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An inclusive and holistic approach to ensure access to contraception

Sarah Hulsmans (Sensoa),

Emilie Peeters & Ines Keygnaert (ICRH, Ghent University)

1. Situation analysis: Access to contraception in Belgium

The use of contraception is widespread in Belgium and the unmet need for contraception is low.[1] About eight in ten women in Belgium are using contraception.[2] And contraception use increases yearly. In 2013, 78.4% of fertile Belgian women used contraception; in 2018, it was 83.8%. This upward trend is confirmed by contraception sales figures in Belgium: between 2004 and 2015, they increased by 6 percentage points (from 48% to 54%).[3]

The increase in contraceptive use is partly due to a sharp rise of usage by young people. 90.5% of young women (ages 15-21) surveyed in the 2018 National Health Survey were using contraception. Again, sales figures between 2004 and 2015 showed that contraceptive use among young people aged 15-21 doubled during that period.[4,5]

The four-yearly European Health Survey also gauges contraceptive prevalence among Flemish youth. The latest figures from 2018 show that in addition to the condom, young people mainly use the contraceptive pill as contraception. 62.6% of Belgian girls and 73% of boys (13-18 years old) indicated that either they themselves or their partner used the pill during their most recent sexual contact. The 15-21 year olds surveyed in the National Health Survey also mainly used the pill (78.9%).[6]

[1] Agentschap Zorg & Gezondheid.(2019.) *Eindrapport Symposium Seksuele Gezondheid, Agentschap Zorg en Gezondheid, 18 februari 2019.*

[2] Charafeddine R., Braekman E., Gisle L., Drieskens S.(2019). *Gezondheidsenquête 2018: Seksuele gezondheid. Brussel, België* (Nr. D/2019/14.440/60). Sciensano.

[3] Cijfers anticonceptiegebruik in België. (n.d.). Sensoa. Retrieved 22 October 2022.

[4] Cijfers anticonceptiegebruik in België. (n.d.). Sensoa. Retrieved 22 October 2022.

[5] The sharp rise of usage by young people can partly be explained by the changes in federal law concerning reimbursement (2004 and 2013) and the governments commitment to provide knowledge about reproduction and the prevention of unwanted pregnancy via the educational-targets in secondary schools. Brandts S., Vermeire, K. (2017). *Tienerzwangerschappen in België tussen 2010 – 2017*.

[6] Dierckens, M., De Clercq, B. & Deforche B. (2019). Studie Jongeren en Gezondheid, Deel 4: gezondheidsgedrag – Seksuele gezondheid en relaties.

Research by the European Parliamentary Forum on Sexual and Reproductive Rights from 2022 shows the same. Belgian young people mainly use the pill, followed by the male condom and the hormonal coil.[7]

The Global Early Adolescent Study of 2019 shows that the knowledge about contraception among students aged 11-15 in Flanders is low. Only a few of the respondents agreed that a girl can take a daily pill (69.64%) or that she can take an injection (45.14%) to protect against pregnancy. 42.66% of them believed that a girl can use herbs to protect against pregnancy.[8]

In 2019, an analysis of Belgian teenage pregnancies assessed that in 2017 for every 1,000 young women aged 15-19 years, 12 got pregnant. This is a reduction of 39% compared to 2010. More than two thirds of those teenagers getting pregnant are above 18 years old. The majority chooses to continue the pregnancy. However, there is a clear distinction based on age: almost three out of four pregnant girls between 10 and 19 years old choses an abortion, while the majority of the pregnant teenagers between 18 and 19 years old become mothers. Brussels and Wallonia have higher teenage pregnancy figures than Flanders.[9,10]

A preliminary study explained that the decline in sexual activity among 17-18 year-old girls between 2014 and 2018 has an impact on the decline in teen pregnancy rates during this period as well as an increase in access to contraception and a change in social norms concerning childbirth. The age at which Belgian and Flemish mothers have their first child is increasing year after year. In 2010, the age at first child for Belgian mothers was 28.2, in 2016 it was 28.9. In 2018, the average age at which a Flemish mother had her first child was 29.1, compared to 25.7 in 1987.[11]

However, more generally, contraception sales figures show that pill use is declining, while sales of IUDs and other alternatives are increasing. In 2004, 85% of women who used contraception bought the pill; in 2015 it was 77%. Other research shows that in 2013, 54.2% of women using contraception chose the pill. In 2018, that dropped further to 48.1%.[12]

Adult women mostly choose the IUD as an alternative to the pill. 21% of users 25-34 years of age switch to an IUD. After 35 years usage increases even more. This is also reflected in the sales figures: between 2004 and 2015, about 6,000 IUDs were delivered each month. Of these, about 5,000 were hormonal and about a thousand were copper IUDs.[13]

[7] European Parliamentary Forum for Sexual and Reproductive Health and Rights. (2022). Contraceptive use and awareness among young people in the European Region.
[8] De Meyer S. & Michielsen K. (2019). Resultaten vragenlijst Mondiaal onderzoek over Jonge Adolescenten.
[9] Brants S. & Vermeire K. (2020). Tienerzwangerschappen in België 2010-2017.
[10] For more information; Brants S. & Vermeire K. (2020). *Tienerzwangerschappen in België 2010-2017.*
[11] Brants S. & Vermeire K. (2020). *Tienerzwangerschappen in België 2010-2017.*
[12] Cijfers anticonceptiegebruik in België. (n.d.). Sensoa. Retrieved 22 October 2022.
[13] Cijfers anticonceptiegebruik in België. (n.d.). Sensoa. Retrieved 22 October 2022.

Following the IUD, are the vaginal ring, the hormonal implant, contraceptive injection and the contraceptive patch. Young people (aged 15-21) mainly choose the hormonal implant or contraceptive injection (6.3%), the patch or the vaginal ring (5.5%) and the IUD (2.8%) as an alternative to the pill.[14]

Barrier methods such as diaphragm or spermicides are very rarely used by young people. Condom use decreases sharply with age. Condom use at first time sex and most recent sexual contact does remain stable.[15]

Research in Belgium also shows that women of Moroccan and Turkish origin use contraception less frequently: 50% of women between 14 and 49 of these communities use contraception, with the pill being the most popular (60% of all contraceptive use).[16]

Women with lower education levels are also less likely to use contraception than higher educated women: these percentages vary between 48% and 69% among lower educated women compared to the 80% for women with higher education degrees.[17]

In 2019, 18.027 abortions took place in Belgium, of which 116 were carried out by women living abroad. The evaluation of the Belgian statistics on voluntary termination of pregnancy shows, among other things, that the cause of failure in avoiding an unplanned pregnancy in 2019 was failure to use contraception in 49.98% of the case, the failure to apply contraception correctly (28.26%) and in 15.80% it was due to failed contraception despite proper use.[18]

2. Contraception policies in Belgium

2.1. Insurance coverage for general public

The general Belgian public is covered by compulsory health insurance that offers an annual reimbursement for contraception up to 25 years of age (male, female or non-binary). This has made certain types of contraception within the reimbursement-price range free for this age group. On top of this reimbursement, private health funds may choose to reimburse more (thus expanding the contraception alternatives free of charge) or to reimburse a small annual amount for women over 25 (no more than 40 or 50 euro a year). The amount of reimbursement varies highly between the health insurance companies. It can range from no reimbursement to complete reimbursement for some long-acting reversible contraceptives (LARCs).

[14] Cijfers anticonceptiegebruik in België. (n.d.). Sensoa. Retrieved 22 October 2022.
[15] Cijfers anticonceptiegebruik in België. (n.d.). Sensoa. Retrieved 22 October 2022.
[16] Agentschap Zorg & Gezondheid.(2019.) *Eindrapport Symposium Seksuele Gezondheid, Agentschap Zorg en Gezondheid, 18 februari 2019*.
[17] Agentschap Zorg & Gezondheid.(2019.) *Eindrapport Symposium Seksuele Gezondheid, Agentschap Zorg en Gezondheid, 18 februari 2019.*
[18] Nationale commissie voor de evaluatie van de wet van 15 oktober 2018 betreffende de zwangerschapsafbreking (wet van 13 augustus 1990). (2021). *Verslag ten behoeve van het parlement 1 januari 2018 – 31 december 2019.*

2.2. Free contraception for people age younger than 25

Since 1 April 2020, certain contraception is fully reimbursed for young people up to 25 years of age. This reimbursement measure is an extension of the existing 2013 legislation that made certain contraception free for women up to 21 years of age except for the condom and sensiplan training. The measure came as proposers of the legislation had found that the number of voluntary terminations of pregnancy in that age group (20 to 25) was high and that they were proportionally impoverished as well.

The applicants of the legislative proposal stated: '*This measure is justified for another additional reason, namely the increasing poverty within that population group". Indeed, the Social Integration Barometer shows that the number of people under the age of 25 with a living wage increased from 22,675 in January 2016 to 43,691 in July 2018. Overall, there are also more living wage-eligible women. Given these alarming figures, the proposers of the bill believe that special attention should be paid to this population category*.'

The Belgian Translaw (2018) has made reimbursement possible for transman and non-binary people.

According to the National Institute for Sickness and Disability Insurance (NIHDI) the reimbursement of contraception for people under 25 is estimated to have a budgetary impact of €5.799 million at the level of the 2020 budget. The rate of the contraceptive allowance was not adjusted, only the age was increased.[19]

2.3. Free contraception for everyone who falls under the system of increased allowance

Everyone older than 25, who falls under the system of an increased allowance can also get free contraception. These are people with a living wage (a state allowance)[20], a guaranteed income for elderly, an allowance for persons with disabilities or allowance for assistance to elderly. This increased allowance is an allowance on top of the 'classic allowance' of compulsory health insurance for all Belgians. All reimbursements are made through compulsory insurance with a health insurance fund.[21]

2.4. Free emergency contraception for everyone

The 2020 legislative measure also made the classic emergency pill (effective in the first 72 hours) free for all women regardless of age, but they still needed a prescription.

[19] Thiéry, D. (2019) *Verslag: Westvoorstel tot wijziging van het koninklijk besluit van 16 september 2013 ter vaststelling van een specifieke tegemoetkoming in de kostprijs van contraceptiva voor vrouwen, jonger dan 21 jaar, teneinde de terugbetalingsmogelijkheden voor contraceptiva en de morning-afterpil uit te breiden, 20 maart 2019* (Nr: DOC 54 3439/004). Commissie voor Volksgezondheid, het leefmilieu en de maatschappelijke hernieuwing.

[20] You are entitled to a state-provided living wage if your income is insufficient and if you are unable to change that condition. If your income is less than the general income, you can ask for the difference to be adjusted so that your income is at the same level as the general income.

[21] *Extra tegemoetkoming in de prijs van voorbehoedsmiddelen - RIZIV*. (n.d.). Retrieved 27 October 2022.

A 2021 amendment to the law made the classic emergency pill available free to all women without a doctor's prescription, without age restriction. The newer emergency pill, the EllaOne, effective up to 5 days after unprotected sexual contact, is not included in the legislation and costs about €15.

In Flanders, women can only get the emergency pill at the pharmacy or at the Sexual Assault Care Centres (SACCs) upon sexual victimisation. In Wallonia, the situation is different and the emergency pill is available through certain family planning centres as well as at the SACCs. It is estimated that about 30,000 contraceptive pills and 5,000 morning-after pills are dispensed annually by the family planning centres in Wallonia. The availability and distribution of the emergency pill and contraception in the centres actually falls outside the current existing legislation, which places the centres in a vulnerable position when providing these 'illegal services'. However, this could be and is an easy way to help avoid unplanned pregnancies. Belgium should provide a federal legal framework for this in the near future.

According to the National Institute for Sickness and Disability Insurance (NIHDI) the reimbursement of emergency contraception for all is estimated at a maximum of €1.08 million at the level of the 2020 budget.[22]

2.5. Access to information on contraception

On the regional and community level (Flanders and Wallonia), different actors work on awareness raising and facilitation of access to information. In Flanders, most awareness raising is done by Sensoa[23], the Flemish expertise centre for sexual health (paid for only by the regional Flemish minister for Welfare, Public Health and Family). In Wallonia, awareness raising is mostly done through the Federations of Family Planning Centres (Fédération de Centres Pluralistes de Planning Familiale[24], Fédération Laïque de centres de Planning Familial[25], Fédération de Centres de Planning et de Consultations[26] et La Fédé militante des Centres de Planning familial solidaires[27]).

According to recent research by European Parliamentary Forum on contraceptive use and awareness among young people in the European Region, Belgian young people get their information about contraception from the Internet (33.5%) and in school (23.2%).[28]

[22] Thiéry, D. (2019) Verslag: Westvoorstel tot wijziging van het koninklijk besluit van 16 september 2013 ter vaststelling van een specifieke tegemoetkoming in de kostprijs van contraceptiva voor vrouwen, jonger dan 21 jaar, teneinde de terugbetalingsmogelijkheden voor contraceptiva en de morning-afterpil uit te breiden, 20 maart 2019 (Nr: DOC 54 3439/004). Commissie voor Volksgezondheid, het leefmilieu en de maatschappelijke hernieuwing.
[23] https://www.sensoa.be/
[24] https://www.fcppf.be/
[25] https://www.planningfamilial.net/
[26] https://fcpc.be/
[27] https://www.sofelia.be/
[28] European Parliamentary Forum for Sexual and Reproductive Health and Rights. (2022). *Contraceptive use and awareness among young people in the European Region*.

Several websites are online to provide correct information on contraception to inform the general public:

2.5.1. Everything about sex

Sensoa (with Flemish funding) manages the website allesoverseks.be[29], meaning ‘everything about sex’. It provides information around 'Sex in Practice', 'STIs and HIV', 'Contraception', 'Body', 'Pregnancy and Fertility', 'Love and Relationships', 'Sex and the Internet' and 'Sex and Boundaries'.

The website also includes a contraception tool intended to help women choose contraception. The contraception tool was developed in 2015 and cost about €30,000 for development, building, drawings and expert checks as to medical accuracy. It is not a stand-alone tool, it is incorporated into campaigns and materials on comprehensive sexuality education.

Allesoverseks.be was reviewed by Ghent University[30] and by AG consult[31] in 2022. It showed that 79% of visitors come for a personal reason, and that most of them are women (62.5%). Divided by age, there are proportionally many 18-year-olds on allesoverseks. Visitors generally find the website through an Internet search engine (70%), followed by the fact that they already knew the website (16%).

The analysis also showed that most visitors seek information about contraception, followed by information on STIs and HIV, sex-life inspiration and sex-positions. Visitors under 25 and women (95% vs. 5% men) are the biggest group of contraceptive information seekers.

Importantly, many visitors visit the contraception tool out of dissatisfaction with their current contraception. They want to research and look up the side effects of their current contraception.

2.5.2. Zanzu

At the end of 2015, Sensoa in cooperation with the German Federal Agency for Health Promotion (BZgA) launched the multilingual website Zanzu.be. The website aims to increase the knowledge of all vulnerable non-native speaking newcomers (ranging from asylum seekers, immigrants, EU -citizens and third country nationals) around sexual health.

The website contains easily accessible information on sexuality and sexual health and is currently available in 14 languages (Albanian, Arabic, Bulgarian, German, English, Farsi, French, Dutch, Polish, Portuguese, Romanian, Russian, Spanish and Turkish). The content is built around six central themes: (1) the body, (2) family planning and pregnancy, (3) infections, (4) sexuality, (5) relationships and feelings, (6) rights and law.

[29] https://www.allesoverseks.be/

[30] Coenen, L. (2022). *Is de patiënt beter geïnformeerd bij het gebruik van de anticonceptiewijzer tijdens het anticonceptieconsult?*. [Master dissertation, Ghent University]

[31] van de Wiel, A. (2022). *Rapport 2022 toptaken allesoverseks.be sensoa.* AG Consult.

Zanzu.be also features other tools (Help Guide, Search window, For professionals section, Feedback window) and offers functionalities such as a print function, language switch via menu bar, a read-aloud function, a glossary of 240 terms, font size reduction or enlargement, download function and size adjustment for the images.

Through the review done by Ghent University in 2018 and by AG consult in 2019 it became clear that the website received many visitors (5500 per day), but few of Sensoa's intended target audience. 86% of those visitors come through search engines based on search terms such as sex, sex photo, sexy, so these people are not looking for info but sex photos. The Ghent University evaluation showed that the knowledge of the body and sexual health of the visitors, often foreign-speaking newcomers, increases after visiting the website and that it helps them make better choices regarding their sexual health.

Health professionals working with non-native speakers stated that Zanzu.be improves communication with non-native speakers. But the survey also found that healthcare providers do not necessarily feel more knowledgeable and comfortable talking about sexual health with Zanzu.be. Counsellors tend not to use Zanzu.be with clients if they know or estimate that their clients are not computer literate.

The Zanzu website originally costs about €230,000 in Flemish funding for development, building drawings and icons, translations and translation tools. In addition, the website requires on average about €35,000/year for technical updates, maintenance, the licences of software tools, support and content updates and translations.

2.5.3. My contraceptives

The Organisation for Youth Education & Sexuality (O'YES), the four Federations of Family Planning Centres developed a website mescontraceptifs.be to inform young people in Wallonia and Brussels on contraceptives and broader sexual and reproductive health information.

2.5.4. My emergency contraception

In Wallonia and Brussels, the Federation of Secular Family Planning Centres (FLCPF[32]) developed a web-based tool to facilitate access to information on emergency contraception for the general public, called https://www.macontraceptiondurgence.be It helps visitors find the best suited emergency contraceptives, but also informs about general contraceptive methods, where to find SRHR services and support in case of sexual assault or rape.

2.5.5. Comprehensive Sexuality Education

In 2018, a new decree on pupil guidance was rolled out. Since then, schools are required to have policies concerning health in place. However, in the decree there is no explicit mention of sexual health. Schools might choose to focus on easier, less

[32] https://www.planningfamilial.net/

controversial topics than sexual health. It's still to be evaluated to what degree schools pay attention to sexual health in their health education policies.[33]

Over the past few years, the Flemish government has designed new curriculum goals, setting out the minimal level of knowledge schools should reach with their pupils. The new goals for secondary schools (+/- 12–18-year-olds) give more attention to sexual health. Schools are not only required to make an effort to reach the goals, but also achieve results. Because the goals now explicitly state which knowledge should be attained, they're also easier to evaluate.[34]

However, the umbrella organisation for catholic education in Flanders and the federation of Rudolf Steiner schools complained that the curriculum goals were so extensive that it became impossible for schools to have their own pedagogical project. On 26 June 2022, the Constitutional Court terminated the new curriculum goals for the last four years of secondary school (+/- 14-18-year-olds).[35] A new commission has been set up by the minister of education to decrease the overall volume of the curriculum goals. It's still to be seen which impact this will have on the sexual health goals.

In Wallonia, a guidebook on sexuality education was prepared by the Organization for Youth Education & Sexuality (O'YES) and Planned Parenthood - science-based and age-specific guidebook for professionals co-created with practitioners. However, Wallonia struggles with the same issues as Flanders. It is difficult to come up with exact figures for CSE. Many actors are involved but there is no common register of CSE activities carried out by various external actors. Nor is there any collection of information from the schools on what each one is doing in terms of CSE. Secondly, CSE is also carried out informally in schools through community life, peer education, conflict management, questions asked by students to their teachers, etc. This dimension of CSE is not always easy to understand or measure.

The only rather complete, reliable and representative data available in Belgium at present come from the Jade software used by all the French-speaking family planning centres in Brussels and by some of the centres in Wallonia. Currently, and with the available figures, it is not possible to prove that more than 10.62% of Brussels students had at least one CSE lesson in 2019 and 6.25% in Wallonia, 2019 being the last relevant year in terms of figures before the Covid-19 pandemic. Repeated lockdowns, school closures, and hybrid teaching in 2020 and 2021 made it very difficult - if not completely impossible - to go out and do CSE in schools. However, it

[33] Agentschap Zorg & Gezondheid.(2019.) *Eindrapport Symposium Seksuele Gezondheid, Agentschap Zorg en Gezondheid, 18 februari 2019*.
[34] Vlaamse Regering.(2021). *Decreet betreffende de onderwijsdoelen voor de tweede en derde graad van het secundair onderwijs en diverse andere verwante maatregelen.* (Nr: B.S. 26/05/2021).
[35] Grondwettelijk Hof. (2022). *Arrest inzake de beroepen tot vernietiging van de artikelen 2, 3 en 4, alsook van de bijlagen 1 tot 7, van het decreet van de Vlaamse Gemeenschap van 12 februari 2021 « betreffende de onderwijsdoelen voor de tweede en de derde graad van het secundair onderwijs en diverse andere verwante maatregelen », ingesteld door de vzw « Katholiek Onderwijs Vlaanderen » en anderen en door de vzw « Federatie van Rudolf Steinerscholen in Vlaanderen » en anderen, 16 Juni 2022.* (Nr. 82/2022)

can be observed that prior to the outbreak, the number of hours of facilitation performed by the Family Planning Centres was increasing each year.[36]

3. Key results of the policies

The European Parliamentary Forum for sexual and reproductive health and rights developed a European Contraception Policy Atlas in 2022. It showed that Belgium is the top of the class when it comes to contraception. The score of 91.1% was achieved in part because of the good practices described. The atlas is based on three major categories: access to supplies, access to information and availability of online information. [37]

It stated: '*As of 2020, the Belgian government reimburses all contraceptives for women under 25 (previously, it was for those under 21). Within the same reform, the morning after pill has become free of charge for women of all ages. These policy changes, alongside excellent websites on sexual and reproductive health, give Belgium an impressive score of 96.4% and result in Belgium taking 1st place out of the 46 countries ranked across Europe. Belgium is a federal state with a population of 11.6 million and a well-rated public health system. Information and counselling for contraception fall under primary health care. The main insurances covering the majority of the population offer an annual reimbursement for contraception, and some long-acting reversible contraceptives (LARCs) can reach 100%. There is a good network of Family Planning Centres. The country has an estimated contraceptive prevalence rate of 59%. There are 6 adolescent births per 1000 adolescents and a 6% unmet need for family planning rate among women aged 15-49.*'[38]

4. Assessments of the weaknesses of the existing policies

4.1. Affordability

Despite the health insurance reimbursement scheme, contraception remains expensive in Belgium. Women under 25 have a free alternative, but women over 25 and those who do not qualify for that increased financial allowance pay the full amount. As of yet, no reimbursement scheme exists for newer forms of contraception. The pill remains the most commonly taken form of contraception, but there is no reimbursement for the fourth-generation pill, in which significant change was made to the synthetic oestrogen.

[36] Piessens C. (2022). *Données du logiciel JADE : Analyse des chiffres 2019*. FLCPF.
[37] European Parliamentary Forum for Sexual and Reproductive Health and Rights. (2022). *Contraception Policy Atlas Europe 2022.*
[38] European Parliamentary Forum for Sexual and Reproductive Health and Rights. (2020). *European Contraception Policy Atlas 2020.*

Research conducted by Solidaris in 2017 showed that women find contraception too expensive in Belgium. It examined why women do not use contraception. 8.2% of the women surveyed answered that it was due to cost. Price was an obstacle for 37.5% of women between 41 and 55 years old, for 38.5% of women between 31 and 40 and for 48.9% of women between 21 and 30. The cost, the study stated, inhibits the use of contraception regardless of women's age.[39]

For people with low socioeconomic status, several factors interact. People in poverty often have little education, which in turn is associated with poor knowledge of the body, the menstrual cycle and contraception. Furthermore, it is also difficult for them to make contraception a priority as they often struggle with other (financial) difficulties as well. When other issues become more pressing, contraception may suddenly be interrupted. In addition, research shows that they often feel that they do not have complete self-determination. They experience that others or the government are in charge of their lives. Making family planning decisions is not evident in this context. In addition, it should also be said that people of low socioeconomic status may experience a desire for children very early on. This may also influence their handling of information about contraception and avoiding an unplanned pregnancy.[40]

The reimbursement scheme, or the availability of contraception free of charge lowers one of the most important barriers to contraception, which is cost. The same can be said for the legislation concerning emergency contraception, which is available for free and without prescription. But Belgium should aim at ensuring that reimbursement included all women of reproductive age to reduce social inequalities in access to contraception. One way to do this would be to ensure that NIHDI would guarantee full reimbursement for all contraceptives and emergency contraceptives, as well as the purchase and placement of long-term contraceptives, and not the different health insurance funds, in order to avoid disparities in coverage.[41]

Access to contraception, as mentioned earlier, is a matter of gender equity. Cost should not be a factor that disadvantages women.

4.2. Accessibility of emergency contraceptives

Emergency contraceptives are only legally accessible at the pharmacy or at the Sexual Assault Care centres. Belgium could make efforts to have quicker and more inclusive access to emergency contraception by making it available in drugstores or over the counter. Schools and centres for student-counselling could also be places where students could have access to emergency-contraception and classic contraception (such as condoms). Midwives and other paramedical personnel could also be included in the distribution of (emergency) contraception.

[39] Solidaris.(2017). *Grande enquête – Contraception 2017.*
[40] Agentschap Zorg & Gezondheid. (2019.) *Eindrapport Symposium Seksuele Gezondheid, Agentschap Zorg en Gezondheid, 18 februari 2019*.
[41] Nationale commissie voor de evaluatie van de wet van 3 april 1990 (wet van 13 augustus 1990). (2020). *Aanbevelingen en besluiten naar aanleiding van de tweejaarlijkse verslagen 2014, 2016 en 2018.*

4.3. Anonymity

Besides price, access to contraception is also a matter of easy physical access and access to information. Young people under 25 can obtain a free alternative, but they also need to know that this is even an option and have the access to contraception. Their reimbursement is done through their parents' health insurance fund until they are 25, which does not guarantee their anonymity. Belgium should find a solution for this privacy-problem.

4.4. Shortcomings of CSE provided

There is a lack of good research on effectiveness and outreach of Comprehensive Sexuality Education (CSE) in Flanders and Wallonia. The government does not systematically measure the outcomes (how many lessons do pupils get, on which subjects) nor the impact (what do the pupils learn) of CSE. Problems researchers experience are among others: a low response rate and a self-selection bias among schools. It's currently unknown how many schools have a sexual health policy in place and how many universities (of applied sciences) have a teacher education course in which trainings on CSE or sexual health policies are embedded. There is a lack of research on how well-prepared Flemish teachers are/feel to give CSE.

Still some studies on reflections of students and teachers on comprehensive sexuality education, clearly indicate the shortcomings of the courses provided today.

Most often there are just a few motivated teachers in a school that organise the CSE. These teachers mostly do it out of personal motivation, taking on the extra task without being granted extra hours to organize it. This leads to large differences between schools. Some schools put a lot of effort in CSE, some take a more minimalist approach. Teachers point out there's very little extra time to put into these topics because their own curriculum is already quite full, there's a teacher shortage, they have no mandate and no working time is being freed up to work on this. Teachers say way they feel ill-prepared to give CSE when they start their professional careers and there's little structural planning or division of tasks of CSE topics among colleagues

Sensoa states that pupils tell them that the Comprehensive Sexuality Education (CSE) they receive in schools is not up to their expectation. There's a very limited amount of lesson time spent on these subjects. The lessons focus mostly on the biological aspects of reproduction, relationships and safe sex, and less on positive aspects of sexuality, such as fun, sexual pleasure, intimacy, open and assertive communication and wellbeing. Pupils often find the lessons hetero- and cis-normative and not representative enough when it comes to the bodies and sexualities they show. There is, however, no representative scientific data to back this up.

Will the new curriculum goals concerning sexual health survive the scrutiny of the new commission? At the moment it is unclear which direction the commission will take to diminish the extensiveness of the curriculum goals. Sexual health goals might be cut, diminished or made vague to make room for other subjects.

If the goals survive, how will the government measure whether schools reach these goals? Without some form of external supervision, the goals might turn out to be an empty gesture. A systematic measurement of whether the (sexual) health goals are attained by the school is necessary to make meaningful statements about the (evolution of the) quality of CSE in Belgium.

At the moment, opposition to CSE is rather low in Flanders. There's a small group of ultra-catholic activists opposed to CSE, abortion and freedom in sexual expression. Most politicians and the general public, however, see CSE as a positive and necessary part of school education. Though this might change in the future, when extreme right-wing parties might gain more votes in the next election(s).

Without proper CSE, we are setting our young people up for failure. Contraception use and success rate are closely linked to knowing how to use them without trial and error. There simply isn't room for mistakes when health (STI risks) and unplanned pregnancies are outcomes to be averted. Young people remain a very vulnerable group, and each generation has the right to easy understandable information.

4.5. Gender stereotypes

Although the most recent legislation adopted in April 2022 about reimbursement of emergency contraception for everyone and other contraception methods for people younger than 25 of age is applying for everyone regardless of gender, contraception too often remains a women's issue and a woman's responsibility. Women are seen responsible for thinking about, taking and following up on contraception. The cost and decision still lies far too much solely with women. To a certain extent the rationale behind this, are biological facts, however gender stereotypes also play an important role.

It is important to make all contraception related policies inclusive of all persons with a reproductive system. This is definitely the case for CSE lessons, often hetero- and cis-normative and not representative for the pupils in class.[42]

4.6. Hormone fatigue

Another major challenge in the Belgian context is the phenomenon of hormone fatigue. EPF's contraceptives use and awareness study found that 44.2% of the Belgian respondents indicated that the biggest reason for not taking any contraception is the fact that they do not want to use hormones. Misconceptions about the pill's side effects also contribute to this. For example, 1 of 3 respondents believe that contraception causes weight gain and reduces sexual desire.[43]

Coming up with policies to combat this societal evolution, has proven difficult, which has become clear from the AG review critiques formulated about the contraception-tool on the website allesoverseks.be The review confirmed that the tool only partly

[42] Vlaamse Scholierenkoepel (2016). Scholieren rapport: Wat 17.000 leerlingen in de nieuwe eindtermen willen.
[43] European Parliamentary Forum for Sexual and Reproductive Health and Rights. (2022). Contraceptive use and awareness among young people in the European Region.

meets hormonal contraception information needs. Unfortunately, there is simply not enough research and clarity on the side effects of (hormonal) contraception, making it hard to meet the user's needs.

4.7. Lack of knowledge

Another challenge are the needs of specific communities such as non-native speakers, newcomers and migrants that have been in Belgium for several generations. There is little qualitative data on these communities, often depending on small studies or based on estimations of experts. Nevertheless, it shows that language and lack of knowledge about and access to contraception are the main issues.

Although websites, like "allesoverseks", "Zanzu", "mescontraceptifs" and "moncontraceptiondurgence" are very good tools, information about sexual health rights is not evenly distributed. Migrant communities, young adults and women with intersecting grounds of discrimination are particularly vulnerable and need specific outreach activities. The implementation of Zanzu remains very important but the high maintenance costs make it difficult to keep the website up to date and able to responds to changing global situations. Because of the high costs for example, Sensoa was not able to add Ukrainian to the available languages, even though the demands rose quickly and Zanzu could have been a great tool for Ukrainian refugees looking for information on sexual health in Belgium.

In general, Belgium should make efforts to reach out to vulnerable communities with information and awareness raising campaigns for the general public.

4.8. Abortion services

The debate surrounding the conditions for legal abortion in Belgium, which periodically flares up and has been stagnant for years, regularly influences contraception legislation. This debate mainly focusses on the legal term for abortion in Belgium (12 weeks), the mandatory waiting period (6 days) and the compulsory contraception consultation. A national evaluation commission of the law on termination of pregnancy writes a biennial report and recommendations to parliament. The resulting discussion often culminates in new bills on contraception, which are easier to amend than the legislation on termination of pregnancy.

The latter is important. The link that lawmakers often make between avoiding unplanned pregnancies and contraception ignores the fact that even when contraception is taken correctly, there is still a significant margin of error that all the accessible legislation in the world cannot solve. Here, it is important to separate contraception from avoiding unplanned pregnancy and approach it from an equal opportunity perspective where the choice of how many children, when and with whom should outweigh abortion avoidance. Likewise, the right to terminate an abortion should be a woman's choice, regardless of whether or not she is on birth control.

5. Main questions and issues for debate

- Cost is a main barrier. Should Belgium guarantee full reimbursement for all women of reproductive age via National Institute for Sickness and Disability Insurance (NIHDI) I to reduce social inequalities in access to contraception?
- Emergency contraceptives are free for everyone but still it can only be accessed in the pharmacy or in the sexual assault care centres (SACCs). Should the accessibility be increased by making emergency contraceptives available over the counter, in drug stores and at schools?
- How can Belgium guarantee anonymity for minors when they want to make use of the free access to contraception, without having to pass through their parents' health insurance?
- How can the quality and impact of comprehensive sexuality education be upscaled by capacity building of teachers, and by making the content comprehensive and gender inclusive?
- How can contraception related policies be made inclusive of all persons with a reproductive system?
- Can investment in research on the impact of hormonal contraceptives be increased as a response to hormone fatigue?
- How can vulnerable and hard to reach groups be reached with up-to-date information on contraception according to the latest medical recommendations, so they may make autonomous informed decisions?
- How can law makers be convinced to separate contraception from avoiding unplanned pregnancy and approach it from an equal opportunity perspective where the choice of how many children, when and with whom should outweigh abortion avoidance?

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