AN HIV SEROPREVALENCE AND BEHAVIORAL SURVEY AMONG MEN-WHO-HAVE-SEX-WITH MEN (MSM) IN SURINAME

Final report

Marieke Heemskerk & research team
Heemskerk Consultants in Social Sciences
03/04/2011
Acknowledgements

Conducting this study would not have been possible without the support and collaboration of many people in Suriname.

I wish to thank numerous homosexual, bisexual, transsexual, and heterosexual men for sharing their time and information about often delicate issues. A special word of thank is reserved for individuals with a central role in gay social life in Paramaribo who facilitated our contact with Men Having Sex with Men (MSM). Suriname Men United served as a resource organization for the duration of the study. We appreciate the support of the manager of club Millennium who welcomed us into his establishment for several weeks in a row.

I also would like to express my gratitude to the excellent team of interviewers and testers/counselors, who worked irregular and late hours under often difficult circumstances. Particularly at some of the more shady cruising sites, the interviewers have been confronted with violence and risky situations. This has not stopped them from continuing the work. The gay men among the interviewers had invaluable knowledge about the target group and used their extensive social networks to make sure that we reached the target number of interviews in a very short time.

This study was commissioned by the Pan American Health Organization (PAHO)/World Health Organization (WHO) office in Suriname, as part of the Global Fund Program ‘Reducing the spread and impact of HIV/AIDS in Suriname through expansion of prevention and support programs’. PAHO helped with logistics, development of the survey forms and study protocol, cleaning of the dataset, and data analysis. In addition, health experts from PAHO and the National AIDS Program (NAO) reviewed the draft document and offered comments and insights that helped produce a better final version. Global Fund is acknowledged for its invaluable financial contribution to fighting HIV/AIDS in Suriname.

The author is responsible for all errors in translation and interpretation.

*Marieke Heemskerk*
Summary

This report presents the results of a Behavioral Surveillance Survey (BSS) with a seroprevalence component among Men who have Sex with Men (MSM) in Paramaribo, Suriname. The study was commissioned by the Ministry of Health and coordinated by PAHO, as part of the grant agreement with Global Fund: 'Reducing the spread and impact of HIV/AIDS in Suriname through the expansion of prevention and support programs'. A 2005 BSS studies among MSM in Suriname indicates that MSM are a relatively ‘untouched’ Most At Risk Population (MARP), which is disproportionately affected by HIV and displays high-risk behaviors. The objectives of the study were to: collect information of the MSM population and visiting sites; collect quantitative data on HIV-related behavior and knowledge; and measure HIV prevalence among MSM in Paramaribo.

Table 1. Seroprevalence rates for the general population and MARPS in Suriname

<table>
<thead>
<tr>
<th>Population group</th>
<th>Seroprevalence</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>General population</td>
<td>1%</td>
<td>2008</td>
</tr>
<tr>
<td>CSW</td>
<td>7.2%</td>
<td>2009</td>
</tr>
<tr>
<td>Prison population</td>
<td>2.2%</td>
<td>2008</td>
</tr>
<tr>
<td>MSM</td>
<td>6.7%</td>
<td>2005</td>
</tr>
</tbody>
</table>

The present study contained four components:

(1) During the **formative and mapping** stage two focus group discussion and consultations with key informants were conducted. This exercise resulted in a characterization of MSM subpopulations and identification of meeting places, and formed the basis of the fieldwork.

(2) 319 MSM participated in a Behavioral Surveillance Survey (BSS) to collect information about HIV/AIDS related knowledge and behavior among MSM.

(3) 65 individuals participated in the HIV seroprevalence study.

The BSS targeted self-identified MSM of 16 years or older who had had sex with at least one other man in the year prior to the survey. To prevent losing valuable information about MSM in the ‘hidden’ group, it was decided to include in the analysis (a) surveyed men who self-identified as straight but were part of the social networks of MSM surveyors, and (b) MSM who indicated that they had not been sexually active in the past year. MSM who were engaged in selling sex for money or who were not regularly sexually active in Suriname were excluded from the study. Less visible MSM were reached by working with personal networks. Participation in the study was voluntary, anonymous, and on the basis of informed consent.

Results

Subgroups identified among MSM include; Hindustani boys, hunters, transgenders, elite group, sex workers (excluded from this study), and **Konde** types. The only formal club night for MSM in Paramaribo is the Friday gay-night at club Millennium. Gay men also meet at: gay-friendly bars and establishments, cruising areas, short stay hotels and other hidden getaways, private parties and socials, winti-preys, and MSM-internet sites.
Interview respondents were, on average, 29.8 years old (SD= 9.6; N=315). The largest ethnic groups in the sample are people of ‘mixed’ descent and Creoles. On average, educational achievement among MSM respondents appears higher than educational levels for the general population: 30.1 percent of respondents had a college or technical degree and 13.5 percent was university educated. With regard to sexual orientation, 45.9 percent of respondents identified as homosexual, 43.1 percent as bisexual, 4.1 percent as transgender, 6.3 percent as heterosexual, and 0.6 percent as a woman (N\text{total}=318).

For men who had had anal sex with another man, the average age of anal sexual initiation with a man was 17.8 years (SD=4.4; N\text{total}=267). Thirty-five men (13.1%; N\text{total}=267) had anal sex for the first time when they were of elementary school age (13 or younger). Seven respondents (2.3%, N\text{total}=311) had, in the past six months, been told by a health worker that they had a venereal disease. Six out of 65 respondents who participated in the seroprevalence study were found HIV-positive (9.2%). Of the 236 respondents who had received an HIV test prior to this study (75.2%; N\text{total}=314), 40 persons (16.9%) had not taken the test voluntarily.

<table>
<thead>
<tr>
<th>Table 2. Respondents who had:</th>
<th># (%)</th>
<th>N\text{total}</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anal sex with another man at least once in his lifetime</td>
<td>295 (93.1%)</td>
<td>315</td>
</tr>
<tr>
<td>Vaginal or anal sex in the past six months</td>
<td>287 (90.5%)</td>
<td>317</td>
</tr>
<tr>
<td>Anal sex with another man in the past six months</td>
<td>264 (83.3%)</td>
<td>317</td>
</tr>
<tr>
<td>Sex with at least one woman in the past six months</td>
<td>150 (47.5%)</td>
<td>316</td>
</tr>
<tr>
<td>Anal sex with more than one man in the past six months</td>
<td>120 (49.4%)</td>
<td>243</td>
</tr>
<tr>
<td>Paid for sex with another man</td>
<td>48 (15.3%)</td>
<td>314</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 3. Respondents who, in the past six months, always used condoms when they:</th>
<th># (%)</th>
<th>N\text{total}</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paid for sex with another man</td>
<td>22 (48.9%)</td>
<td>45</td>
</tr>
<tr>
<td>Had anal sex with a woman (paid or unpaid)</td>
<td>37 (39.8%)</td>
<td>93</td>
</tr>
<tr>
<td>Had vaginal sex with a woman</td>
<td>64 (44.4%)</td>
<td>144</td>
</tr>
<tr>
<td>Had anal sex with a man (paid or unpaid)</td>
<td>157 (59.9%)</td>
<td>262</td>
</tr>
<tr>
<td>Had anal sex with a man or woman (unpaid)</td>
<td>157 (57.1%)</td>
<td>275</td>
</tr>
</tbody>
</table>

The average numbers of male and female sex partners in the six months preceding the survey were, respectively, 4.2 (SD=7.2; N\text{total}=190) and 2.8 (SD=3.2; N\text{total}=111). 92.1 Percent of MSM identified use of a condom as the most important way to prevent the transmission of HIV (234 persons; N\text{total}=254). Nevertheless, 28 percent of respondents (78; N\text{total}=279) had not used a condom the last time they had anal sex, and 44.4 percent had not used a condom the last time they had paid another man to have sex.

Of the 287 respondents who had vaginal or anal sex in the six months preceding the interview, 103 persons (36.3%; N\text{total}=284) had experienced problems with condoms, mostly that the condom ripped or burst. 70.2 percent of the respondents reported always using lubricant (N\text{total}=285).

Only 9.6% of respondents (29; N\text{total}=303) believe that they are at a risk of HIV transmission. Of the 230 persons who believed not to be at risk and who reported why, 104 individuals (45.2%) indicated that
they (always) use condoms, and 45 individuals (19.6%) insisted that they only have safe sex. The analysis shows, however, that in both groups condom use is not consistent, particularly with women.

The majority of respondents rejected the three most common misconceptions about HIV/AIDS: (1) HIV is transmitted through kissing (rejected by 79.1%; 246 respondents; \(N_{\text{total}}=311\)); (2) HIV may be transmitted by a mosquito (rejected by 85.9%; 268 respondents; \(N_{\text{total}}=312\)), and (3) Having unprotected sex with a healthy looking person exposes one to a risk of contracting HIV (affirmed by 83.2%; 262 respondents; \(N_{\text{total}}=315\)).

More than half of respondents (57.8%; \(N_{\text{total}}=308\)) do not feel discriminated because of their sexual orientation. Of the 127 respondents who do feel discriminated, most feel discriminated by people they do not know (68.5%) and close family (30.7%).

Governmental organizations that provide services in the area of HIV/AIDS include the National AIDS program, Regional Health Service clinics, and the Dermatological Service. The most important NGOs in this area are: Maxi Linde foundation, Stg. Lobi, Stg. Mamio Namen Project, Suriname Men united, and He&HIV Foundation. Of these organizations, Suriname Men United and He&HIV Foundation specifically work with MSM. Club Matapi and the Veranda are informal MSM social groups. In the year preceding the interview, 257 respondents (80.6%; \(N_{\text{total}}=319\)) had received information about HIV, and 194 persons (62%; \(N_{\text{total}}=313\)) had received free condoms from an outreach program.

It is concluded that even though many MSM received information about HIV in the past year, sexual risk behavior remains high. For most MSM, condom use is inconsistent, even among those people who report that they feel not at risk because they use condoms and have safe sex. As in the 2005 BSS among MSM, the results suggest a high level of contact with the general population; 47.5 percent (\(N_{\text{total}}=316\)) of MSM did have sex with women in the six months preceding the interview, and 30.7 percent (\(N_{\text{total}}=286\)) did so without protection. It appears that current outreach efforts increased knowledge on HIV transmission and prevention, but have not succeeded in changing behavior. International BSS indicators are reported in Table 4.

The researchers provide recommendations in four sections. In terms of knowledge and capacity building, it is recommended that outreach campaigns integrate strategies aimed at elevating risk awareness rather than focus on the transfer of HIV knowledge alone. Such sessions should make use of innovative methods, such as popular theatre. Outreach activities of GOs and NGOs such as SMU, must develop strategies to include MSM who have hitherto been excluded. Free HIV-testing must be regularly offered on places where MSM meet. Policy initiatives should investigate possible discriminatory regulations within government offices and record MARPS in the national HIV data-base. Further research is warranted to identify the determinants of risk perceptions and sexual risk behavior. It must be investigated how such knowledge can most effectively be used in outreach activities that meet the needs and interests of the various MSM subgroups.

\textit{Table 4. BSS Indicators}
<table>
<thead>
<tr>
<th>No</th>
<th>Nominator</th>
<th># (%) of respondents</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Respondents naming &quot;using a condom&quot; as the most effective means of reducing the risk of HIV infection</td>
<td>234 (92.1%)</td>
<td>254</td>
</tr>
<tr>
<td>2</td>
<td>Respondents who correctly reject the two most common local misconceptions about HIV/AIDS and who know that a healthy looking person can transmit HIV/AIDS</td>
<td>193 (62.7%)</td>
<td>308</td>
</tr>
<tr>
<td>3</td>
<td>Respondents who report anal sex with more than one other man in the last six months</td>
<td>120 (49.4%)</td>
<td>243</td>
</tr>
<tr>
<td>4</td>
<td>Median number of male anal sex partners in the past 6 months among MSM</td>
<td>2</td>
<td>190</td>
</tr>
<tr>
<td>5</td>
<td>Respondents who report condom use at last anal sex with a non commercial partner</td>
<td>198 (71.0%)</td>
<td>279</td>
</tr>
<tr>
<td>6</td>
<td>Respondents who used a condom every time they had anal sex with non commercial partners over the past six months</td>
<td>157 (57.1%)</td>
<td>275</td>
</tr>
<tr>
<td>7</td>
<td>Respondents who have paid for anal sex with another man at least once over the past six months</td>
<td>48 (15.3%)</td>
<td>314</td>
</tr>
<tr>
<td>8</td>
<td>Respondents who report condom use at last anal sex with male commercial partner whom they are paying</td>
<td>24 (53.3%)</td>
<td>45</td>
</tr>
<tr>
<td>9</td>
<td>Respondents who used a condom every time they paid for sex with any man over the past 6 months</td>
<td>22 (48.9%)</td>
<td>45</td>
</tr>
<tr>
<td>10</td>
<td>Respondents who have had unprotected sex with a woman at least once in the last 6 months and who have had unprotected sex with at least one other man in the last 6 months</td>
<td>50 (17.4%)</td>
<td>286</td>
</tr>
<tr>
<td>11</td>
<td>Respondents who have voluntarily requested an HIV test (was the most recent test voluntary) and received the test and received the results</td>
<td>192 (61.1%)</td>
<td>314</td>
</tr>
<tr>
<td>12</td>
<td>Respondents reporting having been exposed to specific HIV prevention interventions</td>
<td>272 (87.5%)</td>
<td>311</td>
</tr>
</tbody>
</table>
# Table of Contents

Acknowledgements .................................................................................................................. 1  
Summary ................................................................................................................................... 2  
Table of Contents ...................................................................................................................... 6  
List of Abbreviations .................................................................................................................. 8  

1. Introduction .......................................................................................................................... 9  
   1.1 MSM as high risk populations in Suriname ................................................................. 9  
   1.2 Objectives .................................................................................................................... 9  
   1.3 Commissioning agency and beneficiaries ................................................................. 10  
   1.4 Report outline ........................................................................................................... 10  

2. Background: Suriname and its HIV .................................................................................... 11  
   2.1 Suriname and HIV/AIDS ......................................................................................... 11  
   2.2 MARPS and HIV/AIDS in Suriname ..................................................................... 13  

3. Methods ............................................................................................................................ 15  
   3.1 Study design ............................................................................................................. 15  
   3.2 Mapping and formative exercise ............................................................................. 15  
   3.3 Study population and inclusion/exclusion criteria .................................................. 16  
   3.4 Sample size and sample technique ....................................................................... 16  
   3.5 Data collection period and locations .................................................................... 18  
   3.6 Behavioral Surveillance Survey ............................................................................. 18  
   3.7 Seroprevalence Study .............................................................................................. 20  
   3.8 Qualitative methods ............................................................................................... 22  
   3.9 Informed consent procedure ................................................................................... 22  
   3.10 Difference with previous BSS and seroprevalence study among MSM ............... 23  

4. Results ................................................................................................................................ 24  
   4.1 MSM population sub-groups ................................................................................ 24  
   4.2 MSM Meeting places ............................................................................................ 25  
      4.2.1 Formal establishments: clubs, bars, restaurants, and cinema ................................ 25  
      4.2.2 Cruising areas .................................................................................................... 26  
      4.2.3 Short stay hotels and other private spots .............................................................. 26  
      4.2.4 Private parties and socials ................................................................................ 26  
      4.2.5 Winti preys ........................................................................................................ 27  
      4.2.6 Internet ............................................................................................................... 27  
      4.2.7 Hair and beauty salons ....................................................................................... 27
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABS</td>
<td>Algemeen Bureau voor de Statistiek</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immuno-deficiency Syndrome</td>
</tr>
<tr>
<td>ARV</td>
<td>Anti Retro Viral</td>
</tr>
<tr>
<td>ATM, Ministry of Labor, Technology, and Environment</td>
<td></td>
</tr>
<tr>
<td>BSRG</td>
<td>Policy plan Sexual and Reproductive Health</td>
</tr>
<tr>
<td>BSS</td>
<td>Behavioral Surveillance Survey</td>
</tr>
<tr>
<td>CAREC</td>
<td>Caribbean Epidemiology Centre</td>
</tr>
<tr>
<td>CBO</td>
<td>Community Based Organization</td>
</tr>
<tr>
<td>CSW</td>
<td>Commercial Sex Worker</td>
</tr>
<tr>
<td>Derma</td>
<td>Dermatological Services</td>
</tr>
<tr>
<td>FBO</td>
<td>Faith Based Organization</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>GO</td>
<td>Governmental Organization</td>
</tr>
<tr>
<td>Ibid.</td>
<td>Ibidem (Latin), meaning: aforementioned, in the same place. The term is used in footnotes and bibliographies to indicate that a citation comes from the same source as the previous (scholarly writing).</td>
</tr>
<tr>
<td>LGBT</td>
<td>Lesbian, gay, bisexual and transgender people</td>
</tr>
<tr>
<td>MARPs</td>
<td>Most At Risk Populations</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
</tr>
<tr>
<td>MSM</td>
<td>Men having Sex with Men</td>
</tr>
<tr>
<td>NAP</td>
<td>National AIDS Program</td>
</tr>
<tr>
<td>NGO</td>
<td>Non Governmental Organization</td>
</tr>
<tr>
<td>NSP</td>
<td>National Strategic Plan on HIV/AIDS</td>
</tr>
<tr>
<td>OAS</td>
<td>Organization of American States</td>
</tr>
<tr>
<td>PAHO</td>
<td>Pan American Health Organization</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Preventing Mother-to-Child Transmission (of HIV)</td>
</tr>
<tr>
<td>RGD</td>
<td>Regional Health Service (Regionale Gezondheidsdienst)</td>
</tr>
<tr>
<td>SMLA</td>
<td>Stichting (Foundation) Maxi Linder Association</td>
</tr>
<tr>
<td>SMU</td>
<td>Suriname Men United</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually transmitted Disease</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
1. Introduction

1.1 MSM as high risk populations in Suriname

This report presents the results of a Behavioral Surveillance Survey (BSS) with an HIV prevalence component among Men who have Sex with Men (MSM) in the city of Paramaribo, Suriname. The study was conducted in support of efforts to combat HIV/AIDS in line with the agreement between the Government of the Republic Suriname and the Global Fund to implement the proposal: 'Reducing the spread and impact of HIV/AIDS in Suriname through the expansion of prevention and support.' The goal of this five year proposal is to strengthen the Ministry's national HIV strategic plan with as aim to 'reduce the further spread and minimize the negative consequences of HIV/AIDS'. One of the objectives of the proposal is 'to promote the adoption of safer sex behaviors through the design and implementation of combined behavior change interventions'.

Estimated adult seroprevalence (15-49 years) in Suriname is 1% (Ministry of Health 2010). This figure is higher among most at risk populations (MARPs). MARPs are subgroups of the population whose specific behavior and/or conditions place them at increased risk of HIV infection. The Ministry of Health has identified various MARPs, including: MSM, male and female commercial sex workers, clients of sex workers, prisoners, and gold miners. Suriname has recognized the need and made a commitment to implement intensive surveillance on these MARPs. The present study is part of these efforts.

In Suriname, as in many other countries of the world, MSM remain disproportionately affected by HIV. As was stated in the proposal that preceded this study, MSM constitute a relatively "untouched" subgroup in Suriname. A 2005 study among the MSM revealed an HIV prevalence of 6.7% and demonstrated high risk behavior, multiple partners and female partners (CAREC/PAHO and SMLA 2005a). A 1998 study among this subgroup found 18.0 percent of the participating MSM HIV-positive, and similarly reported high incidences of unprotected sex with male and female partners (Del Prado et al., 1998). These seroprevalence rates and self-reported high-risk behaviors motivated the decision to target this population for the present study.

1.2 Objectives

In order to better guide the resources for interventions and to measure the progress of targeted interventions, it is necessary to learn more about their sexual behavior, knowledge of HIV/AIDS, and seroprevalence. In this context, the objectives of the current study are to:

- Collect contextual information of the MSM population and visiting sites.
- Collect quantitative data regarding HIV-related behavior, knowledge, attitudes and believes of the MSM population in Paramaribo
- Measure the HIV prevalence among the MSM population in Paramaribo.
1.3 Commissioning agency and beneficiaries

This study was commissioned by the Ministry of Health, as part of the grant agreement with Global Fund: ‘Reducing the spread and impact of HIV/AIDS in Suriname through the expansion of prevention and support programs’. The Ministry of Health has requested PAHO/WHO to provide technical assistance in the overall coordination and implementation of a BSS among MSM with an HIV prevalence and size estimation component. PAHO, in turn, has contracted Heemskerk Consultants in Social Sciences to execute the study. A GIS expert was contracted to construct a geographic map of MSM meeting places.

It is expected that the presented analysis and recommendations will help the Ministry of Health design more effective intervention campaigns aimed at curbing the spread of HIV/AIDS among MSM and their partners. The MSM population may benefit from the study if it leads to better targeted sexual health services for this group. A fierce and continuous response to the HIV/AIDS pandemic is critical to progress towards the Millennium Development Goals, of which MDG 6 projects that, by 2015, the world will have halted and begun to reverse the global HIV epidemic. Fighting HIV/AIDS, however, will also positively affect other MDGs such as eradication of poverty, reduction of child mortality, and improvement of maternal health (UNAIDS 2008).

1.4 Report outline

The remainder of this document proceeds as follows. Chapter 2 provides background information on Suriname, with special emphasis on HIV/AIDS and health policy vis-à-vis the HIV pandemic. Next, in Chapter 3, the methods used for data collection and analysis are justified.

Chapter 4 contains the research results. It begins with a description of MSM sub-groups (4.1), meetings places (4.2), and the demographic and socio-cultural characteristics of the research population (4.3). Subsequent sections discuss sexual orientation (4.4) and sexual initiation (4.5). Sexual health is referred to in section 4.6 on HIV-testing and HIV prevalence, and in section 4.7 on exposure to STIs. Data about male and female partners (4.8) and condom use (4.9) provide more insight in sexual behavior. Risk perceptions are possibly an important factor in explaining sexual behavior, and are analyzed in section 4.10. Section 4.11 exposes knowledge about HIV/AIDS transmission and prevention. Discrimination and stigma, which are discussed in section 4.12, may interfere with access to outreach programs. Such outreach programs and activities of governmental and non-governmental organizations are the focus of section 4.13.

In Chapter 5, the results are discussed and placed in the broader context of HIV/AIDS prevention in Suriname. This discussion and subsequent conclusions form the basis for the recommendations in Chapter 6. Cited literature is listed in the references (Chapter 7), and the survey forms and other bulky data are placed in the Appendices.
2. Background: Suriname and its HIV

2.1 Suriname and HIV/AIDS

The Republic of Suriname (land mass: 163,820 km2) is located on the Northern tip of South America, north of Brazil between Guyana and the French Department of La Guyane (also named French Guiana). Suriname has a small (492.829 people) yet culturally diverse population (ABS 2005). The largest share of the population lives in the coastal area, mainly in the capital city of Paramaribo, where this study was conducted. This urban center, with a surface of 182 km2, houses approximately half of Suriname’s citizens (pop: 246,864; ABS, 2008)

An estimated 1 percent of the adult population of Suriname is infected with HIV (Ministry of Health 2010). The real figure is difficult to estimate because only a small section of the sexually active population gets tested. These are both people who take a voluntary HIV test, and pregnant women who are all tested as part of the prenatal control. Among tested persons, men have higher HIV-prevalence rates than women. Male prevalence decreased from 8.55 percent (of tested men) in 2005 to 5.56 percent in 2006 and 2007. Also among women a slight decrease in prevalence is observed, from 3.01 percent in 2005 to 2.65 percent in 2007 (Ministry of Health 2010).

The year 2007 marks the first year with a decrease in the number of sero-positive men and women (Figure 2.2). In that year, 85 men and 57 women died of the consequences of AIDS in Suriname (Figure 2.3). Since 2002, after years of rising numbers of AIDS-related death, AIDS mortality rates are fluctuating around 90 cases for men (with an exceptional peak in 2005) and 55 cases for women. In 1997 HIV/AIDS was rated 10th on the list of most frequent causes of death in Suriname. A few years later, between 2003 and 2005, HIV/AIDS had moved up to the 5th place. In 2006 and 2007, HIV/AIDS ranked 6th on the list of most frequent causes of death.

Because HIV/AIDS knowledge has been measured in different ways in different subgroups, it is difficult to obtain a good impression of HIV prevention knowledge in the general population. According to the 2006 Multiple Indicator Cluster Survey (MICS), 39.3 percent of women of reproductive age (15-49) has correct knowledge of HIV/AIDS transmission. This means that during the interview, they were able to name at least two ways to prevent infection with HIV/AIDS and correctly identified at least three misconceptions. This survey found that knowledge is most accurate in urban areas (43.3%) and lowest in the interior (17.3%).
Figure 2.2  Number of HIV-positive cases by sex, 2004-2007

![Bar chart showing the number of HIV-positive cases by sex from 2004 to 2007.](chart)

Source: ABS 2009. Geselecteerde Genderstatistieken

Figure 2.3  AIDS-related mortality, 1997-2007

![Line chart showing the number of persons who died of HIV/AIDS related complications from 1997 to 2007.](chart)

Source: MDG report 2010
A more recent study among 1476 teenagers and young adults (ages 15-24) in low-income urban and rural areas shows that 91.3 percent of young men and women are familiar with the concept ‘HIV’ (ProHealth 2007). When asked about ways in which HIV may be transmitted, the largest share of surveyed youngsters mentions sex without a condom (69.1%). Three-quarters of youth mentioned ‘use a condom’ or ‘always use a condom’ as ways to prevent HIV infection (76.7%). Smaller percentages of youth named abstinence (8.3%) and having sex with just one partner (11.6%).

In the present study, standard global HIV/AIDS indicators were used to allow for comparison of the results with those of studies among other MARPs, studies in the general population, and studies in other countries.

### 2.2 MARPS and HIV/AIDS in Suriname

In order to halt and reverse the spread of HIV/AIDS, it is important to gather strategic information that helps us to understand the transmission dynamics. For this reason it is important to determine the potential ‘drivers’ of the epidemic. ‘Drivers’ are the population groups which have high levels of risk behavior, are relatively large in size and have a high prevalence rate. These population groups can also serve as a bridge to the general population. Once these populations are identified and additional behavioral information has been gathered, targeted prevention interventions can be designed and implemented, and progress can be monitored (Protocol, Nov. 2010).

Earlier Behavioral Surveillance and Seroprevalence Surveys among MARPs justify placing particular emphasis on these groups in outreach and monitoring activities. Surveys among commercial sex workers in Paramaribo found prevalence rates of 24.6% in 2004 (CAREC/PAHO and SMLA 2005b) and 7.2% in 2009 (Heemskerk and Uiterloo 2010). A 2008 seroprevalence survey among sex workers in two border districts of Suriname, resulted in prevalence rates of 2.1% in the western border and 4.9% in the eastern border (PAHO et. al 2009). HIV prevalence rates for male CSW tend to be much higher than prevalence rates for female CSW. The above mentioned surveys in Paramaribo found an HIV prevalence rate of 36.2 percent in 2004 and nine out of thirteen male CSW HIV-positive in 2009\(^1\) (Heemskerk and Uiterloo 2010). The seroprevalence survey in the border districts found two out of the three tested male CSW HIV-positive\(^2\). In 2008, 57.6% of all prisoners participated in a seroprevalence study which yielded a prevalence rate of 2.23%.

---

1 The number of male CSW participating in this study was too low, for the HIV prevalence of this sub group, to be of any added value.
2 The number of male CSW participating in this study was too low, for the HIV prevalence of this sub group, to be of any added value.
All listed studies suggest inconsistent condom use and a high level of interaction of MARPs with the general population. This is also true for MSM. Of the MSM who participated in the 1998 study, 30% reported being in a sexual relationship with a woman at the time of the survey. Of those who participated in a BSS among MSM in 2005, 25.5% reported living in with a female partner, while more reported having had sex with at least one woman in the 6 months before the study. Of the men in this study, 31% reported unprotected sex with a female partner, while 18% reported unprotected sex with a male partner in the 6 months before the study (CAREC/PAHO and SMLA 2005a).
3. **Methods**

3.1 **Study design**

The study comprised four components:

1. A formative and mapping exercise
2. A size estimation exercise
3. A Behavioral Surveillance Survey (BSS)
4. An HIV seroprevalence study

The methods and results for the size estimation exercise are described in a separate report and hence will not be discussed further in this report. A cross-sectional design was used for the BSS questionnaire and the HIV prevalence component.

3.2 **Mapping and formative exercise**

Two focus group sessions were held to identify and characterize sub groups in the MSM population places, and locate places where MSM meet at certain times and days. One of these sessions was organized by the MSM organization Suriname Men United (SMU), and one of the sessions was facilitated by the consultant. Because the two focus group sessions generated largely similar results and because no new meeting sites were identified during the fieldwork, we conclude that our listing of MSM meeting places is more or less comprehensive.

The GIS expert collected geographic data by taking a reference point from each site with a GPS (geographic positioning system) devise. Track maker was used as the software to transfer the data from the GPS into the computer. Next, the data were imported in GIS (Global information system software) software Arc Map and symbolized based on type of location. These points were subsequently imported in Google earth Pro in order to obtain the correct geographic coordinates and to create a Google based map.

The image created in Google earth was once more imported into Arc Map and geo-referenced to ensure that all data points were placed in the correct geographic location. The map of MSM meeting places will be used as an internal document and is not presented in this study in order to protect the privacy of the target group.
3.3 Study population and inclusion/exclusion criteria

The study population consisted of self-identified MSM who had manual, oral or anal sex with at least one other man in the year prior to the survey and who were 16 years and older at the time of the interview. MSM who were engaged in selling sex for money were excluded from the study.

One criterion was added to those criteria stated in the Protocol. The men had to either reside in Suriname or stay for at least 6 months or visit Suriname at least every month and be sexually active here.

As mentioned in the BSS component, the questionnaire also included questions to measure the core BSS indicators for the MSM subpopulation. The majority of the questions in the questionnaire were therefore based on these indicators. Most indicators dealing with sexual behavior are based on behavior that ever happened or happened in the 6 months prior to the survey. As was mentioned earlier, the questions had to be prioritized and this meant that the BSS survey did not ask about sexual activity in the past year.

During the analysis it appeared that the sample included two groups of men who indicated that they had never had sex with other men. One group indicated to have had sex in the past 6 months, but only to women. Men belonging to this group identified themselves as either straight or bisexual. The other group consisted of men who reported that they had not been sexually active in the past 6 months (with men or women). However, almost all of these men self-identified as either gay or bisexual. Further analysis showed that the men who indicated to be straight, either belonged to a MSM social network or were recruited at cruising sites for MSM.

To prevent losing valuable information of those MSM who may be part of the ‘hidden’ group, it was decided to include all men who had participated. This also meant that one 15 year old man was included in the analysis.

3.4 Sample size and sample technique

Instead of aiming for a maximum of 500 MSM to participate in the BSS survey, it was decided to aim for 300, since this was feasible for the month timeframe available for fieldwork. As mentioned in the protocol, the BSS survey should be a representative sample of the MSM population. Due to time constraints, it was not feasible to use the recommended RDS sampling technique, which would guarantee a representative sample. Instead we used an adaptation of “targeted sampling” (Kral 2010) that was guided by formative mapping and comprised mixed methods of recruitment. These methods included: approaching persons at mapped meeting
places, allowing for snowball referrals, and adapting to new information on venues, house parties, and referrals while in the field.

Some measurements were put in place to improve the representativeness of the BSS survey sample (see attachment 1; protocol).

1. MSM with profound knowledge of the MSM scene and the extensive personal networks were part of the field workers team. The MSM field workers recruited MSM who would otherwise not be represented in the sample. These field workers visited private addresses, walked around at cruising sites, and hung out at street corners where they recruited MSM who probably would not trust just any other field worker approaching them. Next, the MSM surveyors performed one on one interviews with the participating MSM without the entire research team being present. In the case of cruising sites, the MSM field workers walked in equips of two persons for reasons of safety. The importance of working with insiders to the MSM scene was confirmed by the observation that female fieldworkers who visited the cruising sites generally failed to establish contact with cruising men.

2. Through the personal networks of team members and with assistance of SMU, appointments were made with small (3-8 people) groups of people at places they felt comfortable with. These groups consisted typically of one acquainted MSM and a couple of his friends. Using the small group approach, we were able to recruit MSM who were not likely to be hanging out at the ‘typical’ MSM meeting places.

Using the above strategies, it was possible to take up personal and subgroup networks of MSM in the sample, although this still does not guarantee a representative sample.

Possible respondents were screened for eligibility and eligible men were requested to participate in the survey and/or HIV test. After receiving their consent (for consent form, see attachment 2), the questionnaire was administered. If an approached man refused to participate in the questionnaire and/or HIV test. A non-response form was filled in for some respondents but not used consistently (see attachment 2). A total of 319 MSM participated in the BSS, and 65 persons participated in the seroprevalence study.
3.5 Data collection period and locations

Field research was conducted between 5 November and 23 December 2010 (Table 3.1). The first weeks of November were spent on the development of the questionnaire and research protocol, recruitment and training of the field workers, administrative procedures, and activities related to the size estimation. Interviewing started on November 24th and was concluded on December 23rd, 2010.

Table 3.1 contains a list of the places that were visited by the research team on different days. In addition to these places that were visited by a group of surveyors and testers/counselors, individual surveyors conducted interviews with MSM in their social network at their homes and other places.

Table 3.1  Study locations and dates (2010)

<table>
<thead>
<tr>
<th>Date (2010)</th>
<th>Times</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus group gatherings and field visits to identify MSM meeting places and refine the protocol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23 October</td>
<td>12:00-14:30</td>
<td>Suriname Men United office</td>
</tr>
<tr>
<td>22 October</td>
<td>20:00-22:00</td>
<td>Veranda</td>
</tr>
<tr>
<td>29 October</td>
<td>23:00-03:00</td>
<td>Winti Prey at Casaba-olo</td>
</tr>
<tr>
<td>Distribution of key chains</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12-22 November</td>
<td>Various</td>
<td>Millennium, Suriname Men United, private party</td>
</tr>
<tr>
<td>BSS and seroprevalence study</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24 November</td>
<td>21:00-01:00</td>
<td>Club Matapi</td>
</tr>
<tr>
<td>26 November</td>
<td>21:30-04:00</td>
<td>Dance pub Millenium</td>
</tr>
<tr>
<td>27 November</td>
<td>22:30-04:00</td>
<td>Cruising sites</td>
</tr>
<tr>
<td>28 November</td>
<td>17:00-21:00</td>
<td>Neighborhood centre Flora B</td>
</tr>
<tr>
<td>30 November</td>
<td>21:00-01:00</td>
<td>Anton Dragtenweg (bar/restaurant),</td>
</tr>
<tr>
<td>1 December</td>
<td>19:00-21:30</td>
<td>At the home of a transgender person</td>
</tr>
<tr>
<td>2 December</td>
<td>23:00-2:00</td>
<td>Cruising sites</td>
</tr>
<tr>
<td>3 December</td>
<td>23:00-4:30</td>
<td>Dance pub Millenium</td>
</tr>
<tr>
<td>4 December</td>
<td>23:00-4:30</td>
<td>Cruising sites</td>
</tr>
<tr>
<td>9 December</td>
<td>20:00-2:00</td>
<td>Group of Brazilians interviewed at a private address</td>
</tr>
<tr>
<td>10 December</td>
<td>20:00-4:00</td>
<td>TBL Cinema and dance pub Millenium</td>
</tr>
<tr>
<td>23 December</td>
<td>20:00-24:00</td>
<td>The Veranda</td>
</tr>
</tbody>
</table>

3.6 Behavioral Surveillance Survey

The BSS is a critical tool informing the worldwide HIV/AIDS response. This cross-sectional survey, repeated over time, tracks trends in HIV/AIDS knowledge, attitudes, risk behavior and exposure to interventions in selected segments of the population. The behavioral study was conducted through an administered questionnaire (see Annex 1). The questionnaire included questions to measure the core BSS indicators for the MSM subpopulation, as well as other
topics of interest. Prior to use, the questionnaire was pre-tested on four respondents and where necessary, questions were adjusted or deleted.

The consultant provided a teach-in to seven fieldworkers with regard to approaching the target population and administering the questionnaire. One of the persons who received the teach-in decided not to participate, and two additional persons joined the team in the course of the research. The final survey team included nine persons (including the consultant), among whom four were members of the target group. The remaining five surveyors included one staff member of Suriname Men United, two social scientists, and one personal assistant of the consultant.

In addition, towards the end of the survey work, two individuals who are familiar with the target group agreed to conduct individual interviews within their social networks. Prior to conducting these interviews, the consultant gave them a short briefing on the protocol.

The original protocol was submitted for review to the Ministry of Health National AIDS program. One change to the original protocol was that several questions from the BSS were deleted to shorten the time to administer the survey. The reason to do so was that after the first night of interviewing, the consultant noted that it took the surveyors too much time to ask all original questions. As a result, interviewees were losing interest and some did not want to sit through the entire survey. It was realized that especially when performing the surveys in front of the night club, it would not be possible to spend more than 15 to 20 minutes with a person on his night out. In revising the survey, the following questions were deleted:

6. To whom do you feel sexually attracted?
8. Where do you meet other MSM?
10. In the past 6 months, have you visited club Mystique (before it closed down)?
15. What does it mean to use the condom in the ‘correct way’?
Section on Self-efficacy (Q17-Q18)
Section on Attitudes (Q19)
32. In the past six months, did you receive money in exchange for sex with another man?
36. Where do you usually buy your condoms?
39. What brand of condoms do you use most (for anal sex)?
41. In the past six months, have you experienced the loss of unusual discharge from your penis/anus, or noted that you had blisters or soars on or around your penis/anus?
42. If you did (see 41), how was it treated or resolved?
44. Have you participated in the 2007-2008 needs assessment among MSM, performed by Mamio Namen Foundation\(^3\)
48. About what HIV/AIDS-related topics would you like to receive more information?
49. From whom would you prefer to obtain this information or support (see 48)?

One question was re-phrased, namely:

“13.C. Do you believe that you bear an increased risk of HIV infection if you, every time you have anal sex, use a condom in the correct way?”

This question was considered leading and confusingly phrased, and was reworded as an open question:

“What do you believe is the best way to minimize risks of becoming infected with HIV if you are having vaginal or anal sex?”

Survey forms were checked by the consultant or another team leader for the evening for completeness and consistency.

It was not possible to obtain a valid refusal rate for the BSS because not all people who did not want to participate communicated this to the interviewers. For example, some people would avoid the team when we were at public places and others would simply not show up at meetings. As a result we have not calculated the BSS refusal rate.

### 3.7 Seroprevalence Study

Because we were in a specific research project setting, outside of the regular VCT setting, our approach differed somewhat from the regular VCT procedures, in that the testers/counselors

1. Used a personal identification code that guaranteed anonymity rather than the national code based on name and date of birth,
2. Adapted the risk assessment procedure for the 3 months prior to the study, to prevent the situation where the survey team would have to ask the same questions twice, as time was already limited for the research team and the participants who were on a night out. The participants were already questioned regarding their risk behavior in the BSS questionnaire. Those who proceeded with the testing component were, therefore, only reminded to repeat the test, if they were at risk in the 3 months prior to the study.

\(^3\) Mamio Namen Foundation performed a needs assessment among HIV+ MSM. We deleted this question because the Mamio Namen Foundation specifically targets HIV+ people. Hence a person who responds that he has participated reveals that he is HIV+.
3. Altered the post-test counseling procedure to prevent drawing too much attention to the HIV positive cases. Post test counseling for HIV positive cases was reduced in length. Those who were HIV positive were provided with the telephone number of the counselor for further guidance and assistance and information about additional places to obtain support. They were also referred to their general practitioner for additional medical testing.

Many interview participants who agreed to be tested were not tested immediately. Some individuals from this group did not want to test on the spot (e.g. due to concerns about privacy). Other respondents were interviewed at locations where the testing/counseling team was not present. These respondents were offered the possibility to take an anonymous HIV test at the dermatological service (popularly known as: Derma).

The refusal rate for MSM who participated in the BSS but did not want to perform the HIV test was 80.2 percent. Of these people, 81 individuals expressed the intention to be tested at Derma but only two individuals actually went to take the test at this location. Hundred-and-twelve of the 167 persons who indicated that they did not want to take the HIV-test named a reason for being not interested. The main reasons were that the person had been tested before and/or knew his status ($N_{\text{total}}=112$; Figure 3.1).

**Figure 3.1** Reasons for not being tested on HIV ($N=112$)

- I know my HIV status
- I have been tested for HIV
- No time
- This is not the right moment
- This is not the right place
- I am afraid to get tested
- Interview was done at home
- I do not believe my data will be treated confidentially
- I have not had unsafe sex
- Just because...
- I do not need to know my status
- My partner and I like to do the test together
- Do not like it
- I go elsewhere for testing
- If you go to Derma, everyone sees you
- Never
- Other
The listed reasons for refusal suggest that our sample for the HIV-prevalence study may be biased in two ways:

1. It excludes people who know they are HIV-positive
2. It excludes people who regularly get tested (possible the most conscious people) and who had recently been tested.

Because of the high refusal rate and the mentioned biases, we question the representativeness of the test sample and do not believe that it is appropriate to generalize the result to the entire MSM population.

3.8 Qualitative methods
Qualitative methods were used to obtain more in-depth information about discrimination and stigma of SMS. This issue was elaborated upon because the foundation Suriname Men United (SMU) found it of particular importance. The lead researcher conducted semi-structured interviews on this topic with MSM, sometimes as an extension of the BSS survey. In addition, the research team attended a movie and discussion evening organized by the Dutch embassy in Suriname and SMU, with the theme: “Gay rights are human rights” (December 10, 2010). During this event in the largest cinema of Suriname, the movie “Suddenly last winter” was shown and used as a point of departure for a discussion on gay rights.

The research team also attended a discussion evening about the discrimination of MSM and gay rights organized by the Dutch embassy in Suriname and SMU at the MSM social circle the “Veranda” (December 23, 2010). This event was motivated by the visit of a representative of the LGBT-department of Human Rights Watch to Suriname. The more than 20 MSM who were present at this evening shared their experiences with, and opinions of, the civil rights of MSM in Suriname.

3.9 Informed consent procedure
Prior to starting the interview and testing procedures, the research personnel informed the participant(s) about the research and their rights. It was emphasized that participation was anonymous; that the results would be treated confidentially; that the HIV-test results would not be revealed to anyone other than the person tested; and that participation was voluntary.

When groups of MSM were visited at home or in another place, the group as a whole was provided with the consent procedure, after which each individual could decide whether to participate or not. In other cases the informed consent procedure was performed with each individual separately.
3.10 Difference with previous BSS and seroprevalence study among MSM

In order to be able to compare the results of the present study with those of an earlier BSS among MSM, it is important to consider differences in study approach between the two studies (2005 and 2010). Some of the most important methodological differences are listed below:

- The 2005 study included male commercial sex workers. Anyone who had sold sex in the six months prior to the survey was excluded from the 2010 study.
- The 2005 study only included people who both participated in the interview and took the HIV test. Because of the low number of people who wanted to be tested five years later, this approach was not feasible and we included also people who either only wanted to answer the questions, or only wanted to take the HIV test.
- For the 2005 study, fieldwork took place during five months. For the present study, the consultant was requested to complete fieldwork within one month. This short period has possibly compromised the representativeness of the sample because it did not allow for establishing relationships of trust with the target population, particularly the more hidden segments of this group.
4. Results

4.1 MSM population sub-groups

The following sub groups have been identified:

**Hindustani boys:** These men do not mingle a lot with other ethnic groups and often prefer to date other Hindustani men. The reason for doing so is that it is less obvious for others to find out that they are MSM. In the East-Indian culture it is normal for men to hang out together. Some members from this group believe that they will get involved with a woman on a later age, because that is what is expected by the parents.

**Hunters:** This is a term used for men in the age group of 40 year and older, who are seeking men between 18yr – 24yr. They tend to be financially well off and use their position to hook up with younger MSM. There are some young MSM who like that and therefore meet the needs of these hunters. In some situations the ‘hunters’ seek out younger men for fun and sex, but in other occasions they are interested in establishing a relationship.

**Transgenders:** This group was characterized as “wild, hot and flamboyant”. The Suriname transgenders tend to refer to themselves as shemales, a term that is used internationally. The members of this group tend to stand out due to their female behavior, high heeled shoes, make-up and hair does. Not all transgenders like to dress overly eccentric though, and many just dress and act like regular women. A lot of transgenders use female hormones, which are believed to stimulate both physical and emotional femininity. Others who are financially capable may undergo a sex change.

**Elite group:** The members of this group of highly educated, mostly young professionals tend to have an established position in the community, like doctor, lawyer, manager, or head supervisor. The elite MSM do not mingle much with other MSM and have their own private parties. Normally this groups travels around the world to visit gay events. Some members of this group travel around the world to visit international gay events.

**Sex workers:** Male sex workers, like their female counterparts, go by the principle of “no money, no sex”. Male sex workers typically sell sex on the street as a way of living. They have their own clientele.

**‘Kondre’ types:** These Creole men, who are largely from socioeconomically deprived neighborhoods, were described as “black and loud”. Members from this group often work in the food catering sector. They love cooking and making cultural costumes. The ‘kondre’ types

---

4 The characterization of MSM subgroups was provided by SMU in its focus group report (Van Emden 2010)
are often members of social community groups like, cultural choirs, and organizations that prepare death bodies for the burial. The members of this group may attend *winti preys*.

4.2 **MSM Meeting places**

Formal meeting places for MSM are sparse in Paramaribo. Most establishments that used to specifically target lesbian, gay, bisexual and transgender people (LGBT) have closed down. One of the reasons is that the group of LGBT who are ‘out’ and like to go out to public places among other LGBT is rather small. Hence it is not economically feasible for clubs and bars to exclusively focus on this group.

Yet formal meeting places are not the only way that MSM get in touch with other MSM for socializing, friendship, romantic relationships, or sexual encounters. This chapter describes the various places – real and virtual - where MSM from greater Paramaribo city get together. The description starts with a brief characterization of the MSM population in terms of sub-groups. In our sampling strategy, we have made an effort to recruit individuals from these various sub groups.

4.2.1 **Formal establishments: clubs, bars, restaurants, and cinema**

At present, the only place with a special ‘gay-night’ is night club Millennium, on Friday nights. Reasons to visit the Millennium gay night include: hooking up with other MSM, socializing, drinking, partying, identifying oneself with other MSM, curiosity, being at a place where one can be openly gay or MSM, and collecting booty calls. According to the focus group report, MSM from all subgroups (see 4.1) may visit Millennium, though some groups are better represented as others (Van Emden 2010). The SMU outreach workers distribute condoms and lubricant every Friday in the club.

In addition to night club Millennium, there are various ‘gay-friendly’ bars and other establishments, including Shooters, 8ightball, and Kekemba resort. These places are run by gay men but generally do not wish to have an (exclusive) ‘gay-image’. In addition, MSM may be going out to the Brazilian club Perola, which is not a gay oriented club but is characterized by a tolerant and free sexual moral.

---

5 Most of the information in this chapter was gathered through two focus groups, of which one was organized by Suriname Men United. The focus group report by this NGO for MSM in Suriname contains more detailed information about MSM subgroups, and meeting places and times.

6 These reasons were mentioned by MSM during a focus group organized by SMU, 23 October 2010.

Liberty is a Paramaribo cinema that shows porn movies, mostly in weekends starting from 21h. MSM may visit the place when there is a gay movie. In December 2010, one of the regular cinemas, the Backlot (TBL), showed a gay-awareness movie that attracted a sizable number of gay men. This feature was a one-time event and it is not expect that the cinema will regularly show movies with a gay theme.

In the various formal establishments MSM meet for various reasons, including socializing and hooking up with other MSM.

4.2.2 Cruising areas
In addition to formal establishments, there are outdoors places where MSM meet other MSM with the explicit purpose to have (anonymous) sex, whether paid or unpaid. MSM may be walking, going around by bicycle, or driving around in a car. Men recognize one another by body language, start a conversation, and may go off to a private place to have sex. Such cruising areas typically are dark and shady places and at some of the sites, MSM or their ‘protectors’ may be armed.

Some cruising sites are dominated by transvestite commercial sex workers. In other sites, men also may ask for money when they are approached for sex but typically do not consider themselves commercial sex workers.

4.2.3 Short stay hotels and other private spots
Young couples or people in secretive relationships looking for a place to get together in private and/or have sex, tend to go to cheap (short-stay) hotels and places where they will not be seen in a car. One of these short-stay hotels is specifically for MSM, but gay couples may also use one of the other regular short stay hotels.

Couples may also go to private and dark places outside where they park their car to make out.

4.2.4 Private parties and socials
As with any social group, MSM also meet at private parties. Such parties are typically held at someone’s house and may be regularly returning events, or incidental parties at a certain location. Club Matapi used to organize regular get-togethers for its members but lately the club has not been very active. In addition to parties, the Club has organized thematic discussion evenings, educational get-togethers, and trips to other locations.

A group of young professional gay men meets regularly at the ‘Veranda’, referring to the balcony of the home of one of these men. Meetings used to be weekly, but nowadays men meet less frequently at this location.
4.2.5 Winti preys
Particularly Creole descent MSM from low-income neighborhoods may be found regularly at winti preys. Winti preys are ritual gatherings of the Afro-Suriname Winti religion. Like rituals of other Afro-Caribbean religions, the winti rituals include offerings to ancestral spirits, rhythmic drumming music, and people getting into trance. Followers of the winti religion believe that homosexual men are more closely connected to certain female wintis, which cause their female trades to surface. At the winti prey these wintis may be honored. Another reason for MSM from particularly lower socio-economic classes like going to winti preys is that they feel that they can be themselves there.

Winti preys are typically held in weekends at night, but in the ‘high season’ (july/august) may be held daily. In those months, more people from the Netherlands are attending and hosting winti preys.

4.2.6 Internet
Another important place where MSM meet one another is in cyber space. There are various international gay websites that are popular among Suriname MSM. The sites are visited to meet and chat with other MSM; have internet, phone, or webcam sex; to make friends; to learn about different cultures; to obtain health information from the experiences of others; or to rendezvous. The main sites where Suriname MSM meet other MSM (from Suriname and abroad) include:

- Gaydar [http://gaydar.co.uk/default.asp](http://gaydar.co.uk/default.asp)
- Adam4adam [http://www.adam4adam.com](http://www.adam4adam.com)
- Facebook [www.facebook.com](http://www.facebook.com)

4.2.7 Hair and beauty salons
In many hair and beauty salons we found gay men working. These places cannot be considered meeting places, but we used these locations to get in contact with gay men.

The various physical and virtual meeting places with their characteristics are listed in Table 4.1. The SMU focus group report provides further detail on the times and days that these places are visited.

Figure 4.1 displays the numbers of MSM who were interviewed in the various locations. In this figure, club refers to dance pub Millennium, social network site refers to the places where we met people on private parties and group gatherings, and private address refers to places where MSM were individually visited at home or another location.
Table 4.1  
**Main MSM meeting sites in Paramaribo**

<table>
<thead>
<tr>
<th>Site</th>
<th>Days/times</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bars, Clubs, and other Establishments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Millennium night club</td>
<td>Friday night, 23:00-5:00 am</td>
<td>Gay night in regular dance club. A large diversity of MSM and friends are getting together at gay-night for socializing, dancing, hoop-ups, and more.</td>
</tr>
<tr>
<td>Shooters</td>
<td>Tuesday-Sunday 18:00-</td>
<td>Gay friendly restaurant and bar, with a small dancing room. No special MSM activities.</td>
</tr>
<tr>
<td>8ight Ball</td>
<td>Tue-Sat nights, 22:00-early morning</td>
<td>Gay friendly bar. Particularly Tuesday Karaoke night attracts quite some MSM.</td>
</tr>
<tr>
<td>Kekemba resort</td>
<td>All days, all times</td>
<td>Holliday resort that used to be a gay resort and has changed to gay-friendly. The resort features cabins, a pool, and a restaurant.</td>
</tr>
<tr>
<td>Perola</td>
<td>Evenings, primarily weekend</td>
<td>Brazilian night club. Not specifically catering to MSM but due to the free sexual morale, people feel they can be themselves.</td>
</tr>
<tr>
<td><strong>Cruising sites</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In order to protect the privacy of the target group, the various cruising sites are not listed by name and specific location. Most cruising sites are situated in Central Paramaribo, and one site is in Paramaribo South</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private parties</td>
<td>Evenings/Nights</td>
<td>Certain places host regular gay parties, including the Veranda and club Matapi; on other occasions parties are a one-time event.</td>
</tr>
<tr>
<td>Short stay hotels</td>
<td>Night</td>
<td>Short stay hotels attract couples who seek privacy.</td>
</tr>
<tr>
<td>Winti preys</td>
<td>Evenings/night, typically weekends</td>
<td>These afro-religious gatherings are typically held at the edge of town or in the districts of Para and Saramacca. MSM and lesbian women are regularly present</td>
</tr>
<tr>
<td>Hair and beauty salons</td>
<td>Day time</td>
<td>These are not meeting places. However, we have noted that in many hair and beauty salons, gay and bisexual men are working.</td>
</tr>
</tbody>
</table>
4.3 Demographic and social profile

The sample included MSM in a wide range of ages. The youngest being 15 years of age, and the oldest being 80. On average, interview respondents were 29.8 years old (SD= 9.6), and the median age was 28 (N=315).

Also in terms of ethnicity, the sample proves to be reasonably representative of the population in Paramaribo city. Main differences between our sample and the national population are that we have interviewed relatively more Creole people and relatively fewer Hindustani, Javanese, and Maroons (Figure 4.2). In 2004, when the latest population census was conducted, 18.9 percent defined themselves as Creole, 29.4 percent as Hindustani, and 15.6 percent as Javanese. That these figures differ from those in our sample is partly explained by the fact that our study was conducted in Paramaribo only. Rural populations such as Maroons living in the interior; Hindustani living in Nickerie and other Eastern districts; and the Javanese who dominate the population in the district of Wanica, were excluded from the study.

---

7 This person should technically have been excluded from the study as we targeted men of ages 16 and older. Chapter 3 on methods provides more detailed information on inclusion criteria.
One out of ten respondents had no more than elementary school education (9.7%). By far the largest group, however, had completed high school or gone beyond. Almost one third of respondents had completed technical, college level, or other professional education (30.1%) and 13.5 percent had a university degree (Figure 4.3). These educational levels seem higher than the educational levels for the general population, but the format of national level data collection makes comparison difficult. In the population of age 5 and older, 2.3 percent of men have attended university and 8.0% has attended college, technical education, or another form of professional education (ABS 2005)\textsuperscript{8}. In the general population of ages 16 and older these figures are likely to be higher.

With regard to housing situations, we found that about a third of respondents live alone (34.9%), another third share a living space with their parents or caretakers (34.0%), and 12.9 percent live with a male partner\textsuperscript{9}. One out of every 12 MSM from our sample is living with a female partner (8.5%).

\textsuperscript{8} The ABS records these data for the population of ages 5 and older. completion rates are not recorded in the national census
\textsuperscript{9} N=318, 1 missing case
4.4  Sexual orientation of MSM

Forty-six percent of respondents self-identified as a homosexual (45.9%; 146 persons; N=318). Another 42.8 percent identified as bi-sexual, thus expressing sexual interest in both women and men (Table 4.2).

A number of men who typified themselves as being heterosexual were identified by the MSM surveyors as MSM (20 persons; 6.3 % of the sample). This observation suggests that some men are leading a hidden life as MSM. A small proportion of MSM self-identified as transgender (4.1%) and two persons as a woman (0.6%).

<table>
<thead>
<tr>
<th>Sexual identity</th>
<th>Number and % of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homosexual</td>
<td>146 (45.9%)</td>
</tr>
<tr>
<td>Bisexual</td>
<td>137 (43.1%)</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>20 (6.3%)</td>
</tr>
<tr>
<td>Transgender</td>
<td>13 (4.1%)</td>
</tr>
<tr>
<td>Woman</td>
<td>(2) 0.6%</td>
</tr>
</tbody>
</table>

Table 4.2  Self-identified sexual orientation (N=318)


4.5 Sexual initiation

The typical MSM had anal sex for the first time by the age of 17 (Median=17, Mean=17.8; SD=4.4; N<sub>total</sub>=267). This means that they were, on average, slightly older when they had their first sexual experience than youngsters in low-income neighborhoods and district towns in Suriname. A survey in Latour (Paramaribo neighborhood), Nickerie, Moengo, Lelydorp, and Brokopondo found that boys are on average 14.5 years old when they have their first sexual experience (Ministerie van Volksgezondheid 2008a).

The considerable number of young boys has been exposed to anal sex (Figure 4.4). Two men (0.7%; N<sub>total</sub>=267) reported having had a sexual experience when they were as young as 8 years of age. Another four respondents (1.5%; N<sub>total</sub>=267) were just 9 years of age when they first had anal sex. Another 29 men (10.9%; N<sub>total</sub>=267) were also of elementary school age (10-13) when they had their first experiences with anal sex. The figure also shows that the majority of MSM (N=141; 52.8%; N<sub>total</sub>=267) were legal minors when they first had anal sex.

---

**Figure 4.4 Age of first anal sex with a man**

![Image showing the age distribution of first anal sex experiences among MSM]
4.6 HIV-testing and prevalence

Percentage of MSM who have voluntarily requested an HIV test and received the test and received the results: 61.1% (excluding this study)\(^{10}\).

Of the 65 persons who took the HIV test, 9.2% (6 individuals) was tested positive.

At a national level persons of Creole and Maroon descent are, as compared to individuals from other ethnic groups, relatively more likely to be HIV+ (Ministry of Health 2010). The present seroprevalence study does not find the same pattern but the sample was too small to provide definite conclusions (Figure 4.5). The largest group of people from the study sample who tested positive, both in absolute numbers and as a percentage of the total number of people were tested, self-defined as being of mixed-descent.

*Figure 4.5 Number of MSM who tested HIV positive or negative, by ethnic group (N\(_{\text{total}}\)=65)*

Three quarters of respondents had received an HIV test prior to this study (75.2%; 236 persons; \(N_{\text{total}}=314\); Figure 4.6). For one quarter of MSM in the sample (25.4%; 81 persons; \(N_{\text{total}}=314\) ), their latest test was recent (1-3 months ago). For another quarter of respondents it was more than a year ago that they had been tested (24.5%; 78 persons; \(N_{\text{total}}=314\)). Forty individuals among the 236 persons who had been tested prior to this study (16.9% of number of tested

\(^{10}\) The BSS asked whether the latest test was voluntary. Hence the figure does not include all persons who at some point in time voluntarily requested an HIV test. For example, it is possible that someone has been tested voluntary before, and at a later point in time is obliged by an employer to take the test again.
respondents) had not taken the test voluntarily, but had been required to take the test. For the 314 respondents who answered the question, 62.4 percent (196 respondents) the most recent HIV-test had been taken voluntarily.

Figure 4.6 When was the last time that you took an HIV test? (N=314, excl. 5 missing cases)

Four individuals among those who had been tested voluntarily before the study (N=196; 2.0%) had not obtained the test result. Among the 295 men who had at least once had anal sex with another man, 78 individuals (26.4%) had never been tested. Of those 78 individuals, 22 persons (28.2%) voluntarily received the HIV test provided by the research team and received the result.

4.7 Exposure to STIs
In order to assess exposure to Sexually Transmitted Infections (STI) other than HIV, we asked respondents whether, in the past six months, their general practitioner or other medical personnel had informed them that they had an STI. Seven respondents (2.3%, N_{total}=311) responded affirming, meaning that in the past six months, they had been told they had a venereal disease. The large majority of men (97.4%) said they had not been diagnosed with an STI in the past six months. We suspect that there is some underreporting because feelings of shame and fear of stigma may cause people to hide STIs.
4.8 Male and female partners

Indicators

Percentage of MSM who report anal sex with more than one other man in the last six months:
- 63.2% if counting only those men who had anal sex with at least one man in the past six months and remembered how many (120 individuals; N_{total}=190).
- 49.4% if counting all men who answered the question and remembered how many, including those who did not have anal sex with another man in the past six months (120 individuals; N_{total}=24311).

Almost all respondents had had anal sex with a man at some point in time (93.1%; 295 individuals; N_{total}=317). Seven percent (6.9%) indicated they had never had anal sex with a man. Some of these men had only had oral sex with a man and others denied that they were MSM.

Nine out of every ten respondents had been sexually active in the six months preceding the interview (90.5%; 287 respondents; N_{total}=317). Of the 287 men who had been sexually active in the past six months, 92.0 percent (264 respondents) had had anal sex with a man. 83.3 Percent of all respondents (excl. missing values) had had anal sex with another man in the past six months (N_{total}=317; Table 4.3).

Table 4.3 Sexual behavior with male or female partners

<table>
<thead>
<tr>
<th>Sexual behavior</th>
<th>Number of respondents (%)</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had anal sex with another man at least once in his lifetime</td>
<td>295 (93.1%)</td>
<td>315</td>
</tr>
<tr>
<td>Had vaginal or anal sex in the past six months</td>
<td>287 (90.5%)</td>
<td>317</td>
</tr>
<tr>
<td>Had anal sex with another man in the past six months</td>
<td>264 (83.3%)</td>
<td>317</td>
</tr>
<tr>
<td>Had sex with at least one woman in the past six months</td>
<td>150 (47.5%)</td>
<td>316</td>
</tr>
<tr>
<td>Had anal sex with more than one man in the past six months</td>
<td>120 (49.4%)</td>
<td>243</td>
</tr>
<tr>
<td>Did not have anal sex with another man in the past six months</td>
<td>53 (16.7%)</td>
<td>317</td>
</tr>
</tbody>
</table>

11 30 respondents had not had vaginal or anal sex in the past 6 months, and another 23 persons had not had anal sex with another man in the past 6 months. In order to calculate the indicator, the denominator (valid N) was calculated by adding these 53 persons to the 190 men who had had at least one anal sexual contact with another man in the past six months. (total=243)
The number of different male anal sex partners in the past six months, as recalled by respondents, varied between zero and 70 (Figure 4.7; Table 4.4). Fifty-three men had not had any male anal sex partners in the past six months. Of the 264 men who did have male anal sex in the past six months, 190 men (72.0%) recalled the number of male sex partners they had been with. Including the persons who had zero male anal sex partners, the total number of men who remembered the number of male anal sex partners in the past six months is 243. Of these 243 individuals, 28.8 percent (70 individuals) had had one male anal sex partner. On the other extreme, ten individuals reported that they had had 20 or more different male anal sex partners in the past six months (4.1%; N<sub>total</sub>=243). Of the 243 respondents who recalled the number of male anal sex partners in the past six months, 120 (49.4%) reported that they had had anal sex with more than one man.

Table 4.4   Number of male anal sex partners (N<sub>total</sub>=243)

<table>
<thead>
<tr>
<th>Number of male sex partners</th>
<th>Percentage (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 (none)</td>
<td>21.8% (53)</td>
</tr>
<tr>
<td>1 (one)</td>
<td>28.8% (70)</td>
</tr>
<tr>
<td>&gt;1 (more than 1)</td>
<td>49.4% (120)</td>
</tr>
</tbody>
</table>

On average, respondents had 4.2 male anal sex partners in the six months preceding the interview (SD=7.2; N<sub>total</sub>=190). This figure includes only men who reported anal sex with at least one other man in the past six months, who could recall the number of men involved. The median number of male anal sex partners in the past six months is 2.

Forty-eight men reported that they had paid another man to have sex in the six months prior to the interview (15.3%; N<sub>total</sub>=314).

Of the 287 respondents who reported that they had been involved in vaginal or anal sex in the past six months, 150 respondents had had at least one female sex partner (52.43%;<sup>12</sup> Table 4.3). The number of female sex partners ranged between one and twenty women. The average number of female sex partners in the six months preceding the survey was 2.8 (SD=3.2; N<sub>total</sub>=111, incl. only men who had sex with at least one woman and could recall the number of women). It is noteworthy that among the 118 respondents who indicated to be homosexual, 23 men (19.5%) had had sex with a woman in the past six months.

---

<sup>12</sup>N=286; excluding 2 missing cases, 1 non-answer, and 30 cases on whom the question was not applicable because they had not had sex in the past six months.
4.9 Condoms

**Indicators**

% of MSM who used a condom every time they had anal sex with non commercial partners over the past six months: 57.1% (157 individuals; N\textsubscript{total}=275)

% of MSM who report condom use at last anal sex with non commercial partner: 71.0% (198 individuals; N\textsubscript{total}=279)

% of MSM who report condom use at last anal sex with male commercial partner whom they are paying: 53.3% (24 individuals; N\textsubscript{total}=45)

% of MSM who used a condom every time they paid for sex with any man over the past 6 months: 48.9% (22 individuals; N\textsubscript{total}=45)

% of MSM who have had unprotected sex with a woman at least once in the last 6 months and who have had unprotected sex with at least one other man in the last 6 months: 17.4% (N\textsubscript{total}=287; only counting MSM who have had anal or vaginal sex in the six months preceding the interview)
4.9.1 Access to condoms
In central Paramaribo, access to condoms is excellent. Thanks to efforts of the NAP, among other factors, condoms are freely available from various public locations such as pharmacies, NGOs, governmental organizations, and dispense machines at strategic places. Short-stay hotels also supply condoms with the room. In addition, condoms may be bought at drugstores and Chinese supermarkets.

Various organizations distribute condoms in the street or from their office in town. The most important organization in distributing condoms to MSM is SMU. Sixty-two percent of MSM reported having received condoms in the past year (194 persons; N_{total}=313). Of those who received condoms in the past year, just over half (53.6%; 83 persons) had received condoms from Suriname Men United. Other important sources of condom distribution are the regional health centers (RGD), the NAP, and Lobi Foundation (Table 4.5).

Table 4.5 Number and percentage of respondents who obtained condoms from defined organizations or other sources

<table>
<thead>
<tr>
<th>Organization/Source</th>
<th>Number of respondents</th>
<th>Percentage (N=313)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received condoms</td>
<td>192</td>
<td>62.0%</td>
</tr>
<tr>
<td>Suriname Men United</td>
<td>104</td>
<td>33.2%</td>
</tr>
<tr>
<td>Regionale Gezondheids Dienst (Regional Health Center)</td>
<td>53</td>
<td>16.9%</td>
</tr>
<tr>
<td>National AIDS Program</td>
<td>26</td>
<td>8.3%</td>
</tr>
<tr>
<td>Lobi Foundation</td>
<td>17</td>
<td>5.4%</td>
</tr>
<tr>
<td>Stg. Mamio Namen Project</td>
<td>15</td>
<td>4.8%</td>
</tr>
<tr>
<td>General practitioner</td>
<td>11</td>
<td>3.5%</td>
</tr>
<tr>
<td>Media</td>
<td>1</td>
<td>0.3%</td>
</tr>
<tr>
<td>SMLA</td>
<td>2</td>
<td>0.6%</td>
</tr>
<tr>
<td>Friends/Family</td>
<td>5</td>
<td>1.6%</td>
</tr>
<tr>
<td>Disco/Club/Bar</td>
<td>5</td>
<td>1.6%</td>
</tr>
<tr>
<td>Abroad</td>
<td>5</td>
<td>1.6%</td>
</tr>
<tr>
<td>Other (school, brothel, events, etc)</td>
<td>4</td>
<td>1.3%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>3</td>
<td>1.0%</td>
</tr>
<tr>
<td>Health service</td>
<td>2</td>
<td>0.6%</td>
</tr>
<tr>
<td>Private parties</td>
<td>2</td>
<td>0.6%</td>
</tr>
<tr>
<td>Do not know who I got them from</td>
<td>2</td>
<td>0.6%</td>
</tr>
<tr>
<td>Condom distribution machines</td>
<td>2</td>
<td>0.6%</td>
</tr>
<tr>
<td>Did not receive any condoms</td>
<td>119</td>
<td>38.0%</td>
</tr>
<tr>
<td>Missing</td>
<td>6</td>
<td>1.9%</td>
</tr>
</tbody>
</table>
4.9.2 Condom use in the past six months and during last contact
Condom use is not very consistent among the sample population (Figure 4.8; Table 4.6). Condoms are most likely to be used when having anal sex with a man, and least likely to be put on when having anal sex with a woman. Less than half of the respondents who have paid for sex, always used a condom during such encounters (48.9%; $N_{total}=45$).

*Figure 4.8 Self-reported frequency of condom use during anal or vaginal sex with a male or female partner, paid and unpaid*

Respondents were asked: ‘The last time that you had anal sex with a man or a woman who you did not pay for sex, did you or your partner use a condom?’ More than a quarter of respondents (78 persons; 28.0%; $N_{total}=279$) admitted that they had not used a condom during their last anal sexual activity. Seventy-one percent reported that a condom had been used (198 persons; $N_{total}=279$; Table 4.5).

Condom use during the latest sexual experience with a man who was paid for sex by the respondent appears much lower – though the sample size of this group is too small to draw definite conclusions. Only about half (53.3%) of respondents among those who had paid for sex in the past six months reported the use of a condom at their last anal sex with a male commercial partner whom they paid (24 individuals; $N_{total}=45$; Table 4.6).

Of the 150 MSM who had had sex with a woman in the past six months, 30.6 percent had had unprotected anal or vaginal sex with at least one woman in the six months preceding the

---

13 In this case, the sexual contact could have taken place more than 6 months ago.
interview (Table 4.7). 36.6 Percent of men had unprotected sex with a man in that period, but not all of those had also had sex with a woman (N_{total}=287). A total of 50 respondents reported unprotected sex with a woman and unprotected sex with a man in the past six months. This figure represents 17.4 percent of the number of MSM who had anal or vaginal sex in the past six months (N_{total}= 287; Table 4.7).

Table 4.6  
Condom use the last time that the respondent had anal sex

<table>
<thead>
<tr>
<th>Did you or your partner use a condom the last time you had anal sex with...</th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
<th>N_{total}</th>
</tr>
</thead>
<tbody>
<tr>
<td>...a man or a woman who you did not pay for sex?</td>
<td>198 (71.0%)</td>
<td>78 (28.0%)</td>
<td>3 (1.1%)</td>
<td>279</td>
</tr>
<tr>
<td>...a man who you paid for sex?</td>
<td>24 (53.3%)</td>
<td>20 (44.4%)</td>
<td>1 (2.2%)</td>
<td>45</td>
</tr>
</tbody>
</table>

Table 4.7  
Numbers of MSM reporting unprotected sex with female and/or male partners in the six months preceding the study

<table>
<thead>
<tr>
<th>Sexual behavior in the past six months</th>
<th>number (%; N_{total}=287)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unprotected anal sex with a woman</td>
<td>56 (19.5%)</td>
</tr>
<tr>
<td>Unprotected vaginal sex with a woman</td>
<td>80 (27.8%)</td>
</tr>
<tr>
<td>Unprotected anal or vaginal sex with a woman</td>
<td>88 (30.6%)</td>
</tr>
<tr>
<td>Unprotected anal sex with a man</td>
<td>105 (36.6%)</td>
</tr>
<tr>
<td>Unprotected sex with a woman and with a man</td>
<td>50 (17.4%)</td>
</tr>
</tbody>
</table>

*% of 287 individuals who had anal or vaginal sex in the six months preceding the interview

4.9.3  
Condom failure
Of the 287 respondents who had had vaginal or anal sex in the six months preceding the interview, 103 individuals (36.3%; N_{total}=284, excl. 3 missing cases) had experienced one or more problems with condoms in the six months preceding the interview. The most common problem was that the condom ripped or burst, which had happened to 64 respondents (22.5%; N_{total}=284). Smaller numbers of respondents had experienced that the condom got stuck (n=14; 4.9%) or slid off (n=11; 3.9%); that the condom was damaged when opening the package or when putting it on (n=14; 4.9%); or that the condom was taken off by the partner (n=10; 3.5%). All mentioned causes of condom failure are listed in figure 4.9.
4.9.4 Use of lubricant

The use of lubricant minimizes the risk that a condom rips or breaks. It also reduces the chance of blood contact due to damaging of the skin during anal sex. The results demonstrate that the use of lubricant during anal sex is common: 70.2 percent of the respondents reported that they always use lubricant and another 9.8 percent mentioned using lubricant most of the time ($N_{\text{total}}=285$; Figure 4.10).

Figure 4.10 Reported use of lubricant during anal sex ($N_{\text{total}}=285$)
4.10. Risk perception

Less than one out of every ten respondents (9.6%; 29 persons) believe that they are at a risk of HIV transmission ($N_{\text{total}}=303$, excluding 2 missing values and 14 ‘no answer’s). Eighty-two percent (81.8%; 248 individuals) believe they have not run any risk, and 8.6 percent (26 individuals) indicated that they do not know ($N_{\text{total}}=303$).

Two-hundred and thirty respondents named a reason for believing not to be at risk (Table 4.8). Of these 230 respondents, 104 individuals (45.2%) expressed that they had not been exposed to the risk of HIV infection because “I (always) use condoms”. Another 45 individuals (19.6%) asserted that they had had safe sex in the past six months, and therefore had not been at risk. Besides condom use and practicing safe sex, another often used reason for believing to have no or little exposure to HIV infection risk, is having sex with one partner (mentioned by 29 individuals; 12.6%; $N_{\text{total}}=230$).

Table 4.8 Reasons for believing to not have been at risk for contracting HIV in the six months preceding the interview ($N=230^{14}$)

<table>
<thead>
<tr>
<th>Reasons mentioned for not being at risk of HIV infection</th>
<th>number</th>
<th>% of the 230 respondents believing not to be at risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Always) use condoms</td>
<td>97</td>
<td>42.2%</td>
</tr>
<tr>
<td>Have had safe sex</td>
<td>45</td>
<td>19.6%</td>
</tr>
<tr>
<td>Have sex with just one partner</td>
<td>29</td>
<td>12.6%</td>
</tr>
<tr>
<td>I have not had sex in the past six months</td>
<td>22</td>
<td>9.6%</td>
</tr>
<tr>
<td>I/we have just been tested</td>
<td>16</td>
<td>7.0%</td>
</tr>
<tr>
<td>I have one partner and use a condom</td>
<td>7</td>
<td>3.0%</td>
</tr>
<tr>
<td>I am careful/ conscious/select my partners carefully</td>
<td>4</td>
<td>1.7%</td>
</tr>
<tr>
<td>Do not sleep around/do not have many partners</td>
<td>3</td>
<td>1.3%</td>
</tr>
<tr>
<td>I am single</td>
<td>3</td>
<td>1.3%</td>
</tr>
<tr>
<td>My partner(s) is/are not infected</td>
<td>2</td>
<td>0.9%</td>
</tr>
<tr>
<td>I have only 'soft' sex</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td>Just had a baby</td>
<td>1</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

The remaining responses demonstrate several misconceptions about HIV transmission. The main erroneous belief is that one is safe because one has just been tested. Given the so-called window period of three months in which the HIV infection is not detectable in the blood, it is

---

14 18 persons who do not believe that they have been at a risk of contracting HIV in the past six months did not provide a reason.
possible that a person who just tested negative is in fact already infected. Another misconception is that one reduces chances of HIV infection by ‘not sleeping with just anyone’ or ‘selecting partners carefully’.

Do people who feel protected against HIV because they use condoms and have safe sex indeed consistently use condoms? Our analysis shows they do not; particularly when they have sex with women (Table 4.9). Forty percent of the 104 respondents who felt ‘not at risk’ because of condom use, did not always use condoms when having anal sex with a woman, and 38.5 percent did not always use condoms during vaginal sex with a woman. Similarly, 66.7 percent of respondents who said that they have not been at risk of HIV infection because they exclusively practice ‘safe sex’, had not always used condoms during anal sex with women, and another 56.5 percent had not always used condoms during vaginal sex with women.

Curiously, some respondents who do not believe that they have been at risk because they use condoms, reported never using condoms with certain sex partners in the past six months. Out of the 92 persons who felt not at risk because of condom use, six (6.3%) said they never used a condom when having anal sex with a man. Out of 25 persons who felt not at risk because of condom use and had sex with women, and six reported that they had not used condoms during anal sex with a woman in the six months preceding the study.

Table 4.9  Cross tabulation of risk perceptions and condom use

<table>
<thead>
<tr>
<th>% of respondents who said that, in the past 6 months, they ‘always’ used condoms when they had:.....</th>
<th>Reason for believing not to be at risk (N=230)</th>
<th>“I always use condoms” (N=104) number (%) ; denominator</th>
<th>“I have only had safe sex” (N=45) number (%) ; denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>... anal sex with a non-commercial partner (M/F)</td>
<td></td>
<td>78 (80.5%); N$_{total}$=97</td>
<td>28 (65.1%); N$_{total}$=43</td>
</tr>
<tr>
<td>... anal sex with a man</td>
<td></td>
<td>79 (85.9%); N$_{total}$=92</td>
<td>31 (70.5%); N$_{total}$=44</td>
</tr>
<tr>
<td>... vaginal sex with a woman</td>
<td></td>
<td>32 (61.5%); N$_{total}$=52</td>
<td>10 (43.5%); N$_{total}$=23</td>
</tr>
<tr>
<td>... anal sex with a woman</td>
<td></td>
<td>15 (60.0%); N$_{total}$=25</td>
<td>7 (33.3%); N$_{total}$=21</td>
</tr>
<tr>
<td>... paid money to have sex with a man</td>
<td></td>
<td>2 (40.0%); N$_{total}$=5</td>
<td>4 (40%); N$_{total}$=10</td>
</tr>
</tbody>
</table>

Also when looking at the most recent sexual activity, condoms are not used by all people who feel safe because they “always use condoms”. Thirteen percent (13 individuals, N$_{total}$=100) of respondents who feel not at risk because of consistent condom use, had not used a condom the last time they had sex. Three out of the four persons who reported that they felt not at risk

15 All these figures refer to having sex and being at risk in the six months preceding the survey.
because of consistent condom use and who had had commercial sexual contact with another man, had not used a condom the last time they paid another man to have sex.

Thirty persons named a reason for believing that they had run a risk of contracting HIV. Two thirds of the 30 respondents who are concerned that their behavior has placed them at a risk of HIV infection said they had unsafe sex or sex without a condom (20 individuals; 66.7%). Five respondents (16.7%; N\textsubscript{total}=30) believed they might have been at risk because they had had unsafe oral sex. As will be discussed in the following section, the true risk of HIV transmission through oral sex remains a topic of debate. Other reasons for believing to have run a risk of HIV-infection were mentioned by no more than one or two persons and included: ‘I had multiple partners’; ‘I have been careless’; and ‘I had a relationship with someone who liked brothels’.

4.11 Knowledge about HIV/AIDS transmission and prevention

<table>
<thead>
<tr>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of MSM who correctly identify use of a condom as the most important way to prevent the sexual transmission of HIV, excluding missing values and persons who had misunderstood the question\textsuperscript{18}: 92.1% (234 persons; N\textsubscript{total}=254)</td>
</tr>
<tr>
<td>% of MSM in the complete sample who correctly identify use of a condom as the most important way to prevent the sexual transmission of HIV in an open question: 73.4% (234 persons; N\textsubscript{total}=319)</td>
</tr>
<tr>
<td>% of MSM who correctly reject the two most common local misconceptions about HIV/AIDS and who know that a healthy looking person can transmit HIV/AIDS: 57.3%</td>
</tr>
</tbody>
</table>

\textsuperscript{16} Curiously, only 29 persons said they believed they had been at risk, but 30 person provided a reason for having been at risk.

\textsuperscript{17} 30 respondents named a reason for having been at risk of HIV infection. Among them, one person said he knows that he is HIV-positive.

\textsuperscript{18} The question was asked as an open question: “What is the best way to prevent HIV infection when you have anal or vaginal sex?” Nine respondents misunderstood the question as something like: “Can you get HIV from anal or vaginal sex?” They answered “both” or gave other answers showing that they had not understood that the survey asked for a prevention method.
4.11.1 Knowledge on HIV transmission

Accurate information about HIV and AIDS is a prerequisite if people are to adopt behaviors that reduce their risk of infection. We asked respondents about the various ways that one may or may not be infected by HIV. The correct answers, as well as percentages of MSM who gave correct answers and the share of people who said they did not know, are listed in Table 4.10. Annex 4 contains a detailed description of the behaviors increasing HIV transmission risk, and behaviors that are often erroneously believed to increase risk of HIV infection.

Table 4.10 Answers on questions testing knowledge about HIV transmission. The three most common misperceptions are listed in the shaded areas C and E.

<table>
<thead>
<tr>
<th>You run a risk to be infected with HIV if you:</th>
<th>Correct answer</th>
<th>% Correct answers</th>
<th>Don’t know</th>
<th>N_total</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Are bitten by a mosquito which has bitten an HIV+ person</td>
<td>No</td>
<td>85.9%</td>
<td>4.8%</td>
<td>312</td>
</tr>
<tr>
<td>B Have oral sex without using a condom</td>
<td>Yes</td>
<td>80.4%</td>
<td>5.1%</td>
<td>316</td>
</tr>
<tr>
<td>C Kiss with an HIV+ person</td>
<td>No</td>
<td>79.1%</td>
<td>4.5%</td>
<td>311</td>
</tr>
<tr>
<td>D Use the toilet after an HIV+ person has used it</td>
<td>No</td>
<td>93.0%</td>
<td>2.9%</td>
<td>313</td>
</tr>
<tr>
<td>E Only have unprotected sex with healthy-looking people</td>
<td>Yes</td>
<td>83.2%</td>
<td>2.5%</td>
<td>315</td>
</tr>
<tr>
<td>F Only have unprotected sex with one partner who has no other partners</td>
<td>No*</td>
<td>35.6%</td>
<td>6.5%</td>
<td>306</td>
</tr>
<tr>
<td>H A baby is breastfed by an HIV+ mother</td>
<td>Yes</td>
<td>85.7%</td>
<td>4.5%</td>
<td>314</td>
</tr>
<tr>
<td>I Have sex without using a condom</td>
<td>Yes</td>
<td>94.9%</td>
<td>1.0%</td>
<td>315</td>
</tr>
<tr>
<td>J A baby is delivered by an HIV+ mother</td>
<td>Yes</td>
<td>70.0%</td>
<td>9.0%</td>
<td>300</td>
</tr>
<tr>
<td>K Share a plate with an HIV+ person</td>
<td>No</td>
<td>94.3%</td>
<td>2.2%</td>
<td>315</td>
</tr>
</tbody>
</table>

Three questions in the list were ambiguous to many respondents. Firstly, when asked about a possible risk involved in having sex with only one partner who also only has sex with you, many respondents answered that one can never know if the other person does indeed have no other sex partners. In other words, you run a risk because you never know whether the person lies or is untrustworthy.

Secondly, when asked about being born from an HIV+ mother, many people said that the baby is not necessarily born HIV-positive if the mother takes anti-retrovirals/medication and gets proper medical treatment. However, if the expectant mother does not take such precautions, there is a considerable chance that the baby will be born HIV-positive.

Third, the risk of HIV transmission through oral sex remains a point of discussion. The expertise center for HIV/AIDS and other STIs in the Netherlands, SOAIDS, states on its website that:
Many reports that have appeared support the probability of HIV transmission through insertion of the penis in the mouth, where the receptive partner (who takes the penis in his mouth) has become HIV-infected. Proven and likely risk factors are: ejaculation in the mouth, ‘deep throat’ oral sex, infections in the mouth, bleeding gums, and high viremia of the HIV-positive partner. ...A literature review of the risks of transmission of viral STIs through oral sex concludes that HIV-transmission from the mouth to penis is very unlikely, but that there is a risk of transmission from penis to mouth, even though this risk is much lower than is the case with unprotected anal or vaginal sex.

In Table 4.10, the answer “Yes, it is possible to be infected with HIV through unprotected oral sex” was considered the best answer. Of the 316 respondents who answered the question “does having unprotected oral sex expose one to a risk of HIV infection?” 254 respondents (80.4%) answered “Yes”. Because of the uncertainties surrounding HIV transmission through oral sex, we could not count the answer “No, it is not possible to be infected through oral sex” wrong. We excluded these three questions (B, F, and J) from further analysis.

Most respondents have reasonable to good knowledge of ways that HIV is transmitted. Almost everyone (94.9%; 299 individuals; N_total=315) knows that having sex without a condom exposes one to a risk of HIV infection. The three most common misperceptions are that:

1. HIV can be transmitted by kissing,
2. HIV will not be transmitted by having sex with healthy looking people.
3. HIV may be transmitted by a mosquito who has bitten someone who is HIV-positive

These misperceptions were rejected by a grand majority of people:

1. 79.1 percent of respondents (246 individuals; N_total=311, excl. missing values and ‘no answer’) correctly rejected the misconception that HIV is transmitted through kissing;
2. 83.2 percent of respondents (262 individuals; N_total=315; excl. missing values and ‘no answer’) correctly stated that it is possible to be infected with HIV when having unprotected sex with a healthy looking person; and
3. 85.9 percent of respondents (268 individuals; N_total=312; excl. missing values and ‘no answer’) rejected the misconception that HIV may be transmitted by a mosquito.

Of the 307 respondents who provided an answer to these three questions, 176 Respondents (57.3%) rejected the two misconceptions about HIV/AIDS (1&3) and knew that a healthy looking person can transmit HIV/AIDS.

Other misconceptions are not common. Few respondents believe that one might be infected by sharing a plate (3.5%; 11 individuals; N_total=315) or a toilet (4.2%; 13 individuals; N_total=313) with
an HIV-positive person. For this reason, these statements (rows K and D in Table 10.1) are not considered among the ‘most common misconceptions’.

Sixty-two percent (61.8%; N=197) of respondents named transmission routes other than those that were mentioned by the surveyor. Table 4.11 lists named transmission ways. Their total number adds up to more than 197 because some respondents gave more than one answer. Not all of the mentioned ways are valid ways of HIV transmission (marked by shaded areas). For example, sniffing cocaine is not a likely way of HIV transmission. The transmission ways named by the majority of these 197 people are correct though, including: blood and/or sperm contact (named by 55.3% of respondents who named additional transmission ways); sharing of needles by injection drugs users (22.8%); and blood transfusions (14.2%). The use of used dildos and other sex toys, which were mentioned by two individuals (1.0%; Ntotal=197) could be a risk if the products are shared without sterilization or washing.

Table 4.11   Additional ways of HIV transmission mentioned by respondents (N=197)*

<table>
<thead>
<tr>
<th>Transmission way mentioned</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood and/or sperm contact</td>
<td>109</td>
<td>55.3%</td>
</tr>
<tr>
<td>Dirty needles/Injection drugs users</td>
<td>45</td>
<td>22.8%</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>28</td>
<td>14.2%</td>
</tr>
<tr>
<td>Unsafe sex</td>
<td>13</td>
<td>6.6%</td>
</tr>
<tr>
<td>Oral sex</td>
<td>9</td>
<td>4.6%</td>
</tr>
<tr>
<td>Tattoo needles</td>
<td>5</td>
<td>2.5%</td>
</tr>
<tr>
<td>Being cut by sharp instruments, including medical needles that have not been disinfected.</td>
<td>3</td>
<td>1.5%</td>
</tr>
<tr>
<td>If an infected person has open wounds</td>
<td>2</td>
<td>1.0%</td>
</tr>
<tr>
<td>At the barber's shop</td>
<td>2</td>
<td>1.0%</td>
</tr>
<tr>
<td>Mother to child infection</td>
<td>2</td>
<td>1.0%</td>
</tr>
<tr>
<td>Use of used dildos/sex games</td>
<td>2</td>
<td>1.0%</td>
</tr>
<tr>
<td>When you have another STI</td>
<td>2</td>
<td>1.0%</td>
</tr>
<tr>
<td>Getting into a fist-fight with a sero-positive person</td>
<td>1</td>
<td>0.5%</td>
</tr>
<tr>
<td>Flirting</td>
<td>1</td>
<td>0.5%</td>
</tr>
<tr>
<td>Saliva</td>
<td>1</td>
<td>0.5%</td>
</tr>
<tr>
<td>sniff cocaine</td>
<td>1</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

* Incorrect transmission ways are marked by shaded areas
4.11.2 Knowledge on HIV/AIDS prevention

The respondents were asked an open question about the best way to reduce the risk of being infected with HIV/AIDS when having sex. Almost three quarters of MSM (73.4%, 234 persons) correctly answered that using a condom is the best way to protect oneself against HIV/AIDS (N=319; Table 4.12). When excluding missing values (N=56) and persons had misunderstood the question (N=9), the percentage of respondents who named using a condom as the most important way to protect oneself against HIV/AIDS is 92.1% (N_{total}=254). Eleven (11) individuals among those respondents who had named the condom, also named complementary strategies such as sticking to one partner, using lubricant, and having no oral sex (4.3%; N_{total}=254).

Protective mechanisms other than using a condom were named in much smaller numbers. Of the six individuals who referred to monogamy (2.4%; N_{total}=254), five had also mentioned the condom (Table 4.12). Five respondents (2.0%; N_{total}=254) indicated that one should be tested prior to having sex in order to be protected against HIV transmission.

When respondents were asked in a yes/no manner whether one might be infected with HIV/AIDS when not using a condom, 94.9 percent correctly answered ‘Yes’ (299 persons; N_{total}=315; Table 4.10). This result suggests that almost all respondents know that a condom may be used to protect oneself against HIV.

Table 4.12 Ways to protect oneself against HIV infection

<table>
<thead>
<tr>
<th>What is the best way to protect oneself against HIV infection?</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use a condom (in combination with other strategies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use a condom</td>
<td>222</td>
<td>69.6</td>
</tr>
<tr>
<td>Use a condom and stick to one partner</td>
<td>5</td>
<td>1.6</td>
</tr>
<tr>
<td>Use a condom and lubricant</td>
<td>3</td>
<td>0.9</td>
</tr>
<tr>
<td>Use a condom and have no oral sex</td>
<td>3</td>
<td>0.9</td>
</tr>
<tr>
<td>Don’t know</td>
<td>7</td>
<td>2.2</td>
</tr>
<tr>
<td>One/Stable partner/Being monogamous (in combination with other strategies)</td>
<td>6</td>
<td>1.9</td>
</tr>
<tr>
<td>Being tested (prior to having sex)</td>
<td>5</td>
<td>1.6</td>
</tr>
<tr>
<td>Abstinence</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>Safe sex/be careful</td>
<td>2</td>
<td>0.6</td>
</tr>
<tr>
<td>Use contraceptives</td>
<td>2</td>
<td>0.6</td>
</tr>
<tr>
<td>Avoid blood and sperma contact</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>Avoid bodily contact with HIV+ persons</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>Avoid rough sex</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>Vaginal sex</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>Missing</td>
<td>58</td>
<td>18.2</td>
</tr>
</tbody>
</table>
4.12 Discrimination and stigma

Respondents whether asked they felt discriminated or disrespected because of their sexual orientation, and if so by whom. More than half of respondents (178 respondents; 57.8%; N<sub>total</sub>=308) reported that they do not feel discriminated by anyone because of their sexual orientation. Forty-one percent of interviewed MSM (127 respondents, N<sub>total</sub>=308) did report feeling discriminated by different people and institutions (41.2%; Figure 4.3). The largest share of these 127 respondents (68.5%; 77 respondents) feels discriminated by people they do not know, such as strangers in the street, society, everyone, and heterosexual men.

The second largest source of discrimination is close family (named by 39 persons; 30.7%; N<sub>total</sub>=127). A small share of respondents (8.7%; N<sub>total</sub>=127) feel stigmatized by people working at official institutions such as public, social, and medical service providers.

During a discussion evening about discrimination and stigma of MSM organized by the Dutch embassy in Suriname and SMU at the “Veranda”, the men who were present elaborated on why they felt that the Suriname government is violating the human rights of MSM. One mentioned example was that it remains impossible to legally register (e.g. in the civil registry) as same-sex couples. This may cause problems when one of the partners passes away, when a man wants to add his male partner to his health insurance, and in other administrative procedures. Also the fact that people applying for a position in the national army have to reveal their sexual preference was considered discriminatory. In addition, some homo- and bisexuals feel stigmatized because they are excluded as blood donors at the national blood bank.

The discrimination of MSM is unconstitutional. The constitution of Suriname states, in Chapter V on Personal Rights and Freedoms, Art. 8 that:

“1. All those who reside on the Suriname territory have equal rights to protection of person and goods

2. No-one may be discriminated on the basis of his birth, sex, race, language, religion, ancestry, education, political preferences, economic position or social conditions or any other status”

Furthermore, Art. 16.1 states that: “Everyone has a right to personal freedom and safety”. Even though discrimination on the basis of sexual preference is not explicitly mentioned in the mentioned articles, by referring “all those who reside in Suriname” and “…any other status” the constitution also prohibits the discrimination of gays, bisexuals, and trans-genders because of their sexuality. Art. 17.1 reinforces the idea of that one is free in sexual preference, by stating that “Anyone has a right to have his private life[…] respected”.

In these laws, sexual orientation is inherently included yet not explicitly mentioned.
MSM at the discussion events at TBL cinemas and the Veranda expressed their concern about the fact that Suriname did not support the inclusion of ‘sexual orientation’ in the UN resolution against discrimination. Since 1999, discrimination on the basis of sexual orientation has been denounced in a VN-resolution on discrimination. This protection of MSM and Women having Sex with Women was about to be denulled in 2010, when 79 countries including Suriname voted for the removal of these words. During a revote in December 2010, Suriname chose to withhold its vote.

*Figure 4.11  Number of respondents who feel discriminated by the listed parties (N=127)*
4.13 Organizations and Outreach

<table>
<thead>
<tr>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of MSM reporting having been exposed to specific HIV prevention interventions: 82.4% (257 respondents; N&lt;sub&gt;total&lt;/sub&gt;=312)</td>
</tr>
<tr>
<td>% of MSM who have been given free condoms in the past 12 months: 62.0% (194 respondents; N&lt;sub&gt;total&lt;/sub&gt;=313)</td>
</tr>
</tbody>
</table>

4.13.1 Government organizations and NGOs
Coordination of the national policy on HIV/AIDS is in hands of the National Aids Programme (NAP). The NAP is not an executing agent but rather identifies, includes, and supports organizations that carry out activities that fit within the National Strategic Plan for HIV/AIDS. Several governmental and non-governmental health organizations are providing services related to HIV/AIDS prevention, often as a minor part of their general services. Table 4.13 lists the most prominent governmental and non-governmental organizations with the specific services they provide and their main mission or target group.

4.13.2 MSM interest and social groups
Three MSM groups were identified, among which one registered non-governmental organization (NGO) and two informal social networks. These groups are described below.

**Suriname Men United**
Suriname Men United (SMU) is a Suriname NGO, which specifically targets and works for MSM. The NGO was established on November 5, 2005. SMU provides the following services to its target group:

- Outreach services. Outreach activities focus on the distribution of condoms, and on the assessment and improvement of knowledge of condom use and HIV/AIDS.
- Counseling and psychosocial support. These services are not frequently used. Between January and November 2010, 4-5 people had sought counseling with SMU.
- Support in case of human rights violations. SMU works with two lawyers who research the legal context in the case of complaints of human rights violations, and may assist MSM in court cases.
**Foundation HE+HIV**

Foundation HE+HIV was founded on October 15, 2009, and formally registered in the Paramaribo registry of foundations (stichting register) in April 2010. The main objectives of the Foundation are to:

1. Promote acceptation and equal treatment of men who have sex with men and live with HIV (MSM+)
2. Reduce stigma and discrimination due to homosexuality and HIV.
3. Stimulate the well-being and a healthy lifestyle of MSM+
4. Offer support to MSM living with HIV

**Club Matapi**

Club Matapi exists since the early 1980s. Through the years, the club has been more and less active. At some point in time this social circle organized weekly gatherings, but nowadays the socials are less frequent. Other activities organized by club Matapi in recent years include a gay bicycle tour, an excursion, and a games night. The club used to distribute a newsletter but this bulletin has not appeared for a while.

In addition to the organization of social events, club Matapi also is a source of information and offers emotional support to gay men who have problems coming out or who are HIV+. At present, club Matapi has a mailing list of over 300 gay people from Paramaribo, other places in Suriname, and other countries.

**De Veranda**

De Veranda is a social circle of gay friends, which used to be organized weekly and now slightly less frequently on the veranda of a historic building in central Paramaribo. The men who gather at the Veranda are generally college or more highly educated and may be considered the intellectual elite among the gays.

**4.13.3 Exposure to outreach**

Two-hundred and fifty-seven respondents (82.4%; N_{total}=312) reported that they had received information about HIV in the year preceding the interview. Hundred and ninety-four persons (62.0%; N_{total}=313) had received free condoms from an outreach program. Figure 4.14 lists the places where people received information and/or condoms from in the past 12 months.
Table 4.13  Governmental and non-governmental organizations working in the area of HIV/AIDS, with their main activities.

<table>
<thead>
<tr>
<th>Organization, service, or program</th>
<th>Testing/counseling</th>
<th>Information on HIV/AIDS</th>
<th>Support to people living with HIV/AIDS</th>
<th>Description and/or specific mission</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Government</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National AIDS Program</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>National coordination of HIV/AIDS intervention programs</td>
</tr>
<tr>
<td>Regional Health Service (RGD)</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>General neighborhood health centers</td>
</tr>
<tr>
<td>Dermatological service</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Diagnoses and treatment of dermatological problems, including STIs and HIV</td>
</tr>
<tr>
<td><strong>Non Governmental Organizations (NGOs)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maxi Linder Foundation</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Targets commercial sex workers</td>
</tr>
<tr>
<td>Lobi Foundation</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>NGO working in the area of sexual and reproductive health</td>
</tr>
<tr>
<td>Stg. Mamio Namen Project</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Targets individuals living with HIV/AIDS</td>
</tr>
<tr>
<td>Suriname Men United</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Targets MSM</td>
</tr>
<tr>
<td>He + HIV</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>Supports MSM living with HIV/AIDS</td>
</tr>
</tbody>
</table>

A total of 311 respondents answered both the question about whether they had received HIV/AIDS information and the question about the receipt of condoms in the 12 months preceding the interview. Of these people, 176 respondents (56.6%) had received both information and condoms. 87.5 Percent of respondents (272 persons) had been exposed to at least one form of outreach (received condoms and/or received information) in the past year.

The media form the main source of information on HIV/AIDS. Half (51.0%, N_{total}=312) of the respondents reported that they had obtained HIV/AIDS information for TV, newspapers, and the radio. The main distributor of condoms is SMU, largely due to its distribution activities at the only gay-night in Suriname; Friday night in night club Millennium. 26.5 Percent of respondents had received free condoms from this foundation in the year preceding the BSS (N_{total}=313).
Figure 4.14  Organizations, offices, and people from whom respondents obtained information about HIV/AIDS and/or condoms *

Among the two NGOs working specifically for MSM in Suriname, HE+HIV and SMU, SMU appears most active in outreach to the general MSM population. Nevertheless, even this foundation has not reached much more than a quarter of MSM with the distribution of condoms. With regard to the dissemination of information, SMU reached 12.5 percent ($N_{\text{total}}=312$) of the respondents in the past year. None of the respondents reported receiving information or condoms from HE+HIV, though it is possible that respondents did not mention this organization because it is associated with HIV-positive MSM.

* The numeric information pertaining to this table is listed in Annex 5
5 Discussion and Conclusions

5.1 Discussion
The Suriname Ministry of Health has identified MSM as one of the MARPs because of the relatively high seroprevalence and high incidence of sexual risk-behavior in this population subgroup. The present data confirm this characterization and justify considering MSM as one of the potential ‘drivers’ of the HIV/AIDS epidemic. Drivers are the population groups that have high levels of risk behavior, are relatively large in size and have a high prevalence rate. These population groups can also serve as a bridge to the general population.

In order to halt and reverse the spread of HIV/AIDS, it is important to enhance understanding of transmission dynamics and of the behavior of potential drivers. In this context, the study served to gather information about:

- The size and level of disease (prevalence rate) among MSM
- The level of high-risk behavior by the population at risk
- The interaction among the population at risk and the general population

This section discusses these factors, as well as the extent to which risk behavior among MSM may be explained by knowledge and perceptions.

HIV Prevalence

HIV-prevalence among tested MSM (9.2%) is nine times higher than the estimated HIV-prevalence in the general population (1%). Prevalence rates among MSM in the present study also were higher than those among MSM found in 2005 (6.7%) but lower than seroprevalence among male CSW in Suriname studies. The HIV prevalence rate among MSM in Suriname compares favorably to prevalence rates found among MSM in Latin America (7-25.6 %) and in some Caribbean countries (>20%) (Van Griensven et al. 2009).

Care is warranted in comparing the prevalence figures from this study with those of other studies, for various reasons. In the first place, the sample of the present seroprevalence study was small and there are reasons to doubt its representativeness. Moreover, the inclusion criteria in the various studies differ.

High risk behavior

Earlier studies among MSM in Suriname reported multiple partners, sex with women, and unprotected sex with both men and women (Del Prado et al., 1998; CAREC/PAHO and SMLA 2005a). The findings of the present study are in line with these trends. Inconsistent condom use
was reported regardless of whether the respondents had anal or vaginal sex, and regardless of whether the sex partner was a man or a woman.

Also with commercial sex partners, adequate protection was not always used. Of the 15.3 percent of respondents who reported that they had paid for anal sex with another man in the six months preceding the survey, less than half had always used a condom during such encounters. This finding is particularly worrisome because recent studies found high seroprevalence rates among male commercial sex workers (CAREC/SMLA 2005b; Heemskerk and Uiterloo 2010).

Monogamy is not the norm among the surveyed MSM. About half of the respondents reported that they had had anal sex with more than one other man in the six months preceding the survey. Inconsistent condom use, coupled with a tendency towards having multiple and/or often changing partners elevates the risk of HIV transmission in this group.

**Interaction between the general population and the population at risk**

As in earlier studies, we find a high level of contact between MSM and the general population. About half of the respondents had sex with women in the six months preceding the interview, and 30.7 percent \((N_{total}=286)\) did so without protection. 15.7 percent of respondents had unprotected sex with a man and unprotected sex with a woman, in the six months preceding the interview.

**Knowledge and perceptions as determinants of behavior**

In the past year, 82.4% of respondents received information on HIV/AIDS, primarily through the media. These campaigns may have contributed to the generally high level of knowledge on HIV/AIDS among MSM. More than nine out of every ten MSM know that condoms are the most effective way to reduce the chances of HIV infection. In addition, the majority of MSM (62.7) rejects the three most common misconceptions about HIV.

Good knowledge of HIV transmission and prevention has, however, not invoked risk-avoiding sexual behavior. This observation suggests that other, unmeasured determinants play a role in explaining sexual risk behavior. It also appears that both general knowledge of HIV/AIDs and behavior have little impact on personal risk perceptions. Indeed, even though most respondents use condoms inconsistently and have multiple male and female sex partners, less than one out of every 10 MSM believed that he had been exposed to HIV-infection risk. Among the respondents who reported that they felt not at risk because they used condoms, several had not used condoms during their latest sexual activity and/or never used condoms with certain sex partners.
Figure 5.1 displays the relations between knowledge, perceptions, and behavior. The size of the arrows in this figure indicates the possible degree of impact. The figure conveys that the largest share of behavior remains unexplained by knowledge, while it is plausible that low risk facilitates risk taking behavior. Unknown determinants are a major driving force behind both behavior and perceptions.

*Figure 5.1 Relations between risk behavior, risk perceptions, and knowledge among MSM*

What are these unknown determinants? One factor that may affect sexual behavior is financial inequality between the sex partners. Another possible determinant is that the target group has been saturated with HIV information. The message has been repeated so often that it no longer calls the attention. It also is possible that MSM in a longer-term relationship with another man stop using condoms at some point in time.

Furthermore, it is likely that easy and free access to ARV treatment and improved life expectancies for people living with HIV have decreased fear for this infection. A recent study from Brazil suggests that the increasing availability of antiretroviral drugs across Brazil may have promoted decreased risk perception across all age groups (Bassichetto et al. 2008). Because condoms can easily and freely be obtained throughout Paramaribo, the availability of condoms is not a likely interfering factor in this case.

The determinants of sexual behavior likely differ for the different MSM subgroups. For example, it is possible that financial reasons motivate MSM from poor neighborhoods to have unsafe sex, but that money does not explain involvement in unsafe sex among wealthier men.
Stigma and discrimination

Even though Suriname society is generally tolerant towards MSM, a considerable number of MSM feel discriminated by strangers or close family. In addition, different respondents complained about violations of their human rights by public institutions. Specifically mentioned were questions about sexual orientation during the application procedures for public functions and at the Blood bank.

Lessons learned for future BSS studies

Future BSS and seroprevalence studies should:

- Reserve at least three months for fieldwork
- Include young MSM and MSM active at cruising sites in the team of surveyors.
- Phrase the questions in an easy-to-understand way to facilitate the interview process for both the interviewers and the interviewees.
- Include questions related to other possible determinants of sexual risk behavior in the BSS.

5.2 Conclusions

It is concluded that MSM are among the drivers of the HIV/AIDS epidemic in Suriname: this population is characterized by a high HIV seroprevalence rate, a high incidence of sexual risk behavior, and frequent sexual contact with the general population. The findings justify targeting MSM in HIV-prevention outreach activities, and call for stronger and continued efforts aimed at improving the sexual health of MSM and their families.

In designing these efforts, it is important to realize that there is a discrepancy between knowledge, risk behavior, and risk perceptions. The study reveals that sexual behavior and risk perception are driven by multiple factors other than factual knowledge. Further research may reveal what these determinants are, and to what extent they affect behavior.

Once there is more clarity on the determinants of sexual risk behavior among MSM, it will be possible to design more targeted outreach services. The data suggest that at present, considerable sections of the MSM population are not reached by existing intervention campaigns aimed at MSM. An evaluation of these campaigns may reveal what MSM subgroups remain excluded and what strategies may be applied to include these groups.
6 Recommendations

Recommendations are provided in four sections. The first section proposes activities aimed at making MSM more resilient to HIV/AIDS infection through knowledge and capacity building. The second section focuses on the work of the various support organizations. The third section presents advice to policy makers, and the final section gives directions for further research.

Knowledge and capacity building

- Risk perceptions are low, even among men who display high risk sexual behavior. It is recommended that outreach campaigns integrate strategies aimed at elevating risk awareness rather than focus on the transfer of HIV knowledge alone. Risk perceptions may be influenced by telling people about HIV seroprevalence rates and by sharing personal stories of people who have been infected with HIV. It would be useful to evaluate strategies to raise sexual risk awareness among MSM in other countries in order to design a campaign that meets the particularities of MSM in Suriname.

- Even though knowledge is not the only (or most important) determinant of sexual risk behavior among MSM, access to accurate information is relevant in allowing people to make informed choices. Because the media are the most important source for MSM to obtain information on HIV/AIDS, it is advisable that HIV/AIDS information continues to be spread through public (national and local) radio, TV, and newspapers. Studies in other countries have shown that awareness raising campaigns that use more than one medium, particularly if they incorporate television advertisements, are more effective than those employing only one medium (Keys at al. 2008). Furthermore, even though the optimum time frame for an effective campaign is unclear, ‘one-off, one shot’ mass media campaigns are ineffective’. Instead, campaigns dealing with risk-taking behavior should be ubiquitous and long-term (ibid.).

- In addition to broad media campaigns, it may be possible to reach MSM with targeted campaigns; targeted in the sense of aimed at MSM and targeted at specific determinants that affect behavior. Again, it will be useful to look at and learn from strategies that have been used in outreach activities for MSM in other countries.

- To decrease the risk of people getting tired from hearing the same old message about condoms, an effort must be made to use innovative and original means of communication. For example, in Suriname, local theatre by groups such as A Sa Go is extremely popular in all social circles. One of the theatre groups could be contracted to develop and perform a theatre piece about MSM and HIV.
Outreach activities of GOs and NGOs

- Suriname Men United, as the most important organization that performs outreach among MSM, must continue and expand its outreach activities. At present, most activities seem to focus on the more visible MSM. Cruising areas and other places where hidden MSM convene should be taken into account when developing interventions.
- The results suggest that not all subgroups of the MSM population are equally reached by current outreach programs. An evaluation of intervention programs that target MSM in Suriname may reveal what subgroups remain excluded from existing outreach activities. Once this is clear, SMU and HE+HIV should make a conscious effort to reach these subgroups with activities that fit the interests of MSM in the particular subgroups.
- HIV testing must be offered at locations where MARPs are present and at times when MARPS are present. Bringing the test to people significantly reduces the barrier of conducting an HIV test; about 40% of people who were tested in the present study had never been tested before. The NAP mobile clinic should be in the streets every weekend; not only for MSM, but also for the general population.

Policy initiatives

- The possible presence of discriminatory regulations vis-à-vis MSM within government institutions and services must be evaluated. Where necessary, such regulations should be revised in line with the constitution of Suriname, which prohibits discrimination on the basis of ‘any status’, and in line with international agreements ratified by Suriname.
- The National database on seroprevalence must record whether the person tested belongs to one of the MARPs. This is the only way to obtain more reliable figures on seroprevalence among sub populations.
- Our data show that a number of men have had their first sexual experience with another man at elementary school age. This finding may be an indication of sexual abuse and should be further researched.

Further research

- In-depth, qualitative research must be conducted to better understand the determinants of risk perceptions and sexual risk behavior. Important questions to research include: “why is better knowledge not translated to risk-avoiding behavior?" “And why do men who know that unsafe sex with any man, regardless of his looks, exposes one to the risk of HIV transmission and who know that using a condom is the most effective way to prevent this, have unsafe sex and often with multiple partners?” In identifying the driving forces of
sexual risk perception and sexual risk behavior, it is important to consider possible differences between the different MSM subgroups.

- MSM exist in all neighborhoods, all layers of society, all socio-economic classes, and all ethnic groups. Safe sex campaigns targeting MSM should be aimed at all of the various subgroups. Additional research is warranted to obtain a better understanding of the most efficient way to reach the various groups.

- It is important to standardize ways to measure HIV knowledge and access to outreach activities, at least at a national level. At present, different studies such as the multiple, Cluster Indicator Survey, the BSS, and studies performed by different NGOs use different ways to measure these issues in different target groups. As a result the figures from these different studies cannot be compared with one another.
7. References


Del Prado et al. 1998


Imrie J, Davis MD, Black S, Hart GJ, Davidson OR, Williams IG, Stephenson JM. (2001) “Meeting the sexual health needs of HIV seropositive gay men in a pre-requisite to developing the next
generation of prevention strategies”. (Oral presentation) 14th Meeting of the International Society for Sexually Transmitted Diseases Research (ISSTDR) and International Congress of Sexually Transmitted Infections, Berlin Germany. 24-27 June 2001


Annex 1. BSS Survey form

MSM survey 2010

Location: _____________________ Date: _______________ Time: __________ AM/PM

Name surveyor: ___________________ Respondent code: ________________

Demografische gegevens

1. How old are you now? _______ Years.

2. What is your ethnicity?
   - Creole
   - Hindustani
   - Maroon
   - Chinese
   - Javanese
   - Indigenous
   - Mix
   - Other: ____________________

3. What is the highest form of education you completed?
   - None
   - Specialeducation
   - Elementary school
   - Technical school/vocationall training
   - Middle school
   - High school
   - University
   - Other: ____________________

4. With whom do you live?
   - I live alone
   - With my parents/care takers
   - With my female partner
   - With my male partner
   - Other, ______________________

5. You consider yourself:
   - Homosexual
   - Heterosexual
   - Bisexual
   - Transgender
   - Other, ______________

6. Deleted

7. In the past weeks, did you receive a key chain with a flashlight with a sticker with the AIDS-ribbon from the research team?
   - Yes
   - No
   - Don’t know

8. Deleted
9. Did you go to dance pub Millennium on 5 November (2010)?
   □ Yes □ No □ Don’t know

10. Deleted

11. How many MSM do you believe there are in total in Paramaribo? _______________(number)

Risk perception

12. Do you believe you have been exposed to the risk of contracting HIV in the past six months?
   □ Yes, because: _____________________________________________________________
   □ No, because: _____________________________________________________________
   □ Don’t know □ No answer

Knowledge of HIV transmission and prevention

13. What is the best way to prevent HIV infection when you have anal or vaginal sex?
   __________________________________________________________

<table>
<thead>
<tr>
<th>14. You run a risk to be infected with HIV if you:</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
<th>No answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Are bitten by a mosquito which has bitten an HIV+ person</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B Have oral sex without using a condom</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C Kiss with an HIV+ person</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D Use the toilet after an HIV+ person has used it</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E Only have unprotected sex with healthy-looking people</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F Only have unprotected sex with one partner who has no other sex partners</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H A baby is breastfed by an HIV+ mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I Have sex without using a condom</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J A baby is delivered by an HIV+ mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K Share a plate with an HIV+ person</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

15. Do you know other ways to be infected with HIV?
   □ Yes; _____________________________________________________________
   □ No

16, 17, 18, 19. Deleted
20. In the past six months, did you have vaginal or anal sex (with a man or a woman)?
   □ Ja   □ Nee

21. Have you ever had anal sex with a man?
   □ Yes   □ No

22. How old were you when you first had anal sex?
   □ □ years  □ Don’t know  □ No answer
   □ I never had sex with a man

23. In the past six months, did you have anal sex with men (at least 1 man)
   □ Yes   □ No   □ No answer
   □ I have not had anal or vaginal sex with anybody in the past 6 months

24. If you have had anal sex with men in the past six months, with how many different men did you have sex?
   □ □ (number)  □ Don’t know  □ No answer
   □ I have not had sex with anybody in the past 6 months
   □ In the past six months I have not had anal sex with a man

25. In the past six months, did you have vaginal or anal sex with women? (at least 1 woman)
   □ Ja   □ Nee   □ Geen antwoord
   □ I have not had anal or vaginal sex with anybody in the past 6 months

26. If you have had anal sex with women in the past six months, with how many different women did you have sex? (If you cannot state a number with certainty)
   □ Yes   □ No   □ Don’t know  □ No answer
   □ I have not had anal or vaginal sex with anybody in the past 6 months
   □ I have not had sex with a woman in the past six months

27. In the past six months, how often did you use a condom for anal sex with men or women whom you did not pay for sex?
   □ Always   □ Almost every time   □ Sometimes   □ Seldom   □ Never
   □ I have not had sex with anybody in the past 6 months
   □ In the past six months I have not had anal sex with men or women
28. In the past six months, how often did you use a condom during anal sex with a man (paid or unpaid)
☐ Always ☐ Almost every time ☐ Sometimes ☐ Seldom ☐ Never
☐ I have not had sex with anybody in the past 6 months
☐ In the past six months I have not had anal sex with a man

29. In the past six months, how often did you use a condom during vaginal sex with a woman (paid or unpaid)
☐ Always ☐ Almost every time ☐ Sometimes ☐ Seldom ☐ Never
☐ I have not had sex with anybody in the past 6 months
☐ In the past six months I have not had vaginal sex with a woman

30. In the past six months, how often did you use a condom during anal sex with a woman (paid or unpaid)
☐ Always ☐ Almost every time ☐ Sometimes ☐ Seldom ☐ Never
☐ I have not had sex with anybody in the past 6 months
☐ In the past six months I have not had anal sex with a woman

Sexual behavior during last sexual contact

31. The last time that you had anal sex with someone (man or woman) who you did not pay for sex, did you or your partner use a condom? (May be more than 6 months ago)
☐ Yes ☐ No ☐ Don’t know ☐ Not applicable

Seksueel gedrag met commerciele partners

32. Deleted

33. In the past six months, did you pay money in exchange for sex with another man?
☐ Yes ☐ No ☐ Don’t know

34. If yes, how often did you use a condom at the times that you paid money in exchange for sex with a man, in the past six months?
☐ Always ☐ Almost every time ☐ Sometimes ☐ Seldom
☐ Never ☐ Don’t know ☐ No answer
☐ In the past six months I have not paid for sex with a man

35. If yes, the last time that you paid money in exchange for sex with another man, did you use a condom?
☐ Yes ☐ No ☐ Don’t know ☐ No answer
☐ In the past six months I have not paid in exchange for sex with another man
Experience with condoms

36. Deleted

37. What kind of problems with condoms have you experienced at least once in the past six months? (more options possible)
- Slide off
- Ripped/broke
- Damaged when opening the pack or putting it on
- Taken off by partner
- Got stuck
- Other: ____________________
- No problem
- Not applicable

38. How often do you use lubricant during anal sex?
- Always
- Almost every time
- Sometimes
- Seldom
- Never
- Not applicable

39. Deleted

Seksueel overdraagbare aandoeningen

40. In the past six months, has a medical doctor or other health worker told you that you have an STI?
- Yes
- No
- Don’t know
- No answer

Participation in previous studies

41. In 2007-8, Suriname Men United conducted a needs assessment among MSM. Did you participate in this study?
- Yes
- No
- Don’t know

42. In 2004-2005 The Maxi Linder Foundation in collaboration with other organizations conducted a similar study among MSM. This study comprised a questionnaire and the possibility to get tested on HIV. Did you participate in this study?
- Yes
- No
- Don’t know

Information and support

43. In the past 12 months, have you received information about HIV/AIDS? If so, what organization provided you with information? (more answers possible)
- RGD clinic
- General practitioner
- NAP
- Lobi Foundation
- Mamio Namen Foundation
- Suriname Men United
- Media (TV, Radio, newspapers, magazines, etc.)
- Did not receive information
- Other: ____________________
44. In the past 12 months, have you received free condoms from an outreach program or health professional. If so, from whom? *(More answers possible)*

- RGD clinic
- General practitioner
- NAP
- Mamio Namen Foundation
- Lobi Foundation
- Suriname Men United
- Media (TV, Radio, newspapers, magazines, etc )
- Did not receive information
- Other: ____________________________

45, 46. Deleted

**Stigma and discrimination**

47. Do you ever feel discriminated or disrespected because you are a man who has sex with men?

- Yes
- No
- Don’t know
- No answer

48. If so, who or what organization makes you feel discriminated or disrespected? *(more answers possible)*

- 1 or more family members
- Health workers
- 1 or more friends/acquaintances
- Social/public workers
- People in the neighborhood
- Colleagues / boss/ business partner
- Strangers in the street
- Others; __________________________

**Experience with HIV testing**

49. I do not want to know the result, but did you ever do an HIV test??

- Yes
- No
- Don’t know
- No answer

50. How long ago was the last time that you got tested for HIV?

- 1-3 months ago
- 4-6 months ago
- 7-12 months ago
- more than 12 months ago
- I have never been tested for HIV

51. If so, the last time that you performed the test, did you do it voluntary or was it obliged?

- Eigen vrije wil
- Verplicht
- Ik ben nooit getest op HIV

52. Please do not tell me the result, but were you informed about the result?

- Yes
- No
- Don’t know
- No answer

**Thank you for your assistance!!!**
Annex 2. Consent form

Bepalen van geschiktheid om mee te doen aan het onderzoek

Is de persoon geschikt voor deelname aan het onderzoek? □ Ja □ Nee

Ga met behulp van de inclusie criteria na als de persoon geschikt is voor deelname.

- Als de persoon geschikt is voor deelname, vraag de persoon mee te doen en gebruik het toestemmingsformulier
- Als de persoon niet geschikt is voor deelname, vul de sectie van het non-respons formulier in dat hierop van toepassing is.

Toestemmingsformulier

- De participant is op de hoogte gesteld van de doelen van dit onderzoek en weet dat het bestaat uit een vragenlijst en een HIV test.
- De participant begrijpt dat participatie aan dit onderzoek anoniem is en dat zijn naam of andere persoonsgegevens niet zullen verschijnen op de vragenlijst, het test formulier of in de aantekeningen van de onderzoeker. Als de participant besluit mee te doen aan de vragenlijst of de HIV test, dan krijgt hij een respondent code zonder dat daarvoor zijn persoonsgegevens nodig zijn.
- De participant weet dat hij gevraagd zal worden om zowel de vragenlijst in te vullen als de HIV test te doen, maar dat hij ervoor kan kiezen om alleen de vragenlijst in te vullen of alleen de HIV test te doen.
- Als de participant besluit mee te doen aan de vragenlijst, dan weet hij dat hij op elk moment kan stoppen met het beantwoorden van de vragen, of kan besluiten de vragen die hij niet wil beantwoorden, onbeantwoord te laten.
- Als de participant besluit om mee te doen aan de HIV test, dan weet hij dat hij voor en na het doen van de HIV test counseling zal krijgen, ongeacht het resultaat van de test.
- Hij weet ook dat de resultaten van de vragenlijst en de HIV test, uitsluitend gebruikt zullen worden voor de doelen van het onderzoek en dat de gegevens op geen enkele manier naar hem terug te herleiden zullen zijn.

Kruis aan in de tabel aan welk onder de participant wel/niet wil meedoen:

<table>
<thead>
<tr>
<th>De persoon doet mee aan:</th>
<th>De persoon doet niet mee aan:</th>
</tr>
</thead>
<tbody>
<tr>
<td>De Vragenlijst</td>
<td></td>
</tr>
<tr>
<td>De HIV test</td>
<td></td>
</tr>
<tr>
<td>Als de persoon meedoet met de HIV test. Waar wordt de persoon getest? □ Ter plekke □ Andere lokatie</td>
<td></td>
</tr>
</tbody>
</table>

Datum: ____________________________ Respondent code: ____________________________

Naam veldwerker: __________________ Handtekening veldwerker __________________

Als de persoon niet wil mee doen aan de vragenlijst en/of de HIV test, vul dan het non-response formulier in.

Aanwijzingen:

- Als de participant al op de hoogte is van zijn HIV status, kan hij nog steeds mee doen aan het onderzoek. We willen de HIV prevalentie weten van de groep als geheel en daar horen ook MSM bij die hun status al kennen.
- Als de persoon aan geen van beide onderdelen wil mee doen, kruis dit aan in de laatste kolom van de tabel en vul het non-response formulier in voor de persoon.
Annex 3. Non-response forms

Non-Response formulier

Vul dit formulier in voor elke persoon die is benaderd voor het onderzoek, maar niet geschikt is, of niet wil meedoen aan de vragenlijst en/of de HIV test.

Vul elke sectie in die van toepassing is

De persoon is niet geschikt voor deelname omdat de persoon (meerdere antwoorden zijn mogelijk)
☐ Geen MSM (homoseksueel, bi-seksueel, trans gender enz) is
☐ Wel MSM is, maar in het afgelopen jaar geen handmatige, orale of anale seks heeft gehad met een andere man
☐ Wel MSM is, maar jonger is dan 16 jaar
☐ Wel MSM is, maar niet woont in Suriname, niet blijft voor 6mnden of langer en ‘land niet maandelijksbezoekt
☐ Wel MSM is, maar in de afgelopen 6 maanden geld heeft aangenomen voor seks (seks heeft verkocht)

Waarom wil je de vragenlijst niet invullen? (meerdere antwoorden zijn mogelijk)
☐ Ik heb geen tijd
☐ Ik wil niet over deze onderwerpen praten
☐ Ik vind het niet het juiste moment hiervoor
☐ Ik vind het niet de juiste plek/setting hiervoor
☐ Ik denk niet dat mijn gegevens confidantieel zullen blijven
☐ Anders: ________________________________
☐ Niet van toepassing

Waarom wil je niet meedoen aan de HIV test? (meerdere antwoorden zijn mogelijk)
☐ Ik heb geen tijd
☐ Ik ben al eerder getest op HIV
☐ Ik weet al wat mijn HIV status is
☐ Ik hoef niet te weten wat mijn HIV status is
☐ Ik ben bang om de test te doen
☐ Ik vind het niet het juiste moment voor een HIV test
☐ Ik vind het niet de juiste plek/setting voor een HIV test
☐ Ik denk niet dat mijn gegevens confidantieel zullen blijven
☐ Anders: ________________________________
☐ Niet van toepassing
Annex 4. Sexual activity, contact with HIV+ people, and HIV/AIDS transmission among MSM

Anal sex
Receptive anal intercourse (i.e. being the “bottom”) carries a higher risk of HIV transmission than receptive vaginal intercourse. The lining of the anus is more delicate than the lining of the vagina, so is more likely to be damaged during sex. Any contact with blood during sex increases the risk of infection. If a man takes the insertive (“top”) position in anal sex with a man who has HIV, then he too risks becoming infected.

Oral sex
Oral sex with an infected partner carries a small risk of HIV infection. If a person gives oral sex (licking or sucking the penis) to a man with HIV, then infected fluid could get into their mouth. If the person has bleeding gums or tiny sores or ulcers somewhere in their mouth, there is a risk of HIV entering their bloodstream. The same is true if infected sexual fluids from a woman get into the mouth of her partner.

There is also a small risk if a person with HIV gives oral sex when they have bleeding gums or a bleeding wound in their mouth. Saliva does not pose a risk. HIV infection through oral sex alone seems to be very rare, and there are things you can do to protect yourself.

Kissing
To become infected with HIV you must get a sufficient quantity of the virus into your body. Saliva does contain HIV, but the virus is only present in very small quantities and as such cannot cause HIV infection. Unless both partners have large open sores in their mouths, or severely bleeding gums, there is no transmission risk from mouth-to-mouth kissing.

Sneezing, coughing, sharing glasses/cups, etc
HIV is unable to reproduce outside its living host, except under strictly controlled laboratory conditions. HIV does not survive well in the open air, and this makes the possibility of this type of environmental transmission remote. In practice no environmental transmission has been recorded. This means that HIV cannot be transmitted through spitting, sneezing, sharing glasses, cutlery, or musical instruments. You also can’t be infected in swimming pools, showers or by sharing washing facilities or toilet seats.

Insects
Studies conducted by many researchers have shown no evidence of HIV transmission through insect bites, even in areas where there are many cases of HIV and AIDS and large populations of
insects such as mosquitoes. Lack of such outbreaks, despite considerable efforts to detect them, supports the conclusion that insects do not transmit HIV.

HIV only lives for a short time and cannot reproduce inside an insect. So, even if the virus enters a mosquito or another sucking or biting insect, the insect does not become infected and cannot transmit HIV to the next human it feeds on or bites.

**Breastfeeding**

If the mother’s nipples are chapped and the baby has small cuts in the intestines, for example due to hard feces, blood-blood contact and hence HIV-transmission is possible. Transmission is most likely when the mother combines breastfeeding with bottle-feeding, because the latter increases the chances of constipation for the baby.

Source: AVERT (AVERTing HIV and AIDS) web site. “Can you get HIV from....?”

URL: [http://www.avert.org/can-you-get-hiv-aids.htm](http://www.avert.org/can-you-get-hiv-aids.htm)
Annex 5  Numbers and percentages of respondents who received outreach services in the form of information or condoms from defined organizations, institutions, or persons*

<table>
<thead>
<tr>
<th>Organization who provided outreach service</th>
<th>Information N</th>
<th>Information % (N=312)</th>
<th>Condoms N</th>
<th>Condoms % (N=313)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Media</td>
<td>159</td>
<td>51.0%</td>
<td>10</td>
<td>3.2%</td>
</tr>
<tr>
<td>Suriname Men united (SMU)</td>
<td>39</td>
<td>12.5%</td>
<td>83</td>
<td>26.5%</td>
</tr>
<tr>
<td>Regional Health Service (RGD)</td>
<td>33</td>
<td>10.6%</td>
<td>35</td>
<td>11.2%</td>
</tr>
<tr>
<td>National AIDS Program (NAP)</td>
<td>19</td>
<td>6.1%</td>
<td>26</td>
<td>8.3%</td>
</tr>
<tr>
<td>Lobi Foundation</td>
<td>19</td>
<td>6.1%</td>
<td>17</td>
<td>5.4%</td>
</tr>
<tr>
<td>Stg. Mamio Namen Project</td>
<td>18</td>
<td>5.8%</td>
<td>15</td>
<td>4.8%</td>
</tr>
<tr>
<td>General practitioner</td>
<td>18</td>
<td>5.8%</td>
<td>11</td>
<td>3.5%</td>
</tr>
<tr>
<td>Stg Maxi Linder Association</td>
<td>11</td>
<td>3.5%</td>
<td>8</td>
<td>2.6%</td>
</tr>
<tr>
<td>Colleagues, friends, family</td>
<td>7</td>
<td>2.2%</td>
<td>7</td>
<td>2.2%</td>
</tr>
<tr>
<td>Disco/Club/Bar/Brothel</td>
<td>0</td>
<td>0.0%</td>
<td>13</td>
<td>4.2%</td>
</tr>
<tr>
<td>School</td>
<td>10</td>
<td>3.2%</td>
<td>1</td>
<td>0.3%</td>
</tr>
<tr>
<td>At work</td>
<td>9</td>
<td>2.9%</td>
<td>2</td>
<td>0.6%</td>
</tr>
<tr>
<td>Abroad</td>
<td>5</td>
<td>1.6%</td>
<td>5</td>
<td>1.6%</td>
</tr>
<tr>
<td>Events, incl. world aids day</td>
<td>4</td>
<td>1.3%</td>
<td>1</td>
<td>0.3%</td>
</tr>
<tr>
<td>Other health services (Red Cross, hospital, other)</td>
<td>2</td>
<td>0.6%</td>
<td>2</td>
<td>0.6%</td>
</tr>
<tr>
<td>Dermatological service</td>
<td>2</td>
<td>0.6%</td>
<td>1</td>
<td>0.3%</td>
</tr>
<tr>
<td>Do not remember from whom</td>
<td>0</td>
<td>0.0%</td>
<td>3</td>
<td>1.0%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>0</td>
<td>0.0%</td>
<td>3</td>
<td>1.0%</td>
</tr>
<tr>
<td>Everywhere</td>
<td>2</td>
<td>0.6%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Prison</td>
<td>2</td>
<td>0.6%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Condom distribution machines</td>
<td>0</td>
<td>0.0%</td>
<td>2</td>
<td>0.6%</td>
</tr>
<tr>
<td>Organization who provided outreach service</td>
<td>Information N</td>
<td>Information % (N=312)</td>
<td>Condoms N</td>
<td>Condoms % (N=313)</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>----------------</td>
<td>------------------------</td>
<td>-----------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Internet</td>
<td>1</td>
<td>0.3%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Ms. E. Pengel (HIV activist)</td>
<td>1</td>
<td>0.3%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Own research</td>
<td>1</td>
<td>0.3%</td>
<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

* Excluding seven missing cases for reporting on the receipt of information, and six missing cases for reporting on the receipt of condoms