed out with each other, and yeah, I remember her hugging me. She said, 'When you need to cry, you cry'."

Mental health was also tied to control, or lack thereof, during birth. Participant 5 states, "I felt like I didn't have any control, and I'm a big planner and very type A For example, I had planned my

kraamzorg; I chose the midwife I wanted. I'm such a planner, but it did not go according to plan, and I had not thought of a backup plan." Participant 3 shared how pain and exhaustion left no room for emotional awareness, "I don't remember being frustrated; I just remember screaming a lot. I was just in so much pain, and I was screaming a lot, and that was the whole time. I don't remember having any emotions other than screams." Participants shared physical experiences that shaped their feelings about the care they received and their sense of control during childbirth and recovery. Participant 2 noted how medical staff avoided unnecessary surgery, which brought relief: "She was born at 8:01, and then the placenta was like only 20 minutes later, which was nice because they were getting ready to take me to the OR, and then they didn't have to." Others found that postpartum care, such as Ayurvedic massage and meal preparation, was crucial in restoring physical well-being: Participant 7 shares, "She massaged me every day and made a lot of food for us." Participant 10 experienced an adverse reaction during induction: "They put me on the oxytocin drip within, I think, 10 minutes, I was shaking all over and the pain was excruciating." Daily activities like hydration or exercise were central to managing the physical demands of recovery: Participant 1 shares, "My husband learned a lot about taking care of me, what kind of meals we needed, making sure I stay hydrated."

### 3.5. Theme 5: The Lived Experience of Breastfeeding

The theme of navigating breastfeeding captures the multifaceted experiences of the expatriate women as they navigate the physical, emotional, and logistical aspects of nourishing their infants. Across many of the participants, breastfeeding emerged as a complex journey influenced by physical difficulties, emotional pressures, external support, and evolving personal decisions. The subthemes challenges, feeding decisions, and support highlight the dynamic interplay between maternal intentions, physiological responses, and the surrounding care environment.

#### 3.5.1. When Breastfeeding Does Not Flow

Many participants described breastfeeding as unexpectedly difficult. While initial attempts were sometimes deceptively smooth, ongoing issues such as poor latch, infant fatigue, low milk supply, and maternal pain quickly emerged. Participant 3 states, "The first time was easy, she just latched, so she appeared to be sucking, it seemed really good and fine. After that, it was really hard." Mothers often experienced guilt and fatigue as they struggled to maintain breastfeeding under pressure: Participant 3 shares, "We tried everything to keep her awake. She wouldn't stay awake, and she wasn't gaining weight, and we ended up having to feed her with a syringe, and then we were doing formula for a bit, and after a couple of days, they suggested that we start pumping and finger feeding." Repeated attempts led to emotional exhaustion. Participant 4 shared: "I tried to breastfeed every 3 hours, but don't know what went wrong. I don't know if it's that I was in pain or they didn't help." Medical interventions such as pumping and formula supplementation became necessary, further complicating the emotional landscape of breastfeeding: Participant 4 continues, "It's still a painful story to talk about breastfeeding. In my head, I wanted to breastfeed much longer, but it wasn't easy to do this thing every 3-4 hours."

#### 3.5.2. Negotiating the Breastfeeding Journey

The feeding journey evolved in response to physical struggles, personal comfort, and infant needs. For some, switching to bottle feeding or pumping brought relief and a sense of control: Participant 3 shares, "It was such a relief to stop trying breastfeeding for a bit. So, we did that, we had her on the bottle, she started gaining weight again." Others adapted gradually, balancing formula, breast milk, and partner involvement: Participant 9 states, "Pumping was important for both of us so that my partner could also feed." Participant 6 struggled with breastfeeding until they realized the cause: "Because her weight dropped too much, we needed to add formula. So, my husband was finger feeding her some formula on top of the breast milk, and also, they were like you need to pump to increase your volume, and that worked. Feeding itself was fine, I felt, but it was just the volume that needed more of. Also, we found out he was tongue-tied, and we found someone to clip it, and that helped a lot with breastfeeding." Breastfeeding was not always the preferred or feasible option, especially in hospital settings or due to medical concerns: Participant 12 shares, "It was a bit weird because once she was in the NICU, they gave her formula there." Moms usually just did what felt right, taking advice when it helped, but trusting their instincts most of the time. Participant 3 shares, "I'm only going to put on the breast if it feels easy."

#### 3.5.3. Relational Grounding in Moments of Need

The availability and quality of support, especially from the kraamzorg, lactation consultants, and maternity nurses, played a significant role in how women experienced and managed breastfeeding. Participant 5 shares, "Every single time I breastfed when the kraamzorg was here, she was right next to me, helping me position her, positioning me, moving my hands around, I got incredible support." Participants expressed appreciation for professional guidance and access to community resources: Participant 3 shares, "There are resources, like you can talk to a lactation consultant, and there is also a breastfeeding cafe in town." When support aligned with the mother's needs, it contributed to a sense of confidence and capability. Participant 10 shares how important the kraamzorg was for her breastfeeding journey, "I did struggle with breastfeeding, so I'm glad of the support from the kraamzorg; she helped me with learning to breastfeed, she got us a really good routine." Participant 11 shares her support, "The kraamzorg was helping with breastfeeding; she helped me and gave me many tips." Participant 5 shares how the support of the kraamzorg helped her, "They gave me a medical grade pump the first day of kraamzorg was here, so I got that and had me pumping to increase the milk supply, and then they had me supplement with formula. I think I only ended up having to do it for about 2 days to get the weight up."

## 4. Discussion

This qualitative study aimed to gain insight and explore expatriate women's birth experiences in the Netherlands. This research fills a significant gap in expatriate women's underrepresentation in international research [11]. Through in-depth interviews with

expatriate women, several themes emerged. The findings shed light on the Netherlands' maternal system and the experiences of expatriate women through this system. Thematic analysis of 12 expatriate women's interviews gleaned five themes interconnected to their experience: navigating the healthcare system, encountering care through voice and relationship, living between cultures, navigating body and mind, and the lived experience of breastfeeding.

### 4.1. Relationships with Maternity Care Providers

Relational connection was significantly meaningful to all the participants in shaping their maternal experiences. It was about establishing a mutual, authentic, trusting relationship with their care providers. Expatriate women have a higher risk of developing postpartum depression due to communication and social barriers [20].

### 4.2. Midwifery Care

The Netherlands has a midwifery model of care that consists of community midwives and clinical midwives. Community midwives are considered primary care providers and provide unsupervised maternal care and delivery to low-risk mothers. Community and clinical midwives have the same initial training. Clinical midwives work with higher-risk, more complicated patients and deliver and work with a physician in a hospital setting. The clinical midwife population has grown from 1996, when 183 registered in a hospital practice, to 2018, when 1083 registered. A community midwife delivers babies in a woman's home or a birth center connected to a hospital, while a clinical midwife delivers in a hospital [21]. Research has shown that having smaller midwifery practices, such as three to four midwives, is ideal versus six to eight midwives in practice, which helps the midwife to better connect with the patients and provide more personable care. The Dutch maternity system pays based on patient load, not work hours. The compensation is based on 106 patients per year per midwife to receive the full pay. Working in smaller teams would limit the number of women they can see, affecting the practice financially if they want to be able to spend more time with each woman. Also, having fewer midwives in a practice would mean more on-call and work days for each midwife. Midwives not only provided care during the prenatal period, but also did a home visit after delivery to follow up on the mother's mental and physical recovery. [22].

The mothers shared their experiences navigating the healthcare system, noting that the midwifery practices are large, with six to eight midwives. They saw each midwife at least once and rarely saw the same midwife more than twice. The women felt they received adequate care from their midwives, but did not feel a strong connection with any midwife in the practice. The community midwife practice choice was based on the location where the woman lived. None of the participants had vehicles, and the mode of transportation was riding their bikes, taking public transit, or having a friend with a car transport them. A clinical midwife delivered the majority of the participants because once labor became medical, such as induction, epidural use, or amniotic fluid having meconium, for example, their care moved to a clinical midwife. Only one participant chose a small midwife practice and was able to connect with her midwife during pregnancy.

### 4.3. Kraamzorg Care

Kraamzorgs, also known as maternity home care workers or postpartum doulas, are unique to the Netherlands [9]. They differ from midwives in providing transitional care in the home for both mother and baby. The cost is covered in basic insurance coverage with a small copayment required by the participant with a minimum of 24 hours and a maximum of 80 hours [4]. It is encouraged that a woman uses a kraamzorg organization and service by 16 weeks of pregnancy [23]. Participants shared that the kraamzorg supported them in learning how to perform new tasks such as bathing the infant, changing diapers, and understanding how often a newborn should go to the bathroom. They were also weighing the infant to confirm that the baby was getting enough milk and gaining weight. The care was not limited to the newborn but included care of the mom. The participants shared how they checked their uterus daily, made lunch for them, took care of basic housekeeping, and checked with them on how they were doing mentally. The connection with the kraamzorgs was "felt" during the interviews with the participants and really highlights the theme, encountering care through voice and relationship. Multiple participants got emotional, discussing how essential the kraamzorgs were for their transition and how they missed them and wished they could meet to have tea and continue a friendship.

### 4.4. Culture & Community

Women who are not native to the country of residence often struggle to find a social network, and this lack of support can lead to depressive symptoms and additional stress in their lives [24]. Living between cultures was a significant theme for the participants. Some of the participants had been in the Netherlands a year before pregnancy, while some came to the Netherlands pregnant. The navigating body and mind theme is apparent when listening to the participants' experience in overcoming isolation. having a lack of family available and near during this vulnerable time was hard for many of the women. All participants struggled to find a social network and used multiple techniques to do it. This included attending birth classes in English, Dutch language classes, meetup groups, and joining online communities for expats. In a few cases, work colleagues could offer some guidance, but in most cases, it was limited. Having social connections helped the women feel more confident in navigating the healthcare system of the Dutch. For many participants, the process of acculturation into Dutch culture presented significant challenges. For example, food was a powerful symbol of cultural identity and emotional grounding. There is typically a "honeymoon" phase where expatriates are more likely to try the traditional foods of the host country [25]. Food served as a tangible link to home, culture, and identity. A participant shared that certain grocery stores had more foods from "home", which helped cook some family "favorites." Some participants had discussed that having familiar chain restaurants found in their home country helped when they wanted some familiar nourishment. Home culture traditions, such as having a Thanksgiving meal, helped them feel connected to home.

### 4.5. Breastfeeding Journey

The kraamzorgs are trained to assist with breastfeeding and other difficulties, but mothers often need more expertise [9]. The majority of the participants had struggles with the lived experience of breastfeeding. Participants shared that a registered nurse assisted in the hospital with breastfeeding, and lactation consultants had visited before discharge. The participants did not find this helpful since they are only there for about 6 hours before heading home with their newborn. Once home and alone, the mothers felt overwhelmed and unsure how to "latch" their infant on properly. Most participants' babies had lost over 10% of their birth weight and were instructed to breastpump and feed the infant with a syringe. The kraamzorgs were supportive, and participants' interviews were consistent with each other on breastfeeding recommendations from the kraamzorgs. Lactation consultants (LC) would come to the house, but an extra fee was charged. The women who used this service felt the LCs were superior in knowledge and assistance. The struggle with breastfeeding was mentally and physically demanding for many of the participants, and they thought that it was not the natural experience they had "hyped" up in their minds. Navigating body and mind was experienced with the participants during this postpartum journey.

### 4.6. Methodical Considerations and Limitations

This qualitative study employed Braun and Clarke's reflexive thematic analysis to explore the birth experiences of expatriate women residing in the Netherlands. While this methodology offered rich insights into how women make meaning of their experiences, several considerations and limitations must be acknowledged. The sample size was small, with a high percentage of participants from the United States. For a few participants, English was not their native language, which might have caused some confusion on how to answer a question or the exact meaning of the question. It's important to note that with the small sample, we cannot generalize that all expatriate women's experiences are the same. The interviews were conducted virtually using video. One participant's significant other was home when the interview was conducted, which could have affected the participant's comfort level with sharing sensitive information. I, the researcher, came into this study with a nursing background in maternal care, which may have shaped how I understood and analyzed the data. To stay mindful of these influences, I used reflexive journaling to reflect on my assumptions and ensure I was as transparent and thoughtful as possible in the analysis process. The thematic analysis method facilitated a rigorous and reflective engagement with the data [26]. The final themes represent one interpretation among many possible readings of the participants' narratives.

## 5. Conclusion and Implications for Practice

The study explored the birth experiences of expatriate women in the Netherlands. It sheds light on how different the healthcare experience is in the Netherlands, how it can be overwhelming and lonely, and how vital building a social network is. Five themes were revealed regarding healthcare, relationships, cultures, body and mind, and breastfeeding. These women were navigating a new country with little to no knowledge of the native language. Navigating the healthcare system was a little confusing initially, but with some guidance, they navigated it and felt supported. Participants appreciated aspects of the Dutch maternity care system, particularly the unique role of the kraamzorg. They did have to overcome feelings of isolation, cultural disconnection, and emotional vulnerability. This research highlights the importance of culturally responsive care in maternity services in the Netherlands, especially with the growth of diverse populations. This study shows how important it is for healthcare professionals to be culturally sensitive and provide care that respects and meets the client's needs. Perception of care by clients is often related to how the healthcare provider attempts to meet the client's needs. This includes communication, interactions between the healthcare provider and client, and the client feeling they are a person and not just another patient [27]. Having a support system for expatriate women during pregnancy and postpartum could help offset the feelings of loneliness. Oftentimes, these expatriates are alone or have a limited support system, and this could increase their risk for depression. Having a welcoming environment and offering group prenatal appointments has been demonstrated to help women connect with their peers, improve communication with healthcare providers, and improve maternal health outcomes [28]. Kraamzorg care is exclusive to the Netherlands. It is included in basic insurance, which allows every postpartum woman to have this service. All the new moms felt this was a fantastic service and felt supported. The multigravida moms felt that they already knew most of what the kraamzorg was trying to teach them but enjoyed being taken care of and felt supported. The expatriate woman would benefit from understanding the roles and expectations of the kraamzorg. Meeting with a kraamzorg before delivery could help the mothers understand the care they are receiving and their expectations for themselves and their newborn [29].


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## Declaration of Conflicting Interest

The authors declared no potential conflicts of interest regarding this article's research, authorship, and/or publication.

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## Ethical Approval and Informed Consent Statements

The study was volunteer-based and approved by the Texas Woman's University (TWU) Institutional Review Board (IRB). The IRB review aimed to ensure that the research was conducted safely and ethically for the participants (FDA, 2019). The IRB was federally mandated to review any research that involved human subjects to confirm that the research was done ethically (White, 2020). The

researcher had a letter of support from Rotterdam University of Applied Sciences. TWU's IRB approved the informed consent form. The study posed minimal risk for the participants. The online consent form included information about the purpose of the research and time commitment, and the participant was a volunteer and could withdraw at any time without penalty. The potential risks were disclosed, including potential emotional discomfort, loss of time, and risk of loss of information. All information, recordings, and field notes were kept confidential, and code names were used instead of real names.

## Data Availability Statement

Only the researcher could access audio recordings and transcripts stored on a portable drive, which was password-protected and locked in an office drawer. The field notes and journal were also transferred digitally, stored on a password-protected portable drive, and locked in an office drawer. The informed consent form was completed online, and a copy was emailed to the participant. Potential benefits to the participants included reliving and sharing their birth experience. The participants received a $25 gift card for participating. Participants can request the final copy of the study results.

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