# NATIONAL STRATEGY ON ADOLESCENTS' HEALTH, 2023–2030, INCLUDING ACTION PLAN 2023–2025

SURINAME



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# ACRONYMS

| | |
|---|---|
| ABS | Algemeen Bureau voor de Statistiek |
| BLS | Basic Life Skills |
| BRVK | Bureau Rechten van het Kind |
| CEDAW | Convention on the Elimination of all forms of Discrimination against all Women |
| CRPD | Convention on Rights of Persons with Disabilities |
| CSE | Comprehensive Sexuality Education |
| ECD | Early Child development |
| FP's | Focal Points |
| FCH | Family and Community Health |
| GOS | Government of Suriname |
| GSHS | Global School-based student Health Survey |
| GSWCAH | Global Strategy for Women's, Childre n's and Adolescents' Health |
| IKBEN | Integraal Kinder Beschermings Netwerk |
| ILO | International Labour Organization |
| KJT | Kinder- en Jeugd Telefoon |
| KPS | Korps Politie Suriname |
| MinOWC | Ministerie van Onderwijs, Wetenschappen en Cultuur |
| MOB | Medisch Opvoedkundig Bureau |
| MOH | Ministe rie van Volksgezondheid |
| NAPK | Nationaal Actie Plan Kinderen |
| NAR | Nationaal Anti Drugs Raad |
| NDMP | Nationaal Drugs Master Plan |
| NCCR | Nationaal Coördinatie Centrum voor Rampenbeheersing |
| PI | Pedologisch Instituut |
| SDG's | Sustainable Development Goals |
| SpJz | Ministerie van Sport en Jeugdzaken |
| SoZaVo | Ministerie van Sociale Zaken en Volkshuisvesting |
| SAO | Stichting Arbeidsmobilisatie en Ontwikkeling |
| SRHR | Seksuele en Reproductieve Gezondheid en Rechten |
| RO | Ministerie van Regionale Ontwikkeling |
| TIP | Trafficking in Persons |
| UN | United Nations |
| UNDP | United Nations Development Program |
| UNICEF | United Nations International Children's Fund |
| UNFPA | United Nations Population Fund |
| UN | United Nations |
| WASH | Water, Sanitation and Hygiene |
| WCAH | Women's, Children's and Adolescents Health |

# FOREWORD

In Suriname, young people aged 10-24 years make up a quarter (25%) of the population, with a majority share of adolescents in the age group 10-19 years (16%). The government of Suriname is aware of the huge potential of this population group. Investments in adolescents' health and development will have immediate and long-lasting impact, not only on their current and future health, but also on the health of future generations.

Available data show that substantial shares of our adolescents die early or get sick due to preventable causes, such as suicide (attempts), road and other injuries, all types of interpersonal violence. Exposure to unhealthy food, drugs, tobacco, toxic values and norms, unsafe sexual behavior and lack of regular exercise put them at risks for HIV and other STI's, mental health problems, cardiovascular diseases and other health problems.

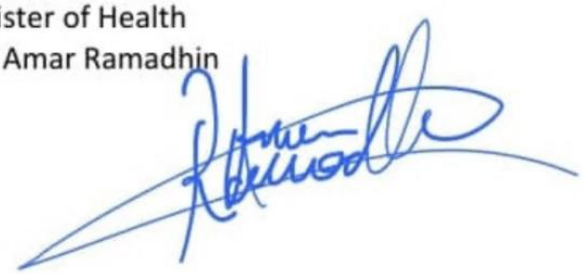
Adolescents are diverse and not all face the same risks, constraints, and deprivations. Available opportunities to enjoy the highest standard of health are still very depended on social determinants, including gender, economic position of the household, ethnicity and sexual orientation.

The Ministry of Health, supported by UNFPA, took the lead in the development of a National Adolescent Health Strategy (AHS) for Suriname, 2023-2030, and a budgeted Action and Monitoring Plan (2023-2025). However, everybody is needed in the national response. The action plan will specifically serve as a practical working document to guide coordinated and integrated actions of all relevant stakeholders on different levels. It will also allow analyses of budget gaps and more targeted mobilization of required funds.

We expect the strategy and action plan to be widely used by all stakeholders, government and non-government, as a working document to guide multi-sectoral and collaborative efforts for the health and well-being of all adolescents, on all levels of response.

We would like to valuable financial and technical support of UNFPA, and the dedicated work and contributions of a wide range of experts in preparing and finalizing this document.

Minister of Health
Drs. Amar Ramadhin



# ACKNOWLEDGEMENTS

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# EXECUTIVE SUMMARY

In Suriname, young people aged 10-24 years, make up a quarter (25%) of the population, with a majority share of adolescents in the age group 10-19 years (16%). This large share of youth is also reflected in the rest of the Americas, and considered to be a great potential for fast socioeconomic development. The World Health Organization defines adolescence as a period of human growth and development transitioning childhood to adulthood, with new risks but also with opportunities to positively influence the immediate and future health of young people.
Investments in this age group can derive a "triple demographic dividend" by improving health now, enhancing it throughout the life course and contributing to the health of future generations.

For adolescents to contribute significantly to national development, conditions are required to ensure that they are and remain healthy, skilled and educated in the broadest sense.
Adolescents can generally be considered a healthy population group. Therefore, the majority of health issues and risks that adolescents are facing are preventable or treatable. Ensuring their healthy development requires a health system that can adequately respond to their diverse needs, and is guided by a multi-sectoral approach, a gender and human rights perspective and aimed at their empowerment, with focus on the most vulnerable youth.

The Suriname government, led by the ministry of health, expressed its commitment to make all efforts to achieve the goals and targets as set in the different international and regional agreements, in particular the health agenda of the Sustainable Development Goals, 2015-2030, the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), the Regional Action Plan Every Women, Every child, Caribbean and the Roadmap Caribbean Adolescent and Youth Health, 2019.

Guided by the main key international indicators for tracking progress in adolescent health, the analysis of the situation on health of adolescents in Suriname shows relatively high prevalence of unintentional injury (traffic accidents, drowning), interpersonal violence, suicide, as well as alarming exposure of adolescents to tobacco smoking, alcohol/substance use, unsafe sexual behavior, overweight and mental health problems. Adolescents' health is also under pressure due to the working of social determinants such as high adolescent birth rates, low rates of completion of secondary education, high unemployment, low use of modern contraception.

This National Adolescent Health Strategy has been developed in a participatory manner in close interaction with key stakeholders from core government ministries and nongovernment actors, for the period 2023-2030, aligned with the SDG's, and includes a three-year Action plan, period 2023-2025.
The strategy is aimed at substantial and sustainable reduction of preventable adolescent mortality and morbidity through a coordinated and multi sectoral national response. The national response will work towards realization of the rights of all adolescents to enjoy the highest attainable standard of physical, mental and sexual/reproductive health and well-being, with specific focus on adolescents in a marginalized and vulnerable position.

The National Adolescent Health Strategy 2023-2030 is guided by a human rights, gender, cultural sensitive, life course and inclusive approach. Five strategic areas of interventions have been identified, that span from the development of an enabling legal and policy environment, institutional and capacity strengthening in the health sector to reducing the impact of social determinants of health inequality and inequity, to empowerment and engagement of adolescents, parents/families, schools and communities and to provision of services that are responding to adolescents needs in all their diversities, and especially reaching those who are in a marginalized position.

These five strategies are:

1. Strengthening of an enabling environment: Legislation, Policy, National coordination and multi-sectoral partnerships
2. Strengthening of adolescent health promotion and community participation
3. Improvement of Sexual and Reproductive Health, HIV/STI, especially at Primary Health Care
4. Strengthening Strategic information for monitoring
5. Advocacy and Social mobilization

The development of the 3-year National Action Plan, is based on ongoing and planned interventions as reported by stakeholders. The general long term outcome indicators and targets are as much as possible align to existing national indicators, and translated to output indicators and performance indicators on the level of the action plan for monitoring of the priority actions for the three-year period 2023-2025.

Many of these actions are so called 'low hanging fruits', that are already being implemented, however require strengthening and/or expansion. These short-term actions include the reactivation of traffic education in schools, the execution of the basic life skills curriculum, the expansion of the school nursing program of the RHS, capacity strengthening of health service providers in the application of the existing IMAN (Integrated Management of Adolescent Needs), already in use by the Medical Mission.

The program on 'Family and Community Health' of the Bureau of Public Health will be in charge of monitoring and periodic revision of the action plan through regular discussion with key stakeholders on progress and compilation of annual plans in which all reported actions will be included. Annually available or required budgets will be attached to all actions to facilitate efficient resource mobilization for identified budget gaps.


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# 1. INTRODUCTION

The World Health Organization defines adolescence as a period of human growth and development transitioning childhood to adulthood. This life phase is characterized by significant physical, psychological, and social changes in many areas such as family and other personal (sexual) relations, educational life, employment and social relations in general. These transitions carry new risks but also present opportunities to positively influence the immediate and future health of young people.

Worldwide, there are nearly 1.2 billion adolescents (10 - 19 years old), a population that has never before been this large and this diverse in terms of ethnicity, sexuality and gender identity. This large share of youth is also the case in our region, and according to PAHO, the largest cohort ever in the history of the Americas, brought about by falling fertility and mortality rates, which create unprecedented opportunities for fast economic growth. Also in Suriname, young people aged 10-24 years make up a quarter (25%) of the population, with a majority share of adolescents in the age group 10-19 years (16%).

This large cohort has the best potential of all age groups, because they are in the economic active/productive age group, to contribute significantly to national development, that is when conditions are created to ensure they are and remain healthy, skilled and educated in the broadest sense. It is repeatedly reiterated in public statements that investment in this age group can derive a "triple demographic dividend" by improving health now, enhancing it throughout the life course and contributing to the health of future generations[1].

However, estimates are that globally, each year there are more than 1.2 million adolescent deaths, which is a tragic loss if we take into account that the majority of adolescent health issues are preventable or treatable. Although adolescents are in general a healthy population group, they have specific needs and pose different challenges for the health-care system than adults or children, due to their rapid biological, emotional and social development. Adolescents are diverse and not all face the same risks, constraints, and deprivations. Ensuring their healthy development requires a multi-sectoral approach aimed at strengthening health systems, the legal and policy environment, as well as protective factors in the social environment, on the community, family and individual level.

Latin America and the Caribbean are still categorized as the world's most unequal regions, characterized by sharp social inequalities that are systematically leaving the most vulnerable behind, including large groups of adolescents and young people. Available opportunities for children and adolescents to survive, thrive and strive are still very depended on their ethnic descent, living area, gender, economic conditions of the family, sexual orientation and the way these forces intersect (ECLAC, 2022, Lancet 2022[2]).

[1] The Health of Adolescent and Youth in the Americas. Implementation of the Regional Strategy and Plan of Action on Adolescent and Youth Health 2010-2018. Washington, D.C.: PAHO; 2018.

[2] Lancet, editorial (2022). Adolescence in Latin America and the Caribbean. www.thelancet.com/child adolescent Vol 6 November 2022

**SDG's and the GSWCAH**

Almost all countries expressed their commitment to the realization of the Sustainable Development Goals (SDGs), which call for equitable opportunities and 'leaving no one behind', thus prioritizing the most vulnerable. In close alignment with the SDGs, in 2016 the 'Global Strategy for Women's, Children's and Adolescents' Health', 2016-2030 (GSWCAH**)** was launched. In follow-up of this global strategy, governments in the Caribbean developed and committed to the Caribbean bound version, which is the 'Regional Plan of Action for Women's, Children's and Adolescents Health (WCAH)', 2018-2030.

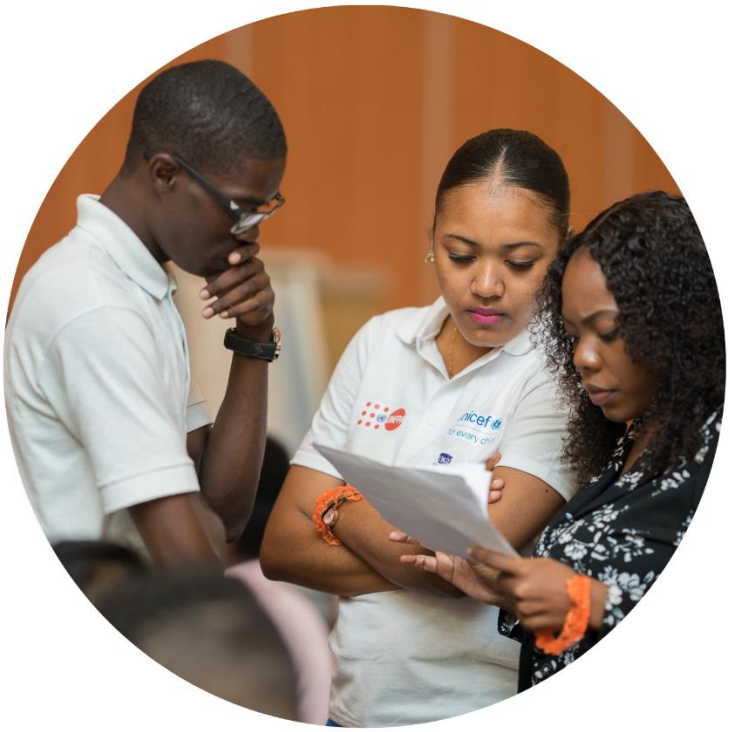

**Global AAHA framework**

The inclusion of adolescent health in the GSWCAH represents an unprecedented opportunity to scale up the response and invest in adolescents, with immediate and long-lasting impact on their health, and that of future generations. Internationally and also regionally, there is an increasing consensus that these investments in adolescents' health and development are critical for the success of the post 2015 development agenda. To provide guidance to countries on how to plan, implement, and monitor a "survive, thrive, and transform" response to the health needs of adolescents, in line with the existing international commitments on adolescents' health, in 2017, the WHO developed a Global Accelerated Action for the Health of Adolescents Framework ("the Global AA-HA! Framework"), in consultation with youth, member states, and major partners, and based on effective evidence-based interventions. Key components in this approach are: 1. Involving adolescents 2. Highlighting policies and interventions that address multiple outcomes, risk factors, and determinants, 3. Priority-setting and learning from best practices, 4. Monitoring of indicators for health and other sectors[3]

[3] WHO (2019). Accelerated Action for the Health of Adolescents (AA-HA!): a manual to facilitate the process of developing national adolescent health strategies and plans. file:///C:/Users/HP/Downloads/9789241517058-eng.pdf

**Regional evaluation of adolescents' health**

The regional evaluation of adolescents' health in Latin America and the Caribbean (PAHO, 2018, PAHO/UNICEF, 2022) shows that interpersonal violence, road traffic injuries, and suicide are still the leading causes of adolescent deaths, and adolescent birth rates are still among the highest in the world. Interpersonal violence causes high percentages of deaths in 15-19 years' age group, respectively 41% in boys and 11% in adolescent girls. The high prevalence of various problems is still not reflected yet in adequate services for adolescents. While interventions like free contraception and sexuality education are available, adolescents do not access the services, face stigma or shame, or are not provided enough information. Violence prevention programs have not achieved the scale and intensity to achieve impact. It appeared that over one in seven adolescents suffer from a mental disorder, with anxiety and depression disorders as the most common mental disorders among adolescents. Mental health and counseling services are largely unavailable. Despite the progress that has been achieved, all countries in the region have to make much more efforts to tackle preventable and treatable adolescent health problems including infectious diseases, undernutrition, HIV, sexual and reproductive health, injury, and violence[4]



[4] PAHO, UNICEF (2022). No Time to Lose. Health Challenges for Adolescents in Latin America and the Caribbean. Washington, D.C.: Pan American Health Organization and United Nations Children's Fund; 2022. License: CC BY-NC-SA 3.0 IGO. https://doi. org/10.37774/9789275126219.

**Roadmap to Adolescent Health and Well-being**

Guided by the AA-HA framework, in 2019, CARICOM took the lead in developing the 'Roadmap to Adolescent Health and Well-being', with broad consultations of representatives of youth from all Caribbean countries and other relevant stakeholders. There is widespread agreement that in order to realize the health and wellbeing of adolescents, countries will need to adopt holistic health policies for adolescents and include programs to educate them about, and help them build judgment and skills for preventing injuries, violence and self-harm, good sexual and reproductive health outcomes, preventing non-communicable diseases (NCDs), and other pivotal aspects of physical and mental health and development[5].

**National Adolescent Health Strategy (AHS) for Suriname, 2023-2030**

It is against these internationally agreed commitments, and the nationally developed legislation and policies that the Ministry of Health, supported by UNFPA, took the lead in the development of a National Adolescent Health Strategy (AHS) for Suriname, 2023-2030, and a budgeted Action and Monitoring Plan (2023-2025). The general long term outcome indicators and targets will be as much as possible align to existing national indicators, and translated to output indicators and performance indicators on the level of the action plan for monitoring of the priority actions for the three-year period 2023-2025. The action plan will further serve as a practical working document to guide coordinated and integrated actions of all relevant stakeholders on different levels. It will also allow analyses of budget gaps and more targeted mobilization of required funds.

[5] CARICOM (2019): Adolescent and Youth Health Road Map for the Caribbean. First Caribbean congress on Adolescent and Youth health, Port of Spain, Trinidad and Tobago, 14–17 October 2019

# 2. METHODOLOGY

In the design of the process for the development of the strategy, the steps followed are in accordance with the AA-HA! Guide regarding the Adolescent Health priority setting. The first phase of 'Needs Assessment' was followed by 'Landscape analysis' and continued with 'Setting of priorities. (See figure below)

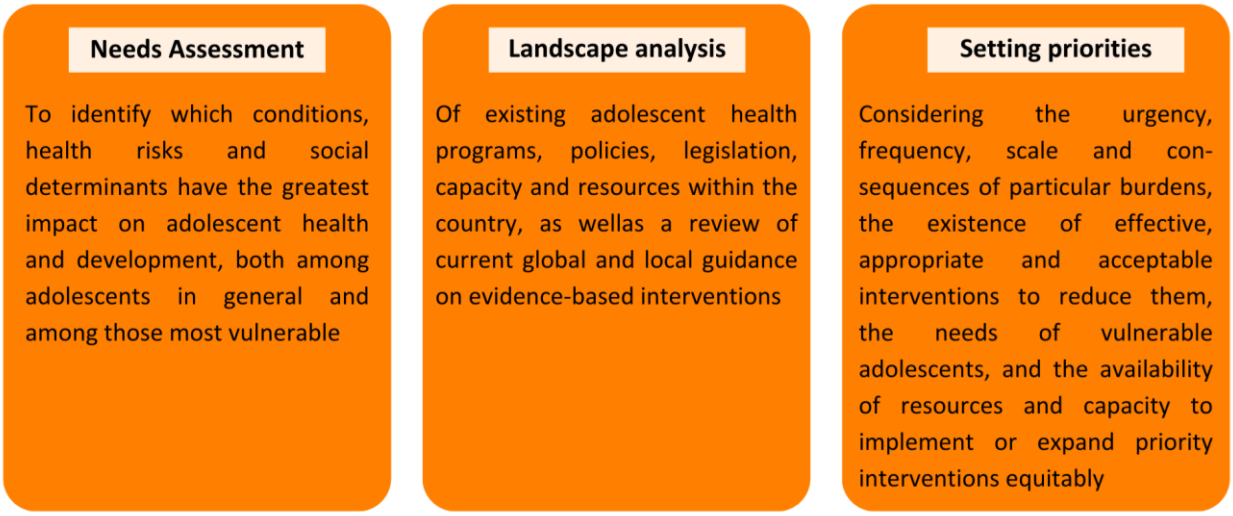



**Figure 1: AA-HA! National adolescent health priority setting**

**Source: AAHA guidance, WHO, 2019**

### Desk review

The first phase of the process was the desk review, during which the focus was on collection and review/analysis of available written data and information to have an adequate insight into the wider sociocultural and economic country context as it relates to adolescents. In this regard information was collected on the legal and policy environment, main issues affecting adolescents and their health, the working of social determinants, current responses of government and non-government stakeholders, achievements and challenges. Where available, relevant data was, as much as possible, disaggregated to reveal the intersectional working of multiple forces of social inequality (age, ethnicity, gender, living area).

### Technical Working Group

The participatory approach and a multi-sector collaboration was ensured throughout the entire process through active engagement of key stakeholders. A first step was the establishment of a technical working group (TWG), composed of representatives of the key ministries with responsibility for youth affairs, which are: the ministry of Health; the ministry of Education, Science and Culture; the ministry of Labor, Employment and Youth Affairs; the ministry of Justice

and Police; the ministry of Social Affairs and Housing; and also, representatives of relevant UN Agencies (UNFPA, PAHO and UNICEF).
The role of the TWG was to guide and support the development of the Adolescent Health Strategy (AHS). During the process, the TWG had weekly (online) meetings to share relevant information and data, discuss the methodology and assisted with obtaining documents and the organization of consultation meetings, including two national consultation workshops. The TWG was also tasked with the revision and approval of all submitted draft documents, including the draft strategy and action plan. This collaborative process eventually led to the final draft of the AHS. Although not formally agreed, the TWG has the potential to transform to a formal inter-ministerial, multi-sectoral TWG, under the leadership of the ministry of Health, to enhance a coordinated and integrated implementation of the national Adolescent Health Strategy.


**Training of youth advocates as facilitators**

To fully engage and enhance the support of youth leaders for this process aimed at improvement of adolescents' health, a selected group of 10 youth leaders who also serve as activists/advocates, in key response areas such as sexual and reproductive health, mental health, interpersonal violence, road safety and education, have been consulted and trained.
The aim of their engagement was multifold. First, they were heard as activists to identify priority issues and feasible actions, taking into account their opinions, experiences and advocacy priorities. Second, they were familiarized with the context of adolescent health and the guidelines of the AAHA process for the development of the AHS. Third aim was capacity building, in particular in strengthening of skills and techniques to perform the responsibilities as

moderator to support the facilitation of group work and guiding of discussions on both days of the National Stakeholder Workshop. Noteworthy is that some of these advocates, active in the 'Youth Advisory Group' (YAG) and in community organizations participated in the second Caribbean Conference on 'Adolescent Health and Well-being' held in Jamaica, during October 20-23, 2022. At time of finalization of this Adolescent Health Strategy in November, a last additional consultation meeting was held with this group to hear about their experiences, best practices, lessons learned and how this information could translate into the Surinamese Adolescent Health Action Plan 2023-2025.

**Consultations meetings with key stakeholders, with use of forms**

Since the start of the assignment concerted efforts have been made through consultation meetings with service providers/policymakers and youth to not only foster and encourage active engagement of all stakeholders, but also to accurately capture their input, feedback and insight given. In addition to the desk review and to ensure the inclusion of updated data, a standardized matrix was developed and disseminated to all main stakeholders, in particular key ministries and UN agencies, for insertion of information on initiated, ongoing and planned actions/interventions relevant to adolescent health and if available more detailed data on available budget and time path. These first-round consultations resulted in a preliminary situation- and response analysis, with distinctions made between 'health outcomes' (burden of disease), health risks, social determinants and national response.

**National Consultation workshops**

The consultation process to engage sector stakeholders in discussion, deliberation and decisions around adolescent health programming and build national consensus was elevated to the national level with the convening of two national workshops. One workshop day was dedicated to "Service Providers/Policy Makers" and another workshop to "Youth representatives/adolescents". The reason for a separate adolescent workshop was to create a safe space for youth where they would feel comfortable to discuss potentially sensitive personal issues, such as sexual and reproductive health (SRH) and mental health, with each other. To ensure active participation of a wide variety of key persons actually engaged and providing services in adolescent health, the list of invitees was carefully selected. Much effort was made to have persons on board actually working in the main areas of adolescent health, such as positive health development, sexual and reproductive health, mental health, interpersonal violence, road safety and education. During both workshops, a multitude of approaches was utilized, including discussion, presentation, reflection and group work. To enable an initial understanding of the current status of adolescent health in Suriname, a fact sheet document on 'Situation of Adolescents in Suriname' was prepared in Dutch as a handout at the workshops. The results of both workshops were as expected:1. Jointly review and validation of assessments on the current status of and response to adolescent health in Suriname and identification of gaps in the desk review 2. Jointly identification of key strategic areas and priorities for programming in adolescent health. 3. Sharing of best practices, potential interventions and collaboration opportunities.

# 3.SITUATION ANALYSIS ADOLESCENTS' HEALTH

## 3.1. Population characteristics

**Definition of Adolescents**

The World Health Organization (WHO), and other UN organizations, define adolescents as persons between 10 and 19 years of age. This age-based definition of adolescents falls in the definition of 'Child', as a person under the age of 18 years, as adopted in the Convention on the Rights of the Child, ratified in Suriname in 1993. Another well-known term is 'youth' or 'young people', which covers a larger age category of 10-24 years. Use of these international acknowledged definitions enables comparison of data and uniformity in monitoring of regionally and internationally agreed indicators on adolescent health. It is also important to recognize the difference within the general age group of 10-19 years, as experiences of adolescents, aged 10-14 years are different than those aged 15-19 years.

Biological transformations during adolescence are constantly inter-acting with a varied and diverse sociocultural- and economic context, which means that experiences of adolescents can show similarities but also significant differences.

However, in Surinamese legislation, there is no single definition of majority or adulthood. There are different legal ages for different situations, for example, the legal age to work (16 years), to get a driver's license, to buy alcohol (18 years), to have sex (16 years), to be held accountable for criminal action (12 years). In addition, in dealing with age, we should also take into account the fact that biological transformations during adolescence are constantly interacting with a varied and diverse sociocultural- and economic context, which means that experiences of adolescents can show similarities but also significant differences. For example, the experiences of a girl, aged 10 years, in a poor household in a rural village can be very different from a girl of the same age living in an affluent urban environment due to differences in cultural traditions and economic conditions. Therefore, in the analysis of factors influencing adolescent health the availability of disaggregated data is key, and age will be as much as possible interlinked with other key determinants such as gender, economic status and living area.

**Size**

The number of adolescents (10-19 years) in the total Surinamese population in 2019 is 98,300 (16.4% of the total population): 25,500 male and 24,100 female.
Young people in the age group 10-24 years make up a population of 145,700 people: 70,566 male and 68,760 female. That is 24.3%, almost a quarter of the Surinamese population.

**Table 1: Size of the Suriname youth population, by age groups and sex, 2012, 2017 and 2019**

| Age category | Total 2012 | Total 2017 | Total 2018 | Total 2019 | | Total Abs. | % | % |
|---|---|---|---|---|---|---|---|---|
| | | | | Male | Female | | | |
| 10-14 | 50,807 | 49,300 | 49,400 | 25,500 | 24,100 | 49,600 | 8.3 | 98,300= 16.4% |
| 15-19 | 45,394 | 48,400 | 48,600 | 25,000 | 23,700 | 48,700 | 8.1 | |
| 20-24 | 44,038 | 46,900 | 47,100 | 24,100 | 23,300 | 47,400 | 7.9 | 7.9% |
| | | | | 74,600 | 71,100 | 145,700 | 598,000 | 24.3% |

**Source: Processed by author. General Bureau Statistics (2019). Demographic Data 2017- 2019 Suriname in cijfers no. 356/2021-01. Paramaribo**

## 3.2. Key indicators of adolescent health and well-being

To ensure healthy development of all adolescents, it is pivotal to have a good understanding of their health status, the impact of various factors that are impacting on their health, taking into account the large diversities in experiences, level of protection, risks, barriers, and specific challenges adolescents have to deal with.
The WHO proposes a set of 12 key indicators for tracking progress in adolescent health (Lancet Commission, 2016). These indicators are divided into three main categories, that can be adopted to local circumstances[6]:

1**. Causes of death and disease**: Indicators include in particular mortality rates due to communicable and non-communicable diseases, maternal conditions, unintentional injury (traffic accidents, drowning), interpersonal violence and suicide.

**2. Health risks**: Progress in exposure to health risks is mainly tracked by looking at prevalence of tobacco smoking, alcohol/substance use, unsafe sexual behavior, overweight and mental health problems

**3. Social determinants of health during adolescence**: These indicators are specifically related to fertility/adolescent birth rates; completion of secondary education; not in education, employment or training [NEET]; child marriages; and satisfying the demand for contraception with modern methods.

Indicators were generally defined for adolescents aged 10–24 years, therefore include the specific adolescent age group of 10-19 years. All indicators are aligned with the framework for the Sustainable Development Goals and with current global policy documents adapted by UN countries, in particular the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) with the Survive, Thrive, Transform agenda and the translation into the Caribbean Regional Plan of Action on Women, Children and Adolescents, focusing on long term health and wellbeing for adolescents7. In the following paragraphs a more detailed picture will be presented on the current situation of adolescents in Suriname, with identification of the main health outcomes/ burden of disease, the health risks and social determinants that have the greatest impact on adolescent health, with a particular focus also on adolescents in a vulnerable position.

[6] Peter S Azzopardi, S (2019). Progress in adolescent health and wellbeing: tracking 12 headline indicators for 195 countries and territories, 1990–2016. Lancet 2019; 393: 1101–18 http://dx.doi.org/10.1016/ S0140-6736(18)32427-9

[7] Ross, D. et.al. Adolescent Well-Being: A Definition and Conceptual Framework. Journal of Adolescent Health 67 (2020) 472e476

## 3.3. HEALTH OUTCOMES

### 3.3.1. Main causes of death

The most common causes that lead to death or illness in adolescents are all preventable. A recent worldwide study on global burden of diseases (Lancet, 2020) revealed that in adolescents aged 10–24 years, three injury causes were among the top causes of death: road injuries (ranked first), self-harm (third), and interpersonal violence (fifth). International data also show that among adolescents and young adults, mental health disorders (anxiety and depression) and substance abuse (alcohol and drugs) are the leading causes of "years living with disability", meaning 'poor health'[8]. Suicide is a key public health concern for all adolescents. Recent mortality data on adolescents in the Caribbean Region reveal more or less the same mortality patterns. Noteworthy is also that among adolescents in the Caribbean the main causes of poor health are drug use disorders and mental health (anxiety, depression), while drowning, and maternal conditions are also among the main causes of death[9] . In Suriname, the availability of disaggregated adolescent-specific data, is a major challenge. To fill this gap, international and regional UN agencies produce estimates, including for adolescents' health in Suriname. With respect to adolescent mortality, in the next table, data on the four leading causes of death in adolescents are presented based on PAHO regional mortality database 2016[10]. In accordance with worldwide patterns, also in Suriname, traffic accidents, suicide and drowning are the most common causes of death among adolescents between the ages of 10 and 14. Among older adolescents, age 15 to 19, main death causes are suicide, traffic accidents and interpersonal violence.

[8] Years Lived with Disability (YLD) measures the burden of living with a disease or disability in the number of years. One YLD represents the equivalent of one full year of healthy life lost due to disability or ill-health.
[9] WHO Global Health Estimates, 2020
[10] PAHO, Adolescent and Youth Health, Country Profile Suriname, 2017

**Table 2: Four main causes of death, by age and sex, 10-24 years in Suriname (per 100,000)**

| 10-14 years | | | 15-19 years | | | 20-24 years | | |
|---|---|---|---|---|---|---|---|---|
| | Male | Female | | Male | Female | | Male | Female |
| Suicide | 8.1 | 8.3 | Road Traffic injuries | 25.0 | 13.0 | Suicide | 36.7 | 14.1 |
| Cardio myopathy | 8.1 | ND* | Suicide | 4.2 | 21.7 | Road Traffic injuries | 27.5 | ND* |
| Malignancies | 8.1 | ND* | Epilepsy | 8.3 | ND | Drowning | 9.2 | 4.7 |
| Epilepsy | | 4.1 | Drowning | 8.3 | ND | Homicide | 13.7 | ND* |

**No Data (ND): * If there is no cause of death reported for a specific age group and sex, the corresponding bar with zero value is not being represented**
**Source: PAHO Regional Mortality Database, Pan American Health Organization (PAHO/WHO), 2016 Edition. Country latest mortality data available as of 2014.**

With respect to mortality trends, in the period 2000-2014, the main four causes of mortality among males, 10-24 years were: 1. Road traffic injuries, 2. Intentional self-harm (Suicide), 3. Accidental drowning/submersion, 4. Assault (Homicide). Among females these four causes of death were: 1. Intentional self-harm (Suicide), 2. (HIV/AIDS) diseases, 3. Road traffic injuries, 4. Complications during pregnancy, childbirth and the puerperium (PAHO, 2017).

### 3.3.2. Unintentional Injuries

**Road Injuries**

In 2021, almost three thousand, 2,997 persons visited the emergency room of the AZP due to traffic accidents. This is an average of 8 persons per day. If we compare the data by sex, we generally see that men have higher registrations in both hospital admissions and fatalities, than women (GBS, 2019)[11]. Most road accidents occur in Paramaribo, Wanica and Nickerie. These are also the most densely populated districts with the best developed infrastructure and thus the most traffic. [12]

In the table below, the registered injuries at the emergency room of the Academic Hospital in the capital city of Paramaribo for 2021, January to December, are presented. The following patterns can be observed, and are hardly different from the patterns of previous years:

1. Most road injuries are in the younger age groups, mainly 15-19 years, 20-24 years and 25-29 years.
2. The majority of road injuries occur among young males, with a share of 70%, compared to a female share of 30%. In 2018, the number of males dying as a result of a traffic accident was almost 5 times higher than the number of women. Of all traffic deaths in 2018 around 84% was male (64 males against 11 females).
3. Of the people treated annually at the emergency care of the Academic Hospital and hospitalized due to road injuries, approximately 20% are adolescents (15-19yrs) of which two third are male. However, in the age groups, 5-9 years and 10-14 years, it is remarkable that there is no significant sex difference. In age group 10-14yrs, females account for 41% against 59% males. A possible explanation is that these younger children are mainly car passengers and/or pedestrians.
4. Disaggregated data on traffic deaths of 2018 show that about 15% of deaths due to road accidents are adolescents or young people (11-20yrs).
5. The burden of road traffic injuries falls disproportionately on vulnerable road users – (motor)cyclists, car passengers and pedestrians. Most traffic accidents involve vulnerable road users. In 2018: motorcyclists (43%), pedestrians (13%) and car passengers (35%), cyclists (4%).

[11] https://statistics-suriname.org/wp-content/uploads/2020/02/Verkeers-en-vervoersstatistieken-2015-2018.pdf
[12] https://statistics-suriname.org/wp-content/uploads/2020/02/Verkeers-en-vervoersstatistieken-2015-2018.pdf

**Table 3 Traffic accidents victims by age and sex, (SEH-AZP, Jan- Dec 2021)**

| Age categories | Male | % | Female | % | Total | % |
|---|---|---|---|---|---|---|
| 00-04 | 48 | 60% | 32 | 40% | 80 | 2.7% |
| 05-09 | 56 | 56% | 44 | 44% | 100 | 3.3% |
| 10-14 | 59 | 59% | 41 | 41% | 100 | 3.3% |
| 15-19 | 252 | 77% | 74 | 23% | 326 | 10.9% |
| 20-24 | 420 | 74% | 148 | 26% | 568 | 18.9% |
| 25-29 | 277 | 71% | 115 | 29% | 392 | 13.1% |
| 30-34 | 207 | 68% | 98 | 32% | 305 | 10.2% |
| 35-39 | 206 | 69% | 90 | 31% | 296 | 9.9% |
| ➢ 39 years | 783 | 69% | 343 | 31% | 1126 | 37.5% |
| Total | 2102 | 70% | 895 | 30% | 2997 | 100% |
| | | | | | | |

**Source: Medische Registratie AZP (overzicht opgemaakt door Korps Suriname verkeersvrijwilligers, KSV)**

Annual numbers of traffic deaths show a fluctuating pattern without a significant drop: In 2018 (76), in 2019 (82), in 2020 (76) and in 2021 (92)[13]. The five key risk factors in road traffic deaths and injuries are drinking and driving, speeding, and failing to use motorcycle helmets, seat belts and child restraints [14]. In addition, distracted driving is a growing threat to road safety considering the use of mobile phone and other in-vehicle technologies. Texting causes cognitive distraction and both manual and visual distraction as well. Even talking on mobile phones without holding or browsing a phone can reduce driving performance.

**Drowning**

Although drowning is identified as one of the major causes of adolescent's death in Suriname (see previous table), recent detailed data are not available. Data from 2009 indicate that share of adolescents in drowning is relatively high and that young males are overrepresented: in 2009, eight adolescents died by drowning, of which six male and two female.
The fact that men die by drowning is attributed, among other things, to their increased exposure to water and riskier behavior such as swimming alone, drinking alcohol, unsafe boating and unsafe use of other water transport.

[13] KPS, 2021
[14] Health at a Glance: Latin America and the Caribbean 2020 https://www.oecd-ilibrary.org/sites/e02c3eae-en/index.html?itemId=/content/component/e02c3eae-en

### 3.3.3. Mental health

In Suriname the burden of mental ill-health is most prominently noticeable in the growing suicide problem (suicide is in the top 10 of causes of death in Suriname). According to latest national mental health plan, main mental health problems among children and adolescents/young adults are anxiety and mood disorders, behavioral disorders, ADHD and communication problems[15]. International research shows that one-third of mental disorders begin before the age of 14, nearly half at age 18 and nearly two-thirds before age 25. Yet only 20-40% of adolescents with mental health problems are diagnosed by health services and only 25% receive proper treatment. Health insurance coverage of mental healthcare is very limited. Furthermore, it appears that adolescents often do not receive help on time, which also has to do with barriers in access to mental health care, such as stigma, additional payment costs, the absence of health services or the lack or the required parental consent. [16] A recent small scale online study among youth, 14-24 years, in Suriname, confirms more or less similar patterns: 71% of respondents agreed that information available about mental health is insufficient, 89% states that mental health is stigmatized, 94% agreed that the government is not doing enough, while 88% never consulted a health professional for mental health problems. Most common problems reported are depression and anxiety[17]. This last result is in accordance with earlier findings of a national (secondary analysis) study (Gunther et.al, 2017) on the risk factors for psychological distress in Suriname, which indicated that 1 in 4 women and 1 in 5 teenagers and young adults between 15 and 24 years may suffer from depression and anxiety disorders. These disorders are also most prevalent in the urban areas of Paramaribo, Wanica, Nieuw Nickerie, Meerzorg and Tamanredjo[18]. No prevention interventions specifically targeting adolescents with mental health needs were identified. The vast majority of mental health services are in Paramaribo and Nickerie.

**Suicide**

In 2020, the number of suicides in Suriname reached 148 or about 4% of the total deaths. Suriname is number 6 in the world. Traditionally the district of Nickerie had the highest suicide rates. However, the last few years, there is a notable decline of suicides in this district, while there is an increase in other districts, such as Sipaliwini, Brokopondo and Wanica. The average age people commit suicide in Suriname is 37 years. In women, the majority of suicides were registered in the age group 15-19 years. Men with the most suicides were registered in the age group between 25-45 years. As for the suicide attempts, unfortunately the last few years there is also an increase in the number of children aged 10-14 that attempt to commit suicide[19].

[15] National mental health Plan, 2015-2020

[16] Peter S Azzopardi, S (2019). Progress in adolescent health and wellbeing: tracking 12 headline indicators for 195 countries and territories, 1990–2016. Lancet 2019; 393: 1101–18 http://dx.doi.org/10.1016/ S0140-6736(18)32427-9

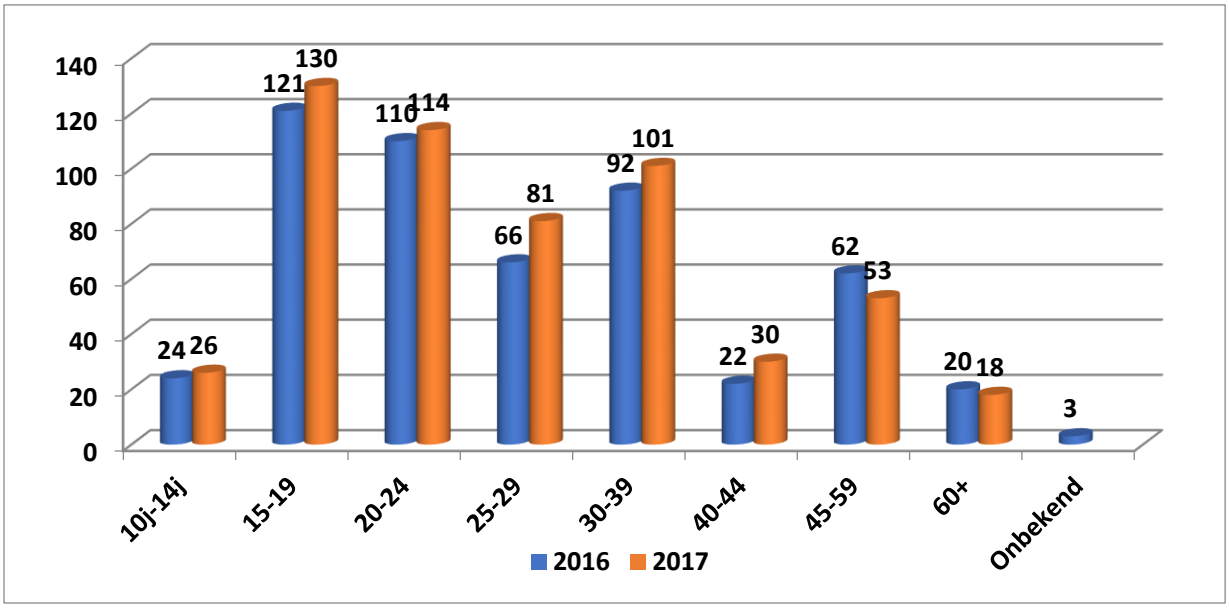
[17] UNICEF: preliminary results online survey, 2022

[18] Gunther, P, et.al. (2017. Prevalence of Psychological Distress in Suriname In Urban and Rural Areas: The Suriname Health Study. In: Journal of Human Psychology

[19] 'National Suicide Prevention and Intervention plan, 2016-2020.

Suicidal thoughts appeared to be also high in the general population of youth. A school survey conducted in 2016, showed that among students, 13-17 years, 16% ever seriously considered attempting suicide during the past 12 months, among males 11% and among females 20%. [20] Self-harm ranks second as a cause of death in adolescents aged 10 years and in first place in adolescents aged 15 to 19 years. In 2017, the Emergency Department of the Academic Hospital registered 553 people (more women than men) who had attempted suicide: 10-19 years (24%), 20-24 years (21%), 25-29 years (15%), representing a share of 60% of young people aged 10-29 years. More women than man attempt to commit suicide, while more men than women actually commit suicide.

**Figure 2: Suicide attempts by age category, 2016 and 2017**




**Source: Academic Hospital, 2018**

'The most common methods of committing or attempting suicide are the ingestion of chemicals, medications, and pesticides and firearms21. Factors contributing to the high suicide rate include easy access to highly effective means of committing suicide (pesticides); sensational media coverage of suicides; stigma surrounding mental health issues; intolerance to LGBTI, and domestic violence. Discrimination also poses a potential risk for suicide in Suriname, especially for LGBT. A study among men who have sex with men (MSM) in Suriname showed that 13.5 % had suicidal thoughts in the previous year; among the transgender respondents this was even higher i.e. 27.8 %[22]. Domestic violence and other forms of violence against children and intimate partner violence in Suriname are also risk factors. A recent survey among 2,551 respondents between the ages of 16 and 25, nearly 70% of whom were women, more than a third said they

[20] Global School Health Survey (GSHS), PAHO, 2016
[21] ibid
[22] van Arkel, Z en Sumter, T, 2014. Public awareness and acceptance, special confidential (health) services, HIV knowledge, multiple condom distribution points and other needs. An assessment of needs of MSM and transgenders in Suriname.

had ever thought about suicide. The survey also found that 15% of respondents identify with the LGBT community. Out of that number, nearly 60% ever had a suicidal thought[23].

[23] Een onderzoek naar suïcidaal gedrag van jongeren tussen 16 en 25 jaar in Suriname. Ministerie van Arbeid, Werkgelegenheid en Jeugdzaken, UNICEF, 2022

### 3.3.4. Non-communicable diseases

A non-communicable disease (NCD) is a medical condition or disease that has a long course and is not contagious or transmissible between people. In Suriname, cardiovascular diseases, cancer and diabetes are the main causes of death. The ministry of Health drafted the National Action Plan for the Prevention and Control of Non-Communicable Diseases for 2015-2020. This plan sets targets to adopt local and national strategies that prevent NCDs, reduce alcohol and tobacco use, integrate NCDs within the country's approach to chronic care, and strengthen Suriname's ability to conduct surveillance and research into NCDs. There is a clear sex disparity in certain NCD risk factors in the country. More men on average smoked tobacco (six times more than women) and men consumed more alcohol while women are more physically inactive and are more likely to be obese. A positive development is the substantial reductions in tobacco smoking between 2010 and 2016, with decline of tobacco smoking for men (from 57% to 43%) and for women (from 12% to 7%). On the other hand, there has been a marginal increase in the prevalence of raised blood glucose and obesity during the period 2010 to 2014/2016. Suriname has shown limited progress towards achieving the non-communicable disease (NCD) targets. To achieve the regional target of 9% mortality rate for NCDs, much more work still needs to be done, including restrictions on alcohol advertisement, policies on salt consumption, limits on saturated fatty acids in foods, and the implementation of the WHO set of recommendations on marketing of food and nonalcoholic beverages to children. Physical inactivity among children and adolescents has remained high and constitutes a major concern which had not been vigorously addressed until recently. Promotion among of school environments for healthy eating and physical activity are therefore needed to effectively address the growing prevalence of childhood obesity.[24].



[24] A Abdulkadri and others, "Addressing the adverse impacts of non-communicable diseases on the sustainable development of Caribbean countries", *Studies and Perspectives series-ECLAC Subregional Headquarters for the Caribbean*, (ECLAC), 2021.

### 3.3.5. Communicable diseases: HIV

In general, the most common communicable diseases, that can threaten adolescents are HIV, Sexually Transmitted infections (STI) and Human Papiloma Virus (HPV). Recent data on prevalence of STI and HPV by age group in Suriname are not available. Fortunately, data on new cases HIV are systematically registered, also by age group, and provide an estimation of the level of sexual risks exposure among adolescents. In 2018, the annual registered new cases of HIV counted 647, of which 343 females and 302 males. The estimated HIV prevalence in the Surinamese population of reproductive age, 15-49 years, is 0.9%, while HIV prevalence among pregnant women is estimated at 1%. The only available data by age are related to period 2000-2013, with 16% of total number of registered HIV cases in age group 16-25 years. Of the total registered HIV-positive women, 24% are in the age group 16-25 years. In contrast, young men make up 8% of total registered HIV+ men. Young women are tested more often than young men because of pregnancy and because young men are less likely to get tested voluntarily (MOH, 2014). Achievement of early diagnosis remains a large problem. Recent estimates are that about 41% of PLHIV (3400 persons) are undiagnosed, while around a third of persons are diagnosed at a late stage in the disease[25]. According to reports of NGO's, PLHIV face significant barriers in the access to ART (HIV medication), including stock outs and out of pocket payment for certain medicines. Also, stigma and discrimination by service providers, family, as well as lack of adequate housing, financial and psycho social support is challenging, especially for PLHIV who are already in a marginalized position.

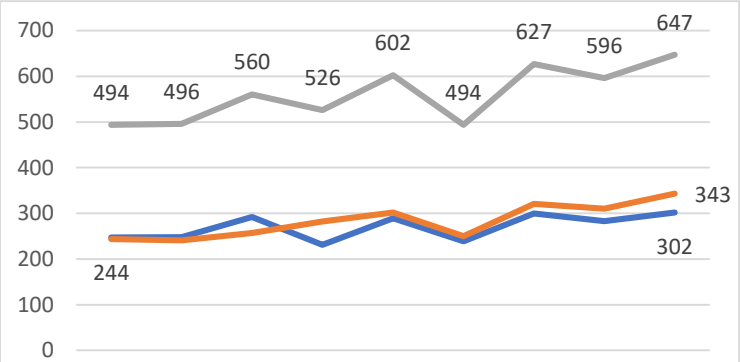



**Figure 3: Registered New HIV cases, 2010-2018**

**Source: Ministry of Health. 2019**

**Impact of COVID-19**

International and regional data showed that COVID-19 resulted in substantial disruptions in access to health services, including services relevant for adolescents' health. A recent study showed that 35% of countries reported disruptions in adolescent services, especially in low-income countries. Decreased care seeking and in general social isolation is particularly related to school closure, lockdowns and travel restrictions. Worldwide indications are also that the already neglected mental health issues in many countries, have been exacerbated during and after the COVID-19 epidemic. Data reveal a significant increase in depression and anxiety, decline in

[25] National HIV Strategy, 2021-2027, MOH

physical activity/exercise, increase in eating disorders, especially in women and young people (WHO, 2022)
UNFPA also reported direct and indirect disruptions in family planning (reduced access, limited supplies, decrease in HPV immunization, reduced availability of outreach, staff, etc. Some countries experienced significant increase in teen pregnancies, and in unsafe abortions.
In Suriname, there are no data available on the impact of COVID-19. However, narratives from service providers and community workers confirm the above identified disruption patterns in services.

### 3.3.6. Interpersonal & Intimate Partner Violence

**Violence in the home**

Surinamese children have a high degree of exposure to violence in their homes and families. Recent research shows that the vast majority of adolescents, aged 11-18, have experienced physical violence, including beatings and psychological violence (72%), emotional violence (74%), sexual violence (13%), and witnessing violence at home (28%). The extent of the sexual violence experienced by children within their own families hardly differs from the sexual violence experienced by children outside the family, namely 8.2% to 8.6%. One in four children (24%) experienced 3-4 combinations of violence at home.
Both physical and psychological violence, starting at a young age, are still widespread and part of traditional disciplinary practice by parents or caregivers. However, a majority of parents acknowledges that times are different and are in favor of use of non-violent methods, especially, 'talking to the child' (78%). Applying these new notions in practice remains a challenge. Just like reporting of sexual violence. While approximately 1 out of 5 parents is aware of cases of sexual abuse that occurred in the past year in their direct vicinity, an alarming 27% didn't take any action mainly due to 'fear of repercussions if they interfere in family matters of others'. Especially in small communities, families are reluctant to make matters public that may harm the reputation of the family. (Terborg, et.al. 2018)

**Bullying**

Interpersonal violence is also experienced in schools. In 2016, the Global Student Health Survey (GSHS) found that 27% of adolescents aged 13-17 experienced peer bullying[26]. Similarly, the 2017 national survey on violence against children found that 27% of adolescents aged 11-18 experienced bullying, 9% of whom experienced long-term bullying. Girls (31%) were more likely than boys (23%) to experience bullying. Bullying is especially common in primary schools, where 35% have suffered from bullying in the past year[27].

[26] Global school-based student health survey (GSHS, 2017)
[27] Terborg, J. Violence against Children in Suriname, Students Survey, 2018

**Intimate personal violence (IPV)**

Nationwide, the prevalence of violence against women/girls is high. Results of a national study presented in 2020 show that of the women with a partner, 32% has experienced physical violence, 13% sexual violence, 35% emotional violence and 16% has experienced economic violence during their lifetime[28]. The results confirm the worldwide pattern of an early start of IPV among women. Women who were married or lived with a partner at a young age had more experience of intimate partner violence than women who started a cohabitation relationship after the age of 19. Women whose first sexual experience occurred before the age of 15 were also more likely to report experience of forced sex than women in an older age category. Intimate partner violence is also strongly linked to HIV and AIDS. Studies show that women who experience violence also have an increased risk of HIV infection[29]. Girls experience a higher prevalence of sexual violence and psychological violence than boys, and this has been linked to suicidal ideation among victims of violence[30].

[28] Joseph, J. et.al. (2019). National Women's Health Survey for Suriname, IDB, 2019
[29] ibid
[30] PAHO, UNICEF (2022). No Time to Lose. Health Challenges for Adolescents in Latin America and the Caribbean. Washington, D.C.: Pan American Health Organization and United Nations Children's Fund; 2022. License: CC BY-NC-SA 3.0 IGO. https://doi. org/10.37774/9789275126219.

## 3.4. HEALTH RISKS

### 3.4.1. Risks related to NCD

NCD in adults can often be traced back to risky behaviors during childhood and adolescence, including physical inactivity, unhealthy diet, tobacco use and harmful use of alcohol.
Recent WHO data show that overweight adolescents are twice as likely to develop cardiovascular disease and have seven times greater risk of developing atherosclerosis in adulthood. Also risk for cancer, stroke, hypertension, and type2 diabetes is increased. Adolescents who start to drink before they are 15 years old are five times more likely to abuse alcohol as adults than those who start drinking at age 19 or older. (WHO, 2021)

In Suriname the Global school-based student health survey (GSHS, 2017) shows the following risk behaviors in adolescents, which contribute to chronic diseases:

1. Use of carbonated soft drinks: 78% of pupils aged 13-17 use soft drinks one or more times a day, with an equal proportion of boys and girls
2. Alcohol abuse: 42% of students drank alcohol at least once during the 30 days prior to the survey: more boys (42%) than girls (39%)
3. Smoking: 15.2% of students used tobacco products during the 30 days prior to the survey: more boys (18%) than girls (13%)
4. Lack of or little physical activity: 44% of students aged 13-17 spent three or more hours a day sitting, mostly watching television, or playing computer games or talking to friends.

**Obesity**

Childhood obesity exceeds 10% in 7 of 11 CARICOM countries with data. Obesity in childhood is linked to high blood pressure, type II diabetes, and low self-esteem.
Childhood obesity in Suriname is also a source of concern because it is a risk factor for diabetes, high blood pressure and other non-communicable diseases. Among adolescents aged 13-17 years, it was estimated in 2016 that 27% was overweight and 10% was obese. Risk factors include: lack of physical activities, unhealthy diet and soda consumption.
In Suriname, 79% of students, 13-15 years, drank carbonated soft drinks one or more times per day during the past 30 days [31]

[31] Preventing childhood obesity in the Caribbean. HCC Country Obesity Fact Sheet. Healthy Caribbean Coalition, 2017

Table 4: Proportions of students overweight and obese, in age group 13-17 years, by age

| | Overweight | | Obese | |
|---|---|---|---|---|
| | Male | Female | Male | Female |
| **13-17** | 28 | 29.1 | 12.2 | 11.1 |
| **Both sexes** | 28.6 | | 11.6 | |

**Source: Global school-based student health survey (GSHS)[32], 2017**

**Tobacco consumption**

The Suriname Global School-based Student Health Survey (GSHS, 2017) shows that about one in ten adolescent students aged 13-15 smoke tobacco, with cigarettes and hookahs being the most common ways to use tobacco. Most adolescents who smoke report that they face no obstacles when buying tobacco products; 78% indicate that they have not been prevented from buying cigarettes in the past 30 days because of their age, and 42% were able to buy cigarettes as single cigarettes in the past 30 days. Surinamese youngsters are also affected by passive smoking exposure. One in three students (ages 13-15) reported being exposed to tobacco smoke at home and 43% were exposed to second-hand tobacco smoke in enclosed public spaces (WHO, 2021). In 2019, tobacco use caused an estimated 546 deaths in Suriname, 62 percent of which occurred among those under 70 years. These deaths amount to 12,700 years of life lost, which are lost productive years in which many of those individuals would have contributed to the workforce[33].

**Substance abuse**

Drug and substance abuse is associated with increased risky sexual behavior, early sexual debut, risk of teenage pregnancies and exposure to HIV and other sexually transmitted diseases, poor academic performance, relapse of class, and school dropout. The results of the Global School-based Student Health Survey (GSHS) (2017) in Suriname show:

•41% of students have consumed alcohol in the past month, especially boys and girls between 16 and 17 years old.

•5% of young people aged 13-17 years' report having used marijuana at least 1 time in their lives Marijuana, crack cocaine and 'blaka jonko' are the most commonly used illegal drugs, while alcohol is the most commonly used legal drug.

The age for the use of alcohol and drugs is decreasing. Marijuana use among young people is about 5%. About 27% don't think marijuana is harmful to their health. For all substances, the use among men was between 2 times and 20 times higher than in women. For cocaine, crack and ecstasy, use in the general population was measured at less than 1%. (National Drugs Report, 2018).

[32] GSHS, tool by the WHO, to support countries with measuring and assessing the behavioral and protective risks in 10 key areas among adolescents (13 to 17).

[33] WHO, 2021. Tobacco control in Suriname: status and context WHO FCTC Investment Case for Suriname

### 3.4.2. Sexual risk-taking behavior

#### Early sexual initiation

In Suriname, a national survey on violence against children, aged 11-18 years, reported that at the age of 15, one out of four students, is already sexually active. This share rises to 70% among 18-year-olds. More boys than girls stated to ever had sex: Almost twice as many boys as girls, respectively 29.2% against 15% report that they previously had sex. The proportion of children who reported sexual initiation was the highest in the interior (31%), followed by children living in urban areas (22%) and the rural coastal plain (19%), (Terborg, 2018). The latest MICS shows that 8% of teenage girls (15-19 years) reported having had sex with a partner aged 10 years or older in the past year. Young women who are in sexual relationships with older men may be at higher risk of HIV infection. In girls, early unprotected sexual intercourse also increases the risk of HPV and the risk of cervical cancer (UNAIDS, Prevention Gap report, 2016)[34]. Sex before the age of 15 among young women is highest for those living domestically, girls with only a basic education or belonging to poor households (MICS 2018).

#### Lack of knowledge on HIV and low HIV testing

**Table 5: Young people (ages 15-24) by HIV/AIDS indicators and sex (%), 2018**

| | Male | Female |
|---|---|---|
| Have comprehensive knowledge of HIV/AIDS | 32.3 | 34.5 |
| Know all three means of HIV transmission from mother to child | 40.9 | 38.3 |
| Know a place to get tested for HIV | 72.9 | 62.9 |
| Have been tested for HIV in the last 12 months and know the results | 31.7 | 12.5 |
| Have had sex in the last 12 months | 45.7 | 52.9 |

**Source: Multiple Indicator Cluster Survey (MICS), 2019**

MICS 2018 shows that among young people 15-24 years the level of knowledge on HIV is still low, with only about one third of youngsters equipped with knowledge on HIV transmission ways. It is also obvious that, despite relatively high frequency of sexual contact, HIV testing is very low: only 1 in 8 youngsters has been tested for HIV in the last 12 months.

#### Unprotected sex

The national survey on violence against children, aged 11-18 years, found that 8% did not use protection /condom at first time sex. This percentage was the highest among children in the interior, namely 11%[35]. The most experience with pregnancy was also reported by students in the interior: 4.7%, followed by students living in urban areas (2.8%) and the lowest in the rural coastal areas (1.1%). Data from the MICS survey (2018) indicate that men have nearly 2 times more condom use than women and that condom use among women with non-regular partners has decreased from 56% in 2010 to 33% in 2018. Young women buy the condom much less (19%)

[34] https://www.unaids.org/sites/default/files/media_asset/2016-prevention-gap-report_en.pdf
[35] Terborg, J. (2018). Students Survey. Violence against children in Suriname. DNA, IGSR, UNICEF

than young men (82%), almost never have the condom with them (84%) compared to young men (36%) and have also used the condom less often than young men at the last time they had sex. Condom use among young male adults (15-24 years) who have had sex with a non-regular partner in the past 12 months is higher (66%) compared to their female peers (33%). Access to condoms remains problematic for young girls because of stigma and taboo.

**Immunization**

Since 2013, HPV vaccination for girls 9-13 years is provided through school vaccination programs of RHS and Medical Mission. HPV coverage girls 9-13 yrs., 2013: 67%, 2015:77%, 2016: 38% .[36]

### 3.4.3. Unsafe abortions

Since 2014, the annual number of births has fallen from 10,407 in 2014 to 9,809 in 2018. Births of adolescent mothers also show a decrease from 1456 in 2014 to 1337 in 2018. Decrease in the birth rate cannot be automatically attributed to a decrease in pregnancies, which is unlikely because it was previously observed that the use of contraceptives decreased. A possible more plausible explanation is that there is an increase in (unsafe) abortions.

About 8% of young women aged 15-24 years have experience with an abortion (MICS 2010). There is evidence that young women in particular terminate unintended pregnancies with an unsafe abortion. Reports from the Emergency Department (ED) show that about 500 young women sign up every year because of complications due to an unsafe abortion. Approximately 80% of these women are in the age group 15-34 years, of which 38% are aged 15-24 years and 0.5% in the age category 10-14 years (F. Poese, 2017)

Almost any abortion-related death and disability can be prevented through sex education, use of effective contraception, providing safe, legally induced abortion, and timely care for complications.

## 3.5. SOCIAL DETERMINANTS

The social determinants of health are the structural conditions young people have to deal with in their day-to-day life. Key social determinants influencing development and opportunities for adolescents include gender, family structure, norms and values, financial position of their household as well as (legal) access to health (health insurance coverage) educational- and employment opportunities, stigma due to living with disabilities or chronic illnesses, ethnicity, sexual orientation or gender identity. These factors can function, often simultaneously, either as barriers or as important components for enabling and protecting adolescents' health.

[36] MOH/National Immunization Program 2019.

### 3.5.1. 3.5.1. Health insurance

While the majority of adolescent health issues are preventable or treatable, adolescents face multiple barriers in accessing health care and information. Recent evaluations of adolescents' health show that global progress has been slow, and that adolescents remain a neglected age group in the organization of access to universal health coverage[37]. In most countries, health systems and services, and health insurance coverage packages are mainly designed for either young children or adults[38]. In Suriname, data of MICS 2018, shows that there are significant gaps in coverage with health insurance, including coverage of adolescents, in particular between 16 years and 19 years. In the current national health insurance scheme, only children 0-16 years are eligible for free access through basic social care. It appeared from the MICS data that health insurance coverage is lowest among the younger age group of women: 15-19 (80%), 20-24 (69%), 25-29 (71%), and in the lowest income groups: poorest (65%) and second poorest (69%). About 31% of children aged 5-17 had health insurance through an employer[39].
Major barriers to accessing free health insurance are often a lack of information about obtaining a basic health insurance card and/or the appropriate social support networks for guidance through the required procedure. Also, major services in the area of adolescent health are not or insufficiently included in the existing basic health care packages. While mental health is acknowledged as a priority health problem, the government health insurer (SZF) set consultation fee for psychologists at a maximum of 142 Srd (6US$ rate 23.6) with a limited number of consultations[40], while also private health insurers are very limited in coverage of mental health costs in their packages. Although contraceptives are in the basic healthcare package, the level of accessibility differs by type of health insurance coverage. Clients with a social security 'BAZO' (Basic care) card are restricted in their access as they can only obtain one cycle per consult, while procedures are complicated and time consuming. More permanent birth control methods, such as sterilization and certain brands of IUD have to be paid out of pocket.[41]

### 3.5.2. Poverty

Socio-economic inequalities are still reflected in widespread poverty, concentrated mainly in the interior, and also in low-income urban and rural communities. In 2020, the unemployment rate was 7.5%, with even higher unemployment rates among women (12%) and young people (16%), compared to men (5%). Suriname has a government-mandated minimum wage, which per June 2022 has been raised to Srd.20, - per hour[42]. However, large groups of persons in private and public sector still earn below this minimum wage, even civil servants. Recently, as of December

[37] Pan American Health Organization. The Health of Adolescent and Youth in the Americas. Implementation of the Regional Strategy and Plan of Action on Adolescent and Youth Health 2010-2018. Washington, D.C.: PAHO; 2018. file:///C:/Users/HP/Downloads/9789275119938_eng%20(1).pdf
[38] Plant International UK. (2019). *Adolescent Health: The Missing Population in Universal Health Coverage. May 2019.* London.
[39] SITAN, UNicef
[40] The 'Surinaamse Vereniging van Psychologen en Orthopedagogen' (SVPO) suggested a minimum fee of US$25 per consult, which has not been approved.
[41] Reproductive Health Commodity Security Assessment for the Caribbean, 2020, UNFPA
[42] https://cds.gov.sr/de-boodschap/beschikking-minimum-uurloon

31, 2021, the government calculated the poverty line at Srd. 3,365 per adult person43, indicating that the vast majority of households, including young people, live in poverty.
Impact of poverty is gender specific and increases the vulnerability of young people and reinforces the negative influences of problems such as drop-outs, teenage pregnancies, child marriages, interpersonal violence and unsafe sex. Although hard data is not available it is most likely that the COVID-19 pandemic has been particularly devastating for low-income people, with large groups of individuals losing their jobs and income. The existing safety nets appear to function inadequately and are insufficient to ensure equal access to services for all children, including children from poor households. Apart from, triggering risky behavior, poverty related stigma also feeds low self-esteem and social isolation.
The latest MICS survey confirmed once again the strong correlation between poverty and other variables. The highest percentage of women with the highest adolescent birth rates, married before the age of 18 years, experiences with IPV, low use of contraceptives, including condoms are found in the low-income groups.

### 3.5.3. Family structures

Family can be protective but also harming. The recent national study on violence against children show that prevalence of violence is higher in families where one or more members are using alcohol and/or drugs. It also appears that children living without parents, with other family or in residential institutions report more experience with violence. Census data show that approximately one third of workers in the formal labor market are women, and about a third of households are (single) headed by a woman (Census 2012). The majority of households has no or inadequate access to social protection services, including financial aid, family counseling and guidance. Limited but consistent evidence indicates that lower family socioeconomic status and lower level of parental education are associated with higher rates of adolescents births/teenage pregnancy. Adolescents living in families in an instable position (for example due to drug/alcohol abuse, domestic violence) have higher risks of suicide, substance abuse, depression, and other mental problems.

### 3.5.4. Gender and sexual norms

**Gender Norms**
A major barrier to achieving gender equality is the continued dominance of traditional gender norms, which forms the basis of the unequal appreciation and participation of men and women in private and public life. Most of the messages around gender that boys and girls receive during their childhood reinforced stereotypical hierarchical based norms such as men being protectors, risk-takers and main providers of their families, while women are expected to be submissive, and

[43] Starnieuws: https://m.starnieuws.com/index.php/welcome/index/nieuwsitem/71345

sole caretakers of household, care of children and other family members. Against this normative climate, male adolescents are more likely to engage in higher-risk behaviors, such as drinking and driving, speeding, fighting, having multiple sexual partners, resulting in higher risk of injuries, HIV/STI infection, drugs/substance abuse. On the other hand, female adolescents are more likely to be vulnerable to gender-based violence, including sexual, physical, and emotional violence. In addition, prevailing gender norms are often used to condone violence against women and forced sex, putting them at increased risk of sexual and other types of violence.
The impact of gender stereotypical upbringing is strongly reflected if health data are differentiated by gender, and impact on behavior is revealed, f.e. lower use of condoms, higher prevalence of IPV among females, while on the other hand a higher percentage of young men as victims of street- and gang violence, traffic accidents, suicide.

**Sexual taboos**

Unequal gender norms are also reflected in sexual norms, guiding sexual behavior, in particular a double sexual moral. Men are often encouraged to engage in sexual activity at a young age. Women, on the other hand, are more reserved because they were expected to be sexually reserved and more likely to be guided by male partners. A recent study on gender – and sexual norms in 10 vocational schools among students and teachers confirmed the persistence of norms that feed gender and sexual inequality. A significant share of students and teachers still hold on to norms that facilitate gender- and sexual stereotyping, for example stigmatized perceptions that '*Pregnant girls should be removed from schools, because they are a bad example', 'HIV+ youth should not be allowed in schools', 'LGBT youth should keep their sexual orientation to themselves and not 'bother' others with it', 'Girls should not have condoms with them, as it is not proper behavior for girls', 'If a girl is sexually abused, it is often her own fault'*.
In general, talking openly about sexuality is still problematic, especially in families, while it continues to be challenging to incorporate sexuality education in school, even if teachers are trained.[44]

Taboo on sharing/reporting on sexual violence is also a hard challenge to tackle. The recent IDB study showed that 35% of women interviewed perceive violence between a husband and wife as a private matter. While the vast majority of women (96%) agreed that women should have at least some authority in their homes and that even though women do not deserve violent treatment from their partners, a significant part (16%) still agreed that her partner's controlling behavior was justified. There was a significant relationship between having a partner who exhibited multiple controlling behaviors and the prevalence of lifetime physical and/or sexual IPV (12%).

[44] Terborg, J., Benschop, R. en Ch. Akoi (2019). Samenwerken aan een veilige school. Begin & eind studie 'initiatief voor Gender Responsief Onderwijs' (iGROW). Een pilotproject voor verbetering van seksuele en reproductieve gezondheid en terugdringen van gender gerelateerd geweld op 10 LBO-scholen. IGSR, 2019

### 3.5.5. Education

There is enough evidence to state that educational level is a basic factor influencing adolescents' health. Major health problems and health risk behavior can be correlated with lower educational levels. For example, higher education is associated with reduced teenage pregnancy/motherhood, older age at marriage and reduction of child mortality. In countries that already have high secondary education participation, schools facilitate to more explicitly promote health has the potential for leverage above and beyond the health benefits of educational participation alone [45].

The primary enrollment rate in Suriname is high, almost 100%, and there is also a high secondary school enrollment rate. However, the share of students who completed these educational levels is significantly lower. In 2019, 94% of children of primary school age were enrolled in kindergartens; the enrollment rate has not varied significantly by gender over the past two decades. However, the proportion of students who have completed these levels of education is significantly lower (see table below).

**Table 6: Complete education rate by sex, MICS 2018**

| | Male | Female | Tot |
|---|---|---|---|
| **Completed primary education** | **80%** | **90%** | **85%** |
| **Completed lower secondary education** | **41%** | **58%** | **49%** |
| **Completed higher secondary education** | **19%** | **28%** | **23%** |

Completion rates fall sharply at higher levels of education. While the completion rate in primary and lower secondary education is 85% and 49% respectively, the completion rate in upper secondary education drops to 23%. This gradual decline in the proportion of students completing high school can be attributed to high recurrence rates and dropout rates at this level. It was found that at all levels of education, completion rates are the lowest among children living in interior rural areas and those belonging to the poorest households. Across all three levels, female completion rates are higher than that of males. In lower secondary, the gap between female and male completion is the most prominent in favor of females, (17% compared to 10% in primary and 9% in upper secondary)[46]. MICS data also show that lower educational levels are related to higher teen pregnancies, lower HIV knowledge and higher prevalence of interpersonal violence.[47]

[45] Our future: a Lancet commission on adolescent health and wellbeing, WHO, 2016 www.thelancet.com Vol 387 June 11, 2016

[46] UNICEF, factsheets Education

[47] MICS, 2018

### 3.5.6. Child labor

About 6% of children aged 5-17 in Suriname are engaged in child labor. This share is higher in boys (7.5%) than in girls (4.5%) and higher in the 15-17 age group (7.7%). The proportion of children in employment is significantly higher in the interior (18%) than in urban areas (4%) and in rural coastal areas (5%). Children who do not go to school (14%) are slightly more than twice as likely to be involved in child labor as children who go to school (6%). Children from the poorest households (11%) are 5 times more likely to be involved in child labor compared to children from rich households (2.2%). In absolute terms, it is estimated that around 1,700 children are involved in dangerous work (22.5% male and 4.9% female). The share of children age 15-17 involved in hazardous working conditions is higher as compared to other age groups. The three dominant ethnic groups among working children are the Hindustanis, the Maroons and the mixed ethnic category. In urban areas one-half of the children engaged in child labor other than hazardous work are working in 'agriculture, forestry, hunting, fishery' compared to 40.4 per cent of such children in rural area. (MICS 6, 2018).

### 3.5.7. Technological skills and access

The MICS 2018 survey shows that less than half of young people (40%), aged 15-24, have at least one information and communication technology (ICT) skill. ICT skills are much more present in urban areas (46%), than in rural areas (31%) and least inland (10%). No significant differences were found between boys and girls. Young people in the richest households (73%) were almost six times more likely to have ICT skills than children in the poorest households (13%). Young people with a higher education (87%) and upper secondary education (63%) were most likely to have at least one ICT skill. The inequality in access to ICT skills and distance learning came to light during COVID-19. Children, especially in low-income households, in remote areas and inland had less access to adaptive measures to start classes via television, computers/laptops and other electronic devices, as well as to the Internet and mass media channels, such as educational TV These children have had their learning interrupted due to the spread of COVID-19 and they were not benefiting from other school-based support mechanisms.

### 3.5.8. Fertility

| CARICOM countries | Adolescent birthrate, 2019[1] |
|---|---|
| Guyana | 73 |
| Belize | 68 |
| Suriname | 61 |
| Barbados | 31 |
| Bahamas | 29 |
| Dominica | 28 |
| Grenada | 28 |
| Trinidad and Tobago | 29 |

Between 2010 and 2015 the Caribbean's adolescent fertility rate was 30% higher than the global average (UNFPA, 2019). One of the main focus response areas on the regional level[48]. According to regional estimates, for 2019, five countries have reached the target of an adolescents' rate of 40 or less: The Bahamas (29), Barbados (31), Dominica (28), Grenada (28) and Trinidad & Tobago (29). Unfortunately, Suriname is still in the highest regional ranks with an adolescent birth rate of 61 in 2019, together with Guyana (73) and Belize (68)[49]. The persistence of high rates among adolescents in these particular countries can be ascribed to the high share of populations living in tribal societies, mainly indigenous and Maroons, were decline in fertility rates has been much slower, due to multiple factors, including persistence of traditional gender norms and high value of fertility, low access to basic services in interior areas, including family planning education, awareness and counseling. In the Caribbean, Suriname is among the top three of countries with the highest adolescent birth rates: Guyana (73), Belize (68) and Suriname (61).[50]

**Adolescent Birth Rate[51]**

Just like in the rest of the Caribbean, national fertility figures in Suriname show a persistent decline since the 1970's. However, internal disparities are large if social/ethnic groups are compared. The Maroon population has the highest fertility in the adolescent and adult ages, with 4.47 children per woman (Census 2012). Recent MICS data (2018) reaffirms the much higher fertility rate among women with low level of education and in lower wealth categories.

Fertility is a major factor influencing girl adolescents' development and opportunities in life. It is well known that unintended adolescent pregnancies are one of the major barriers in the educational and occupational careers of girls. Early pregnancy interferes with educational opportunities, particularly in the case of young mothers, who may have to leave school and tend not to return. In Suriname, in 2018 the % of births from adolescent mothers was 14.5 %. In absolute numbers in 2018: 1.532 live births from adolescents (ABS, 2019).

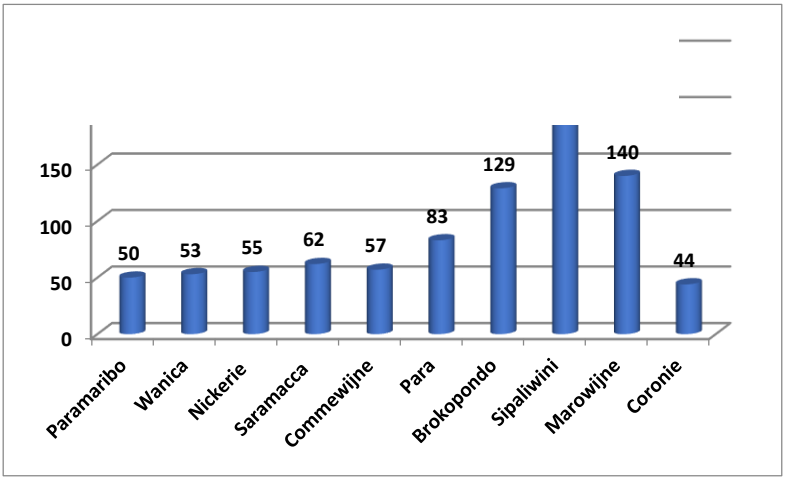
[48] Global Strategy, Regional Framework on Adolescent pregnancy

[49] Desk Review on 'Sexual Reproductive Health and Gender-Based Violence' in the Caribbean region, J.Terborg, CFPA

[50] PAHO, Gender and Health indicators, 2019

[51] The adolescent fertility rate: the number of births per 1,000 women ages 15 to 19.

**Figure 4: Adolescent birth rate by district, MICS 2018**




In this year, approximately 12% (140 to 160 young girls) of these births were from adolescent mothers below 16 years. In Suriname in the main interior districts of Sipaliwini, Marowijne and Brokopondo, adolescent rates are much higher, respectively 210, 140 and 129 per 1,000 girls aged 15-19 respectively (MICS 2018). Of great concern is the fact that Suriname has the third highest Maternal Mortality Ratio (MMR) out of 12 CARICOM member states and is ranked fifth out of 14 countries in relation to the Infant Mortality rate (IMR) and the Under-5 Mortality Rate (UMR). (Population policy Suriname, 2022). A study on maternal mortality over the period 2010-2014 shows that 17% of maternal mortality can be attributed to adolescent mothers (Kodan et.al. 2019).

**Demand for contraceptives**

Family planning with modern methods is essential to prevent unintended and closely spaced pregnancies, leads to less unsafe abortions and less adverse maternal and perinatal outcomes. Data of the last three MICS studies show that among all reproductive sub age groups there is a significant downward trend in the use of modern contraceptives. Overall, the Contraceptive Prevalence Rate (CPR) went down from 46% in 2006 to 39% in 2018.
Striking is that this decline is mainly caused by sharp drops in the CPR among the younger age groups, with the highest decline among adolescents. While in 2006, contraceptive use among adolescents (15-19 years) was almost 39%, in 2018 only 23% of adolescents reported the use of contraceptives. The same trend can be observed in the age group 20-24 years, where CPR dropped from 40% in 2006 to 35% in 2018, while the age group 25-29 shows a decline from 46% (2006) to 40% in 2018. The % of adolescents who are not able to meet the need for contraception is 75% among the unmarried and 60% among the married and cohabitating relationships. The use of contraceptives is lowest among Maroons (28%), Indigenous (31%) and Creoles (36%). Lowest wealth quintile reported lowest use: 29% and richest reported highest use: 44%.

Family planning services are offered in first line care through basic clinics of the Regional Health Services (RHS), the Medical Mission (MM) and general practitioners. A substantial part of family planning services (including IUD, injectables and child wish counseling), is provided by 'Stichting Lobi Health Center (SLHC)', member association of the International Planned Parenthood federation (IPPF). For almost 55 years, St. Lobi offers comprehensive and integrated packages of SRHR services with use of different communication channels, including social media, with specific

focus on youth. Noteworthy is that this NGO works from a human rights, gender equality and adolescent's friendly approach.

Nationwide, the most common modern contraceptives commodities distributed are condoms, oral contraceptives and in a lesser extent Depovera and IUD. The clinics of the RHS in the rural areas and the MM in the interior only provide oral contraceptives and condoms. Currently the use of contraceptive methods is relatively low and has decreased in the last decade. A recent conducted regional study on reproductive health commodities (UNFPA, 2020) showed the following results for Suriname: The availability of a wide range of modern contraceptives, and free and informed choice continue to be a challenge, especially due to the lack of long-acting reversible contraceptives (LARC) and Emergency contraception. Emergency contraception, which is a critical commodity for the prevention of unplanned pregnancies and clinical Management of Rape, is not easy to obtain, the offer of female condoms is very limited, stock outs of commodities, including condoms (also related to impact of COVID-19). If these barriers are not tackled, reproductive health outcomes will remain poor or get worsened. [52]

### 3.5.9. Child marriages

Child marriage violates many internationally recognized rights, in particular the right for women and men to freely choose a spouse with their free and full consent, which is defined as a capacity to understand the meaning and responsibility of marriage, to have access to full information about her future spouse, knowledge about the institution of marriage, and her right to exercise a choice about whether to marry, who to marry, and when to marry[53].

There is sufficient evidence for the negative consequences of child marriages, in particular for girls. Lesser educational and career opportunities, health problems due to early pregnancy and increase risk of maternal and newborn mortality, increased vulnerability for HIV/STI and intimate partner violence are all related to child marriage.[54]

Data from the Multi-Indicator Cluster Survey (MICS) in Suriname (2018) show that the proportion of women aged 20-24 years who were married or in a union before age of 15 was 9% and before the age of 18 was 36%. Early union or early cohabitation is however more common than formal legal child marriage. Women in the rural interior and rural coastal areas, and the poorest households were more likely to marry before 15 years of age and before 18 years of age. Child marriage is higher for girls than boys. Early marriage of girls is more common in rural areas (57%) and among poorer families. Lower educational levels are strongly associated with early marriage, especially before the age of 15. Primary educational level is 48.7% vs higher educational level of 25.5%. Girls who marry before the age of 18 are also more likely to experience domestic violence and less likely to remain in school. As a result, they have worse economic and health outcomes than their unmarried peers, which outcomes are eventually passed down to their own children.

[52] UNFPA, Reproductive Health Commodity Security Assessment for the Caribbean, December 2020
[53] CEDAW, CRC
[54] Helen, C. (2020). The Lancet Commission. *A future for the world's children? A WHO–UNICEF–Lancet Comission*.

Adolescent pregnancy has a substantial impact on a girl's life, not only with respect to her own social and mental wellbeing but also in terms of opportunities to contribute to national development. In a recent regional study on the 'Assessment of the Economic Impact of Adolescent Pregnancy and Early Motherhood, by applying the MILENA in Suriname'[55], it was estimated that for 2016/2017 the issue of 'Adolescent Pregnancy and Early Marriage' had an estimated opportunity loss (due to loss of income, employment and economic activity) of SRD 1.500, 000,000, (in USD: 56,585,175) equal to 1.6% of GDP. These results demonstrate that adolescent pregnancy not only has negative consequences for girls and their families, but also for the country as a whole.

### 3.5.10. Youth gambling addiction

Despite lack of hard data, there are strong indications that gambling addiction in Suriname is increasing, also among young people under the age of 18[56]. Gambling opportunities in Suriname have been widespread for decennia, with large numbers of casino's that are easily accessible. In the past ten years, access has widened tremendously with the introduction of online gaming and sport betting shops close to all communities all over the country. Especially for people who are struggling to meet basic needs, gambling is often perceived as a very attractive mean for fast income generation. One of the few surveys that have been conducted on gambling among youth in the Caribbean is the "Jamaica Child and Adolescent Gambling Survey (2007). This study revealed that one out of every five adolescents had a gambling problem or are at risk of developing the problem, with young males at higher risk. Also in Suriname, among key persons and service organizations working with youth, especially in low-income communities, there is increased concern about the number of young people engaged in gambling. Since 11 August 2016, the Hazard Games Act of 1962, has been amended and adopted in the national parliament (DNA), however, still not entered into force. It is well researched that addictive gambling negatively affect one's family and social relations, and in particular is damaging for mental health[57]. Apart from enforcement of legal measurements to prohibit adolescents access to gambling, national response should also include educational and awareness raising on the risks of gambling, especially for parents and other caregivers, teachers to provide guidance to children to prevent engaging in gambling.

[55] UNFPA (2022). Socioeconomic Impact of Adolescent Pregnancy and Early Motherhood. An application of the MILENA methodology in Suriname

[56] unitednews.sr/gokken-in-suriname-loopt-uit-de-hand/

[57] https://cds.gov.sr/de-boodschap/parlementarier-dijksteel-pleit-voor-aanpak-gokverslaving-als-maatschappelijk-vraagstuk/

### 3.5.11. Stigmatization and discrimination of vulnerable young people

Recent studies show that populations in a marginalized position, including gay, bisexual, lesbian and transgender youth, people living with HIV (PLHIV), sex workers and undocumented migrants, still experience multiple forms of stigma and discrimination, manifest in domestic violence, public violence by the police and by people on the street, mainly because of the deep-seated social, cultural and legal discrimination.[58] LGBT youth are often confronted with bullying and other forms of mental violence in schools. At time of finalization of this strategy, society was shocked by a video, that went viral, about the brutal assault of a 15-year-old student by other students because of his assumed homosexual behavior[59].
The latest MICS study confirms persistence of discriminatory attitudes towards people with HIV. Notable is that these negative attitudes are highest among young people aged 15-24 (74%) (MICS, 2018).
While no recent data are available, previous study on sex workers in small goldmining camps revealed that about one third of the sex workers started sex work at age 15-19 years. Narratives of key persons of the 'Meldpunten Kindermishandeling' (Centers for reporting on Child Abuse) and informal reports indicate growing number of young female sex workers in low-income neighborhoods. These girls usually provide these services in a disguised manner, with the high risk that when problems occur, they tend not to seek help out of fear for repercussions. Stigmatization is also still reflected in the opinions and attitudes of (health) service providers, which create a large barrier in access to services. Even if services are available, people who experienced stigma earlier tend to stay away.

**Adolescents with disabilities**
The number of children, 0-18 years, with at least 1 disability is estimated at 6,677, of which 3,154 (47%) are boys and 3,523 (53%) are girls. The proportion of children aged 0-9 years is 34%, 10-14 years is 32% and 15-19 years is 34%. (8th Census, 2012). The proportion of children, 0-18 years, with a visual, auditory and/or movement disorder is 2.2%, 0.7% and 0.4% respectively. In 2013 there were 7 homes for children with disabilities, with a total of 159 children, namely 82 boys and 77 girls (Terborg, 2013). Children aged 5-17 years living in rural interior (20%) were more likely to have functional impairments, compared to children living in rural coastal areas (15%) and urban areas (12%). Moreover, children in the poorest household (18%) are more likely to have functional limitations than children in the richest households (8%). With the ratification of the Convention on the Rights of Persons with Disabilities in 2017, the Surinamese government has committed itself to the implementation of this international legislation.

[58] LGBT Platform Suriname, Heartland Alliance for Human Needs & Human Rights, & Akahatá Equipo de Trabajo en Sexualidades y Género. (2014). *Human Rights Situation for LGBTI Persons and Sexual Rights in the Republic of Suriname (List of Issues submitted to the Working Group on the Suriname report Human Rights Committee, 113th Session)*.
Bakboord (2017) Lespeki mi
[59]https://dwtonline.com/ik-kan-niet-naar-het-filmpje-kijken-mi-bere-e-koti-mi/

### 3.5.12. Conservation and protection of the environment

The Surinamese population is increasingly exposed to the negative effects of climate change and pollution of the environment. Increase in plastic waste, loss of biodiversity, mercury pollution and deforestation (due to mining, among other things), major floods and related famine, and outbreaks of diseases are current issues that directly affect young people. Especially for the groups of young people and their families who are already in a vulnerable position, for example because they are poor or live in areas with fewer facilities, negative consequences are even greater. By 2017, 90 % of the population in rural areas had access to basic drinking water from an improved water source, while 89 % of households had at least basic sanitation services. In urban areas, 98% of the population has access to basic drinking water (MICS, 2018). Climate change poses a direct threat to children's ability to survive and develop. For example, proofed mercury pollution due to small goldmining directly affects air quality, food quality (in particular fish) increasing risks of neurological problems, asthma, and other NCDs in children, floods can threaten children's lives by endangering water and sanitation, leading to disease, as well as preventing access to education. In crisis situations, there is also a greater risk of young people being exposed to violence and abuse. However, young people are also increasingly engaged in protection of our environment and already contribute to the protection and maintenance of a clean and healthy environment. That is why it is important that also adolescents are actively involved in the decisions and measures regarding climate change.

# 4. NATIONAL RESPONSES ON ADOLESCENT HEALTH

## 4.1. International acknowledged interventions to improve Adolescent Health

Numerous publications, including reviews of interventions show positive health outcomes for adolescents as a result of multi-sectoral interventions on multiple levels ranging from the health sector to non-health sectors such as education, social protection, environment, employment, facilitated by a supportive legal and policy environment.[60] [61]To increase knowledge on what really works in improving adolescents' health, several academic reviews have been conducted on interventions with the greatest impact on adolescent health. [62] Based on existing global evidence, the WHO (2017) promotes interventions and measurements that have shown to be effective in enhancing adolescent health, also in comparable low- and middle-income countries to Suriname[63]. These interventions can be used as an 'essential package for adolescent health', and are presented in detail in annex 1 of this report. Apart from this essential package, there are also some recommendations with respect to what is important to consider in countries' national responses. With respect to structural, long-term actions, evidence show that in the key areas of interventions special attention should be paid to positive youth development[64]:

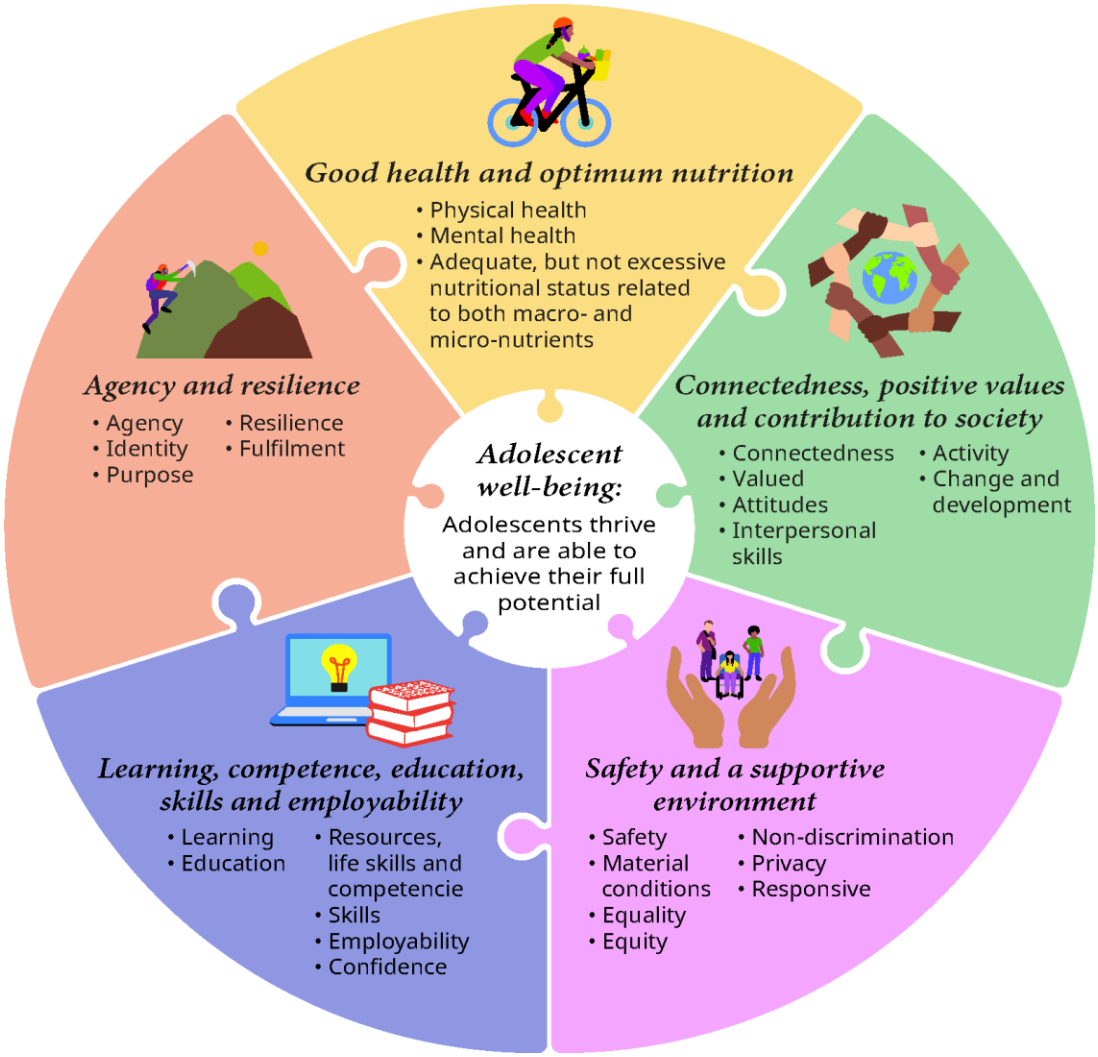
**Positive Youth Development**

In contrast to approaches that emphasize risks and problems in response to improve adolescents' health, a 'positive youth development' (PYD) approach focuses on building knowledge, skills, attitudes (self-love, self-confidence) building linkages to sources of support and in this manner contribute to strengthen resilience, and healthy relationships, and supporting youth to be active partners in development efforts on family, community, school level. WHO (2020) recognizes five interconnected domains to achieve well-being for adolescents within each of these domains. Adolescent well-being is defined as a state where adolescents have the support, confidence, and resources to thrive in contexts of secure and healthy relationships, realizing their full potential and rights[65]. The five domains, with health as one of the domains, are underpinned by gender, equity, and rights considerations. The definition of well-being has the emphasis on the quality of life, implying adequate material conditions (e.g., income, food, and housing) and social attributes (education, health, political voice, social networks, and connections). In the figure below it is emphasized that an individual's well-being is heavily influenced by their relationships and the

[60] Global Strategy for Women's, Children's and Adolescents' Health, 2015
[61] PAHO, UNICEF (2022). No Time to Lose. Health Challenges for Adolescents in Latin America and the Caribbean. Washington, D.C.: Pan American Health Organization and United Nations Children's Fund; 2022. License: CC BY-NC-SA 3.0 IGO. https://doi. org/10.37774/9789275126219.
[62] Adolescent Health, The Missing Population in Universal Health Coverage, 2019
[63] AAHA guidance
[64] Our future: a Lancet commission on adolescent health and wellbeing, WHO, 2016 www.thelancet.com Vol 387 June 11, 2016
[65] ibid

dynamic interplay of personal, societal, and environmental structures and processes. This approach recognizes the need for youth to have necessary skills, resources and support to succeed, make changes for themselves, and contribute to positive well-being for themselves and others and to be surrounded by structures and people that positively reinforce them. [66]

**Figure 5: Five interconnected domains for adolescent well-being**




**Source: PMNCH, WHO, 2020[67]**

[66] United States Agency for International Development, 2017 (USAID). A Systematic Review of Positive Youth Development Programs in Low- and Middle-Income Countries

[67] Ross, D. et.al. Adolescent Well-Being: A Definition and Conceptual Framework. Journal of Adolescent Health 67 (2020) 472e476

Other key components of national response, based on a positive youth development approach are:

1. **Improve parent–adolescent communication** is also linked to adolescent self-esteem and self-worth, better social functioning and fewer mental health problems. For LGBT youth, supportive parent– adolescent relationships are protective against risky behaviors. Given that families and parents remain the most important figures in the lives of most adolescents
2. **Guaranteeing and supporting access to at least free, quality secondary education** for all adolescents presents the single best investment for health and wellbeing. Strong associations were found between the average years of education for 15–24-year-old women and girls and adolescent birth rates, all-cause and injury mortality among 15–19-year-old boys and girls, and maternal mortality amongst 15–24-year-olds. Higher average levels of education were associated with lower total adolescent mortality in both sexes, injury mortality (boys only), and maternal mortality, after adjustment for national wealth. The single factor most consistently associated with lower child mortality and lower fertility rates is female schooling.[68]
3. **Health insurance coverage** [69]requires accessible packages of care matched to local need and acceptable to adolescents and young adults. Especially adolescents in a vulnerable position with limited access to financial resources should be covered by an essential package of care that is part of basic health insurance. Reducing or eliminating payments for adolescents for core prevention services, such as health education and counselling has the potential to enhance access. In the determination of an essential package, the different living circumstances of adolescents and their exposure to risks should be taken into account.
4. **Adolescent-friendly health services provided by competent providers**. Important to note here is that availability of services alone is not sufficient. Much more important is the quality of the services, meaning that services should respond to adolescents' specific needs and circumstances. Practice show that adolescents have relatively little experience with use of health care. If they need care, it is often related to sensitive issues such as use of contraceptives, HIV/STI testing, overweight, bullying, intimate partner violence, depression. Attitude of providers can restrict access by judging adolescents in a way that causes shame, fear, f.e. because of concern that parents will be informed about their problems. Therefore, friendly services that recognize adolescents' desires for privacy and confidentiality will be more attractive and require specific competencies and attitudes of the provider, in particular being non-judgmental and non-discriminatory. To address the excess morbidity and mortality affecting young males, special efforts to attract/engage boys are important to initiate.
5. **School-based educational programming**: School health programs that address key priorities in an integrated way are a high priority for intersectoral action on adolescent health. Every school can become a health-promoting setting. School based prevention programs have shown protective effects against smoking tobacco, drugs and cannabis use, alcohol use and unsafe sex, and even mental health issues. School based suicide prevention programs increase short-term

[68] https://blogs.worldbank.org/health/female-education-and-childbearing-closer-look-data

[69] Adolescent Health. The Missing Population in Universal Health Coverage. May 2019. This paper was funded through a charitable grant made by the AstraZeneca Young Health Program (YHP) to Plan International UK.

knowledge of suicide and knowledge of suicide prevention, and help in dealing with mental health issues. Comprehensive sexuality education and providing access to modern contraception are likely to have major benefits in reducing school dropout in settings where early pregnancy is common.

6. **Engage and empower adolescents: Establishing systems for the training, mentoring, and participation of youth health advocates** has the potential to transform traditional models of health-care delivery to create adolescent-responsive health systems. In Trinidad and in Suriname, there are documented best practices with the training and engagement of peer care navigators, who supported youth in compliance to the use of contraceptives, and HIV medication.[70]
7. **Strengthening of a supportive legal and political environment:** Laws are key in protecting adolescents from harm, f.e. preventing against violence, sexual abuse, child marriage, alcohol and substance abuse, child labor. Legislation is also important to guarantee access to services, f.e. addressing explicitly the age at which minors can access contraceptives, or do an HIV test, or an abortion without parental consent. Laws will often be ineffective without actions to change community and professional attitudes. Pivotal as well is political commitment and funding. In this regard joining of forces to strengthen advocacy for prioritizing adolescents' health and well-being on the political agenda[71]
8. **Digital media and broadband technologies** offer outstanding new possibilities for engagement and service delivery[72], especially because these means guarantee more privacy and confidentiality. to support a healthy lifestyle with communication of social norms, accessible and respectful services, and targeted education. Will help to create an appropriate environment through social marketing of key messages. In this regard positive outcomes have been experienced with provision of (self) care through digital means, f.e. digital education and counselling of young women who are considering an abortion.
9. **The most powerful actions for adolescent health and wellbeing are intersectoral, multilevel, and multi-component**[73] : The most effective strategies use a combination of high-quality health-worker training, adolescent-friendly facility improvements, and broad information dissemination via the community, schools, collecting data for quality improvement, promotion of adolescents' literacy about their own health, and engaging adolescents around practice policies and mass media to drive demand. These demands coordinated multi-sectoral action across a range of service delivery programs are designed to address multiple risk factors and vulnerabilities at one time. These programs should be supported by an enabling environment, including legislation, health insurance, to ensure that adolescents have unhindered access to services, with an emphasis on the most vulnerable and marginalized adolescents and their families to ensure equity.[74]

[70] Linkages project, USAID
[71] International Association for Adolescent Health (IAAH)
[72] Our future: a Lancet commission on adolescent health and wellbeing, WHO, 2016
www.thelancet.com Vol 387 June 11, 2016
[73] Rehana A. Salam et.al. Adolescent Health Interventions: Conclusions, Evidence Gaps, and Research Priorities
Journal of Adolescent Health 59 (2016) S88eS92. http://dx.doi.org/10.1016/j.jadohealth.2016.05.006
[74] Adolescent Health. The Missing Population in Universal Health Coverage. May 2019

## 4.2. Legislative environment

In the past three decennia, Suriname has ratified all major international conventions that are also key in the protection of rights of adolescents, including:

1. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1993),
2. The Convention on the Rights of the Child (CRC, 1993), including two Optional Protocols to the Convention, on 1. the involvement of children in armed conflict; 2.the sale of children, child prostitution and child pornography,
3. The Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (2002).
4. The ILO Act 138 on Labor of Children and Youth, adopted in 2018. This Act aims to eradicate child labor and to harmonize the Surinamese labor law concerning child labor with ILO standards.
5. The Convention on the Rights of people with a disability, 2017

On national level, several legislative reforms took place to harmonize with international agreements and obligations.

1. The law on Domestic Violence was approved (2009)
2. The Moral Law was revised (2009), with revision of articles related to sexual violence of children
3. The Law on Tobacco Control (2013), containing provisions governing smoke-free places; tobacco advertising, promotion, and sponsorship (TAPS); and tobacco packaging and labeling.
4. The law on basic health insurance (2014) with free healthcare of children from 0-16 years,
5. Law on residential care (2014)
6. The law on child labor and youth was approved (2018), establishing a minimum age for labor of 15 years.
7. The Inter-Ministerial Trafficking in Persons Working Group was renewed and a National Plan of Action for the Prevention and Response to Trafficking in Persons under the pillars of “Prevention, Protection, Prosecution, Partnership and Policy was launched.
8. Legislation regarding traffic safety: Random breath testing check points, speed limits, wearing of a seat belt, child seats for infants and booster seats for older children, mandating helmet use, wearing a motorcycle helmet correctly are all highly cost-effective measurements that have proven to reduce traffic related fatalities significantly and legalized in Suriname (WHO, 2018).

In the past years, several important laws have been drafted, however still in the process of finalization and submission to the state bodies for approval. These laws are: 1. Draft revised marriage legislation, 2. Draft legislation on Foster Care, 3. Draft legislation on the Child Ombuds bureau, 4. Draft legislation on Protection of children in the media. Currently three laws are being evaluated, which are: 1. Evaluation law on basic health insurance, 2. Evaluation and Revision of the Law on Residential care, 3. Evaluation of the law on ‘Domestic Violence’.

At present, a working group with experts on human rights are preparing required legislation to enable the establishment and well-functioning of a National Human Rights Institute in accordance with the Paris Principles. Since 11 August 2016, the Hazard Games Act of 1962, has been amended and adopted in the DNA, however still not entered into force.


**Legal minimum ages**

Despite the progress that has been achieved in strengthening the legislative environment, there are still gaps and restrictions in legislation, resulting in insufficient protection of adolescents' rights, including access to health information and services. This restrictive environment is concurring with a regional context characterized by early sexual debuts, high rates of adolescent pregnancies, high rates of IPV in adolescents' sexual relations and high share of young people in annual new HIV/STI infections. Legal minimum ages are important instruments for advancing the rights of adolescents and should be primarily aimed at protection from rights violations. [75]

In Suriname the age of sexual consent is 16 years, meaning that sexual activity with a child under that minimum age is considered child sexual abuse and constitutes a criminal offence, even if this child consented to the sexual act. In sharp contradiction with this piece of legislation, the age of marriage for girls is still 15 years, (for boys, marriage age is higher: 17yrs) which is lower than the legal age of sexual consent. This implies that the current marriage law "legalizes" sexual activity with an underage person, which is a violation of girl's rights. This discrepancy is also reflected in the fact that annually young girls, younger than 16 years are getting pregnant and delivering

[75] Legal minimum ages and the realization of adolescents' rights A review of the situation in Latin America and the Caribbean, UNICEF, 2016 https://www.comprehensivesexualityeducation.org/wp-content/uploads/20160406_UNICEF_Edades_Minima_Eng1_.pdf

babies in hospitals. In all these cases, we can assume that the health providers waive the suspicion of the partner/perpetrator if he is the intimate partner.[76]

While by law, the age of sexual consent is set at 16 years, in practice the majority of parents and (health) service providers are reluctant to acknowledge and accept that adolescents are sexually active and need access to sexual and reproductive health services. This is contradictory messaging, as on one hand children are allowed to be sexually active at age 16, and even to get married, and on the other hand they are not allowed to autonomous access SRH services [77].
In Suriname, there is no specific age in legislation related to use of SRH services, and no requirement of explicit parental consent. However, this uncertainty about legal standards creates space for own interpretations by service providers, influenced by perceived restrictive norms on sexual behavior for young people. Without clear formal guidance it is most likely that healthcare providers' attitude will be based on personal preferences with the risk that adolescents, especially those younger than 18 years, are denied services if these services are not in line with providers' perceptions/moral norms.
This lack of autonomy, that is use of services without parental permission, is one of the main barriers in accessing sexual and reproductive health services, also in many other Caribbean countries.[78] For example, in many Caribbean countries, young people require parental or guardian consent to HIV testing (UNAIDS, Prevention Gap report, 2016)[79].
Fear of potential legal liability also contributes to this reluctance to provide sexual related services to youngsters.[80] Region wide there is a growing call to governments to align to the General Comment No. 15 (2013) on adolescent health and development, in which the CRC Committee has emphasized that "States parties should ensure that [adolescents] have access to appropriate information, regardless of their marital status and whether their parents or guardian's consent."

[76] Legal minimum ages and the realization of adolescents' rights A review of the situation in Latin America and the Caribbean, UNICEF, 2016 https://www.comprehensivesexualityeducation.org/wp-content/uploads/20160406_UNICEF_Edades_Minima_Eng1_.pdf
[77] Cenac, V., Maitland. R., Newton S. 2020. (DRAFT) UNFPA SRH Legislative Review 2020 in 22 Countries of the English and Dutch Speaking Caribbean. United Nations Population Fund, UNFPA Sub-Regional Office for the Caribbean, Kingston, Jamaica
[78] Some countries developed policies which allowed minors to access HIV testing without parental consent, including Guyana which allows access at any age[78], and Trinidad and Tobago which afforded this right to adolescents from 14 years old. The only Caribbean countries where there are legislated provisions specifying the age at which adolescents may have autonomous access to SRH services are Antigua and Barbuda, St. Vincent and the Grenadines and St. Lucia. In all these countries this age is set at 16 years. Some of the countries, such as Grenada and St. Vincent and Grenadines require medical prescriptions for emergency contraception. (Terborg, 2022.)
[79] https://www.unaids.org/sites/default/files/media_asset/2016-prevention-gap-report_en.pdf
[80] https://www.unicef.org/ECAO_Current_State_of_Legislation_in_Eastern_Caribbean.pdf, pg. 132

## 4.3. Policy environment

Under the leadership of the ministry of Social Affairs and Housing, in particular the 'Bureau for Child Rights', a national action plan for children has been drafted, 2019-2021, with 'Improvement of Health' as one of the seven priority areas[81]. In the context of policies and strategies, there are a number of national strategies and action plans that can be specifically related to improving adolescents' health. In general, the ministry of Health acknowledges in several health-related plans that the most cost-effective health care services are those at the primary healthcare level, with emphasis on prevention and reduction to the exposure to risk factors through a multi sectoral approach. (HiAP, 2017) (NSPHW, 2019).

### 1. National Strategic Plan for Health and Wellbeing (NSPHW), 2019-2028

The Ministry of Health developed the 'National Strategic Plan for Health and Wellbeing (NSPHW)', 2019-2028, which is aimed at full implementation of a model of care that emphasizes Primary Health Care (PHC), is people-centered, ensures the right to access of health for all, is equitable and where the people of Suriname receive comprehensive, integrated and quality healthcare services, adequate health infrastructure, delivered by (health) service providers that are competent and sufficient in number. Cross cutting in this approach is the principle of 'Universal Health Coverage (UHC), which implies structural (re)building of the health system, addressing the social determinants of health and reduction of structural health inequities, building an enabling legislative and regulatory framework as well as sufficient and sustainable funding. (UN 2019).

### 2. National Policy on Sexual and Reproductive Health and Rights, 2020-2030

In alignment with the NSPHW, in 2020, the 'National Policy on Sexual and Reproductive Health and Rights (SRHR), '2020-2030', was launched, aimed at 'Prevention and reduction of SRHR related morbidity and mortality through universal access to sexual and reproductive health and rights. This policy emphasizes the human rights and primary healthcare based 'AAAQ framework', with four essential elements of the right to sexual and reproductive health, which are availability, accessibility, acceptability and quality[82]. Against this SRHR policy, the Maternal and Newborn Health Strategy, 2020-2025, and Operational Plan 2021-2023, and Annual Plan 2021-2022 were developed and are being implemented. One of the key strategic objectives (2.5) of this MNH plan is to 'Implement standards for age-appropriate adolescent health care and services and mechanisms for ongoing monitoring of the quality and coverage of access to integrated and preventive health care for adolescents'

### 3. 'Health in All Policies' (HiAP) that was launched in 2017 (HiAP, 2017).

In 2017 the Council of Ministers approved and embraced the HiAP model of care. This model emphasizes the importance of universal health coverage beyond the health sector and the need for 'whole-of-government' and 'whole-of-society' approaches. 'Addressing the social determinants of health inequity and the key health risk factors starts at the family and community

[81] Nationaal Aktie Plan Kinderen, 2019-2021
[82] National Policy on SRHR, MOH, 2020

level' is a statement in the HiAP, which clearly reflects the key message of: "*Local solutions to local health challenges*". Although the process of applying a multi-sectoral approach was enforced with the launch of HiAP (2017), there is still lack of adequate structures and mechanisms for inter-sectoral collaboration and limited awareness among key decision makers in the government, private sector and NGO's, regarding the 'health in all policies' approach.
To structure the national (multi sectoral) response, HiAP Focal points have been established in key ministries to ensure multi sectoral collaboration. However, these FP have not been active. It is only recently that this HiAP approach is being reactivated.

### 4. Road Safety Action Plan

The National Road Safety Committee, installed in 2016 by the Ministry of Justice and Police, finalized a strategic plan and a plan of action in 2018 to strengthen policy development and coordination of road safety in Suriname[83]. Educating children in school about road safety is one of the instruments proposed in the action plan to reduce the number of children involved in traffic accidents. To work towards a more systemic approach, the 'Traffic Institute' has been established. For the past ten years, annually a traffic month is declared as an instrument to raise awareness on road safety, with active participation of civil society, especially the Corps of Traffic Volunteers.

[83] Road Safety Strategisch Plan Suriname, 2018-2021. Ministerie van Volksgezondheid

## 4.4. Response Health sector to Adolescent Health

### Departments in the Ministry of Health relevant for Adolescent Health

### The department 'Family and Community Health' (FCH)

At the Ministry of Health, the department 'Family and Community Health' (FCH), part of the Bureau of Public Health, is responsible for coordinating all health areas related to family health, including child- and adolescent health. Unfortunately, it is only recently (in 2022) that a staff person has been appointed to specifically coordinate the response regarding adolescent health. Therefore, it will also be the first time that a national strategy and action plan on adolescent health is being developed. The FCH is also responsible for the coordination and integrated implementation of the Sexual and Reproductive Health and Rights Policy, 2020-2030, and the Maternal and Newborn Health Strategy, 2020-2025, and Operational Plan 2021-2023, and Annual Plan 2021-2022. In all these documents specific attention is given to improving adolescents' health, in particular related to increasing access to sexual and reproductive health services, with emphasis on modern contraceptives, comprehensive sexuality education, and adequate coverage by health insurance during pregnancy. At the Bureau of Public Health, there are other departments responsible for important components of adolescent health, such as the 'Immunization program', which is in charge of vaccination starting from newborn age and continues during adolescence. To reduce the risk of getting cervical cancer, the BOG started in 2017 with the Human Papillomavirus (HPV) vaccination program. Girls, age 9 to 13, in approximately 200 primary schools nationwide are vaccinated with the HPV vaccine as a preventive measure to reduce the risk of cervical cancer. The department of Epidemiology, responsible for collecting health data is still suffering from lack of staff and funding, which also explains existing large gaps in disaggregated data on mortality. Latest data on adolescents' mortality is from 2009.

**Non-Communicable Diseases**

There is a focal point NCD who is in charge of coordination of the national NCD plan, first developed for the period 2015-2020 and currently being updated. Main focus areas of the plan are on public awareness of the NCD burden, healthy lifestyle promotion, health systems strengthening, strengthening of the legal framework, strengthening of surveillance and operational research and monitoring and evaluation. Notable is that in the conceptualization of NCD's, mental health and injuries are not included. These two issues, also key to adolescent health are covered in two other plans, namely the Suriname Mental Health Plan, and the National Road Safety Plan**.**

The existing NCD plan includes interventions which are key to adolescent health, in particular those aimed at: 1. Reduction of risk factors related to tobacco and alcohol use, 2. Promotion of the availability, accessibility and consumption of healthy, tasty foods and 3. Promotion of physical activity to support healthy lifestyle and reduce risk factors. However, youth/adolescents are not mentioned as a specific target group, while no specific interventions targeting adolescents are included in the action plan. Most of the implemented actions are concentrated around tobacco control, including legal prohibition to sell tobacco to youth and the use of tobacco in schools and surroundings. However, tobacco continues to harm the health and economy of Surinamese citizens, as over 80,000 Surinamese continue to smoke. A recent study recommends additional measurements, including tax-increasing measures, awareness programs about illegal cigarettes. The country should also conduct its own study on the extent of the illicit trade in tobacco products, and stricter enforcement of illegal sale of e-cigarettes that are prohibited in Suriname. [84]

With respect to prevention of childhood overweight and obesity, actions in Suriname have an occasional character, f.e. public exercising on health highlight days, healthy food fairs, public walks, safe spaces for people to exercise. To encourage a more structural response, the WHO developed the 'Childhood Obesity Prevention Scorecard' (COPS) with 15 indicators to measure a country's response to childhood overweight and obesity. In the Caribbean regional snapshot on the status of the COPS, it appeared that in the list of 20 Caribbean territories, Suriname is the only country that has not implemented any of the 15 proposed interventions/policies, including the following 10 items[85] :

- National policy, strategic plan or action plan on obesity
- Nutrition policy or guidelines for all schools
- Regulation banning the marketing of unhealthy foods to children
- Regulation banning trans fats (legislative limit on trans-fat)
- Taxes on Sugary Drinks
- Taxes on unhealthy foods
- Subsidies on local fruits and vegetables
- Mandatory physical education in all government schools
- National program(s) contributing to childhood obesity prevention (COP) efforts

[84] WHO, 2021. Tobacco control in Suriname: status and context WHO FCTC Investment Case for Suriname
[85] Preventing childhood obesity in the Caribbean. HCC Country Obesity Fact Sheet. Healthy Caribbean Coalition, 2017

- Regulation banning or restricting the sale and marketing of SSBs and or all EDNP foods in and around all schools and ensuring the provision of free drinking water

**Focal Point Mental Health**

In 2014 a focal point for mental health was installed at the Ministry of Health, and a national mental health plan 2015-2020 was developed, including a working plan 2015-2017. Currently this plan is being updated. Existing strategies focus on revision of legislation, increasing access to mental health services, in particular through integration of mental health services in primary healthcare, and widen access, also through expansion of mental health coverage in the basic health insurance package. As part of the implementation of this plan, the MOH also developed the 'National Suicide Prevention and Intervention plan, 2016-2020. One of the five priority areas is empowerment of vulnerable groups, with emphasis on actions aimed at children and adolescents, including: development and implementation of programs to support parents, school- and community-based programs to educate and guide children aimed at prevention of violence and strengthening of self-confidence, coping, resilience.

In the past years in multiple health facilities, first and second line, health workers were trained in early detection of suicidality. In primary healthcare, the Medical Mission is the only first line responder that has protocols available for early diagnosis and referral for mental health. Private GPs and those working for the RHS have no protocols for mental illnesses. Some years ago, the RHS offered the service of "Spiritual Guides", mainly counselors for psycho-social first responders. However, this project was discontinued due to lack of funds. Anno 2022, access to mental health is still hindered by many barriers, including self-stigma in seeking help for mental problems[86].

Access to mental health care and support has been slightly improved taking into account that more hospitals have inhouse psychiatric or psychological polyclinical care, while more social workers are available for counseling of patients. At the Emergency room, all suicide attempts are referred to specialized psychiatric care. However, it appeared that the majority of patients is lost in follow-up. Consultations with the psychiatrist and psychologists are still limited covered by health insurance, while most services are concentrated in Paramaribo and aimed at adults.

Collaboration between government departments responsible for youth mental health, f.e. the 'Psychiatrisch Centrum Suriname (PCS), 'Medisch Opvoedkundig Bureau'(MOB) and 'Pedologisch Instituut' (PI) is lacking, while there is also no or little partnering with Surinaamse Vereniging van Pyschologen en Orthopedagogen (SVPO) or other relevant stakeholders in the non-government sector. Overall, it can be stated that the Surinamese government has no special program specifically aimed at adolescent mental health. Multiple service providers reported the severe lack of psycho-social support for children and adolescents that are at risk or victims of family violence/interpersonal violence. To fill these gaps some private initiatives have been undertaken to establish foundations/NGO's that are specifically focused on support to parents/families with children with behavioral problems, such as for parents of children with autism, and for parents of children with ADHD. Consultation sessions with youth and service providers, and small online studies affirm the great need for: 'Education and awareness raising activities on mental health'

[86] National Suicide Prevention and Intervention plan, 2016-2020

to be structurally provided through school-based, community-based programs targeting adults as well as youth aimed at strengthening of skills in dealing with (negative) emotions, and building resilience. Also, expansion of access to mentoring, counseling, guidance, short term and long-term therapy services for adolescents that are covered by basic health insurance or for affordable rates, and regular mental screening as part of school health screening.

**Youth Suicide Action Plan 2022-2024**

Ministry of Labour, Employment and Youth. The overall goal of the action plan is: to reduce suicidal thoughts and actions among young people and to increase mental health awareness." The priority areas are as follows: [87]

1. Offering low-threshold and youth-friendly assistance to young people with suicidal behaviour.
2. Raise awareness about young people's mental health.
3. Increasing young people's resilience to suicide
4. Restricting access and control of the means used to commit suicide.


[87] Youth Suicide Action Plan 2022-2024, Ministry of Labour, Employment and Youth, 2022

**National Traffic Institute**

Suriname has also committed itself to achieving the goals of the Decade for Road Safety and the SDGs. In 2016, the Minister of Justice and Police installed a Road Safety Commission to promote policy development and coordinate road safety in Suriname. They developed a national road safety plan, including action plan for the period 2018-2021. As a follow-up of this plan the Road Safety Institute has been established, to serve as a central point for optimizing road safety and coordinating activities related to road safety in general. This institute functions under the Ministry of Justice and Police, and works closely with other relevant stakeholders. The focus is on response, utilizing the internationally recognized five E's, namely: engineering, education, enforcement, engagement and evaluation. Apart from permanent traffic education through different channels, one of the specific actions targeting adolescents is 'Supervised driving for young persons from 17 years of age the so-called 2toDrive'.

**The National Anti-Drug Council / Executive Office of the NAR**

The most recent national Plan on Drugs is for the period 2019-2023. For monitoring of drug demand, a regular survey is being conducted to estimate the prevalence of drug consumption in high schools in Suriname, with technical and financial assistance of the European Union and the OAS. The National Anti-Drug Council (NACD), together with the executing office are in charge of coordination of the implementation of the national plan. For this purpose, a 'Stakeholders network' has been established, composed of representatives of relevant ministries and NGOs. Provision of drug and alcohol prevention activities in schools, community centers and sometimes to individuals is mainly implemented by NGO's. Activities take place in all districts and are mostly organized on request and in case funding is available.

**HIV Program**

In 2022, the Ministry of Health launched the 4th national HIV Strategic Plan 2022-2028. The HIV Program and HIV Unit fall directly under the responsibility of the Director of the MoH, and are responsible for the coordination and monitoring of the national plan. In the plan, the broad category of youth is acknowledged as a vulnerable population, including available evidence showing that early sexual activity increased, sex with multiple partners continued, while use of condoms among young people also remains low.
Preventive actions aimed at this group should be intensified and should particularly aim at developing of a national condom policy, including strengthening of targeted condom distribution (including reintroduction of the female condom) and strengthening of partnerships with NGO's and private sector. With regard to psycho-social counseling and guidance of children/adolescents living with HIV, there is a big gap that has to be filled. The system of HIV care for adolescents and Orphans and Vulnerable Children (OVCs) is not well developed. A big challenge is the provision of continuous care to HIV+ adolescents who, due to their age, are removed from residential care without adequate alternative care. In general, support to children and adolescents are not covered under the peer counselor, buddy and health navigator systems. To increase access of young people to tailored health information and services, the HIV program has as one of its priorities the development of a 'Code of Conduct' to guide the provision of adolescent friendly

HIV services. Terms of Reference were developed to conduct a needs assessment for children, but the assessment has not yet been completed. The intention is to identify the needs and develop a system for supporting PLHIV who are reaching adolescence.

**Regional Health Services (RHS)**

Since 2014, the Regional Health Service Foundation has the responsibility over 287 primary schools spread over the coastal plain of Suriname. This school health program targets children in the age category 6 – 15 years in primary school, with an approximate total size of 100,000. The school program consists of two main parts: 1. Health screening, 2. Vaccination. The objectives of the school health program are to timely detect disorders that could hinder the learning process such as visual disturbances and hearing disorders, other disorders such as orthopedic abnormalities, 3. Screening for diseases (psychical and mental scan) 4. Providing health education, 5. Vaccination, in accordance with guidelines of the national Immunization program. Data is registered per pupil per school on standardized forms. In case referral is needed, the school principal is informed, as well as parents/guardians of the pupil. Results of referral are also updated on the forms. In case of signs of disorders, pupils are referred to a medical or other specialist, outcomes are being monitored by RHS. Due to COVID-19, the school program has been put on a hold and is only now being reactivated. Providing services according to protocol is challenging. Lack of transport to visit schools, lack of an adequate class room/space to conduct the screening in a private and confidential matter, severe shortage of school nurses, while also there is much lost in follow-up. It appears that in case pupils are referred there is often low response from parents, school and doctors, with the result that RHS has little information on whether the child was really helped.

Currently, with technical and financial support from UNICEF, the RHS is implementing a pilot on school health specifically focused on promotion of healthy lifestyle, with initial focus on healthy food, drinking of water and exercising. This program, will cover all primary schools in the coastal area and will be officially launched in November this year. Efforts will be made to slowly expand this health promotion pilot to other issues relevant for healthy lifestyle, and integrate these in the school curriculum. In this regard actions include training of school nurses and teachers in these topics, and development of visual materials, guidelines, other promotional materials and the purchase of computers and beamers for RHS rayons.

**Medical Mission**

The MM is responsible for the provision of primary health care services for approximately 56,000 people in mostly interior areas of Suriname, inhabited by mainly Maroons and Indigenous. Services are provided through 56 health clinics by trained health workers, of which a majority is from the local communities. The Medical Mission is the only PHC provider that developed an adolescent friendly protocol according to the "Integrated Management of Adolescent Needs" (IMAN) guidelines. [88] The Medical Mission is also exceptional with the inclusion of policy objectives that are specifically aimed at 'increasing access of adolescents to care, according to the IMAN guidelines. One of the targets set in the latest policy plan, 2019-2021, is also '90 percent of children in primary school are screened in accordance with the school health protocol'. [89].
Annually, each clinic has to organize at least 7 interventions for adolescents, based on identified needs. The emphasis is on enhancement of healthy choices among adolescents, in particular healthy eating, exercising, vaccination, safety on the road, safe sex, etc. In the planning and implementation of these activities there is close partnership with youth, youth organizations, and also good collaboration with the local school and teachers. Interventions also included education of parents and other adults in the community to ensure support to adolescents. [90]

[88] Integrated Management of Adolescent Needs – The Medical Mission, April 2014
[89] Policy Plan Medical Mission, 2019-2021
[90] Interview with Janice Robinson, head 'Health Promotion' of the Medical Mission

For several years now, 'Sexual Education' is included in the curriculum of the MM health workers, and the provision of sexual education sessions in schools upon the request of primary and secondary schools. Issues included in the sexual education sessions include HIV, teen pregnancy, condom use demonstrations. Youth can visit the MM clinic any time for free condoms – without being questioned. However, the consulted MM health worker conveyed that very few young persons come for condoms to the clinic. MM does not give special guidance to pregnant adolescents, but during the regular consultations the health worker may discuss issues specific to the situation of the pregnant girl. MM health workers are also trained and receive refreshing courses in provision of psychosocial support as a first response to mental health problems. Although health workers of MM are relatively more trained than other PHC providers, and also willing to provide sexuality education, easy talking about sexuality, especially the more sensitive sexual issues, such as sexual orientation, masturbation, sexual practices, remains a challenge. They often feel insecure, and find it difficult to win trust of youth. Considering the restricted cultural environment and existing hierarchal social relations, youth are reluctant to speak with health workers, even if safe spaces are created. An important service gap is the lack of experienced staff for guidance and counseling. There are indications that more than before young local girls are involved in sex work in the gold camps, while there is also increased drug- and alcohol use among girls.

**Youth Dental Care**

The Youth Dental Care Foundation (Stichting Jeugd Tandverzorging, JTV) was established in 1980. Its main tasks are the training of Youth Dental Caretakers and the responsibility for the service. The JTV offers dental care to the youth up to the age of 18. The specialty of the youth dental caretaker lies in dealing with children and assessing and keeping everyone's teeth clean. The services of the JTV Foundation are reasonably accessible to everyone in the coastal plain. Because bad teeth are considered a behavioral disease, it is very important that the child gets acquainted with the youth dental care provider at an early stage. An important part of the Youth Dental Care Foundation is the prevention program aimed at maintaining clean and healthy teeth. This program includes nutritional advice and instructions for oral hygiene, information programs at micro, meso and macro level, Assessing the teeth and possibly referring to the dentist.
The Foundation now has 24 clinics operational, spread over 6 districts of the country, largely housed at RHS clinics or close to a school complex. The clinics have been modernized and work is still being done to improve community service. Currently, about 1/3 of the school-age youth receives (free) treatment of the JTV Foundation. Recently, adults also have the opportunity to be treated by JTV. For several years now, in addition to the cash payment of treatments, one can also use a subscription system.

## 4.5. Response Non-Health sector to Adolescent Health

Youth care is cross cutting in all line ministries responsible for the social sector, in particular ministry of Education, ministry of Social Affairs and Housing, ministry of Regional Development and Sports, ministry of Justice and Police, ministry of Labor, Employment and Youth. While the ministry of health has the lead in the national response to improve adolescent health, contributions of other ministries are crucial, especially to contribute to a more supportive and enabling environment. Each of these ministries has more or less specific areas of focus and often also specific target groups of youth, including vulnerable youth. However, there is also much overlap, which again reiterates the importance of collaboration. In this paragraph a brief overview will be presented of the response of stakeholders, apart from the ministry of Health, in various key areas of adolescent health. For a systematic overview, these main interventions are grouped as follows:

1. **National programs for early school leavers/drop outs**
2. **School-based interventions**
3. **Community-based interventions**
4. **Family-based intervention**
5. **Mass media, social media based**

### A. National programs for economic empowerment of out of school youth in a vulnerable position

**Vocational training for out of school youth**

The ministry of Education and the ministry of Labor, Employment and Youth are leading in this area, with the provision of multiple training opportunities for 'out of school', 'unemployed' youth aimed at economic empowerment to strengthen their position in the labor market. Most of these training activities are of short term and free of charge or low costs. Apart from young people from the general population, target groups also include specific groups such as teen mothers, youth in correctional facility and detention, young people with a disability. Some of the educational activities also include strengthening of life skills, such as building confidence, conflict resolution skills. In addition to government projects, there are several NGO's also working with vulnerable youth for them to (re)enter the labor market. One such NGO is the RUMAS Foundation, who works exclusively with boys, more specifically boys between the age of 15 and 24 who dropped out from school. Through short- and long-term projects they provide survival training, job placement, job coaching, mentoring, social skills training and education and awareness on HIV, human rights and mental health. Some NGOs are primarily focused on economic empowerment of youth with a disability, through skilled training and support.

**Teen mother program**

The former Ministry of Sport and Youth had developed a special 'Teen mother Program', successfully implemented during many decennia, with regular activities and annual weekend getaways aimed at guidance, counseling and empowerment of large groups of teen mothers. Currently, the department of Youth, which is now under another ministry, ministry of Labor, Employment and Youth, is making efforts to reactivate this program. A group of about 100 teen mothers, in school and out of school, has been identified, and offered motivational sessions, and vocational training, among others 'computer training'. Collaboration with St. Lobi has been initiated to explore a more sustainable, long-term project specifically aimed at provision of sexuality education, and guidance and counseling in the prevention of unsafe sex and development of a healthy lifestyle. Also, several community organizations offering guidance and counseling to teen mothers that are still in school.

**B. School based interventions**

**Development and implementation of curricula for Basic Life Skills program**

The Ministry of Education, in particular the departments of 'Basic Life Skills' and 'Centrum Nascholing Suriname' (CENASU) are responsible for developing school curricula for primary and secondary schools and training of teachers and other relevant staff. After a long stand still, the department of Basic Life Skills is reactivated. Main activities are the development and piloting of curricula for primary and lower secondary schools and training materials on several topics based on the four Basic Life Skills themes: 1. Self and Interpersonal relationships, 2. Sexuality and sexual health (including Comprehensive Sexuality Education), 3. Appropriate Eating and fitness and 4. Managing the Environmental. These lessons will be delivered by trained teacher librarians and teachers who teach the subject "*Levensbeschouwelijke vorming*". Coaching will also be a very important aspect of the implementation of these lessons.
Notable in this regard is that a national study revealed that the vast majority of parents, 81%, is in favor of sexual education, starting in primary school (Terborg, 2018). The preference of sexual education provided by schools is partly related to the acknowledged limited capacity of many parents to talk to their children about sex in an appropriate manner.

Another project will also be implemented by the unit BLSE in collaboration with the Guidance department of the MOESC, called 'Students Against Destructive Decisions'. This project is for students by students under guidance of a guidance counselor or other teacher within the school. The purpose of this project is to help students develop coping skills, proper decision-making skills and other crucial skills they need to keep them from alcohol, drugs, mental issues, teenage pregnancies, suicide, obesity, youth crime and other problems youth have to cope with. Students from secondary education will participate in this project.

As part of a three-year project, financed by the European Union, from 2017-2019, CENASU executed a pilot project 'IGROW' among 10 lower secondary vocational schools on 'Safe schools', composed of several components, including 1. development of curricula for both students and

teachers with key topics on 'gender-based violence, sexuality' 2. A base- and end line study among students, teachers, school leaders and parents to measure the effects of the program. At end line, students showed improved communication and improved self-confidence, growing awareness to talk about sexuality and significant increase in rejection of stigmatizing and discriminatory statements, in particular with respect to sexual- and gender stereotypes. The special 'Gender Sensitive Prevention and Management of Behavioural Problems' (GPAG) curriculum that has been developed by CENASU will be structurally incorporated in the training of teachers in lower secondary education [91]. St. Lobi Health Center and 'Youth Empowerment Suriname (YES) are two major NGO's that developed CSE curricula which are used to provide sexuality education for many years now, in primary schools and secondary schools. YES, also provides coaching programs with longer duration, f.e. annual basic skills trainings and coaching in communications, leadership, building self-esteem and develop self-confidence. However, most of these interventions are small scaled, due to lack of sustainable funds. Despite several efforts to structurally integrate basis life skills and comprehensive education (according to standards of the UNESCO), and promising result, progress is slow and instable. Most SRHR interventions of both NGO's and government are very dependent on foreign donor resources, with the consequence that sustainability of initiated programs and services is often not guaranteed.

**School based psycho-social providers**

In the past 5 years, the 'Department of Guidance of the ministry of Education' has developed and is slowly establishing a school care system, starting in primary schools. A growing number of primary schools has trained school care coordinators and remedial teachers, who are among others responsible for the provision of guidance and counseling to students in need. The overall responsibility for coordination of all school care measures is in the hands of the school coordinator. Currently, the department of guidance is expanding the school care program to lower secondary schools, and also reactivating community school care teams to strengthen decentralized care for youth and their parents. In addition, also the Moravian School Foundation (EBGS) operating 56 schools for primary education and 9 schools for junior secondary education trained and installed school care coordinators.
On higher secondary and tertiary level, most schools and the university have the availability of a student deacon for students who experience (mental health) problems. This year, the university started with a fulltime 'Student psychologist'.
Exceptional is the response of 'Natuur Technisch Instituut (NATIN), where additional psychological care for students is initially covered by the school fund, and parents are offered a payment arrangement to contribute in the costs[92].

[91] See: Results of 'iGROW' (CSE pilot program in 10 Lower vocational schools) (Terborg, J., Benschop, R., Akoi, C. 2019):
[92] Interview with Juljo Cruden, d.d. 12 October 2022, psychologist partnering with NATIN in provision of consults to students

**Development of protocols to promote safe and healthy schools:**

Increasingly, schools are engaged in projects aimed at creation of a safe and healthy school environment. As part of the 'IGROW' pilot project in lower vocational schools, code of conducts and other protocols were developed for both teachers and students to improve school climate. The Moravian foundation introduced a 'bully protocol' in all its elementary schools and training of teachers and other staff members in application of the protocol. Also developing guidelines and curriculum with regard to physical education, healthy nutrition, alcohol and tobacco abuse and care for the environment.
Just recently, the Ministry of Education has publicly expressed zero-tolerance against bullying in schools, after a video of 15-year-old student, being severely abused by peers, because of his assumed sexual orientation, went viral. In response to the incident, the Ministry of Labour, Employment & Youth Affairs (AWJ) has also expressed its resolute disapproval and called to stopped bullying. It is acknowledged by these ministries that much more need to be done in terms of education, awareness and capacity strengthening to ensure safe schools.

**Provision of incidental educational sessions for schoolchildren, by external organizations (government and NGO's)** on a variety of issues regarding sexual abuse, online harassment, drugs- and alcohol abuse, prevention of injuries, including related to fire. One of the major government institutions providing educational sessions on various themes is the department 'Youth Affairs' of the 'Corps Police Suriname'. On own initiatives and/or request of schools, sessions are delivered for students and teachers on 'Violence against children, in particular sexual violence', 'Drug abuse', 'Road Safety'. The National Drugs Council works together with NGOs to provide school-based education on drug- and alcohol abuse. In recent years, the Child Helpline, of the ministry of Social Affairs, is also actively involved in provision of education on various themes that are related to 'child protection', and works mainly in primary schools.
Several NGO's and service clubs collaborate with schools to prepare and implement occasional projects aimed at education and awareness raising of students and teachers on healthy life style issues, including environmental topics. Most of these educational activities are concentrated in schools in Paramaribo, and highly dependent on donor funds. Due to the ongoing economic crisis NGO's are forced now to ask a fee (to cover transport and incentives for educators) which is a major barrier for schools, as also they lack funds.

**Restart, after 3 years, of the project 'School crossing guards':** This year, during the school holidays, 125 children from 4th and 5th grade of primary schools were trained by the department of Traffic, Police Corps.[93] The major NGO partnering with the government is the KSV (Corps Traffic volunteers). They are an active organization focusing on education and awareness raising, as well as on advocacy.

[93] https://m.starnieuws.com/index.php/welcome/index/nieuwsitem/71716

**School hygiene interventions**

Especially in areas with relatively lower access to adequate sanitation and clean drinking water, mainly the interior and remote districts, interventions are undertaken to improve sustained access to safe drinking water, sanitation and improvement of hygiene behaviors in schools. In this regard UN agencies, such as PAHO and UNICEF supported government and CSO with the implementation of several school-based projects, among others the development and piloting of the WASH tool in the Upper-Suriname River area.

**School gardens**

There are several civil society organizations promoting, developing and implementing school gardens and aquaponics systems, mainly at primary schools in Paramaribo and Wanica. Schoolchildren and teachers are actively involved in these projects that are generally aimed at promoting a healthy, safe and environmentally friendly way of growing your own food. One of the active organizations is the SUWAMA foundation. All of these projects are short term due to limited funding of foreign donors. On the side of the government, the ministry of Social Affairs is supporting residential child care institutions to grow their own garden.

### C. Community based empowerment

**Establishments of community based 'Meldpunten Kindermishandeling'**

To decentralize access to services for prevention and reduction of violence against children, the ministry of Justice and Police established 'Meldpunten Kindermishandeling' (Centers for Reporting Child abuse) in three communities with relative high prevalence of child abuse, namely Apoera, Latour and Coronie. In 2019, delivery of services at these reporting points was further strengthened with the development of operational plans, capacity building of service providers, and establishment of case management teams to ensure an integrated approach in service provision.

**Development and implementation of educational and awareness raising programs** on a wide range of issues, incl. suicide prevention, internet use, dangerous games, gender-based violence, teenage pregnancy, child labor, sexual abuse and child abuse. Numerous community organizations, including neighborhood organizations, religious organizations, service clubs, scouts, sports organizations, are working on community development with young people/adolescents as important members and as well as target groups. Especially on community level, youth advocates are closely engaged in reaching populations in a marginalized position, such as youth in underserved communities, youth with a disability, LGBT, or youth in residential care. Several service clubs and environmental NGO's are active in educating and raising awareness among young people on climate change and protection of our environment. Main activities are training community leaders in life skills, gender equality and awareness of sexual and domestic violence. Also, among Indigenous and Maroon youth, several NGO's are active in empowering, coaching, training of youth, including adolescents.

**Establishment of community sport facilities/sport fields in districts and neighborhoods.**

In the past years community sports facilities (sport fields) have been established in over thirty locations throughout the country. The ministry of Regional Development and Sports is responsible for the management and exploitation of these fields. There are plans to strengthen collaboration with the ministry of Education, to use the sport facilities to also increase sport and exercising for schoolchildren.

### D. Family based/individual interventions

**Guidance and counseling, coaching of adolescents, and their families**

Multiple ministries, in particular the ministry of Social Affairs, the Ministry of Education and the ministry of Justice and Police have departments that are specifically in charge of several components of 'Child Protection'. In the past years many of these service providers, mainly social workers, received training in key aspects of Child Protection, while several initiatives were taken to strengthen inter-ministerial collaboration. Currently, the ministry of Social Affairs is executing a few small scale projects, among others, 1. Project 'Who am I?', aimed at improving contact with foster children and biological parents. 2. Project 'Support to mental health in residential child

care': Training of residential workers in provision of psycho-social support to children in care. One of the main obstacles experienced by all departments is the severe lack of means for implementation, such as adequate transport to conduct outreach visits, motivated staff, and basic office supplies.

**Parental Support**

Against the background of prevention of violence against children, several 'parenting programs' have been developed and piloted by both government and non -government organizations. For some years now, the ministry of Social Affairs, with the support of UNICEF, is piloting a **'**Positive Parenting Program (PPP)". This program is aimed at strengthening parental skills for parents who struggle with raising their children, and also include training for community workers who are professionally engaged with children after school hours, such as social workers, sports coaches, etc. Some non-government organizations developed curricula and manuals for 'parenting programs', that are delivered on an incidental basis and on a small scale.

**Helpline/Mi Line**

The Child Helpline 123, operated by the KJT (Kinder- en Jongeren Telefoon) of the Ministry of Social Affairs and Housing' was set up in 2007 and last year upgraded to a 24-hour Helpline for children. The name of the Helpline was changed to 'Mi Lijn', (My Line), to expand access to adults in need, especially female victims of violence. Apart from provision of counseling, advise and referral through the helpline, KJT also links this instrument to mass media education and awareness activities to enhance reporting of violence, support to non-violent parenting, empowering of youth and promotion of child rights, including participation in discussions and decision-making.

**E. Mass media/Social media interventions**

Both government and civil society organizations, often with support of UN agencies, have developed varied mass media educational and awareness raising campaigns, TV and radio productions, aimed at promotion, education, raising awareness on some key issues impacting on adolescent health but also promotion of positive youth development in general. Targeting populations are varied and include children and youth but also often parents and other caretakers. Notable are the mass media campaigns of the Foundation Child Help Line (KJT), that conducted campaigns on a regular basis, such as 'Be a Hero and Report' campaign (report violence); 'Click it 2 Win it' campaign (right to free expression and participation). More recent campaigns were focused on the prevention of corporal punishment in the home, while there are current preparations for campaigns on prevention of 'Bullying'. KJT also developed several media productions (Kidstalk and Kidstalk-Teen) to allow children and youth to experience their right to free expression and to give shape to the principle of participation contained in the CRC.

In addition to these mass media campaigns through TV, radio and internet (social media channels) also use is made of billboards, posters, folders and flyers. Despite increase in mass media productions little is known about the effects of these type of interventions.

### F. Research and data collection

The most reliable and available source with updated information on children's health are the MICS reports. Occasionally, if funds are available, nationwide studies are conducted, f.e. the national study on violence against children (2017). Main sources producing administrative, surveillance data are mainly for government institutions, such as the Bureau of Public Health, the Academic Hospital, the general statistical bureau. Presently, some studies are ongoing on adolescents' mental health, suicide. The ministry of Labor, Employment and Youth is also finalizing a national inventory of psycho-social service providers working in child/youth protection.

## 4.6. Gaps and Challenges

The previous overview of national responses relevant to improvement of adolescent health indicates that apart from the health sector, also other non-health and non-state actors are actively involved in the development and implementation of interventions on multiple levels and in multiple priority areas, including nutrition, mental health, sexual and reproductive health, traffic safety and interpersonal violence. Overall, it can be stated that in the national response there have been achievements and progress in areas that are all key to adolescent and youth health (capacity building of service providers, school-, family and community-based interventions, data collection), with a wide variety of stakeholders varying from community organizations, NGO's, faith-based organizations, service clubs, to government organizations and UN agencies, and other developmental partners. However, adolescents and young people still face persistent barriers in key areas and experience major obstacles and challenges, often of a structural character. Tackling social determinants such as poverty, low education completion rates, unemployment, gaps in health insurance coverage and inadequate social protection of the most vulnerable groups are issues that need substantial strategic investments that are incorporated in a national development strategy.
Based on the situation analysis and current response, main gaps identified, with a more or less structural character that can be dealt with on a short-middle term period, are:

1. **Lack of a coordinated, multi-sectoral and integrated approach to work towards a structural improvement of the main determinants of adolescent health.**
Currently, interventions on both government and non-government sides are fragmented and poorly coordinated and monitored. A major barrier, of a structural kind, is the weak institutional capacity of many health and social services at both government and non-government organizations. This is manifested in poor management, chronic shortage of staff and other basic resources such as office supplies, transportation for outreach, stock outs of commodities (f.e.

contraceptives, condoms) and other activities. Another obstacle is the frequent disruption or discontinuity of ongoing projects or structures due to change in government. Established structures aimed at improved coordination and integration of response are currently on hold, due to 'changes in policy insights', f.e. the 'Ik Ben Netwerk'. Many 'Pilot projects', are successfully implemented, however roll-outs are stagnated because donor funding stopped and national government funds are not or not sufficiently available to ensure continuation.

2. **Lack of sustainable and decentralized adolescent responsive health services that are in accordance with AAAQ standards.**
Overall, there is a severe lack of services specifically for adolescents, in particular adolescents that are already in a vulnerable position. Apart from the RHS, the Medical Mission and St.Lobi that offer health services on a large scale, that are adjusted to specific needs of youth, there are hardly other providers targeting adolescents with regular health services. Continuum of care is not adequate due to lack of a referral system composed of service providers that can guarantee consistency of services based on guidelines, structures and mechanism to enable effective referral and counter referral providers. Adolescent health care brings additional challenges, since adolescents may not have access to adequate health insurance and often lack the ability to cover out-of-pocket health expenses.
With respect to school-based and community-based interventions, there are projects, however quite limited in terms of content, scale and duration. Overall, there is also not yet national policy to promote health in schools, and no structural collaboration between schools and service providers. Although in all health-related plans, interventions on community level are included, most of these community activities are initiated and led by civil society organizations, and highly dependent on donor funds. The vast majority of these project is of short duration.

3. **Lack of strategic information to monitor maternal and newborn health status and inequities and to inform the development of transformative approaches to health interventions**. Lack of collection of standardized data on all levels for evidence based and context bound input for development of policies and programs, and systematic monitoring of interventions to facilitate accountability. Lack of capacity regarding epidemiology. For many years no public reports have been produced, meaning that there is no systematic dissemination of data for policy purposes.

4. **Lack of meaningful engagement and participation of young people in efforts to improve their own health and development remain limited and incidental, rather than structural.** There are several organizations, composed of youth and/or led by youth, also working on youth health related issues, that demonstrated sufficient potential and capacities to contribute to improvement of adolescents' health in creative and innovative ways. However, most key ministries, including the ministry of Health lack structures, mechanisms and staff to structurally engage these young leaders/advocates in the preparation and implementation of health programs.

# 5.STRATEGIC FRAMEWORK

Taking into consideration the current health status of adolescents, identified responses and challenges, based on desk reviews and various types of direct and indirect consultations with key stakeholders, in this chapter the strategic framework with vision, mission, goals and key strategic areas are presented. The strategic directions for the period 2023-2030, are aligned with the relevant global and regional strategies, in particular the SDG's, the Regional Strategy for Women's, Children's and Adolescents' Health, regional reports on evaluation of the implementation of action plans on adolescents' health and their recommendations [94]. On national level the strategic areas, and the translation in the more detailed Action plan, 2023-2025, are closely related to the existing developmental framework and national plans, relevant to adolescents' health.

## 5.1. Vision, Mission, Goal

### VISION

By 2030, preventable adolescent mortality and morbidity has substantially been reduced and achievements are sustained through a coordinated and multi sectoral national response

### MISSION

Ensure that all adolescents realize their right to enjoy the highest attainable standard of physical, mental and sexual/reproductive health and well-being, in particular those adolescents that are in a vulnerable position.

### GOAL

To significantly reduce preventable adolescent and youth morbidity and mortality, and the negative effects of risk factors and social determinants

[94] PAHO (2018). The Health of Adolescent and Youth in the Americas. Implementation of the Regional Strategy and Plan of Action on Adolescent and Youth Health 2010-2018. Washington, D.C.: PAHO; 2018.

## 5.2. Principles and guidelines:

The national strategy on adolescent health is guided by the following principles and guidelines:

**Integrate 'Positive adolescent development in all interventions: Regardless of type of intervention, policies, services or programs,** depart from a positive approach, with the best interest of the adolescent in mind, that is focused on prevention and health promotion and supporting, empowering, strengthening basic skills and attitudes of both boys and girls.

**Application of a life course approach:** Life experiences in adolescent hood are interconnected with early childhood development. There should be a continuum of care in which the age group 10-14 years is adequately prepared and protected to make the transition to the older, more mature group of 15-19 years.

**A gender and rights-based approach:** Against the agreed obligations and commitments of Suriname to realize the rights as agreed in key international conventions such as CRC and CEDAW, this strategy and its action plan will contribute to changing social norms and structures that perpetuate gender and health inequities, and increased access of girls and boys to health information, services, and commodities, including those related to SRHR.

**Addressing inequities in adolescent and youth health:** It is important to have the availability of disaggregated data to assess health status of all, and ensure that barriers encountered by vulnerable and marginalized adolescents are identified and targeting of interventions are developed and implemented so that greater equity can be achieved.

**Multi- and Inter-sectoral collaboration:** The major causes of mortality and of health challenges among adolescents and youth require influencing underlying determinants outside of the health sector. Strong political commitment facilitating multi-sectoral collaboration and broad adolescent engagement and community support for social and behavioral change is crucial to ensure funding and effective implementation of planned actions. Developing inter-sectoral and multidisciplinary partnerships will be essential among government ministries, the private sector, NGOs, community-based organizations, activists, parents, and young people themselves.

**Research and the use of new technology:**
Policies and programs should be evidence-based, updated and aligned to the actual needs and life circumstances of diverse populations of adolescents. To reach all adolescents, in particular those in a vulnerable position and those 'hard to reach', efforts should be made to use alternative communication channels, interactive media and social media, that also enable provision of confidential and private services.

## 5.3. Strategic Areas and Strategic Objectives

The National Adolescent Health Strategy 2023-2030 has identified five strategic areas of interventions, that span from the development of an enabling legal and policy environment, institutional and capacity strengthening in the health sector to reducing the impact of social determinants of health inequality and inequity, to empowerment and engagement of adolescents, parents/families, schools and communities and to provision of services that are responding to adolescents needs in all their diversities, and especially reaching those who are in a marginalized position.

**FIVE STRATEGIC AREAS:**

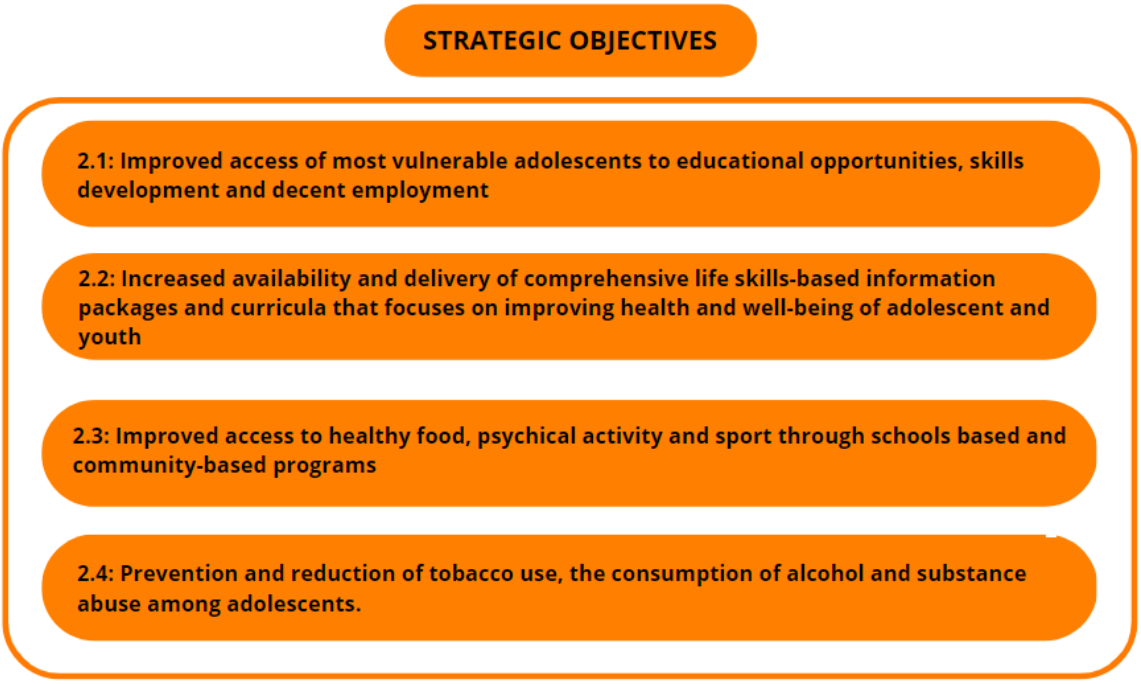
1. **Strengthening of an enabling environment: Legislation, Policy, National coordination and multisectoral partnerships**
2. **Strengthening of adolescent health promotion and community participation**
3. **Improvement of Sexual and Reproductive Health, HIV/STI, especially at Primary Health Care**
4. **Strengthening Strategic information for monitoring**
5. **Advocacy and Social mobilization**

### 5.3.1. Strengthening of an enabling environment: Legislation, Policy, Coordination and Partnerships

In policy and legislation, practice shows adolescence can easily be ignored due to their specific age group. In general, the focus is more on either children or adults. Improvement of adolescent health requires an appropriate policy and legal environment, that protects adolescents against child marriage, traffic accidents, violence, sexual abuse, but also recognizes their right to information, and services that respect their right to privacy and confidentiality, and also reduce their exposure to dangerous and unhealthy substances (tobacco, alcohol, unhealthy sugar, fatty and salt rich food). A multi-sectoral approach will require an effective management and coordination structure and mechanisms to respond in an adequate and integrated manner to the identified needs and demands of a diverse population, in particular those in a vulnerable position. For implementation of sustainable programs, appropriate human resources should be in place, with competencies, skills and attitudes that are in accordance with quality of adolescents' care standards. Access to care also implies eliminating persistent financial barriers and guaranteed access to basic health insurance.

### 5.3.2. Strengthening of adolescent health promotion and community participation

In consultations with both youth and adult/service providers/policy makers it is widely acknowledged that, in order to realize the health and wellbeing of adolescents, education in the broadest term is key. Educational- and awareness raising programs are key elements of positive adolescent health development, based on positive values and norms, that can be delivered through school-based, family-based, community-based and individually-based programs. In accordance with the 'Positive Adolescent Health Development' frame of reference, education and skills building aims to increase adolescents' resilience and protective factors, foster connectedness, health relationships, and seeks to empower them to participate in a positive way in their own health, the health of their families, and the health of their communities[95].[96] Best practices worldwide show that effective responses are varied, using mixed approaches of school-based (in particular for the younger age groups), health facility based and community based. Actions include promotion, skills development, support to stay in school, find work, as well as teaching of comprehensive (sexual) health education in classrooms and provision of other school-based health services. School-based or health facility-based interventions, go hand in hand with engaging families and other key community groups of the surrounding community. [97].[98]

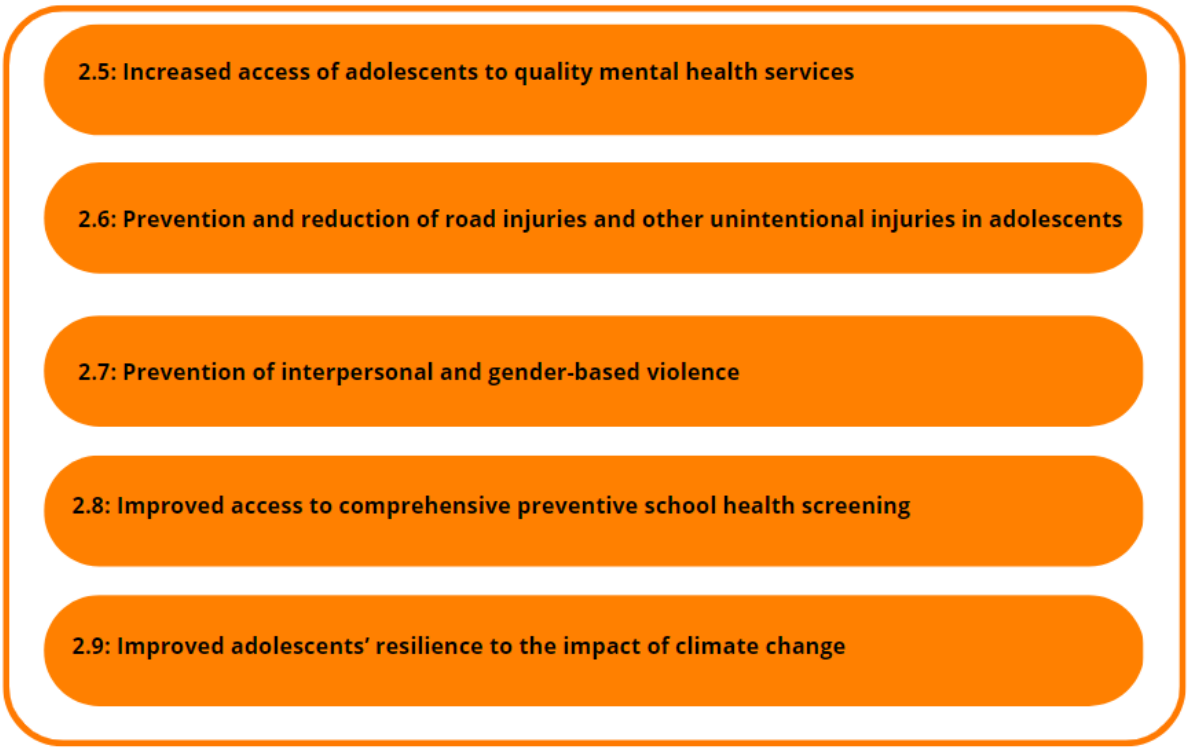



[95] CARICOM (2019): Adolescent and Youth Health Road Map for the Caribbean. First Caribbean congress on Adolescent and Youth health, Port of Spain, Trinidad and Tobago, 14–17 October 2019

[96] Essential package of interventions for school-age children (ages 5–14 years) Review www.thelancet.com Published online November 16, 2017 http://dx.doi.org/10.1016/S0140-6736(17)32417-0 7

[97] Susan Horton, Elia De la Cruz Toledo, Jacqueline Mahon, John Santelli, and Jane Waldfogel. Identifying an Essential Package for Adolescent Health: Economic Analysis IN: Child and Adolescent Health and Development file:///C:/Users/HP/Downloads/DCP3%20CAHD_Ch%2026.pdf

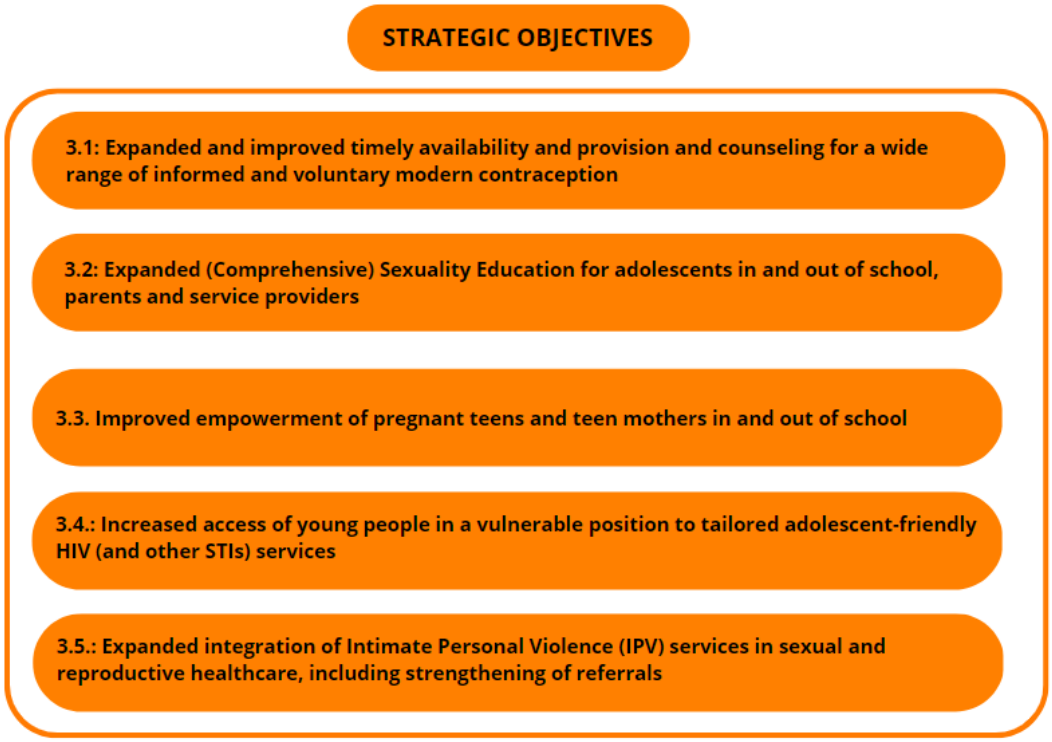
[98] Bund, Donald, et.al. (2017). Investment in child and adolescent health and development: key messages from Disease Control Priorities, 3rd Edition. Lancet. http://dx.doi.org/10.1016/ S0140-6736(17)32417-0




### 5.3.3. Improvement of Sexual and Reproductive Health, especially at Primary Health Care

In the response to adolescent health, it is pivotal to direct specific attention to the key area of sexual and reproductive health. In Suriname, just like in the Caribbean region and wider world, adolescence is in particular the age group where sexual practices are initiated, experimented and girls and boys become more exposed to risks of sexual violence, including intimate partner violence, unintended pregnancy, unsafe abortion, HIV/STI infection, HPV infection, and other sexual related issues such as stigma and discrimination because of sexual orientation or sex work. While on one hand adolescents' need for knowledge, guidance, counseling and commodities regarding sexual and reproductive health increases, on the other hand many adolescents face multiple barriers to accessing these health care services. Lack of adequate insurance coverage or fear for breach of confidentiality when using their parents' insurance, unfamiliarity with procedures to be followed when using specific services, are all documented problems that adolescents experience in their efforts to protect themselves. Adolescents are the hardest group to reach since many are no longer in school and feel uncomfortable accessing health services predominantly designed for adults. Although the concept of adolescent-friendly health services is widely used in policy documents, the current quality of health services is not yet in accordance

with the proposed standards of adolescents sexual and reproductive health care.[99] A comprehensive approach to sexual and reproductive health and rights is critical and entails not

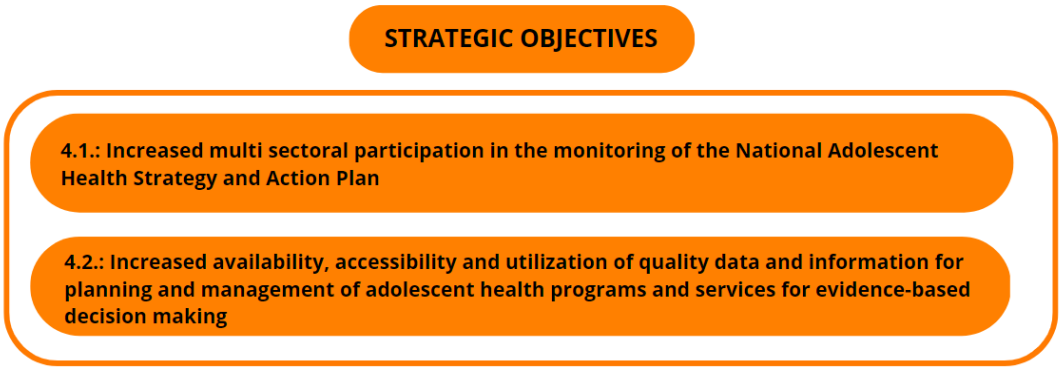



only prevention, contraception and treatment of disease (e.g. HIV), but promotion of sexual health in all its diversities (WHO 2002, IPPF 2022).

### 5.3.4. Strengthening Strategic information for monitoring

Adequate monitoring requires the availability of regularly obtained administrative data for surveillance on prevalence of mortality and morbidity in adolescence, and data on behavior, attitude and perceptions among different target groups of adolescents and service providers. In (re) building of a national health information system it is crucial that generation and use of strategic information related to the health and development of adolescents and youth, is integrated. As reiterated in multiple plans, to have a clear view on groups most vulnerable and marginalized (f.e. LGBT, disabled youth, youth with HIV), data of different target groups need to be disaggregated by age and sex, but also by socioeconomic status, education, ethnicity, rural/urban residence, and employment. Major building blocks for this strategy to work are: availability of staff and capacity strengthening of departments in the key ministries in charge of data collection, facilitation of the use and sharing of these data and information among all relevant stakeholders to enhance implementation of evidence-based policies and programs.

[99] Bund, Donald, et.al. (2017). Investment in child and adolescent health and development: key messages from Disease Control Priorities, 3rd Edition. Lancet. http://dx.doi.org/10.1016/ S0140-6736(17)32417-0




### 5.3.5. Advocacy and Social mobilization

Empower and engage adolescents and youth as partners and agents of change. Adolescents and youth can be powerful advocates and activists, with key roles in program design, implementation, and monitoring. Young people can substantially contribute to effective mobilization of different groups of adolescents with the use of a diverse range of creative and innovative communication channels and messages on healthy life choices. Reaching adolescents at high risk and those in vulnerable position with use of innovative, adolescent responsive technology, including use of telehealth, chat etc.


# DRAFT ACTION PLAN

# ADOLESCENT HEALTH STRATEGY

# 2023-2025

# MINISTRY OF HEALTH

# SURINAME

## 5.4. Action Plan 2023-2025

This three-year action plan for Adolescent Health, 2023-2025, is based on the comprehensive situation analysis on adolescents' health, the identified areas for (improved) response, and information provided by key stakeholders/service providers, mainly from government departments working in main areas of adolescent health. To a lesser extent, also relevant actions reported by civil society organizations are included. The plan will be used as a working document to guide collaborative and integrated actions aimed at improvement of adolescent health and wellbeing.
The general long term outcome indicators and targets are as much as possible align to existing national indicators, and translated to output- and performance indicators on the output level. The program on 'Family and Community Health' of the Bureau of Public Health will be in charge of monitoring and periodic revision of the action plan through regular discussion with key stakeholders on progress and compilation of annual plans in which all reported actions will be included. Annually available or required budgets will be attached to all actions to facilitate efficient resource mobilization for identified budget gaps.

The identified actions per strategic area, build, as much as possible, on existing action plans, including the 'Child Action Plan, 2019-2021', the Maternal and Newborn Health action plan 2021-2023 and the recently presented 'Youth Suicide Prevention Action Plan', 2022-2025.

| STRATEGIC AREA 1. STRENGTHENING OF AN ENABLING ENVIRONMENT: LEGISLATION, POLICY, NATIONAL COORDINATION AND MULTISECTORAL PARTNERSHIPS | | | | | |
|---|---|---|---|---|---|
| **Strategic Objective 1.1: Strengthened 'Adolescent Health' Program at the department of Family and Community Health to coordinate integrated and multisectoral implementation of the Adolescent Health Action Plan.** | | | | | |
| **OUTPUT 1.1.1: Capacity strengthened to coordinate multi sectoral implementation of the Adolescent Health Action Plan** | | | | | |
| **PERFORMANCE INDICATORS** | **ACTIONS** | **LEAD AND CO PARTNERS** | **TIME FRAME** | | |
| | | | **2023** | **2024** | **2025** |
| Strengthened capacity of 'Adolescent Health' Program of the department of Family health. | Hiring of additional staff and allocation of required budgets | FCH/BOG/MOH | X | X | |
| Increased cooperation between Adolescents Health program staff and other relevant departments/keypersons in Ministry of Health and other ministries | Establishment of an inter-ministerial working group specifically focused on coordinated monitoring of Action plan Adolescent Health, composed of staff of FCH, MOH and other ministries | FCH/MOH/AWJ/ MinOWC | X | X | X |
| Increased number of partnerships between MOH and other ministries, NGO's and private sector aimed at improvement of AH | Support actions (workshops, meetings) to promote the exchange and dissemination of best practices and lessons learned for the improvement of AH | FCH/BOG/MOH | X | X | X |
| | Strengthen and promote partnership with relevant ministries/private sector to increase access of adolescent to health services | | | | |
| Adolescent health is integrated in 'Health in All Policies approach' | Integrate Adolescent Health in 'Health in All Policies approach' to scale-up interventions | FCH/BOG/MOH | X | X | |
| Strengthened resource mobilization for financing of planned AH interventions | Resource mobilization for financing of planned AH interventions | FCH/MOH/ UN agencies/other donors | X | X | X |

| Strategic Objective 1.2: Increased availability and implementation of legislation and regulations to ensure that Adolescent Health is effectively addressed and aligned/updated with agreed/ratified international commitments on Adolescent Health | | | | | |
|---|---|---|---|---|---|
| **OUTPUT: Adolescent- protective laws, regulations in key sectors are developed, revised and/or approved** | | | | | |
| **PERFORMANCE INDICATORS** | **ACTIONS** | **LEAD AND CO PARTNERS** | **TIME FRAME** | | |
| | | | **2023** | **2024** | **2025** |
| Revised Marriage legislation is approved, with age of marriage for boys and girls elevated to 18 years. | Finalize revision and adoption of Marriage legislation with elevation of minimum age of marriage for girls and boys to 18 years, and the possibility for parents to request dispensation for child marriage is repealed | BIZA/JUSPOL | | X | |
| Revision of Abortion legislation is promoted and advocated | Advocate and promote revision of Abortion legislation | NGO's/FCH/MOH | X | X | X |
| Legislation to clarify age of consent has been drafted and approved | Develop draft legislation to ensure that all adolescents, 15-19yrs have access to SRHR services | JUSPOL/FCH | X | X | X |
| The Bill on "Protection of the privacy of the child in the media" has been drafted and submitted for approval | Finalization and submission of draft law on "Protection of the privacy of the child in the media" | BRK/SOZA/JUSPOL | X | X | X |
| The 'Children's Ombudsman Institute' Act has been approved and implementation started | Approval of the 'Children's Ombudsman Institute' Act | JUSPOL/FCH | X | X | |
| The revised Domestic Violence Act adequately protects children and adolescents | Evaluation and Revision of the Domestic Violence Act, with specific articles on tackling violence against children | JUSPOL/FCH | X | X | |
| Drafted legislation to prohibit corporal punishments against children in all settings | Develop draft legislation to prohibit corporal punishments of children in all settings | BRK/JUSPOL/NGOs | X | X | X |
| Legislation on 'Crisis Care of children' is approved | Design, submission and approval Legislation on 'Crisis Care of children' | BRK/JUSPOL/NGOs | | X | |

| | | | | | |
|---|---|---|---|---|---|
| Ratification of Protocol 29 to the Forced Labour Convention | Ratification of Protocol 29 to the Forced Labour Convention | AWJ/JUSPOL/NGOs | X | X | X |
| Legislation on residential child care is revised and improved | Revision of legislation related to residential child care | BRK/JUSPOL/NGOs | X | X | X |
| Law on foster care is approved | Finalisation of the law on foster care | JUSPOL/BRK | X | X | X |
| **Strategic objective 1.3: Increased proportion of adolescents with coverage of essential AH services by health insurance** | | | | | |
| **OUTPUT: Increased advocacy and promotion for timely health insurance coverage for all adolescent health services, especially of targeting vulnerable groups to increase equity** | | | | | |
| **PERFORMANCE INDICATORS** | **ACTIONS** | **LEAD AND CO PARTNERS** | **TIME FRAME** | | |
| | | | **2023** | **2024** | **2025** |
| Increased proportion of adolescents with coverage of essential AH services by health insurance, including mental health services, sexual and reproductive healthcare, health education, counseling, including adolescents in vulnerable positions (f.e. HIV+, migrants) | Advocate for the establishment/expansion of a national standardized essential Adolescent Health package, that is covered by basic health insurance | FCH/MOH/National Health Insurance/NGOs | X | X | X |
| | Develop and promote educational and awareness raising materials on procedures to obtain health insurance, in particular for adolescents | | X | X | X |
| | Strengthen structural cooperation with social protection services to support vulnerable adolescents /families who cannot access health services because of transport, unexpected medical costs, residence/opportunity costs | BRK/Soza/Min of Finance, National Insurance | X | X | X |

| **Strategic Objective 1.4. Expanded network of skilled, motivated, integrated, and adequately distributed health workers, community workers and other relevant professionals to deliver quality adolescents healthcare** | | | | | |
|---|---|---|---|---|---|
| **OUTPUT: Increased capacity of health providers for delivering adolescents health friendly SRH services according to AAHA guidelines, and relevant (IMAN) protocol** | | | | | |
| **PERFORMANCE INDICATORS** | **ACTIONS** | **LEAD AND CO PARTNERS** | **TIME FRAME** | | |
| | | | **2023** | **2024** | **2025** |
| Increased capacity of health providers for delivering adolescents health friendly services according to AAHA guidelines, and IMAN (Integrated Management of Adolescent Needs)) protocol<br><br>Improved access of community workers and other social actors to the knowledge and skills to plan and implement effective interventions to improve adolescents' health at the family, school, and community levels<br><br>Increased access of adolescents to appropriate health services through adoption of an adolescent-friendly approach | Adapt, disseminate and promote IMAN protocol as guideline for provision of AH services | FCH/MOH/BOG | X | X | X |
| | Train/provide refresher courses for Primary Health Care workers in the application of the IMAN protocol to deliver an integrated package of health services for adolescents | FCH/RGD/MZ | X | X | |
| | Adjustment, promotion and use of PAHO/WHO training tools, for essential adolescent health services | FCH/RGD/MZ | X | X | |
| | Enhance integration of national AH protocols in curricula of COVAB | FCH/COVAB | X | X | |
| | Enhance integration of guiding principles of AH in curricula of relevant training institutions and programs | FCH/RGD/MZ | X | X | X |
| | Introduce/implement e-learning module for adolescent health providers | FCH/RGD/MZ/NGOs | X | X | |
| | Adapt and apply tools to improve the knowledge and skills of community workers and other social actors to plan and implement effective interventions | FCGH/St. LOBI/NGOs | X | X | |

| STRATEGIC AREA 2: STRENGTHENING OF ADOLESCENT HEALTH PROMOTION AND COMMUNITY PARTICIPATION | | | | | |
|---|---|---|---|---|---|
| **Strategic Objective 2.1: Improved access of most vulnerable adolescents to educational opportunities, skills development and work** | | | | | |
| **OUTPUT: Increased numbers of adolescents with access to vocational training and employment opportunities, especially youth that are of part of economically disadvantaged, socially marginalized, and vulnerable groups.** | | | | | |
| **PERFORMANCE INDICATORS** | **ACTIONS** | **LEAD AND CO PARTNERS** | **TIME FRAME** | | |
| | | | **2023** | **2024** | **2025** |
| Increased access to educational opportunities for early school leavers<br><br>Increased number of adolescents in livelihood and employment programs<br><br>Increased percentage of adolescents with completed secondary education | Identify and train early school leavers to increase their chances in the job market | AWJ/ (SNTA) | X | | |
| | Promote technical training/ professions among female pupils in secondary education, in particular vocational education | MinOWC | X | X | X |
| | Increase the access of children with disabilities to inclusive and special education | MinOWC | X | X | X |
| | Improve the access to education of migrant children with undocumented status | MinOWC | X | X | X |
| **Strategic Objective 2.2: Increased availability and delivery of comprehensive life skills-based information package and curriculum that focuses on improving health and well-being of adolescent and youth** | | | | | |
| **OUTPUT: Development and delivery of comprehensive life skills-based information package and curriculum that focuses on improving health and well-being of adolescent and youth** | | | | | |
| **PERFORMANCE INDICATORS** | **ACTIONS** | **LEAD AND CO PARTNERS** | **TIME FRAME** | | |
| | | | **2023** | **2024** | **2025** |
| Comprehensive life skills-based information packages and curricula is available and delivered | Development of audio-visual education and awareness programs about healthy nutrition and exercise for children | BLS/CENASU/RHS /NGO | X | X | X |
| | Development of a policy on BLSE | BLS/Spotlight Caribbean | | | |

| | | | | | |
|---|---|---|---|---|---|
| | Development of curriculum on psychoactive substances, abuse and its consequences | BLS/CENASU/ NGO | X | X | X |
| | Development of curricula and training of service providers/community workers in prevention and early recognition of mental health problems, incl. suicidality, among various groups of young people | BLS/CENASU/ NGO | X | X | X |
| | Development of mental health risk assessment tools for school nurses and school-based health center staff. | RGD/MZ/BLS | X | X | X |
| | Development and piloting of BLS curriculum for Lower Secondary (9th and 10th schoolyear) 'Levensbeschouwelijke vorming'. | BLS/CENASU/ NGO | X | X | X |
| | Implementation of BLS lessons for Environmental Education | | | | |
| | Project: Students against destructive decisions | BLS/OAS | X | X | X |
| **Strategic Objective 2.3: Improved access to healthy food, psychical activity and sport through schools based and community-based programs** | | | | | |
| **OUTPUT: Increased promotion of school-based and community based healthy nutrition, psychical activity and sports** | | | | | |
| **PERFORMANCE INDICATORS** | **ACTIONS** | **LEAD AND CO PARTNERS** | **TIME FRAME** | | |
| | | | **2023** | **2024** | **2025** |
| Increased integration of promotion of healthy food and exercising in community programs | Support to neighborhood organizations for provision of information and awareness about healthy food and exercise for children | MinOWC/FCH/ NGOs | X | X | X |
| | Develop and disseminate guidelines for school canteens and food stalls stocking vending machines with healthy choices | MinOWC/FCH/ NGOs | X | X | X |
| Increased promotion of healthy food in schools | Increase the prices of unhealthy foods, e.g. energy drinks, sugary and high-fat foods | MinOWC/FCH/ NGOs | X | X | X |

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|---|---|---|---|---|---|
| Improved availability of healthy food in schools | Develop and implement community treatment programs to address childhood obesity | MinOWC/FCH/ NGOs | X<br>X | X<br>X | X<br>X |
| Improved access of children in and out of school to sufficient exercise | Construction and rehabilitation of sports facilities, spaces, parks, playgrounds and fences | | X | X | X |
| | Reintroduction of school swimming in all primary schools | MinOWC/ROS/ NGOs | X | X | X |
| | Reintroduction of physical education in all primary schools based on a standardized physical education curriculum | MinOWC/ROS/ NGOs | X | X | X |
| | Developing and implementing programs that increase girls' participation in sport | MinOWC/ROS/ NGOs | X | X | X |
| Increased number of schools with school gardens | Promote edible school gardens to serve as incubators for nutrition education and to promote consumption of produce | MinOWC/LVV/ NGOs | X | X | X |
| **Strategic Objective 2.4: Prevention and reduction of tobacco use, the consumption of alcohol and substance abuse among adolescents.** | | | | | |
| **OUTPUT: Increased interventions aimed at prevention and reduction of tobacco use, alcohol and drug abuse among adolescents** | | | | | |
| **PERFORMANCE INDICATORS** | **ACTIONS** | **LEAD AND CO PARTNERS** | **TIME FRAME** | | |
| | | | **2023** | **2024** | **2025** |
| Increased interventions aimed at prevention and reduction of tobacco use, alcohol and drug abuse among adolescents | Information provided by community and media campaigns to young people about the dangers of using (synthetic) drugs | MOH/FCH/ MinOWC /NGOs | X | X | X |
| | Integrating drug education and awareness in parent guidance/family training/coaching programs | | X | X | X |
| | Development of a drug helpline and promotion of existing online alcohol self-help program | | X | X | X |

| | | | | | |
|---|---|---|---|---|---|
| | Training of teachers in early detection, initial interventions and referral in case of indications of drug and alcohol problems | | X | X | X |
| | Tightening of the control of compliance with the Tobacco Act, in particular related to young people | | X | X | X |
| | Tightening the control of compliance with the prohibition on the sale of alcohol to young people | | X | X | X |
| | Introducing buddy system and training buddies for young people with drug and alcohol problems | | X | X | X |
| **Strategic Objective 2.5: Increased access of adolescents to quality mental health services** | | | | | |
| **OUTPUT: Increased promoting and supporting the prevention, timely diagnosis and effective treatment of mental health challenges and diseases in adolescents and youth** | | | | | |
| **PERFORMANCE INDICATORS** | **ACTIONS** | **LEAD AND CO PARTNERS** | **TIME FRAME** | | |
| | | | **2023** | **2024** | **2025** |
| Implementation of the Youth Suicide Prevention Action Plan', 2022-2025. | Support coordinated actions aimed at prevention of Youth Suicide | Min. of Labor, Employment and Youth | X | X | X |
| Improved capacity of providers involved in provision of mental health services to young people<br><br>Increased promotion, education and awareness raising on mental health of youth focused on different groups<br><br>Improved supply of (online) services for education, counseling and treatment of mental health problems among adolescents | Strengthening of programs on 'Youth mental health' at the Psychiatric Centre Suriname (PCS), in close collaboration with SVPO | PCS/SVPO | X | X | X |
| | Promotion of (international) guidelines and delivery of training for association of journalists and media houses regarding responsible reporting on suicide and suicide attempts | SVPO/Journalists | X | X | X |
| | Development and delivery of short educational video productions and 'lessons letters' on 12 mental health issues for lower and higher secondary schools | MinoWC /UNICEF | X | X | X |
| | Training of school care coordinators in delivery/use of videos and lessons letters | MinoWC /UNICEF | X | X | X |
| | Education and awareness-raising community programs on mental health issues among youth | FCH/RGD/MZ | X | X | X |

| | | | | | |
|---|---|---|---|---|---|
| Development of educational materials on mental health appropriate for primary schoolchildren | MinoWC /UNICEF | X | X | X |
| Educational sessions in schools on mental health, especially in areas with high prevalence of suicide (Nickerie) and underserved areas (Interior) | MinoWC /UNICEF | X | X | X |
| Development and provision of online mental help programs through anonymous chatting with trained counselors | KJT/st.LOBI/ NGOs | X | X | X |
| Expansion and dissemination of mental health resources directory for youth online and through social media | SVPO/FCH | X | X | X |
| Development of protocols for diagnosis and referral of children registered at Pedologic institute and MOB. | MOB, PI, SVPO, and MOH | X | X | X |
| Reactivation of the service of “Spiritual Guides”, in the RHS as first responders for psycho-social counseling | RHS/SVPO | X | X | X |
| Production of adolescent attractive messaging by youth influencers through popular online platforms like ‘TikTok’, ‘Snap Chat’ | NGOs/MOH | X | X | X |
| Training for teachers and parents/guardians to recognize the early warning signs of mental health conditions in adolescents and adequately refer mental health problems in children and young people | NGOs/MOH | X | X | X |
| Training of counselors to facilitate mental health support (talking) groups for youth and parents in need | NGOs/MOH | X | X | X |

| Strategic Objective 2.6: Prevention and reduction of road injuries and other unintentional injuries in adolescents | | | | | |
|---|---|---|---|---|---|
| **OUTPUT: Increased promotion of the prevention and reduction of road injuries and other unintentional injuries in adolescents** | | | | | |
| **PERFORMANCE INDICATORS** | **ACTIONS** | **LEAD AND CO PARTNERS** | **TIME FRAME** | | |
| | | | **2023** | **2024** | **2025** |
| Increased provision of educational and awareness raising activities on prevention and reduction of road accidents | Implementation of general and specific traffic information programs aimed at young people on preventing and reducing risky behavior in traffic | JUSPOL/NGOs | X | X | X |
| | Promote the use of reflective or fluorescent clothing; light-colored clothing and helmets; and reflectors on the rear of vehicles to reduce injuries | | X | X | X |
| | Restoration of the training of 'Traffic Brigadiers' in schools | JUSPOL/NGOs | X | X | X |
| Increased provision of educational and awareness raising activities on prevention and reduction of drowning and other accidents | Re introduce learning basic swimming skills, water safety and safe rescue skills in primary schools | MOH/FCH/ MinOWC | X | X | X |
| | Increasing public awareness of adolescents' vulnerability to drowning | | X | X | X |
| | Study and evaluate all drowning deaths (in particular of young people) to find out the cause and prevent it in the future | | X | X | X |
| | Continuation of education on prevention of fires | | X | X | X |

| Strategic Objective 2.7: Prevention of interpersonal and gender-based violence | | | | | |
|---|---|---|---|---|---|
| **OUTPUT: Increased activities aimed at prevention of interpersonal and gender-based violence among adolescents** | | | | | |
| **PERFORMANCE INDICATORS** | **ACTIONS** | **LEAD AND CO PARTNERS** | **TIME FRAME** | | |
| | | | **2023** | **2024** | **2025** |
| Prevention of interpersonal violence | Continuation and expansion of outreach education and awareness programs for schools, especially in underserved areas. | BGA | X | X | X |
| | Preparing and implementing awareness campaigns and programs through multiple channels, including mass media and social media | BGA/WRC | X | X | X |
| | Implementation projekt 'Indigenous in action against violence against women and girls' | ROS/FCH/Projekt a /VIDS | X | | |
| | Implementation '<br>Stop Bullying in school' | New Monday,<br>Min AWJ | X | | |
| Strengthening and guidance of families to cope with conflicts through constructive communication | Implementation of positive parenting (including focus on teenage parents) programs | Soza/MinOWC/NGOs | X | X | X |
| Increasing access to child protection services in districts and inland areas | Extension of Hotlines to other districts/residential areas | KJT/JUSPOL | X | X | X |
| Increased number of services providers trained | Training relevant service providers in preventing and tackling violence against children | BRK/KJT/NGO's | X | X | X |
| Prevention and tackling child victims of trafficking | Availability of adequate education, health care and other social services, for child victims of trafficking | JUSPOL/BRK | X | X | X |

| Strategic Objective 2.8: Improved access to comprehensive preventive school health screening | | | | | |
|---|---|---|---|---|---|
| **OUTPUT: Increased number of schools in coastal and interior that are covered by regular and incidental school health screening** | | | | | |
| **PERFORMANCE INDICATORS** | **ACTIONS** | **LEAD AND CO PARTNERS** | **TIME FRAME** | | |
| | | | **2023** | **2024** | **2025** |
| Reinforcement/Strengthening of school health screening in primary schools | Strengthening of the expansion and improvement of the School health program of the RHS | RHS/FCH | X | X | X |
| | Supporting the integration of healthy lifestyle education into the school health screening program of the RHS | RHS/FCH | X | X | X |
| | Strengthening of the expansion and improvement of the school health program of the Medical Mission | MM/FCH | X | X | X |
| **Strategic Objective 2.9: Improved adolescents' resilience to the impact of climate change** | | | | | |
| **OUTPUT: Increased proportion of adolescents with access to safe water, sanitation and hygiene (WASH) services and lives in a safe and sustainable climate and environment, including in humanitarian contexts** | | | | | |
| **PERFORMANCE INDICATORS** | **ACTIONS** | **LEAD AND CO PARTNERS** | **TIME FRAME** | | |
| | | | **2023** | **2024** | **2025** |
| Increased access of adolescents to hygiene and sanitation practices and have access to climate-resilient WASH services.<br><br>Increased participation of adolescents in national response on climate change on multiple levels | Educational and awareness raising activities to improve hygiene and sanitation practices and access to climate-resilient WASH services, especially in vulnerable communities | MM/FCH | X | X | X |

| STRATEGIC AREA 3. IMPROVEMENT OF SEXUAL AND REPRODUCTIVE HEALTH, REDUCTION OF HIV/STI, ESPECIALLY AT PRIMARY HEALTH CARE LEVEL | | | | | |
|---|---|---|---|---|---|
| **Strategic Objective 3.1: timely availability and provision and counseling for a wide range of informed and voluntary modern contraception** | | | | | |
| **OUTPUT: Improved timely availability, provision and counseling for a wide range of informed and voluntary modern family planning methods, including LARCS.** | | | | | |
| **PERFORMANCE INDICATORS** | **ACTIONS** | **LEAD AND CO PARTNERS** | **TIME FRAME** | | |
| | | | **2023** | **2024** | **2025** |
| Increased numbers of health facilities with provision and counseling for a wide range of informed and voluntary modern family planning methods, including LARCS | Promote face to face family planning education and counseling for adolescents and free contraceptives including emergency contraceptives for youngster under 20 years, especially in underserved communities and vulnerable youth | **FCH/LOBI/ RHS/MM/UNFPA** | X | X | X |
| | Training of health workers, including health educators, in the use of standardized family planning education tools, focused on adolescents | | X | X | X |
| | Develop and implement specific FP promotion programs, especially for the three interior districts, led by Medical Mission | | X | X | X |
| | Integrate HIV, Syphilis and Hepatitis B screening and pregnancy testing with SRH counseling services and contraceptive provision, including for HIV+ adolescents | | X | X | X |
| | Education and awareness about the need for HPV vaccination for girls | | X | X | X |
| Enabling environment stimulated for youth/adolescents to responsibly fulfill their sexual and reproductive rights | Advocate, promote and develop awareness programs focused at creating constructive and open communication between parents and their children about sexuality and contraceptive use | FCH/LOBI/MM/RHS/BGA/UNFPA | X | X | X |

| | | | | | |
|---|---|---|---|---|---|
| | Increase SRH information and services for adolescent ITPs[100] | | X | X | X |
| | Promote and advocate for the availability of education and free commodities for menstrual hygiene for girls in need | | X | X | X |
| | Developing of a national condom policy to also strengthening of targeted condom distribution (including reintroduction of the female condom), | | X | X | X |
| **Strategic Objective 3.2: Expanded (Comprehensive) Sexuality Education for adolescents in and out of school, parents and service providers** | | | | | |
| **OUTPUT: Increased supply of (Comprehensive) Sexuality Education for adolescents in and out of school, parents and service providers** | | | | | |
| **PERFORMANCE INDICATORS** | **ACTIONS** | **LEAD AND CO PARTNERS** | **TIME FRAME** | | |
| | | | **2023** | **2024** | **2025** |
| Increased number of Primary and Secondary schools with integration of (Comprehensive) Sexuality Education | Teacher training in Basic Life Skills Education | BLSE /CENASU | X | X | X |
| | Implementation of BLS curriculum through School Media libraries | | X | X | X |
| | Development of BLS training materials on CSE | BLSE | X | X | X |
| | Integration of BLS in curriculum Special Education | BLSE /Pedologisch Instituut | X | X | X |
| Increased integration of (Comprehensive) Sexuality Education in community projects for out of school youth, parents and community workers | Integration of (Comprehensive) Sexuality Education in community projects for out of school youth, parents and community workers | LOBI/RHS/MM/ NGOs | X | X | X |

[100] Part of the joint project for building ITP resilience through integrated policies

| Strategic Objective 3.3. Improved empowerment of pregnant teens and teen mothers in and out of schools | | | | | |
|---|---|---|---|---|---|
| **OUTPUT: Increased interventions aimed at empowerment of teen mothers in and out of school** | | | | | |
| **PERFORMANCE INDICATORS** | **ACTIONS** | **LEAD AND CO PARTNERS** | **TIME FRAME** | | |
| | | | **2023** | **2024** | **2025** |
| Empowerment of Teen mothers in and out of school in multiple districts: Para, Commewijne, Moengo, Nickerie, Saramacca | Psycho-social support for teen mothers | AWJ/FCH/ ST.LOBI/other NGOs | X | X | X |
| | Capacity training for staff Youth Affairs (AWJ) to guide and counsel teenmothers | | X | X | X |
| | Skilled training for teen mothers in school: Computer training, Textile art and work courses, Manicure and Pedicure training | | X | X | X |
| | Skilled training for teen mothers out of school: Computer training, Textile art and work courses, Manicure and Pedicure training | | X | X | X |
| (Re) Establishment of a national program on 'Prevention and Reduction of Teen pregnancy' | (Re) establishment of the national program on 'Prevention and Reduction of Teen pregnancy' | | X | | |
| | Community interventions aimed at prevention and reduction of unintended adolescent pregnancies | | X | X | X |
| **Strategic Objective 3.4: Increased access of young people in a vulnerable position to tailored adolescents' friendly HIV (and other STIs) services** | | | | | |
| **OUTPUT: Increased interventions to improve access of young people in a vulnerable position to tailored HIV care and other SRH care** | | | | | |
| **PERFORMANCE INDICATORS** | **ACTIONS** | **LEAD AND CO PARTNERS** | **TIME FRAME** | | |
| | | | **2023** | **2024** | **2025** |
| Improved system of HIV care for adolescents and Orphans and Vulnerable Children (OVCs) | Development of a 'Code of Conduct' to guide the provision of psycho-social support to HIV+ adolescents | MOH/FCH/Sozavo/NGOs | X | X | X |
| | Support to children and adolescents who are not covered under the peer counselor, buddy and health navigator systems | | X | X | X |

| | | | | | |
|---|---|---|---|---|---|
| | Identify the needs and develop a system for supporting PLHIV who are in residential care and reaching adolescence. | | X | X | X |
| Increased protection of LGBT youth against stigma and discrimination in schools and in communities | Support education and awareness raising programs to reduce stigma and discrimination of LGBT youth | MinOWC/NGOs | X | X | X |
| Increase demand and engagement of young males in prevention of sexual and reproductive health problems | Stimulate greater involvement of men in prevention of sexual and reproductive health problems and increased contraceptive use | FCH/LOBI/UNFPA /BGA | X | X | X |
| **Strategic Objective 3.5: Expanded integration of Intimate Personal Violence (IPV) services in sexual and reproductive healthcare, including strengthening of referrals** | | | | | |
| **OUTPUT: Increased number of SRH services with integration of IPV services, including for adolescents** | | | | | |
| **PERFORMANCE INDICATORS** | **ACTIONS** | **LEAD AND CO PARTNERS** | **TIME FRAME** | | |
| | | | **2023** | **2024** | **2025** |
| Increased number of healthcare providers trained in provision of SRHR services to (female) survivors of IPV | Training of healthcare providers in provision of SRHR services to (female) survivors of IPV | MOH/BGA/NGOs | X | X | X |
| Increased promotion of SRHR services to (female) survivors of IPV | Promotion of SRHR services to (female) survivors of IPV | | X | X | X |

| STRATEGIC AREA 4: STRATEGIC INFORMATION FOR MONITORING | | | | | |
|---|---|---|---|---|---|
| **Strategic Objective 4.1: Capacity building on integration of priority indicators for monitoring of adolescent health** | | | | | |
| **OUTPUT: Increased capacity for monitoring of adolescent health based on agreed priority indicators** | | | | | |
| **PERFORMANCE INDICATORS** | **ACTIONS** | **LEAD AND CO PARTNERS** | **TIME FRAME** | | |
| | | | **2023** | **2024** | **2025** |
| Staff of Family and Community Health and other departments of core ministries, is trained in monitoring of adolescent health with use of indicators that are aligned to the relevant international and regional agreements | Training of staff of Family and Community Health, and other government departments in the monitoring of adolescent health | FCH | X | X | |
| **Strategic Objective 4.2: Increased multi sectoral participation in the monitoring of the National Adolescent Health Strategy and Action Plan** | | | | | |
| **OUTPUT: Increased alignment of strategies and action plans of key relevant stakeholders to the National Adolescent Health Strategy and Action Plan** | | | | | |
| **PERFORMANCE INDICATORS** | **ACTIONS** | **LEAD AND CO PARTNERS** | **TIME FRAME** | | |
| | | | **2023** | **2024** | **2025** |
| All relevant actors in public and private sector are fully informed of the national AHS and Action plan | Present, promote, and widely disseminate the Adolescent Health Strategy and Action plan | MOH/BOG, PHC, GP, NGO'S, Hospitals | X | X | X |
| Key ministries and service providers (RHS and Medical Mission) use standardized format for annual reporting on actions on adolescent health | Develop a (standardize) annual reporting system for monitoring purposes, with clear indicators and targets, that comply with international definitions. | MOH/BOG, NSCMH, PHC, GP, NGO'S, Hospitals | X | X | X |
| Number of annual work plans of participating stakeholders are aligned to the operational plan | Conduct annual workshops to enhance and support the development and use of (standardized) annual work plans that are aligned to the operational plan | MOH/BOG<br>MOH/BOG | X | X | X |

| **Strategic Objective 4.3.: Increased availability, accessibility and utilization of quality data and information for planning and management of Adolescent Health programs and services for evidence- based decision making** | | | | | |
|---|---|---|---|---|---|
| **OUTPUT: Increased availability, accessibility and utilization of quality data and information for planning and management of Adolescent Health programs and services for evidence- based decision making** | | | | | |
| **PERFORMANCE INDICATORS** | **ACTIONS** | **LEAD AND CO PARTNERS** | **TIME FRAME** | | |
| | | | **2023** | **2024** | **2025** |
| Routine data on AHS is collected, analyzed and annual public reports are disseminated | Strengthen the capacity at BOG to improve systematic, regular collection and analysis of data on adolescents' health | MOH/Epi/ PAHO | X | X | X |
| | Produce and disseminate regular (annual) public reports with disaggregated data on adolescents' deaths and morbidity | | X | X | X |
| | Enhance integration of basic adolescent health indicators in regular nationwide data collection systems, such as MICS, CENSUS | | X | X | X |
| Studies and assessments have been conducted to improve adolescents' access to (health) services | Conduct study on barriers in access to SRH for adolescents in the three interior districts | MOH/Epi/ PAHO/UNFPA/ Projekta/Parea, other NGOs | | X | |
| | Global Youth Tobacco Survey 2022, 13-15 year old students | | X | X | |
| | Study to the economic consequences of Adolescent Pregnancy (AP) and Early Motherhood (EM). MILENA study | | X | | |
| | Research on problems of children with addicted parents, gender and human rights | | | X | X |
| | Study on factors influencing youth gambling and identify most vulnerable adolescents | | | X | X |
| | Study on knowledge, attitudes and behavior of general public towards rights of LGBTQ | | X | | |

| STRATEGIC AREA 5: ADVOCACY AND SOCIAL MOBILIZATION | | | | | |
|---|---|---|---|---|---|
| **Strategic Objective 5.1.: Increased advocacy and political leadership support to engage and empower adolescents, families and communities in improving adolescent health** | | | | | |
| **OUTPUT: Strengthened networks, alliances and youth advocates to build political and social will to implement priority actions on adolescent health** | | | | | |
| **PERFORMANCE INDICATORS** | **ACTIONS** | **LEAD AND CO PARTNERS** | **TIME FRAME** | | |
| | | | **2023** | **2024** | **2025** |
| Strengthened networks and alliances (government, civil society, the private sector, UN agencies) that are promoting priorities in adolescent health | Promote and develop partnerships and alliances to help build political and social will for implementation of the Action Plan on adolescent health | FCH/MOH/UN/NGO | X | X | X |
| Strengthening of youth advocates/activist in promoting adolescent health | Support youth advocates with opportunities and resources to actively engage in the decision-making processes on adolescents' health and implementation of programs | FCH/MOH/UN/NGOs | X | X | X |
| **Strategic Objective 5.2. Expanded social communication interventions using social media, mass media and innovative technologies to promote adolescent health** | | | | | |
| **OUTPUT: Increased application of social communication interventions to promote adolescent health** | | | | | |
| **PERFORMANCE INDICATORS** | **ACTIONS** | **LEAD AND CO PARTNERS** | **TIME FRAME** | | |
| | | | **2023** | **2024** | **2025** |
| A communication strategy to promote adolescent health is developed and implemented<br><br>Capacity of relevant stakeholders and youth leaders for the planning and implementation of effective social communications interventions to promote adolescent health is strengthened | Development of a communication strategy with use of existing and new technologies to promote health and social norms and increase demand and use of adolescents' health interventions and services | FCH/MOH/UN | X | X | X |
| | Prepare guidelines for developing communication and social mobilization strategies | FCH/MOH/UN | X | X | X |

| | | | | | |
|---|---|---|---|---|---|
| | Training of relevant stakeholders, including youth leaders in the planning and implementation of effective social communication interventions to promote adolescent health | FCH/MOH/UN | X | X | X |

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# Annex 1: AA-HA! adolescent evidence-based interventions at a glance

| Positive development | Unintentional Injury | Violence | Sexual and reproductive health, including HIV |
|---|---|---|---|
| • Adolescent-friendly health services<br>• Health-promoting schools<br>• Improving hygiene and nutrition<br>• Child online protection<br>• e-health and m-health interventions for health education and the involvement of adolescents in their own care<br>• Parenting interventions<br>• Adolescent participation and interventions to promote competence, confidence, connection, character and caring | • Laws on drinking age, blood alcohol concentration, seat-belt and helmet wearing, graduated driver licencing<br>• Traffic calming and safety measures<br>• Pre-hospital and hospital care<br>• Community campaigns and individual interventions to promote behavioral change related to safe driving and good laws to encourage behavioral change<br>• Population, community-based and individual level drowning prevention measures<br>• Assessment and management of adolescents who present with unintentional injury, including alcohol-related injury<br>• Infrastructure design and improvement | INSPIRE strategies to preventing and responding to all forms of violence against children and adolescents:<br>• Implementation and enforcement of laws: banning violent punishment, criminalizing sexual abuse and exploitation of children, prevent alcohol misuse, limit youth access to firearms and other weapons<br>• Norms and values: changing adherence to restrictive and harmful gender and social norms, community mobilization programs, bystander interventions<br>• Safe environments: addressing “hotspots”, interrupting the spread of violence, improving the built environment<br>• Parent and caregiver support through home visits, community approaches and | • Comprehensive sexuality education<br>• Information, counselling and services for comprehensive sexual and reproductive health, including contraception<br>• Prevention of and response to harmful practices, such as female genital mutilation and early and forced marriage<br>• Pre-pregnancy, pregnancy, birth, post-pregnancy, abortion (where legal) and postabortion care, as relevant to adolescents<br>• Prevention, detection and treatment of sexually transmitted and reproductive tract infections, including HIV and syphilis<br>• Voluntary medical male circumcision (VMMC) in countries with generalized HIV epidemics<br>• Comprehensive care of |

| | | | |
|---|---|---|---|
| | • Vehicle safety standards | comprehensive programs<br>• Income and economic strengthening: cash transfers, group saving and loans, microfinance<br>• Response and support services: screening and interventions, counselling and thera-peutic approaches, programs for juvenile offenders, foster care interventions<br>• Education and life skills: increasing school enrolment, safe and enabling school environment, life and social skills training | children (including adolescents) living with, or exposed to, HIV |
| **Communicable diseases** | **Non-communicable diseases, nutrition and physical activity** | **Mental health, substance abuse and self-harm** | **Conditions with particularly high priority in humanitarian and fragile settings** |
| • Prevention, detection and treatment of communicable diseases, including tuberculosis<br>• Routine vaccinations, e.g. human papillomavirus, hepatitis B, diphtheria-tetanus, rubella, measles<br>• Prevention and management of | • Structural, environmental, organizational, community, interpersonal and individual level interventions to promote healthy behavior (e.g. nutrition; physical activity; no tobacco, alcohol or drugs)<br>• Prevention, detection and treatment of non-communicable | • Care for children with developmental delays<br>• Responsive caregiving and stimulation<br>• Psychosocial support and related services for adolescent mental health and well-being<br>• Parent skills training, as appropriate, for managing behavioral disorders in adolescents<br>• Structural, | • Assess conditions and ensure adequate nutrition for adolescent population groups according to age, gender, weight, physical activity levels and other key factors<br>• Ensure core health services to support adolescents with disabilities in an emergency<br>• Medical screening of former child soldiers, |

| | | | |
|---|---|---|---|
| childhood illnesses, including malaria, pneumonia, meningitis and diarrhoea<br>• Case management of meningitis | diseases<br>• Prevention, detection and management of anemia, especially for adolescent girls; iron supplementation where appropriate<br>• Treatment and rehabilitation of children with congenital abnormalities and disabilities | environmental, organizational, community, interpersonal and individual level interventions to prevent substance abuse<br>• Detection and management of hazardous and harmful substance use<br>• Structural, environmental, organizational, community, interpersonal and individual level interventions to prevent adolescent suicide<br>• Management of self-harm and suicide risks | and clinical management and community- based psychosocial support for survivors of sexual and/or gender-based violence<br>• Implement a minimal initial sexual and reproductive health service package<br>• Ensure safe access to and use and maintenance of toilets; materials and facilities for menstrual hygiene management and other interventions to improve water, sanitation and hygiene<br>• Promote mental health through normal recreational activities for adolescents, re-start of formal or informal education, and involvement in concrete, purposeful common interest activities<br>• Provide psychological first aid and first-line management of adolescent mental, neurological and substance-use conditions |

# Annex 2: List of participants in national workshops

**List National Workshop 'Strategie Adolescenten Gezondheid', Saturday 13th August 2022**

**Participants: Youth representatives and youth advocates**

| Nr | Naam | Organisatie | Functie |
|---|---|---|---|
| 1. | Vincke Ivana | VIDS | Jongeren medewerker |
| 2. | Hakiem A. Lalmahomed | Women's Rights Centre Suriname | Vrijwilliger |
| 3. | Michelle Belfor | UNFPA | Programme Assistant |
| 4. | Seran Naarden | Women's Right Centre | Facilitator |
| 5. | Matai Isaï Yudistrh Zamuël | UNICEF Suriname | Long Term Partner |
| 6. | Sunaina Mohan | Vereniging Jongeren van Commewijne | Co-Founder |
| 7. | Regiljo Nijman | Conscious Coaching | Trainer/leerkracht |
| 8. | Melody Hoefdraad | Individual | Facilitator |
| 9. | Sewbaran Shivanie Ranjana Shveta | Studentencommissie Faculteit der Medische Wetenschappen | Bestuurslid |
| 10. | Shiroemenie Somaroe | Ati Gi Ati | Ondervoorzitter |
| 11. | Koniki Kelvin | Nationaal Jeugdparlement van Suriname | Voorzitter |
| 12. | Cheyenne Samson | Green Heritage Fund Suriname | Consultant |
| 13. | Fay King | Facillitator | Facillitator |
| 14. | Valerie Setrosentono | Individual | Facilitator |
| 15. | Chathera Adrai | YAG of the UNFPA | Female Vice Chair |
| 16. | Lansdorf Joey | Stichting Nafasi | Educator |
| 17. | Sarafina Naarden | Stichting Nafasi | Mental health coach |
| 18. | Petra Raisa Hofwijk | She Empowerment Alternative | Project Coordinator |
| 19. | Romario Sahai | JCI SYMA | Local President |
| 20. | Priscilla Joëlla Hofwijk | She Empowerment Alternative | Founder |
| 21. | Isaura Morsen | Women's Right Centre | Jurist |
| 22. | Zaviska Lamsberg | JCI UNIFY | Director |
| 23. | Lienga Ernie | BOG | Coördinator Adolescent Health |
| 24. | Engin Kevin pengel | Stichting Wan Okasi youth | Penningmeester |
| 25. | Suzanna Bridgewater | Women'S Way Foundation Suriname | Co- Chair |
| 26. | Cindy Giddings | Y.A.M / ST Nafasi | Voorzitter/ Sociaal werker |
| 27. | Pinas, Duncan W. | Katholieke Jongeren Suriname (KJS) | Vice voorzitter |

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|---|---|---|---|
| 28. | Neghaney Sedney | Leo club | Vice Leo Associate |
| 29. | Ansoe Sowena | stg. JOSU | |
| 30. | Ayush Gajadien | Youth Advisory Group - UNFPA | Vice Chair |
| 31. | Lennox Relyveld | Youth Advisory Group UNFPA | Male chairperson |
| 32. | Savaira Naarden | Stichting Liefdevolle Handen | Adiministratief medewerker/ peerecudator |
| 33. | Demidof Syreeta | BOG | Public Health arts |
| 34. | Simran Mokiem | Jeugd Rode Kruis Suriname | Vrijwilliger |
| 35. | Shivanie Ranjana Shveta Sewbaran | Studentencommissie Faculteit der Medische Wetenschappen | Bestuurslid |
| 36. | Bhaggoe Mitesh | Directoraat AWJ | Onderdirecteur |
| 37. | Bronne Anisha | Medische Zending Jongeren | Jeugd |
| 38. | Jakoemo Geneviefe | Medische Zending Jongeren | Jeugd |
| 39. | Cumberbatch Daniel | Social and mental Health Advocacy Foundation Suriname | facilitator |
| 40. | Altaaf Baldew | | |
| 41. | Dheli Irina | Ministry of Social Affairs and Housing | |
| 42. | Ramjatan Shushtha | | |
| 43. | Koster Zoe | Boyscouts | scout |
| 44. | Vrij Rael | Boyscouts | scout |

**List National Workshop 'Strategie Adolescenten Gezondheid', Monday 15th August 2022**

**Participants: Service Providers and Policymakers**

| | Naam (volledig) | Organisatie | Afdeling / Bureau | Functie |
|---|---|---|---|---|
| 1. | Mahalia Somedjo - Breidel | Stichting Lobi Health Center | Educatie & Training | Coordinator Educatie en Training |
| 2. | Irina Palata- Dehli | Ministerie van Sociale Zaken en Volkshuisvesting | AMW (Algemeen Maatschappelijke dienst) | Maatschappelijk werker |
| 3. | Jacintha Jong-A-Lock - Dundas | Stichting 'Kinder-en Jongerentelefoon' | KJT | Direkteur |
| 4. | Renatha Simson | KAMPOS Samenwerkingsverband van Tribale volken in Suriname | NVT | Coordinator |
| 5. | Mw. S. Castelen-Misidjan | COVAB | Onderwijs/Decanaat | Studentendecaan |
| 6. | Lucretia Hoepel | Bureau voor Openbare Gezonheidszorg | Family and Community Health | Sub coordinator PMTCT |
| 7. | Bhaggoe Mitesh | Nationaal Jeugd Instituut | Od NJI | Onder direkteur NJI |
| 8. | Moenesar Madhoeri | Direktoraat Jeugdzaken van Ministerie van AWJ | Onderdirektoraat Nationale Jongeren Aangelegenheden | Onder direkteur |
| 9. | Savora Furhaga Omanette | Bureau voor Openbare Gezonheidszorg | Non-Communicable Diseases | Beleidsmedewerker |
| 10. | Shylina Lingaard | Vereniging van Inheemse Dorpshoofden in Suriname | Strategisch management | Strategisch management medewerker |
| 11. | Plet-Burleson | Vereniging van Sociaal Werkers in Suriname | Nvt | Voorzitter |
| 12. | Samoedj Sharona | Regionale Gezondheidsdienst | RHS Livorno | Verpleegkundige |
| 13. | Lienga Ernie | Bureau voor Openbare Gezonheidszorg | FCH | Coördinator Adolescent Health |
| 14. | Usila Jibodh | Bureau voor Openbare Gezonheidszorg | Family Health | Beleidsmedewerker |
| 15. | Lamsberg - Macnack Cher | Ministerie van Onderwijs Wetenschap en Cultuur | Basic Life Skills Education | Coordinator |
| 16. | Genevra Fujooah | Ministerie van Onderwijs Wetenschap en Cultuur | Pedologisch Instituut (Speciaal Onderwijs) | Coordinator |
| 17. | Patra Joshua | Stibula | . | Vrijwilliger |
| 18. | Summerville lilian | Korps politie suriname | Jeugdzaken | Hoofd |

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# Annex 3.: Indicators SDG for adolescent health

**SDG GOALS AND TARGETS RELEVANT TO ADOLESCENT HEALTH**

| Core global SDG targets | National Indicators | Baseline 2020 | National Targets by 2030 |
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| **Prevention and reduction of preventable maternal mortality and morbidity (SDG, 3.1)** | Maternal mortality ratio (SDG 3.1.1) | MMR: 120/100.000 (WHO,2017) | MMR: < 30/100.000 (WCAH, 2018) |
| | Antenatal care coverage, at least four visits | 68% (MICS,2018) | 10% increase |
| | Proportion of births attended by skilled health personnel (SDG, 3.1.2) | 99% (MICS, 2018) | 1% increase |
| **Prevention and reduction of preventable deaths of newborns and children under 5 years of age (SDG, 3.2)** | Under five mortality rate | UFMR: 17/1000 (MICS, 2018) | UFMR: <14/1000 live births (WCAH, 2018) |
| | Neonatal mortality rate (SDG 3.2.2) | NMR:12/1000 (MICS, 2018) | NMR: 7/1000 live births (WCAH, 2018) |
| **End the epidemics of AIDS (SDG, 3.3)** | Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations (SDG, 3.3.1) | # of new annual HIV infections 2016: approx. 300 (MOH, 2017) | Reduction new annual HIV infections by 50% (WCAH, 2018) |
| **Ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs. SDG 3.7** | Proportion of women of reproductive age (15-49 years) who have their need for family planning satisfied with modern methods. (SDG, 3.7.1) | 39% (MICS,2018) | Proportion of Adolescents satisfied with modern contraceptive methods: 90% (WCAH, 2018) |
| | Adolescent Birth Rate (aged 10–14 years; aged 15–19 years) per 1000 women in that age group (SDG, 3.7.2) | Adolescent birth rate: 64 per 1000 girls aged 15-19 (MICS, 2018) | 10% reduction in Adolescents birth rate in girls and adolescents 10–19 years (WCAH, 2018) |
| **Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential** | Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn, and child health, infectious diseases, non-communicable diseases and service capacity and access among the general and most disadvantaged population (SDG, 3.8.1.) | Not Available (NA) | To be Determined (TBD) |

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| **medicines and vaccines for all. (SDG, 3.8)** | Proportion of people covered by health insurance or a public health system per 1,000 population (SDG, 3.8.2) | 75% (Zorgraad, 2017) | TBD |
| | Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis. (SDG, 3.b.3) | NA | TBD |
| **Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries (SDG, 3c)** | Health worker density and distribution (SDG, 3.c.1) | NA | TBD |
| | Number of general practioners (GP)/10.000 and distribution | 5 GP's per 10,000<br>11 GP's per 10,000 in Paramaribo<br>1-2 GP's per 10,000 in the interior | 10 per 10,000 population (WHO, 2013c). |
| | Number nursing and midwifery personnel /10.000 | 4.3 nurses and midwifes per 10.000 | 23 per 10,000 (WHO, 2010) |
| **Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks. (SDG, 3.d)** | International Health Regulations (IHR) capacity and health emergency preparedness (SDG, 3.d.1) | NA | TBD |
| By 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes (SDG,4.1) | | | |
| By 2030, eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including persons with disabilities, indigenous | | | |

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| peoples and children in vulnerable situations | | | |
| Build and upgrade education facilities that are child, disability and gender sensitive and provide safe, non-violent, inclusive and effective learning environments for all (SDG4.5.) | | | |
| **Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the PoA of ICPD and the BPfA and the outcome documents of their review conferences. (SDG, 5.6)** | Proportion of women (aged 15-49) who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care (SDG, 5.6.1) | NA | TBD |
| | % of family planning demand met with modern contraceptives (benchmark: 75%) | | |
| | SRH Knowledge among adolescents – measures sexuality education | | |
| | Proportion of facilities that provide care for complications related to unsafe abortion, and/or safe abortion when not against the law | | |
| Target 5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation. | Percentage of women aged 20-24 who were married or in a union before age 18 (i.e. child marriage)<br>Percentage of girls and women aged 15-49 years who have undergone FGM/C, by age group (for relevant countries only)<br>Existence of laws and regulations that guarantee all women and adolescents informed choices regarding their sexual and reproductive health and reproductive rights regardless of marital status. | | |

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| **End all forms of discrimination against all women and girls everywhere. (SDG, 5.1)** | Whether or not legal frameworks are in place to promote, enforce and monitor equality and non- discrimination on the basis of sex. (SDG, 5.1.1) | See: paragraph 3.1.2. | TBD |
| **Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation. (SDG 5.2)** | Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual psychological violence by a current or former intimate partner, in the previous 12 months, by form of violence and by age (SDG, 5.2.1) | 32% (IDB, 2019) | TBD |
| | Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner, in the previous 12 months, by age and place of occurrence (SDG, 5.2.2) | NA | TBD |
| **Significantly reduce all forms of violence and related death rates everywhere (SDG, 16.1)** | Proportion of population subjected to physical, psychological or sexual violence in the previous 12 months (SDG, 16.1.3) | NA | TBD |
| **End abuse, exploitations, trafficking and all forms of violence against and torture of children (SDG 16.2)** | Number of victims of human trafficking per 100,000 population, by sex, age group and form of exploitation (SDG, 16.2.2) | NA | TBD |
| | Proportion of young women and men aged 18-29 who have experienced sexual violence by age 18 (SDG, 16.2.3) | NA | TBD |
| **Promote the rule of law at the national and international levels and ensure equal access to justice for all (SDG, 16.3)** | Proportion of victims of violence in the previous 12 months who reported their victimization to competent authorities or other officially recognized conflict resolution (SDG, 16.3.1) | NA | TBD |
| **Provide universal access to safe, inclusive and accessible, green and public spaces, in particular for women and children, older persons and persons with disabilities (SDG, 11.7)** | Proportion of women subjected to physical or sexual harassment, by perpetrator and place of occurrence (previous 12 months) (SDG,11.7.2) | NA | TBD |