FINAL REPORT
OF THE
SURINAME LEGAL ENVIRONMENT
ASSESSMENT FOR HIV

The Country Coordinating Mechanism Suriname (CCM Suriname)

&

The Global Fund
To Fight AIDS, Tuberculosis and Malaria

The Faculty of Law The UWI Rights Advocacy Project (U-RAP)

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Paramaribo, July 2018
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<th>Description</th>
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<tbody>
<tr>
<td>ADEK</td>
<td>Anton De Kom University</td>
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<tr>
<td>AIDS</td>
<td>Acquired immunodeficiency syndrome</td>
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<td>ARV</td>
<td>Antiretroviral drugs</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
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<tr>
<td>BAZO</td>
<td>Basis Zorgverzekering. (Basic Health Insurance)</td>
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<tr>
<td>BSS</td>
<td>Behavioural Surveillance Study</td>
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<tr>
<td>CBO</td>
<td>Community Based Organization</td>
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<td>CCM</td>
<td>Country Coordinating Mechanism</td>
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<td>CD4</td>
<td>Cluster Differentiation antigen 4</td>
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<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of All Forms of Discrimination against Women</td>
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<td>COCON</td>
<td>Communication Culture and Development Foundation</td>
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<tr>
<td>COVAB</td>
<td>Stichting Centrale Opleiding voor Verpleegkundigen en beoefenaren van Aanverwante Beroepen (Foundation Central Training for Nurses and practitioners of Related Professions)</td>
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<tr>
<td>CRC</td>
<td>Convention on the Rights of the Child</td>
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<td>CSW</td>
<td>Commercial Sex Worker</td>
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<td>CVC</td>
<td>Caribbean Vulnerable Communities Coalition</td>
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<tr>
<td>eMTCT</td>
<td>Elimination of Mother-to-Child Transmission</td>
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<td>EID</td>
<td>Emerging Infectious Diseases</td>
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<tr>
<td>FBO</td>
<td>Faith Based Organization</td>
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<td>FDG</td>
<td>Focus Group Discussions</td>
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<tr>
<td>FHH</td>
<td>Foundation He and HIV</td>
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<tr>
<td>FHLE</td>
<td>Family Health and Life Education</td>
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<td>GAM</td>
<td>Global Aids Monitoring</td>
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<td>GARPR</td>
<td>Global Aids Response Program Reporting</td>
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<tr>
<td>GCCHL</td>
<td>Global Commission on HIV and the Law</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HIVDR</td>
<td>HIV Drugs Resistance</td>
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<td>HTC</td>
<td>HIV Testing and Counseling</td>
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<tr>
<td>ICCPR</td>
<td>International Covenant on Civil and Political Rights</td>
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<td>ICESCR</td>
<td>International Covenant on Economic, Social and Cultural Rights</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>IEC</td>
<td>Information, Education and Communication</td>
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<td>ILO</td>
<td>International Labor Organization</td>
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<tr>
<td>LEA</td>
<td>Legal Environment Assessment</td>
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<tr>
<td>LGBTI</td>
<td>Lesbian, gay, bisexual, transgender and intersex</td>
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<tr>
<td>LLRM</td>
<td>Legal Literacy Review Manual</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
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<td>MZ</td>
<td>Medical Mission of the Moravian congregation in Suriname</td>
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<td>NAP</td>
<td>National AIDS Programme</td>
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<td>NSRHR</td>
<td>National Sexual and Reproductive Health and Rights Policy</td>
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<td>NSP</td>
<td>National Strategic Plan on HIV/AIDS</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<tr>
<td>OAS</td>
<td>Organization of American States</td>
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<td>PAHO</td>
<td>Pan American Health Organization</td>
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<td>PANCAP</td>
<td>Pan-Caribbean Partnership against HIV/AIDS</td>
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<tr>
<td>PCS</td>
<td>Psychiatric Centre Suriname</td>
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<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
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<td>RGD</td>
<td>Regional Health Service</td>
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<tr>
<td>SOGI</td>
<td>Sexual Orientation and Gender Identity</td>
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<tr>
<td>S&amp;D</td>
<td>Stigma &amp; Discrimination</td>
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<tr>
<td>SDG</td>
<td>Sustainable Development Goals</td>
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<tr>
<td>SOZAVO</td>
<td>Social Affairs and People’s Development</td>
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<tr>
<td>SRHR</td>
<td>Sexual and Reproductive Health and Rights</td>
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<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
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<tr>
<td>SBW</td>
<td>Suriname Civil Code</td>
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<tr>
<td>TANA</td>
<td>Towards a New Alternative</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TIA</td>
<td>Trans In Action</td>
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<tr>
<td>TWG</td>
<td>Technical Working Group</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNAIDS</td>
<td>United Nations Joint Programme on HIV/AIDS</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Emergency Fund</td>
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<tr>
<td>UNODC</td>
<td>United Nation Office on Drugs and Crime</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>UWI</td>
<td>University of the West Indies</td>
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<tr>
<td>URAP</td>
<td>The Faculty of Law Rights Advocacy Project; University of the West Indies</td>
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<tr>
<td>VL</td>
<td>Viral Load</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>WSW</td>
<td>WomenSWay</td>
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Map of Suriname
Acknowledgements

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I would also like to thank Jane Nanhu. I am tremendously grateful for all her expert editorial and judicial suggestions as well as additional research.

This report is dedicated to all Surinamese people living with HIV, activists working in the field of HIV, those responsible for the development and implementation of policy and legislation and those responsible for the compliance with the international human rights conventions, regulations, commitments and national legislation with respect to HIV/AIDS.

Carla Bakboord
PART I   INTRODUCTION

This legal environment assessment of the Republic of Suriname is commissioned by The Faculty of Law UWI Rights Advocacy Project (U-RAP) as part of the CVC Global UNDP Grant, which supports legal and social science research aimed at promoting human rights, equality and social justice in the Caribbean. To conduct the Suriname LEA, a national consultant was hired to set up an LEA Task Team to provide research, analytical, coordination, implementation and writing support throughout the process of the national LEA. The consultant’s team consists of the leading researcher who is an anthropologist, a judicial expert and a sociologist. The LEA is based on the UNDP Legal Environment Assessment for HIV manual.

In this assessment HIV-related stigma refers to the negative beliefs, feelings and attitudes towards people living with HIV, groups associated with people living with HIV (e.g. families of people living with HIV) and other key populations at risk of HIV infection, such as people who use drugs, sex workers, MSM, migrants, inmates and ex-inmates and transgender people. HIV-related discrimination refers to the unfair and unjust treatment (act or omission) of an individual based on his or her real or perceived HIV status.

Specific Objectives
The specific objectives are:
1. Painting a comprehensive picture of Suriname’s legal and policy framework;
2. Identifying Gaps and Obstacles, challenges, and recommended solutions.

A brief overview of the country context and the contextual background to HIV

The Republic of Suriname is situated on the North-East coast of South-America, bordering French Guyana in the East, Guyana in the West, Brazil in the South, and the Atlantic Ocean in the North. Suriname is multi-ethnically diverse, mainly because of the 17th and 18th century slave trade and indentured labour from India, Indonesia and China. The population consists of Hindustanis (27.4%), the descendants of contracted laborers from India, Creoles with mixed European and Black African ancestry (15.6%) Maroons (21.7%), Indonesians or Javanese (13.7%), Mixed ethnic group (13.4%), Indigenous (3.8%), Chinese (1.5%), Caucasians 0.3%, others and unknown (2.6%) (General Bureau of Statistics in Suriname ABS).
The population consists of several vulnerable groups. Most vulnerable groups are those having less access to the basic commodities such as safe drinking water, basic sanitation, electricity and or having less access to health care and social services which also includes the inhabitants of the interior, the poor, elderly, children, pregnant women, people with disability, people living with HIV and many others such as the MSM, SW and Youth. There is an ongoing dialogue between the LBGTQ community, which still suffers from social stigma and discrimination, and the government regarding their constitutional rights.

The first case of HIV/AIDS in Suriname was registered in 1983. Since the nineties several NGO’s working in the field of HIV/AIDS had been established. In 2002 the Government of Suriname initiated a process for the systematic and strategic control of HIV and AIDS, following the adoption of the UNGASS Declaration of Commitment on HIV and AIDS in 2001. Suriname developed its first National Strategic Plan on HIV/AIDS (NSP) in 2004 in an attempt to control and reduce the negative impact of HIV and AIDS on the community. The NSP has since served as the national framework for expanding and strengthening Suriname’s multi-sector response to the epidemic. For example, the third NSP for the period 2014-2020 emphasizes multi-sectorial coordination and collaboration, integration, capacity building, strategic information and human rights and equity. And it has a special focus on achieving universal access with respect to prevention, treatment and care.

In 2005 the prevalence rate among men who have sex with men was approximately 6.7% and in 2012 it was 5.98% for sex workers. While the vast majority of the HIV diagnosed persons from 2000-2013 were between the ages of 15 – 55, most of those diagnosed were of Creole or Maroon descent. Data with respect to drug abusers is not available during the period of this assessment. In 2016, Suriname had <500 new HIV infections and <200 AIDS-related deaths. There were 4900 (4400 - 5600) people living with HIV in 2016, among whom 48% (38% - 58%) were accessing antiretroviral therapy. Among pregnant women living with HIV, 89% (77% - >95%) were accessing treatment or prophylaxis to prevent transmission of HIV to their children. An estimated <100 children were newly infected with HIV due to mother-to-child transmission. Among people living with HIV, approximately 36% (32% - 41%) had suppressed viral loads. One of the key populations most affected by HIV in Suriname is: Sex workers, with an HIV prevalence of 5.8%. Since 2010, new HIV infections have decreased by 6% and AIDS-related deaths have increased by 17%.
Methodology accountability

A consultative, and participatory approach has been used to conduct this study. The consultant followed the proposed methodology in the UNDP Legal Environment Assessment for HIV Manual by comparing Suriname’s de jure and de facto legal and policy practices according to 22 + 1 additional Factor Statements in the above-mentioned manual that serve as indicators or principles in four key areas where HIV-related discrimination is likely to occur with respect to:

- access to essential services
- equality of people living with HIV in public and private life
- key-populations
- access of justice

Factors

Factor 1: Public education, research and information exchange  
Factor 2: HIV prevention  
Factor 3: Testing, counselling and referral  
Factor 4: Treatment, care and other health services  
Factor 5: Social protection and material assistance  
Factor 6: Protection of privacy and confidentiality  
Factor 7: Political, social and cultural life  
Factor 8: Family, sexual and reproductive life  
Factor 9: Education and training  
Factor 10: Employment, work and economic life  
Factor 11: Private and public housing  
Factor 12: Entry, stay and residence  
Factor 13: Non-criminalization of HIV exposure and transmission  
Factor 14: Women  
Factor 15: Children and youth  
Factor 16: People who use drugs  
Factor 17: Adults engaged in commercial sex  
Factor 18: Men who have sex with men, and transgender people  
Factor 19: People under state custody  
Factor 20: Maroon and indigenous people in the hinterland, people in Nickerie and Migrants  
Factor 21: Legal protection  
Factor 22: Legal awareness, assistance and representation  
Factor 23: Access to a forum, fair trial, and enforcement of remedies

In collaboration with the Country Coordinating Mechanism (CCM) a technical working group (TWG) has been set up and stakeholders have been identified. The consultant team conducted a desk review, held consultation meetings with stakeholders, designed a Legal Literacy Review
Manual (LLRM) and developed a Communication, Dissemination and Impact Strategy Plan in collaboration with the TWG.

PART II   SURINAME INTERNATIONAL, REGIONAL NATIONAL HUMAN RIGHTST FRAMEWORK IN THE CONTEXT OF HIV

International and regional human rights law is set out in various instruments, i.e. treaties, conventions, covenants which can be signed and ratified by states. Once a state has signed and ratified such an instrument it becomes a member state and agrees to be legally bound by that convention and to ensure that the principles and provisions of that instrument are met and implemented at the national level. The member state is required to report periodically to the relevant treaty monitoring body on its compliance with the provisions of each treaty.

Suriname- Status of ratification of Human rights treaties with respect to HIV and vulnerable populations:

▪ International Covenant on Civil and Political Rights (ICCPR)
▪ International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)
▪ International Covenant on Economic, Social and Cultural Rights (ICESCR)
▪ Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW)
▪ Convention on the Rights of the Child (CRC)
▪ The Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography
▪ Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women ”Convention of Belem do Para”
▪ Convention on the Rights of Persons with Disabilities (CRPD)
▪ American Convention on Human Rights “Pact of San Jose”
▪ ILO Convention 111
▪ ILO Employment Agencies Convention, 1997, no 181

During the consultation meetings with the identified stakeholders, key-populations and vulnerable groups, it was noticed that most of them are not aware of the international conventions, which Suriname has ratified, what they encompass, what the State’s obligations are and how they can use these conventions both at the national and international levels when
their rights are violated. Some faith based organizations are aware of the conventions but they do not use them in their work.

While the international and regional declarations, commitments and guidelines are not legally binding, contrary to the international conventions, they are generally reflections of the application and interpretation of accepted international and regional human rights principles to the HIV epidemic. In this respect, they are important guidance for Suriname in its interpretation of its own human rights standards in the context of HIV and AIDS. Moreover, many international and regional strategies and plans include guidelines on law and policy responses to HIV and AIDS. As such, they provide important and persuasive guidance for national response to HIV and AIDS.

See below some of the International and regional HIV and AIDS declarations, commitments and guidelines Suriname has committed itself to:

- UNGASS Political declarations on HIV/AIDS
- Sustainable Development Goals
- Program of Action, International Conference on Population and Development
- The Beijing Declaration and Platform for Action, and the World Summit
- The Montevideo Consensus for Population and Development
- The ILO Code of Practice on HIV/AIDS and the World of Work
- Pan Caribbean Partnership Against HIV/AIDS (PANCAP)

Although Suriname has signed, ratified and adopted various international and regional human rights conventions, declarations, commitments and agreements, it has occurred that Suriname commits interventions at international conferences that are in conflict with the rights guaranteed by the Conventions. Moreover, though de jure measures to eliminate discrimination have been improved, de facto, the LGBT community is facing outright discrimination which is being tolerated or even supported by institutions.¹

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¹ Suriname does not back OAS homo declaration 11/06/2013 DWT
PART III SURINAME HIV/AIDS LEGAL ENVIRONMENT ASSESSMENT ANALYSIS

In this part of the legal assessment which refers to national legislation, policy and actions, a distinction is being made based on four categories as mentioned in the UNDP manual: 1. Access to essential services, 2. Equality of people living with HIV in public and private life, 3. Key populations, and 4. Access to justice. Within these categories the 23 factors have been intersected.

The Suriname Constitution in relation to the four categories

1. Access to essential services
   Art. 36: Everyone has the right to health. The State promotes general health care through systematic improvement of living and working conditions and provides information for the protection of health.

2. Equality of people Living with HIV in public and private life
   Art. 8: All persons who are on the territory of Suriname have equal rights to the protection of persons and goods. No person may be discriminated against on account of his birth, gender, race, language, religion, origin, education, political opinion, economic position or social circumstances or any other status.
   Art. 14: Everyone has the right to life. This right is protected by law.
   Art. 26: Everyone has the right to work, in accordance with his capacity.
   Art. 38: Everyone has the right to education and cultural experience.

3. Key-populations
   Articles 8, 9, 17 and 36 stipulate that everyone who is on Surinamese territory has the right to health, physical, psychological and moral integrity respectively, the right to privacy and equal rights to protection of person. No one may be subjected to torture, degrading or inhuman treatment or punishment. It would be that the legal system is designed to be open and tolerant however conditions on the ground do not always match these ideals
   Article 38: Everyone has the right to education and cultural experience.
4. Access to Justice

Article 10: Everyone is entitled to fair and public treatment of his / her complaint within a reasonable period of time by an independent and impartial judge in case of violation of his or her rights and freedoms.

Article 11: No one can be held against his will from the judge that the law appoints him.

Article 12: Everyone can have assistance in court. The law lays down rules concerning the provision of legal assistance to financially persons.

Although PLHIV and other key populations are not specifically mentioned, the Constitution and the Revised Penal Code clearly indicate that discrimination is not allowed in any way. Hence PLHIV and other key populations can be placed in- any other status- of Article 8. Also the Ministry of Justice through its Minister has pronounced for the guarantee of the enforcement and the experience of human rights by all people. As such Suriname’s Constitution enshrines anti- discrimination on the basis of health. It lays the overarching conditions for the just treatment and care of persons who have health conditions such as HIV.

However, it appears that human rights, in the context of HIV-related persecution, are being undermined in various ways. Suriname is lagging far behind by adapting national legislation to the international treaties. This also counts in the context of HIV related discrimination. Article 294 of the Revised Penal Code of 30 March 2015, indicates that those who, knowing that they are infected with the Human Immunodeficiency Virus (HIV), deliberately commit sexual acts by which another, unfamiliar with this circumstance, can be infected with that virus, is punished with imprisonment of up to fifteen years and a fine of the fifth category. In accordance with art. 306b this operation suffers an aggravation for other sex offenses.

The possible undesirable consequences of the excessive use of criminal law to prosecute HIV contamination can be used selectively, thereby violating the prohibition of discrimination. People living with HIV are often confronted with stigmatization, discrimination, marginalization and various forms of abuse. As a result, the right to equality and the right to a fair trial can be violated without arbitrariness.

National Policy and actions

There are a number of policy documents that contain provisions on access to services, equality of people living with HIV in public and private life, key populations and access to justice. The National Strategic Plan for a multi sectoral approach of HIV in Suriname 2014-2020 lays out clear objectives pertaining to, among others; unrestricted access to voluntary,
confidential or anonymous HIV testing, preventing is a priority, treatment for HIV is free of charge as well as CD4, VL, and EID, promoting social acceptance of people living with HIV and their active involvement and participation in all stages of the national response and sexual and reproductive rights and health education is included in the objectives of the national health policy. Additionally, HIV on the workplace is policy of the Ministry of Labor.

**Gaps and Obstacles**

Enforcement of the Constitution is selective. Referring to the experiences of the vulnerable groups, it appears that national policy is not sufficiently aimed at a holistic approach and prevention. There are services with protocols providing care to PLHIV, but in practice it turns out that not all service providers adhere to protocol and therefore do not treat the clients correctly. Moreover, there seems to be little or no control over the adherence to protocol and therefore sanctions cannot be imposed. PLHIV do not have full access to education. Domestic violence against vulnerable women is still a major issue in Suriname which includes feminicide. PLHIV experience fear of discrimination. Poverty is the driving force for the HIV epidemic. There are insurance companies that stop the insurance of PLHIV and breeches of confidentiality of service providers as mentioned in the needs assessment among MSM and transgenders. The Discrimination Law art.500a, of the Revised Penal Code does not address gender identity or HIV positive status. Laboratory tests are only available in Paramaribo. Article 294 of the Penal Code can withhold persons from being tested. Due to fear of sanctions, stigma and discrimination, key-populations and vulnerable groups are often less inclined to make use of formal prevention and care services. Sexual and reproductive rights and health education is not mainstreamed in the curriculum of the primary and secondary education. Societal pressures and customs, especially in rural areas, inhibited the full exercise of these rights, particularly with respect to marriage and inheritance. Children under the age of sixteen are not allowed to access health services without parental guidance. There are no specific HIV programs for drug users in the NSP. Due to fear of sanctions, stigma and discrimination, sex workers are often less inclined to make use of formal prevention and care services. No focus on other (health) needs of MSM and transgenders. There are no specific programs for ex-inmates. Therefore, after they leave the prison ex-inmates are hard to reach. HIV is not accepted in the villages and in Nickerie, hence people are afraid of stigma. One does not test or take medication, because one is afraid that they will be seen and then be stigmatized. Most inmates know how to find their way to the
IHR court. Inmates share their knowledges with each other and know that they have right to file a complaint to the IHR if they experience human rights violation in the prison. However, they don’t receive any notification by the staff whether their complaints are being received by the Inter-American Court of Human Rights. Many members of the selected target groups have less or no knowledge of their human rights, the conventions Suriname has ratified and how to find their way to justice.

**Recommendations**

Be specific in laws which implement and support raising HIV-related awareness, stigma reduction, training and information exchange programs, and ensures that HIV research adheres to the highest ethical standards. The state shall make specific legislation that protects everything related to persons living with HIV such as education and training and increase the accessibility and coverage of training facilities for Basic Life skills programs to ensure that more people are trained in this program.

Reviewing of Article 294 of the Penal Code as it is discriminating against PLHIV. Other transmittable infections which can also harm other persons, are not included. Utilize PANCAP model Anti-discrimination Bill to inform the creation of Suriname’s anti-stigma legislation; Adopt a national health plan covering the public and private sectors, with universal access to primary care; and ensure that the costs of healthcare services and health insurance, whether privately or publicly provided, are affordable for everyone. Enforcing law and penalties in instances of breach of confidentiality. Comprehensive sexual and reproductive health and HIV services must be integrated as well as to scale up integrated, family-centered health care services and information. Conduct legal literacy training sessions for the staff of the institutions and the selected key-populations. Promoting and implementing laws and policies related to violence against women, gender equality and HIV. Transforming harmful cultural and social gender norms through effective school-based interventions, for example by focusing on the socialization of boys and girls and empower boys and young men through multi-sectorial approaches, with respect to gender equality and sexual and reproductive health and rights.

Integrate HIV programs for drug users in the NSP. Empower sex workers to challenge human rights’ abuses Countering anti-homosexual and anti-transgender practices and stigmatizing myths through strategic engagement with the media and through education. Include sexual and reproductive health and rights policy within the prison facilities, using the study results and recommendations formulated in 2009. Implement HIV awareness programs from a cultural and
language perspective. Building alliances with both the private, the public as the civil society sector, such as representatives of the parliament, faith based organizations, women organizations and labor unions, to raise awareness to respect the human rights of the identified key-populations and vulnerable groups.
PART I INTRODUCTION

1.1 Background
Creating an enabling environment is a critical element in an effective national HIV and AIDS response. The progress that Suriname has made in improving policy environment indicates the Government’s leadership and commitment in collaboration with the NGO’s in the fight against HIV and AIDS ever since the first case of HIV infection was diagnosed in 1981 in Suriname.

According to the UNAIDS ‘Report on the Global AIDS Epidemic’, an estimated 35.3 million (32.2 million–38.8 million) people were living with HIV around the world in 2012. The report shows that an estimated 0.8 percent of adults aged 15–49 years worldwide are living with HIV, although the burden of the epidemic continues to vary considerably between countries and regions. Promising progress has been achieved in the Caribbean, which still remains the second most heavily affected region by HIV. These contexts have low and/or concentrated epidemics affecting key-population and vulnerable groups such as men who have sex with men (MSM), sex workers, transgender people and people who use drugs (Legal environment assessment manual UNDP 2014).

In the ‘Political Declaration on HIV/AIDS’ (2016) governments committed themselves to protecting the human rights of people living with HIV, women and members of vulnerable populations. Governments subsequently committed to review, as appropriate, laws and policies that adversely affect the successful, effective and equitable delivery of HIV prevention, treatment, care and support programs to people living with and affected by HIV. The Declaration recognizes that a country’s legal environment—its laws and how they are implemented and enforced—plays a critical role in the national response to HIV.

To support governments to meet their commitments and targets relating to eliminating HIV stigma and discrimination and to create enabling legal environments, an independent Commission led by UNDP on behalf of the Joint UN Programme on HIV/AIDS (UNAIDS),

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5 The term ‘key populations’ used throughout this inception report comprises youth, women, sex workers, MSM, transgender people and people who use drugs and maroon and indigenous population; ex-inmates, migrants.
developed actionable, evidence-informed and human-rights-based recommendations for effective HIV response. Accordingly, there is commitment to conduct a national Legal Environment Assessment (LEA) of laws, policies and practices that affect people living with HIV, key populations, women, youth and other population groups identified as critical for the national HIV response.

This legal environment assessment of the Republic of Suriname is commissioned by The Faculty of Law UWI Rights Advocacy Project (U-RAP) as part of the CVC Global UNDP Grant, which supports legal and social science research aimed at promoting human rights, equality and social justice in the Caribbean. To conduct the Suriname LEA, a national consultant was hired to set up an LEA Task Team to provide research, analytical, coordination, implementation and writing support throughout the process of the national LEA. The consultant’s team exists of the leading researcher who is an anthropologist, a judicial expert and a sociologist. The LEA is based on the UNDP Legal Environment Assessment for HIV manual.

In this assessment HIV-related stigma refers to the negative beliefs, feelings and attitudes towards people living with HIV, groups associated with people living with HIV (e.g. families of people living with HIV) and other key populations at risk of HIV infection, such as people who use drugs, sex workers, MSM and transgender people. HIV-related discrimination refers to the unfair and unjust treatment (act or omission) of an individual based on his or her real or perceived HIV status. Discrimination in the context of HIV also includes unfair treatment of key populations, such as sex workers, people who use drugs, MSM, transgender people, people in prison and other closed settings, and in some social contexts women, young people, migrants, refugees and internally displaced persons. HIV-related discrimination is usually based on stigmatizing attitudes and beliefs about populations, behaviors, practices, sex, illness and death. Discrimination can be institutionalized through existing laws, policies and practices that negatively focus on people living with HIV and marginalized groups, including criminalized populations.

Legal Environment Assessment for HIV. An operational guide to conduct national legal, regulatory and policy assessments for HIV
1.2 Objectives
The main objectives are:

❖ To identify and examine legal and human rights issues with respect to HIV/AIDS affecting the selected target group in Surname;
❖ To understand how the legislative environment can play a role in influencing HIV prevention, treatment and impact mitigation effects;
❖ To strengthen Suriname’s response to HIV by creating an enabling and protective legal environment in line with international, regional and national human rights and HIV and health commitments.

The specific objectives are:
3. Painting a comprehensive picture of Suriname’s legal and policy framework;
4. Identifying Gaps and Obstacles, challenges, and recommended solutions.

1.3 Target population
People living with HIV, women, youth, drug-users, and adults engaged in sex work, MSM, transgender persons, migrants, indigenous and maroon population, ex-inmates and incarcerated persons.

1.3.1 A brief overview of the country context and the contextual background to HIV
The Republic of Suriname is situated on the North-East coast of South-America, bordering French Guyana in the East, Guyana in the West, Brazil in the South, and the Atlantic Ocean in the North. The country covers an area of 163,820 square kilometers. Administratively, the country is divided into ten districts that are subdivided into 62 regions. The coastal area comprises of 2 urban districts and 6 rural districts, and an interior with 2 districts. The 2 urban districts, the capital city of Paramaribo and Wanica, cover 0.5 % of the land and contain 70% of the total population. Suriname is multi-ethnically diverse, mainly because of the 17th and 18th century slave trade and indentured labour from India, Indonesia and China. The population consists of Hindustanis (27.4%), the descendants of contracted laborers from India, Creoles with mixed European and Black African ancestry (15.6%) Maroons (21.7%), Indonesians or Javanese (13.7%), Mixed ethnic group (13.4%), Indigenous (3.8%), Chinese (1.5%), Caucasians 0.3%, others and unknown (2.6%) (General Bureau of Statistics in Suriname ABS).

The population consists of several vulnerable groups. Most vulnerable groups are those having
less access to the basic commodities such as safe drinking water, basic sanitation, electricity and or having less access to health care and social services which also includes the inhabitants of the interior, the poor, elderly, children, pregnant women, people with disability, people living with HIV and many others such as the MSM, SW and Youth. There is an ongoing dialogue between the LBGTQ community, which still suffers from social stigma and discrimination, and the government regarding their constitutional rights.

The first case of HIV/AIDS in Suriname was registered in 1983. In the mid-1980s Willy Alberga, Ruben del Prado, Robert Wijdenbosch, Corrie Promes and Judy Rijchaart and other volunteers started to share information about HIV and AIDS. Soldiers, police and prison guards were then the risk groups. It soon became clear that the number of infections with the then unknown virus was much worse than one might have suspected. Unfamiliarity and fear led to terrible events; stigma and discrimination. The volunteers were not allowed to come to the funeral because one would know that the deceased family member had AIDS. It also occurred regularly that the food of the patients in the lung pavilion had been stolen. The family was aware of that, but did not say anything. They were already happy that someone took care of them. Also the nurses did not take care of them. There was no adequate legal environment and although Suriname has ratified some international human rights conventions, there was no human rights approach with respect to HIV/AIDS. In an interview with Willy Alberga, she reveals the following:

"At that time PLHIV had no rights at all. Patients laid there just to rot. There was no question of integrity. They were treated by their families like street dogs. Therefore, some committed suicide. We strived for providing information, support and medication. It had to be on the political agenda. We wanted the government to take a stand and be responsible for the consequences. We held a press conference. Everyone was there and they found it very impressive. In Brazil, the medicines were free. But those generics (counterfeit, not expensive AIDS inhibitors) were not allowed to export from Brazil. We explained that there are thousands of Brazilians in Suriname. Among them there were a lot of sex workers, a vulnerable group for the transmission of HIV. When they discovered that they were infected, they went back to Brazil and received the medicines there. That situation in the interior was explosive because of all the conditions people lived there. We advised the Surinamese government to inform the Brazilian government to provide medication to at least those thousands of Brazilians working in Suriname. There were already so many infected cases registered. The media had picked up this
information and they covered it. And so it reached The National Assemblée (the Parliament) through the member of the Parliament with Mr. Rogers in the early nineties.”

Since then several NGO’s working in the field of HIV/AIDS had been established and in 1991 Ethel Pengel was the first one who disclosed her status through various media channels. Her disclosure supported others and so HIV got a face. In 2002 the Government of Suriname initiated a process for the systematic and strategic control of HIV and AIDS, following the adoption of the UNGASS Declaration of Commitment on HIV and AIDS in 2001. Suriname developed its first National Strategic Plan on HIV/AIDS (NSP) in 2004 in an attempt to control and reduce the negative impact of HIV and AIDS on the community. The NSP has since served as the national framework for expanding and strengthening Suriname’s multi-sector response to the epidemic. For example, the third NSP for the period 2014-2020 emphasizes multi-sectorial coordination and collaboration, integration, capacity building, strategic information and human rights and equity. And it has a special focus on achieving universal access with respect to prevention, treatment and care.

Within the framework of the NSP the Suriname Aids Response Progress Report 2015,\(^7\) indicates that government efforts have resulted in advances in the coordination and organization of services as evidenced by an increase in access to treatment for persons living with HIV and a steady decline to zero infants born with the HIV infection. However, careful attention must be given to populations that are affected at disproportionate rates as is revealed in the next paragraph.

1.4 Brief overview of the status of HIV Epidemic on key-populations and vulnerable groups

The estimated HIV prevalence rate for the adult population between the ages of 15 – 49 is roughly 0.9%, the rate among affected key populations is higher than the general population. In 2005 the prevalence rate among men who have sex with men was approximately 6.7% and in 2012 it was 5.98% for sex workers. While the vast majority of the HIV diagnosed persons from 2000-2013 were between the ages of 15 – 55, most of those diagnosed were of Creole or Maroon descent.\(^8\) Data with respect to drug abusers is not available during the period of this assessment.

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\(^7\) *Suriname AIDS Response Progress Report 2015*

\(^8\) *Id at p. 8.*
Since the first registered case of HIV in 1983, scaling-up of HIV-testing led to an increase in the number of persons tested for HIV and consequently to an increase in the number of newly registered HIV-cases. This increase continued until 2006, with a maximum of 781 newly registered cases. However, since 2007 there has been a steady decline in the number of newly registered HIV-cases; 473 in 2013 (see figure 1).  

**Figure 1.1: Number of registered HIV positive people by sex, 2000-2013**

None of the data disaggregated by sex, indicates how and if trans persons are classified in studies. According to a representative of the NAP it is probably that when one is registered as a male and one has become a female, they would still be registered as male.

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9 M&E Unit, Ministry of Health. 2014. HIV Master database.
### Table 1.1 HIV prevalence in key populations

<table>
<thead>
<tr>
<th>Key population</th>
<th>Sex</th>
<th>Year</th>
<th>Prevalence (%)</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant women</td>
<td>Women</td>
<td>2006</td>
<td>1.4</td>
<td>National HIV test database 10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2007</td>
<td>0.9</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2008</td>
<td>0.8</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2009</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2010</td>
<td>0.9</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2011</td>
<td>1.1</td>
<td>PMTCT focal point surveillance/ Civil Registry Office 11 12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2012</td>
<td>1.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2013</td>
<td>1.1</td>
<td></td>
</tr>
<tr>
<td>Sex workers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paramaribo</td>
<td>All</td>
<td>2005</td>
<td>24.1</td>
<td>BSS and Seroprevalence among SW in Paramaribo 13 14 15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2009</td>
<td>7.2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2012</td>
<td>5.8</td>
<td></td>
</tr>
<tr>
<td>Goldmines</td>
<td>Women</td>
<td>2012</td>
<td>1.0</td>
<td>BSS and Seroprevalence among SW and their clients in gold mining areas 16</td>
</tr>
<tr>
<td>MSM</td>
<td>Men</td>
<td>2005</td>
<td>6.7</td>
<td>BSS and Seroprevalence among MSM in Paramaribo 17</td>
</tr>
<tr>
<td>TB patients</td>
<td>All</td>
<td>2008</td>
<td>27.8</td>
<td>National TB Programme surveillance 18</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2009</td>
<td>30.8</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2010</td>
<td>33.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2011</td>
<td>32.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2012</td>
<td>28.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2013</td>
<td>22.6</td>
<td></td>
</tr>
<tr>
<td>Miners</td>
<td>Men</td>
<td>2012</td>
<td>0</td>
<td>BSS and Seroprevalence among SW and their clients in gold mining areas 19</td>
</tr>
<tr>
<td>STI clients</td>
<td>All</td>
<td>2008</td>
<td>2.8</td>
<td>BSS and Seroprevalence among STI patients 20</td>
</tr>
<tr>
<td>Blood donors</td>
<td>2008</td>
<td>0.025</td>
<td></td>
<td>National Blood Bank surveillance 21</td>
</tr>
<tr>
<td></td>
<td>2009</td>
<td>0.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2010</td>
<td>0.057</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2011</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2012</td>
<td>0.055</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2013</td>
<td>0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: M&E Unit Ministry of Health, 2014

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10 National HIV Test Database
11 PMTCT focal point surveillance
12 Civil Registry Office
13 BSS and Seroprevalence among SW in Paramaribo 2005
15 BSS and Seroprevalence among SW in Paramaribo 2012
16 BSS and Seroprevalence among SW and their clients in gold mining areas
19 BSS and Seroprevalence among SW and their clients in gold mining areas 2012
20 Caffe, I. 2009. HIV prevalence study and behavioral surveillance survey among STI patients in Suriname.
Aggregated by age, the majority (86%) of HIV positive persons, enrolled in the National HIV Master Database from 2000 – 2013, were between the ages of 15 to 55 years.  

Table 1.2 Cumulative number of HIV cases by age group, 2000 - 2013

<table>
<thead>
<tr>
<th>Age group</th>
<th>Men</th>
<th>Women</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 5</td>
<td>222</td>
<td>192</td>
<td>24</td>
</tr>
<tr>
<td>6-15</td>
<td>20</td>
<td>64</td>
<td>12</td>
</tr>
<tr>
<td>16-25</td>
<td>278</td>
<td>869</td>
<td>5</td>
</tr>
<tr>
<td>26-35</td>
<td>948</td>
<td>1209</td>
<td>11</td>
</tr>
<tr>
<td>36-45</td>
<td>996</td>
<td>739</td>
<td>9</td>
</tr>
<tr>
<td>46-55</td>
<td>594</td>
<td>356</td>
<td>8</td>
</tr>
<tr>
<td>56-65</td>
<td>220</td>
<td>136</td>
<td>3</td>
</tr>
<tr>
<td>65+</td>
<td>115</td>
<td>43</td>
<td>2</td>
</tr>
<tr>
<td>Unk</td>
<td>0</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>3393</td>
<td>3608</td>
<td>89</td>
</tr>
</tbody>
</table>

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

Figure 1.2 Cumulative number of HIV cases by Age category and Sex, 2000 - 2013

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

From 2010 to 2012, a declining trend in the number of hospitalizations has been observed, re-hospitalizations excluded. Hospitalizations occur more among males than females, with 30% more males hospitalized between 2001 and 2012 than females and an according male/female

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22 M&E Unit, Ministry of Health. 2014. HIV Master database.
ratio of 1.3 (median) (range 0.8-1.7). From 2001-2012, no apparent decrease in hospitalizations was noted among men and women from different ethnic backgrounds.

**Figure 1.3 Hospitalization by sex, 2001-2002**

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

Hospitalizations among male East Indians (Hindustani group) are a point of concern, as a 100% increase in hospitalizations is seen among these males in 2012 compared to 2001. These data are not disaggregated by sexual orientation. As MSM belong to the key-populations, it would be interesting to obtain insight in this phenomenon. Since the LEA is focused on Maroon and Indigenous population it is advised to include East Indian males in the follow-up studies to get a better understanding in the causes of the increasing hospitalizations within this ethnic group. In addition, a relatively small increasing trend is seen in general, among the Creole and Maroon HIV patients.

In 2007-2009 a sexual behavior and seroprevalence survey in prisons in Suriname had been carried out. The total survey population at the time of the seroprevalence survey consisted of 701 prisoners. Of this number, a little over half (N= 404; 57.6%; N tot. = 701) took an HIV test. Of this majority, 9 (2.2%; N tot. = 404) were tested HIV positive. The other 297 (42.4%; N tot. =701) did not want or could not do the HIV test. As a consequence, a misrepresentation may occur if the found prevalence is generalized to the total prison population since the HIV test coverage was not 100%. It is possible that there could be HIV positive prisoners even among the group who did not take the HIV test. No data with regard to prisoners were collected after this survey. With respect to (ex) drug abusers and HIV there was no data available.

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23 M&E Unit, Ministry of Health. 2014. HIV Master database.
24 M&E Unit, Ministry of Health. 2014. HIV Master database.
25 Bakboord C. 2017
26 Source: MD. Deborah Stijnberg
27 Source: MD. Deborah Stijnberg
Recent data

In 2016, Suriname had <500 new HIV infections and <200 AIDS-related deaths. There were 4900 (4400 - 5600) people living with HIV in 2016, among whom 48% (38% - 58%) were accessing antiretroviral therapy. Among pregnant women living with HIV, 89% (77% - >95%) were accessing treatment or prophylaxis to prevent transmission of HIV to their children. An estimated <100 children were newly infected with HIV due to mother-to-child transmission. Among people living with HIV, approximately 36% (32% - 41%) had suppressed viral loads. One of the key populations most affected by HIV in Suriname is: Sex workers, with an HIV prevalence of 5.8%. Since 2010, new HIV infections have decreased by 6% and AIDS-related deaths have increased by 17%.  

Table 1.3 HIV and AIDS Estimates 2016

<table>
<thead>
<tr>
<th>Adults and children living with HIV</th>
<th>4900 [4400 - 5600]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults aged 15 and over living with HIV</td>
<td>4800 [4200 - 5500]</td>
</tr>
<tr>
<td>Women aged 15 and over living with HIV</td>
<td>2200 [1900 - 2500]</td>
</tr>
<tr>
<td>Men aged 15 and over living with HIV</td>
<td>2600 [2300 - 3000]</td>
</tr>
<tr>
<td>Children aged 0 to 14 living with HIV</td>
<td>&lt;200 [&lt;100 - &lt;200]</td>
</tr>
<tr>
<td><strong>Adult aged 15 to 49 HIV prevalence rate</strong></td>
<td><strong>1.4 [1.2 - 1.6]</strong></td>
</tr>
<tr>
<td>Women aged 15 to 49 HIV prevalence rate</td>
<td>1.3 [1.2 - 1.5]</td>
</tr>
<tr>
<td>Men aged 15 to 49 HIV prevalence rate</td>
<td>1.5 [1.3 - 1.6]</td>
</tr>
<tr>
<td>HIV prevalence among young women</td>
<td>0.8 [0.7 - 1.0]</td>
</tr>
<tr>
<td>HIV prevalence among young men</td>
<td>0.7 [0.4 - 1.0]</td>
</tr>
<tr>
<td><strong>Adults and children newly infected with HIV</strong></td>
<td><strong>&lt;500 [&lt;500 - &lt;500]</strong></td>
</tr>
<tr>
<td>Adults aged 15 and over newly infected with HIV</td>
<td>&lt;500 [&lt;500 - &lt;500]</td>
</tr>
<tr>
<td>Women aged 15 and over newly infected with HIV</td>
<td>&lt;200 [&lt;200 - &lt;200]</td>
</tr>
<tr>
<td>Men aged 15 and over newly infected with HIV</td>
<td>&lt;200 [&lt;200 - &lt;500]</td>
</tr>
<tr>
<td>Children aged 0 to 14 newly infected with HIV</td>
<td>&lt;100 [&lt;100 - &lt;100]</td>
</tr>
<tr>
<td><strong>HIV incidence per 1000 population (adults 15-49)</strong></td>
<td><strong>1.10 [0.87 - 1.37]</strong></td>
</tr>
<tr>
<td>HIV incidence per 1000 population (all ages)</td>
<td>0.62 [0.47 - 0.80]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Death Category</th>
<th>Estimated Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult and child deaths due to AIDS</td>
<td>&lt;200 [200 - 200]</td>
</tr>
<tr>
<td>Deaths due to AIDS among adults aged 15 and over</td>
<td>&lt;200 [200 - 200]</td>
</tr>
<tr>
<td>Deaths due to AIDS among women aged 15 and over</td>
<td>&lt;100 [100 - 100]</td>
</tr>
<tr>
<td>Deaths due to AIDS among men aged 15 and over</td>
<td>&lt;100 [100 - 100]</td>
</tr>
<tr>
<td>Deaths due to AIDS among children aged 0 to 14</td>
<td>&lt;100 [100 - 100]</td>
</tr>
<tr>
<td>Orphans due to AIDS aged 0 to 17</td>
<td>1600 [1200 - 1900]</td>
</tr>
</tbody>
</table>

**Table 1.4 HIV testing and treatment cascade**

<table>
<thead>
<tr>
<th>People living with HIV</th>
<th>Estimated Numbers</th>
<th>Source: Spectrum</th>
</tr>
</thead>
<tbody>
<tr>
<td>People living with HIV who know their status</td>
<td>3000</td>
<td>Source: GAM (case surveillance)</td>
</tr>
<tr>
<td>Percent of people living with HIV who know their status</td>
<td>62 [55 - 71]</td>
<td>Source: Spectrum</td>
</tr>
<tr>
<td>People living with HIV who are on ART</td>
<td>2400</td>
<td>Source: Spectrum</td>
</tr>
<tr>
<td>Percent of people living with HIV who are on ART</td>
<td>48</td>
<td>Source: Spectrum</td>
</tr>
<tr>
<td>People living with HIV who have suppressed viral loads</td>
<td>1800</td>
<td>Source: GAM; Viral load testing coverage: 89%</td>
</tr>
<tr>
<td>Percent of people living with HIV who have suppressed viral loads</td>
<td>36</td>
<td>Source: Spectrum</td>
</tr>
</tbody>
</table>
Table 1.5 Antiretroviral therapy (ART)

| Coverage of adults and children receiving ART (%) | 48 [38 - 58] |
| Adults aged 15 and over receiving ART | 48 [37 - 57] |
| Women aged 15 and over receiving ART | 54 [41 - 64] |
| Men aged 15 and over receiving ART | 43 [38 - 49] |
| Children aged 0 to 14 receiving ART | 81 [62 - >95] |

| Number of adults and children receiving ART (#) | 2400 |
| Adults aged 15 and over receiving ART | 2300 |
| Women aged 15 and over receiving ART | 1200 |
| Men aged 15 and over receiving ART | 1100 |
| Children aged 0 to 14 receiving ART | 90 |

Late HIV diagnosis [with the initial CD4 cell count <200 cells/ mm3] (%) 37

| Late HIV diagnosis among adults aged 15 and over | 38 |
| Late HIV diagnosis among women | 35 |
| Late HIV diagnosis among men | 39 |

| Adults and children known to be on ART 12 months after starting (%) | 57 |
| Adults known to be on ART 12 months after starting | 62 |
| Children known to be on ART 12 months after starting | ... |

Table 1.6 Elimination of mother-to-child transmission

<p>| Coverage of pregnant women who receive ARV for PMTCT (%) | 89 [77 - &gt;95] |
| Pregnant women who received ARV for PMTCT (#) | 110 |</p>
<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant women needing ARV for PMTCT (#)</td>
<td>&lt;200 [&lt;200 - &lt;200]</td>
</tr>
<tr>
<td>Early infant diagnosis (%)</td>
<td>90 [78 - &gt;95]</td>
</tr>
<tr>
<td>New HIV infections averted due to PMTCT (%)</td>
<td>&lt;100 [&lt;100 - &lt;100]</td>
</tr>
</tbody>
</table>

**Table 1.7 Sex workers**

<table>
<thead>
<tr>
<th>Feature</th>
<th>Value</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population size estimate (#)</td>
<td>2228</td>
<td></td>
</tr>
<tr>
<td>HIV prevalence (%)</td>
<td>5.8</td>
<td>Source: GARPR 2014</td>
</tr>
<tr>
<td>Condom use (%)</td>
<td>99.3</td>
<td>Source: GARPR 2012</td>
</tr>
</tbody>
</table>

**Table 1.8 Men who have sex with men**

<table>
<thead>
<tr>
<th>Feature</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population size estimate (#)</td>
<td>1317</td>
</tr>
<tr>
<td>Condom use (%)</td>
<td>53.3</td>
</tr>
</tbody>
</table>

**Table 1.9 TB and HIV**

<table>
<thead>
<tr>
<th>Feature</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-management of TB and HIV treatment (%)</td>
<td>38 [30 - 50]</td>
</tr>
<tr>
<td>Estimated TB-related deaths among people living with HIV (#)</td>
<td>&lt;100 [&lt;100 - &lt;100]</td>
</tr>
</tbody>
</table>

Source: UNAIDS Country Factsheets Suriname
1.5 **Methodology accountability**

A consultative, and participatory approach has been used to conduct this study. The consultant followed the proposed methodology in the UNDP Legal Environment Assessment for HIV Manual by comparing Suriname’s de jure and de facto legal and policy practices according to 22 + 1 additional Factor Statements in the above-mentioned manual that serve as indicators or principles in four key areas where HIV-related discrimination is likely to occur with respect to:

- access to essential services
- equality of people living with HIV in public and private life
- key-populations
- access of justice

**Factors**

Factor 1: Public education, research and information exchange  
Factor 2: HIV prevention  
Factor 3: Testing, counselling and referral  
Factor 4: Treatment, care and other health services  
Factor 5: Social protection and material assistance  
Factor 6: Protection of privacy and confidentiality  
Factor 7: Political, social and cultural life  
Factor 8: Family, sexual and reproductive life  
Factor 9: Education and training  
Factor 10: Employment, work and economic life  
Factor 11: Private and public housing  
Factor 12: Entry, stay and residence  
Factor 13: Non-criminalization of HIV exposure and transmission  
Factor 14: Women  
Factor 15: Children and youth  
Factor 16: People who use drugs  
Factor 17: Adults engaged in commercial sex  
Factor 18: Men who have sex with men, and transgender people  
Factor 19: People under state custody  
Factor 20: Legal protection Maroon and Indigenous people in the hinterland and people in Nickerie  
Factor 21: Legal protection  
Factor 22: Legal awareness, assistance and representation  
Factor 23: Access to a forum, fair trial, and enforcement of remedies
In collaboration with the Country Coordinating Mechanism (CCM) a technical working group (TWG) has been set up and stakeholders have been identified. The consultant team conducted a desk review, held consultation meetings with stakeholders, designed a Legal Literacy Review Manual (LLRM) and developing a Communication, Dissemination and Impact Strategy Plan in collaboration with the TWG.

**Overview Technical Working Group**

The legal assessment was overseen by a Technical Working Group (TWG) made up of key stakeholders from a range of disciplines and sectors, including key government ministries, Civil Society organizations working on HIV and human rights issues and/or representing affected populations, international organizations and UN agencies. The TWG worked with the consultants to guide the assessment. This included providing assistance with reviewing the process, findings and recommendations throughout the various stages of the project and ensuring that the views of decision-makers and key affected populations were reflected in the assessment process.

See Annex 2 for the list of the TWG

**Desk review**

The legal environment assessment includes a desk review of relevant international and regional commitments, national laws, regulations and policies as well as research reports, submissions and case studies relevant to HIV, law and human rights in Suriname. The results of the desk review are incorporated in this report.

See Annex 1 for a list of documents reviewed

**Consultation meetings**

National stakeholders, key-informants, individual experts and resource persons have been engaged around building a comprehensive picture of Suriname’s legal and policy framework, identifying Gaps and Obstacles, challenges, and recommended solutions for creating an enabling and protective legal environment in line with international, regional and national human rights and HIV and health commitments. Consequently, three focus group discussions meetings ( one in collaboration with The Caribbean Regional Network of People Living with HIV and AIDS (CRN+) and individual and digital consultations have been held with the stakeholders, key-informants and experts.

See Annex 3 for the list of national stakeholders, key-and resource persons and experts.
Focus Group Discussions

Focus Group Discussions (FGDs) were used to obtain qualitative data from selected populations, as indicated in the term of reference, on their experiences of stigma, discrimination and human rights violations in the context of HIV and AIDS, how laws, policies and practices impact upon rights and the ability to access services in the context of HIV and whether affected populations are able to access justice and enjoy rights. The factors listed in the UNDP manual have been used for the consultation meetings.

Focus group discussions included stakeholders working in the field with populations vulnerable to and at higher risk of HIV exposure such as persons living with HIV or AIDS, people who use drugs, prisoners, young people, and immigrant workers. They also included key service providers, such as health care providers and social workers at various levels.

Individual consultations

Individual consultations included populations vulnerable to and at higher risk of HIV exposure such as persons living with HIV or AIDS.

Consultations with key-informants, experts and resource persons

Key informants, experts and resource persons were selected from across a range of sectors, including from government, the parliament, the judicial sector, civil society, the private sector and other partner institutions. They include relevant government officials from key government institutions and ministries such as the National AIDS Program, Ministry of Health and Ministry of Labor. They also include members of the Court of Justice, the Office of the Prosecutor, the National Assembly, legal experts and gender focal points. Key informants also include representatives of Civil Society Organizations working with and for people living with HIV and other affected populations, faith based organizations as well as development partners working on health, HIV and related issues.

These informants provided qualitative information on the views of decision-makers on key HIV, law and human rights issues; the impact of the legal and regulatory framework upon the response to HIV and AIDS as well as recommendations for strengthening the legal and regulatory framework to protect rights and promote access to services in the context of HIV and AIDS.
**Limitations**

Some factors beyond our control had influence on the timely availability of resource persons, TWG, stakeholders for consultations, interviews and data that has to be put at our disposal. This had caused some backlog in the time set aside for the activities and had led to a limited impact assessment.

The following limitations to the Legal Assessment should be noted:

1. Limited availability of existing research on the nature and extent of HIV-related stigma and discrimination against the selected key populations at higher risk of HIV exposure.
2. Limited availability of people living with HIV and key populations at higher risk of HIV exposure.
3. Time and resource constraints.
4. Limited availability of stakeholders

For this reason, the consultancy team was able to conduct a limited number of focus group discussions and consultations with the selected key population, vulnerable groups and key-informants. The assessment does not implicate to provide definitive evidence of stigmatizing and discriminatory practices for purpose of law and policy review, but rather seeks to give voice to some of the experiences related by affected populations, for purposes of law and policy review. The invaluable perspectives provided by informants and focus groups are gratefully acknowledged.
PART II SURINAME INTERNATIONAL, REGIONAL NATIONS HUMAN RIGHTS FRAMEWORK WITH RESPECT TO HIV

2.1 Suriname- Status of Ratification of Human rights treaties with respect to HIV and vulnerable populations

International and regional human rights law provides an overarching framework for an analysis of HIV, law and human rights issues in Suriname. International and regional human rights law is set out in various instruments (treaties, conventions, covenants) which can be signed and ratified by states. Once a state has signed and ratified such an instrument it becomes a member state and agrees to be legally bound by that convention and to ensure that the principles and provisions of that instrument are met and implemented at the national level. The member state is required to report periodically to the relevant treaty monitoring body on its compliance with the provisions of each treaty.

Suriname is one of the countries that have signed and ratified Human Rights treaties. Countries that adopt these human rights treaties have the duty to respect, protect, promote and apply universal human rights standards and fundamental freedoms to everyone, regardless of their political, economic and cultural systems. A treaty is only binding on Suriname when it is ratified and published in the Treaties Gazette (Verdragenblad) of the Republic of Suriname published by the Ministry of Foreign Affairs. Then any citizen can go to the court in case of self-executing provisions such as human rights, even if the treaty is not adapted to the national legislation. It is then up to the judge whether he or she will enforce the treaty.

According to a judge, judges take decisions on the basis of a treaty more often in family matters. For example when a child is the legal child of a man who is not the biological father, the law says that only the legitimate father can submit the claim for the denial of legitimacy. In Suriname, case law was developed based upon provisions in Article 17 of the Constitution and human rights treaties. In 2008 jurisprudence has gone so far that in particular with regard to the right to family life of a person with the biological father and his family Article 17 (1) (“Pact of San Jose”) and Article 17 ICCPR, the child, (if it has reached the legal age) or the mother may also claim it. (Verdict of June 17, 2008 A.R. no. 051963).

Also in the claims for legal paternity, a judge allowed the claim for paternity in a case without the permission of the ? and the family relationship was established. There were lawyers who thought it was too far-reaching, but now it is established case law. There is a provision namely
Article 336 Civil Code that states that legal recognition of a child by the biological father is also possible when the mother objects without reasonable grounds or doesn’t give permission. The new draft Civil Code has adapted the relevant provisions to aforementioned developments. However, the new draft Civil Code is still pending parliamentary approval.

There once was a case of sexual offense at the Public Prosecutors’ office. Commissioned by the prosecutor, both parents were confined the father for being guilty of a sexual offense and the mother for passively permitting/allowing the offense. Then the defense appealed claiming that, according to the Convention on the Rights of the Child, both parents cannot be confined at the same time as there would be no parent looking after the children. The public prosecutor honored the claim of the defense. We have not found such a provision in the CRC. Article 9 paragraph 4 shows that one can correctly deduce that in certain cases both parents can be imprisoned. If the judge has honored the claim of the defense and the prosecutors support the defense, a wrong interpretation has been given to "the best interest of the child".

As criticized by a representative of the Ministry of Foreign Affairs and other stakeholders they find it unfortunate that Suriname is lagging behind in bringing national legislation in line with international treaties.

These international human rights treaties ratified by Suriname also relate to human dignity and seek to provide basic health. As a result, with regard to HIV, every person has the right to information, the right to medicines to prevent HIV and the right to make responsible choices about intimacy. The latter concerns: freedom from violence and violations of physical integrity, freedom from discrimination and freedom from a vulnerable position. These rights aim to increase the quality of life of the seropositive person (Ahmed, 2011, Jürgens et al., 2009). Unfortunately, during the consultation meetings with the identified stakeholders, key-populations and vulnerable groups it was noticed that most of them are not aware of the international conventions, which Suriname has ratified, what they encompass, what the State’s obligations are and how they can use these conventions both at the national and international levels when their rights are violated. Some faith based organizations are aware of the conventions but they do not make use of them yet. According to the principles of Hinduism, Arya Samaj, there is no ground for discrimination. Ahimsa, which stands for free of violence, guarantees that.
<table>
<thead>
<tr>
<th>Treaty</th>
<th>Suriname State party</th>
</tr>
</thead>
<tbody>
<tr>
<td>x  International Covenant on Civil and Political Rights (ICCPR)</td>
<td>28 December 1976 Optional protocol 28 December 1976</td>
</tr>
<tr>
<td>x  International Covenant on Economic, Social and Cultural Rights (ICESCR)</td>
<td>28 December 1976</td>
</tr>
<tr>
<td>x  International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)</td>
<td>15 March 1984</td>
</tr>
<tr>
<td>x  Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)</td>
<td>1 March 1993</td>
</tr>
<tr>
<td>x  Convention on the Rights of the Child (CRC)</td>
<td>1 March 1993</td>
</tr>
<tr>
<td>The Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography,</td>
<td>18 May 2012;</td>
</tr>
<tr>
<td>Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women &quot;Convention of Belem do Para&quot;</td>
<td>February 19, 2002</td>
</tr>
<tr>
<td>Convention on the Rights of Persons with Disabilities (CRPD)</td>
<td>March 29, 2017</td>
</tr>
<tr>
<td>American Convention on Human Rights “Pact of San Jose”</td>
<td>December 4, 1975</td>
</tr>
<tr>
<td>ILO Convention 111</td>
<td>January 4, 2017</td>
</tr>
<tr>
<td>ILO Employment Agencies Convention, 1997, no 181</td>
<td>April 2006</td>
</tr>
</tbody>
</table>
HIV is shadowed by increasing challenges to human rights. The virus continues to be marked by discrimination against those who live on the fringes of society or who are assumed to be at risk of infection because of behaviors, ethnicity, sexual orientation, gender or social characteristic stigmatized in a particular society. International human rights dictates that governments should protect all its citizens regardless of their status. This box illustrates the various human rights articles which are relevant to HIV/AIDS.

### Human rights relevant to HIV/AIDS

- The right to non-discrimination, equal protection and equality before the law;
- The right to life;
- The right to the highest attainable standard of physical and mental health;
- The right to liberty and security of person;
- The right to freedom of movement;
- The right to seek and enjoy asylum;
- The right to privacy;
- The right to freedom of opinion and expression and the right to freely receive and impart information;
- The right to freedom of association;
- The right to work;
- The right to marry and to found a family;
- The right to equal access to education;
- The right to an adequate standard of living;
- The right to social security, assistance and welfare;
- The right to share in scientific advancement and its benefits;
- The right to participate in public and cultural life;
2.2 International and regional HIV and AIDS declarations, commitments and guidelines

Suriname has committed itself to

There are also several international and regional declarations, commitments and guidelines which deal specifically with HIV, human rights and gender equality. While not legally binding, contrary to the international conventions (see table 2.1), they are generally reflections of the application and interpretation of accepted international and regional human rights principles to the HIV epidemic. In this respect, they are important guidance for Suriname in its interpretation of its own human rights standards in the context of HIV and AIDS. Moreover, many international and regional strategies and plans include guidelines on law and policy responses to HIV and AIDS. As such, they provide important and persuasive guidance for national response to HIV and AIDS. (see table 2.2)

Table 2.2 Non-Binding Suriname’s International and regional HIV and AIDS declarations, commitments and guidelines

<table>
<thead>
<tr>
<th>1.</th>
<th>2001 Adoption of UNGASS Declaration of Commitment on HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>UNGASS Political Declaration on HIV/AIDS - Universal Access.</td>
</tr>
<tr>
<td>3.</td>
<td>UNGASS Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS.</td>
</tr>
<tr>
<td>4.</td>
<td>Sustainable Development Goals 2015</td>
</tr>
<tr>
<td>7.</td>
<td>Commitment to the principles of the UN Sustainable Development Goals which is included in the development Plan 2017-2012.</td>
</tr>
<tr>
<td>10.</td>
<td>United Nations General Assembly resolution 65/277 — Political Declaration on HIV and AIDS: intensifying Our Efforts to Eliminate HIV and AIDS</td>
</tr>
</tbody>
</table>

29 www.planningofficesuriname.com accessed on 23 January 2018
30 http://undocs.org/A/RES/65/277 accessed 16 February 2018
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>13.</td>
<td>A National HIV/AIDS Workplace Policy was developed by the Ministry of Labor</td>
</tr>
<tr>
<td>14.</td>
<td>2011 WHO/UNAIDS, The Treatment 2.0 Framework for Action. Catalyzing the next phase of treatment, care and support&lt;sup&gt;32&lt;/sup&gt;</td>
</tr>
<tr>
<td>15.</td>
<td>2010 UNAIDS 2011-2015 Strategy&lt;sup&gt;33&lt;/sup&gt;&lt;sup&gt;34&lt;/sup&gt;</td>
</tr>
<tr>
<td>16.</td>
<td>UNAIDS strategy 2021&lt;sup&gt;35&lt;/sup&gt;</td>
</tr>
<tr>
<td>17.</td>
<td>First meeting of ministers of Health and Education to stop HIV and AIDS in Latin America and the Caribbean Ministerial Declaration Preventing through Education, June 2010&lt;sup&gt;36&lt;/sup&gt;</td>
</tr>
<tr>
<td>18.</td>
<td>Pan Caribbean Partnership Against HIV/AIDS PANCAP</td>
</tr>
</tbody>
</table>

2.3 **Sexual and Reproductive Health and Rights (SRHR)**

The right to sexual and reproductive health is an integral part of the right of everyone to the highest attainable physical and mental health as enshrined in article 12 of the International Covenant on Economic, Social and Cultural Rights. The realization of the right to sexual and reproductive health requires that State parties also meet their obligations under other provisions of the Covenant. Evidence shows that good access to SRHR services, and an environment that upholds, protects and respects the rights of all people, helps to prevent new HIV infections and enables those living with HIV in all their diversity to live full and productive lives.<sup>37</sup>

The right to sexual and reproductive health is also reflected in other international human rights instruments. The adoption of the Programme of Action of the International Conference on

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Population and Development (ICPD) in 1994 further highlighted reproductive and sexual health issues within the human rights framework. Since then, international and regional human rights standards and jurisprudence related to the right to sexual and reproductive health have considerably evolved. Most recently, the 2030 Agenda for Sustainable Development includes goals and targets to be achieved in the area of sexual and reproductive health.\(^{38}\)\(^{39}\)

The Montevideo Consensus advances the spirit and ambition of the ICPD Programme of Action. It outlines how future implementation of ICPD must be grounded in a human rights framework that includes a gender, ethnicity/race, age and intercultural perspective. In Montevideo, Latin American governments committed to eliminating social, economic and gender inequalities, fulfilling the human rights of all people, and securing sexual and reproductive rights and health without discrimination based on sex, age, ethnicity, HIV status, sexual orientation or gender identity, among other issues. With respect to sexual rights: it is the first intergovernmental document to recognize sexual rights beyond just women’s human rights: “Embrace the right to a safe and full sexual life, as well as the right to take free, informed, voluntary and responsible decisions about their sexuality, sexual orientation and gender identity, without coercion, discrimination or violence, and that guarantee the right to information and the means necessary for their sexual health and reproductive health” (Paragraph 34)\(^{40}\)\(^{41}\)

2.3.1 Suriname’s obligation related to sexual rights, gender identity and non-discrimination

Although Suriname has signed, ratified and adopted various international and regional human rights conventions, declarations, commitments and agreements such as the American Human Rights Convention of the OAS which is binding and the Montevideo consensus which is non-binding that also protects the rights of PLHIV, LGBT, sex workers and other identified key-populations, it has occurred that Suriname commits interventions at international conferences that are in conflict with the rights guaranteed by the Conventions. For example, in 2013 the

\(^{38}\) General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights) 2 May 2016

\(^{39}\) See Convention on the Elimination of All Forms of Discrimination against Women, art. 12; Convention on the Rights of the Child, arts. 17, 23-25 and 27; and Convention on the Rights of Persons with Disabilities, arts. 23 and 25. See also Committee on the Elimination of Discrimination against Women general recommendation No. 24 (1999) on women and health, paras 11, 14, 18, 23, 26, 29, 31 (b); and Committee on the Rights of the Child general comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health.


OAS General Assembly has adopted a resolution condemning discrimination of and violations of human rights of lesbian, trans, gay, bisexual and intersex people. Suriname was one of the Caribbean OAS member states whose objections against the resolution have been put on record. Suriname has not voted against, but have merely noted their objections. Suriname emphasizes that the State supports equal rights for every individual, but it would first have to hold a national discussion before the country could vote for this resolution. Nirmala Badrising the Surinamese representative at the OAS said; 'We have a multi-cultural society and sexual orientation, identity and expression are part of a much broader issue that requires national debates'.

The Inter-American Human Rights (IHR) Court issued the Advisory Opinion following a request from the Government of Costa Rica, for which all signatory countries to the American Convention on Human Rights are bound. In its decision, the Court reiterated its consistently held view that sexual orientation and gender identity are categories protected by the American Convention, in which all States "must recognize and guarantee all the rights that are derived from a family bond between people of the same sex", including marriage. Reference? It requires governments to "guarantee access to all existing forms of legal domestic systems, including the right to marriage, to ensure the protection of all the rights of families formed by same-sex couples without discrimination". Reference? The IHR Court also ruled that transgender people have the right to change their name in their identification documents in accordance with their self-perceived gender identification.

UNAIDS considers that the implementation of this decision will provide definitive support for HIV prevention, treatment and care enabling countries in Latin America and the Caribbean to make progress towards the zero discrimination target.

The resolution such as the Montevideo consensus is non-binding, but the convention is. The Inter-American Court has now repeatedly indicated that the Convention guarantees non-discrimination on the basis of sexual orientation and gender identity. Hence Human Rights Committee’s statements are interpreting international obligations of Suriname’s ratified

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42 Suriname does not back OAS homo declaration 11/06/2013 DWT
43 http://www.corteidh.or.cr/docs/opiniones/seriea_24_esp.pdf  
http://www.corteidh.or.cr/docs/comunicados/cp_01_18.pdf  
http://www.corteidh.or.cr/tablas/abccorte/abc/index.html#2
conventions. As stated by some stakeholders, they regret that Suriname does not commit itself to its obligations.

Although de jure measures to eliminate discrimination have been improved, de facto the LGBT group is facing outright discrimination which is being tolerated or even supported by institutions. Two cases have dominated the news recently. One case was of a song (‘Bullet’) openly calling for violence against gays. The LGBT Platform supported by other civil society organizations filed a complaint with the Prosecutor’s Office. The call to violence was deemed covered under the right to the freedom of speech by the authorities. The other case was of a transgender woman who at first had successfully won the legal battle to be registered officially as a woman. In response, the Union of Gospel Churches and Pentecostalism, mobilized a protest march and a media campaign. Probably due to this pressure, the State (the Ministry of Home Affairs, responsible both for gender and for civil registration) appealed the court decision. Another complaint was also filed with the prosecutor’s office by the LGBT Platform in collaboration together with other civil society organizations. It was about a case of discrimination by the Union of Gospel and Pentecostalism, who publicly called upon the judicial sector, the government and society for not respecting the human rights of LGBT persons. The organizations received a response from the Attorney General that the call of the Union fell under the right to free speech. So the complaint has not been investigated. Up to now no follow-up by civil society had been undertaken.

According to a key-informant in Suriname people do not or barely stand up for their right. This is also reflected when the rights of key populations and vulnerable groups are violated. Many are being bullied at school. But how many really use the legislation to stop this form of violence?

One of the fundamental reasons is the stakeholders’ lack of faith that justice will be done. Additionally court rulings often take too long and the judicial system does not work properly. If for example members from the target group go to the police, they are often not treated correctly and are laughed at. This is the reason why many no longer use these services. On the other hand, by not using it you are not in a position to say that it does or does not work. If you use it, it can be disheartening.

People are involved in all kinds of networks and are in patronizing dependency relationships. Hence one is afraid to take legal action as they can be excluded, fall victim to repressive measures and may not be able to do business anymore. Surinamese small scale society is seen by some as an obstacle. There are too few visible activists filing lawsuits. And the activists out
there do not have that much room to settle their affairs on different fronts. The pool of people in organizations is small.

In the CRC Concluding observations on the combined third and fourth periodic reports of Suriname, the Committee recommends, referring to the General principles (arts. 2, 3, 6 and 12), that the State party ensure that all children in the State party enjoy equal rights under the Convention, both in law and in practice, without discrimination, and intensify efforts to ensure the effective elimination of any form of discrimination against children from Amerindian and Maroon communities, children of Haitian migrants, children living with HIV/AIDS, lesbian, gay, bisexual, transgender and intersex children and other groups of children in marginalized situations through, among other things, awareness-raising campaigns and education, especially at the community level and in schools. In its Penal Code Suriname enacted specific legislation on the prevention of discrimination based on sexual or gender orientation. But in the contemporary situation, LGBT people and PLHIV are still being discriminated. To respect and follow up on both international conventions, regional HIV and AIDS declarations, commitments and guidelines and national legislation, the Ministry of Health, the Global Fund and Country Coordinating Mechanism have taken the initiative to design an implementation report for the set-up of a human right desk for the above identified key-populations and vulnerable groups.


[45] Bakboord 2017
2.4 Suriname human rights, declarations, commitments and guidelines related to HIV

In this part of the legal assessment a distinction is being made based on four categories as mentioned in the UNDP manual; 1. Access to essential services, 2. Equality of people living with HIV in public and private life, 3. Key populations and 4. Access to justice. Particular attention is being paid to the human rights of children and women and those of other marginalized, vulnerable populations and key populations at higher risk of HIV exposure. As they are often marginalized by society and by law and face unacceptable levels of stigma and discrimination, which hampers their ability to access HIV prevention, treatment and care services, placing them at higher risk of HIV infection. An important remark has been made by a member of the TWG with respect to key-populations. He emphasized that due to the traditional gender roles, men are also a significant part of the key-populations who are high at risk of HIV infection. This target group has often been left out, while their behavior not only places them at risk, but also their sexual partners and other vulnerable groups. Another remark has been emphasized by a stakeholder who indicates that the general population has few or no knowledge about HIV. ‘We do involve them enough in the dialogue’, she says. They recommend, in the nearby future, to also pay special attention to men as a key-category of being at high risk of HIV infection and to involve the general population in the dialogue.
2.4.1 Conventions, declarations (b), commitments and guidelines related to HIV with respect to access to essential services incorporated in general comments

**International Covenant on Civil and Political Rights (ICCPR)**

Art. 6: Right to life

General Comment No. 6: The Right to Life (April 30, 1982), para. 5 stating the states are obliged to take measures aimed at reducing the spread of epidemics;

Art. 7: No one shall be subjected without his free consent to medical or scientific experimentation;

Art 9: Right to liberty and security of person;

Art. 15: Right to Participate in Social and Cultural Life.

Art. 17: Right to Privacy;

Art 19: Right to Information;

**International Covenant on Economic, Social and Cultural Rights (ICESCR)**

Art. 9: Right of everyone to social security, including social insurance.

Art. 11: Right to an Adequate Standard of Living.

Art. 12: Right to highest attainable standard of health;

General Comment No. 14 (11 August 2000): Right to highest attainable standard of health

Para. 16: States are obliged to take measures to control epidemics, including establishing prevention and education programs to address HIV.

Para. 43: The right to health includes essential primary care; essential drugs; equitable distribution of all health facilities, goods, and services; and nondiscriminatory access to health facilities, goods, and services, especially for vulnerable or marginalized groups.

**Convention on the Rights of the Child (CRC)**

General Comment 3 (17 March 2003): HIV/AIDS and the rights of the child contains provisions on prevention, education, child sensitive services, HIV testing and counseling, and
PMTCT: right-based approaches including non-discrimination and participation.

Universal Declaration on Human Rights
Art. 25(1) Everyone has the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his [or her] control.

2001 ILO Code of Practice on HIV/AIDS & the World of Work
There is no justification for asking job applicants or workers to disclose HIV-related personal information. Nor should co-workers be obliged to reveal such personal information about fellow workers. Access to personal data relating to a worker’s HIV status should be bound by the rules of confidentiality consistent with the ILO’s code of practice on the protection of workers’ personal data, 1997.

4.8 Continuation and Employment Relationship
HIV infection is not a cause for termination of employment. As with many other conditions, persons with HIV-related illnesses should be able to work for as long as medically fit in available, appropriate work.

4.9: Prevention
Prevention of all means of transmission can be achieved through a variety of strategies which are appropriately targeted to national conditions and which are culturally sensitive. Prevention can be furthered through changes in behavior, knowledge, treatment and the creation of a non-discriminatory environment.

The social partners are in a unique position to promote prevention efforts particularly in relation to changing attitudes and behavior through the provision of information and education, and in addressing socio-economic factors.

4.10: Care and support
All workers, including workers with HIV, are entitled to affordable health services. There should be no discrimination against them and their dependents in access to and receipt of benefits from statutory social security programmes and occupational schemes.

5.2: Employers and their Organizations
(1) Support for confidential voluntary HIV counseling and testing. Employers, workers and their representatives should encourage support for, and access to, confidential voluntary counseling and testing that is provided by qualified health services;

8.1 Prohibition in recruitment and employment
HIV/AIDS screening should not be required of job applicants or persons in employment. There is no justification for asking job applicants or workers to disclose HIV-related personal information.

8.2 Prohibition for insurance purposes
HIV testing should not be used as a condition of eligibility for insurance purposes; epidemiological surveillance in accordance with the ethical principles of scientific research; voluntary testing; and tests and treatment after occupational exposure;

9.6: Social security coverage
9.8: Employee and family assistance programs.

2010 ILO Recommendation 200 on HIV/AIDS and the World of Work, Principles
19. All persons covered by this Recommendation, including workers living with HIV and their families and their dependents, should be entitled to health services. These services should include access to free or affordable: (a) voluntary counselling and testing; (b) antiretroviral treatment and adherence education, information and support; (c) proper nutrition consistent with treatment; (d) treatment for opportunistic infections and sexually transmitted infections, and any other HIV-related illnesses, in particular tuberculosis; and (e) support and prevention programs for persons living with HIV, including psychosocial support.

20. There should be no discrimination against workers or their dependents based on real or perceived HIV status in access to social security systems and occupational insurance schemes, or in relation to benefits under such schemes, including for health care and disability, and death and survivors’ benefits.

International Guidelines on HIV/AIDS and Human Rights 2006 consolidated version
Guideline 5: Privacy and Confidentiality: Anti-discrimination and protective laws; para. 22. States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV and people with disabilities from discrimination in both the public and private sectors, that will ensure privacy and confidentiality and ethics in research involving human subjects, emphasize education and conciliation and provide for speedy and effective administrative and civil remedies.

Guideline 6 as revised in 2002: States should also take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV prevention, treatment, care and support, including antiretroviral and other safe and effective medicines, diagnostics and related technologies for
preventive, curative and palliative care of HIV and related opportunistic infections and conditions: Access to Prevention, Treatment, Care, and Support.

**Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030**

Reaffirm the 2001 Declaration of Commitment on HIV/AIDS and the 2006 and 2011 Political Declarations on HIV and AIDS, and the urgent need to scale up significantly our efforts towards the goal of universal access to comprehensive prevention programs, treatment, care and support.

**2001 UNGASS Declaration of Commitments on HIV/AIDS**

Para. 47-54: Prevention must be the mainstay of our response with national time-bound targets.

Para. 52:
- ensure that a wide range of prevention programs which take account of local circumstances, ethics and cultural values, is available in all countries, particularly the most affected countries, including information, education and communication, in languages most understood by communities and respectful of cultures, aimed at reducing risk-taking behavior and encouraging responsible sexual behavior;
- expanded access to voluntary and confidential counseling and testing.

Para. 55: Strengthen health care systems and address factors affecting the provision of HIV-related drugs, including anti-retroviral drugs, inter alia affordability and pricing, including differential pricing, and technical and health care systems capacity.

Para. 58: Realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS and the respect for the rights of people living with HIV and AIDS drives an effective response.

Paras. 68 and 69: Alleviating social & economic impact.

Develop and accelerate the implementation of national poverty eradication strategies to address the impact of HIV/AIDS on household income, livelihoods, and access to basic social services, with special focus on individuals, families and communities severely affected by the epidemic; and develop a national legal and policy framework that protects in the workplace the rights and dignity of persons living with and affected by HIV/AIDS.

**Sustainable Development Goals**

SDG 1: No poverty

SDG 3: Good health and well-being: Children, adolescents and adults living with HIV access testing, know their status and are immediately offered and sustained on affordable quality
treatment

SDG 10: Reduced inequalities: Young people, especially young women and adolescent girls, access combination prevention services and are empowered to protect themselves from HIV.

**2009 Partnership with faith-based organizations UNAIDS strategic framework.**

The objectives include: encourage global and national religious leaders to take supportive public action in the AIDS response; create strong partnerships between UNAIDS and established FBOs working on HIV; promote strengthened links, including coordination and oversight, with FBOs at the country level in order to ensure that there is an appropriate interface as part of a comprehensive national AIDS response; strengthen the capacity of FBOs to work on HIV issues and the capacity of UNAIDS staff to work with FBOs; target FBOs not yet working on HIV to include HIV-related activities in their work; mobilize local faith communities to become involved in the local AIDS response; and identify and document examples of FBO good practice. PANCAP meeting has been held in Paramaribo with LGBT’s and FBO’s 2018 with respect to HIV.

**2004 UNAIDS & WHO, Policy Statement on HIV Testing.**

Stigma and discrimination continue to stop people from having an HIV test. To address this, the cornerstones of HIV testing scale-up must include improved protection from stigma and discrimination as well as assured access to integrated prevention, treatment and care services. The conditions under which people undergo HIV testing must be anchored in a human rights approach which protects their human rights and pays due respect to ethical principles. Young people require special attention to their needs through the provision of confidential youth friendly health services. Public health strategies and human rights promotion are mutually reinforcing.

The conditions of the ‘3 Cs’, advocated since the HIV test became available in 1985, continue to be underpinning principles for the conduct of HIV testing of individuals. Such testing of individuals must be: Confidential, be accompanied by Counselling and only be conducted with informed Consent, meaning that it is both informed and voluntary.

47 DWT, February 10, 2018
2006 Political Declaration on HIV/AIDS
Para. 22: Ensure a wide range of prevention programs;
Para. 24: States commit to overcome legal, regulatory or other barriers that block access to effective HIV prevention, treatment, care and support, medicines, commodities and services;
Para. 25: Ensure access to HIV/AIDS education, information, voluntary counseling and testing and related services, with full protection of confidentiality and informed consent, and to promote a social and legal environment that is supportive of and safe for voluntary disclosure of HIV status.

2011 Political Declaration on HIV/AIDS
Paras. 58-64: Prevention: expanding coverage, diversifying approaches and intensifying efforts to end new HIV infections; and
Paras. 65-76: Treatment, care and support: eliminating AIDS-related illness and death.

2011 WHO/UNAIDS, The Treatment 2.0 Framework for Action:
Catalyzing the Next Phase of Treatment, Care and Support
Ushering the next phase of HIV treatment scale up through promoting innovation and efficiency gains in five priority areas:
1) optimize drug regimens;
2) provide point of care diagnosis;
3) reduce costs;
4) adapt delivery systems; and
5) mobilize communities.
Conventions, declarations, commitments and guidelines related to HIV with respect to Equality of people living with HIV in public and private life

2.4.2 Conventions, declarations, commitments and guidelines related to HIV with respect to Equality of people living with HIV in public and private life

International Covenant on Civil and Political Rights (ICCPR)
Art. 9: Right to liberty and security of person;
Art. 15: Right to Participate in Social and Cultural Life;
Art. 17: Freedom from arbitrary or unlawful interference with his privacy, family;
Art. 19: Right to Hold Opinions and Freedom of Expression;
Art. 23(2): Protects the right to marry and found a family.

International Covenant on Economic, Social and Cultural Rights (ICESCR)
Art. 6: Right to work
Art. 11: Right to housing.
Art. 13 protects the right to an education, accessible to all, without discrimination, especially in regards to the most vulnerable groups.

Charter of the Organization of American States
Art. 24: Obligates states to attempt to supply all persons with adequate housing.

Convention on the rights of the Child (CRC)
Art. 28: Protects the right to education

ILO Convention 111 and approved Act.

International Guidelines on HIV/AIDS and Human Rights
Guideline 4: States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV or targeted at vulnerable groups. Criminal and/or public health legislation
should not include specific offences against the deliberate and intentional transmission of HIV but rather should apply general criminal offences to these exceptional cases. Such application should ensure that the elements of foreseeability, intent, causality, and consent are clearly and legally established to support a guilty verdict and/or harsher penalties.

Guideline 5: The HIV status of a parent or child should not be treated any differently from any other analogous medical condition in making decisions regarding custody, fostering or adoption.

Guideline 10: States should ensure that Government and the private sector develop codes of conduct regarding HIV issues that translate human rights principles into codes of professional responsibility and practice, with accompanying mechanisms to implement and enforce these codes. International Guidelines on HIV/AIDS and Human Rights.

Guideline 11: States should ensure monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights, including those of people living with HIV, their families and communities.

1994 International Conference on Population and Development (ICPD) Programme of Action

Paras. 7.2 - 7.48: On reproductive rights and reproductive health; family planning; sexually transmitted diseases and prevention of HIV; human sexuality and gender relations; and adolescents. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. Reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases.
1995 Beijing Platform for Action
Para. 94: Similar to ICPD Para. 7.2:
Para. 96: The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behavior and its consequences.

2001 UNGASS Declaration of Commitment on HIV/AIDS
Para. 58: Realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS and the respect for the rights of people living with HIV and AIDS drives an effective response.
Para. 60: By 2005, implement measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and health services, including sexual and reproductive health, and through prevention education that promotes gender equality within a culturally and gender sensitive framework.

2006 Political Declaration on HIV/AIDS
Para. 25: Promote a social and legal environment that is supportive of and safe for voluntary disclosure of HIV status.
Para. 29: Realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS and the respect for the rights of people living with HIV and AIDS drives an effective response.
Para. 30: On sexual and reproductive health.
Para. 25: Promote a social and legal environment that is supportive of and safe for voluntary disclosure of HIV status.

Political Declaration on HIV/AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030 reaffirming the previous Political Declarations.
Art. 1: We, Heads of State and Government and representatives of States and Governments assembled at the United Nations from 8 to 10 June 2016, reaffirm our commitment to end the AIDS epidemic by 2030 as our legacy to present and future generations, to accelerate and scale
up the fight against HIV and end AIDS to reach this target, and to seize the new opportunities provided by the 2030 Agenda for Sustainable Development to accelerate action and to recast our approach to AIDS given the potential of the Sustainable Development Goals to accelerate joined-up and sustainable efforts to lead to the end of the AIDS epidemic, and we pledge to intensify efforts towards the goal of comprehensive prevention, treatment, care and support programmes that will help to significantly reduce new infections, increase life expectancy and quality of life, the promotion, protection and fulfilment of all human rights and the dignity of all people living with, at risk of, and affected by HIV and AIDS and their families;

2008 UNAIDS Report of the International Task Team on HIV-Related Travel Restrictions

Findings and recommendation 6

Strongly encourage all countries to eliminate HIV-specific restrictions on entry, stay and residence and ensure that people living with HIV are no longer excluded, detained or deported on the basis of HIV status.

2008 UNAIDS, Criminalization of HIV Transmission, Policy Brief 1:

UNAIDS urges governments to limit criminalization to cases of intentional transmission i.e. where a person knows his or her HIV positive status, acts with the intention to transmit HIV, and does in fact transmit it.

2012 Global Commission on HIV and the Law:

Risks, Rights and Health.

The 2001 ILO Code of Practice on HIV/AIDS and the World of Work,

Provides guidance on implementing work place policies on HIV Principles.

2010 ILO Recommendation 200 on HIV/AIDS and the World of Work

Para. 25: HIV testing or other forms of screening for HIV should not be required of workers, including migrant workers, jobseekers and job applicants.

Sustainable Development Goals

SDG 16. Peace, justice and strong institutions Punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV are removed.
SDG 17. Partnership for the goals: AIDS response is fully funded and efficiently implemented based on reliable strategic information. People-centered HIV and health services are integrated in the context of stronger systems for health.

Montevideo consensus
Embrace the right to a safe and full sexual life, as well as the right to take free, informed, voluntary and responsible decisions about their sexuality, sexual orientation and gender identity, without coercion, discrimination or violence, and that guarantee the right to information and the means necessary for their sexual health and reproductive health.
Human rights, declarations, commitments and guidelines related to HIV with respect to KEY POPULATIONS

UNAIDS STRATEGY 2016-2020
TARGETS FOR 2020

Target 1
90% of people (children, adolescents and adults) living with HIV know their status, 90% of people living with HIV who know their status are receiving treatment and 90% of people on treatment have suppressed viral loads

Target 2
Zero new HIV infections among children, and mothers are alive and well

Target 3
90% of young people are empowered with the skills, knowledge and capability to protect themselves from HIV

Target 4
90% of women and men, especially young people and those in high-prevalence settings, have access to HIV combination prevention and sexual and reproductive health services

Target 5
27 million additional men in high-prevalence settings are voluntarily medically circumcised, as part of integrated sexual and reproductive health services for men

Target 6
90% of key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants, have access to HIV combination prevention services

Target 7
90% of women and girls live free from gender inequality and gender-based violence to mitigate the risk and impact of HIV

Target 8
90% of people living with, at risk of and affected by HIV report no discrimination, especially in health, education and workplace settings

Target 9
Overall financial investments for the AIDS response in low- and middle-income countries reach at least US$ 30 billion, with continued increase from the current levels of domestic public sources

Target 10
75% of people living with, at risk of and affected by HIV, who are in need, benefit from HIV-sensitive social protection

Fewer than 500 000 new HIV infections
Fewer 500 AIDS-related
2.4.3 Human rights, declarations, commitments and guidelines related to HIV with respect to key populations

**Women**

**Convention on the Elimination of All Forms of Discrimination CEDAW**
Arts. 1-5: Right to non-discrimination;
Arts 5, 6, 12, 16, 32: Right to be free from violence and harmful traditional practices;
Art 10: Right to equality in education;
Arts 11, 13, 16: women’s economic rights;
Art 12: Right to health.
Art 16: Right to equality in family life;

**Convention of Belem do Para**
Art. 3: Every woman has the right to be free from violence in both the public and private spheres;
Art. 4: Every woman has the right to the recognition, enjoyment, exercise and protection of all human rights and freedoms embodied in regional and international human rights instruments.

**International Guidelines on HIV/AIDS and Human Rights**
Guideline 5: Anti-discrimination and protective laws, para. 22 (f): Anti-discrimination and protective laws should be enacted to reduce human rights violations against women in the context of HIV, so as to reduce vulnerability of women to infection by HIV and to the impact of HIV and AIDS. More particularly, laws should be reviewed and reformed to ensure equality of women regarding property and marital relations and access to employment and economic opportunity, so that discriminatory limitations are removed on rights to own and inherit property, enter into contracts and marriage, obtain credit and finance, initiate separation or divorce, equitably share assets upon divorce or separation, and retain custody of children. Laws should also be enacted to ensure women’s reproductive and sexual rights, including the right of independent access to reproductive and STD health information and services and means of contraception, including safe and legal abortion and the freedom to choose among these, the right to determine number and spacing of children, the right to demand safer sex practices and the right to legal protection from sexual violence, outside and inside marriage, including legal provisions for marital rape. The age of consent to sex and marriage should be consistent for
males and females and the right of women and girls to refuse marriage and sexual relations should be protected by law.

Guideline 8: States, in collaboration with and through the community, should promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.
(a) States should support the establishment and sustainability of community associations comprising members of different vulnerable groups for peer education, empowerment, positive behavioral change and social support.
(b) States should support the development of adequate, accessible and effective HIV-related prevention and care education, information and services by and for vulnerable communities and should actively involve such communities in the design and implementation of these programs.
(c) States should support the establishment of national and local forums to examine the impact of the HIV epidemic on women. They should be multi-sectorial to include Government, professional, religious and community representation and leadership and examine issues such as: (i) The role of women at home and in public life; (ii) The sexual and reproductive rights of women and men, including women’s ability to negotiate safer sex and make reproductive choices; (iii) Strategies for increasing educational and economic opportunities for women; (iv) Sensitizing service deliverers and improving health care and social support services for women; and (v) The impact of religious and cultural traditions on women.
(d) States should implement the Cairo Programme of Action of the International Conference on Population and Development and the Beijing Declaration and Platform for Action of the Fourth World Conference on Women. Primary health services, programs and information campaigns in particular should include a gender perspective. Violence against women, harmful traditional practices, sexual abuse, exploitation, early marriage and female genital mutilation, should be eliminated. Positive measures, including formal and informal education programs, increased work opportunities and support services, should be established.
(e) States should support women’s organizations to incorporate HIV and human rights issues into their programming.
(f) States should ensure that all women and girls of child-bearing age have access to accurate and comprehensive information and counseling on the prevention of HIV transmission and the risk of vertical transmission of HIV, as well as access to the available resources to minimize that risk, or to proceed with childbirth, if they so choose.
Sustainable Development Goals
SDG 5 Gender equality: Women and men practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV.
SDG 1 End poverty in all its forms.
SDG 3 Ensure healthy lives and promote well-being for all at all ages.

2006 Political Declaration on HIV/AIDS
Para. 27: To ensure that pregnant women have access to antenatal care, information, counseling and other HIV services and to increasing the availability of and access to effective treatment to women living with HIV and infants in order to reduce mother-to-child transmission of HIV, as well as to ensure effective interventions for women living with HIV, including voluntary and confidential counseling and testing, with informed consent, access to treatment, especially lifelong antiretroviral therapy and, where appropriate, breast-milk substitutes and the provision of a continuum of care;

Para. 31: To strengthen legal, policy, administrative and other measures for the promotion and protection of women’s full enjoyment of all human rights and the reduction of their vulnerability to HIV and AIDS through the elimination of all forms of discrimination, as well as all types of sexual exploitation of women, girls and boys, including for commercial reasons, and all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls;

This strategy promotes the crucial role of sexual and reproductive health in national development, in the Montevideo Consensus and the Program of Action of the International Conference on Population and Development (ICPD).

The Global Strategy for Women’s, Children’s and Adolescent’s Health (2016-2030)
The Global strategy is a roadmap to achieve the highest attainable standard of health for all women, children and adolescents—to transform the future and ensure that every newborn, mother and child not only survives, but thrives. The new Strategy - updated through a process of collaboration with stakeholders led by WHO - builds on the success of the 2010 Strategy and
its Every Woman Every Child movement as a platform to accelerate the health-related Millennium Development Goals and puts women, children and adolescents at the heart of the new UN Sustainable Development Goals.

**Children**

**Convention on the Rights of Child**

General Comment No. 3 on Children and HIV/AIDS, para. 8: Of particular concern is gender based discrimination combined with taboos or negative or judgmental attitudes to sexual activity of girls, often limiting their access to preventive measures and other services. Of concern also is discrimination based on sexual orientation. In the design of HIV/AIDS-related strategies, and in keeping with their obligations under the Convention, States parties must give careful consideration to prescribed gender norms within their societies with a view to eliminating gender-based discrimination as these norms impact on the vulnerability of both girls and boys to HIV/AIDS. States parties should, in particular, recognize that discrimination in the context of HIV/AIDS often impacts girls more severely than boys.

Art. 2: The right to non-discrimination
Art. 3 jo: The right of the child to have his/her interest as a primary consideration also with regard to the right to life, survival and development (art. 6)
Art. 9: The right not to be separated from parents
Art. 12 jo 17: The right to have his/her views respected the right to access information and material aimed at the promotion of their social, spiritual and moral wellbeing and physical and mental health art. 17;
Art. 16: The right to privacy
Art. 19: The right to be protected from violence
Art. 20: The right to special protection and assistance by the State
Art. 23: The rights of children with disabilities
Art. 24: The right to health; preventive health care, sex education and family planning education and services;
Art. 26: The right to social security, including social insurance
Art. 27: The right to an appropriate standard of living adequate for the child's physical, mental, spiritual, moral and social development
Arts. 28 and 31: The right to education and leisure
Arts. 32, 33, 34 and 36: The right to be protected from economic and sexual exploitation and abuse, and from illicit use of narcotic drugs

Arts. 35 and 37: The right to be protected from abduction, sale and trafficking as well as torture or other cruel, inhuman or degrading treatment or punishment

Art. 39: the right to physical and psychological recovery and social reintegration

**International Guidelines on HIV/AIDS and Human Rights**

Guideline 8: States, in collaboration with and through the community, should promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.

**2004 UNICEF Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS**

Five key strategies:

1. Strengthening the capacity of families to protect and care for orphans and other children made vulnerable by HIV and AIDS;
2. Mobilizing and strengthening community-based responses;
3. Ensuring access to essential services for orphaned and vulnerable children;
4. Ensuring that governments protect the most vulnerable children;
5. Raising awareness to create a supportive environment for children affected by HIV and AIDS.

**Adults engaged in commercial sex.**

**International Guidelines on HIV/AIDS and Human Rights**

Guideline 4:

(b) Criminal law prohibiting sexual acts (including adultery, sodomy, fornication and commercial sexual encounters) between consenting adults in private should be reviewed with the aim of repeal. In any event, they should not be allowed to impede provision of HIV prevention and care services;

(c) With regard to adult sex work that involves no victimization, criminal law should be reviewed with the aim of decriminalizing, then legally regulating Occupational Safety and Health conditions to protect sex workers and their clients, including support for safe sex during
sex work. Criminal law should not impede provision of HIV prevention and care services to sex workers and their clients. Criminal law should ensure that children and adult sex workers who have been trafficked or otherwise coerced into sex work are protected from participation in the sex industry and are not prosecuted for such participation but rather are removed from sex work and provided with medical and psychosocial support services, including those related to HIV.

**People who use drugs**

**International Guidelines on HIV/AIDS and Human Rights**

Guideline 4: (d) Criminal law should not be an impediment to measures taken by States to reduce the risk of HIV transmission among injecting drug users and to provide HIV-related care and treatment for injecting drug users. Criminal law should be reviewed to consider: the authorization or legalization and promotion of needle and syringe exchange programs; the repeal of laws criminalizing the possession, distribution and dispensing of needles and syringes.

**Men who are having sex with men and transgender persons**

**International Covenant on Civil and Political Rights ICCPR**

The ICCPR enshrines the rights of all people to non-discrimination and equality before the law. Article 2(1) holds the principle of non-discrimination: Each State Party to the present Covenant undertakes to respect and to ensure all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant, without distinction of any kind such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Art. 26 contains the principle of equality: All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Art 17 deals with the right to privacy, which the Human Rights Committee has interpreted as protecting the right to private consensual sexual conduct between adults.
Art.23 is regarding the right to marry and found a family. The ICCPR does not specifically refer to sexual orientation. However, the United Nations Human Rights Committee has found that the treaty includes an obligation to prevent discrimination on the basis of sexual orientation.

**International Guidelines on HIV/AIDS and Human Rights**

Guideline 4: (b) Criminal law prohibiting sexual acts (including adultery, sodomy, fornication and commercial sexual encounters) between consenting adults in private should be reviewed with the aim of repeal. In any event, they should not be allowed to impede provision of HIV prevention and care services.

**People under state custody**

**International Covenant on Civil and Political Rights**

Article 10 (1), which provides that “all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.”

**1993 WHO Guidelines on HIV Infection and AIDS in Prisons**

General principles (right to health); voluntary and anonymous HIV testing; preventive measures (i) education and information, (ii) sexual transmission, (iii) transmission by injection, (iv) use of other substances that may increase the likelihood of HIV transmission; management of HIV-infected prisoners (non-segregation); confidentiality in relation to HIV/AIDS; care and support of HIV-infected prisoners; Tuberculosis in relation to HIV infection; specific needs of women prisoners; prisoners in juvenile detention centers; foreign prisoners; semi-liberty and release; early release; and contacts with the community and monitoring.

Guideline 4: Criminal Laws and Correctional Systems (e) Prison authorities should take all necessary measures, including adequate staffing, effective surveillance and appropriate disciplinary measures, to protect prisoners from rape, sexual violence and coercion. Prison authorities should also provide prisoners (and prison staff, as appropriate), with access to HIV-related prevention information, education, voluntary testing and counseling, means of prevention (condoms, bleach and clean injection equipment), treatment and care and voluntary participation in HIV-related clinical trials, as well as ensure confidentiality, and should prohibit mandatory testing, segregation and denial of access to prison facilities, privileges and release programs for HIV-positive prisoners. Compassionate early release of prisoners living with AIDS should be considered.
2007 WHO, UNODC, and UNAIDS Effectiveness of Interventions to Manage HIV in Prisons
Provision of Condoms and Other Measures to Decrease Sexual Transmission, Recommendations on condom provision and measures to decrease sexual transmission

Migrants and Indigenous and Maroon populations

International Covenant on Civil and Political Rights
Article 10 (1), which provides that “all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.”

International Covenant on Economic, Social and Cultural Rights (ICESCR)

The Committee on Economic, Social and Cultural Rights has interpreted the right to health to include an obligation on States to refrain from denying or limiting equal access for all persons, including asylum seekers and illegal migrants, to preventative, curative and palliative health services. Moreover, according to the Committee, it is a core obligation of States parties to ensure primary health care and to provide essential drugs.

Art. 27 In those States in which ethnic, religious or linguistic minorities exist, persons belonging to such minorities shall not be denied the right, in community with the other members of their group, to enjoy their own culture, to profess and practice their own religion or to use their own language.

Art 1: 1. All peoples have the right of self-determination determination. By virtue of that right they freely determine their political status and freely pursue their economic and cultural development.
2. All peoples may, for their own ends freely dispose of their natural wealth and resources without prejudice to any obligations arising our of international cooperation, based upon the principal of mutual benefit, and international law. In no case may a people, be deprived of its own means of subsistence.
UNAIDS Strategy 2016-2020 targets for 2020

Target 6. 90% of key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants, have access to HIV combination prevention services.

UN Declaration on Human Rights

Art. 1 Everyone is born free and equal in dignity and rights Art 2; Everyone is entitled to all the rights set forth in this declaration without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

The Minority Declaration

Art. 2 1. Persons belonging to national or ethnic, religious and linguistic minorities have the right to enjoy their own culture, to profess and practice their own religion and to use their own language, in private and in public, freely and without interference of any form of discriminations.
2. Persons belonging to minorities have the right to participate effectively in cultural, religious, social economic in public life.
3. Persons belonging to minorities have the right to participate effectively in decisions on the national and, where appropriate regional level concerning the minority to which they belong or the regions in which they live, in a manner not incompatible with national legislation.

ILO Convention concerning indigenous and Tribal Peoples

Art 3: Indigenous and tribal peoples shall enjoy the full measures of human rights and fundament all freedoms without hindrance or discrimination.
Art 7: 1. The peoples concerned shall have the right to decide their own priorities for the process of development as it affects their lives, beliefs, institutions and spiritual wellbeing and the land they occupy or otherwise use and to exercise control, to the extent possible over their own economic, social and cultural development.

UN Declaration on Indigenous Peoples Rights

Indigenous peoples have the right to self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development.
Human rights, declarations, commitments and guidelines related to HIV with respect TO ACCESS TO JUSTICE

2.4.4 Human rights, declarations, commitments and guidelines related to HIV with respect to access to justice

**International Covenant on Civil and Political Rights ICCPR**

Art. 2 (3) (a) obliges states “to ensure that any person whose rights or freedoms as herein recognized are violated shall have an effective remedy, notwithstanding that the violation has been committed by persons acting in an official capacity; (b) To ensure that any person claiming such a remedy shall have his right thereto determined by competent judicial, administrative or legislative authorities, or by any other competent authority provided for by the legal system of the State, and to develop the possibilities of judicial remedy; (c) To ensure that the competent authorities shall enforce such remedies when granted.”


The establishment of a national human rights institution.

**International Guidelines on HIV/AIDS and Human Rights.**

Guideline 7: Legal Support Services dictate that “States should implement and support legal support services that will educate people affected by HIV about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related legal issues and utilize means of protection in addition to the courts, such as offices of Ministries of Justice, ombudspersons, health complaint units and human rights commissions.”
2.5 National legal framework with respect to human rights

The Global Commission on HIV and the Law (GCHL) has found that there are instances where legal and justice systems have played constructive roles in responding to HIV, by respecting, protecting and fulfilling human rights. Compelling evidence shows that it is the way to reduce vulnerability to and mitigate the impact of HIV. Good laws can widen access to prevention and health care services, improve the quality of treatment, and enhance social support for the infected and affected and thereby protecting their human rights. Examples include instances where police cooperate with community workers, condom use can increase and violence and HIV infection can decrease amongst sex workers; harm reduction programs can contribute to a significant drop in HIV infection rates for people who use drugs. Effective legal aid can make justice and equality a reality for people living with HIV and thus create better health outcomes. Court actions and legislative initiatives can help introduce gender-sensitive sexual assault law and recognize the sexual autonomy of young people. To underscore its international commitment to sexual reproductive health and rights, as stated in the National Sexual and Reproductive Health and Rights Policy of Suriname, 2013-2017, the Surinamese Government ratified a number of agreements that speak to the issue of health, including access to health care, health education and promotion, and gender equality as we have seen in the above tables. As such we can conclude that the Suriname government acknowledges Sexual and Reproductive Health and Rights as main cornerstones of population and development policies and crucial conditions for achieving the SDG’s.

However, it appears that human rights, in the context of HIV-related persecution, are being undermined in various ways. The possible undesirable consequences of the excessive use of criminal law to prosecute HIV contamination have been subjected to increasing criticism. In the first instance, criminal law can be used selectively, thereby violating the prohibition of discrimination. People living with HIV are often confronted with stigmatization,
discrimination, marginalization and various forms of abuse. As a result, the right to equality and the right to a fair trial can be violated without arbitrariness (IPPF, GNP +, & ICW, 2008, Boilers, 2009c, UNAIDS, 2012, UNDP, 2012). As emphasized above (2.1) Suriname is lagging far behind by adapting national legislation to the international treaties. This also counts in the context of HIV related discrimination.

**Constitutional protection**

Suriname has no specific health law or HIV law to protect PLHIV. So it does not specifically recognize the need to protect rights to equality and prohibit discrimination against people living with HIV as well as other key populations. The basis prohibition of discrimination is in general regulated in our Constitution and further in the Penal Code. Hence key populations could also be considered in the Constitution as being referred to by the minister of Justice and Police. Pursuant to the Decree on Mission descriptions for Departments 1991 (S.B. 1991 No. 58, as last amended by S.B. 2017 No. 11), the Ministry of Justice and Police is responsible for maintaining fundamental human rights and freedoms. During the Universal Periodic Review (UPR) 2016 in Geneva, the Minister of Justice and Police, Dr. Mrs. J.van Dijk - Silos, LLM, pronounced the guarantee of the enforcement and the enjoyment of human rights by all people. She has therefore made a clear choice for human rights and is convinced that there must be a good, correct legal experience in the Republic of Suriname regardless of sexual orientation and gender identity (SOGI). As a first step towards the realization of the policy of the Ministry of Justice and Police concerning the promotion of human rights of LGBTI persons, the Minister has taken the decision to introduce for installation of the Diversity and Inclusion Committee (Appendix 8: Decision). Among others the Committee had the task of providing the necessary information to the Minister of Justice and Police and assisting her with hearings. The information collected in this way will serve as a basis for the follow-up process that the Ministry will follow in order to arrive at a concrete policy on promoting the human rights perception by LGBTI people.

The frame of reference used to set up the hearings consisted of the human rights standards on the one hand and social values on the other. The human rights standards that have been guiding relate to the prevailing International and Regional Human Rights standards to which Suriname is a party and the ensuing commitment of the State of Suriname to comply with these instruments. As stated in the report of the Diversity and Inclusion Committee, social values relate to the values determined by the fundamental rights mentioned in the Constitution of the
State of Suriname. These values form the basis for the way in which citizens ideally should live together on Surinamese territory (Report Hearing 2017).

With respect to the four areas as indicated in the UNDP manual; Access to services Equality of people Living with HIV in public and private life, Key-populations and Access to justice, the Surinamese Constitution states the following.

1. **Access to essential services**
   
   Art. 36: Everyone has the right to health. The State promotes general health care through systematic improvement of living and working conditions and provides information for the protection of health.

2. **Equality of people Living with HIV in public and private life**
   
   Art. 8: All persons who are on the territory of Suriname have equal rights to the protection of persons and goods. No person may be discriminated against on account of his birth, gender, race, language, religion, origin, education, political opinion, economic position or social circumstances or any other status.
   
   Art. 14: Everyone has the right to life. This right is protected by law.
   
   Art. 26: Everyone has the right to work, in accordance with his capacity.
   
   Art. 38: Everyone has the right to education and cultural experience.

3. **Key-populations**
   
   Articles 8, 9, 17 and 36 stipulate that everyone who is on Surinamese territory has the right to health, physical, psychological and moral integrity respectively, the right to privacy and equal rights to protection of person. No one may be subjected to torture, degrading or inhuman treatment or punishment. It would be that the legal system is designed to be open and tolerant however conditions on the ground do not always match these ideals.  

   Article 38: Everyone has the right to education and cultural experience.

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50 NSP 2014.2020, Pancap 2015; Bakboord C. 2017
51 Dr. Monique A. Veira, LLM Surinaams Juristenblad, 2016, no.2
4. Access to Justice

Article 10: Everyone is entitled to fair and public treatment of his / her complaint within a reasonable period of time by an independent and impartial judge in case of violation of his or her rights and freedoms.

Article 11: No one can be held against his will from the judge that the law appoints him.

Article 12: Everyone can assisted in court. The law lays down rules concerning the provision of legal assistance to financially persons.

Although PLHIV and other key populations are not specifically mentioned, the Constitution clearly indicates that discrimination is not allowed in any way. Hence PLHIV and other key populations can be placed in- any other status- of Article 8. As indicated above also the Ministry of Justice through her Minister has pronounced for the guarantee of the enforcement and the experience of human rights by all people. As such Suriname’s Constitution enshrines anti-discrimination on the basis of health. It lays the overarching conditions for the just treatment and care of persons who have health conditions such as HIV. The main legislations, regulations and policies pertaining to the protection or discrimination to HIV and AIDS are compiled in table 2.3 below.

Table 2.3 National legislation with respect to HIV

<table>
<thead>
<tr>
<th>HIV Related National legislation,</th>
<th>Changes with regard to sex crime, sexual abuse, exploitation LGBT discrimination and HIV. Rape within marriage is now considered a crime. Articles 291, 292 and 533, including restrictive access of adolescents to contraceptives have been removed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revised Criminal Code of 30 March 2015</td>
<td>Draft legislation had already been developed by the Inter-Ministerial Committee for Gender Regulation.</td>
</tr>
<tr>
<td>Draft legislation on prevention and reduction of sexual harassment in the workplace</td>
<td>Further revisions of the revised marital law are underway. Some discriminatory regulations with regard to women are also considered. Minimum age for entering marriage for women is brought from 13 to 15</td>
</tr>
<tr>
<td>Law</td>
<td>Details</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Bill against Stalking and Harassment</td>
<td>A stalker can now get up to 12 years in prison, and can be fined 150,000 SRD.</td>
</tr>
<tr>
<td>The Act Curbing Domestic Violence</td>
<td>This law provides a fast procedure for protection of victims of domestic violence at an early stage.</td>
</tr>
</tbody>
</table>
PART III SURINAME HIV/AIDS LEGAL ENVIRONMENT ASSESSMENT ANALYSIS

The information below is a result of consultations with the stakeholders, key-persons, experts, resource persons, key-populations and vulnerable groups and desk-review.

3.1 National legislation and policies HIV with respect to access to essential services

FACTOR 1. PUBLIC EDUCATION, RESEARCH AND INFORMATION EXCHANGE

Every person enjoys an equal right to seek, receive and impart reliable and accurate information about bio-medical and socio-economic aspects of HIV. The State implements and supports raising HIV-related awareness, stigma reduction, training and information exchange programmes, and ensures that HIV research adheres to the highest ethical standards.  

1.1 National Laws, Policies and actions

There are no specific laws that promote or prohibit every person enjoying an equal right to seek, receive and impart reliable and accurate information about bio-medical and socio-economic aspects of HIV. There are a number of policy documents that contain provisions on access to HIV information, awareness-raising, stigma-reduction, training, and research.

The National Strategic Plan on HIV/AIDS refers to the Surinamese Constitution endorsing that every citizen has the right to healthcare (article 17) protection of the right of persons to live free from discrimination (article 8). To apply this in the HIV response, a need was felt to adjust the

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52 UNDP Legal Environment Assessment for HIV. An operational guide to conducting national legal, regulatory and policy assessments for HIV.
legal environment in a way that clearly defines stigma & discrimination (S&D) on a number of grounds and to make sanctioning of discriminatory acts and breaches of confidentiality possible. In this regard, the PANCAP ‘Justice for All’ program was introduced. Many measures were taken to reduce S&D in the workplace, including the initial planning for an installation of a Human Rights Commission with an according Human Rights Desk and the formulation of HIV workplace policies. An implementation plan to set up the Human Rights desk on behalf of PLHIV, sex workers and LGBTQI populations has been designed.53

Sexual and reproductive rights and health education is included in the objectives of the national health policy in order “To facilitate the mobilization of adequate and sufficient human and financial resources to support the implementation of activities, including information and education”.54

As part of the ‘PANCAP migrant project’ Suriname reported on improving its legal and policy framework, implementing innovative health financing mechanisms, empowering migrant communities and making services more migrant friendly in 2012. In the implementation phase of the PANCAP migrant project, (2013-2014) IEC Information, Education and Communication material specifically aimed at Brazilian migrants was developed and distributed. Surinamese governmental employees from both health and non-health sectors were trained in ‘Stigma and Discrimination, Cultural Sensitivity and Human Rights related to Health and Migration’. To ensure continuity of this process of sensitization to migrant specific issues under service delivery personnel, this training was concluded by a Training of Trainers.

1.2 Gaps and Obstacles

1. There are no specific laws that promotes that every person enjoys an equal right to seek, receive and impart reliable and accurate information about bio-medical and socio- economic aspects of HIV.

2. Although sexual and reproductive rights and health education are included in the objectives of the national health policy, it is not mainstreamed in the curriculum of the primary and secondary education.

53 Bakboord 2018; Implementation plan for a human rights office directed on the protection and compliance with human rights of vulnerable groups and important populations. Ministry of Home Affairs/ Global Fund
3. No follow-up on recommendations given in various studies with respect to implementing tailor made education programs on HIV and sexuality. 

4. Insufficient circulation of factual information, data gathering and analysis.

5. No information with respect to sexual and reproductive health and rights in some prisons. And if it is provided, it is mainly for perpetrators of moral delicts. These men do not attend these meetings due to stigma and discrimination. Everyone will know what kind of information will be provided.

6. No policy with respect to sexual behavior in the prisons.

1.3 Main Recommendations

The state should:

1. Be specific in laws which implements and supports raising HIV-related awareness, stigma reduction, training and information exchange programmes, and ensures that HIV research adheres to the highest ethical standards.


3. Circulation of factual information, data gathering and analysis.

FACTOR 2. HIV PREVENTION, EDUCATION AND TRAINING

Every person has equitable and suitable access to a wide range of effective human-rights based and evidence informed measures aimed at preventing HIV transmission.

2.1 National Laws, Policies and actions

1. Articles 37, 38 and 39 of the Constitution state that every citizen has the right to education and that the state recognizes the right of all citizens to education and recognizes and guarantees equal opportunities for education. There are no specific policies/ laws, except the Ministerial declaration on Comprehensive Sexual Education.

2. Prevention is one of the priority areas of the National Strategic Plan(NSP) for a Multi sectorial approach of HIV in Suriname 2014-2020. The NSP primary prevention


56 UNDP Legal Environment Assessment for HIV. An operational guide to conducting national legal, regulatory and policy assessments for HIV.
activities were implemented focusing on education and awareness of HIV. For each target population appropriate activities were planned and implemented. The general population was reached through mass media campaigns focusing on sexual behavior and knowing one’s status and an information center ‘Libi!’ was set up to include HIV-education for the public in a more holistic setting of promoting healthy lifestyles. Public education and outreach activities are mainly provided by NGO’s.

3. The Basic Life Skills Programme (Ministry of Education Science and Culture) aims at sensitizing students and pupils on gender equality as related to culture and tradition. It was introduced in Suriname as part of the regional initiative for Family Health and Life Education (FHLE) in 1995.

2.2 Gaps and Obstacles
1. Law of 22 September 1960 to regulate Primary Education in Suriname (Journalism 1960 No. 108), as it reads after the amendments published in Official Gazette 1965 no. 127, Official Gazette. 1965 no. 128) is not specific about implements and supports raising HIV-related awareness, stigma reduction, training and information exchange programmes, and ensures that HIV research adheres to the highest ethical standards.
2. Due to fear of sanctions, stigma and discrimination, key-populations and vulnerable groups are often less inclined to make use of formal prevention and care services.
3. Poverty is the main factor that puts vulnerable groups at risk.
4. With current ad-hoc planning of prevention activities there is insufficient national coverage of prevention campaigns and no universal access to all prevention services and commodities.

2.3 Main Recommendations
1. The state shall make specific legislation that protects everything related to persons living with HIV such as Education and training and increase the accessibility and coverage of training facilities for Basic Life skills programs to ensure that more people are trained in this program.
2. Develop national CSE guidelines, curriculum for young people and training of teachers currently teaching as well as curriculum for teachers in training through an inclusive and participatory process.
3. Review approaches to prevention activities and strategies for specific groups with a view to reducing the risk of HIV transmission for example decentralize the
prevention and early treatment of STIs, promote greater involvement of PLHIV representatives in all stages of the national response.

**FACTOR 3. TESTING, COUNSELING AND REFERRAL**

*Every person has unrestricted access to voluntary, confidential or anonymous HIV testing accompanied by quality counselling and referral to essential services. Arbitrary, mandatory or compulsory HIV testing is prohibited.*\(^{57}\)

### 3.1 National Laws, Policies and actions

1. Article 294 of the Criminal Code of 30 March 2015, indicates that those who, knowing that they are infected with the Human Immunodeficiency Virus (HIV), deliberately commit sexual acts by which another, unfamiliar with this circumstance, can be infected with that virus, is punished with imprisonment of up to fifteen years and a fine of the fifth category. In accordance with art. 306b this operation suffers an aggravation for other sex offenses.

2. The National Strategic Plan for a multi sectoral approach of HIV in Suriname 2014-2020 (NSP 2014-2020) lays out clear objectives pertaining to unrestricted access to voluntary, confidential or anonymous HIV testing.

3. The National Strategic Plan 2014-2020 states that HIV testing now widely available accompanied by available guidelines for rapid testing.

4. eMTCT program HIV positive pregnant women receiving ART.

5. HIV testing free of charge.


7. Within current HIV projects there is a focus on MSM, among other key populations and thus HTC services, including referrals are available and therefore somewhat accessible.

### 3.2 Gaps and Obstacles

1. Article 294 of the Penal Code can withhold persons from being tested.

2. NSP → The eMTCT program review revealed that the implementation of the program does not include all 4 eMTCT prongs yet.

3. Due to fear of sanctions, stigma and discrimination, and no sanctions being taken

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\(^{57}\) UNDP Legal Environment Assessment for HIV. An operational guide to conducting national legal, regulatory and policy assessments for HIV.
against service providers who breach the law and regulations, these groups are often less inclined to make use of formal prevention and care services.  

4. There are still companies that mandate testing and fire employees who are HIV positive, insurance companies that stop the insurance of PLHIV and breaches of confidentiality of service providers as mentioned in the needs assessment among MSM and transgenders (NSP).

5. No specific nationwide guidelines/ policy (in the health sector/ health service delivery) on addressing the needs of people based on diversity of gender, sex characteristics and sexuality.

3.3 Main Recommendations

1. Reviewing of Article 294 of the Penal Code as it is discriminating against PLHIV. Other transmittable infections which can also harm other persons, are not included. Utilize PANCAP model Anti-discrimination Bill to inform the creation of Suriname’s anti-stigma legislation;

2. A need to reinforce the link with the Maternal and Child Health (MCH) program and expanding the scope of the Sexual Reproductive Health (SRH) and Family Planning (FP) package to improve eMTCT program.

3. Conduct sensitivity and stigma training of social service providers to: facilitate PLHIV access to services; execute HIV testing awareness campaigns and to respect HIV policy on the workplace.

FACTOR 4. TREATMENT, CARE AND OTHER HEALTH SERVICES

People living with HIV enjoy the right to the highest attainable standard of physical and mental health, including equitable and sustainable access to comprehensive health care. The State takes concrete steps to progressively realize universal access to HIV-related treatment and care.

4.1 National Laws, Policies and actions

1. Article 36 of the Constitution of the Republic of Suriname states that:

58 Bakboord C. 2017
59 UNDP Legal Environment Assessment for HIV. An operational guide to conducting national legal, regulatory and policy assessments for HIV
60 Constitution of the Republic of Suriname
2. Everyone has the right to health. The State promotes general health care through systematic improvement of living and working conditions and provides information for the protection of health. This indicates that the state is obliged to ensure adequate health for every citizen in Suriname.

The National Strategic Plan Policy reveals that treatment for HIV is free of charge as well as CD4, VL, and EID. Due to the recently instated (2014) ‘Basic Health Insurance Services’ migrants living and working in Suriname are now able to access more affordable health insurance. However, as reported in the NSP reaching the small scale gold miners stays a challenge as most are mobile and operate in remote areas in the interior away from established maroon and indigenous villages. ‘New Chinese’ migrants form another group of growing migrants in Suriname. It is challenging to reach this group of migrants, because there is relatively little known about them and they don’t mingle with the rest of the population.

   A. The National Basic Health Insurance Act regulates a care provision for when someone becomes ill. This law states with regard to the basic package that:
      - Everyone is obliged to have at least basic health insurance;
      - Everyone is obliged to pay the premium for this insurance;
      - Everyone is accepted by the health insurance company regardless of whether you already have one disorder or disease.
   B. All residents of Suriname, including foreign nationals who live in Suriname, are entitled to the care included in the basic package.
   C. The National Basic Health Insurance Act came into effect on 9 October 2014.
      - Anyone with the Surinamese nationality in the age group from 0 to 16 years and people over 60 years of age are exempted from the premium payment. This premium is paid by the government.
   D. Every employer is obliged to pay part of the premium, at least 50%. The remaining part pays the employee. The employer is obliged to make agreements about this and about the manner of deduction.61

4.2 Gaps and Obstacles
1. The above law cannot be implemented anymore, due to an absence of financial sources.

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61 National Basic Health Insurance Act
2. Suriname has no specific health law that protects PLHIV. So it does not specifically recognize the need to protect rights to equality and prohibit discrimination against people living with HIV as well as other key populations. The basis for discrimination is regulated in our Constitution. Hence the key populations can also be calculated below. But since key populations are still being stigmatized and discriminated, many groups experience exclusion (Bakboord 2017).

3. Laboratory tests are only available in Paramaribo.

4. A study executed in 2017 shows that four major problems regarding HIV/AIDS services for migrants were identified. Four major issues have been identified in this study. Each of them has in their own manner, a negative impact on the accessibility of HIV services to migrants in small-scale gold fields.

5. The lack of data about migrants obstructs the provision of services because the problem cannot be properly mapped, which makes it difficult to find an appropriate solution.

6. The minimum inclusion of migrants in the national policy of Suriname does not promote the accessibility of the service to migrants. Many migrants do not understand where they have to go within the healthcare system and within the ministries there are still ambiguities about communication to the migrants and between the ministries themselves.

7. In Suriname's interior accessibility is worse since health care is more limited to the coastal plains.

8. Also, distance, cost and language barriers are a problem for migrants seeking help for care.

9. Redundancy within the health service delivery sector is not in place. There have been reports of the CD4 machine being defect for an extended period of time, the incapacity of the Central Lab to be an accredited reference lab, unavailability of free market lubricants for an extended period of time.

4.3 Main Recommendations

The state shall:

1. Ensure that privatization does not threaten to the availability, accessibility, acceptability and quality of healthcare facilities, goods and services.

2. Adopt a national health plan covering the public and private sectors, with universal

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62 Policy Analysis of the Access of the HIV/AIDS Services for Migrants from the Surinamese Goldfields
Jara Schmidt, Radboud University Nijmegen, Malaria Program Suriname (Intern) 2017
access to primary care; and ensure that the costs of healthcare services and health insurance, whether privately or publicly provided, are affordable for everyone.


FACTOR 5. SOCIAL PROTECTION AND MATERIAL ASSISTANCE

People living with HIV enjoy the right to an adequate standard of living, including equitable access to social protection and other forms of material assistance, particularly in the event of unemployment, sickness or disability.63

5.1 National Laws, Policies and actions

1. Under article 500a of the Revised Penal Code, which deals with occupational discrimination, sexual orientation is explicitly mentioned as a ground for discrimination. However, gender and PLHIV are not mentioned.

2. The National Strategic Plan emphasizes:
   - to increase the promotion of sensitized social protection measures for people living with HIV with regard to Eliminate Mother-to-Child transmission;
   - the right to access to affordable and proper health care and social security;
   - Access to material assistance at the Ministry of Social Affairs;
   - Improved social protections programs for the poor.

5.2 Gaps and Obstacles

1. The Discrimination Law art.500a, of the Revised Penal Code does not address gender identity or HIV positive status.

2. Poverty is a crucial factor for the high HIV prevalence in Suriname.

5.3 Main Recommendations

1. Include gender and PLHIV in article 500a of the Revised Penal Code.

2. Develop and Implement programs for specific target groups to reduce poverty.

FACTOR 6. PROTECTION OF PRIVACY AND CONFIDENTIALITY

63 UNDP Legal Environment Assessment for HIV. An operational guide to conducting national legal, regulatory and policy assessments for HIV.
People living with HIV enjoy effective protection from arbitrary or unlawful interference with their privacy. Their medical and personal information is subject to strict rules of data protection and confidentiality.\textsuperscript{64}

6.1 National Laws, Policies and actions

1. In line with the Surinamese Constitution and to apply this in the HIV response, a need was felt to adjust the legal environment to make sanctioning of discriminatory acts and breaches of confidentiality possible. In this regard, the PANCAP ‘Justice for All’ programme was introduced.

2. There is no specific law in Suriname which says that medical information of people living with HIV must be confidential. Suriname does have a draft law with regard to healthcare (Act on the professions in individual health care) which is derived from the Dutch Act on the professions in individual health care (BIG). There is a specific provision in Article 88 with regard to dealing with information from patients and it reads as follows:

   “Everyone is obliged to observe confidentiality with regard to everything that has been entrusted to him in the exercise of his profession in the field of individual health care, or what has come to his knowledge as secret, or what knowledge of his knowledge has come and of which he had to understand the confidential character.”\textsuperscript{65}

6.3 Gaps and Obstacles

1. There are insurance companies that stop the insurance of PLHIV and breeches of confidentiality of service providers as mentioned in the needs assessment among MSM and transgenders (NSP).

2. No zero-tolerance policies in place and effective grievances procedures for breaches of privacy and confidentiality.

3. No operation level policies and guidelines to facilitate proper handling of matters with a privacy or confidentiality concern.

\textsuperscript{64} UNDP Legal Environment Assessment for HIV. An operational guide to conducting national legal, regulatory and policy assessments for HIV

\textsuperscript{65} Law of November 11, 1993, governing regulations concerning appeals in the field of individual healthcare in the Netherlands. De Ware Tijd, Suriname, 24 September 2014
6.4 **Main Recommendations**

1. The concept law on the professions in individual health care must be adopted as soon as possible and promulgated in Suriname so that it can be in force and that this guarantees the privacy of citizens including people living with HIV/AIDS.

2. Enforcing law and penalties in instances of breach of confidentiality
3.2 National legislation and policies HIV with respect to equality of people living with HIV in public and private life

FACTOR 7. POLITICAL, SOCIAL AND CULTURAL LIFE

People living with HIV enjoy full equality and inclusion in political, social and cultural life. The State ensures the right of people living with HIV, HIV advocates and service workers to peaceful assembly and association.\(^6\)

7.1 National Laws, Policies and actions

1. Women and minorities participate in the political process.
2. Intervention strategies for Gender-sensitivity are among the principles of the NSP.
3. NSP promotes social acceptance of people living with HIV and their active involvement and participation in all stages of the national response.
4. National Strategic Plan: linkage between HIV and poverty.

7.2 Gaps and Obstacles

1. Fear of discrimination
2. Poverty is the driving force in the HIV epidemic
3. Government tends to exclude PLHIV in decision and policy making
4. Although HIV is an issue that affects a society irrespective of gender, socio-economic status, religion, position, etc. there seems to be little variety in the demographic that is willing to champion HIV related issues as PLHIV, which may point to existing biases in society.

7.3 Main Recommendations

1. Involve PLHIV in decision and policy making, programme designs, implementation, monitoring and evaluation, so that it will be easily accepted by persons targeted

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\(^6\) UNDP Legal Environment Assessment for HIV. An operational guide to conducting national legal, regulatory and policy assessments for HIV
FACTOR 8. FAMILY, SEXUAL AND REPRODUCTIVE LIFE

People living with HIV enjoy full equality in family life and the right to the highest attainable standard of sexual and reproductive health. The State facilitates the prevention of vertical transmission. 67

8.1 National Laws, Policies and actions
1. Domestic violence Act protects everybody including PLHIV and other key-persons and vulnerable groups.
2. Couples and individuals have the right to decide the number, spacing, and timing of their children; manage their reproductive health; and have access to the information and means to do so free from discrimination, coercion, and violence.
3. Sexual and Reproductive Programs have been expanded for young people.
4. National Strategic Plan Emtct programs.

8.2 Gaps and Obstacles
1. Domestic violence against vulnerable women is still a major issue in Suriname which includes feminicide.
2. Female victims of intimate partner violence have less access to health services. 68
3. Domestic violence toward PLHIV is an issue.
4. No specific programs for survivors of domestic violence with regard to HIV.
5. No study has been conducted among PLHIV who are victims of domestic violence.

8.3 Main Recommendations
1. The Gap report recommends that comprehensive sexual and reproductive health and HIV services must be integrated as well as to scale up integrated, family-centered health care services and information.
2. Conduct studies to gain insight in how to make interventions.

67 UNDP Legal Environment Assessment for HIV. An operational guide to conducting national legal, regulatory and policy assessments for HIV
68 Bakboord C. Living in Fear, A study to the relation between intimate partner violence, decision making and sexual and reproductive health UNFPA 2009
FACTOR 9. EDUCATION AND TRAINING

People living with HIV enjoy the right to equal educational opportunity. Where appropriate, special measures are employed to provide reasonable accommodation for people living with HIV and increase their representation in educational institutions.\(^6^9\)

9.1 National Laws, Policies and actions

1. Under article 500a of the Revised Penal Code, which deals with occupational discrimination, sexual orientation is explicitly mentioned as a ground for discrimination.

9.2 Gaps and Obstacles

1. PLHIV do not have full access to education. E.g. TANA and the Central Education for Nurses and related professions (COVAB) do not allow for PLHIV to enroll in their institution.

9.3 Main Recommendations

1. Conduct legal literacy training sessions for the staff of the institutions.
2. Report to the Ministry of Health.

FACTOR 10. EMPLOYMENT, WORK AND ECONOMIC LIFE

People living with HIV enjoy equal rights to: work in the public and private sectors, including just, favorable, safe and healthy conditions of work; property and inheritance; and credit. Where appropriate, special measures are employed to provide people living with HIV with income-generating opportunities and reasonable accommodations in the workplace.\(^7^0\)

10.1 National Laws, Policies and actions

1. In general, the Constitution prohibits discrimination.
2. HIV strategies in relevant sectors, including the workplace, have been developed and implemented.
3. HIV on the workplace policy of the Ministry of Labor.

\(^6^9\) UNDP Legal Environment Assessment for HIV. An operational guide to conducting national legal, regulatory and policy assessments for HIV

\(^7^0\) UNDP Legal Environment Assessment for HIV. An operational guide to conducting national legal, regulatory and policy assessments for HIV
10.2 **Gaps and Obstacles**

1. Enforcement of the Constitution is selective.
3. Societal discrimination against the LGBT community in areas of employment and housing.
4. PLHIV experience societal discrimination in employment and property. Women living with HIV still experience discrimination at the workplace.  

10.3 **Main Recommendations**

1. Include PLHIV and other vulnerable people who are not specific mentioned, in the Constitution.
2. That stakeholders start a dialogue with employers; both public and public sector.

**FACTOR 11. PRIVATE AND PUBLIC HOUSING**

*People living with HIV enjoy equal access to adequate private and public housing, including residential facilities. Where appropriate, special measures are employed to provide reasonable accommodations for people living with HIV and protect their rights in their place of residence. Segregation, exclusion and coercive or punitive measures based on HIV status are prohibited.*

11.1 **National Laws, Policies and actions**

1. The National Strategic Plan: There is a strong link to HIV and Poverty – it involves exposure to risks due to poor housing and education.
2. No data found on law or policy that prohibits the denial of housing based on HIV status.
3. There is no law that prohibits the denial of housing based on HIV status.

11.2 **Gaps and Obstacles**

1. There were reports of societal discrimination against the HIV community in their access to housing. They were denied to buy a house from Foundation Public Housing which

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71 Bakboord C. Lespiki mi (2007)
72 Ibid
73 UNDP Legal Environment Assessment for HIV. An operational guide to conducting national legal, regulatory and policy assessments for HIV
falls under the Ministry of Social Affairs and Housing. 74

11.3 Main Recommendations
1. Report to the Ministry of Social Affairs and Housing and the Minister of Labor that they see that sanctions are administered to the offenders.

FACTOR 12. ENTRY, STAY AND RESIDENCE
The State does not impose restrictions on the entry, stay and residence of people living with HIV based on their HIV status. People living with HIV are not returned to countries where they face persecution, torture or other forms of cruel, inhuman or degrading treatment. Migrants and mobile populations have equitable and sustainable access to comprehensive HIV-related services. 75

12.1 National Laws, Policies and actions
Only with respect to Yellow Fever a health certificate is being requested from persons from risk countries.

FACTOR 13. NON-CRIMINALIZATION OF HIV EXPOSURE AND TRANSMISSION
HIV exposure and non-intentional transmission are not criminalized. Deliberate and intentional transmission of HIV is prosecuted under general rather than HIV-specific criminal law. 76

13.1 National Laws, Policies and actions
1. Intentional sexual intercourse by HIV-infected Article 294. The one who, knowing that he/she is infected with the Human Immunodeficiency Virus deliberately commit sexual acts by which another, unfamiliar with this circumstance, can be infected with that virus, is punished with imprisonment of a maximum of 15 years and a fine of the fifth category.

74 Ibid
75 UNDP Legal Environment Assessment for HIV. An operational guide to conducting national legal, regulatory and policy assessments for HIV
76 UNDP Legal Environment Assessment for HIV. An operational guide to conducting national legal, regulatory and policy assessments for HIV
2. Acting with HIV infection Article 306b [1]. If in the offense as described in the Articles 296, 298, 299, 300, 301, 303, 303a and 304 the accused knows or has serious reasons to suspect that by committing the sexual act, another person can be infected with the Human Immunodeficiency Virus (human immunodeficiency virus), the prison sentence can be increased by at most half. [2] If in the offense as described in articles 295 and 297 the accused knows or has serious reasons to suspect that by committing the sexual act, another person may be infected with the Human Immunodeficiency Virus (human immunodeficiency virus), imprisonment of at most twenty years and a fine of the fifth category can be imposed.

13.2 Gaps and Obstacles
1. Although the above law also protects vulnerable populations, it also prohibits individuals to do a HIV test.

13.3 Main Recommendations
1. Deliberate and intentional transmission of HIV should be prosecuted under general rather than HIV-specific criminal law.

III. KEY POPULATIONS AND VULNERABLE GROUPS

3.3 National legislation and policies HIV with respect to key-populations and vulnerable groups

FACTOR 14. WOMEN
The State takes all appropriate measures to reduce specific HIV vulnerabilities of women, eliminate HIV-related discrimination against them and provide them with equitable and sustainable access to comprehensive HIV-related services.77

77 UNDP Legal Environment Assessment for HIV. An operational guide to conducting national legal, regulatory and policy assessments for HIV
14.1 National Laws, Policies and actions

1. The law provides for protection of women’s rights to equal access to education, employment and poverty.

2. The Domestic Violence Act protects and prevents women from being a victim of domestic violence, which includes sexual violence.

3. Article 295 of the Criminal Law (Penal Code) criminalizes rape within marriage on an equal footing. Both men and women can be victim of rape

4. Sexual and reproductive health is not only about health, but of equal importance is the link with rights. Therefore, the national policy is guided by a human rights based approach and integrates a gender perspective, which reflects the political will to eliminate all forms of discrimination based on sex and to acknowledge, protect and respect the rights of all individuals, including their sexual and reproductive rights.

5. The National Sexual and Reproductive Health and Rights policy is imbedded in a national conceptual framework. This framework is not only in accordance with national guidelines but also in full accordance with the strategic and conceptual framework that is developed as part of the first Reproductive Health Strategy of the WHO (2004). The framework targets core elements of SRH, which could be adapted to the specific priorities, needs and circumstances of the respective countries. Combating sexually transmitted infections (STIs), including HIV, Reducing Gender based violence and Promoting Sexual Health and Rights belong to Suriname’s core elements. National Sexual and Reproductive Health and Rights Policy (NSRHR) also focuses on the improvement of the quality of sexual and reproductive health care of women.

6. Part of the NSP guiding principle is acknowledgement and protection of rights as guaranteed by Suriname’s 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, particularly women and children.

14.2 Gaps and Obstacles

1. No specific HIV policy with respect to lesbian and bisexual women.

2. Societal pressures and customs, especially in rural areas, inhibited the full exercise of

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78 WET van 30 maart 2015, houdende nadere wijziging van het Wetboek van Strafrecht (G.B. 1911 no. 1, zoals laatstelijk gewijzigd bij S.B. 2012 no. 70) in verband met herziening van het Wetboek van Strafrecht

these rights, particularly with respect to marriage and inheritance.

3. Lack of empowerment to promote safe sex.

4. There is still little awareness / information in the community (Nickerie).

14.3 Main Recommendations

The Gap Report identified the following approaches:

1. Empowering girls and young women through multi-sectorial approaches, for example integration with economic empowerment interventions and possibly through engagement with families.

2. Integrating services against gender-based violence into HIV services such as through addressing violence during HIV testing and counselling.

3. Promoting and implementing laws and policies related to violence against women, gender equality and HIV.

FACTOR 15. CHILDREN AND YOUTH

The State takes all appropriate measures to reduce specific HIV vulnerabilities of children and youth, eliminate HIV-related discrimination against them and provide them with equitable and sustainable access to comprehensive HIV-related services.80

15.1 National Laws, Policies and actions

1. Parental permission to marry is required until the age of 21. The marriage law sets the age of marital consent at 15 for girls and 17 for boys, provided parents of the parties agree to the marriage.

2. The special legal position of minors in the draft Civil Code with regard to medical treatment (article 7: 447, 448 paragraph 1 second sentence, 450 paragraph 2, 465 draft SBW).

3. Patients aged 16 and older who will be capable of acting can act entirely independently within the framework of the treatment agreement81. In the draft Civil Code the joint consent of both the minor and the legal representative(s) is required for the treatment of competent patients between the ages of 12 and 1682. The treatment can,

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80 UNDP Legal Environment Assessment for HIV. An operational guide to conducting national legal, regulatory and policy assessments for HIV


82 Art. 7: 450 lid 2 concept SBW op: http://www.gov.sr/media/59802/boek_7.tekst_dna.pdf
however, be carried out without the permission of the legal representative(s) if this is "apparently required" to prevent serious disadvantage for the minor "or if the minor continues to wish the treatment deliberately after the refusal of consent.\(^3\)

4. Part of the NSP guiding principle is acknowledgement and protection of rights as guaranteed by the Surinamese Constitution and international agreements on human rights, including the rights of persons with HIV, and children.

5. At some schools the policy is that one must state at the registration which diseases the child has. This includes HIV.

6. NGOs host outreach programs in schools located in target communities.

7. COCON has designed a SRHR app for youth which is operational.

### 15.2 Gaps and Obstacles

1. Children under the age of 16 are not allowed to access health services without parental guidance.

2. Low condom use.

3. Tend to have multiple partners.

4. Youth from rural interior lack knowledge of HIV.

5. Little knowledge of their rights.

6. Little knowledge of HIV, sexual and reproductive health and rights\(^4\).

7. Despite years of consequent funding by UNICEF the Basic Life Skills Programme has never been integrated in the school curriculum and is still referred to by the State as a ‘pilot’.

### 15.3 Main Recommendations

1. The Gap Report recommended, empowering girls and young women through multi-sectorial approaches, example integration with economic empowerment interventions and possibly through engagement with families.

2. The Gap Report recommended, transforming harmful cultural and social gender norms through effective school-based interventions, for example by focusing on the socialization of boys and girls and empower boys and young men through multi-

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\(^3\) Art. 7: 440 lid 2 concept SBW op: http://www.gov.st/media/59802/boek_7.tekst_dna.pdf

in: Mr. dr. Monique A. Veira, Suriname Jurist Journal, 2016, no.2

\(^4\) Research Sipaliwini
sectorial approaches, with respect to gender equality and sexual and reproductive health and rights.

3. Develop national CSE guidelines, curriculum for young people and training of teachers currently teaching as well as curriculum for teachers in training through an inclusive and participatory process.

FACTOR 16. PEOPLE WHO USE DRUGS
The State takes all appropriate measures to reduce specific HIV vulnerabilities of people who use drugs, eliminate HIV-related discrimination against them and provide them with equitable and sustainable access to comprehensive HIV-related services.85

16.1 National Laws, Policies and actions
1. National Drugs Master plan 2011-2015. Memorandum on the National Policy of Suriname with regard to all aspects of the drugs problem86.; Policy, to take procedures to measure and possibly prevent the relation between drug use and HIV/AIDS;

2. Objective: Preventing the spread of HIV by making society aware of the link between alcohol, drugs and HIV.


4. In the Guidance Residential Addiction Care it is stated that the National Drugs Council operates from the perspective of international human rights and the Suriname Constitution. Hence all clients have access to health care.

16.2 Gaps and Obstacles
1. No specific HIV programs for drug users in the NSP.

2. No access to condoms within the Psychiatric Centre Suriname under which the Bureau for Alcohol and Drugs is headed. Because “providing condoms means stimulating

85 UNDP Legal Environment Assessment for HIV. An operational guide to conducting national legal, regulatory and policy assessments for HIV

86 National anti-drugs council Paramaribo May 2011. apps.who.int; Accessed on February 2018

87 apps.who.int accessed on February 4, 2018
sex”. So the clients have sex secretly. There is still a taboo atmosphere in the institutions.

3. Many drug users do not have a doctor's card. Addiction is not yet covered by insurance companies (PCS).

4. Heavy addicts who live with HIV do not have an income or house.

5. A good safety net is missing for the addicts. The Ministry of Social Affairs and Housing (Sozavo) does provide social assistance of SRD 350 p/month.

6. No access to housing for drug addicts living with HIV.

16.3 Main Recommendations

1. Integrate HIV programs for drug users in the NSP.

2. Provide access to medical services for drug users.

FACTOR 17. ADULTS ENGAGED IN COMMERCIAL SEX.

The State takes all appropriate measures to reduce specific HIV vulnerabilities of adults engaged in commercial sex, eliminate HIV-related discrimination against them and provide them with equitable and sustainable access to comprehensive HIV-related services.\(^{88}\)

17.1 National Laws, Policies and actions

Article 66 of the Police Penal Code states that ‘the woman of known immoral behavior, who is visible on the public road or places of the public highway, and deliberately attracts the attention of the passersby’ is punishable by law. The article therewith distinguishes between sex work in clubs (regulated) and sex work on the streets (illegal). De facto, this means street sex workers are vulnerable to all kind of mistreatment from pimps, clients, and even police, without having any legal redress. Sex workers shared stories of being robbed, raped and/or beaten. Their illegal status also impacts on their ability to keep themselves safe of diseases, as in illegal encounters everything has to happen fast and there is no room for much negotiation on condom use.

17.2 Gaps and Obstacles

1. Due to fear of sanctions, stigma and discrimination, these groups are often less inclined

\(^{88}\) UNDP Legal Environment Assessment for HIV. An operational guide to conducting national legal, regulatory and policy assessments for HIV
to make use of formal prevention and care services.
2. Criminalization of sex work.
3. Difficult to reach sex workers in the interior.

17.3 Main Recommendations
1. Decriminalize sex work for adults who apply voluntary to do this work; and upgrade all levels of the Ministry of Justice and Police on the human rights of sex workers.
2. Empower sex workers to challenge human rights’ abuses.
3. Scale up and fund health and social services for SW.

FACTOR 18. MEN WHO HAVE SEX WITH MEN, AND TRANSGENDER PEOPLE

The State takes all appropriate measures to reduce specific HIV vulnerabilities of MSM, and transgender people, eliminate HIV-related discrimination against them and provide them with equitable and sustainable access to comprehensive HIV-related services.\(^{89}\)

18.1 National Laws, Policies and actions
1. Art. 15, 175a, 176, 176 of the Penal Code include specific legislation regarding discrimination and hate speech based on sexual orientation, specifically protecting the LGBT community
2. Same-sex relationships are legal in Suriname.
3. Under article 500a of the Revised Penal Code, which deals with occupational discrimination, sexual orientation is explicitly mentioned as a ground for discrimination.

18.2 Gaps and Obstacles
2. Still stigma and discrimination in the access to services (Bakboord: 2017).
3. No focus on other (health) needs of MSM & Transgenders
4. The Discrimination Law does not address gender identity, or HIV-positive status. But

\(^{89}\) UNDP Legal Environment Assessment for HIV. An operational guide to conducting national legal, regulatory and policy assessments for HIV
it addresses a national minority. Hence PLHIV and transgenders belong to a national minority group.

5. The amended penal code does not set standards for determining what constitutes such discrimination or hate speech.

6. Due to fear of sanctions, stigma and discrimination, these groups are often less inclined to make use of formal prevention and care services.

7. Gender identity is not mentioned in the Gender Policy.

18.3 Main Recommendations

The Gap Report specified the following interventions:

1. Countering anti-homosexual and anti-transgender practices and stigmatizing myths through strategic engagement with the media and through education.

2. Consider new testing strategies, including home-based testing and couples testing and promoting the strategic use of antiretroviral therapy.

3. Increase domestic spending to finance evidence-informed programmes proportionate to the HIV burden among gay men and MSM and transgender people.

FACTOR 19. PEOPLE UNDER STATE CUSTODY

The State takes all appropriate measures to reduce specific HIV vulnerabilities of people under state custody, eliminate HIV-related discrimination against them and provide them with equitable and sustainable access to comprehensive HIV-related services. Terminally ill people living with HIV are considered for early release and given proper treatment outside prisons.

19.1 National Laws, Policies and actions

The rights of people under state custody are recorded in Suriname among others in the following laws:

1. Delinquents Care Act, Penitentiary Decree and Penitentiary Institution Regulations and the Constitution.

2. Right to free medical treatment. The observation of the medical service on behalf of the detainees is entrusted to the medical (s) to be appointed by the minister for this purpose. This has been laid down in the aforementioned legislation. HIV/AIDS is not

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90 UNDP Legal Environment Assessment for HIV. An operational guide to conducting national legal, regulatory and policy assessments for HIV.
specifically mentioned. In the legislation it is generally formulated.

3. Within the institution the inmates are tested by the doctor and if positive they have access to medicines.

4. Right to a humane treatment. The penitentiary officials are obliged to treat the detainees with humanity and justice but also with appropriate severity. There must be no discrimination.

5. Foundations such as Double Positive, share information on HIV in the institutions.

19.2 Gaps and Obstacles

1. Ex-inmates hard to reach.

2. No sexual and reproductive health and rights policy within the prison facilities which comes under the Ministry of Justice and Police.

3. Many inmates do not have a medical insurance card. With support of the social workers of the facility the inmates can get an insurance card but have to pay for it. There is a contradiction. Once they are in detention according to BAZO/SOZAVO the detainees fall under the supervision of state and hence the state has to pay for the medical insurance (BAZO). But in practice this does not happen.

19.3 Main Recommendations

1. Include sexual and reproductive health and rights policy within the prison facilities, using the study results and recommendations formulated in 2009.

2. Provide adequate health insurance for inmates.

FACTOR 20. MAROON AND INDIGENOUS PEOPLE IN THE HINTERLAND, PEOPLE IN NICKERIE AND MIGRANTS

The State takes all appropriate measures to reduce specific HIV vulnerabilities of Maroon and Indigenous people, eliminate HIV-related discrimination against them and provide them with equitable and sustainable access to comprehensive HIV-related services.  

20.1 National Laws, Policies and actions

1. The National Strategic Plan Policy reveals that treatment for HIV is free of charge as well as CD4, VL, and EID. This also counts for migrants.

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91 UNDP Legal Environment Assessment for HIV. An operational guide to conducting national legal, regulatory and policy assessments for HIV
2. Health care services in the interior are provided by the NGO Medical Mission of the Moravian Church in Suriname (MZ) which is subsidized for 75% by the government.

3. At schools, the policy is that when enrolling one must notify which diseases the child has.

20.2 Gaps and Obstacles

1. In the interior, relatively smaller proportions obtain care from doctors, and relatively larger proportions obtain care from community health workers compared with any of the other regions. This is not by choice. Most Medical Mission (MZ) clinics only have community health workers and no doctors.

2. Because there is only medical dispatch in the interior, they cannot cover everything: information, guidance, care therefore, due to no access to information Maroon and Indigenous people in the interior can hardly protect themselves.

3. The caregivers in the interior have only received training from the MZ, but they have to do everything, so it is too much and that does not work out well, e.g. HIV/AIDS counseling.

4. There is no specific budget for projects/information in the interior.

5. HIV is not accepted in the villages and in Nickerie, hence people are afraid of stigma. One does not test or take medication, because one is afraid that they will be seen and then stigmatize. Additionally in the (small) villages it is clear why one is going to visit a medical center. People know each other, so people are afraid of stigma. In Nickerie (due to stigma) many are afraid to get tested at Foundation Lobi and the Regional Health Service (RGD) and therefore, travel to Paramaribo.

6. Schools in the South (interior) and some in the district of Nickerie are not willing to educate children with respect to sexuality and HIV/AIDS because of the taboo atmosphere.

7. Many indigenous do not use contraceptives. Due to certain gender related cultural norms and values they assume that the partners do not have multiple partners.

8. No sanctions when service providers violate the law.

9. A lot more indigenous people go to the goldfields and return to the villages. Some have unprotected sex. The stakeholders assume that this is one of the determinants why HIV infections among the indigenous population in the villages increase.

10. Illegal migrants have less access to the measures taken by the government to reduce specific HIV vulnerabilities, eliminate HIV-related discrimination against them and
provide them with equitable and sustainable access to comprehensive HIV-related services.

20.3 **Main Recommendations**

1. Implement HIV awareness programs from a cultural and language perspective.
2. Decentralize specific programs for communities and illegal migrants.
3. More donor budget is needed to get people to test, to take medication and to carry out other specific projects.
3.4 Access to Justice

FACTOR 21: LEGAL PROTECTION

Every person enjoys the right to an adequate and effective protection against violations of human rights based on HIV status, vulnerability, advocacy or service work.\(^\text{92}\)

21.1 National Laws, Policies and actions

1. In March 2015, the Penal Code was amended to include specific legislation regarding discrimination and hate speech based on sexual orientation, specifically protecting the LGBTI community. Art. 15, 175a, 176, 176 of the Penal Code include specific legislation regarding discrimination and hate speech based on sexual orientation, specifically protecting the LGBT community. HIV status is not specifically mentioned.

2. In prison facilities, inmates have permission to file a complaint to the Inter-American Human Rights (IHR) court (by writing a letter) when they think that their human rights are being violated. The letters are first being verified by the responsible officers before it is being sent to the OAS.

3. Migrants are protected by international treaties and can use national legislation for adequate and effective protection against violations of their human rights based on HIV status, vulnerability, advocacy or service work.

21.2 Gaps and Obstacles

1. LGBT community, PLHIV and the selected key-populations still experience, violations, stigma and discrimination.

2. Inmates don’t get any notification whether their complaints are being received by the Inter-American Court of Human Rights IHR.

3. Illegal migrants have less or no access to justice.

\(^{92}\) UNDP Legal Environment Assessment for HIV. An operational guide to conducting national legal, regulatory and policy assessments for HIV
21.3 **Main Recommendations**

1. Building alliances with both the private, the public as the civil society sector, such as representatives of the parliament, faith based organizations, women organizations and labor unions, to raise awareness to respect the human rights of the identified key-populations and vulnerable groups.

2. Setting up a network of stakeholders of key-populations and vulnerable groups to collaborate on identified and selected human rights violated topics.

**FACTOR 22. LEGAL AWARENESS, ASSISTANCE AND REPRESENTATION**

The State implements and supports educational programs aimed at raising legal literacy among people living with HIV. People living with HIV have equal access to adequate and affordable legal assistance and representation.  

22.1 **National Laws, Policies and actions**

1. On behalf of the Ministry Health and NGO’s a needs assessment has been conducted that reveals that there is an interest in a human rights desk for the benefits of vulnerable groups and key-populations.  

2. On behalf of the Ministry of Health an implementation report for the set up for a human rights desk for the benefits of vulnerable groups and key-populations this desk has been developed.

3. Training sessions to raise legal literacy among people living with HIV, key-populations and vulnerable groups have been conducted.

22.2 **Gaps and Obstacles**

1. Due to Sigma and discrimination the target group hardly file complaints.

2. Many members of the target groups have less or no knowledge of their human rights, the conventions Suriname has ratified and how to find their way to justice.

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93 UNDP Legal Environment Assessment for HIV. An operational guide to conducting national legal, regulatory and policy assessments for HIV.

94 Bakboord C. 2017 Lespiki mi.

95 Bakboord 2018. Draft implementation plan for the purpose of a human rights desk, aimed at the protection and observance of the human rights of vulnerable groups and key-populations.
22.3 **Main Recommendations**

1. Implement the Human Rights Desk for PLHIV and key-populations.\(^96\)
2. Conduct ongoing legal literacy training sessions for the target group.

**FACTOR 23. ACCESS TO A FORUM, FAIR TRIAL, AND ENFORCEMENT OF REMEDIES**

*People living with HIV, HIV advocates and service workers are guaranteed equal access to a forum administering justice, the right to a fair trial, and effective enforcement of remedies.*\(^97\)

23.1 **National Laws, Policies and actions**

There are no laws that prohibit PLHIV, HIV advocates and service workers to equal access to a forum administering justice, the right to a fair trial, and effective enforcement of remedies.

23.2 **Gaps and Obstacles**

Many members of the target groups have less or no knowledge of their human rights, national legislation and how to have access to justice.

23.3 **Main Recommendations**

Conduct ongoing legal literacy training sessions for the target group.

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\(^96\) Ibid 2017.

\(^97\) UNDP Legal Environment Assessment for HIV. An operational guide to conducting national legal, regulatory and policy assessments for HIV.
Annex 1  Resources

Studies and articles


2017 Lespiki mi (respect my rights) ‘A study into the experience of sex workers, lesbian, gay, bisexual and transgender men and women as well as people living with HIV (including youth) with stigma and discrimination & national policy and strategies that hamper their access to health care services in Suriname. Global Fund, FHH, WSW, TIA, Pepfar, USAID, Pancap. Paramaribo.

2018 Draft implementation plan for the purpose of a human rights desk, aimed at the protection and observance of the human rights of vulnerable groups and key populations. MOH & Global Fund. Paramaribo.

Bakboord, C. & Schmeitz, M. 2011 Love, Sex, Marriage and HIV: Building Responsive Policy: Gender, Sexual Culture and HIV/AIDS in the Caribbean. International Development Research Centre (IDRC Canada) UN Women Caribbean Office University of the West Indies’ (UWIHARP), Cave Hill, Barbados; the Foundation Ultimate Purpose, Suriname; the UWI Institute for Gender & Development Studies (IGDS) St. Augustine Unit, Trinidad and Tobago UNICEF.


Jürgens et al., 2009 Ten reasons to oppose the criminalization of HIV exposure or transmission. Reproductive Health Matters, 17(34), 163-172.

Mohamed, P. 2014 Pancap Justice for all consultations phase 2 - Country report Suriname

Veira, M. 2016 The rights of patients in Suriname. From total helpless to complete independent patient? Surinaams Juristenblad, 2016, no.2
Reports

ADEK

CRN+
2017  Review of the existing laws and legislations that impact the HIV response in eight Caribbean Countries October 2017

MOH:
2014  HIV Master Database M&E Unit MOH,
      National Strategic plan for a multi-sectoral approach of HIV 2014-2020, MOH.

MINJUSPOL
2017  Rapportage Hearing Commissie Diversiteit & Exclusiviteit; Hoe is het gesteld met stigma en discriminatie &acceptatie van LGBTI mensen in Suriname?

OAS

UNDP:
2014  Legal Environment Assessment for HIV. An operational guide to conducting national legal, regulatory and policy assessments for HIV.

UNAIDS:
2009  Partnership with Faith-based Organizations UNAIDS Strategic Framework.
UNESCO

WHO,

Human rights conventions, commitments, declarations, laws & legislation

1.  Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)
2.  Convention on the Rights of the Child (CRC)
3.  International Covenant on Civil and Political Rights (ICCPR)
4.  International Covenant on Economic, Social and Cultural Rights (ICESCR)
5.  Universal Declaration of Human Rights (UDHR)
6.  Convention Against Torture (CAT)
7.  Convention of Belem do Para
8.  CRC General Comment 3 on HIV and the Rights of the Child
10.  2010 ILO Recommendation 200 on HIV/AIDS and the World of Work, Principles
12.  2001 UNGASS Declaration of Commitment on HIV/AIDS
13.  Sustainable Development Goals
15.  2009 Partnership with faith-based organizations UNAIDS strategic framework
16.  2006 Political Declaration on HIV/AIDS
17.  2011 Political Declaration on HIV/AIDS
18.  2011 Political Declaration on HIV/AIDS Intensifying our Efforts to Eliminate HIV/AIDS
21.  UNAIDS 2011-2015 Strategy getting to zero
22.  2014 UNAIDS 90-90-90 An ambitious treatment target to help end the AIDS epidemic
23.  Charter of the Organization of American States
25.  1995 Beijing Platform for Action
27.  2008 UNAIDS, Criminalization of HIV Transmission, Policy Brief 1
28.  2012 Global Commission on HIV and the Law
29.  Montevideo consensus
31. The Global Strategy for Women’s, Children’s and Adolescents Health (2016-2030)
32. 2004 UNICEF Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS
33. 1993 WHO Guidelines on HIV Infection and AIDS in Prisons
34. 2007 WHO, UNODC, and UNAIDS Effectiveness of Interventions to Manage HIV in Prisons
39. Yogyakarta PRINCIPLES
40. Constitution of the Republic of Suriname
41. Criminal Code: Act of 30 March 2015, containing further amendment of the Penal Code (Official Gazette 1911 No. 1, as last amended by S.B. 2012 No. 70) in connection with review of the Criminal Code. (ARTICLES 175 / 175a and 294)
42. Draft legislation on prevention and reduction of sexual harassment in the workplace
43. Civil Revised marriage legislation
44. Bill against Stalking and Harassment
45. The Act Curbing Domestic Violence
47. OSLO DECLARATION ON HIV CRIMINALISATION Prepared by international civil society in Oslo, Norway on 13th February 2012
48. Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030
49. ILO Convention concerning indigenous and Tribal Peoples
50. UN Declaration on Indigenous Peoples Rights
51. The Minority Declaration

Websites


www.planningofficesuriname.com accessed on 23 January, 2018

http://undocs.org/ accessed 16 February, 2018
## Annexes 2

### Technical Working Group

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<tr>
<th>Constituency</th>
<th>Name</th>
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<tbody>
<tr>
<td>MOH</td>
<td>An Autar</td>
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<tr>
<td>MOH</td>
<td>Bharti Manurat</td>
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<tr>
<td>Head Centre Of Excellence/ Infectiologist</td>
<td>Stephen Vreden</td>
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<tr>
<td>CVC</td>
<td>Lita Tromp</td>
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<tr>
<td>Global Fund Program coordinator TB/HIV</td>
<td>Commiesie Eric</td>
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<tr>
<td>UNAIDS Country Director, ODIIT, Martin</td>
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<tr>
<td>Civil Society</td>
<td>Tania Kambel</td>
</tr>
<tr>
<td>Private Sector</td>
<td>Joan Telgt</td>
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<tr>
<td>UNICEF</td>
<td>Sandhya Soekhoe</td>
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<tr>
<td>CCM Suriname</td>
<td>Mylene Pocorni</td>
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<tr>
<td>USAID - LINKAGES</td>
<td>Rachel Eersel</td>
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<tr>
<td>Ministry Labor</td>
<td>John Courtar</td>
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## Annex 3

### Key-stakeholders for consultation

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<th>Categories</th>
<th>Organization</th>
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<td>MSM</td>
<td>Suriname Men United &amp; Plus.Sr (FHH), Parea</td>
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<td>Transgender persons</td>
<td>TIA &amp; Urban House, Chances for Life, Suriname Men United, LGBT Platform &amp; Plus.SR (FHH)</td>
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<td>Sex workers</td>
<td>Chances for Life, Liefdevolle Handen &amp; Sucos</td>
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<td>PLHIV &amp; youth lgbt</td>
<td>Double Positive &amp; Plus.SR (FHH)</td>
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<td>Women &amp; Girls</td>
<td>Stichting Hoop voor kinderen, Parelhuis, Women’s Way, Foundation Moederhart, Foundation Sari,</td>
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<td>Migrants</td>
<td>Trop Clinic, Bem Eistar &amp; Chances For Life</td>
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<td>Ex-inmate/prisoners</td>
<td>Double Positive &amp; Chances for Life, Social workers of Santo Boma and Duisburglaan Penitentiary Institution, Headed under the Delinquency Care of the Ministry of Justice &amp; Police</td>
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<tr>
<td>Drug users</td>
<td>Bureau Alcohol &amp; Drugs, Liefdevolle Handen, Gelooof en Liefde, Stg. De Stem, Stichting Gelooof en Nieuw Leven, Nationale Anti-drugs Raad</td>
</tr>
<tr>
<td>Youth</td>
<td>YAM, Cocon, Youth Parliament, Youth Double Positive, Youth &amp; New Monday</td>
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<tr>
<td>Marron</td>
<td>Marron female network, Pater Albrinck Stichting &amp; Foundation for the interior</td>
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<tr>
<td>Indigenous</td>
<td>VIDS</td>
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### Key-informants, experts and resource persons

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<th>Representatives of the</th>
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<tr>
<td>Court of Justice</td>
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<td>Office of the Prosecutor</td>
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<td>Ministry of Health</td>
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<td>Ministry of Foreign Affairs</td>
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<td>Centre of People’s Development</td>
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<td>Suriname Men United</td>
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<td>Religious leaders</td>
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<td>The National Assembly</td>
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<tr>
<td>Gender Focal Points</td>
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<td>Anton de Kom University of Suriname</td>
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Annex 4 Questionnaires

Questionnaire for key-stakeholders

1. Which human rights instruments protect the rights of your target group with respect to HIV and AIDS?
2. Does your target group, feel supported by the international conventions?
3. Which legal products and regulations protect your target group with respect to HIV and AIDS?
4. Does your target group, feel supported by the legal system?
5. Which policies and programs protect your target group with respect to HIV and AIDS?
6. Does your target group, feel supported by the policy and programs?
7. Which punitive laws and regulations pose barriers to human rights and access to health in the context of HIV and AIDS?
8. Which policy poses barriers to human rights and access to health in the context of HIV and AIDS?
9. Does your target group know when your rights are breached? Can you give some examples?
10. When your target group experience health problems, where do they go?
11. Does your target group know where to turn to in case of violence or abuse of your rights?
12. What are the Gaps and Obstacles and weaknesses in the current legal, regulatory and policy framework?
13. What HIV-related programs/services are needed for your target group?
14. What do you recommend for law review and reform, strengthening access to justice as well as ensuring enforcement of rights, to create an effective response to HIV and AIDS.
Questionnaire for faith based organizations

1. What rules, rules, verses, views from your sacred scriptures can be considered to be protective towards the vulnerable target groups in relation to HIV / AIDS.

2. Are you familiar with international human rights conventions that guarantee the observance and perception of the rights of these vulnerable target groups in relation to HIV / AIDS? If yes which one?

3. Does your denomination, policies, programs and activities related to these vulnerable target groups relate to HIV / AIDS? (For example training, information, counseling etc ..). If yes which one? And do the members of your denomination use this?

4. What punitive regulations, rules, verses and views can impede access to health services in the context of HIV and AIDS for vulnerable target groups. (E.g. access to contraception, access to HIV testing, access to HIV inhibitors)

5. Do you know if your members know when their rights regarding HIV / AIDS are violated? If so, can you give some examples of one or more cases?

6. Do you know if your members know where to go when they are victims of violence or when their rights have been violated? If so, can you give some examples of one or more cases?

7. Do you think there are shortcomings in our national laws, regulations and policies regarding HIV / AIDS? If yes which one?

8. Which HIV-related programs and services do you think are necessary for the prevention and improvement of the quality of life of the vulnerable groups in relation to HIV?

9. Do you have legislative and regulatory recommendations (e.g revision and enlargement) to strengthen access to justice and ensure respect for the human rights of the vulnerable target groups, thereby ensuring effective actions aimed at improving services related to HIV and AIDS can be undertaken.