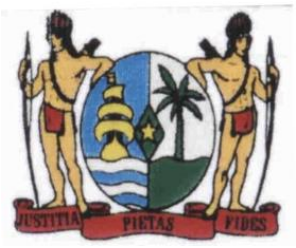


Suriname

AIDS Response Progress Report

January 2009 – December 2011

Ministry of Health
Henck Arronstraat 64
Paramaribo - Suriname

April 10th, 2012

Table of Contents

List of Acronyms

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

Introduction

The Government of Suriname adopted the UNGASS Declaration of Commitment in June 2001, thus emphasizing the national commitment to the response against HIV and AIDS.

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

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

A great deal of the progress was made possible through external financial assistance. The majority of this funding consisted of the Global Fund grants. As donor funding reduces over time and in particular as the current Global Fund HIV/AIDS grants ceased to exist, it is of utmost importance to move from donor support to full coverage by the Government. The policy of MOH is based on the assumption of an overarching policy. In this all needed health services are integrated and linked with each other whereby Primary Health Care (PHC) is discharging a fundamental role. Another starting point that is founded in MOH its view is that HIV is recognized as a chronic disease. Within this framework prevention and addressing risk factors as well as providing care and treatment are key components of the response and the Ministry has commenced with the implementation of various strategies such as the integration of HIV-services in the existing healthcare and the increased governmental budget for HIV.

In this 2012 update of the UNGASS Declaration of Commitment in the fight against HIV/AIDS outlines the report writing process, an overview of the status of the epidemic, the programmatic and political national response to HIV/AIDS and its monitoring based on the UNGASS indicators. The update is concluded by identified challenges and associated remedial actions.

1. Status at a glance

1.1. Report writing process

All public sector stakeholders were part of the report writing process. The different departments, involved in HIV, were asked to provide information relevant to their field of work. The UN agencies, PAHO/WHO, were also part of the process by filling out the NCPI part B. A consensus meeting was held with the different stakeholders to discuss the analysis process and the results.

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

1.2 The status of the epidemic

Suriname has a generalized epidemic with an estimated prevalence of 1% of the adult population (age 15-49) (UNAIDS 2010 Global report). These estimates are in line with the HIV prevalence of 1%, found among pregnant women since more than5 years. Meanwhile the prevalence in the MARPs (Most at Risk Populations) such as MSM and Sex Workers (SW) is higher than the general adult population i.e. 6.7% among MSM in 2004 and 6.7% among sex workers in the capital city Paramaribo in 2009.

Since the first case of HIV was registered in 1983, scaling-up of HIV-testing led to an increase in the number of persons tested on HIV, and an increase in the number of newly registered HIV-cases. This increase continued till 2006, with a maximum of 740 newly registered cases. However, since 2007 there has been a steady decline in the number of newly registered HIV-cases; 527 in 2010 (see figure 1) [1].

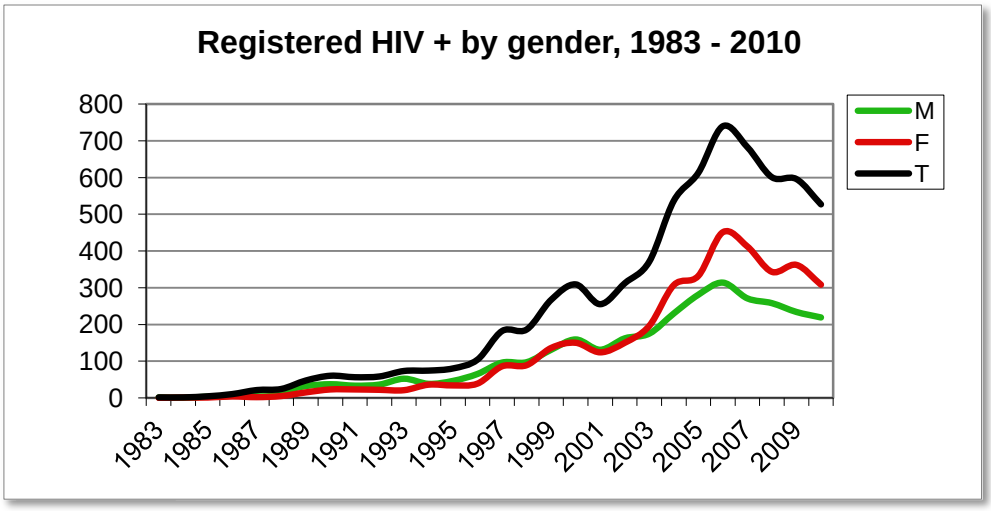


Figure 1: Number of people reported HIV positive by gender, 1983 - 2010

Among the HIV test done in the past years, the diagnosed women are more men, especially since 2003, when HIV testing of pregnant women was introduced and more women got tested.

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

Although there is a decrease in new infections, the annual numbers of HIV related hospitalizations after the initial decrease from 255 in 2004 to 215 in 2008, is showing a slight increase. In 2010 the hospitalizations were already 237. The increase is primarily due to the increase in men hospitalized because of HIV. Most hospitalized women are in the age group 20 - 44 years while the majority of male patients are in the age group 25 - 49 years.

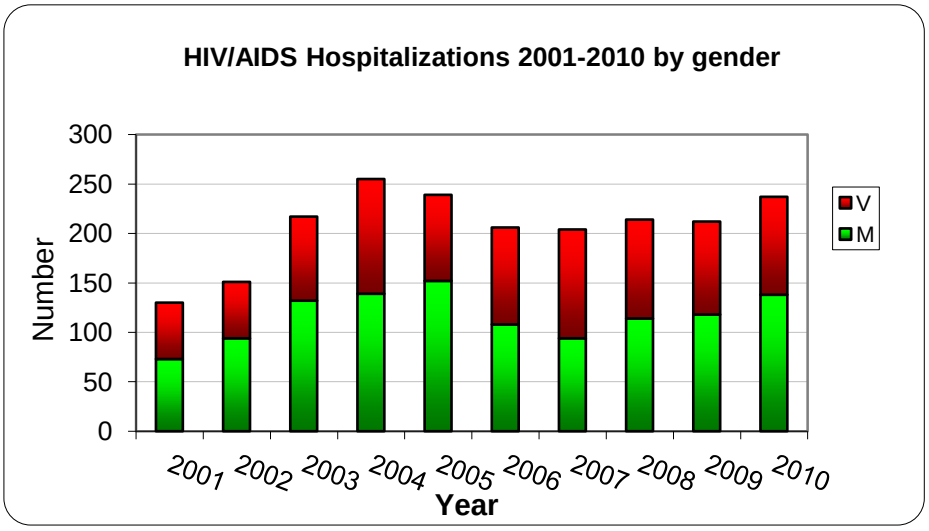


Figure 2: Number of hospitalizations for HIV/AIDS by sex, 2001 – 2010

Source: Bureau of Public Health, Epidemiology department

With the increasing availability of anti-retrovirals, especially since the start of the Global Fund in 2005, the numbers of people on treatment have been steadily increasing. There is a more than 3 times increase of people on treatment from 346 in 2005 to 1276 in 2011 (see figure 3)

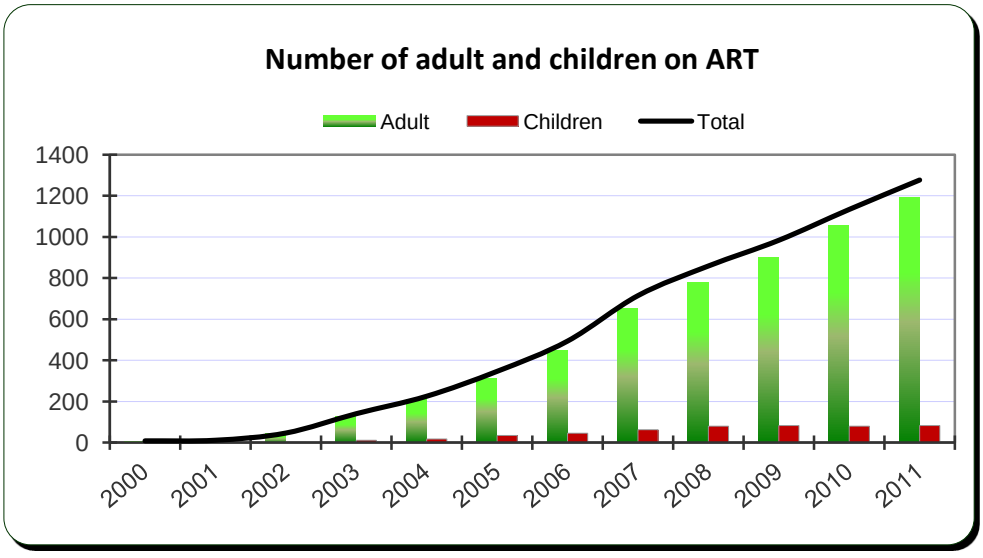


Figure 3: Number of adult and children on ART, 2000 – 2011

From 1997 to 2010, the cumulative number of certified cases of AIDS deaths is 1713. There are indications that the annual death rate due to AIDS has decreased. In 2005 a maximum of 181 persons deaths due to AIDS were registered, but in 2009 this number dropped to 106. AIDS dropped from fifth to sixth place on the list of most frequent causes of death, in 2006. Some explanations for this decrease could be the increase of early diagnostics, especially in the context of PMTCT, and the steady increase of people on antiretroviral drugs (ARV).

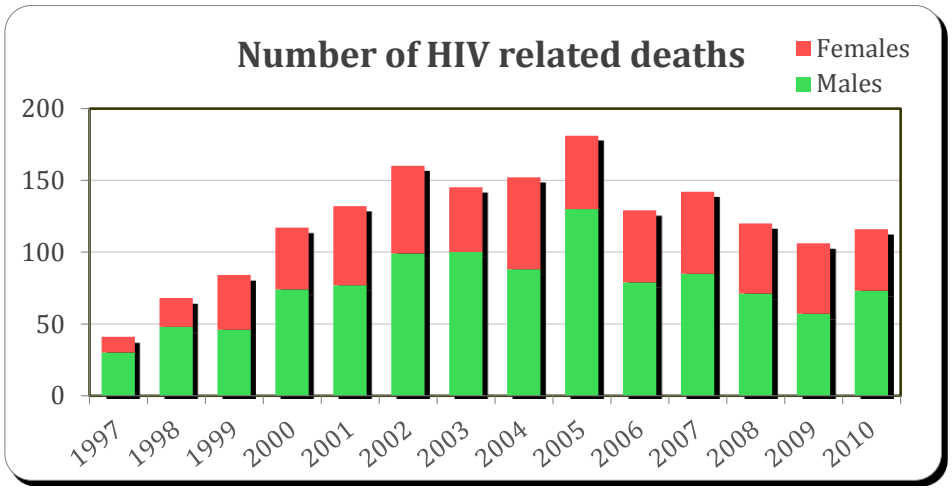


Figure 4: Number of HIV related deaths, 1997 – 2010

1.3 Policy and programmatic response

The National Strategic Plan for a multi sectoral approach of HIV/AIDS guides the HIV response in Suriname.

The following 5 priority areas for strategic interventions were identified:
1. National Coordination, Policy and Capacity building
2. Prevention of further spread of HIV
3. Treatment, Care and Support
4. Reduction of stigma and discrimination of PLHIV
5. Strategic Information for policy development and service provision

The NSP outlines a multi sectoral approach involving other ministries and all relevant sections of society and it serves as the national framework for expanding and strengthening the multi sectoral response against HIV/AIDS. In 2009 the Ministry of Health (MOH) has set up a structure for leadership of the national HIV response. There is strengthened coordination of the HIV-response through establishment of a national multi-sectoral HIV-board, with its Technical Working Groups on Prevention, Treatment and Care and Monitoring & Evaluation as it working-arms.

1.4. UNGASS indicators overview table, 2006 – 2011

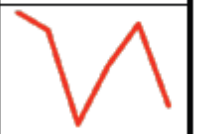
No	Indicator name	Source	Comments	Years						Trend
Reduce sexual transmisision of HIV by 50% by 2015										
	Indicators for the general popuations	*Source*	*Comments*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011**	
1.1	Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	MICS		41				41.9		
1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	MICS		9.2				9.6		
1.3	Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	MICS		1				2.5		
1.4	Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse	MICS						37		
1.5	Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	MICS		30.2				20.3		
1.6	Percentage of young women and men aged 15-24 who are HIV infected	National HIV Test database		1	0.9	0.9	1	0.7		
	Indicators for sex workers	*Source*	*Comments*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011**	
1.7	Percentage of sex-workers reached with HIV prevention programmes	BSS					36.29			
1.8	Percentage of sex-workers reporting the use of a condom with their most recent client	BSS	*vaginal*				98.4			
			anal				87			
			oral				94			
1.9	Percentage of sex-workers who received an HIV test in the last 12 months and who know their results	BSS					94.70			
1.10	Percentage of sex-workers who are HIV-infected	IBBS					7.20			

Indicators for men who have sex with men		Source	Comments	2006	2007	2008	2009	2010	2011*
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*					55.20%	
1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	BSS	*Looked at condom use with last paying partner*					53.3	
1.13	Percentage of men who received an HIV test in the last 12 months and who know their results	BSS						97	
1.14	Percentage of men who are HIV-infected	IBBS	2010 IBBS was conducted but for HIV testing there was a high refusal rate of 80%						

Reduction of HIV among injecting drugusers	
Indicator 2.1 - 2.5	Not Applicable for Surinamese setting

Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths										Trend
No	Indicator	Source	Comments	2006	2007	2008	2009	2010	2011*	
3.1	Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	Treatment database	Denominator =100	64	79	83	86	79	112	
3.2	Percentage of infants born to HIV-infected women receiving a virological test for HIV within 2months of birth	PMTCT database	Nominator: Number of living children born out of HIV infected mothers for whom a PCR result is known; Denominator: Number of children born out of HIV pos mothers (excluding still births, early deaths)							
			N/A		17.6	16.5	2.5	67.6	76.4	
3.3	Estimated percentage of child HIV infections from HIV positive women delivering in the past 12 months (modelled)	Spectrum sofware, 2012		18.1	12.3	10.2	8	7.1	5.6	

*Preliminary data: still subject to change

Have 15 million people living with HIV on ART by 2015										Trend
No	*Indicator*	*Source*	*Comments*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011**	
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	66.6	
4.2	Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral treatment	Treatment database		81	78	62	72	79	65.2	
Reduce TB deaths in people living with HIV by 50% by 2015										Trend
No	*Indicator*	*Source*	*Comments*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011**	
5.1	Percentage estimated HIV-positive incident TB cases that received treatment for TB and HIV	NTP / treatment database			32	60	50	45	56	
Reach a significant level of annual global expenditure (US22-24 billion) in low-and middle-income countries										Trend
6.1	Domestic and International AIDS spending by categories and financing sources	NASA					4,037,170.46	6,129,853.40	4,674,508.15	
Critical enablers and synergies with developmenr sectors										
No	*Indicator*	*Source*	*Comments*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011**	
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	
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: Not available *** 2011: preliminary data; still subject to change**

2. Overview of the AIDS epidemic

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

2.1. HIV test surveillance

Of the persons tested for HIV in Suriname, the prevalence among the tested men is higher compared to women. An explanation is that women are being tested regularly because of the PMTCT program , compared to the men who are mostly being tested when they have symptoms.

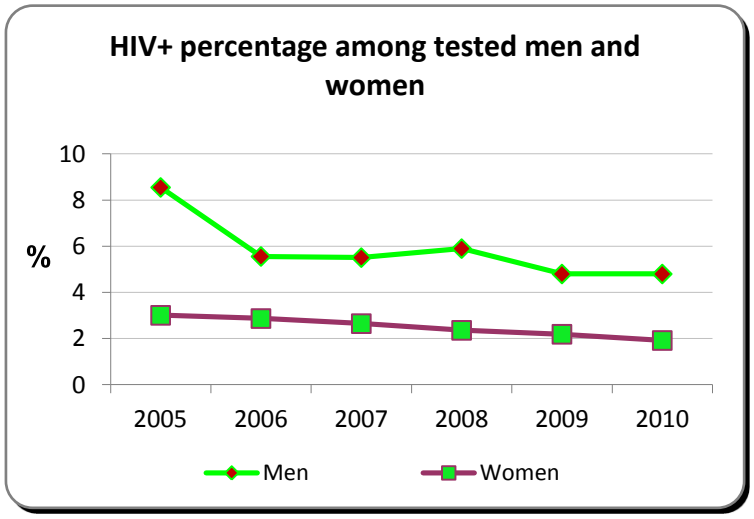


Figure 5: Percentage of HIV positive tested men and women among men and women testing for HIV, 2005 – 2010

2.2. Screening of pregnant women

Pregnant women constitute a cross-section of the general, sexually active population and therefore provide a reasonable estimation of the extent to which HIV has spread among the population. In 2005, 78% of all pregnant women were tested for HIV, which increased to 84% in 2010 (see figure 6).

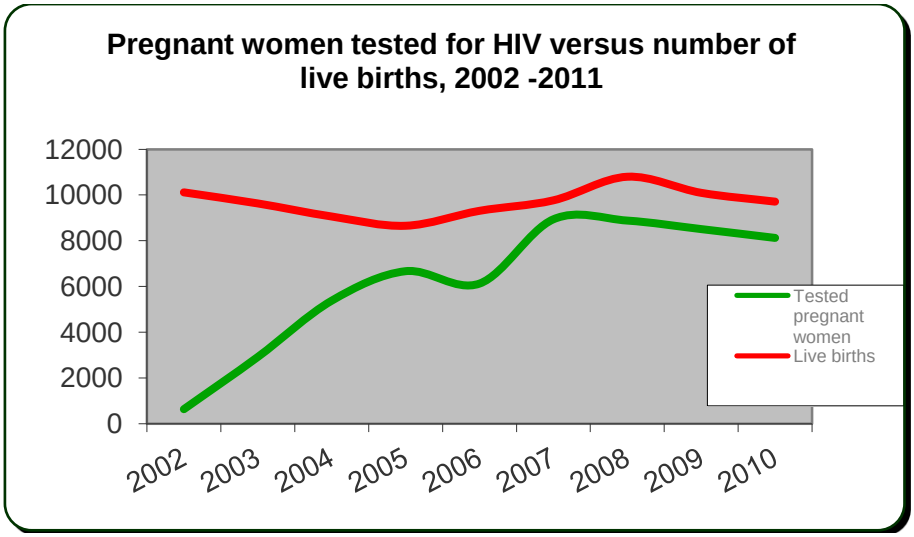


Figure 6: HIV test coverage based on pregnant women tested compared to live births, 2002 – 2010

The HIV prevalence found was on average 1.0% from 2003 to 2010. The prevalence in the age group 15-24 year is slightly less compared to the prevalence in all ages. In 2010 the prevalence in the 15-24 year age group the prevalence was 0.7%.

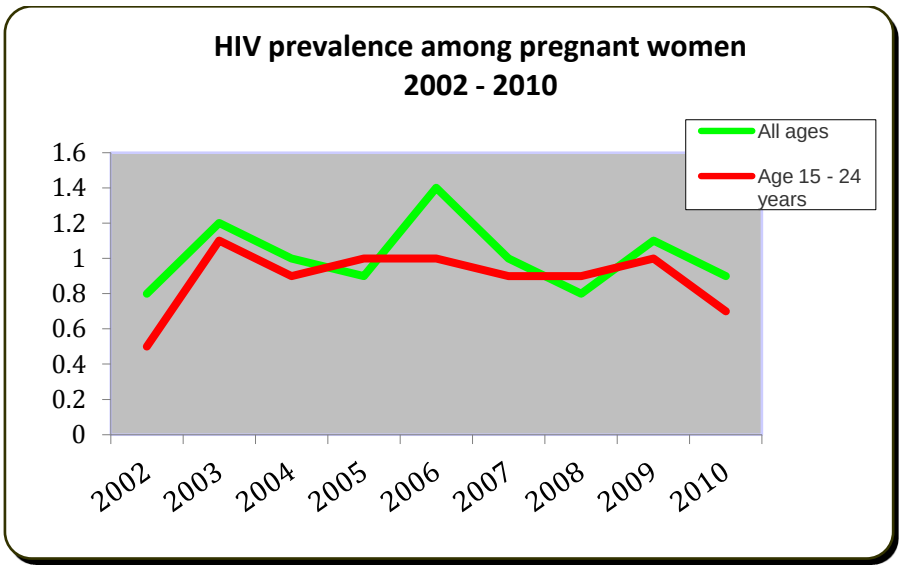


Figure 7: HIV prevalence among pregnant women, 2002 – 2010

2.3. Screening of Blood donors

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

[2] Bloodbank annual data

2.4. Screening of Tuberculosis patients

From 2000 - 2003 on average 64 % of TB patients were tested on HIV. Of these persons tested, 23% were HIV positive. In the next 4 years, from 2004 – 2008, the average percentage of testing went up (to 72 %), while the HIV prevalence remained more or less the same (24%).

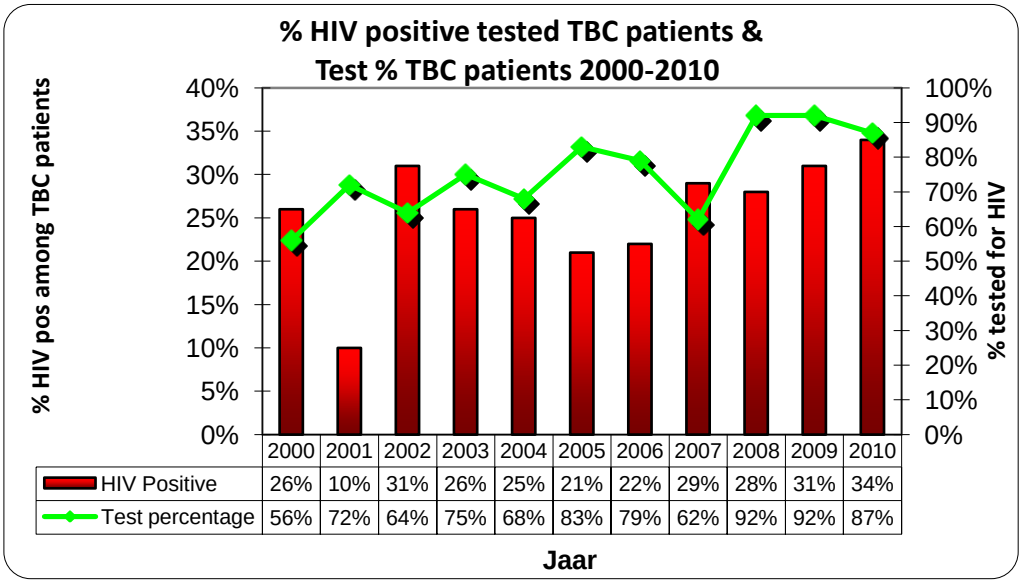


Figure 8: Percentage of TB patient tested for HIV and HIV prevalence among TB patients, 2000– 2010
Source: National Tuberculosis Programme, 2011

2.5. Special surveys among MARP's

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

These populations are:

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

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

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

Table 2: Overview of HIV prevalence among MARPS, 1986 - 2009

In 2010, HIV-testing was included in the BSS study for MSM, but because of a high refusal rate for takingthe HIV test of 20% of surveyed MSM, the conclusions might not be valid Based on thethe estimated HIV prevalence generated from Spectrum software, indeed the SW's prevalence is declining steadily but the prevalence of MSM is declining much slower and is rather staying stable at 6% (figure 9)

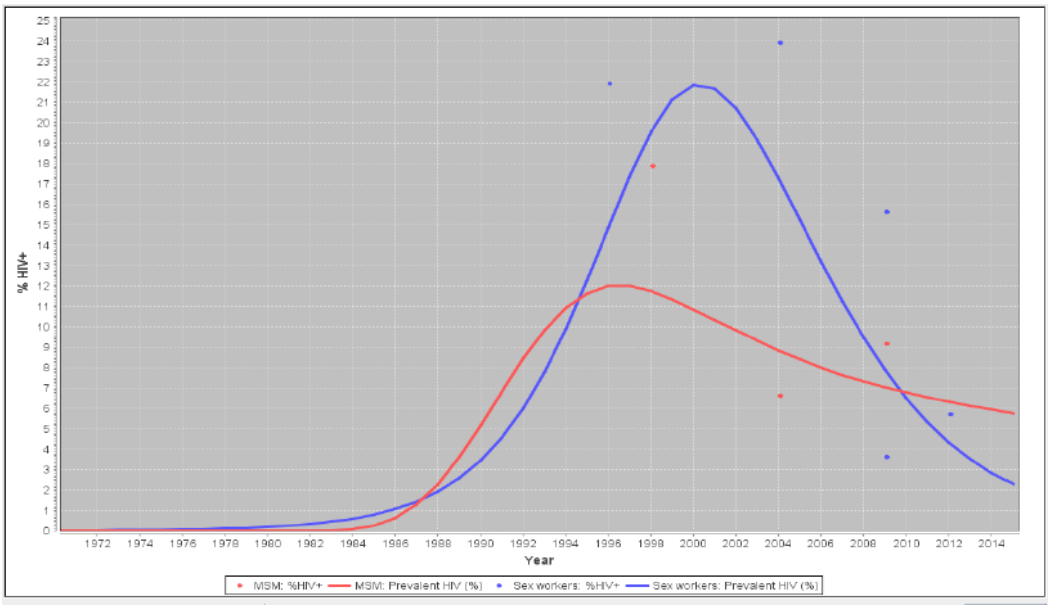


Figure 9: Estimated MSM and SW prevalence curve from Spectrum files, march 2012

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

3. National response to the AIDS epidemic

For the implementation of the NSP 2009 – 2013, Suriname came to the development of a new national Coordination structure (figure 10).

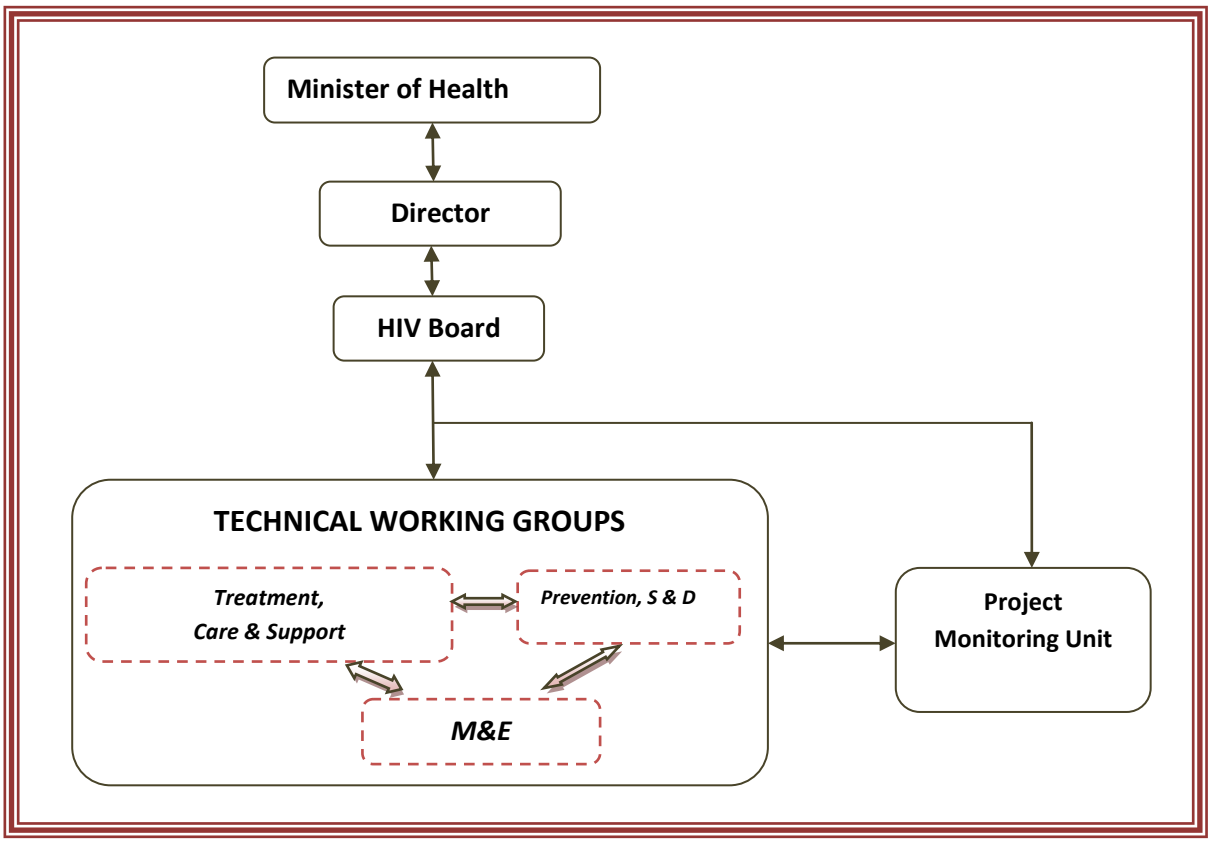


Figure 10: Organizational structure of the Suriname HIV/AIDS Programme

An HIV Board was installed, residing under the Director of Health. This Board has technical working groups advising and implementing the technical part of the HIV response. For good monitoring of the HIV related projects, such as Global Fund, a Project Monitoring Unit is responsible.

3.1 Multi-sectoral Participation

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

HIV is of high priority in Suriname's current Multi-Annual Development Plan, 2006-2011, and in several other national policy documents, among others the "National Gender Action Plan" and the "Sexual and Reproductive health Policy".

Based on the NSP, increased efforts were made to include more partners in the response, which generated rewarding results. Since 2004, the private sector and faith based organisations increased their involvement and separate structures and mechanisms were put in place for an effective participation in the response. In this regard the Suriname Business Coalition (SBC) was established, and together with the government, resources were mobilized for the development of HIV workplace policies and programs, which in the past years have been implemented.

3.2 Financial commitment to the national HIV response

As part of the national commitment and actions the government is providing support through increased budget allocations for the HIV response.

In 2008 the government of Suriname, in particular the Ministry of Health, allocated a specific budget for the national coordination of the HIV response, amounted US$ 800,000. In the approved budget for 2009, the allocated government funds have been scaled up to US$1,007,714.

On a much smaller scales other ministries have also increased their expenditures on HIV. As external financial sources decrease the government of Suriname is spending more on HIV as shown by NASA done for 2009 -2011 (figure 11)

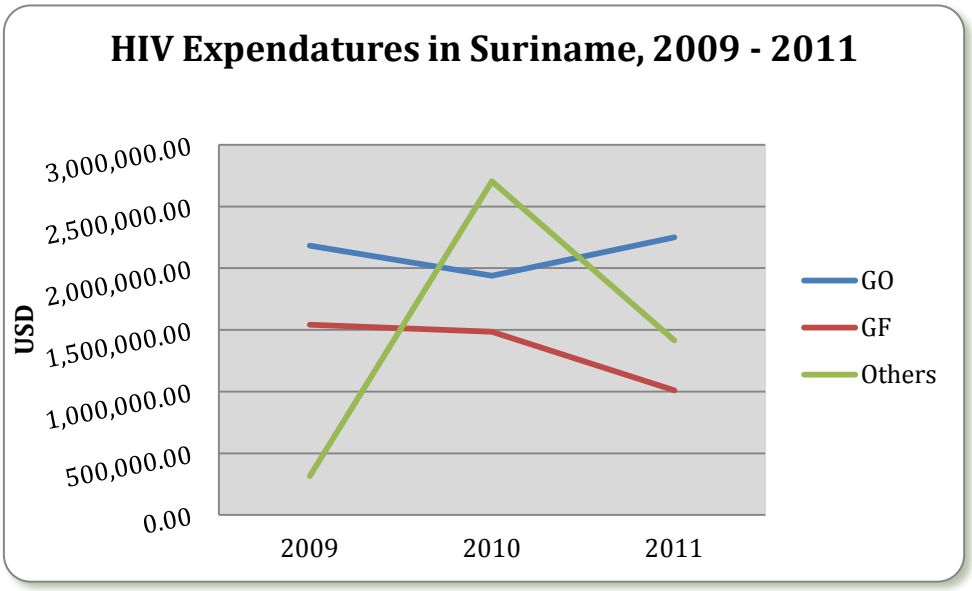


Figure 11: HIV expenditures by funders 2009 - 2011, NASA results

4. Best practices

Suriname provides treatment and care through its decentralized Primary Health Care network of Primary Health Care centers. The PMTCT program is embedded within this network. This PMTCT program has made significant progress leading to:

- An increase of women being tested on HIV. In the beginning years of the program about 30% were tested. This number increased significantly and is now around 85%
- A decrease of infants – born out of HIV-positive mothers - with HIV. In 2010, of the 54 known PCR's, 4 were tested positive. In 2011, of the 81 known PCR's, one baby was tested positive. In January 2012 there were 15 deliveries. Of the 10 PCR results already in, none are positive
- An increase in the HIV positive mothers and their children receiving ARV to prevent transmission from mother to child. In 2011, 98% of the children born out of HIV positive women received ART

Several actions led to these successes:

- A Focal Point was installed in 2010 (as result of the exchange program in 2009 with Belize). Since the introduction of the Focal Point there is an improved communication between the MOH and its partners in the field. Also, there is now a more reliable overview of the current situation on PMTCT
- The national guidelines have been updated in 2010 according to the latest WHO guidelines and healthcare workers are trained in these
- Women are informed and encouraged to utilize existing health services. The aim is that pregnant women visit antenatal services as early as possible. On World AIDS Day 2010 a campaign has started to promote this
- The integration of services: the aforementioned integration of PMTCT into maternal- and child health services has been strengthened. A good example of this is the 's Lands Hospital (one of the 5 major hospitals in Suriname). A documentary has been made of the PMTCT program in Suriname, and using the setting of 's Lands Hospital as a best practice where PMTCT is integrated in all the mother and child services (such as the "mother and child clinic", "under 5 clinic" and "family planning clinic"). Unique is the active involvement of the male partners of the pregnant women. It is nowadays not uncommon to observe that these services are significantly visited by male partners

5. Major challenges and remedial actions

Major challenges

While there are successes, some major challenges remain to be addressed, such as:

- the vulnerability of communities and individuals (especially MARPs) due to HIV related stigma and discrimination, gender inequalities, poverty and socio-cultural barriers
- the elimination of transmission of HIV from mother to child
- the utilization of the existing health services
- sustaining and improving current achievements while major grants have ceased to exist

Remedial actions

In order to overcome these challenges, programs, policies and health services have to be improved. It is therefore critical to move away from donor funding and to integrate and link all needed health services with each other whereby Primary Health Care (PHC) is discharging a fundamental role. Within this framework the Ministry has commenced with the implementation of various strategies[3]:

Financing

Noticeably there is a growing trend of activities and services that are being financed by the Ministry of Health. Over the years MOH its contribution has increased to a total of SRD 5.5 million per year. Based on the current exchange rate it is about approximately US$ 1.64 million.

Leadership and Governance

MOH has set up a structure for leadership to the national HIV response. There is strengthened coordination of the HIV-response through establishment of a national multi-sectoral HIV-board in 2009, with its Technical Working Groups on Prevention, Treatment and Care and Monitoring & Evaluation as it working-arms.

Capacity building

The Centre of Excellence (CoE) for HIV Care and Treatment was put in place to support building specific HIV capacity in the decentralized PHC delivery networks of the country, to assure integrated HIV services and the improvement of quality delivery systems.

Integration of HIV services

MOH is focusing on assuring that specific capacity needs for prevention, treatment and care are available in the existing Primary Health Care (PHC) system of Suriname. Implementation requires involvement of a number of strategies. And it also requires decisions to be taken on different levels. One of the results MOH is aiming at from a particular point of view is the inclusion of ARTs in the “Nationale Geneesmiddelen Klapper (NGK)” (National Essential Medicines List).

[3] GF sustainability plan 26 September 2011 (Firoz Abdoel Wahid and Hedwig Goede)

An onset has been made with the further integration of HIV services in the existing health system and with other programs. For example, PMTCT is integrated with the reproductive health program and integration is also taking place with the TB program and the STI program.

Similar to Care and Treatment the integration of HIV prevention is taking place. An information center for Health Promotion and HIV Prevention, named Libi! (Live!) is established. HIV education and information is integrated into health promotion and healthy lifestyle initiatives through this information centre "Libi!" is also collaborating with the Public and Civil Society Organizations.

From the point of view that HIV is recognized as a chronic disease MOH will be building linkages between HIV as a chronic disease and Non Communicable Diseases (NCDs).

Strengthening Service Provision

MOH is embarking on strengthening comprehensive PHC which will provide the foundation for sustainable health care, including for HIV. Integration of HIV services will only have positive results on HIV prevention, care and treatment, when there is sufficient health system capacity. Therefore, to achieve sustainable results in HIV it is important to put efforts in strengthening the service provision component of the health system. The overall strategy on Health Systems is that HIV services will be integrated into PHC. MOH has taken actions in planning and renewing actions and activities that will provide a foundation for the sustainability of the provision of HIV services within the existing PHC system. As mentioned specific HIV capacity is being built through the CoE in Care and Treatment with the task of building national capacity in HIV Care and Treatment. In this way the required capacity needed for Care and Treatment will be available in the decentralized service delivery system.

Other challenges with remedial actions

Key Issues	Challenges	Remedial actions
Strategic Planning	Commitment and Capacity of implementing agencies	Strengthening capacity of the implementing agencies based on the needs assessment (this is already in progress)
Prevention	- Lack of capacity within NGOs working with MARPS - Prevention efforts to be effective and resulting in reduction of transmission - Lack of specific cultural, socio-economic, environmental and behavioral data on subpopulations for targeted interventions - Reduction of S&D	- Strengthening capacity of NGOs - Implementation of developed tailor-made intervention programmes for sub-populations - Develop and conduct research program to collect specific data for tailored interventions

Treatment, Care and Support	- Addressing the specific needs of the group of orphans and vulnerable children - Implementation of psychosocial support system for people living with HIV and their families	Establishing a governmental foundation to structure the care and support given to PLHIV
M&E	- Timeliness of data gathering - Human resources for data collection and processing - Integration and harmonizing different data sets	Continue with implement action plan based on evaluation current data collection, aggregation and analysis
Human Rights	Having monitoring and enforcement mechanisms in place for the promotion and protection of human rights	Integrated Human Rights committee at the Ministry of Justice and Police

Other points of attention:

Involvement of PLHIV in the care team

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

Condom supply

MOH has started with preparations to assure that most at risk people will have the accessibility towards free of cost condoms. A strategy will be proposed for strengthening the social marketing of condoms and ensuring a public-private mix. Specific points of attention are to strengthen the process of free of cost condoms and a policy in which a mixture of target groups who are in need of free condoms are listed and prioritized. Development of this policy is in a concluding phase

Other vulnerable populations (OVPs)

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

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

6. Support from the country's development partners

Suriname's development partners showed continued support of HIV and AIDS efforts through different sectors. Guided by the multi-sectoral approach, in the past years increased efforts have been made to involve government ministries at the national and district level, local and international NGOs, community based organizations, religious organizations, international donors, private sector, United Nations and other multilateral agencies. Since 2010, Suriname also receives funding through the Caribbean Partnership Framework with support from the President's Emergency Plan for AIDS Relief (PEPFAR II).

Coordination of all assistance, both technical and financial, to the implementation of the NSP remains the responsibility of the National AIDS Program of the Ministry of Health.
This approach implies harmonization of individual and group efforts into an effective coordinated national response. Each partner is therefore encouraged to bring into play their individual comparative advantages into the process.

7. Monitoring and Evaluation environment

The M&E activities continues to be part of the National Health Information System, within the Ministry of Health. Integrated with monitoring and evaluation of other priority diseases, actions are still guided by decisions made by the M&E Technical Working Group of the MOH.
Good progress has been made in the collection of data regarding HIV prevention, treatment, care and PMTCT. Important now is the integration of all data sources, improvement of data quality, more in depth analysis and use of data for evidence based policy making.

Some of the challenges still facing are:

- Timeliness of data gathering
- Human resources for data collection and processing
- Integration of different data sets
- Enhance quality of collected data

Remedial actions

Initial steps have been set to integrate the different data sets by creating a data warehouse at national level. To complete the process the following actions are important:

- Data cleaning of available data
- Creating secure way of data transfer
- Set up operational research to validate and investigate data results
- Look into M&E human resource plan

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

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

a) NAC or equivalent (HIV Board)	
b) NAP	
c) Others , (please specify)	Yes
TWG M&E	Yes
TWG Treatment, Care & Support	Yes
TWG Prevention , S & D Reduction	Yes

2) With inputs from:

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

3) Was the report discussed in a large forum? Yes

4) Are the survey results stored centrally? Yes

5) Are data available for public consultation? Yes

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

Name / title:	Maltie Algoe, M.D.	Deborah Stijnberg, M.D.	Firoz Abdoel Wahid, M.D
Date:	10 .04 .2011	10 .04 .2011	10 .04 .2011
Address:	H.A.E. Arronstr 64 Paramaribo	H.A.E. Arronstr 64 Paramaribo	H.A.E. Arronstr 64 Paramaribo
Email:	nhis_moh_suriname@yahoo.com	d.stijnberg@nhivs.org	f.abdoelwahid@nhivs.org
Telephone:	(597)410441 # 298	(597)410441 # 298	(597)410441 # 298

ANNEX 2
National Composite Policy Index
(NCPI)
SURINAME
2012