Universal Periodic Review of Belgium

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&

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Executive Summary

1. Several indicators show that Belgium is making significant progress in terms of providing access to sexual and reproductive health services and the fulfillment of sexual and reproductive rights. The unmet need for family planning in Belgium, for example, is very low and the prevalence of modern contraceptives is among the highest in Europe. In Belgium, high-quality comprehensive sexuality education is part of the school curriculum and the country has one of the lowest teenage pregnancy rates in Europe. Together with the Netherlands Belgium belonged to one the first countries worldwide to allow same-sex marriage and the rights of sexual minorities are recognized and protected by the law. Access to safe abortion services has been regulated and reimbursed by the government since the adoption of the abortion law in 1990. The Belgian abortion law combines strong policies and programmes aimed at the prevention of unintended pregnancies. As a result, Belgium has one of the lowest abortion rates in Europe. However, a number of challenges remain and require urgent action from the federal and regional governments in order to ensure inclusive and full access to sexual and reproductive health and rights (SRHR). This is particularly true for vulnerable and marginalized populations and / or populations who face barriers and / or stigma and discrimination. While not exhaustive, the report below focuses on such populations and aims to contribute to a society in which all individuals are able to realize their sexual and reproductive health and rights.

Belgium under review in the 1st UPR cycle

2. Belgium received 41 recommendations related to SRHR and gender equality of which it accepted 25 and noted 16. Rather vague responses were given to recommendations concerning sexual exploitation of children (4), domestic violence (2), the gender pay gap, legislation on discrimination of gender identity and the implementation of CRC, CEDAW and ICESCR. Those topics are recurring in the accepted recommendations and will be reflected on in this submission.
3. Five accepted recommendations were on the ratification of the Optional Protocol of the International Covenant on Economic, Social and Cultural Rights, which Belgium ratified on 20 May 2014. Sexual exploitation and violence on children and minors were the subject in 3 recommendations. Actions by Belgium in this regard and follow-up concerns will be reflected in a number of chapters in the report. Domestic violence and violence against women, subject of 7 recommendations, will be partly discussed in the chapter on sexual violence. Information regarding the implementation of three recommendations on services for migrant women and children will be covered in a number of chapters.
4. Five recommendations were rather general and asked Belgium to make progress towards gender equality (3), the gender pay gap and to eradicate stereotypes against women. In this respect Belgium has from 28 July 2011 introduced quota to guarantee that women are represented in executive boards of stock market listed companies. The boards have to contain a minimum of one third of men or women.

Sexual and reproductive health and rights, a responsibility of different governments

Belgium has three linguistic Communities (Flemish, Francophone and German-speaking). In the 1970s, a process of decentralization of political powers to the Communities began with regard to “matters related to the person”. This included (sexual) health promotion, and it gave the Communities full and autonomous political decision making over education. There is also a system of ‘subsidiarity’, which means that some governmental responsibilities have been subcontracted to civil society for implementation, such as family planning services, sexuality education and the promotion of sexual health. The organization Sensoa, for example, is the partner organization of the Flemish government for sexual health promotion in Flanders. Both the decentralization of powers to the Communities and the way the Communities have organized the practical implementation through civil society have led to totally different approaches to and regulations for sexual health promotion in the different communities of Belgium.

Main Topics

Access to abortion services

5. In 1990, the 1867 Penal Code was amended to partially decriminalize abortion. This means that when specific conditions are met abortion is not considered as a crime. In fact, these conditions are guidelines and procedures for the care and treatment of unintentionally pregnant women, and do not belong in criminal law. However, abortion is still part of the penal code which contributes to judgment and stigma.
6. Since the adoption of the so called abortion law, termination of pregnancy is legal up to 12 weeks after conception when the individual is “in a state of distress as a result of her situation”. The individual is the sole judge of whether she is in distress and, hence, decides herself on the termination of pregnancy. There is a six day period of compulsory "reflection" prior to the termination. In practice, this does not seem to constitute a barrier as it is practiced with a degree of flexibility, especially in cases when the individual nears the 12 week time limit. The physician is responsible for informing the individual about the risks of undergoing the procedure and, if born, the various possibilities for taking care of the child. Abortions can be carried out at abortion centers, at family planning centers or at hospitals.
7. It is possible to terminate a pregnancy more than 12 weeks after conception, but only if two physicians agree that continuance of the pregnancy would gravely endanger the individual’s health or when it is certain that, if born, the child would be affected by a particularly serious pathological condition, recognized as incurable at the time of diagnosis. Such abortions must be performed in hospitals. In most hospitals, an ethical commission, comprised of minimum two physicians, advises on the abortion, as mentioned above. The costs for an abortion are covered by the government when the patient has health care insurance. Patients only pay a limited amount (‘copayment’) of the real cost. The costs for an abortion for medical reasons performed in a hospital are partially reimbursed by the government.

8. An individual who is more than 12 weeks pregnant and cannot invoke medical reasons is usually (informally) referred to a clinic abroad, as psychosocial reasons are not accepted for terminations of pregnancies beyond 12 weeks gestation. It is estimated that every year around 500 individuals have an abortion abroad, e.g. in the Netherlands (up to 24 weeks of pregnancy1) or the UK (up to 24 weeks of pregnancy[2]). They have to pay for the travel and medical costs themselves.
9. The liberalization of the penal code has not lead to higher abortion figures; to the contrary, Belgium has one of the lowest abortion rates worldwide: as of 2009, the abortion rate was 9.2 abortions per 1000 women aged 15–44 years. The political differences regarding abortion and the fact that Belgium has one of the lowest abortion figures in the world partly explains why the abortion legislation has not been adjusted in the 25 years of its existence.

Recommendations for action

- The federal government, the federal minister for Justice and the federal parliament decriminalize abortion and initiate a debate on the topic of termination of pregnancy beyond 12 weeks.

Sexual rights of young people: Comprehensive sexuality education for children and young people

10. In Belgium, comprehensive sexuality education (CSE) is a competence of the regional governments. During the past decades, the focus of sexuality education shifted from medical information to a more holistic approach, integrating relational and emotional aspects, attitudes and skills.
11. At the end of the millennium, comprehensive sexuality education was included as part of curriculum objectives in the Flemish education system. The minimum standards for CSE have been formulated and integrated as cross-curricular goals and subject related goals (e.g. biological aspects are covered in biology lessons and moral and ethical aspects are covered in religion and philosophy lessons) and schools must demonstrate their efforts to achieve these goals without obliging them to reach specific results. In practice schools are quite autonomous in deciding how much time and energy they would like to devote to CSE. This means that despite a legal framework enabling CSE, the quality of CSE can differ considerably between and within schools. One of the reasons is that the curriculum on CSE is not defined, lacking age-specific and content-specific guidelines. Schools and teachers do not always have a clear overview of what aspects of CSE have (already) been covered in which courses and at what age.
12. In the Francophone and German-speaking Communities, in 1995 and 1997, respectively, the Brussels and Walloon regional governments passed decrees authorizing family planning agencies to be paid and trained to offer sexuality education. Since 2000, various evaluations of the provision of sexuality education have influenced the Communities' policies. For example, the need to provide sexuality education in out-of-school settings was identified,

[1] See http://www.rijksoverheid.nl/onderwerpen/abortus

[2] See http://www.nhs.uk/conditions/Abortion/Pages/Introduction.aspx

and so this was introduced in some regions. In these two Communities, most of the sexuality education – both in and out of schools – is provided by trained family planning center professionals. In 2012, the government of the Francophone community obliged comprehensive sexuality education to be part of the curriculum, considering access to CSE as a right. A year later, in 2013 a protocol or kind of 'Memorandum of Understanding on CSE' was proposed by the minister of health and equal opportunities and adopted by the governments of the French Community, the Walloon Region and the Commission of the French Community of the Brussels -Capital Region. This MoU puts forward a number of standards, principles and criteria in view of the implementation of CSE, partly based on the WHO Standards for Sexuality Education in Europe.[3] Like in Flanders, the quality of sexuality education depends on the efforts of each individual provider and their competence, and each school is free to determine whether or not to prioritize the subject.[4]

Recommendations for action:

- The regional governments set standards and guidelines for the provision of CSE (e.g. based on UNESCO and WHO Europe guidelines on CSE) and ensure that all schools comply with it, and promote the creation of a curriculum for children and young people, based on age, maturity, specific needs of different groups, and a holistic approach.
- Ensure that University Colleges and training centers for teachers integrate CSE in the training curriculum for both future and existing teachers.
- The regional governments support centers of expertise on CSE which can support schools and teachers in providing CSE (through inter alia: developing materials and guidelines, and training the trainers).
- The regional governments ensure that CSE evaluations are being performed by official education inspectors in order to supervise and promote quality. As such, schools should be held accountable for ensuring that every pupil receives high-quality CSE.

<u>Sexual rights of young people:</u> <u>The age of sexual consent</u>

13. The age of sexual consent is the minimum age at which a person is considered legally competent to give consent to sexual acts. Consent means that you can make an informed choice and are able to assess the consequences of that choice. In Belgium, the age of consent is 16 year old, as specified by Article 372 of the Criminal Code which reads: "*Any indecent assault committed without violence or threat on the person or with the assistance of the person of a*

[3] See http://pro.guidesocial.be/actualites/le-cadre-d-application-trop-vague-de-l-evras-decrie-par-les-acteurs-de-terrain.html
[4] IPPF-EN (2011) Summary Assessment report on national policies on young people's SRHR across Europ https://www.ifpa.ie/sites/default/files/compendium_on_young_peoples_sexual_and_reproductive_health_and_rights_policies_in_europe.pdf [May 2015].; Health Behaviour in School-aged Children, WHO, 2012 http://www.euro.who.int/en/health-topics/Life-stages/child-and-adolescent-health/adolescent-health/health-behaviour-in-school-aged-children-hbsc2.-who-collaborative-cross-national-study-of-children-aged-1115 [2012]; 'Young People and sexuality', of the Flemish Office of the Children's Rights Commissioner, (in Dutch) http://www.kinderrechtencommissariaat.be/publications/detail/jongeren-en-seksualiteit [May 2015]

child of either sex, aged less than sixteen, shall be punished by imprisonment …. Before the age of 16 a person cannot give consent for sexual acts from a legal point of view.

14. Studies have shown that most children and young people go through a process of sexual intimacy, from less intimate sexual acts to more intimate sexual acts. In the majority of the cases the sexual partner is a peer. The current law does not take into account the sexual process and development young people go through. The prohibition of sexual acts under 16 leads to a number of undesired consequences and negative side effects. In some cases consensual sexual acts between sexual minors are problematized, surrounded by taboos, and find themselves in a legal grey zone or there is a reluctance from teachers and educators to deal with the sexuality of children and young people younger than 16 years.
15. Although minors seldom perceive consensual sexual relations between minors as problematic, this might change when the law on the age of consent is enacted.
16. The legal framework can have a negative impact on the actions and/or mindset of educators and teachers, especially when age-appropriate sexual behavior is criminalized. There are incidents of police forces being contacted, where, instead of police interventions pedagogical action is required.
17. Interventions from the police or judiciary or over-negative reactions from educators may be perceived by minors as a violation of their self-determination or as a reduction of their freedom of choice on matters regarding their sexuality. Some police or judicial interventions or reactions may be traumatic for the parties involved.
18. The current legal framework creates uncertainty whether parents should prohibit sexual activities of their children younger than 16 years, whether educators are punishable if they have knowledge of sexual activity among young people under 16 and do not intervene, or whether pharmacists are allowed to provide emergency contraception to those under 16. It might contribute to a shyness or reluctance within schools, youth facilities and other institutions to conduct a holistic and proactive policy on sexuality. Within schools, or at home, it can also contribute to a taboo regarding adolescent sexuality. Furthermore, the legal framework can contribute to children and young people being reluctant themselves to seek information about sexuality or to seek help from adults, when they experience a negative sexual experience. Young people aged above 16 who engage in sexual acts with peers younger than 16 may fear negative reactions or punishment. In the agreement of the federal government (2014 – 2019) as well as in the policy declaration of the minister of justice the intention to adjust the legal framework regarding the age of consent is mentioned but at the time of writing no concrete initiatives were taken.

Recommendations for action:

- The parliament initiates a debate on an appropriate legal framework on the age of sexual consent. The framework should be adapted to the societal reality of young people's sexuality and adolescents and youth should be involved in the debate and the decision making process. An adjusted legal framework on the age of consent is enacted, which de-criminalizes consensual sexual acts between minors who are equal, clarifies the

legal gray area of the current legislation and provides sufficient protection against possible sexual abuse of minors.

Sexual rights of young people: Sexual violence

19. Sexual violence is widespread in Belgium. However, the scope of the problem is not well documented and studied. There is little research on sexual violence and official statistical data are assumed to represent a small fraction of actual reported cases. Studies show that 9 % of women and 3% of the men in Belgium have been the victims of sexual abuse before the age of 18.[5] Non-documented migrants, asylum seekers and refugees run a high risk of sexual violence.[6]

20. In Belgium an average of ten rapes per day are registered but that is only a small part of reality. 90% of victims do not report the crime.[7] In three out of four cases of sexual abuse of adults, the offense is not reported because the perpetrator is known by the victim. In cases of sexual abuse against women, the perpetrator is in 48% of the cases the partner, in 10% of the cases a family member, in 13% an acquaintance and in 7% a colleague.[8] Impunity of the perpetrators of sexual violence remains high due to under-reporting and/or a lack of evidence, amongst others. Addressing sexual violence requires a holistic and multi-sectoral response, involving different ministries such as education, justice, home affairs and health. Close collaboration and/or coordination between different sectors, ministries and services dealing with victims and perpetrators are an important prerequisite to ensure an effective response. Research has shown that a number of factors such as age, gender, socio-economic status and sexual orientation determine a person's vulnerability to sexual violence.

21. In recent years, a number of civil society organisations have put the topic of sexual violence higher on the political agenda. Within the federal and regional governments there seems to be strong political engagement to address sexual violence in a multidisciplinary way involving line ministries like health, interior and justice. The topic is mentioned as a priority in the government agreement of 2014.[9] A new Interfederal Action Plan (NAP) to combat gender-based violence prioritizing sexual violence has been drafted and is awaiting adoption. The Istanbul Convention on Preventing and Combating Violence will be ratified in 2015. The so called Sexual Aggression Set (SAS), a set which is used in relation to victims of a sexual offense, in order to gather evidence, has been evaluated. The recommendations of this evaluation report, contributing to better use of the SAS and a stronger legal position of the victims, are being discussed and integrated in the revision of the existing policy guideline on the SAS.

[5] Buysse, A. e.a. (2014). Sexpert: seksuele gezondheid in Vlaanderen: valorisatierapport. Gent: Academia; http://www.sensoa.be/feiten-en-cijfers/feiten-cijfers-seksueel-grensoverschrijdend-gedrag-jongeren

[6] See http://icrhb.org/sites/default/files/PhD%20Ines%20Keygnaert%20SV%26SH%20published%202014.pdf

[7] 'Rape in Belgium', Amnesty International Flanders, 2014.
https://www.aivl.be/sites/default/files/bijlagen/DossierVerkrachtinginBelgie18022014.pdf

[8] See figures on http://www.hulpnaverkrachting.be/ [May 2015]; http://www.sensoa.be/feiten-en-cijfers/feiten-cijfers-seksueel-grensoverschrijdend-gedrag-jongeren [May 2015]

[9] See http://www.premier.be/sites/default/files/articles/Accord_de_Gouvernement_-_Regeerakkoord.pdf [May 2015]

After the last UPR for Belgium (May 2011), a number of initiatives have been taken such as:

- A campaign 'Viol, brisez le silence' (French) 'Verkrachting. Doorbreek de stilte' (Dutch) and launch of the website 'aideapresviol.be ' / 'hulp na verkrachting' with information and support for victims of sexual abuse by the federal government, the police and the Institute for the equality of women and men. The Institute for the equality of women and men also developed a brochure for victims of sexual violence "Seksueel geweld. Wat nu?" "Violence sexuelle. Comment s'en sortir?";[10]
- The development of a handbook on sexual offences with guidelines for police forces;
- The development of overarching frameworks on 'Sexuality and policy', an initiative of the Flemish government, taking action on the prevention of sexual abuse in a number of sectors (youth (care), education, sport and welfare).

Recommendations for action:

At the end of 2013 the Institute for the equality of women and men developed a policy note with a number of recommendations and a listing of all measures that still have to be taken by the different government institutions at both the regional and federal level in order to address sexual violence in a multidisciplinary and holistic way. Several government bodies, women's organisations, NGOs, academics, lawyers and representatives from government institutions in the field of interior, justice and health care were consulted in this exercise. Below is a selection of recommendations that need to be taken forward by the different governments. Although there seems to be a political willingness within the different government bodies to continue to prioritize the topic, due to the elections and government formation process in 2014, most of the recommendations have not yet been put in practice at the time of writing.

- The federal and regional ministers for equal opportunities support the government institution, the Institute for the equality of women and men, to be further charged with the coordination of the NAP and to continue to play a convening role, encouraging the different government bodies to take a pro-active approach and share best practices on addressing sexual abuse.
- The regional governments, responsible for sports, youth and education policies and the federal government responsible for migration and asylum, should invest in prevention campaigns and awareness raising initiatives on sexual abuse, to be taken forward in sectors such as sports, youth, education and in the asylum sector.
- The Ministry for Migration and Asylum should invest in the prevention of sexual abuse in the reception centers for asylum seekers and the support of victims.
- The minister of interior and justice should take measures contributing to a standardized approach of sexual abuse (e.g. through the implementation of the updated handbook on sexual offenses, through standardized

[10] See http://igvm-iefh.belgium.be/fr/publications/seksueel_geweld_wat_nu_.jsp [February 2014] and http://igvm-iefh.belgium.be/nl/publicaties/seksueel_geweld_wat_nu_.jsp [February 2014]

support of victims, through the use of standardized communication protocols / procedures with victims in all police zones). Victims reporting a sexual offense with the police should receive high quality counselling and support and be guaranteed easy access to police and the judiciary system.

- Given the low reporting rate, all government bodies playing a pivotal role in addressing sexual violence, in particular Justice and Home Affairs undertake all necessary steps to address barriers for victims for sexual violence in reporting a crime. The Judiciary system and police should continue to raise awareness for victims of sexual violence regarding their rights, the reporting procedures and access to police and justice.
- In the basic training of police (inspectors), magistrates, social workers, health care workers and other professions dealing with victims, there should be more attention paid to the problem of sexual violence. A specialized training on this topic for police (inspectors) and health care workers should be developed and be part of their training curriculum.
- Family doctors should receive better training on sexual health and sexual abuse, enabling them to recognize symptoms and to discuss this sensitive topic with their patients.
- The minister for health should encourage hospitals to invest in the formation of multidisciplinary teams which offer psychosocial and medical support to victims of sexual abuse. Reference hospitals which meet a number of quality criteria could support peripheral hospitals or hospitals with less capacity.

<u>Sexual rights of young people: Access to sexual and reproductive health services for undocumented migrants, refugees and asylum seekers</u>

22. The International Bill of Human Rights obliges all states to take responsibility for the residents within their borders, including undocumented migrants, refugees and asylum seekers. The Bill obliges all states to guarantee their right to the highest attainable standard of health, including sexual and reproductive health (SRH), taking into account of all its dimensions (availability, accessibility, affordability and quality).[1] However, in practice, these populations face numerous barriers to accessing SRH services, due to lack of legal residence status, health insurance and other barriers, such as cultural and language barriers that require assistance of interpreters. Although in Belgium undocumented migrants, refugees and asylum seekers do have the right to access health services, including sexual and reproductive health services, many of them are not aware of their rights and the available services.
23. Due to the high costs, many medical services are not accessible to undocumented migrants, unless they are reimbursed. The Social Welfare Center refunds medical costs under the following conditions: the undocumented migrants can prove that they reside on the territory of the Social Welfare center, they do not have the financial

[1] Romero-Ortuno R. *Access to health care for illegal immigrants in the EU: should we be concerned?* European Journal of Health Law 11: 245-272, 2004.

means to pay a private or public health insurance, and they need 'urgent medical care' (see below), decided by the treating physicians.

24. There are cases of undocumented migrants who suffer from a chronic illness (for instance people living with HIV and AIDS) but are still being sent back to their country of origin, even though the continuity and quality of care is not guaranteed in their country of origin. Officials' interpretation of 'accessibility' and 'availability' of health care in the country of origin is sometimes problematic. When there is access to ART services for people living with HIV or AIDS in the capital of a given country, for example, this does not necessarily mean that the person is able to access ART services in other parts of the country or able to access the adequate medication and care, as there might be waiting lists, stock outs and out of pocket payments due to weakness of the health systems.[11]
25. 'Urgent medical care' is in principle regulated by a Royal Decree in 1996, which states that it can be both preventive and/or curative. Therefore, urgent medical care refers to a wide variety of care provisions. An operation, childbirth, an examination, physiotherapy, medication, contraception, abortion etc., can all be considered in regard of the above-mentioned decree. Over time the common interpretation of the term 'urgent' has in some cases and in some municipalities evolved towards 'strictly necessary' or 'acute'. The rather inaccurate description in the law leaves too much room for interpretation. Besides, some health workers are not familiar with the content and procedures related to the decree on 'urgent medical care' and interpret it as 'acute' medical care. The lack of a clear definition of the urgency of medical care results in uncertainty for patients and health providers.[5] On the positive side: there are a number of Social Welfare Centers working together with physicians who are familiar with these administrative procedures and the provision of health care for undocumented migrants.
26. Undocumented migrants, asylum seekers and refugees often face mental health problems because of their uncertain residence status, numerous socio-economic problems, traumas or the fear of being picked up by the police, their access to mental health care is however rather limited. In Belgium, the consultation of a psychologist, not working in a Center for Mental Health Care, is not reimbursed by the government. For undocumented migrants, asylum seekers and refugees access to Centers for Mental Health Care is also complicated by language and cultural barriers and long waiting lists.
27. As mentioned in the previous section, sexual violence is a very serious problem among undocumented migrants, refugees and asylum seekers.[4] Research has shown that refugees, asylum seekers and unaccompanied minors are vulnerable to sexual and gender-based victimization within reception facilities. [12]

[11] See http://www.sensoa.be/nieuws/oplossing-rond-hiv-medicatie-voor-mensen-zonder-papieren-de-maak; K. VAN HOORDE, De grenzen van de medische regularisatieprocedure: een balans tussen een effectief beleid en een adequate bescherming? Irreguliere migranten met hiv/aids, 2014, http://lib.ugent.be/fulltxt/RUG01/002/167/360/RUG01-002167360_2014_0001_AC.pdf

[5] Idem 6

[4] Keygnaert et al. Sexual health is dead in my body: participatory assessment of sexual health determinants by refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands BMC Public Health 2014, 14:416

[12] Keygnaert et al. Hidden violence is silent rape: sexual and gender-based violence in refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands. Cult Health Sex. 2012 May; 14(5): 505–520.

Recommendations for action:

- The authorities at different levels (federal, regional, local) address all barriers limiting access to sexual and reproductive health by investing in decent housing, employment, education and societal participation and ensure accessible, available and affordable sexual and reproductive health services for undocumented migrants, refugees and asylum seekers so they are able to realize their sexual and reproductive health and rights.
- Governments and local authorities should not limit the notion of urgent medical care and ensure that all undocumented migrants can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the patient to financial hardship.
- Local authorities, in particular, Social Welfare Centers and other organizations dealing with undocumented migrants should inform them in a pro-active way about their sexual and reproductive health and rights, including access to sexual and reproductive health services and to psychological care (e.g. for victims of sexual abuse).
- The migration authorities should guarantee confidentiality for undocumented migrants. There should be a clear distinction between accessing health care and the procedure linked to residence status. Undocumented migrants should not be deported to the country of origin when the continuity or quality of their care is not guaranteed.
- The migration authorities should ensure a safe environment in reception facilities for refugees and asylum seekers by investing in the capacity of professionals in the reception and asylum sector, developing preventive measures, identifying risk factors for sexual violence and intervening when sexual violence occurs.

<u>Interfederal HIV plan</u>

28. Since 2005, there is an increase in the number of new HIV diagnoses in Belgium, among Belgians and non-Belgian residents. Over a period of 12 years, the annual number of new HIV diagnoses nearly doubled (+ 87%). In 2013 1,115 new HIV diagnoses were reported and unprotected sex between men was the most frequently reported mode of transmission. HIV remains a significant public health problem in Belgium especially among key populations. The HIV epidemic affects mainly two groups: Men who have Sex with Men (MSM) and men and women who come from sub-Saharan Africa and have contracted the virus through heterosexual intercourse.
29. Since 30 September 2013, Belgium has a national HIV Plan providing a commonly agreed framework for the AIDS response in Belgium. The plan responded to the need for a coordinated HIV response in Belgium, a country where different government bodies and organizations are responsible for addressing the epidemic. The federal and regional health ministers from the previous government unanimously rallied behind the plan which was developed through multi-stakeholder consultations and in accordance with international recommendations. The overall objective of the HIV-plan is to reduce new cases of HIV infections, to encourage access to HIV services and

programmes for prevention, screening, care and support, and to reduce HIV-related stigma and discrimination.[13] However, at the federal level there is no government body or focal point coordinating, monitoring or evaluating the implementation of the plan.

30. At the time of writing most of the more than fifty recommendations of the plan, aimed at a coherent and efficient AIDS response in Belgium, were not being implemented.

Recommendations for Action

- The federal minister of health should appoint a full time staff position responsible for the monitoring and evaluation of the implementation of the HIV plan, including through regular meetings of the different working groups and the Positive Council (an advisory board of People living with HIV and AIDS that contributed to the design of the plan).
- The federal and regional ministers for health invest further in the implementation of the national HIV plan and take measures aimed at reducing late diagnoses, addressing HIV - related stigma and discrimination, the reimbursement of treatment regardless of the strength of the immune system and the creation of a framework enabling HIV testing in a non-medical setting.
- As stipulated in the HIV plan, the federal and regional ministers for health should appoint the council of people living with HIV and AIDS (Positive Council) as an advisory committee, thereby contributing to the active engagement of people living with HIV in the AIDS response in Belgium (so called GIPA principle[14]).

[13] For the English version of the Belgian HIV-plan: http://www.publichealth.itg.be/wp-content/uploads/2013/10/HIV-plan_ENG.pdf [May 2015]
[14] See http://data.unaids.org/pub/BriefingNote/2007/jc1299_policy_brief_gipa.pdf