Overview of the Consultation in Suriname 2018

Dialogue between Religious and Key Populations' Leaders: The Right to Health and Wellbeing for All

Introduction

Hon. Patrick Pengel, Minister of Public Health, Suriname, Dr. Yitades Gebre, PAHO/WHO Representative, Suriname, Dr Edward Greene, my colleague co chair Mr. Colin Robinson, CAISO: Sex and Gender Justice, Mr Dereck Springer, Executive Director of PANCAP, other dignitaries on the platform and in the audience. Greetings

According to the late Howard Thurman, a civil rights activist in the United States and the academic supervisor of the late Dr Martin Luther King Jr., "The concept of reverence for personality… is applicable between persons from whom, in the initial instance, the heavy weight of status has been sloughed off. Then what? Each person meets the other where he is and there treats him as if he were where he ought to be. Here we emerge into an area where love operates, revealing a universal characteristic unbounded by special or limited circumstances" (From *Jesus and the Disinherited*). In other words, for Thurman, love of neighbour is the universal principle which undergirds all human endeavours. It is this spirit of love that is at the basis of the dialogue between religious and key populations' leaders this week.

The situation of HIV in the Caribbean

This dialogue is taking place in the context of some very stark but positive realities. According to the UNAIDS 2017 Global AIDS Update there were an estimated 310 000 [280 000–350 000] people living with HIV in the Caribbean at the end of 2016 with five countries accounting for 92%: Haiti (48%), The Dominican Republic (22%), Jamaica (10%), Cuba (8%) and Trinidad and Tobago (4%). The annual number of new infections among adults across the Caribbean has remained static for the last six years at an estimated 17 000 [15 000–22 000] as reported in 2016. In Cuba, estimated numbers of new HIV infections more than doubled between 2010 and 2016 from 1,600 [1,400-1,800] to 3,200 [2,600-3,600]. In the Caribbean there was a 55% reduction of AIDS-related deaths from 2000 to 2016. Deaths declined from an estimated 21 000 [16 000–26 000] in 2000 to an estimated 9400 [7300–12 000] in 2016. From 2000 to 2016 the number of people accessing antiretroviral treatment more than doubled. Eight countries in the Caribbean have adopted the World Health Organization recommendation that antiretroviral therapy should be initiated in every person living with HIV at any CD4 cell count. New infections among children (aged 0–14 years) in the

Caribbean decreased by 44% between 2010 and 2016: from an estimated 1800 [1500–2200] in 2010 to fewer than 1000 [<1000–1000] in 2016. Of all people living with HIV in the Caribbean, 36% were unaware of their HIV status in 2016. Late diagnosis is a challenge, particularly for men. In 2016 more than half (52%) of Caribbean people living with HIV were on treatment as compared to 24% in 2010. Retaining people on treatment has proven challenging for most countries in the region. Only Haiti has >89% of diagnosed people living with HIV on treatment. One-third (33%) of Caribbean people living with HIV on treatment were not virally suppressed in 2016. In 2016 at least three of four people on treatment achieved viral suppression in Barbados, Dominica, Guyana, St. Lucia, Suriname and Trinidad and Tobago.

The Caribbean is on track to be the first region in the world to eliminate MTCT and congenital syphilis. Cuba was the first country in the world to do so in 2016. Six other Caribbean countries—Antigua and Barbuda, British Virgin Island, Bermuda, The Cayman Islands, Montserrat and St Kitts Nevis were certified by WHO in December 2017 as having achieved this landmark while six other Caribbean Countries are in close range of being certified. This means that of the 11 countries that have achieved the WHO target, seven are in the Caribbean.

In addition, many Caribbean countries still criminalize same sex relations and in those countries key populations such as men who have sex with men, sex workers and transgender persons are subjected to pervasive stigma, discrimination and violence.

Focus of the Consultation

It is against this background that this dialogue was conceptualized. The four areas to be addressed are as follows:

1. Gaps in Treatment and Prevention of HIV.
    - Access to data in order to address the prospects and requirements for achieving 90-90-90 targets by 2020
- Prevention gaps with special reference to public education.

2. Stigma and discrimination, especially in relation to key populations.
    - Establish mechanism for enhancing partnerships between the key population and religious groups.
    - Articulate clearly the major determinants of stigma and discrimination and what is required by the partnership to break down these barriers.
3. Promote a viable legislative environment, especially as it affectively deals with human rights, human sexuality and human dignity.

- Explore the nature of partnerships required among Religious Leaders, representatives of LGBTI and parliamentarians that would foster a positive legislative environment.

4. The relationship between faith and governance with particular reference to understanding the following:
    a) How secular and faith governance overlap or diverge from each other?
    b) Why sacredness and wholeness of each person is to be identified?
    c) What Social action to promote dignity and wholeness is required?

- Need for clarity on the issue of governance; governance not only by government but by religious groups and the religious sector.
- Need for commitment to jointly speed up the response to HIV through partnership.

The three activities to be undertaken to help us reach our goals are:

1. This public session to be addressed by the Minister of Health here in Suriname. We are pleased to have followers and viewers in cyber space and around the world joining us through the live streaming of this public session.
2. Worship will be held at the beginning and end of each day and there will be reflections on the experience of worship and what it means for our time together in discussion and debates.
3. Selected religious leaders and representatives of key population will share testimonies of their experiences working with each other. Space will also be created for each group (religious leaders and key populations) to have separate discussions. Opportunities for feeding ideas from these discussions into plenary discussions will be fostered and facilitated.

Outcomes Expected

In the final analysis the outcomes expected are based on the premise that **r**eligious leaders and key populations' can identify specific gaps in the response to HIV and make a concerted commitment (from both groups) to pursue steps towards addressing these gaps. To this end we anticipate the following seven specific outcomes:

1. The dialogue will address stigma and discrimination by answering the question what can religious leaders and key populations leaders/members do to improve the environment for testing and treatment to enable increased access and reduce stigma and discrimination?
2. To foster and encourage support for the PANCAP Model Anti-discrimination Legislation that promotes human rights and human dignity
3. Forging a regional partnership between religious leaders and key populations, especially in relation advocating/lobbying /monitoring regional governments to ensure they adhere to all international agreements to which they are signatories,

such as CEDAW, The Paris Agreement, and the UN 2016 High level Political Declarations

4. Encourage FBOs to include members of key populations in their administrative and programmatic structures.
5. Members of key populations, who are also people of faith, can engage and describe their own religious and spiritual perspectives.
6. Religious Leaders and key populations to create networks that allow them to partner with each other to provide services to key populations.
7. Leadership of Key populations to demonstrate an appreciation of the religions basis of disagreements and to continue to engage in constructive dialogue with Religious Leaders as a prerequisite for increasing access of key populations to public health.

In pursuit of all the foregoing focus on **The Right to Health and Wellbeing for All** we therefore anticipate an atmosphere of spirited and robust discussions, dialogue and debates over the next three days. It is our hope that in the end there will be a consensus on the way forward for partnerships and collaborations between religious leaders and key populations across the region.