Joint Shadow Report – NETHERLANDS

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Authors

The Federation of the Somali Associations in the Netherlands (FSAN): FSAN is a non-profit, non-political organization founded in the Netherlands in 1994. 52 regional and district organizations in Netherlands fall under the umbrella of FSAN. Its purpose is to support and advise local Somali refugee organizations as well as Dutch institutions that work closely with the Somali community in the Netherlands. Moreover, it delivered training to youth, religious leaders and 'key persons' from Somali and Sudanese communities to start a house-to-house campaign against FGM. FSAN has also been liaising with African organisations in Sierra Leone, Ethiopia, Eritrea and Sudan. It is a member of the Inter-African Committee in Europe and a founding member of the End FGM European Network. Between 2007-2009 FSAN was the national coordinator of the National Action Plan against FGM in the Netherlands, which was funded by the European Commission**.**

Pharos: Pharos is the Dutch centre of expertise on health disparities. Their expertise focuses on sustainable improvement of the quality, effectiveness and accessibility of care and prevention for people with limited health literacy, non-western migrants and refugees; but also on reducing existing health disparities between different groups of people. Pharos has been appointed by the Dutch government as the national knowledge centre for FGM and has taken up the fight against FGM since 1993. Their programme on FGM focuses on three priorities: **Prevention** of FGM, Contribution on

Medical and psychosocial **Care** for circumcised women, Collecting and dissemination of **knowledge** on FGM, for instance on prevalence and risk on FGM in the Netherlands. *Pharos* is a Dutch member of the End FGM European Network.

End FGM European Network (End FGM EU): End FGM EU is a European umbrella network of 19 organizations working in 12 European Union Member States to ensure a sustainable European action to end female genital mutilation in Europe and beyond. Its vision is "a world free of all forms of female genital mutilation (FGM) where women and girls are empowered and can fully enjoy their human rights". Its mission is to be the driving force of the European movement to end all forms of FGM, joining the forces of communities and civil society organisations, and building synergies and cooperation with all relevant actors in Europe and globally.

Moreover, the following Dutch specialists participated in drafting this report:

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INTRODUCTION

The present joint shadow report is produced by FSAN and Pharos in coordination with End FGM EU, in order to highlight the current situation and propose concrete recommendations on the issue of prevention, protection, prosecution and integrated policies concerning female genital mutilation (FGM) in the Netherlands. Despite this report focuses only on this harmful practice, its aim is not to single it out in isolation, but just to put emphasis on it while still seeing it in the *continuum* of gender-based violence against women and girls and in a holistic and comprehensive manner.

This report represents the Dutch chapter of a wider coordinated effort of End FGM EU to engage all its members who are under GREVIO revision to present an **FGM-focused report** in order to bring to the experts' attention the topic, which is too often neglected by State authorities. This project stems from our Guide on the Istanbul Convention as a tool to end female genital mutilation. It puts in practice the Guide's holistic approach by considering its full application to FGM as a form of violence against women and girls which needs to be addressed through prevention, protection, prosecution and integrated policies. It does not only analyses the application of the specific FGM Article 38 of the Istanbul Convention, but addresses the full range of articles in the Convention and how they are applied to tackle FGM in the Netherlands.

1. Legal Framework[1]

Criminal Law

FGM is considered as a form of child abuse under Articles 300-304, 307 and 308 of the Dutch Penal Code, punishable by a prison sentence of up to 12 years or a fine of up to 76,000 euros[2]. Since 2006, it has been **possible to prosecute someone for carrying out FGM abroad**, if the suspect has Dutch nationality or is a permanent resident of the Netherlands. However, in 2013, the Penal Code and the Code of Criminal Procedure were amended to increase the scope for criminal prosecution in cases of forced marriage, polygamy and FGM. In particular, with regard to FGM, cases of FGM performed abroad are now punishable in the Netherlands where the victim is a Dutch citizen or permanent resident, even if the offender is a foreign national and/or not a resident of the Netherlands. Moreover, since 1 July 2009 **the limitation period has been extended**, such that a woman between the age of 18 and 38 can report having undergone FGM at a younger age.

Child Protection Law

Under Dutch Youth Law, **FGM is considered as a form of child abuse** (Article 1(1), Jeugdwet). Dutch law provides opportunities for early intervention to prevent harm to a child. For instance, the threat of FGM can be a factor considered by a Juvenile Court to put a girl under supervision (onder toezicht stellen, OTS-Article 1(255)(1) ABW). In the case of an imminent threat of FGM, the Juvenile Court may, under extreme circumstances, impose a heavier child protection measure such as 'home outplacement' (Uithuisplaatsing-Article 1, 265b of the Civil Code).

Asylum Law

A girl or woman can qualify for temporary residence in the Netherlands if she is **at risk of FGM** in her country of origin (Article 29(1)(b), Aliens Act, 2000), provided that she demonstrates that her country-of-origin authorities cannot/do not want/do not offer her protection and therefore she will not be able to escape the risk if she lives there. Article 29 of the Aliens Act refers to Article 3 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR), which is transposed in the 2000 Aliens Act, paragraph C 3.2.

[1] For a more detailed information visit: https://uefgm.org/index.php/legislative-framework-nl/

[2] In the event that parents themselves carry out FGM on their daughter or a child over whom they exercise parental authority or whom they care for or raise, the term of imprisonment may be increased by one third (Article 304(1)). Allowing and/or supporting the procedure being performed, ordering it, paying for it, providing the means for it and/or assisting the cutter during FGM are considered soliciting, abetting or co-perpetration under Dutch criminal law (Articles 47 and 48).

Professional Secrecy Law

Health-care providers who take part in performing FGM can be tried under medical disciplinary law. According to the Inspectorate for Health Care (Inspectie Gezondheidszorg en Jeugd), producing the bulletin 'Vrouwelijke genitale verminking' (IGZ, 2010), which brings together relevant legislation and standards regarding FGM, care providers should not perform FGM or re-infibulation, on minors or adults.

Since 1 July 2013**, organisations and self-employed professionals are required to abide by a Reporting Code**, as stipulated under the law on Mandatory Reporting of Domestic Violence and Child Abuse[3], which **includes the prevention of FGM**. The reporting code helps professionals such as doctors, teachers and youth-institution staff to respond early and appropriately to signs of mistreatment in the home.

2. Policy Framework[4]

National Action Plans

Since 2008, the Dutch Government has addressed FGM as one of the forms of domestic violence[5] tackled in the National Action Plan (NAP) 2008-2011, particularly in terms of availability of appropriate shelter and assistance facilities for victims of violence, including FGM. In November 2011 another NAP was adopted for the period 2012-2016 called 'Kinderen Veilig', to take action against all forms of child abuse, including FGM. Finally, in May 2018, a new NAP on Domestic Violence and Child Abuse for the period 2018-2022[6] was approved which includes explicitly FGM and focuses on prevention for specific groups, among which girls and women from FGM-affected communities.

Since 1 January 2015, municipalities are responsible for combating domestic violence and child abuse and coordinate their efforts with the central government.

[3] See here: https://www.rijksoverheid.nl/onderwerpen/huiselijk-geweld/meldcode

[4] For more detailed information read the Policy Framework here: https://uefgm.org/wp-content/uploads/2016/11/COUNTRY-INFO-PAGES_NETH%CE%95RLANDS_HIGH.pdf

[5] See also here: https://www.government.nl/topics/domestic-violence/what-is-domestic-violence

[6] See here: https://www.rijksoverheid.nl/documenten/beleidsnota-s/2018/04/25/geweld-hoort-nergens-thuis-aanpak-huiselijk-geweld-en-kindermishandeling.

PHAROS CENTRE OF EXPERTISE ON HEALTH DISPARITIES · FSAN Federatie Somalische Associaties Nederland · End FGM EUROPEAN NETWORK

Multi-agency institutional mechanism: the Dutch "Chain Approach"[7]

In 1993 the Government issued an official statement prohibiting all forms of FGM, on the grounds that the practice violates the prevailing view in the Netherlands around equality and social position of women. All types of FGM are regarded as serious, irreversible forms of bodily injury, entailing a high risk of physical and psychological effects. In 2005, the Council for Public Health and Health Care (RVZ) published an advice on how to effectively combat FGM in the Netherlands[8]. In the same year, the Government issued a position paper taking on board many of the recommendations put forward by RVZ, adopting a two-track policy of promoting prevention, on the one hand, and upholding the statutory prohibition of FGM, on the other hand, using a 'chain approach' involving multi-agency action at different levels.

The Dutch **"Chain Approach"**, established in 2006, entails the **collaboration of a range of stakeholders** at national and municipal level **to prevent, protect against, prosecute and provide services around FGM**, guided by sector-specific protocols, trainings and regular meetings. It is an integrated and coordinated way of tackling FGM connecting multiple actors from different sectors and involving the affected communities. Each link in the chain knows its role and the one of the other links, ensuring an effective response. It is led by the Ministry of Health, Welfare and Sports and foresees a chain of prevention, care, law enforcement and education – especially through the engagement of the indispensable "key persons" belonging to the affected communities –. Participating actors include **civil society** organisations such as FSAN and Pharos, public and youth **health services** (GGD'en), **medical professionals** (midwives, maternity care, general practitioners, gynaecologists, paediatricians), **child-protection institutions**, child abuse advice and reporting points, **schools**, **police**, and key members of **FGM-affected communities** and community-based organisations. In 2012, responsibility for fighting FGM was delegated to **municipalities**, which play a fundamental role in the chain.

The **110 key persons[9]** work in the community, share information about FGM in meetings and home visits, and act as a **liaison between practicing communities, professionals[10] and authorities**. They started to be trained by FSAN and Pharos in 2003, and since the Chain

[7] See also EIGE here: http://eige.europa.eu/gender-based-violence/good-practices/netherlands/joined-action-fgm

[8] Available here: https://www.raadrvs.nl/uploads/docs/Onderbouwing_advies.pdf

[9] Key figures are of Eritrean, Ethiopian, Egyptian, Somali, Sudanese, Nigerian, Sierra Leonean, Guinean, Togolese, Ghanaian, Burkinabe and Malian descent, and speak, in addition to Dutch, Swahili, Tigrinya, Amharic, Arabic, Somali, English and French. To have a better view on their required profile and roles, please consult this document in the section "Key Dutch figures on FGM": https://uefgm.org/wp-content/uploads/2016/11/COUNTRY-INFO-PAGES_NETH%CE%95RLANDS_HIGH.pdf

[10] In particular, "key persons" bring their communities in close connection with the Dutch Community Health Services, that cooperate with communities to spread health information and services

Approach has been launched in 2005, they have been fully incorporated in such multi-agency system. "Key persons" are trained to work as facilitators to discuss FGM with and within risk communities and are organized in a national network which has district/municipality focal points. Between 2003 and 2009 the participation of imams, Koranic school teachers and youth has also been encouraged. Moreover, in November 2009, the Dutch Ministry of Health, Welfare and Sports nominated **four National FGM Ambassadors** from affected communities of **Ethiopia**, **Nigeria**, **Sudan**, and **Somalia** with a view to strengthening community engagement in the promotion of the abandonment of FGM and institutionalise their crucial role in ending the practice. These Ambassadors represent the Dutch Government's good will to end FGM both in the country, by being actively involved in grassroots-level meetings, and abroad, including by carrying out study tours to Ethiopia and Sierra Leone to promote better communication and knowledge transfer around the abandonment of FGM.

In 2009, the Ministry of Health, Welfare and Sport and Ministry of Justice, along with other organisations and institutions, signed a "Statement Opposing Female Circumcision"[11] developed by municipal health care authority (GGD Nederland), in order to officially support parents opposed to FGM when they go back to their countries of origin during school holidays.

Multidisciplinary guidelines and protocols

Several national protocols were developed by Pharos in cooperation with other professionals' and civil society organisations[12].

MAIN ISSUES AND RECOMMENDATIONS

1. Prevention

Article 13

Information campaigns and materials are available in the Netherlands around GBV including FGM. However, the affected population would benefit from an increased amount of **simpler**

[11] Available here : http://www.pharos.nl/information-in-english/female-genital-mutilation/protocols-and-materials/prevention-materials/statement-opposing-female-circumcision

[12] Model action protocol for the Veilig Thuis organisations (domestic violence and child abuse hotline);Model protocol on medical care for women and girls who have undergone FGM, a multidisciplinary guide developed by members of sexual health and rights professional organisations, FSAN (for the patient perspective) and Pharos; Position statement Youth Health Care specifically on the prevention of FGM (it offers tools for physicians and nurses in the YHC for discussing the subject of girl circumcision with parents and children who originate from high-risk countries).

and visually accessible tools, such as leaflets and brochures, but also social media stories, videos specifically targeting those people from the communities with low literacy rates, as well as young people. These materials should focus on GBV, and particularly FGM, and on available support services for survivors.

Moreover, it is very important to **strengthen early information provision on FGM for newly arrived migrants and asylum seekers**, within reception centres and community settings, to ensure that awareness on the topic starts since the very beginning of their stay in the country.

Article 15

The Dutch prevention policy focuses on awareness and education, early detection and risk assessment. Different organizations and groups play a part in this prevention policy. An important component is represented by the Youth Health Care professionals (visiting children 0-18), who are trained to do FGM risk assessments and discuss FGM with parents and to educate them about the medical risks and laws, including through disseminating the document 'Statement opposing female circumcision'. Other essential actors for FGM prevention are the 110 key persons, who are trained to discuss FGM with and within affected communities. Midwives play also a crucial role in FGM prevention and detection with pregnant women and have trained FGM focal points.

FGM is included within the university curricula of midwives as a compulsory module, but is only facultative for all other medical students. For this reason, research[13] based on women witnessing and on analysis of the recording rate of FGM showed little knowledge of medical professionals on FGM, which undermines their preventive role. **Compulsory initial and continuous training on FGM should be extended to all relevant medical professions** (particularly those who specialize in gynaecology, obstetrics and psychology), **including general practitioners** (GPs), as they play a central role in the coordinated healthcare cycle. Such mandatory training for GPs would make the support for FGM affected women and girls more systematic and widespread, since it would give them the right tool to increase the prevention of FGM and provide adequate treatment and aid to FGM survivors during routine controls.

[13] Allwood, E. (2017). Female Genital Mutilation and Women's Healthcare Experiences with the General Practitioner in the Netherlands: a Qualitative Study. Master Thesis: Maastricht University & Pharos, available at https://www.pharos.nl/nl/kenniscentrum/algemeen/webshop/product/35/veiled-pain

Trainings should focus not only on the cultural and medical issues around FGM, but also around how to talk about it with patients and how to start the conversation about it in a gender-, cultural and child-sensitive way.

2. Protection

Articles 19 & 21

As mentioned previously, GPs in the Netherlands are not equipped to provide adequate general support services for women affected by FGM, since they are not trained for this purpose. Therefore, in the country there is a system in place called the "**Consultation hours on FGM**" for women, which is implemented in 11 locations throughout the territory. Within the Chain Approach, key persons are trained to refer and guide women and their partners to the consultation hours, where trained professionals speak to them, provide all the necessary information and, if needed, refer them to other specialized healthcare professionals. We recommend that **financing for the Consultation hours should keep being available**, as long as GPs are not trained to provide this kind of support and referral service.

Article 22

In the Netherlands, upon referral by a GP, FGM survivors can access a wide range of specialized services, such as gynaecological, psychological and sexological care, as well as reconstructive surgery. Within the Dutch healthcare system, GPs visits are free of charge, while all specialized healthcare services are reimbursable under a paying insurance, while no reimbursement is up to now foreseen for costs for genital surgery. The former Ministry of Health opened the discussion around the issue, and currently there is a debate at national level around the opportunity of providing insurance coverage for the surgery, particularly since it is considered that its medical benefits are unclear and there is a lack of evidence around the results.

While we fully agree that the focus should be placed on a comprehensive and holistic healthcare support and accompaniment for FGM survivors, made of physical, psychosocial and sexological treatment, we would like to suggest a **woman-centered approach** to the issue. If after having gone through such mandatory extensive **multidisciplinary support**, the woman still expresses the need to undergo **reconstructive surgery** as a solution for her physical and psychosocial complications, **financial reimbursement should be provided**. Moreover, we would like to recommend to the Dutch government that when these specialized services are needed to treat the physical and psychological health of a survivor of GBV, including FGM, due to the particular vulnerability of the subjects, such package is covered **under basic insurance**.

Articles 60 & 61

As a general remark, the **Dutch asylum procedures should be more gender- and child-sensitive**. Moreover, it appears clear that the Dutch asylum authorities while assessing asylum applications tend to prioritise policies trying to contain the refugee influx over the protection of girls at risk of FGM, which raises quite some concerns.

For instance, Dutch asylum authorities and the judiciary often wrongly overstress in their negative decisions not to grant international protection to girls the **alleged ability of their mothers who oppose the practice to defend them from being cut and resist social pressure**. We recommend the Dutch asylum authorities and judges to recognize the specificity of FGM as a social norm in practicing communities and the consequent pressure that is put on families to perform it as key elements in the international protection status assessment. Mothers, including when educated and economically independent, are not necessarily and systematically able to protect their girls against their communities simply because of their opposition to the practice, as shown in the landmark decision by the UN Committee on the Rights of the Child (CRC) early this year against Denmark[14]. On this regard, we also recommend the Dutch authorities **ratify the UN CRC 3rd Protocol on individual complaints**, in order to provide an additional way of access to justice for girls at risk of FGM who were refused protection through the domestic legal system in the Netherlands.

Moreover, it is worrying that the Dutch authorities produce Country of Origin Information (COI) country reports[15] which regarding FGM are not sustained by sufficient evidence-based data or statistics and make use of anonymous sources -in open contradiction with authoritative UN sources- to justify negative asylum decisions. We recommend that the Dutch authorities ensure **gathering, updating, analysing and using quality COI in a gender-, culture- and child-sensitive way**.

[14] See https://www.ohchr.org/Documents/HRBodies/CRC/CRC-C-77-DR-3-2016.pdf. It has to be noted that the European Court of Human Rights (ECtHR) adopted a few decisions on the principle of non-refoulement applied to refused Dutch refugee applications of girls at risk of FGM (see the case *Soumah v. the Netherlands and 4 others* https://hudoc.echr.coe.int/eng#{%22itemid%22:[%22001-179963%22]}) and that the UN Committee Against Torture (CAT) also issued an opinion on an individual complaint supporting the fear of ill-treatment of a Guinean woman who had undergone a reconstructive surgery in the Netherlands and was at risk of being deported back (see http://www.refworld.org/pdfid/568a963e4.pdf).

[15] For instance, the COI on Guinea Conakry of 2014.

3. Prosecution

The law criminalizing FGM is used in the Netherlands as a preventive tool to sensitise affected populations, and also thanks to this, attitudes concerning the practice are changing. There has not been information concerning FGM cases being prosecuted, and there is lack of information available on reported FGM cases.

4. Integrated Policies

Article 7

The Dutch Chain Approach is a very positive practice and sets an example to follow for other countries. The involvement of all sectors and levels of society is an important feature of the system ensuring an inclusive, integrated and coordinated approach to tackle FGM. It would be very beneficial in order to strengthen the effectiveness of such model to expand it throughout the whole national territory. In this sense, **municipalities that are implementing the chain approach should share lessons learned, experiences and best practices with municipalities who are not yet involved, to expand the national outreach**.

Moreover, apart from the local authorities' level, a **structural cooperation should be strengthened between key persons and professionals** at municipal level, particularly in local health structures (GGDen), ensuring regular contact and meetings between the two, therefore leading to a more efficient referral system for women and girls affected by FGM.

Article 8

Systematic, coordinated and institutionally supported community engagement through the involvement of the key persons in the Dutch Chain Approach is one of the reasons for its success. The government and a few municipalities have continuously financed the work of key persons and the role of FSAN as national coordinating NGO for community engagement and training. However, such financing is subjected to yearly project proposals and is not a structural long-term support. Moreover, it is not homogenous among all municipalities throughout the national territory, and normally key persons only receive small compensations for their prestation and not real salaries for their work.

This does not ensure sustainability and efficiency of the community engagement, which is vital for the outreach of the Chain Approach to the affected population. Therefore, we recommend **converting the project financing of the work of key persons in structural financing**.

Moreover, funding for community engagement should not only be increased at national level, but **financing for key persons should also be made more systematic and sustained at regional level**, within the 26 country regions. In particular this would be very important to enhance key persons' cooperation and interaction with professionals and to ensure sustainability of their activities within the local context.

Moreover, it would also be important that key persons and community leaders are provided with the **appropriate financial means to transfer the knowledge they have acquired in the Netherlands concerning FGM in their countries of origin**, in order to multiply the effect of their training and impact. This would entail the provision of geographically flexible funding to ensure key persons can also make a difference in their countries of origin.

Beyond the increased financial support, key persons also need **access to continuous moral and psychological support services** and **sustainable training on stress management**, due to the frontline work that they carry out. Being from a migrant background, on the one hand, they are exposed in Dutch society to xenophobia, and, on the other hand, they are also the target of criticism within their own communities, since they are often seen as traitors of their traditions. There have been documented cases of key figures who, due to being isolated from their communities and being accused to be paid by the "white people" to destroy their own culture, have decided to stop their work.

Article 10

Within the Dutch policy framework of the Chain Approach, protocols are in place which require healthcare practitioners in the maternity and child health clinics to discuss FGM with women and girls' parents and inform them about the medical and legal consequences of such practice. However, currently no systematic monitoring is made of the correct implementation and the effectiveness of such important policy. Moreover, systematic monitoring is also not conducted regarding the preventive work that municipalities carry on concerning FGM, within their responsibility to prevent of domestic violence and child abuse.

Therefore, it would be key to **establish a national systematic monitoring and periodic evaluation mechanism** to ensure that policies are correctly implemented in practice at professional and municipality level.

Article 11

The Netherlands collects a lot of data on violence against women, including FGM. There is a Central Bureau of Statistics for VAW and FGM which centralizes all data coming from health professionals, police and Safe Houses (Veilig Thuis) for victims of violence. However, the police do not collect any specific data, since they do not register the exact form of violence against women, while the 26 Safe Houses do register the number of FGM cases they receive but have

different registration methods, which makes it very difficult to compare data and draw national trends and statistics.

Therefore, it would be crucial to **promote and stimulate more uniformity in data collection** at local and national level. The government is aware of such challenge and has included the point in the new NAP 2018-2020, whose implementation will need to be closely followed.

CONCLUSIONS

In conclusion, FSAN, Pharos and End FGM EU would like to call upon the Dutch authorities to keep working towards putting an end to FGM, by taking the following measures:

- Increased visually accessible information material specifically targeting people from the communities with low literacy rates;
- Strengthen early information provision on FGM for newly arrived migrants and asylum seekers;
- Extend compulsory initial and continuous training on FGM to all relevant medical professions, including general practitioners, including on communication skills;
- Ensure availability of funding for consultation hours, as long as GPs are not trained to provide this kind of support and referral service;
- Provide financial reimbursement for women who express the need to undergo reconstructive surgery as a solution for their physical and psychosocial complications after having gone through mandatory extensive multidisciplinary support; moreover, provide basic insurance coverage for access to all specialized services, within which also reconstructive surgery, for women who survived GBV, including FGM;
- Ensure that asylum procedures are more gender- and child-sensitive, specifically in terms of: recognition of the specificity of FGM as a social norm and the consequent pressure put on families to perform it; gathering, updating, analysing and using quality COI in a gender-, culture- and child-sensitive way;
- Ratify the 3rd Protocol of the UN Committee on the Rights of the Child to allow for individual complaints under the UN Convention on the Rights of the Child;
- Encourage municipalities that are implementing the chain approach to share lessons learned, experiences and best practices with municipalities who are not yet involved, to expand the national outreach;
- Strengthen structural cooperation between key persons and professionals at local level to ensure more efficient referral systems for women and girls affected by FGM;

- Convert the project financing of the work of key persons in structural financing at national, regional and local level, to ensure the sustainability of their work;
- Support key persons through continuous moral and psychological support services and training on stress management;
- Provide key persons with the appropriate financial means to transfer the knowledge they have acquired on FGM in their countries of origin;
- Establish a national systematic monitoring and periodic evaluation mechanism on the implementation and the effectiveness of the Dutch policy legislative and framework;
- Promote and stimulate more uniformity in data collection on violence against women, including FGM, at local and national level.

We thank the GREVIO for the opportunity given to civil society to provide our expertise and concrete recommendations to improve Dutch authorities' actions to end FGM.