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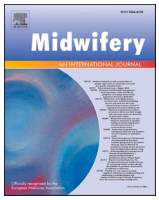

Understanding the relationship between maternity care providers and middle-class Chinese migrant women in the Netherlands: A qualitative study

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ABSTRACT

Objective: This study aims to provide insights into the formation and the quality of the maternity care provider-woman relationship between midwives, maternity care assistants and middle-class Chinese migrant women in the Netherlands.
Design: online in-depth interviews addressing interpersonal trust, women's autonomy in shared decision making and culturally sensitive care
Participants: 46 middle-class Chinese migrant women, 13 midwives and 12 maternity care assistants in the Netherlands
Findings: Midwives and maternity care assistants reported challenges interpreting the needs of middle-class Chinese migrant women in care practices while Chinese migrant women experienced receiving insufficient emotional support. Midwives and maternity care assistant tended to attribute women's different preferences for care to culture which reinforced difficulties of addressing women's needs. Middle-class Chinese migrant women experienced a lack of responsive care, feelings of being overlooked, being uncomfortable to express different opinions and challenges in developing autonomy in the shared decision-making process.
Conclusions: A trusting relationship, effective communication with maternity care providers, and a culturally sensitive and safe environment could be beneficial for middle-class migrant mothers. Chinese migrant women held ambivalent attitudes towards both traditional Chinese health beliefs and Dutch maternity care values. Each individual woman adopted the practice of the "doing the month" tradition to a different extent. This indicated the need for maternity care providers to recognize women's various needs for more responsive and individualized care, especially for first-time migrant mothers to negotiate their ways through the new healthcare system.
Implications for practice: We suggest a more proactive role for maternity care providers addressing the individual's subjectivity and preferences. Our findings are relevant and applicable for maternity care professionals conducting shared decision making with middle-class and highly educated migrant women living in Western contexts.

Introduction

In the context of migrant motherhood, expectant mothers and new mothers often struggle rebuilding their social networks and managing social and cultural differences when receiving professional care during pregnancy and the early postpartum period. Compared to native-born women, migrant women have a higher chance of experiencing the absence of postnatal social support that can increase the risk for developing depressive symptoms that stresses the need for additional attention and care to this specific group of women (Evagorou et al., 2016). Since most of the existing studies are conducted among lower-educated migrant women with low socioeconomic status, vulnerabilities and risks of highly educated middle-class migrant mothers are often overlooked due to their assumed competency in allocating various resources (van Blarikom et al., 2022). In this regard, there is a strong need to understand how they navigate the new health system and which factors may contribute to their hardships.

Studies show that migrant women with non-Western backgrounds

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living in Western settings often receive delayed care and perceive that their care providers have difficulties assessing and responding to their cultural needs (Merry et al., 2020). Migrant women experience challenges in expressing themselves freely and report that the received care is not culturally appropriate (McLeish, 2005). Evidently, when women's specific health and cultural needs are overlooked, misinterpreted and stereotyped by care providers, it can lead to negative health outcomes including poor mental health (Ng and Newbold, 2011; Shaburdin et al., 2022). To address migrant women's culturally informed needs, the concept of culturally sensitive care has been introduced in ongoing education and training programs of healthcare providers and implemented widely in care practices (Briscoe, 2013). A recent study found that culturally sensitive maternity care training resulted in significantly increased knowledge and self-perceived cultural competence and skills among midwives (Fair et al., 2021). Culturally competent healthcare is necessary for building women's trust which, in turn, can improve the quality and acceptability of maternity care for women (Billett et al., 2022). Meanwhile, another study showed that women reported negative experiences of childbirth and felt abnormal and anxious as they experienced that their midwifery care providers did not provide culturally competent maternity services (Stapleton et al., 2013). For example, "doing the month (*zuo yuezi*)" is a prevalent postpartum tradition among ethnic Chinese women. The traditional practices include limiting physical activities, keeping the body warm and eating special food to restore the health of a postpartum woman (Liu et al., 2015). However, some practices of this tradition have been proven to be potentially harmful for women's health and may have adverse effects on postpartum depression, such as not taking a shower/bath after childbirth (Liu et al., 2020; Wong and Fisher, 2009). Additionally, several studies highlight that adherence to such practices stems from family expectations and Chinese women experience ambivalence about following or not following confinement (Chee et al., 2005; Matthey et al., 2002).

Previous research addresses that having a trusting relationship is one of the most important characteristics of quality care (Perriman et al., 2018). Lack of trust can significantly impact on women's confidence in the system of maternity services and the professionalism of individual maternity care professionals (O'Brien et al., 2021). In addition, women's autonomy in the shared decision-making process has a positive impact on women's sense of control, particularly for migrant women from diverse ethnic groups. Nevertheless, several studies identify that migrant women were uncomfortable to express different opinions with their care providers and felt pressured to accept the intervention (Gele et al., 2017; Vedam et al., 2019). Maternity care providers described the complexity of respecting a woman's choice when expectations were in conflict with evidence-based care (Records and Wilson, 2011). It remains challenging for care providers how women's preferences should be balanced with professional advice in the daily practices.

The midwifery model of care is based on respect for the intricacy of the natural physiology of childbirth and makes the women and her life the central focus of prenatal care (Rooks, 1999). Another core principle of this care model is to respect for human dignity. From this point of view, midwives (are expected to) promote and respect women's health and rights and provide women with appropriate information for decision making. Midwifery care also emphasizes on informed choice recognizing women's right to decline the recommended option of care (International Confederation of Midwives, 2014; Thachuk, 2007). In the Netherlands, maternity care is organized in two echelons: primary and secondary/tertiary care. Primary care midwives work autonomously and are responsible for women who are at low risk for experiencing obstetric complications. Women who have a medical indication are referred to second/tertiary care where hospital-based midwives and obstetricians provide care collaboratively (Perdok et al., 2016; Royal Dutch association of Midwives, 2022). Additionally, the home-based postpartum maternity care is offered to all mothers for the first eight to ten consecutive days by maternity care assistants who identify risks for women and newborns and provide childcare related information (Lambermon et al., 2021). Lack of sufficient knowledge of the maternity care system in the host country is the most frequently reported impeding factor affecting migrant women's use of care and it may potentially hinder women's ability of making autonomous decisions (Boerleider et al., 2013). In urban China, the obstetric care is mainly physician-based, and midwives can only practice in labor wards and help obstetricians to care for women during birth. Under this model of highly medicalized care, Chinese women are often used to a highly controlled pregnancy and expected to undergo excessive prenatal screening tests to detect congenital anomalies (Huang et al., 2012). In this regard, Chinese migrant women may expect and prefer medicalized maternal services in the host society.

As discussed above, this study adopts three key concepts: the interpersonal trust, culturally sensitive health care and women's autonomy in shared decision making, to provides unique insights into the formation and functioning of the relationship between Dutch maternity care providers (primary care midwives and maternity care assistants) and middle-class Chinese migrant women in the Netherlands. In this research article, we aim to address (a) Dutch maternity care providers' experiences of meeting and addressing care needs of Chinese middle-class migrant women; and (b) Chinese middle-class women's expectations about and experiences of this provision of care, respectively: Based on this we address the following two research questions: (1) How do Dutch maternity care providers address and respond to middle-class Chinese migrant women's care needs? (2) What are the expectations of Chinese women in maternity care and how do they feel their specific needs and preferences are addressed?

Methods

Design

A qualitative research design was used including interviewing and participant observation to explore Chinese migrant mothers' (including expectant mothers) relationships with Dutch maternity care providers (primary care midwives (*'verloskundigen'*) and maternity care assistants (*'kraamverzorgenden'*). During the data collection period from March 2020 to September 2021, 46 Chinese migrant women, 13 Dutch midwives and 12 Dutch maternity assistants participated online in-depth interviews.

Recruitment and the inclusion criteria

Conducting interviews with Chinese migrant mothers was a part of a larger research study which focused on Chinese migrant mothers' experiences with postpartum depressive symptoms in the Netherlands. The current study recruited Chinese migrant mothers through WeChat[1] groups and referrals by midwifery practices in the Netherlands. The snowball sampling method was also adopted to overcome geographic accessible limitations during several COVID-19 lockdowns. The target group was Chinese migrant (expectant) mothers in the Netherlands who had experienced or were experiencing depressive symptoms in their pre- and/or postpartum period. This time period ranged from approximately 24 weeks of pregnancy until six months postpartum. Before the interview, every Chinese woman completed the Edinburgh Postnatal Depression Scale (EPDS) or a Lifetime version of the EPDS and women who scored 9 or higher were invited to the interview. Women with EPDS scores of 9 or higher were defined as exhibiting depressive symptomatology. The EPDS score was used as a screening procedure only in this

[1] Due to the restriction of COVID-19 lockdowns, the person-to-person accessibility to potential participants was limited and hereby WeChat, the most important digital communication platform for oversea Chinese, has become the major source to recruit Chinese migrant women across the Netherlands.

study. Women's scores showed that they were experiencing/had experienced mild depressive symptoms. Only 1 of the participating 46 women was diagnosed with postpartum depression and received treatment. All participating Chinese women were middle class with a higher education level. The inclusion criterium for Dutch midwives and maternity care assistants was that they have/had provided services to Chinese migrant women in the Netherlands. The invitation for both midwives and maternity care assistants was sent through email to midwifery and maternity care practices. The study information written in both English and Dutch was also shared on the Facebook group of maternity care assistants.

Digital interviews with Chinese (expectant) mothers

Given the impact of COVID-19, in-depth interviews with Chinese migrant women were conducted digitally through audio call, text messages and voice messages. The information letter was sent to each participant before conducting the interview. The information letter is written in both English and Chinese (simplified characters) and it included a brief introduction of the study, the study aims, key topics and related questions. The interviewer kept checking with participating Chinese women about whether the interview questions were clear and understandable during the interview. Oral or written consent was provided before the interview. Flexible open-ended questions were prepared to explore experiences of the usage of Dutch maternity care services and relationships and interactions with Dutch maternity care providers during pregnancy, childbirth and early postpartum. All participants were assigned pseudonyms.

Digital interviews with Dutch midwives and maternity care assistants

Before the interview, an information letter written in Dutch was sent to each participant. Written consent for participation and recording of interviews were received before the interview. The interview was semi-structured with open-ended questions. The topics focused on interactions and relationships with Chinese women, the process of nurturing interpersonal trust, the shared decision-making process, and the perceptions of Chinese women expressing their needs and preferences.

Data analysis

Our study combined the grounded theory approach and thematic analysis (Gale et al., 2013). Firstly, the interview transcripts were broken down into paragraphs, lines and phrases. To get a general sense of the contents, interviews were summarized for all authors. Then, the first and third author performed a thematic content analysis starting with open coding on ATLAS.ti. During open coding, the researchers explored experiences expressed in the interviews and determined how experiences were narrated and how meanings could be understood. As the analysis progressed, meanings needed to be related to each other to broader generalizations (themes). Those codes came directly from the text were and became the initial coding scheme. Researchers grouped related patterns emerging from the data and then continued discussing the patterns together to allow themes to be clarified. This process was repeated until themes were tentatively labelled and defined. During the coding process, we critically reflected on our assumptions and interpretations to avoid bias. Through writing, re-writing, reviewing and discussing definitions of themes among authors, key themes were developed, i.e., culturally sensitive care, the development of interpersonal trust, and women's autonomy in shared decision making.

Results

The age range of participating middle-class Chinese migrant women was between 25 and 43. More than half of them (54%) have lived in the Netherlands less than 5 years and 17 women have lived in the Netherlands longer than 5 years. Almost all participating Chinese women (45 out of 46) were married at the time of study participation. One Chinese woman was in a registered partnership. There were 6 out of 13 participating Dutch midwives who have been practicing midwifery care more than 10 years. Among them, 4 midwives had served only one Chinese migrant woman, and 9 of them had served more than one Chinese migrant woman in the recent decade (Table 1).

Findings

Based on three key concepts- 'culturally sensitive care', 'interpersonal trust', and 'women's autonomy in shared decision making', we identify the key themes as: barriers to address and respond to women's preferences; the process of strengthening interpersonal trust; the ambivalence between the autonomous decision and professional advice; acknowledgement and misattribution of needs seen as culturally conditioned; addressing women's emotional needs and supporting women's autonomy.

Barriers to address and respond to women's preferences: More medicalized care?

We observed that many Chinese women felt the approach to pregnancy in the Dutch context was less attentive and sometimes careless. In the Netherlands, a pregnancy with low risks is usually not considered and treated as medical condition. Comparing to more suggested prenatal screening tests by obstetricians in the hospital and the attentive care during pregnancy in urban China, Chinese migrant women wished for more attention and responsive care from their midwives regarding the bodily changes and the development of the fetus through more ultrasound scans. In addition, most Chinese women believed in that "technology and modern science are superior to nature". Even though the majority of Chinese expectant mothers in the study had low risks during their pregnancy, we observed a high preference for more medicalized care including prenatal screening and diagnosis for birth defects, and medicalized hospital birth. In this regard, due to the different way of understanding care and the disparity of care expectations, many Chinese women often perceived their worries were neglected by midwives, while Dutch midwives interpreted Chinese women's concerns and requests were "overreacting, unnecessary and inexplicable".

> My friends in Shanghai told me the obstetricians did all available prenatal screening tests and ultrasound scans to reassure healthy children. The technology and skills are available as requested. A

Table 1
Socio-demographic characteristics of participating Chinese women.

Characteristics	Variables	Numbers
Age (years)	20–30	6
	30–40	36
	40–50	4
Transnational couples	Yes	28
	No	18
Highest Educational Attainment	High vocational college	2
	Undergraduate degree	17
	Master's degree	24
	Doctoral degree	3
The length of migrating to the Netherlands at the time of childbirth	Less than a year	4
	1–5 years	25
	5–10 years	14
	10 years and above	3
First-time experience of Dutch maternity care services	Yes	30
	No	16

> child with some physical and mental disabilities is going to have a very tough life in China, not even mentioning a 'high quality' of life. Here in the Netherlands, my midwife was confused by my request and kept asking 'what do you want to know and why do you want to do the test'. I just wanted to be certain about my baby's health.
>
> Yingyu, a Chinese mother with two sons living in Delft

Chinese expectant mothers have been seeking for a sense of reassurance and certainty through requesting more medicalized care during pregnancy. Consequently, some Dutch midwives reported that it has been challenging for them to respect women's individuality and response to their needs at the same time. "When I asked her why you needed an additional ultrasound scan, she said 'I want to be assured'. After I told her there was no need for another ultrasound scan, she was skeptical about my advice and felt disappointed. I knew if I won't provider another scan, I would lose some of her trust."

The process of strengthening interpersonal trust

This theme depicts how the concept of interpersonal trust is established and how trust is influenced by the different understanding of health and care held by Chinese women compared to mainstream health norms in the Netherlands. Every Dutch midwife in the study indicated that "Chinese women are nice clients" and highlighted a positive impression of Chinese women because mostly Chinese women were actively seeking health information and had strong willingness to accept and adopt health advice. Many Chinese women addressed that trust in professionalism of Dutch midwives was already there before their first visit to the midwifery practice since they tended to hold medical doctors in high regard in general. Before being in contact with midwives, they acquired new knowledge to comprehend the roles and functions of Dutch midwives through social media and the newly established social network in the Netherlands.

However, several Chinese migrant women developed doubts about the professionalism of midwives after their first contact. Especially for first-time mothers, these doubts increased the feeling of insecurity upon the existing challenge of comprehending new experiences of pregnancy. Most Chinese women did not express their doubts to midwives. Instead, they turned to information on both Dutch and Chinese social media and from social networks in both China and the Netherlands to facilitate the transnational care and services. As compared to being treated by different unfamiliar physicians during each hospital visit in urban China, it is conceivable that Chinese migrant women gradually develop interpersonal trust and better relationships towards their midwives in the Dutch context throughout repeated consults with the same midwife during pregnancy. Furthermore, providing adequate healthcare related information and explanations by midwives has helped Chinese women to alleviate certain concerns of how the Dutch midwifery care arranged and functioned.

> I had some doubts in professionalism of the Dutch midwifery care since the beginning contact with my midwife. Did she have adequate medical training? Later throughout our contacts, she explained scientific knowledge of the fetus's development with patience and gave me advice on which exercise was good for my condition. She helped me to 'fight' against the traditional Chinese norm of understanding a pregnant woman's body.
>
> Liuyang, a first-time mother living in Amsterdam

"A culture thing"

All midwives and maternity care assistants emphasized the need of continuous training of cultural diversity in care practices. Providing culturally sensitive care was understood differently by different maternity care assistants. Several maternity care assistants believed that "we received some training on cultural diversity and cultural sensitivity. Women from different cultures are different than us [Dutch women], so we should provide different care services to them". Some of them addressed that "I must respect and accept the cultural difference. I am not here to criticize their culture". When asking the actual indication of the cultural difference in health and care with Chinese migrant women, many maternity care assistants shared a general impression of Chinese women's attitudes and behaviors as "keeping problems to themselves" and "being reluctant to ask for help".

All maternity care assistants mentioned the Chinese postpartum tradition "doing the month" and they often used terms like "old-fashioned", "outdated" and "traditional" to describe their perceptions of this postpartum tradition. In particular, they often used the phrases "their culture", "a cultural thing", "other cultures" and 'others" when describing differences between Dutch and Chinese health and care beliefs. "'Doing the month' is their cultural thing. They do things differently. I do not agree but I am not here to judge." One specific practice of "doing the month" custom that Chinese women were not allowed to take a shower in the first week after childbirth has become the most controversial practice between most maternity care assistants and Chinese women. Most of maternity care assistants shared a concern of the potential harm of this and other Chinese postpartum practices to women's health. "This tradition is not hygienic. I had to respect their culture, so I had to let it go. It's their cultural thing." "She followed this tradition because of the demand from her mother-in-law, even though I told her several times that this wasn't good for hygiene and her recovery."

Women's growing autonomy in decision making

All midwives in our study emphasized the need to respect women's autonomy in decision making and to offer more care related information and explanations to assist women's decision making. In midwives' understanding, Chinese women's desire for more prenatal screening tests was strongly influenced by contextual factors such as social networks and social media. Midwives also reported that most Chinese expectant mothers came to request more prenatal screening tests without knowing and exploring their own values in the family context. "Many Chinese women do not think about the potential impact after receiving the test result and are not clear about what decision suits their condition. They often wanted to hear my opinions and follow my suggestions."

Many Chinese women emphasized that due to the extra attention they received from midwives, they started to reflect on their increasing involvement in the decision making and collaborative relations with midwives. They mentioned they were not given much freedom to make autonomous decisions by their parents when they were young. Now when it came to major healthcare decision making during pregnancy, some women preferred care providers to lead and make the "right" health decision for them. Some women felt being left alone with health decisions instead of sharing responsibilities with midwives. This attitude was often perceived as a lack of autonomy by midwives. In these occasions, midwives found themselves in a dilemma providing the "right" answers and solutions as women expected. "This is an important life decision for them [Chinese women] and I cannot make it for them." Another part of Chinese women felt the Dutch approach of shared decision-making liberating and empowered, and appreciated being encouraged by their midwives to make autonomous choices, like Dan.

> My parents always made decisions for me when I was young. Now I am an independent woman in a new environment. But unwittingly, I am dependent on others to make a right decision for me. In my first pregnancy, I was mostly dependent on the midwife. In my second pregnancy, I was given more time to ask questions. The midwife did not force her own opinions on me. I started to learn to gain some control over my desires and needs.
>
> Dan, a mother with two daughters living in The Hague

Being responsive to women's emotional needs & supporting women's autonomy

As described above, there were conflicts in care beliefs between maternity care assistants and Chinese women. The way maternity care assistants expressed their concerns was perceived as a lack of empathy by Chinese women and resulted in women receiving inadequate emotional support. Because of this, some Chinese women said that they were less willing to show their vulnerabilities to maternity care assistants. After childbirth, a large part of Chinese new mothers considered their physical condition particularly vulnerable and sensitive. They chose to follow certain practices of "doing the month" to recover their strength, such as avoiding cold beverages, eating spicy food or limiting their physical activities. "I felt my body did not belong to me anymore. I felt weak in many ways, and I believed following these rules can help me to recover faster."

Yet this perception of vulnerability and what activities women can or cannot perform did not always align with maternity care assistants' beliefs of care during this recovery period. Accordingly, maternity care assistants faced difficulties responding to women's specific needs. Additionally, several maternity care assistants highlighted that there was no need for providing additional emotional support. "When the woman's own mother is there after birth, I think she must feel safe because she is not alone anymore. Also, they are a wealthy family living in a big house in Amsterdam." A few maternity care assistants addressed that they had sensed "something is going on" with Chinese women's mental health status. However, the emotional support was insufficient due to maternity care assistants' assumption of Chinese women receiving adequate social support from family members. As a result, some Chinese women reported experiencing a lack of responsive care and emotional support, which could have increased the risk of experiencing depressive symptoms.

In addition, a large part of Chinese women reported that they have been experiencing additional ambivalence and stress balancing between the Chinese traditional customs and the professional advice from maternity care assistants. "The pressure is from both sides. No one is satisfied with my decisions." However, some Chinese women with less supportive family members addressed the mitigating effects of maternity care assistants on balancing the power with women's mothers/in-laws when it concerned how to care for women. Several maternity care assistants recognized and acknowledged these women's ambivalent situation and have tried to provide a sense of validation to encourage women to make autonomous decisions for their own good. To a certain extent, the authority of maternity care assistants as health professionals has helped Chinese women to gain self-confidence to cope with this additional stress in more authoritative family contexts. "She [a maternity care assistant] helped me to regain my power to make my own decisions. I got 'science' to support me." The role of maternity care assistants acted as a shield supporting women's autonomy in decision making.

> At the home of a young Chinese woman, I saw how her Chinese mother-in-law bossed her around in every respect, such as how many eggs a woman after birth must eat per day and whether she could walk outside. She asked my opinions about these rules. I shared what I believed and encouraged her to make her decisions for her own comfort.
>
> A Dutch maternity care assistant in Delft

Discussion

Our interview-based study provided unique insights into the formation, tension and dynamics of the relationship between Dutch maternity care providers and Chinese migrant women from both perspectives of women and care providers. In the process of nurturing a trusting relationship, midwives showed a caring attitude that helped to empower women's autonomy and to assist women's decision making in line with their individual preferences. Our findings added to the literature in which middle-class migrant mothers were often understudied. Even with less language barriers and more effective communication, middle-class Chinese migrant women experienced a lack of understanding of their preferences for more medicalized care during pregnancy by midwives (Gong and Bharj, 2022). Even though well-educated middle-class Chinese migrant women in our study were privileged enough to have access to various information and resources to fulfill their needs in transnational care, most women still experienced ambivalence about seeking reassurance from Dutch maternity care providers to gain a sense of control over their body. Our study revealed and emphasized the different needs and preferences for maternity care for middle-class Chinese migrant mothers in the unique Dutch context. Chinese migrant women with different class background may have other specific needs, but also face similar difficulties in receiving expected care. One might assume that our findings can be extended to the understanding for middle-class Chinese migrant women in other European contexts (Cai et al., 2022).

This study also contributes to the ongoing discussion of the midwifery profession that expectant mothers increasingly prefer more medicalized care and there is an increasing emphasis on assessing and managing "risk pregnancies" using technology (Bowman-Smart et al., 2020; Lupton, 2012; Ravitsky, 2017). Our findings that most expectant Chinese mothers perceived their pregnancy as a high-risk condition and wished to rely on technology for reassurance of a "healthy child" contribute to a broader debate around the interplay between technology, fear and uncertainty related to maternal and obstetric care. In our study, expectant Chinese mothers experienced intense anxiety and uncertainty due to the fact that third trimester ultrasound scans and other prenatal screening tests in Dutch primary midwifery care are usually only offered due to a medical indication (Dutch Association of Obstetrics and Gynaecology, 2017; National Institute for Health and Care Excellence, 2021). The general trend of medicalization of pregnancy and childbirth in urban China has affected Chinese women's expectations of care that also contributes to the heightened sense of anxiety for expectant mothers (Gong, 2016, pp. 46–52). This uncertainty has caused an enormous fear among these women of carrying "abnormal" or "imperfect" fetuses. They never felt secure and they feared their children to lose advantages for future career opportunities which could lead to a "low quality" of life (Zhu, 2013). Moreover, Dutch midwives in our study perceived their roles as guiding women to reflect about what decisions better suit their values and the social context. Nevertheless, the mismatch between requesting more medicalized care by Chinese migrant women and promoting the natural course of pregnancy and birth by Dutch midwives may result in women experiencing their concerns and anxieties being silenced. This may in turn have led to the experience of unmet needs for maternity care services.

When Chinese women were asked to make choices based on their needs, not all women wanted to gain autonomy to the same degree. Some Chinese women found it a burden and felt anxious about making their own choices. Still, we have seen how some middle-class Chinese women have tried to gain autonomy in the shared decision-making process despite finding it challenging. Women in our study who had positive relationships with maternity care providers were able to acknowledge their self-development in gaining maternal confidence and efficacy (Swanson et al., 2012). Shared decision making should be a relational process to create a contextualized safe space for the individual woman. In the context of healthcare, autonomous decision making should not "stand alone" without considering the social context and relations in which one is embedded (Osamor and Grady, 2016). Moreover, maternity care providers in our study indicated that they valued women showing their vulnerabilities. This had positive effects on care providers as it made it more feasible to offer responsive care to women's various needs. In turn, such interactions can nurture the development of trusting relationships women and care providers.

In addition, we observed an increasing need for Chinese women to share their ambivalent feelings and attitudes towards maternity care assistants who they considered as an important source of science-based insight and emotional support. Different perceptions of physical vulnerability held by Chinese women and maternity care assistants, such as outdoor physical activities, have resulted in women experiencing a sense of being neglected and receiving inadequate emotional support. Despite the fact that middle-class Chinese women are more able to mobilize various resources to cope with health-related risks and uncertainties, their emotional needs should be addressed and responded sufficiently. Quality of care can only be realized if a genuine and balanced dialog is facilitated acknowledging women's dynamic needs (Lambermon et al., 2021).

We observed that the language barriers did not hinder the effective communication between maternity care assistants and Chinese mothers concerning practical matters. Yet, the language-based or cultural misunderstanding and misperceptions appeared regarding cultural differences-related topics due to cultural misunderstanding, such as the confinement of 'no shower in the first week after childbirth', which reinforced the "us and others" division. It is notable that many maternity care assistants often tended to interpret women's different care expectations and needs as "a cultural thing" and homogenized and stereotyped women's health beliefs solely based on women's country of origin. This narrative of "their culture" reflects an association with clients' social and cultural background and problematic behaviors and poor health decisions that reinforced stereotypical and overgeneralized views. Some maternity care assistants perceived Chinese migrant women as a group of "others" whose reactions were shaped only by cultural differences that could be learned in advance. Many of them responded to women's preferences and needs "appropriately" as they were taught in the training to categorize different beliefs and practices into "cultural differences". In fact, this attitude and cultural exoticization of Chinese women inadvertently perpetuate the "us and others" division and thereby can result in the experience of exclusion on the part of migrant women (Malatzky et al., 2018).

Providing culturally sensitive care should emphasize the development of self-reflection of one's own cultural identities as a health professional to engage with clients' differences. Our findings also confirm that more "cultural knowledge" or "cultural sensitivity" does not always contribute to better care (Chaouni et al., 2020). Each individual woman relates to the cultural tradition differently. It is essential for maternity care providers to recognize the dynamic complexity of women's cultural identities with respect and to empathically listen to women's life experiences, preferences and concerns instead of assuming "culture" in a simplistic category based on ethnicity and geography and neglecting the subjectivity of individuals (Kleinman and Benson, 2006; Shaburdin et al., 2022). Furthermore, understanding the complexity and multilayered dynamic within women's social, economic and environmental contexts can help to create a balanced focus in the health risk discourse that is crucial to achieving health equity.

Limitations

There are several limitations in this study. Due to the regulation of COVID-19 during the data collection period, the accessibility to Chinese migrant women was limited to digital contact. It was impossible to conduct intense field observation at participants' home. Observing interactions between Chinese women and Dutch maternity care assistants at women's home was therefore not feasible. Participating Chinese women reported experiencing postpartum depressive symptoms and they might have biased their perceptions of received care and services. However, a meta-analysis by Moore and Fresco on depressive realism suggests that depressed individuals are able of making realistic inferences (Moore and Fresco, 2012). In addition, some midwives and maternity care assistants had limited experiences of providing care to Chinese migrant women possibly suggesting that they might have had a restricted understanding of this specific group of women.

Implications

One important implication for the Dutch maternity care system is that care providers should be offered more time to have a constructive dialog that can inform women thoroughly about the prenatal care approaches and care procedures, especially for migrant women. In the ongoing training for midwives and maternity care assistants, there is a strong need to stimulate the attitude of providing respectful and responsive care instead of offering explanations of specific cultural needs. Maternity care providers play vital roles to provide sufficient information tailored to women's knowledge and needs, and to stimulate women participate in shared decision-making to enhance women's involvement.

Availability of data and materials

Quotes from the interview contents are published in this article. Full transcripts are not publicly available. Parts of the transcripts can be available from the corresponding author on a reasonable request.

Ethical approval

This study was evaluated and approved by the Medical Ethics Review Committee of VU University Medical Center (number: 2019.660). Participants were informed about the purpose of the study and agreed to interviews being recorded. All participants provided informed (written or oral) consent before the interview started. All data was stored in encrypted files which only four authors of this article were allowed to access to the data.

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CRediT authorship contribution statement

Haiyue Shan: Conceptualization, Project administration, Data curation, Formal analysis, Writing – original draft, Writing – review & editing. **Sawitri Saharso:** Conceptualization, Investigation, Writing – original draft, Writing – review & editing. **Nandy van Kroonenburg:** Project administration, Data curation, Formal analysis, Writing – original draft, Writing – review & editing. **Jens Henrichs:** Conceptualization, Investigation, Writing – original draft, Writing – review & editing.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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