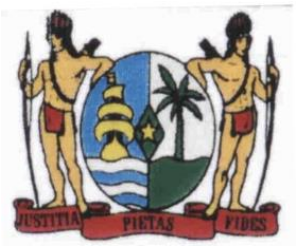

Suriname

AIDS Response Progress Report

2012 - 2014

Ministry of Health
Henck Arronstraat 64
Paramaribo - Suriname

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List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
BOG	Bureau of Public Health
BSS	Behavior Surveillance Survey
BTD	Blood bank
CAREC	Caribbean Epidemiology Center
CCPAP	Common Country Program Action Plan
CRIS	Country Response Information System
CoE	Centre of Excellence
DD	Dermatological Department
HIV	Human Immunodeficiency Virus
IEC	Information Education and Information
ILO	International Labor Organization
M&E	Monitoring and Evaluation
MARPS	Most At Risk Populations
MICS	Multiple Indicator Cluster Survey
MM	Medical Mission
MOH	Ministry of Health
MSM	Men who have sex with men
NASA	National AIDS Spending Assessment
NGO	Non-Governmental Organization
NSP	National Strategic Plan
NTP	National Tuberculosis Programme
PM	Patient Monitoring
PMTCT	Prevention of mother to child transmission
RHS	Regional Health Services
SBC	Suriname Business Coalition
STI	Sexually Transmitted Infections
SW	Sex Worker
TB	Tuberculosis
TWG	Technical Working Group
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
VCT	Voluntary counseling en testing

Introduction

The Government of Suriname adopted the UNGASS Declaration of Commitment in June 2001 and reemphasized the national commitment to the response against HIV and AIDS through the Political Declaration on HIV and AIDS in June 2011.

In 2002, in accordance with regional and international agreements, the Surinamese Government initiated a process for the systematic and strategic control of HIV. In 2007, based on a broad national consultation process and results based strategic frameworks, the second National Strategic Plan for HIV (NSP) 2009-2013 was developed. The HIV response in Suriname is guided by this National Strategic Plan for a multi sectoral approach of HIV/AIDS. The overarching objective of this NSP is: "to halt the spread of HIV and to increase the quantity and quality of life of people living with HIV". Suriname is now in the process of developing the third NSP.

Suriname has made important strides forward in many areas regarding the response against HIV. From 2007 on there has been a decline in the number of newly registered HIV-cases. According to the Global Report of the UNAIDS 2010, Suriname is one of the few countries in the Caribbean that has experienced a decrease of more than 25% of the incidence rate of HIV-infection. Also, mortality-rates are slightly decreasing since 2006. This is probably due to the increased access to HIV-testing (including the almost tripled screening of pregnant women) and the nationwide treatment with ARV's and increased availability of condoms.

A great deal of the progress was made possible through external financial assistance. The majority of this funding consisted of the Global Fund grants. As donor funding reduces over time is of utmost importance to move from donor support to full coverage by the Government. Therefore the Government has gradually increased the national budget for HIV. The policy of Ministry of Health (MOH) is based on the assumption of an overarching policy. In this policy, all needed health services are integrated and linked with each other whereby Primary Health Care (PHC) is fulfilling a fundamental role. Another starting point that is founded in MOH its view is that HIV is recognized as a chronic disease. The Ministry of Health also recognized HIV as a chronic disease. Within this prevention and treatment framework are key components of the MOH's response. The MOH has commenced the integration of HIV-services in the existing healthcare and the increased governmental budget for HIV.

This 2014 update of the GARPR Declaration of Commitment in the fight against HIV/AIDS outlines the report writing process, an overview of the status of the epidemic, the programmatic and political national response to HIV/AIDS and its monitoring based on the GARPR indicators. The update is concluded by identified challenges and associated remedial actions.

1. Status at a glance

1.1. Report writing process

The Research, Planning and Monitoring Unit of the Ministry of Health were part of the report writing process. The different departments involved in HIV were asked to provide information relevant to their field of work. The civil society and UN agencies in country were also part of the process by filling out the NCPI part B.

Since there have been recent in-country discussions during the Mid-Term Review and Treatment 2.0 consultations' meetings, most of the information for this report was taken out of these discussions. A national consensus meeting was therefore not held, however if additional information was needed, the different stakeholders were contacted to discuss the analysis process and the results.

Although there has been an increase in available data, the need for additional operational research to explain and validate certain findings became evident during the writing process.

1.2 The status of the epidemic

Suriname has a generalized epidemic with an estimated current prevalence of 1% of the adult population (age 15-49) (UNAIDS 2010 Global report). These estimates are in line with the HIV prevalence of 1%, found among pregnant women since more than 5 years. Meanwhile the prevalence in the MARPs (Most at Risk Populations) such as Men having Sex with Men (MSM) and Sex Workers (SW) has traditionally been higher than the general adult population i.e. 6.7% among MSM in 2004 and 5.86% among sex workers in the capital city Paramaribo in 2012.

Since the first case of HIV was registered in 1983, scaling-up of HIV-testing led to an increase in the number of persons tested for HIV, and an increase in the number of newly registered HIV-cases. This increase continued until 2006, with a maximum of 717 newly registered cases. However, since 2007 there has been a steady decline in the number of newly registered HIV-cases; 459 in 2012 (see figure 1)[1].

[1] HIV quick reference sheet Suriname, updated March 2012

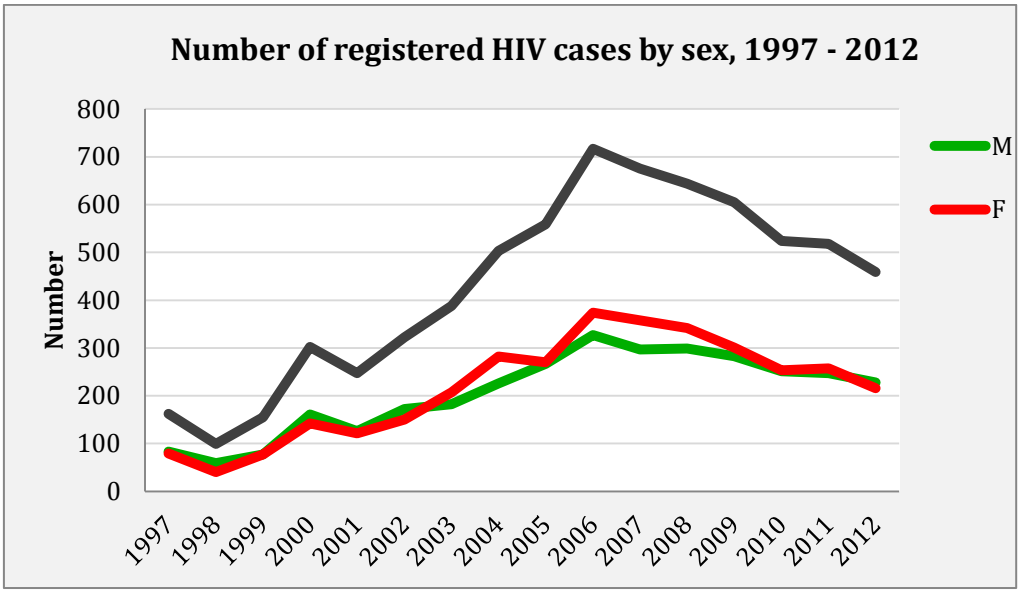


Figure 1: Number of registered HIV positive people by sex, 1983 - 2012

Source: HIV Masterdatabase M&E Unit MOH, 2014

Among the HIV test done in the past 10 years, the numbers of diagnosed females is slightly more than men, especially since 2003, when HIV testing of pregnant females was introduced and more women got tested. However, the prevalence of HIV in men that are tested is higher.

Although there is a decrease in new infections, the annual number of HIV related hospitalizations after the initial dip from 2004 to 2008, is showing a slight increase. In 2010 the hospitalizations were already 237. The increase is primarily due to the increase in men hospitalized because of HIV. The majority of hospitalized women are slightly younger than the hospitalized men 20 - 44 years while the majority of male patients are in the age group 25 - 49 years.

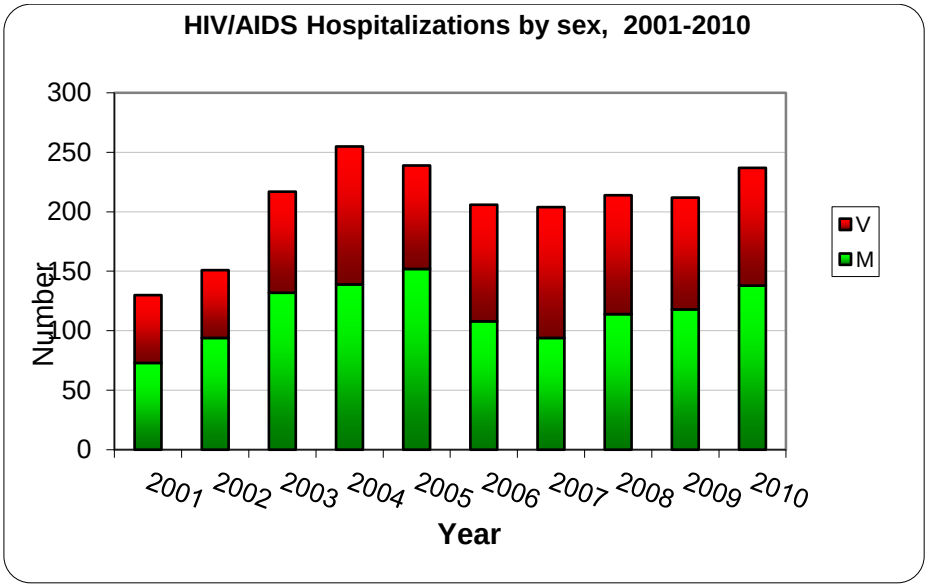


Figure 2: Number of hospitalizations for HIV/AIDS by sex, 2001 – 2010

Source: Bureau of Public Health, Epidemiology department

With the increasing availability of anti-retrovirals, especially since the start of the Global Fund in 2005 and the 100% financing of ARVs by Government in 2012, the numbers of people on treatment have been steadily increasing. There is approximately 4 times people on treatment from 346 in 2005 to 1382 in 2012 (see figure 3)

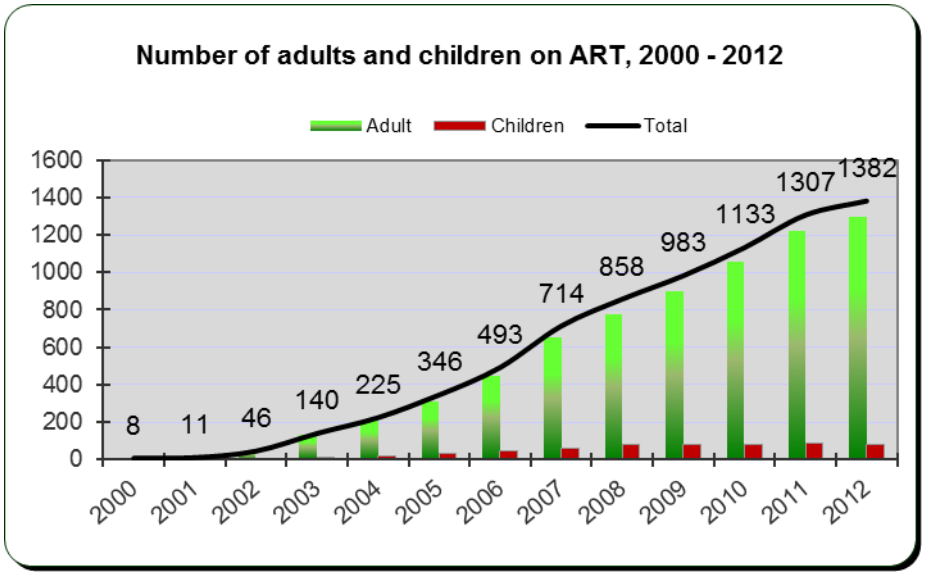


Figure 3: Number of adult and children on ART, 2000 – 2012

Source: HIV Treatment database NAP, 2013

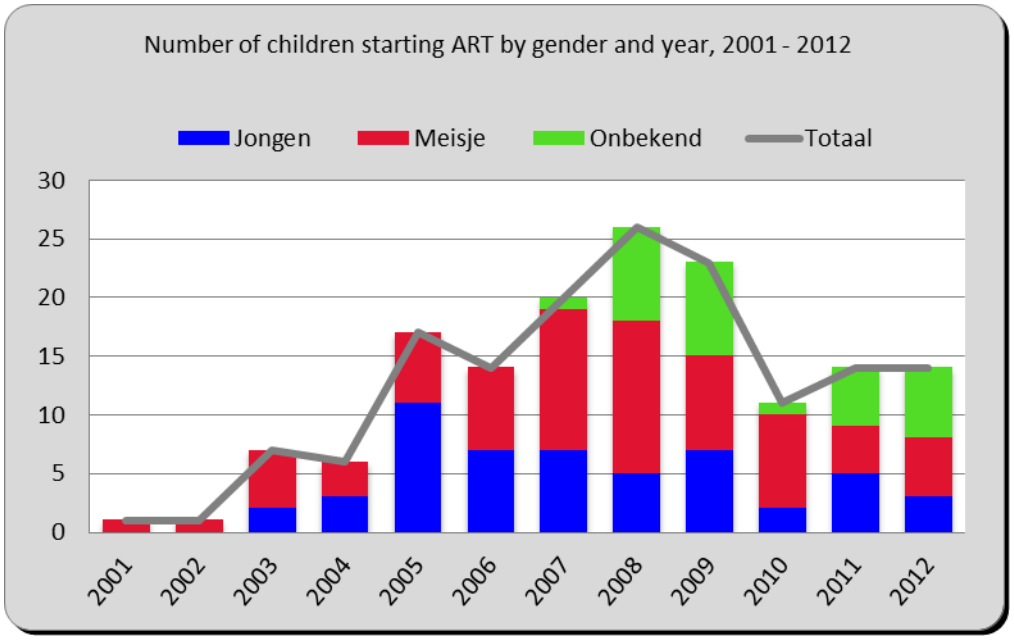


Figure 4: Number of adult and children on ART, 2000 – 2012

From 1997 to 2010, the cumulative number of certified cases of AIDS deaths is 1801. There are indications that the annual death rate due to AIDS has decreased. In 2005 a maximum of 181 persons deaths due to AIDS were registered, but in 2009 this number dropped to 106. AIDS dropped from fifth to sixth place on the list of most frequent causes of death, in 2006.

Some explanations for this decrease include the increase of early diagnostics, especially in the context of Prevention of Mother to Child Transmission (PMTCT) and the steady increase of patients on antiretroviral drugs (ARV). In 2011, AIDS ranked 7th on the list of most frequent causes of death. However, not all death certificates have been received.

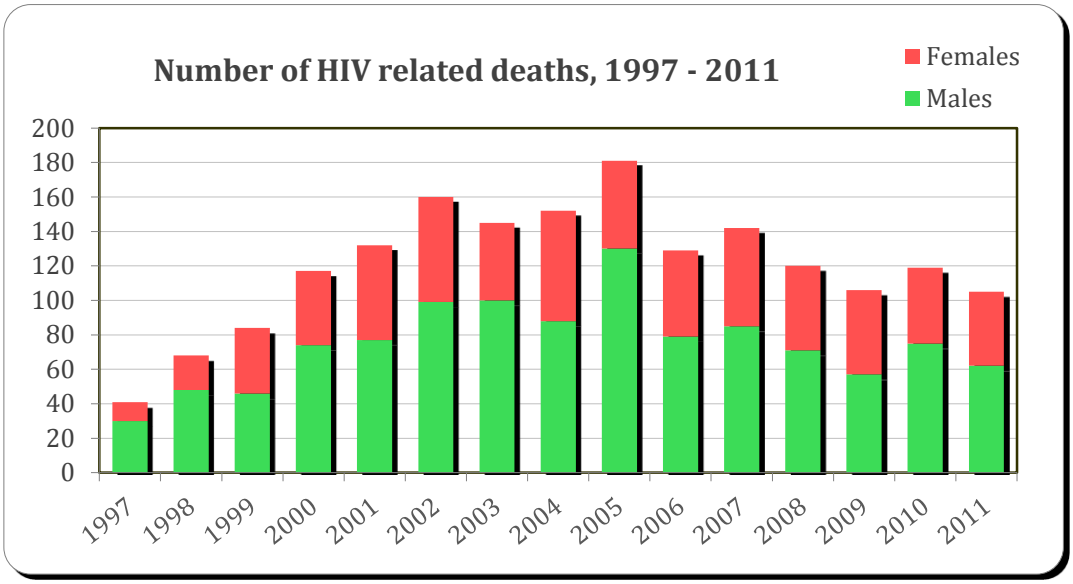


Figure 5: Number of HIV related deaths, 1997 – 2011

Table 1: AIDS mortality, 1997 – 2011

Year	AIDS – MortalityNumbers			% of Total mortality	Rank	% of death certificates received
	Male	Female	Total			
1997	30	11	41	2.0 %	10	**69%**
1998	48	20	68	3.1 %	9	**80%**
1999	46	38	84	3.5 %	8	**80%**
2000	74	43	117	4.1 %	6	**86%**
2001	77	55	132	5.0 %	6	**85%**
2002	99	61	160	5.3 %	6	**96%**
2003	100	45	145	4.9%	5	**94%**
2004	88	65	152	5.4%	5	**85%**
2005	130	51	181	5.9%	5	**91%**
2006	78	51	129	4.5%	6	**83%**
2007	85	57	142	4.7%	6	**85%**
2008	71	49	120	3.8 %	6	**95%**
2009	57	49	106	3.5%	6	**90%**
2010	75	44	119	3.9%	6	**93%**
2011	**63**	**42**	**105**	**3.4%**	**7**	**88%**

Source: Causes of deaths in Suriname, Epidemiology/Biostatistics, BOG

1.3 Policy and programmatic response

Until 1996, HIV /AIDS policy, research, education and control were coordinated by the National AIDS Program (NAP) under the Ministry of Health. In 1996 the activities were modified in content, organization and framework. The Program was placed within the Dermatology Department of the Ministry of Health as a result activities regarding sexually communicable diseases were included in the package of benefits.

The designation of the Program was therefore changed to National HIV/AIDS /STI Program.

Various local and national activities within the framework of the HIV/AIDS/STI prevention among women are financed from regular budget funds and finances from foreign donors. Activities include: Scientific research, workshops, group discussions, information meetings, radio and television programs and seminars.

The National Aids Program has been foremost in the fight against HIV/AIDS. The Program has implemented of policies in cooperation with the Governmental and Non-governmental Organizations (NGOs).

In 2001, the Government of Suriname adopted the UNGASS Declaration of Commitment and in 2002, the government initiated a process for the systematic and strategic control of HIV which resulted in the development of the first National HIV/AIDS strategic plan 2004-2008 with a multi-sectorial approach for HIV. The coordination of this strategic plan was placed at the National AIDS Program at the Ministry of Health.

In 2007, the second National Strategic Plan (NSP) was developed for the period of 2009-2013. Presently the Ministry is in the process of developing the third NSP.

The NSP 2009-2013 with its multi sectoral approach to HIV/AIDS has guided the HIV response in Suriname. The following 5 priority areas for strategic interventions were identified:

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
5. Strategic Information for policy development and service provision

The NSP outlines a multi sectoral approach involving other ministries and all relevant sections of society and it serves as the national framework for expanding and strengthening the multi sectoral response against HIV/AIDS. In 2009 the Ministry of Health (MOH) developed a leadership structure for the national HIV response. This resulted in strengthened coordination of the HIV-response through establishment of a national multi-sectoral HIV-board, with its Technical Working Groups on Prevention, Treatment and Care and Monitoring & Evaluation as it working-arms. There is national commitment to the response against HIV/AIDS; this is shown by the increase of funding for HIV program (ARVs are fully funded by government).

The MOH has initiated processes to re-integrate HIV in existing structures and this has changed the focus of the abovementioned structures. The TWG on Treatment & Care has been changed into a platform of Treatment & Care consisting of representatives of Ministries, Centre of Excellence (CoE) and civil society. The TWG on M&E not only the responsibility for HIV, but addresses all M&E related matters within the MOH.

Specific policy and programmatic responses for 2012 and 2013 were:

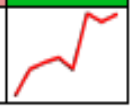
1 The midterm review of the 2009-13 NSP

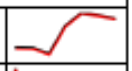
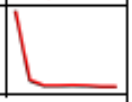
2 The midterm evaluation of ten political targets

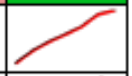
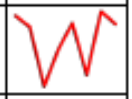
3 The analysis of the conditions needed to introduce the treatment 2.0 concept for HIV treatment and care in Suriname. After data-analysis and national consultations the HIV situation analysis 2013, and the action plan 2014 with activities needed to prepare for 'Treatment 2.0' in Suriname were developed.

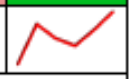
The recommendations coming out of these 3 activities are to be included in the next NSP for Suriname.

1.4. GARPR indicators overview table, 2006 – 2013

No	Indicator name	Source	Comments	Years								Trend
Reduce sexual transmisision of HIV by 50% by 2015												
	Indicators for the general popuations	*Source*	*Comment*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*	*2013**	
1.1	Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	MICS		41				41.9				
1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	MICS		9.2				9.6				
1.3	Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	MICS		1				2.5				
1.4	Percentage 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	MICS						37				
1.5	Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	MICS		30.2				20.3				
1.6	Percentage of young women and men aged 15-24 who are HIV infected	PMTCT surveillance system		1	0.9	0.9	1	1	1.1	1.1	1.1	
	Indicators for sex workers	*Source*	*Comment*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*	*2013**	
1.7	Percentage of sex-workers reached with HIV prevention programmes	BSS					36.29			11.15		
1.8	Percentage of sex-workers reporting the use of a condom with their most recent client	BSS	vaginal				98.4			99.30		
			anal				87			98.90		
			oral				94			96.00		
1.9	Percentage of sex-workers who received an HIV test in the last 12 months and who know their results	BSS					94.70			93.70		
1.10	Percentage of sex-workers who are HIV-infected	IBBS					7.20			5.80		
	Indicators for men who have sex with men	*Source*	*Comment*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*	*2013**	
1.11	Percentage of men reached with HIV prevention programmes	BSS	*1. Received HIV information in last 12 months 2. Received condoms in last 12 months*						55.20%			
1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	BSS	*Looked at condom use with last paying partner*						53.3			
1.13	Percentage of men who received an HIV test in the last 12 months and who know their results	BSS							97			
1.14	Percentage of men who are HIV-infected	IBBS	2010 IBBS was conducted but for HIV testing there was a high refusal rate of 80%									
Reduction of HIV among injecting drugusers												
	Indicator 2.1 - 2.5		Not Applicable for Surinamese setting									
Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths												Trend
No	*Indicator*	*Source*	*Comment*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*	*2013**	
3.1	Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	Treatment database	Denominator=100	64	79	83	86	79	112	107	111	

3.2	Percentage of infants born to HIV-infected women receiving a virological test for HIV within 2months of birth	PMTCT database	Nominator: Number of living children born out of HIV infected mothers for whom a PCR result is known; Denominator: Number of children born out of HIV pos mothers (excluding still births, early deaths)									
			N/A		17.6	16.5	2.5	67.6	98.2	92.6	85	
3.3	Estimated percentage of child HIV infections from HIV positive women delivering in the past 12 months (modelled)	Spectrum sofware, 2012		8.53	3.57	3.17	3.18	3.21	3.19	3.11	3.11	

Have 15 million people living with HIV on ART by 2015											Trend
No	*Indicator*	*Source*	*Comments*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*	*2013**	
4.1	Percentage of eligible adults and children with currently receiving antiretroviral therapy	Treatment database		24.1	35.8	44.1	51.2	58.5	69.9	74		
4.2	Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral treatment	Treatment database		81	78	62	72	79	65.2	82.2	78.7	

Reduce TB deaths in people living with HIV by 50% by 2015											Trend
No	*Indicator*	*Source*	*Comments*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*	*2013**	
5.1	Percentage estimated HIV-positive incident TB cases that received treatment for TB and HIV	NTP database			32	60	50	45	56	69		

Reach a significant level of annual global expenditure (US22-24 billion) in low-and middle-income countries	Trend

6.1	Domestic and International AIDS spending by categories and financing sources	NASA					4,037,170.46	6,129,853.40	4,674,508.15	N/A	N/A	

Critical enablers and synergies with developmenr sectors											
No	*Indicator*	*Source*	*Comment*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*	*2013**
7.2	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
7.3	Current school attendance among orphans and non-orphans aged 10-14	MICS	*Orphans*					85.6			
			Non-Orphans					96.6			
7.4	Proportion of poorest households who received external economic support in the past 3 months			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

N/A: Not available * 2013: preliminary data; still subject to change

2. Overview of the AIDS epidemic

HIV surveillance is part of the regular surveillance in Suriname. HIV testing is conducted among different groups such as pregnant women, TB patients, blood donors and in the general population. Furthermore, studies among the identified vulnerable groups are conducted periodically.

2.1. HIV test surveillance

Although a slightly higher number of women are tested positive compared to men, the prevalence among the tested men is higher compared to women. An explanation is that women are being tested regularly because of the PMTCT program, compared to the men who are mostly being tested when they have symptoms.

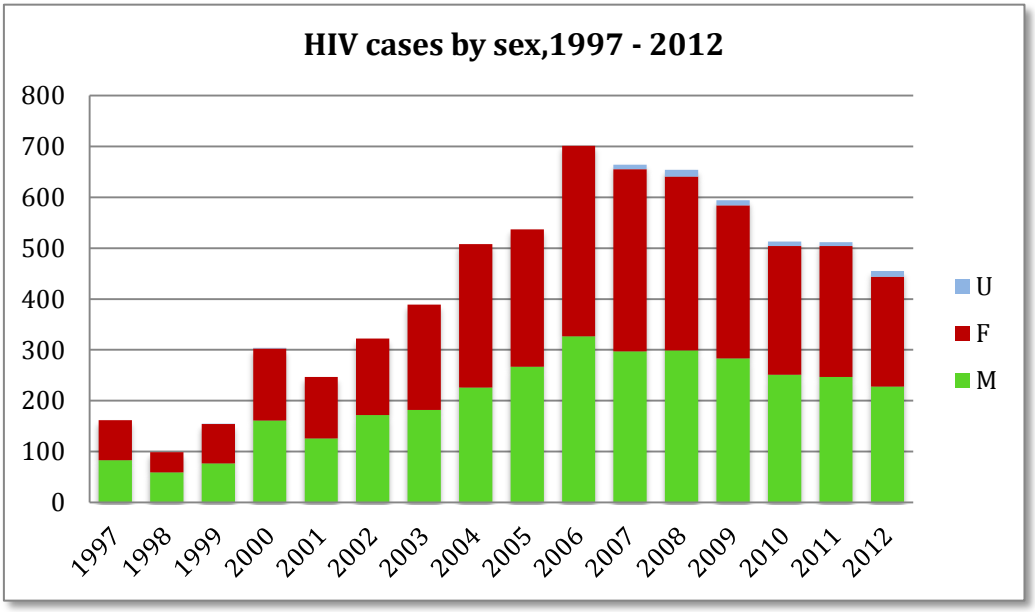


Figure 6: HIV cases by sex, 1997 – 2012
Source: Mortality Statistics, Bureau of Public Health, MOH Suriname

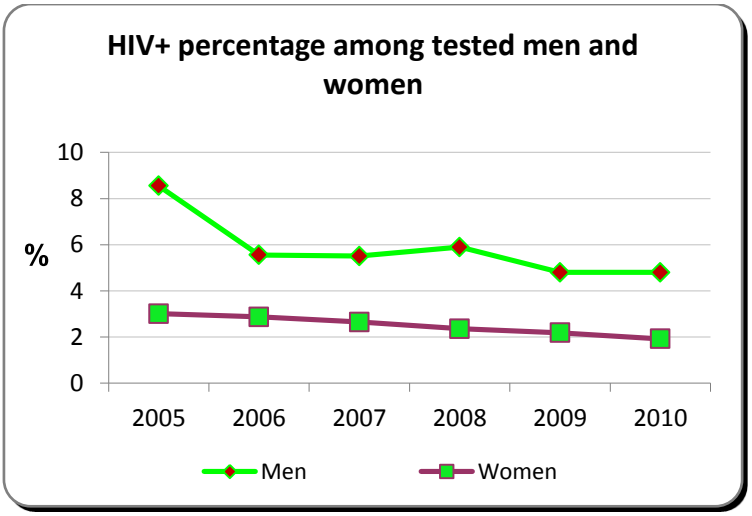


Figure 7: Percentage of HIV positive tested men and women among men and women testing for HIV, 2005 – 2010

2.2. Screening of pregnant women

Pregnant women constitute a cross-section of the general, sexually active population and therefore provide a reasonable estimation of the extent to which HIV has spread among the population. In 2005, 78% of all pregnant women were tested for HIV, which increased to 84% in 2010 (see figure 8).

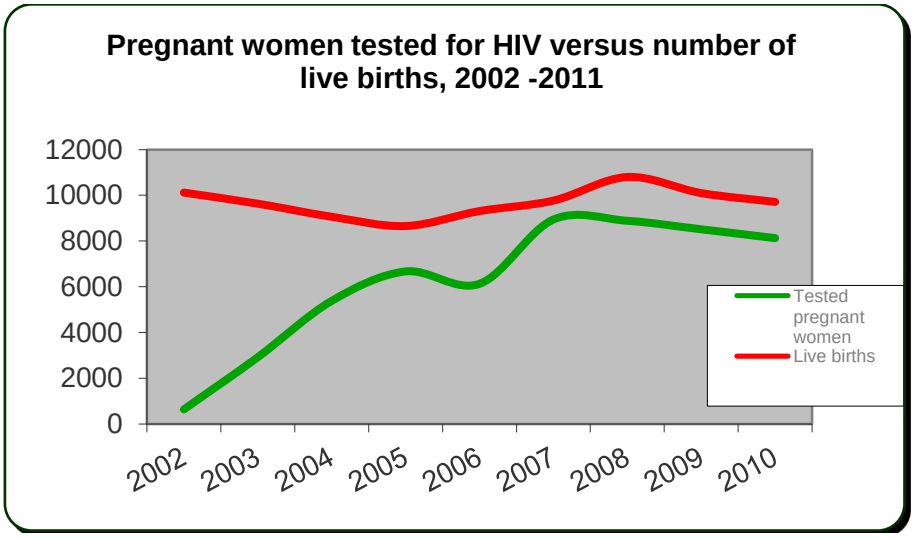


Figure 8: HIV test coverage based on pregnant women tested compared to live births, 2002 – 2010

The HIV prevalence found was on average 1.0% from 2003 to 2013. This prevalence of around 1% is still found although the method of calculation was changed to using test data in 2009 to the use of the registered HIV from the PMTCT focal point system put against the registered number of births at civil registry office.

The prevalence in the age group 15-24 year is slightly less compared to the prevalence in all ages. In 2010 the prevalence in the 15-24 year age group the prevalence was 0.7%.

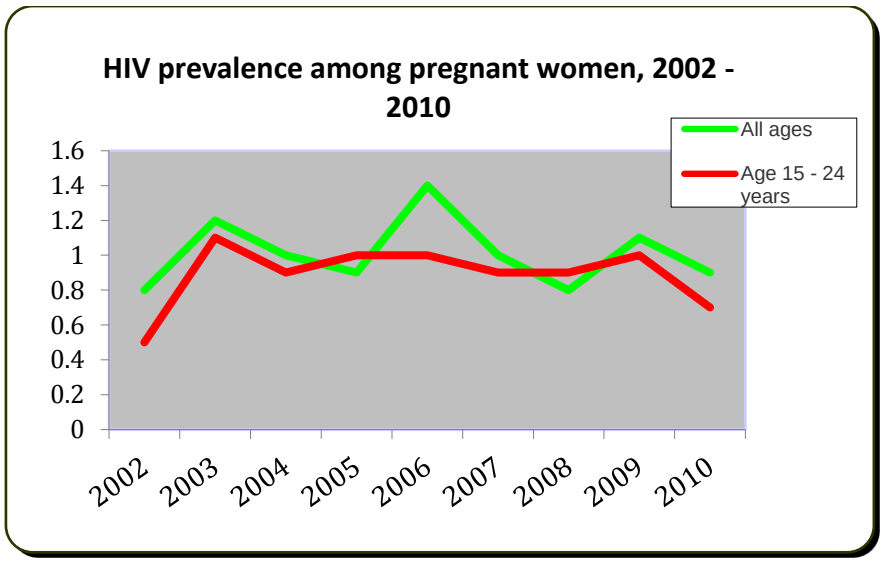


Figure 9: HIV prevalence among pregnant women, 2002 – 2010

2.3. Screening of Blood donors

During the period 2004-2011, HIV prevalence among active blood donors was 0.025%[2] annually. This was the result of blood screening of all donated blood, performed by the blood bank according to documented operating procedures and external quality assurance schemes.

2.4. Screening of Tuberculosis patients

From 2000 - 2003 on average 64 % of TB patients were tested on HIV. Of these persons tested, 23% were HIV positive. In the next 4 years, from 2004 – 2008, the average percentage of testing went up (to 72 %), while the HIV prevalence remained more or less the same (24%). In the past years the HIV prevalence among TB patients reached a high of 34% in 2010 and 2011, followed by some initial decline to 23% in 2013 with a test rate of 96%.

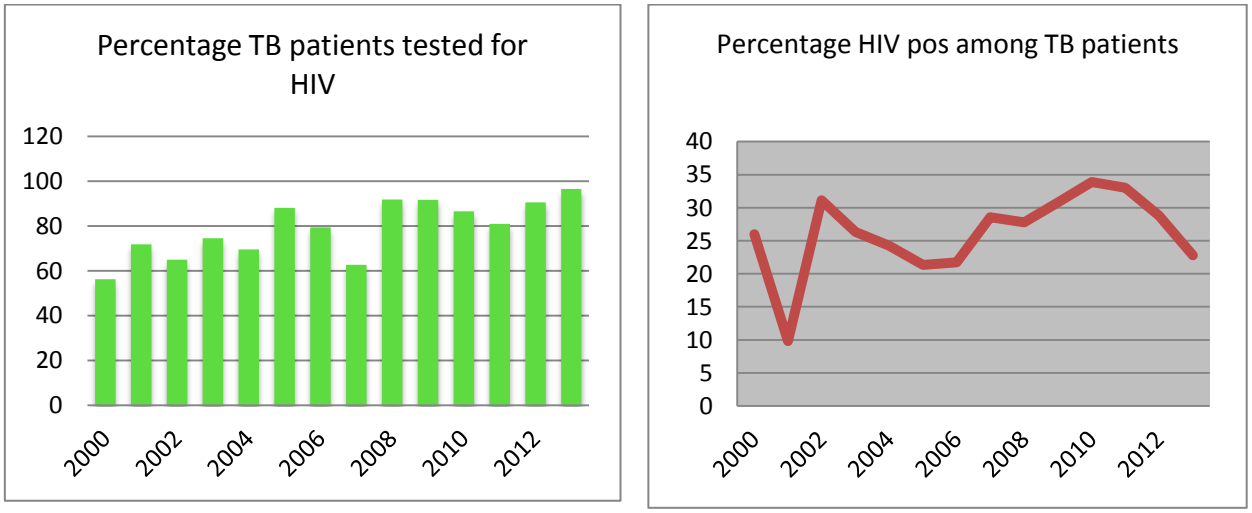


Figure 10: Percentage of TB patient tested for HIV and HIV prevalence among TB patients, 2000– 2013

Source: National Tuberculosis Programme, 2014

[2] Bloodbank annual data

2.5. Special surveys among MARP's

Suriname has recognized the need to implement intensive surveillance on populations whose behaviors places them at increased risk to HIV, and has identified subpopulations whose specific behaviors are driving forces of the HIV epidemic.

These populations are:

- Male and Female Sex Workers
- Clients of Sex Workers
- Men having Sex with Men (MSM)
- Prisoners
- STI clinic clients
- Gold miners

In the past years, HIV prevalence studies have been conducted among high risks subpopulation (see table 2). For sex workers a decline of the prevalence is visible. In order to draw conclusions for MSM, more HIV prevalence data is needed.

Year	SWs	MSM	Prisoners	Military	STI Clinics Clients
1986	0.00				0.00
1989	1.00				0.60
1990	2.50				
1991					1.03
1992	22.00		0.00		
1996					
1998		18.00			
1999				1.40	
2004	24.10	6.70			
2008					2.8
2009	7.2				
2010					
2012	5.8				
2013					

Table 2: Overview of HIV prevalence among MARPS, 1986 - 2013

In 2010, HIV-testing was included in the BSS study for MSM, but because of a high refusal rate for taking the HIV test of 20% of surveyed MSM, the conclusions might not be valid Based on the estimated HIV prevalence generated from Spectrum software, indeed the SW's prevalence is declining steadily but the prevalence of MSM is declining much slower and is rather staying stable at 6% (figure 11)

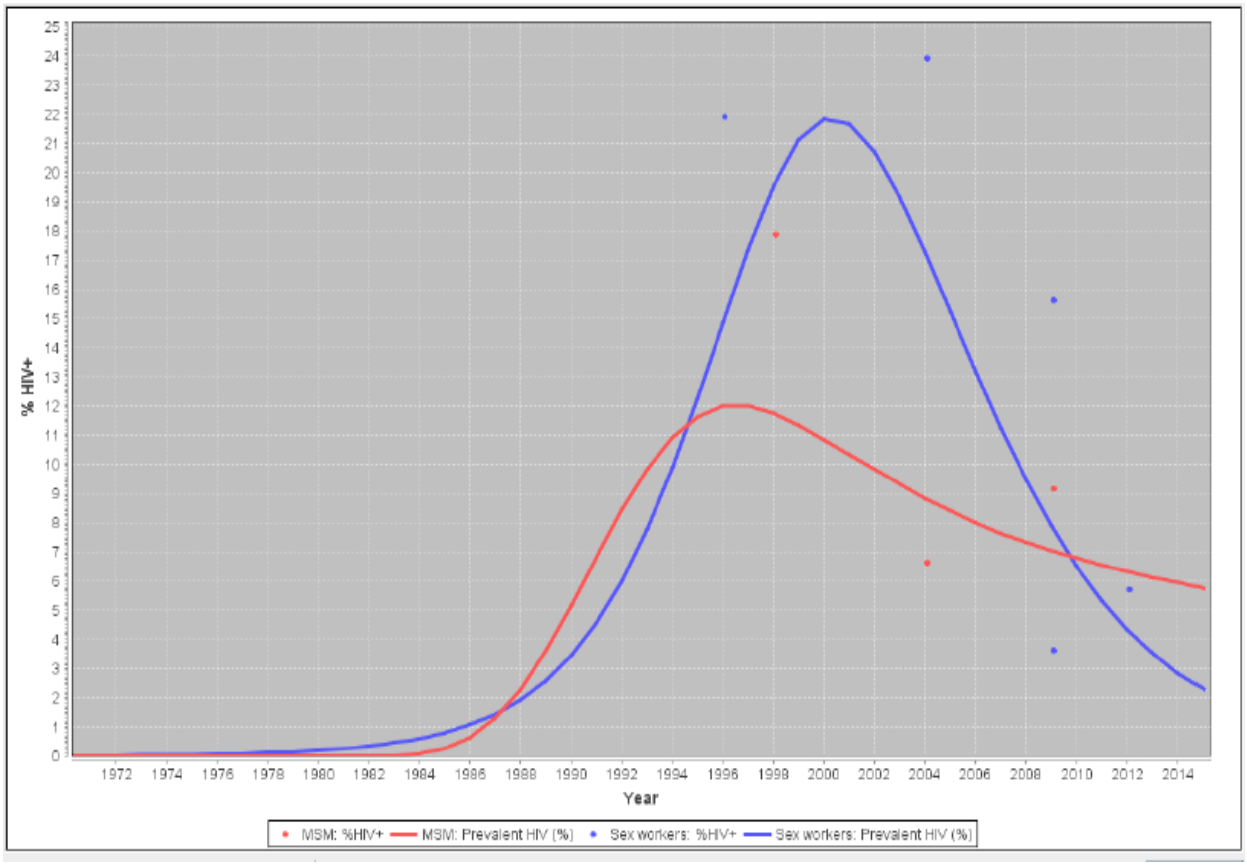


Figure 11: Estimated MSM and SW prevalence curve from Spectrum files, march 2012

MSM: HIV prevlance ***SW: HIV prevalence***

3. National response to the AIDS epidemic

For the implementation of the NSP 2009 – 2013, Suriname came to the development of a new national coordination structure (figure 12).

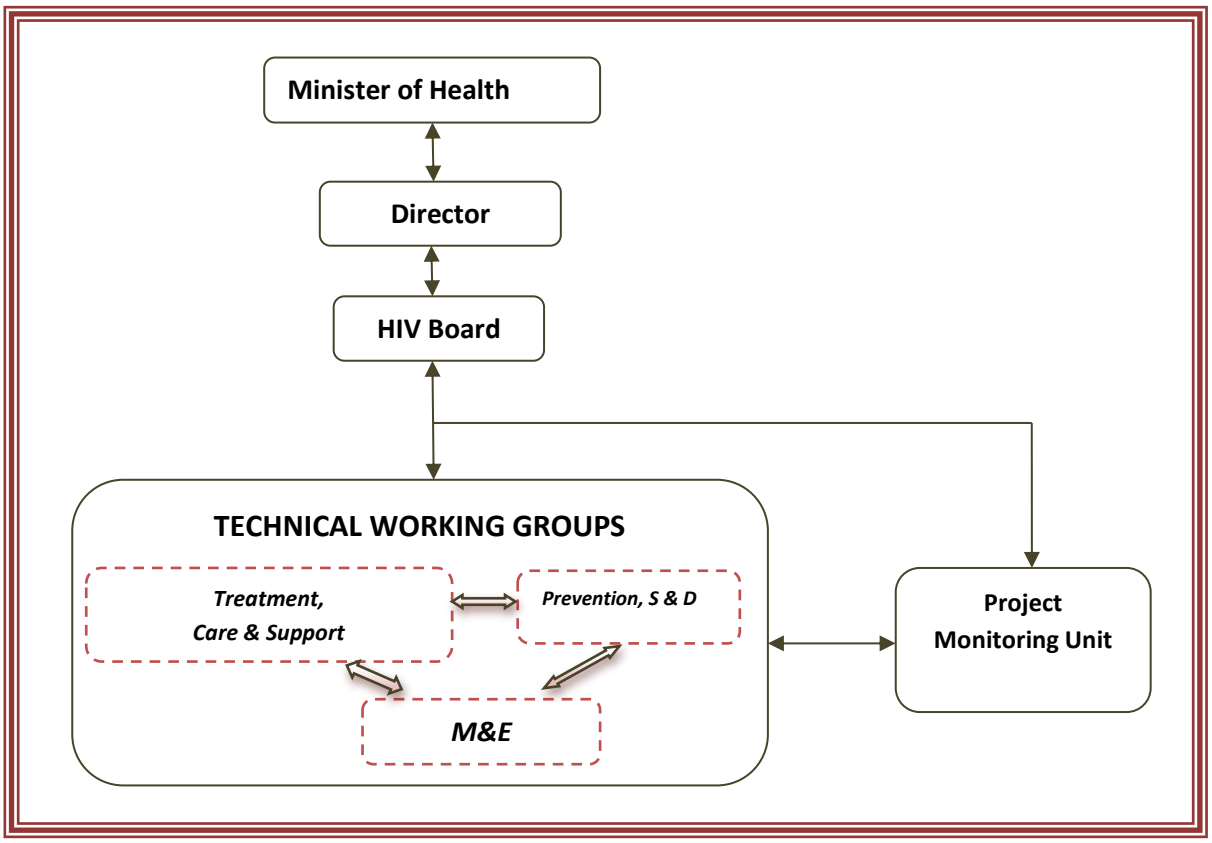


Figure 12: Organizational structure of the Suriname HIV/AIDS Programme

An HIV Board was installed, residing under the Director of Health. This Board had technical working groups advising and implementing the technical part of the HIV response. For good monitoring of the HIV related projects, such as Global Fund, a Project Monitoring Unit is responsible. Initially the HIV Board proved to be effective and supported the scaling up of HIV treatment and care. Sustaining the activities as proposed by this structure and integrating these activities proved to be challenging though.

As it is Suriname is in the interface of integrating HIV care in existing health care structures in government. To accomplish this a ' the HIV Treatment and Care Platform' was created consisting of representatives of all stakeholders involved in HIV treatment and care. These representatives meet two to four times a year to consult on technical matters regarding the National AIDS Response.
For coordinating the day to day activities in HIV treatment and care a Focal point Treatment and Care was established. To promote evidence based HIV treatment and care the Centre of Excellence (COE) for HIV treatment and care and other neglected infectious diseases was established in 2010.

The objectives of this COE were to be a clinical expertise center for treating HIV and other neglected infectious diseases, to serve as a reference point for clinics treating PLHIV, to do operational research and to do HRH development.

This structure has led to strengthened coordination and implementation of the response.
However, taking the HIV integration into consideration, the MoH has initiated processes to re-integrate HIV into existing structures.

The TWG on Treatment & Care has been changed into a Platform on Treatment & Care; the TWG on M&E is presently not only responsible for HIV, but for all M&E related matters within the MoH.

3.1 Multi-sectoral Participation

In order to speed up mainstreaming of HIV in government policies and programs, the HIV Board, besides persons of civil society, consists of members from Ministry of Social Affairs, Labor and Education.

HIV is a high priority in Suriname's current Multi-Annual Development Plan, 2006-2016, and in several other national policy documents, among others the "National Gender Action Plan" and the proposed "Sexual and Reproductive Health Policy".

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 increased their involvement 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 and implementation of HIV workplace policies and programs. The SBC is still active in HIV workplace policies and has lately also started integrating HIV and NCD policies in their programs .

3.2 Financial commitment to 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 2013 the government of Suriname, in particular the Ministry of Health, allocated a specific budget for the national coordination of the HIV response, amounted US$ 863,902.40.

On a much smaller scale other ministries have also increased their expenditures on HIV. As external financial sources decrease the government of Suriname is spending more on HIV as shown by National AIDS Spending Account (NASA) for 2009 -2011 (figure 13). It is assumed that the trends are the same for 2013, but this needs to be supported by a new NASA, which will be one of the activities of the financial department of the MOH for the coming year.

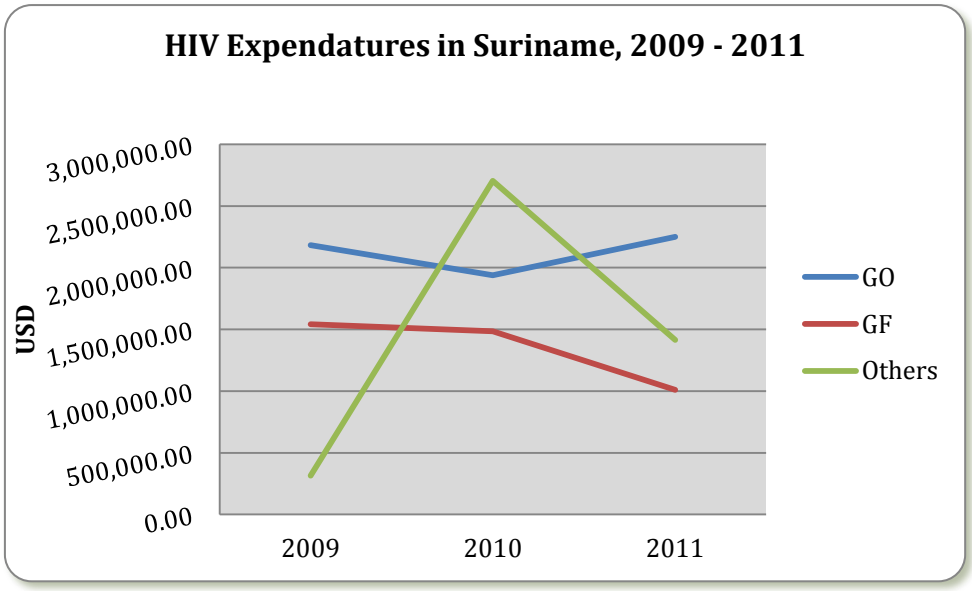


Figure 13: HIV expenditures by funders 2009 - 2011, NASA results

4. Best practices

Suriname continues to strengthen their response to the HIV/AIDS epidemic.

Best practices identified are:

Access to treatment

It is the priority of the MOH to sustain HIV treatment and care program and has therefore increased national funding in the last years. Currently, the government generated the most of the budget for the NSP. In 2012, there was 19% external funding for HIV care and treatment in Suriname.

TB/HIV approach

In 2011, the National HIV and Tuberculosis Programmes within the Ministry of Health developed and implemented national TB guidelines. Compulsory HIV testing of all TB patients is included in these guidelines. Through the implementation of an integrated TB/HIV approach, the treatment compliance for HIV patients on ARVs has improved with the use of DOT supporter.

eMTCT

Suriname continues to provide treatment and care through its decentralized Primary Health Care network of Primary Health Care centers. The PMTCT program is embedded within this network. This PMTCT program has made significant progress and is now working towards the elimination targets. The progress was possible through several actions:

- The installation of a focal point system to monitor the HIV pregnant women and their babies

- The installation of a monitoring group to assess the progress of implementation of the PMTCT program

- The integration of services: the aforementioned integration of PMTCT into maternal- and child health services has been strengthened. A framework has been developed to incorporate the four prong approach integrating services not only within the health sector, but also across other sectors.

- The national guidelines are now in revision to include option B+. Although not yet formalized, option B+ is being advocated and offered in favorable conditions in hospital setting. Healthcare workers have been informed about the newest WHO guidelines.

Integrated chronic care management for HIV

The project named 'One Stop Shop for Chronic Diseases' started in 2012 as a risk management clinic for chronic diseases, involving risk management for NCDs and HIV. There are some adjustments still to be made in the risk management program for PLHIV, but it looks promising as a best practice for integrated chronic care management.

HIV treatment cascade

In 2013 Suriname started the process of cleaning and linking existing M&E databases making development of a HIV treatment cascade and HIV epidemiological profile possible in the near future.

5. Major challenges and remedial actions

5.1. Major challenges

Although there have been best practices and Suriname has made progress in reaching targets, there are still some major challenges such as:

- Sustainability of prevention programmes in the face of diminishing resources and maintaining a focus on youth and high risk populations
- Re-orientation and promotion of the utilization of health services for key population
- Linkage of HIV positive persons into care and keeping them in care
- Adherence to ARV regimens
- Achieving complete antenatal coverage and sustaining and strengthening the integration of HIV services within the health sector and across other sectors
- Finding innovative ways to reach boys and men to make use of health services
- Addressing stigma & discrimination
- Insufficient data which provide more insight into the scope and nature of the present HIV/AIDS epidemic i.e. testing coverage, data on youth

Remedial actions / recommendations were discussed during the Mid-Term Review of the 10 Political Targets and can be found in annex 2

5.2. Other points of attention

Sustaining the involvement of PLHIV in the care team
At hospitals persons living with HIV are currently involved with care and support and it is noticed that they contribute tremendously in teaching peers in self-management of HIV. Certain peer-counselors are already paid by the Ministry of Health and are on the public budget.

Other vulnerable populations (OVPs)
Because of the existing gap in development between the coastal area and the interior of Suriname extra attention is given to processes to strengthen links and integration of HIV prevention and Stigma and Discrimination Reduction with initiatives of local community development and / or actions. The strategy to integrate within community development programs is at the center stage.

Migrant and mobile populations
The MOH has started with a minimal provision of services towards hard to reach populations which are migrant and mobile populations and which situated within the gold mining areas of the country. The approach used is to provide HIV education and condom distribution linked to the Malaria program that is implemented in the gold mining areas (with support of Global Fund).

Suriname is in the process of studying opportunities to reach these at risk populations with other HIV services that are in need. At the moment this is being done through the implementation of the PANCAP migrant project.

Revision of HIV treatment guidelines
The current HIV treatment guidelines need to be revised to be in alignment with the 2013 WHO guidelines. A costing study is underway to determine the additional costs associated with changing the current guidelines for initiation of treatment (from CD4 cell count 200 to CD4 cell count 350 or 500)

Major next steps are:

- Development of third National Strategic Plan
- Implementation of work plan on Treatment 2.0 to expand and sustain HIV treatment & care, including scaling up of HIV testing & counseling, linking persons to care, retaining persons in care, alignment of current National HIV treatment guidelines with 2013 WHO guidelines on initiation of ART, improvement of efficiency in utilization of financial resources, improvement in quality of care for comprehensive service provision and involvement & strengthening of community involvement
- Scale-up PMTCT program to reach the targets on Elimination Initiative, including the adoption of option B+
- Scale-up targeted prevention programs

6. Support from Suriname'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. Since 2010, Suriname also receives funding through the Caribbean Partnership Framework with support from the President's Emergency Plan for AIDS Relief (PEPFAR II). Also under this PEPFAR program, Suriname is working at improvement of their strategic information and lab services with a cooperative agreement with the CDC.

Coordination of all assistance, both technical and financial, to the implementation of the NSP remains the responsibility of the National AIDS Program of the Ministry of Health.
This approach implies harmonization of individual and group efforts into an effective coordinated national response.

The UN agencies in country have been providing support through the UNDAF. A Program Coordination Group Health, HIV and Nutrition has been established, co-chaired by MoH and PAHO to coordinate all HIV related projects.

The CDC/ PEPFAR project has well established support programs, which were continued.

A valuable addition to NAP in Suriname has been the HRH programs coming out of the sub agreement with CHART. A result of this sub agreement was the building/ renovation of a chronic health care clinic, known as the 'One Stop Shop' for NCDs and HIV in 2012. Through the CHART funds, there was also a more structured approach to training of health care professionals in 2013. The coming fiscal year 2014-15 the focus will be on quality improvement in HIV care facilities.

7. Monitoring and Evaluation environment

The M&E activities continue to be part of the National Health Information System, within the Ministry of Health. Integrated with monitoring and evaluation of other priority diseases, actions are still guided by decisions made by the M&E Technical Working Group of the MOH.
Good progress has been made in the collection of data regarding HIV prevention, treatment, care and PMTCT. In the 2013 and the beginning of 2014, the M&E unit within the CDC cooperative agreement worked at integration of the different HIV data sources and now has a HIV master database for more HIV case based surveillance. Important next steps are the improvement of data quality, more in depth analysis and use of data for evidence based policy making.

Some of the challenges still facing are:

- Good use of unique identifier to prevent duplicates and improve integration separate data sources
- Timeliness of data gathering
- Human resources for data collection and processing
- Quality and completeness of collected data
- Inclusion of more clinical data such as psychosocial information, reasons for dropout etc.

Remedial actions

To deal with some these challenges the following actions are important:

- Data entry at site level
- Obtain electronic data already collected at site level and integrate it in the master database at national level
- Improve use of unique identifier nationwide
- Set up operational research to validate and investigate data results
- Look into M&E human resource plan

Annex 1 Consultation/preparation process for the Progress Report on monitoring the follow up to the Declaration of Commitment on HIV/AIDS

1) Which institutions/entities were responsible for filling out the indicator forms?

a) NAC or equivalent (HIV Board / Platform of Treatment & Care)	Yes
b) NAP	**Yes**
c) Others , (please specify)	**Yes**
TWG M&E	**Yes**
TWG Treatment, Care & Support	**Yes**

2) With inputs from:

Ministries	Health	Yes
	Education	Yes
	Labour	Yes
	Foreign Affairs	**No**
	Others (Please specify)	
	Social Affairs	Yes
Civil society organizations		Yes
People living with HIV		Yes
Private sector		**No**
United Nations organizations		Yes
Bilaterals		**No**
International NGOs		**No**

3) Was the report discussed in a large forum?

No, since there have been recent in-country discussions during the Mid-Term Review and Treatment 2.0 consultations' meetings, most of the information for this report was taken out of these discussions. A national consensus meeting was therefore not held, however if additional information was needed, the different stakeholders were contacted to discuss the analysis process and the results.

4) Are the survey results stored centrally? Yes

5) Are data available for public consultation? Yes

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

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Annex 2 Mid-Term Review Towards the 10 Political Declaration Targets

SURINAME **Mid-Term Review Towards the Ten Political Declaration Targets**										
	Target 1 Reduce sexual transmission of HIV by 50% by 2015	Target 2 Reduce transmission of HIV among people who inject drugs by 50% by 2015	Target 3 Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths	Target 4 Reach 15 million people living with HIV lifesaving antiretroviral treatment by 2015	Target 5 Reduce tuberculosis deaths in people living with HIV by 50 percent by 2015	Target 6 Close the global AIDS resource gap by 2015 and reach annual global investment of US$22-24 billion in low-and middle-income countries	Target 7 Eliminate gender inqequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV	Target 8 Eliminate stigma and discrimination against people living with and affected by HIV trhough promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms	Target 9 Eliminate HIV-related restriction on entry, stay and residence	Target 10 Eliminate parallel systems for HIV-related services to strenghten integration of the AIDS response in global health and development efforts, as well as to strenghten social protection systems
10 Key Questions										
Is this a priority target for the country?	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Does the National Strategic Plan or equivalent address this target?	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
What key actions have been taken to reach this target since 2011?	Continued implementation and expansion of the National Condom Distribution Program Outreach to SW and MSM	Not Applicable	Installation of PMTCT focal point system Revised PMTCT protocol in 2010 and training for healthcare providers Integration of PMTCT into Family & Community Health Department and formation of coordination system for the Elimination Initiative in the Bureau of Public Health	Increased access and availability of HIV testing Sustained Political Commitment to reducing the impact of HIV/AIDS Capacity strengthening of Health Care Workers	Development and implementation of National TBC guidelines in 2011 Introduction of compulsory testing of all TBC patients for HIV and other co-morbidities Implementation of an integrated HIV/TB approach	Request and negotiations to increase budgetary allocations for HIV Received external funding for HIV programme	Development and implementation of National guidelines for PMTCT programme Awareness campaigns that were specifically targeted towards women	S&D related activities were comprised of training for Health Care Workers and various sectors of the Armed Forces	Not applicable	MoH led the coordination efforts to operationalize and implement the HIV/AIDS National Strategic Plan Development and dissemination of HIV/AIDS workplace policy by Min of Labour in collaboration with ILO and the MoH Min of Defense has a HIV plan

What key challenges or constraints have been encountered in addressing this target?	Absence of a National Communication Strategy High risk populations (SW and MSM) are hard to reach and "hidden" Donor supported prevention interventions and outreach have not been maintained over time as resources ceased to exist or the term for execution had expired.	Not applicable	High levels of stigma (self/internal-stigma and external stigma) Health care workers report serving women with low levels of education, information about the health care system and the importance of seeking prenatal care. Women also lack information on treatment options and the availability of services. Difficulty achieving 100% antenatal coverage	Maintaining patient adherence to ARV regimens Maintaining current treatment and care standards, and also increasing quality of care, and number of people requiring care Reluctance to access services due to perception of high levels of stigma and discrimination	Patient retention in treatment and medication compliance after DOT treatment is complete. Low levels of knowledge among Health Care Workers (HCW) on issues of co-morbidity HIV / TBC Absence of a technical working group to strengthen system of care for patients with HIV and TBC	The Global Fund grant for HIV/AIDS ended Suriname is classified as upper middle income country and this places limits on its eligibility for funds from the Global Fund Insufficient involvement of the private sector in the national HIV response	Men's poor health seeking behaviour Developing innovative ways to encourage men to get tested for HIV	Stigma and Discrimination-related programmes were implemented but not sustained HIV is associated with sex and is highly stigmatized Reducing Stigma and Discrimination requires a multi-faceted approach which is difficult to mount	Not applicable	Ccontinued perception of HIV as a vertical programme Inadequate inter-sectoral participation Ministries and the general population's perception that HIV is a health problem that should be addressed by the Ministry of Health
Is the country on track to reach this target?	Yes	Not applicable	Yes	Yes	Yes	Yes	No	No	Not applicable	No
What are the key programmatic actions necessary to stay on track and/or achieve this target?	Maintain and strengthen the condom distribution programme Target youth through strengthening HIV prevention interventions in schools Target specific high risk groups)SWs and MSM) with customized/ tailored revention interventions	Not applicable	Intensify efforts to reach 100% antenatal coverage Strengthen the psychosocial support system for HIV positive women Increase partner's involvement	Increase awareness and testing Scale up Prevention Interventions Reduce stigma and discrimination	Establish a National TB/HIV technical working group Develop a system and protocol for increasing patients' with HIV/TB retention in treatment and maintaining adherence following completion of TB treatment Increase the focus on prevention	Develop clear strategic directions for the national programme (i.e., a new NSP) and cost the implementation Develop mechanisms for increasing the involvement and responsibility of the private sector Continue to write proposals and seek external funding as opportunities arise	Re-orient services to target men through outreach and at HIV testing sites Increase interventions that focus on men and boys Tailor services to sexually diverse groups	Systematically collect better data on stigma and discrimination and use to develop evidenced-based interventions Increase efforts to ensure that HIV/AIDS is treated as a chronic disease and fully integrated into Health services Scale up systems for providing clients with the psychosocial support and counselling	Not applicable	The need to design and implement inter-sectoral coordination structure Educate and sensitize staff from all Ministries on the social determinants of HIV and the implications for their sectors Ministry of Health should provide technical support to non-health Ministries with incorporation of HIV into their programmes, where appropriate

What policy/enabling environment changes are necessary to keep on track and/or achieve this target?	Strengthen inter-sectoral approach to HIV through the development of a structural mechanism to facilitate engagement of all Government ministries to incorporate heath (and HIV) in their planning Strengthen evidence-based interventions Develop and implement a National HIV Communication Strategy	Not applicable	Involve non-health Ministries and key stakeholders with developing and implementing mechanisms to facilitate greater access to available services Review procedures (and policies) at health facilities to identify barriers to access including factors that contribute to stigma and discrimination Develop and implement empowerment strategies for women	Shift the focus of care to one of "chronic care management Adapt treatment protocols to treatment 2.0 standards Reduction of stigma and discrimination	Introduce policy on 12 HIV/TB collaborative activities Develop HIV/TB treatment guidelines and protocols	Facilitate greater intersectoral involvement in the national HIV response Increase cooperation and collaboration across sectors, and clarify responsibilities and share costs for activities	Conduct studies to identify the best methods to reach and engage men in the health system Increase the use on an integrated health approach Include services for men in the mobile health service units	Develop and implement a system for recording and addressing complaints of discrimination Review the completed report that analysed Surinamese laws and policies in regard to stigma and discrimination in order to determine the specific amendments that may be needed to protect the rights of PLHIV; Enforce law and penalties in instances of breach of confidentiality	Not applicable	Same as Above
What new investments are necessary to keep on track and/or achieve this target?	Strengthening the involvement of CBOs, FBOs and civil society Building capacity for incorporating health and HIV across sectors in all policies	Not applicable	Exploring the feasibility of introducing Option B+ Creating a cadre of qualified counselors using existing structures Providing recognition to post-delivery care and introducing the care to strengthen the support systems for HIV positive women.	Introducing Treatment 2. Conducting operational research with the aim of using the findings to address treatment challenges Continuous Training for all health care workers	Establishing and supporting the operations of a National TB/HIV technical working group	Strengthening capacity in project administration and management Increase the efficiency of project implementation	Concerted effort will be needed to scale up health promotion directed to men and men's issues and incorporate HIV into those services.	Explicitly incorporate social support mechanism into care and treatment protocols and procedures Conduct operational research and systematically collecting more and better information on stigma and discrimination	Not applicable	Continue efforts to implement "health in all policy" – These efforts should/will include HIV.

What are your recommendations to national stakeholders to ensure the implementation of suggested changes?	Review the organizational structure for the National HIV Response Provide support to partners and Ministries with developing, planning and incorporating health issues into their workplans Develop mechanism for joint inter-sectoral operational planning	Not applicable	Expand the Elimination Initiative Coordination Working Group to include a wider range of stakeholders	Sustain HIV Treatment and Care Platform Ensure sufficient Human Resources	Sustain funding for the DOT programme for TB/HIV	Clarify management roles and responsibilities and ensure a well-defined division of labour for NSP implementation Refine and improve the NSP implementation coordination structure	Develop clear plans for health promotion directed towards men and men's issues	Assign a specific person within the National Programme to coordinate and advance efforts on stigma and discrimination reduction Increase the involvement of communities in addressing stigma and discrimination Revisit the role of civil society and faith based organizations in reducing stigma and discrimination and increase their involvement	Not applicable	Explicitly include integration in the revised National Strategic Plan and include accompanying activities and performance indicators Create linkage between HIV programme and NCD inter-sectoral committee to facilitate HIV integration -- Consider using non-communicable disease integration as an entry point for including HIV integration

What are your recommendations for sustaining progress along this target beyond 2015?	Education and prevention interventions targeting youth and developed with youth input will be critical to maintaining progress. Continue to monitor trends and emerging patterns and target high risk populations. Integration and strengthening of an inter-sectoral approach to health (and HIV) promotion will be critical.	Not applicable	Explicitly address The Elimination Initiative in revised NSP including both strategic directions and performance expectations and targets	Address introduction of Treatment 2.0 in the revised NSP including the change of focus to 'chronic care management'	Guarantee resources (financial and human) for HIV/TB collaborative activities	Development a revised National Strategic Plan should be in alignment with the timeframe of the government policy	Continue to include gender related issues in the NSP for HIV	Incorporation in the revised HIV/AIDS NSP of actions in the following areas: self-stigma, stigma in general population, S&D complaints, engagement MSM and SWs in IEC material	Not applicable	Integration of HIV in the general services

Annex 3 National Composite Policy Index (NCPI) SURINAME 2014

National Composite Policy Index (NCPI) 2014

Country: SURINAME

Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:

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NCPI Data Gathering and Validation Process

NCPI Respondents

NCPI - PART A

		Respondents to Part A				
Organization	Names/Positions	A.I	A.II	A.III	A. IV	**A.V**
MOH	Dr Martelise Eersel Director of Health of MOH Suriname					
MOH	Dr Maltie Mohan – Algoe Head of Research, Planning & Monitoring	x	x	x	x	**x**
MOH	Dr Deborah Charles - Stijnberg HIV M&E Officer	x	x	x	x	**x**
MOH	Dr Monique Holtuin Focal Point Technical Unit NAP	x	x	x	x	**x**
MOH	Ashvini Gangadin, Legal department	x	x	x	x	**x**
Ministry of Labor		x	x	x	x	**x**
Ministry of Social affairs	Nathalie Valpoort Ingrid Corinde Responsible for social support programs aimed at PLHIV	x	x	x	x	**x**
Ministry of Education	Rahiema Kalloe Hilly Dinmohammed	x	x	x	x	**x**

NCPI Respondents

NCPI - PART B

		Respondents to Part B				
Organization	Names/Positions	A.I	A.II	A.III	A. IV	**A.V**
PAHO	Dr Rachel Eersel, HIV/STI Advisor	x	x	x	x	**x**
UNICEF	Elly van Kanten, HIV Officer	x	x	x	x	**x**
UNFPA	Ingrid Caffe HIV Officer	x	x	x	x	**x**
UNDP	Miriam Hubbard, Governance Programme Officer	x	x	x	x	**x**
St Lobi	Nancy Bandhoe Director	x	x	x	x	**x**
He&HIV **Civil Society**	Maarten Colom Coordinator	x	x	x	x	**x**
SMU **Civil Society**	Kenneth van Emden Director Suriname Men United	x	x	x	x	**x**
Foundation Liefde volle Handen **Civil Society**	Diana Blinker Coordinator	x	x	x	x	**x**

National Commitments and Policy Instrument (NCPI)

Part A – Government officials

I. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?

(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

Yes	No

IF YES, what is the period covered *[write in]*:

NSP HIV/AIDS 2004-2008 & 2009 - 2013

IF YES, briefly describe key developments/modifications between the current national strategy and the prior one.

IF NO or NOT APPLICABLE, briefly explain why.

Since the implementation of the national multisectoral strategy,

there has been an increase in the number of people who are getting tested.

There has also been a decline in the percentage of infections and a better awareness of the disease.

The mortality rates also declined because of the medicines

IF YES, complete questions 1.1 through 1.10; ***IF NO***, go to question 2.

MOH, NAP, Ministry of Labor (ATM), Ministry of Education, Ministry of SOZAVO, Ministry of Justice and Police, Ministry of Defense,

1.1. Which government ministries or agencies have overall responsibility for the development and implementation of the national multi-sectoral strategy to respond to HIV?

Name of government ministries or agencies *[write in]*: MOH

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

SECTORS	Included in Strategy		Earmarked Budget	
Education	Yes	No	Yes	No
Health	Yes	No	Yes	No
Labour	Yes	No	Yes	No
Military/Police	Yes	No	Yes	No
Social Welfare[2] (SOZAVO)	Yes	No	Yes	No
Transportation	Yes	No	Yes	No
Women	Yes	No	Yes	No
Young People	Yes	No	Yes	No
Civil Society	Yes	No	Yes	No
NGO's	Yes	No	Yes	No

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?

1.3. Does the multisectoral strategy address the following key populations/other vulnerable populations, settings and cross-cutting issues?

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS		
Discordant couples	Yes	No
Elderly persons	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children[3]	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Sex workers	Yes	No
Transgender people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations[4]	Yes	No
SETTINGS		
Prisons	Yes	No
Schools	Yes	No
Workplace	Yes	No
CROSS-CUTTING ISSUES		
Addressing stigma and discrimination	Yes	No
Gender empowerment and/or gender equality	Yes	No
HIV and poverty	Yes	No

Human rights protection	Yes	No
Involvement of people living with HIV	Yes	No
IF NO, explain how key populations were identified?		

1.4. What are the identified key populations & vulnerable groups for HIV programmes in the country?

People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgender people	Yes	No
Women and girls	Yes	No
Young women/ young men	Yes	No
Other key populations/vulnerable subpopulations	Yes	No

1.5. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?

Yes	No

1.6. Does the multisectoral strategy include an operational plan?

Yes	No

1.7. Does the multisectoral strategy or operational plan include:

a) Formal programme goals?	Yes	No	N/A
b) Clear targets or milestones?	Yes	No	N/A
c) Detailed costs for each programmatic area?	Yes	No	N/A
d) An indication of funding sources to support programme implementation?	Yes	No	N/A
e) A monitoring and evaluation	Yes	No	N/A

1.8. Has the country ensured "full involvement and participation" of civil society[5] in the development of the multisectoral strategy?

Active involvement	Moderate Involvement	No Involvement

IF ACTIVE INVOLVEMENT, briefly explain how this was organised:
IF NO or MODERATE INVOLVEMENT, briefly explain why this was the case:
Civil society is part of the national planning and consultation processes in HIV treatment and care. MoH supports civil society activities but not to its full extend MoH provides capacity building activities for civil society

1.9. Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?

Yes	No	N/A

1.10. Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

Yes, all partners	Yes, some partners	No	N/A

IF SOME PARTNERS or NO, briefly explain for which areas there is no alignment/harmonization and why:

2.1. Has the country integrated HIV in the following specific development plans?

SPECIFIC DEVELOPMENT PLANS			
Common Country Assessment/UN Development Assistance Framework	Yes	No	N/A
National Development Plan	Yes	No	N/A
Poverty Reduction Strategy	Yes	No	N/A
National Social Protection Strategic Plan	Yes	No	N/A
Sector-wide approach	Yes	No	N/A
Other *[write in]*: There are specific social security measures aimed at PLWHIV	Yes	No	N/A

2.2. IF YES, are the following specific HIV-related areas included in one or more of the development plans?

HIV-RELATED AREA INCLUDED IN PLAN(S)			
Elimination of punitive laws	Yes	No	N/A
HIV impact alleviation (including palliative care for adults and children)	Yes	No	N/A
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support	Yes	No	N/A
Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support	Yes	No	N/A
Reduction of stigma and discrimination	Yes	No	N/A
Treatment, care, and support	Yes	No	N/A
Women's economic empowerment (e.g. access to credit, access to land, training)	Yes	No	N/A
Other *[write in]*:	Yes	No	N/A

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?

Yes	No	N/A

3.1. IF YES, on a scale of 0 to 5 (where 0 is "Low" and 5 is "High"), to what extent has the evalua-tion informed resource allocation decisions?

LOW					HIGH
0	1	2	3	4	5

4. Does the country have a plan to strengthen health systems?

Yes
Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications? Focussed on access to care: increasing insurance coverage and equality in insurance coverage. For example in 2013 introduced free health insurence for 0-17 and > 60 years (BZSR= basic health insurance of Self Reliance) There are also pilot projects/ clinics (OSS) in integrating NCD care with HIV care.

5. Are health facilities providing HIV services integrated with other health services?

Area	Many	Few	None
a) HIV counselling & testing with sexual & reproductive health	√		
b) HIV counselling & testing and tuberculosis		√	
c) HIV counselling & testing and general outpatient care	√		
d) HIV counselling & testing and chronic non-communicable diseases	√		
e) ART and tuberculosis	√		
f) ART and general outpatient care	√		
g) ART and chronic non-communicable diseases	√		
h) PMTCT with antenatal care/ maternal & child health	√		
i) Other comments on HIV integration:			

6. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate strategy planning efforts in your country's HIV programmes in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:

Key achievements in strategy planning efforts have been:
The management of the PMTCT program: integrating PMTCT in antenatal care; the introduction of a focal point PMTCT leading to decrease in MTCT of HIV

Third HIV treatment guidelines developed in 2009; process of updating these guidelines has been initiated.

Option B+ is being advocated and provided in favourable conditions.

- More access to HIV testing is now available (three times as much in pregnant women). Early infant diagnosis of HIV is available
- There is nationwide use of ARVs, free of charge and fixed dose combinations are available. In 2012, 71.4 % of PLHIV started on the preferred first line regimen (AZT, 3TC/NVP).
- Demonstrated country ownership in providing finances to sustain the HIV response in the phase of declining donor funds; 0-5% is external funding
- Initiation to integrate HIV as chronic disease in the health services with other chronic diseases (NCDs)
- NGO's are involved in providing HIV services

What challenges remain in this area:

The national coordination, policy and capacity building needs to be integrated successfully in national health policies.

- The HIV treatment guidelines entail starting ART with a CD4 count of 200. Considering the latest 2013 WHO HIV guidelines of initiating ART with a CD4 count of 500, there is a need to revisit the national guidelines
- There are still some regimens in use that are potentially more toxic than the combinations that are now advocated by the WHO.
- Rapid testing is not readily available or used at every moment of the day in all hospitals. And testing coverage among identified groups is not clear and there is also no linkage to care. There is a need to expand the testing coverage and have systems in place to link those in need of care
- There is an increase in male hospitalizations, possibly a sign of increased late HIV diagnosis in males.
- 37% of patients have a first CD4 count below 200
- Retention in care is a challenge; in 2012 there was a loss to follow-up of 31%
- In 2012, there were some stock-outs in ARVs; no written stock-out prevention plans are available

II. POLITICAL SUPPORT AND LEADERSHIP

Strong political support includes: government and political leaders who regularly speak out about HIV and AIDS and demonstrate leadership in different ways: allocation of national budgets to support HIV programmes; and, effective use of government and civil society organizations to support HIV programmes.

1. **Do the following high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?**

A. Government ministers

Yes	No

B. Other high officials at sub-national level

Yes	No

1.1. In the last 12 months, have the head of government or other high officials taken action that demonstrated leadership in the response to HIV?

(For example, promised more resources to rectify identified weaknesses in the HIV response, spoke of HIV as a human rights issue in a major domestic/international forum, and such activi-ties as visiting an HIV clinic, etc.)

Yes	No

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:
Suriname facilitated and hosted the Caribbean PAHO Sustaining HIV treatment meeting in May 2013

2. **Does the country have an officially recognized national multisectoral HIV coordination body**
(i.e., a National HIV Council or equivalent)?

Yes*	No

Yes, till 2012 there was a HIV board; Now we have a Platform Treatment & Care.

IF NO, briefly explain why not and how HIV programmes are being managed:

2.1. IF YES:

IF YES, does the national multisectoral HIV coordination body:		
Have terms of reference?	Yes	No
Have active government leadership and participation?	Yes	No
Have an official chair person?	Yes	No
IF YES, *what is his/her name and position title? The National HIV coordination body is chaired by the Permanent Secretary of Health (Director of Health)*		
Have a defined membership?	Yes	No
IF YES, *how many members? The HIV council consists of staff of the MoH involved in HIV policy making, clinicians involved in treating PLWHIV, staff of the Ministries of Labor, Legal affairs, Social affairs, Education*		
Include civil society representatives?	Yes	No
IF YES, *how many? CCM Members*		
Include people living with HIV?	Yes	No
IF YES, *how many?*		
Include the private sector?	Yes	No
Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes	No

3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?

Yes	No	N/A

IF YES, briefly describe the main achievements:
▪ The national HIV board and The national platform for HV treatment and care established interdepartmental and intradepartmental coordination of the HIV program. ▪ Increasing the number of people on treatment, sustaining social support for PLWHIV, creating workplace policies that adhere to ILO conventions, adapting sexual education in schools

What challenges remain in this area:
Sustaining the work of this national board and the national treatment platform. Charting donor activities to prevent duplication of efforts is a challenge

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

13.5 % (Source: NASA 2011)

5. What kind of support does the National HIV Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Capacity-building	Yes	No
Coordination with other implementing partners	Yes	No
Information on priority needs	Yes	No
Procurement and distribution of medications or other	Yes	No
Technical guidance	Yes	No
Other [write in below]: Financial support	Yes	No

6. Has the country reviewed national policies and laws to determine which, if any, are incon-sistent with the National HIV Control policies?

Yes	No

6.1. IF YES, were policies and laws amended to be consistent with the National HIV Control policies?

Yes	No

IF YES, name and describe how the policies / laws were amended
There are Laws in the process of being amended as a result of the PANCAP migrant project .

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:
One inconsistency in the anti-stigma and discrimination policy is the difference in the age of consent for sexual activity, which is 16 for heterosexual couples and 21 for same sex couples.

7. **Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the political support for the HIV programme in 2013?**

Very										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:
Country ownership

What challenges remain in this area:
Country ownership

III. HUMAN RIGHTS

1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable groups? Circle yes if the policy specifies any of the following key populations and vulnerable groups:

KEY POPULATIONS AND VULNERABLE GROUPS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgender people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations *[write in]*:	Yes	No

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?

Yes	No

IF YES to Question 1.1. or 1.2., briefly describe the content of the laws:
Article 8 of the constitution of Suriname: 1. All who are within the territory of Suriname have an equal claim to protection of person and property 2. No one may be discriminated against on the grounds of birth, sex, race, language, religious origin, education, political beliefs, economic position or any other status
Briefly explain what mechanisms are in place to ensure these laws are implemented:
Cases can be brought to court
Briefly comment on the degree to which they are currently implemented:
PLHIV are hesitant to come forward because of stigma (even if it is self-perceived stigma)

2. Does the country have laws, regulations or policies that present obstacles[6] to effective HIV prevention, treatment, care and support for key populations and vulnerable groups?

Yes	No

***IF YES,* for which key populations and vulnerable**		
People living with HIV	Yes	No
Elderly persons	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgender people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable populations[7] [write in below]:	Yes	No

Briefly describe the content of these laws, regulations or policies:
• Different age of consent for opposite and same sex conduct. • No condoms distributed in prison, but detainees are cared for and treated if found HIV positive • Health care providers are not allowed to test and treat under 16s without consent of their parents

Briefly comment on how they pose barriers:
• Different age of consent for opposite and same sex couples marginalizes same sex couples, can also have negative effect on preventive measures and getting tested • No condoms in prison lead to high risk sexual encounters in prisons. • The parental consent for HIV testing can prevent sexual active youth to go in for an HIV test.

IV. PREVENTION

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

Yes	No

***IF YES,* what key messages are explicitly promoted?**		
Delay sexual debut	Yes	No
Engage in safe(r) sex	Yes	No
Fight against violence against women	Yes	No
Greater acceptance and involvement of people living	Yes	No
Greater involvement of men in reproductive health	Yes	No
Know your HIV status	Yes	No
Males to get circumcised under medical supervision	Yes	No
Prevent mother-to-child transmission of HIV	Yes	No
Promote greater equality between men and women	Yes	No
Reduce the number of sexual partners	Yes	No
Use clean needles and syringes	Yes	No
Use condoms consistently	Yes	No
Other [write in below]:	Yes	No

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

Yes	No

2. Does the country have a policy or strategy to promote life-skills based HIV education for young people?

Yes	No

2.1.

Is HIV education part of the curriculum in:		
Primary schools?	Yes	No
Secondary schools?	Yes	No
Teacher training?	Yes	No

2.2. Does the strategy include

a) age-appropriate sexual and reproductive health elements?

Yes	No

b) gender-sensitive sexual and reproductive health elements?

Yes	No

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

Yes	No

3. Does the country have a policy or strategy to promote information, education and communi-cation and other preventive health interventions for key or other vulnerable sub-populations?

Yes	No

Briefly describe the content of this policy or strategy:
• Activities that combat stigma and discrimination • Outreach activities under vulnerable groups • Capacity building activities in vulnerable groups

3.1. IF YES, which populations and what elements of HIV prevention does the policy/strategy address?

Check which specific populations and elements are included in the policy/strategy

	IDU[8]	MSM[9]	Sex workers	Customers of Sex Workers	Prison inmates	Other populations[10] *[write in]*
Condom promotion		√	√	√		Youth
Drug substitution therapy						
HIV testing and counselling		√	√	√		Youth
Needle & syringe exchange						
Reproductive health, including sexually transmitted infections prevention and treatment		√	√	√		Youth
Stigma and discrimination reduction		√	√	√		Youth
Targeted information on risk reduction and HIV education		√	√	√		Youth
Vulnerability reduction (e.g. income generation)						

3.2.Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate policy efforts in support of HIV prevention in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:
• Decrease in number new persons testing positive. • Suriname mapping report of migrant populations under the PANCAP migrant project • EIC material produced as a result of the mapping report of the migrant populations • As a result of cooperation between Brazil and Suriname NGO's were trained in communicating HIV prevention to youth

What challenges remain in this area:
According to the midterm review of progress toward the ten political declaration targets in Suriname: • Absence of a national communication strategy on STI prevention • High risk groups are hard to reach and "hidden" • Prevention interventions and outreach have not been maintained over time

4. Has the country identified specific needs for HIV prevention programmes?

Yes	No

IF YES, how were these specific needs determined?
Outcome of the review of the ten political targets of UNAIDS June 2013

IF YES, what are these specific needs?
According to midterm review of progress towards the ten political declaration targets specific needs are • Strengthening the inter-sectoral approach to HIV • Strengthening evidence –based interventions • Development and communication of a National HIV communication strategy

4.1.To what extent has HIV prevention been implemented?

The majority of people in need have access to...	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Blood safety	1	2	3	4	N/A
Condom promotion	1	2	3	4	N/A
Economic support e.g. cash transfers	1	2	3	4	N/A
Harm reduction for people who inject	1	2	3	4	N/A
HIV prevention for out-of-school young	1	2	3	4	N/A
HIV prevention in the workplace	1	2	3	4	N/A
HIV testing and counselling	1	2	3	4	N/A
IEC[11] on risk reduction	1	2	3	4	N/A
IEC on stigma and discrimination	1	2	3	4	N/A
Prevention of mother-to-child transmission	1	2	3	4	N/A
Prevention for people living with HIV[12]	1	2	3	4	N/A
Reproductive health services including sexually transmitted infections	1	2	3	4	N/A
Risk reduction for intimate partners of key populations	1	2	3	4	N/A
Risk reduction for men who have sex	1	2	3	4	N/A
Risk reduction for sex workers	1	2	3	4	N/A
Reduction of Gender based violence	1	2	3	4	N/A
School-based HIV education for young	1	2	3	4	N/A
Treatment as prevention	1	2	3	4	N/A
Universal precautions in health care	1	2	3	4	N/A
Other*[write in]*:	1	2	3	4	N/A

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in implementation of HIV prevention programmes in 2013?

Very										Excellent
0	1	2	3	4	5	6	7	8	9	10

V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?

Yes	No

If YES, Briefly identify the elements and what has been prioritized:
• Increase access to testing and ART • Organize psychosocial care structures for PLWHIV
Briefly identify how HIV treatment, care and support services are being scaled-up?
• Increase access and availability of HIV testing and ART • HCW capacity development • Psychosocial support programs scaled –up and coordinated by the MoH • Sustaining political commitment to reducing the impact of HIV/ AIDS

1.1. To what extent have the following HIV treatment, care and support services been imple-mented?

The majority of people in need have access to...	**Strongly disagree**	**Disagree**	**Agree**	**Strongly agree**	**N/A**
Antiretroviral therapy	1	2	3	4	N/A
ART for TB patients	1	2	3	4	N/A
Cotrimoxazole prophylaxis in people living with HIV	1	2	3	4	N/A
Early infant diagnosis	1	2	3	4	N/A
Economic support	1	2	3	4	N/A
Family based care and support	1	2	3	4	N/A
HIV care and support in the workplace (including alternative working	1	2	3	4	N/A
HIV testing and counselling for people	1	2	3	4	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	1	2	3	4	N/A
Nutritional care	1	2	3	4	N/A
Paediatric AIDS treatment	1	2	3	4	N/A
Palliative care for children and adults	1	2	3	4	N/A

The majority of people in need have access to...	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Post-delivery ART provision to women	1	2	3	4	N/A
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual	1	2	3	4	N/A
Post-exposure prophylaxis for occupational exposures to HIV	1	2	3	4	N/A
Psychosocial support for people living with HIV and their families	1	2	3	4	N/A
Sexually transmitted infection	1	2	3	4	N/A
TB infection control in HIV treatment and care facilities	1	2	3	4	N/A
TB preventive therapy for people living with HIV	1	2	3	4	N/A
TB screening for people living with HIV	1	2	3	4	N/A
Treatment of common HIV-related infections	1	2	3	4	N/A
Other*[write in]*:	1	2	3	4	N/A

2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?

Yes	No

Please clarify which social and economic support is provided[13]:
• PLWHIV are eligible for small monthly allowance. • Some clinics offer support of social workers in house

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

Yes	No

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

Yes	No	N/A

IF YES, for which commodities?

5. **Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2013?**

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:
• Increasing number of PLWHIV on treatment • Fewer HIV related deaths

What challenges remain in this area:
Linking and Retaining PLWHIV to care

6. **Does the country have a policy or strategy to address the needs of orphans and other vulnerable children?**

Yes	No	N/A

6.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes	No

6.2.IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	No

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:
• Successes in PMTCT program and HIV treatment reduces number of new OVC • Care and support for OVC by remaining family members is stimulated. • Acceptance of OVC in schools

What challenges remain in this area:
• Psychosocial problems of youth growing up with HIV • Self stigma • Poverty and socio-economic problems • Some OVCs still grow up in orphanages/ housing for adolescents is a challenge

VI. MONITORING AND EVALUATION

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

Yes	In Progress	No

Briefly describe any challenges in development or implementation:
Challenges in implementation are related to human resources. Due to lack in human resources in regards to M&E not all can be implemented accordingly

***1.1. IF YES, years covered** [write in]:*

2009-2013

1.2. IF YES, have key partners aligned and harmonized their M&E requirements (including indi-cators) with the national M&E plan?

Yes, all partners	Yes, some partners	N/A

Briefly describe what the issues are:

2. Does the national Monitoring and Evaluation plan include?

A data collection strategy	Yes	No
IF YES, does it address:		
Behavioural surveys	Yes	No
Evaluation / research studies	Yes	No
HIV Drug resistance surveillance	Yes	No
HIV surveillance	Yes	No
Routine programme monitoring	Yes	No
A data analysis strategy	Yes	No
A data dissemination and use strategy	Yes	No
A well-defined standardised set of indicators that includes sex and age disaggregation (where appropriate)	Yes	No
Guidelines on tools for data collection	Yes	No

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

Yes	In Progress	No

3.1. IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities?

%

4. Is there a functional national M&E Unit?

Yes	In Progress	No

Briefly describe any obstacles:
High workload

4.1.Where is the national M&E Unit based?

In the Ministry of Health?	Yes	No
In the National HIV Commission (or equivalent)?	Yes	No
Elsewhere *[write in]*?	Yes	No

4.2. How many and what type of professional staff are working in the national M&E Unit?

POSITION [write in position titles in spaces	**Fulltime**	**Part time**	**Since when?**
Permanent Staff [Add as many as needed]			
M&E Manager	x		2008
M&E Officer		x	
Data entry personnel		x	
Members of the TWG M&E			
- Director of Health			
- Head of Planning			
- Head of Epidemiology			
- PAHO Technical Officer			
	Fulltime	**Part time**	**Since when?**
Temporary Staff [Add as many as needed]			
Medical students		x	2007

4.3. Are there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

Yes	No

Briefly describe the data-sharing mechanisms:

What are the major challenges in this area:
▪ Major challenge is human resource. ▪ Due to few people with also other responsibilities is often difficult to produce reports in timely matter to be shared with others. ▪ All difficulties with data collection/entry makes in difficult

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

6. Is there a central national database with HIV- related data?

Yes	No

IF YES, briefly describe the national database and who manages it.
In the national database, testing, PMTCT, laboratory, and pharmacy data are gathered. These data are managed by the M&E officer of the MoH

6.1.IF YES, does it include information about the content, key populations and geographical coverage of HIV services, as well as their implementing organizations?

Yes, all of the above	Yes, but only some of the above	No, none of the above

IF YES, but only some of the above, which aspects does it include?
Content, some geographical coverage and some info about implementing organisations

6.2.Is there a functional Health Information System[14]?

At national level	Yes	No
At subnational level	Yes	No
IF YES, at what level(s)? *[write in]*		

7.1.Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?

Estimates of Current and Future Needs	Estimates of Current Needs Only	No

7.2. Is HIV programme coverage being monitored?

Yes	No

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

Yes	No

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

Yes	No

IF YES, for which population groups?
SW, MSM, and for treatment adults and children based on estimates
Briefly explain how this information is used:

(c) Is coverage monitored by geographical area?

Yes	No

IF YES, at which geographical levels (provincial, district, other)?
Briefly explain how this information is used:

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

Yes	No

9. How are M&E data used?

For programme improvement?	Yes	No
In developing / revising the national HIV response?	Yes	No

For resource allocation?	Yes	No
Other *[write in]*:		

Briefly provide specific examples of how M&E data are used, and the main challenges,
▪ Data is being used to decide on strategies for a good HIV response. ▪ Furthermore data is often used for allocation of funds in the development of proposals to external funders and for development of national strategic plan ▪ International reporting

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

At national level?	Yes	No
IF YES, what was the number trained:		
At subnational level?	Yes	No
IF YES, what was the number trained		
At service delivery level including civil society?	Yes	No
IF YES, how many?		

10.1. Were other M&E capacity-building activities conducted other than training?

Yes	No

IF YES, describe what types of activities
TA programme to link different data-bases leading to development of a HIV epidemiology profile and a HIV treatment cascade for Suriname

11. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the HIV-related monitoring and evaluation (M&E) in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:
▪ Regular studies among vulnerable group to inform decision making ▪ Being able to do reporting to external organisations ▪ Recently initial alignment of different HIV data sources ▪ Development of a HIV treatment cascade

What challenges remain in this area:
▪ Human resource: for data entry, collection ▪ Data completeness: because information is not centralized often not all information is reported at all and /or not in a timely matter ▪ Quality of the incoming data

National Commitments and Policy Instrument (NCPI)

Part B - Civil society organizations, bilateral agencies and UN organizations

I. CIVIL SOCIETY INVOLVEMENT

1. **To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?**

LOW					HIGH
0	1	2	3	4	5

Comments and examples:
▪ Participation of civil society in drafting and executing the National Strategic Plan for HIV ▪ The civil society has not contributed to strengthening political commitment; moreover, it is only seen as a researcher in its field. ▪ LGBT platform has been established and have been able to advocate for their rights. ▪ One of their major activities, the Coming Out Week in 2013, was supported by the First Lady of Suriname with a public acknowledgment of their rights ▪ Suriname Men United launch a media campaign entitled" Ik ben Surinamer, gelijke rechten voor iedereen" in November /December 2013 ▪ PGA (parlementarians for global action) workinggroup voiced themselves that they stand for equal rights for all including sexual orientation.

2. **To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?**

LOW					HIGH
0	1	2	3	4	5

Comments and examples:
- Civil society has been involved as CCM members and representatives of civil society have participated in the Mid-term review of the 10 UN political targets and the discussion on the baseline situation analysis report on Treatment 2.0. - They will be involved in the preparation of the third National Strategic Plan as well as the concept note for Global Fund. - It was only in the draft reviewing process that Foundation He+HIV had some input. - We were attended to the meetings but never received a draft and no feedback

3. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") are the services provided by civil society in areas of HIV prevention, treatment, care and support included in:

a. The national HIV strategy?

LOW					HIGH
0	1	2	3	4	5

b. The national HIV budget?

LOW					HIGH
0	1	2	3	4	5

c. The national HIV reports?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:
▪ For her HIV testing and counselling services at the Lobi Foundation, which are part of the NSP-policies, the organization can get support for clinical supplies from the Ministry of Health. ▪ NGO's are contracted by Sub-Recipient (Lobi Foundation, SMU, New Beginnings) of the Transitional Funding Mechanism Global Fund grant and also directly by the Ministry of Health. ▪ Civil society provides input in national HIV reports. ▪ The national HIV strategy makes mention of a lot of things, but in reality, they do not confer with the grass root NGO's. ▪ We don't have no knowledge in the national strategy, national HIV budget and national HIV reports.

4. **To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society included in the monitoring and evaluation (M&E) of the HIV response?**

   a. ***Developing the national M&E plan?***

LOW					HIGH
0	1	2	3	4	5

   b. ***Participating in the national M&E committee / working group responsible for coordination of M&E activities?***

LOW					HIGH
0	1	2	3	4	5

   c. ***Participate in using data for decision-making?***

LOW					HIGH
0	1	2	3	4	5

Comments and examples:
▪ Ad-hoc participation of civil society in HIV M&E working groups. ▪ When it suits NAP, they can call the stakeholders, but actual decision making happens during meetings of " consultants"

5. **To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society representation in HIV efforts inclusive of diverse organizations (e.g. organizations and networks of people living with HIV, of sex workers, community-based organizations , and faith-based organizations)?**

LOW					HIGH
0	1	2	3	4	5

Comments and examples:
▪ The TFM-project of the Ministry of Health financed by Global Fund and monitored by the Lobi Foundation is mainly implemented with NGO's involved with or representing the target groups like MSMs and SWs. ▪ HIV efforts are mainly carried out by civil society, but there is a lack of diversity but there is a lack of diversity in types of organisations. ▪ Civil society partners/ networks with other organisations in the fight against HIV/Aids.

6. **To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society able to access:**

a. Adequate financial support to implement its HIV activities?

LOW					HIGH
0	1	2	3	4	5

b. Adequate technical support to implement its HIV activities?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:
▪ Limited funding for HIV- activities, also given the fact that worldwide development aid is diminishing. ▪ Through international development partners ▪ We look for our own sponsors/ donors to finance our HIV activities.. ▪ The support is very poor

7. **What percentage of the following HIV programmes/services is estimated to be provided by civil society?**

Prevention for key-populations				
People living with HIV	<25%	25-50%	51–75%	>75%
Men who have sex with men	<25%	25-50%	51–75%	>75%
People who inject drugs	<25%	25-50%	51–75%	>75%
Sex workers	<25%	25-50%	51–75%	>75%
Transgender people	<25%	25-50%	51–75%	>75%
Palliative care	< 25%	25-50%	51-75%	> 75%
Testing and Counselling	<25%	25-50%	51–75%	>75%
Know your Rights/ Legal services	<25%	25-50%	51–75%	>75%
Reduction of Stigma and Discrimination	<25%	25-50%	51–75%	>75%
Clinical services (ART/OI)*	<25%	25-50%	51–75%	>75%
Home-based care	<25%	25-50%	51–75%	>75%
Programmes for OVC**	<25%	25-50%	51–75%	>75%

* ART = Antiretroviral Therapy; OI=Opportunistic infections

** OVC = Orphans and other vulnerable children

8. **Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to increase civil society participation in 2013?**

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:

- Increasing participation of NGOs in policy preparation, formulation and implementation.
- NGOs are involved in providing individual patient support through the system of buddy help and peer counsellors. This system is supported by the MoH with professional assistance from a psychologist.
- Civil society is also represented in the Country Coordinating Mechanism (CCM) for the Global Fund (GF) in Suriname and is, as a member of CCM, involved and informed about all HIV GF projects. The CCM has strengthened their role in the last years and are doing now supervisory visits in the field. The current HIV TFM GF project focuses on MSM and Sex Workers and NGOs are involved in providing services to the target groups.
- Trust and partnership among NGO's has increased somewhat
- Civil society fights for inclusion in all decision making bodies to have a voice and to represent their constituencies

What challenges remain in this area:

- Integration of civil society services in national programming and budgeting.

- The NGOs make an important contribution to HIV care, however they report several challenges for sustaining their services. The challenges mentioned during a consultation round on baseline situation analysis report on Treatment 2.0 include:
  - Insufficient funds
  - Insufficient capacity in human resources (quantitative and qualitative)
  - Need for stronger regulatory and supportive role of government
  - Not enough feedback/ involvement in new developments
  - Stigma and discrimination
  - Legislation against stigma and discrimination absent /not enforced
- The MSM target group needs a specific approach. And the "guide book" has not been written yet.
- Under estimation of civil society to implement programs / projects
- Lack of civil society on the decision making entities

II. POLITICAL SUPPORT AND LEADERSHIP

1. **Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?**

Yes	No

IF YES, describe some examples of when and how this has happened:
▪ Civil society has been involved as CCM members and representatives of civil society have participated in the Mid-term review of the 10 UN political targets and the discussion on the baseline situation analysis report on Treatment 2.0. ▪ NGO's are contracted by Sub-Recipient (Lobi Foundation) of the Transitional Funding Mechanism (TFM) Global Fund grant to implement activities of the GF proposal. The TFM focused on MSM and SWs ▪ Civil society provides input in national HIV reports. They will be involved in the preparation of the third National Strategic Plan as well as the concept note for Global Fund.

III. HUMAN RIGHTS

1.1 **Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable subpopulations? Circle yes if the policy specifies any of the following key populations:**

KEY POPULATIONS AND VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgender people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No

1.2. **Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?**

Yes	No

IF YES to Question 1.1 or 1.2, briefly describe the contents of these laws:
Article 8 (sub 1 and 2) of the Suriname Constitution ▪ 1. All who are within the territory of Suriname shall have an equal claim to protection of person and property. ▪ 2. No one shall be discriminated against on the grounds of birth, sex, race, language, religious origin, education, political beliefs, economic position or any other status.

Briefly explain what mechanisms are in place to ensure that these laws are implemented:
▪ People who feel that their rights are being infringed upon have the opportunity/freedom to bring a case forward against the Government. ▪ Although the current legal system provides ways to implement these laws they are not widely used.

Briefly comment on the degree to which they are currently implemented:
▪ The Constitution is complied with fairly well. ▪ Openly discriminating is frowned upon, but in real life, gays are discriminated against

2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?

Yes	No

2.1. IF YES, for which sub-populations?

KEY POPULATIONS AND VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgender people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable populations[17] *[write in]*:	Yes	No

Briefly describe the content of these laws, regulations or policies:
▪ The law forbids presenting SRH information and commodities to people younger than 16 years old.

Briefly comment on how they pose barriers:

3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?

Yes	No

Briefly describe the content of the policy, law or regulation and the populations included.
▪ There are laws against domestic violence, violence in schools, stalking; populations included are women and children. ▪ There is a law providing women who are victims of violence to ask for specific protection e.g. through restraining orders. ▪ It is in effect. Surinamese law protects all women against any form of violence/assault.

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

Yes	No

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:
▪ Human rights is mentioned as a principle in the HIV National Strategic Plan 2009-2013 (page 16). ▪ Human Rights are mentioned in the National Strategic Plan on HIV.

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, key populations and other vulnerable populations?

Yes*	No

IF YES, briefly describe this mechanism:
▪ * General mechanisms exist , but not specifically for HIV. ▪ The institution dealing with these issues is a division of the Ministry of Labour. ▪ Organisations have their own ways to document and address those cases

6. *Does the country have a policy or strategy of free services for the following? Indicate if these services are provided free-of-charge to all people, to some people or not at all (circle "yes" or "no" as applicable).*

	Provided free-of-charge to all people in the country		Provided free-of-charge to some people in the country		Provided, but only at a cost	
Antiretroviral treatment	Yes	No	Yes	No	Yes	No
HIV prevention services[18]	Yes	No	Yes	No	Yes	No
HIV-related care and support interventions	Yes	No	Yes	No	Yes	No

If applicable, which populations have been identified as priority, and for which services?
▪ The following subgroups have been identified as priority for HIV prevention: ▪ Youth/adolescents ▪ Sex workers/MSM ▪ Armed forces ▪ Pregnant women for PMTCT-services ▪ HIV+ for free ARV ▪ Pregnant women and unborn children and women and children

7. **Does the country have a policy or strategy to ensure equal access for women and men to HIV prevention, treatment, care and support?**

Yes	No

7.1. **In particular, does the country have a policy or strategy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?**

Yes	No

8. **Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support?**

Yes	No

IF YES, Briefly describe the content of this policy/strategy and the populations included:
▪ The Ministry of Health ensures health-care services to all people in the country ▪ Not aware of the content of the Policy but the NSP has some strategies

8.1. **IF YES, does this policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations?**

Yes	No

IF YES, briefly explain the different types of approaches to ensure equal access for different
▪ The Ministry of health ensures health care to all, regardless of nationality, sex and or sexual orientation.

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

Yes	No

IF YES, briefly describe the content of the policy or law:
▪ There are personal policy of some of the multinationals and food handling organizations.

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

a. 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

Yes	No

b. Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts

Yes	No

IF YES on any of the above questions, describe some examples:
▪ A subdivision within the Ministry of Labour records all cases of discriminatory conduct related to HIV. ▪ Moreover, Suriname signed the ILO conventions.

1. In the last 2 years, have there been the following training and/or capacity-building activities:

a. Programmes to educate, raise awareness among people living with HIV and key popula-tions concerning their rights (in the context of HIV)[19]?

Yes	No

b. Programmes for members of the judiciary and law enforcement[20] on HIV and human rights issues that may come up in the context of their work?

Yes	No

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

a. Legal aid systems for HIV casework

Yes	No

b. Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV

Yes	No

13. **Are there programmes in place to reduce HIV-related stigma and discrimination?**

Yes	No

IF YES, what types of programmes?		
Programmes for health care workers	Yes	No
Programmes for the media	Yes	No
Programmes in the work place	Yes	No
Other *[write in]*: There are no national programmes, but NGO's have their own activities and also the regional GF PANCAP grant has activities in country on stigma & discrimination.	Yes	No

14. **Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2013?**

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:
▪ In 2013,the LGBT community launched a campaign to advocate for non-discrimination of people with a different sexual orientation (city walk and TV ads campaign). ▪ The Lesbian Bi- sexual Gay Transgender (LBGT) platform started their activities and was, formally, acknowledged by the government.

What challenges remain in this area:
▪ Absence of coordination mechanism (platform for promotion/protection of human rights in relation to HIV) ▪ More awareness amongst lawyers, judges, target groups and other civil society organizations how to use existing laws and the legal system to promote and protect human rights. ▪ This same government, still, will not give two gay men/ women legal marital status like heterosexuals.

15. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the effort to implement human rights related policies, laws and regulations in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:
▪ To my knowledge no key achievements. ▪ The LBGT platform got permission and support to host its " Coming Out" activities since 10 October, 2011

What challenges remain in this area:
▪ Weak national capacity to coordinate, implement and monitor ▪ Though the LBGT population has a voice, it is still stifled and very weak. ▪ There is still so much to do and so many hurdles to take.

IV. PREVENTION

1. Has the country identified the specific needs for HIV prevention programmes?

Yes	No

IF YES, how were these specific needs determined?
▪ Surveys, national surveillance data, stakeholders consultation ▪ In collaboration with stakeholders (see the NSP) ▪ The needs assessment studies performed by the National Aids Programme (NAP) determined the specific need for HIV prevention.

IF YES, what are these specific needs?
▪ Adolescents' friendly services ▪ Condom distribution ▪ Integrated HIV testing & counselling ▪ Appropriate information on HIV for target populations ▪ Better ART medicines, more access to healthcare for the target population.

1.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access to...				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Blood safety	1	2	3	4	N/A
Condom promotion	1	2	3	4	N/A
Harm reduction for people who inject	1	2	3	4	N/A
HIV prevention for out-of-school young people	1	2	3	4	N/A
HIV prevention in the workplace	1	2	3	4	N/A
HIV testing and counselling	1	2	3	4	N/A
IEC[21] on risk reduction	1	2	3	4	N/A
IEC on stigma and discrimination	1	2	3	4	N/A
Prevention of mother-to-child transmission of HIV	1	2	3	4	N/A
HIV prevention component	**The majority of people in need have access to...**				
	Strongly disagree	**Disagree**	**Agree**	**Strongly agree**	**N/A**
Prevention for people living with HIV	1	2	3	4	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	1	2	3	4	N/A
Risk reduction for intimate partners of key populations	1	2	3	4	N/A
Risk reduction for men who have sex with men	1	2	3	4	N/A
Risk reduction for sex workers	1	2	3	4	N/A
School-based HIV education for young people	1	2	3	4	N/A
Universal precautions in health care	1	2	3	4	N/A

2. **Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV prevention programmes in 2013?**

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:

▪ Intersectoral PMTCT approach : Reduction in PMTCT
▪ Treatment coverage increased (Treatment as Prevention): increased access to ARVs for HIV+
▪ The school-based HIV education system has been initiated by the Ministry of Education
  ○ They have trained the major union (FOLS) to spread the message.
  ○ The curriculum is constantly updated.

What challenges remain in this area:
▪ No national prevention program, including communication ▪ Difficult to reach specific target groups (partners of key populations, vulnerable populations) ▪ Limited dedicated budget for specific prevention programs ▪ ▪ special programs to reach vulnerable groups MSMs, SWs, HIV+ ▪ more research for evidence based data to adjust policies/programs ▪ In multi- racial Suriname, the diverse religious organisations, sometimes, tend to halt the teachers in spreading the message of abstinence/ safe sex.

V. TREATMENT, CARE AND SUPPORT

1. **Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?**

Yes	No

IF YES, Briefly identify the elements and what has been prioritized:
▪ The National Strategic Plan provides this. ▪ Through a consultative process on the baseline situation analysis report on Treatment 2.0 held in November 2013, elements have been identified. Treatment protocols will be revised aligned with the 2013 WHO guidelines (after a costing study is conducted on changing the CD4 cell count threshold for initiation of ART from 200 (national guidelines) to 350 or 500). Care and support services have been identified as essential for implementation of Treatment 2.0

Briefly identify how HIV treatment, care and support services are being scaled-up?
▪ HIV knowledge of doctors, paramedics, all in the field of medicine is constantly upgraded.

1.1. To what extent have the following HIV treatment, care and support services been implemented?

HIV treatment, care and support service	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Antiretroviral therapy	1	2	3	4	N/A
ART for TB patients	1	2	3	4	N/A
Cotrimoxazole prophylaxis in people living with HIV	1	2	3	4	N/A
Early infant diagnosis	1	2	3	4	N/A
HIV care and support in the workplace (including alternative working arrangements)	1	2	3	4	N/A
HIV testing and counselling for people with TB	1	2	3	4	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	1	2	3	4	N/A
Nutritional care	1	2	3	4	N/A
Paediatric AIDS treatment	1	2	3	4	N/A
Post-delivery ART provision to women	1	2	3	4	N/A

HIV treatment, care and support service	The majority of people in need have access to...				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)	1	2	3	4	N/A
Post-exposure prophylaxis for occupational exposures to HIV	1	2	3	4	N/A
Psychosocial support for people living with HIV and their families	1	2	3	4	N/A
Sexually transmitted infection	1	2	3	4	N/A
TB infection control in HIV treatment and care facilities	1	2	3	4	N/A
TB preventive therapy for people living with HIV	1	2	3	4	N/A
TB screening for people living with HIV	1	2	3	4	N/A
Treatment of common HIV-related infections	1	2	3	4	N/A
Other*[write in]*:	1	2	3	4	N/A

1.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:
▪ Increased access and availability of HIV testing (VCT sites) and increased awareness of the need for testing through awareness and testing campaigns ▪ Sustained Political Commitment to reducing the impact of HIV/AIDS – The Government of Suriname through the Ministries of Health and Finance has increased their budget to sustain the HIV response in the phase of declining donor funds; presently 0-5% is external funding ▪ Strengthened Health Care Worker Capacity -- investments have been made in building the capacity of health care workers through training on treatment protocols and training psychosocial care. ▪ Reduction in MTCT ▪ increased access to ARVs for HIV+ ▪ Better contact with the Ministry of Social Affairs, better interaction between NGO's working in the field of HIV prevention, care and support.

What challenges remain in this area:
▪ Maintaining patient adherence to ARV regimens ▪ Maintaining current treatment and care standards, and also increasing quality of care, and number of people requiring care (CD 4 <350 or CD4 <500) ▪ Reluctance to access services due to perception of high levels of stigma and discrimination ▪ special programs to reach vulnerable groups MSMs, SWs, HIV+ ▪ more research for evidence based data to adjust policies/programs ▪ Distrust among NGO's, poor communication with the governmental agencies.

2. Does the country have a policy or strategy to address the needs of orphans and other vulnerable children?

Yes	No

2.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes	No

UNICEF Definition is used

2.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	No

3. **Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?**

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:
▪ Reduction in MTCT ▪ increased access to ARVs for HIV+

What challenges remain in this area:
▪ Shifting the focus of care to one of "chronic care management" ▪ Adapting treatment protocols to treatment 2.0 standards ▪ Linking persons diagnosed with HIV to care and retaining them in care ▪ Adhering to treatment ▪ Increasing testing and counselling to reach vulnerable populations ▪ Strengthening psychosocial support ▪ special programs to reach vulnerable groups MSMs, SWs, HIV+ ▪ more research for evidence based data to adjust policies/programs