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'Having children is like rain, as they say in our region': exploring refugees' reproductive agency

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ABSTRACT

Migrants with refugee backgrounds in the Netherlands face significant reproductive health challenges, including higher rates of unintended pregnancies and limited access to contraception. This study explores how post-migration realities affect the reproductive agency of refugees from Afghanistan, Somalia, Eritrea and Syria. Utilising a participatory approach, eight peer researchers from these communities conducted eight focus-group discussions and 118 in-depth interviews, involving four migrant grassroots organisations and two Dutch non-governmental organisations. The findings reveal that refugees must navigate multiple tensions: (1) adapting to a new country, including securing housing, employment and adjusting to social norms and gender dynamics; (2) navigating cultural norms and family expectations; and (3) obtaining resources such as knowledge and contraception, within a healthcare system that may lack cultural sensitivity and reflect broader societal stigma. These challenges may require strategies that differ from Dutch notions of individualistic reproductive choices. Reproductive services must be sensitive to this complex navigation and adopt a culturally sensitive approach, focusing on refugees' strengths and agency rather than solely on issues like cultural taboos, lack of knowledge, low literacy or language barriers.

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Introduction

Migrant women and girls with refugee backgrounds in the Netherlands are especially vulnerable to unintended pregnancies. Among asylum seekers, the abortion rate (14.4/1,000 women) and teenage birth rate (49.1/1,000) are significantly higher than the national averages (8.6/1,000 and 5.8/1,000, respectively) (Goosen et al. 2009), indicating a high incidence of unintended pregnancies and unprotected sex (Goosen

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2014). These unintended pregnancies can severely affect women's psychosocial health and hinder their participation in society (Schonewille et al. 2022).

One reason for reproductive health disparities is that refugees often have limited access to care, especially contraception, compared with the population more generally (Allotey et al. 2004; Kurth et al. 2010; Cignacco et al. 2018). A Norwegian study of Somali immigrants found a high unmet need for contraception, with nearly 50% of women experiencing unintended pregnancy (Gele et al. 2019). Effective communication is central for providing good reproductive care to migrant women (Pavlish, Noor and Brandt 2010; Allotey et al. 2004; Gurnah et al. 2011). However, language barriers can often result in misunderstandings, with women not fully understanding healthcare providers' explanations or feeling uninformed when making decisions (Pavlish, Noor and Brandt 2010). These misunderstandings can erode trust in healthcare providers and healthcare services. Although interpreters can improve communication, they are not always available, leading to reliance on family members, which raises confidentiality concerns (Pavlish, Noor and Brandt 2010). Women also fear that interpreters, who are members of their community, may disclose sensitive information to others (Degni et al. 2012). Additionally, the gender of both the interpreter and healthcare provider can affect women's comfort in discussing intimate topics such as contraception, with many preferring female providers (Gurnah et al. 2011).

In addition, several studies have highlighted the prevalence of racism and discrimination in reproductive healthcare, with biases such as undervaluing large families or assuming Muslim women lack autonomy negatively affecting care (Allotey et al. 2004; Royer et al. 2015). Additionally, the challenging living conditions of asylum seekers and refugees, including poverty and violence, further hinder access to contraception and care (Allotey et al. 2004; Goosen 2014; Kurth et al. 2010; Cignacco et al. 2018).

Views on family planning

Many refugees come from large families and prefer to have large families themselves, a preference rooted in cultural and religious views and social norms. Having many children is often linked to fertility, masculinity and social status (Allotey et al. 2004; Royer et al. 2015; Russo et al. 2020; Agbemenu, Volpe and Dyer 2018). In economies that are traditionally dependent on agriculture or manual labour, large families are seen as a means of economic stability (Royer et al. 2015; Agbemenu, Volpe and Dyer 2018). Children are valued both for practical reasons and as symbols of happiness and prosperity. For migrants, the desire for a large family may also stem from a need to rebuild a sense of the community and support lost during migration (Allotey et al. 2004).

However, migration brings unique challenges for large families, including financial strain and limited family support networks (Russo et al. 2020; Allotey et al. 2004). Refugees often recognise that smaller families may allow for better allocation of resources and attention to each child, as well as more opportunities for education and work (Russo et al. 2020). As a result, women and men may be more open to discussing and using contraception (Royer et al. 2015; Degni et al. 2014). On the other hand, refugees may have concerns about contraception, particularly the use of

hormonal methods, fearing potential impacts on fertility and side effects such as weight gain, irregular bleeding and long-term fertility issues (Omar et al. 2022; Agbemenu, Volpe and Dyer 2018). Religious beliefs play an essential role in family planning decisions and contraception (Russo et al. 2020). Furthermore, the power dynamics within relationships can affect women's reproductive agency (Russo et al. 2020; Gele, Musse and Qureshi 2019; Kolak et al. 2024).

While previous studies have explored factors affecting the reproductive agency of people with refugee backgrounds, there is a significant gap in understanding how individuals navigate varying cultural norms and contexts. Additionally, most research has focused primarily on women's perspectives, with men's viewpoints receiving less attention. This study aimed to explore how post-migration realities affect the reproductive agency of both women and men with refugee backgrounds in the Netherlands and to identify factors that either hinder or promote their agency. The study includes refugees from the four currently largest migrant populations in the Netherlands: Afghanistan, Somalia, Eritrea and Syria.

Materials and methods

Theoretical approach

Reproductive agency is a key concept within this study. Reproductive agency can be viewed as being able to set individual reproductive goals and take actions to achieve them (Kabeer 1999). However, controlling fertility and making active reproductive decisions are not common practices worldwide, as many people perceive having children as a destiny or a divine gift (Willan et al. 2020). Moreover, reproductive agency is strongly connected to power relations within relationships and to the social norms and expectations of communities and families. Mahmood (2001) argues that agency is often seen as the capacity to pursue one's interests against tradition or other obstacles, while we might also consider the desire for freedom in the light of other desires, such as being a valued family member. Reproductive agency is not an absolute 'to have or have not'; it is shaped by the restrictions and possibilities of one's specific context. Willan et al. (2020) suggest using the concept of 'distributed agency' (Campbell and Mannell 2016) to describe seemingly small but meaningful actions that are feasible within one's context, such as women secretly using contraception when their partner disapproves. In this study, we operationalised reproductive agency as the strategic negotiations individuals enter into to situate themselves and their reproductive choices within a social context, maintain relationships and make sense of their experiences, in line with the definitions of sexual agency advanced by Cense (2019) and Bell (2012).

Methodology

Participatory approach: working with peer researchers

This research we describe adopted a participatory approach and was undertaken by peer researchers who shared the cultural background of the participants. Discussing sexual and reproductive choices can be sensitive, especially for migrants with refugee

backgrounds who may distrust Dutch institutions. Peer researchers can build rapport with participants, leading to richer data and better insights into sensitive topics such as sexual health (Devotta et al. 2016; Page, Cense and van Reeuwijk 2023). Eight peer researchers were involved in all stages of the project, from developing the research instruments to data analysis and the dissemination of results. The recruitment and training of the peer researchers were crucial. Given the unique cultures, sensitivities and languages of each refugee group, two peer researchers were selected per ethnic group (one male, one female). Selection criteria included fluency in Dutch or English as well as their first language, at least 5 years' residence in the Netherlands, aged 25+ with preferably higher education or relevant work experience and a social role within the cultural community.

Intensive training in the first year of the work equipped peer researchers with the necessary skills for data collection. Training also addressed their attitudes towards sexuality, gender norms and reproductive rights, emphasising ethical professionalism when handling diverse views. The peer researchers' expertise was central to developing culturally sensitive instruments, including determining suitable questions. A strong sense of teamwork developed during the first year, with personal views and differences being valued. In a second year of work, during data collection, peer review meetings were held every two months to address challenges and find solutions collaboratively. Peer researchers worked as freelancers under contract, receiving regular payment for recruitment, focus-group supervision, interview conduction, transcription and result interpretation. They also played a key role in disseminating the findings to health care professionals. These arrangements sought to foster equality and shared decision-making within the research team (Fine et al. 2003). Migrant organisations similarly contributed by advising, recruiting and helping to disseminate results.

Data collection

The research involved two rounds of data collection. In 2021 and 2022, we conducted eight separate focus-group discussions (FGDs) with men and women in each of the four ethnic groups (Table 1). The migrant organisations with which we collaborated recruited participants with different marital states, ages and backgrounds (like religion and level of education). There were no exclusion criteria. The FGDs focused on reproductive choices, pregnancies, abortion and contraception, exploring community concerns and social norms. Both a peer researcher and a Rutgers/Pharos researcher facilitated the FGDs, which were held online (due to COVID-19) and at migrant organisations' offices.

Next, also in 2022, we conducted individual in-depth interviews in participants' native languages to explore their life stories and views on reproductive choices. The topic list was tailored to each community to ensure cultural sensitivity. During

Table 1. Country of origin and gender of participants of the eight FGDs ($n = 59$).

	Afghanistan	Eritrea	Somalia	Syria	Total
Man	10	6	9	6	31
Woman	8	6	6	8	28
Total	18	12	15	14	59

recruitment, migrant organisations and peer researchers made efforts to ensure diversity, with a particular focus on reaching unmarried women. Given the potential reluctance to discuss the cultural taboo of premarital sexual activity with community members, a white Dutch anthropologist additionally conducted nine interviews with young unmarried women from the same four communities, who were recruited by the migrant organisations. These shared efforts resulted in 118 interviews, representing a wide range of participant backgrounds (see Tables 2 and 3).

Analysis

Data analysis was conducted in several stages. First, all interviews and focus groups were transcribed verbatim. Most were transcribed and translated by the peer researchers themselves, while some of them in Dutch were transcribed by a transcription agency. The second step involved coding, aided by the use of MaxQDA. The first two authors coded the data, with regular consultations about the coding tree. The analysis adopted constant comparative method, as originally developed by Glaser and Strauss,

Table 2. Characteristics of interviewed participants ($n = 118$).

	Afghanistan	Eritrea	Somalia	Syria	Total
Gender					
Man	11	15	12	12	50
Woman	19	18	16	15	68
Total	30	33	28	27	118
Age					
0–20	2	0	0	1	3
20–30	11	19	6	13	49
30–40	6	7	12	7	32
40–50	4	2	6	4	16
50–60	4	4	3	2	13
60+	3	1	1	0	5
Total	30	33	28	27	118
Number of children					
None	9	13	6	13	41
1 or 2	4	10	7	8	29
3 or 4	3	6	6	5	20
5 or more	3	4	5	1	13
Unknown	11	–	4	–	15
Total					118
Marital state					
Married	18	16	19	14	67
Unmarried	11	13	8	12	44
Divorced	0	1	0	1	2
Widow	1	0	1	0	2
Unknown	–	3	–	–	3
Total					118

Table 3. Mean (range) number of years in The Netherlands and environment in country of origin.

	Afghanistan	Eritrea	Somalia	Syria	Total
Years in The Netherlands	15 (1–28) years	7 (1.5–36) years	17 (1.5–30) years	5 (1 month – 11 years)	
Environment in country of origin					
Rural area	6	17	2	9	34
Urban area	17	16	21	13	67

as the basis for Grounded Theory (Strauss and Corbin 1998). This method proceeded in three stages: (1) open coding, in which text segments ere assigned codes based on their meaning; (2) axial coding, where codes were grouped into categories; and (3) selective coding, where overarching themes were assigned that reflected the content of these categories.

The FGDs were analysed using open and axial coding prior to the interviews, with the analysis informing the interview topic list. After data collection, open and axial coding were applied to the interviews, followed by selective coding for the entire dataset. Finally, the analysis was presented to the entire research team for feedback from the peer researchers. This yielded several in-depth questions that prompted the first two authors to re-examine the data (e.g. the connection between low demand for contraception information and participants' awareness of their rights). The first two authors then began drafting the report which was presented to the peer researchers, migrant organisations and a supervisory committee for validation. Given the importance of language and meaning in interpreting the findings, involving peer researchers and communities in the validation process was a crucial step.

Ethics

Several measures were taken to ensure the research adhered to ethical guidelines, as outlined in the European Code of Conduct for Research Integrity (ALLEA 2023). These steps included ensuring voluntary participation, obtaining informed and written consent, safeguarding participant identities by using codes instead of names and verifying publicly used quotes with peer researchers to prevent recognition. The study was reviewed on ethical grounds and approved by the Ethics Committee of Utrecht University[1]. All the names in this article are pseudonyms.

Findings

Analysis led to the identification of three main themes regarding the reproductive agency of refugees: (1) adapting to a new country; (2) navigating social norms and family expectations; and (3) obtaining resources (see Figure 1 above).

Adapting to a new country

Position as migrants in Dutch society

Refugees in the Netherlands face prolonged uncertainty regarding residency and family reunification. Building a new life – learning a new language, securing housing and finding employment – all require significant effort, making parenting especially challenging. Tegeisti, a young Eritrean woman, had her first child shortly after arriving in the Netherlands. She explained that she waited to have another child until she felt more settled in the country:

> When we had our first child, it was very tough for us because we were not used to the customs here. We were busy arranging things for our son and at the same time we both had to go to language school, and we both wanted to get an education as well. Because of this, we also deliberately waited a while before having another child until we felt more confident. (Tegeisti, Eritrean woman, 29 years old, 7 years in NL, married, 2 children)

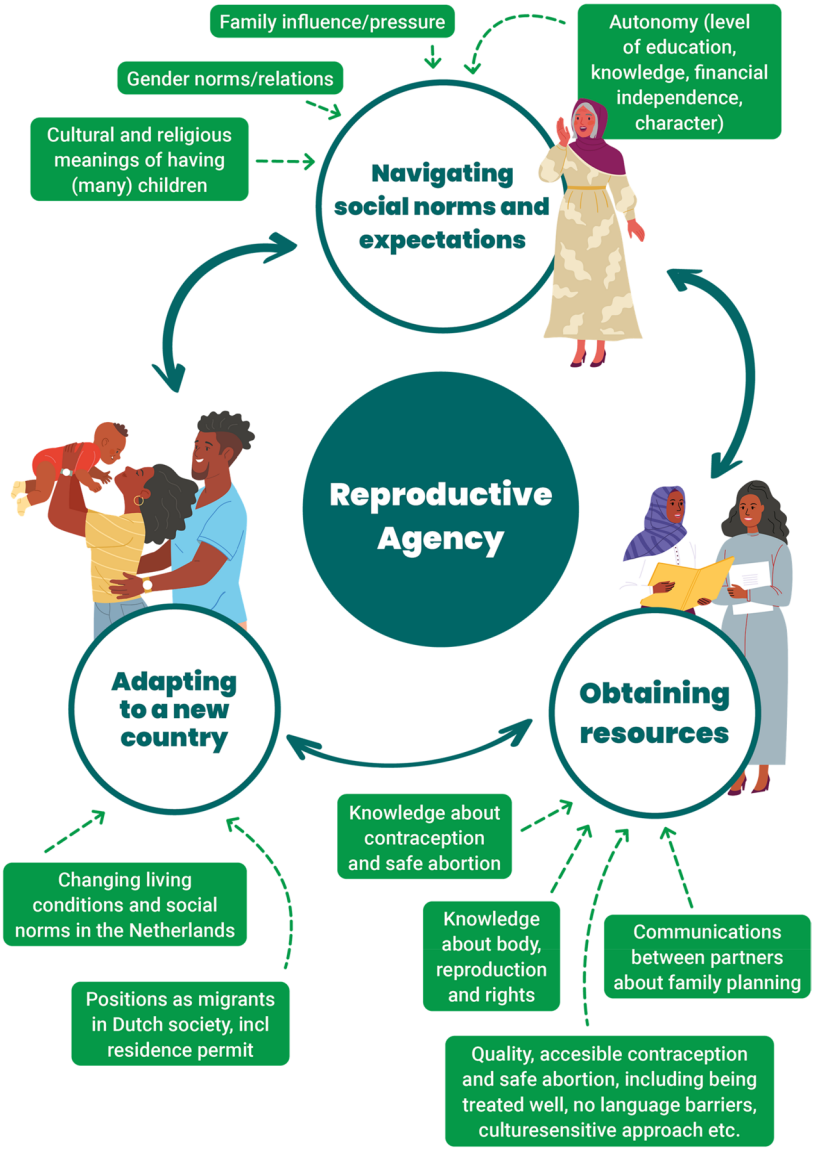

Figure 1. Factors influencing refugees' reproductive agency.

Many participants cited lack of family support as a limiting factor in having more children. Without extended family, the responsibility of childcare falls solely on the parent(s). Rahwa, a single mother living in the Netherlands for 6 years, said: 'It is very difficult to raise a child here without family and not knowing how everything works' (Rahwa, Eritrean woman, 23 years old, unmarried, 1 child).

Changed lived conditions

Participants said that people should not have more children than they can care for, especially since caregiving conditions in the Netherlands differ greatly from those in their countries of origin, in terms of demands and available resources. Poverty also

limited the number of children people can care for. Fariha, a young Afghan woman, shared that her parents struggled financially, which influenced their decision not to have more children: 'The biggest reason is just a small house or too low income. My father doesn't work, and my mother has a minimum income. For a while, they both didn't work, so it was very tough' (Fariha, Afghan woman, 19, unmarried, no children). Several participants mentioned that their views on family size had changed after arriving in the Netherlands. Muna, a Somali woman, explained:

> I also wanted to have ten children, but when I came to the Netherlands, with two children without a father, I saw that it was very difficult to raise more children here. Here, children need more, like taking them to school, activities, even playing outside I have to go with them. After four children, I changed my mind. (Muna, Somali woman, 46 years old, in NL for 14 years, married, 4 children)

Changed social norms

Many people from refugee backgrounds come from collectivist cultures, in which people care for each other's children. In contrast, the Netherlands has an individualistic culture, in which everyone is expected to take care of their own child(ren), both emotionally and financially.

> The way of life here is built around your children. You live for your child and his/her future. I have four children. You are constantly busy with your children as a parent. In Eritrea, things are a lot easier and non-committal. In Eritrea, you are free; your parents help you. If you sign them up for school, they go to school with the neighbourhood children and return home together. Here, you are obliged to take them to a childcare centre, and then you pick them up again. It feels like a big prison. (FGD Eritrean men)

> Participants also observed a significant difference between the Netherlands and their country of origin regarding gender equality, which provides women with greater agency and opportunities. This shift had altered their views about gender roles, including accepting that women can pursue education and work, and allowing their daughters to choose a husband and start a family when they feel ready. As one participant stated, 'People living here in the Netherlands have integrated and adopted Dutch values and norms. The mindset of people here is more open-minded, and they generally decide for themselves who they want to marry, when, and so on' (Atal, Afghan man, 35 years old, 18 years in the Netherlands, married, with children).

Additionally, Dutch society offers new opportunities, particularly for young people with refugee backgrounds, who have access to education and employment. As a result, early marriage and childbirth are no longer assumed. The decision to delay having children is often rooted in a sense of responsibility, as individuals want to provide a better start for their children than they had. This desire for personal development and a better future for their children was reflected in the stories of participants like Nahom, a 23-year-old Eritrean man, who wanted to wait before having children despite his family's expectations.

> The reason I am not listening to them now and cannot live up to their expectations is that I know what kind of living conditions I am currently in. I don't want to have a child

> now and give him the same fate I had; my body is here but my head is somewhere else. I want to wait so I can improve my life, I can prepare to have children and give my children the upbringing that children in the Netherlands get. I am just not ready now. (.) Soon I will turn 24, in Eritrea this would be the age when I might already be married with a child but here it is different. I might want to start having children in about six years, by which time I will be almost 30. That seems like a better time to have children, hopefully, I will also be a bit more stable then. (Nahom, Eritrean man, 23 years old, 5 years in NL, unmarried, no children)

In conclusion, adapting to a new country involved overcoming numerous obstacles, including language barriers, securing housing and work and the absence of family support. These factors hindered refugees' reproductive agency. Prolonged uncertainty regarding residency and family reunification further exacerbated these challenges. Conversely, new opportunities for women and young people broadened the range of choices available to them.

Navigating social norms and family expectations

Most participants in this study grew up in Syria, Eritrea, Somalia or Afghanistan, while some were born in the Netherlands to parents who had earlier migrated from these countries. The social norms surrounding sexuality, marriage and childbearing that participants experienced in their home countries share strong similarities. In many cases, these norms continued to significantly influence their expectations of themselves and others after migration.

Cultural and religious meanings of having (many) children

Marriage was often viewed as a key milestone to adulthood and a prerequisite for starting a family. For most participants, having children was seen as a source of happiness. As Rahel, an Eritrean woman, expressed, 'Having children is a blessing, and if you have many, it is wealth. That warm and loving feeling that we had at home as a family, I want to have with my family here too' (Rahel, 29 years old, 7 years in the Netherlands, married, two children). For many people, in this study children were considered a gift from God or Allah.

Gender roles and norms

Gender roles and power dynamics within both the community and broader Dutch society, along with family structures, influenced women's opportunities for education and economic independence, and their reproductive agency. 'I think there is a very big difference between the Netherlands and Syria. Here women have the right to choose whether they want children or not, want to marry or not, but in Syria, men always decide these things' (Nasreen, Syrian woman, 43 years old, 6 years in NL, divorced, no children). Gender norms also affected men's reproductive agency. For example, in some families, men face the pressure to remarry if a couple struggles to conceive. Rashid, a 60-year-old Afghan man, described how he resisted family pressure to take a second wife, explaining:

> In the eyes of some family members, I am a coward or a loser, afraid of my wife. They don't understand that I don't go for a second wife to have children. But I cannot marry someone just for this. I know there is poverty in Afghanistan and that some men go there to marry very young girls. That is disrespectful and barbaric. (Rashid, 28 years in NL, married, no children)

Family expectations and pressure

In many cultures, having children is a natural expectation. As Eritrean Fiyori, who was born in the Netherlands, explained, 'With us, it's like: okay, if you get married, then you get children'. Although married, she wished to wait before having children and frequently felt the need to defend her choice to her family:

> Especially at gatherings, like dinners and parties, I find it quite cheeky when people ask you every time: 'Where are the children?'. I usually just laugh and say: 'Yes, I'm still studying'. When you're studying, it is not convenient to have a baby'. (Fiyori, 25 years old, born in NL, married, no children)

The extent to which family members influenced the timing and number of children varies significantly. Many participants reported that parents often stressed the importance of marrying early and have many grandchildren. Even after migration, family expectations can remain strong. As one participant in the focus group of Eritrean women stated:

> It has been my experience that my parents always wanted to influence my family planning. I have two children and whenever I speak to my parents on the phone, almost the first thing they say is: hello, aren't you going to make more children? Sometimes it almost makes you insecure or if you are just speaking to them, you quickly ask another question to avoid the subject. Even if they are distant and live in Eritrea, they want influence and won't leave you alone.

Men also experienced pressure from family. Adnan was a Syrian man in his late 30s. He was married and had three children. He had lived in the Netherlands for 7 years. He mentioned how his mother-in-law kept interfering with the number of children they have: 'My wife's mother advises us to have many children. If the baby is a boy, she says we should have a brother for him and if the baby is a girl, she says we should have a sister, and so on'. The strong influence of mothers-in-law was reflected in many participants' stories.

Navigating the many questions and comments is emotionally complex. To avoid damaging family relationships, many people responded with jokes or distractions and tried to explain that life in the Netherlands differs from that in their country of origin.

> I have enough children. I regret that my family is not satisfied with the number of children. People say, why don't you have more children? You do like Europeans [use contraception]. In the beginning, I said, yes, it will be fine and that's how you get on for a year or two. Whenever I talk about this, I say, Inshallah it will come. They put a lot of pressure on you. It's not pleasant, but they mean well. (Muna, Somali woman, 46 years old, 14 years in the Netherlands, married, 4 children)

Several participants referred to God, to reduce family pressure. For instance, Bashir, a Somali man with two children, expressed: 'Towards my mother, I always say 'It is not in my hands. God decides when and how much'. That is a satisfactory answer for

her. I don't want [to have] an endless discussion, especially with my mother' (Bashir, 60, 14 years in NL, married, 2 children).

Autonomy

Despite high family pressure, most participants indicated they made their own decisions regarding the timing and number of children. Their agency was linked to their autonomy, which was primarily grounded in independence – financial or otherwise. As Miriam, an Eritrean woman, explained: 'If you work and earn enough money to live, you can make your own decisions' (Miriam, 22 years old, 4 years in NL, married, 2 children). Additionally, literacy, education and self-confidence play a significant role. Many participants argued that character plays a role in determining whether someone can be assertive and able to counter the remarks, like Yasmin illuminated:

> People sometimes say: 'You should have more children'. I will respond: 'Will you come and help me raise them?' (laughs) 'Will you babysit?' or 'Will you carry it for nine months then give birth?' It is easy for them to state what you should do but getting that done is different. I'm not at a loss for words. (Yasmin, Somali woman, 37 years old, 20 years in the Netherlands, married, 5 children)

Young women and men with refugee backgrounds who had grown up in the Netherlands expressed the entitlement to make their own choices. Zala was an Afghan woman in her 30s who was pregnant with her second child. She talked about how children are always referred to in the family and that although her husband was inclined to bend to the pressure, she made him realise that they needed to go their own way:

> [It comes up] on visits or just sometimes unexpectedly. Someone happened to be pregnant or had a child and then be like, 'Look, she has a child' or if you then took a child in your arms 'Oh, it looks good on you'. Just like that. In the beginning, I was irritated by that, but at a certain point I didn't care, I thought to myself: I'll decide for myself when I stop taking the Pill or when I just really want a child. And in the beginning, through a bit of that murmur from others, my husband also wanted a child…. I said to him, 'Yes, but then I'll quit my education, you shouldn't expect me to work or study then either, because I don't feel like doing that either'. Also, because I just felt young. But he understood, I just finished my education and so almost a year later I got pregnant.

In summary, cultural and religious beliefs regarding family size and gender roles, along with associated family expectations, strongly influenced refugees' reproductive agency. Maintaining family harmony necessitated the subtle navigation of conflicts between personal desires and communal pressures. This navigation was emotionally demanding and involved avoiding certain conversations, using humour and seeking respectable excuses for not having children such as a study. Enhancing individual autonomy, both financially and emotionally, can expand people's agency.

Obtaining resources

Knowledge about contraception and safe abortion

Many participants reported that adequate knowledge of contraception was strongly associated with enhanced reproductive agency. For example, Reda, a 27-year-old

Syrian woman, shared: 'Yes, I had a plan around children. I wanted to take it easy and finish my education, but the pregnancy came about suddenly due to insufficient information on the use of contraceptives'.

Levels of knowledge about contraception and abortion varied significantly among participants. Those from urban areas had more knowledge than those from rural areas. People with higher education and better literacy were also better able to access and understand the information they had received. Younger people tended to be better informed than older individuals. However, participants were often reluctant to admit to a lack of understanding or the need for further information. Despite this, our research shows that many refugees do seek more information, provided it is offered respectfully and patiently, acknowledging the barriers people face in asking questions. Kiros, a 21-year-old Eritrean man, explained:

> They think we don't want to learn or think we don't need it…. That is not true, we want to learn, and we want to know what is good for us and our health. It's just the way. I have also learned a lot since living here and have opened up more. I have learned how to talk to people and tell them what I need, only some topics just remain difficult. We can't just forget everything we grew up with and become like Dutch people. (Kiros, Eritrean man, 21 years old, 5 years in NL, unmarried, no children)

Knowledge of body, reproduction and rights

In addition to contraception knowledge, a broader understanding of male and female bodies, sexuality and reproduction is essential for reproductive agency. Several respondents mentioned receiving information from staff during their stay in asylum centres, but, as Nahom, a young Eritrean man, noted, the information given was often difficult to understand:

> There was an interpreter present, but it was too much information for me. Before I came to the Netherlands, I never received any information [on reproduction]. Such information was just not available for us, so it was all very new for me. (Nahom, Eritrean man, 23 years old, 5 years in NL, unmarried, no children)

Literacy significantly affected access to information. As Said, a Somali man, explained: 'Most parents in our community are low-literate or illiterate. They cannot read and often struggle with Dutch. It would be helpful to have information in their mother tongue' (Said, Somali man, 55 years old, 10 years in NL, married, 12 children). Safi also said:

> If I had known what I know today, we would have made different choices. For example, we would not have children for the first 2 years. Getting to know each other well and seeing if we are ready to have children. (Safi, Somali man, 33 years old, 15 years in the Netherlands, married, 3 children)

Communication between partners about family planning

Many participants viewed communication about contraception and joint decision-making as central to a healthy relationship. However, due to gender inequality, not all felt there was space for shared decision-making. Yordanos, an Eritrean woman, described the challenge of lacking information and access to contraception, as well as having limited agency within her marriage control over her fertility.

> I did not know about contraception or other ways to prevent pregnancy so that choice was made for me. My husband did want many children and when I didn't want any more children after our second son, he kept pushing for another child. If it had been up to me, I would have stayed with my two sons. (…) If I had been well informed about contraceptives and it was as accessible there as it is here in the Netherlands, I would have taken it secretly if necessary so I could prevent a third pregnancy. (Yordanos, Eritrean woman, 37 years old, 2 years in NL, married, 3 children)

Accessible high-quality care on contraception and safe abortion

Familiarity with the Dutch healthcare system, particularly regarding access to contraception, and having the confidence to discuss these issues with a general practitioner (GP) are key aspects of reproductive agency. However, participants' experiences with GPs and other healthcare providers were often negative. Language barriers hindered effective care, and the lack of an interpreter involvement led to frequent misunderstandings.

Cultural barriers also complicated the delivery of care related to contraception and sexuality, leaving individuals feeling misunderstood, as in Tegeisti's case: 'Some advice doesn't fit our culture, some things just don't fit us. I never go home with the feeling that I was truly helped'. (Tegeisti, Eritrean woman, 29 years old, 7 years in NL, married, 2 children). Additionally, the gender of the GP influenced the level of comfort, particularly for women, in discussing contraception and abortion.

> Our GP is a man. I asked for a woman once. I was embarrassed. It was very difficult for me to ask for this. I did not feel comfortable with him because he was a man. He is nice, but a man is a man. (Sahar, Afghan woman, 24 years old, 3 years in the Netherlands, married, 2 children)

Participants who had received abortion care in the Netherlands described having overwhelmingly positive experiences. They highlighted the support and aftercare provided by counsellors. Participants stressed that healthcare professionals should devote enough time and attention to building a relationship of trust before they talk about sensitive issues like family planning.

> They should also remain respectful in their words and not make people feel stupid. After all, ignorance and stupidity are two different things. If you are ignorant about something, it is good to get explanations in 'general' terms so that it does not feel like it is about you. Take taboos into account, touch on the topics, and be patient so that the other person feels confident enough to share their story. (Timnit, Eritrean woman, 53 years old, 26 years in the Netherlands, divorced, 3 children)

Many participants noted significant room for improvement in the attitudes of Dutch healthcare providers. Syrian Omer provides a clear example: 'Sometimes a doctor may look at you and say, because you are from the Middle East, you like to have a lot of children, but you don't care to take care of them. I find that inappropriate' (Omer, Syrian man, 40 years old, 8 years in NL, married, 5 children). Participants also felt that some healthcare providers expected them to adopt Dutch norms and did not respect their cultural views.

Concluding, access to accurate information and reproductive care is crucial for enhancing reproductive agency. However, our study highlighted significant gaps in

knowledge about contraception and reproductive health among refugees, compounded by literacy barriers and mistrust of healthcare providers. Participants emphasised the need for healthcare professionals to build trust and rapport before addressing sensitive topics like family planning.

Discussion

This study provides insights into the reproductive agency of refugees in the Netherlands, highlighting the complex interplay of cultural, social and structural factors that influenced their reproductive choices. The findings underscore the significant challenges refugees face in adapting to a new country, navigating social norms and family expectations, and obtaining necessary resources. Many of our findings align with those found by other scholars in other contexts. Our study contributes to the existing body of knowledge by exploring how individuals navigate these challenges. The subtle strategies adopted align with the concept of distributed agency (Campbell and Mannell 2016) and differ from Dutch notions of individual reproductive choices. A culturally sensitive approach involves understanding individuals' complex navigation of diverse interests and valuing the small but meaningful steps people take.

Findings from this study have important implications for policy and practice. There is a clear need for better access to culturally sensitive healthcare services and interpreters, and to comprehensive sexual education that recognises and respects cultural differences. Healthcare professionals should approach reproductive choices with sensitivity, patience and respect for cultural differences, creating a trusting environment. Moreover, healthcare providers must be trained to recognise and question their own biases, ensuring that refugees receive respectful and non-discriminatory care. Practitioners who strive towards shared goals (Agbemenu, Volpe, and Dyer 2018) can enhance individuals' agency and foster greater equality in the relationships between healthcare professionals and clients from refugee backgrounds.

Reflection on the use of participatory approach

This study would not have been possible without the dedicated efforts of peer researchers and migrant organisations. Their commitment encouraged participation from individuals with refugee backgrounds. A total of 109 interviews were conducted by eight peer researchers, whose shared language and cultural connections fostered participant comfort, promoted mutual understanding and minimised the risk of the interviewer appearing inappropriate or insensitive. However, this insider perspective may have led to some participants to feel inhibited. While most were candid, a few provided brief responses. In the FGDs we observed that young unmarried women were particularly affected by cultural norms surrounding virginity and chastity. To explore this further, a white female anthropologist conducted an additional nine interviews with young women. These interviews provided more details about their dating practices and their struggles with family expectations related to marriage and pregnancy. These interviews provided valuable additional insights but were limited to women fluent in English or Dutch. The data also

revealed that participants' narratives varied depending on whether the interviewer shared a similar or Dutch background. This is understandable, as interviews are dynamic interactions where participants adjust their responses depending on the interviewer's perceived knowledge, expectations or judgements. While both types of interviews are valuable and complementary, future research should allow participants to choose their interviewer – especially for sensitive topics – to enhance comfort and agency.

Limitations

Some limitations of the study should be noted. While patterns could be identified in participants' responses, it is important to emphasise the significant variations within regions, ethnic groups, religious communities and individuals. Despite including a diverse range of participants, not all perspectives could be represented. Furthermore, this study explored individuals' beliefs about having children and contraception, perceptions of their current situation, and the challenges they faced in achieving their goals. These topics are difficult to discuss, not only due to language and taboos but also because they require reflection and openness. Some participants who have very recently arrived in the Netherlands may be unaccustomed to expressing their opinions or reflecting on their experiences, making interview participation challenging. Genuinely including these individuals would require a more immersive approach, such as ethnographic research, where researchers live alongside participants for an extended period.

Conclusion

Findings from this study underscore the importance of understanding the unique reproductive health challenges faced by refugees. By addressing the structural, social and cultural barriers that limit reproductive agency, policymakers and healthcare providers can support refugees in making reproductive choices. However, the hardening political climate surrounding migration in the Netherlands negatively affects the reception of newcomers and their ability to settle in, thereby restricting individuals' – and especially women's – reproductive agency. This study also highlights the value of involving the people concerned in research, policy and services. Meaningful representation not only enhances the quality of work but also promotes equality.

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Data availability statement

Qualitative data collected in this study are not publicly available, as they contain potentially identifying information about the research participants.

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