



SURINAME

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

JANUARY 2003 – DECEMBER 2005

**MINISTRY OF HEALTH
SURINAME
APRIL 2005**

I. STATUS AT A GLANCE

Introduction

In June 2001 the Government of Suriname adopted the UNGASS Declaration of Commitment, thus underlining national commitment to the fight against HIV/AIDS. A review of the achievements during the reporting period indicates that Suriname has made accelerated progress towards the UNGASS targets.

In 2003 the process of formulation of a National Strategic Plan on HIV/AIDS was initiated. The NSP was completed and formally adopted by the Council of Ministers in 2004. During 2004-2005 the NSP served as the framework for expansion and strengthening of the national 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.

Major achievements during the reporting period include the introduction and up scaling of ARV treatment from 0 in 2002 to over 500 persons by December 2005. Various national protocols and guidelines were developed to strengthen and standardize care and treatment, including clinical treatment protocols, a VCT protocol and a PMTCT protocol. Coverage of PMTCT screening of pregnant women increased from 30% in 2003 to 70% in 2005. Introduction of free HIV testing and expansion of the number of VCT sites contributed to rapid increase of the number of VCT clients from 500 in 2003 to almost 2000 in 2005.

Remaining challenges are the lack of sufficient trained staff, the lack of an adequate and supportive legislative framework and the persisting stigma & discrimination of PLWHA. While a second Global Fund grant was secured aimed at up scaling of prevention, the concern remains that the national response is strongly built on external funds and the Government has not been consistent in the scaling up of sufficient domestic resources to guarantee a sustainable national response to HIV/AIDS.

Summary overview of core UNGASS or UNGASS-related indicators

Indicators	2003	2005	Comments & data source
1. The amount of national funds spent on HIV/AIDS	NA	US\$ 273,000	The current line item budget system of the Government makes it difficult to arrive at an accurate estimate of the funds disbursed for HIV/AIDS. A budget analysis conducted in the context of the National Strategic Plan estimated that in 2004-2005 the total cost for NSP implementation was US\$ 1,945,000 of which the Government provided US\$ 273,000 – mostly in kind. This estimate suggests that the majority of the finances for HIV/AIDS are from external sources. Data source: National Strategic Plan for HIV/AIDS

2. National Composite Policy Index	NA		See annex 2 for available information.
3. Percentage of schools with teachers who have been trained in life-skills based HIV education and who taught it during the last academic year	0	NA	Around 1000 teachers have been trained in components of life skills and have integrated these skills in their teachings. However, a formal training and life-skills based curriculum, which has not yet been introduced, will be introduced in 2006 in 20 pilot schools (4%), followed by national implementation in 2007. Data source: Basic Life Skills Program
4. Percentage of large enterprises/companies with HIV/AIDS workplace policies and programs	0	3 (9%)	Currently only 1 of 29 larger enterprises (>100 employees) has an HIV workplace policy. In addition 2 companies have HIV workplace programs. Data source: NSP Annual Review Report 2005.
5. Percentage of women and men with sexually transmitted infections at health care facilities, who are appropriately diagnosed, treated and counseled	NA	NA	Data not available
6. Percentage of HIV+ pregnant women receiving a full course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission	15% (30)	30% (60)	Concerning screening of pregnant women, it can be stated that the screening has increased from 30% to 70% in 2005. Data source: ARV treatment database.
7. Percentage of persons with advanced HIV infection receiving ARV combination therapy	91	528	According to estimates of prevalence of 1.9%, 3000-4000 persons in Suriname are in need of ARV.

8. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	NA	40 infants 300 families	Through the National AIDS Program monthly 300 care packages for families and 40 for infants are distributed.
9. Percentage of transfused blood units screened for HIV	100%	100%	All blood donations are routinely screened at the only blood bank in Suriname Data source: National Blood Bank
Knowledge and behavior			
10. Percentage of young women and men aged 15-24 who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission	NA	NA	Due to delay in national youth survey this data is not available.
11. Percentage of young women and men who have had sex before the age of 15	NA	NA	See comment above.
12. Percentage of young women and men who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months	NA	NA	See comment above.
13. Percentage of young women and men aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular	NA	NA	See comment above.

partner			
14. Ratio of current school attendance among orphans to that of non-orphans aged 10-14	89%	NA	Data source: UNICEF estimate – 2003 State of the World’s Children.
Impact			
15. Percentage of young men and women aged 15-24 who are HIV infected	NA	NA	National estimate of adult prevalence 15-49 yrs. (calculated with UNAIDS software) was 1.7 in 2003 and 1.9 in 2004.
16. Percentage of adults and children with HIV still alive 12 months after initiation of ARV treatment	73%	92%	Data source: ARV treatment database, National AIDS Program Suriname

II. OVERVIEW OF THE AIDS EPIDEMIC

The Republic of Suriname is situated on the North-East coast of South-America, bordering French Guyana in the East, Guyana in the West, Brazil in the South, and the Atlantic Ocean in the North. The country covers an area of 163,820 square kilometers. Seventy percent of the population lives in two urban districts covering 0.4% of the land area, while 10% lives in scattered tribal settlements in the interior (80% of the land area).

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, 2004). The total number of registered HIV/AIDS cases was 3032 in 2004 (Ministry of Health), corresponding to 40-50% of the estimated number of persons infected. Preliminary 2005 data recorded 602 new cases. The gender distribution of new HIV+ cases has shifted over the years and since 2004 there are more females than males. 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.

Sero-surveys found prevalence rates of 24% among street sex workers in 2004¹, and 6.7% among men who have sex with men in 2005². This data places Suriname in the category of countries with a generalized epidemic, with concentrated epidemics in sub-populations.

The annual number of hospitalizations due to HIV/AIDS also shows a rising trend. In 2003 and 2004 respectively 264 and 286 persons were hospitalized due to HIV/AIDS. The year 2004 was the first year with more females. The most frequently occurring age group is 20-39 years.

In 1999 HIV/AIDS entered the list of ten most important causes of death in Suriname on the tenth place. In 2000 it moved to the sixth place and has remained there. HIV/AIDS is the leading cause of death for the age-group 24-49. One hundred and fifty-two persons died from HIV/AIDS in 2004.

¹ 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.

² 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.

III. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

National commitment

The issue of HIV/AIDS has been included as a priority in Suriname last two Multi-Annual Development Plans. Commitment on the highest level is also evident in the personal involvement of the President, the First Lady and various members of parliament in the national response.

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 PLWHA, youth, and commercial sex workers. These NGOs continued to function as major partners in the national response to HIV/AIDS.

For several years the performance of the NAP has been hampered by a lack human and financial resources, but in the past two years the completion of the National Strategic Plan and the increased availability of resources have contributed to re-establishment of the NAP as the national coordinating mechanism for the fight against HIV/AIDS.

The NSP identifies 5 priority areas for strategic interventions: 1.Coordination, policy formulation, legislation and advocacy; 2.Prevention; 3.Reduction of stigma and discrimination; 4.Treatment, care and support; 5. Monitoring and Evaluation. The NSP strategies include the Three Ones approach and the 3x5 initiative. Evaluation of NSP implementation in November 2005 indicated that over 80% of the planned activities have been implemented.

In addition to the availability of resources and continued commitment of the Government, the broad based partnerships with NGO's, UN agencies and other development partners contributed to the effective implementation of the NSP.

In 2005 the Government initiated the formation of a new multi-sectoral National AIDS Committee. The new NAC will function as a high level policy-formulating body and is envisioned to include representation of key Government agencies, NGO's, private sector, civil society and PLWHA.

Prevention

During the reporting period efforts were aimed at strengthening the technical capacity at NAP and other agencies to effectively apply Behavior Change Communication (BCC) strategies. Prevention staff was hired for the NAP and 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. In addition to ongoing upgrade training of prevention workers the Government initiated longer term measures to counter the lack of staff trained in prevention. The development of a Health Education track at the Teacher Training College was initiated in 2005 that is expected to yield the first graduates in 2008.

Prevention strategies integrate ABC messages aimed at the general population and sub-groups identified as priority populations in the NSP. NGO's, CBO's and the religious community are actively involved in the planning and implementation of prevention programs.

During the reporting period distribution of free condoms to priority populations continued and the NAP implemented a successful campaign aimed at introduction and promotion of the female condom.

The Basic Life Skills program has initiated the development of HIV/SRH curricula for all levels of education and will continue to lead the process of integration of HIV prevention in the education system.

In 2005 a second Global Fund grant was secured that will enable rapid up scaling of national-level and targeted prevention efforts. The priority populations for this grant are youth, MSM, CSW, the interior and migrant populations.

HIV testing

In recognition of the critical role of HIV testing efforts were made to improve national access to voluntary counseling and testing. In this respect 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 six by the end of 2005, and free VCT services were introduced. A high profile “Know your Status” campaign was launched to promote HIV testing. The scaling up of VCT services will continue with establishment of VCT sites in all districts.

Treatment, care and support

The first efforts to provide ARV in Suriname were modest due to lack of funds. A working group consisting of volunteers, Government, and PAHO/WHO established an ARV treatment fund. A live broadcasted fundraising telethon triggered an unprecedented public response and sufficient funds were donated to ensure treatment for 200 patients for two years. With these funds public ARV treatment was started in Suriname in June 2002. In 2004 Suriname’s Global Fund grant was approved, and the availability of these funds provided the resources for the Ministry of Health to work towards accelerated expansion of ARV treatment and care. During 2002- 2005 the number of persons under ARV treatment increased from 0 to 500.

From the start the strategic decision was made to apply a public health approach and aim for integration of treatment in primary 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. Progress includes development of national protocols for HIV/AIDS treatment of adults and children. These protocols include flowcharts, intake forms and patient cards for monitoring of treatment.

- Training of health workers to use these protocols
- Procurement and free provision of ARV
- Procurement of medication for treatment of opportunistic infections.

Training of health workers is ongoing. The aim is to sufficiently equip all health workers to be able to appropriately assess, diagnose and guide HIV/AIDS patients, thus ensuring access to high quality HIV/AIDS care and treatment for all in Suriname.

Traditionally the NGO's have taken on a leading role in the provision of care and support to PLWHA. During the reporting period the Government took on a more coordinating role. 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 PLWHA. Efforts to strengthen and expand care and support services included appointment of a full time care and support project officer at NAP, training and appointment of peer counselors and buddies, and development of a system to provide care packages to PLWHA.

IV. 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 actions needed.

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 ongoing outward migration of highly trained staff and the low government wages contribute to this lack of professional staff. Short-term actions are the provision of upgrade training to staff and contracting of technical experts, but for the longer term human resource planning, career planning and public sector reform will be necessary to attract and retain highly professional staff.

Effective procurement of ARV and other commodities has proven to be a challenge, resulting in periodic shortages of essential supplies. While procurement training has been provided to key officials, systems for effective forecasting and procurement are still insufficiently developed. Technical expertise is needed and will be sought for development of effective systems for supply chain management of ARV and health commodities.

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. The Government is seeking to learn from other countries with similar settings to apply their lessons learned in the national process of service delivery.

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.

V. SUPPORT REQUIRED FROM COUNTRY'S DEVELOPMENT PARTNERS

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.

For the near future additional support will be needed for rapid strengthening of the procurement component. Support from development partners is also needed to identify and present best practices and lessons learned on global level, and to support the national process to deal with emerging challenges on the road to achieving universal access.

MONITORING AND EVALUATION ENVIRONMENT

In 2003 a joint Government-CAREC assessment was conducted of the monitoring and evaluation practices and capacity. The assessment report identified the gaps and weaknesses in the M&E system. Major weaknesses identified were limited M&E capacity in most agencies and the lack of coordination of M&E efforts. In response to the assessment the national HIV/AIDS/STI surveillance team was established consisting of representation of all key actors in surveillance. The surveillance team meets regularly to discuss and agree on key issues. In addition the surveillance team spearheaded the compilation of surveillance reports, the development of an M&E plan for the NSP and the implementation of M&E training.

Remaining challenges are the development of effective systems for collection and collation of program-level data, including ARV treatment and PMTCT, and the fostering of capacity and commitment on service-provider level to provide complete and timely data.

Annex I: Preparation / consultation process for the National Report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

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

a) NAC or equivalent	*Yes	No
b) NAP	*Yes	No
c) Others	*Yes:	No

(Please specify): HIV theme group meeting

With inputs from:

Ministries:	Education	*Yes	No
	Health	*Yes	No
	Labor	*Yes	No
	Foreign affairs	Yes	*No
	Others	Yes:	No

(Please specify)

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
Others	Yes:	No

(Please specify)

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

Name/ Title: _____

Date: _____

Signature: _____

Annex II: National Composite Index part A

I. Strategic plan

1. Has your country developed a national multi-sectoral strategy/action framework to combat HIV/AIDS?

Yes.

Sectors included	Strategy/Action framework	Focal point/responsible
Health	Yes	Yes
Education	Yes	Yes
Labor	Yes	Yes
Transportation	No	No
Military	Yes	Yes
Women	Yes	Yes
Youth	Yes	Yes
Vulnerable groups in the community	Yes	Yes
NGO's	Yes	Yes

1.2 If yes, does the national strategy/action framework address the following areas, target populations and cross-cutting issues?

Program	
a. Voluntary counseling and testing?	a. Yes
b. Condom promotion and distribution?	b. Yes
c. Sexually transmitted infection prevention and treatment?	c. Yes
d. Blood safety?	d. Yes
e. Prevention of mother-to-child transmission?	e. Yes
f. Breastfeeding?	f. Yes
g. Care and treatment?	g. Yes
h. Migration?	h. Yes
Target populations	
i. Women and girls?	i. Yes
j. Youth?	j. Yes
k. Most at-risk-populations?	k. Yes
l. Orphans and other vulnerable children?	l. Yes
m. HIV/AIDS and poverty?	m. Yes
n. Human rights?	n. Yes
o. PLHA involvement?	o. Yes

1.3 If yes, does it include an operational plan?

Yes. Annual operation plans are developed.

1.4 If yes, do the strategy/operational plan include?

Formal program goals Yes

Detailed budget of costs Yes

Indications of funding sources Yes

1.5 Has your country ensured 'full involvement and participation' of civil society

Yes.

1.6 Has the national strategy/action framework been endorsed by key stakeholders?

Yes.

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

Yes.

2.1 If yes, in which development plan? a) UNDAF b) CCA
c) Multi Annual development plan

Covering which of the following aspects?

	a)	b)	c)
HIV prevention	×	×	×
Care and support	×	×	×
HIV/AIDS impact alleviation			×
Reduction of income inequalities as relates to HIV/AIDS prevention/care			
Reduction of income inequalities as relates to HIV prevention/care			
Others:			

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

Yes. An economic impact study was conducted.

4. Does your country have a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services, military, peacekeepers and police?

The NSP identifies armed forces as a priority population and provides the general framework.

Detailed plans of action are being developed for the military.

Overall, how would you rate strategy planning efforts in the HIV and AIDS programs?

2005: 7

2003: 6

II. Political support

1. Does the head of the government and/or other high officials speak publicly and favorably about AIDS efforts at least twice a year?

Head of the government Yes
 Other high officials Yes

2. Does your country have a national multisectoral HIV and AIDS management/coordination body recognized in law? (National AIDS Council or Commission)*

The National AIDS Committee established in 1987 is currently not functioning. The process was started in 2005 to form a new NAC.

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

Yes.

The UNAIDS expanded theme group acts as such a body.

If yes, does it include?

Terms of reference	Yes
Defined membership	Yes
Action plan	Yes
Functional Secretariat	Yes
Date of last meeting	Date: 9 th of February 2006

4. Does your country have a national HIV and AIDS body that is supporting coordination of HIV-related service delivery by civil-society organizations?

An NGO network – Suriname HIV NGO Network (SHAN) was established in 2003.

If yes, does it include?

Terms of reference	Yes
Defined membership	Yes
Action plan	Yes
Functional Secretariat	Yes
Date of last meeting	Date:

Overall, how would you rate the political support for the HIV/AIDS program? 7

III. Prevention

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

Yes.

1.1 In the last year, did you implement an active program to promote accurate HIV and AIDS reporting by the media?

Yes.

2. Does your country have a policy or strategy promoting HIV and AIDS-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.

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

3. Does your country have a policy or strategy to promote information, education and communication and other preventive health interventions for most-at-risk populations?

Yes.

3.1 Does your country have a political strategy for these most-at-risk populations?

Injecting drug users, including: Risk reduction information, education and counseling? Needle and syringe programs? Treatment services? If yes, drug substitution treatment?	Not applicable
Men who have sex with men?	No
Sex workers?	Yes
Prison inmates?	No
Cross-border migrants, mobile populations?	No
Refugees and/or displaced population?	Not applicable
Other most-at-risk populations?	No

4. Does your country have a policy or strategy to expand access, including among most-at-risk populations, to essential preventative commodities (including, but are not limited to access to confidential voluntary counseling and testing, condoms, sterile needles and drugs to treat sexually transmitted infections)?

Yes.

4.1 Do you have programs in support of the policy or strategy?

A social-marketing program for condoms yes

A blood-safety program yes

A program to ensure safe injections in health care settings yes

A program on antenatal syphilis screening yes

Other programs

Overall, how would you rate policy efforts in support of prevention? 7

5. Which of the following prevention activities have been implemented in 2003 and 2005 in support of the HIV-prevention policy/strategy?

	2003	2005
a. A program to promote accurate HIV and AIDS reporting by the media.	×	×
b. A social-marketing program for condoms.		×
c. School-based AIDS education for youth.	×	×
d. Behavior-change communications.	×	×
e. Voluntary counseling and testing.	×	×
f. Programs for sex workers	×	×
g. Programs for men who have sex with men		×
h. Programs for injecting drug users.	×	×
i. Programs for other most-at-risk populations.	×	×
j. Blood safety	×	×
k. Programs to prevent mother-to-child transmission of HIV	×	×
l. Programs to ensure universal precautions in health care settings		×
m. Other:		

Overall, how would you rate the efforts in the implementation of HIV prevention programs? 7

IV. care and support

1. Does your country have a policy or strategy to promote comprehensive HIV and AIDS care and support, with sufficient attention to barriers for women, children and most-at-risk populations? (Comprehensive care includes, but is not limited to, confidential voluntary counseling and testing, psychosocial care, access to medicines, and home and community-based care).

Yes.

2. Which of the following activities have been implemented under the care and treatment of HIV and AIDS programs?

	2003	2005
a. HIV screening of blood transfusion	×	×
b. Universal precautions		×
c. Treatment of opportunistic infections (OI)		×
d. ART		×
e. Nutritional care		×
f. Sexually transmitted infection care	×	×
g. Family planning services	×	×
h. Psychosocial support for people living with HIV and their families	×	×
i. Home-based care		×
j. Palliative care and treatment of common HIV-related infections: pneumonia, oral thrush, vaginal candidiasis and pulmonary TB (DOTS)		×
k. Cotrimoxazole prophylaxis among HIV-infected people		×
l. Post exposure prophylaxis (e.g. occupational exposures to HIV, rape)		×
m. Other		

Overall, how would you rate the efforts in care and treatment of the HIV/AIDS program? 7

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

Yes. The ministry of Social Affairs supports vulnerable households with financial difficulties by providing basic nutritional needs and a better access to health care.

Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children? 5

V. Monitoring and Evaluation

1. Does your country have one national monitoring and evaluation (M & E) plan?

In draft.

National Composite Index part B

I. Human rights

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

Yes. General non-discrimination measures are included in our constitution and civil legislation.

2. Does your country have non-discrimination laws or regulation which specify protections for certain groups of people identified as being especially vulnerable to HIV and AIDS discrimination (i.e., groups such as injecting drug users, men who have sex with men, sex workers, youth, mobile populations and prison inmates)?

No.

3. Does your country have laws and regulations that present obstacles to effective HIV prevention and care for most-at-risk populations?

Yes. There is some legislation that theoretically serves as barriers. These include certain aspects of CSW and promotion of condoms and other contraceptive. Since the government is not actively pursuing this legislation in practice they don't limit prevention efforts.

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

Yes. It is included in the NSP.

5. Has the government, through political and financial support, involved vulnerable population in government HIV-policy design and program implementation?

Yes.

6. Does your country have a policy to ensure equal access, between men and women, to prevention and care?

Yes. Policy documents and written constitutions where equal access to prevention and care for men and women is assured.

7. Does your country have a policy to ensure equal access to prevention and care for most-at-risk populations?

Yes. Policy documents and written constitutions where equal access to prevention and care for most at risk populations is assured.

8. Does your country have a policy prohibiting HIV screening for general employment purposes (appointment, promotion, training, benefits)?

No.

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

Yes.

10. Does your country have the following monitoring and enforcement mechanisms?

Collection of information on human rights and HIV and AIDS issues and use of this information in policy and program development reform	No
Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions and ombudspersons which consider HIV- and AIDS- related issues within their work	No
Establishment of focal points within governmental health and other departments to monitor HIV-related human rights abuses	No
Development of performance indicators or benchmarks for compliance with human rights standards in the context of HIV and AIDS efforts	Yes

11. Have members of the judiciary been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work?

No.

12. Are the following legal support services available in your country?

Legal aid systems for HIV and AIDS casework	No
State support to private sector laws firms or university based centers to provide free pro bono legal services to PLWHA in areas such as discrimination	No
Programs to educate, raise awareness among PLWHA concerning their rights	Yes

13. Are there programs designed to change societal attitudes of discrimination and stigmatization associated with HIV and AIDS to understanding and acceptance?

Yes.

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS? 5

Overall, how would you rate the effort to enforce the existing policies, laws and regulations? 5

III. Prevention

1. Which of the following prevention activities have been implemented in 2003 and 2005 in support of the HIV-prevention policy/strategy?

	2003	2005
a. A program to promote accurate HIV and AIDS reporting by the media.	×	×
b. A social-marketing program for condoms.		×
c. School-based AIDS education for youth.	×	×
d. Behavior change communications.	×	×
e. Voluntary counseling and testing.	×	×
f. programs for sex workers.	×	×
g. Programs for men who have sex with men.		
h. Programs for injecting drug users, if applicable.		
i. Programs for other most-at-risk populations.	×	×
j. Blood safety.	×	×
k. Programs to prevent mother-to-child transmission of HIV.	Yes	Yes
l. Programs to ensure safe injections in health care settings.		Yes
m. Other:		

Overall, how would you rate the efforts in the implementation of HIV-prevention programs? 8