[National Strategic Plan - Republic of Suriname]

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LIST OF ABBREVIATIONS

ABS	General Statistics Bureau
AIDS	Acquired Immuno Deficiency Syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral drugs
BCC	Behavior Change Communication
BEG	Very essential drugs
BLSP	Basic Life Skills Program
BOG	Bureau for public health
CA	Foundation Claudia A
CAREC	Caribbean Epidemiology Center
CARICOM	Caribbean Community
CCNAPC	Caribbean Coalition of National AIDS Program Coordinators
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CSW	Commercial Sex Worker
DD	Department of dermatology
FHI	Family Health International
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People living with or affected by AIDS
HIV	Human Immunodeficiency Virus
HRM	Human Resource Management
IBBS	Integrated Biological and Behavioral Surveillance
ICPD	International Conference on Population and Development
KAPB	Knowledge, Attitude, Practice and Behavior
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MOP	Multi-Annual Development Plan
MSM	Men who have Sex with Men
MVG	Ministry of Public Health
MZ	Medical Mission
NAC	National AIDS Committee
NAP	National AIDS Program
NAT	Nickerie AIDS Team
NRL	National Reference Laboratory
NSP	National Strategic Plan for HIV/AIDS
PAHO	Pan-American Health Organization
PANCAP	Pan-Caribbean Partnership against HIV/AIDS
PEP	Post-Exposure Prophylaxis
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
RGD	Regional Health Service
SARA	Situation and Response Analysis of the HIV response
SBC	Suriname Business Coalition
SMLA	Foundation Maxi Linder Association
SMNP	Foundation Mamio Names Project
SMU	Foundation Suriname Men United
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
SOZAVO	Ministry of Social Affairs and Public Housing
SRH	Sexual and Reproductive Health
SZF	State Health Fund
TA	Technical Assistance
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children’s Fund
UWI	University of the West Indies
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

REPUBLIC OF SURINAME, March 2009

Preface

Much has happened since the discovery of HIV and AIDS in the United States, now more than 25 years ago. We now know how the virus is transmitted and how we can prevent it from spreading. No trouble or expense has been spared to control the virus. Still, the virus spread worldwide, especially in Sub-Saharan Africa and the Caribbean Region to which Suriname belongs.

It is clear that campaigns and measures do not lead to behavior change in general and sexual change in behavior in particular in one day, one month or one year.

One of the alarming elements of the epidemic in our country is the great number of infections among young women and older men. A ray of hope is may be the discrete drop in sexually transmitted diseases in our country. This trend may well indicate that our message of safe sex is slowly but surely getting through to people. But the number of STD and HIV cases is not dropping fast enough. That is why we present this plan for the next 5 years, whereby we have the opportunity to adjust our national strategy for the control of HIV and AIDS.

This National Strategic Plan must contribute to the prevention, treatment and support that better connects to our target groups. Also, we will introduce new methods that have served as “best practice” in other countries.

Our joint effort is required to stop the HIV epidemic. Let us not leave any stone unturned and protect our population against HIV.

The Minister of Public Health,
C.W. Waterberg

1. BACKGROUND

In 2002, in accordance with regional Caribbean and international agreements, the Surinamese Government initiated a process for the systematic and strategic control of HIV. In 2004, based on a national consultation process, the National Strategic Plan for HIV (NSP) 2004-2008 was developed for a multisectoral approach to HIV. In 2007, in anticipation of the termination of the first NSP, the preparations for the second NSP for the period 2009-2013 were set in motion. This process is outlined in the next paragraph.

1.1 Development of the NSP

The development of the second NSP for HIV 2009-2013 took place in stages via various tracks. The first annual evaluation of the NSP 2004-2008 took place in 2005. On the basis of the results of that evaluation, an adjusted work plan for 2006 was drawn up. In 2007, in order to obtain a better overview of the national response, a national 'mapping' (inventory) was performed. In this regard, via a survey, the response in all sectors was mapped. This inventory was used as input for the preparation and execution of a 'Joint Review and Revision process' (JR&R) led by the National AIDS Program (NAP).

On August 10, 2007, the JR&R project was officially launched. On this occasion, five technical workgroups (TWG) were established for each field of priority of the NSP, namely prevention, coordination, treatment and care, stigma en discrimination, monitoring and evaluation. Each TWG consisted of about five to seven experts on the subject that were charged with reviewing the first NSP headed by a Chair. In this regard, specific attention was devoted to: 'results and successes, 'shortcomings and obstacles' and 'recommendations'. This review was performed from a result-based approach, whereby from the beginning results and activities were tested against previously set indicators for impact, outcome and output.
Every TWG was assisted by a facilitator who was available as 'resource person'. This facilitator also recorded the discussions within the TWG. The results of the TWG were presented in a so-called "TWG consolidation workshop" with all TWG members and representatives of the NAP presents as well as the Ministry of Public Health and international partners.

The national consultation process reached its high point in the National Consultation Meeting on November 30, 2007. In this meeting, the concept of the strategic plan was presented to a broad and varied group of relevant participants in the response with the objective to secure broad social support and cooperation for the implementation of the NSP. In this meeting, the participants had the opportunity to exchange ideas and experiences in workgroups and to make specific recommendations for changes in or additions to the previously received documents. In the semifinal stage, the team of consultants worked on finalizing all documents. These documents were then presented by the Ministry of Public Health to the Council of Ministers and other decision-making authorities in Suriname.

In this second National Strategic Plan for a multisectoral approach to HIV 2009-2013, the ongoing and active involvement of a broad social field confirms once again the growing awareness and the will and the possibility to take on HIV in Suriname with combined forces.

1.2 Components of the NSP

The NSP is a five-year plan (2009-2013) and provides an overview of the national objectives, points of departure, strategies and expected results per field of priority based on an extensive situation and response analysis of the HIV epidemic in Suriname. Furthermore, attention is devoted to the necessary structures and mechanisms for implementation of the NSP.
As a result of the NSP, an action plan was developed for the period 2009-2010. This plan is a tool for the NAP as coordination point and, in the medium-long term, for all executing partners in the national response. It provides an overview of agreed activities, responsibilities and estimated costs. This two-year action plan will be reviewed annually in close consultation with all relevant partners in the execution with the NSP as point of departure. For specific focus on the fixed fields of attention, some specific components have been added to this NSP:

1. A separate part of the NSP is the 'Monitoring and Evaluation (Action) Plan'. This plan systematically indicates the manner in which monitoring and evaluation of the national response will take place. Based on a result-oriented approach and nationally fixed indicators, this (action) plan describes in detail the structure and the process of collection, analysis and distribution of strategic information for the development of specific policies and effective services and programs. More in particular, the M&E will serve as an 'early warning system' for the monitoring of the implementation of the two-year action plans (2008/2009; 2010/2011 and 2012/2013).

2. In view of the specific development and capacity-building, attention has been focused separately on establishing the main points and conditions for the development of a 'capacity-building strategy' for relevant sectors within and outside of health care to work more effectively on the organizational and technical strengthening of both the NAP and other partners in the response.

2. SITUATION ANALYSIS 2004-2008

2.1 Epidemiology of HIV, AIDS and STI

Great lack of reliable HIV prevalence figures

Suitable and reliable prevalence figures, which could give us insight in the presence of HIV in and spreading of HIV across the Surinamese population and in the high-risk behavior of various subpopulations, are insufficiently available. These figures are insufficiently available because a 'HIV/STI 'third generation sentinel surveillance system'[1] in Suriname does not yet function adequately.

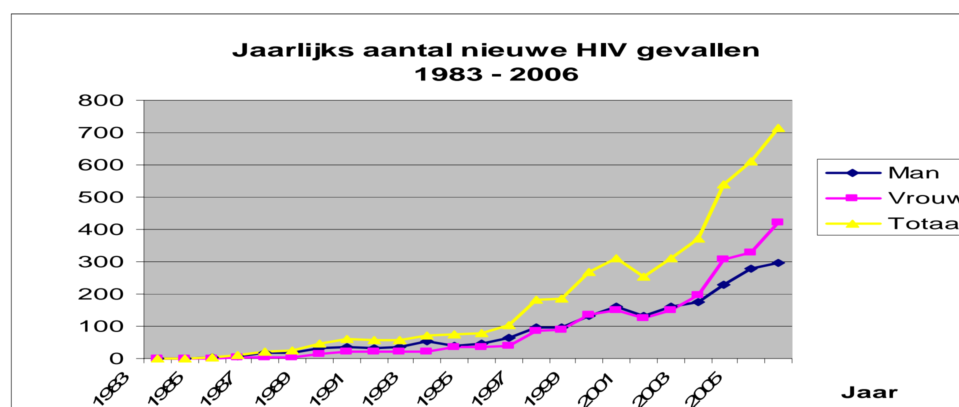
Estimations are taking place mainly based on passive surveillance: information is collected only on persons who, for whatever reason, become visible because they register at health care centers and wish to be tested for HIV. This is the group of the 'HIV registered persons'. The surveillance data on these persons that is available is consistently differentiated by age, gender and ethnic descent.

Suriname has a generalized HIV epidemic

HIV is prevalent in all layers and groups of society. According to estimations, about 2.4% (UNAIDS 2008) of the adult population (age 15-49) is infected with HIV. Since the first registration of HIV in 1983, an upward trend has been noticeable in the annual reports of new HIV cases in Suriname. In 2005 and 2006, the cumulative total of registered HIV cases was 3,645 and 4,385 respectively.

According to data, 610 new HIV cases were reported in 2005. The number of new registrations in 2006[2] was 740. The increase in the number of new cases does not mean an increase in unsafe sexual behavior or new infections per se. An increase in the number of HIV registered persons may also be the result of a more active HIV testing policy. In the past years, people have been stimulated in various ways to have themselves tested for HIV, among others, by means of general HIV testing campaigns.

Figure 1



Source: HIV/AIDS/STI Surveillance Report, 2004-2006

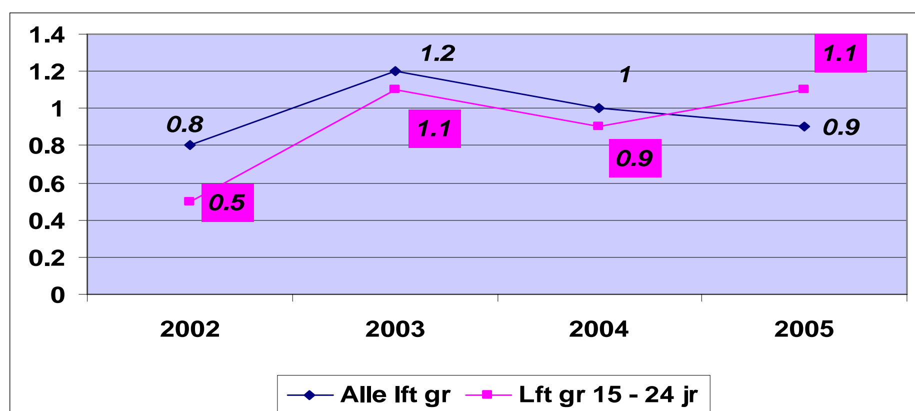
[1] See: Guidelines CAREC on Third Generation Surveillance HIV

[2] Factsheet Ministry of Public Health, HIV/AIDS Surveillance Team, Nov. 26, 2007. Revised: Feb. 4, 2008

HIV prevalence among pregnant women

Because pregnant women constitute a cross-section of the general, sexually active population, they provide a reasonable indication for an estimation of the extent to which HIV has spread among the population. 5,420 and 6,733 pregnant women were tested in 2004 and 2005 respectively. In 2005, the number of pregnant women tested was equal to 78%[3] of all pregnant women. The HIV seroprevalence found was 1.0% in 2004 and 0.9% in 2005[4]. The Het percentage HIV-positive persons among pregnant women showed a slight increase in the age category 15-24, from 0.9 in 2004 to 1.1% in 2005.

Figure 2: Share of HIV+ among pregnant women tested



Source: HIV/AIDS/STI Surveillance Rapport, 2004-2006

Blood donors

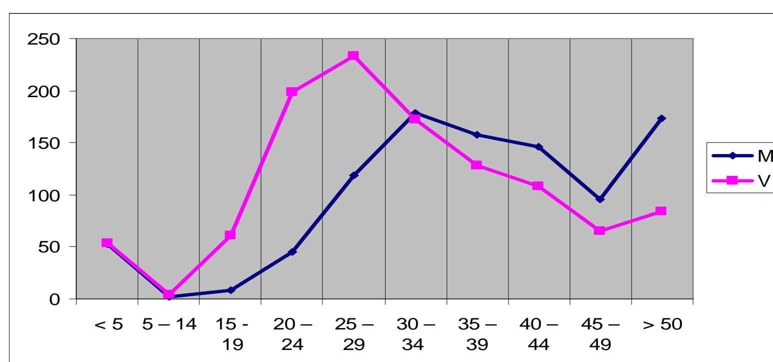
In general, there are hardly any or no HIV reports among blood donors. In the period 2003-2006, HIV prevalence among active blood donors was 0.03%[5] annually. This was the result of strict behavior criteria in the selection of donors.

There is an increase in reported HIV cases among women, in particular young women

Since the beginning of the HIV epidemic in Suriname, the number of reports of women with HIV, in comparison to men with HIV, has continued to increase and is even higher since 2003. The increase in the number of registered HIV infections among young women is remarkable. From 2001 to 2005, in the age group of 15-24, there were more registered HIV-positive women than registered HIV-positive men.

[3] Screening coverage estimated based on the total number of births in 2005: 8,657
[4] HIV/AIDS/STI Surveillance Team, M.Mohan-Algoe, Powerpoint ‘Update on HIV/AIDS in Suriname’ August 2007
[5] HIV/AIDS/STI Surveillance Report 2004-2006

Figure 3: HIV-positive persons by sex and age, 2001-2005



Source: HIV/AIDS/STI Surveillance Team

One explanation for this (gender) trend is that (young) women are biologically, socially, economically and culturally vulnerable. They are also more susceptible to HIV infection than men. Another explanation could be that many more women than men have themselves tested for HIV. The HIV test is offered to all pregnant women as part of prenatal care.

Furthermore, it is evident that mostly women register at all locations where persons may have themselves tested of their own free will, the so-called *Voluntary Counseling and Testing* (VCT) sites.

For now, there is no information available yet as to the background of the gender differences in free HIV testing behavior.

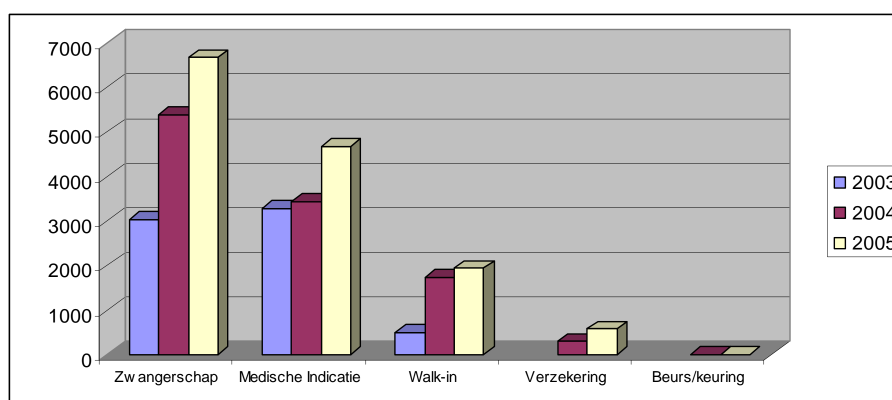
There is an increase in the number of registered HIV+

Since 1983, the cumulative number of registrations of HIV-positive persons has increased to 4,358 persons in 2007 of which 2,215 are women and 2,143 are men.

There is an increase in the annual number of persons diagnosed with HIV, up to 740 in 2006 of which 435 women and 305 men[6]. This increase is partly due to the improved accessibility to testing facilities strengthened by recent public HIV testing campaigns, such as 'Sabi Libi' (*know how to live*), and especially due to HIV screening of pregnant women. The latter is clearly visible in the strong overrepresentation of women in the total of registered HIV-positive persons in 2006.

[6] HIV/AIDS/STI Surveillance Rapport 2004-2006

Figure 4: HIV tests by reason of testing



Source: HIV/AIDS/STI Surveillance Team

There is a decrease in deaths by AIDS

As of 1997, the cumulative number of certified cases of AIDS deaths in 2006 is 1,207. There are indications that the annual death rate due to AIDS has decreased. In 2004 en 2005, 171 and 181 persons respectively died of AIDS, but in 2006 this number dropped to 130. On the list of most frequent causes of death, in 2006, AIDS dropped from fifth to sixth place. Causes for this decrease are, in particular, the increase of early diagnostics and the wider availability of antiretroviral drugs (ARV).

Reports of medical practitioners indicate decreasing STI trend

Prevalence and trends in sexually transmitted infections (STI) are good indicators of the presence of sexually transmitted HIV and behavior change. The HIV/AIDS/STI Surveillance team keeps up-to-date with the reports of STI diagnoses at the Department of Dermatology (DD) and the medical practitioners. Available figures from medical practitioners, collected by the Department of Epidemiology of the Bureau for Public Health (BOG), indicate a slow drop in the number of STI registrations in the past years, namely from 1,658 in 2001 to 939 in 2006. In 2004, the number of registered persons was 1,315. In 2005, it was 1,051, and in 2006 the number dropped to 939 registered diagnoses[7].

There is a clear link between HIV and Tuberculosis (TB)

Tuberculosis is an important opportunistic infection for people with HIV who have decreased resistance. Since a couple of years, HIV screening of TB patients has increased. In 2004, HIV seroprevalence among TB patients was 24.6%. In 2005 this share was 21.3% and 2006 showed a slight increase to 22.3%. These percentages may be considered very high and imply that a quarter of the TB issue in Suriname may be the consequence of an HIV infection.

[7] BOG, Department of Epidemiology/Biostatistics, 2008

High-risk behavior, knowledge and attitudes

HIV transfer in Suriname mainly takes place through unprotected sex. HIV spreads most easily in sexual networks of people with several partners having unprotected sexual contact at the same time. This is due to people with an HIV infection being very contagious very shortly after their infection, so quickly changing contacts promote quick transfer of HIV. Concentrated HIV infections in sexual networks with high-risk behavior may build a bridge to the rest of the population and, in this way, stimulate the spreading of HIV. With the exception of some insight on sex workers, there is currently little information available in Suriname on the existing sexual networks and the sexual behavioral patterns therein; especially, among men who have sex with men and among migrants and other difficult-to-reach populations.

In Suriname, there are 'concentrated HIV epidemics' among people and subpopulations with high-risk behavior

High-risk behavior, in fact, means unprotected vaginal and, particularly, anal sex with many different partners. Commercial sex workers and men who have sex with men (MSM) are generally identified as persons of high-risk behavior. In Suriname, there has not been any regular surveillance yet of the behavior of these groups with increased risk for HIV. Incidental studies have been done among male and female street sex workers and MSM in Paramaribo.

There are a great many sex workers active in Suriname, in clubs or in the streets. Most of these sex workers operate in the center of Paramaribo and, partly, around the gold mines in the interior. Studies among female sex workers in 1998 and, recently, in 2005, showed an HIV prevalence of 22% and 21% respectively. Among male sex workers (mostly transsexuals) the share of HIV-positive persons was 36%.[8] Recent data on HIV prevalence among sex workers in clubs is not available[9]. In the latest behavioral study among sex workers, most sex workers (62%) never had an HIV test and 70% reported condom use in their last contact with a client. Only 23% reported consistent condom use with clients in the month preceding the survey. 51% previously had contracted an STI earlier. The basic knowledge on HIV was reasonable to good. 78% knew that 'condom use' and 'exclusive sex with a monogamous partner' could prevent HIV, while 74% knew the difference between HIV and AIDS. Reports of drug use were relatively high: 46% of the sex workers reported drug use[10].

[8] Caribbean Epidemiology Center (CAREC) and the Maxi Linder Foundation (SMLA) (2004). HIV/AIDS and Commercial Sex Work in Suriname: an HIV seroprevalence and behavioral study among commercial sex workers (CSW) in Suriname.

[9] The most recent seroprevalence study dates back to 1991. At that time, an HIV prevalence of 2.5 was found

[10] Caribbean Epidemiology Center (CAREC) and the Maxi Linder Foundation (SMLA) (2004). HIV/AIDS and Commercial Sex Work in Suriname: an HIV seroprevalence and behavioral study among commercial sex workers (CSW) in Suriname.

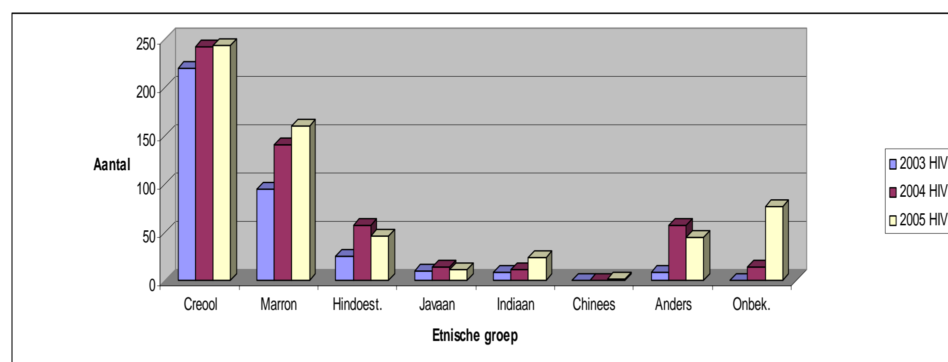
Men who have sex with men (MSM) have a relatively high HIV prevalence
In 1988, among MSM (including male sex workers) and in 2005 (exclusive of sex workers), prevalence percentages were registered of 20% and 7%.[11].[12] respectively. At the moment, a study is being conducted into the sexual behavior of men in Surinamese prisons. Although there are indications that unsafe anal sex is not limited to man-to-man contact but also occurs in heterosexual relations, no study data is available in this regard. Further study is necessary to establish the characteristics and extent of sexual networks of men, their sexual behavior, knowledge and attitudes.

Some Surinamese men have extensive sexual networks with different contacts and run a higher risk of HIV infection
Study results of subpopulations show that, on average, men have more sexual partners per given time unit than women and are a lot more involved in unprotected, incidental sexual contacts. Partly, this behavior is conditioned by culturally set patterns, such as polygamy, and men having several partners [13] . There are indications that, especially, mobile men (e.g. mine workers, gold miners, migrants, etc.) and men with a street-oriented lifestyle often have different partners. Hard data in this regard is still forthcoming.

The number of registered HIV-positive persons and AIDS deaths differentiate strongly by ethnicity
In the total number of registered persons, the share of persons from Creole and Maroon descent is the largest[14]. The differences within ethnic groups could, among others, relate to ethnically and culturally determined sexual behavioral patterns, perception with regard to health and disease, access to care and information, and help-seeking behavior[15].

[11] Caribbean Epidemiology Center (CAREC) and the Maxi Linder Foundation (SMLA) (2005). An HIV seroprevalence and behavioral study among men who have sex with men (MSM) in Suriname.
[12] Del Prado, R & Antonius, C ,1998. AIDS and Behavior Change. A population survey, a KAPB Survey, and an HIV Seroprevalence Study in Paramaribo, Suriname.
[13] Terborg, J. 1998. Sexual Transmitted Diseases and HIV/AIDS among Ndjuka and Saramacca Maroons in the hinterland of Suriname. See also Terborg, J. 'Liefde en Conflict'. Academic thesis, 2002
[14] HIV/AIDS/STI Surveillance team, Powerpoint 'Update on HIV/AIDS in Suriname', August 2007
[15] Medical Mission /Pro Health, 2005. Evaluation of the STI/HIV/AIDS program 1998-2003'

Figure 5: HIV registered persons by ethnic descent, 2003-2005



Source: HIV/AIDS/STI Surveillance Team

HIV transfer among injecting drug users is negligible in Suriname

A recent study of the National Anti-Drugs Council shows that only 0.3% of the estimated 800 to 1,000 drug users inject[16]. Although not much drug injection is taking place right now, in general, an increase of drug use has been detected. Because transfer of HIV can take on explosive proportions among users who share injection needles and materials, this issue must be closely monitored. The sexual networks of drug users and the risks of HIV transfer must also be mapped.

Surinamese population: knowledge, attitudes and behavior

There is an increase in the basic knowledge on HIV

The recently conducted Multiple Indicator Cluster Survey (MICS) study 2006 shows that the basic knowledge on HIV is growing. In 2000, only 36% of the women between the ages of 12 and 49 had correct knowledge of HIV, however, in 2006, this percentage increased to 67%. Knowledge is strongly dependent on the level of education and place of residence. There is less knowledge among persons who live in the interior and in the districts and among young people with low-level education[17]. A recent survey of the Ministry of Public Health in five residential areas shows that the larger part of the young people has knowledge about the difference between HIV and AIDS, knows that HIV is transmitted via sex and that social contact with an HIV-positive person is safe[18].

Still, the assessment of risk by young people in general is low and there are large groups of young people displaying high-risk behavior

Young people are fairly well-informed about HIV, but there are still large groups displaying high-risk behavior, in other words, they are practicing unprotected sex and have many different contacts. The MICS study of 2006 shows that 60% of the women in the age group of 15-24 had sex with a non-regular partner in the past twelve

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[16] National Drug Board, MOH.
[17] Multiple Indicator Cluster Survey (MICS) 2006, Government of Suriname/Unicef, July 2006
[18] MVG/ProHealth, 2007 Report 'Young people and their health'

months and only about 50% of these women used a condom in the last contact with this partner[19].

Another recent study[20] into the sexual behavior of young people shows that sexual behavior varies by sex, ethnicity, place of residence and age. Age of first sex is around age 15 for men and around age 17 for women. Adolescent men reported more partners than their female peers: 41% reported three or more partners in the last year. Condom use was moderate (48% the last time) despite proper knowledge of HIV and the preventive effect of condoms.

The majority, 61%, of the interviewed women in the age category 10-24 was once pregnant; 61% said that the pregnancy was not planned. In spite of this, 64% of the young people were of the opinion that they did not run the risk of contracting HIV.

Condom use is increasing but mostly in incidental loose contacts

Various studies report increased condom use, especially among young people and especially in sexual contacts with incidental partners. For example, 48% of the young people reported condom use in their last sexual contact. Young people experience problems in the access to condoms and the correct and consistent use of condoms[21].

Social, economic and cultural factors for high-risk behavior

HIV occurs in all social layers but worldwide it is acknowledged that there is a strong link between HIV and poverty and that poverty can be a driving force in the epidemic. Aspects of poverty make people vulnerable to infection with HIV. It involves exposure to risks due to poor housing and education but also due to economic dependency and lack of education and access to information. In Suriname, the majority of the population lives below the poverty line[22].

Ethnic and cultural factors influence sexual behavior

The sexual culture in Suriname shows great diversity by sex and ethnicity. The average age of first sex, first pregnancy, use of contraceptives, standards of marriage, and sexual practices show great differences when women and men, and ethnic groups, are compared to one another. Sexual standards and values with which boys and girls grow up also determine the extent to which they are exposed or threatened by HIV. Also, the help-seeking behavior is often culturally determined. That is why it is important that behavioral interventions are geared towards the specific characteristics of the social, economic and cultural contexts in which various target groups live and work. Further study into the influence of social and cultural (gender, ethnicity, culture, religion, etc.) factors on sexual behavior is necessary to be able to develop effective policies and programs.

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[19] Idem
[20] Idem
[21] Idem
[22] See: 'The MDG baseline report, Suriname, 2005: indicates that 60% of the population lives below the poverty line.

Criminalization and discrimination obstruct access to adequate prevention and care

In Suriname, sex workers, drug users and men who have sex with men, often live in a sphere of illegality, marginalization, stigma and discrimination. This problematic context makes them extra vulnerable to HIV infection. For fear of sanctions, stigma and discrimination, these groups are often less inclined to make use of formal prevention and care services. Based on experiences of caregivers, it may be assumed that stigmatized groups are not likely to register for treatment and go into hiding, or apply self-medication. Especially, if they expect that a positive HIV diagnosis could mean more difficulties for them.

3. PRINCIPLES AND POINTS OF DEPARTURE OF THE NSP

The NSP is an integrated part of the Multi-Annual Development Plan 2006-2011 and, as such, falls within this larger development framework. Considering the specific aspects and issues related to the HIV epidemic, it is important to put explicit emphasis on a number of principles and points of departure. These are important values, standards, national and international agreements based on which the NSP can be tested with regard to implementation as well as to monitoring and evaluation.

Principles

- 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.
- The right of access to affordable and proper health care and social security.
- Respect for diversity in ethnic descent, language, sexual preferences and social and economic circumstances in the development of programs.
- Gender-sensitivity of intervention strategies that, in particular, must take into account both the great vulnerability of women and girls and the important role of men in the development/stimulation of responsible and safe sexual behavior.
- Support with facts and proof of policies and services. More quantitative and qualitative studies to determine the needs and more evaluation and monitoring of services to measure efficiency and effectiveness.
- HIV policy and programs must be integrated in and contribute to strengthening and improving existing health care systems.
- Transparency of policy and accountability for the execution towards clients, to each other, and to the financiers of the HIV response.

Points of departure for the implementation of the NSP

- The HIV response is a priority of the entire Government of Suriname, including all relevant ministries and departments.
- The NSP is in accordance with national objectives, principles and programs (MOP, Government policy statement and Policy Note of the Ministry of Public Health and the Policy Note Sexual and Reproductive Health), regional (Caribbean Regional Strategic Plan of Action) and international obligations and commitments (MDG, UNGASS, CEDAW, Beijing, CRC, ICPD, etc.).
- The Government actively involves civil society in the national HIV response.
- The Government is seeking close cooperation with international development partners for technical and material support for the national HIV response.
- In view of the diminished dependency and increased sustainability, increased financing from Government resources is pursued. The Government, the Ministry of Public Health is, after all, responsible for controlling the HIV problem.

4. NATIONAL STRATEGIC PLAN

This Chapter describes the national objectives, secondary objectives and expected results. For each result, the most important executing parties and their responsibilities are described.

4.1 National objectives

- General objective: to push back the further spreading of HIV and minimize the negative consequences of HIV on society.

4.2 Fields of priority, indicators and budgeted activities

- The NSP has five fields of priority that are closely linked and woven into an integrated whole:
    1. national coordination, policy and capacity-building
    2. prevention of the further spreading of HIV
    3. treatment, care and counseling
    4. pushing back the stigma and discrimination surrounding HIV
    5. strategic information for policy and rendering of services
- The fields of priority are set forth in terms of secondary objectives
- Each of the secondary objectives knows specific results and main activities

	National HIV indicators
1.	The number of HIV-related deaths
2.	The percentage of adults and children with HIV that is still being treated 12 months after the start of ARV therapy
3.	The percentage of young women, men and women in the age group 15-24 that is infected with HIV
4.	The percentage of newly born babies from HIV positive mothers that is infected with HIV

Indicator		Activity	
1. National coordination, policy and capacity-building			
A. In at least 2 relevant sectors HIV strategies have been developed and implemented	1.01	Relevant ministries, such as Education and Community Development, Social Affairs and Public Housing, Defense, Regional Development, Labor, Technology and Environment, will develop and implement HIV strategies and programs	200,000
	1.02	The ministries of Labor, Technology and Environment, the unions and trade & industry will further develop and implement the 'Tripartite Agreement for HIV policy' in the workplace	100,000
B. HIV/AIDS has been integrated in at least 2 public health care departments/programs	1.03	The Ministry of Public Health will integrate in at least the TB program and STI program HIV strategies and will encourage and support other departments of the Ministry in the development of their HIV policy and HIV programs based on the need	50,000
C. A national council for HIV/AIDS has been installed and mechanisms have been put into action for national coordination	1.04	The Ministry of Public Health will introduce a multisectoral national structure for policy coordination and advice	20,000
D. There are structures in place and mechanisms at work for a national coordination	1.05	The network of NGO's that is active in HIV will meet at least twice a year for consultation and coordination	20,000

E. A capacity-building plan for the NAP and at least 3 partners has been implemented	1.06	The NAP will draw up a capacity-building plan for executing partners based on the need, and attract technical expertise for the implementation of this plan	525,000
	1.07	Out of networks with national, regional and international organizations training courses and other capacity-building activities will be undertaken based on national priorities	500,000
F. A two-yearly activities plan has been prepared based on the NSP; the costs hereof have been determined and financial contributions applied for	1.08	The Ministry of Public Health will guarantee that financing of the implementation of the NSP will take place more and more from government resources	0
	1.09	Every year, the NAP will fill out the “UNGASS” funding matrix with the partners after which an efficient use of donor funds will be pursued	75,000
2. Prevention of the further spreading of HIV			
A. A national HIV communication strategy has been developed and implemented	2.01	Based on studies, the NAP will develop and apply communication strategies per subpopulation	60,000
B. Prevention interventions have been conducted in at least 3 subpopulations and groups with increased risk of HIV	2.02	NGO’s will conduct behavior change interventions for CSW and MSM based on qualitative and evaluative studies	500,000
	2.03	The armed forces (military, fire department, police, penitentiary officers) will develop and implement prevention strategies for mobile men (with many different contacts)	60,000
	2.04	On the basis of qualitative studies, the Ministry of Police and Justice will implement a prevention strategy for prisoners in the penitentiary institutions and cell blocks	65,000
	2.05	NGO’s and participants in the gold mining industry will develop prevention strategies for (migrant) workers in and around the gold mines based on studies	500,000
	2.06	NGO’s will implement behavioral change interventions for young people in vulnerable communities and target groups	500,000
	2.07	The NAP will support interventions by preparing documentation and providing information	400,000

C. At least 3 media campaigns for subpopulations have been developed and implemented	2.08	Communication specialists develop educational and awareness programs based on the developed strategies in order to boost awareness and knowledge and bring about behavior change	100,000
	2.09	The NAP, NGO's and the media houses will implement national campaigns on • diminishing stigma and discrimination • partner reduction • circumcision of boys and young men	150,000 250,000 250,000 250,000
D. Circumcision will be introduced nationally as a general strategy for health intervention and, in particular, as HIV prevention		The Ministry of Public Health will implement a pilot project, including a promotion campaign, for circumcision	60,000
		On the basis of the results of this pilot project, a program will be developed to integrate circumcision in standard health care services	1,000,000
E. Sexual and reproductive health care programs for young people have been expanded	2.10	The NAP will develop guidelines and documents for a 'youth-friendly' HIV-related service based on studies into the needs and perceptions of young people	100,000
	2.11	NGO's will undertake 'evidence-based' behavior change interventions for education and counseling of young people and children living under risk-promoting conditions (in particular, non-school going young people, unemployed young people, delinquents, sexually abused children, etc.)	500,000
F. The procurement, logistics and distribution of condoms and lubricants have been improved	2.12	The NAP will develop a condom policy and strategies for the promotion of consistent and correct use	30,000
	2.13	Private traders are involved in the social marketing strategies for the promotion of the male and female condom	100,000
	2.14	The NAP will strengthen the logistics for the procurement and distribution of male and female condoms and lubricants	1,000,000
	2.15	Vulnerable target group will be provided with free condoms and lubricants	400,000
	2.16	Condom promotion and distribution campaigns for the sexually active population will be expanded	500,000

G. The number of VCT services integrated in existing lab services has increased	2.17	The NAP will evaluate the implemented VCT activities and improve the VCT services, where required	100,000
	2.18	The Medical Mission, the RGD and other primary health care providers will expand services and, where possible, integrate them in existing lab services	100,000
H. PMTCT services for pregnant women have been improved and expanded	2.19	The Ministry of Public Health will evaluate the PMTCT strategy and adjust protocols	100,000
	2.20	RGD, MZ, private medical practitioners and hospitals will improve and expand services for pregnant women and neonatal women	200,000
I. 2 programs aimed at the prevention and early treatment of STI's have been implemented	2.21	The Department of Dermatology, based on qualitative and evaluative studies, will improve and expand prevention and early treatment of STI, among others, by means of the procurement, implementation and exploitation of a mobile STI clinic	200,000
	2.22	NGO's, the private sector and media houses will contribute to the increase of awareness about STI and safe sex through educational and awareness programs	250,000
J. Safe blood transfusion is guaranteed	2.23	The National Blood Bank of the Surinamese Red Cross will monitor and guarantee the quality of blood for transfusion, and promote voluntary donation and rational use of blood	125,000
K. Preventive measures for blood-to-blood HIV-transmission have been applied to health care institutions	2.24	MVG, MZ and RGD will prevent blood-to-blood HIV transmission in health care institutions by further developing and improving protocols, making available services for prevention of HIV infection including PEP and training of health care providers in monitoring the implementation of safety regulations	100,000

3. Treatment, care and counseling			
A. A model has been developed for HIV/AIDS treatment and care, including a policy for 'continued care' and referral network	3.01	The MVG develops and introduces a model for the delivery of health care services with regard to HIV/AIDS treatment	50,000
	3.02	The MVG will develop a national policy plan for 'continued care' including setting up and bringing into operation an explicit referral system between volunteer aid and home care, primary and specialist care	250,000
	3.03	On the basis of this strategy, the NAP will have (referral) protocols developed, health care providers trained, and mechanisms for supervision and quality control developed	250,000
	3.04	The NAP will regularly update and spread the HIV handbook as the need arises	75,000
	3.05	The NAP and the National TB Programs will jointly develop protocols for the treatment of HIV/TB co-infection	100,000
	3.06	Institutions for primary health care (RGD, MZ and private medical practitioners) expand services for clinical management of HIV and opportunistic infections	400,000
	3.07	Hospitals improve the care of HIV/AIDS by increasing the clinical expertise and integration of the treatment protocols. Appointing special focal points, possibly in cooperation with existing infection committees, will benefit the quality of the care even more	150,000
	3.08	Hospitals and specialists will further improve and expand the treatment, specialist care and hospitalization of patients with HIV	250,000
B. HIV/AIDS is included in the curriculum of nurses and medical practitioners	3.09	Medical and nursing training courses will review their HIV/AIDS curriculum and adjust this, in particular, in the field of antiretroviral therapy	100,000

C. At least 1 lab in Suriname can determine viral load	3.10	The Ministry of Public Health will improve and expand the possibilities for early HIV diagnostic, in particular, by means of the procurement of instruments and materials for performing 'viral load' determinations	450,000
	3.11	Training of lab personnel in 'viral load' testing will be organized	50,000
D. There are 8 distribution outlets for ARV	3.12	The Ministry of Public Health will improve the procurement and logistic of ARV's and medication against opportunistic infections	3,500,000
E. The system for financing of ARV is strengthened and made sustainable	3.13	The Ministry of Public Health will strengthen the system for financing of ARV's and make it sustainable by means of agreements with health care insurers	20,000
	3.14	The Ministry of Public Health will have ARV's included in the National Medicines Register /BEG list	0
	3.15	The Ministry of Public Health will have medicines for opportunistic infections (OI) included in National Medicines Register /BEG list	0
	3.16	The NAP will develop and maintain a reliable patient information system with the NHIS for the monitoring of the treatment and adherence coverage	250,000
F. The HIV/AIDS program cooperates with other public health programs	3.17	The existing cooperation of the HIV/AIDS program with other public health programs (TB, STI) will be studies and, where necessary, intensified	0
G. There will be at least 2 relief centers available for PLHIV	3.18	NGO's will improve and expand daytime and long-term care of seropositive children	350,000

H. There will be psychosocial services available for PLHIV	3.19	The NAP and NGO's will evaluate the developed 'peer counselor/buddy system' for PLHIV and, where necessary, revise and strengthen it	600,000
	3.20	The NAP will develop protocols for non-medical care with NGO's and health care institutions (including palliative care), including self-care, home care and volunteer aid	60,000
	3.21	NGO's (including home care organizations, religious organizations, employer's organizations) and the NAP will strengthen community care, home care and volunteer aid, including palliative care, material care (including food parcels) and psychosocial counseling	1,300,000
	3.22	The NAP will support the network of interreligious organizations in integrating the care and counseling of PLHIV in pastoral care	200,000
	3.23	The Ministry of Social Affairs and Public Housing will integrate the care of persons with HIV in its family coaching programs	75,000
	3.24	The NAP will have studies conducted into the number of orphans in Suriname and the characteristics of this group, in particular, the characteristics of HIV-related orphans	100,000
4. Pushing back stigma and discrimination surrounding HIV			
A. Annually, at least 1 activity will be organized by the PLHIV for the promotion of their social acceptance	4.01	PLHIV organizations, in cooperation with the NAP, will carry out programs for representation and social acceptance	200,000

B. Interventions for the control of stigma and discrimination within health care institutions have been implemented	4.02	NGO's will develop and implement relevant training courses and materials for service providers in health care, education, (social) services and other sectors based on (evaluation) studies	500,000
	4.03	The NAP and PLHIV organizations will conduct studies in the field of stigma and discrimination and will adjust the programs that need to increase the social acceptance of PLHIV	400,000
C. Supporting legislation has been developed	4.04	The NAP will support NGO's in strengthening the 'Human Rights Desk' for PLHIV	350,000
	4.05	The NAP will conduct a 'legal assessment' for facilitating a "friendly, protective" legal climate for PLHIV	50,000
	4.06	On the basis of studies and the "International Guidelines for Human Rights and HIV", the NAP will strengthen capacity to integrate human rights in HIV policies and programs	100,000
	4.07	Various ministries will develop and implement training courses for service providers, law enforcers, legislators, police officers, lawyers, etc. on sectoral legislation and protocols on PLHIV	100,000
	4.08	NGO's will contribute to the increase of the sense of justice by developing and implementing advocacy and lobbying strategies and programs on human rights and HIV	150,000
5. Strategic information for policy and rendering of services			
A. A database is available from which data for impact indicators may be retrieved	5.01	Annually, the HIV/STI Surveillance team will report on the status of the epidemic	25,000
	5.02	The NAP will support executing partners in their reporting	500,000
B. There is a National Monitoring and Evaluation system in operation	5.03	The NAP will set up a 'strategic information unit for the strategic overview, monitoring and evaluation of the NSP	1,000,000
	5.04	The Ministry of Public Health will install an "Advisory Group/Reference Group Strategic Information" for support	60,000

	5.05	The National HIV/AIDS/STI Surveillance team, based on regional (CAREC) guidelines, will set up and implement a 'third generation surveillance'	500,000
	5.06	The NAP, based on the national M&E Plan, will initiate and coordinate IBBS23	500,000
C. Policy decisions are based on evidence of nationally and internationally conducted research	5.07	The NAP will stimulate, coordinate and strengthen biomedical and social and scientific research based on a national HIV research strategy	150,000
	5.08	Every two years, the NAP will conduct a consultation on research priorities and draw up a national research agenda	100,000
	5.09	Researchers of national and international organizations will carry out HIV-related research ('action research') based on national priorities and share their results	1,000,000
	5.10	The NAP will stimulate research results to be shared with policy-makers and program makers via public presentations, publications, information technology, etc.	100.000
D. Annually, the progress of the National HIV program has been reported; and the NSP action plan has been evaluated and revised every two years	5.11	Every two years, the NAP will undertake a joint review of the implementation of the NSP with all executing partners and draw up a progress report	60.000
	5.12	The NHIS will monitor the progress of care in the public sector and prevention services via HMIS24	50.000
E. The National Reference Laboratory has been expanded and strengthened	5.13	The Bureau for Public Health will strengthen the National Reference Laboratory for the benefit of quality control of treatment and examination	500.000

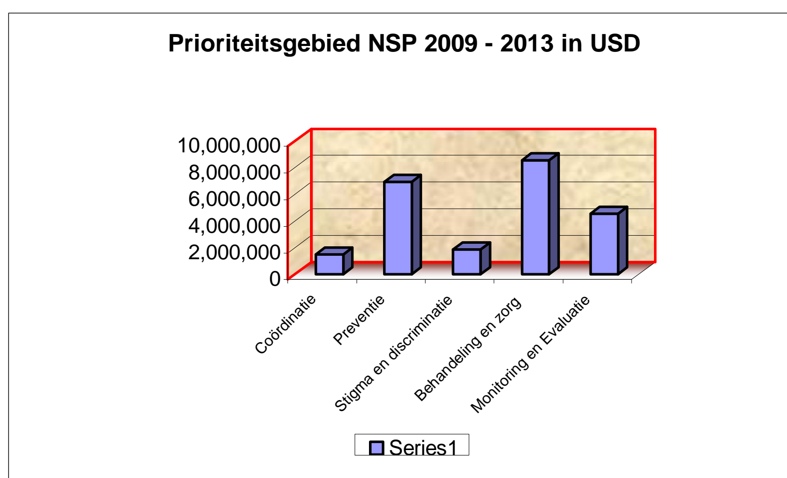
[23] Integrated Biological and Behavioral Surveillance, the recommended method to monitor the trends in HIV/STD and behavior in certain sections of the population.
[24] Health management information systems

4.3 Financing

The total costs for the NSP 2009-2013 have been estimated at USD 24,415,000. These costs may be divided as follows:

Costs per field of priority National Strategic Plan 2009-2013

	Fields of Priority	In USD	In %
1	National coordination, policy capacity-building	1,490,000	6.10
2	Prevention of the further spreading of HIV	7,950,000	32.56
3	Treatment, care and counseling	8,580,000	35.14
4	Pushing back stigma and discrimination surrounding HIV	1,850,000	7.58
5	Strategic information for policy and rendering of services	4,545,000	18.62
	TOTAL	24,415,000	100



An annual government contribution is available for financing of the NSP 2009-2013. In addition, projects are submitted to various donors of which the Global Fund is considered the biggest. For the year 2009, de resources have been partly secured as is evident from the “Financial gap” while project proposals are being prepared for the coming years.

Financial gap analysis in USD

	BUDGET					
	Total	2009	2010	2011	2012	2013
Financiers internal:						
Surinamese Government – Ministry of Public Health	10,007,714	1,007,714	1,500,000	1,750,000	2,000,000	2,250,000
Financiers external:						
Global Fund – SUR 305-GO1	945,655	945,655				
Global Fund – SUR 506-GO1	1,800,000	600,000	600,000	600,000		
Dutch Embassy	261,783	261,783				
UN organization	20,625	20,625				
Subtotal	3,028,063	1,828,063	600,000	600,000		
Financing internal & external	11,535,777	2,835,777	2,100,000	2,350,000	2,000,000	2,250,000
Total costs NSP	24,415,000	4,883,000	4,883,000	4,883,000	4,883,000	4,883,000
Financing deficit	12,879,223	2,047,223	2,783,000	2,533,000	2,883,000	2,633,000

5. IMPLEMENTATION OF THE NATIONAL HIV STRATEGY

This Chapter outlines the roles and responsibilities of the most important groups of participants involved in the implementation of the NSP and the action plans related thereto. In this regard, special attention is devoted to a number of key areas in the implementation of the NSP:

1. Planning, Revision and Reporting
2. Strategic information, M&E and Research
3. Capacity-building and Technical Assistance
4. Budget, Financial Management and Reporting

5.1 Stakeholders, roles and responsibilities

- The NAP is responsible for an effective national coordination of the implementation of the NSP and for reporting on its progress.
- Executing organizations are responsible for services, research, training and other activities, as agreed in the two-yearly action plan. Executing organizations are public and private organizations and are considered to comply with the national strategies, protocols and points of departure as set forth in the NSP.
- Development partners, such as the United Nations and technical organizations and financing mechanisms such as the GFATM, the IDB, and bilateral donors, provide technical and material support to the implementation of the NSP and the two-yearly action plans, and are considered to operate within the NSP priorities in close coordination with the NAP.

5.2 Planning, revision and reporting

- The NAP is responsible for the annual preparation of the two-yearly National Action Plan for the implementation of the NSP.
- The National Action Plan contains activities of all executing organizations in the national response. In order to guarantee the feasibility, only activities have been included for which guaranteed financing and other resources are available. The Action Plan serves as an important management instrument of the NAP, and for fundraising.
- Annually, based on the reports of all executing organizations, the NAP will report on
  - the implementation of planned activities in the Action Plan, and the progress in achieving the (secondary) goals of the NSP.
- Based on the evaluation of the progress, the Action Plan will be revised for the next two years with the cooperation of all executing organizations.

5.3 Strategic information, M&E and research

- The NAP is responsible for the development and the implementation of the Strategic Information strategy.
- The objective of the Strategic Information Unit is to collect and analyze data from various sources and transform this data into strategic information for use by various partners in the national HIV response.
- The basis of the Strategic Information is constituted by the national indicators for the HIV response at the level of impact, outcome and output[25].
- Third generation surveillance as prescribed by CAREC/PAHO is the method for monitoring the epidemic, the response, and the quality of care and prevention.
- Components of third generation surveillance are:
    - epidemiological surveillance;
    - behavioral surveillance;
    - evaluation of quality and access to services;
    - specific program evaluation.
- Research methods that are used herefor are, among others:
    1. integrated HIV/STI and behavioral sentinel surveillance in certain groups;
    2. HIV/AIDS/STI, mortality and morbidity surveillance;
    3. population research, among others, via multi-indicator cluster surveys (MICS);
    4. Institutions and services surveys/audits;
    5. activity reports by executing organizations.
        - HIV/STI behavioral sentinel surveillance will be outsourced by the NAP to local researchers providing international technical assistance, where required.
        - Mortality and morbidity surveillance are part of the national NHIS system performed by the existing HIV surveillance group, in particular the Department of Epidemiology of the BOG.
        - MICS (or other national medical screening of the population such as DHS) will be performed by the Ministry of Public Health with technical and financial support of development partners.
        - Surveys and audits at institutions and of services are carried out by third parties to evaluate the access to and quality of certain services, such as VCT, PMTCT, ART according to (where necessary, adjusted) international protocols.
        - Reporting by executing organizations must take place regularly (monthly, quarterly or annually) by means of simple forms, where possible, automated.
- To support the third generation surveillance, biometric, social and scientific research will have to be stimulated. An advisory committee will advise the

[25] See Annex. These are based on international commitments and regional ‘best practices’.

NAP annually on priorities for HIV research. The NAP will guarantee that all research results will be broadly accessible, via publications, national HIV conferences, and other methods.

- Medical and ethical review of HIV-related research is crucial. If possible, this will be guaranteed by existing structures but, where necessary, by a specific committee.

5.4 Capacity-building and technical assistance

- The NAP will develop a "capacity-building team" with the main objective of ensuring that executing organizations are able as much as possible to adequately perform their responsibilities and duties.
- Based on the NSP 2009-2013 and the Action Plan, the NAP will have a capacity and training need determination of the NAP and all executing organizations performed. This assessment includes the technical and institutional capacity that is necessary for individuals and organizations.
- The NAP will also make an overview of the available national, regional and international technical assistance that can be tapped in order to help alleviate the identified shortcomings in capacity.
- Based on the above, the capacity-building team will develop a capacity-building strategy for the NSP and regular annual plans. They will be responsible for the implementation and reporting.
- The Ministry of Public Health will invite the UN organizations to develop a 'Joint UN Implementation Support Plan' with agreements on international TA. Other international technical organizations (such as FHI, UWI, etc) will be invited to propose what type of technical support they can offer in the implementation of the NSP.
- The NAP is responsible for developing technical protocols, coordinating training courses for relevant service providers as well as for quality control. Technical protocols will be developed on an 'adopt and adapt' basis, meaning that international best practice training manuals will be used as a basis and adjusted to the local context, where necessary.
- The capacity-building team is also responsible for the development of a (virtual and/or material) 'national HIV Information center' based on which an information need determination among the executing organizations will be performed.

5.5 Budget, financing, financial management and reporting

NSP budget and financing

- The Ministry of Public Health (administration team) is responsible for the regular determination of costs for implementation of the NSP and for raising the funds for this. In this regard, a 'costing' will be performed with international technical assistance. The Ministry of Public Health will also develop a fundraising strategy and related action plan.

- The financing of the NSP and the budget of the action plan 2009/2010 is partly external (from development partners), partly national (Government, business community, contributions from other local executing organizations).
- Donors will be asked to harmonize their financial support as much as possible with financial systems of the Government of Suriname (financial year, reporting, financial audit, etc.)
- Flows of money go via the Ministry of Public Health (for example, funds of GFATM, IDB, NEDA) or directly to executing organizations (for example, NGO's and ministries).

Financial management and reporting

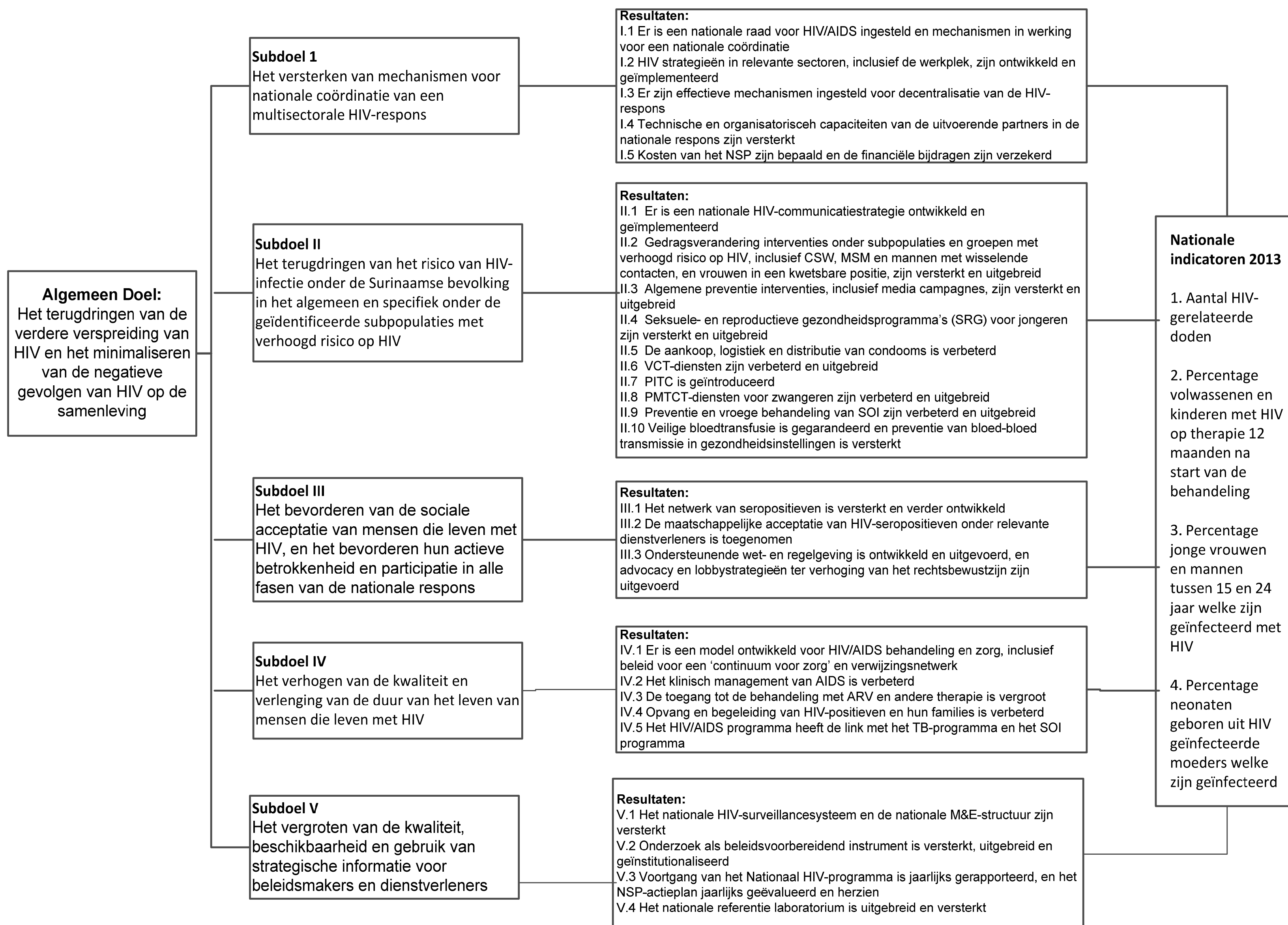
- Executing organizations with a direct link to donors report about their expenses to their donors, but they will be requested to send a copy of their financial and progress reports to the NAP.

Notes in the preparation of the budget action plan 2009/2010 and NSP budget

- In preparing the estimations for 2009/2010, only actually guaranteed activities have been included.
- Certain entries (activities) belong to the regular operational activities of the Government and/or ministries, or institutions. No amount has been budgeted for this.
- Certain activities regard the recruitment of personnel. These entries will have to be included in the budgets of the respective ministries (for 2009 by means of a Note of Amendment) after approval of the Budget NSP.

The points of departure for the indicative budget 2009-2013 are

1. real costs for the implementation in past years;
2. the estimated costs of the Action Plan 2009/2010;
3. estimations of new activities based on regional comparisons;
4. gradual increase of scope and access to services over the years.


Algemeen Doel:
Het terugdringen van de verdere verspreiding van HIV en het minimaliseren van de negatieve gevolgen van HIV op de samenleving
Subdoel 1
Het versterken van mechanismen voor nationale coördinatie van een multisectorale HIV-respons
Resultaten:
I.1 Er is een nationale raad voor HIV/AIDS ingesteld en mechanismen in werking voor een nationale coördinatie
I.2 HIV strategieën in relevante sectoren, inclusief de werkplek, zijn ontwikkeld en geïmplementeerd
I.3 Er zijn effectieve mechanismen ingesteld voor decentralisatie van de HIV-respons
I.4 Technische en organisatorisceh capaciteiten van de uitvoerende partners in de nationale respons zijn versterkt
I.5 Kosten van het NSP zijn bepaald en de financiële bijdragen zijn verzekerd
Subdoel II
Het terugdringen van het risico van HIV-infectie onder de Surinaamse bevolking in het algemeen en specifiek onder de geïdentificeerde subpopulaties met verhoogd risico op HIV
Resultaten:
II.1 Er is een nationale HIV-communicatiestrategie ontwikkeld en geïmplementeerd
II.2 Gedragsverandering interventies onder subpopulaties en groepen met verhoogd risico op HIV, inclusief CSW, MSM en mannen met wisselende contacten, en vrouwen in een kwetsbare positie, zijn versterkt en uitgebreid
II.3 Algemene preventie interventies, inclusief media campagnes, zijn versterkt en uitgebreid
II.4 Seksuele- en reproductieve gezondheidsprogramma's (SRG) voor jongeren zijn versterkt en uitgebreid
II.5 De aankoop, logistiek en distributie van condooms is verbeterd
II.6 VCT-diensten zijn verbeterd en uitgebreid
II.7 PITC is geïntroduceerd
II.8 PMTCT-diensten voor zwangeren zijn verbeterd en uitgebreid
II.9 Preventie en vroege behandeling van SOI zijn verbeterd en uitgebreid
II.10 Veilige bloedtransfusie is gegarandeerd en preventie van bloed-bloed transmissie in gezondheidsinstellingen is versterkt
Subdoel III
Het bevorderen van de sociale acceptatie van mensen die leven met HIV, en het bevorderen hun actieve betrokkenheid en participatie in alle fasen van de nationale respons
Resultaten:
III.1 Het netwerk van seropositieven is versterkt en verder ontwikkeld
III.2 De maatschappelijke acceptatie van HIV-seropositieven onder relevante dienstverleners is toegenomen
III.3 Ondersteunende wet- en regelgeving is ontwikkeld en uitgevoerd, en advocacy en lobbystrategieën ter verhoging van het rechtsbewustzijn zijn uitgevoerd
Subdoel IV
Het verhogen van de kwaliteit en verlenging van de duur van het leven van mensen die leven met HIV
Resultaten:
IV.1 Er is een model ontwikkeld voor HIV/AIDS behandeling en zorg, inclusief beleid voor een 'continuum voor zorg' en verwijzingsnetwerk
IV.2 Het klinisch management van AIDS is verbeterd
IV.3 De toegang tot de behandeling met ARV en andere therapie is vergroot
IV.4 Opvang en begeleiding van HIV-positieven en hun families is verbeterd
IV.5 Het HIV/AIDS programma heeft de link met het TB-programma en het SOI programma
Subdoel V
Het vergroten van de kwaliteit, beschikbaarheid en gebruik van strategische informatie voor beleidsmakers en dienstverleners
Resultaten:
V.1 Het nationale HIV-surveillancesysteem en de nationale M&E-structuur zijn versterkt
V.2 Onderzoek als beleidsvoorbereidend instrument is versterkt, uitgebreid en geïnstitutionaliseerd
V.3 Voortgang van het Nationaal HIV-programma is jaarlijks gerapporteerd, en het NSP-actieplan jaarlijks geëvalueerd en herzien
V.4 Het nationale referentie laboratorium is uitgebreid en versterkt
Nationale indicatoren 2013
1. Aantal HIV-gerelateerde doden
2. Percentage volwassenen en kinderen met HIV op therapie 12 maanden na start van de behandeling
3. Percentage jonge vrouwen en mannen tussen 15 en 24 jaar welke zijn geïnfecteerd met HIV
4. Percentage neonaten geboren uit HIV geïnfecteerde moeders welke zijn geïnfecteerd

General objective:
To push back the further spreading of HIV and minimizing the negative consequences of HIV on society

Secondary objective 1
To strengthen mechanism for national coordination of a multisectoral HIV response

Results:

- I.1 A national HIV/AIDS Council has been established and mechanisms have been put into operation for national coordination
- I.2 HIV strategies in relevant sectors, including the workplace, have been developed and implemented
- I.3 Effective mechanisms have bee established for decentralization of the HIV response
- I.4 Technical and organizational capacity of the executing partners in the national response have been strengthened
- I.5 Costs of the NSP have been determined and the financial contributions secured

Secondary objective II
To push back the risk of HIV infection among the Surinamese population in general and, specifically, among the identified subpopulations with increased risk of HIV

Results:

- II.1 A national HIV communication strategy has been developed and implemented
- II.2 Behavior change interventions among subpopulations and groups with increased risk of HIV, including CSW, MSM and men with many different contacts, and women in a vulnerable position, have been strengthened and expanded
- II.3 General prevention interventions, including media campaigns, have been strengthened and expanded
- II.4 Sexual and reproductive health care programs for young people have been strengthened and expanded
- II.5 The procurement, logistics and distribution of condoms have been improved
- II.6 VCT services have been improved and expanded
- II.7 PITC has been introduced
- II.8 PMTCT services for pregnant women have been improved and expanded
- II.9 Prevention and early treatment of STI have been improved and expanded

II.10 Safe blood transfusion is guaranteed and prevention of blood-to-blood transmission in health care institutions has been strengthened

Secondary objective III
To promote social acceptance of people living with HIV and to promote their active involvement and participation in all stages of the national response

Results:
III.1 The network of seropositives has been strengthened and further developed
III.2 Social acceptance of HIV seropositives among relevant service providers has been increased
III.3 Supporting legislation has been developed and implemented and advocacy and lobbying strategies to increase the sense of justice have been implemented

Secondary objective IV
To increase the quality of life and the life expectancy of people living with HIV

Results:
IV.1 A model has been developed for HIV/AIDS treatment and care including a policy for 'continued care' and a reference network
IV.2 The clinical management of AIDS has been improved
IV.3 Access to treatment with ARV and other therapies has increased
IV.4 Care and counseling of HIV positive persons and their families have been improved
IV.5 The HIV/AIDS program has been linked to the TB program en STI program

Secondary objective V
To increase the quality, availability and use of strategic information for policymakers and service providers

Results:

V.1 The national HIV surveillance system and the national M&E structure have been strengthened

V.2 Research as policy-preparing instrument has been strengthened, expanded and institutionalized

V.3 Progress reports on the national HIV program have taken place annually and the NSP action plan has been evaluated and revised annually

V.4 The national reference lab has been expanded and strengthened

National Indicators 2013

1. Number of HIV related deaths

2. Percentage of adults and children with HIV in therapy 12 months after the start of the treatment

3. Percentage of young women and men between the ages of 15 and 24 that are infected with HIV

4. Percentage of neonatals born from HIV-infected mothers that are infected

Figure 1

Jaarlijks aantal nieuwe HIV gevallen – Annual number of new HIV cases

Man – Male
Vrouw – Female
Totaal – Total
Jaar – Year

Figure 2

Alle lft gr – All age groups
Lft gr 15-24 jr – Age group 15-24

Figure 4

Zwangerschap - Pregnancy
Medische indicatie – medical indication
Walk-in - idem
Verzekering - Insurance
Beurs/keuring – Grant/physical

Figure 5

Creool – Creole
Marron – Maroon
Hindoestaan – Hindustani
Javaan – Javanese
Indiaan – Indigenous people
Chinees – Chinese
Anders – Other
Onbekend – Unknown

Etnische groep – Ethnic group

Aantal - Number

Chart Hoofdstuk 4.3.

Prioriteitsgebied NSP 2009-2013 in USD – Field of priority NSP 2009-2013 in USD

Coordinatie - Coordination
Preventie - Prevention
Stigma en discriminatie – Stigma and discrimination
Behandeling en zorg – Treatment and care
Monitoring en evaluatie – Monitoring and evaluation