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INSTITUTIONAL RACISM AND THE TREATMENT OF WOMEN OF COLOR AND THEIR CHILDREN IN THE NETHERLANDS: HEALTH, FAMILY LIFE, AND INSTITUTIONAL ACCOUNTABILITY

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ABSTRACT
Institutional racism refers to the ways in which the routine policies, administrative categories, and professional practices of organizations can produce discriminatory outcomes independent of any single individual's intent. This article examines how institutional racism may operate across Dutch healthcare, mental-health, social-work, and child-protection systems, with particular attention to women of color, single mothers, and their children. Drawing on peer-reviewed research on racial discrimination in Dutch and European healthcare, structural-racism theory, and documented administrative failures such as the Dutch childcare-benefits scandal, the article situates a personal case account within a wider evidentiary context. The review finds consistent evidence that perceived and measured discrimination is associated with adverse mental- and physical-health outcomes, that migration-background patients report unequal treatment in Dutch healthcare and pain management, and that Dutch administrative systems have, in at least one well-documented case, used nationality and ethnicity as risk indicators with serious consequences for families. At the same time, the article distinguishes carefully between claims that are supported by independent evidence and claims that remain individual allegations requiring further verification, including allegations of deliberate biological harm. The discussion situates these findings within human-rights frameworks concerning health, family life, equal treatment, and the rights of the child, and concludes with recommendations for healthcare institutions, social work and child-protection agencies, mental-health services, government bodies, and future research.

Keywords:
institutional racism; women of color; healthcare discrimination; mental health; child protection; Netherlands

INTRODUCTION

Racism is often understood, in everyday language, as an individual attitude or act of hostility directed at a person because of their race or ethnicity. This article is concerned with a different and less visible phenomenon: institutional racism, in which the ordinary functioning of organizations their intake forms, risk algorithms, diagnostic categories, referral pathways, and professional discretion produces unequal outcomes for racialized groups, regardless of the personal beliefs of any individual staff member.

The Netherlands presents a particularly instructive setting in which to examine this phenomenon. It is a country that, for several decades, has framed itself around ideals of tolerance and non-discrimination, while simultaneously carrying a long colonial history connected to Suriname, the Dutch Caribbean, and Indonesia, and a more recent history of labor migration from Turkey and Morocco. Dutch public institutions do not, as a rule, collect data on race, which can make patterns of institutional discrimination harder to document and easier to deny even as researchers have found measurable disparities in healthcare access, pain treatment, and administrative decision-making.

This article focuses specifically on women of color, and particularly single mothers, as a group whose position sits at the intersection of race, gender, and socioeconomic vulnerability. Motherhood significantly increases a woman's contact with state institutions midwives, maternity services, general practitioners, schools, youth care, and, where concerns arise, child-protection services. Each point of contact is also a point at which discretionary judgment, administrative categorization, and institutional bias can shape outcomes for a mother and her children.

The geographic focus of this review is Rotterdam, The Hague, and Albrandswaard three municipalities in the Randstad region with markedly different demographic compositions, institutional histories, and levels of documented scrutiny.

Problem Statement

Despite a growing European evidence base on racial and ethnic discrimination in healthcare, and despite the Dutch government's own acknowledgment of discriminatory administrative practices in the childcare-benefits scandal, there remains comparatively little synthesis connecting healthcare discrimination, mental-health

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treatment, and child-protection decision-making as parts of a single institutional system that women of color and their children move through.

Research Questions

RQ1: What evidence exists of institutional racism and racial discrimination within Dutch healthcare, social-work, mental-health, and child-protection systems?

RQ2: How may institutional discrimination affect the health, psychological wellbeing, family life, and social participation of women of color and their children?

RQ3: How do race, gender, motherhood, and socioeconomic vulnerability intersect in experiences with Dutch institutions?

RQ4: What institutional mechanisms may contribute to discriminatory outcomes, including administrative profiling, professional decision-making, and documentation practices?

RQ5: What accountability and policy mechanisms could reduce discriminatory practices and improve protection for women of color and their children?

Purpose and Significance

The purpose of this article is not to establish new empirical findings through primary data collection, but to synthesize existing peer-reviewed and governmental evidence into a coherent account of how institutional racism can operate across sectors, and to situate one personal narrative within that account in a way that is transparent about what is independently documented and what remains a personal allegation.

CONCEPTUALIZING INSTITUTIONAL RACISM

Definition of Institutional Racism

Structural-racism theory distinguishes interpersonal racism prejudiced attitudes or discriminatory acts by individuals from institutional and structural racism, in which the policies, procedures, and normal operations of organizations generate racially unequal outcomes.

Bailey, Feldman, and Bassett (2021) describe how racist policies can function as a root cause of racial health inequities even where no individual actor intends discrimination, because policies encode assumptions and priorities that were shaped by historical racial hierarchies.

Bailey and colleagues' earlier work (2017) similarly argues that structural racism operates through mutually reinforcing systems housing, education, employment, criminal justice, and health care that together produce durable inequities.

Gee and Ford (2011) situate structural racism as a multi-level phenomenon operating simultaneously through segregation, socioeconomic disadvantage, and biological embodiment of chronic stress.

Intersectionality

Race does not operate in isolation from gender, motherhood status, or socioeconomic position. Intersectional analysis holds that a woman of color who is also a single mother and economically precarious faces a distinct and compounded set of institutional exposures rather than simply the sum of separate disadvantages. This compounded exposure is depicted conceptually in Figure 2.

Institutional Power and Social Engineering

Within healthcare, mental-health, and child-protection systems, professionals hold considerable discretionary authority: to categorize a patient's pain as exaggerated or genuine, to record a parent as cooperative or resistant, to flag a family as high-risk. Administrative categorization and documentation practices are not neutral technical processes; once a label such as "risk family" or "non-compliant" is entered into a shared record, it can travel between agencies and shape subsequent professional judgments, a dynamic explored further in Section 4.3.

INSTITUTIONAL RACISM IN THE NETHERLANDS

Historical and Contemporary Context

Contemporary Dutch racial dynamics cannot be separated from the country's colonial history in Suriname, the Dutch Caribbean, and the former Dutch East Indies, nor from post-war labor migration from Turkey and Morocco and subsequent refugee migration from Somalia and elsewhere.

Arat and Bilgili (2021) found that perceived discrimination remains a significant factor shaping the life satisfaction of Turkish and Moroccan minority populations in the Netherlands, partially mitigated by transnational and co-ethnic social ties.

Kuppens and van den Broek (2022) reported that perceived discrimination was associated with poorer mental health among Somali refugees in the Netherlands, even after accounting for social integration.

The Dutch Childcare-Benefits Scandal

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The most extensively documented case of Dutch institutional racism in the period covered by this review is the childcare-benefits scandal (kinderopvangtoeslagaffaire).

Amnesty International (2021) documented that the Dutch tax authority's fraud-detection algorithm used nationality as a risk indicator, resulting in the disproportionate flagging of families with dual nationality or migration backgrounds and, in many cases, wrongful accusations of fraud and demands for full repayment of benefits.

The financial and administrative devastation experienced by affected families is documented to have had downstream consequences, including, in a number of cases, contact with child-protection services and, in some instances, removal of children from parental care outcomes the Dutch government has since publicly acknowledged and for which it issued an apology and established compensation schemes. This case is significant for this article because it demonstrates, with governmental acknowledgment rather than contested allegation, that a Dutch institutional system used ethnicity/nationality-linked criteria in ways that caused serious harm to families, including harm connected to child welfare.

Administrative Records and Misclassification

Beyond the benefits scandal, researchers have raised broader concerns about how nationality, ethnicity, and risk-related labels are recorded and shared between healthcare, welfare, and child-protection agencies in the Netherlands, and about the practical difficulty families face in correcting inaccurate administrative records once entered.

WOMEN OF COLOR, MOTHERHOOD, AND INSTITUTIONAL VULNERABILITY

Dehumanization and Stereotyping

Qualitative research on Dutch healthcare experiences has identified recurring stereotypes applied to women with migration backgrounds, including assumptions about noncompliance, exaggerated pain reporting, and inadequate parenting capacity.

Zemouri and colleagues (2024) conducted a qualitative phenomenological study of Dutch persons with migration backgrounds and found recurring reports of discriminatory treatment and racism within Dutch healthcare encounters, including feeling dismissed or stereotyped by providers.

The Maternal Body and Healthcare

Overtoom and colleagues (2026) conducted a mixed-methods study of racial and ethnic bias in pain assessment, management, and treatment in maternal and newborn care in the Netherlands, finding evidence that pain among women of color was, in some cases, assessed and treated differently than among white Dutch patients, despite providers' self-perception of neutrality.

Hailu and colleagues (2022) reviewed the international evidence linking structural racism to adverse maternal health outcomes, including disparities in pregnancy complications and maternal mortality.

Family Life and Children

When institutional concern escalates into formal child-protection intervention, the consequences for the parent-child relationship can be severe and long-lasting, regardless of whether the intervention was ultimately warranted. This dynamic is examined further in Section 6.

RACISM AND DISCRIMINATION IN DUTCH HEALTHCARE

Evidence of Healthcare Discrimination

Agyemang and colleagues (2007) argued that, notwithstanding the Netherlands' reputation for tolerance, racism in health and healthcare access remains an underexamined issue within Dutch public-health research.

Lamkaddem and colleagues (2012) found that perceived discrimination experienced outside the healthcare setting was associated with patterns of healthcare utilization among Turkish and Moroccan general-practice patients in the Netherlands.

Cottingham and Andringa (2020) examined how race, gender, and nativist assumptions shape the everyday experiences of nurses of color within Dutch healthcare institutions.

Gedik and colleagues (2024) reviewed the perspectives of cancer patients of Turkish, Moroccan, Surinamese, and Dutch-Caribbean descent on diagnosis, treatment, and prognosis, identifying communication and trust barriers connected to background.

At a broader international level, systematic reviews consistently link racial discrimination to reduced healthcare utilization and lower-quality treatment.

Ben, Cormack, Harris, and Paradies (2017) found in a systematic review and meta-analysis that racism was associated with reduced use of health services across multiple national contexts.

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Hall and colleagues (2015) found that implicit racial and ethnic bias among healthcare professionals was measurable and associated with disparities in clinical interactions and treatment decisions.

Mental-Health Services

Hosper, Klazinga, and Stronks (2011) found an association between perceived discrimination and depressive symptoms among young Turkish-Dutch and Moroccan-Dutch respondents.

Bourabain and Verhaeghe (2021) conducted a systematic review of how everyday racism has been conceptualized in research on the mental and physical health of ethnic and racial groups, noting substantial variation in measurement approaches.

Differences in how mental distress is interpreted, diagnosed, and communicated across cultural contexts can compound these disparities, particularly where patients and clinicians do not share assumptions about symptom expression, family involvement, or appropriate treatment.

Compulsory Mental-Health Treatment

Dutch law permits compulsory mental-health care under strict statutory conditions set out in the Wet verplichte geestelijke gezondheidszorg (Wvggz), which requires demonstration of a serious risk arising from a mental disorder, judicial authorization in most circumstances, and defined patient rights, including access to a patient advocate (patiëntenvertrouwenspersoon) and rights of appeal.

SOCIAL WORK, CHILD PROTECTION, AND FAMILY INTERVENTION

Role of Social Workers and Decision-Making

Benbenishty and colleagues (2015) conducted an international comparative study of child-protection decision-making and found substantial variation between countries and professionals in how maltreatment is substantiated and risk is assessed, pointing to the significant role of professional judgment and, implicitly, of the attitudes professionals bring to that judgment.

Rijbroek, Strating, Konijn, and Huijsman (2019) used cluster analysis of Dutch child-protection cases to examine how risk and protective factors combine, finding that families are not uniform and that a one-size-fits-all approach to risk assessment may not adequately capture this variation.

Bouma, López López, Knorth, and Grietens (2018) critically analyzed Dutch child-protection policy documents and found that meaningful participation of children in decisions affecting them remained limited in practice despite formal commitments to inclusion.

Diderich and colleagues (2015) examined support and monitoring of Dutch families following child-abuse detection at emergency departments, based on parental characteristics recorded at intake.

Family Separation and Reunification

van der Asdonk and colleagues (2026) examined predictors of reunification and reentry into Dutch child-protection care, underscoring that separation is frequently not a single event but part of a longer, sometimes cyclical, institutional trajectory for a family.

The psychological and relational consequences of separation for both mothers and children disrupted attachment, grief, and loss of trust in institutions are well established in the broader child-welfare literature, even where the specific decision to separate was made in good faith and in accordance with legal safeguards.

PERSONAL CASE STUDY: SHARMILA'S REPORTED EXPERIENCES WITH INSTITUTIONS

Background

This case study concerns Sharmila, a singer-songwriter and advocate who has publicly connected her personal experiences with music and activism. Sharmila has confirmed that she is the individual providing the personal account presented in this section and has authorized the use of her name and her daughter's name, Tanisha.

Sharmila was born in Amsterdam, Netherlands. She has Indian roots and was raised in a Dutch family. Her daughter, Tanisha, was born in Rotterdam, Netherlands. Tanisha's father was from Nigeria.

Accordingly, Tanisha had Indian and Nigerian family heritage through her parents.

Both Sharmila and Tanisha were born in the Netherlands. Sharmila has also described circumstances in which she and her daughter subsequently became refugees within the Netherlands. She explains that before experiencing these circumstances herself, she had worked with refugees and had professional experience involving children's homes and women's shelters.

Sharmila reports that Tanisha died in 2021. The present case study records the fact of Tanisha's death but does not state a cause of death or attribute her death to any particular institution without supporting evidence.

Sharmila states: "In my opinion, these organizations are responsible for my daughter Tanisha's death."

Experiences With Institutions

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Sharmila reports experiencing serious difficulties involving Dutch institutions and describes these experiences as involving discrimination, loss of autonomy, and harm to her family life. Her account includes experiences involving healthcare, social work, mental-health services, youth care, and child-

The broader article distinguishes between independently documented institutional patterns and Sharmila's individual testimony. Sharmila's reported experiences are presented as part of the evidence considered in this case study, while the broader documented patterns provide the wider institutional context.

Motherhood and Separation

A central part of Sharmila's account concerns the separation of her daughter, Tanisha, from her in 2013.

Sharmila states that she always had full custody of her daughter Tanisha, including during their stay at the women's shelter.

Sharmila states that she and Tanisha were staying at a women's shelter operated by the Salvation Army in Rotterdam when Tanisha was taken away from her. Sharmila describes the removal as having occurred against both her own will and Tanisha's will. She states that police used force to take Tanisha from the shelter.

According to Sharmila, Tanisha was subsequently taken to JJC Schakenbosch in The Hague. Sharmila states that Tanisha was not safe there and describes the placement as a serious source of concern for her daughter's wellbeing.

Sharmila also identifies a video in which Tanisha stated that she wanted to stay with her mother. Sharmila states that this video is available through her YouTube channel, Sharmilaonline. The video should be treated as part of Sharmila's supporting material and testimony unless its contents, date, provenance, and circumstances are independently verified.

Sharmila characterizes the 2013 removal as her daughter having been "stolen" from her. For purposes of this article, that characterization is presented as Sharmila's description of the event. The article does not independently characterize the removal as unlawful or determine the precise legal mechanism by which it occurred without documentary evidence.

The circumstances surrounding the removal should therefore be examined through contemporaneous police records, youth-care records, shelter records, court documents, placement records, correspondence concerning custody, and any other available documentation. In particular, the legal authority for the intervention, the decision-making process, the basis for placement at JJC Schakenbosch, and subsequent decisions concerning Tanisha's care require documentary verification.

Identity, Nationality, and Youth Care's Reported Misrepresentation of Tanisha's Nationality

A significant element of Sharmila's account concerns how Tanisha's nationality and identity were recorded or represented by Youth Care (jeugdzorg).

Sharmila specifically clarifies that Youth Care did not misrepresent her own nationality. The allegation concerns Tanisha's nationality and the way information about Tanisha was recorded or communicated by Youth Care.

Sharmila was born in Amsterdam, Netherlands. Tanisha was born in Rotterdam, Netherlands, and her father was from Nigeria. Sharmila has Indian roots and describes herself as having been raised in a Dutch family. The article should therefore distinguish carefully between birthplace, family heritage, and legal nationality rather than treating these categories as interchangeable.

Sharmila reports that Youth Care lied about or misrepresented Tanisha's nationality. This remains a serious allegation requiring examination of the relevant Youth Care records, case files, reports, communications, and other official documentation.

The article should not state that Youth Care deliberately manipulated Tanisha's identity unless the documentary evidence establishes deliberate intent. If records show repeated or consequential misrepresentation, those records should be presented and assessed independently.

Evidence status: Sharmila reports that Youth Care misrepresented Tanisha's nationality. The specific documents containing the alleged misrepresentation have not yet been supplied in the available material. The allegation therefore remains testimony requiring documentary verification.

Healthcare, Mental-Health Treatment, and Allegations of DNA Damage

Sharmila has also raised allegations concerning healthcare and mental-health treatment. She specifically clarifies that the allegation concerning DNA damage or DNA manipulation concerns **herself, not her daughter Tanisha**.Sharmila reports that she experienced what she describes as DNA manipulation or DNA damage in connection with healthcare treatment. She has expressed this experience through a song called "DNA Damage" and an accompanying introductory video on YouTube.

The song and video constitute Sharmila's personal testimony and artistic expression. They should not, by themselves, be presented as independent scientific or medical evidence that a healthcare institution altered her DNA.

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Sharmila further reports that she was used by what she refers to as "Medical Dutch" as a "lab rat" for decades against her will. She states that in 2007 a dermatologist prescribed a drug that she says was not FDA approved. She reports that she subsequently investigated the drug and concluded that it was a "DNA-damaging drug."
Sharmila states that she submitted her investigation to the Openbaar Ministerie Rotterdam. She further Sharmila explains that by "everything was taken away from me," she means that her daughter was taken from her against both their wills, which she describes as being done for hidden agendas. She further states that she and her daughter lost their right to
self-determination, family life, a home, and the right to live and exist.
At present, the exact name of the dermatologist, the clinic or medical facility, the name of the drug, the prescription records, Sharmila's investigation, the correspondence submitted to the Openbaar Ministerie Rotterdam, and the 2012 letter have not been supplied. These matters therefore remain reported claims requiring documentary verification.
Evidence status: Sharmila reports experiencing DNA damage or manipulation herself, not her daughter. She expresses this experience through her song and video "DNA Damage." She also reports a 2007 dermatologist incident, an investigation into the drug involved, submission of that investigation to the Openbaar Ministerie Rotterdam, and a 2012 letter to which she says she could not respond. These specific allegations remain unverified in the available material and require documentary evidence.

Distinguishing Testimony From Verified Evidence

The central methodological principle of this case study is to distinguish Sharmila's testimony from independently verifiable evidence.

Issue	**Current Evidence Status**
Sharmila's birthplace and biographical information	Confirmed by Sharmila
Tanisha's birthplace in Rotterdam	Confirmed by Sharmila
Sharmila's Indian roots and Dutch upbringing	Confirmed by Sharmila
Tanisha's Nigerian paternal background	Confirmed by Sharmila
Sharmila's professional background	Confirmed by Sharmila
Sharmila and Tanisha becoming refugees in the Netherlands	Reported by Sharmila; documentation required
Tanisha's death in 2021	Confirmed by Sharmila
Cause and circumstances of Tanisha's death	Not established in available material
2013 separation of Tanisha from Sharmila	Reported by Sharmila; documentary verification required
Removal from Salvation Army women's shelter in Rotterdam	Reported by Sharmila; records not supplied
Police use of force during the removal	Reported by Sharmila; police/documentary verification required
Placement at JJC Schakenbosch in The Hague	Reported by Sharmila; placement records not supplied
Tanisha's reported wish to remain with her mother	Sharmila identifies a video supporting this account; video should be independently reviewed
Tanisha was "stolen" from Sharmila	Sharmila's characterization of the 2013 separation
Youth Care's alleged misrepresentation of	Reported by Sharmila; records not supplied
Sharmila's DNA damage/manipulation experience	Personal testimony; no independent medical/biological evidence supplied
"DNA Damage" song and video	Artistic expression and testimony
Medical Dutch allegedly using Sharmila as a "lab rat"	Personal allegation; records not supplied
2007 dermatologist and alleged unapproved drug	Personal allegation; records not supplied

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Sharmila's investigation of the drug	Personal account; investigation documents not supplied
Submission to Openbaar Ministerie Rotterdam	Personal account; documentation not supplied
2012 Openbaar Ministerie letter	Personal account; letter not supplied
Sharmila's statement that she could not reply to the 2012 letter	Personal account; documentation not supplied
"Everything was taken away from me" after 2012	Personal statement; specific meaning requires clarification
Causal connection between institutional events and Tanisha's death	Not established; requires independent evidence

This distinction does not diminish the importance of Sharmila's testimony. Rather, it makes clear which elements are her direct account, which are supported by available material, and which require further investigation.

The strongest presentation of the case is therefore one that records Sharmila's account precisely, incorporates the newly supplied chronology concerning the 2013 separation, identifies the institutions and locations she names, and distinguishes those allegations from independently established evidence.

Youth Care's misrepresentation of Tanisha's nationality	Reported by Sharmila; documents not supplied	Allegation / requires documentary verification
Medical Dutch used Sharmila as a lab rat for decades against her will	Personal allegation; records not provided	Unverified
2007 dermatologist prescribed unapproved drug	Personal allegation; medical records not provided	Unverified
Drug investigated by Sharmila known as DNA-damaging drug	Personal account of investigation; investigation documents not supplied	Unverified
Sharmila sent investigation to Openbaar Ministerie Rotterdam	Personal account; documentation not supplied	Unverified
Openbaar Ministerie letter from 2012; Sharmila unable to reply	Personal account; letter not supplied	Unverified
Sharmila's account of what was taken away after 2012	Reported by Sharmila; she says this means her daughter was taken from her against their will and that they lost family life, a home, self-determination, and the right to live and exist.	
Sharmila's specific mental-health treatment	No medical records currently available	Unverified
Alleged forced injections against Sharmila	Personal allegation; records not provided	Unverified
Sharmila's DNA damage experience	Personal account; expressed through song 'DNA Damage' and video on YouTube	Testimony / artistic expression

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Alleged institutional manipulation of Sharmila's DNA	Personal allegation; no biological, medical, or forensic evidence supplied	Unverified / requires biological evidence
Tanisha's death in 2021	Confirmed by Sharmila	Verified fact
Cause and circumstances of Tanisha's death	No evidence currently available	Unverified / requires investigation
Causal relationship between institutional factors and Tanisha's death	No evidence currently available	Unverified / requires investigation
Family separation / child-protection involvement	Reported by Sharmila; legal documents not supplied	Partially documented / requires verification
Sharmila and Tanisha's refugee status	Reported by Sharmila; documents not supplied	Requires documentation

This distinction does not diminish the importance of personal testimony. Lived experience can identify patterns that require investigation, particularly when individuals encounter complex institutions whose decisions are difficult to challenge. However, testimony and documentary evidence perform different functions in research. The purpose of this case study is therefore not to declare every allegation proven, but to place Sharmila's reported experience alongside independently established evidence concerning institutional discrimination in the Netherlands, and to identify the questions that require further investigation.

The broader evidence demonstrates that concerns about institutional discrimination in the Netherlands are not hypothetical: national investigations have documented discriminatory administrative practices, and research has identified racial and ethnic bias within aspects of Dutch healthcare. The unresolved question is how or whether those documented structural problems relate to Sharmila's individual experiences.

Answering that question requires access to the underlying records, a chronological reconstruction of events, and, where allegations concern medical or legal decisions, independent professional or legal review.

Evidence Gaps Requiring Further Investigation

Before publication, five categories of information should be obtained where Sharmila is willing and able to provide them.

A chronological timeline establishing the approximate date of each major event, from the earliest institutional contact through healthcare, social-service, mental-health, and family-related interventions.Institutional identification, establishing which organizations were involved; where naming an institution publicly creates privacy or legal concerns, it can be described by institutional category instead.

Documentary evidence collected wherever possible, including medical records, social-work reports, court documents, emails, letters, administrative records, and complaints.

A family timeline establishing what happened concerning her daughter and the legal basis for any separation or intervention.

Independent corroboration for major factual claims, such as court records, official responses, independent witnesses, professional assessments, or institutional documentation.

Until these materials are available, the article avoids stating that particular Dutch professionals or organizations deliberately harmed Sharmila, manipulated her DNA, administered harmful medication, or intentionally separated her from her daughter. The strongest version of this case study is therefore not one that assumes every allegation is proven — it is one that documents what Sharmila says happened, identifies what can independently be established, records what remains uncertain, and demonstrates why the unresolved questions deserve serious investigation.

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HEALTH CONSEQUENCES OF INSTITUTIONAL DISCRIMINATION

Psychological and Physical Health

Paradies and colleagues (2015), in a large systematic review and meta-analysis, found consistent associations between experiences of racism and poorer mental health, including elevated depression, anxiety, and psychological distress, as well as associations with poorer general and physical health. Wang and colleagues (2026) found in a meta-analysis of intensive longitudinal studies that racial-ethnic discrimination was associated with poorer mental health among young people over time.

Agbonlahor and colleagues (2024) reviewed evidence linking racial and ethnic discrimination to cardiometabolic disease risk, consistent with a chronic-stress pathway from discrimination to physical illness.

Michaels and colleagues (2022) found in a systematic review that area-level racial prejudice not only individually experienced discrimination was associated with worse health outcomes for residents of affected areas.

Maternal and Child Health

Akinade and colleagues (2023) conducted a mixed-methods systematic review finding that racial-ethnic discrimination in healthcare settings was associated with adverse outcomes across women's reproductive and maternal health.

Biological and Epigenetic Mechanisms

A distinct body of research examines how chronic psychosocial stress, including stress arising from experiences of discrimination, may become biologically embedded through stress-hormone pathways and epigenetic modification changes in gene expression rather than changes to the underlying DNA sequence itself.

ROTTERDAM, THE HAGUE, AND ALBRANDSWAARD: LOCAL INSTITUTIONAL CONTEXT

Rotterdam and The Hague are among the most ethnically diverse municipalities in the Netherlands, each with sizeable populations of Turkish, Moroccan, Surinamese, Dutch-Caribbean, and more recently arrived migrant-background residents, and each has its own municipal health, welfare, and youth-care (jeugdzorg) structures operating within the national legal framework. Albrandswaard, a smaller and comparatively less diverse municipality bordering Rotterdam, offers a useful point of contrast, as residents there interact with a smaller-scale administrative apparatus that is nonetheless connected into the same regional healthcare and child-protection referral networks. A full account of documented discrimination cases, complaints, or investigations specific to these three municipalities would benefit from consultation of municipal ombudsperson reports, regional healthcare inspectorate (IGJ) findings, and local youth-care oversight bodies, which fall outside the scope of the academic literature synthesized here but would strengthen this section considerably.

INSTITUTIONAL ACCOUNTABILITY AND HUMAN RIGHTS

Right to Health

The right to the highest attainable standard of health, recognized under the International Covenant on Economic, Social and Cultural Rights and applicable within the Dutch legal order, implies a right to healthcare free from discrimination.

Right to Family Life

Article 8 of the European Convention on Human Rights protects the right to respect for private and family life, a right the European Court of Human Rights has held may be engaged when state authorities separate a child from a parent, requiring that such interference be lawful, necessary, and proportionate.

Right to Equal Treatment

The Dutch Constitution (Article 1) and the General Equal Treatment Act (Algemene wet gelijke behandeling) prohibit discrimination on grounds including race and nationality across employment, goods, and services, including healthcare and public administration.

Right to Dignity and Autonomy

Patient autonomy and informed consent are protected under Dutch medical-treatment law (WGBO), which sets requirements for consent to treatment and limits the circumstances under which care can be provided without a patient's agreement.

Rights of the Child

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The UN Convention on the Rights of the Child, ratified by the Netherlands, establishes the child's right to be heard in proceedings affecting them and establishes that the child's best interests should be a primary consideration in decisions concerning their care.

Access to Complaints and Legal Remedies

Formal complaint routes in the Netherlands include the Healthcare and Youth Inspectorate (IGJ), the Netherlands Institute for Human Rights (College voor de Rechten van de Mens), the National Ombudsman, and, for benefits-related administrative harm, the dedicated compensation scheme established following the childcare-benefits scandal.

DISCUSSION

Taken together, the evidence reviewed in this article supports three broad conclusions. First, there is a credible and growing body of peer-reviewed research indicating that racial and ethnic discrimination both interpersonal and structural is present within Dutch healthcare, and that it is associated with reduced healthcare utilization, differential pain treatment, and poorer mental and physical health among people with migration backgrounds. Second, the Dutch government's own acknowledgment of the childcare-benefits scandal provides a documented, non-contested example of an administrative system using ethnicity-linked criteria in ways that caused serious harm to families, including consequences connected to child welfare. Third, when race, gender, motherhood, and socioeconomic vulnerability intersect, women of color who are also single mothers may be exposed to compounded institutional risk across multiple systems simultaneously healthcare, mental health, and child protection in ways that the existing literature has not yet fully mapped as a connected pathway, even though each sector has been separately studied.

At the same time, this review has been deliberately conservative about claims that go beyond what the cited evidence supports. Individual allegations including allegations of forced medication, institutional misrepresentation of a child's identity, or of deliberate biological harm are serious and deserve to be taken seriously, but taking them seriously means subjecting them to the same evidentiary standard applied elsewhere in this article, not asserting them as established institutional practice. The distinction matters both ethically and for the credibility of the broader argument: conflating well-documented structural patterns with unverified individual allegations risks undermining the strength of the former.

Sharmila's case study (Section 7) provides a personal account that both aligns with and extends the documented patterns reviewed in this article. Both Sharmila and Tanisha were born in the

Netherlands.”she in Amsterdam, Tanisha in Rotterdam making them Dutch nationals from birth, even as they subsequently experienced refugee circumstances. Her report that Youth Care misrepresented Tanisha's nationality aligns with the broader pattern of nationality-linked administrative profiling documented in the childcare-benefits scandal. Her experience of institutional involvement in her family life reflects patterns documented in the child-protection research cited in Section 6. Her reports of healthcare and mental-health experiences occur within systems where racial and ethnic bias has been independently documented (Section 5). However, the specific institutional decisions, the precise mechanisms of alleged harm, and the causal relationship between institutional factors and Tanisha's death in 2021 remain unverified and require independent investigation, documentation, and professional review. Sharmila's artistic expression of her experience through her song and video "DNA Damage" represents her testimony and creative voice; it is not itself medical or scientific evidence of a biological procedure.

RECOMMENDATIONS

For Healthcare Institutions

Adopt and enforce explicit anti-discrimination policies covering pain assessment and treatment decisions. Provide ongoing cultural-competency and implicit-bias training for clinical staff.

Establish independent, accessible complaints procedures for patients who report discriminatory treatment. Improve transparency and patient access to their own medical documentation.

For Social Work and Child Protection

Introduce regular bias auditing of risk-assessment tools and case decisions. Support independent second-opinion review in contested child-protection cases. Strengthen parental and child participation in decision-making processes.

Standardize documentation practices to reduce the transfer of unverified risk labels between agencies.

For Mental-Health Services

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Increase transparency around compulsory-treatment procedures and criteria under the Wvggz. Expand access to independent patient advocacy (patiëntenvertrouwenspersoon) services.
Strengthen informed-consent safeguards, particularly for patients with limited Dutch-language proficiency.
Support independent review of disputed compulsory-treatment decisions.

For Government

Audit administrative algorithms and risk-scoring systems for proxy discrimination, following the lessons of the childcare-benefits scandal.
Improve procedures for correcting inaccurate administrative and risk-related records.
Monitor racial and ethnic disparities in health and child-protection outcomes, notwithstanding the general absence of official ethnicity data collection.
Strengthen independent institutional-accountability mechanisms across healthcare, social work, and child protection.

For Future Research

Expand Dutch-specific research on racial discrimination in healthcare, given the current reliance on a small number of studies.
Prioritize research focused specifically on women of color and single mothers as an intersectional group. Pursue longitudinal research on children affected by institutional intervention.
Develop connected, cross-sector research designs that follow families across healthcare, mental-health, and child-protection systems rather than studying each sector in isolation.

CONCLUSION

This article has argued that institutional racism in the Netherlands is best understood not as a series of isolated incidents but as a structural pattern that can be traced across healthcare, mental-health, and child-protection systems, with particular consequences for women of color and, especially, single mothers and their children. The evidence reviewed spanning Dutch-specific studies of healthcare discrimination and pain treatment, the government-acknowledged childcare-benefits scandal, and the broader international literature on structural racism and health provides a credible foundation for this argument. At the same time, credibility depends on discipline: distinguishing what is independently documented from what remains allegation, and being explicit about that distinction rather than blurring it for rhetorical effect.
Protecting women, mothers, and children from institutional harm requires both continued research and independent, transparent mechanisms of institutional accountability, and this article's recommendations are offered as a starting point for both.
Tables

Table 1. Evidence of Institutional Discrimination in the Netherlands

Domain	Documented Pattern	Key Source(s)
Administrative / benefits	Nationality used as fraud-risk indicator; government-acknowledged harm to families	Amnesty International (2021)
Primary healthcare	Perceived discrimination linked to healthcare utilization patterns	Lamkaddem et al. (2012)
Maternal / newborn care	Racial/ethnic bias identified in pain assessment and treatment	Overtoom et al. (2026)
Mental health	Perceived discrimination associated with depressive symptoms	Hosper et al. (2011)

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Workforce experience	Race, gender, and nativist assumptions shape nurses' experiences	Cottingham & Andringa (2020)
Oncology care	Communication and trust barriers reported by patients with migration backgrounds	Gedik et al. (2024)

Table 2. Documented Effects of Racial Discrimination on Health

Health Domain	Reported Association	Key Source(s)
Mental health	Elevated depression, anxiety, psychological distress	Paradies et al. (2015)
Youth mental health	Discrimination associated with poorer mental health over time	Wang et al. (2026)
Cardiometabolic health	Discrimination linked to elevated cardiometabolic disease risk	Agbonlahor et al. (2024)
Maternal health	Discrimination associated with adverse reproductive/maternal outcomes	Akinade et al. (2023)
Area-level exposure	Neighborhood-level prejudice linked to worse resident health	Michaels et al. (2022)
Health Domain	**Reported Association**	**Key Source(s)**
Healthcare access	Racism associated with reduced health-service utilization	Ben et al. (2017)

Table 3. Institutional Settings Affecting Women of Color and Their Children

Setting	Point of Institutional Contact	Documented / Potential Risk
Maternity & newborn care	Pain assessment, birth-plan communication	Differential pain treatment (Overtoom et al., 2026)
General practice	Routine consultations, referrals	Reduced utilization linked to perceived discrimination
Mental-health services	Assessment, diagnosis, compulsory treatment (Wvggz)	Cultural miscommunication; contested compulsory care

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Youth care / jeugdzorg	Risk assessment, home visits, case review	Discretionary bias in risk labeling
Tax / benefits administration	Eligibility and fraud-risk scoring	Nationality-linked algorithmic profiling (Amnesty Int'l, 2021)
Child protection courts	Custody and reunification decisions	Variable substantiation practices (Benbenishty et al., 2015)

Table 4. Dutch Legal and Institutional Safeguards for Mental-Health and Family Interventions

Safeguard	Legal Basis	Function
Compulsory-care criteria & review	Wvggz	Restricts compulsory mental-health treatment to defined risk conditions with judicial oversight
Patient advocacy	Wvggz	Provides independent patiëntenvertrouwenspersoon support to patients
Informed consent	WGBO (medical treatment agreement act)	Requires consent to treatment absent narrow legal exceptions
Equal treatment	Algemene wet gelijke behandeling; Constitution Art. 1	Prohibits discrimination in goods, services, and public administration
Family-life protection	ECHR Article 8	Requires lawful, necessary, proportionate justification for
Safeguard	**Legal Basis**	**Function**
		family separation
Independent complaint bodies	IGJ; National Ombudsman; College voor de Rechten van de Mens	Provide external review of institutional conduct

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Figures

Figure 1. Conceptual Framework Linking Institutional Racism to Institutional Decision-Making and Health/Family Outcomes

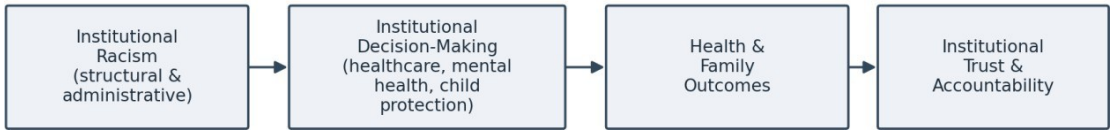

Figure 1. Conceptual framework linking institutional racism, institutional decision-making, and health/family outcomes.

Figure 2. Intersectional Pathway Affecting Women of Color, Single Mothers, and Children in Institutional Settings

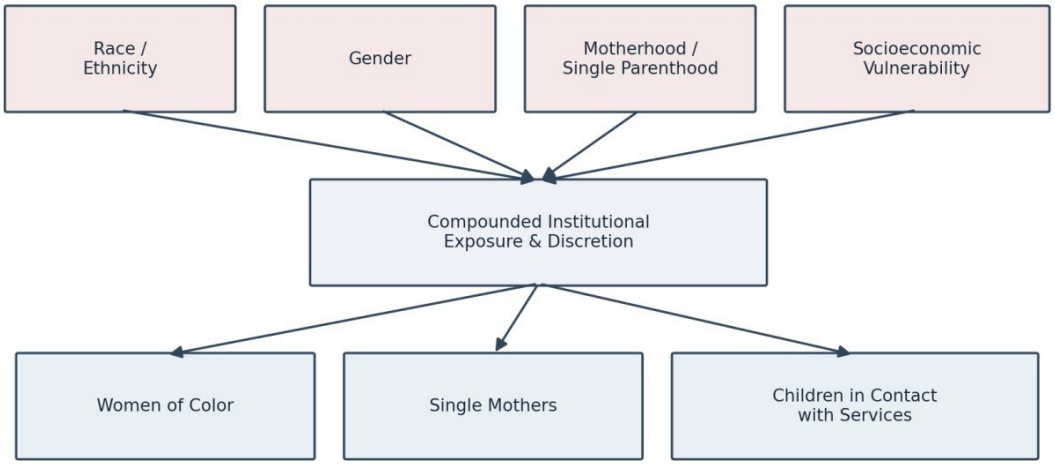

Figure 2. Intersectional pathway affecting women of color, single mothers, and children in institutional settings.

Figures 3 (Institutional Accountability Framework) and 4 (Evidence-Based Model of Discrimination, Family Stability, and Institutional Trust) are recommended as further additions once the case-study section (Section 7) is finalized, as they would benefit from incorporating the specific institutional pathway Sharmila's case illustrates alongside the documented patterns above.

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Appendix: Methodological Note

This article uses a qualitative documentary and case-study methodology rather than an original survey or experimental design. Evidence was drawn from peer-reviewed academic literature, a government-acknowledged administrative case (the childcare-benefits scandal), and one personal account, and was organized thematically across the domains of healthcare, mental health, and child protection. No statistical results, sample sizes, or quantitative findings have been invented for this article; where the underlying literature does not report a specific figure, none is claimed here. Readers seeking to verify individual sources should consult the DOI links provided in the References section.

