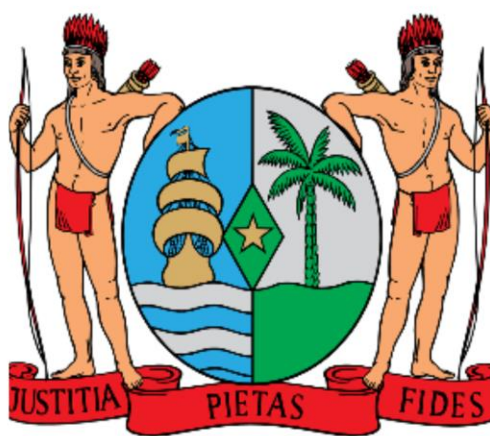
National Sexual and Reproductive Health and Rights Policy of Suriname, 2020-2030

Ministry of Health



National Sexual and Reproductive Health and Rights Policy of Suriname

2020-2030

Paramaribo, March, 2020

Table of Contents

Acronyms ... 4
Preface ... 6
Glossary ... 7
1. Introduction ... 12
2. Policy Framework ... 14
2.1. International frameworks ... 14
2.2. Regional policy frameworks ... 18
2.3. National policy frameworks ... 20
3. Contextual analysis on SRHR ... 23
3.1. Social determinants ... 23
3.1. 1. Population dynamics ... 23
3.1.2. Legal and policy framework ... 24
3.1.3. Social inequalities, including gender inequality ... 27
3.1.4. Socio cultural environment ... 28
3.1.5. Sexual Rights of specific groups ... 29
3.1.6. Health system ... 30
3.1.6.1. Health services ... 30
3.1.6.2. Health financing ... 31
3.1.7. Availability of qualified human resources ... 32
3.1.8. Availability of data and translation into policies and programs ... 33
3.2. Sexual and Reproductive Health Status of the population ... 35
3.3. Main barriers and challenges ... 41
4. Vision and Goal ... 45
5. Strategic objectives and outcomes ... 45
6. Essential sexual and reproductive health services ... 48
7. Core SDG targets, national indicators, baseline and targets ... 51
References ... 54

Acronyms

AAAQ	Availability, Accessibility, Acceptability and Quality
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal care
ART	Anti-Retroviral Therapy
BOG	Bureau of Public Health
BPfA	Bejing Platform for Action
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
COHSOD	Council for Social and Human development
CPD	Center for People's Development
CPS	Contraceptive Prevalence Survey
CRC	Convention on the Rights of the Child
CSE	Comprehensive Sexuality Education
DNA	De National Assembly
EmOC	Emergency Obstetric Care
EMTCT	Elimination Mother to Child Transmission
FSW	Female Sex Worker
GBV	Gender Based Violence
GBS	General Bureau for the Statistics
GO	Governmental Organization
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
ICPD	International Conference on Population and Development
IGSR	Institute for Graduate Studies
IMR	Infant Mortality Rate
IUD	Intra Uterine Contraceptive Device
LGBT	Lesbians, Gays, Bisexuals and Transgenders
MARPS	Most at Risk Populations
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MM	Medical Mission
MMR	Maternal Mortality Rate
MSM	Men having Sex with Men
MOH	Ministry of Health
MHA	Ministry of Home Affairs
MSAH	Ministry of Social Affairs and Housing
NBG	National Gender Bureau
NGO	Non-Governmental Organization
NHIS	National Health Information System

NSPHW	National Strategic Plan for Health and Wellbeing
PAHO	Pan-American Health Organization
PHC	Primary Health Care
PLHIV	People Living with HIV
PMTCT	Prevention Mother to Child Transmission
PoA	Program of Action
RGD	Regional Health Services
SPAOGS	Stichting Post Academisch Onderwijs Geneeskunde Suriname
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
TFR	Total Fertility Rate
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children Fund
UNIFEM	United Nations Development Fund for Women
WCAH	Women, Child, and Adolescent Health
WHO	World Health Organization

Preface

The health and wellbeing of all citizens in Suriname is one of the top priorities of the Government of Suriname, as clearly stated in both the 'Development Plan 2017-2021' and the 'National Strategic Plan for Health and Wellbeing in Suriname 2019 – 2028'.
This commitment is also clearly reflected in this national policy on Sexual and Reproductive Health and Rights (SRHR) 2020-2030, and in full accordance with the government's commitment to achieve the Sustainable Development Goals by 2030.
The government acknowledges Sexual and Reproductive Health and Rights as cornerstones of population and development policies, and will make all efforts to ensure universal access to sexual and reproductive health-care services, including family planning, information and education, and the integration of reproductive health into national strategies and programs by 2030.
The SRHR policy is meant to provide policy guidance and ensure proper coordination, integration and harmonious delivery of comprehensive SRH services and the development of an enabling socio-economic, cultural and legal environment in which all citizens can enjoy sexual and reproductive health of the highest quality and have the opportunity to fully exercise their rights.
The Ministry of Health expresses gratitude to all the relevant stakeholders, representatives of various ministries, Non-Governmental Organizations and developmental partners for their valued input, which helped to develop and finalize this document. We also thank the UNFPA for their continuous assistance in this field and the consultant dr. Julia Terborg for her technical support in drafting this policy.

Antoine Elias

Minister of Health

Glossary

Universal Health Coverage

Universal Health Coverage (UHC) means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

This definition of UHC embodies three related objectives:

- Equity in access to health services - everyone who needs services should get them, not only those who can pay for them;
- The quality of health services should be good enough to improve the health of those receiving services; and
- People should be protected against financial-risk, ensuring that the cost of using services does not put people at risk of financial harm.

UHC is firmly based on the WHO constitution of 1948 declaring health a fundamental human right and on the Health for All agenda set by the Alma Ata declaration in 1978. UHC cuts across all of the health-related Sustainable Development Goals (SDGs), (WHO 2010, General Assembly UN 2012).

Sexuality

Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors (WHO 2002).

Sexual health

A state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled (WHO, 2002).

Reproductive health

A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so (ICPD 1994).

Reproductive rights
Human rights related to reproduction, parenthood, reproductive health and fertility, including menopause, right to services and supplies, such as safe, effective, affordable and acceptable methods of family planning of their choice, ante – and postnatal care, skilled attendants at birth, safe abortion services, infertility services and autonomous decision making about reproduction (ICPD 94).

Sexual rights
The fulfilment of sexual health is tied to the extent to which human rights are respected, protected and fulfilled. Sexual rights embrace certain human rights that are already recognized in international and regional human rights documents and other consensus documents and in national laws. Rights critical to the realization of sexual health include:

- the right to life, liberty, autonomy and security of the person;
- the right to equality and non-discrimination;
- the right to be free from torture or cruel, inhuman or degrading treatment or punishment;
- the right to privacy;
- the right to the highest attainable standard of health (including sexual health) and social security;
- the right to marry and to found a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage;
- the right to decide the number and spacing of one's children;
- the right to information, as well as education;
- the right to freedom of opinion and expression, and
- the right to an effective remedy for violations of fundamental rights.

The application of existing human rights to sexuality and sexual health constitute sexual rights. Sexual rights protect all people's rights to fulfil and express their sexuality and enjoy sexual health, with due regard for the rights of others and within a framework of protection against discrimination. Sources: (WHO, 2006 and 2010) (Montevideo Consensus 2013).

Social determinants of health: The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries (WHO, 2008).

Gender identity
Gender identity refers to a person's innate, deeply felt internal and individual experience of gender, which may or may not correspond to the person's physiology or designated sex at birth. It includes both the personal sense of the body, which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical, or other means, and other expressions of gender, including dress, speech, and mannerisms *(*UNFPA and Promundo, 2010).

Gender-based Violence (GBV)
GBV is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between females and males. The nature and extent of specific types of GBV vary across cultures, countries and regions. Examples include sexual violence, including sexual exploitation/abuse and forced prostitution; domestic violence; trafficking; forced/early marriage; harmful traditional practices such as female genital mutilation; honor killings; and widow inheritance.
(UNICEF, UNFPA, UNDP, UN Women). "Gender Equality, UN Coherence and You".

Gender equality (Equality between women and men)
This refers to the equal rights, responsibilities and opportunities of women, men, girls and boys. Equality does not mean that women and men will become the same but that women's and men's rights, responsibilities and opportunities will not depend on whether they are born male or female. Gender equality implies that the interests, needs and priorities of both women and men are taken into consideration, recognizing the diversity of different groups of women and men. Gender equality is not a women's issue but should concern and fully engage men as well as women. Equality between women and men is seen both as a human rights issue and as a precondition for, and indicator of, sustainable people-centered development (UN Women).

Gender equity
Means fairness and justice in the distribution of benefits and responsibilities between women and men, recognizing their different needs and interests, and requiring a redistribution of power and resources (UNWOMEN).

Unsafe abortion
A procedure for terminating an unwanted pregnancy either by people lacking the necessary skills or in an environment lacking the minimal medical standards or both (WHO, 2017).

Cervical cancer
Cancer that forms in tissues of the cervix (the organ connecting the uterus and vagina). Human Papilloma Virus (HPV) is the primary cause of cervical cancer. Over three quarters of sexually active women get it at some point in their lives. There are over 100 types of HPV, but two types (16 and 18) cause 70% of cancers (WHO, 2017).

Comprehensive sexuality education
Involves the provision of accurate, age-appropriate and up-to-date information on physical, psychological and social aspects of sexuality and reproduction, as well as sexual and reproductive health and ill health. Accurate information can address gaps in knowledge, dispel misconceptions and build comprehensive understanding, as well as foster empowering skills, positive attitudes and values, and healthy behaviors. All interventions should ensure that individuals have the knowledge and skills necessary to make well informed choices about sexuality and reproduction and to follow up on their choices. Within the health sector, information can be made available in the context of preventive or curative care consultation, or

in non-clinical settings in the context of health education outreach. Within the education sector, age-appropriate comprehensive sexuality education (CSE) curricula guidance and standardized content are available for preschool through university levels, and can be provided in school as well as in out-of-school settings (WHO, 2016).

STILTE

1. Introduction

The basis and mandate of the National Sexual and Reproductive Health and Rights Policy is drawn from our constitution which states that every citizen is entitled to fundamental rights and freedom. The Constitution of Suriname recognizes that "Everyone has a right to health, it being the duty of the State to promote general health care by systematic improvement of living and working conditions and the dissemination of information on health protection." (Article 36)

Sexual and Reproductive Health: The state of complete physical, mental and social well-being, not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes' (Program of Action (PoA), International Conference on Population and Development, 1994).

The right to good health includes sexual and reproductive health, which is defined as 'the state of complete physical, mental and social well-being, not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes' (Program of Action (PoA), International Conference on Population and Development, 1994).

Universal access to health and universal health coverage

In addition to our constitution, the countries of the American Region committed to move forward towards universal health, adopting the right to health, equity, and solidarity, as core values[1]. Through an integral approach, the strategy articulates the conditions that will allow countries to focus and assess their policies and measure progress around four simultaneous, interdependent strategic lines:

1. Expanding equitable access to comprehensive, quality, people- and community centered health services;
2. Strengthening stewardship and governance;
3. Increasing and improving financing with equity and efficiency, and advancing toward the elimination of direct payments that constitutes a barrier to access at the point of service;
4. Strengthening multi-sectoral coordination to address the social determinants of health that ensure the sustainability of universal coverage.

Objective of the national policy on SRHR

Against this background the government of Suriname, under the leadership of the Ministry of Health formulated its first Sexual and Reproductive Health and Rights (SRHR) policy in 2012, covering the period 2013-2017. The Minister of Health officially approved this policy document.

[1] Approval of the strategy for universal access to health and universal health coverage (Res. CD53/5, Rev. 2) in the 53rd Directing Council of the Pan American Health Organization (PAHO, 2014)

In accordance with international agreements and the national development plan, in the past years several national policies and programs have already been developed in areas directly related to Sexual and Reproductive Health. This second national SRHR policy for the ten-year period 2020-2030 should be perceived as an overarching framework to:

- Guide and enhance a coordinated, integrated and monitored national Sexual and Reproductive Health response, led by the Ministry of Health;
- Facilitate the development of legislation, regulations, standards and guidelines for the delivery of all Sexual and Reproductive Health services in order to ensure quality and standardization of services;
- Enhance the integration of SRHR services at all levels of health service delivery, in particular in primary health care;
- Facilitate the mobilization of adequate and sufficient human, material and financial resources to support the implementation of activities, including information and education;
- Strengthen a multi-sectoral approach and collaboration between government and non-government partners, including private sector, civil society and community-based organizations.

This policy provides the agreed intentions and main directions to achieve the goal(s), based on collected evidence, compiled of both statistical data as well as daily experiences of key stakeholders (service providers, users, etc.). It is within this larger framework, that also the strategic areas and national targets for the period 2020-2030 are identified, as the roadmap for implementation of the policy.

Methodology

This policy was developed through multiple consultations with key stakeholders in a phased process that was led by the Ministry of Health. At the start of this process, already in 2018 and 2019 consultation workshops on SRHR were held with a wide variety of key stakeholders. This consultation phase was followed with the development of an initial policy framework, based on desk review and preliminary exploration of available data. This first draft was presented by the consultant to a core group of experts in SRHR, composed of key government officials, UN staff and key NGO's. After a basic agreement was reached on this policy framework, the consultant proceeded with the further development of the situation analysis, using as much as possible available recent statistical data and information, obtained not only through extensive review of relevant international and national guidelines and strategies/plans, but also through bilateral consultation of key informants. Guided by the larger policy conceptual framework, achievements and gaps, strategic directions for the period 2020-2030 were formulated, and again discussed with and reviewed by the core experts' group, which eventually resulted in a draft national policy on SRHR.

In a second phase of the consultation process, the draft policy was shared with a larger group of staff in the Ministry of Health, for their review. The document was disseminated two weeks in advance, to ensure that everybody had sufficient time to read and commented on the draft. With all relevant comments processed, the SRHR policy was finalized and officially presented to the high authorities for their formal approval.

2. Policy Framework

2.1. International frameworks

To underscore its international commitment to sexual reproductive health and rights, the Surinamese Government ratified a number of agreements and also committed to non-binding agreements that speak to the issue of health including access to health care, health education and promotion, and gender equality. Among these are the Human Rights Conventions, the Program of Action of the International Conference on Population and Development (PoA of ICPD), the Convention for the Elimination of All Forms of Violence Against Women (CEDAW), the Beijing Declaration and Platform for Action, the Convention on the Rights of the Child (CRC), the Montevideo Consensus, the Convention on the Rights of Persons with Disabilities and the Sustainable Development Goals (SDGs).

Box 1: SDG's

- **SDG Target 3.7**: to "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 by 2030"
- **SDG Target 5.6**: to "ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the ICPD Program of Action and the Beijing Platform for Action and the outcome documents"
- **SDG10** – reducing inequalities within and among countries – is crucial for further improvement of sexual and reproductive health.

The Sustainable Development Goals (SDGs): The government acknowledges Sexual and Reproductive Health and Rights as main cornerstones of population and development policies, and crucial conditions for achieving the 2030 agenda **for Sustainable Development.** In particular, protection and promotion of SRHR stands out as a core pledge under SDG 3 on health, and SDG 5, SDG 10 on gender equality (see box 1)**.**

Human Rights Based Approach: the Availability, Accessibility, Acceptability and Quality (AAAQ) framework

Sexual and reproductive health is not only about health, but of equal importance is the link with rights. Therefore, this national policy is guided by a human rights-based approach and integrates a gender perspective, which reflects the political will to eliminate all forms of discrimination based on sex, gender identity and sexual orientation and to acknowledge, protect and respect the rights of all individuals, including their sexual and reproductive rights.
The Committee on Economic, Social and Cultural Rights (ESCR Committee) has set forth four essential elements of the right to health: **availability, accessibility, acceptability and quality** (known as the AAAQ framework).[2] This framework has been adopted by a number of UN Treaty Monitoring Bodies and domestic courts in assessing states' obligations under the right to health. Notably, in 2016, with the 'General Comment 22' on the right to sexual and reproductive health, the ESCR Committee applied the AAAQ framework to sexual and reproductive health care, providing states with clear guidance on the measures they must take to fulfil their human rights obligations.[3]

Elements of the AAAQ framework regarding the right to sexual and reproductive health
The elements of the AAAQ framework are interrelated, to ensure that they holistically address these different facets of the right to health in the provision of SRH care. The AAAQ framework contains four interrelated and essential elements for comprehensive sexual and reproductive health care, as mainly described in the 'ESCR Committee, General Comment No. 22' (2016)**:**

1. Availability

An adequate number of functioning healthcare facilities, services, goods and programs should be available to provide the population with the fullest possible range of sexual and reproductive health care. This includes ensuring the availability of facilities, goods and services for the guarantee of the underlying determinants of the realization of the right to sexual and reproductive health, such as safe and potable drinking water and adequate sanitation facilities, hospitals and clinics.
Ensuring the availability of trained medical and professional personnel and skilled providers who are trained to perform the full range of sexual and reproductive healthcare services is a critical component of ensuring availability. Essential medicines should also be available, including a wide range of contraceptive methods, such as condoms, oral contraception including emergency contraception, injectable and long term methods (reversible such as implants and IUDs and irreversible such as tubal ligation and vasectomy), commodities to

[2] Committee on Economic, Social and Cultural Rights (ESCR Committee), General Comment No. 14: The right to the highest attainable standard of health (Art. 12), (22nd Session, 2000), in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at XX, para. XX, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008).
[3] ESCR Committee, General Comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social, and Cultural Rights), U.N. Doc. E/C.12/GC/22 (2016) [hereinafter ESCR Committee, Gen. Comment No. 22].

ensure post abortion care, and medicines, including generic medicines, for the prevention and treatment of sexually transmitted infections and HIV, reproductive cancers and infertility. Unavailability of goods and services due to ideologically based policies or practices, such as the refusal to provide services based on conscience, must not be a barrier to accessing services. An adequate number of healthcare providers willing and able to provide such services should be available at all times in both public and private facilities and within reasonable geographical reach.

2. Accessibility

Health facilities, goods, information and services related to sexual and reproductive health care should be accessible to all individuals and groups without discrimination and free from barriers. Accessibility includes physical accessibility, affordability and information accessibility.

- **Physical accessibility**
  Health facilities, goods, information and services related to sexual and reproductive health care must be available within safe physical and geographical reach for all, so that persons in need can receive timely services and information. Physical accessibility should be ensured for all, especially persons belonging to disadvantaged and marginalized groups, including, but not limited to, persons living in rural and remote areas, persons with disabilities, refugees and internally displaced persons, stateless persons and persons in detention. When dispensing sexual and reproductive services to remote areas is impracticable, substantive equality calls for positive measures to ensure that persons in need have communication and transportation to such services.

- **Affordability**
  Publicly or privately provided sexual and reproductive health services must be affordable for all. Essential goods and services, including those related to the underlying determinants of sexual and reproductive health, must be provided at no cost or based on the principle of equality to ensure that individuals and families are not disproportionately burdened with health expenses. People without sufficient means should be provided with the support necessary to cover the costs of health insurance and access to health facilities providing sexual and reproductive health information, goods and services.

- **Information accessibility**
  Information accessibility includes the right to seek, receive and disseminate information and ideas concerning sexual and reproductive health issues generally, and also for individuals to receive specific information on their particular health status. All individuals and groups, including adolescents and youth, have the right to evidence-based information on all aspects of sexual and reproductive health, including maternal health, family planning, sexually transmitted infections, HIV prevention, post-abortion care, infertility and fertility options, and reproductive cancers.
  Such information must be provided in a manner consistent with the needs of the individual and the community, taking into consideration, for example, age, gender, language ability,

educational level, disability, sexual orientation, gender identity and intersex status. Information accessibility should not impair the right to have personal health data and information treated with privacy and confidentiality.

3. Acceptability

All facilities, goods, information and services related to sexual and reproductive health must be respectful of the culture of individuals, minorities, peoples and communities and sensitive to gender, age, disability, sexual diversity and life-cycle requirements. However, this cannot be used to justify the refusal to provide tailored facilities, goods, information and services to specific groups.

4. Quality

A key component in the access to SRHR services is **quality**. It is not sufficient to just have services available and affordable. Facilities, goods, information and services related to sexual and reproductive health must be of good quality, meaning that they are evidence-based and scientifically and medically appropriate and up-to-date. This requires trained and skilled healthcare personnel and scientifically approved and unexpired drugs and equipment. The failure or refusal to incorporate technological advances and innovations in the provision of sexual and reproductive health services, such as assisted reproductive technologies and advances in the treatment of HIV and AIDS, among other advances, jeopardizes the quality of care.

In summary:

- **Availability:** SRH services must be available in sufficient quantity and continuous supply.
- **Accessibility:** SRH services must be accessible to everyone, in terms of physical access, affordability, access to information and non-discrimination.
- **Acceptability:** SRH services must be acceptable to consumers, culturally appropriate and be sensitive to vulnerable groups.
- **Quality:** SRH facilities, goods and services must comply with applicable quality norms and standards.

2.2. Regional policy frameworks

On the regional level Suriname committed to multiple regional agreements related to sexual and reproductive health. In follow up of the ICPD Program of Action, in 2013 the Montevideo Consensus was adopted, including its 'Operational Guidelines'. In 2019, Suriname submitted its first country report, 2013-2018, at the Third Regional conference on ICPD in Lima, Peru.[4]

The government also committed to the **'Regional Plan of Action for Women's, Children's and Adolescents Health (WCAH)', 2018-2030 (see box 2.).** This plan is a context bound translation of the earlier developed **'Global Strategy for Women's, Children's and Adolescents' Health' (2016–2030):** Within the overall framework of the SDGs, this strategy provides guidance to accelerate in particular women's, children's and adolescents' health. It takes a life-course, gender-based approach and views women's, children's and adolescents' health from an integrated and multi-sectoral perspective.

Box: 2. Regional Plan of Action for WCAH, 2018-2030. Strategic Lines of Actions

- Strengthen a transformative policy environment to reduce health inequities among women, children, and adolescents.
- Promote universal, effective, and equitable health and well-being for all women, children, and adolescents in their families, schools, and communities throughout the life course.
- Expand equitable access to comprehensive, integrated, quality health services for women, children, adolescents, and families, that are people-, family-, and community-centered.
- Strengthen information systems for the collection, availability, accessibility, quality, and dissemination of strategic information.

Other relevant ongoing regional agreements on SRHR, include:

1. **The CARICOM Integrated Strategic Framework for the reduction of Adolescent Pregnancy** (2014).

UNFPA collaborated with CARICOM for the development of an 'Integrated Strategic Framework' (ISF) for the Reduction of Adolescent Pregnancy in 2014, which was officially approved by the CARICOM's 'Council for Human and Social Development' (COHSOD). The overall goal of the ISF is to reduce the number of adolescent pregnancies in each country of the English- and Dutch speaking Caribbean by at least 20 per cent within the time period 2014-2019.

2. **The "Adolescent and Youth Regional Strategy and Plan of Action "Washington, D.C.: PAHO (2010):** At the 48th and 49th meetings of the Directing Council in 2008 and 2009, the Regional Strategy for Improving Adolescent and Youth Health and a Plan of Action on Adolescent and Youth Health, respectively, were approved. The Plan of Action 2010 – 2018 embraces seven strategic areas for joint collaboration, each with specific objectives, actions and indicators: strategic information and innovation; enabling environments for health

[4] Suriname Progress report on the implementation of the Montevideo Consensus, 2013-2018

and development using evidence-based policies; integrated and comprehensive health systems and services; human resources capacity-building; family, community, and school-based interventions; strategic alliances and collaboration with other sectors; and social communication and media involvement.

3. **Agreements on Sexuality education**:
    a. 56th Directors Council, CARICOM standing Committee of Ministries of Education resolution to advance Health and Family Life Education (HFLE), 1994;
    b. The Mexico Ministerial Declaration “Preventing through Education” (2008), Caribbean Cooperation in Health.
4. **Convention of Belém do Pará (2002):** The Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women or the Convention of Belem do Para. To align Surinamese legislation to this convention, a national law ‘Domestic Violence Act’ was developed and approved by parliament in 2009.

2.3. National policy frameworks

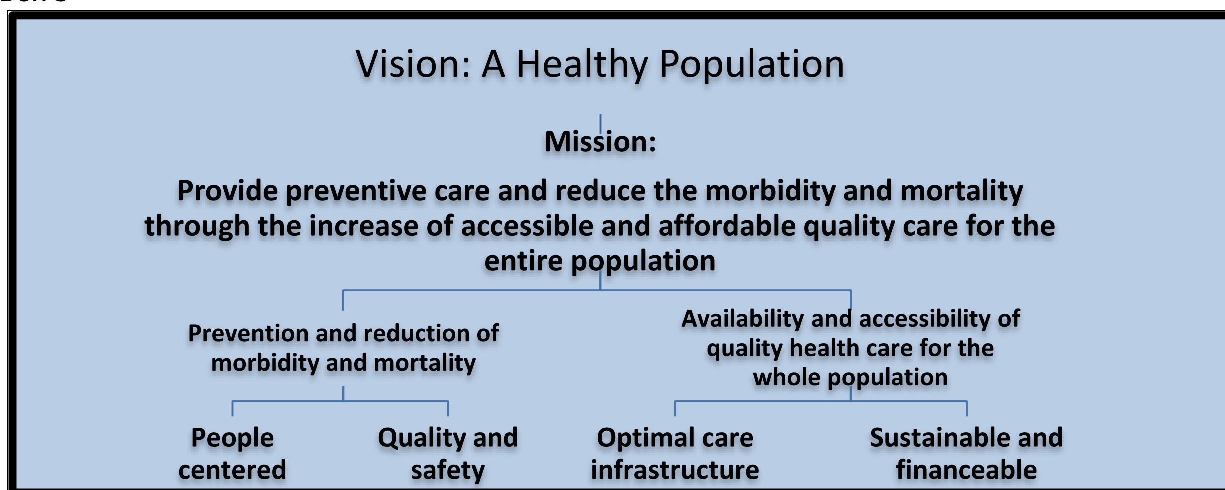
The National Sexual and Reproductive Health and Rights policy is imbedded in a national policy framework that follows, in general, the directions, principles and guidelines set in the:

1. **'Development Plan, 2017-2021'**: The government of Suriname has identified two key health policy areas in its Development Plan for 2017-2021. These are the 'Prevention and reduction of morbidity and mortality' and 'Availability and accessibility of quality health care for the whole population'.
2. **Health in all Policies (2017)**: A recent assessment of health equity in Suriname reports inequities in health status and prevalence of risk factors across ethnic, geographic, gender and socio-economic status. In addressing the social determinants of health, health inequities, and the SDG-2030 health agenda, the government of Suriname has approved a 'Health in All Policies Approach' (HiAP).
3. '**Gender vision policy 2021-2035':** In 2019 the long term 15-year period 'Gender vision policy 2021-2035' was developed by the 'Bureau for Gender affairs (BGA) to integrate a gender perspective in the development framework. Seven priority areas are identified, namely: health, education, labor, gender based violence, legal and regulatory framework, environment and climate change and power- and decision making.
4. **The 'National Strategic Plan on Health and Wellbeing, 2019-2028**', of the Ministry of Health (MOH). (explained below)

National Strategic Plan for Health and Wellbeing

The Ministry of Health has adopted a vision and a mission statement (Box 3) that focuses its plans, actions and responsibilities on the transformation of the health system to achieve strategic goals in both policy areas aligned with building and strengthening a health system that is people-centered, that promotes healthy lifestyles, that provides effective preventive services and optimal care with quality and safety, and responds to the needs and expectations of the population.

Box 3



The SRHR policy follows the principles as formulated within the National Strategic Plan for Health and Wellbeing (NSPHW), 2019-2028, which is aimed at full implementation of a primary health care approach to health systems that is people-centered, ensures the right to health, is equitable and where the people of Suriname receive care and benefits according to their needs and contribute according to their capacity.

The NSPHW speaks of the building of a 'Model of Care', which is elaborated into the following principles:

Values and Principles	Trust, equity, quality and solidarity, supported on principles of ownership, integrity, and professionalism constitute the pillars towards universal access to health and universal health coverage is a reality.
People-centered care	People centered care focuses on the "whole person", care that considers the physical, mental, emotional and social dimensions of the person during the entire life course. It means empowering people to better manage their health through strategies such as health education, self-care and self-management of diseases, and adopt intercultural and gender-based approaches to health care, adapted to the specific needs of the person.
Universal access to health and universal health coverage	All people and communities have access, without any kind of discrimination, to comprehensive, appropriate and timely, quality health services determined at the national level according to needs, as well as access to safe, affordable, effective, quality medicines, while ensuring that the use of these services does not expose users to financial hardship, especially groups in conditions of vulnerability.
Comprehensive, integrated, quality health services	Comprehensive, quality, universal and progressively expanded health services, in accordance with health needs and priorities, should be available to all people, with no difference in quality without distinction of their economic or social condition. Furthermore, these services should be designed with due regard to the differentiated and unmet needs of all

	people and the specific needs of groups in conditions of vulnerability. The first level of care plays a very important role in coordinating the continuum of services and the flow of information throughout the entire network of services, regardless of where care is delivered.
Human resources: competent and sufficient in number	Achieving a first level of care with expanded roles and increased capacity to deliver and coordinate care requires improved human resources capacity. Steps in the right direction should include increasing employment opportunities with attractive labor conditions and incentives, particularly in underserved areas; and consolidating multidisciplinary health teams with diverse competencies determined by needs and cultural characteristics of different population groups.
Access to medicines and appropriate technologies and infrastructure	Improvement of the availability and rational use of medicines (including vaccines) and other health technologies, to expand the capacity to provide quality health services, particularly at the first level of care, is an important component of transformation. Providing access to integrated health information, e-health services (including telehealth and telemedicine) and other technologies to improve communications and capacity to provide quality services
Strong Leadership and Governance	Strengthening the leadership capacity of the Ministry of Health as the national health authority by establishing new legislation or mechanisms or using existing ones, in order to promote the formulation and implementation of inclusive policies and regulations and to ensure accountability and transparency. The policy-making process should include dialogue with all stakeholders and social participation to ensure that all groups are represented and that special interests do not prevail at the expense of public health interests. Plans should include defined targets that are monitored and evaluated frequently and established mechanisms for social participation in planning, monitoring and evaluation, to promote transparency.

3. Contextual analysis on SRHR

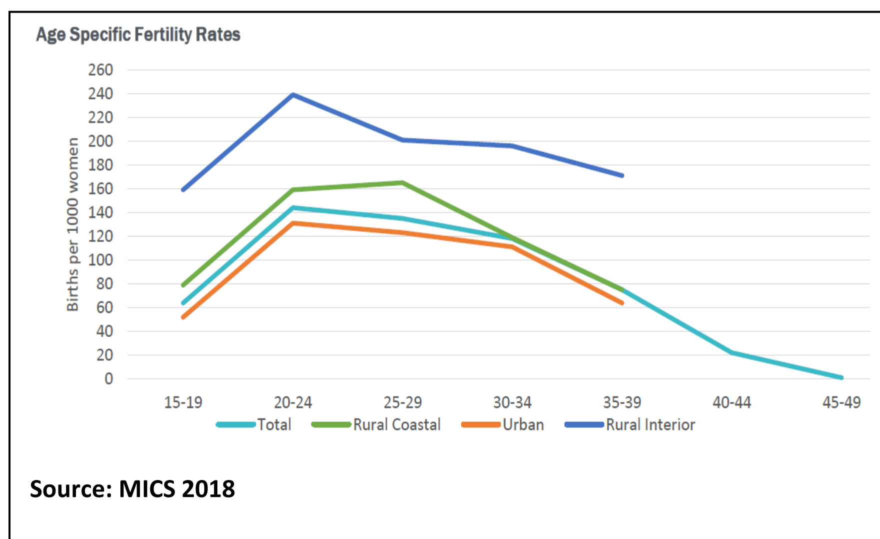
3.1. Social determinants

Guided by the key components and basic principles of the policy framework, in this chapter an overview is provided of the contextual environment, in particular the current sexual and reproductive health status of the Surinamese population, against the background of the social determinants of health. Understanding the specific Surinamese context is essential for the development of effective policies and programs that takes into consideration specific circumstances of different population groups. From this evaluation and analysis, barriers in achieving the targets are identified as well as required and feasible responses for the next ten years.

3.1. 1. Population dynamics

Suriname is a relatively large country, 163.000 km2, with a very small population, of which 78% is concentrated in the urban coastal areas and approximately 10% in the sparsely populated interior, most of them Indigenous Peoples and Maroons. For 2018, Suriname's population is estimated at 568,000, with almost equal share of women, 49.8%. Annual average number of life births is around 10.000 births. In the last decades Suriname went through significant changes in demographic profile, mainly caused by urbanization, ageing and migration. While population size did not increase significantly, there are clear changes in population composition. Suriname has a large share of youngsters, with children below 19 years constituting nearly 37% of the total population. In accordance with trends in the Caribbean, also in Suriname the growth of the 60 years and older age group is tremendous, which grew by almost 30% from census 2004 to census 2012, placing Suriname in the category of countries with 'Moderate to Advanced ageing'. In the past decade the inflow of (labor) migration has increased significantly, mainly composed of persons from Brazil, Dominican Republic, Guyanese, Haitians, Chinese, Cubans working in a wide variety of sectors, including small gold mining, agriculture and fishery, construction and health. Notable is that the majority of sex workers in Paramaribo and small goldmines are female migrants from the Dominican Republic (Duyves and Heemskerk, 2019).

The total fertility rate (TFR) per 2018 for Suriname as a whole is 2.17 children per woman aged 15 to 44yrs (ABS, 2019).



Source: MICS 2018

The Maroon population has the highest fertility in the adolescent and adult ages, with 4.47 children per woman (Census 2012), which probably explain the enormous growth of this ethnic group from 72.000 (Census 2004) to 117.000 according to census 2012, which made them the second largest population group in Suriname, following the Hindustanis. The fertility rate is higher in rural areas, among women with low level of education and women with lower level of well-being (MICS 2018).

The decline in the total fertility rate and a decrease in the general mortality rate have led to an increase of life expectancy, which is currently 68.7 years for males and 75.1 years for females (WHO, 2016)[5].

3.1.2. Legal and policy framework

Legislation, policies and regulations play a pivotal role in protecting or violating people's human rights, including sexual and reproductive rights. The advocacy of the past five years has been accompanied by significant progress in legislation and policy development to guarantee the right to health. In the following table an overview is presented of the current status of relevant international and national legislation related to Sexual and Reproductive Health.

SRHR related legislation

SRHR related international legislation		
International legislation	**Status**	**Comments**
Convention on the Elimination of all forms of Discrimination Against Women (CEDAW)	Ratified March 1993	Combined 4th, 5th and 6th report submitted 21 June 2017
The CEDAW optional protocol	Not ratified	
The Convention on the Rights of the Child (CRC)	Ratified in March 1993	In 2013: Combined 3rd and 4th country report submitted to the UN
The Belém do Pará Treaty, an inter-American Convention	Ratified by Suriname on February 19, 2002	In line with this treaty national legislation has been developed and approved in 2009 and 2012
Two optional protocols of the CRC	Ratified in Nov. 2011	These protocols are about the sale of children, child prostitution, child pornography, and the involvement of children in armed conflict.

[5] See: https://www.who.int/countries/sur/en/

ILO agreement 103	Not ratified	This agreement focuses on the protection of maternity. Part of ILO agreement is covered by recently approved national legislation on 'Family Employment Protection Act (2019).
The ILO Code of Practice on HIV/AIDS and the World of Work	Signed in January 5, 2015	The Decent Work Country Program 2014-2016 has been implemented. Preparations are ongoing to start second Decent Work Country Program, 2019 - 2021.
Convention on the Rights of People with Disability	Ratified, March 2017	A national policy document and an action plan are being formulated.
SRHR related national legislation		
National legislation	**Status**	**Comments**
Regulation of the Ministry of Education regarding pregnant learner retention and re-entry	Regulation exists since 1985	There is no law or policy regarding pregnant learners' retention and reentry. Annually, the Ministry of Education sends a circular letter to all schools in the secondary educational level, in which the ministry stated that the government does not allow removal from school due to pregnancy with reference to the right of every child to education. An unwritten rule communicated to all registered girls is that a second pregnancy in schools will not be accepted and removal will be definite.
Abortion legislation In Suriname abortion is illegal and penalized in the Article 309, paragraphs 355-358 of the Surinamese Penal Code	Surinamese Penal Code , 1993	Under Suriname's criminal code, abortion is illegal under all circumstances, there are no exceptions. However, since establishment of this law, there have been no cases of prosecution or penalization for abortion.
Marriage legislation	Suriname marriage legislation was revised through the "Revision of the Marriage Act 1973", (2003)	Minimum age for entering marriage for women was brought from 13 to 15 and for men from 15 to 17 years. Further revisions of the revised marital law are underway, elevating marriage age to 18 years for both women and men.
The Act Curbing Domestic Violence	June 3, 2009	This law enforces a fast procedure for protection of victims of domestic violence at an early stage through the procedure of requesting a 'protection order'.
Revision of moral law	Restrictive articles removed, 2010	Articles 291, 292 and 533, including restrictive access of adolescents to contraceptives, have been removed.
Revision Penal Code with regard to sex crime, sexual abuse and exploitation, child pornography.	Revised in 2010	Revision includes changes with regard to sex crime, sexual abuse and exploitation, child pornography. Rape within marriage is now considered a crime. All sex with minors younger than 16 yrs. is forbidden, even when minor gives his or her consent.
Bill against Stalking and Harassment	Approved April 2012	A stalker can get up to 12 years in prison, and fined 150,000 SRD.
Law on National Health Insurance	Approved, October 2014	All Surinam residents, including foreigners living in Suriname, are entitled to a basic healthcare package. Anyone with the Surinamese nationality, aged 0-16

		years and 64 years and older, is exempted from the premium payment. Every employer is required to pay a portion of the premium, at least 50%. The remaining part is paid by the employee. Currently this law is being revised.
Revision of the Penal Code with regard to trafficking in persons (2015).	Approved, 2015	This code was revised in line with the United Nations Convention against Transnational Organized Crime, including the 'Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children' and the 'Protocol against the Smuggling of Migrants by Land, Sea and Air'.
Revision of hate speech, The Surinamese Penal Code: The Discrimination Law art.500a,	Approved, 2015	The Penal Code was amended with articles sanctioning hate speech. Sexual orientation is added as a ground for non-discrimination complaints. Violation of this law can result in a prison sentence of up to one year or a fine. The amended penal code does not set standards for determining what constitutes such discrimination or hate speech.
Draft Law on 'Violence and Sexual Intimidation in the workplace'	The draft law was presented to Parliament in 2019.	Draft law is being discussed and revised in parliament
Draft Law on 'Equal Treatment in the workplace'	The draft law was presented to Parliament in 2019.	Draft law also relates to SRHR. Draft is being discussed and revised in parliament
Family Employment Protection Act (2019).	Approved, 2019	Employed women are entitled to paid maternity leave for at least 16 weeks and men to 8 days paternity leave. Women who give birth to multiple births, i.e. three or more children, are entitled to maternity leave up to a maximum of 24 weeks.
Revision of the Penal Code by adding penalization of 'grooming of children under the age of 16years'.	Approved, January 2020	Grooming is defined as the behavior whereby an offender who gained a child's trust through chat or email contact, seduces the child into sharing intimacy. The offender makes the child susceptible to sexual abuse in the digital and physical world.

Policy framework

Against the background of the Development Plan 2017-2021, in the past years multiple and serious efforts have been made to build a systematic and focused response on a wide variety of issues related to sexual and reproductive health and rights, guided by national strategic plans and policies, inter alia, a National HIV Plan (2014-2020), a National Policy for a Structural approach of domestic violence (2014-2017), a National Action Plan Trafficking, a National Cancer Control Plan (2019-2028), a National Safe Motherhood and Newborn Health Action Plan (2013-2016) as well as a Gender Action Plan (2019-2020) and a Gender Vision Policy Document (2021-2035). In the gender vision policy document 2021- 2035, health and gender-based violence are identified as priority areas.

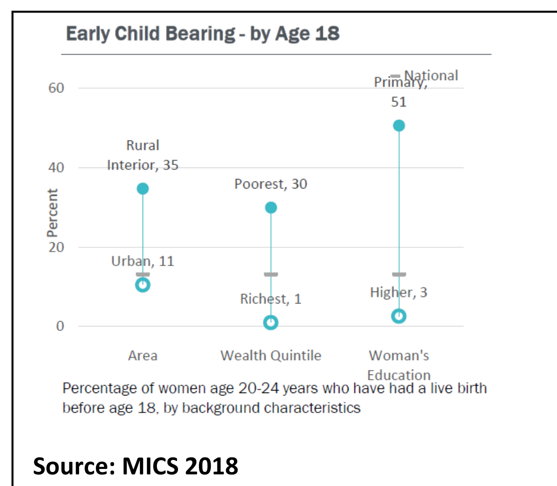
Currently, a strategy for adolescent health 2019-2030 and a strategy for maternal and new born health 2020-2030, are being drafted. The national maternal health and mortality reduction priority plan (July 2019- Sept 2020) is awaiting validation. With the development and implementation of the 'Health in All Policies' (HIAP) (2017), the government aims at integrating

health in all policies and strengthen inter-ministerial and inter-sectoral cooperation. This policy emphasizes the need of addressing social determinants of health in collaboration across all levels and sectors of government and close partnerships with the private sector, civil society, and community-based organizations in the search for effective responses.

While key policies are developed or being developed, a major challenge remaining is the lack of adequate structures and mechanism to ensure coordinated and integrated implementation of policies and programs. Currently, the area of 'Sexual and Reproductive Health' is part of the portfolio of the department of 'Family Health' at the Bureau of Public Health. However, capacity at this department is insufficient for adequate coordination. In the past years, efforts have been made by the Ministry of Health to establish some additional structures, namely working groups in the areas of HIV, cancer control, adolescent health and maternal health. Recently a multi-sectoral steering committee on maternal and new born health has been installed aimed at reduction of maternal and new born mortality and morbidity. Also at present, a governmental 'Think Tank' is adjusting the current law on national health insurance and health financing, to ensure access to basic healthcare for all, in particular for the most vulnerable.

3.1.3. Social inequalities, including gender inequality

Poverty and social inequality remain critical challenges in Suriname. The Gini coefficient is estimated at 0.44 which according to global standards constitutes a fairly high level of inequality. Suriname has not yet developed a poverty reduction strategy. Inequalities are still reflected in widespread poverty, mainly concentrated in the interior districts of Brokopondo and Sipaliwini (Development Plan 2017-2021) and also in low income urban and rural communities. In June 2016, the Ministry of Social Affairs and Housing reactivated efforts for defining a national poverty line, in accordance with the current government's social agreement.



Percentage of women age 20-24 years who have had a live birth before age 18, by background characteristics

Source: MICS 2018

Multiple studies, including the latest MICS 2018, show the close relationship between socioeconomic status (SES), living area and fertility rate, level of contraceptive use, knowledge about HIV transmission and experiences of sexual and gender-based violence.

Despite widely acknowledged educational achievements of women in the past decade, women remain vulnerable in key areas of society. Even when higher educated than men and having major responsibilities as single heads of one-third of all households, women suffer major disadvantages in the broader economic, political system and the realm of private family life.

About one-third of households is comprised of single female headed households, where poverty levels are usually higher (Census 2012, Sobhie 2017). Women also account for two-thirds of the unemployed, are concentrated in the lower paid jobs in both formal and informal sectors, overloaded with additional unpaid caring tasks, including caring for family members

transferred by health and caring facilities to the home. Earlier mentioned critical factors affect women's daily life, including their sexual and reproductive health. Denial of coverage of costs of delivery and postnatal care (especially in informal jobs), inadequate protection against sexual harassment and violence, lack of economic power, traditional culture, are all conditions increasing women's and girls' vulnerability to violence, sexual abuse, unwanted pregnancy and unsafe abortion.

Women living in the interior, as well as those that moved to the urban's low income neighborhoods in search for a better future, are faced with harsh conditions and relatively more vulnerable to health risks due to low educational level and lack of income sources. A major barrier in the achievement of gender equality is the persistence of gender stereotyping among key leaders in the public sector, as well as in the private family domain, where labor and responsibility division are still mainly guided by traditional norms. In recent years, there is an increased call by different societal groups to address male responsibility for sexual and reproductive behavior and promotion of shared responsibility in family- and household caring, as a pivotal strategy in achieving gender equality.

3.1.4. Socio cultural environment

Suriname is a multi-ethnic, multi lingual and multi religious society. This diverse socio-cultural context must be considered, as it also shapes sexual and reproductive knowledge, attitudes and practices. Fertility, marriage and sexual relations patterns differ strongly by ethnic group, age and geographical area. Marriage patterns vary from legal marriages to traditional marriages, including polygenic and arranged/forced marriages. In the private domain of family and kinship, sexual and reproductive behavior is still highly influenced by constructions of male and female sexuality. The demand for children is not simply determined by modern knowledge on advantages of the use of contraceptives, but also by economic position n and cultural perceptions on fertility, masculinity, femininity and sexuality. In communities where people have little access to resources, children are valued as an important source of social support and economic security. Although sexuality is much more publicly discussed than before, some issues are still difficult to talk about, inter alia promiscuity (of females), sexual abuse, same sex relations and commercial sex. The persistent stigma and taboo on sexual behaviors, remain an important obstacle, hindering reporting of sexual problems and people's access to SRH services, including obtaining condoms, accessing HIV testing, counseling, treatment and care, abortion, cervical cancer screening, or support or counseling services for victims of gender-based violence. Recent studies show high prevalence of different types of sexual violence in children and young people, in particular related to adolescents and youth, in both homes and school (Terborg et.al 2018, MICS 2018, Terborg et.al. 2019). Although teachers and parents are in favor of sexuality education to children, there is much reluctance, mainly due to lack of skills, to talk about sex and sexual relations with children/young people. Efforts of the Ministry of Education to integrate sexuality education in school curricula have not been successful yet.

Indicators	2010 MICS 5	2018 MICS 6	2018 MICS 6
	females	females	males
Comprehensive knowledge about HIV prevention among young people	41.9	40.2	41.5
Knowledge of mother to child transmission of HIV	51.8	44.3	42.2
Accepting attitude towards people living with HIV	21.1		
% of women and men of 15-49 years reporting having heard of HIV who report discriminatory attitudes towards people living with HIV		67.5	63.6
Condom use with non-regular partners	55.5	33.1	66.4
Women and men who know where to be tested for HIV	85	81.9	76.1
Women and men who have been tested for HIV and know the results	20.3	21.2	12.9
Sexually active women and men who have been tested for HIV and know the results	33.4	30.4	10.5
HIV counseling during antenatal care	49.3	28.6	
HIV testing during antenatal care	79.5	25.5	

Source: MOH, 2018

Table above with recent data from the MICS (2018), differentiated in the two last columns by 'female' and 'male', show that compared with earlier MICS (2010) positive changes in sexual knowledge, attitudes and sexual behavior are slow, while in some areas there is even a back lash, indicating the strong influences of structural factors on behavior.

3.1.5. Sexual Rights of specific groups

Sexual health cannot be achieved or maintained without respect for, and protection of, human rights. The persistent inequities in access to health care, including sexual and reproductive health services and the disparities in quality of these services, are a clear manifestation of the neglect for the SRH rights of certain population groups, in particular adolescents, people with disabilities, elderly, Lesbians, Gays, Bisexuals and Transgenders (LGBTs) and also males in general. Recent studies on key populations, including men who have sex with men (MSM), trans women, sex workers in Paramaribo and gold mining areas, LGBTs and People Living with HIV (PLHIV) show that these groups experience structural stigma and discrimination at home as well as in public places. Stigma and discrimination manifest itself in domestic violence, public violence by the police and by people in the street, as well as through social media channels, such as face book. They are often faced with humiliation, exclusion, and dismissal, including in workplaces. Special mentioning is made of problems and obstacles in accessing health care services, mainly due to unfair treatment by service providers (Bakboord 2017, Duyves and Heemskerk, 2019). MICS 2018 shows high levels of discriminatory attitude towards people with HIV, and low levels of knowledge on HIV transmission. Outreach services conducted by the Ministry of Health in close partnership with NGO's showed significant achievements in reaching sex workers, MSM, with free condoms and lubricant, free HIV testing, and counseling on

condom use and safe sex (National HIV Plan, MOH, 2017). However, most of these services are provided as part of temporary projects funded with donor means. All recent studies on key populations[6] in Suriname recommend the need for continuous sexual health education, mitigation of stigma and discrimination and specific prevention measures such as provision of hepatitis B vaccination and Post Exposure Prophylaxis (PEP) and Pre-Exposure Prophylaxis (PrEP). It is also stressed in multiple studies that outreach to key populations should be sustainable and be continued with social contracting of CSOs, regardless of availability of donor funding, while the effectiveness of outreach programs should regularly be evaluated (Korenromp et.al., MOH, 2019).

3.1.6. Health system

3.1.6.1. Health services

Primary care in the coastal area is provided by the Regional Health Services and private general physicians. The Foundation 'Medical Mission Primary Health care', provides health care free of charge to the population in the interior. Basic obstetric care is available in the 51 clinics of the Medical Mission (MM), however often not adequately equipped to provide emergency obstetric and newborn care, while budgets for preventive (outreach) services are low.
Hospital care is concentrated in the capital Paramaribo, where 5 of the 6 hospitals in Suriname are located. In the coastal areas basic healthcare is mainly provider through the government clinics of the Regional Health Services (RHS). In the past five years, the number of policlinics of the RHS with obstetric facilities has increased to 17. Also access to secondary health care has expanded with the current construction of two hospitals with comprehensive obstetric services in the remote semirural district of Marowijne and one hospital in Wanica (semi-rural). Privatization of healthcare services has increased, in particular in the area of lab diagnostics, elderly homecare, sales of condoms and oral contraceptives. There are also indications that the services of private general practitioners in the urban coastal areas are expanding rapidly.
With the establishment of the basic health insurance law, and the expansion of options for consumers to choose their health provider, a large switch occurred of clients moving from Regional Health Services (RGD) clinics to private general practitioners. This significant decline of RGD clients is also reflected in the sharp fall of deliveries at RGD community clinics. Probably clients prefer to have their delivery in the hospital. Adequate referral services, as part of a continuum of care health system, remain a big challenge.
Main NGO activities include health education, awareness raising, counseling, data collection and research, and advocacy. Various projects have been executed with regard to the protection of pregnant woman, women who breastfeed and children with regard to high exposure to mercury and methyl mercury (Medical Mission, 2017). Several NGO's, operating at both national and community level, are also contributing as basic SRHR care providers, in the areas of inter alia HIV/STI, child sexual abuse, gender-based and sexual violence, adolescent sexual health, sexual rights of LGBT, sexworkers and other minority groups. For more than 50 years,

[6] The five key populations are men who have sex with men, people who inject drugs, people in prisons and other closed settings, sex workers and transgender people (WHO, 2018).

the Stichting Lobi Health center (SLHC), member association of International Planned Parenthood federation (IPPF), operates as the largest NGO providing comprehensive and integrated packages of SRHR services in the coastal urban and semi-rural areas, in particular Paramaribo, Wanica and Nickerie. These services include among others: early detection/prevention of reproductive cancers, HIV /STI testing and counseling, family planning- and basic fertility services.

Despite strict legislation that penalizes abortion, there is safe access to private paid abortion services performed by gynecologists[7]. However, many women and teenage girls in a weak financial position who cannot afford these services, opt for self-induced medical abortions through general practitioners or self-use of the 'abortion pill' (misoprostol), with high risk of unsafe abortions. Indications are that annually around 500 women visit the emergency room because of complications due to unsafe abortions[8].

The Ministry of Education, in particular the departments of 'Basic Life Skills' and 'Centrum Nascholing Suriname' (CENASU), is primary responsible for developing school curricula for primary and secondary schools, including on topics related to Comprehensive Sexuality Education (CSE). However, government interventions have been limited to pilot projects, mainly with donor funds. Structural integration of CSE in schools has not been achieved yet, although results of incidental projects are promising. A recent base- and end line study among students, teachers, school leaders and parents of a pilot program in lower vocational schools, shows positive effects of CSE sessions. 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[9]. 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.

3.1.6.2. Health financing

According to the World Bank classification of countries, Suriname is an upper-middle income country with a current per capita GDP of US$15,080 in 2017. In terms of health expenditure, the latest official data available show a total health expenditure of 4.2% of GDP. Share of public health expenditure of total government expenditures almost doubled from 8.6% in 2010 to 16.6% in 2017 (WHO, 2019, mentioned in Korenromp et.al. 2019).

An important achievement towards universal healthcare coverage was the approval of the 'National Basic Health Insurance' that came into effect in 2014. According to this law the government subsidizes children under 16, those over age 60. Employees pay up to 50% of the premium and employers cover the other half; the government pays the coverage of those

[7] In the combined initial and second periodic report submitted by the Government of Suriname, see CEDAW/C/SUR/1-2, (2002), paragraph "Reproductive Health", the government of Suriname stated that women have access to abortion because the penal code is not applied. They referred to the abortion law as a 'dead letter law'.

[8] Source: presentation drs. F. Poese on 'World Population Day', 2018

[9] See: Results of 'iGROW' (CSE pilot program in 10 Lower vocational schools) (Terborg, Benschop, Akoi, 2019):

unable to pay. The basic health care package includes access to primary health care services, secondary care, and a defined package of tertiary care.
There are still large problems with sustaining quality healthcare in hospitals and other health institutions due to lack of financing resources. According to estimates of the World Bank (2019), out-of-pocket expenditures for health still represent more than 20% of the total. This implies that the problem of equity in health financing persists, negatively affecting the most vulnerable groups. (World bank 2019, mentioned in Korenromp et.al. 2019). Recent studies on maternal and newborn mortality indicate that barriers in obtaining a health insurance card were factors leading to delayed antenatal care and increased risk of obstetric complications (Kodan et.al. 2017, Bikha 2019). Major barriers in accessing free health insurance are often lack of information on how to timely obtain a health care insurance card and/ or the proper social support networks for guidance through the required procedure.
Coverage of basic healthcare is limited, especially in some areas such as mental health, post-natal home visits, family planning (variety of modern contraceptives methods), safe abortion (only available as a private service) and palliative care. A study on supply chain of hormonal contraceptives found that these medicines are well integrated in the regular medicines supply system (Verhage and Terborg, 2012). However, in recent years, short periods of stock-outs appeared due to financial constraints at the largest, government owned Drug Supply Company Suriname (BGVS). For now, the negative effects could be mitigated as hormonal contraceptives are also available through private commercial distributors and Foundation Lobi Health Center, the major provider of family planning services in Suriname (St. Lobi Health Center, 2019).

3.1.7. Availability of qualified human resources

Suriname's health sector has to deal with the serious challenge of having sufficient and qualified workers available, which is directly impacting on the quality of care. Recent research data show that substandard care factors were observed in 95% of all maternal deaths during 2010-2014, and mostly related to quality of services by health professionals (delay in diagnosis, delay in treatment and inadequate monitoring of patients). (Kodan et.al. 2017)
The need for a sufficient skilled workforce of nurses and allied health professions is heightened with an increased focus on primary care, health promotion and prevention. Limited training capacity and brain drain due to migration are key factors hampering progress in keeping skilled workers, especially skilled birth attendants/midwifes. The current nursing and midwifery personnel density (per 10.000 population) is 4.3. There is a huge need for skilled workers to provide preventive SRHR services in almost all areas, especially regarding sexuality education, counseling and guidance. To fill the need for midwives, the Suriname Midwifery school was established to train midwives for both secondary and primary health facilities. To improve quality, the school developed a 'Competency Based Education' (CBE) plan of action. However, implementation is pending. Lack of regulation, accreditation, and proper delegation of authority and supportive supervision of midwives are barriers that still hinder optimal use and efficient functioning of midwives. For example, midwives are not allowed to provide certain modern contraceptives, such as insertion of an IUD or apply a Depo Provera injection which represent a major barrier to the delivery of these family planning methods at primary health care. Structural changes, including adjustment of the 'Midwifery Act', are required to ensure

that midwives can make optimal use of their midwifery skills and experiences, and have appropriate employment protection, remuneration, incentives and motivation. Against the background of the regional target to reduce maternal mortality to < 30 per 1000 live births in 2030, the national Obstetric Congresses have been organized in 2016 and 2019 to develop essential national protocols and to improve capacity for adequate implementation of national guidelines and (postnatal) care strategies. In addition, the Foundation for Continuing Education of Medical Professionals (SPAOGS) regularly offers accredited courses, also in the area of SRHR, to health professionals. Since 2010, approximately 45 graduates in ‘Master Public Health’ were delivered by the Anton de Kom University. However, only a few has key positions in SRHR. With respect to emergency preparedness in the area of SRHR, capacity is still very low. Since 2018, UNFPA collaborates with National Disaster Coordination (NCCR) to build capacity for integration and implementation of the ‘Minimum Initial Service Package for Sexual and Reproductive Health’ (MISP), including by the district teams responsible for drafting the district preparedness plans, which were submitted to the district commissioners in December 2019. To further enhance adherence of district plans, capacity building on MISP will be continued under the EnGenDer program, which was just recently launched in January 2020.

3.1.8. Availability of data and translation into policies and programs

An assessment report on the status of the national health information in Suriname states: ‘*The major challenge facing the health information systems in Suriname is the fragmentation of the system between coastal and interior, individual hospitals and clinics, programs and national systems, and public and private health services. There is no central repository data warehouse that cohesively links all relevant data on diseases and disabilities, risk factors, health services and demographics, common data forms, methods of collection and operational definitions. Ultimately, uses of data for decision making are severely constrained because of this fragmentation* (PAHO, MOH 2007).

In the past years, multiple efforts have been made at the Ministry of Health to develop a national health information system (NHIS) that would be responsible for collecting national data and would allow for a coordinated and centralized analysis of all national health data. However, progress is slow. Presently there is no ‘Logistic Management Information System’ (LMIS) to ensure an effective supply management in Suriname and stock-out of essential medicines, including reproductive health commodities, is a recurrent problem which is undermining the capacity of the public health sector to provide quality health care.

In 2018, the Commission ‘Maternal Mortality Suriname’ (MaMs) was formed to review all maternal deaths in Suriname. The MaMS Commission identifies and audits, in collaboration with the MOH/ Bureau of Public Health, every maternal death and advises the government on priority measurements to prevent and reduce maternal mortality.

From 2014 to 2019 multiple studies have been conducted on maternal mortality and morbidity and perinatal mortality. In addition, several nationwide studies have been implemented recently: ‘Violence against Children’ (UNICEF, 2017), ‘Global School based Student Health Survey’ (PAHO, 2017), ‘Violence against women’ (IDB, 2018), ‘Prevalence of poverty’ (IDB, 2019), ‘MICS 6’ (UNICEF, 2018), HIV Legal Environmental Assessment Report (2018), National Women’s health Survey (2019). Only a few of these studies are regular measurements that can be used for monitoring.

3.2. Sexual and Reproductive Health Status of the population

<table>
<tr><th colspan="2">Provision of family planning information and services
(including counseling for a broad range of modern contraceptives)</th></tr>
<tr><th>Baseline data</th><th>Social determinants</th></tr>
<tr><td>Contraceptive prevalence rate (CPR):
• Married women or in union, use one or more modern methods of contraception
MICS:
• 2000: 42%
• 2010: 47%
• 2018: 39%

MICS 2018:
• Total fertility rate 2018 (TFR): 2.8

Demand satisfied:
• 57% of married women are satisfied with modern methods of contraception for family planning.

Unmet need for family planning
• has increased from 16.9% in 2010 to 28.4% in 2018

Major use of short-term methods against a very low use of long term methods:
• Oral contraceptives: 24.1%
• Injectables: 5.2%
• Female Sterilization: 4.1%,
• Male condoms 2.7%
• IUD 2.2%, Implants 0.1% Female Condoms: 0.1%, Diaphragm:0% Vasectomy: 0%</td><td>MICS 2018:
Fertility rates by region and wealth quintile
• The fertility rate is the highest in the rural interior area, among women with the lowest educational level and women in the lowest wealth quintile.
• The interior district Sipaliwini has the highest fertility rate.

Disparities in contraceptive use
• Large disparities in contraceptive use, with lowest contraceptive use in the interior
• The proportion of women using contraceptives is higher among women living in urban areas, among women with higher levels of education and in richer quintiles.
• Disparities among age groups are quite relevant and reveal the limited access and use of contraception by young people. Unmet need for family planning: 59.7% among 15-19 years old against 15.5% among women 44-49 years old
• Only 37% of women aged 15-49 years in the interior district of Sipaliwini is of the opinion that their demand for family planning is satisfied with modern methods, while this is around 60% in the urban area.</td></tr>
<tr><th colspan="2">Prevention and reduction of Adolescent Fertility and Child Marriages</th></tr>
<tr><th>Baseline data</th><th>Social determinants</th></tr>
<tr><td>Adolescent Fertility rate:
MICS 2018:
• Adolescent birth rate: 64 per 1000 girls aged 15-19
Central Civil Registry, 2018:
Annual Live Births from Adolescents
• In 2018 the percentage of births from of adolescent mothers was 14.5 %. In absolute numbers in 2018: 1532 live births from adolescents
Live births registered to mothers/girls younger than 15</td><td>MICS 2018:
• Fertility rates is the highest among women younger than 18 years, among those living in the interior, and women with lowest education levels and living in the poorest wealth quintiles.
• Adolescent and teenage birth rate is the highest in the interior, among teenagers with lowest educational level (ECE/no schooling, 388 per 1000). 210 births per 1000 in Sipaliwini versus Paramaribo with 50 per 1000.
• Early childbearing among adolescent girls is disproportionately higher among the most disadvantaged women: those who are poor, who live in rural areas, and who belong to Indigenous and Maroon groups.
• 13% of women age 20-24 have had a live birth before age 18
• 15% of women age 20-24 have had a live birth before age 15</td></tr>
</table>

<table>
<tr><td>years: In 2014, 2015 and 2016, the numbers were respectively 66, 41 and 42 live births.</td><td>Adolescents aged 15-19 years use contraceptives much less frequently than older women.</td></tr>
<tr><td>Child marriages:
MICS 2018:
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%
Central Bureau for Civil registry (CBB):
From 2012 to 2016, marriages in age group 15-19 years
Females: dropped from 178 to 149. Males: dropped from 18 to 14</td><td>MICS 2018:
The highest Child marriage incidence is found in the rural Interior and the lowest in the urban.
There are also important disparities in child marriages among socio-economic characteristics, highlighting the difference between urban (32.7%) and rural interior (57.1%) girls or educational level with 48.7% vs 25.5% (primary level and higher educational level respectively).
Early marriage has increased since the previous 2010 MICS, when the proportion of women aged 20-24 years who were married or in a union before age 18 was 23%.
Similar increasing trend is registered in the proportion of girls married before the age of 15: 8.8% of the girls were married or in a union before the age of 15 (MICS 2018) compared to 5.4% in MICS 2010.</td></tr>
<tr><td colspan="2">Antenatal, childbirth, and postnatal care, including basic and comprehensive emergency obstetric and newborn care</td></tr>
<tr><td>Data</td><td>Social determinants</td></tr>
<tr><td>Maternal Mortality Ratio (UN interagency group on MM estimates, 2019) (WHO, 2017):
2010: 148/100.000
2015: 122/100.000
2017: 120/100.000
At the regional level Suriname is in the third place in the list of countries with the highest mortality rates, following Haiti and Guyana.
Kodan et.al. 2017:
The main causes of which women die are infections (27 %) (obstetric (9%) and non-obstetric sepsis (18 %), bleeding (20%), high blood pressure (14%), indirect causes (other than non-obstetric sepsis) (14%).
63% of maternal deaths occurred during the postpartum period.</td><td>Kodan et.al. 2017:
Maternal deaths mostly occurred in the urban hospitals (84%)
Substandard care factors (95%) were mostly health professional related (80%) due to delay in diagnosis (59%), delay or wrong treatment (78%) or inadequate monitoring (59%).
Substandard care factors most likely led to death in 47% of the cases.
Major inequities between population groups, the highest % deaths (69%) was among poorer population groups and the Maroon ethnic group (37 %), while the share of this ethnic group is only 14.7% in the overall population).
Preliminary data on maternal deaths (2015 and 2018) show that 15 % of the women were not insured
In 27 % of the deaths there was insufficient health seeking behavior (poor compliance or refusal of treatment) and in 15 % delay of transport. Insufficient coverage of health insurance: 15 % had no health insurance
Terborg et.al, 2013:
Insufficient appropriate health seeking behavior and delay in seeking care for services are influenced by multiple factors, such as lack of birth planning, lack of health insurance coverage, late prenatal control and delay in healthcare seeking, due to barriers related to transport, finance, ethnic cultural perceptions, gender inequality, domestic violence, insufficient education/information on safe motherhood issues, including danger signs, healthy nutrition as well as lack of adequate social/community support, and lack of cultural and gender sensitive services.</td></tr>
</table>

Neonatal and infant mortality **MICS 2018** • Infant Mortality rate is 17 per 1000 live births • Neonatal Mortality rate is 12 children per 1000 live births.	**MICS 2018** • The highest neonatal mortality rate is found in Paramaribo, Para and Sipaliwini with 27 %, 16 % and 10 % respectively ().
Antenatal and post-natal care **MICS 2018**: • At least one antenatal visit: 85% • At least 4 ANC visits: 68% • ANC visit during the first trimester:56% • Skilled attendance at birth: 99% • Institutional deliveries: 93% • Postnatal care for mother within 2 days after delivery: 91% • Post-natal care for newborn within two days after delivery: 94% • C-sections: 16% • 80% reported to have blood pressure checked and had their urine specimen taken. Only 20% reported to have received the neonatal tetanus protection and 72% reported to have been tested for HIV. • At national level, about 16% of the women had a C-section.	**MICS 2018:** • Women with no education and from the poorest wealth index quintile are also less likely to deliver with the assistance of a doctor • The incidence of a C-section is relatively higher among those with a higher education, a higher wealth status and those living in the urban area. 31% of mothers with high school and university education reported to have undergone a C-section, while this percentage is 24% for mothers from the richest wealth quintile. • Insufficient appropriate health seeking behavior and delay in seeking care for services by women living in rural areas, among the lowest wealth quintile and lower education levels • Decrease of pregnant women who attend at least one antenatal visit from 95 to 87 % between 2010 and 2018, could be ascribed to socio-economic factors, including decreased access to health insurance. • More than 90% of mothers in the interior received care after delivery. The percentage for the health checks for the newborn is lower. The percentages for both the mothers' check and the health check for the newborn is slightly higher for the urban area.

Prevention of unsafe abortion and treatment of complications of unsafe abortion	
Baseline data	**Social determinants**
• Estimates of annual abortions vary between 5,000 to 10,000 per year, which equates to an abortion rate of 43 to 86 abortion per 1,000 women between 15-44 years. (Terborg, 2011).	• MICS 2010: Highest abortion prevalence among Indigenous, Creole and Mixed descent, respectively 24%, 15% and 10%. • Although abortion is illegal, women do get support from some gynecologists in public and private hospitals, but the treatment is not registered as abortion, it is registered mostly as Dilatation and Curettage (D&C). But they are not covered by health insurance. • Reliable figures on the incidence of abortion cannot be obtained as there is a strict law that penalizes abortion in all cases • There are indications that abortions take place without medical attendance, based on reports of hospitalized women due to post-abortion complications related to incompetent use of Misoprostol. • Reports from emergency care service showed that in 2015 and 2016 respectively 558 and 490 women were treated for vaginal blood loss due to a spontaneous abortion. Approximately 80% of these women are in the age category 15-34 years, of which 38% aged 15-24 years and 0.5% in de age category 10-14 years (F. Poese, 2017)

Prevention and treatment of infertility	
Baseline data	**Social determinants**
No information available	• Services to assist clients with infertility are mainly limited to education and counseling. Modern infertility treatment is not included in state health insurance. High tech fertility treatment services are available, however private and very expensive. • Infertility remains a very sensitive issue surrounded with stigma and taboo, especially in Suriname society where both women and men are expected to demonstrate fertility
Prevention and treatment of reproductive tract infections with particular attention to HIV and other sexual transmitted diseases	
Baseline data	**Social determinants**
• **HIV prevalence**: 1.4 % of the general adult population (age 15-49) (UNAIDS 2019) **HIV prevalence among pregnant women**: 1.0%. • **Newly registered HIV-cases 2018:** estimated approx.: 300 (MOH, 2018) **Elimination Mother to Child Transmission (EMTCT):** • **PMTCT coverage (%) > 95% (**http://aidsinfo.unaids.org/) • The number of infants born infected with HIV in the period 2015-2017: between 3-4 HIV infected infants. **HIV stigma and discrimination** **MICS 2018**: • % of women and men of 15-49 years who report discriminatory attitudes towards people living with HIV is around 60-64 %. • For younger people age 15-24 years, stigmatization is much higher, about 69-74%.	**MICS 2018**: • Irrespective of age-group, HIV testing among women is higher than men • Although at average 70% of the women are HIV tested during Antenatal care, only 25% receive proper counseling and information during and after the test **MICS 2018**: • Stigmatization is high under both men and women. • Overall, women display a higher stigmatization attitude than men
Promotion and protection of Sexual Rights of sexual minorities, including LGBTIQ, msm, female sex workers and transgenders	
Baseline data	**Social determinants**
Bakboord (2017) • Recent legal assessment on HIV and Qualitative study on sex workers, LGBT and PLHIV show multiple forms of stigma and discriminations against these groups • Criminalization of sex work Duyves and Heemskerk (2019)	Recent studies on key populations, including men who have sex with men (MSM), trans women, sex workers in Paramaribo and gold mining areas, LGBTs and People Living with HIV (PLHIV) show that these groups: • Experience structural stigma and discrimination at home as well as in public places. Stigma and discrimination manifest itself in domestic violence, public violence by the police and by people in the street. • They are often faced with humiliation, exclusion, and dismissal, including in workplaces. • Special mentioning is made of problems and obstacles in accessing

	health care services, mainly due to unfair treatment by service providers (Bakboord 2017, Duyves and Heemskerk, 2019).
Prevention, detection, care and referrals for cases of sexual and gender-based violence	
Baseline data	**Social determinants**
Terborg/IGSR/DNA (2018): **Sexual violence children, aged 11-18 yrs.**: • 13% has experienced sexual violence in the past year • 10% reports recent experiences of sexual violence by adults. • 8.2% children experience sexual violence in their own family • 8.6% experienced outside of their family **IDB (2019):** • Of ever-partnered women, 32% experienced physical and/or sexual IPV in their lifetime and 6% experienced it in the 12 months prior to data collection. • Emotional violence was most common (lifetime, 35%; current, 9.2%). • Almost one in three women experienced physical IPV in their lifetime **DICV, Police, (2018)** **Femicide** the number of gender-related killings of women aged 15 years and older was 4, 7, 5, 11 and 4 between 2013-2017 respectively.	**Violence against children (Terborg, 2018):** • Sexual violence highest in the interior: 29%. • Urban areas: 12% • Rural areas: 12% • Unsafe first sex, one or multiple pregnancy at age below 18 yrs is reported mostly by children, living in the interior **Violence against women and girls (IDB, 2019)** • Lower educational attainment is associated with higher prevalence of current physical IPV. • Unmarried women with partners showed higher rates of both physical and sexual violence over their lifetime than currently married women. • Lifetime physical and sexual IPV experienced by ever-pregnant women was higher than that experienced by those who were never pregnant. • Women between the ages of 25 and 29 were more likely than women from any other age group to be currently experiencing physical IPV (9 %). • Women who were married or lived with a partner at a young age had higher lifetime physical and/or sexual IPV prevalence than those whose first union was at 19 years or older. • Lifetime physical IPV was higher among women who identified their ethnicity as African (34%). • Lifetime sexual IPV was higher among those who were financially independent, which is counter-intuitive.
Prevention, detection, and management of reproductive cancers	
Baseline data	**Social determinants**
Available data only for 2013-2014: (MOH, 2019) • Breast (18% of all cases), prostate (12%), and cervix (10%) • **Breast cancer mortality rate**: 12 per 100,000 • **Cervical cancer mortality rate:** 9.6 per 100,000 • **Prostate cancer mortality rate:** 16.3 per 100.000	**MOH/PAHO, 2019**: • In the period 2008-2013, more than 80% of women with cervical cancer presented with late-stage disease (Dams, 2016). • Almost 30% of cervical cancer cases and almost 20% of breast cancer cases are younger than 45 years. • Breast and cervix cancer incidence highest among Creole females: 77.1 respectively 44.8/ 100,000 and relative high cervical cancer incidence in the Indigenous:38.5/ 100,000 • Creole males have the highest rate of prostate cancer (incidence rate 115/ 100,000 male population
MOH/National Immunization Program 2019: • Since 2013, HPV vaccination for girls 9-13 years through school	**MOH/National Immunization program, 2019:** • Lack of education and awareness on relevance of HPV vaccination among parents and some healthcare workers, among others influenced by anti-vaccination movement (social media).

vaccination programs of RGD and Medical Mission. • HPV coverage girls 9-13 yrs., 2013: 67%, 2015:77%, 2016: 38% • No data available for 2017, 2018	• Lack of financial means to reach target populations, in particular in hard to reach areas (including some areas in the interior)
Provision of comprehensive sexuality education for populations in school and out of school	
Baseline data	**Social determinants**
Sexual activity: **MICS 2018**: • About 75% of the adult population is sexually active, and for young adolescents this is about 50%.	**MICS 2018:** • 18 % of males aged 15-24 years report having sex before aged 15, and for young women 15-24 this is 13%. • 8% of teenage girls aged 15-19 report having sex with a partner 10 years or older in the last year. • Sex before age 15 among young women is the highest for those living in the interior, girls with only a primary education or those belonging to the poorest quintile.
HIV knowledge **MICS 2018**: • Knowledge about HIV prevention among men/women, 15-49 years: 42 vs-45%. • For young male and females, aged 15-24 years: 32 versus 35%.	**MICS 2018:** • Knowledge about HIV is the highest among women age 15-24 years living in the urban or those with a higher educational level, compared to their peers living in the Interior, or with only a primary education (lowest).
MICS 2018: Condom use • Condom use among young male adults (15-24 years) who had sex in the last 12 months with a non-regular partner is higher (66%) compared to their female peers (33%).	**MICS 2018:** • Women having sex with a non-regular partner using a condom is the highest for those living in Paramaribo and the lowest for those living in Nickerie • For both men and women (15-49 years) reporting sex with multiple partners, condom use was around 50%. • Access to condoms remains problematic for young girls due to stigma and taboo. Of women, aged 15-24 years, only 19% ever bought condoms, against 82% of young men in same age category. 84% of young women never had condoms in their pocket against 36% of young men. (Terborg 2013)

3.3. Main barriers and challenges

Against the background of the guiding international, regional and national policy frameworks and taking into account in particular the essential elements of the right to sexual and reproductive health: **availability, accessibility, acceptability and quality**, the following areas of barriers and challenges are identified:

1. Weak coordinated multi sectoral and integrated approach to address the social determinants of sexual and reproductive health.

Multiple recent studies, including the latest nationwide MICS 2018, show the significant influence of structural factors such as gender, socioeconomic status (SES) and geographical area on sexual reproductive health, including on level of contraceptive use, knowledge about HIV transmission, experiences of sexual and gender-based violence, and stigma and discrimination. Factors contributing to inequities and vulnerabilities are often complex, requiring the engagement of multiple sectors on multiple levels to address inequities and the social determinants of health. A strong and inclusive partnership should be in place with the participation of key line ministries, a wide range of civil society organizations, community-based organizations, faith-based organizations, the private sector, academia, professional associations and development partners. In this regard the 'Health in All Policies' (HiAP), which is currently mainly focused on inter-ministerial collaboration, needs to structurally expand its partnership with nongovernmental partners. Coordination and monitoring of a multi-sectoral approach in health, requires strengthening of leadership in the Ministry of Health, to ensure efficient use of human and financial resources, sustainable engagement of identified partners and integrated implementation of policies, legislation and programs. It is also highly required that the national policy on sexual and reproductive health and rights, 2020-2030, will be closely coordinated and accompanied by (specific) institutionalized structures, mechanisms and regulatory frameworks to enhance integrated implementation, and effective monitoring and evaluation of this policy.

2. Lack of equitable access to high-quality and continuous health care and services for all.

The situation analysis shows large disparities in access to sexual and reproductive health services due to economic inequality, geographical barriers, stigma and discrimination, in particular of populations groups in a vulnerable position, such as adolescents, low educated and poor (pregnant) women. Of great concern is that 20% of health expenses are out of pocket, indicating financial barriers in access to health that are confirmed by results of recent studies revealing lack of health insurance as a factor explaining delayed antenatal care and maternal- and newborn mortality. Coverage of basic healthcare is limited, while access to quality and continuous care is not guaranteed. Especially in some areas such as mental health, post-natal health, family planning (variety of modern contraceptives methods), and safe abortion (only available as a private service) out of pocket payment is required. Taking this in consideration the government is currently revising the law and also exploring alternative models of healthcare financing. Apart from financial barriers, access to quality health is also seriously challenged by the lack of sufficient and qualified workers, including skilled birth attendants/midwives and stock outs of commodities as a result of a weak supply chain management system. Structural

changes are required to ensure that midwives have appropriate employment protection, remuneration, incentives and motivation, including expanding their competencies. In terms of acceptability, quality of care should be improved in strengthening capacity to deliver services that are age-, gender- and cultural sensitive. Evidence suggest that populations with specific needs, including adolescents and youth, and key populations such as female sex workers, MSM, transgenders and LGBT experience unfriendly and judgmental attitudes and responses of care workers. Facilitating policies, capacity building and close monitoring should ensure that especially SRH services dealing with sensitive issues such as STI/HIV, unintended (teen) pregnancies, abortion, sexual abuse and gender-based violence should be free of any form of stigma and discrimination by health providers.

3. Limited opportunities for systematic and consistent participation of families, individuals, schools, and communities to reach those most in need.

The recent findings of multiple studies on the low level of knowledge about contraceptives, STI/HIV transmission, sexual and reproductive rights, low reporting of sexual abuse and violence call for urgent, accelerated and innovative responses in the areas of health promotion and prevention services. However, practice show that in most primary health care facilities of the RGD and the Medical Mission, the key component of community participation is still weak and stagnated by the absence of a national strategy on health promotion, persistent budgetary constraints and lack of health personnel that is trained to adequately respond to needs of diverse population groups. Little use is made of modern, communication technologies to positively influence sexual and gender norms and values and healthy sexual lifestyles of young people. Also, the regional agreed strategy of provision of comprehensive sexuality education to youth in and out of school is very slow in its implementation

The primary health care model, which is the guideline of the Ministry of Health, requires a strong emphasis on health promotion, health education and self-care, with active involvement of communities. Women, men, families, and communities should be supported in the adoption of a healthy lifestyle, also in the area of SRH, and utilization of a continuum of health services. Community engagement and empowerment should be systematically encouraged and facilitated with supportive policies, funding, and institutionalized mechanisms.

4. Lack of strategic information to monitor SRH status and inequities and to inform the development of transformative approaches to SRH interventions.

The national health information system is still struggling with many challenges. Most collection of SRH data is still very fragmented, with many health departments of both secondary and primary care facilities, collecting routine SRH data, with little coordination and sharing. This often results in lack of consistency in data collection and contradictory statistics on key health indicators. The high demand for regular surveillance data on SRHR issues for evidenced based interventions cannot be satisfied due as well to the lack of adequate human and financial resources for regular data collection and analysis. Nationwide studies are strongly dependent on donor funding, and almost never treated as baseline studies, that should feed into

systematic interventions that are monitored and evaluated. Assessment of health status on local district/community remains a challenge as most national data on morbidity and mortality are difficult to be disaggregated by place of residence, and therefore biased in revealing disparities within and between communities and limits targeted interventions.

4. Vision and Goal

Based on the policy framework, the response to the identified core elements of SRH will focus on the following vision, goal, strategic areas and outcomes:

Vision
All people are enabled and supported in achieving their full potential for sexual and reproductive health and well-being

Goal
Prevention and reduction of SRHR related morbidity and mortality through universal access to sexual and reproductive health and rights

5. Strategic objectives and outcomes

Based on the conceptual frame of reference, the essential package of SRHR services and the main gaps identified in the situation and response analysis, the following strategic objectives and outcomes have been formulated for the period 2020-2030:

STRATEGIC OBJECTIVES	OUTCOMES
1. Strengthen a transformative enabling environment through strengthening of leadership for the coordinated and multi-sectoral implementation of policies, legislation and programs	a. Developed and/or strengthened structures and mechanisms, led by the Ministry of Health, to ensure coordinated and integrated implementation of the national policy on SRHR b. Increased integration of SRHR policies and programs into 'Health in All Policies' (HiAP) c. Adequate alignment, implementation and monitoring of national policies and legislation with agreed/ratified international commitments on SRHR, incl. revised Midwifery Act a. Developed and reviewed protocols and guidelines to be used by healthcare professionals, including midwives, to ensure the delivery of quality and effective sexual and reproductive health services d. Increased allocation of governmental and non-governmental human and financial resources to enable effective implementation of policies, legislation and protocols. e. Increased mobilization of official development aid (ODA) to complement domestic financing of sexual and reproductive health programs.
2. Promote universal, effective, and equitable Sexual and Reproductive health and well-being for	a. Enhanced use of the school platform for the promotion of mental and physical, sexual and reproductive health and wellbeing of children and adolescents, including comprehensive sexuality education (see WCAH 2018)

all in their families, schools, and communities throughout the life course, and ensure access for all , including adolescents and youth and key populations, to comprehensive and age-appropriate information, and services to be able to make informed choices about their sexuality and reproductive lives	b. Revised basic life skills school programs that are aligned with the UN International technical guidance on sexuality education (UNESCO, 2018) c. Increased systematic empowerment and engagement of communities in improving their own health through the development of supportive policies, funding, institutionalized (community) structures and mechanisms d. Established structures, mechanisms and partnerships on national and community level for regular provision of comprehensive sexuality education to general and vulnerable groups, including on sensitive issues such as LGBTI, prevention of unsafe abortions, sexual abuse in the home. e. Expanded sexual health education and outreach interventions targeting key populations (female sex workers, MSM and transgenders) f. Increased promotion of healthy life styles, self-care and self-management of diseases through community health education g. Increased access to integrated health information, e-health services (including telehealth and telemedicine) and other technologies to improve communications, in particular to populations for whom existing services are hard to reach.
3. Strengthen health care systems capacity to enable universal access to quality SRH care	a. At least a basic package of essential quality SRH services (as defined in this policy) is covered by health insurance b. Improved and timely availability and rational use of SRHR commodities at primary health care, commodities for testing and treatment of STI/HIV, infertility and reproductive cancers c. Expanded, easy access to a comprehensive, integrated, quality essential package of SRH services, that include (free) provision and counseling for a wide range of modern contraceptives, including irreversible methods such as implants and IUDs, tubal ligation and vasectomy, in particular for underserved and vulnerable population (as identified in this policy) d. Improved services for prevention, detection, counselling, care and referral pathways for cases of sexual and gender based violence e. Established services for post abortion care f. Strengthened coordination of the continuum of SRHR services (prevention, promotion, curative, rehabilitative and palliative care) and the flow of information throughout the entire network of services, regardless of where care is delivered. g. Strengthened and expanded SRH services in primary health care that are responsive to the needs of populations in vulnerable positions, including adolescents and young people in and out of school in line with WHO standards of quality of care for adolescents h. Increased engagement of men in sexual and reproductive health and use of services i. Increased availability of health care providers, social workers and other relevant professionals that can deliver quality integrated

	SRHR services in accordance with relevant national guidelines and protocols, under attractive labor conditions and incentives, particularly in underserved areas j. Increased promotion of workplace friendly environment for SRHR k. Strengthened capacity of the government and other institutions in the preparedness and response to emergencies to ensure the delivery of a Minimum Initial Service Package on RH during emergencies and implementation of Minimum Standards for Prevention and Response to GBV in Emergencies (GBViE).
4. Strengthen information systems for the collection, availability, accessibility, and dissemination of strategic information to enable monitoring and evidence based and effective implementation of SRHR policies and programs	**a.** Increased availability of rights-based and gender-sensitive data collection and analysis on sexual and reproductive health and rights issues, and dissemination on both the national and community level for evidence- based decision making **b.** Adequate use of this strategic information for monitoring and evaluation of SRHR related policies, programs, budgets, legislation, and regulations. **c.** Increased accessibility of population and household data that are widely utilized as a public good, to guarantee zero invisibility and to leave no one behind, while safeguarding the rights of respondents to privacy f. Strengthened structures and mechanisms for effective monitoring of the implementation of the SRHR policy

6. Essential sexual and reproductive health services

In accordance with the Program of Action of ICPD and the regional outcome document 'Montevideo Consensus' (2013), the recent comprehensive and integrated definition of SRHR (report of the Guttmacher–Lancet Commission[10]) and the results of the specific context/situation analysis of SRHR in Suriname, the government of Suriname commits to the delivery of 'Essential sexual and reproductive health services', that meet human rights standards, including the "Availability, Accessibility, Acceptability, and Quality" framework of the right to health.

In this national SRHR policy, the following essential SRHR services are identified:

ESSENTIAL SEXUAL AND REPRODUCTIVE HEALTH SERVICES	
1.Provision of accurate information and counseling on sexual and reproductive health, including evidence-based, comprehensive sexuality education	Comprehensive sexuality education and information involves the provision of accurate, age-appropriate and up-to-date information on physical, psychological and social aspects of sexuality and reproduction, as well as sexual and reproductive health and ill health. All interventions should ensure that individuals have the knowledge and skills necessary to make well informed choices about sexuality and reproduction and to follow up on their choices. Within the health sector, information can be made available in the context of preventive or curative care consultation or in non-clinical settings in the context of health education outreach. Within the education sector, age-appropriate comprehensive sexuality education (CSE) curricula guidance and standardized content are available for preschool through university levels, and can be provided in school as well as in out-of-school settings.
2.Provision of a choice of safe and effective contraceptive methods (including counseling for a broad range of modern contraceptives)	Contraception is the intentional prevention of pregnancy by artificial or natural means. A range of modern contraceptive methods (short- and long-term methods), commodities and services should be accessible, acceptable, available and affordable, and they should be provided without coercion by skilled providers in settings that meet standards for quality of care.
3.Provision of safe and effective antenatal, childbirth, and postnatal care, including basic and comprehensive emergency obstetric and newborn care	Good quality antenatal, intrapartum and postnatal care are vital to reducing adverse outcomes of pregnancy, labor and delivery, and to optimizing the well-being of women and their infants. Interventions during this period may include: overall promotion of a healthy lifestyle and nutrition; risk identification, and prevention and management of pregnancy-related or pre-existing conditions; management of labor and childbirth including Basic and Comprehensive Emergency Obstetric and Newborn care; provision of respectful, dignified care, and effective communication between women and caregivers; care and support for GBV victims during and after pregnancy; postpartum contraception; diagnosis and treatment of STIs; and provision of mental health care.

[10] See also: 'Sexual health and its linkages to reproductive health: an operational approach'. © World Health Organization 2017

4.Prevention of unsafe abortion and treatment of complications of unsafe abortion	Safe abortion care includes: provision of information; counselling; recognition and management of complications from unsafe abortion; provision of post-abortion contraception, when desired; and having in place referral systems for all required higher-level care.
5.Prevention and treatment of reproductive tract infections with particular attention to HIV and other sexual transmitted diseases	Sexually transmitted infections (STIs) and reproductive tract infections (RTIs) can occur without noticeable symptoms. Left untreated, STIs can have short- and long-term psychological, social and financial effects on individuals, in addition to effects on overall health, fertility and sexuality. STIs can be prevented through delaying sexual debut, non-penetrative sex, use of condoms, vaccination to prevent HPV and hepatitis B, circumcision for HIV prevention, and pre- and post- exposure prophylaxis. STIs can be controlled through early identification and treatment, appropriate case management, improving health care-seeking behavior, partner notification, and preventing and managing complications (e.g. pelvic inflammatory disease).
6. Prevention, detection, care and referrals for cases of sexual and gender-based violence	Gender-based violence (GBV) can take many forms, including physical, sexual and emotional. Care and health services for women who have been subjected to violence should be woman-centered: they should be organized around women's health needs and perspectives. Health sector interventions to address GBV include: early identification through clinical inquiry; first-line support and response; treatment and care for intimate partner violence and sexual assault (e.g. emergency contraception, presumptive treatment for STIs, post-exposure prophylaxis for HIV, mental health care), in addition to first aid and other medical needs as suture of wounds etc.). It is also critical to establish referral pathways to ensure that the health sector facilitates the access of survivors to supportive services (namely social, police and justice).
7.Prevention, detection, and management of reproductive cancers	Services include primary prevention (e.g. HPV vaccination, sexuality education), secondary prevention (screening and treatment) and tertiary prevention (treatment of invasive cancer)
8.Prevention, management and treatment of infertility	Failure to become pregnant after 12 months of regular, unprotected sexual intercourse is defined as infertility. Interventions for fertility care range from improved fertility awareness to advanced medical technologies, including assisted reproductive technologies, such as in-vitro fertilization (IVF). Offering fertility care also provides an important opportunity to engage men, who are generally less willing to access health services or discuss issues related to sexual and reproductive health.
9.Provision of information, counseling, and care related to sexual function and satisfaction	Sexual function represents the complex interaction of various physiological, psychological, physical and interpersonal factors. Identifying and addressing sexual concerns and difficulties, as well as offering treatment for sexual dysfunctions and disorders, are critical components of sexual health care. Psychosexual counseling provides patients with both support and specific information or advice relating to their sexual concerns. Such treatment focuses on the need to make adjustments in sexual practices or to enhance methods of coping with a sexual event or disorder. Pharmacotherapies may also be part of the treatment.

Again it is reiterated that essential SRHR services should be community-centered, and sensitive to gender, age, sexual orientation, and culture, in particular in underserved areas and groups. Sexual and reproductive health and rights needs are universal; however, some have distinct SRHR needs and all efforts will be put in place to meet their needs (Gutmacher, Lancet, 2018). In this policy underserved and vulnerable population groups are:

- Adolescents, aged 10-19 years
- Racial and ethnic minorities, immigrant groups, indigenous groups
- People who are displaced, including refugees, people in emergency context (natural or man-made)
- People with disabilities
- People in a disadvantaged position: poor, rural, less educated, living in urban slums
- People who inject drugs
- Sex workers
- People of diverse sexual orientation, gender characteristics and sex characteristics

7. Core SDG targets, national indicators, baseline and targets

The General Bureau of Statistics (GBS), Suriname's National Statistics Office (NSO) has selected a set of official national SDG indicators that will guide the monitoring of SDG's[11].

In the matrix below approved national key indicators are listed relevant for monitoring of implementation of SRHR policy. In accordance with the SDG agreements, all data will as much as possible be disaggregated by age, sex, ethnicity, residence, wealth quintile, and other relevant variables.

Core global SDG targets	National Indicators	Baseline 2020	National Targets by 2030
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 2018: 54 per 1000 girls aged 15-19 (ABS, 2019)	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	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	Not Available (NA)	To be Determined (TBD)

[11] See: 'Finaal geselecteerde ontwikkelingsindicatoren' (Final selected development indicators), Planbureau, Augustus 2019

and affordable essential medicines and vaccines for all. (SDG, 3.8)	disadvantaged population .(SDG, 3.8.1.)		
	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 11 GP's per 10,000 in Paramaribo 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
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
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.	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	NA	TBD

(SDG 5.2)	persons other than an intimate partner, in the previous 12 months, by age and place of occurrence (SDG, 5.2.2)		
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

References

ECLAC (2013)
Montevideo Consensus
Bakboord, C. (2017)
Lespeki mi (Respect me), Women's Rights Center, 2017
General Bureau for the Statistics (2014)
Census 2012
General Bureau for the Statistics (2019)
Demographic Statistics 2015-2018
Government of Suriname (2018)
Suriname Progress report on the implementation of the Montevideo Consensus, 2013-2018
Government of Suriname (2017)
Development Plan, 2017-2021. Suriname Planning Office, 2017
Government of Suriname (2019)
Multiple Cluster Indicator Survey (MICS) 6. UNICEF, 2019
Joseph, J. et.al. (2019)
National Women's Health Survey for Suriname, IDB, 2019
Kodan LR, Verschueren KJC, van Roosmalen J, Kanhai HHH, Bloemenkamp KWM (2017)
Maternal mortality audit in Suriname between 2010 and 2014, a reproductive age mortality survey. BMC Pregnancy Childbirth. 2017 Aug;17(1):275.
Heemskerk et al. (2011)
An HIV seroprevalence and behavioral survey among men who have sex with men (MSM) in Suriname
Heemskerk M and Duijves C. (2019)
Integrated Biological and Behavioral Survey Among Men Who Have Sex with Men and Trans Women, Paramaribo, Suriname, 2018-19. Final Report. Social Solutions, Paramaribo, Suriname for the Suriname Ministry of Health. 2019a.
Heemskerk M and Duijves C. (2019)
Integrated Biological and Behavioral Survey among Female Sex Workers in Paramaribo and gold mining areas, Suriname, 2018-19. Draft report. Social Solutions, Paramaribo, Ministry of Health. 2019b.
Medical Mission (2017)
Bevorderen van Gezondheid in de Kleinschalige Goudwinning (PROSAMIGO), Medische Zending, Febr. 2017
Ministry of Health (2019)
National Strategic Plan for Health and Wellbeing, 2019-2028,
Ministry of Health (2019)
National Safe Motherhood Action Plan
Ministry of Health (2019)
Evaluation of safe motherhood and neonatal health plan of action (2013-2016), 2017; MOH Suriname
Ministry of Health (2019)
National Cancer Control Plan, 2019-2028. MOH/PAHO
PAHO (2007)
Assessment of the Suriname national health information systems, PAHO, MOH, 2007

PAHO (2014)
Strategy for universal access to health and universal health coverage (Res. CD53/5, Rev. 2) in the 53rd Directing Council of the Pan American Health Organization (PAHO, 2014)

PAHO (2010)
Adolescent and Youth Regional Strategy and Plan of Action 2010–2018, Washington DC

Planbureau (2019)
Finaal geselecteerde ontwikkelings indicatoren, Augustus 2019

Starrs. A. (2018)
Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission et.al. Lancet 2018; 391: 2642–92. Published Online May 9, 2018 http://dx.doi.org/10.1016/ S0140-6736(18)30293-9

Sobhie, R. (2015)
Hoe arm is Suriname? Institute for Graduate Studies, Anton de Kom Universiteit

Terborg, J. (2013)
Gezondheid van moeder en kind in vijf gemeenschappen

Terborg, J. (2018)
Report on Violence against Children (Students report), UNICEF/IGSR, 2018

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

United Nations (2015)
Sustainable Development Goals

United Nations (2019)
Trends in Maternal Mortality: 2000 to 2017.

UN Committee on Economic, Social and Cultural Rights (2016)
General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), May 2016

UNFPA/CARICOM (2014)
Integrated strategic framework for the reduction of adolescent pregnancy in the Caribbean, UNPA

UN General Assembly (2012)
Resolution on 'Global health and foreign policy', adopted by the General Assembly on 12 December 2012, 14 March 2013

UNFPA (2019)
Nairobi Commitments

WHO (2016)
Sexual health and its linkages to reproductive health: an operational approach, WHO, 2016

WHO (2018)
Global Strategy for Women, Children and Adolescents health, 2016-2030 (Every Woman Every Child Initiative, 2015)

WHO (2018)
WHO recommendations on adolescent sexual and reproductive health and rights. Geneva: World Health Organization; 2018. License: CC BY-NC-SA 3.0 IGO.

WHO (2018)
Regional Plan of action for women's, children's, and adolescents' health, 2018 – 2030. 56 directing council, 70th session of the regional committee of WHO for the Americas, Washington, D.C., USA, September 2018

WHO (2010)
Health systems financing: the path to universal coverage. WHO, 2010
WHO (2008)
Closing the gap in a generation: health equity through action on the social determinants of health: final report of the commission on social determinants of health. WHO 2008
World Health Assembly (2012)
Outcome of the World Conference on Social Determinants of Health. Sixty-fifth world health assembly wha65.8 agenda item 13.6 26 may 2012

National Sexual and Reproductive Health and Rights Policy of Suriname, 2020-2030

Paramaribo, March, 2020

At the request of the Ministry of Public Health Suriname

With technical and financial support from the United Nations Population Fund