SURINAME

COUNTRY REPORT ON
THE UNGASS DECLARATION OF COMMITMENT
TO HIV/AIDS

JANUARY 2005 – DECEMBER 2007

MINISTRY OF HEALTH
SURINAME
JANUARY 2008

CONTENT **PAGE**

List of Acronyms

VI. **Introduction……………………………….…………………………4**

VII. **Status at a glance……………………………………………………..5**

VIII. **Overview of the AIDS epidemic………………………………………. 8**

IX. **National response to the AIDS epidemic………………………………11**

X. **National Programs and Behavior……………………………………...15**

I. **Best practices…………………………………………………………20**

II. **Major challenges and remedial actions………………………………. 21**

III. **Support from country's development partners………………………….24**

IV. **Monitoring and evaluation environment………………………………26**

ANNEXES

1. **Consultation/preparation process for the Country Progress Report**
2. **National Composite Policy Index Questionnaire**
3. **M&E worksheet**

List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti retroviral therapy
ARV	Anti retroviral
CAREC	Caribbean Epidemiology Center
CCPAP	Common Country Program Action Plan
BCC	Behavior Change Communication
BLSP	Basic Life Skills Program
DS	Dermatological Services
GTT	Global Task Team
HR	Human Resource
HIV	Human Immunodeficiency Virus
IEC	Information Education and Information
ILO	International Labor Organization
IBBS	Integrated Biological and Behavioral Surveillance
IDB	International Development Bank
JR&R	Joint Review and Revision
KAPB	Knowledge, Attitude, Practice and Behavior
MARPS	Most At Risk Populations
MICS	Multiple Indicator Cluster Survey
MSM	Men who have sex with men
MOH	Ministry of Health
MM	Medical Mission
NAC	National AIDS Commission
NAP	National AIDS Program
NGO	Non Governmental Organization
NSP	National Strategic Plan
NSHP	National SOA/HIV Program
NHIVS	National HIV Secretariat
OPEC	Organization of the Petroleum Exporting Countries
OVC	Orphanages and other Vulnerable Children
PLHIV	People living with HIV
PMTCT	Prevention of mother to child transmission
RGS	Regional Health Services
TB	Tuberculosis
SBC	Suriname Business Coalition
SMLA	Stichting Maxi Linder Association
SMU	Suriname Men United
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
SW	Sex Worker
UNDAF	United Nations Development Assistance Framework
UNGASS	United Nations General Assembly Special Session
UNFPA	United Nations Population Fund
UWI	University of the West Indies
VCT	Voluntary counseling en testing

I. INTRODUCTION

In June 2001 the Government of Suriname adopted the UNGASS Declaration of Commitment, thus underlining national commitment to the fight against HIV and AIDS.
In May 2004, the Government of Suriname and its partners developed the National Strategic Plan on HIV/AIDS 2004-2008 (NSP). The overarching objective of this NSP is: "to halt the spread of HIV and to reduce the negative effects of HIV and AIDS on the community". The NSP outlines a multi sector approach involving all sections of society. Since then this NSP served as the national framework for expansion and strengthening of the multi sectoral response against HIV/AIDS. Approval of a Global Fund grant and continued strong partnerships with UN and other partners provided the necessary financial resources for rapid expansion of national programs. In 2005 a second Global Fund grant enabled rapid up scaling of national-level and targeted prevention efforts.

Now, three years later, there are more stakeholders involved than ever before in financing and implementing this NSP. Responsibility for coordination of these various, national and international, actors in the HIV arena lies with the National AIDS Program of the Ministry of Health. The wide variety of stakeholders, both in terms of technical focus as well as geographic coverage, poses a challenge to coherent implementation of the NSP. The past two years have brought about significant increases in knowledge and lessons learned, both locally and globally, on how to respond more effectively to HIV.

A recent finalized joint review of the first NSP, covering the period 2004-2007, indicates that Suriname has made accelerated progress towards the UNGASS targets.
The Government of Suriname has decided that stock had to be taken, by reflecting on the achievements so far, reviewing progress made, deciding on priorities and setting realistic yet ambitious targets towards universal access to HIV prevention, treatment, care and support for the remainder of this NSP period and beyond.

Based on the 'Three Ones[1]' principles, Suriname's commitment to move towards universal access for HIV prevention, treatment, care and support, and the recommendations of the Global Task Team (GTT) for better HIV coordination of the international donors and multi lateral institutions, the focus of the joint review and revision (JR&R) that started in August 2007, was forward-looking and concentrates on developing consensus around a results-based framework for action for the period 2008 to 2013. The JR&R process provided an opportunity for partners to jointly review progress, identify achievements, constraints and gaps that need to be addressed and plan for the future.

The JR&R drew upon existing documentation to the extent possible and ensures that all analyses and conclusions were linked to relevant government-led processes. It was a country-led, participatory process towards a National Results-Based HIV Framework 2009-2013, a 'costed' National HIV Plan of Action 2008-2009 and a "National HIV Policy" for Suriname.

1 One national HIV coordinating authority, one national HIV plan with one monitoring plan

II. STATUS AT A GLANCE

Status of UNGASS National Indicators in Suriname, based on 2005/2006 data

#	Indicator	Status	Sources/Comments
	National Commitment and Actions		
1	Domestic and International AIDS spending by categories and financing sources		See for more details the narrative, chapter 4.1.1 , page 11
2	National Composite Policy Index		See Annex 2
3	% of donated blood units screened for HIV in a QA assured manner	**100%**	Source: National Blood Bank of Suriname, 2006
4	% of adults and children with advanced HIV infection receiving ART	**41%**	According to UNAIDS estimated HIV adult prevalence in Suriname (2005) and CAREC guidelines to estimate HIV+ in need of ART (2006) Proxy indicator: '% of adults with advanced HIV infection receiving ART' Source: Ministry of Health (MOH), 2006
5	Percentage of HIV + pregnant women who received ART to reduce the risk of MTCT	**N.A**	Data mining in process – expected to be available in first quarter of 2008 Source: Ministry of Health (MOH), 2007
6	% of estimated HIV + incident TB cases that received treatment for TB and HIV	**N.A.**	Data mining in process – expected to be available in first quarter of 2008 Source: Ministry of Health (MOH), 2007
7	% of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results		Proxy indicator: 'women, 15-49, who have received an HIV test and who know their results'
	% of women, 15-49, who have received an HIV test	**33%**	Preliminary Report on 'Multi Cluster Indicator Survey' (MICS), 2006 Source: Government of Suriname/Unicef, 2006
	% of women who received an HIV test and who received their results	**90.6%**	Idem.
8	% of MARPS that have received an HIV test in the last 12 months and who know their results		Great difficulties to identify all MARPS and estimate size of these populations. Convenient sample based survey data available on sex workers.
	Female sex worker	**58.8%**	
	Male sex worker	**74.5%**	

2 Caribbean Epidemiology Center (CAREC) and Maxi Linder Foundation (2004). HIV/AIDS and Commercial Sex Work in Suriname: an HIV sero-prevalence and behavioral study among commercial sex workers (CSW) in Suriname.

#	Indicator	Status	Comments
	Total sex workers	**61.8%**	Proxy indicator: 'female and male sex worker, who ever had an HIV test done' Source: CAREC/PAHO/SMLA'Sero survey among sex workers', 2005[2].
9	% of MARPS reached with HIV prevention program	**N.A**	Great difficulties to identify all MARPS and estimate size of these populations
10	% of OVC aged 0-17 whose households received free basic external support in caring for the child	**N.A**	Not required to report; prevalence of OVC in Suriname is far below 5% : 0.3% of children aged 10-14 years have lost both parents and can be considered orphans (MICS, 2006).
11	% of schools that provided life skills-based HIV education in the last academic year	**N/A**	Sexual health education is integrated in curriculum of 5th and 6th grade of primary school and continues in secondary school. Adding specific life skills based HIV education is implemented in a limited number of schools as a pilot: See narrative for details
#	**Indicator**	**Status**	**Comments**
	National Knowledge & Behavior		
12	Current school attendance among orphans and among non-orphans aged 10-14	**10-14 yrs Among orphans: 84.1% Among non-orphans: 95.0% Ratio= 0.9 -1.0**	Source: Preliminary report MICS, 2006
13	% of young women and men aged 15-24 who both correctly identified ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission		Proxy indicator: 'women, 15-24 who correctly identified ways of preventing sexual transmission of HIV and reject major misconceptions about HIV transmission' Source: Preliminary report MICS, 2006
	Females, 15-19 years	**40.5%**	
	Females, 20-24 years	**41.6%**	
	Females, 15-24 years	**41.0%**	
14	% of MARPS who both correctly identify ways of preventing the sexual transmission of HIV and who reject misconceptions about HIV transmission		'Sero survey among sex workers' Source: CAREC/PAHO/SMLA, 2005 Convenient sample based survey data available on sex workers.
	Correctly identify ways of preventing sexual transmission of		Proxy indicator: '% of sex workers who correctly identify ways of

	HIV		preventing sexual transmission of HIV'
	Male sex workers	**74.5%**	
	Female sex workers	**79.4%**	
	Total sex workers	**78.4%**	
	Reject misconceptions about HIV transmission		Proxy indicator: '% of sex workers who reject misconceptions about HIV transmission'
	Male sex workers	**61.7%**	
	Female sex workers	**43.8%**	
	Total sex workers	**47.3%**	
15	% of young women and men aged 15-24 who have had sexual intercourse before the age of 15	**8%**	Proxy indicator: '% of women and men, aged 10-14, who reported to have had sexual intercourse' Source: Ministry of Health/ProHealth, 2006[3]
16	% of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months		Proxy indicator: 'women, aged 15-24 who had sex with more than one partner in the last 12 months' Source: Preliminary report MICS, 2006
	Females, 15-24 years	**3.4%**	
	Females, 15-19 years	**3.0%**	
	Females, 20-24 years	**4.0%**	
17	% of women and men aged 15-49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse	**48,9 %**	Proxy indicator: 'women 15-24 years, who reported sex with a non-regular partner in the last 12 months, and reported use of a condom' Source: Preliminary report MICS,2006
18	% of female and male sex workers reporting the use of a condom with their most recent client		'Sero survey among sex workers' Source: CAREC/PAHO, SMLA, 2005 Convenient sample based survey data available on sex workers.
	Female sex worker	**67.5%**	
	Male sex worker	**78.7%**	
	Total sex workers	**69.7%**	
19	% of men reporting the use of a condom the last time they had anal sex with a male partner	**89.1%**	Convenient sample based survey data available on MSM 'Survey among Men who have Sex with Men (MSM)'[4] Source: CAREC/PAHO, SMLA, 2005
20	% of injecting drug users reporting the use of a condom the	**N.A**	No significant indicator in Suriname

3 Ministry of Health/ProHealth (2006) 'Onderzoek naar 'Jongeren en hun gezondheid'. This sample survey has been conducted in 5 selected districts.

4 Caribbean Epidemiology Center (CAREC) and Maxi Linder Foundation (2005). An HIV sero-prevalence and behavioral study among men who have sex with men (MSM) in Suriname.

#	Indicator	Status	Comments
	last time they had sexual intercourse		According to national data prevalence of intravenous drug use is only 0.3% of all identified 800-1000 regular drug users
21	% of injecting drug users reporting the use of sterile injecting equipment the last time they injected	**N.A**	Idem
#	**Indicator**	**Status**	**Comments**
	National level programme impact		
22	% of young people aged 15 – 24 who are HIV infected	**1.1%**	Proxy indicator: 'HIV seroprevalence among pregnant women, aged 15-24 years' Source: Ministry of Health, 2006
23	% of MARPS who are HIV infected		'Sero survey among sex workers', 'Sero Survey among MSM' Proxy: 'HIV seroprevalence among MSW and FSW, and MSM' Source: CAREC/PAHO, SMLA, 2005 Convenient sample based survey data available on sex workers.
	Male sex worker	**36.2%**	
	Female sex workers	**21.1%**	
	MSM	**6.7%**	
24	% of adults and children with HIV known to be on treatment still alive 12 months after initiation of ART	**80.3%**	Source: Ministry of Health, 2007
25	% of infants born to HIV-infected mothers who are infected	**N.A**	Data mining initiated – expected to be available in first quarter of 2008

III. OVERVIEW OF THE AIDS EPIDEMIC

The Republic of Suriname is approximately 163,830 square kilometres, situated on the North-East coast of South-America, often categorized as the most mixed country of the Caribbean, in terms of ethnic cultures, religions and languages. Suriname comprises many ethnic groups, practicing almost all world religions and speaking more than 15 languages.

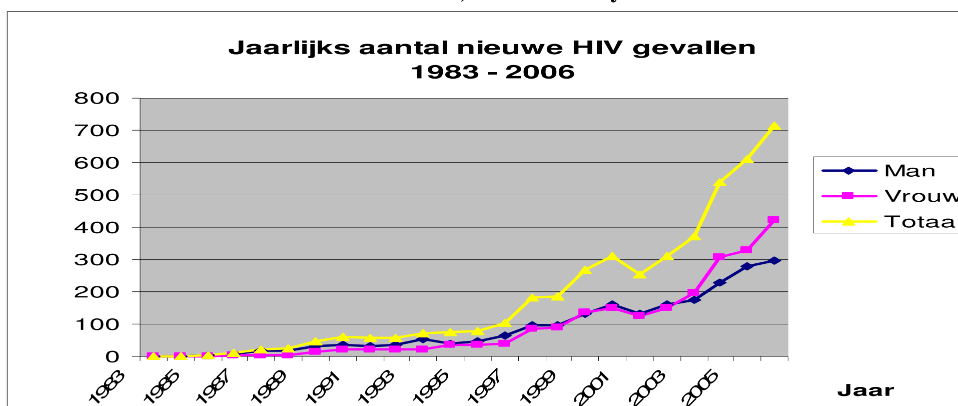
In 2006 the population size was approximately 504.257 persons (50.3% men and 49.7% women), of which 70% lives in the coastal urban areas with concentrations in the capital of Paramaribo and the district of Wanica, which occupy only 0.4% of the total land area. About 20% of the population lives in rural areas and about 10% lives in scattered tribal settlements in the interior traditionally inhabited by Maroons and Indigenous people whose living conditions and health status show large disparities with urban areas. The interior is currently facing large inflows of local and foreign labor migrants attracted by the booming and rapidly expanding gold mining activities in these areas.

On national level, the population of outward labor migrants is mainly comprised of Brazilians, Guyanese, Haitians and Chinese. Internal migration patterns are dominated by families of the

interior moving to Paramaribo, where they often live in low income communities and face multiple socio-economic and cultural problems.
Traditionally, there is a high mobility of persons between Suriname and bordering countries Guyana and French Guyana, many involved in informal petty trade.
Suriname has a relatively young population, with about 20% younger than 8 years and about 31 % in the age group 10-24 years. Approximately 60% of the population lives below the poverty line, and about one third of households is headed by single women. In 2000, life expectancy at birth averages 70 years for women and 68 years for men.

The first case of HIV/AIDS was registered in Suriname in 1983 and currently an estimated 1.9% of the adult population is infected with HIV (UNAIDS, 2005). In 2006 a total annual number of 715 new cases were recorded, while the total cumulative number of registered HIV/AIDS cases reached 4.358, consisted of 2.215 women and 2.143 men. (Ministry of Health. 2006)

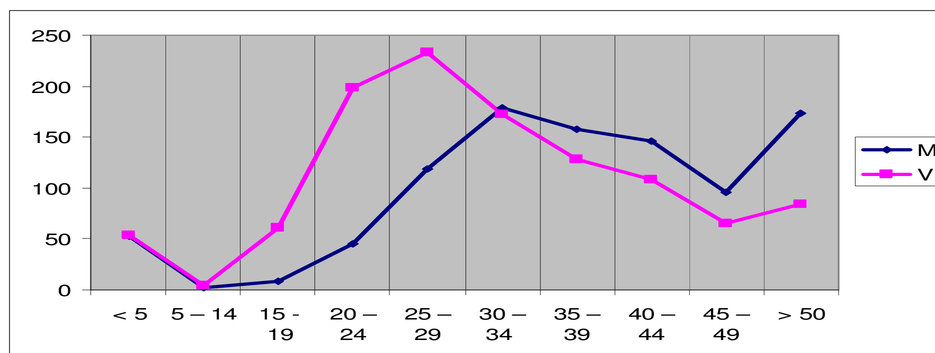
Figure 1: Annual number of new HIV cases, 1983-2006 by sex



Source: HIV/AIDS/STI Surveillance Team

The gender distribution of new HIV+ cases has shifted over the years and since 2004 females account for the majority of reported HIV+, in particular in the younger age groups of 15-19 years and 20-24 years. This unequal gender pattern can be ascribed to several factors: the huge scaling up of HIV screening of pregnant women, much more women than men applying for VCT and the higher vulnerability of (young) women to HIV infection due to their relative weak economic and socio cultural position.

Figure 2: HIV+ by sex and age, 2001-2005

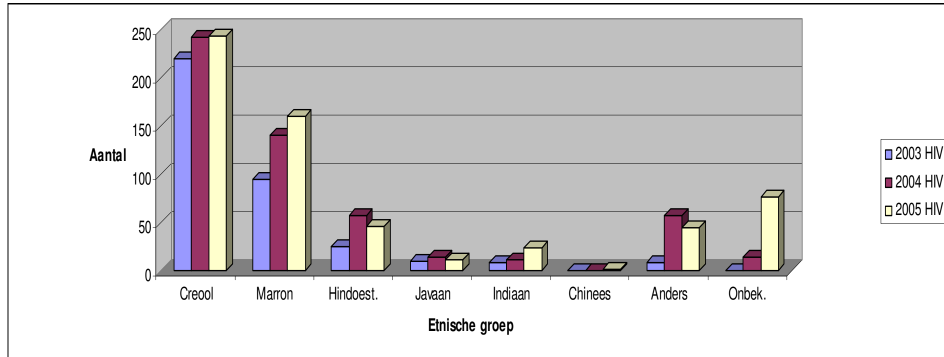


Source: HIV/AIDS/SOA Surveillance Team

In terms of age distribution, the highest registered prevalence is in the age-group 15-49 years. Sixty to eighty percent of the annual new cases are in this age-group.
In accordance with the regional Caribbean pattern, the main mode of HIV transmission in Suriname is unprotected sexual contact.

Reported HIV cases show large disparities if ethnic groups are compared. Creoles and Maroons account for the largest groups of HIV positives.[5]. Disparities between ethnic groups need closer study. Possible explanations could be ethnic culturally determined sexual patterns, perceptions about health and diseases, access to services and seeking aid behavior.[6].

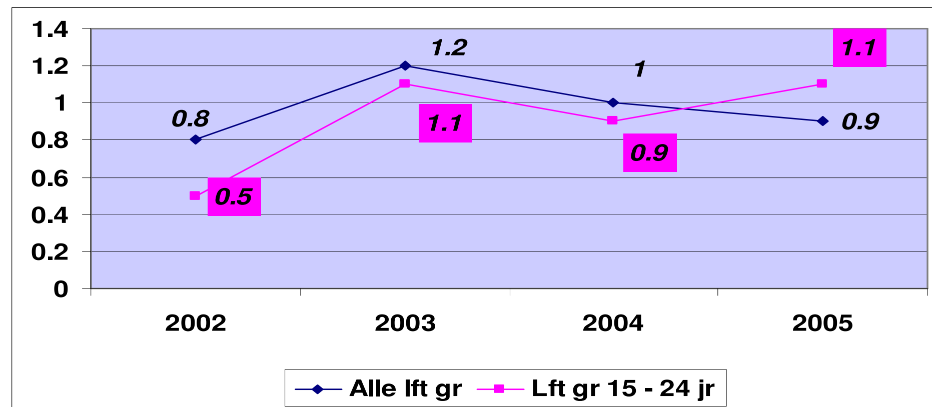
Figure 3: Reported HIV+ case by ethnic background, 2003-2005



Source: HIV/AIDS/SOA Surveillance Team

In 2005, HIV screening coverage of pregnant women reached a proportion of approximately 78%. HIV prevalence found among pregnant women was 1.0% in 2004 and 0.9% in 2005. HIV prevalence is 1.1%, among young pregnant women, aged 15-24 years (2005).

Figure 4: HIV seroprevalence among pregnant women, 2002-2005



Source: HIV/AIDS/SOA Surveillance Team

The Most at Risk Populations (MARPS) so far most identified in Suriname are the sex workers (SW) and men who have sex with men (MSM). Recent sero surveys, conducted in the capital

5 HIV/AIDS/SOA Surveillance Team, Powerpoint 'Update van HIV/AIDS in Suriname' Augustus 2007

6 Medische Zending/ProHealth, 2005. 'Evaluation of the STI/HIV/AIDS program 1998-2003'

Paramaribo, found prevalence rates of 24.1% among street sex workers in 2005[7], and 6.7% among men who have sex with men in 2005[8]. These data confirm earlier sero surveillance findings, indicating that Suriname's HIV epidemic is generalized but at the same time with concentrated epidemics in sub-populations.

Co-infection of Tuberculosis and HIV is increasingly an area of concern and interventions.
With respect to TB, in 2004 HIV sero prevalence among TB patients was 24.6%, in 2005: 21.3% and in 2006: 22.3%. These results indicate that almost one quarter of the TB epidemic is closely connected to the HIV epidemic. In this regard the close collaboration between the HIV and TB programs has been identified as a priority action to be implemented on short term.

The annual numbers of HIV related hospitalizations suggest a decreasing trend. Hospitalizations went down from 255 in 2004 to 239 in 2005 and reduced further to 206 in 2006. There are fewer women hospitalized than men. Most hospitalized women are in the age group 20 - 44 years while the majority of male patients is in the age group 25 - 49 years.

A declining trend can also be assumed with regard to AIDS mortality. While in the period 1999 - 2005, HIV/AIDS rose from the tenth to the fifth place on the list of main causes of death in Suriname, in 2006 AIDS went down to the sixth place. In absolute terms, reported AIDS deaths declined from 152 in 2004 to 129 in 2006. In the age group 25-49, AIDS is the second leading cause of death.

There is no information available on the prevalence of HIV due to intravenous drug use. However, we can assume that injecting drug use as a mode for HIV transmission is not significant in Suriname considering the fact that only 0.3% of the estimated 800-1000 drug users in Suriname have reported to inject drugs (2006)[9].

IV. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

4.1 National commitment and action

Since 2004 the HIV response in Suriname is guided by the National Strategic Plan for a multi sectoral approach of HIV/AIDS, 2004-2008. Mid 2007 preparations started for a joint review and revision of the current NSP and at the end of December 2007 this process resulted in the development of a draft second NSP 2009-2013 and a two year Action plan 2008-2009, which will be submitted to the Council of Minister for official approval. Both NSP's were developed as results based strategic frameworks and based on a national and broad consultative process.
The priority areas for strategic interventions remained more or less the same with slightly different focuses. The current 5 priority areas of the NSP are:
1. National Coordination, Policy and Capacity building
2. Prevention of further spread of HIV
3. Treatment, Care and Support
4. Reduction of stigma and discrimination of PLHIV

7 Caribbean Epidemiology Center (CAREC) and Maxi Linder Foundation (2004). HV/AIDS and Commercial Sex Work in Suriname: an HIV sero-prevalence and behavioral study among commercial sex workers (CSW) in Suriname.

8 Caribbean Epidemiology Center (CAREC) and Maxi Linder Foundation (2005). An HIV sero-prevalence and behavioral study among men who have sex with men (MSM) in Suriname.

9 National Drugs council, 2006

5. Strategic Information for policy development and service provision

4.1.1 Allocation of government funds for the national HIV response

As part of the national commitment and actions the government is providing support through increased budget allocations for the HIV response.
In 2007 the government of Suriname, in particular the Ministry of Health, allocated a specific budget for the national coordination of the HIV response, amounted US$ 500.000. In the recently approved budget for 2008, the allocated government funds have been scaled up to US$ 800.000.
On a much smaller scales other ministries have also increased their expenditures on HIV, however not specified as such and therefore not identifiable on their budget.
In order to facilitate the production of accurate figures on government expenditures on HIV, UNAIDS has offered support to introduce the application of the National AIDS Spending Assessment (NASA) account model in Suriname and will assist in making these data available for the next UNGASS meeting in June 2008.

1.1 National coordination structure

In 1987 the National AIDS Committee was established in Suriname, followed by establishment of the National AIDS Program (NAP) in 1988, as a division of the Ministry of Health. In the early 1990s, the NAP supported the foundation of a number of NGOs aimed at provision of specialized programs for PLHIV, youth, and sex workers. These NGOs continued to function as major partners in the national response to HIV.
In 1996 the NAP was placed under the Dermatological Services (DS), following the international trend of placing HIV under the programs of sexual transmitted infections, and the name was changed to National SOA/HIV program (NSHP).

For several years the performance of the NAP has been hampered by a lack of human and financial resources. In 2002, with the technical and financial support of the UN theme group on AIDS, a situation and response analysis was conducted followed by the development of the National Strategic Plan, which was finalized and approved by the government in 2004. The NSP provided an excellent condition for successful mobilization of resources, in first instance primarily aimed at the institutional strengthening of the NAP. A Steering Committee was established with the NAP as the implementing unit.
With the approval of two grants of the Global Fund for HIV in 2005, support of several development partners and technical assistance from UNAIDS, the implementation process of the newly developed national coordination structure started. This structure is based on the three ones principles and composed of the following components:

1. The National HIV Council
2. The National HIV Policy Council
3. The National HIV Partnership Committee
4. The National HIV Secretariat (NHIVS)

Implementation of this new structure is slow, which is partly due to lack of capacity. All staff that was hired to execute the GF grants and their related portfolio, was also assigned the responsibility for the coordination of the implementation of the National Strategic Plan.
The recent joint review revealed that in practice the NAP has mainly functioned as the Project Management Unit, executing the Global fund grants. It is acknowledged by all stakeholders that this position can not be maintained as the NAP is expected to play a leading role in the coordination of a multi sector national HIV response. Continuing in this manner would mean that

this institution will seize to exist with the end of the current Global Fund grant that currently provides full funding to the daily exploitation of the NAP, including staff salaries.

In this light a comprehensive study has been conducted aimed at organizational and institutional strengthening of the NAP. Based on the results of this particular study and identified priority issues in the second NSP, an implementation plan is being developed to implement the new structure which will be made more sustainable and less dependable on external resources.
Preparations are in place for the installation of the National HIV Council, which will function as a high level performance monitoring body and is envisioned to include representation of key Government agencies, NGO's, private sector, civil society and PLHIV. The National HIV Partnership is official established but does not function as well as wished. This platform will play an important role in the constant monitoring of the process through regular feed back meetings in which partners will report on their work. In addition, applied strategies and actions will be reviewed and where needed adjusted.

4.3 Multisectoral Participation

HIV has been included as a priority in Suriname's current Multi-Annual Development Plan, 2006-2011, and in several other national policy documents, among others the National Gender Action Plan and the 'Sexual and Reproductive health Policy. An important strategy being implemented by the Ministry of Health is the integration of SRH, including STI and HIV prevention, treatment and care in the primary health care system.

In order to speed up mainstreaming of HIV in government policies and programs, the 'HIV Policy Council' was established. This is an inter-ministerial consultation comprised of relevant permanent secretaries lead by the ministry of health.
Based on the NSP, increased efforts were made to include more partners in the response, which generated rewarding results. Since 2004, the private sector and faith based organisations enlarged their involvement and separate structures and mechanisms were put in place for an effective participation in the response. In this regard the Suriname Business Coalition (SBC) was established, and together with the government, resources were mobilized for the development of HIV workplace policies and programs, which are currently being prepared and implemented. The inter religious council identified and integrated HIV as a priority issue in their policies and programs and currently a inter religious network for HIV is being build for joined action, in particular in the field of HIV prevention, and psycho-social counselling of PLHIV.

4.4 Summary Findings from the National Composite Policy Index (See also Appendix 2)

Strategic Planning

- NSP 2004 -2008:
  - Sectors included (health , education, armed forces)/young people, women
  - Budget not based on sector but on activity/output level
  - Identification of target population unknown (probably through analyses of available data (prevalence/ incidence and other available information
  - Active involvement of civil society in development operational plan through consultation, studying of drafted documents.
  - NSP is integrated in national development plans (MADP) especially with the areas Prevention /Therapy/Care and support /Stigma and discrimination)
  - The impact of HIV and AIDS on the national development is not evaluated for planning purposes.

- There is progress experienced in monitoring and strengthening of the health infrastructure but this does not result in an update of the target population and budgets.
- Overall there is a sense that the planning efforts have slightly improved (e.g.a more programmatic, in-depth approach, better use of knowledge)

Political Support

- No specific efforts through civil society to increase political support also no body promote interaction between government and civil society.

Prevention /Treatment Care and support

- Policy development in most cases is lacking (prevention, IEC, promotion of comprehensive HIV treatment care and support, OVC)
- Most activities are implemented without a structured approach. (According to respondents there is a slight growth in the prevention efforts and implementation: more awareness and in-depth discussion on approaches)
- Overall the efforts in policy on OVC are less positive rated than other sections

Monitoring and Evaluation

- Overall rating of M&E efforts is low; there is however more understanding on the need and value of data. There is a general confusion on tasks and responsibilities. What are the difference between NAC/NAP, M&E department/NHIS of the ministry of Health.

Human rights:

- Initiatives and focus on this area with regard to HIV is lacking. There are laws for protection against discrimination in general; also service delivery is non- discriminatory.
- Possible discrimination exists at the service level due to attitudes of health care delivery staff on the work floor. Free services are guaranteed by funding through project funds (Global fund) posing threats for continuation after ending of funds.
- Respondents are not quite sure if human rights are explicitly mentioned in although absence seems unlikely especially since there is close collaboration with UN agencies who in general explicitly refer to the promotion of human rights.(human right desk to record and address anti- discrimination)
- In so far cases against violations of rights were conducted this was due to empowerment of individuals than from an national proactive approach

Civil Society Participation:

- Civil society participation into the process was good. The sector was well represented in reviewing and revising of the NSP and overall there is participation in efforts related to HIV.
- Access of civil society to financial and technical support is also rated good (3,3) although this access varies with organizational strength and size.
- The effort nationally to increase the participation of civil society is positively rated and has increased over the year

Prevention / Treatment, Care and Support

- Even within civil society sector there seems to be an agreement that although no reliable data is available there is common knowledge that interior areas are more in need than other because they have been underserved. Although efforts in implementing services in prevention and treatment have increased, in the case of prevention questions on effectiveness and efficiency exist.
- Civil society contribution in services is high (more than 75%) in most areas (prevention programs to youth and vulnerable sub populations, home based care and support to orphans and other vulnerable children). 50-75% cases of counseling and testing are efforts from civil society and less than 25% of clinical services delivered.

V. NATIONAL PROGRAMS AND BEHAVIOUR

PREVENTION PROGRAM

5.1 Information, Education and communication (IEC)

Due to the active participation and initiatives of civil society, there was a tremendous increase in number of educational and awareness activities on individual, community and national level. Prevention strategies, aimed at the general population and identified high risk populations, include capacity building, development of educational and awareness raising programs and materials and mass media campaigns in several languages. A large number of service providers were trained in Suriname and abroad, while a more structural approach was developed by the establishment of a 'Health Education' track at the Teacher Training College in 2007.

A main conclusion of the joint review was that preventions program could have been more effective if interventions were 'evidenced based', that is guided especially by information about 'behavior and perceptions' of identified target groups. Critical is also that executed interventions are evaluated and adjusted to real needs of target groups.

5.2 Behavioral Change Communication (BCC)

Increased awareness on the limited and temporary impact of knowledge on behavior, lead to much more emphasize on a more structural approach by the promotion and strengthening of behavioral change communication strategies. During the reporting period efforts were aimed at strengthening the technical capacity at NAP and other partners in the response in order to strengthen Behavior Change Communication (BCC) knowledge and skills for the development of effective strategies.

BCC training was provided to prevention managers from Government agencies and NGO's with support from UNFPA, CAREC and the University of the West Indies (UWI). In several communities, including areas with identified high risk sexual behavior, BCC community projects have been initiated by mainly NGO's and supported by both government and UN agencies.

5.3 Provision and distribution of Condoms

Condoms, in different branches are both sold for a minimum price and distributed free-of charge for certain high risk groups, mainly by government and in a lesser extent sold by private retailers. In the period 2005-2007, annually about half a million condoms were made available through UNFPA funds and distributed through the NAP, main primary healthcare service providers and NGO's. Apart from the government, also private enterprises are involved in import and distribution of condoms, however, with a much smaller share than the government.

During the reporting period distribution of free condoms to high risk and vulnerable populations continued and the Ministry of Health implemented a campaign aimed at introduction and promotion of the female condom. Approximately 24.000 free female condoms were distributed through different channels; inter alia pharmacies, basic clinics, NGO's etc.

A major challenge is the development of a national condom policy, including a social marketing strategy, based on results of a national condom survey. This activity has been identified for several years as one of the priorities; however implementation is delayed due to lack of sufficient funds.

5.4 Basic Life Skills Program (BLSP)

Even before HIV became a national issue, selected elements of sexual health education were already incorporated in the curriculum of the 5th and 6th grade of primary school and continued in the secondary cycle. Within the context of the HIV response, the Basic Life Skills program of the Ministry of Education has initiated the development of HIV and SRH curricula for all levels of education and will continue to lead the process of integration of HIV prevention in the education system in both Paramaribo, the capital, and districts. In 2007 about 11 of the 282 primary schools, provided at least 30 hours of life skills based training to the fifth and the sixth grade. In secondary education 9 of the 106 secondary schools included life skills based HIV education in their curricula. Currently the BSLP started implementation of the integration of SRH, including HIV, in the existing subject 'nature sciences' of the primary school curriculum.

5.5 Voluntary, Counseling and Testing (VCT)

In recognition of the critical role of HIV testing, universal access to voluntary counseling and testing was significantly improved. A national VCT protocol including the national rapid test algorithm was developed and introduced. The number of VCT sites was increased from two in 2003 to eleven by the end of 2007, and free VCT services were introduced in both the urban areas and districts. A high profile "Know your Status" campaign was executed to promote HIV testing. The scaling up of VCT services resulted in an accelerated rise in annual HIV tests. While in 2005 the total number of HIV tested persons through VCT sites was about 2000, in 2006 annual provided VCT for HIV went up tremendously to 10.151.
The current trend show much more women than men are likely to visit a VCT site to do a test.
VCT audits and evaluation studies are being prepared.

5.6 Prevention of Mother To Child Transmission (PMTCT)

Within the context of scaling up of PMTCT, the HIV test was incorporated in the regular prenatal blood screening of all pregnant women. In 2005 a record number of 6.733 pregnant women was tested, equal to achievement of 78% HIV screening coverage of all pregnant women. In 2005 and 2006 respectively 63 and 92 pregnant women were diagnosed with HIV.
PMTCT is expected to be performed according to the national protocol, including adequate pre- and post counseling and voluntary HIV testing. There are however reports of persistent inconsistencies and incompleteness's in the implementation of the protocol. In this regard evaluation of the implementation of the PMTCT protocol is identified as a priority issue aimed at improvement of the quality of this service.

1.1 Sex work program

Suriname is one of the few countries in the Caribbean region with a well-established separate program for people involved in sex work (SW), including both women and men.
Since 1994 the foundation 'Maxi Linder' (SMLA) has developed and implemented a wide range of prevention and care and support programs for this subpopulation of MARPS. Although HIV prevalence among SW has more or less remained the same in the past years, provision of services was scaled up. The estimated number of sex workers in the country is approximately 2000, with the largest concentrations in Paramaribo and some other urban areas. There are indications of growing numbers of sex workers related to the blooming gold mining industry in Suriname. In this regard interventions on sex work in Paramaribo, will be extended to some relevant areas in the districts and in the interior. Most interventions are outreach activities and include provision of education, free condoms, VCT and psycho-social support. Programs are being prepared for economic empowerment of sex workers through strengthening alternative occupational skills and creating job opportunities for people who want to leave sex work.

5.8 Men who have sex with men program

In 2007, a Dutch Donor 'Schorer Foundation' provided technical and financial support for a four year program for Men who have sex with Men (MSM), which will be coordinated and implemented by two NGO's, i.e. a recently established MSM NGO 'Suriname Men United' (SMU) and the newly established 'MSM+' division of the longer existing NGO 'Mamio Namen' foundation, which is mainly focused on care and support of PLHIV. In 2005, with the support of CAREC a sero survey has been conducted among MSM, which provided some insights on (sexual) behavior of this target group. However, much more data need to be collected, in particular on the existing subpopulations of MSM, the sexual networks, and how they are connected with the general population. In this regard some interventions are being prepared in the field of research but also in the field of services. The Dutch embassy in Paramaribo has made funds available for the implementation of a 'small grants' program especially targeting MSM groups.

5.9 HIV and workplace programs

Guided by the NSP and in particular by the 'ILO Code of Practice on HIV and the world of work', the business sector, the Ministry of Labor and workers unions joined forces in the response against HIV, which resulted in some milestone achievements in the workplace response against HIV.

First, the establishment of the Suriname Business Coalition against HIV (SBC) in December 2005, funded by the Dutch Embassy, currently includes ten medium to large companies in Suriname (with 1000-2500 employees). In three of the nine companies, based on KAPB surveys, draft HIV policies were developed and integrated in existing HR policy. Guided by international standards and the specific Surinamese experiences, the SBC developed an adjusted model policy on HIV in the workplace, which would make it much easier for the remaining enterprises to follow in policy development. Non governmental organizations such as Maxi Linder Foundation and Mamio Namen Project contributed by providing HIV sensitization and training for workers, including human resource managers. Working towards a more systematic and strategic approach, the SBC recently developed a costed strategic plan for the period 2008-2009, including an action plan.

Second, the start of the HIV/AIDS Workplace Education Project of the Ministry of Labor, funded by ILO and OPEC, in July 2007, which will address the areas of policy formulation, prevention and reduction of stigma and discrimination in both public and private sector.
The Ministry of Labor has also prepared a 'zero' draft HIV workplace policy and planned to promote workplace interventions through the existing structure of the enterprises' health and safety' committees.

TREATMENT, CARE AND SUPPORT PROGRAMMES

5.10 ART program

In 2002 the first national HIV/AIDS treatment protocol was developed, followed up by several adjusted editions. Till 2002 treatment of HIV+ was very limited. In 2003 a national revolving fund was established, which enabled start of public ARV treatment on a small scale. In 2004 Suriname's Global Fund grant was approved and resources became available to the Ministry of Health to work towards the global goal of universal access to ART. Since 2005, ARV is provided free of charge, to all eligible HIV+ persons, and interventions to appropriately assess, diagnose

and guide PLHIV and AIDS patients, thus ensuring access to high quality HIV and AIDS care and treatment for all in Suriname, rapidly increased.

From the start the strategic decision was made to apply a public health approach aimed at the integration of treatment in primary health care. The main argument was that Suriname has a well-functioning decentralized primary care system that ensures access to the most remote areas in the interior. In this regard health workers of primary healthcare clinics were trained and treatment coordinators were assigned. This process resulted in fully integrated ARV treatment in the basic health care of the Regional Health Services (RHS), the main primary health care institution in the coastal area. Integration of treatment in the basic clinics of the Medical Mission (MM), covering the population in the hinterland, still poses some problems due to the remoteness of the areas and related logistic and infrastructural limitations.

Government personnel are also trained in procurement of ARV and medication for treatment of opportunistic infections. Considerably challenging is motivating medical doctors from the private clinics and specialist to get involved in training and treatment with ARV.
In accordance with CAREC guidelines, the number of HIV+ in need of treatment is about 20-30% of the estimated national amount of HIV+. In Suriname this means that approximately 2000 HIV + persons are in need of ARV.

With the scaling up of HIV screening coverage of pregnant women, expansion of VCT sites, and introduction of free access to treatment in 2005, the number of persons diagnosed with HIV and illegible for treatment with ARV, more than tripled in 2007.
During 2005 - 2007 the cumulative number of persons under ARV treatment increased from 350 in 2005 to 412 in 2006, to 729 in 2007[10]. Considering the estimated number of people in need for ARV, in 2006 the estimated coverage of ARV treatment was 41%.
Currently negotiations between the Ministry of Health and government and private health insurance agencies are ongoing to include ARV treatment in the healthcare package, and in the Essential Medicine List, as Special Essential Medicines.

Main areas in the field of treatment and care that need improvement are: efficient procurement of ARV, strengthening and maintenance of the patient information system for adequate monitoring of treatment and adherence coverage.

5.11 Psycho-social care Program

Traditionally the NGO's have taken on a leading role in the provision of care and support to PLHIV, as much as possible supported and facilitated by the NAP. With input from the major stakeholders an assessment was conducted of the gaps and a plan of action was formulated for development of a comprehensive care and support system for PLHIV.
Efforts to strengthen and expand care and support services included appointment of a full time care and support project officer at NAP, selection and training of peer counselors and buddies, and provision of care packages to PLHIV.
Continued challenges are in general the lack of a structured continuum of care system for PLHIV and in particular the lack of social protection services, availability of professional counselors, supervision of counselors, and evaluation of existing counseling programs.

10 Data 2007 are preliminary, as data still have to be updated till end of December 2007

5.12 Reduction of stigma and discrimination

Stigma and discrimination remains one of the most difficult obstacles to deal with. In close cooperation with NGO's, NAP implemented several interventions aimed at reduction of stigma. A national committee on stigma and reduction was reinstalled, 'anti stigma' workshops were conducted in several work places, several national media campaigns were developed and broadcasted through main media channels.
A relatively large project, supported by the Dutch embassy, is training of the total staff of all six (6) hospitals in Suriname in anti stigma and discrimination. The impact of this training on attitude, knowledge and behavior of participants is currently being evaluated.

In general impact of anti stigma and discrimination interventions have not been measured in a systematic and consistent manner. However, some survey results and narrative based experiences from both service providers and PLHIV indicate that in general social acceptation of PLHIV has increased. Increased correct knowledge on main modes of HIV transmission resulted in people expressing less fear and reluctance to have social contact with PLHIV. Still, there are also reports of persistent unfriendly treatment, refusal to hire or dismissal of HIV+ workers, which indicate the need for more efforts to make services and workplaces more PLHIV friendly and supportive.

HIV RELATED KNOWLEDGE AND BEHAVIOR

5.13 Knowledge of HIV prevention in general population and young people

Results from national studies as well as community studies show significant increase in basic knowledge on HIV mode of transmission and prevention methods. While in 2000 only 36% of nationally surveyed females, 12-49 years, had correct knowledge on HIV/AIDS, in 2006 this proportion rose to 67%. Community surveys in 5 districts revealed that 91% of youngsters, aged 10-24 years knows the difference between HIV and AIDS, while 99% knows that social contact is not a mode of HIV transmission. 'Condom' as a main prevention method was mentioned by 77% of all youngsters while 'faith full to one partner' and 'abstinence' was mentioned by relative lower proportions, respectively 12% and 8%.
Knowledge appears to be strongly connected to educational level and living area. Knowledge is found less among low educated populations, and people living in rural areas and in the interior.[11]

5.14 Sexual behavior among young people

Notable are the wide disparities between sexual behavior of youngsters by sex, ethnicity, age and living area.[12] Although especially young people show adequate knowledge about HIV, in general risk estimation is low, which is also reflected in persistent high risk behavior among subpopulations of youth.

According to the national MICS (2006), 60% of all 15-24 year females had sex with a non-regular partner in the last 12 months, of which only 48.9% used a condom in the last contact with this partner.[13]

11 Multiple Indicator Cluster Survey (MICS) 2006, Government of Suriname/Unicef, july 2006

12 MOH/ProHealth, 2007, Rapport 'Jongeren en hun gezondheid'

13 MICS

A large sample survey on 'Youth and Health'[14] of the Ministry of Health in the coastal area of Suriname (5 districts) showed that only 47% of sexually active, aged 15-24, reported condom use the first time of sex and 48% at the last sexual contact. The general pattern is that condoms are mainly used in casual contacts.
Approximately 60% of the studied 10-24 years was ever pregnant, of which 61% was unplanned. Average age of sexual initiation is 15 years for men and for women: 17 years. 41% of the males reported three or more partners. Despite these identified high risk behavioral patterns, 64% of the youth perceive no risk for HIV infection.
Young people reported to still face obstacles in access to condoms and other HIV related services, and difficulties in correct and consistent use of condoms.
29% of the sexually active young people has ever done the HIV test. Most these youngsters are women, aged 15-19 (32%) and 20-24 years (45%). Among men, the experience with HIV testing in age groups 15-19 and 20-24 is much less, respectively 8% and 25% (Ministry of Health, 2006).

5.15 Sexual behavior among high risk groups

Outreach prevention strategies definitely impacted on knowledge of HIV and sexual behavior among sex workers. According to the recent conducted survey among street sex workers[15], 62% of all street sex workers reported to have ever done a HIV test, 70% reported use of a condom in the last contact with a client. However, in accordance with the international findings, condoms are often not used with regular clients and boyfriends: Only 23% of sex workers reported consistent use of condoms with clients.

More than half of the studied sex workers had an STI before. Basic knowledge of HIV is reasonable to good: 78% knows that condom use and monogamous sex with a faithful partner are main prevention methods, while 78% knows the difference between HIV and AIDS.
Reports of regular drug use are relatively high among street sex workers. Approximately 46% reported use of drugs.

VI. BEST PRACTICES

1.1 Joint review and revision of the NSP

The joint review and revision of the NSP 2004-2008, started in mid 2007 by the NAP, with support of UNAIDS, provided an excellent opportunity for a broad national based review of implemented policies, strategies and programs, as well as joint considerations of priority issues, key challenges and recommendations on strategic areas for the next five year plan 2009-2013 and a two year action plan 2008-2009.

A representation of 35 experts and vanguard stakeholders participated actively in 5 (five) 'Theme working groups' (TWG), and reviewed the progress and constraints in the HIV response. Supported with technical advisers, a joint situation and response analysis was drafted, discussed and approved by all TWG's in a separate 'consolidation' workshop. Based on the results of these discussions the review was lifted to the highest level of the national consultation meeting, where

14 MOH/ProHealth, 2007, Rapport 'Jongeren en hun gezondheid'

15 Caribbean Epidemiology Center (CAREC) and Maxi Linder Foundation (2004). HIV/AIDS and Commercial Sex Work in Suriname: an HIV sero-prevalence and behavioral study among commercial sex workers (CSW) in Suriname.

all stakeholders were offered the opportunity to deliver their comments and suggestions, either directly at the meeting or by mail.

The result of this approach is an NSP, that truly reflects the daily experiences and lessons learned of all stakeholders. Although, strengthening and expansion of the national response needs to be continued, the quality of the review demonstrated the great progress made in the building of a multi-sectoral response.

1.1 Outreach Programs for CSW and MSM

Suriname is one of the few countries with a well-established and functioning outreach program for commercial sex workers, lead by the Maxi Linder Association, which was founded in October 1994. This association is named after 'Maxi Linder', the first labor organizer for female sex workers in Suriname. Maxi Linder was a pioneer in working to create solidarity, foster development, and achieve empowerment among all sex workers.

Current activities of the SMLA includes: empowerment, field outreach activities on regular bases, recruiting sex workers to participate in educational workshops, VCT, assistance in applying for health insurance/social cards and provision of condoms free of charge. After several efforts to set a more structural program for MSM, in 2006 the Foundation 'Suriname Men United' was established and efforts are intensified to institutionalize MSM interventions. At present several actions are being conducted to identify several subpopulations of MSM and their needs. In addition the SMU started outreach to MSM by providing regular education and distribution of condoms and lubricants.

1.2 Public-private partnership in the response on HIV in the world of work

The labor force accounts for a majority of the national population and prevention of HIV can be considered critical in this 'backbone of the economy'. In this regard the active involvement of the private sector and trade unions is identified as a major strategy in the response against HIV.

The growing partnership between the Ministry of Labor, trade unions, the private sector and development partners in the response against HIV in the workplace and the joined interventions that have been implemented in the past years demonstrates a good example of a successful approach towards HIV in the workplace. This collaboration resulted in importance achievements, in particular the development of draft national policy on HIV in the workplace, the integration of HIV in human resource policies of some large companies, the current implementation of a two year prevention and capacity building program by the Ministry of Labor and the development of a two year strategic action plan by the private sector, led by the 'Surinamese Business Coalition'. This plan is developed in accordance with identified priorities in the NSP, and will be implemented in close cooperation with the government and NGO's.

VII. MAJOR CHALLENGES FACED AND ACTIONS NEEDED TO ACHIEVE THE GOALS/TARGETS

Recently consultations were held with stakeholders to discuss obstacles to achieving universal access in Suriname. The consultations identified the following challenges and the main actions needed.

7.1 Restructuring and operationalization of the national coordination structure is too slow and lacks sustainability

The joint review revealed agreement on the observation that the restructuring and operationalization of the national coordination structure is too slow, and lacks guarantees for sustainability. A critical issue is the sustainability of the current Global Fund driven programs, in particular universal access to key services, such as VCT and ART. A structural challenge is the strong dependency of the current response on external funding. While this challenge is not an immediate threat, measures must be developed to ensure continuation of the programs and services beyond expiration of the Global Fund grants. In light of the current socio-economic conditions of Suriname and the limited available resources, this issue needs attention from the highest level of Government.

Institutionalization of the three ones principles (one national coordination body, one national strategic framework and one monitoring and evaluation system) is adopted by the Surinamese government, however implementation is slow.
In this regard more effort is needed to strengthen the government's contribution in a multi-sectoral approach and expand mobilization of resources. Increased advocacy, technical support and more funds are needed for implementation of mainstreaming of HIV in policies and programs of the different ministries and departments.

National coverage of the HIV response is still limited. Most interventions are concentrated in Paramaribo, leaving especially remote districts and the interior relatively underserved.
Hence, scaling up of services and other interventions in underserved areas and communities is needed. While Suriname has fairly well-developed systems for provision of primary health care in the urban, rural and interior setting, the integration of treatment has proven challenging, in particular for remote and sparsely populated areas. The main challenge lies in the development of effective systems for distribution of ARV and other products, the decentralized provision of laboratory services and other necessary services to enhance adherence, and the application of quality control measures.

7.2 Weak national monitoring and evaluation system

Despite several important interventions to strengthen the HIV surveillance system, the general monitoring and evaluation system can still be considered weak. Main challenges are the lack of 'evidenced based' policies and interventions. Due to lack of capacity and funds, necessary evidence has not been collected while existing data have not sufficiently been utilized for policy purposes.

A main conclusion of the joint review is that policymakers and implementers need more and reliable information on: Trends in sexual behavior: MARPS and general population, high risk sexual networks and connection with general population, impact of interventions and coverage of identified vulnerable groups. There is an urgent need for the development of an adequate monitoring- and evaluation strategy/plan, including: national indicators, data needs: IBBS, population-based surveys, structure of data collection, reporting and dissemination system

7.3 Lack of a systematic and strategic approach in the capacity building process

The lack of availability of sufficient and qualified human resources remains an important obstacle in the response of both government and non-government stakeholders. A major challenge that affects all areas of the national response is the lack of sufficiently trained and/or

experienced staff, in particular in the government sector. The high turnover of government staff and lack of full-time workers in the NGO's contributes to this lack of professional staff.

Short-term actions are the provision of upgrade training to staff, for example the training of HIV nurses, and contracting of technical experts. For the longer term human resource planning, career planning and public sector reform will be necessary to attract and retain highly professional staff.

With the rapid scaling up of services and need to conform to quality standards, capacity needs grows. As budget for extra staff is often not available in most healthcare institutions, scaling up of HIV services activities are added to the already heavy tasks of existing service providers, leading on the long run to the serious question of burn out, in particular in the area of counseling.

For a more effective and efficient approach in capacity building, information is needed about impact of current interventions on capacity building and remaining capacity gaps. In this regard proposed actions for systematic strengthening of capacity are the establishment of a separate capacity building unit in NAP, the development of a capacity data bank (available capacity, needs, gaps) and mobilization of needed technical and organizational support for GO and NGO partners.

7.4 Lack of an adequate and high quality 'continuum of care 'system' with good coverage of high risks and vulnerable groups

While HIV prevention, treatment and care services have been scaled up in an accelerated manner in the past years, there appear to be lack of information on quality and impact of services, and coverage of Most at Risk Populations (MARPS) and other vulnerable groups. The central question is: Are services cost effective, do they really contribute to achieving the goals of the NSP.

Another concern regards the efficiency of service provision and the link between services. The big challenge is to develop and integrate a 'continuum of care' system, including HIV prevention, care and support services, in existing (health)care system and improve quality and coverage of services. Concrete short term actions planned are: Evaluation of quality and impact of provided services, capacity strengthening of (health) workers and service/support systems, development of a quality control system, improvement and expansion of the referral network, strengthening of procurement and supply management system of ART and other health commodities, strengthen collaboration between HIV and TB program, and continuous technical guidance/coaching at the implementation level.

7.5 Poor involvement of People living with HIV

Achievements in the area of empowerment of PLHIV are still relatively poor. Due to the persistent stigma and discrimination on both national and community level, most PLHIV are very reluctant to expose them as such and even if opportunities for active involvement in the response are offered, participation remains low. Despite several efforts, PLHIV have not organized themselves yet as an interest group.

A main strategy identified in facilitating participation of PLHIV is empowerment of PLHIV in social and economic sense through 1. working on comprehensive support to individuals and their families and 2. working towards a more protective and supportive legal and social secure environment.

7.6 Lack of integration of human rights and gender sensitive approaches in policies and programs

A main challenge in the response against HIV is to deal with some of the structural conditions driving the HIV epidemic. Poverty, gender inequality, stigma and discriminatory attitudes and persistent unhealthy sexual values and perceptions can all be considered social determinants of behavior functioning as underlying drivers of the HIV epidemic. In this regard more and improved efforts are needed for integration of human rights and gender sensitive approaches in HIV policies and programs, guided by principles and guidelines of national and international commitments made by the Surinamese government and civil society.

Planned actions are scaling up of interventions in the area of review of existing laws and regulations, systematic auditing of VCT, PMTCT, ART, in particular respect and protection of basic rights: 'informed consent', voluntary, confidentiality, and advocacy and lobby to increase public awareness on rights and responsibilities. Within this context, with the support of the IDB, preparatory actions are currently being undertaken to conduct an assessment of HIV related legislation and regulations aimed at developing of a national HIV legal framework.

VIII. SUPPORT REQUIRED FROM COUNTRY'S DEVELOPMENT PARTNERS

Suriname's development partners showed continued support of HIV and AIDS efforts through different sectors. Guided by the multi-sectoral approach, in the past years increased efforts have been made to involve government ministries at the national and district level, local and international NGOs, community based organizations, religious organizations, international donors, private sector, United Nations and other multilateral agencies. This approach implies harmonization of individual and group efforts into an effective coordinated national response. Each partner is therefore encouraged to bring into play their individual comparative advantages into the process, but with the overall coordination, monitoring and evaluation of the NAP.

Since the start of the HIV epidemic, Suriname has longstanding and effective working relations with various bilateral and multilateral partners. In light of the identified challenges these partnerships are considered essential for the provision of the necessary technical and financial support. One of the main problems experienced in the area of funding is that the majority of funds are focused on project funding and less on process funding. Most of project funding are short term and eventually results in adhoc, fragmented interventions with temporary results.
In this regard a main challenge is to convince international partners of the relevance of program funding, including institutional strengthening, which provides more opportunities to build local capacity and care systems for sustainability on the long term.

Within this context the newly developed UNDAF approach could serve as a good initiative to work towards program support. A United Nations Development Assistance Framework (UNDAF) has been signed in 2007 by the Surinamese government and the United Nations, shortly followed by the agreement on a Common Country Programme Action Plan (CCPAP) for a 4 year period: 2008-2011. In this Action Plan, identified priority programmes re subdivided into priority projects. HIV/AIDS is identified as a priority project under the program 'Improved social services'. Within the context of the 'Three Ones' principles, the UN agreed to contribute to the strengthening of the coordinating and monitoring capacity of the NAP, with particular focus on 1. the development, implementation and monitoring and evaluation of costed annual

work plans and 2. the development and implementation of prevention strategies, in particularly focused on high risk and vulnerable groups (women, children and youth).

In the recently formulated action plan for HIV, 2008-2009, some immediate key areas, where both financial and technical support is required, are identified:

1. Operationalization of a sustainable National Coordination structure

1.1 Filling in existing human resources gaps in the NAP, in particular hiring of
   a. Expert on Monitoring and Evaluation to lead Strategic Information Unit
   b. Expert on IEC and BCC
   c. Expert for leading the newly formed 'Capacity building' unit
   d. Technical assistance for back-stopping sub managers NAP

1.1 Integrating the NAP in the existing government structure
1.2 Development and implementation of a national communication strategy for effective and regular feedback between NAP and implementing government and non-government partners
1.3 Decentralization of response aimed at increasing national coverage of services

2. Development and implementation of a National Monitoring and Evaluation (Action) Plan

3. Development and scaling up of evidence based, targeted prevention, care and support interventions for CSW, MSM, armed forces, STI visitors, gold miners, prisoners, people living in the interior, internal migrants, vulnerable youth and women

4. Development of a national condom policy and strategies for social marketing of condoms in different high risk and vulnerable groups

5. Finalization and implementation of national policy on HIV in the workplace, and expansion of sustainable 'HIV workplace' programs.

6. Preparing and implementation of audits/evaluation of services/programs, in particular PMTCT, VCT , ART, psycho-social support to PLHIV and awareness raising programs

7. Strengthening of the existing quality control system and include regular monitoring and improving quality of HIV related services.

8. Development of an efficient and effective system of 'continuum of HIV care', as an integrated part of the existing healthcare system.

9. Development of a evidence-based capacity building strategy aimed at capacity strengthening of all partners in the HIV response

10. Development and strengthening of the integration, acknowledgement and protection of human rights and gender sensitive approaches in all HIV policies and programs

IX. MONITORING AND EVALUATION ENVIRONMENT

In response to a joint Government-CAREC assessment on the HIV monitoring and evaluation practices and capacity, conducted in 2003, and the identified gaps and weaknesses in the M&E system, the national HIV/AIDS/STI surveillance team was established consisting of representation of all key actors in surveillance. This team spearheaded the compilation of surveillance reports and the implementation of M&E training for government and non-government stakeholders. While significant progress has been made regarding collection of 'passive surveillance' data, the recent joint review of the NSP agreed on the persistency in the weakness of the monitoring and evaluation system, in particular the lack of 'evidenced based' policies and interventions. A main obstacle remains the lack of sufficient human and financial resources for on one hand the development of effective systems for timely collection of reliable integrated IBSS data and on the other hand the analysis and translation of these data into strategic information, to be used for the development of effective policies and services. Considering this obstacle, one of the main areas of focus in the national strategic action plan is the institutional strengthening of the 'Strategic Information' unit at the NHIVS and the development of a national monitoring and evaluation (action) plan for HIV.

Integrated Biological and Behavioral Surveillance (IBBS)

An important source for estimating the prevalence and spread of HIV in the general population are data about size of MARPS and HIV prevalence in these subpopulations.

The most identified MARPS in Suriname are street sex workers and MSM, and related programs are being strengthened or developed.

However, existing survey data and narratives suggest considerable unsafe behavior in subpopulations. Little is still known about these MARPS, their sexual networks and sexual risk behavior and how they are connected with the general population.

Currently some behavioral studies have been started up among some high risk and vulnerable groups, in particular prisoners, people living in the interior (Maroons and Indigenous), commercial sex workers outside of Paramaribo, gold miners and clients of STI policlinics.

An important contribution in health behavior of youth with a diverse background was a study conducted in 2006 by the Ministry of Health, which will inform the development of the integration of youth friendly services in the basic health care clinics in the coastal areas.

The only national study including some selected HIV indicators is the 'Multi Indicator Cluster Survey' (MICS), conducted in 2006. However, data are limited as only females were surveyed.

With the scaling up of treatment with ARV, there is an urgent need for the availability of reliable patient information for adequate monitoring of treatment and adherence, as well as procurement of supplies. Currently a evaluation study is being conducted on the impact of anti stigma workshops for health workers of all hospitals in Suriname.

ANNEX 1: Preparation/Consultation Process for the National Report on Monitoring the Follow-up to the Declaration of Commitment on HIV/AIDS

1) Which institutions/entities were responsible in filling out the indicators forms?

a) NAC or equivalent	*(Yes)*	No
b) NAP	***(Yes)***	No
c) Others (please specify)	*(Yes)*	No

2) With inputs from:

Ministries:

Education	***(Yes)***	No
Health	***(Yes)***	No
Labour	***(Yes)***	No
Foreign Affairs	Yes	***(No)***
Gender Affairs	**NA**	

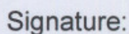
Civil society organizations	***(Yes)***	No
People living with HIV/AIDS	***(Yes)***	No
Private sector	***(Yes)***	No
UN organizations	***(Yes)***	No
Bilaterals	**(Yes)**	No
International NGOs	***(Yes)***	No
Nursing and Medical Schools	***(Yes)***	No
Faith based organizations	***(Yes)***	No

3) Was the report discussed in a large forum?	***(Yes)***	No
4) Are the survey results stored centrally?	***(Yes)***	No
5) Is data available for public consultation?	***(Yes)***	No

6) Who is the person responsible for submission of the report and for follow-up if there are questions on the Country progress Report?

Name/Title: Mr. Milton Castelen, LLM, Coordinator National AIDS Program

Date: 1/30/08

Signature: 

NCPI

Custom Analysis Extract of :

NCPI - Suriname

NCPI – Contact Details

COUNTRY:

Suriname

Name of the National AIDS Committee Officer in charge:

Milton Castelen

Postal address:

Tourtonnelaan #7

Tel:

+597470416

Fax:

470448

E-mail:

info@nhivs.org

Date of submission:

1/30/2008

NCPI Respondents

[Indicate all respondents whose responses were compiled to fill out (parts of) the NCPI in the below table]

NCPI - PART A [to be administered to government officials]

Organisation	basic life skills
Name/Position	M.Gilds-Mullen/Coordinator
Respondents to Part A [indicate which parts each respondent was queried on]	A.I / A.II / A.III / A.IV / A.V
Organisation	Dermatology Services
Name/Position	D.Hordijk/Manager counseling +Testing
Respondents to Part A [indicate which parts each respondent was queried on]	A.III / A.IV / A.V
Organisation	Ministry of Labor
Name/Position	J Souprayen/ HIV Focal Point
Respondents to Part A [indicate which parts each respondent was queried on]	A.I / A.II / A.III / A.IV / A.V
Organisation	National Aids Programme
Name/Position	Z.Pengel/Program Manager Treatment, Care + support/ T.Vreden Prevention Programme Manager
Respondents to Part A [indicate which parts each respondent was queried on]	A.I / A.II / A.III / A.IV / A.V
Organisation	Joint Programme GOS -EC-ACP/UNFPA
Name/Position	I Caffe /Project Coordinator
Respondents to Part A [indicate which parts each respondent was queried on]	A.I / A.II / A.III / A.IV / A.V

Other respondents to Part A

none

NCPI - PART B [to be administered to nongovernmental organizations, bilateral agencies, and UN organizations]

Organisation	Lobi Foundation
Name/Position	G.Leckie/ Director
Respondents to Part B [indicate which parts each respondent was queried on]	B.I / B.II / B.III / B.IV
Organisation	Mamio Namen Project Foundation
Name/Position	E.Pengel /Director
Respondents to Part B [indicate which parts each respondent was queried on]	B.I / B.II / B.III / B.IV
Organisation	UNFPA
Name/Position	J.Quallo-Rosberg/ Representative
Respondents to Part B [indicate which parts each respondent was queried on]	B.I / B.II / B.III / B.IV

Other respondents to Part B

none

PART A

[to be administered to government officials]

I. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy/action framework to combat AIDS?

Yes

IF YES, period covered:

2004-2008

IF NO or N/A, briefly explain

IF YES, complete questions 1.1 through 1.10; otherwise, go to question 2.

1.1 How long has the country had a multisectoral strategy/action framework?

3 years

1.2 Which sectors are included in the multisectoral strategy/action framework with a specific HIV budget for their activities?

Sector		
Health	Strategy/Action framework	Yes
	Earmarked budget	Yes
Education	Strategy/Action framework	Yes
	Earmarked budget	Yes
Labour	Strategy/Action framework	Yes
	Earmarked budget	Yes
Transportation	Strategy/Action framework	No
	Earmarked budget	No
Military/Police	Strategy/Action framework	Yes
	Earmarked budget	Yes
Women	Strategy/Action framework	Yes
	Earmarked budget	Yes
Young people	Strategy/Action framework	Yes
	Earmarked budget	Yes
Agriculture	Strategy/Action framework	No
	Earmarked budget	No
Finance	Strategy/Action framework	No
	Earmarked budget	No
Human Resources	Strategy/Action framework	No
	Earmarked budget	No
Justice	Strategy/Action framework	Yes
	Earmarked budget	No
Minerals and Energy	Strategy/Action framework	No
	Earmarked budget	No
Planning	Strategy/Action framework	No
	Earmarked budget	No
Public Works	Strategy/Action framework	No
	Earmarked budget	No
Tourism	Strategy/Action framework	No
	Earmarked budget	No
Trade and Industry	Strategy/Action framework	No
	Earmarked budget	No
Other::social Affairs	Strategy/Action framework	Yes
	Earmarked budget	No

IF NO earmarked budget, how is the money allocated?

thrugh donor funding available e.g. Global Fund.

Part A. Section I. Strategic plan

1.3 Does the multisectoral strategy/action framework address the following target populations, settings and cross-cutting issues?

a. Women and girls	Yes
b. Young women/young men	Yes
c. Specific vulnerable sub-populations [3]	Yes
d. Orphans and other vulnerable children	Yes
e. Workplace	Yes
f. Schools	Yes
g. Prisons	Yes
h. HIV, AIDS and poverty	Yes
i. Human rights protection	No
j. Involvement of people living with HIV	Yes
k. Addressing stigma and discrimination	Yes
l. Gender empowerment and/or gender equality	Yes

[3]Sub-populations that have been locally identifi ed as being at higher risk of HIV transmission (injecting drug users, men having sex with men, sex workers and their clients, cross-border migrants, migrant workers, internally displaced people, refugees, prisoners, etc.).

1.4 Were target populations identified through a process of a needs assessment or needs analysis?

No

IF YES, when was this needs assessment /analysis conducted? Year:

IF NO, how were target populations identified?

Use of existing data

1.5 What are the target populations in the country?

women, young people, MSM, CSW, Military, prison population.

Part A. Section I. Strategic plan

1.6 Does the multisectoral strategy/action framework include an operational plan?

Yes

1.7 Does the multisectoral strategy/action framework or operational plan include:

a. Formal programme goals?	Yes
b. Clear targets and/or milestones?	Yes
c. Detailed budget of costs per programmatic area?	Yes
d. Indications of funding sources?	Yes
e. Monitoring and Evaluation framework?	Yes

1.8 Has the country ensured "full involvement and participation" of civil society[4] in the development of the multisectoral strategy/action framework?

Active involvement

IF active involvement, briefly explain how this was done:

through stakeholder workshops, study of draft documents.

IF NO or MODERATE involvement, briefly explain:

[4]Civil society includes among others: Networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations;
AIDS service organizations; Community-based organizations; organizations of key affected groups (including MSM, SW, IDU, migrants,
refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector
is considered separately.

1.9 Has the multisectoral strategy/action framework been endorsed by most external Development Partners (bi-laterals; multi-laterals)?

Yes

Part A. Section I. Strategic plan

1.10 Have external Development Partners (bi-laterals; multi-laterals) aligned and harmonized their HIV and AIDS programmes to the national multisectoral strategy/action framework?

No

IF SOME or NO, briefly explain

each organization has its own programs and agenda .

2. Has the country integrated HIV and AIDS into its general development plans such as:
a) National Development Plans,
b) Common Country Assessments/United Nations Development Assistance Framework,
c) Poverty Reduction Strategy Papers,
d) Sector Wide Approach?

Yes

2.1 IF YES, in which development plans is policy support for HIV and AIDS integrated?

a) National Development Plans

2.2 IF YES, which policy areas below are included in these development plans?

HIV Prevention	Development Plans	a)
Treatment for opportunistic infections		a)
Antiretroviral therapy		a)
Care and support (including social security or other schemes)		a)
Reduction of stigma and discrimination		a)

Part A. Section I. Strategic plan

3. Has the country evaluated the impact of HIV and AIDS on its socio-economic development for planning purposes?

No

3.1 IF YES, to what extent has it informed resource allocation decisions?

4. Does the country have a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services such as military, police, peacekeepers, prison staff, etc?

Yes

4.1 IF YES, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of one or more uniformed services?

Behavioural change communication	Yes
Condom provision	Yes
HIV testing and counselling(*)	Yes
STI services	No
Treatment	No
Care and support	No
Other:	No
	No
	No

(*)If HIV testing and counselling has been implemented for uniformed services beyond the pilot stage, what is the approach taken?
Is it voluntary or mandatory (e.g. at enrolment)? Briefly explain:

mandory at enrollment in policeforce

Part A. Section I. Strategic plan

5. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?

Yes

5.1 Has the National Strategic Plan/operational plan and national AIDS budget been revised accordingly?

No

5.2 Have the estimates of the size of the main target population sub-groups been updated?

No

5.3 Are there reliable estimates and projected future needs of the number of adults and children requiring antiretroviral therapy?

No

5.4 Is HIV and AIDS programme coverage being monitored?

Yes

(a) IF YES, is coverage monitored by sex (male, female)?

Yes

(b) IF YES, is coverage monitored by population sub-groups?

Yes

IF YES, which population sub-groups?

Pregnant woman, Sex workers,

(c) IF YES, is coverage monitored by geographical area?

No

IF YES, at which levels (provincial, district, other)?

national level

5.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

Yes

Part A. Section I. Strategic plan

Overall, how would you rate strategy planning efforts in the HIV and AIDS programmes in 2007 and in 2005?

2007	7
2005	6

Comments on progress made in strategy planning efforts since 2005:

a more structured approach with better use of knowledge.

Part A. Section II. Political Support

II. POLITICAL SUPPORT

Strong political support includes government and political leaders who speak out often about AIDS and regularly chair important meetings, allocation of national budgets to support the AIDS programmes and effective use of government and civil society organizations and processes to support effective AIDS programmes.

1. Do high officials speak publicly and favourably about AIDS efforts in major domestic fora at least twice a year?

President/Head of government	No
Other high officials	No
Other officials in regions and/or districts	No

2. Does the country have an officially recognized national multisectoral AIDS management/coordination body? (National AIDS Council or equivalent)?

No

IF NO, briefly explain:

various efforts with variating succes.

2.1 IF YES, when was it created? Year:

2.2 IF YES, who is the Chair?

2.3 IF YES, does it:

(*) If it does include civil society representatives, what percentage?

Part A. Section II. Political Support

3. Does the country have a national AIDS body or other mechanism that promotes interaction between government, people living with HIV, civil society and the private sector for implementing HIV and AIDS strategies/programmes?

No

3.1 IF YES, does it include?

(*)If it does include regular meetings, what is the frequency of the meetings:

IF YES, What are the main achievements?

IF YES, What are the main challenges for the work of this body?

Part A. Section II. Political Support

4. What percentage of the national HIV and AIDS budget was spent on activities implemented by civil society in the past year?

between 60% and 70%

5. What kind of support does the NAC (or equivalent) provide to implementing partners of the national programme, particularly to civil society organizations?

6. Has the country reviewed national policies and legislation to determine which, if any, are inconsistent with the National AIDS Control policies?

No

6.1 IF YES, were policies and legislation amended to be consistent with the National AIDS Control policies?

6.2 IF YES, which policies and legislation were amended and when?

Part A. Section II. Political Support

Overall, how would you rate the political support for the HIV and AIDS programmes in 2007 and in 2005?

2007	7
2005	6

Comments on progress made in political support since 2005:

more structured approach

Part A. Section III. Prevention

III. PREVENTION

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?

Yes

1.1 IF YES, what key messages are explicitly promoted?

Be faithful

Reduce the number of sexual partners

Use condoms consistently

1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

No

2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?

Yes

2.1 Is HIV education part of the curriculum in

primary schools?	Yes
secondary schools?	Yes
teacher training?	No

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes

2.3 Does the country have an HIV education strategy for out-of-school young people?

No

Part A. Section III. Prevention

3. Does the country have a policy or strategy to promote information, education and communication (IEC) and other preventive health interventions for vulnerable sub-populations?

No

IF NO, briefly explain:

more adhoc activities

3.1 IF YES, which sub-populations and what elements of HIV prevention do the policy/strategy address?

(*)If Other sub-populations, indicate which sub-populations

Overall, how would you rate policy efforts in support of HIV prevention in 2007 and in 2005?

2007	6
2005	5

Comments on progress made in policy efforts in support of HIV prevention since 2005:

programs have more clear and coordinated approach. no clear strategy available

Part A. Section III. Prevention

4. Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV prevention programmes?

No

IF NO, how are HIV prevention programmes being scaled-up?:

Common agreement that underserved areas must be upscaled.

IF YES, to what extent have the following HIV prevention programmes been implemented in identified districts* in need?

*** Districts or equivalent geographical/de-centralized level in urban and rural areas**

Part A. Section III. Prevention

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2007 and in 2005?

2007	7
2005	5

Comments on progress made in the implementation of HIV prevention programmes since 2005:

more funding available resulting in more activities, improvement is needed.

Part A. Section IV. Treatment, care and support

IV. TREATMENT, CARE AND SUPPORT

1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care).

Yes

1.1 IF YES, does it give sufficient attention to barriers for women, children and most-at-risk populations?

No

2. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV and AIDS treatment, care and support services?

No

IF NO, how are HIV and AIDS treatment, care and support services being scaled-up?

no data available but patients can be registered for treatmant. Training of health personel in service delivery more focus on underserved areas

IF YES, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts* in need?

***Districts or equivalent de-centralized governmental level in urban and rural areas**

Part A. Section IV. Treatment, care and support

3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?

No

4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral drugs, condoms, and substitution drugs?

No

4.1 IF YES, for which commodities?:

Part A. Section IV. Treatment, care and support

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support services in 2007 and in 2005?

2007	5
2005	4

Comments on progress made since 2005:

limited activities, need to be upscaled

Part A. Section IV. Treatment, care and support

5. Does the country have a policy or strategy to address the additional HIV- or AIDS-related needs of orphans and other vulnerable children (OVC)?

No

5.1 IF YES, is there an operational definition for OVC in the country?

5.2 IF YES, does the country have a national action plan specifically for OVC?

5.3 IF YES, does the country have an estimate of OVC being reached by existing interventions?

IF YES, what percentage of OVC is being reached?

Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children?

2007	5
2005	4

Comments on progress made in efforts to meet the needs of OVC since 2005:

no action taken in this area. private ngo's with insufficient government support

Part A. Section V. Monitoring and Evaluation

V. MONITORING AND EVALUATION

1. Does the country have one national Monitoring and Evaluation (M&E) plan?

Yes

IF YES, Years covered:

2004/2008

1.1. IF YES, was the M&E plan endorsed by key partners in M&E?

Yes

1.2. IF YES, was the M&E plan developed in consultation with civil society, including people living with HIV?

Yes

1.3. IF YES, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

No

2. Does the Monitoring and Evaluation plan include?

a data collection and analysis strategy	No
behavioural surveillance	No
HIV surveillance	Yes
a well-defined standardized set of indicators	Yes
guidelines on tools for data collection	Yes
a strategy for assessing quality and accuracy of data	No
a data dissemination and use strategy	No

3. Is there a budget for the M&E plan?

No

IF YES, Years covered:

3.1 IF YES, has funding been secured?

Part A. Section V. Monitoring and Evaluation

4. Is there a functional M&E Unit or Department?

No

IF NO, what are the main obstacles to establishing a functional M&E Unit/Department?

lack of personnel

4.1 IF YES, is the M&E Unit/Department based

4.2 IF YES, how many and what type of permanent and temporary professional staff are working in the M&E Unit/Department?
Number of permanent staff:

Position	Full time/Part time	Full time
		Full time
		Full time
		Full time
		Full time

Number of temporary staff:

Part A. Section V. Monitoring and Evaluation

4.3 IF YES, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit/Department for review and consideration in the country's national reports?

IF YES, does this mechanism work? What are the major challenges?

4.4 IF YES, to what degree do UN, bi-laterals, and other institutions share their M&E results?

5. Is there an M&E Committee or Working Group that meets regularly to coordinate M&E activities?

Yes, but meets irregularly

IF YES, Date last meeting:

N/A

Part A. Section V. Monitoring and Evaluation

5.1 Does it include representation from civil society, including people living with HIV?

No

IF YES, describe the role of civil society representatives and people living with HIV in the working group

6. Does the M&E Unit/Department manage a central national database?

Yes

6.1 IF YES, what type is it?

NHIS

6.2 IF YES, does it include information about the content, target populations and geographical coverage of programmatic activities, as well as their implementing organizations?

No

6.3 Is there a functional Health Information System (HIS)?

National level	Yes

(*)If there is a functional sub-national HIS, at what level(s) does it function?

6.4 Does the country publish at least once a year an M&E report on HIV, including HIV surveillance data?

No

Part A. Section V. Monitoring and Evaluation

7. To what extent are M&E data used in planning and implementation?

2

What are examples of data use?

number of persons on ART

What are the main challenges to data use?

no reliable data available

8. In the last year, was training in M&E conducted

At national level?	No
At sub-national level?	No
Including civil society?	No

Overall, how would you rate the M&E efforts of the AIDS programme in 2007 and in 2005?

2007	5
2005	3

Comments on progress made in M&E since 2005:

more awareness on the value of data

Part B. Section I. Human rights

PART B

[to be administered to representatives from nongovernmental organizations, bilateral agencies, and UN organizations]

I. HUMAN RIGHTS

1. Does the country have laws and regulations that protect people living with HIV against discrimination? (such as general non-discrimination provisions or provisions that specifically mention HIV, focus on schooling, housing, employment, health care etc.)

No

1.1 IF YES, specify:

2. Does the country have non-discrimination laws or regulations which specify protections for vulnerable sub-populations?

No

2.1 IF YES, for which sub-populations?

IF YES, Briefly explain what mechanisms are in place to ensure these laws are implemented:

IF YES, Describe any systems of redress put in place to ensure the laws are having their desired effect:

Part B. Section I. Human rights

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for vulnerable sub-populations?

Yes

3.1 IF YES, for which sub-populations?

Women	No
Young people	Yes
IDU	No
MSM	No
Sex Workers	No
Prison inmates	No
Migrants/mobile populations	No
Other:	No
	No
	No

IF YES, briefly describe the content of these laws, regulations or policies and how they pose barriers:

It is prohibited to deliver sex related information to young people

Part B. Section I. Human rights

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

Yes

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV and/or most-at-risk populations?

No

IF YES, briefly describe this mechanism

6. Has the Government, through political and financial support, involved most-at-risk populations in governmental HIV-policy design and programme implementation?

Yes

IF YES, describe some examples

1. construction of NSP, various groups (MSM,sexworkers) 2. regular consultation 3. involvement in donor funded programs.

Part B. Section I. Human rights

7. Does the country have a policy of free services for the following:

HIV prevention services	Yes
Anti-retroviral treatment	Yes
HIV-related care and support interventions	Yes

IF YES, given resource constraints, briefly describe what steps are in place to implement these policies:

1. not comprehensive enough 2. no guaranteed continuity of funds.

8. Does the country have a policy to ensure equal access for women and men, to prevention, treatment, care and support? In particular, to ensure access for women outside the context of pregnancy and childbirth?

No

9. Does the country have a policy to ensure equal access for most-at-risk populations to prevention, treatment, care and support?

No

9.1 Are there differences in approaches for different most-at-risk populations?

No

IF YES, briefly explain the differences:

Part B. Section I. Human rights

10. Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

No

11. Does the country have a policy to ensure that AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

Yes

11.1 IF YES, does the ethical review committee include representatives of civil society and people living with HIV?

No

IF YES, describe the effectiveness of this review committee

It is possible to avoid the committee depending on the specifics (e.g. size) of the reseach

12. Does the country have the following human rights monitoring and enforcement mechanisms?

- Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work	No
- Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment	No
- Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts	No
- Performance indicators or benchmarks for reduction of HIV-related stigma and discrimination	No

IF YES, on any of the above questions, describe some examples:

Part B. Section I. Human rights

13. Have members of the judiciary (including labour courts/employment tribunals) been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work?

No

14. Are the following legal support services available in the country?

Legal aid systems for HIV and AIDS casework	No
Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV	No
Programmes to educate, raise awareness among people living with HIV concerning their rights	Yes

15. Are there programmes designed to change societal attitudes of stigmatization associated with HIV and AIDS to understanding and acceptance?

Yes

IF YES, what types of programmes?

Media	Yes
School education	Yes
Personalities regularly speaking out	Yes
Other::community workshops	Yes

Part B. Section I. Human rights

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS in 2007 and in 2005?

2007	4
2005	3

Comments on progress made in promoting and protecting human rights in relation to HIV and AIDS since 2005:

increased awareness on this issue.

Overall, how would you rate the effort to enforce the existing policies, laws and regulations in relation to human rights and HIV and AIDS in 2007 and in 2005?

2007	4
2005	1

Comments on progress made in enforcing existing policies, laws and regulations in relation to human rights and HIV and AIDS since 2005:

more awareness and empowerment of individuals, not a national pro-active approach

Part B. Section II. Civil society participation

II. CIVIL SOCIETY[5] PARTICIPATION

1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national policy formulation?

3

2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on AIDS or for the current activity plan (e.g. attending planning meetings and reviewing drafts)

4

3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included

a. in both the National Strategic plans and national reports?	4
b. in the national budget?	3

4. Has the country included civil society in a National Review of the National Strategic Plan?

Yes

IF YES, when was the Review conducted? Year:

2007

5. To what extent is the civil society sector representation in HIV-related efforts inclusive of its diversity?

3

List the types of organizations representing civil society in HIV and AIDS efforts:

1. variety in target groups (young people, sex workers, MSM..........) 2. types of service offered (counseling and testing, prevention, care and support......................................)

**[5] Civil society includes among others: Networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations;
AIDS service organizations; Community-based organizations; organizations of vulnerable sub-populations (including MSM, SW, IDU,
migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private
sector is considered separately.**

Part B. Section II. Civil society participation

6. To what extent is civil society able to access

a. adequate financial support to implement its HIV activities?	3
b. adequate technical support to implement its HIV activities?	3

Overall, how would you rate the efforts to increase civil society participation in 2007 and in 2005?

2007	7
2005	5

Comments on progress made in increasing civil society participation since 2005:

more support for ngo's. good awareness on strenght of ngo's

Part B. Section III. Prevention

III. PREVENTION

1. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV prevention programmes?

No

IF NO, how are HIV prevention programmes being scaled-up?:

1. no data available but common knowlegde of underserved area. 2. upscaling of services.

IF YES, to what extent have the following HIV prevention programmes been implemented in identified districts in need?

***Districts or equivalent geographical/de-centralized levels in urban and rural areas**

Part B. Section III. Prevention

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2007 and in 2005?

Comments on progress made in the implementation of HIV prevention programmes since 2005:

Part B. Section IV. Treatment, care and support

IV. TREATMENT, CARE AND SUPPORT

1. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV and AIDS treatment, care and support services?

No

IF NO, how are HIV and AIDS treatment, care and support services being scaled-up?:

common knowledge, no data available, upskaling in underserved area.

IF YES, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts* in need?

***Districts or equivalent geographical de-centralized governmental levels in urban and rural areas**

Part B. Section IV. Treatment, care and support

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support services in 2007 and in 2005?

2007	6
2005	5

Comments on progress made in the implementation of HIV treatment, care and support services since 2005:

training of health care workers, better acces to ART.

2. What percentage of the following HIV programmes or services is estimated to be provided by civil society?

Prevention for youth	>75%
Prevention for IDU	<25%
Prevention for MSM	>75%
Prevention for sex workers	>75%
Counselling and Testing	25-50%
Clinical services (OI/ART)*	<25%
Home-based care	>75%
Programmes for OVC**	>75%

***OI Opportunistic infections; ART Antiretroviral therapy**
****OVC Orphans and other vulnerable children**

Part B. Section IV. Treatment, care and support

3. Does the country have a policy or strategy to address the additional HIV and AIDS-related needs of orphans and other vulnerable children (OVC)?

No

3.1 IF YES, is there an operational definition for OVC in the country?

3.2 IF YES, does the country have a national action plan specifically for OVC?

3.3 IF YES, does the country have an estimate of OVC being reached by existing interventions?

IF YES, what percentage of OVC is being reached?

Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children?

2007	3
2005	1

Comments on progress made since 2005:

limited government support. ngo effort.

ANNEX 3: Country M&E Sheet

Country: SURINAME AS OF: December, 2007

1. **Existence of national M&E plan**

Yes: **Years covered:**	**In progress:** **Years covered:**	No: There is currently no separate plan, however the NSP has an M&E Section

2. **Existence of a national M&E budget**

Yes: **Amount**: **Years covered**:	In progress: Years covered:	NO

3. Amount secured as of today: _____

4. Existence of an M&E unit for HIV/AIDS within

National AIDS Program	Ministry of Health	Elsewhere: ___________
Not fully staffed	**There is a HIV/AIDS surveillance team**	

5. M&E focal point on HIV/AIDS within the government

Focal point is within the Ministry of Health: National AIDS Program

6. **Existence of information system:**

Health Information System

YES National level: **YES** Sub-national*:	

** If yes, please specify the level, i.e., district*

Education Information System

National level: **YES** Sub-national*: District	

** If yes, please specify the level, i.e., district*