Letter of 7th May 2012 from the Minister for European Affairs and International Cooperation to the House of Representatives on policy on sexual and reproductive health and rights, including HIV/AIDS

In consultation with the House, four development cooperation policy spearheads have been identified, each of which is being fleshed out in more detail. The House received a letter (Parliamentary Papers, House of Representatives 32605, no. 54) on food security in October 2011 and one on water (Parliamentary Papers, House of Representatives 32605, no. 65) in January 2012. The letter on security and the rule of law will follow shortly. This letter sets out policy intentions in the field of sexual and reproductive health and rights.[1] It discusses specific intentions in the following areas:

- better information and greater freedom of choice for young people about their sexuality;
- improved access to contraceptives and medicines;
- better health care during pregnancy and childbirth, including safe abortion;
- greater respect for the sexual and reproductive rights of groups who are currently denied these rights.

The Netherlands has long been a staunch supporter of sexual and reproductive health and rights, of which family planning is an important part. This is internationally recognised and valued, not only because of the positive results achieved in the Netherlands itself (notably the low teenage pregnancy and abortion rates), but also because of its pioneering role in this field and its willingness to take a high-profile stance on difficult issues such as LGBT (Lesbian Gender Bisexual Transgender) rights and abortion.

For each of these policy pillars, concrete intentions have been formulated and will be closely monitored on the basis of indicators. They will be achieved in collaboration with multilateral organisations, private parties (including Dutch and international NGOs and businesses) and bilateral programmes in eight partner countries. Total expenditure on sexual health will rise from €396 million in 2011 to €427 million in 2015.

[1] In the interests of effective communication and readability, the term 'sexual health' is used wherever possible in this document to mean sexual and reproductive health and rights, including HIV/AIDS. The term 'sexual health' covers all the various elements of sexual and reproductive health and rights and HIV/AIDS. Where relevant, elements are explicitly identified by name.

Investing in sexual health pays off …

Since the Conference on Population and Development in Cairo in 1994, agreements have been made on the agenda for sexual health, most of which have been incorporated in Millennium Development Goals 5 and 6. Since then, a great deal has been invested by developing countries and the international community, and to great effect. In 1990 an estimated 546,000 women were dying annually from problems related to pregnancy and childbirth – 1,500 women a day. That annual figure has now fallen by 188,000, mainly because more women are attended by professionals during childbirth. In addition, more and more people are using modern contraceptives and the number of children per mother have has dropped worldwide. Investing in family planning is extremely cost-efficient: a study in Ethiopia[2] has shown that every euro invested in family planning yields at least twice that value in savings in education, water, sanitation, healthcare expenditure and other areas.

Currently, over 6.6 million people living with HIV in developing countries are receiving antiretroviral treatment.[3] More pregnant women with HIV are receiving quality antenatal counselling and treatment, as a result of which fewer HIV-positive children are being born. This in turn creates good prospects for a new 'HIV-free generation'. It has also cut the maternal mortality ratio,[4] particularly in southern Africa. In the countries worst affected by HIV the number of new infections has declined by more than 25% because of changes in behaviour, especially among the young, but also because people receiving treatment are much less infectious. The report 'Results in Development' which I sent to the House in September 2011 shows how Dutch aid has helped to achieve these results.

… and is as vital as ever …

Although progress has been made across the board in sexual health, there are still major disparities between and within countries and population groups as regards access to sexual health care. The use of contraceptives and professionally attended deliveries in developing countries has risen more sharply among the rich than among the poor. It is still the case, however, that a third of women worldwide give birth without professional attendance and over 215 million women have unmet needs for contraceptives. Research shows that two-thirds of maternal mortality can be prevented by reaching these women with family planning

[2] http://www.usaid.gov/our_work/global_health/pop/techareas/repositioning/mdg_pdf/ethiopia.pdf.
[3] http://www.who.int/hiv/pub/progress_report2011/en/index.html.
[4] Progress towards MDGs 4 and 5 on maternal and child mortality: an updated systemic analysis. Lancet, vol. 378. September 2011.

and quality care before, during and after childbirth. Moreover, seven out of ten unwanted pregnancies and abortions can be prevented if all women who want contraception can actually use it.[5]

Although the number of people receiving treatment for HIV has risen sharply, over half of those in need in low- and middle income-countries still have no access to antiretroviral drugs. In addition, about half of those infected by HIV are unaware that they have the virus. In 2009 there were 7,000 new infected cases per day worldwide. Over half of these were women and 45% were under 24 years old. Prevention aimed at high-risk groups such as young people (and particularly girls) therefore remains essential. Unfortunately the effectiveness of prevention programmes is hampered by taboos, and by stigmatisation of and discrimination against, drug addicts, gay men, transgender people and sex workers.

Millennium Goals 5 and 6[6] will not be achieved, particularly in Africa. Although maternal mortality has declined in 147 countries the speed in sub-Saharan Africa is still lagging behind the global trend. The highest maternal mortality ratios occur in countries with a serious HIV epidemic and in countries embroiled in long-term conflicts. In such cases there is a complex of factors such as violence (including sexual violence) and lawlessness, inadequate services and institutional weakness. For every woman who dies there are about 20 who sustain lasting, and sometimes serious, physical problems as a result of pregnancy.

... also to the other spearheads of this policy

There are several connections between sexual health, other priorities and broader foreign policy. Investing in sexual health helps to slow down population growth because if women have the choice, they tend to have fewer children. This is important because a high rate of population growth hampers development, particularly in countries with precarious ecosystems, where also education and health systems and land and water resources are already under considerable pressure. The pressure created by population growth directly impacts food security: in a number of African countries, in particular, the growth in food production is insufficient to feed a fast-growing population. Conversely, chronically malnourished women more often have problems during pregnancy and childbirth and their children are often underweight at birth. This not only leads to loss of productivity and

[5] http://www.guttmacher.org/pubs/FB-AIU-summary.pdf.
[6] Millennium Goal 5 aims to reduce maternal mortality by 75% between 1990 and 2015 and create universal access to reproductive health care. Millennium Goal 6 aims to halt the spread of HIV and AIDS and to reduce the number of cases of malaria and other major diseases.

diminished economic growth but also to higher healthcare expenditure. In smaller families, children are healthier and women are more productive, which contributes to economic productivity, among other things, and boosts food security. A higher population growth rate also brings severe pressure to bear on the availability of water and other natural resources, while access to safe drinking water and good hygiene means healthy mothers and children. Scarcity of land, food, water and jobs can also breed conflicts and erode security. Conversely, the sexual and reproductive health and rights of women come under added pressure in times of conflict and in other humanitarian disaster situations.

Investing in sexual health leads to smaller, healthier and better educated families, and ultimately contributes to the 'demographic dividend': rising productivity leading to long-term economic growth. By contrast, neglecting sexual health in countries with a high population growth rate and low use of contraceptives seriously undermines the impact of other development investments.

What can the Netherlands offer?

Achieving the objective of good sexual health requires sound legislation, which must then be adhered to, universal access to information and contraception, and access to appropriate care. This approach has produced good results in the Netherlands. The rates of teenage pregnancies and abortions in this country are among the lowest in the world and no babies are now born with HIV. The Dutch harm reduction[7] policy has benefited efforts to reach injecting drug users. This policy has now been adopted by many other countries.

The Netherlands is more than just a donor – it is a committed player. We contribute Dutch insight and involvement through the international and bilateral programmes we support. Our strength lies in exposing the deeply rooted causes of gender inequality, discrimination, stigmatisation and exclusion, and in pushing for pragmatic and innovative solutions. This combination of activism and pragmatism and our persistence as a donor have contributed to our international reputation as a pioneering and reliable country. We should use this position to save the lives of mothers, give young people control over their bodies and their relationships, turn the tide of the AIDS epidemic and give a voice to marginalised groups in society. In this letter, therefore, I am building on the expertise acquired over the past 20 years.

[7] Harm reduction: interventions that sustainably break the habit and reduce the damage to health caused by substance addiction. In practical terms, it means needle exchange and methadone provision programmes.

What are our aims?

The Netherlands wishes to make a substantial contribution to achieving Millennium Goal 5, namely:

- to further reduce maternal mortality (the aim is a 75% reduction between 1990 and 2015) and create universal access to reproductive health;

and Millennium Goal 6, namely:

- to halt the spread of HIV (the aim is 50% reduction of HIV infections among young people between 2011 and 2015).

The Netherlands will make this contribution by forging partnerships with national governments in partner countries, and with international and civil society organisations and businesses to facilitate cost-effective, life-saving interventions and to improve sexual and reproductive rights.

Concrete target figures have been agreed worldwide for life-saving interventions:

- 90% of births attended by trained health workers;
- 80% of HIV patients treated with antiretrovirals;
- 90% of HIV-positive pregnant women treated in order to prevent mother-to-child transmission.

These goals and targets have been internationally agreed. In monitoring progress, we make as much use as possible of national and global research and monitoring systems.

On the basis of its expertise and added value, the Netherlands will focus on four result areas with its strategic partners worldwide and in eight partner countries.

Result area 1:

Young people know more and are thus equipped to make healthier choices about their sexuality.

The Netherlands will specifically focus on:

- Comprehensive sexuality education at school and elsewhere;
- access to youth-friendly services and preventive measures;

- opportunities for young people to make their voices heard and to stand up for their rights.

Why?

Many young people[8] are already sexually active or soon will be. It is important for them to be able to make sensible choices that contribute to a positive experience of sex. Unfortunately, the sexuality of young people is often a taboo subject, as a result of which young people often have too little factual knowledge about sexuality and sexual health. In addition, they frequently have little or no access to contraceptives and sexual health services. This has serious repercussions. For instance, every year, 16 million 15- to 19-year-old girls worldwide become pregnant.[9] This is partly due, on the one hand, to early marriages and sexual relationships (forced or otherwise), and on the other hand to inadequate access to contraceptives for this age group. In particular, girls who have had little or no education often become mothers when they are very young. Complications during pregnancy and childbirth are the number one cause of death for girls in this age group. Almost 50% of all new HIV infections are in young people under 24, and in Africa 75% of them are girls.[10]

Investing in the sexual health of young people pays off. In many countries 60% of the population are aged under 24. Young people will largely determine future demographic trends, but they are also a source of energy and change. They must be given not only a voice but also access to information and services. Research shows that young people who are better informed about sexuality become sexually active at a later age, have fewer sexual partners, become parents later in life, have fewer children and are more likely to practise safe sex.

What and how?

In order to provide young people with better information about sexual and reproductive health and rights and to give them more voice the Netherlands will:

- support the implementation of a comprehensive sexuality education policy at schools in collaboration with the national responsible institutions. Dutch knowledge institutions may be deployed through the NICHE programme (Netherlands Initiative for Capacity building in Higher Education), for example to develop culturally appropriate communication materials;

[8] All those aged between 10 and 24 (WHO definition).
[9] Source: http://www.unfpa.org/public/home/factsheets/young_people.
[10] Source: IPPF, 2011.

- seek collaboration with local organisations to reach young people who do not attend school. This can be achieved via TV, radio, internet or through youth representatives in villages. In Benin a two-weekly radio programme for young people is produced jointly with Population Services International (PSI). The programme has an audience of hundreds of thousands, with options to respond by phone or on Facebook;
- set up joint ventures with international and national organisations such as the International Planned Parenthood Federation (IPPF) and Marie Stopes International (MSI) to provide youth-friendly services;

Between 2011 and 2014, IPPF will deploy Dutch grant funding to prevent over four million unwanted teenage pregnancies by reaching young people in 20 countries with information about contraception and sexuality and by providing youth-friendly services in clinics. These provide a safe environment where young people can seek sexual healthcare services such as HIV and STI testing and treatment, contraceptive information and reproductive health commodities, and safe abortion. Within four years, IPPF will be in a position to provide 6.2 million of these services to young people and will distribute over 16 million condoms per year to this section of the population.

- lobby for young people to be given a voice so that they can make their problems and wishes heard. This can be done with assistance from the embassies in partner countries at strategic national meetings and international gatherings. We will also appoint a youth representative who will work in close collaboration with the Netherlands' Ambassador for Sexual Health and Aids. Young people will be included in Dutch delegations to relevant international meetings and thus have a say in policies that affect them;
- facilitate the initiative to set up an international 'young people and ICPD' partnership jointly with NGOs like CHOICE and Dance4life, in order to promote cooperation between young people and the government at country level, and thus together identify and tackle the main obstacles to the sexual health of young people in that particular country;
- in multilateral platforms, including the Human Rights Council, the Commission on Population and Development and the Commission on the Status of Women, pursue efforts to enshrine the rights of young people in international agreements.

Monitoring

We will monitor progress among others on the basis of the following result indicators:

- a higher percentage of young people with accurate knowledge about HIV;
- an increasing number of youth-friendly centres, with growing numbers of clients;
- a decline in the teenage pregnancies rates.

Result area 2:

A growing number of people obtain access to antiretrovirals, contraceptives and other life-saving resources that promote good sexual health.

The Netherlands will specifically focus on:

- a wider choice and greater availability of contraceptives;
- greater availability of medical resources to prevent maternal mortality and sexual health problems;
- removing culturally-determined and knowledge-related obstacles for women to use contraceptives.

Why?

Sexual health requires effective and affordable medical supplies. They include drugs such as hormonal contraceptives and antiretrovirals, and also male and female condoms and obstetric equipment. In many developing countries not everyone who needs these resources has access to them, especially the poor and those living in rural locations. The causes for this may vary, in terms of both supply and demand: transport may be irregular, commodities may be too expensive for the end-user, there may be insufficient choice (not every contraceptive is suitable for everyone), service providers may fail to provide appropriate information, women (especially the young) may be deprived of the right to make independent choices, or the government may assign insufficient priority to this issue. Medical supplies may also be of poor quality. Contraceptives are frequently not included in the national list of 'essential medicines' to be purchased as a matter of priority, or are not included in the basic insurance package. Reproductive healthcare commodities may also be expensive due to international trade agreements.

What and how?

To boost access to commodities for sexual and reproductive health the Netherlands will:

- contribute to the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) led by UNFPA, which helps governments in 45 countries to improve their planning, purchasing and distribution systems and to make them more

sustainable. Obstacles on the demand side will also be removed so that people can be given the choice to use the contraceptives that are most suitable for them;

- contribute to the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), financing and promoting access to affordable medicines and products such as antiretrovirals in 150 low- and middle-income countries and simultaneously strengthening the procurement and supply policies of these countries. With the anticipated contribution from the Netherlands, it will be possible to treat some 30,000 extra people with antiretrovirals (and cure 32,000 TB patients);
- support Product Development Partnerships (PDPs) that develop new preventive tools such as the International AIDS Vaccine Initiative (IAVI), PATH (female condoms) and the International Partnership for Microbicides;
- promote public-private partnerships (PPPs) that can help remove obstacles to the availability of resources, such as Universal Access to Female Condoms (UAFC). We will mainly focus on crucial products (including those for medical abortion) and on innovative marketing approaches;

> So far, the female condom is the only contraceptive that women can use on their own initiative to protect themselves against both unwanted pregnancy and HIV. However, it is still an under-used resource. The Universal Access to Female Condoms Joint Programme (UAFC), an organisation founded and established in the Netherlands, is a public-private partnership. In 2012 it is once again receiving funding to boost demand for female condoms, help various condom producers to meet WHO quality standards and reduce the price. In 2012, 2.7 million female condoms will be sold in at least three countries and two new types will be launched on the market.

- work with local and international NGOs and Dutch civil society organisations (the SRHR Alliance Unite for Body Rights Programme) in partner countries, which play a vital role in bringing supply of and demand for contraceptives closer together;
- jointly drawing up plans with the Ministry of Economic Affairs, Agriculture and Innovation for funding the Top sector life science (one of the government's leading sectors), in which activities targeting sexual health willbe given priority funding.

Monitoring

We will monitor progress among others on the basis of the following result indicators:

- more couples using contraceptives;
- more AIDS-infected clients taking antiretroviral drugs;
- number of new, user-friendly products and medicines on the market that prevent maternal mortality and HIV infection.

Result area 3:

Public and private clinics provide better sexual and reproductive care used by an increasing number of people.

The Netherlands will specifically focus on:

- better cooperation between public and private care providers;
- a better-integrated approach to HIV and sexual health in national healthcare policy in partner countries;
- better quality obstetric care;
- innovative ways of keeping or making sexual health care affordable and accessible.

Why?

Sexual health services cannot be effective without a well-functioning healthcare system in which the public and private sectors are well coordinated. A shortage of funding and qualified staff means that the quality of care and access to care are often lacking, especially in rural areas. There are often also extra barriers for poor women, young people, marginalised groups and people with disabilities.

In Ethiopia, for instance, a trained midwife is present at only 10% of births (the average for sub-Saharan Africa is 47%). Worldwide, unsafe abortions account for no less than 13% of maternal mortality; in some countries this figure is as high as 25-40%. Within individual countries, there are considerable differences between rich and poor in terms of access to good care. Great efficiency gains can be made by providing a continuum of care, that is to say patient centred approaches with integrated services (for instance combining testing for STIs with information on contraceptives).

What and how?

To promote better sexual health services, the Netherlands will:

- prioritise sexual health care in eight of its 15 partner countries. Targeted efforts will be made to improve reproductive care in cooperation with private partners, NGOs and governments;

o Embassies work with international and local NGOs in all eight SRHR partner countries to provide better information for young people and improve capacity in private and public care in the field of family planning and the diagnosis and treatment of HIV and STIs.

- In Mozambique and Ethiopia we work with the government to strengthen public maternal health services, and to improve integration with HIV prevention. Public health services often provide the only form of health care in rural areas.
- In all 15 partner countries, embassies lobby for respect for human rights, including sexual and reproductive rights, in national fora and in policy and political dialogue.
- 20.7% of the total approved SRHR budget (€1.6 billion in the 2012-2015 period) will be deployed bilaterally.
- This amounts to €297 million for the eight partner countries and €35.6 million for the Southern Africa regional HIV programme.

- support efforts to improve access to safe abortion, at both international and country level, through partners like IPAS and the IPPF;
- promote better sexual health care in humanitarian aid and post conflict reconstruction situations by consistently tabling it with relevant UN agencies and NGOs;
- ensure, as part of the food security policy spearhead, that sufficient attention is paid to the nutrition of girls and pregnant women. Malnourishment during pregnancy causes extra complications during pregnancy and childbirth, and increases maternal mortality. Malnutrition causes HIV infection to take more aggressive forms;
- professionalize midwives as a crucial link in the system of professional support in pregnancy and childbirth. They also play an increasingly important role in the provision of contraceptives. Through the NICHE programme, the Netherlands supports the training of midwives in Ghana. It also supports a UNFPA programme and the International Confederation of Midwives, based in The Hague;
- continue to invest in financial sustainability and accessibility by deploying Dutch expertise in the field of health insurance;
- explore innovative partnerships with ICT providers to enable care provision to be supported by means of m-health and e-health.

Monitoring

We will monitor progress among others on the basis of the following result indicators:

- an increase in the number/percentage of pregnant HIV-positive women being treated to prevent mother-to-child transmission of the HIV virus;
- an increase in the number of doctors, nurses and midwives per thousand inhabitants;
- improved adherence to the latest WHO guidelines on safe abortion and after-care (2012).

Result area 4:

More respect for the sexual and reproductive rights of groups who are currently denied these rights.

At both national and international level the Netherlands will specifically focus on:

- raising respect for the human rights of specific groups, such as sexual minorities, drug users and sex workers;
- providing these groups with access to sexual health facilities and commodities;
- lobbying for women's and girls' right of self-determination in matters of sexuality;
- promoting a rights-based approach in policy and legislation in partner countries.

Why?

Worldwide opposition to reproductive and sexual rights is considerable and growing. Many countries have legislation that makes it difficult for women and young people to obtain access to information about sexual health or sexual health services. Safe abortion is embedded by many constraints, leading to dangerous, clandestine practices and greater maternal mortality that could have been prevented.

In addition, a great many people suffer from stigmatisation and discrimination and therefore lack access to information and/or sexual health care. In many countries this undermines the effectiveness of HIV prevention policy. In Eastern Europe and Central Asia, for instance, the transmission of the HIV virus between injecting drug users continues to rise due to the absence of adequate prevention (or harm reduction) policies – indeed, in some cases prevention efforts are even prohibited. Homosexuals and transgender people all over the world run a disproportionate risk of contracting HIV. Yet many have no access to information or care because their existence is not recognised. In many countries, sex work is illegal, as well as socially stigmatised. That makes sex workers vulnerable to exploitation, sexual violence and health problems like HIV and other STIs. At the same time they are hard to reach and provide with information. In June 2011, at the UN summit in New York on HIV/AIDS, men who have sex with men, injecting drug users and sex workers were for the first time explicitly recognised as *key populations*. That is a good start, but it needs to be translated into concrete improvements. It is also important that the target groups are themselves closely involved in devising solutions. The Netherlands is a traditional staunch supporter to improve the position of such groups.

What and how?

To ensure that sexual and reproductive rights are accorded greater respect in legislation, policy, implementation and society in general, the Netherlands will:

- use the key populations fund (giving effect to the motion introduced by MP Wassila Hachchi, Parliamentary Paper 32 500 V, no. 37) to support a platform of five NGOs so as to place their activities for and with marginalised and excluded groups on a firmer footing. This will enable over 400,000 LGBT people, sex workers and injecting drug users in 16 countries to be reached and given access to sexual health care, including HIV prevention and treatment;
- strategically deploy the Ambassador for Sexual Health and Aids (ASRA) to champion sexual and reproductive rights. In multilateral fora, the Netherlands will approach potential allies, on the basis of available evidence that respecting the sexual and reproductive rights of all promotes public health. Our aim is to embed these rights firmly in the development goals that will replace the Millennium Development Goals after 2015;
- provide financial and substantive support during the run-up to the 20th anniversary of the International Conference on Population and Development (ICPD+20) in 2014. This will involve the Netherlands hosting an international consultation on sexual and reproductive rights;
- incorporate the findings of stepping-out programmes for sex workers in a policy that will relate to the specific problems and needs of the women concerned. The international meeting ‘Stepping Up, Stepping Out, Taking Out’ in April 2012 marked the start of this process;

With the help of seven local partners in four countries, two Dutch NGOs have reached over 5,000 sex workers in the space of two years, providing them with advice and training in setting up their own small business, microcredit, strengthened social networks, shelter and information about health and safety. This has improved the working and living conditions of this hard-to-reach group.

- devote attention to sexual and reproductive rights in at least three partner countries (Rwanda, Uganda and Kenya) in the context of the spearhead on security and the rule of law. Attention will of course also be devoted to this in the eight partner countries in which sexual health is a priority in its own right, for example by strengthening the capacity of civil society.

Monitoring

We will monitor progress among others on the basis of the following result indicators:

- increased use of sound problem analyses at country level for formulation of policies on the sexual health of marginalised groups;
- better national legislation, enforcement and concrete policy in the field of sexual and reproductive rights (For: raising the marriageable age for girls and more liberal legislation on abortion. Against: female genital mutilation and the criminalisation of homosexuality).

Stakeholders and partners

Fortunately there is now international awareness that extra efforts are needed to achieve Millennium Development Goals 5 and 6. This shared sense of urgency is reflected in 'Every Woman, Every Child', a global movement launched in September 2010 by the UN Secretary-General. The Partnership for Maternal, Newborn and Child Health (PMNCH), which brings together partners of every kind (governments, NGOs, knowledge institutions, business, multilaterals), plays an important role in the movement, for example by encouraging all partners to do what they do best and work together effectively.

The Netherlands deploys around half the funding available for sexual health via multilateral organisations and global funds. UNFPA, GFATM, UNAIDS, GAVI and WHO are the main recipients. But UNICEF, UNWOMEN and the World Bank also use Dutch funding to promote sexual health. We have chosen these channels because the organisations and funds in question can achieve much more than bilateral donors, due to their specific mandate and expertise, their greater reach and their composition. UNFPA, for instance, has long been the agency that monitors compliance with the agreements made in Cairo. The organisation is well-placed as a strategic partner to challenge opposition. The Netherlands' consistent support, both for UNFPA's core mandate and for specific programmes for midwives and reproductive health commodity security, has significantly contributed to the progress that has been made. And without the Global Fund and UNAIDS we would never have been able to change the course of the HIV epidemic. Through our involvement in the governance of various international organisations and our contacts in partner countries we stimulate optimal cooperation.

Such cooperation must primarily take shape at country level, because that is where concrete results are achieved and where national governments determine and implement policy. That is why our cooperation with partner countries is so important. The Netherlands has been an active partner in health care sectors in Bangladesh, Yemen, Ethiopia, Mozambique, Mali and Ghana for some time. Efforts will now be directed more than before at achieving results in

the field of sexual health, by positively influencing national policy as well as supporting targeted activities.

New programmes are being set up in Benin and Burundi. There is also a regional programme combating HIV/AIDS in Southern Africa, the region hardest hit by the HIV epidemic.

The Netherlands works closely with NGOs, both through the embassy programmes and directly through the ministry in The Hague. Civil society can be instrumental in boosting debate on inequality, discrimination and taboos regarding sexual health and influencing government policy or calling governments to account. NGOs often play a crucial role in reaching disadvantaged groups and in providing sensitive services, like safe abortion or sexuality education for young people. Four large international organisations were supported from the first Choices and Opportunities Fund, to provide a combination of service provision, capacity building and advocacy. Experience shows that it is especially difficult for smaller NGOs (in both the South and the North) to obtain funding for advocacy and capacity building. So there are plans to make the international funding of NGO activities more efficient, by setting up an SRHR-Civil Society Fund.

Knowledge and research

Dutch SRHR policy has always been pragmatic. We continue to look for approaches that work in practice. Knowledge and research are crucial in this respect. Internationally recognised expertise and research in the field of sexual health is provided by a number of institutes to which the Netherlands has contributed significantly in recent years. An example is the Guttmacher Institute, which only recently published worrying data on the increase of unsafe abortion and a slowdown in contraceptive uptake. Contributions to the World Bank and WHO also provide support for influential knowledge institutions. I moreover believe it important to make optimal use of expertise in the Netherlands so as to link policy and practice. To this end I am talking to the main actors, both NGOs and knowledge institutions and universities, with a view to setting up a knowledge platform that will be operational by the end of this year. The platform will focus mainly on research into the long-term impact of interventions and the underlying causes of success and failure. Northern and Southern knowledge institutions will work with NGOs in the platform, so that research capacity in the South will also be strengthened.