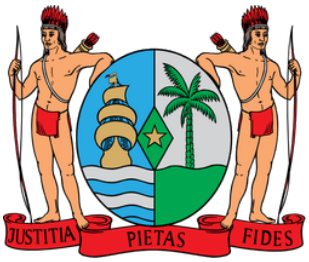

Suriname

AIDS Response Progress Report 2015

Ministry of Health
Henck Arronstraat 64
Paramaribo - Suriname

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List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
BOG	Bureau voor Openbare Gezondheidszorg (Bureau of Public Health)
BCC	Behaviour Change Communication
BSS	Behavior Surveillance Survey
CAREC	Caribbean Epidemiology Center
CCM	Country Coordinating Mechanism
CVC/COIN	Caribbean Vulnerable Communities/El Centro de Orientación e Investigación Integral
DD	Dermatologische Dienst (Dermatological Services)
EID	Early Infant Diagnosis
eMTCT	Elimination of mother to child transmission
GARPR	Global AIDS Response Progress Report
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
IEC	Information Education and Communication
LTFU	Lost to follow-up
LGBT	Lesbian, Gay, Bisexual, and Transgender
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MICS	Multiple Indicator Cluster Survey
MoH	Ministry of Health
MSM	Men who have sex with men
NASA	National AIDS Spending Assessment
NCD	Non Communicable Diseases
NGO	Non-Governmental Organization
NSP	National Strategic Plan
NTP	National Tuberculosis Programme
PAHO	Pan-American Health Organization
PANCAP	Pan Caribbean Partnership against HIV/AIDS
PHC	Primary Health Care
PLHIV	People Living with HIV
PMTCT	Prevention of mother to child transmission
S&D	Stigma and Discrimination
SMLA	Stichting Maxi Linder Association
STI	Sexually Transmitted Infections
SW	Sex Worker
TB	Tuberculosis
TFM	Transitional Funding Mechanism
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations Programs on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session

VCT	Voluntary counseling en testing
VL	Viral load
WAD	World Aids Day

Introduction

With the adoption of the *UNGASS Declaration of Commitment on HIV and AIDS* in 2001, Suriname has declared its commitment to the systematic and strategic control of HIV and AIDS, as indicated by the development of the first HIV/AIDS National Strategic Plan (NSP) in 2004. To date many advances have been made in the coordination and organization of services, as shown by an increase in access to treatment for persons living with HIV and a steadfast decline to zero infants born infected with HIV. The Government has, in addition, increased its financial commitment to the HIV response and is increasingly assuming its leadership role in strengthening the HIV response throughout the health system and multi-sectoral partners.

Suriname has now developed the third HIV NSP for the period 2014–2020; this NSP is aligned with national development and health sector strategies and is based on regional and international recommendations. The focus of the third HIV NSP remains on achieving Universal Access with 'Prevention' and 'Treatment and Care' as priority areas with identified cross-cutting issues ('Multi-sectoral coordination and collaboration', 'Integration', 'Capacity Building', 'Strategic Information' and 'Human Rights and Equity'). The coordination and organization of the HIV response will be further strengthened with the Ministry of Health (MoH) in a leadership role. Additional focus of planned activities will remain on targeted key populations to maximize the progress towards the set targets and on community participation as one of the main strategies to effectively reach the target populations and to involve them in the response.

This 2015 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 policy and programmatic response, the national response to HIV/AIDS, the challenges and remedial actions and the support received from developmental partners during the reporting period as well as the support needed to achieve the targets. The last chapter outlines the monitoring and evaluation environment.

1. Status at a Glance

1.1. Report writing process

The Research, Planning and Monitoring Unit (Planning Unit) of the MoH led the process of report writing. Since there have been recent in-country discussions on the development of the third HIV NSP and the joint TB/HIV Concept Note, the report is primarily based on these discussions and reports. At these in-country discussions there was a wide range of stakeholders present from other departments of the MoH, non-health line Ministries, key affected populations, civil society, private sector, Country Coordinating Mechanism (CCM) Suriname, United Nations (UN) organizations and Global Fund Country Team. Additional information was gathered from the different departments involved in HIV. A national consensus meeting was held on Tuesday, June 9th, 2015, simultaneously with the official presentation of the third HIV NSP, HIV Epidemiological Profile and Joint TB/HIV Concept Note. At this meeting the national HIV estimates from the Spectrum file 2015 were also presented. Participants' feedback during this meeting has been incorporated into the final version of this report.

1.2 The status of the epidemic

The estimated HIV prevalence for the adult population between the ages of 15 – 49 is 0.9% (0.8%-1.0%); however the HIV prevalence among key affected populations is higher than the general population, 6.7% in 2005 for MSM and 5.8% in 2012 for SW. [1,2] The number of people of all ages living with HIV in 2013 is estimated to be 4,000.[3] There has been a decline noted of the estimated HIV prevalence in the adult population from 1.3% in 1996 to 0.9% in 2013. Since 2006, a declining trend of the HIV prevalence among pregnant women is seen from 1.4 in 2006 to 1.1 in 2011.[4] In 2012 and 2013, the HIV prevalence among pregnant women remained the same. HIV prevalence among TB patients decreased from 28.5% in 2012 to 22.6% in 2013.[5] HIV prevalence among blood donors has not been more than 0.057% since 2004; the prevalence in 2012 was 0.055 and in 2013 0%.[6]

The first HIV case in Suriname was registered in 1983; since then the number of new cases diagnosed with HIV has increased due to increased HIV testing. From 2000 to 2013, 7,090 new HIV cases have been diagnosed. The newly HIV diagnosed cases by year reached a peak in 2006 with 781; since 2007 there has been a steady decline in the number of newly HIV diagnosed cases till approximately 500 per year. This decrease is in line with the UNAIDS estimates stating that the incidence of HIV has decreased with more than 80% (UNAIDS 2010). From 2002 till 2012, there are more HIV reported cases among females compared to males. In 2012 the male to female ratio was 1.0 and in 2013 the male to female ratio was 1.2. It is important to note that during 2000-2011, three times more HIV tests were done among females compared to males. Aggregated by age, the majority (86%) of the HIV diagnosed persons from 2000-2013 were between the ages of 15 – 55 years; most of the diagnosed HIV cases are of Creole or Maroon descent.[7]

1 CAREC/PAHO and Maxi Linder (2005), An HIV seroprevalence and behavioral study among men-who-have-sex-with-men (MSM) in Suriname. Paramaribo, Suriname
2 Looking for Sex Workers in Suriname "An Evaluation of methods to estimate the size of Sex Workers in Suriname" – D. Stijnberg
3 UNAIDS, 2013
4 PMTCT focal point surveillance / Civil Registry Office
5 National TB programme surveillance
6 National Bloodbank, 2014
7 National HIV Master database, M&E Unit MoH, 2014

From 2010–2012, there is a declining trend in the hospitalizations excluding re-hospitalizations with resp. 96 hospitalizations in 2010, 95 in 2011 and 81 in 2012. Males are more hospitalized than females with a male to female ratio of 1.3. However for re-hospitalizations there is an increasing trend observed between 2008–2011, resp. 116 re-hospitalizations in 2008, 119 in 2009, 133 in 2010 and 156 in 2011 in which more males are re-hospitalized than females.

Mortality for AIDS shows a declining trend since 2006 and this is consistent till 2013. The number of AIDS deaths from 2001-2013 is around 2.6 (median) per 10,000 population (range 1.6-3.6).[8] The status of the epidemic is further detailed under the prescribed headings of chapter 2 'Overview of the AIDS epidemic'.

1.3 Policy and programmatic response

The policy of the MoH is based on the assumption of an overarching policy in which all needed health services are integrated and linked with each other whereby Primary Health Care (PHC) is fulfilling a fundamental role. The MoH recognized HIV as a chronic disease and has commenced the integration of HIV-services in the existing healthcare system. In addition, the MoH has increased the governmental budget for HIV.

In 2014, the MoH led the process of the development of the third HIV NSP. The third HIV NSP was drafted taking into account the regional and international recommendations for prevention, treatment, care and support, such as Treatment 2.0 Framework for Action, HIV continuum of Care, the 2020 Treatment cascade targets 90-90-90, the eMTCT, the WHO policy on TB/HIV collaborative activities, and the Caribbean Regional Strategic Framework on HIV 2014 – 2018.

National consultations were held during the drafting process and the key stakeholders indicated that there is a need for a sustainable multi-sectoral approach to the HIV response in an appropriate model of care and with the government in a leadership position. Based on these consultations the third HIV NSP was developed for the period 2014–2020.

The goals of the NSP are:

- Reduce New Infections
- Improve the Quality of Life of People living with HIV (PLHIV)

Main Strategic Objectives for 'Prevention' and 'Treatment':

- Reduce HIV transmission among key and vulnerable population groups (MSM, SW, Youth/Adolescents and others) and in the general population
- Expand high quality comprehensive HIV treatment, care and support
- Eliminate Mother-to-Child transmission (eMTCT)

Strategic Objectives for the Crosscutting themes:

- Facilitate the incorporation of health and HIV prevention interventions across sectors
- Ensure the multi-sectoral provision of HIV treatment and support in different sectors
- Incorporate HIV interventions into the existing health and social service delivery system
- Rational resource allocation across sectors and strategic interventions
- Ensure that prevention and treatment interventions incorporate human rights and equity principles that include gender sensitivity and reduce stigma and discrimination
- Strengthen human resource capacity for management, coordination and implementation of the HIV response

8 Bureau of Public Health, Ministry of Health. 2014. Surveillance Epidemiology department.

- Improve use of data and information to inform decision making

Expected Results:

- 50% reduction in Sexual Transmission of HIV
- 90% of estimated persons with HIV get tested
- 90% of PLHIV in need of treatment are being treated with Lifesaving Antiretroviral Treatment
- 90% on Antiretroviral Treatment have a suppressed viral load
- Eliminate New HIV Infections Among Children by 2020

The guiding principles of the NSP

Universal access

- The right of access to affordable and proper health care and social security
- HIV policy and programs must be integrated in and contribute to strengthening and improving existing health care systems

Inclusion

- The strategic response will reflect the involvement of all major sectors and stakeholders

Evidence-based

- Policies, interventions and approaches should be based on sound evidence or experience

Sustainability

- The strategies and financing for the expanded response will be consistent with available resources, structures and opportunities and in keeping with what is required to reduce and mitigate the impact of the disease

Human Rights

- Acknowledgement and protection of rights as guaranteed by the Surinamese Constitution and international agreements on human rights, including the rights of persons with HIV, their fellow human beings, persons with high-risk behavior and groups in a vulnerable position, in particular, women and children.
- Respect for diversity in ethnic descent, language, sexual preferences and social and economic circumstances in the development of programs.

Equity

- The program should aim to achieve equitable health outcomes across all populations and settings and promote gender equity

Based on the newly drafted HIV NSP a change in the coordination structure has been proposed (See Annex 2). This coordination structure will be further detailed in 2015.

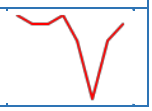
Specific policy and programmatic responses for 2014:

- The analysis of HIV related data resulting in the drafting of HIV EPI profile
- The development of a joint TB/HIV Global Fund Concept Note addressing key populations (MSM, Transgenders, SW, Adolescents)
- The decision to change the initiation of treatment at CD4 of 350 in 2015 and CD4 of 500 in 2017

The policy and programmatic responses are further detailed in prescribed headings of chapter 3 'National response to the AIDS epidemic'.

1.4. GARPR indicators overview

TABLE 1: GARPR INDICATORS OVERVIEW TABLE, 2006 – 2013

Reduce sexual transmission of HIV by 50% by 2015										Trend
Indicators for the general populations										
Source	Comments	2006	2007	2008	2009	2010	2011	2012	2013	
1.1 Percentage of young women and men aged 15–24 who correctly identify ways of preventing 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 1 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										
National HIV Test database /From 2011: PMTCT surv		1	0.9	0.9	1	0.7	1.2*	0.7	0.9	
Indicators for SW										
Source	Comments	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 MSM										
Source	Comments	2006	2007	2008	2009	2010	2011	2012	2013	
1.11 Percentage of men reached with HIV prevention programmes										
BSS	*Based on 2 questions:* *1. Received HIV information in last 12 months* *2. Received condoms in last 12 months*						55.2%			
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%									

GARPR indicators overview table, cont'd	
Reduction of HIV among injecting drugusers	
Indicators 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**
Source	Comments	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/ PMTCT surv	Denominator =100 until 2010; den number pos mothers	64	79	83	86	79	93	95	90	
3.2 Percentage of infants born to HIV-infected women receiving a virological test for HIV within 2months of birth										
PMTCT database	N/A		17.6	16.5	2.5	67.6	96.3	96.3	100	
3.3 Estimated percentage of child HIV infections from HIV positive women delivering in the past 12 months (modelled)										
Spectrum sofware, 2015	Estimated MTCT rate at 6 weeks	6.52	1.87	2.22	2.54	3.43	1.53	0.66	0.76	

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)

Have 15 million PLHIV on ART by 2015										**Trend**
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	76.8	
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	79.8	80.8	87.4	86.6	89.6	82.2	73.8	

Reduce TB deaths in PLHIV by 50% by 2015										**Trend**
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	58	

Reach a significant level of annual global expenditure (US22-24 billion) in low-and middle-income countries										**Trend**
Source	Comments	2006	2007	2008	2009	2010	2011	2012	2013	
6.1 Domestic and International AIDS spending by categories and financing sources										
NASA	Total Spending				4,037,170	6,129,853	4,674,508	3,768,103	4,962,635	

Critical enablers and synergies with development sectors									
Source	Comments	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 *For indicator 1.6 starting from 2011 another methodology was used; Number diagnosed positive in that age group=nom; den= Mothers of live births in that age group

Source: M&E Unit, MoH, 2014

2. Overview of the AIDS epidemic

2.1. Context Suriname

The Republic of Suriname, bordered by French Guiana in the east, Brazil in the south, Guyana in the west and the Atlantic Ocean in the north, is located on the northeast coast of South America. Suriname has a total area of 163,820 km^2 and consists of a narrow coastal plain with swamps and rolling hills, comprising 20% of the land surface and a vast tropical rainforest, comprising 80% of the land surface.

The country is divided into ten administrative districts that are subdivided into 62 administrative regions. Of the districts, two urban and six rural are located along the coastal area of Suriname, while the remaining two districts are situated in the interior of Suriname.

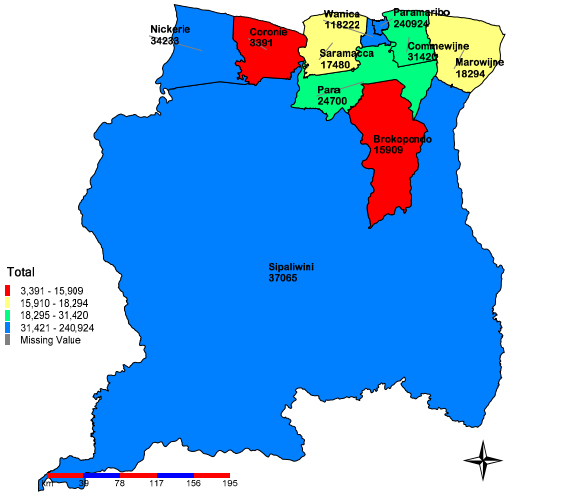


FIGURE 1: MAP OF SURINAME DIVIDED IN ADMINISTRATIVE DISTRICTS

Source: Central Bureau of Statistics, Census 2012

The urban district Paramaribo, in which the capital city Paramaribo is situated, and Wanica cover 0.5% of the land surface and contain 70% of the total population. The rural area is divided into rural urban and rural interior. The latter is scarcely populated, mainly by traditional Indigenous and Maroon populations. Less than 70,000 persons live in these traditional villages.[9] Access to these villages is possible mainly through the river, some can be reached by road, but some can only be reached by air.

The vital statistics profile for the country from 2004 to 2012 shows a population growth of 48,800 rising from 492,829 in 2004 to 541,638 in 2012, with 49.96% males and 50.04% females.[10] About 70% of the population lives in the urban districts. The registered live births increased from 9,000 to 10,000 to give a crude birth rate of 20 per 1,000 population and a total fertility rate of 2.5. The population consists of people from many ethnic backgrounds: 27.4% are East Indian (Hindustani), 21.7% are Maroon, 15.7% are Creole, 13.7% are Javanese, while 13.4% and 7.6% are from a 'mixed' and 'other' ethnicity, respectively. Dutch is the official language and Sranan Tongo, the 'native language', and many other languages are also spoken by the population. Suriname is classified as a 'Upper Middle Income' Country by the World Bank as of 2010; the GDP is 9,376 US$ and the main economy is mining (Gold, Oil and Bauxite)[11].

2.2 HIV prevalence

Suriname has an estimated HIV adult (15 – 49 years) prevalence of 0.9% (UNAIDS, 2013) with pockets of higher HIV prevalence among key populations (MSM and SW). The same trend is seen in the estimated HIV prevalence curves generated from Spectrum software 2015.

9 Goede 2012, Migrant and Mobile Population in the Goldmining Areas,

10 Algemeen Bureau voor de Statistiek. September 2013. Resultaten achtste volks-en woningtelling in Suriname (volume1); Demografische en sociale karakteristieken en migratie. Publicatie nummer: 294/2013-05.,page:13, 20, 21

11 World Bank, 2014

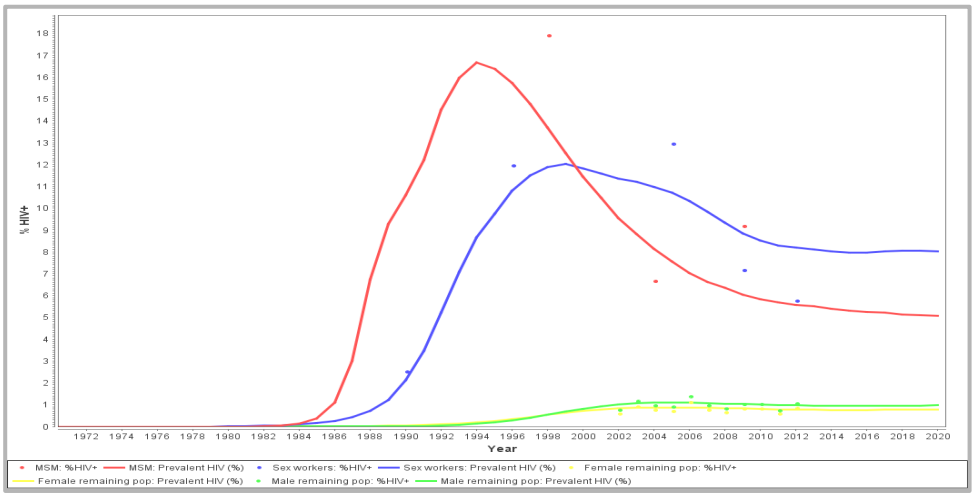


FIGURE 2: ESTIMATED HIV PREVALENCE CURVES FROM SPECTRUM FILES, MARCH 2015

Source: Spectrum file, 2015, M&E Unit, MoH

Since 1986, HIV prevalence studies have been conducted among subpopulations; however in the last two years, 2013 and 2014, no prevalence studies were conducted. The next round of prevalence studies is scheduled for 2015.

TABLE 2: OVERVIEW OF HIV PREVALENCE AMONG KEY AND VULNERABLE POPULATIONS, 1986 – 2014

Year	SW (Paramaribo)	SW and their clients (Goldmines)	MSM	Prisoners	Military	STI Clinic Clients
1986	0.0					0.0
1989	1.0					0.6
1990	2.5					
1991						1.0
1992	22.0			0.0		
1996						
1998			18.0			
1999					1.40	
2004	24.1					
2005			6.7			
2008						2.8
2009	7.2					
2010						
2012	5.8	1.0*				

** Same survey: BSS and Sero-prevalence among SW and their clients in goldmining areas*

Source: MoH, M&E Unit

2.3 HIV cases

Since the first registered case of HIV in 1983, scaling-up of HIV-testing led to an increase in the number of persons tested for HIV and consequently to an increase in the number of newly registered HIV-cases. This increase continued until 2006, with a maximum of 781 newly registered cases. However, since 2007 there has been a steady decline in the number of newly registered HIV-cases. The number of new HIV cases from 2010 till 2014 was respectively 532 in 2010, 526 in 2011, 510 in 2012 and 473 in 2013 (see figure 3). [12] The data of 2014 has not yet been analyzed.

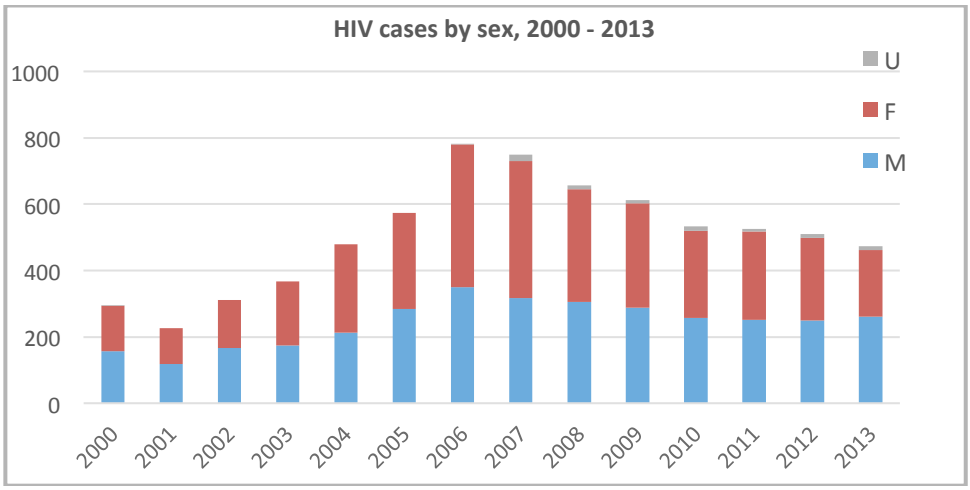


FIGURE 3: NUMBER OF REGISTERED HIV POSITIVE PEOPLE BY SEX, 2000-2013

Source: HIV Master database M&E Unit MOH, 2014

Aggregated by age, the majority (86%) of HIV positive persons, enrolled in the National HIV Master Database from 2000 – 2013, were between the ages of 15 to 55 years. Most of the women are in the 26 – 35 years age group, while the men are at an older age.[13]

TABLE 3: CUMULATIVE NUMBER OF HIV CASES BY AGE GROUP, 2000 - 2013

Age group	Men	Women	Unkn
< 5	222	192	24
6-15	20	64	12
16-25	278	869	5
26-35	948	1209	11
36-45	996	739	9
46-55	594	356	8
56-65	220	136	3
65+	115	43	2
Unk	0	0	15
Total	3393	3608	89

Source: National HIV Master database, M&E Unit MOH 2014

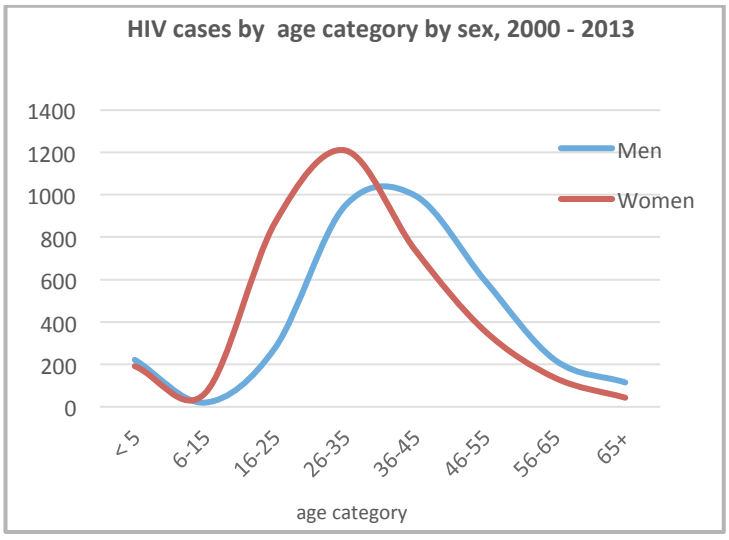


FIGURE 4: CUMULATIVE NUMBER OF HIV CASES BY AGE CATEGORY AND SEX, 2000 - 2013

Source: National HIV Master database, M&E Unit MOH 2014

12 M&E Unit, Ministry of Health. 2014. HIV Master database.
13 M&E Unit, Ministry of Health. 2014. HIV Master database.

2.4 HIV hospitalizations

From 2010 to 2012, a declining trend in the number of hospitalizations has been observed, re-hospitalizations excluded. Hospitalizations occur more among males than females, with 30% more males hospitalized between 2001 and 2012 than females and an according male/female ratio of 1.3 (median) (range 0.8-1.7). [14]

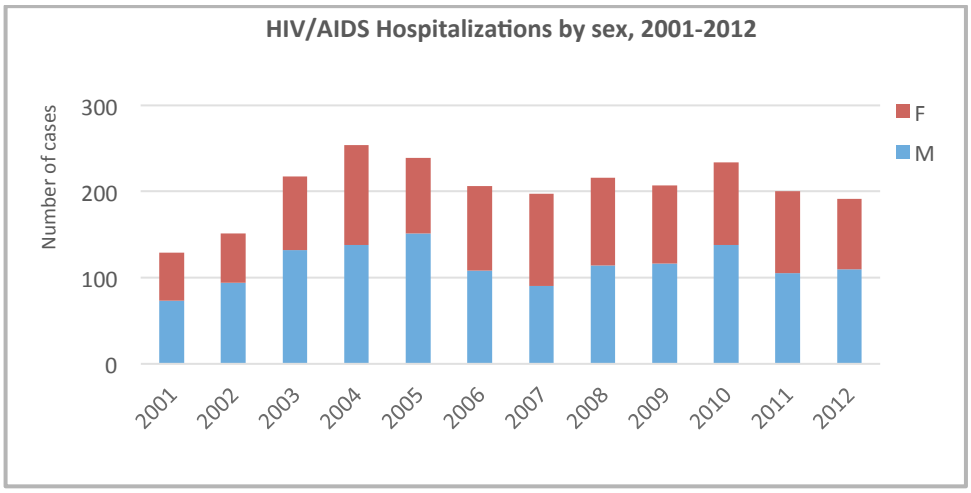
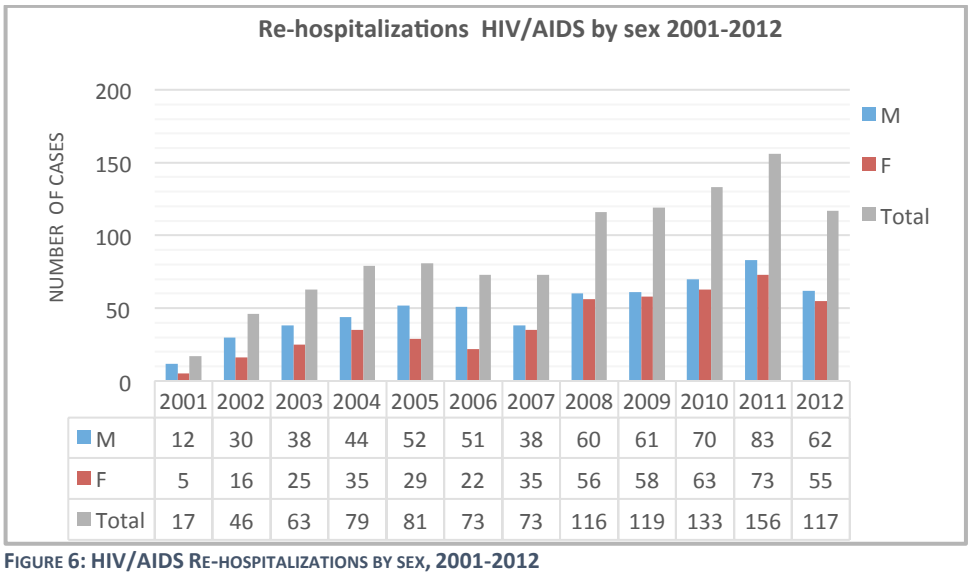


FIGURE 5: HIV/AIDS HOSPITALIZATIONS BY SEX, 2001 - 2012

Source: BOG, Epidemiology department

Re-hospitalizations include cases that are hospitalized more than once; one case can be counted more than once in one year or over the years. An increasing trend in re-hospitalizations is observed between 2008 and 2011 with more males re-hospitalized than females. [15]



	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
M	12	30	38	44	52	51	38	60	61	70	83	62
F	5	16	25	35	29	22	35	56	58	63	73	55
Total	17	46	63	79	81	73	73	116	119	133	156	117

FIGURE 6: HIV/AIDS RE-HOSPITALIZATIONS BY SEX, 2001-2012

Source: BOG, Epidemiology department

14 M&E Unit, Ministry of Health. 2014. HIV Master database.
15 M&E Unit, Ministry of Health. 2014. HIV Master database.

2.5 AIDS Mortality

The AIDS mortality rate in 2012 was 1.86 per 10,000 population.[16] AIDS mortality is reported through the anonymous so called C-forms, which state the cause of death. These forms, from all over the country, are sent to the Epidemiology unit from the Bureau of Public Health (BOG). Coverage of the C-forms has consistently been above 90%, with 2001 as an exception. Mortality for AIDS shows a declining trend since 2006 and this is consistent till 2013. The number of AIDS deaths from 2001-2013 is around 2.6 (median) per 10,000 population (range 1.6-3.6). [17]

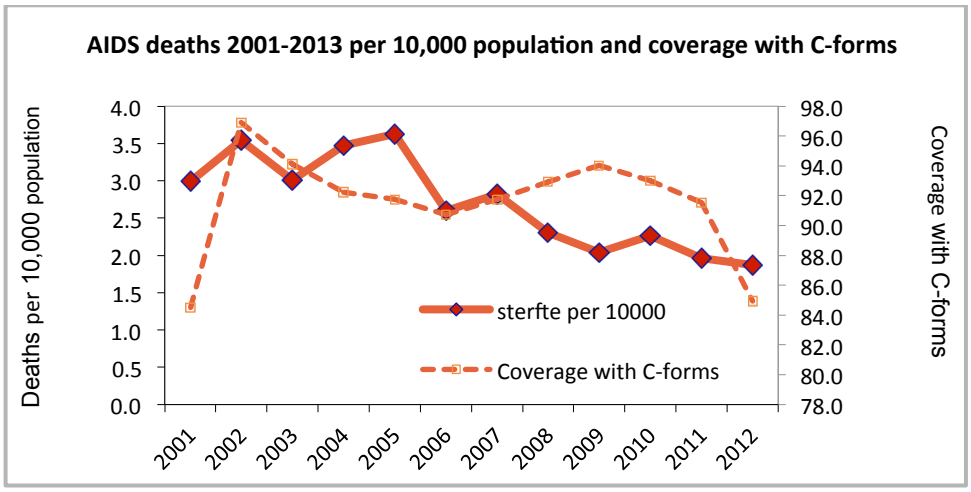


FIGURE 7: AIDS DEATHS PER 10,000 POPULATION AND COVERAGE WITH C-FORMS, 2001 - 2013

Source: BOG, Epidemiology Department

Both among hospitalizations and mortality, men are disproportionately affected with respectively on average 1.3 and 1.5 times more men compared to women being hospitalized and dying. This is an indication that men only come into the healthcare system when they already have symptoms.

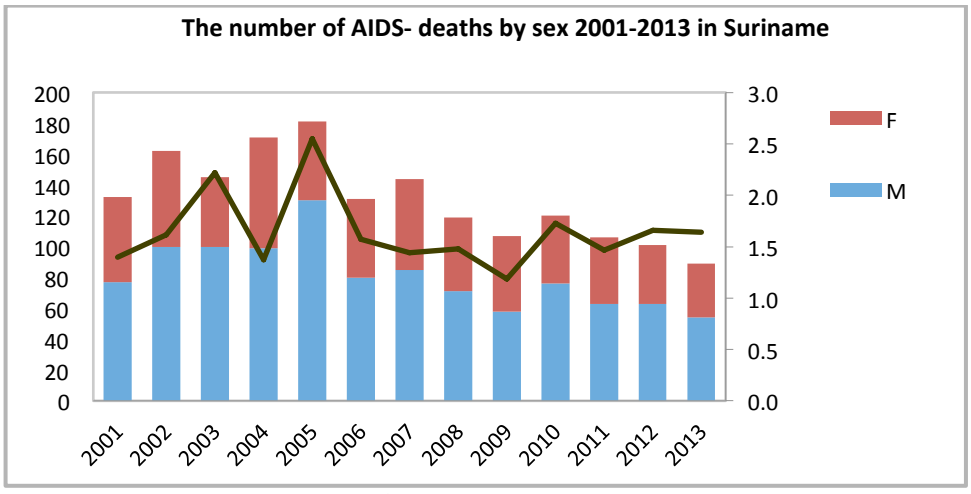


FIGURE 8: AIDS MORTALITY BY SEX AND MALE/FEMALE RATIO, 2001-2012

Source: BOG, Epidemiology department

16 Epidemiology Department , Bureau of Public Health, 2011
17 Bureau of Public Health, Ministry of Health. 2014. Surveillance Epidemiology department.

2.6 HIV Continuum of Care

In 2013 the treatment cascade for HIV was introduced.[18] This cascade provides a way to follow persons living with HIV/AIDS through the health care system and to identify the gaps in connecting and keeping individuals living with HIV/AIDS in a sustained, quality continuum of care.

The initial step is estimating how many people with HIV were in fact also diagnosed. To get an idea about this initial step in the cascade, the number of people in the HIV master index database in 2012 or later was compared with the estimated 4,000 PLHIV in Suriname (UNAIDS, 2013); a percentage of 60% was found.

The next steps of the treatment cascade were analyzed using people enrolled from 2007 to 2012, after the initiation of CD4 testing in Suriname. Of the 3,274 adult persons (15+ years) diagnosed HIV positive in the years 2007 to 2012, 922 (28.16%) have never entered into care, based on never having done a CD4 test. Of the persons entering into care, 86% had an initial CD4 test done within 3 months of diagnosis. For 38% of those people entered into care the first CD4 was below 200. [19]

Of the adults enrolled from 2007 to 2012 only 38.9% had a recorded viral load (VL) result of which the majority (65%) had a last recorded VL of less than 1000 copies/ml, classified as virally suppressed. This accounts for only 25% of the 2007-2012 cohort. [20]

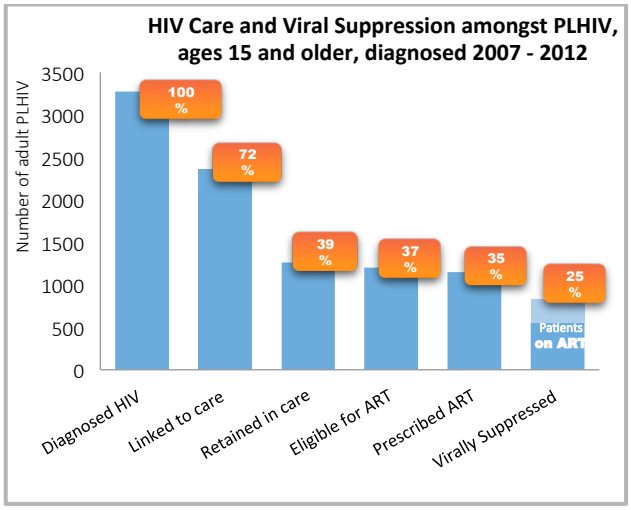


FIGURE 9: HIV CONTINUUM OF CARE FOR PLHIV ENROLLED FROM 2007 – 2012

Source: National HIV Master database, M&E Unit MOH 2014

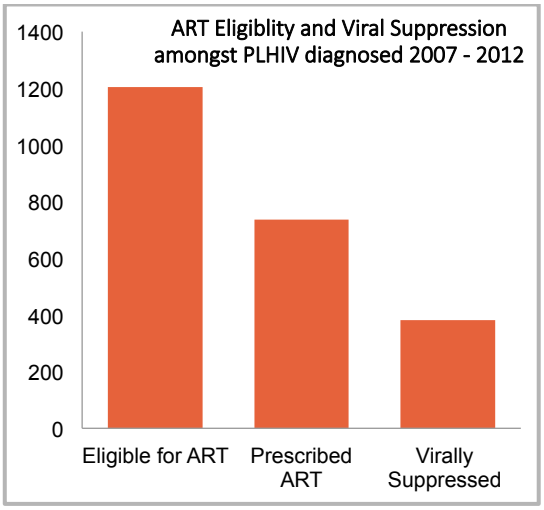


FIGURE 10: ART ELIGIBLE AND VIRAL SUPPRESSION OF PLHIV ENROLLED FROM 2007-2012

Based on a CD4 on record in 2012, 1,265 (53.78%) of those entered into care were also retained in care. Just looking at the number eligible for treatment, based on a CD4 nadir of 200 (as per the national guidelines), and the number receiving treatment, respectively being 1,205 and 1,148, it would seem that 95% of people in need of treatment also get the treatment, but this is not the case. The number receiving treatment is a subset of the persons diagnosed getting ART, irrespective of eligibility. In fact of the 1,205 with a CD4 nadir of 200 or less, 61% really received ART; leaving 40% untreated as seen in figure 10.

18 PAHO/WHO. 2014. HIV Continuum of Care Monitoring Framework 2014; Addendum to meeting report: Regional consultation on HIV epidemiologic information in Latin America and the Caribbean.
19 M&E Unit, Ministry of Health. 2014. HIV Master database.
20 M&E Unit, Ministry of Health. 2014. HIV Master database.

Looking at the CD4 at diagnosis, 46% of men compared to 31% of women have a first CD4 less than 200. The percentage of PLHIV entering into care from 2007-2012 with their first CD4 below 50 even seems to increase over the years as seen in figure 11.

TABLE 4: FIRST CD4 FOR PLHIV DIAGNOSED 2007-2012 BY CATEGORY BY SEX

First CD4 Category (copies/ml)	Men	Women
<50	233	140
50-200	302	239
201-350	235	236
351-500	148	229
>500	228	362
Total	**1542**	**1705**

Source: National HIV Master database, M&E Unit MOH 2014

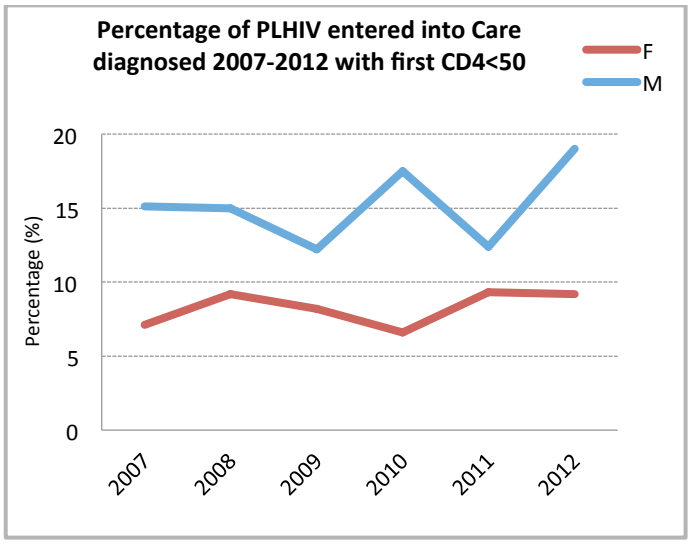


FIGURE 11: PERCENTAGE OF PLHIV ENTERED INTO CARE, DIAGNOSED 2007-2012 WITH A FIRST CD4 LESS THAN 50 COPIES/ML

Source: National HIV Master database, M&E Unit MOH 2014

3. National Response to the AIDS epidemic

In 2014, the MoH led the development process of the NSP 2014–2020 in consultation with various health sector and non-health sector stakeholders. The process included the review of the NSP according to the priority areas of the NSP 2009-2013 and revealed the accomplishments and gaps in the HIV response. These accomplishments and gaps from the review covering the period 2009–2013 and the ones in 2014 will be described in the following subchapters and chapters 4 and 5.

3.1 National Coordination, Policy and Capacity Building

A multi-sectoral leadership structure, the HIV Board, was established in 2009, residing under the Director of Health, with Technical Working Groups (TWGs) on Prevention, Treatment and Care and Monitoring & Evaluation (M&E), complemented by an additional Project Monitoring Unit. This HIV Board generated an active participation of stakeholders in the HIV response and the integration of HIV-related activities in multiple sectors and successfully achieved the scaling up of HIV treatment and care under this structure. However, in the process of reintegrating HIV treatment and care into the health system, the MoH chose a more horizontal approach for the management of the HIV program, resulting in the dismantling of the HIV Board and the integration of its related TWGs and their core responsibilities into existing health structures of the MoH. Part of the reintegration was the uptake of HIV in existing programs and structures which included the integration of HIV in NCD/Healthy Lifestyle programs, with as example the opening of a 'One Stop Shop' for chronic diseases and focus shift of the health information center 'Libi!' that now addresses HIV and NCD issues in an integrated way. With the new NSP 2014–2020, a change in the coordination structure is proposed to further integrate HIV into existing health structures.

With the integration of the HIV response in mind and the increasing demand of technical and financial skills to manage and implement donor funded projects, a capacity building plan was developed targeting both the MoH personnel as well as the executing partners. Implementation resulted in an improved financial, technical and organizational capacity of the MoH, NGOs and other civil society organizations. The development partners have provided support in various capacity building activities. Building activities were, among others, conducted under the Caribbean Vulnerable Communities Coalition (CVC) and El Centro de Orientación e Investigación Integral (COIN) as sub-recipients of a Pan Caribbean Partnership against HIV and AIDS (PANCAP) Grant provided by the GF. The training in country was focused on Peer Education training based on the sex positive model developed for CVC/COIN (2014); advocacy training and capacity building for the NGO's.

The Government of Suriname is continuously increasing the financial responsibility of the national HIV response and as part of the national commitment and sustainability of actions, the government is providing support through increased budget allocations for the HIV response. Since 2010, the government is financing all ARVs and is not dependent on external funding for ARVs.

According to the draft NASA report 2012-2013, the preliminary data for the 2012 and 2013 expenditure amounts to USD 3,768,103 and USD 4,952,635 respectively. In 2013, 60.8% was financed with public resources, 38.4% was financed with international resources.[21]. The Government's spending has increased over the years from USD 2,181,662 in 2009 to USD 3,017,484 which guarantees sustainability of efforts. When comparing 2012 with 2013, an increase can be noted in the funding by international resources. This was mainly due to funds provided by specific international sources.

21 Draft NASA report 2012 - 2013

TABLE 5: HIV EXPENDITURES BY PUBLIC, PRIVATE AND INTERNATIONAL FINANCIAL SOURCE

Financial Source	2009	2010	2011	2012	2013
Total spending	**4,037,170**	**6,129,853**	**4,674,508**	**3,768,103**	**4,962,635**
public:	2,181,662	1,939,620	2,249,605	3,099,120	3,017,484
%	54.04 %	31.64%	48.12%	82.25%	60.80%
private:	81,798	82,633	81,800	17,170	41,336
%	2.03%	1.35%	1.75%	0.46%	0.83%
international	1,773,710	4,107,600	2,343,104	651,814	1,903,816
%	43.93%	67.01%	50.13%	17.30%	38.36%

Source: Draft NASA report 2012-2013

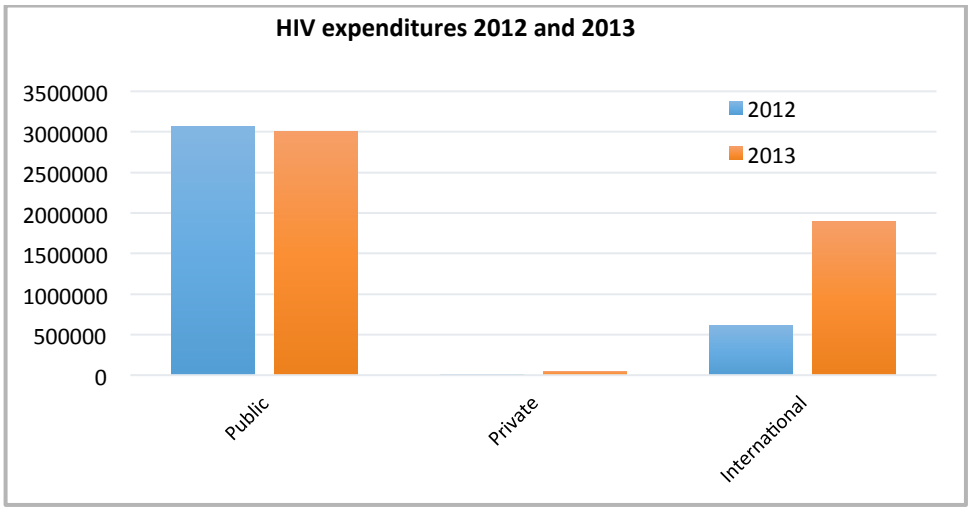


FIGURE 12: HIV EXPENDITURES 2012 AND 2013 BY PUBLIC, PRIVATE AND INTERNATIONAL FINANCIAL SOURCE

Source: Draft NASA report 2012-2013

The preliminary data further indicates that in 2012 as well in 2013, most of the funds were allocated to 'Care and Treatment', respectively 55.1% in 2012 and 47.5% in 2013. The funds allocated to 'Prevention' increased in 2013 in comparison with 2012; this was due to prevention activities funded by international resources.

TABLE 6: HIV EXPENDITURES BY SPENDING CATEGORIES

AIDS Spending Categories	2012	%	2013	%
Preventions	677,959	18.0 %	1,579,249	31.8 %
Care and Treatment	2,075,209	55.1 %	2,361,080	47.5 %
OVC	12,858	0.3 %	60,951	1.2 %
Policy and Management	913,364	24.2 %	783,902	15.8 %
Improving Human Resources	52,550	1.4 %	17,500	0.4 %
Enable Environment	36,164	1.0 %	156,454	3.2 %
Research			3,500	0.1 %
Grand Total	**3,768,103**	**100.0 %**	**4,962,635**	**100.0 %**

Source: Draft NASA report 2012-2013

TABLE 7: HIV EXPENDITURES 2012 AND 2013 BY DETAILED FINANCIAL SOURCE

Financial Source	2012	%	2013	%
Central government revenue	2,652,855	70.4	2,524,930	50.8
Employer's compulsory contributions to social security	202,733	5.4	233,662	4.7
Employee's compulsory contributions to social security	139,983	3.7	161,338	3.3
Government transfers to social security	103,549	2.8	97,553	2.0
For-profit institutions and corporations			17,500	0.4
Households" funds	17,170	0.5	23,836	0.5
Government of Netherlands			616,654	12.4
Government of United States	309,964	8.2	667,435	13.4
Other governments / other bilateral	86,880	2.3		
The Global Fund to Fight AIDS, TB and Malaria	205,303	5.4	346,839	7.0
UNAIDS Secretariat			3,000	0.1
United Nations Population Fund (UNFPA)	7,288	0.2	6,335	0.1
PSI (Population Services International)			157,700	3.2
Other International not-for-profit organizations and foundations	42,379	1.1	105,853	2.1
Grand Total	**3,768,103**	**100.0**	**4,962,635**	**100.0**

Source: Draft NASA report 2012-2013

When looking at the HIV expenditures by beneficiary populations in 2013, it can be noted that the most part of the HIV spending benefits the PLHIV (44.2%) and the General Population (44.1%). The preliminary data indicates that a small portion is spent on key populations: Female SW (2.2%) and MSM (1.2%).[22]

TABLE 8: HIV EXPENDITURES BY BENEFICIARY POPULATION

Beneficiary Population	2012	%	2013	%
PLHIV not disaggregated by age or gender	2,146,680	57.0	2,191,014	44.2
Injecting drug users (IDU) and their sexual partners			4,000	0.1
Female SW and their clients			108,853	2.2
MSM	7,963	0.2	60,907	1.2
Orphans and vulnerable children (OVC)	12,858	0.3	60,951	1.2
Children born or to be born of women living with HIV	112,811	3.0	141,381	2.8
Children and youth living in the street			3,500	0.1
People attending STI clinics	22,220	0.6		
Health care workers			17,500	0.4
Female adult population			129,900	2.6
Youth (age 15 to 24 years) not disaggregated by gender	180,000	4.8		
General population not disaggregated by age or gender	935,139	24.8	2,190,980	44.1
Non-targeted interventions	246,556	6.5		
Specific targeted populations not elsewhere classified	103,877	2.8	53,650	1.1
Grand Total	**3,768,103**	**100.0**	**4,962,635**	**100.0**

Source: Draft NASA report 2012-2013

22 Not all international sources were included for the key populations

3.2 Prevention of the further spreading of HIV

In the past years many prevention measures have been conducted reaching the general population by means of mass media campaigns as well as an increased focus on targeted key populations. As part of the behavioral change strategy, key populations, such as MSM, SWs and youth were reached primarily by means of outreach services.

The structural integration of the HIV program, as promoted by the MoH, has included the increasing programmatic uptake of HIV prevention in the TB and MCH programs and the linkage with the STI program of the Dermatology Services (DD). The integration of HIV prevention in healthy lifestyles initiatives as part of the chronic diseases/NCD program is taking form through the health information center Libi! and the One-Stop-Shop for chronic diseases. To reach key populations in the interior, such as gold miners, SWs and migrants, a linkage was established with the Malaria program to provide HIV prevention services through this program.

Key populations

SWs and MSM

Outreach activities for SWs and MSM are carried out by specific NGOs and include individual counseling, group sessions, HIV prevention education, condoms and lubricants distribution and referral to HIV/STI and other services. Outreach services for SWs in the gold mines are conducted in collaboration with the malaria program. It appears that over time a decrease of the HIV prevalence of SW in Paramaribo can be noted with BSS data showing prevalence of 24.1% in 2005 to 7.2% in 2009 and to 5.8% in 2012, indicating successful implementation. [23] [24] In addition, the target group seems to have knowledge about prevention of HIV (96.5%), HIV testing behavior (82.7%) and condom use (90%), although consistent and correct use of condoms still seems to be an issue.[25] However, there is still a higher prevalence among SWs than the general population, confirming the fact that SWs should still be a priority group for targeted HIV prevention activities.

TABLE 9: SUMMARY OF SW DATA FROM BSS STUDIES CARRIED OUT IN 2005, 2009 AND 2012 IN PARAMARIBO

SW Data	2005	2009	2012
Seroprevalence			
Street and Club	no data	Total SW: 7.2% (N=231) ; FSW: 3.8% (n=236); MSW: 69.3% (n=13)	Total SW: 5.8% (N=191); FSW: 3.8% (n=178); MSW: 30.8% (n=4)
Street	Total SW: 24.1% (n=241); FSW: 21.1% (n=194); MSW: 36.2% (n=47)	Total SW: 15.7%	no data
Received information	no data	63.4% had never heard about SMLA (street). 66% (in clubs) had never heard of SMLA.	26.2% received info about HIV/AIDS in the previous year.
Condom distribution	The majority obtained condoms at Maxilinder.	< 70% received free condoms in the year prior to the interview.	80.1% received free condoms in the year prior to the interview.

23 BSS and Sero-prevalence among SW in Paramaribo 2005
24 BSS and Sero-prevalence among SW in Paramaribo 2012
25 BSS and Sero-prevalence among SW in Paramaribo 2012, 40.4% of the SWs experienced a condom failure.

SW Data – cont'd	2005	2009	2012
Condom Use			
Consistent use	71.8% used a condom during last sex with client (overall). 25% indicated consistent condom use.	96% reported consistent condom use (during the month prior to interview).	89.9% reported consistent condom use with clients (in the month prior to the interview).
Correct Use	no data	93.5% experienced condom failure (break).	40.4% experienced condom failure.
Source	72% received condoms from Maxilinder, 17% pharmacy and 10% supermarket	49.2% got their condoms from the supermarket. 23.3% at SMLA (street workers) 19.3% at the club (club workers).	37.2% got their condoms at the supermarket. 14.2% at the pharmacy. 24.3% at the club/bar (where they worked).
Age			
Age group	40% 15-24	72.8% 20 - 34 year	No data
Average age	29	30	29.3
Range	15-61	18 – 55	17 – 51
Knowledge of HIV			
Correctly identified using a condom as the most effective way to prevent HIV infection	No data	No data	96.50%
Correctly identified two ways to prevent HIV infection	0.75	No data	No data
Correctly identified using a condom and abstinence as the best way of preventing sexual transmission of HIV and who reject 3 major misconceptions about HIV transmission	no data	no data	66.50%
Risk perception	31.5%	61.70%	57.20%
Drug use	51% (n=241) using drugs of which 64% currently using marijuana and 9% currently using cocaine	16.6% used cocaine; 17.8% has used marihuana; 11% reported using marihuana at the time of the study; 7% reported using cocaine at the time of the study. 2 respondents reported injecting drugs at the time of the study.	No data
Testing behavior	60% had been tested before the survey.		82.7% had taken a HIV test in the year preceding the interview.

Source: HIV Epidemiological Profile in Suriname, 2000-2013

The HIV prevalence among MSM is still much higher than the general population, with a tested HIV prevalence of 6.7% in 2005 and a self-reported prevalence of 5.4% in 2014[26] [27] When looking at BSS

26 Maxilinder Foundation, University of Suriname. 2005. An HIV-seroprevalence and behavioral survey among men-who-have-sex-with-men (MSM) in Suriname.

27 MSM self-reported prevalence of 5.4% in 2014.

studies conducted among MSM in 2005 and 2011, a decrease can be noted in consistent condom use, 82% in 2005 and 57.1% in 2012 and also a decrease in HIV knowledge, 80% correctly identified 2 common misconceptions in 2005 and only 57.3% in 2011 and the risk perception decreased from 50% in 2005 to 9.6% in 2011. In addition, in a recent needs assessment among MSM in 2014, 44% of the men interviewed in 2013 (N=208) indicated being attracted to both men and women and 28% having multiple sex partners, the need to focus on this target group remains[28]

TABLE 10: SUMMARY OF MSM DATA FROM BSS STUDIES CARRIED OUT IN 2005 AND 2011 IN PARAMARIBO

MSM Data	2005	2011
Seroprevalence	6.7% (n=329)	9.2% (n=65)
Outreach		
Info received		87.5% were exposed to at least one form of outreach in the past year.
Condom use		
Sources condoms		62. % received condoms (33.2% from SMU, 16.9% from RGD, 8.3% NAP)
Consistent condom use	82% used condom during anal sex with non-commercial partner	57.1% used a condom every time they had sex with non commercial partner. 17.4% had unprotected sex with a women and unprotected sex with a man during the last 6 months.
HIV knowledge		
Correctly identified using a condom as the most effective way to prevent HIV infection		73%
Correctly identifies 2 common misconceptions	80%	57.30%
Risk perception	50.00%	9.60%
Drug use	67% never used; 16% (54 respondents) using drugs at time; 88 respondents have ever or using marihuana; 12 experimented with cocaine; 5 with XTC, 1 with amphetamines; 4 ever injected drugs	
Testing behavior	40% tested before the survey	61.1% tested before the survey

Source: HIV Epidemiological Profile in Suriname, 2000-2013

Outreach services implemented under the Global Fund's HIV Transitional Funding Mechanism (TFM) and CVC/COIN of the Vulnerabilised Group component of the PANCAP R9 Global Fund Grant continued to be the main HIV prevention services for SW and MSM. The estimated number of MSM in Paramaribo is 1,317 and for the total of Suriname 5,000 (when taken the wider definition of MSM into account) at the end of 2011.[29] In 2014, 31.3% of MSM in Paramaribo were reached with outreach services. The estimated number of SW in Suriname at the end of 2010 is 2,228[30]; 59% have been reached with outreach services. To support these outreach services, a draft manual on outreach for MSM and SWs and IEC material for MSM have been developed in 2014 under the GF's TFM.

28 Arkel van, Z., & Sumter, T. (2013). Public Awareness and acceptation, special confidential (health) services, HIV knowledge, multiple condom distribution points and other needs: draft report of an assessment of needs of MSM and transgenders in Suriname. Paramaribo: De bron Centrum voor Leren en Ontwikkeling.

29 Marieke Heemskerk et al 'A Size Estimation of Men-Who-Have-Sex-With Men (MSM), residing in Paramaribo, February 2011', page 32,

30 Stijnberg, D, 'Looking for Sex Workers in Suriname; an evaluation of methods to estimate the size of Sex Workers in Suriname, 2012', page 47

Youth

Organizations such as the Youth Advocacy Movement (YAM) and a Youth Advisory Group (YAG) and several other NGOs provide HIV prevention outreach services to schools in targeted communities. When observing the sexual behavior of this group, studies implemented in 2012 and 2013 among youth show that about 80% of the persons, between 15-24 years of age, were sexually active with 15 years as the average age of first sexual encounter. Looking at the MICS 2010, 10.1% of age group 15-19 year and 9.0% of 20-24 years reported sex before the age of 15; with the highest percentage being found in the interior (33.4%) compared to the urban(6.8%) and coastal (9.3%) areas (Bureau of Statistics, Ministry of Social Affairs and Housing, 2012). In some villages in the rural interior e.g. Trio indigenous village of Kwamalasamutu there is even mention of sexual initiation at the age of 9.[31] Although youth (15-24 year) from rural interior (Brokopondo and Sipaliwini) have higher percentages of sex before age 15 and sex with multiple partners, they seem to have less knowledge regarding HIV and also the use of condoms is much lower than in the urban or coastal areas (MICS 2010). The comprehensive HIV knowledge in the age group 15-24 year in the MICS was low (42%) with the rural interior (Sipaliwini and Brokopondo) being the lowest (24.1%). In regards to testing it should be noted that 91% of the 15 – 24 year old knew places where to get tested but only 63% ever had an HIV test done (Bureau of Statistics, Ministry of Social Affairs and Housing, 2012).

In regards to condom use, in the CARISMA study of 2013, a remarkable difference between boys and girls was found. Although both seem to have equal access to condoms, boys seem to walk more frequently with condoms (36% of boys compared to 84% of interviewed girls who said never to walk with condoms); also the boys use it more frequently (82% of boys compared to 19% of girls ever used a condoms). Looking at girls with more than 1 partner and the use of condoms at their last sexual encounter, the MICS reports on average 39% using a condom with the interior having a lower percentage of use.

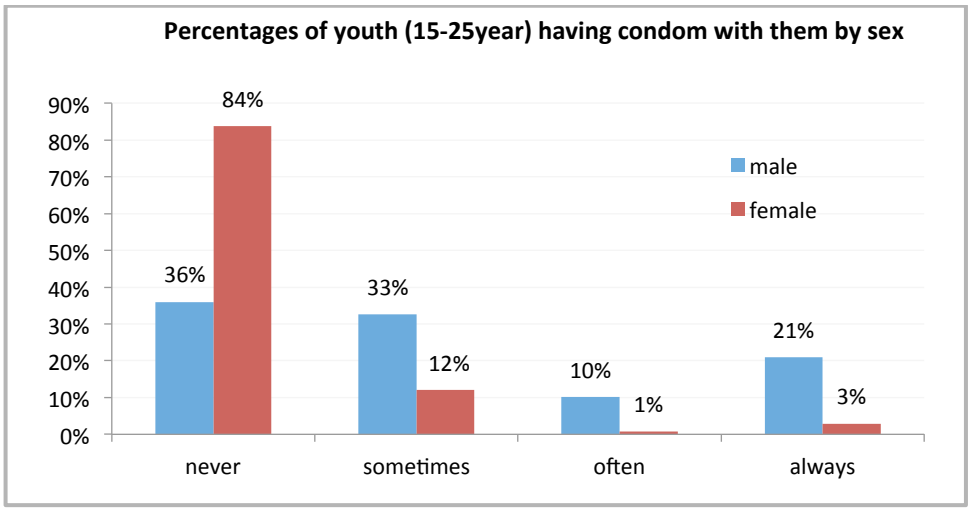


FIGURE 13: PERCENTAGE OF YOUTH (15 - 25) HAVING CONDOM WITH THEM BY SEX, 2013

Source: CARISMA study, 2013

Furthermore, the number of teenage pregnancies (1 in every 6 live births has a teenage mother) is also an indication of the risk for HIV youth are exposed to. Looking at the HIV cases diagnosed, 14% were between the ages 15 to 24 years, with the majority being of either Creole or Maroon descendent. Based on these data, there is a need to further expand HIV prevention services for the youth.

31 Heemskerk, M, State of the Art Diagnosis on Comprehensive Sexuality Education Final report

Migrants

An estimated number of 20.000 Brazilian migrants are active in the Surinamese goldmines [32]. From 2010, Suriname participated in the Regional 'PANCAP Migrants Project' to improve access to HIV services for mobile and migrant populations.[33] In the implementation phase (2013-2014) IEC material specifically aimed at Brazilian migrants was developed and distributed. Surinamese governmental employees from both health and non-health sector were trained in 'Stigma and Discrimination, Cultural Sensitivity and Human Rights related to Health and Migration'. To ensure continuity of this process of sensitization to migrant specific issues under service delivery personnel, this training was concluded by a Training of Trainers. HCW of specific health services were also trained to improve migrant friendly services. To further improve migrant friendly services the 'Malaria clinic for migrants' in Paramaribo has started to extend services to HIV testing and counseling.

Condom distribution

The distribution of condoms has been expanded via a wide range of distribution points throughout the country, free of charge through the information center 'Libi!'. The number and type of distribution outlets, such as taxi stands, barber shops and particularly short stay hotels have increased over time and linkages with other programs such as the malaria and TB programme have been established to reach key populations. NGOs working with MSM, SWs, youth and other key populations are collecting condoms on a regular basis to distribute them further and the Regional Health Services (RGD), Medical Mission and Malaria program collect condoms to distribute them through their large network of clinics in the coastal area as well as in the interior and gold mining areas. Distribution of free male condoms increased from1.178.043 in 2012 to 1.196.382 condoms in 2013. Distribution of lubricants increased to 194.460 in 2013. Distribution of female public condoms increased from 15.000 in 2012 to 40.000 in 2013.[34]

HIV testing

HIV testing is widely available throughout the health system. People can get tested at either hospital or private laboratories and since the introduction of VCT in 2005, also at one of the 11 VCT sites. From the 182,139 HIV tests done from 2005 – 2011, the majority was done at the hospital (40.8%) followed by the private laboratories (29.8%) and the VCT sites (22.8%).

TABLE 11: NUMBER OF HIV TESTS DONE BY LABORATORY TYPE, 2005 – 2011

Lab Type	Frequency	Percentage
Hospital	74.358	40.82
Private	54.409	29.87
VCT	41.646	22.86
Medical Mission	9.504	5.22
Unknown	2.222	1.22
Total	182.139	100%

Source: National HIV Test database, M&E Unit, MoH 2014

The revision of HIV testing and counseling guidelines and the use of rapid testing have both contributed significantly to the scaling-up and expansion of services. VCT personnel are trained regularly and there is a quality control system in place for VCT sites. The number of performed HIV tests

32 De Ware Tijd, March 5, 2012
33 PANCAP. Final reports PANCAP Migrant project (4): component 1-4 with ppt for component 1 and 2
34 NAP, Libi Information Center, 2012 and 2013

increased from 2,535 to 26,070 yearly done in the period 2000 to 2011. The vast majority (74%) of these tests were done among women. [35]

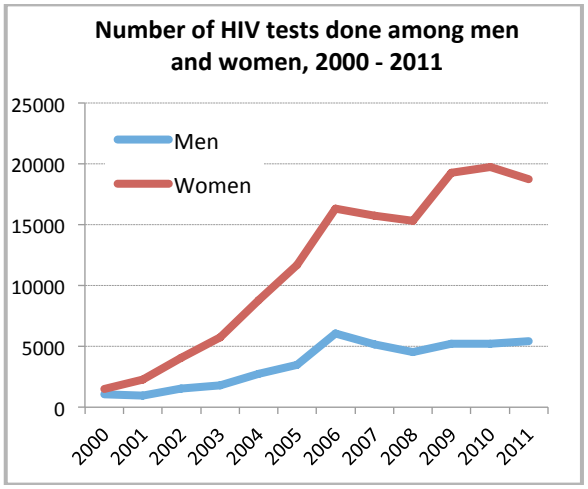


FIGURE 14: NUMBER OF HIV TESTS AMONG MEN AND WOMEN, 2000-2011

Source: National HIV test database, M&E Unit M0H 2014

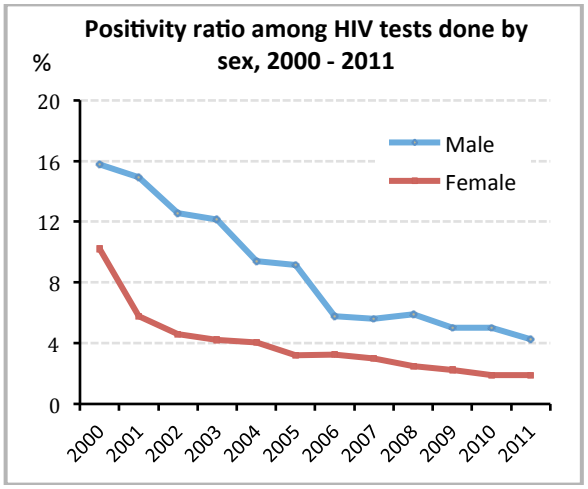


FIGURE 15: POSITIVITY RATIO AMONG HIV TESTS DONE BY SEX, 2000-2011

Source: National HIV test database, M&E Unit MoH 2014

The percentage of tests with a positive diagnosis declined between 2000 and 2011, from 16% to 4% and 10% to 2% for men and women, respectively. Of the persons tested, most were of Maroon and the Creole descent, with a combined percentage of 49% (2000-2011). Comparing the test percentage with the ethnic compositions among the general population, than except for the Maroon and Creole populations, all ethnicities appear to be underrepresented. [36]

TABLE 12: HIV TEST PERCENTAGE BY ETHNICITY, 2000-2011

Ethnicity	Un-known	Neg	Pos	Total	Test percentage 2000-2011 (%)	Ethnic composition according to Census 2012 (%)
Caucasian		14		14	0.01	--
Chinese	5	1680	5	1690	0.90	1.5
Creole	291	49242	3107	52640	27.97	15.7
Mixed		654	5	659	0.35	13.4
East Indian	152	29121	537	29810	15.84	27.4
Amer-Indian	16	4439	206	4661	2.48	3.8
Javanese	68	15968	135	16171	8.59	13.7
Maroon	207	36960	1771	38938	20.69	21.7
Other/Unknown	554	41788	1292	43634	23.18	3.0
Total	**1293**	**179866**	**7058**	**188217**	**100.00**	**100.00**

Source: National HIV test database, M&E Unit MoH, 2014

35 National HIV Test Database
36 National HIV Test Database

STI s

The reporting of STI by different primary care providers, are done according to the syndromic approach. Data comes from 3 sources:

- Medical Mission, which provides primary care in the interior
- BOG through a "telefonade" (sentinel surveillance system) which includes information from 25 sentinel stations mostly from the Regional Health Services (RGD). The RGD is responsible for primary care in the coastal area. Some private family doctors are also part of this surveillance system.
- Dermatological Services from the MoH; all STI patients are screened for HIV and a VCT site is part of the services offered here.

TABLE 13: SYNDROMIC REPORTING OF STI'S, 2004 – 2012

YEAR	Genital Ulcer			Genital discharge			Genital warts	Total
	MZ	DD	BOG	MZ	DD	BOG	MZ	
2004	52	53	61	916	110	1315	20	2527
2005	34	28	60	528	111	1051	15	1827
2006	34	26	88	497	402	1076	33	2156
2007	18	47	25	457	440	742	8	1737
2008	87	32	29	420	494	617	3	1682
2009	29	170	5	402	146	574	8	1297
2010	20	107	4	368	146	551	14	1210
2011	13	111	11	301	101	443	4	984
2012	13	101	9	294	150	447	4	1018
Total	271	675	292	4183	2100	6816	101	14438

Source: BOG, Epidemiology department

Data from the Dermatological Services from 2009-2012 presented in the table above differs from earlier reported cases. For genital ulcers the indicator reported in these years were the positive Lues cases (VDRL (positive) and TPHA (reactive)) and for genital discharge the cases presented here were positive for gonorrhea culture. This indicator thus gives a good indication of Lues positive cases.

eMTCT program

Suriname has committed itself to the 'Elimination of Vertical Transmission of HIV' and officially launched the PMTCT programme nationwide in 2009, which also includes Hepatitis B and syphilis. To upscale the development and implementation of *e*MTCT various measures were taken in recent years, such as the establishment of a coordination structure and focal point system, the development of an *e*MTCT framework with the inclusion of a four prong approach and these measures were continued in 2014.[37] [38] HIV testing is provided to all pregnant women and ART for all HIV positive women and their babies. In the national guidelines of 2010, option B is the recommended PMTCT option, however in a small number of MCH sites, option B+ is used. In the next round of revision of treatment guidelines, option B+ will be the recommended PMTCT option.

37 eMTCT framework
38 National Safe Motherhood and Neonatal Health Action Plan

From 2002 till 2012, an increase is seen of the percentage of HIV positive pregnant women who received ART from 64% in 2006 till 92.8% in 2013. [39]

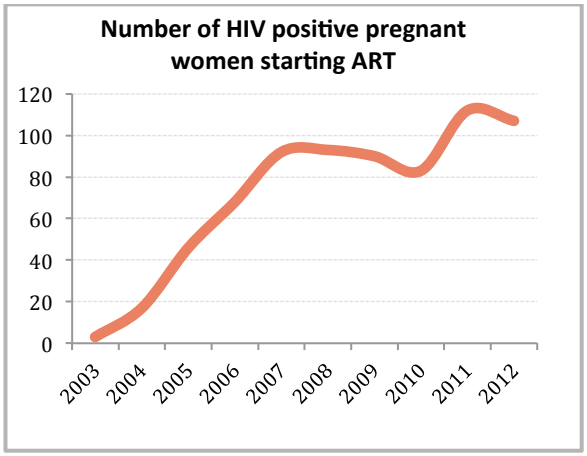


FIGURE 16: NUMBER OF HIV POSITIVE PREGNANT WOMEN, STARTING ART 2003-2012

Source: National HIV treatment, PMTCT Focal point surveillance

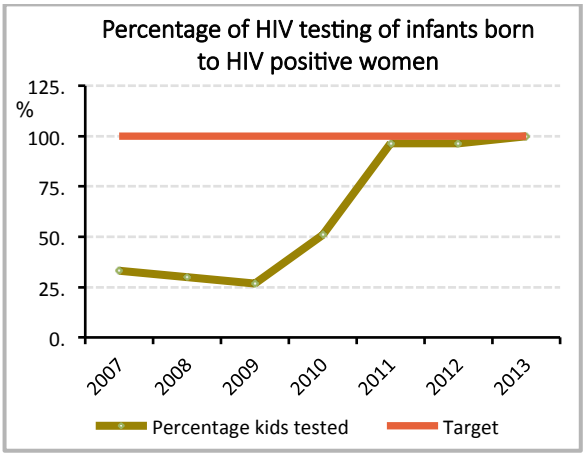


FIGURE 17: PERCENTAGE OF HIV TESTING OF INFANTS BORN TO HIV POSITIVE WOMEN, 2007-2013

Source: PMTCT database, National database, M&E Unit 2013

In 2011 and 2013 all infants born to HIV positive mothers have received ART; in 2012 there was a challenge to provide 2 infants with prophylaxis due to a system failure and they both died at the age of 3 months. HIV testing of infants born to HIV positive women has increased from 33% in 2007 to 100% in 2013, reducing the children lost to follow up / not tested enormously. [40] [41] After delivery, HIV positive women are provided with parlodel tablets and infant formula. Infants born to HIV positive women are tested for HIV according to the national protocol and are monitored by the focal point system up until the second PCR test. All these measures have resulted in a decrease in the reported rate of MTCT of HIV from 12.5% in 2007 till 1.9% in 2011. In 2012, an increase was registered to 4.6%.[42] For 2013, there has not been a report of an HIV infected baby born to HIV positive mothers.

Pregnant women are tested for Hepatitis B and Syphilis, however there is no comprehensive system in place to capture these data. This will be addressed in the 2014-2020 NSP.[43]

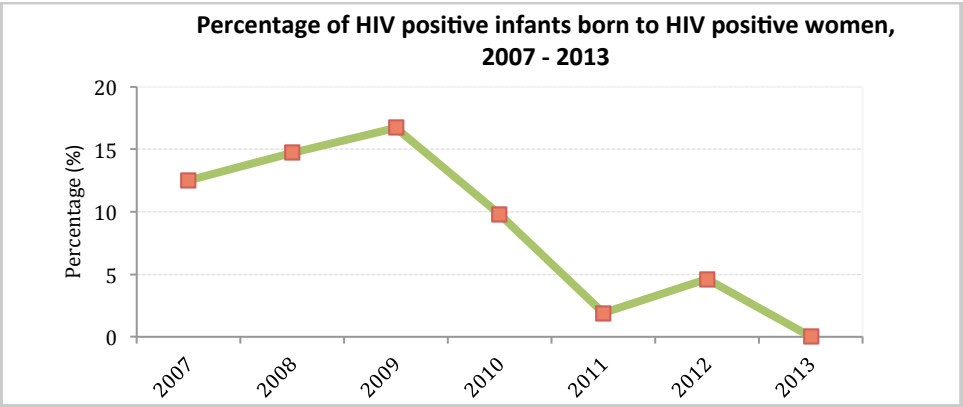


FIGURE 18: REPORTED RATE OF MTCT OF HIV; PERCENTAGE OF INFANTS BORN TO HIV POSITIVE MOTHERS WHO TESTED POSITIVE FOR HIV, 2007-2013

Source: PMTCT database, National PMTCT focal point surveillance

39 M&E Unit, Ministry of Health. 2014. HIV Master database.
40 M&E Unit, Ministry of Health. 2014. HIV Master database.
41 PMTCT focal point surveillance.
42 PMTCT focal point surveillance.
43 2014-2020 NSP pg 34, 11.1.6 and 11.1.8

Screening

Screening of Blood Donors

The policy of the Blood Bank in Suriname is to strive for optimum safety of the blood supply, through a focus on fixed voluntary donors and screening of each donor. Each new blood donor (the so-called First Time Donors) that tests positive in the HIV screening test is immediately discharged from the list of blood donors and their donation is also destroyed. The quality of blood products is guaranteed through close cooperation with the MoH, the International Red Cross, the PAHO, the Sanquin Blood Supply Foundation, the Public Health Agency of Canada, the National External Quality Assessment Scheme (NEQAS) in England and the International Consortium for Blood Safety (ICBS) in Brazil (Blood bank, 2014). National and international developments in guaranteeing the quality of blood products are closely followed and on January 10, 2014, the Blood bank of the Suriname Red Cross was formally presented with the official ISO 9001 -2008 certificate by the National Certification Commission of the Ministry of Trade and Industry.

The HIV sero-prevalence among blood donors is 0.022%. The positive tests in the table include donations from both active and new donors and the percentage positive tests are highest among new donors.

TABLE 14: HIV SERO PREVALENCE AMONG BLOOD DONORS, 2004 - 2013

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Total
Active blood donors	3,427	3,391	3,309	3,233	3,558	3,377	3,479	3,585	3,620	3,477	34,456
New blood donors	789	447	411	406	469	582	456	557	441	474	5,032
Total number of blood donors	4,216	3,841	3,720	3,639	4,027	3,959	3,935	4,142	4,061	3,951	39,491
Total number of blood donations	7,627	7,242	7,881	8,925	9,685	10,063	10,180	10,128	10,015	10,102	91,848
HIV 1/2/0	1	1	1	0	1	1	3	0	3	1	12
HTLV 1/2	0	0	0	0	0	2	1	0	3	1	7
Hepatitis B	1	1	1	0	0	5	5	2	2	6	23
Hepatitis C	0	3	0	4	0	4	3	2	1	3	20
Malaria	0	0	0	1	0	0	0	0	0	0	1
Syphilis	1	0	1	0	0	4	3	6	0	3	18
Chagas	-	-	-	-	-	-	-	4	0	0	4
HIV prevalence among active blood donors (%)	0.024	0.026	0.027	0.000	0.025	0.030	0.057	0.000	0.055	0.000	0.022

Source: De Nationale Bloedbank, Surinaams Rode Kruis 2014

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%.

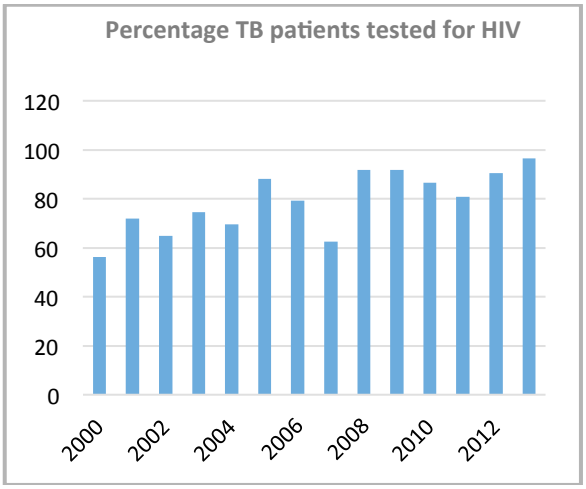


FIGURE 19: % OF TB PATIENT TESTED FOR HIV, 2000– 2013

Source: National Tuberculosis Programme, 2014

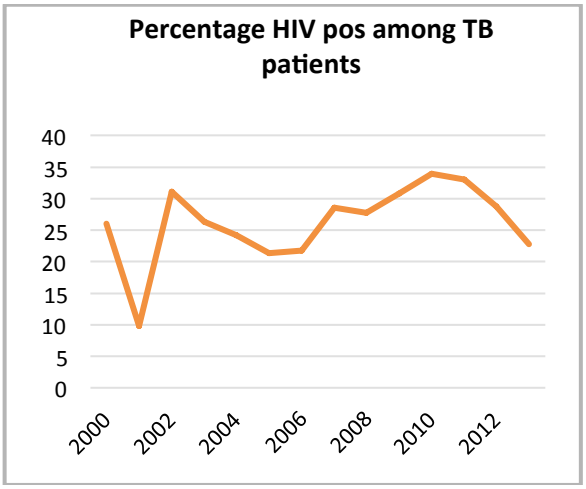


FIGURE 20 : HIV PREVALENCE AMONG TB PATIENTS, 2000-2013

3.3 Treatment, Care and Support

Suriname has chosen a decentralized HIV care model starting from 2005, meaning that in principle all physicians from the Medical Mission, RGD, private clinics and hospitals can prescribe treatment and provide other treatment services to HIV patients. In 2010, 102 health facilities provided ART with an average of 11 ART patients per facility.[44] In addition to the decentralized model, sustainable mechanisms were introduced to ensure free access to ARVs for all HIV positive persons. ARVs were placed on the Essential Medicines List and are financed by the government.

Adults and Children on ART

Since the availability of ARV in Suriname, the number of people receiving treatment has increased. According to the national protocol, initiation of treatment is still at CD4<200, however the MoH will update the protocol according to Treatment 2.0 strategy. In 2015, initiation of treatment will start at CD4<350 and as per in 2017, initiation will start at CD4<500. The Government will finance the cost related to ARVs as well as cost related to HIV laboratory services.

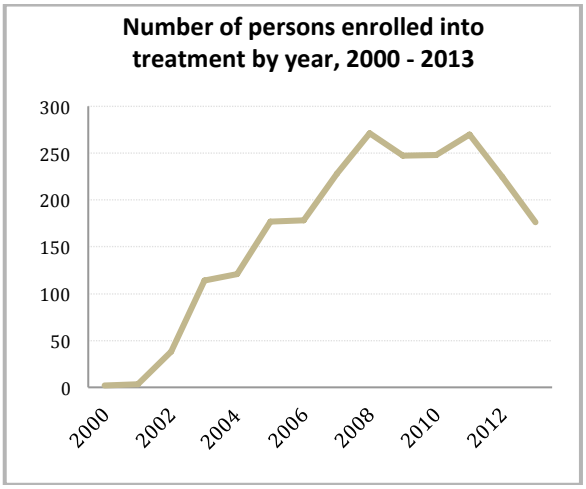


FIGURE 21: NUMBER OF PERSONS ENROLLED INTO TREATMENT, 2000-2013

Source: HIV Master database MoH, 2014

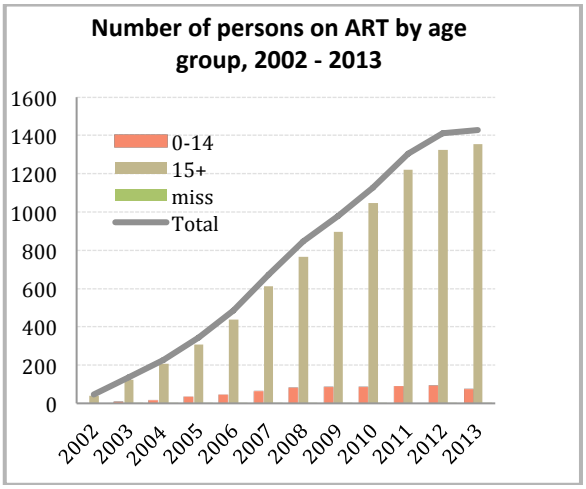


FIGURE 22: NUMBER OF PEOPLE ON ART BY AGE GROUP, 2002-2013

Source: HIV Master database, MoH, 2014

44 PAHO/WHO. 2013. Anti-Retroviral Treatment in the Spotlight: A Public Health Analysis in Latin America and the Caribbean.

From 2000 to 2013, a cumulative number of 2,139 PLHIV (15 and older) have started ART.[45] Unfortunately 37 % [46] of those are now LTFU without documented reason. This will be researched to improve retention in care and HIV treatment outcomes. When observing the differences in the sexes, it seems that until 2011 almost as much men as women yearly enrolled into treatment, while in the last 2 years almost twice as much men compared to women yearly enrolled into treatment. [47]

The number of children (<15 years) enrolled in treatment has been declining, at the end of 2013, there were 71 children on treatment. Children yearly enrolled into treatment, increased to a maximum of 26 in 2008; from 2009 on, the yearly numbers declined to only 6 children enrolled into treatment in 2013. Of children enrolled from 2001 to 2013, 83 (52%) were still on treatment in 2013. About one third of the children enrolled into treatment from 2001 to 2013, were younger than 1 year at time of the enrollment. [48]

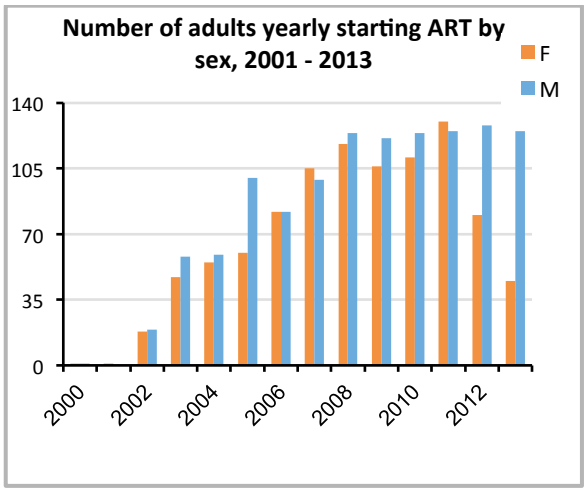


FIGURE 23: NUMBER OF ADULTS (>14 YEARS) YEARLY STARTING ART BY SEX, 2000-2013

Source: HIV Master database MOH, 2014

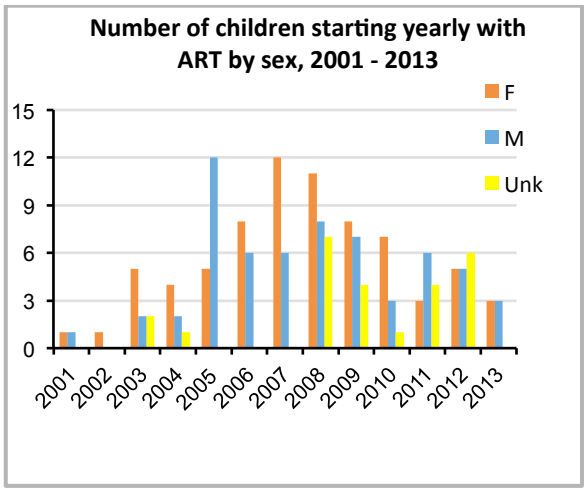


FIGURE 24: NUMBER OF CHILDREN (<15 YEARS) YEARLY STARTING ART BY SEX, 2000-2013

Source: HIV Master database MOH, August 2014

Psycho-social support

The psycho-social support system has been centrally coordinated by the MoH and the services provided by community health workers (HIV-buddies) and HIV adherence counselors (peer counselors) continued during 2014. The number of buddies and counselors are currently not sufficient and this will is addressed in the new HIV NSP 2014-2020.

TB and HIV program collaboration

Collaboration between the TB and HIV program has been initiated: working relationships between the internal medicine specialists treating HIV patients and the pulmonologist treating TB patients have been established; an ad-hoc TB/HIV workgroup was formed in 2013, but is not active anymore. Plans are undertaken to install a TB/HIV committee to plan and monitor TB/HIV collaborative activities. International guidelines will be used as reference to develop national TB/HIV collaborative guidelines. The implementation of the 12 TB/HIV collaborative activities as of 2014 is listed in the table below.

45 MoH, Suriname Epi- profile,pg 24, 2014
46 MoH, Suriname Epi- profile,pg 24, 2014
47 M&E Unit, Ministry of Health. 2014. HIV Master database.
48 M&E Unit, Ministry of Health. 2014. HIV Master database.

A. Establish and strengthen the mechanisms for delivering integrated TB and HIV services	**A.1.** Set up and strengthen a coordinating body for collaborative TB/HIV activities functional at all levels	Initiation started in 2013, but structure is inactive. It will be reactivated in 2015
	A.2. Determine HIV prevalence among TB patients and TB prevalence among PLHIV	HIV prevalence among TB patients is known. No structured data collection of TB among HIV patients. This will be addressed in this Concept Note.
	A.3. Carry out joint TB/HIV planning to integrate the delivery of TB and HIV services	Currently only ad hoc planning exists. Joint planning started with the Concept Note. It will be institutionalized under a single TB/HIV manager that will be appointed.
	A.4. Monitor and evaluate collaborative TB/HIV activities.	Indirectly done by analyzing HIV and TB data separately. Will be analyzed jointly in the future. TB and HIV databases will be linked and joint frame of analysis designed
B. Reduce the burden of TB in PLHIV and initiate early antiretroviral therapy (the Three I's for HIV/TB)	**B.1.** Intensify TB case-finding and ensure high quality anti-tuberculosis treatment	Clinical algorithm was drafted, but the monitoring of its implementation at the primary care level is not fully implemented. At secondary level; every HIV patient is actively screened for TB but the system lacks a proper tool to compile the data about the activity. It will be part of the effort to jointly analyse the data.
	B.2. Initiate TB prevention with Isoniazid preventive therapy and early antiretroviral therapy	TB guidelines address recommends early ARV treatment PLHIV and TB. This is followed by the clinicians but there is a lack of a proper tool to compile the data about the activity. Guidelines for IPT exist in the TB Guidelines but are not followed regularly.
	B.3. Ensure control of TB Infection in health-care facilities and congregate settings	No proper infection control policy in place. Will be addressed by both the TB and HIV NSPs. With technical support from PAHO. Priorities for the Sanatorium and ambulatories receiving HIV and TB patients.
C. Reduce the burden of HIV in patients with presumptive and diagnosed TB	**C.1.** Provide HIV testing and counseling to patients with presumptive and diagnosed TB	> 90% of all TB patients (confirmed and presumptive TB) are tested for HIV. Most of the patients with early dead are not being tested. This will be improved. The staff of the TB program is trained in PITC. HIV Counseling and testing of TB suspects will be conducted at the NTP according to new NSP and this Concept Note.
	C.2. Provide HIV prevention interventions for patients with presumptive and diagnosed TB	TB patients are offered condoms at the national tuberculosis program. PITC will be introduced. Currently patients with TB diagnosed and presumptive are referred for HIV testing. There is room for improvement, especially the social support aspects that will be addressed jointly with the HIV social support care system created with the support of this Concept Note.
	C.3. Provide co-trimoxazole preventive therapy for TB patients living with HIV	Only provided at CD4<200. Will be expanded to all TB/HIV patients.
	C.4. Ensure HIV prevention interventions, treatment and care for TB patients living with HIV	Needs to be better structure and strengthened. Currently it consist of HIV testing in the laboratory and condom distribution a at TB clinic for TB patients. HIV testing and counselling will be implemented at the TB clinic.
	C.5. Provide antiretroviral therapy for TB patients living with HIV	There is a lack of information and there is a need for systematic capture of the information. Another component of the joint analytical system.

TABLE 15: IMPLEMENTATION STATUS 12 TB/HIV COLLABORATIVE ACTIVITIES

Source: HIV NSP, 2014 - 2020

In the years 2000-2013, the percentage of TB patients screened for HIV increased from 56% to 97%. The highest percentage of positive was noted in 2010 with 33.5% which decreased to 22.6% in 2013. Of the TB patients 58% received anti-retroviral therapy during TB treatment in 2013.[49] There is no surveillance data available of TB screening in HIV patients.

Laboratory services

To ensure timely access to services for HIV positive persons, laboratory services for the clinical management of HIV have been extended. CD4 testing, viral load testing and HIV RNA-PCR and HIV DNA-PCR for early infant diagnosis are available in country and operational expenses are covered by the MoH. There are agreements with laboratories outside of Suriname to have them accept HIV genotype testing from Suriname against current rates

Early Warning Indicators

For the Early Warning Indicators (EWI) the data is not analyzed by site but at the national level taking patients from all clinics into account.

TABLE 16: RESULTS EARLY WARNING INDICATORS 2-5 FOR 2007-2012

EWI		2007	2008	2009	2010	2011	2012
2. Retention in Care	Num	182	219	216	215	242	185
	Den	228	271	247	248	270	225
	Perc (%)	***79.82***	***80.81***	***87.45***	***86.69***	***89.63***	***82.22***
3. Pharmacy Stock-outs	Num			1	5	2	10
	Den	12	12	12	12	12	12
	Perc (%)			***8.33***	***41.67***	***16.67***	***83.33***
4. ARV Dispensing practices	Num	0	0	0	0	0	0
	Den	228	271	247	248	270	225
	Perc (%)	***0.00***	***0.00***	***0.00***	***0.00***	***0.00***	***0.00***
5. Viral Suppression at 12 months	Num		4	32	75	108	79
	Den	0	4	41	98	138	111
	Perc (%)		***100.00***	***78.05***	***76.53***	***78.26***	***71.17***

Source: HIV Epidemiological Profile, 2000-2013

The retention in care of people one year after starting ART was on average 85% from 2007 to 2012 with almost no change in these years. For the pharmacy stock-outs, data from the national dispensing agency is used.[50] The months without stock-out have gone from 1 in 2007 to 10 in 2012.

The viral suppression was only calculated on the persons having a VL result available at 12 months after initiation of ART. A decline in persons virally suppressed (<1000 copies/ml) can be noted.

49 MOH. 2014. National TB programme surveillance.
50 Not all stock-outs also lead to an interruption of medication to the patients as the pharmacies could still hold stocks.

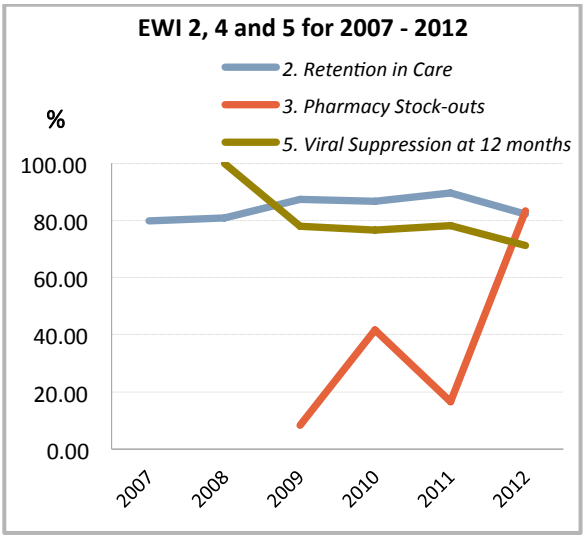


FIGURE 25: RETENTION IN CARE, PHARMACY STOCK-OUTS AND VIRAL SUPPRESSION AT 12 MONTHS, 2007-2012

Source: HIV Epidemiological Profile, 2000-2013

TABLE 17: RETENTION IN CARE, PHARMACY STOCK-OUTS AND VIRAL SUPPRESSION AT 12 MONTHS, 2007-2012

EWI Color Score card for 2012			
INDICATOR	2012	TARGET	COLOR
1.On-time pill pick-up	N.A	100	
2. Retention in Care	82	≤ 20	
3. Pharmacy Stock-outs	83	≥ 70	
4. ARV Dispensing practices	0	≥ 90	
5. Viral Suppression at 12 months	71	≥ 80	

Source: HIV Epidemiological Profile, 2000-2013

3.4 Pushing back the Stigma and Discrimination surrounding HIV

Stigma and discrimination (S&D) against the most vulnerable populations, including PLHIV, LGBT, SW and sexually active youth/adolescents, have continued to adversely affect universal access to treatment and care during the past years. A clear example of the extent of S&D experienced is provided by a recent needs assessment among MSM and Transgenders.[51] This assessment states that almost half of MSM experienced S&D based on their sexual orientation and that S&D was experienced most by the transgender group. In addition, S&D by health care workers and breaches of confidentiality were named as one of the common barriers to services.

In the MICS 2010, 56.9% of interviewed women responded that they would not buy fresh vegetables from a shopkeeper or vendor if they knew that the person had HIV. Although the data is from a couple years ago, it gives an indication that discriminatory attitudes towards PLHIV probably still exist.

The PANCAP 'Justice for All' program aiming of eliminating S&D in the HIV response to the Caribbean, was introduced in 2013 and currently the country is preparing the implementation of this program. A country consultation has taken place regarding the constitutional protection of persons living with HIV and key measures were proposed to ensure a proper legal environment that clearly defines discrimination and states all medical information as private and subject to protection. Additional measures were proposed to adjust the legal environment in such a way that sanctions can be taken against any organization or person, including the State, in case of discriminatory acts or a breach of confidentiality.[52]

3.5 Strategic information for policy and rendering of services

Suriname has increasingly worked to improve their data system. Over the past years, Suriname has put in efforts to set up a system that ensures the structural gathering of information on HIV testing,

51 Arkel van, Z., & Sumter, T. (2013). Public Awareness and acceptation, special confidential (health) services, HIV knowledge, multiple condom distribution points and other needs: draft report of an assessment of needs of MSM and transgenders in Suriname. Paramaribo: De bron Centrum voor Leren en Ontwikkeling.

52 Mohamed, P., Ministry of Health. 2014. PANCAP Justice for all consultations; phase 2 DRAFT country report.

treatment, hospitalizations and mortality. To achieve this, the Monitoring & Evaluation (M&E) Unit of the MoH was strengthened, specifically with regard to the collection of program data, integration of the different HIV data sources and the development of an HIV master database to support the implementation of case-based surveillance. In addition, a system has been initiated that gathers behavioral data of special groups by means of Integrated Biological and Behavioral Surveys. As a result, regular comprehensive reporting of routine program indicators on country progress on prevention and treatment and care, has improved. Further information on monitoring and evaluation is detailed in chapter 7 'Monitoring and Evaluation Environment'

3.6 Suriname HIV / AIDS Quick Reference Sheet 2004 – 2013

TABLE 18: SURINAME HIV / AIDS QUICK REFERENCE SHEET 2004 – 2013

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Number of registered HIV cases	478	573	781	749	657	612	532	526	510	473
AIDS hospitalizations **	255	239	206	204	214	212	234	200	191	
Women	*116*	*87*	*98*	*110*	*100*	*94*	*96*	*95*	*81*	
Men	*139*	*152*	*108*	*94*	*114*	*118*	*138*	*105*	*110*	
HIV Mortality	152	181	129	142	120	106	119	105	101	89
Women	*64*	*51*	*51*	*57*	*49*	*49*	*44*	*42*	*38*	*35*
Men	*88*	*130*	*78*	*85*	*71*	*57*	*75*	*63*	*63*	*54*
Number of people on ART	226	345	485	673	845	979	1128	1303	1410	1428
Adult	*209*	*311*	*441*	*614*	*768*	*899*	*1049*	*1220*	*1325*	*1357*
Children	*17*	*34*	*44*	*59*	*77*	*80*	*79*	*83*	*85*	*71*
Estimated HIV prevalence among adults (15 - 49 years) (UNAIDS) (%)	1.3	1.9	1.9	2.4	1.1	1.1	1.1	1.1	0.9	
HIV prevalence among TB patients (%)	24	21	22	29	28	31	34	32	29	23
HIV prevalence among SW in Paramaribo (%)	24.1					7.2			5.8	
HIV prevalence among MSM (%)		6.7								
HIV prevalence among children born out of HIV infected mothers (%)				13	15	17	10	2	5	0

Source: M&E Unit, MoH, 2014

4. Best Practices

Suriname continues to strengthen their response to the HIV/AIDS epidemic. Various initiatives have started and have been instrumental in strengthening of the response. Since these initiatives have not yet been evaluated on 'criteria' of best practices, Suriname considers them promising practices with the potential to become a best practice.

Effective leadership and governance structure

Country Coordinating Mechanism (CCM) Suriname was established to respond to the requirements and recommendations of the Global Fund. CCM Suriname has successfully submitted proposals to Global Fund with the recent example of the approval of a Malaria and a Joint TB/HIV Concept Note. CCM Suriname has played an important role in leading the process of Concept Note development as well as bringing together various stakeholders, including the key populations, to ensure a coordinated, multi-sectoral, country-led and country-driven approach during country dialogues. CCM has also been instrumental in bringing the different development partners and donors together for the national response for HIV, TB and Malaria.

Community-based outreach program

Outreach services to SW are provided by 2 NGOs in Suriname. New strategies, by the involvement of SW in the design and implementation of the intervention, have provided good results in the outreach for SW. The existing outreach services consist of Behaviour Change Communication (BCC), Condom distribution, Client-initiated testing & counseling and referral to services. Through the involvement of the SW, the BCC was changed; instead of providing education session during the night, these sessions were and continued to be provided either at home or in the morning hours. For the condom distribution, besides the usual distribution during outreach activities, additional distribution points have been established where the SWs come frequently e.g. hairdressers. In addition, information on distribution point for condoms has been communicated through an App. The outreach services are constantly evolving through the active involvement of the SW; a new approach is that at scheduled times outreach workers will be available for the target group at set places.

HIV treatment cascade

In 2013, Suriname started the process of cleaning and linking existing M&E databases; this has resulted that the individual data sources (VL/CD4/PCR results, PMTCT data, HIV testing and ART data) from the public and private sector have been linked together to establish a case-based surveillance system. The so-called HIV Master Index Database has made more complex analyses possible and has provided data in 2014 for the drafting of a HIV Epidemiological Profile document, including HIV treatment cascade.

Migrant project

Suriname was one of the countries participating in the PANCAP migrant project ' Improving Access to HIV Services for Mobile & Migrant Populations in the Caribbean' which effectively commenced in October 2010 with technical support of GIZ, EPOS Health Management and financial support of the German Federal Ministry for Economic Cooperation and Development. This project in which a multiple prong approach (legal, financial, community and health service delivery) was used to strengthen the conditions of migrants access to HIV prevention, treatment and care services in Suriname as well as other participating Caribbean countries, reached its peak in 2013 and 2014 with the implementation of different activities that came forth out of earlier legal, financial, social and health service delivery situational analysis reports.

As part of this project:

- The law on venereal diseases will be offered for amendment to remove barriers that were identified as preventing equal access of migrants to sexual and reproductive health services in Suriname.
- IEC materials (prints as well as auditory) aimed at Brazilian, and Chinese migrants where produced and distributed.
- The IOM adapted training 'Stigma, Discrimination, Cultural sensitization and Human Rights related to Health and Migration' was given to public service providers of mixed back grounds (health, defense, social affairs). The mixed background of the trainees lead to very fruitful discussions sensitizing them to hidden barriers in migrant services within their own organizations, as well providing insight in the different barriers each different professional group faced. Some individuals were also trained as trainer to help sustain transfer of this information in their respective organizations.
- A manual specifically aimed at sensitizing health care workers providing health services to migrants was developed.
- Focus group discussions were specifically developed for the healthcare workers, with the focus on healthcare delivery for migrants, exchange of experiences between health centers providing health services for migrants and exchange of knowledge on services provided by the health centers and NGOs. These trainings not only enhanced the understanding among the healthcare workers for the migrants, but also increased the knowledge on each other services and strengthened the relation among the healthcare workers themselves and the NGOs providing services to migrants.
- A VCT training was conducted for the staff of these NGOs, the National Tuberculosis Program and the Malaria Clinic (Migrant Clinic) and VCT sites will be opened at these places soon.

In addition the services of the migrant friendly clinic are being expanded from predominantly malaria services to specific services for HIV and neglected infectious diseases. The migrant friendly clinic has been instrumental in the linkage of malaria programme with the HIV programme especially in the gold-mining areas for the distribution of condoms and information material.

As a result of this project Suriname will now be working towards a national strategic plan to improve health access of migrants to HIV care in specific and all other health care services in general.

TB/HIV collaboration

Through the development of Joint TB/HIV Concept Note, a writing team was established consisting of representatives of the TB and HIV programs amongst other key stakeholders. This has strengthened the relation between the two programs by reviewing the epidemiological data, recognizing the gaps and discussing new strategic plans to deal with the major problems and weaknesses. In addition, both programs have recognized the need to modify the way both HIV and TB programs and projects were being managed, opening an opportunity for integration of activities in all levels, including planning. This has resulted that a TB/HIV Manager position has been included in the coordination structure of the new HIV NSP 2014–2020 and a TB/HIV committee will be installed to monitor the implementation of the 12 TB/HIV collaborative activities.

Integration of HIV prevention for the reduction of S&D

The MoH is integrating HIV prevention in healthy lifestyle promotion in an effort to de-stigmatize HIV. For example there were activities on World AIDS Day (WAD) in which the focus was on the promotion of a healthy lifestyle (safe sex, no smoking, healthy eating habits). The activities consisted of fairs, information sessions in schools and healthy-lifestyle song competition. The MoH together

with NGOs carried out activities on and around WAD under the theme and slogan *'Ik kies voor een gezonde leefstijl'* (translated: '*I choose for a healthy lifestyle'*). The message that was communicated through the various activities was one that focused on a healthy lifestyle and not just safe sex. People were exposed to the thought that a healthy sex life or healthy sexual choices is as important as for example healthy eating habits, no smoking, adequate rest, etc.). With this approach the MoH underlined the fact that an unhealthy sex life can lead to a chronic disease as smoking and an unhealthy diet can do in the hope that people realize that a HIV infection is practically not more or less than another chronic disease. Furthermore, the MoH focused on the first person singular (*I* choose for a healthy lifestyle). This was done to trigger the need for the individual to take charge of his or her own health.

5. Major Challenges and Remedial Actions

5.1. Major Challenges

In the previous GARPR key challenges were reported; progress to address these challenges are mentioned in the table below.

TABLE 19: PROGRESS ON CHALLENGES IN PREVIOUS GARPR

Key challenged reported in previous report	Progress
Sustainability of prevention programmes in the face of diminishing resources and maintaining a focus on youth and high risk populations	Prevention has been mentioned as one of the two priority areas in the new HIV NSP 2014- 2020 with accompanied operational costed plan. Specifically, prevention targeting Youth and high-risk populations are addressed in the third HIV NSP by the development of a National Prevention Strategy, which includes a National Communication Strategy targeting the general population, identified key populations and vulnerable groups to ensure that evidence-based interventions using communication channels suitable for target groups will be implemented on a regular basis.
Re-orientation and promotion of the utilization of health services for key population.	Uitilization of health services by the key populations is included in the approved joint TB/HIV Concept Note which will be implemented as of January 2016.
Linkage of HIV positive persons into care and keeping them in care	HIV testing and counseling guidelines will be revisited to focus more on 'linkage to care'. In addition, setting up a 'tracking system' to link HIV positive persons into care and keeping them in care is part of the approved joint TB/HIV Concept Note which will be implemented as of January 2016.
Adherence to ARV regimens	The MoH will increase the number of HIV buddies and peer counselors to ensure continued provide support for persons on ART.
Achieving complete antenatal coverage and sustaining and strengthening the integration of HIV services within the health sector and across other sectors	In the planning.
Finding innovative ways to reach boys and men to make use of health services	In the planning.
Addressing S&D	PANCAP Justice for All program in Suriname is in implement-tation and S&D initiatives are integrated in healthy lifestyle promotion.
Insufficient data which provide more insight into the scope and nature of the present HIV/AIDS epidemic i.e. testing coverage, data on youth	The MoH has set-up a HIV Master Index Database by linking the individual databases with data from public and private sector. BSS on youth still needs to take place.

Current challenges

Leadership and governance

A successful governance structure was established and then altered to accommodate the necessary re-integration of the HIV response in the health system, taking the 'chronic care' component into consideration. The integrated delivery of HIV services with NCD has been initiated, but needs to be revisited ensure the delivery of quality HIV services in an appropriate model of care. Although the process of applying a multi-sectoral approach was started, there is still limited awareness in the non-health ministries to the concept of health in all policies in general and the importance of the critical role and responsibility they carry in the implementation of the HIV program specifically. The governance structure needs further adjustments to ensure an integrated and multi-sectoral execution of all necessary components of the HIV response with the MoH in a leadership position The overall coordination, financial, technical and organizational capacity of the executing partners, specifically NGOs, needs further strengthening to ensure an equal collaboration of MoH and executing partners in the management and implementation of donor funded projects. The classification of Suriname as an upper middle-income country increases financial pressure on the government, as it challenged yearly to sustain and expand its investment in the national strategic response.

Prevention

There are some gaps and challenges in reaching the target populations effectively. In absence of a national prevention strategy and a national communication strategy, media campaigns were planned on an ad-hoc basis and there seems to be insufficient coverage of the campaigns, specifically in the interior. Reaching all target populations in need remains an additional challenge, specifically reaching SW in remote areas and 'hidden' MSM. The Youth, especially in the interior needs attention and a national prevention strategy targeting youth needs to be developed.

Even though HIV testing services have been scaled up, there are still some gaps and challenges that need to be addressed if Suriname wants to reach all HIV positive persons. It is therefore necessary to increase the awareness for the necessity of HIV testing with a specific focus on linkage to care. In addition, to increase the coverage of HIV testing and counseling (HTC), new approaches need to be explored for the delivery of HTC taken the national epidemiological context into consideration.

Treatment, Care & Support

Most of the focus of the eMTCT program has been on the prevention of vertical transmission of HIV (prong 3) and also on the primary prevention of HIV among women of reproductive age (prong 1). Prong 2 and 4 (Prevention of unintended pregnancies / family planning, and provision of ongoing care to mothers, children and families) are not yet (fully) implemented.

The treatment protocols and guidelines need to be revisited for alignment with the latest WHO treatment guidelines. The MoH has already taken the decision to change the current treatment guidelines by initiating treatment at CD4 <350 in 2015 and initiation of treatment will start at CD4<500 in 2017. A baseline report on Treatment 2.0 has been drafted and needs to be implemented. There are challenges in keeping persons linked to care, retained in care and adherent to treatment and no national system is in place to follow-up on patients who have left the healthcare system. Furthermore, psychosocial support according to the community systems approach for persons with HIV was extended; however there are challenges in quantity and quality of the current capacity of the HIV buddies and peer counselors.

Laboratory services for the clinical management of HIV have been extended over the years; Treatment for HIV is free of charge as well as CD4, VL, EID, and HIV testing but these laboratory tests are only centrally available. Other laboratory tests needed for clinical management are not free of charge.

The collaboration between the TB and HIV programs has been initiated, however a proper link needs to be established for the joint planning of integrated activities and to improve the screening and surveillance of HIV and TB in both programs and to better address the high mortality and morbidity among patients with a HIV/TB co-infection.

Human Rights

There are anecdotal human rights complaints, but there is no Human Right Desk in place to document, monitor and provide services related to human rights violations.

Monitoring & Evaluation

Although the HIV Master Index Database is in place, there is still a need to further improve this database, not only by improving the data quality of the data base itself, but also by working towards the improvement of the data quality supplied by the local reporting partners. The challenges and remedial actions will be detailed in chapter 7.

5.2 Remedial Actions

Establish an effective leadership and governance structure

- In the third HIV NSP a new leadership and governance structure is proposed in which the HIV focal points' work are integrated with other work areas
- The Program will be supported and advised by technical advisory groups on treatment, care & support; on prevention and on M&E. The revisiting of the appropriate model of care will be discussed in these groups. The groups will have representation of other sectors as well as of the key affected populations.
- Coordination will be strengthened with development partners / funding agencies to ensure efficiency
- Capacity building strengthening activities for NGO's will be continued.

Expand and re-orient the outreach services for the key populations and adapt the HIV testing & counseling strategy

- The current outreach services for MSM, TG, SW will be strengthened; NGOs will receive training in the outreach manual and evaluation moments with the outreach workers are set-up twice a year.
- The outreach services for the youth will be defined with the active involvement of the youth themselves.
- New VCT sites are being established at NGOs providing services to MSM and SW. To further expand the HIV testing and counseling (HTC) services, a review of the current HTC strategy will first be conducted taking the national epidemiological context into consideration.

Revisit the delivery of HIV care with focus on increasing linkage to care, retention in care and adherence to treatment by expanding psychosocial support services and integrating with chronic diseases

- An appropriate model of care will be set up, which will include quality services defined by national standards and aligned with international recommendations; setting up systems to increase the linkage to care and the provision of psycho-social support:
  - Treatment 2.0 action plan will be implemented and national treatment guidelines will be updated to be aligned with the latest WHO treatment guidelines
  - HIV testing & counseling guidelines will be revised with the focus on linkage to care
  - The psycho-social support system will be revisited and guidelines will be developed. This includes the expansion of the HIV buddies and peer counselors.
- The implementation of the 12 TB/HIV collaborative activities will be initiated. With technical assistance of the PAHO a work plan will be developed and implemented

Strengthen HIV data management and surveillance

- Improvements have been made, but there is a need for the availability of real-time quality program data. The master database needs to be strengthened by improving the quality and completeness of the data..

See further under Chapter 7.

Establish a HR desk

- To capture information on the human rights violations and to address these violations, a HR desk will be established with the involvement of stakeholders and taking previous assessments into consideration.

6. Support from Suriname's development partners

Suriname's development partners showed continued support towards the HIV national response. Support was received through technical assistance mainly from the technical partners or financial resources from donors.

The support received varied, but was mainly in the areas of Prevention, Human Rights, M&E and Capacity Building. Main development partners and donors who provided support were:

- UN partners in country (PAHO, UNFPA, UNICEF, UNDP) and UNAIDS Secretariat:
- The Global Fund to Fight AIDS, Tuberculosis and Malaria through the TFM grant and the regional PANCAP grant;
- PSI:
- PEPFAR: CDC ; CHART,
- German Federal Ministry for Economic Cooperation and Development and technical support of GIZ an EPOS Health management:
- Dutch Government:
- ABC (Brazilian Cooperation Agency)-
- USAID through FHI360:

7. Monitoring and Evaluation Environment

7.1 Overview of current monitoring and evaluation system

Over the past 3 decennia Suriname has consistently worked towards improving the HIV surveillance system. In the last year individual data sources (HIV testing data, VL/CD4/PCR results, PMTCT data and ART data) have been linked together to establish a case based surveillance system, the so-called HIV Master Index Database. Since all data in the data sources contained an 11-digit Unique Identification Code the linkage was possible using probabilistic matching (fuzzy matching) to match similar variants of patient codes. The HIV mortality data and HIV hospitalization data have not been linked into this master index database.

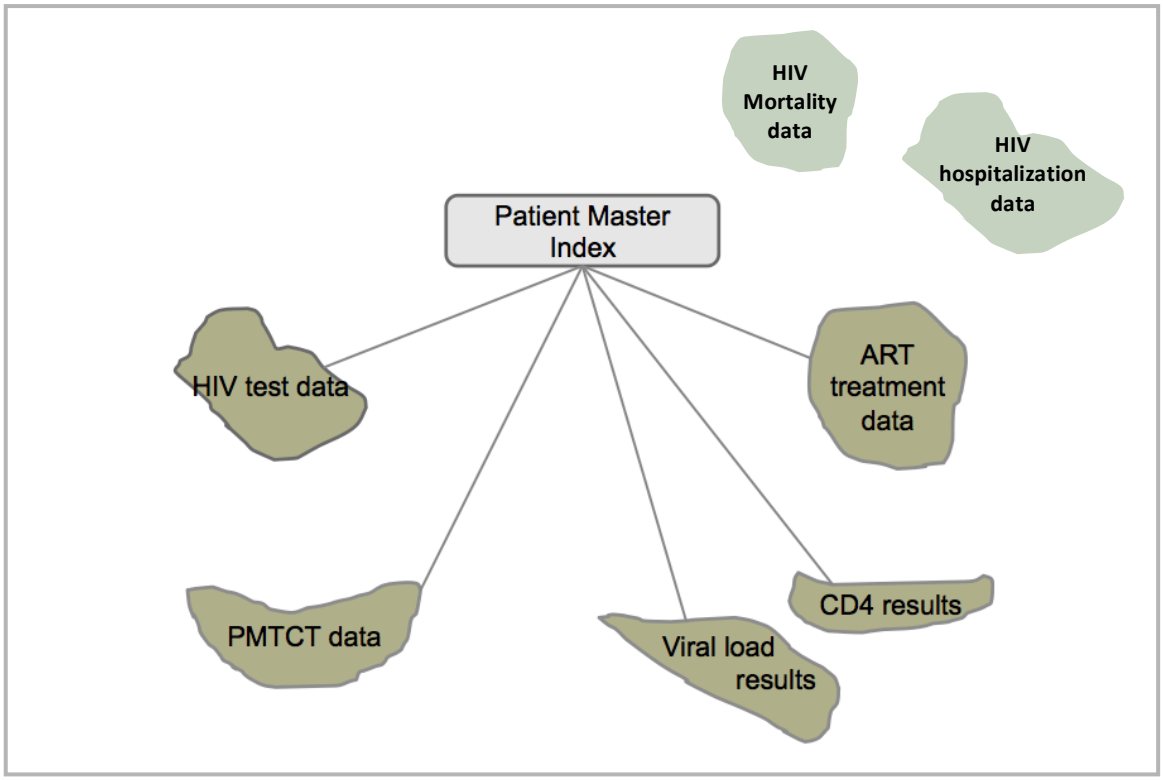


FIGURE 26: LINKAGE OF HIV DATABASES

Source: Planning Unit, 2014

The different HIV data sources consist of the following:

- HIV test database covering public and private sector i.e. from hospital laboratories (public and private), private laboratories and VCT sites.
- CD4, VL, PCR data from the Academic Hospital Laboratory
- National ART database with ARV dispenses from all pharmacies who dispense ART medications
- PMTCT database covering data from the PMTCT program (pregnant women and their babies) from hospitals and primary health clinics.

Data is also collected on identified groups (MSM, SW, Youth) through BSS, sero-prevalence studies, MICS and other studies. In addition, data on TB patients are collected from the national surveillance of TB patients; esp. data on HIV screening among TB patients.

7.2 Challenges

The linkages made many more complex analyses possible. However there are still gaps in information:

- There is insufficient staff committed and skilled in monitoring and evaluation
- The Unique Identification Code (UIC) is not being used properly to prevent duplicates and consistently across all data sources. In addition, an UIC is not collected during outreach services for the key populations, making it impossible to link them to other services.
- Data is not collected in a timely manner, making it difficult to do real-time analysis of the program status
- The collected data is not always complete; the methodology for data collection is not always consistent, trend analysis is sometimes not possible and/or accurate.
- There is no link between the HIV master database and the national mortality data as the mortality database does not use identifier information. It is therefore difficult to know whether there are HIV positive persons registered in the database who are deceased. There is also no link with the HIV hospitalization data.
- ART data comes from pharmacy dispenses in which the pick-up date is used as a proxy; historical data on pick-up is lacking. There is no system in place in the health clinic to capture clinical data, including information on change in ART regimens
- There is no system in place to monitor HIV patients for linkage in care, retention in care and adherence to treatment
- Data on TB screening among HIV patients is not available, because the screening is not yet common practice.
- Supplementary data such as psychosocial information, reasons for dropout are also not being recorded
- Operational research is minimum

7.3 Remedial actions

To guide the HIV response with quality strategic information it will be necessary to:

- Develop and disseminate an M&E plan for collection and analysis of the data
- Develop an Operation Manual outlining roles and responsibilities for data collection, timeliness, data quality including the use of unique identification code and developing a data management strategy with supporting tools, equipment and mechanisms to facilitate effective data collection, transfer, storage, analysis
- Increase staff and stakeholders trained in M&E
- Establish or reinforce linkages between different relevant databases , including mortality database
- Assess and strengthen the ART data coming from the pharmacy dispenses
- Establish a system to capture HIV clinical data as well as data on TB screening among HIV patients

- Establish a tracking system to monitor HIV patients along the continuum of care
- Conduct BSS for identified key population on a regular basis
- Conduct operational research on treatment cascade and develop a national HIV evaluation and research agenda to guide research and evaluation efforts.
- Tap into sources of technical support available to expand health research

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Annex 1

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

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
Focal Points at Planning Unit involved in the national HIV response	Yes

Was the report discussed in a large forum?

A national consensus meeting was held on June 9th 2015, simultaneously with the official presentation of the third HIV NSP, HIV Epidemiological Profile and Joint TB/HIV concept note. At this meeting the national HIV estimates from the Spectrum file 2015 were also discussed.

Are the survey results stored centrally? **Yes**

Are data available for public consultation? **Yes**

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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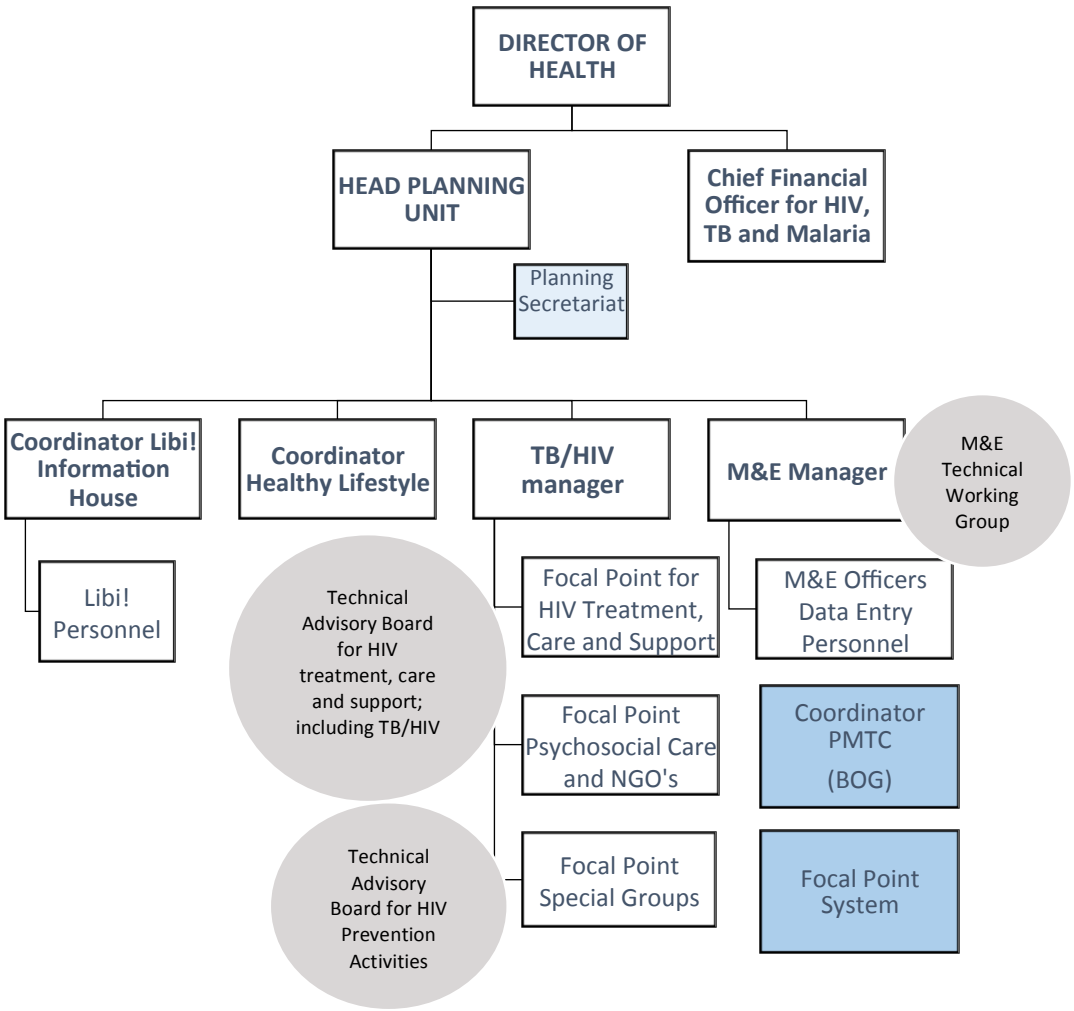
Annex 2:

Coordination structure HIV National Strategic Plan 2014 – 2020



The Technical Advisory Boards/Working Groups consist of a variety of stakeholders and provide technical guidance to the focal points.

Since PMTCT has been re-integrated into the MCH program, the Coordinator for PMTCT and Focal Point system are not housed within the Central Office of the MoH.