

# Permeability of abortion care in the Netherlands: a qualitative analysis of women's experiences, health professional perspectives, and the internet resource of Women on Web

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**Abstract:** *Despite a relatively permissive abortion law, women in the Netherlands encounter difficulties in accessing abortion care. Little is known about their experiences. This study explores women's experiences with (online) abortion services and relevant health professionals' experiences delivering care, with the goal of identifying key barriers encountered by abortion-seekers in the Netherlands. An exploratory qualitative research design with a constructivist approach and an abbreviated grounded theory method was used. Interviews with 20 women who had had an abortion and 14 health professionals who provide abortion care, and 200 emails of women seeking abortion care through the non-governmental organisation Women on Web, were coded inductively and deductively (using the Candidacy Framework) thereby generating themes. Abortion-seekers faced barriers including: (i) burden of taboo, (ii) vulnerability (emotional, financial, and social), (iii) health professional evaluation and (iv) disempowerment and distress. The overarching theme was women's lack of autonomy in access to abortion care. The key barriers to abortion access in the Netherlands are the institutionalisation of taboo in abortion law and care, complex candidacy regulations, lack of permeability for certain marginalised groups, and women's inability to speak openly about abortion. To increase the permeability of abortion care, and thereby women's autonomy, legislators and policy-makers must trust women to make their own reproductive decisions and avoid actions that stigmatise abortion and hinder access to care, while actively developing systemic support for vulnerable groups. DOI: 10.1080/26410397.2021.1917042*

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## Introduction

Examining barriers to abortion care is important, as denying women\* desired abortions may be associated with poorer maternal bonding, lower child development scores and greater economic insecurity.<sup>1-5</sup> Women who are denied a wanted abortion may experience more partner violence,<sup>6</sup> more anxiety, lower self-esteem, and less life satisfaction,<sup>7, 8</sup> and have less aspirational life plans<sup>9</sup> compared to those who are successful in having a

wanted abortion. Unintended pregnancies are associated with greater odds of having a low birth weight baby, and stillbirth or neonatal death may be more common.<sup>10</sup> The risk of morbidity and mortality associated with childbirth for these women is higher compared to abortion after unwanted pregnancy.<sup>11</sup> Accessible abortion without delay is critical because first trimester abortions have fewer complications than second trimester abortions.<sup>12</sup> Barriers to legal abortion can lead women to seek abortion care outside the formal healthcare system.

Accessible abortion care can be seen as a prerequisite for achieving reproductive justice. A principle of reproductive justice is the right not to

\*In this article the terms *woman* and *women* are used to signify persons with a uterus who do, or do not, identify as female.

have a child; this includes safe and dignified fertility management.<sup>13</sup> This is in line with the UN Human Rights Committee’s declaration on women’s right to safe abortion and prohibition of restrictions leading to an unsafe abortion. The Committee calls on States to remove existing barriers and refrain from creating new barriers denying effective access to safe and legal abortion.<sup>14</sup>

The trajectory of potential barriers in accessing abortion care should be studied by examining abortion-specific experiences within individual and (inter)national contexts.<sup>15</sup> Dixon-Woods et al.<sup>16</sup> argue in their Candidacy Framework that one must also include patient-professional aspects alongside utilisation to promote a deeper understanding of access. Candidacy describes the ways in which people’s eligibility for medical intervention is jointly negotiated between individuals and health services. When appearing at health services, individuals must provide an accurate description of the health problem to justify their candidacy for care to health professionals (HPs). Individuals then experience judgment by the HPs who decide on the candidate’s suitability for a procedure. These negotiations occur in a health-care culture where some services are easier to use (more “permeable”) than others. Services that are less permeable require resources and competencies that tend to be problematic for socio-economically disadvantaged people.

In the Netherlands, abortion care is more permeable than in many other countries.<sup>17</sup> Abortion is legal if the following criteria are met, as dictated by the *Wet Afbreking Zwangerschap* (Termination of Pregnancy Law): a woman declares herself in an “emergency situation”, a doctor is assured her decision is voluntary, and the abortion is performed by a physician in a specially licensed clinic. Abortion is legal after a five-day reflection period and if performed before 24 weeks. Early terminations within six weeks and two days after the first day of the last menstrual period have no mandatory waiting period. Abortion care is free for all women insured under the Long-Term Care Act (WLZ), which applies to women legally living or working in the Netherlands. People who stay in the Netherlands without valid residence documents (e.g. women who travel from abroad for an abortion, or undocumented migrants), must pay for the treatment.

In the Netherlands, the abortion rate is one of the lowest in the world at 8.8/1000 women of reproductive age. In 2018, 31,002 women chose

to terminate their pregnancy. The majority (55%) of terminations took place before seven weeks and most women were 25–30 years old and multiparous; 11% of these abortions concerned women travelling from abroad.<sup>18</sup> Abortion-seekers come to the Netherlands from other countries because abortion is illegal or they exceed the gestational age limits in their country of residence.<sup>19</sup>

Most abortions take place in abortion clinics separate from the regular healthcare system; only 5% take place in hospitals. Most women are referred to a clinic by their general practitioner (GP), which begins the mandatory five-day waiting period. Women can also go directly to a clinic without a referral; then, the five days start with clinic registration. In 2020, an evaluation of the abortion law revealed that for some, the five-day mandatory waiting period caused friction, especially if the wait risked passing gestational limits.<sup>20</sup>

World-wide, a growing number of women seek information on self-managed abortion at home with pills bought online.<sup>21</sup> The non-governmental organisation Women on Web (WoW) provides online medical abortion services by a medical team. An online consultation allows the team to determine if there are contraindications. If not, a licensed doctor writes a prescription and medical abortion pills are sent by mail to the women in countries where abortion is illegal. In 2018, WoW started online consultations for women living in the Netherlands, with the aim of gauging abortion accessibility problems. In a survey of 172 online consultations, the most frequent barriers the women identified were: keeping it secret from their partner or family (33%), high cost (22%), stigma (11%), abortion clinic demonstrators (11%), no childcare (10%), distance to clinics (9%) and being in an abusive relationship (5%).<sup>22</sup> The results of this survey indicate that, despite the relatively permissive Dutch abortion law, difficulties in accessing abortion care exist.

Little is known about women’s experiences accessing abortion care in the Netherlands and qualitative research is necessary to understand permeability of abortion care within Dutch healthcare culture. This study investigates women’s experiences with (online) abortion services and relevant HPs’ experiences delivering care, to identify key barriers for women seeking an abortion in the Netherlands. The research question is: how do women experience access to abortion care in the Netherlands and what

barriers exist? Ultimately this research will inform a public health initiative to improve access to abortion care.

## Methods

COREQ criteria for reporting qualitative research ensured comprehensive data collection and analysis.<sup>23</sup>

### Study design

This exploratory qualitative research used a grounded theory method and a constructivist medical anthropological approach within a reproductive justice theoretical framework.<sup>13</sup> This framework is intersectional and links reproductive health and rights to social justice issues, e.g. poverty, marginalisation and health literacy. Experiences of fertility and reproduction cannot be understood as separate from the social context.

### Interviews

Semi-structured in-depth interviews were guided by a topic list (the Appendix). The topic list included barriers from the literature and was developed using the Candidacy Framework outlined in the introduction.<sup>16</sup> The interview questions focused on the accessibility of abortion care.

Women who had had an abortion and HPs involved in abortion care were recruited by email. Opportunistic sampling of groups involved in support for abortion, the research team's personal and professional networks and purposive sampling of expert groups (e.g. general practitioners, abortion physicians and advocates) was performed. Since it was difficult to recruit women from vulnerable groups, social workers, volunteers and doctors working for NGOs that support migrants and undocumented women were recruited as respondents.

Interviews took place from February–June 2020 and lasted 30–90 min. One interview was conducted by EdG, the rest by LH. Two interviews were face-to-face, the rest were online video calls due to Covid-19 regulations at the time. The interviews were recorded and the data transcribed verbatim by volunteer midwifery students or a professional company.

### Online consultations

In addition to the interviews, email data from online consultations from WoW were included in the study. Women who complete a WoW online

consultation form can consult WoW staff members by email. Communication is available in multiple languages. All email texts written by women living in or travelling to the Netherlands concerning abortion were selected, translated, if necessary, and included in the analysis. WoW does not register nationality, only preferred language in communication. Before the online consultation started, the respondents agreed with the Terms of Use, and gave consent for WoW to use anonymised information for scientific research purposes.

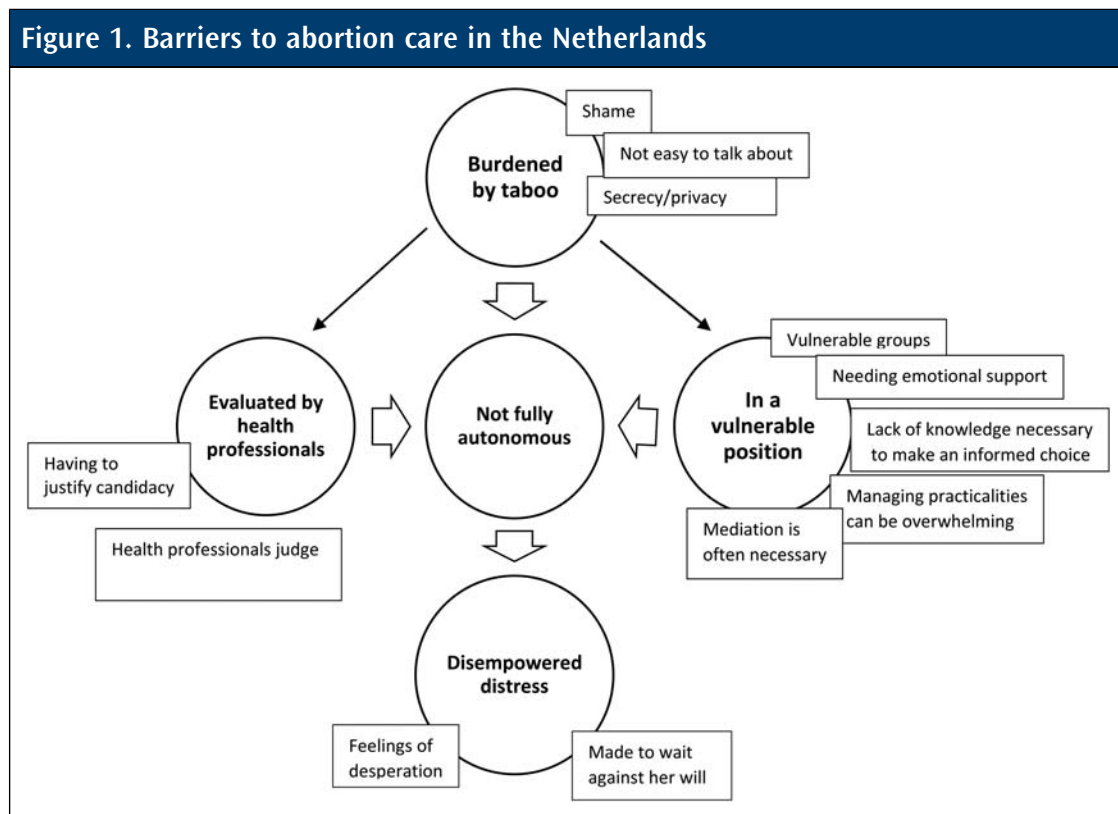
### Data analysis

All interviews were inductively coded by the first author (LH) using an abbreviated grounded theory method<sup>24</sup> and the qualitative data analysis software MaxQDA (VERBI GmbH™). Open coding started from the bottom up, with each interview adding and building on the list of codes. Cases with opposing points of view were actively sought in the data. Interviews continued until data saturation was reached. Interviews were also coded deductively using the Candidacy Framework. To heighten reliability, all methodological decisions were recorded in an audit trail.

The selected WoW emails were deductively coded (by LH) using the list of codes constructed in the interview analysis. New codes were added as necessary. The codes were grouped into themes and subthemes (axial coding) and an overarching theme was identified (selective coding) (see Figure 1).

### Ethical considerations

Ethical approval was sought from the medical ethics committee of the Amsterdam University Medical Center. As this study does not fall within the scope of the Medical Research Involving Human Subjects Act (WMO) in the Netherlands and only involved interviews, formal assessment was not deemed necessary for ethical approval (reference number W20\_489 # 20.541). In conducting the study, we gave due consideration to ethical matters by following the Amsterdam UMC Research Code,<sup>25</sup> hereby respecting participants' privacy, autonomy and dignity. Data was stored anonymously in a password-protected database. Written informed consent was provided prior to each interview wherein participants gave permission for the anonymous use of quotes. Researchers conducted interviews with empathy. Although the focus of the face-to-face interviews



was on experience of care rather than the motivation for, or feelings about, abortion, some participants reported feelings of distress. Following the interviews, all respondents were sent an email with a link to contact a (neutral, non-religious) organisation specialised in abortion after-care if they felt the need to talk about emotions arising from the interview. The women who had reported distress in their emails were counselled at the time by WoW staff.

## Results

In depth interviews took place with 34 participants of whom 20 had sought abortion care in the Netherlands from 2010 to 2020. The average age at the time of the abortion was 27 years (range 19–35 years). For most, the abortion was for their first pregnancy. One participant ultimately decided not to abort and one participant miscarried while awaiting an abortion. The average distance to the abortion clinic was 24 km (range 2–80 km). One participant was an

undocumented migrant. Two participants sought abortion care during the Covid-19 lockdown (March–May 2020). Fourteen HPs were interviewed (see Table 1).

## Online consultations by email

From November 2018–June 2020, 350 women living in or travelling to the Netherlands completed a WoW online consultation form. Most wanted a home self-managed abortion and hoped to access abortion pills online rather than go to an abortion clinic. WoW staff responded that abortion is legal in the Netherlands and explained how to access an abortion clinic. The majority were non-Dutch speaking (mostly Polish and English) and lived outside the four largest cities (see Table 2). Average age was 28 years (range 14–47) and all indicated that it had been less than nine weeks since their last menstrual period.

Of the 350 consultations, 200 were abortion-seekers who continued corresponding with WoW staff, often further explaining their situation or

**Table 1. Characteristics of the participants in in-depth interviews**

Characteristics		Frequency
<b>Abortion-seekers* (N = 20)</b>		
<b>Nationality/ethnicity</b>	Dutch	12
	Dutch bi-cultural	4
	Non-Dutch (Suriname, South Africa, UK)	4
<b>Residence</b>	In 4 largest cities (Amsterdam, Rotterdam, The Hague, Utrecht)	11
	Smaller cities and rural areas	9
<b>Religion</b>	None	14
	Catholic	4
	Hindu	1
	Muslim	1
<b>Education</b>	Higher professional and university education	16
	General- and (pre)-vocational secondary education	4
<b>Age at time of abortion</b>	15-19 years	1
	20-24 years	5
	25-29 years	10
	30-35 years	4
<b>Parity</b>	0	14
	1	2
	2	1
	>2	3
<b>Previous abortions</b>	0	17
	1	2
	2	1
<b>Type of abortion</b>	Medical	6
	Surgical <12wks	12
	Surgical >12wks	0
<b>Health professionals (N = 20)</b>		
Abortion clinic director		1
Abortion physician		3
Clinic Receptionist		1
General practitioner		3
Support organisations		
Physician		1
Social worker		1
Project co-ordinator		2
Volunteers		2
* 18 abortion-seekers identified as female, 2 as non-binary		

**Table 2. Characteristics of online consultations with Women on Web**

Characteristics	Frequency
Online consultations	350
<b>Age</b>	
10–14 years	1
15–19 years	17
20–24 years	99
25–29 years	105
30–34 years	60
35–39 years	53
40–44 years	14
45–49 years	1
<b>Language</b>	
Dutch	51
English	132
Polish	129
Portuguese	12
Spanish	10
other	16
<b>Residence in the Netherlands</b>	
Living in the 4 largest cities (Amsterdam, Rotterdam, The Hague, Utrecht)	76
Smaller cities and rural areas	267
Missing	7

requesting more information. These emails were included in the analysis.

In the grounded theory analysis of the 34 in-depth interviews with abortion-seekers and HPs, and the 200 abortion-seekers' emails, most expressed overall satisfaction with Dutch abortion care. However, four main themes described the obstacles to access abortion care: abortion-seekers were burdened by taboo, in a vulnerable position, evaluated by HPs and often felt disempowered and distressed.

### Burdened by taboo

Most respondents described abortion as a taboo subject, shameful, stigmatising and one which should be kept secret. According to one HP, the (Christian) stigma of abortion as sinful has been institutionalised in the abortion care system in the Netherlands since abortion care is separate from routine health care and is in the penal code.

*"[...] The moment they are confronted with an unwanted pregnancy, I think every woman in the Netherlands will immediately feel the stigma.[...]"*



*will have the idea that they are doing something forbidden. [...] they have to take a train for three hours to a separate clinic and there are anti-abortion protestors, that's how out-of-the-ordinary it is.*" (HP 3, GP)

*"You can go to any general practitioner or gynecologist for the contraceptive pill, counseling during pregnancy and help with getting pregnant, but finding a pill to terminate the pregnancy suddenly becomes difficult."* (HP 14, abortion physician)

Protestors regularly stand outside abortion clinics shouting anti-abortion slogans to women trying to enter. Many are religiously motivated, and some even dress as (fake) nuns and priests who attempt to instil fear of harmful consequences, stress the importance of motherhood and promise to help women take care of their baby. All protestors use a moralising discourse as one woman seeking an abortion witnessed:

*"When I got there, a man was standing across the street and he was screaming, [...] he had a very big sign saying 'Jesus is lord' [...] and he was yelling at the couple that came outside [the clinic] 'You are murderers, you go to hell' [...] I was in shock."* (Abortion-seeker 2, 27 years old)

For a few women, knowing there could be protestors was a barrier in accessing regular abortion care. A woman looking for abortion care online illustrates:

*"I find it too big a step to go to a clinic myself. I have often heard that they are standing outside protesting and that is why I would prefer it if I could do it at home with my partner."* (Email 22, in Dutch, 26 years old)

The anti-abortion lobby has reinforced this taboo by using a discourse of guilt and regret.

*"Because of the taboo and misinformation from the anti-abortion side, women are wrongly saddled with an unjustifiably great fear of regret and feelings of guilt."* (HP 14, abortion physician)

Several HPs named taboo as the biggest barrier to abortion care because taboo makes it very difficult for women to talk about their wish for an abortion.

*"The biggest barrier is still the taboo. It is said, there is no taboo, but the taboo is real. It is still very difficult for women to talk about it [...] the step to [choose for abortion] is huge because it still cannot be talked about. It is still not accepted. Well, it is*

*accepted, but you don't talk about it."* (HP 13, receptionist abortion clinic)

Women found it difficult to talk with family and friends because they were often afraid of their emotional or judgemental reactions. Sometimes talking with others only made the process more difficult.

*"I deliberately did not want to talk to other people because I was too afraid that someone else's opinion would influence me in a bad way. That I would feel guilty [...] So I kept it to myself."* (Abortion-seeker 4, 31 years old)

For migrants, especially those newly arrived in the Netherlands, keeping the abortion secret was often imperative and was motivation for seeking a self-managed abortion:

*"Unfortunately I cannot talk to anyone about my pregnancy, especially my family. I come from a conservative and religious family where sex before marriage is considered a sin and it would be a huge disappointment for them. I don't want to go to the clinic because there's a big risk I might get caught by my parents."* (Email 56, in English, 15 years old)

### In a vulnerable position

#### *Vulnerable groups*

According to the HPs, women who encounter the most difficulty in accessing abortion care have financial and/or health literacy issues. Women who are temporarily in the Netherlands, e.g. travellers and (often Polish) seasonal workers, and undocumented migrants are especially vulnerable. A social worker illustrates:

*"The most problems we actually run into are with undocumented women. They do not know how to find their way, at first often because of the language barrier and once they manage to find an entrance somewhere, they often find out that [...] they have to pay the costs of 600 euros themselves [...]. They simply don't have that money, so they are almost forced to continue that pregnancy in an illegal setting."* (HP 4, social worker)

Other vulnerable groups are women who are single parents, receive no (economic) support from their partner or experience violence. In the 200 WoW emails, eight concerned domestic violence and five women had been raped.

*"I'm officially a US citizen, currently [visiting] in the Netherlands. I do not have a BSN [Dutch*

registration]. I do not have access to 400 [euros] nor do I have access to a clinic. I was raped so I want to get this out of me now!” (Email 136, in English, 36 years old)

#### *Needing emotional support*

Women in the process of accessing abortion care often find themselves on an emotional rollercoaster. Respondents described feelings of fear, shock, panic and confusion. Many women were assessing their relationship and the suitability of their partner as a father. Some relationships suffered. In relationships that survived, women often expressed the need for more partner involvement in decision-making and their partner’s presence during the abortion.

*“But the fact that he was not even allowed inside [the clinic], completely excluded him from my story and I found that difficult because I thought hey it is something that we have to go through together [...].”* (Abortion-seeker 4, 31 years old)

Most women expressed the need for emotional support from their family and friends, but due to the difficulty in talking about abortion, they did not always get this support. Due to Covid-19 measures, some women were not allowed to bring a companion to the clinic and found this emotionally difficult.

*“I think it is a common thread that [...] you have to do this in solitude. That it is a secret you cannot share with anyone. [...] It seems that it becomes more bearable the moment you can share your entire process of deliberation with someone.”* (HP 8, volunteer)

Most women expressed a need for empathy and emotional support from their GP and abortion clinic HPs. HP conduct was an important factor in patient satisfaction. Women were often emotionally vulnerable, so one unfortunate comment from an HP was enough to upset them, thus greatly impacting their abortion experience. However, most women were pleased with how they were treated by HPs in the abortion clinic:

*“I had a doctor sitting across from me who was very understanding and very warm in her communication and then that was really only very pleasant for me. Because of that warmth and the amount of information, I could immediately make a well-considered choice.”* (Abortion-seeker 5, 19 years old)

A majority of respondents expressed the wish for some sort of emotional support after the abortion, such as a telephone call from abortion clinic personnel to ask how they were doing.

#### *Lack of knowledge to make an informed choice*

To make an informed choice, women need to assess their pregnancy symptoms in a timely manner and have information on available abortion options, locations and gestational limits. Many women were quick to discover they were pregnant and most correctly assessed the gestational age. However some women, especially those from vulnerable groups, were late seeking abortion care, thus limiting their options.

Before they were pregnant, most respondents lacked knowledge about the Dutch abortion care system.

*“Yes, I actually knew so little about what you do at four weeks of pregnancy, what options there are and how it all works. Only after this whole experience did I find out that there is so much on your plate as a woman [...].”* (Abortion-seeker 9, 29 years old)

Many foreign women living or travelling in the Netherlands who consulted WoW mistakenly thought that they could easily order abortion pills online. However, sending abortion pills by mail was illegal in the Netherlands at the time. The prescribing doctor for WoW lived in the Netherlands and could have been penalised.

*“I live in the Netherlands, am pregnant please help me. Please help me. Will I get some [pills] at pharmacy. [...] Please send me the medicine.”* (Email 79, in English, 28 years old)

Almost all the women had searched the internet for information on abortion options and services, but did not always find the neutral, scientific information they were seeking. Many women wanted help in their decision-making process.

*“Well, the only thing I found annoying is that I thought I could go to my doctor to get some kind of step-by-step plan, [...] you can do this, or you can do that, and that was actually not there at all. When I googled, the scariest stories came up [...] I found it very difficult to find a site where I could find neutral or scientific information about how abortion care is organized in the Netherlands. [...] I found that annoying, but at the same time, because I was helped so well by the receptionist [at the clinic],*

*that gap was actually filled again in a very short time.”* (Abortion-seeker 5, 19 years old)

#### *Managing practicalities can be overwhelming*

Women must manage practicalities in order to access abortion e.g. arranging for childcare, work leave, transportation to a clinic, and obtaining the correct documents (proof of having waited the mandatory five days with a letter from a physician or a clinic intake form, and Dutch health insurance and/or a BSN registration number and proof of work in the Netherlands). Since March 2020, women have also had to navigate Covid-19. For most Dutch respondents, these practicalities are relatively easy and not a barrier to abortion care. However, for others, bridging language barriers and finding the fee was problematic. This was especially difficult for women who were undocumented, travelling in the Netherlands or newly arrived migrants.

*“I have tried for the past few days to find another solution for accessing an abortion but because I am a foreigner from another country, I can’t get one without paying €595 euros and I do not have that money. I do not work right now [...] I cannot have this baby I don’t have any money I don’t have any access to help, I came to the Netherlands to try and fix my life but I cannot with an unexpected baby in a country I can’t even get health insurance in yet.”* (Email 70, In English, 25 years old)

Of the 200 WoW emails, 75 consultations were with Polish-speaking women (often seasonal workers). These women were generally unsure if they had (or how to get) correct documentation and rarely spoke Dutch or English. Most abortion clinic websites are in Dutch. Two respondents mentioned having to copy and paste the clinic’s information into Google translate to understand it. Women were sometimes told by abortion clinic staff that speaking Dutch or English was a prerequisite for a medical abortion, so they could communicate later about complications. HPs regularly used professional interpreters in abortion clinics. However, receptionists do not use interpreters, thus non-Dutch/English-speaking women often need help from others to make an appointment. A Polish woman asking WoW for help illustrates:

*“I’m in 16 weeks. I found a clinic where they perform abortions up to 22 weeks. I’m having trouble making an appointment because my English is*

*poor. I don’t want to ask a stranger for help. That is why I am asking you for help.”* (Email 102, in Polish, 26 years old)

Transportation to an abortion clinic in the Netherlands was not difficult for most respondents. Exceptions were women who did not own a car or who lived on an island in the north of the Netherlands. Due to Covid-19, transportation was a real impediment for one woman to access abortion care:

*“[...] It was difficult to go on the boat [and then by public transport] in the corona time due to high contamination [risk]. And then the cost of the boat and public transport were also inconvenient for her. ... Then she would have to travel back and forth for seven hours to take a pill.”* (HP 12, GP)

#### *Mediation is often necessary*

Mediation is often necessary for the most vulnerable groups who rarely speak Dutch. Respondents named up to 10 organisations that help women in their decision-making or accessing abortion care, for example, Women on Waves, Abortion Network Amsterdam, Doctors of the World or Fiom for Dutch-speaking women. This mediation includes online information on options and services, volunteers accompanying women to the clinic, support organisations finding money for an abortion or helping with transportation and accommodation for women travelling to the Netherlands.

*“Sometimes we help by sending the link to the clinic, and then women can do it from there. Sometimes it is full help with finances, making appointments, booking overnight stays [...] translation in the clinic and going along and arranging the transport and stuff. [...] If you look at how many women we have contact with, I think that there are certainly at least five a week on average during the past year.”* (HP 10, physician support organisation)

HPs in abortion clinics sometimes intercede on behalf of their patients who cannot pay.

*“But sometimes that they really just cannot afford it, that they do not dare to ask family or friends and indeed do not have a BSN and are not in the [asylum] procedure and then I have to puzzle with Dokters van de Wereld [Doctors of the World] to see what is possible.”* (HP 6, abortion physician)

Mediation was often necessary to manage practicalities and help navigate the complicated rules



and regulations required to qualify for an abortion. HPs in abortion clinics try to find solutions while keeping within the law. A few respondents mentioned how HPs try to help women circumvent the mandatory five-day waiting period, which starts only after a face-to-face conversation with a physician.

*“I got the impression [...] from the conversation with the receptionist at the clinic that the referral letter and the reflection period, [...] that it could be played with a bit [...]. [...]so if you called the doctor, she can put a different date on the referral letter retroactively, as if you had spoken to each other tête-à-tête.”* (Abortion-seeker 3, 27)

### Evaluation by health professionals

Women decide if they want an abortion, but the HP decides how, when and if they can have an abortion. This evaluation is determined by law, medical protocol and practice, and is influenced by HPs’ preferences and convictions, and how they “filter” the information a woman gives. Hence evaluation, despite being something HPs have to do, is seldom neutral and we elaborate on how HPs “judge” later in this section.

### Having to justify candidacy

Women mentioned having to justify their candidacy before being deemed eligible for a (free) abortion. Women had to meet certain medical and legal conditions to qualify. They needed to have the correct documents (e.g. proof of Dutch health insurance) and prove they had waited the mandatory five days. Though not in the law, abortion clinics only treated women if they had an ultrasound as proof of gestational age within the limits (and an intrauterine pregnancy). At the time, during the first Dutch Covid-19 lockdown, testing was not yet possible and women with Covid-19 symptoms were not admitted to the clinic. If a woman wanted sedation during a surgical abortion, her body mass index could not be too high. If a woman wanted a medical abortion, she had to speak Dutch or English.

HPs routinely checked whether women have made their decision voluntarily and are certain of their choice. If HPs doubt whether a woman is certain about an abortion, or if she is a minor, they often refer her to a support organisation specialised in helping with unwanted pregnancy decision-making. A few women felt that they would only get (a referral for) an abortion if they

appeared to be totally sure, even though they were not.

*“I knew the only way I would get that abortion was to say I really wanted it. So it was a very counter-intuitive conversation, because yes, I was trying to convince [the GP] of something that I actually didn’t want. So that was a difficult conversation. Fortunately, I was glad it was short and that I eventually got the referral.”* (Abortion-seeker 13, 34 years old)

Most women appreciated that HPs checked their motivation and verified their voluntary choice. However, some women experienced this as an interrogation:

*“Questions were asked of which I wondered if they were necessary to ask, and they did not say: ‘we are going to ask uncomfortable questions’ or ‘you don’t have to answer’. It seemed to me as if I had to cooperate fully because otherwise, I would not be helped. While I had thought you go there, and they do an abortion, and then you’re done.”* (Abortion-seeker 20, 28 years old)

The ultrasound, required by the clinic, was often an emotionally loaded and difficult moment in the process of accessing abortion care. Although women were not obliged to look, many did:

*“And then you do that ultrasound. That was very emotional to see [...] you think oh, there’s really something there. Then of course it becomes very real, even more real.”* (Abortion-seeker 15, 27 years old)

For women travelling from Poland to the Netherlands for an abortion, it was especially difficult to arrange for an ultrasound in Poland. Because abortion is illegal there, women pretend they have a wanted pregnancy and ask for a photograph with the gestational date, while trying not to arouse suspicion.

### Health professionals judge

When calling for an appointment in the abortion clinic, the receptionist will ask questions to filter out who is eligible for an abortion:

*“[...] I try at least to extract the relevant information to know if she can be treated by us. So, how far along are you in pregnancy? Have you already discussed it with a doctor or someone else? [...] It is very important that you ask questions so that the women do not come for nothing.”*

*Especially the foreigners, they often have a long journey.”* (HP 13, receptionist abortion clinic)

In the following example, a woman had to delay her abortion appointment because she did not have the correct GP referral, and so did not comply with the mandatory five-day reflection period:

*“[The GP said] Yes, I hear that you want to receive that referral letter, but unfortunately that is not possible [...] you must come by in person today and reschedule the appointment [for the abortion], it cannot take place. Because a telephone conversation is not enough [for a referral].”* (Abortion-seeker 3, 27 years old)

Women can choose between a medical and a surgical abortion. Several respondents were under the impression that the abortion clinics prefer surgical abortions and that this coloured the information they received.

*“I did receive signals from [the receptionist] that such a pill is actually not recommended by the clinic. That it could be quite an intense experience at home. And that they actually more or less advise against it.”* (Abortion-seeker 3, 27 years old)

Some abortion clinics state on their website that medical abortions have many drawbacks and are not recommended. One respondent who was five weeks pregnant was not offered a choice.

*“I don’t think the abortion pill was mentioned at all and it was just a curettage. On their website it also says that it is probably more effective when you do a curettage than an abortion pill. No, [it was] not named as a choice.”* (Abortion-seeker 10, 35 years old)

During the interviews, some HPs explained that women often underestimated the process of terminating the pregnancy by abortion pill. They mentioned that women often had more pain and blood loss than expected and therefore, it was important to stress this aspect.

*“Many people think that the abortion pill is just a pill that you buy at the pharmacy or at the Kruidvat [drugstore] and that’s that. So we always make it very clear: don’t be mistaken in the treatment with an abortion pill because it is quite a process.”* (HP 13, receptionist abortion clinic)

The HPs’ preferences, assumptions and convictions influenced women in their access to an

abortion. Some women had been confronted by GPs with negative or anti-choice attitudes, while HPs in abortion clinics were generally supportive, including for abortion.

*“I went to the doctor. That was not very nice [...] he said that because of his own objections to abortion he could not help me or refer me [...] He told me where the abortion clinic was, but he said he could not help me further. And he me gave the phone number of a psychologist, [...] not to help me with my doubts, but to convince me not to do it.”* (Abortion-seeker 9, 29 years old)

Several respondents felt judged by their own GP.

*“He came across as if he thought I was stupid, like oh, there you have a bunch of stupid teens who just had unsafe sex, and who have been irresponsible [...].”* (Abortion-seeker 5, 19 years old)

One participant felt discrimination due to HPs’ perceived stereotypes about women of colour having multiple abortions.

*“I found the questions very uncomfortable, and a bit offensive because I felt I was treated like ‘oh, how many times has this happened to you?’ And I thought does this have to do with how I look? That you already have this expectation or a certain judgment.”* (Abortion-seeker 18, 20 years old)

### Disempowered distress

#### *Made to wait against her will*

To access an abortion, a woman must wait the mandatory five-day reflection period, but sometimes women had to wait even longer due to the abortion clinic’s capacity. Although clinics did their best to schedule women in, sometimes even creating extra spots and calling in extra physicians, the waiting time was often 1–2 weeks. Waiting longer, despite being certain of their decision, was disempowering and often emotionally distressing.

*“So I’m completely confused, I don’t know what to do now, I don’t want to wait any longer [...] And I never thought about the fact that those five days [of] waiting time were quite long for people who are very certain of their decision. And what I didn’t know was that there are so few clinics in the Netherlands. And that it is very busy and [...] there is a waiting time. So that also played a part in that panic [...].”* (Abortion-seeker 3, 27 years old)

This feeling of distress and urgency often had to do with being conscious of the development of the foetus. Women wanted to be able to abort when the foetus was still “no more than a fertilisation”, “cells”, or as big as a “a pea”.

*“So it took forever. [...] I would have preferred to terminate the pregnancy at an earlier stage. Because it at a certain moment it became more and more difficult [...] it is really starting to become a child and it starts to get ears, then ... yes, I still find that difficult. So a kind of grief that didn’t have to happen, that shouldn’t have been done to me.”* (Abortion-seeker 20, 28 years old)

When a pregnancy is not yet visible on the ultrasound, abortion clinics are not able to perform a Very Early Medical Abortion (VEMA) since they lack laboratory facilities to check serum hormone levels. Therefore, women who were quick to assess their symptoms, make decisions and arrange for a referral were told at the clinic that it was too early for a surgical abortion if the pregnancy was less than six weeks after their last menstrual period. This was upsetting since it sometimes led to an additional delay, on top of the five-day mandatory reflection period and the clinic’s capacity, and women did not want to wait any longer.

*“I was really upset. That was really a huge downer. That I thought: gosh, then I have to walk around with this for a week now. What’s that going to do to me? What does that do to the hormones?”* (Abortion-seeker 10, 35 years old)

Whereas most women did not want to wait and wanted an abortion as soon as possible, others preferred more time to reflect and did not mind waiting.

*“That reflection period? Well, I think in my case, because I had such doubts [...] that I figured out all the options for myself. So besides being a terrible period, because you are forced to think about something that you might rather not think about so much, I think it was okay too.”* (Abortion-seeker 15, 27 years old)

#### *Feelings of desperation*

Not wanting to go to a GP or clinic and wanting a home SMA, but not getting one, often led to feelings of desperation. This was especially true for women from vulnerable groups who were frantic to keep their pregnancy secret.

*“The problem is that I just can’t go to clinic. It’s just too hard for me. I tried to go before but I have serious anxiety attacks. I really hope there are options for me. Otherwise I have to buy online from websites that are not really reliable. I’m really scared and alone. [...] I was forced to have sex and that’s why I have this problem right now. I’m all alone and have nobody to talk with. I just can’t go to a clinic its mentally too hard for me. Please, please, please, help me. I’m begging you.”* (Email 52, in English, 27 years old)

*“Please reply, I rather kill myself than go to a clinic.”* (Email 8, in English, 25 years old)

#### *Not fully autonomous*

The overarching theme of this research is that while accessing abortion care in the Netherlands, the respondents did not feel fully autonomous in their decision-making (see Figure 1).

Women were not fully autonomous due to taboo and needed the support of others. They wanted to talk with others to make an informed choice and arrive at an autonomous decision, but this was difficult due to the stigma attached to abortion.

*“So it is not that abortion care is bad in the Netherlands. If you want you can go to a clinic. So women are autonomous in this. But autonomy starts with to what extent you are free to have that conversation with yourself, I want it or I don’t want it. and that has to do [...] with stigma. That you have the idea that you are doing something that is not allowed.”* (HP 3, GP)

Women were also not fully autonomous due to their vulnerable position and lack of knowledge about abortion options and services. This made it difficult to make an informed decision.

*“I had absolutely no idea how it worked, I had just googled it. [...] I did not know if I made the right choice by going for this procedure or if it was [...] better to choose a pill. I also had the idea that [...] the GP gave a different advice than the clinic itself and also on the internet [...] it is difficult to really understand the benefit or disadvantage is of the one kind of procedure [...] it would have helped me if I had had a better idea of what it would be like from the moment I stepped into [the clinic].”* (Abortion-seeker 3, 27 years old)

Self-managed abortion with abortion pills bought online and taken at home is not a current legal option in the Netherlands. Some women who tried to access abortion pills online through WoW were clear about their choice for SMA:

*“The reason for my request is that the abortion clinic provides the abortion pill until 9 weeks, and this week is my 10th week, and I still prefer, knowing the possible risks, to have the abortion with pills at home.”* (Email 2, in Dutch, 39 years old)

These women were disappointed when they realised that they did not have the choice for a home abortion despite their informed decision, and this led to feelings of disempowerment and distress.

Finally, women did not feel fully autonomous due to having to pass an HP evaluation to be eligible for an abortion.

*“They were so like ‘are you sure? Are you sure?’ I was like, ‘yes, otherwise I would not be here’. I felt treated like a small child, and I get that from a political point of view, but I’m a highly educated woman who knows very well what she’s doing there ... [...] it felt so unbelievably paternalistic.”* (Abortion-seeker 11, 29 years old)

## Discussion

This study has shown that abortion-seekers can experience obstacles in accessing abortion care and their autonomy can be compromised in the process. Most respondents were burdened by taboo. Feelings of shame and the imperative to keep the pregnancy and/or abortion secret made it difficult to talk about abortion. Abortion-seekers were in a vulnerable position, due, for example, to their (temporary) migrant or undocumented status, need for emotional support, lack of knowledge to make an informed decision, difficulty in managing practicalities and need for mediation by support organisations. Once in the GP’s office or abortion clinic, abortion-seekers must justify their candidacy, and are evaluated by HPs who filter, influence and judge. If abortion-seekers cannot access the type of abortion they want (when they want it), this leads to feelings of disempowerment and distress.

### Abortion care: for some more permeable than for others

The Candidacy Framework of Dixon-Woods et al.<sup>16</sup> uses the terms “candidacy” and “permeability” to

refer to negotiated eligibility for health care and the ease with which people can use services, respectively. Women who have recently arrived, or who live in the Netherlands temporarily, find it difficult to navigate the system of abortion care and justify their candidacy. For them the system is less permeable. This is in line with Schoevers<sup>26</sup> who found that undocumented migrants in the Netherlands encounter barriers in accessing reproductive health care because they lack information on services and finances, experience sexual and/or physical violence, and fear deportation. Being in a vulnerable position in society jeopardises reproductive health rights.

Threats to the permeability of Dutch abortion services are comparable to those found in studies in other Western, high-income countries<sup>27, 28</sup> and encompass the aforementioned legal and financial requirements (eligibility) for a (free) abortion. Poor health literacy (e.g. in Dutch or English languages) to make an appointment or receive the abortion pill also threatens permeability. Perceived stigma and protestors surrounding abortion clinics make abortion services less permeable.

Dutch society appears to be divided between a group for whom candidacy for abortion care is clear and this service is quite permeable, and a more vulnerable group whose candidacy is not clear, and who find abortion care complicated and the service less permeable. The first group will probably make it to the abortion clinic. They are insured and generally satisfied with abortion services; they speak of needing emotional support, the right information and help with decision-making. The latter group often struggles even to make an appointment or obtain the fee to pay for abortion care. They described themselves as desperate.

### Taboo is institutionalised in Dutch abortion law and care

Since Dutch abortion law is in the penal code, this reinforces the idea that abortion is morally wrong, and a taboo that produces stigma. Women may not be aware that abortion is in the penal code but they do feel the stigma due to the fact that abortion care is segregated in special clinics and not available in routine healthcare settings. Negative (societal) attitudes towards abortion lead to moral conflict and feelings of guilt and shame, making the abortion decision process more difficult.<sup>29</sup> Stigmatisation is enhanced by the anti-abortion lobby that instils fear of harmful consequences, future infertility and a “post-abortion

syndrome”, despite the lack of evidence to support this.<sup>30</sup> The anti-abortion lobby’s discourse of guilt and regret is reproduced in the law: the purpose of checking women’s motivations and the mandatory waiting period is to minimise regret. Beynon-Jones<sup>31</sup> describes the “discursive labour in which women have to engage in order to negotiate an antiabortion repertoire of (inevitable) regret and position themselves as “certain” about their decisions to end their pregnancies” (p. 237). Thus, health services and HPs providing abortion (unintentionally) reinforce the stigmatisation of women seeking abortion care by confirming the social importance and centrality of motherhood in women’s lives.<sup>32, 33</sup>

Women in this study felt a loss of control and were often distressed when required to wait longer than they wanted in order to comply with a visible pregnancy on ultrasound and the legal waiting period, or when they realised that a wanted self-managed abortion was not a legal option. This is significant, because it suggests a mechanism by which abortion stigma can negatively influence the abortion-seeker’s (psychological) health, even in the presence of abortion policies that are liberal, compared with other Western European countries.

#### Autonomy in abortion: more than choice

Stigma surrounding abortion may keep women from seeking or receiving crucial social support.<sup>34</sup> In a systematic review of abortion stigma, Hanschmidt et al.<sup>35</sup> found that women who had abortions experienced fear of social judgment, self-judgment and a need for secrecy. Secrecy was associated with increased psychological distress and social isolation. Similarly, Astbury-Ward et al.,<sup>36</sup> in their study on perceptions of abortion in England and Wales, argue that fear of social responses, even long after an abortion, lead to secrecy. Women’s perceptions of abortion as a “deeply disgraceful and personally stigmatising event” often prevent them from seeking social support. Recently, an online survey, undertaken as part of a pro-choice campaign among a representative sample of 1054 Dutch people, showed that 7 in 10 Dutch people say they do not know anyone with an abortion experience. However, this is unlikely as about 1 in 8 pregnancies will end in an abortion. This suggests that despite the perception that Dutch society is more liberal and that women living in the Netherlands are more empowered than in many other countries,

abortion – although a legal right – is still a taboo subject in the Netherlands.<sup>37</sup> In our interviews, respondents indicated that not being able to talk about abortion decisions with their partner, friends or family and not being able to ask for much needed support made the process of seeking an abortion lonely and difficult. Taboo was experienced as a barrier to accessing abortion care.

Recently, the World Health Organization<sup>38</sup> recommended that individuals in the first trimester can self-administer medication for an abortion without direct supervision of an HP. Aiken et al.<sup>39</sup> argue that interest in self-managed abortion (as an alternative to the clinic) in the UK suggests a demand for more autonomous abortion care options. While the project of giving women access to abortions that are both safe and expressive of their autonomy is laudable, we must be wary of reinforcing abortion stigma by making an abortion done at home, alone and in secrecy, the norm. This study shows that autonomy in abortion care is more than just choosing options, it is about coming to an informed decision in the open with the help of others, if so desired.

#### Implications for practice

This research suggests that for abortion care permeability in the Netherlands to improve: (1) (research on) a structural solution is needed to lower the (financial and health literacy) barriers that marginal groups encounter, (2) the abortion law and care should be scrutinised for and divested of taboo, and (3) abortion needs to be normalised and become a subject that can be talked about openly. Lowering the cost of abortion for uninsured women, developing health literacy programmes for recently arrived migrants, removing the mandatory waiting period from the law, and initiating (social) media campaigns to normalise the subject of abortion could improve reproductive justice for all women living in the Netherlands.

#### Strengths and limitations

The authors are female, feminists and committed to improving abortion access. This background is visible in the topic list and the importance assigned to the results regarding women’s autonomy. However, autonomy is also an important theme in international literature on abortion.



This is the first known qualitative study exploring access to abortion care in the Netherlands, a country known for its relatively liberal laws and attitudes towards abortion. The 20 in-depth interviews with abortion-seekers provided a wealth of thick description, which was a strength. A limitation is that the participants in the face-to-face interviews were mostly highly educated, non-religious and white. To counteract this lack of diversity, 14 HPs were interviewed and expressly asked about their experiences with abortion-seekers from vulnerable groups. The 200 WoW emails captured the perspectives of diverse women seeking information on abortion. This was a qualitative analysis which did not aim to specifically explore differences in the nationality or ethnicity of women. We also feel polarising the discussion in this way is not useful and prefer to focus on marginality, vulnerability and health literacy. As a member check, the results were shared with six HPs and a feedback focus group discussion was held with five interviewed abortion-seekers. They recognised some or all of the obstacles found in the analysis, which allowed for triangulation among the interview and email analysis results and the feedback, thus strengthening the study's validity.

Another limitation was that most of the interviews took place online rather than face-to-face and so there was less chance to build rapport and gain trust. Yet, in the feedback focus group, participants mentioned that although the interviews felt less personal online, being in their own environment did give them the feeling of safety and control necessary to share their abortion experiences.

## Conclusion

This qualitative study analysed how women experience access to abortion care in the Netherlands. Four major themes were found: abortion-seekers felt burdened by taboo, in a vulnerable position, evaluated by HPs and felt disempowered distress. The overarching theme from the data was that abortion-seekers were not fully autonomous. The key barriers to abortion access in the Netherlands are complex candidacy regulations, the lack of permeability for certain marginalised groups, the institutionalised taboo in abortion law and care, and women's inability to speak openly about abortion. To heighten the permeability of abortion care in the Netherlands, legislators and policy-makers must trust women to make their own reproductive decisions and avoid practices that stigmatise abortion and hinder access to care, while actively developing systemic support for vulnerable groups.

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## Data availability statement

*Due to the nature of this research, participants of this study did not agree for their transcripts of the interviews to be shared publicly, so supporting data is not available.*

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## **Appendix. Topic list**

### **Topic list abortion seekers**

Step-by-step account of what happened after pregnancy test and how this was experienced

*Assessing symptoms and deciding on procedure*

Consultation with partner / friends / family

Knowledge of procedure options/ laws / regulations?

Internet: easy to find information / clinic?

Decision-making process

Privacy, stigma, or religious concerns

Time between test and the appointment

*Navigating system*

Contact GP

5-day reflection period

Appointment by phone/ What decisions/ choice procedure

Language barrier

*Enough information?*

*Practicalities*

Work / school/ childcare/transport

Necessary documents

Costs

Protesters? Did you know this in advance?

*In the clinic*

Questions asked

Information given

informed consent, privacy,

Support

Judgments from health professionals

Calculation GA/ ultrasound

Procedure

Feeling in control (autonomy)

Complications

*Permeability*

How easy / difficult was it to arrange and have the abortion done?

### **Topic list health professionals**

How easy or difficult is it for women in the Netherlands to arrange an abortion?

*What obstacles* do women in the Netherlands encounter if they want an abortion?

Failure to recognise pregnancy / uncertain of last period / underestimating GA

Difficulties in decision making / uncertainty / privacy / family and partner support / stigma

Logistical problems such as arranging transport / childcare / work / school / accommodation

Navigation system: making an appointment / referral letter / information / language barrier

Capacity clinics

Financial problems / no insurance

Legislation: 5 days reflection period / gestational limits / counseling / parental consent

Harassment by protesters / partner

*Permeability Dutch abortion care*

Are there groups for whom it is more difficult? Migrants / undocumented / women from countries where abortion is prohibited?

How do women justify their candidacy

Judgments from health professionals who decide the suitability of the candidate for a procedure.

## Résumé

En dépit d'une législation relativement permissive sur l'interruption de grossesse, les femmes aux Pays-Bas se heurtent à des difficultés pour bénéficier des soins post-avortement. On sait peu de choses de leur expérience. Cette étude se penche sur l'expérience des femmes avec les services d'avortement (en ligne) et l'expérience des professionnels de santé concernés qui dispensent les soins, dans le but d'identifier les principaux obstacles rencontrés par les femmes souhaitant avorter aux Pays-Bas. Une méthode de recherche qualitative exploratoire avec une approche constructiviste et une version abrégée de la méthode de théorisation ancrée ont été utilisées. Des entretiens avec 20 femmes qui avaient avorté et 14 professionnels de santé qui avaient prodigué des soins après l'avortement, ainsi que 200 courriels de femmes recherchant des soins post-avortement par le biais de l'organisation non gouvernementale *Women on Web*, ont été codés inductivement et déductivement (à l'aide du cadre d'accessibilité/candidacy framework), générant ainsi plusieurs thèmes. Les femmes souhaitant avorter ont rencontré des obstacles, notamment: (i) la charge du tabou de l'avortement, (ii) la vulnérabilité (psychologique, financière et sociale), (iii) l'évaluation des professionnels de santé et (iv) la perte d'autonomie et le désarroi. Le thème commun était le manque d'autonomie des femmes dans l'accès aux soins en cas d'avortement. Les principales barrières à l'accès à l'avortement aux Pays-Bas sont l'institutionnalisation du tabou dans la législation et les soins relatifs à l'avortement, la réglementation complexe sur l'éligibilité aux soins, la faible accessibilité de certains groupes marginalisés et l'incapacité des femmes de parler ouvertement de l'avortement. Pour élargir l'accès aux soins post-avortement, et par conséquent accroître l'autonomie des femmes, les législateurs et les décideurs doivent se fier aux femmes pour prendre leurs propres décisions reproductives; ils doivent éviter les mesures qui stigmatisent l'avortement et entravent l'accès aux soins, tout en établissant activement un soutien systémique pour les groupes vulnérables.

## Resumen

A pesar de una ley sobre aborto relativamente permisible, las mujeres en los Países Bajos enfrentan dificultades para acceder a los servicios de aborto. Se sabe poco sobre sus experiencias. Este estudio explora las experiencias de las mujeres con servicios de aborto (en línea) y las experiencias de profesionales de salud pertinentes proporcionando los servicios, con el objetivo de identificar las principales barreras encontradas por personas que buscan un aborto en los Países Bajos. Se utilizó un diseño de investigación cualitativa exploratoria con un enfoque constructivista y el método de teoría fundamentada abreviada. Las entrevistas con 20 mujeres que habían tenido un aborto y 14 profesionales de salud que proporcionaron servicios de aborto, y 200 mensajes electrónicos de mujeres que buscaban servicios de aborto por medio de la organización no gubernamental *Women on Web*, fueron codificadas por inducción y deducción (utilizando el Marco de Candidatura), lo cual generó temas. Las personas que buscaban un aborto enfrentaron barreras tales como: (i) la carga de tabú, (ii) vulnerabilidad (emocional, financiera y social), (iii) evaluación de profesionales de salud y (iv) desempoderamiento y angustia. El tema general fue la falta de autonomía de las mujeres para acceder a los servicios de aborto. Las principales barreras para acceder a los servicios de aborto en los Países Bajos son: la institucionalización de tabú en la ley y los servicios de aborto, complejas normativas de candidatura, falta de permeabilidad de ciertos grupos marginados y la incapacidad de las mujeres para hablar abiertamente sobre el tema del aborto. Para aumentar la permeabilidad de los servicios de aborto, y por ende la autonomía de las mujeres, los legisladores y formuladores de políticas deben confiar en que las mujeres pueden tomar sus propias decisiones reproductivas y deben evitar acciones que estigmaticen el aborto y obstaculicen el acceso a los servicios, a la vez que generan activamente apoyo sistémico a favor de grupos vulnerables.