Turkish immigrants and their views on abortion, contraception, and pregnancy

A grounded theory analysis

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Abstract

Objective: To identify possible factors that identify the decision-making progress of Turkish women in the Netherlands surrounding abortion, contraception, and pregnancy. This qualitative research uses grounded theory to analyze interviews conducted with Turkish women who live in the Netherlands, as either first-generation immigrants or second-generation immigrants. The interviews intended centered around cultural factors, religion, financial factors, healthcare and sexual health education.

Data: Research has shown that Turkish women in the Netherlands have higher abortion rates than native Dutch citizens. Turkish women are among those with the highest risk of unplanned pregnancy in the Netherlands. Existing literature has ignored these women in favor of general practitioners and abortion clinics. This research has attempted to focus on the experiences of Turkish women living in the Netherlands without judgment.

Conclusion: Cultural and religious factors cause Turkish women to feel pressure to adhere to a certain image. The clash between these two factors creates double standards in which some Turkish women might feel no other option than to get an abortion. The lack of sexual health education exacerbates this problem by upholding the stigma surrounding contraception. Financial considerations and distrust in healthcare providers influence these decisions and attitudes even more.

Keywords: Reproductive health, Turkish immigrants, Culture, Contraception, Abortion, Pregnancy

Introduction

The Netherlands is a multicultural country with a population that consists of people from many different backgrounds. As of January 1, 2022, 4 442 184 of Dutch citizens had a migration background. That amounts to 25.3% of the total population (CBS, 2022). In 2020, 28.532 abortions were performed on Dutch citizens, which is slight decrease compared to the previous year (Ministerie van Volksgezondheid, 2021). Research has shown that Turkish women in the Netherlands have higher abortion rates than native Dutch citizens (Ketting & Visser, 1994; Loeber, 2008). Research based in western Europe and the USA suggests that this trend is not unique to the Netherlands (Larsson et al., 2016).

Fertile women who do not use any form of contraception but are having intercourse are at a higher chance of unplanned pregnancy than others. In the Netherlands, 8% of women fall within this group. Women with a non-Western background comprise the largest share of this percentage, which means that there is a higher risk of unplanned pregnancy among non-Western women living in the Netherlands. Research has shown that Turkish and Moroccan women are at most risk for unplanned pregnancies (De Graaf & Wijsen, 2017). Moreover, in 2021, more than half of Dutch citizens with a migration background were of non-Western descent. At that time, there were 422 030 Turkish people living in the Netherlands (Statline, 2021).

The existing literature and research do not offer a thorough explanation for the relatively high number of abortions among Turkish women in the Netherlands. Dutch and other researchers chosen to employ quantitative methods, focusing on entities such as the general practitioner (GP) or abortion clinics, while leaving women themselves out of the conversation. However, given the relevant discussions and events surrounding eugenics which still impact this world today, one could argue that this topic deserves more attention. Not only does this topic have historical relevance, but Turkish president Recep Tayyip Erdogan is still calling on Turkish women to stop using birth control, even when the Turkish fertility rate is one of the highest among Europe (BBC, 2016). Moreover, research has shown that unplanned births can lead to significant mental health issues, such as anxiety and depression. They can also bring conflict into

relationships. Family planning services such as abortion and contraception can therefore have positive effects on mental health and relationship satisfaction (Sonfield et al., 2013).

This research focuses on Turkish women living in the Netherlands and the factors that might influence their decision-making process regarding abortion and contraception. The research question is: What are the factors that influence the decision-making process of Turkish women in the Netherlands regarding abortion and contraception? This research has made use of qualitative interviews in which Turkish women in the Netherlands have been asked about their attitudes and influences surrounding abortion, contraception, and pregnancy. This research aims to contribute to a better understanding of the racial and ethnic differences within the Dutch healthcare system, with a specific focus on reproductive healthcare. Moreover, this research could contribute to the literature surrounding migration and reproductive healthcare and offer more inclusive approaches in researching this topic. My hope is to draw more attention to this topic and provide some insights into these issues. The Netherlands stands for equality in reproductive healthcare, but it might not reach all of the intended target audience. Research such as this could provide governments like that of the Netherlands with a better idea and framework for their social policies.

Theoretical Framework

To examine the attitudes of Turkish women living in the Netherlands regarding abortion and birth control, this research has made use of grounded theory. This chapter will outline theory that is relevant to this research, and it will follow the same structure as the chapter in which the findings will be discussed.

Culture

The first topic that is of importance for this research, is culture. Pinto (2004) introduced the concepts of ‘fine mesh’ and ‘wide mesh’ when comparing Turkish and Dutch cultures. Dutch culture is described as a wide mesh culture, in which the individual and their values and norms are central in the community. The Turkish culture can be described as a fine mesh culture, in which the group and its values and norms are central in the community. In a fine mesh culture, individuals deeply care about the reputation and honor of

their family. Moreover, in a fine mesh culture, there is a clear distinction of gender roles within the community (Pinto, 2004).

This divergence between individualistic and collectivistic cultures has also been described by sociologist Hofstede (2004). He attempted to illustrate this by creating several cultural dimensions, one of them being Power Distance. According to Hofstede, Power Distance scored low in the Netherlands but high in Turkey. This means that in Turkey, the relationship between parents and their children was different than in the Netherlands. In Turkey, authoritarianism and corporal punishment would be more acceptable, and people are raised to be respectful of their parents. Hofstede also described the Netherlands as a highly feminine country, and Turkey as more masculine. This masculinity was characterized by more traditional gender roles, and the superiority of men over women. The last distinction between the two countries according to Hofstede was that the Netherlands was highly individualistic, and Turkey was more collectivistic. This means that in Turkey, the greater good of the group, or family, surpasses that of the individual.

The combination of religion and culture makes this a complicated topic. On one hand, higher levels of religion can lead to anti-abortion sentiment in Turkey (Norris & Inglehart, 2012). On the other hand, contraception is still seen as a taboo topic. Moreover, the availability of contraception is lower than in the Netherlands. Therefore, contraception use in Turkey is relatively lower than in most European countries (Milewski & Carol, 2019). This is why women in Turkey might feel like abortion is the only option for them, even if they cannot obtain it legally (Bankole et al. 1998). This could partly explain why abortion rates in Turkey might be high, despite the anti-abortion sentiment.

Sexual Health Education

Sexual health education in Turkey varies from non-existent to limited. Often, the only information children receive is during biology class in high school (Aslan, 2022). Moreover, the majority of parents do not educate their children regarding sexual health issues. Research has shown that the topic of sex and sexual health is considered a taboo in the Turkish society (Mertoğlu, 2019; Aslan, 2022). People are expected to

educate themselves through friends and media. The lack of sexual health education in Turkey has led to a lack of awareness among young people. This can lead to sexually transmitted diseases and unplanned pregnancies. The research on this topic is limited, but a number of studies have shown that many young people are basing their actions on wrong information when it comes to their sexual health and activity. One major obstacle for better sexual health education in Turkey is the fact that there is a common belief in conservative countries such as Turkey that it will incentivize young people to increase their sexual activity. However, research has shown the positive effects of comprehensive sex education, such as an increase in knowledge about sexual health and sexuality, as well as stronger sense of autonomy (Aslan, 2022).

Religion

Despite Turkey having one of the most liberal abortion policies among Muslim majority countries, the legality of abortion still highly depends on the situation (Loeber 2008). Research by Van Tubergen and Sindradóttir has shown that Turkish immigrants in Europe are among those who maintain the highest levels of religiosity (2011). For second-generation Turkish immigrants, religious and ethnic values being transmitted through their Turkish parents can influence their attitude toward abortion (Milewski & Carol, 2019). Not only can parents transmit their attitudes onto their children, but religious institutions also play a role. The influence of religion in general, and Islam more specifically, on attitudes towards abortion has been well documented. Religious institutions such as Islam frame pregnancy as a gift from god, a process that men and women should not try to change (Jelen 2014; Shapiro 2014). Therefore, religion can influence one's perception of pregnancy. A US-based study suggested that there are two different ways pregnancy is perceived. The most common way is based on *intentions*, where people regard pregnancy as a deliberate choice. This approach includes either actively avoiding or actively pursuing pregnancy. Another approach is more of a fatalistic approach, where people view pregnancy as *predetermined* (Manze et al., 2019). This approach is based on the belief that an outside force, such as fate or god, influences the chance of pregnancy. Such an outlook could influence the way people perceive or engage with family planning services (Jones et al., 2016).

Contraception

A study by Kulu and Gonzalez-Ferrer has shown that Turkish migrants have higher fertility rates than native Dutch citizens (2014). This is not surprising, as Turkish president Recep Tayyip Erdogan has a record of urging Turkish women to refrain from using birth control as well as urging them to have at least three children (BBC, 2016). In 1970, the fertility rate in Turkey was 5.0. It has since decreased to 2.5, which is still higher than any European country (Loeber, 2008). Moreover, there is a significant difference between the type and efficacy of contraception used among Turkey and the Netherlands. Whereas in the Netherlands women mostly use highly effective forms of contraception, Turkish couples are drawn to traditional methods that have been known to be unreliable, such as the 'pull-out method' (Loeber, 2008). This is in line with a study based in Sweden, that showed that there are significant differences in contraception use and type among people with a migration background compared to native Swedish women. Migrants were shown to use lower proportions of contraception, as well as different types of contraception, than non-migrants in Sweden (Larsson et al., 2016).

Healthcare

A study based in the Netherlands focused on the role of the GP in providing sufficient information about contraception to people with a migration background. This research showed that contraceptives were significantly less often discussed with and prescribed to refugees and other migrant women compared to native Dutch women (Raben & van den Muijsenbergh, 2018). In 2021, Dutch women reported that they were overall satisfied with their first consultation regarding contraceptives with their GP. However, women with a non-Western background were less satisfied with their consultations (Van Ditzhuijzen et al., 2021).

In The Netherlands, the GP is the main liaison for reproductive healthcare. The GP is the person who informs about and prescribes contraceptives, and who can direct women towards abortion clinics. The Institute of Medicine (IOM) has reported that women of color are less likely to receive adequate service from their healthcare provider. Reasons for this ethnic or racial disparity are possible cultural or linguistic

barriers that could negatively affect patient-provider relationships. Another barrier could be a lack of trust in the relationship between a physician and their patient. The IOM reported that minority communities often have increased levels of distrust for the health system (Eastman, 2002).

Research has shown that Turkish people generally experience higher levels of discrimination than other migrant groups (Weichselbaumer, 2016). This can be due to a process called 'othering', which is the action of putting people into categories. In this case, native Dutch people are categorized as 'us', while Turkish migrants are being categorized as 'them'. Othering can often be seen in the process of migration, in which the native citizens and the state are labeling newcomers as the 'other'. Othering can be caused by distrust between a patient and a healthcare provider, especially when it concerns an intercultural relationship. Healthcare providers in these situations often lack cultural competence to build trust with their patients. Moreover, when the burden of 'foreign' disease is placed on migrants, this could further maintain the distrust and consequent othering (Alpers, 2018).

Othering is often caused by a distrust between two parties. Research has shown that this distrust can be caused by differences in belief systems, behavior, perceptions, and values. Therefore, patients tend to trust their healthcare provider more if they share characteristics, such as gender, age, culture, language and ethnicity. A Norwegian study has shown that migrant patients often perceive the healthcare in their home country as better, which led to increased distrust in the Norwegian healthcare system (Alpers, 2018). Moreover, negative experiences often circulate in migrant communities. Once the othering has started, it can be reversed by positive experiences that disprove the original distrust between patient and provider (Alpers, 2018).

Data & Methods

In order to answer the research question, I have chosen to conduct 11 semi-structured interviews. This type of interview is well-suited for research surrounding racial or ethnical issues (Mizock et al., 2011).

Semi-structured interviews allow for a more open conversation, in which the researcher or participant can ask further questions based on previous responses. During these interviews, the participants were heavily encouraged to do so. I felt that this was especially important when discussing sensitive issues such as abortion, contraception, and discrimination.

I started out with an interview guide, which I used as a loose model for what the interviews could look like. During the second interview, the topic of sexual health education came up, which was then included in the interview guide. It is in line with grounded theory to adapt the interview as new and important codes emerge from the data. Therefore, during the entirety of the data collection period, the interview questions were revised and changed according to what I felt was right after having done more interviews. After the 6th interview, the language of the interviews switched to Dutch, and with that I changed the entire interview guide to be more efficient. Not only did I translate it into Dutch, I removed or added questions, and I changed the order of the questions.

The original plan was to conduct 12 interviews. I used a technique called 'snowball sampling', which means that I started out with one person, and they would spread the word. This worked until the 6th interview, after which I hit a proverbial wall. I decided to reach out to people on Facebook, Instagram and I even approached people in public if I heard them speaking Turkish. This paid off, and I was able to conduct 11 interviews. The first 6 participants shared many characteristics (age, opinions, religion etc.), which is why in hindsight, it was a good thing to find participants on the internet and in public. Having people from different ages, religions and social bubbles made the data more diverse and therefore reliable.

This research focused on the underlying reasons that migrants or immigrants might get an abortion. Because there was almost no existing research on this topic in The Netherlands, I chose to focus on Turkish women, since the Turkish population in The Netherlands is relatively big. Other research did not specify how someone can be defined as a migrant or immigrant, so I asked the participants if they would describe themselves as Turkish, and what 'being Turkish' means to them. All of the participants classified themselves

as Turkish, or as a combination of Turkish and Dutch. Their reasoning behind this varied, but almost all mentioned their identity, culture, nationalism, and upbringing, when describing their 'Turkishness'. One participant mentioned having to sing the national anthem at school when she was a child. Therefore, I believe they were the right persons to conduct these interviews with. After this paragraph will be a table in which all participants and their age, background, and religion will be listed. All names have been replaced with a pseudonym.

Pseudonym	**Age**	**Background**	**Religion**
Derya	27	Born in Turkey, moved here in 2018	Atheist
Bahar	24	Born in Turkey, moved here in 2016	Spiritual
Sedef	23	Born in Italy, moved here in 2017	Atheist, grew up Muslim
Zehra	27	Born in Turkey, moved here 1-2 years ago	Spiritual
Gizem	27	Born in Turkey, moved here in 2019	Atheist
Perin	24	Born in Turkey, moved here at age 6	Atheist, grew up Muslim
Yıldız	66	Born in Turkey, moved here 42 years ago	Muslim
Feryal	48	Born in Turkey, moved here 20-30 years ago	Muslim
Burçin	28	Born in Paris, moved here at age 3-4	Muslim
Duygu	25+	Born in the Netherlands	Muslim
Melek	24	Born in the Netherlands	Muslim

Before the interviews, the participants were given an informed consent form which also provided them with any information they might need regarding the topic. This form has been added to the appendix. When several participants were not able to sign this form online, I made sure to go through it with them and get their verbal consent. At the start of each interview, the participants were reminded of their rights and options, and I checked up with them regularly to see if they were comfortable.

For the analysis of the transcripts, I made use of grounded theory. The first step in this method was the initial coding, in which I generated many codes while keeping an open mind. In the next step, focused coding, I identified the most common codes and codes that seemed most important to the research. I also combined some of the initial codes from the first step. Lastly, I used theoretical coding to provide a clear theoretical understanding of the research topic. This step allowed me to move away from separate samples of data towards a coherent theory (Bryman, 2016) (Charmaz, 2006). The results of this analysis will be discussed in the next chapter.

One thing that was important during the data collection phase was my own positionality as a researcher. I made sure to reflect on my position in relation to the participants as well as to the topic. As a white woman, I am aware of my own opinions and biases that could have influenced me during the interviews and the analysis thereof. When it concerned racial or ethnical issues, I tried being as open as possible without inserting my own opinions. Instead, I chose to focus on things that I did have in common with the participants, such as having a uterus and being a woman in a patriarchal society. Even though I did not match the ethnicity or race of the participants, I did my best to display cultural sensitivity. Several participants noted that they felt very safe speaking to me and mentioned that our shared gender was an important factor for them.

Findings

The findings of this research are presented in this chapter. The findings will be divided into several categories to keep it clear and concise. This research focuses on the underlying factors that influence Turkish women in their decision-making process surrounding abortion and contraception. This chapter will be centered around those factors. The topics that will be discussed are religion, culture, financial considerations, healthcare, and sex education. Together, they might offer insight into the factors that might influence the participants to get an abortion or not.

At the start of the interviews, all participants were asked if they believed women should have the right to make all decisions about their own body. Their reply was a unanimous 'yes'. When further asked about factors that could influence their own bodily autonomy, not all of them felt that they were able to make decisions about their own body. Several factors for this came up, including societal pressures, religion, family, and more. The first topic that will be discussed here is religion.

Culture

The biggest finding of this research has to do with culture. What emerges is a picture of pressure on what it means to be a Turkish woman. For many participants, to be a Turkish woman means to get married and bear children (in that order). Sex is not something to be discussed openly, but it is expected (for childbearing) after marriage. Views on abortion and contraception all seem to stem from maintaining this image. The first participant who articulated this was Burçin, who mentioned her family's cultural values as a reason for possibly getting an abortion. This is the first instance of the concepts of 'fine mesh' culture, power distance and collectivism showing in the findings (Hofstede & McCrae, 2004; Pinto 2004).

Burçin: "For us, you have to get married before having children. I really want to have children, but I am not ready for marriage. So, I would not get a child without getting married. In most cases, your family wouldn't support you. In our culture, that is very prominent. You have to get married before getting children. If I were to get pregnant from a boy that I like very much, then I would not be able to keep it [the baby]."

Despite growing up in the Netherlands, the pressure from her family is big enough for her to hide possible pregnancies and abortions from her mother. Her comments are in line with previous research, which states that second generation Turkish immigrants have mostly adopted the cultural opinions of the host country, but they still hold on to traditional Turkish values (Loeber, 2008). This can create conflict between them and the first-generation immigrants in their social bubble, such as their parents.

The pressure of waiting for marriage before having children was not limited to Burçin, as it was mentioned by other participants as well.

Gizem: "[…] in Turkey, it's not really a free choice, there's always other aspects that kind of like force you to get abortion. […] in Turkish culture, you should get kids if you're married. It's not possible to just live with your partner in the same apartment and then have kids."

These quotes demonstrate the idea that Turkey is a fine mesh culture, in which familial reputation and honor are highly influential for its citizens (Pinto, 2004). It is also in line with the Power Distance and Collectivism dimensions described by Hofstede and McCrae (2004). The former suggests that in Turkey, respect for ones' parents is deeply engrained in society. The latter suggests that Turkey is a collectivistic country in which the greater good (of a family) is more important than the individual. Both of these ideas seem to be confirmed by the findings.

What emerges is a picture of pressure on what it means to be a woman in Turkey – To be a woman means to get married and bear children (in that order); sex is for childbearing. Views on abortion and contraception all seem to stem from maintaining this image.

Another participant, Perin, described feeling pressure of not getting pregnant at a young age. Her reason for starting birth control during her teenage years can be explained by the pressure to maintain the image of a Turkish woman who does not get pregnant before marriage. She also tries to protect her family from shame, which is in line with the fine mesh culture idea.

Perin: "[…] when I became sexually active, the biggest fear of behind my, in my, my mind was definitely that I would get pregnant because, um, I was still a teenager living at home, and that is possibly one of the worst things that can happen to you if you're a young Turkish girl, I feel like."

During the interviews, it became clear that family and cultural pressure affect the participants' motivations to get an abortion or to use birth control. Participants who grew up in Turkey mentioned that within their culture, birth control was not commonly used or was even frowned upon, confirming the idea that contraception is considered a taboo in Turkey (Milewski & Carol, 2019).

Gizem: "[…] using birth control is also not something really common in our country because, um, they just think that women should like have sex when they're married. But this is almost never the case. Um, but like, just the parents they expect from them, to not get pregnant before marriage. And they're also afraid that using like birth control […] would maybe stop them from reproducing. They're also kind of against using those things. But if accidentally this happens and if they, like, their daughter gets pregnant, then, then they should get abortion."

Gizem perfectly explains how maintaining this image of a Turkish woman can create double standards. While birth control is frowned upon in Turkey, women are expected to not get pregnant before marriage. If they do get pregnant however, they are expected to get an abortion.

This next quote further demonstrates that 'society' in Turkey is against birth control because women should not be having sex (before marriage).

*Derya: "I think the reason why people are against it, *laughs* because if anticonception is so easy, they are afraid of we're going to have lots of sex and 'oh, what would the society do if you have lots of sex?'. What would we do?"*

Other participants described that in Turkish culture, newlywed couples are often pressured into having children. It is often the family doing the pressuring. This cultural trend of shaming young women for having sex out of wedlock does not prevent them from having sex, but instead they feel like they have to hide their sexual activity from their families.

Perin: "Like with birth control, I think I started when I was 17 and my mom didn't know, for example. Um, but it was purely my decision then. I had to keep the fact that I was sexually active, hidden away from her. So, um, those kinds of things I definitely dealt with, so I don't feel like I always had, um, body autonomy."

Cultural standards such as the previously mentioned taboo on sex and birth control methods, can lead to differences in birth control usage among Turkish and Dutch women. This is in line with previously

mentioned research on this topic that showed a difference in birth control use and efficacy among migrants and native citizens (Loeber, 2008; Larsson, 2016).

Gizem: "I have some Dutch, Native Dutch friends, and I know that […] they use more ways to prevent unwanted pregnancy than women with a migration background. Like, using birth control pills more often, and using like a spiral and like, more than Turkish women."

The difference in birth control use and efficacy can partly be explained by the lack of sexual health education in Turkey. Not only can it lead to wrong information about birth control and sex, it can also uphold the taboo surrounding these topics. Just two of the participants received some form of sexual health education, and they both grew up in the Netherlands. The participants who did not receive any sex education were asked how this influenced them throughout their lives.

When I asked Feryal if she regrets never receiving any sex education, she said*: "During your upbringing [in Turkey], you learn that everywhere- if the man says something, that you have to say 'yes'. That you have to cater to your husband. But nowhere do they consider that 'you' play a factor as well. I think that is a shame. I can honestly tell you that I had my first orgasm when I was thirty, and this was after I divorced my Turkish ex [husband]."*

This quote demonstrates the fine mesh culture that is present in Turkey, in which gender differences are prevalent (Pinto, 2004). It is also in line with Hofstede's (2004) account of Turkey as a masculine country, in which men are superior to women. Other participants, such as Burçin, mentioned that they were taught not to talk to men about sensitive topics. Burçin explained that she was not even able to talk about these issues with her mother. Other participants mentioned not receiving any sex education from their parents, further maintaining the image of the Turkish woman who does not need to know about sex, because it is a concern for after marriage.

Perin: "But at one point I was also feeling like I lived almost a double life because I couldn't even tell my parents I had a boyfriend at the time. […] And thank god nothing really drastic or bad happened in that

period. But I know that if something bad had happened, I still wouldn't be able to probably reach out to my parents just because of the sheer fact that they never even spoke a word to me about sex in general, for me to feel comfortable enough to go to them about these things."

Moreover, she noted that her parents treated her brother differently than how they treated her. She said her brother *"did get the talk from my dad"*, and when I asked her how she felt about that, she said *"well, shit, to be honest with you."*. These findings suggest that the superiority of men as characterized by Hofstede (2004) is sustained by the lack of sex education in Turkey.

When asked if she ever received any kind of sex education, Derya replied: *"I was harassed when I was eight, in second grade. A guy kissed me. I used to play lots of Sims back then, and you used to make babies by kissing. I was freaking out that I might be pregnant. I was eight. And I was freaking out that I might be pregnant because of kissing. Oh my god, that's one of my biggest traumas, I think."*

She explained that after this incident, she told her mother about it. Her mother told her father who made her feel bad about it and questioned her story. In her eyes, the lack of sex education led to a decreased sense of autonomy. These findings demonstrate that a lack of sex education can uphold the male dominance that is prevalent in Turkey and can influence the cultural values that Turkish immigrants use to measure their worth.

This section has shown that many participants still hold on to a certain image of who they should be as Turkish women, regardless of how long they have lived in the Netherlands. This image is further influenced by religion, which is what the next section will discuss. Afterwards, there will be a short discussion of how these two factors clash.

Religion

Four out of eleven participants labeled themselves as an atheist. They consequently felt that religion did not affect any of their choices or opinions regarding abortion, contraception, or pregnancy. This first quote demonstrates that sentiment which was common among participants who are atheist.

Derya: "[…] me not having a religion definitely makes it simpler. I have less rules to pay attention to. Less questions in my mind."

Aside from atheism, another common label that came up during the interviews was spiritualism. Participants who are spiritual and classified this as a religion, felt that their religion does affect them deeply. When asked if religion affects her view of abortion, Bahar replied: *"Well, I'm spiritual, which is already, still a religion, I think. Um, it does because I, um... It does in a positive way, in a non-conventional way, because I believe my life is holy and I'm divinely protected, and my eggs and my babies would have been as well. […] If I make a choice of not having a baby, I believe that choice is made by my spirits, gods, and all my ancestors. So, I actually spiritually believe that abortion is okay. Cause if I make that choice, then that choice has been powered by my life force."*

Moreover, aside from being spiritual or Muslim, several participants described how growing up as a Muslim has affected their attitudes toward abortion, contraception, and pregnancy. Two participants mentioned having to unlearn certain ideas and opinions that they adopted from their parents, and forming their own.

Sedef: Oh, yeah, of course. today, like, I mean, I would still do what's best for me. For sure. But like, it definitely took a lot of years of unconditioning and unlearning things like that.

Besides from the participants who described themselves as atheist and spiritual, there were several participants who labeled themselves as Muslim. Most of the participants who are Muslim said that religion does not affect their view on abortion, contraception, or pregnancy at all. These participants also mentioned that they are not very religious. Two participants who labeled themselves as Muslim had a different opinion.

Duygu: "From a religion standpoint I do not agree [with abortion]. I would not do it myself. I think everything has a reason. If it happens to you, it happens because it was meant to happen. Because it was fate."

Duygu explained that while she does not agree with abortion due to her religious beliefs, she still thinks that every woman should have full bodily autonomy. Moreover, she mentioned that contraception is completely fine and allowed within Islam, and that no one should be forced into anything they do not want. Her wording in this quote suggests that she believes getting pregnant is an act of fate. This is in line with previously mentioned research that shows some people see pregnancy as *predetermined*. Most non-religious people view pregnancy through an *intentional* lens, in which pregnancy is to be either avoided or pursued (Manze et al., 2019).

Whereas Duygu believes birth control is allowed in Islam, Melek said that Muslims should not use it unless it is for a medical reason. This is because children are a gift of god, and birth control would unnaturally intervene in this process. However, she said she will start using contraception once she gets married. This suggests that she does not think about the option of pregnancy before marriage, linking back to the previous section about cultural factors. Moreover, Melek explained that getting pregnant while using birth control means that the pregnancy is an act of god. This is a similar but slightly different version of the fatalistic approach to pregnancy that Duygu displayed earlier.

Melek: "If you get pregnant- because you're using contraception, and sometimes you'll see that people don't expect it and still get pregnant with a very small chance. And then I do believe that it is something from god, and that you should find the silver lining in it."

Aditionally, Melek described feeling conflicted about abortion. On the one hand, she feels like it should be allowed in certain cases, for example when it concerns rape or medical emergencies. But on the other hand, she feels like pregnancy is a gift from god. Therefore, she did not know for certain if abortion should be a personal choice or not. Moreover, she mentioned that her opinion would be different if she was not religious.

This section has shown that religion can have different effects on people's opinions towards abortion, contraception, and pregnancy. Among the participants who had a negative perception of abortion,

were only second-generation Muslim immigrants. These findings resonate with the previously mentioned research about religion, which suggested that second-generation Turkish immigrants often take on their parents' religious and ethnic values, which can lead to negative attitudes toward abortion. Moreover, these same participants shared a fatalistic view of pregnancy, whereas all the other participants saw pregnancy as intentional.

The combination of religion and culture makes many participants feel trapped and conflicted. On one hand, religion can lead to a negative perception of abortion (Norris & Inglehart, 2012), while on the other hand, contraception is not widely accepted in Turkish culture (Milewski & Carol, 2019). While religion might forbid abortion, pregnancy before marriage is frowned upon. Several participants who said they are religious admitted that if they were to get pregnant before marriage, they would get an abortion. These findings show that there are clashing cultural norms that have an impact on many of the participants. This is to uphold the image of the Turkish woman that the participants strive to adhere to, intentionally and unintentionally.

Financial considerations

A common sentiment among the participants was discontent with the price of birth control in the Netherlands. Many of them noted that money plays or has played a factor regarding abortion, contraception, and pregnancy. This first participant spoke of 'unfairness' when it comes to birth control.

Perin: "And now I feel like, also with the IUD, it's ridiculously expensive, a hundred euros. And if for someone who would, who's also messy, for example, and who doesn't make a habit of taking a pill every day, that would probably be a better option. But if you can't afford it, then you literally can't get it. So, there's a lot of unfairness when it comes to that."

Moreover, many participants spoke about not wanting to get an IUD in Turkey. This is in line with the fact that IUDs are not commonly used in Turkey, and there is still a stigma surrounding reproductive

healthcare and family planning there. This is demonstrated by Turkish president Recep Tayyip Erdogan calling on Turkish women to stop using birth control (BBC, 2016).

Discontent about the high prices of IUDs was a common sentiment among the participants. Yet, IUDs are one of the most reliable forms of birth control, according to Planned Parenthood (n.d.). According to their website, an IUD is 99% effective. The cost of an IUD in the Netherlands ranges from €80, to €150. The procedure itself can range from €250 to €500, and in some cases will be covered by insurance (Spiraalplaatsen, n.d.). Derya was one of the participants who said she has an IUD.

Derya: "[…] my IUD was, um, above a hundred euros. 150, and then my insurance covered it. Which, I was lucky because I got the extra insurance apparently, but it was expensive. Like, when the money came back, I was really happy. Like really happy. I didn't know that it was going to come back, but that would, that saved my week."

She also admitted that she might not use any type of birth control if she did not have the funds for it. That would lead to her having a higher chance of unplanned pregnancy. This demonstrates that financial considerations can be a factor for many people when deciding on a type of birth control.

Derya: "If I had lots of stuff to pay and few income- have little income […] then maybe I would have kept an extra insurance for anti-conception out of it. Maybe thinking then 'well, I can use condoms. Or not.', you know? Just to keep taking the risk. Would be cheaper."

Lastly, several participants spoke of their dissatisfaction with the Dutch insurance system. Especially the fact that birth control is only covered until age 21 was met with disapproval.

Bahar: "[…]my birth control and the application and aftercare and the checkups, none of those were covered in my insurance. […] as a woman, if this is not covered in my insurance and my menstrual products are not covered in my insurance, then my womanhood has no definitive meaning in the healthcare system. It doesn't have no meaning, it's just like an empty word. It's the same. I'm a man with a vagina."

The majority of participants have made the point that by forcing women to pay for feminine healthcare, that they do not even want to need, the Dutch healthcare system is placing an extra burden on them for simply existing. If someone cannot afford to pay for family planning services, they are at a higher risk for unplanned pregnancies and consequently abortions.

Healthcare

This section will discuss the Dutch healthcare system, with a specific focus on reproductive health. Since the GP is the primary liaison for any sexual health issues, it seemed important to ask the participants about their relationship with a healthcare professional. During the interviews, participants spoke about how they felt discriminated against based on their gender, age, race, ethnicity, and language. This is in line with previously mentioned research, which suggested that Turkish migrants are especially prone to discrimination (Weichselbaumer 2016).

Discrimination

In general, many of the participants described having bad experiences with the Dutch healthcare system. Several of them instinctively related this to being foreign. It was mostly participants who did not grow up in the Netherlands who described feeling this way. The first participant who mentioned feeling discriminated against for being foreign was Sedef, who was born in Turkey but did not grow up there.

Sedef: "The healthcare system, like, I've had bad experiences with it. And so have a lot of other people that I know. Almost all like people who are foreign have had bad experiences."

Earlier in the interview she mentioned how she felt that doctors here often do not take women seriously. She felt that this made her decision surrounding any possible abortions more difficult. Moreover, when asked to elaborate on any bad experiences she had, she replied that when she went to the GGD (Gemeentelijke Gezondheidsdienst/ municipal health service) to get an IUD, *"I was made to feel like, as a non-Dutch person, as a non-EU person or just like as a as an immigrant, that I am like, not worthy to take-*

to like- how do I say this… To make use of these free services that the Netherlands offered. […] because I'm, I'm not from here."

Other participants felt the same way, but they used very specific wording such as being 'non-white'.

Bahar: "The diversity of my doctors at least is very limited. And racism in feminine care is as bad as racism in any other healthcare system. So, as a non-white person, in the Netherlands, I don't think anybody would feel that comfortable in going in knowing the stats."

The next participant also used the words 'non-white' to describe herself. Although she was born in Turkey, she lived in many places before coming here, including Denmark. That is why she compares herself to a white Danish woman in this quote.

Sedef: "[…] immigrant women being treated differently, especially when you're like a non-white immigrant. Like, I think if I was a white Danish woman, I would be a lot more welcomed, you know? If we are more like them- like, we are very similar. But I'm being… yeah, Turkish. And I can't even imagine, like, if I had like, you know? A headscarf and like, a proper, like, you know? More of an accent. Like darker skin, you know? Then it's just… Who knows how they'd treat you then?"

These previous few quotes suggest that these participants were feeling 'othered' by their Dutch GPs. This is in line with the previously mentioned research on 'othering', which noted that this phenomenon is often present in intercultural patient-provider relationships (Alpers, 2018).

Most participants mentioned gender, culture, ethnicity, race, and age as the main reasons for feeling discriminated. However, some participants related their experiences with feeling discriminated in the Dutch healthcare system to speaking a different language. Research has shown that language can play a role in 'othering', since patients and healthcare professionals might feel like they cannot fully express themselves in a language that is not their native language (Alpers, 2018).

Bahar: "I feel racism a lot as in, if I don't speak Dutch there, I feel like I'm very dismissed […]."

The feeling of being discriminated in Dutch healthcare was a common sentiment among all non-Dutch speaking participants. This suggests that language might be playing a bigger role than the participants previously thought. When patients feel othered, possibly due to their language, they might not talk as openly with their healthcare providers about sensitive issues such as reproductive healthcare.

Only one Dutch speaking participant described experiencing discrimination within the Dutch healthcare system. She moved here over 20 years ago and speaks fluent Dutch. Nevertheless, she feels that immigrants get treated differently by doctors. She also brings up the point that many Turkish immigrants prefer going to Turkey for their healthcare.

Feryal: "Immigrants ['allochtonen'] get treated worse by doctors, in my experience. And that is why you can see that over the past couple of years, that a lot of Turkish people go to Turkey, and they buy their healthcare there. Not because the healthcare is better there, but because they want to be treated better, as a patient."

In fact, the topic of participants and/or their acquaintances going 'back' to Turkey because they feel like they receive better healthcare there, was a big theme. Half of the participants mentioned going to the doctor in Turkey, because they felt like they weren't getting the help they needed, or they weren't being taken seriously, in the Netherlands. As a matter of fact, one participant told me she refuses to go to the doctor here. She goes to Turkey for all her check-ups and even gets all her birth control pills from the pharmacy in Turkey.

Gizem: "I don't like the healthcare system in the Netherlands, and I just got insured because I had to get insured. Cause I, I received a letter saying that I have to get it. Um, but I go to Turkey quite often, so then I just get my birth control pills from Turkey. Because here, I need to go to my GP first if I needed to. But in Turkey you can just go to pharmacy and get the birth control pill you want. Um, and just in general for all my check-ups. And yeah, if I'm not, if I really don't have to, I don't go to a doctor in the Netherlands and I don't get my pills from here."

She mentioned feeling like *"people with a migration background just go to the doctor more often"*. That is why she thinks Dutch people do not realize how bad the system is. Her perception of the healthcare in Turkey as 'better' seems to accentuate her distrust in the Dutch healthcare, in line with the previously mentioned research. This distrust can explain her 'othering' of Dutch people in her response. When I asked her what needs to change before she would go see a doctor here, she replied *"if the system changed in here or if it improves, then I would go."*.

Gender

Another common theme among the participants was the factor of gender when it comes to Dutch healthcare. Many participants mentioned having a gender preference for their GP. This can be due to the idea that patients are more likely to trust their GP if they are the same gender (Grimen, 2009). In this case, many participants reported having had bad experiences with male doctors or GPs, as seen in this quote.

Sedef: "[…] I just have also bad experiences with men. […] At the GP's office, who was a man. I didn't feel comfortable. I felt super uncomfortable and like I got out and I had a panic attack, and I was like, 'I'm never coming back here'. I did go to the hospital for a gynecologist, which was a man, and I felt really uncomfortable again."

While two participants mentioned having a preference for male doctors, all other participants who admitted to having a gender preference, said they would prefer a female GP. They mentioned not feeling comfortable enough with a male doctor and admitted that this would affect their ability to discuss sensitive topics such as reproductive healthcare.

Sedef: "[…] it's so important to me now, that like, I don't even… I don't want to see any male GP's. Or any male therapists. Like I just don't feel comfortable enough."

This relates back to the concept of 'othering'. Whereas the feeling of being othered can be changed by positive experiences, these participants' preconceptions about male GPs were only confirmed by their

negative experience. This demonstrates the idea that distrust can lead to more othering (of the healthcare professional).

There was one participant who mentioned having a preference for a female GP, based on previous negative experiences. However, she changed her mind after having many positive experiences with her current male GP. This confirms the idea that othering and distrust can be changed by positive experiences.

Burçin: "In the beginning, I struggled if it was a man. […] But I had such a strong trust bond with my general practitioner, that it felt okay with him."

While many of the participants mentioned their bad experiences with male or female doctors as a reason for their preference, there might be a cultural influence here as well. For Feryal, her upbringing seems to have influenced her. When I asked if she had ever discussed birth control with her GP, she said *"Yes, it was a woman, so it didn't feel like a tough subject."* When I asked her if it would have been different with a male GP, she replied *"I think that I would personally have more trouble with it. I don't have a preference, absolutely not. Just a personal barrier. It would be more difficult because of my background. But even though you do not have a preference in your head, your body has been programmed during your upbringing. Especially your emotions. And I think that this could be a barrier. When I grew up, you would never talk about sexual topics in general, with no one, but especially not with men. I think this conditioning still influences me to this day."*

While she feels that she does not have a preference when it concerns the gender of her GP, she admits that she was conditioned during her upbringing. This relates back to her religion, her culture, and the lack of sex education during her childhood. Her quote demonstrates a combination of the main findings of this research.

Discussion

This research aimed to investigate some of the underlying reasons for why Turkish women might or might not get an abortion. The biggest finding was the cultural impact that influenced both first-generation

and second-generation participants. Out of the data emerged a certain image of what it means to be a Turkish woman that many participants seemed to (attempt to) adhere to one way or another. Not all of them were aware of it, but the ones who were, mentioned wanting to break free from the pressure that they were feeling.

The findings seemed to be in line with theory that suggests Turkey is a collectivistic country, in which the relationship between children and parents is highly regarded. Several participants expressed wanting to protect their family from any shame or negative reputation by not getting pregnant at a young age or before marriage. They also displayed a willingness to hide any possible sexual activity, pregnancy or even abortion from their families. For some participants, their family's opinion was more important than their own wants and wishes. The cultural pressure to not get pregnant before marriage conflicts with the taboo that still rests on birth control. These double standards are upheld by the lack of sexual health education in Turkey. Many of the participants grew up without comprehensive knowledge about sex and birth control. Religion plays another factor in this research, with many participants feeling a certain influence because of it. Among participants who were Muslim, there was a shared view of pregnancy as an act of fate. Several of them did not agree with abortion, but regarded cultural reasons as a possible loophole. The cultural pressure of not getting pregnant before marriage surpasses almost anything else.

The next factor that influenced the participants' decisions and attitudes surrounding abortion, contraception, and pregnancy were financial considerations. A common sentiment among participants was the discontent about the cost of contraception in the Netherlands. Moreover, many participants spoke about financial factors as a reason for not wanting to get pregnant. Lastly, the idea that there is a stigma surrounding contraception in Turkey was confirmed in these findings. Several participants said they would not have used contraception if they were still living in Turkey. This stigma could be upheld by the lack of sexual health education that was mentioned before.

Another factor that is of significance to this research, is healthcare. In the Netherlands, the general practitioner is the primary liaison for any sexual health issues. Therefore, having a good relationship with your healthcare professional is imperative when it comes to getting the necessary information that one might

need. Many participants spoke about feeling discriminated against, based on their gender, age, race, ethnicity, and language. Participants were feeling othered based on bad experiences with their healthcare provider. Moreover, many participants mentioned cultural values as a reason for distrusting male GPs, which in turn leads to othering. Cultural and religious factors played a part in this, making some participants hold back information or unwilling to discuss their sexual health with certain healthcare providers. When patients are feeling othered in their relationship with a healthcare professional, they risk not asking or receiving the right information about reproductive healthcare. This could lead to them not using the right and most efficient type of birth control. Together with the clash between culture and religion, as well as financial factors, distrust and othering in healthcare is one of the several factors that this research has managed to uncover when it comes to abortion and Turkish women living in the Netherlands.

There are several limitations of this research. Firstly, the sample of this research is not representative of the Turkish population, or of the immigrant population in the Netherlands. I tried to use the snowball method to find participants, which led to the first few participants to be in the same social bubble. Afterwards, the participants started differing by age and opinion. The data sample consisted of mostly young women, with a few exceptions. The results might have been different if it had included more older women. Moreover, the nature of this research and the fact that the participants knew the topic beforehand, means that the sample consists of women who are willing to talk about it in the first place. Moreover, the results of this study would have differed if only first-generation or second-generation women were interviewed. It would also have been different if the study had included men, to see how their opinions and actions would influence the outcome. Another option would have been to interview native Dutch women alongside Turkish immigrants, to see how the results would compare. However, the structure and timeframe of the thesis would not have allowed any of these options without taking away from the experience of the current participants. I wanted to focus only on them, and hear their experiences and opinions. Another limitation is the fact that this research could not focus specifically on migrant women who have had an abortion, as this is a vulnerable group and there was no opportunity to go through a board of ethics. Moreover, the interviews were held in

English and Dutch, but for some participants it would have been better to communicate in Turkish. This is a bit ironic, since this research has mentioned that language can be a source of othering. A last limitation is that I tried to keep questions as open as possible, but one participant told me that she would have preferred a bit more guidance, as she has ADHD. As someone with ADHD myself, I felt like I should have been more aware of this.

I learned a lot during this research. The interviews were a big learning curve for me. I started with many questions that were repetitive and redundant. In between the interviews, I did a lot of reflection and changed them to be more efficient and precise. This research could have gone in any direction and with all the data I had gathered, it was hard to stick to one course and to keep it narrow. I learned to be resourceful when I could not find enough participants for my interviews. This was tough for me, as I had to step out of my comfort zone. I approached people in public transport and I reached out to different online platforms. Another lesson I learned is time management. Due to my ADHD, I tend to procrastinate a lot, but I kept up with this thesis (relatively) and I am very proud of myself. In hindsight I could have asked different questions and done things a lot more efficiently, but that is another lesson I learned.

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Appendix A

CHECKLIST ETHICAL AND PRIVACY ASPECTS OF RESEARCH

INSTRUCTION

This checklist should be completed for every research study that is conducted at the Department of Public Administration and Sociology (DPAS). This checklist should be completed *before* commencing with data collection or approaching participants. Students can complete this checklist with help of their supervisor.

This checklist is a mandatory part of the empirical master's thesis and has to be uploaded along with the research proposal.

The guideline for ethical aspects of research of the Dutch Sociological Association (NSV) can be found on their website (http://www.nsv-sociologie.nl/?page_id=17). If you have doubts about ethical or privacy aspects of your research study, discuss and resolve the matter with your EUR supervisor. If needed and if advised to do so by your supervisor, you can also consult Dr. Jennifer A. Holland, coordinator of the Sociology Master's Thesis program.

PART I: GENERAL INFORMATION

Project title:	Abortion and migration
Name, email of student:	Cornalie Barlagen, 627766cb@eur.nl
Name, email of supervisor:	Dr. Bonnie French, french@essb.eur.nl
Start date and duration:	February 2022 – June 2022

Is the research study conducted within DPAS YES - ~~NO~~

If 'NO': at or for what institute or organization will the study be conducted?

(e.g. internship organization)

PART II: HUMAN SUBJECTS

1. Does your research involve human participants. YES - ~~NO~~

   If 'NO': skip to part V.

If 'YES': does the study involve medical or physical research? ~~YES~~ - NO

Research that falls under the Medical Research Involving Human Subjects Act (WMO) must first be submitted to an accredited medical research ethics committee or the Central Committee on Research Involving Human Subjects (CCMO).

2. Does your research involve field observations without manipulations that will not involve identification of participants. ~~YES~~ - NO

   If 'YES': skip to part IV.

3. Research involving completely anonymous data files (secondary data that has been anonymized by someone else). ~~YES~~ - NO

   If 'YES': skip to part IV.

PART III: PARTICIPANTS

1. Will information about the nature of the study and about what participants can expect during the study be withheld from them? ~~YES~~ - NO

2. Will any of the participants not be asked for verbal or written 'informed consent,' whereby they agree to participate in the study? ~~YES~~ - NO

3. Will information about the possibility to discontinue the participation at any time be withheld from participants? ~~YES~~ - NO

4. Will the study involve actively deceiving the participants? ~~YES~~ - NO

Note: almost all research studies involve some kind of deception of participants. Try to think about what types of deception are ethical or non-ethical (e.g. purpose of the study is not told, coercion is exerted on participants, giving participants the feeling that they harm other people by making certain decisions, etc.).

Does the study involve the risk of causing psychological stress or negative emotions beyond those normally encountered by participants? ~~YES~~ - NO

Will information be collected about special categories of data, as defined by the GDPR (e.g. racial or ethnic origin, political opinions, religious or philosophical beliefs, trade union membership, genetic data, biometric data for the purpose of uniquely identifying a person, data concerning mental or physical health, data concerning a person's sex life or sexual orientation)?

YES - ~~NO~~

Will the study involve the participation of minors (<18 years old) or other groups that cannot give consent? ~~YES~~ - NO

Is the health and/or safety of participants at risk during the study? ~~YES~~ - NO

Can participants be identified by the study results or can the confidentiality of the participants' identity not be ensured? ~~YES~~ - NO

Are there any other possible ethical issues with regard to this study? ~~YES~~ - NO

If you have answered 'YES' to any of the previous questions, please indicate below why this issue is unavoidable in this study.

This research will collect data regarding ethnic origin, religious or philosophical beliefs, data concerning physical health and possibly data concerning a person's sex-life or sexual orientation, insofar as this data is voluntarily shared with the researcher. The researcher might ask the participants for this information, but will never push the subject if the participants do not feel comfortable sharing. These questions are unavoidable in this study, because some of this information is the main focus of the study.

What safeguards are taken to relieve possible adverse consequences of these issues (e.g., informing participants about the study afterwards, extra safety regulations, etc.).

The participants will be informed of all their rights and options beforehand, and will be ensured of their anonymity. Moreover, the participants will have to sign a consent form. Participants will be ensured that there are no moral or ethical judgments from the researcher, and that they are able to speak freely. Participants will be allowed to choose to hold their interviews online or offline, in whichever way they feel comfortable. They may at any time choose to withdraw from the study. They may at any time refuse to answer any question. They will be allowed at any time to take a break or end the interview completely. They will be given the option to receive information about the study afterwards.

Are there any unintended circumstances in the study that can cause harm or have negative (emotional) consequences to the participants? Indicate what possible circumstances this could be.

Participants may feel uncomfortable discussing their reproductive health. They will be fully informed about the study before participating, and will be able to refuse to answer any question.

Please attach your informed consent form in Appendix I, if applicable.

Continue to part IV.

PART IV: SAMPLE

Where will you collect or obtain your data?

In Rotterdam, The Netherlands.

What is the (anticipated) size of your sample?

The goal of this research is to interview 12 people.

What is the size of the population from which you will sample?

Around 879 749. (Women with a non-Western migration background above the age of 18)

Continue to part V.

Part V: Data storage and backup

Where and when will you store your data in the short term, after acquisition?

On my laptop and phone.

Who is responsible for the immediate day-to-day management, storage and backup of the data arising from your research?

Me (the researcher).

How (frequently) will you back-up your research data for short-term data security?

It will be saved in my iCloud Drive, which only I have access to. It will therefore be secure.

In case of collecting personal data how will you anonymize the data?

In the interview transcripts a person's name will be replaced with a pseudonym or with a tag that typifies the person. This is also done when reference is made to other identifiable people.

Note: It is advisable to keep directly identifying personal details separated from the rest of the data. Personal details are then replaced by a key/ code. Only the code is part of the database with data and the list of respondents/research subjects is kept separate.

PART VI: SIGNATURE

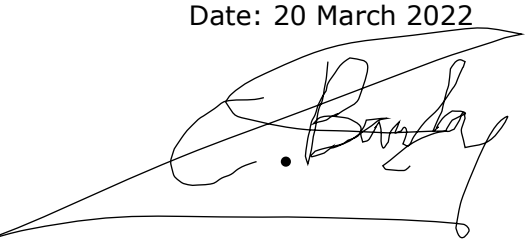
Please note that it is your responsibility to follow the ethical guidelines in the conduct of your study. This includes providing information to participants about the study and ensuring confidentiality in storage and use of personal data. Treat participants respectfully, be on time at appointments, call participants when they have signed up for your study and fulfil promises made to participants.

Furthermore, it is your responsibility that data are authentic, of high quality and properly stored. The principle is always that the supervisor (or strictly speaking the Erasmus University Rotterdam) remains owner of the data, and that the student should therefore hand over all data to the supervisor.

Hereby I declare that the study will be conducted in accordance with the ethical guidelines of the Department of Public Administration and Sociology at Erasmus University Rotterdam. I have answered the questions truthfully.

Name student: Cornalie Barlagen

Date: 20 March 2022



Name (EUR) supervisor: Bonnie French

Date: 20 March 2022

Appendix B

Information and consent form

Information sheet

Name of the student:	Cornalie Barlagen, 627766cb@eur.nl
Erasmus University Rotterdam / specific School:	Erasmus School of Social and Behavioural Sciences
EUR data protection officer:	privacy@eur.nl
Project Title:	Abortion and migration

Introduction

I am Cornalie Barlagen, and I'm a student at the Erasmus University Rotterdam. I am doing research on women with a migration background and abortion. In this form will be information about my research. I am inviting you to be part of this research. If this consent form contains any words that you do not understand, please ask me to explain at any moment.

Purpose of the research

Research has shown that women with a migration background in the Netherlands are having more abortions than native Dutch women. However, there is no conclusive answer on why. Most research on this topic excludes women from the conversation. I think it is important to do research **with** people, not just **about** them. I want to learn more about the possible factors that influence women to make decisions surrounding abortion or reproductive health. This research could encourage other researchers to focus on this topic.

Type of research intervention

This research takes place over a few months, from now until mid-June. I will only interview each person once, and each interview will last for about one hour, depending on how much you're willing to tell me.

Participant selection

You're being invited to take part in this research because I feel that your experience and ideas as a woman with a migration background can contribute much to our understanding and knowledge of ethnic disparities in reproductive health in the Netherlands.

Voluntary Participation

Your participation in this research is entirely voluntary. It is your choice whether to participate or not. You may change your mind later and stop participating even if you agreed earlier.

Right to Withdraw

You have the right to withdraw your consent to use the personal data that you have provided at any time (unless the data has been anonymized). You do not have to justify your decision to withdraw your consent and there are no consequences for withdrawing your consent.

Procedures

I am inviting you to take part in this research project. If you accept, you will be asked to participate in an interview with me. If you do not wish to answer any of the questions during the interview, you may say so and the interviewer (me) will move on to the next question. You will be able to choose if the interview will be held online or offline. You will be able to ask me for any special adjustments and I will attempt to meet them where possible. The entire interview will be recorded. Your answers and information will be completely anonymized.

At the end of the interview/ discussion, I will give you an opportunity to review your responses. If you do not agree with my notes or if I did not understand you correctly, you may ask me to modify or remove parts of them.

Potential Risks and Discomforts

During the interview, personal questions may be asked regarding some sensitive topics. This may evoke memories and emotions. Therefore, you may appreciate bringing someone who is close to you, such as a friend, to the interview. You may also refuse to answer any question at any time.

Potential Benefits

There will be no direct benefit to you, but your participation could contribute to a better understanding of why women with a migration background are having more abortions. You will be able to ask me for the results of my research afterwards.

Privacy

During this research we will ask you to provide personal data. Personal data is information that can directly (your name) or indirectly identify (your age, your background) you as an individual.

As indicated above, this research project involves making audio recordings of interviews with you for the purpose of transcribing and analysing this data. The audio recordings will be transcribed (that is, put into writing). This research will not be published. The data will never directly or indirectly identify you as a person; all data will be anonymous.

Confidentiality

Only I will know your personal data. Direct identifiers, such as your name, are kept separately from your answers as soon as possible. They will be replaced with a pseudonym or a code. I have designed the questions in such a way that your answers will not directly or indirectly identify you.

Retaining and Sharing your data

Your personal data (for example, audio or video recordings, forms, and other documents created or collected as part of this study) will be stored in a secure location until the end of the thesis trajectory.

Sharing the Results

You can ask me to share the results of the study with you afterwards. My student email will be provided in this form, you will be able to reach me there.

Your Privacy Rights and Contact Information

You have the right to request access to your personal data and to change these if they are not right or to erase your data.

If you want to invoke your rights or if you have a question concerning privacy about this study, you can contact Erasmus University's DPO (Data Protection Officer) at fg@eur.nl. If you would like to lodge a complaint concerning privacy, you can do this with the national supervisory authority in the Netherlands on personal data (Autoriteit Persoonsgegevens).

Who to Contact

If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact me: Cornalie Barlagen, 627766cb@eur.nl

Certificate of consent

I have read the Informed Consent Form and I understand what the purpose of the research is and that data will be collected from me. The research has been explained to me clearly and I have been able to ask questions.

By signing this Form, I

1. consent to participate in this research.
2. confirm that I am at least 18 years old.
3. understand that participating in this research is completely voluntary; and
4. understand that my data will be anonymised for analysis.

Consent Special categories of personal data

I give my consent to the collection, processing, use and storage of my personal data for the purposes of this research including data related to health, race, ethnic origin, religious beliefs or ideological convictions, and sexual behavior. ☐

Audio/Video

I hereby consent to having audio and/or video recordings made during the research and to have my answers transcribed. ☐

Quotes ☐

I hereby consent to having my answers quoted in this research. When quotes are used, your (real) name and other direct identifiers will not be mentioned.

Name of the participant:

Signature of the participant: **Date:**

You will be given a copy of the full Informed Consent Form.