Questionnaire UN

Introduction and context

This report/questionnaire has been filled out for the UN Working Group on discrimination against women and girls by Tamia Peereboom, on behalf of the Amsterdam-based organization Share Network.

To answer the questions of this questionnaire, we have attempted to focus on the SRHR of WOC and migrant women in the Netherlands, especially how they are effected by crises caused by migration. This was not always possible due to lack of available information on, amongst others, government websites. It was difficult to attain general information regarding the accessibility of SRH for WOC and migrant women. This might be part of a bigger problem; namely an assumption that the needs of WOC in the Netherlands are already fully met, or that they are simply not seen as a priority. We answer these questions by combining general information on the handling of crises in the Netherlands, with the accessibility of healthcare for women. By taking information of different topics from various sources, we are able to portray an overview of crisis response and the impact on SRH in the Netherlands.

Due to time constraint, we were forced to use online reports to answer the questions below. If the working group wishes to attain more information on this topic for the Netherlands, Share Network would be willing to do further research after the deadline of the 31st of August. It would be possible to interview doctors, patients and women’s rights organizations on the topic of this questionnaire. If the working group is interested in this offer, they can contact us on info@share-network.org or tamia@share-network.org.

Concept/definition of crisis

1. Please provide information on the legal and policy framework used by your State to manage situations of crisis and on how the concept of “crisis” has been defined or framed.

The Dutch government doesn’t seem to have a real legal/policy framework to manage situations of crisis and there is not a clear definition of crisis.

1. Please list the type of situations that would fit the concept of “crisis” in your State and indicate what situations are excluded.

To answer this question, I have looked into the way the Dutch government has dealt with certain situations, to analyse whether or not the government sees these situations as crises. There are not any clear criteria for what is seen as a crisis, so this is an analysis of where the government’s priorities lay - what gets attention.

When speaking of crisis explicitly in the last five years, there are references to the Corona crisis and the crisis in Venezuela (Adviescommissie voor Vreemdelingenzaken, 2020). There doesn’t seem to be any special category dealing with any press releases or other documents concerning crises in the Netherlands. When searching for the keyword ‘crisis’ on the general governmental website, there are various results. The most recent result is the ‘Crisis- en herstelwet’, which refers to a law designed to reduce the shortage on the housing market, which is in crisis, according to this law.

Crises often mentioned in the news include the so-called ‘nitrogen-crisis’ and the climate crisis. These are crises which aren’t understood as related to women’s rights in the Netherlands. Research shows that the word ‘crisis’ is used more than ever; when looking at parliamentary documents between 1885 and 2020, we can see that the last 15 years, the word ‘crisis’ has been used twice as many times as the sum of the 120 years before that (Ostaijen, 2020). It’s remarkable that ‘crisis’ is such popular word to use, but there doesn’t seem to be any proper guidelines as to what exactly is a crisis, and in what ways these crises affect human rights in the Netherlands.

Challenges and good practices

1. Please highlight any challenges faced in the provision of SRH services and good practices in ensuring women’s and girls’ SRHR in situations of crisis.

According to research, there are complex problems regarding the provision of SRH services to women and girls. I will be focusing mostly on the provision of these services for migrant women and women of color in the Netherlands. I will be looking at the provision of SRH services in times of various kinds of crisis.

Migration crisis

Officially, the term ‘migration crisis’ is used in Europe when talking about the migrant groups that have been passing the Mediterranean Sea since 2013. The term ‘crisis’ has been commonly used to describe this situation when, within a week, a few hundred refugees drowned while attempting to cross the Mediterranean Sea. For this report, I will not only be looking at the migrants whom arrived in the Netherlands since 2013, but also before. There are two reasons for this decision. Firstly, not a lot of research has been done on the provision of SRH services to migrant women when looking at specifically the Netherlands. Secondly, if there is a problem with the provision of SRH for refugee women when there’s not a crisis, it can be suspected that these complications would only become worse during an actual (migration) crisis.

 In an article from Tankink (2009), the limitations of Dutch SRH services for refugee women becomes very clear. In her research, she looks at the common act by refugee women of being silent about any health complications. In chapter 13, she discusses the health issues these women experience in relation to sexual violence. The refugee women she interviewed all came from countries which were in war. She describes that the women have specific gynecological problems caused by multiple rapes and harm done to their reproductive organs (Tankink, 2009, p. 282). She describes the experience of one refugee woman, whose complaints did not have a clear physical cause. There was no doctor that asked her about non-physical causes, such as what she had experienced during the war. There was also no professional translator available (Tankink, 2009, p. 283). She describes another refugee woman who was too scared to let herself be tested for cervical cancer. She’s scared because of her past experiences with rape, but she can’t tell the doctor about it because her husband is with her during those appointments. The women whom Tankink interviewed, kept their past with sexual violence a secret. One of the refugee women cannot have children anymore as a consequence of the rapes the experienced. Doctors advised IVF, but because she was still in the asylum procedure, she does not qualify for it (Tankink, 2019, p.285). Many other, similarly painful, experiences are laid out in this article.

There are various organizations and initiatives active in the Netherlands to ensure proper communication to migrant women regarding their SRHR. For example, the *Wijzer in the Liefde* is a guide made by a collaboration between the Dutch municipal health services, the health organization Pharos and the center for sexual health Rutgers. It’s a guide for all professionals working with refugees and migrants to help make sexuality a topic that can be discussed. There are many initiatives such as this one, many of them being the result of collaboration between the Dutch governmental institutions and non-profit organizations. It seems as though there is being put a lot of effort into the provision of information on SRH in the Netherlands for migrant women.

 Even though this effort is being made, there are also articles showing this is insufficient. Research by Jonkers et al. (2011) notes that immigrant women reported that health care providers often paid insufficient attention to their pregnancy-related complaints and experienced delays in receiving information about diagnosis and treatment. When looked at the cases by professionals, it was reviewed that the majority of the women in this article had in fact received sub-standard care. Suggestions made in this article are the need for more sensitivity to social factors of immigrant women’s health problems and generally more education for these women on the dangers of pregnancy and the SRH policies in the Netherlands.

 In a parliamentary paper containing questions and answers regarding the accessibility of abortion related care for undocumented women in the Netherlands, an area in which the Dutch government is lacking proper policy, comes to light (Ministerie van Volksgezondheid, Welzijn en Sport, 2019). It becomes clear that there are no official funds from the government available to finance abortions for undocumented women, even though it is known that at least 28% of undocumented women in the Netherlands have been victims of sexual violence. In this paper, the minister of the Ministry of Public Health and Sports exemplifies that abortion clinics are responsible for their own finances and can decide what to charge undocumented women, as long as its under the mandated maximum tariff. The minister indicates that the clinics themselves should provide themselves with financial buffers if they wish to help undocumented women for a lower fee. The minister concludes from this that abortion services are accessible enough for undocumented women, even though he ends this paper with the note that abortion clinics may not want to charge lower fees for undocumented women in order to avoid attracting even more undocumented women. He closes with the statement that he doesn’t see it necessary to have an additional measures.

 The Netherlands is known for putting a lot of effort into the abidance of rights for women on an international level, but seems to fail to do the same for the undocumented women in their own state (Dokters van de Wereld, 2018). Failing to make SRH accessible and affordable for undocumented women has dire consequences. Dokters van de Wereld started a consultation hour for undocumented women. Stories include that of women not being able to afford contraception. By the time Dokters van de Wereld was able to arrange contraceptives for her, she was already pregnant. Due to her religion she did not want an abortion; this situation could’ve been avoided by making sure she would qualify for contraceptives under the normal healthcare system. But the barriers are not just of financial nature. Another factor in the inaccessibility is the lacking of information and knowledge. There is a website (www.zanzu.nl) that have SRH information in multiple languages, but for the migrant and refugee women without internet access or access to a laptop, this information is still not easy to reach.

Financial crisis

In a letter to parliament dated 19th of July 2019, the Dutch government set out the lessons learned from the financial crisis. The lessons on which the government wants to focus are, amongst others:

* To strive for a trend-based budgetary policy
* To achieve an economy that is resistant to shocks
* To spare vulnerable groups
* Policy on an international level
* Budgetary measures coordinated with the EU

Source: Ministerie van Algemene Zaken (2019)

It’s clear to see that all these lessons are regarding the economic situation during a crisis. Keeping in mind that this letter was set up regarding the financial crisis, it could still be argued that the social aspects of the financial crisis are ignored in this letter. The only lesson that slightly touches upon the subject of this questionnaire, is the sparing of vulnerable groups. In the letter, when referring to vulnerable groups, the authors mean lower educated people, the self-employed, employees with flexible contracts and employees with a migration background. The letter acknowledges that structural challenges regarding these groups cannot be solved with crisis-related policy; it needs a structural solution. The letter sadly lacks a more in depth analysis of the way vulnerable groups suffer disproportionally.

Covid-19 crisis

Regarding access to non-biased and scientifically accurate information about sexual and reproductive health matters and services:

According to Rutgers, the Dutch knowledge centre for sexuality, the provision knowledge of sexual development for young people has come into question. The schools closed on the 16th of march 2020 due to the coronavirus. That week would have been the start of the annual ‘week of spring fever’, a week which is focused on teaching students about their sexual development. This information may not reach the children as well as it would’ve, now that all the schools switched to online teaching.

Regarding pregnancy-related health services, including pre- and post-natal care, assistance during child-birth, and emergency obstetric care:

 During the covid-19 crisis, pregnant women with medical complications could still get the full range of medical help and the option to give birth in the hospital – the same as before the crisis. The majority of pregnant women without medical complications could also still give birth in hospitals. There were a few exceptions, in cases where there was too much pressure on the hospitals. In those cases, it was not always possible for women to give birth in the presence of their own midwife. Instead, they would get a midwife from the hospital assigned to them. In other cases, hotels would be transformed into birthing centers, where women would be able to give birth with almost the same facilities as in the hospitals.

 For pre-natal care, women would have appointments via the telephone, instead of in person. In the case of making an ultrasound, women had to come to the hospital alone.

Regarding safe abortion services including surgical and non-surgical methods of termination of pregnancy and humane post-abortion care, regardless of the legal status of abortion:

According to Rutgers, it has not been the case in the Netherlands that there has been a reduced availability of contraceptives. There are ways to get certain contraceptive measures, such as the IUD, even if you’ve contracted the corona virus. In addition to this, the abortion clinics and hospitals are still able to provide reproductive health care in these times. Remarkably, there is no mention of the way the availability of SHRH differs for WOC and ethnic minorities in the Netherlands.

On the other hand, there has been a plea to make abortion pills more accessible. The court of The Hague has decided that it will not be possible for women to receive an abortion pill via mail. This means that the situation to receive abortion pills will stay the same: women who are pregnant have to visit an abortion clinic in order to receive the pill. Various women’s rights organizations are unhappy with this decision, as they don’t want to force women with an unwanted pregnancy to travel to an abortion clinic in the time of a global pandemic.

General good practices

I’d like to point out that the majority of (recent) research on this topic has been rather positive on the way SRHR are met for migrant women. An article by Loeber (2008), amongst others, mainly focusses on the positive influence of the Dutch SRH on immigrant women, e.g. lower total fertility rate and giving birth to their first child at a later age. The article of Loeber (2008) is focused on Turkish immigrant women in the Netherlands, and also points out the lower abortion rate amongst Turkish immigrant women, compared to women living in Turkey.

The report by Dokters van de Wereld on the lack of accessibility to SRH for undocumented women that was referred to earlier in this document, mentions that the SRHR of women in the Netherlands is in many areas well guaranteed (2018, p.4). This includes, but isn’t limited to, affordable contraceptives and no fees for abortions. The effects of this are low ratings of teenage pregnancy, high levels of contraceptive usage and good obstetric care. Internationally, the Netherlands has been fulfilling a role in the promotion of women’s rights, empowerment and access to safe abortion related care (Dokters van de Wereld, 2018, p.9). The Netherlands can improve by allowing undocumented women to have the same level of accessibility to services such as abortion, as Dutch women who speak the language and are familiar with the Dutch infrastructure do. Furthermore, the Netherlands is in need of more research on other medical issues with regard to reproductive and sexual health.

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