Belgian Development Cooperation in the Field of Sexual and Reproductive Health and Rights

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Introduction

The promotion of sexual and reproductive health and rights (SRHR) is an integral part of Belgian cooperation policy.

This paper has various goals. It seeks to present the position of Belgian Development Cooperation on this subject, and also explain the principles on which it is based, the strategic areas and specific fields of activity to which it intends to devote particular attention, and the conditions for carrying out its policy.

Sexual and reproductive health is an aspect of human rights. It is vital to personal well-being – not just in relation to reproduction but also in terms of sexual relationships and personal self-fulfilment. Yet reproductive health problems are one of the leading causes of morbidity and mortality in developing countries. As they primarily affect women and girls, they constitute a major brake on the socio-economic development of communities and countries.

Failure to respect sexual and reproductive rights results in serious problems such as a rise in the number of teenage pregnancies, high maternal and infant morbidity and mortality, rising rates of sexually transmitted infections (STIs) including HIV, a high rate of abortions, including unsafe and illegal ones, and female infertility. Violence and sexual exploitation, in particular trafficking in young women, the impunity of those who commit these crimes and offences and the stigmatisation of victims and vulnerable people – indeed, their exclusion from life in society – are also consequences of the failure to respect these rights.

This situation is fostered by gender inequality, the lack of empowerment of women and serious gaps in education, including teaching about sexual and reproductive health. The lack of access to health services, family planning centres, means of contraception and centres for screening and treating STIs/HIV is both the cause and consequence of the failure to respect sexual and reproductive rights. The main victims are adolescent boys and girls, vulnerable people such as those living with HIV, or migrants (whether legal or illegal), refugees, rural populations and ethnic minorities.

The weight of local traditions and religious or other types of prohibitions also hamper the implementation of policies aimed at instilling respect for these rights and encouraging access to related counselling and health services.

Lack of respect for SRHR falls within the general framework of underdevelopment and extreme poverty and is, therefore, among the goals assigned to Belgian Development Cooperation. Indeed, Article 3 of the law of 25 May 1999 on Belgian international cooperation emphasises that "*the priority goal of Belgian international cooperation is sustainable human development, to be achieved by combating poverty based on the idea of partnership and with respect for criteria of relevance to development…*" Article 3 also emphasises that the goals of Belgian international cooperation include contributing "*to respect for human dignity, (…), human rights, and basic freedoms, with particular attention to the fight against all forms of discrimination on social, ethnic, religious or philosophical grounds or based on gender*".

Consequently, Belgium's policy must contribute to respect for human rights, basic freedoms and the fight against all forms of discrimination. Sexual and reproductive rights are part and

parcel of human rights and basic freedoms and are based on international treaties and conventions ratified by Belgium.

Belgium's policy is also in line with its commitment to the Millennium Development Goals (MDGs), and is based on the recommendations and action plan of the 1994 International Conference on Population and Development (ICPD) in Cairo.

The subject of SRHR is also included in the strategy papers on the focal sectors and topics in the 1999 law – basic health care, including reproductive health, education and training, rebalancing of rights and opportunities for women and men, and rights of the child – and in the government's policy paper on Belgium's contribution to the global fight against HIV/AIDS.

In July 2005, the Chamber of Representatives adopted a resolution aimed at producing a specific strategy paper on SRHR. This Chamber resolution followed numerous initiatives taken after the ICPD by both the legislature and civil society. For example, several specific cooperation programmes were financed in the South, the Platform for Population and Development was created, specialised research centres were established in Belgian universities and academic institutions, and the Commission on Women and Development made this topic one of its priorities.

Chapter I: The global issue

1. ***The situation in the world***

Numerical data from international reports of the World Health Organization (WHO) and UNAIDS[1] illustrate the scale of the problems caused by failing to respect sexual and reproductive rights in the world.

- In the poorest countries, unprotected sexual relations are the second highest risk factor – after malnutrition – for illness, disability and death.[2]

- Each year, 529,000 women, 99% of them living in developing countries, die during pregnancy or delivery or from the consequences of childbirth. It is estimated that 61% of the deliveries in the world are performed by qualified personnel, whereas in Africa the figure is only 40%.

- More than 120 million couples have no access to contraceptives.

- Each year, 80 million women become pregnant against their will. The pregnancies are either unwanted in the context of the relationship between a couple or pregnancies due to sexual coercion. Of these women, 46 million choose to terminate their pregnancy. For 18 million of them, 40% of whom are below the age of 25, the termination is performed in unsafe conditions, leading to 68,000 deaths due to complications.

- It is estimated that each year some 340 million people contract the four most common STIs. At least a third of these infections involve young people under the age of 25. These infections result in infertility among some 180 million couples in developing countries.

- There are an estimated 40 million people living with HIV in the world. The number of new infections in 2006 was put at 4.3 million, with 2.9 million people dying from AIDS. Worldwide, more than 17 million women over the age of 15 are living with HIV. In sub-Saharan Africa, 74% of young people aged between 15 and 24 living with HIV are girls. It is estimated that each day 1,500 children under the age of 15 are infected by HIV most often through mother-to-child transmission.

- Each year 3 million young girls are victims of genital mutilation.

- Each year 257,000 women die of cervical cancer, most of them in poor countries that do not have means of screening for this disease.

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[1] Most of the numerical data come from the 2005 WHO and 2006 UNAIDS reports.
[2] WHO 2002 report.

- Some 2.7 million children are stillborn because of their mother's poor health or the absence or poor quality of health care during the pregnancy or delivery.

In contrast, it is much more difficult to obtain accurate and reliable data on sexual violence. Partial data are provided by police and public health services, non-governmental organisations (NGOs) or surveys. Sexual violence assumes various forms, such as sexual violence by the person's partner, incest and sexual violence within the family, mass rape, trafficking in women and children for the sex industry, sexual relations under coercion at school, sexual assaults in refugee camps and used as a weapon of war in conflicts, and various forms of traditional practices such as sexual initiation under coercion from a family member, marriages of very young girls, and the inheritance of a widow by the brother of the deceased.

Sexual violence against women, and especially girls, is especially damaging to their health, given that from the biological and physiological standpoint they are more sensitive to infections and to STIs, including HIV, than men and boys. Sexual violence against women and young girls is also the cause of early pregnancies with all the inherent risks of morbidity, disability (including traumatic fistulas), subsequent infertility and mortality for the mother and/or the child. In addition to the harm to the victims' physical health, the psychological damage can often be irreparable.

2. ***The international response***

The acknowledgment of sexual and reproductive rights stems from the ICPD (Cairo, 1994) and the World Conference on Women (Beijing, 1995). The statement of these rights is consistent with the main human rights conventions: the International Covenant on Economic, Social and Cultural Rights (1976), the 1981 Convention on the Elimination of All forms of Discrimination Against Women (CEDAW), and the 1990 Convention on the Rights of the Child (CRC).

In 1994, the representatives of 179 nations participated in the ICPD in Cairo. Citing human rights and gender equality, the Cairo Declaration calls on states to guarantee every individual's SRHR as a major contribution to sustainable development and the fight against poverty. The conference was able to show that the failure to respect sexual and reproductive rights and the absence of care in the area of sexual and reproductive health have a very negative effect not only on individuals, especially women, but also on the development of communities and countries.

The Fourth World Conference on Women, held in Beijing in 1995, emphasised that the right to sexual and reproductive health is vital for women to be able to participate in all areas of life in society.

These two conferences enabled considerable progress to be made in recognising SRHR as an essential component of the fight against poverty and strengthening the position of women. For the first time they resulted in universally accepted definitions (with the exception of sexual rights and sexual health). Since sexual activities, sexual well-being and their associated rights go well beyond the sole needs of reproduction and the transmission of life, the WHO has closed these gaps by proposing working definitions.

Definitions

Gender[3]: The biological differences between men and women do not change. But the social roles, acquired and not innate, evolve over time and vary from one society to another. The term *gender* relates to the economic, social, political and cultural characteristics and possibilities related to the fact of being a man or a woman (DGDC, strategy document on *rebalancing the rights and opportunities of women and men*).

Sexuality: Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction.

Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors (WHO Working Definition).

Sexual health: Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled (WHO Working Definition).

Reproductive health: Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so (ICPD, Para. 7.2).

Sexual rights: Sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus documents. These include the right of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive health care services;
- seek, receive and impart information in relation to sexuality;
- sexuality education;
- respect for bodily integrity;
- choice of partner;
- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage;
- decide whether or not, and when to have children; and
- pursue a satisfying, safe and pleasurable sexual life.

(WHO Working Definition)

Reproductive rights:

- The right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so (ICPD, Para. 7.3).
- The right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, and the right of access to health care for a safe pregnancy and childbirth (ICPD, Para. 7.2).
- The right of women to decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. (Beijing Platform for Action, Article 96).

[3] http://www.dgcd.be/documents/fr/notes_strategiques/gender/note_gender_fr.pdf

The MDGs that follow from the Millennium Declaration adopted by the UN General Assembly in 2000, as well as the policy follow-up declaration adopted in 2005, constitute an international framework for sustainable development and poverty reduction. Four of the eight MDGs are directly related to health and reproductive rights (goals 3, 4, 5 and 6), and the other four are also closely associated with them.

The Millennium Development Goals

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. ***Promote gender equality and empower women***
4. ***Reduce child mortality***
   - Reduce by two thirds, between 1990 and 2015, the mortality rate among children under five
5. ***Improve maternal health***
   - Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio
   - Universal access to reproductive health by 2015
6. ***Combat HIV/AIDS, malaria and other diseases***
   - Between now and 2015, halt and begin to reverse the spread of HIV/AIDS
7. Ensure environmental sustainability
8. Develop a global partnership for development

As a result of the international debate on SRHR, the policy statement of the 2005 World Summit (World Summit Outcome)[4] emphasised the importance of reproductive health to achieve the MDGs. This declaration stresses that reproductive health is important to meeting not only the goals related to health (Article 57), but also the one on gender equality and the empowerment of women (Article 58). Consequently, the resolution produced by this world summit proposed making "*universal access to reproductive health by 2015*" a target of MDG5. This proposal was ratified at the end of 2006 by a decision of the UN General Assembly.

The European Union (EU) makes the promotion of SRHR one of the cornerstones of its support for achieving the MDGs. This European desire is reflected in several resolutions and decisions, such as Regulation (EC) No. 1567/2003 of the European Parliament and of the Council of 15 July 2003 on aid for policies and actions on SRHR in developing countries. This regulation relates to the period 2003–2006. The actions for the period 2007–2013 are described in the communications of the Commission to the Council and the European Parliament *Investing in people* and *External Actions through Thematic Programmes under the Future Financial Perspectives* (COM(2005)324)[5]. One of the conclusions of the EU External Relations Council regarding the MDGs of 24 May 2005 emphasised that "*The EU further recognises that the MDGs cannot be attained without progress in achieving the Cairo goal of universal sexual and reproductive health and rights*" (ICPD)[6].

[4] United Nations General Assembly: Resolution adopted by the General Assembly 60/1 2005 World Summit Outcome.

[5] http://ec.europa.eu/development/body/development_policy_statement/docs/communication_edp_statement_en.pdf#zoom=1000

[6] Conclusions of EU External Relations Council – Accelerating progress towards MDGs, 24 May 2005

Furthermore, even though Belgium is not essentially connected with them, it seems that three regional normative documents in Africa can be cited in the policy dialogue on SRHR. These are especially essential given that 13 of our 18 partner countries are African states. These three documents were adopted by the African countries under the aegis of the African Union:

- The **Abuja Declaration**, adopted at Abuja (Nigeria) in 2006 by the Special Summit of the African Union on AIDS, Tuberculosis and Malaria, emphasises the commitment of the African countries to dedicating 15% of their national budgets to health care.
- The 41 African states which signed the **Protocol on the Rights of Women in Africa** of the African Charter on Human and Peoples' Rights, adopted at **Maputo** (Mozambique) in 2003, pledged to guarantee the rights of women and to take measures to eliminate practices harmful to the health of women and their general well-being.
- Following this Protocol, the **Maputo Plan of Action**[7] (2007–2010) was adopted in 2006 by the Special Session of the Conference of Ministers of Health of the African Union. This Plan of Action offers a continental framework for promoting health rights in the area of sexuality and reproduction in Africa.

  It establishes a genuine strategy with a view to:

  - integrating the programmes and services of SRHR and the fight against STIs, HIV, and cancers of the reproductive system;
  - repositioning family planning as a key strategy for attaining the health-related MDGs;
  - working to meet the sexual and reproductive health needs of adolescents and young people in order to make this an essential aspect of sexual and reproductive health;
  - combating unsafe abortions; and
  - offering quality and affordable services to promote safe motherhood, child survival, and maternal, newborn and children's health.

If carried out effectively, the implementation of the Maputo Plan of Action would allow Africa to see a considerable reduction in the serious health problems and the violations of personal dignity and rights that result from the failure to respect SRHR.

[7] The Maputo Plan of Action for the operationalisation of the continental policy framework for sexual and reproductive health and rights 2007–2010

3. *Difficulties in making SRHR a reality*

Despite the efforts arising from the action plans that emerged from the ICPD and the Beijing World Conference on Women, and in spite of the entire international community's commitment to the MDGs, numerous difficulties and obstacles remain in making SRHR a reality in the developing countries.

3.1. Lack of leadership, good governance and resources

Although most of the governments in the South have signed the main international treaties on human rights, children's rights and women's rights, and several regional protocols and action plans have been produced, the principles are still far from being translated into local legislative or regulatory provisions and being applied.

Due to lack of leadership, political will, good governance and/or sufficient resources, the governments and parliaments do not always apply a consistent policy on sexual and reproductive health in the various sectors involved (legislation, public health, education, care for victims, justice, etc.).

3.2. Gender inequalities and lack of empowerment of women

In many countries, there is still considerable inequality between men and women. Discrimination against women and girls has a direct effect on their health and their sexual and reproductive rights. Social restrictions, a lack of financial security, an absence of property and inheritance rights, economic dependence, dependence in household decisions and restrictions on access to primary, secondary and higher education contribute to women' sexual dependence and inability to demand protected and responsible sexual relations. The lack of respect for the rights of women, especially the right to privacy and confidentiality, and their subjugation to men are, if not yet taught, at least instilled by traditional customs. Furthermore, too often the men still fail to meet their responsibilities in terms of their sexual behaviour and the results of their sexual activities. The liberation of women requires first and foremost a change of attitude and behaviour on the part of men.

3.3 Harmful traditional practices and customs

Sociocultural practices and traditions often conflict with individual rights. Many communities believe that the survival of the community takes precedence over respect for these rights. Sexuality, reproduction and relations between men and women are influenced by local traditions, religious or animist prescriptions and prohibitions, and the power relationships within communities. The genital mutilation of young girls and adolescents is an example of this, as are sexual initiation rites, the early marriage of girls or the sexual subordination of women to a traditional chief and the inheritance of a widow and orphans by the brother of the deceased. The traditional supportive care for pregnancies and deliveries is sometimes unsafe and often responsible for women resorting late to qualified medical care if there is an obstetrical complication.

3.4 Lack of counselling, information, education

Men and women do not have enough information about their rights in the area of sexuality and reproduction, prevention and treatment of health problems and the various options for choosing means of contraception and family planning.

The lack of counselling, information and education, for boys and girls, men and women, leads to irresponsible sexual behaviour, practices of social discrimination, a negative attitude towards women and girls, and the limited possibility for women and girls to manage their own sexual and reproductive lives.

Information and advice about sexual and reproductive health are too rarely part of the subject matter taught in primary and secondary schools.

3.5 Limited access to quality health care

In many countries the poorest people, and in particular women and adolescents, have only limited access to health care and care in the area of sexual and reproductive health. Among other things, basic health care involves sexual information and education, information and counselling on family planning, access to modern contraceptives (including condoms), care during pregnancy and delivery, and prevention, screening and treatment of STIs/HIV. The health systems must also provide reference mechanisms to cope with complications during pregnancy, unsafe deliveries, abortions and cancers that go beyond the competence level of primary care centres.

There is not yet sufficient follow-up on pregnancies and, above all, assistance with delivery by trained personnel. The result is a high level of maternal mortality or complications such as obstetrical fistulas.[8]

There is a major shortage worldwide – and in particular in the countries of the South – of skilled health personnel, especially women, trained to provide quality reproductive health care. Such care requires that the health personnel have the obstetric skills needed, but also skills in the areas of communication, human relations and listening, and that they respect the patient's privacy and the confidentiality of information.

There is also a lack of psychosocial health and supportive care for the victims of unwanted pregnancies, complications during pregnancy and delivery, abortions conducted in unhealthy conditions, rape and sexual violence.

Many couples, women and adolescents who want to protect themselves against an unwanted pregnancy, STIs/HIV are unable to do so because the means of contraception, such as condoms, are unavailable or too expensive.

3.6 Lack of attention to adolescents and young people

Generally speaking, too little attention is given to the sexual and reproductive rights of adolescents and young people. Although they are sexually active at an increasingly early age, they rarely have access to sexual education, information, means of contraception and suitable care. This makes them highly vulnerable to unwanted pregnancies, unsafe abortions, STIs, HIV and all forms of sexual violence.

Unmarried girls are particularly vulnerable to the consequences of unwanted pregnancies. They run a greater risk of complications during pregnancy and delivery. They are often forced to stop going to school to care for their children, which mortgages their future and that of their future family and lessens their chances of breaking the vicious circle of poverty. These young

[8] An obstetrical fistula is an anatomical injury to the tissues of the vaginal, vesical or rectal wall. This injury is fostered by a difficult delivery that is not treated in time.

women are often expelled from their family, and their chances of marriage are reduced, with disastrous consequences in countries where the social status and security of women are closely connected to their marital status.

In sexual education campaigns, young people are not taught enough about communicating and negotiating, respecting their own limits and those of their partner, and assuming their responsibilities for the consequences of their sexual activity.

Young people have too little opportunity to make their voices heard and to participate in programmes and services related to sexuality, reproduction, and sexual and reproductive health care.

The services, and also the communities and the nearby family environment, themselves sometimes lack the skills and resources necessary to meet the specific needs of adolescents, even though this attention is critical to the development of their personality, their behaviour and their future position in society.

3.7 Sexual violence during conflicts and natural disasters

The systematic and extensive use of sexual violence as a weapon of war has been recognised by the International Criminal Court as a crime against humanity and a violation of international humanitarian rights. All forms of sexual violence such as rape, forced prostitution and sexual slavery are used as weapons of war. Women and girls, especially, but also men, boys, and young children are the victims. Such a tactic gives rise to serious trauma for the victims but also for society at large.

Sexual assaults also take place in post-conflict situations, causing population movements. Refugees and displaced persons are particularly vulnerable. Similar acts of violence occur during or following natural disasters.

Sexual violence remains a common practice in certain regions. Instead of being protected and assisted, the victims are stigmatised, and the perpetrators of these assaults remain unpunished.

Humanitarian assistance programmes during armed conflicts and natural disasters pay too little attention to the health care, reception and protection of people who are victims of sexual assaults. Furthermore, these programmes do not dedicate sufficient attention to including basic sexual and reproductive health care services, even though this is included in the international directives for drawing up humanitarian programmes.

3.8 Lack of research

There is not enough operational research into the causes of difficulties in gaining access to reproductive health care services and their lack of use by the population. Similarly, studies are needed to understand the problems of incorporating sexual and reproductive health prevention and treatment programmes into the basic health care systems. The impact of integrating HIV/AIDS activities into reproduction health services also needs to be documented.

Insufficient resources are still devoted to scientific research aimed at marketing effective and acceptable contraceptive methods, as well as means of protection against STIs/HIV such as

microbicides[9] and vaccines against AIDS. Research designed to refine simple and inexpensive methods of screening, prevention and treatment must also be continued.

Lastly, more interdisciplinary research should be conducted into the causes and effects of sexual violence and harmful practices so that appropriate solutions can be put forward.

[9] A gel or other product for vaginal use, making it possible to reduce or even eliminate the risk of infection with HIV/AIDS.

Chapter II: Belgian Development Cooperation policy

Belgium is committed to supporting the protection of sexual and reproductive rights in developing countries through its policy of international cooperation. This commitment has been given specific expression in its programmes for some time now.

As shown in the previous chapter, the issue of implementing SRHR is not just a matter of public health and human rights, it is also a fully fledged part of the achievement of all the MDGs and, more particularly, the fight to reduce poverty. This means that Belgian Development Cooperation supports the policy of its partner countries in various fields to improve the sexual and reproductive health of men and women, based on making full use of their rights in this regard.

Yet Belgian Development Cooperation's support is not solely multisectoral. It is also specific, whilst naturally preserving a holistic dimension in its programmes and projects.

Belgium's commitment to promoting SRHR is also reflected in both its multilateral action and its bilateral programmes and projects, both direct and indirect. It is demonstrated by the substantial increase in funding devoted to it in recent years.

Belgium will continue its promotion of SRHR by joining in with the action carried out by the EU and the international community.

In accordance with the Paris Declaration, Belgium will seek to harmonise its policy and its cooperation activities with those of other donors and align them with the development policy of the beneficiary countries.

1. ***Cooperation principles***

Belgian Development Cooperation's policy in the field of SRHR is based on three fundamental principles: an approach based on human rights; a global and positive approach to sexuality and reproduction; and the right to health care for all.

1.1 An approach based on human rights

A country's development policy must promote the economic and social development of all its citizens by respecting their rights. The same is true regarding the reception and accommodation of non-citizens, who most often are refugees and migrants.

Respect for sexual and reproductive rights combats inequality between men and women, young and old, rich and poor, powerful and weak, as well as discrimination against vulnerable groups and people with a different sexual orientation. Failure to respect these rights has a negative impact on reproductive health.

An approach based on the human rights of sexual and reproductive health has three essential components: legal framework; programmes and services; and participation. Legal framework

implies that the law and regulations and the mechanisms for following up on their implementation guarantee the sexual and reproductive rights of all citizens (including the weakest and most vulnerable) and protect them against exploitation, harmful practices, violence, discrimination and exclusion. Programmes and services must be available for information, education, care and assistance. They must be accessible to all, financially affordable, of good quality, suited to the age of those concerned and the cultural environment, and capable of maintaining confidentiality. Participation means that men, women and young people have the right to be informed in an objective manner and to educate themselves so that they can make their own free choices – with regard to sexual and reproductive matters, for example – and actively participate in the programmes and services.

1.2 A global and positive approach to sexuality and reproduction

In the past, sexuality was addressed in a restrictive and negative fashion. It was related solely to the need for reproduction and the transmission of life. Talking about sexuality was taboo, which kept people in ignorance and encouraged discrimination. Today there are calls to discuss sexuality and reproduction more widely and more positively with men and women by considering various emotional, psychological and cultural factors from the viewpoint of physical, emotional and social well-being.

Since sexuality affects the intimate aspects of life, confidentiality and respect for privacy are needed. The individual has the right to not be identified and to be certain that no personal information is disclosed. Lastly, respect for other people's values is also indispensable: the people responsible for informing, educating, caring and assisting others must do so with an attitude of openness to these people's values, without making judgments or imposing their viewpoint.

1.3 Health care for all

Universal access to sexual and reproductive health care through their integration into the primary health care system is one of the leading goals of the Action Plan of the ICPD (Para. 7.6). This universal access is also essential to achieve the MDGs covering the health of the mother and child and the fight against HIV/AIDS.

The basic right to health care was emphasised by Belgium once again in 2001 during a conference on this topic organised by the Belgian presidency of the EU and which was also attended by several health ministers from developing countries. This conference resulted in the Antwerp Declaration: ***Health care for all.***[10]

2. Strategic fields

Drawing on its broad experience in the field of SRHR, Belgium has identified six strategic fields to which it will devote special attention and which will be systematically taken into account in its actions.

[10] www.itg.be/internet/hca/DEC16-11EN.pdf

2.1 Promoting the integration of sexual and reproductive rights into national policies

One of the particular features of the cooperation partnerships taking shape between the donor and recipient countries of assistance is that it is no longer up to donor countries to impose priorities on their partners. The principle of appropriateness of development policies makes the recipient countries responsible for their economic and social policy and their national strategy for reducing poverty. It is our partner countries that must define the sectoral priorities and central themes of their development approach.

Through political dialogue, Belgium will continue to encourage its partner countries to integrate SRHR into their national strategies for poverty reduction and their sectoral plans. Belgium will be prepared to support them in this effort and back the implementation and assessment of these strategies at central, regional or community level, and to do so in the various sectors.

2.2 Promoting gender equality and the empowerment of women and girls

Women and girls must be considered and treated as fully fledged citizens in the same way as men and boys, and enjoy the same rights, opportunities and responsibilities in all areas of life. Governments must guarantee that these rights are protected and that women have access to information about these rights and the power to make use of them.

Belgium will continue to speak out for equal rights and opportunities for men and women and the strengthening of women's position in society. In particular, it will advocate recognising each woman's right to sexual and reproductive health care as defined in the ICPD's Programme of Action.

In particular, Belgium will support the initiatives of its partner countries aimed at: guaranteeing girls universal access to education; strengthening the economic and political power of women within their community and society; and developing and promoting methods of STI prevention and birth control which strengthen women's self-determination, such as the female condom and microbicides. The Belgian government will also support initiatives designed to increase the participation, awareness and assumption of responsibility by men and boys in promoting gender equality, preventing and combating sexual violence and harmful practices, and ensuring care for and non-discrimination of victims.

2.3 Devoting more attention to adolescents and young people

In its various support programmes, Belgium wants to promote appropriate, specific, user-friendly and accessible information and services for adolescents and young people in relation to their sexuality and sex life that encourage adolescents to participate in designing and carrying out programmes.

2.4 Strengthening health systems

Belgium advocates a global and integrated approach to health problems, with adequate means for prevention (condoms, means of contraception, vaccines), diagnosis, treatment and care, and effective and efficient use of available resources, as well as an increase in the quantity and quality of skills of medical personnel.

The Belgian government also wants to support the development of effective, fair and appropriate health systems in its partner countries which offer quality and universally accessible health care.

Lastly, Belgium will give particular attention to the integration of reproductive health care into the health system. This must include: family planning; prevention and treatment of STIs/HIV through information and provision of contraceptives; care during pregnancy and delivery; neo-natal care; prevention of mother-to-child transmission of HIV; prevention of unsafe abortions and (where legal) terminations of pregnancy in safe conditions; the prevention of sexual violence; reception and care for victims; and the strengthening of the capabilities of medical personnel.

2.5 Promoting a global approach to AIDS

Belgium will continue to ensure that the greater attention being paid to the fight against HIV/AIDS does not come at the expense of overall improvement in sexual and reproductive health, and that HIV prevention programmes are integrated into a general policy of improving access to sexual and reproductive health services.

As part of the fight against the spread of HIV, the Belgian government will continue to promote respect for the civil, political, legal, economic, social and cultural aspects of human rights. It will combat all forms of discrimination and inequality between men and women. Prevention, treatment and care for the poorest and most vulnerable populations, such as refugees, displaced persons and migrants, must also be guaranteed.

Belgium will pursue an integrated approach to the issue of HIV and gender. The legal status of women, adolescents and children must be strengthened. Special attention must be devoted to social dividing lines between men and women regarding HIV prevention, care and impact mitigation.

Lastly, Belgium will continue to focus its support on the fight against HIV/AIDS in the areas of health, education, agriculture and cooperation with the private sector.

2.6 Supporting awareness-raising, information and education

As part of its support for activities in the field of teaching, education and communication, Belgium will ensure that appropriate and specific information is provided on sexuality, reproduction, family planning, rights, prevention of STIs/HIV, the dangers of certain traditional practices, and sexual exploitation and violence. In the programmes it supports, it will ensure that men and boys receive sufficient attention so that they understand their role and responsibility in the area of sexual and reproductive health and learn to communicate and negotiate better with their partners and to respect them. It will also ensure that girls are informed and warned about the dangers and consequences of marriage and pregnancy at an

early age and that awareness-raising campaigns on this subject are conducted within communities.

Belgium will train development cooperation staff and increase their awareness of SRHR and implementation of Belgian policy in this regard.

3. *Specific areas of cooperation*

Based on its expertise, lessons learned from the past and the needs of its partner countries, Belgium has identified three specific areas of cooperation: an integrated approach to sexual and reproductive health care; the fight against violence and harmful practices; and sexual and reproductive health care and respect for rights in humanitarian crisis, conflict and peacebuilding situations.

3.1 Integration of sexual and reproductive health care into general health care

Belgium will continue to promote the integration of sexual and reproductive health care into general health policy and services. This approach guarantees sustainable operational strategies that can ensure a smoothly running health care system.

Consequently, the Belgian government will continue to support its partner countries' policy of increasing the financial, geographical and cultural accessibility of public health care. To this end, and working with other donors, it will use the available resources in an effective and coordinated manner – making use, for instance, of 'vertical' funds – to enhance the quality and accessibility of health care, of which sexual and reproductive health is a part.

Lastly, Belgium will continue to support improvements in the quality of medical staff and boosting their professional skills through training, retraining and incentives, with particular attention to teaching communication techniques that respect the right to privacy and confidentiality of information. Belgium will also pay special attention to the training and employment of female medical personnel to promote the use of available services by women and girls.

In particular, Belgium will ensure that health care services are adapted to the needs of women and girls.

3.2 The fight against sexual violence and harmful practices

In view of the impact of sexual violence, sexual exploitation, trafficking in women and children, and harmful practices such as genital mutilation, sexual initiation rituals, and early marriage on girls, women and society at large, Belgium will undertake to provide greater support to the initiatives to eliminate all these practices and combat all forms of violence and abuse of women and children.

In particular, as part of the political dialogue with those partner countries where female genital mutilations are still practised on a large scale, Belgium will ensure that special attention is given to compliance with the terms of the Maputo Protocol, which these countries signed and which most of them have also ratified, and that it is translated into national law

and implemented. Belgium will support civil society and local organisations which have acquired experience with regard to this issue as well as actions promoting a community approach that supports abandoning genital mutilations and encourages dialogue with the traditional authorities. Lastly, it will support the national and regional awareness-raising campaigns to change the behaviour of local communities.

3.3 Care and rights during humanitarian crises, conflicts and peacebuilding

Belgium wants to contribute to developing and strengthening the rule of law by supporting initiatives in the field of conflict prevention and peacebuilding and by helping populations which are victims of domestic or international armed conflicts or other crisis situations such as natural disasters.

The Belgian government will ensure that sexual and reproductive health care and respect for associated rights are taken into consideration in humanitarian aid and peacebuilding programmes.

Belgium will ensure the follow-up and implementation of the *Brussels Call to Action* produced by the International Conference on Sexual Violence in Conflict and Beyond[11] held in Brussels in June 2006. The *Brussels Call to Action* calls on governments, the European institutions, the United Nations, humanitarian organisations and civil society to make the fight against sexual violence a priority in all humanitarian, peacebuilding and development actions in countries affected by conflicts.

In all the programmes it supports, Belgium will promote partnership with other actors and a multidimensional approach which includes: prevention of sexual violence; reception, protection and medical and psychological assistance for women and men and for children who are traumatised or born as a result of rape; and legislative and legal measures to punish the perpetrators of these crimes.

Belgium wants to collaborate in a worldwide coalition against sexual violence in conflicts, which would mobilise not just the international community and civil society organisations but also the regional security organisations.

4. Implementation of the policy

Without wishing to anticipate the budgets that will be available in the future to continue and expand our programmes, but taking into account the government's desire to devote 0.7% of its Gross National Income (GNI) to Official Development Assistance (ODA) in 2010, we can estimate that annual spending specifically devoted to promoting SRHR, which was €22.5 million in 2005, will increase proportionally each year.

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[11] In June 2006, with the support of Belgium and the European Commission, UNFPA held an International Conference on Sexual Violence in Conflict and Beyond. This conference had a considerable international impact and enabled the adoption of a document, the *Brussels Call to Action to Address Sexual Violence in Conflict and Beyond*, inviting the states and organisations to make a commitment to carrying out actions to prevent and respond to sexual violence in conflict and post-conflict situations and participate in a worldwide coalition against such violence.
www.dgdc.be/documents/en/news/brussels_call_to_action_to_address_sexual_violence_in_conflict_and_beyond.pdf

We also reiterate the desire to double the Belgian contributions to multilateral efforts to combat HIV between now and 2010, from about €15 milion per annum to about €30 million per annum.

Parliament's support will be critical to achieving these budget goals.

In its bilateral contacts with its partners in both the EU and international bodies, Belgium will continue to advocate respect for sexual and reproductive rights and a holistic and multisectoral approach to them. It will promote joint action by governments, international organisations, donors and civil society to build a positive consensus based on respect for rights and human dignity. Belgian Members of Parliament will be encouraged to continue their dialogue with developing country counterparts and policymakers on the implementation of the ICPD's action plan.[12]

Belgium will use its diplomatic resources to encourage those African states that have not yet ratified the Maputo Protocol (11 July 2003) to do so, and will support the governments which have signed the Maputo action plan in carrying it out, in particular with regard to a woman's right to dignity, integrity and security, the elimination of discrimination and harmful practices such as female genital mutilation, the protection of women and girls during armed conflicts, and the right to sexual and reproductive health and related care.

As a non-permanent member of the UN Security Council in 2007 and 2008, Belgium will ensure that the issue of SRHR, in particular sexual violence, is taken into account in conflict and post-conflict situations and in the framework of humanitarian or military-humanitarian interventions. This will also be a concern of our country in bodies other than the Security Council.

The involvement of women in conflict resolution, as encouraged by Security Council Resolution 1325 ('Women, Peace and Security'), will be defended whenever necessary. In the framework of peacekeeping operations, or where our country contributes to putting together forces of foreign troops, Belgium will ensure that the rules on respect for SRHR are respected by the military personnel deployed.

The Belgian government will support information, awareness-raising and communication campaigns dealing with SRHR in both Belgium and developing countries. It will also support the networks in Belgium and the South that aim to exchange information and share skills.

In accordance with the Paris Declaration on aid effectiveness, as far as governmental cooperation is concerned, Belgium will harmonise its programmes with the cooperation policy of the countries which it is assisting. The political dialogue will emphasise the necessity of putting SRHR at the centre of their policy and strategies for reducing poverty. At the request of partner countries, Belgium will strengthen the institutional and human capacity in the area of SRHR. The formulation, implementation and assessment of policies can be backed at various levels by financial support, technical assistance, training and retraining, and organising seminars. Belgium will actively contribute to improving the coordination and harmonisation of donors' initiatives.

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[12] IPCI: International Parliamentarians Conference on the Implementation of the ICPD Programme of Action, Ottawa (2002) – Strasbourg (2004) – Bangkok (2006)

As far as multilateral cooperation is concerned, Belgium will continue to work with the international organisations which play a normative role and/or promote SRHR in their programmes. In particular these are UNFPA, WHO, UNAIDS, UNICEF, UNIFEM, the World Bank, and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

In the European framework, Belgium will support the development assistance policies pursuing the same goals and, as in other fields, will promote the sharing of expertise and the division of duties through more effective harmonisation. In the aid planning process of the Tenth European Development Fund (10th EDF) which comes into effect on 1 January 2008, Belgium will promote an additional appropriation, under ‘encouraging good governance’, to make the measures taken by the partner countries to integrate SRHR into their poverty reduction strategies eligible for these incentive funds.

As part of its indirect cooperation, Belgium will continue to encourage the NGOs of the North and South working to promote SRHR to conduct activities within local communities.

Universities and academic institutions will be encouraged to continue and expand their operational and clinical research, as well as their research in support of policy on SRHR. The studies will involve both the scientific and medical areas of health and the psychological, anthropological, cultural, economic, social and political aspects, enabling a better grasp of the problems and refinement of new methods of prevention and care related to sexual and reproductive health. The universities and academic institutions will also be encouraged to strengthen their partnerships and networks for sharing knowledge, expertise and experience with their counterparts in the South and South–South networks.

Through the channel of emergency assistance and conflict prevention, Belgium will ensure that preventive and curative reproductive health and, in particular, care and support for victims of sexual violence are integrated into the actions and training of personnel for peacekeeping missions and humanitarian actions.

With the aid of an external appraisal, Belgian Development Cooperation will seek to define the criteria and a method enabling it to measure the impact of its cooperation programmes and projects on sexual and reproductive health and the promotion of associated rights.

Annex 1: The Belgian contribution up to now

Basic health, including reproductive health*,** is one of the five focal sectors of Belgian Development Cooperation set out in the law of 25 May 1999 on Belgian international cooperation. That law also considers ***equal rights and opportunities for women and men to be an overarching theme in development cooperation. More recently, ***rights of the child*** were also incorporated into the law as another overarching theme in our cooperation.

The issue of sexual and reproductive health and rights (SRHR) features in the strategy documents that were drawn up regarding the health sector and the topics of gender and rights of the child, as well as in ***the government's policy paper on the Belgian contribution to the fight against HIV/AIDS worldwide***.

Belgium's specific commitment to promoting SRHR can be seen in the increase in financial resources being dedicated to these areas by Belgian Development Cooperation.

For example, in the second half of the 1990s, i.e. after the ICPD in 1994 and the Beijing Conference in 1995, there was a steep rise in Belgian Development Cooperation's spending on the specific area of sexual and reproductive health. From 2000 onwards, it stabilised at a level of about €17.5 million per annum. Then therewas a considerable increase in 2004, when spending reached €30.5 million, and spending in 2005 came to €22.5 million. An analysis of Belgian Development Cooperation's specific contributions to reproductive health over the last ten years shows that a substantial share of the resources was dedicated to the fight against HIV/AIDS.

While Belgian Development Cooperation continues to support – as it has always done – the integration of sexual and reproductive health into its support for the health sector, certain spending in this sector is also specifically dedicated to sexual and reproductive health (e.g. prenatal and perinatal care policy; support for health centres and hospitals, for example in the field of reproductive health care and prevention), the construction of maternity hospitals, and the training of health personnel. In 2005, the spending on this sector was nearly €60 million. However, there is no specific indicator for sexual and reproductive health, so it is impossible to be completely sure of the total spending on sexual and reproductive health in the health sector.

The two tables below show the amounts spent on health care from 1996 to 2005. The first table gives the amounts that were spent specifically on sexual and reproductive health care, while the second table shows the additional sums spent on general health care. While some proportion of these amounts is dedicated to reproductive health care, it is difficult to pinpoint the exact percentage of the sums that are spent in this area.

Reproductive health 1996–2005 (in thousands of €)										
	1996	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**
Policy	2,512	2,138	1,842	2,174	4,345	4,263	4,648	2,975	5,070	5,529
Care	114	123	81	53	2,056	2,003	2,518	2,468	1,246	510
Family planning	0	141	0	10	4	372	0	7	116	186
Sexual and reproductive rights	0	0	0	0	0	0	0	55	415	703
STIs – HIV/AIDS	2,869	2,932	3,586	3,157	11,505	10,419	16,802	12,675	25,528	17,275
Training	0	0	0	0	0	0	0	67	65	143
TOTAL	**5,496**	**5,334**	**5,509**	**5,393**	**17,909**	**17,057**	**23,967**	**18,248**	**32,440**	**24,347**

On average, 55% of these amounts was dedicated to multilateral cooperation, 15% went on aid in the form of governmental cooperation, while 25% involved subsidies for NGOs and 5% subsidies for universities and scientific institutions.

Basic health 1996–2005 (in thousands of €)										
	1996	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**
Policy and management	3,747	1,590	2,072	6,016	5,013	3,273	8,910	5,377	6,208	12,468
Basic health	17,396	22,807	26,288	22,634	25,593	25,836	21,716	19,619	16,475	23,501
Infrastructure	1,503	965	1,726	3,149	3,147	5,275	3,780	2,796	996	4,682
Nutrition	131	153	199	35	49	144	137	424	617	626
Training	7,768	6,952	10,090	9,468	9,054	10,325	3,957	2,750	3,895	3,778
Contagious diseases	3,155	6,880	6,924	7,533	8,341	9,048	10,076	9,119	10,748	11,908
Research	698	815	650	297			2,081	2,085	2,589	2,342
TOTAL	**34,398**	**40,162**	**47,949**	**49,132**	**51,197**	**53,901**	**50,657**	**42,170**	**41,528**	**59,305**

On average, 15% of these amounts was dedicated to multilateral cooperation, 53% went on aid in the form of governmental cooperation, while 20% involved subsidies for NGOs and 12% subsidies for universities and scientific institutions.

In terms of geographical distribution, in 2005 about half of the contributions for reproductive health (€11,312,000) was spent on programmes and projects in Africa, including about €7 million in Central Africa, while more than €36 million was spent on basic health care in Africa.

As far as its **multilateral cooperation** is concerned, Belgium continues to regard its contribution to **UNFPA** as crucial. This is because that organisation plays a central role in following up on and implementing the ICPD Action Plan. To this end, a Belgian contribution of €3 million was made to UNFPA's general resources (core funding), and funding was also provided for a number of Junior Professional Officers at UNFPA.

A contribution is also made to a certain number of specific programmes and projects. Below is a list of the programmes:

- *Support for reproductive health and gender needs for displaced populations with special attention to adolescents*. This project, worth a total of €2,354,990 (2000–2004) took place in seven countries: Liberia, Sierra Leone, Palestine, Rwanda, Burundi, the Democratic Republic of Congo (DRC) and Colombia.

- *Adolescent sexual and reproductive health promotion and HIV prevention in sub-Saharan Africa*. This project, worth a total of €2,974,722 (2001–2004), aimed to improve the sexual and reproductive health of young people in Côte d'Ivoire, Mali and Niger, with a particular focus on the prevention of HIV.
- *The prevention of and response to sexual violence against women, young people and children in DRC* (2004–2007), worth a total of €7,820,000.

This last programme was implemented based on the principle of joint programming with **UNICEF** and the **Office of the High Commissioner for Human Rights (OHCHR)**. This programme is our most significant specific action in this area. It was applauded as an exemplary programme by the then Secretary-General of the United Nations, Kofi Annan, and was also cited as an example to follow in December 2006 at the meeting of the UNAIDS Programme Coordinating Board in Lusaka, Zambia. This programme is innovative in that it provides a holistic response to the problem of sexual violence, and so meets the medical, economic, psychosocial, legal and safety concerns of the populations involved, and in that it is based on a partnership between the various international institutions concerned and local NGOs.

Belgian Development Cooperation is supporting **WHO** research programmes on reproductive health and the development of guidelines to prevent cervical cancer. A contribution has also been made to a specific research programme in the member states of the Southern African Development Community (SADC). The total amount of the contribution to the WHO for reproductive health came to €322,000 in 2005.

Belgium's multilateral cooperation on the fight against HIV/AIDS includes contributions to **UNAIDS**, which comes to about €5 million per annum (including payment of experts), and to the Global Fund to Fight AIDS, Tuberculosis and Malaria (**GFATM**), for which we provide on average €5 million in funding per annum, and this is on the increase: in 2006, our contribution will come to €8 million. The UNAIDS programmes essentially aim to strengthen institutional capacities and supply technical assistance for public health systems – and that includes the area of sexual and reproductive health. The funds for the GFATM for programmes to fight HIV/AIDS are shared between treatment and care programmes, prevention, counselling and screening programmes, programmes aimed at strengthening health systems and epidemiological monitoring. In accordance with the prescriptions laid down by the WHO, UNAIDS and the aid beneficiary countries' national programmes, the HIV/AIDS approach is multisectoral, so it includes sections covering aspects that are not strictly of a medical nature, such as promoting SRHR. Belgium attaches particular importance to the joint UNAIDS/UNICEF programme for reducing mother-to-child, transmission of HIV supporting the availability of antiretroviral medicines in forms that can be used for children, preventing illness among young people, and taking care of orphans and vulnerable children.

The Belgian annual contribution to the fight against HIV/AIDS is currently some €25 million per annum (a total that has been rising continually since 1995, when it was only €1 million). Close to two-thirds of this sum (€15 million per annum) is dedicated to multilateral programmes. We should also emphasise the decision made by the Minister for Development Cooperation to double the Belgian contributions to UNAIDS and GFATM by 2010.

Recently, the government decided to give €1 million to the **International Partnership for Microbicides** (IPM) for a three-year period starting in 2007. This public-private partnership conducts clinical research into developing a vaginal gel to prevent heterosexuals contracting

HIV. This product is very important for women as it means that they can decide for themselves to use a means of protecting themselves against infection.

As part of Belgium's multilateral contributions to promoting sexual and reproductive health, it also makes an annual contribution (€500,000 in 2005 and €400,000 in 2006) to the **World Bank Institute** with a view to integrating the fight against HIV/AIDS and sexual and reproductive health into national policies for reducing poverty (the Poverty Reduction Strategy Papers – PRSPs), while paying attention to the harmonisation of the policies of donor countries and organisations, the government's macro-economic management, and the joint coordination mechanisms of the World Bank, the UNDP and UNAIDS. This programme also intends to strengthen health systems, with a particular focus on considering the SRHR of the most vulnerable levels of society. This programme is currently being implemented in Mali and Mozambique. Discussions are continuing about extending it to DRC.

In terms of **(direct bilateral) governmental cooperation**, the main thrust of the aid involves helping partner countries to put in place health systems that offer accessible, quality care to the poorest population groups, with a particular focus on HIV prevention and treatment. Belgium is contributing to strengthening policy and services in this regard, the supply of medicines and diagnostic and prevention equipment.

Over the period 2004–2005, Belgian Development Cooperation financed – via support for health districts – numerous projects that aimed to improve primary health care, including services covering sexual and reproductive health care. Below are some examples:

- Belgium has contributed €2.3 million (approximately €460,000 per annum) to a five-year programme in Benin, which started in 2005, to improve the safety of transfusions (especially after mothers deliver babies) in the departments of Atacora, Donga, Mono and Couffo.
- In Algeria, an integrated four-year public health project at Tamanrasset, worth €2.9 million and which started in late 2004, aims to improve the health of the local population with activities in various areas: the fight against STIs/HIV, the fight against maternal and perinatal mortality, and family planning, with a particular focus on young people.
- In Burkina Faso, a health project and a project for detecting AIDS and tuberculosis were recently completed to the north-east and east of Ouagadougou.
- In Mali, a programme to combat STIs worth €400,000 was signed in 2006.
- In Morocco, a support programme for the national programme combating AIDS has been running since 2003, with a Belgian contribution of approximately €400,000 per annum.
- In DRC, Belgian Development Cooperation has been supporting the national programme combating AIDS since 2003, making a contribution of approximately €1.4 million per annum. This programme covers the provinces of Équateur and Bas-Congo and the city of Lubumbashi.
- In Tanzania, Belgian Development Cooperation is financing a project to detect STIs, and in 2007 it started funding an information and education campaign on sexual and reproductive health in a number of districts around Dar es Salaam.

Three other programmes should be mentioned here:

- *Reproductive Health Makueni, Kenya*: a programme promoting improvements to reproductive health in the district of Makueni (€25 million over five years).

- The *National programme for combating family and sexual violence* in Peru (€1.74 million over three years): this programme has as its partners a network of public institutions (the police and the courts) and emergency centres for women (in the municipalities). It takes in the care, prevention and reintegration into society of victims of family and sexual violence on the basis of equality of opportunities and respect for human rights. Victims of violence who receive help from the programme are encouraged to take part in small-scale pilot projects to generate revenue or get them into work, as a way of emerging from their position as a victim and gaining their independence.

- The *Promoción de los derechos sexuales y reproductivos de los y las adolescentes* [Promoting the sexual and reproductive rights of adolescents] programme (€2.06 million over four years) in Ecuador has been implemented in 11 of the country's towns and aims to develop the networks bringing together the authorities, civil society and the local communities. This programme is centred around: promoting and defending the rights of adolescents, with an emphasis on their sexual and reproductive rights; incorporating the gender dimension; and encouraging young people – via assistance to youth organisations and groups – to play an active role in information sessions on SRHR.

Belgian Development Cooperation is backing the Olame Centre's *Assistance for supportive care for traumatised women* project in **South Kivu (DRC)**. This programme, launched in January 2004, aims to provide rehabilitation for women who have been victims of sexual violence, reintegrate them into society and strengthen the centre's capacities. It is providing a sum of €155,648 over two years for this purpose.

As far as **indirect bilateral cooperation** is concerned, Belgian Development Cooperation co-finances **Belgian NGO** actions that are primarily focused on the field of primary health care, taking care of AIDS sufferers and preventing mother-to-child of HIV. Two programmes in the area of reproductive health are: *Sexual and reproductive health education in Cuba* of the NGO FOS (€280,000 over five years) and *Maternal health* of the Louvain Développement consortium (€500,000 over five years). In the area of prevention and treatment of STIs, including HIV, a number of NGOs are recipients of co-financing for their projects: ACDLg/ACDST, Médecins Sans Frontières, Médecins du Monde, Solidarité protestante and SongES.

Belgian Development Cooperation is also financing **micro-activities and local NGO projects**, including some that aim to promote SRHR and strengthen the position of women.

The **Dutch-speaking universities (VLIR) and Francophone universities (CIUF-CUD)** are carrying out studies that aim to prepare the way for policies on integrating SRHR into the strategy documents for reducing poverty. They are also supporting multidisciplinary research carried out by their partner institutions on improving reproductive health and on stepping up the fight against HIV/AIDS.

The **Institute of Tropical Medicine** is carrying out research, strengthening institutional capacities and organising training programmes co-financed by Belgian Development

Cooperation. It is performing operational research on reproductive health and HIV prevention, in particular among Kenyan adolescents, sex professionals in Cambodia and in Côte d'Ivoire, is supporting partner institutions in Africa and Asia in the area of HIV research, and is organising reproductive health and antiretroviral treatments and care courses. Belgian Development Cooperation also funds scholarships for students from developing countries. As part of the current five-year programme (2003–2007), about €3.5 million has been dedicated to reproductive health activities.

The **International Centre for Reproductive Health** (ICRH) at Ghent University specialises in sexual and reproductive health, focusing on: mother-to-child transmission of HIV; microbicides; promotion of the use of female-controlled barriers such as the diaphragm; cervical cancer; reduction of the vulnerability of specific groups such as sex professionals; women and adolescents; sexual violence with a particular focus on female genital mutilation; and an approach that is sensitive to gender and respects human rights, in particular during armed conflicts and humanitarian disasters.

The Flemish Association for Development Cooperation and Technical Assistance (Vlaamse Vereniging voor Ontwikkelingssamenwerking en Technische Bijstand – **VVOB**) and the Association for the Promotion of Education and Training Abroad (Association pour la Promotion de l'Education et de la Formation à l'Etranger – **APEFE**) receive financing for HIV prevention projects and supporting and training health personnel.

Emergency aid providing general medical equipment is given to limited initiatives of nine to 18 months duration. In the future, the emphasis will need to be laid more on reproductive health and the prevention of sexual violence and taking care of the victims.

Annex 2: List of abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women (1981)
CIUF	Conseil interuniversitaire de la Communauté française (Interuniversity Council of the French Community – umbrella organisation of Francophone universities)
CRC	Convention on the Rights of the Child (1990)
DGDC	Directorate-General for Development Cooperation
EU	European Union
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development (Cairo 1994)
ICRH	International Centre for Reproductive Health (Ghent University)
MDGs	Millennium Development Goals
NGO	Non-governmental organisation
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNIFEM	United Nations Development Fund for Women
VLIR	Vlaamse Interuniversitaire Raad (Flemish Interuniversity Council – umbrella organisation of Flemish universities)
WHO	World Health Organization

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