

## Suriname - Health in All Policies (HiAP) Brief

# Health of the Population – Health of the Country

## Health and development

Poor health and health inequities cause personal suffering and missed opportunities for social and economic development. Each year, Suriname loses 170 000 productive life-years due to ill-health and premature death. “Communicable diseases, maternal, neonatal, and nutritional disorders”, “Non-communicable diseases” and “Injuries” account for **27%**, **58%**, and **15%** respectively.

Benchmarking against 15 comparator countries<sup>1</sup> shows that for all Suriname’s 15 largest contributors to the burden of disease, there is considerable room to improve compared with the “best-in-class” (see table).

Comparator countries (similar level of income per capita)	Overall rank	The 15 largest contributors to the burden of disease in Suriname (listed according to size of burden)														
		1. HIV/AIDS	2. Stroke	3. Preterm birth complications	4. Ischemic heart disease	5. Self-harm	6. Major depressive disorder	7. Road injury	8. Diabetes	9. Iron-deficiency anaemia	10. Low back pain	11. Neonatal encephalopathy	12. Congenital anomalies	13. Lower respiratory	14. Chronic kidney disease	15. Adverse medical treatment
Serbia	1	5	14	2	11	13	1	6	4	1	13	1	2	1	2	3
Cuba	2	4	3	1	9	12	12	4	3	7	2	3	3	6	5	9
Macedonia	3	2	15	6	14	5	6	2	7	2	14	2	4	2	4	2
Montenegro	4	1	13	3	13	14	13	8	2	3	12	6	1	3	3	1
Panama	5	11	2	4	4	10	4	9	8	5	9	5	11	7	12	5
Jamaica	6	12	11	5	1	1	5	1	12	11	5	12	6	4	10	13
Colombia	7	9	1	8	5	8	14	7	1	9	10	8	12	10	6	4
Iran	8	3	6	9	15	4	15	15	5	6	15	4	15	5	1	7
Brazil	9	6	8	10	7	9	11	12	6	4	11	11	9	11	7	6
South Africa	10	15	10	11	3	2	3	3	12	8	8	14	5	15	13	8
Dominica	11	7	4	12	2	3	10	10	11	10	7	13	10	12	8	11
Saint Vincent and the Grenadines	12	10	7	14	8	7	7	5	14	13	3	9	8	9	9	10
Dominican Republic	13	8	9	13	12	6	2	14	9	12	1	10	13	13	11	15
Belize	14	14	5	7	10	11	9	13	15	15	4	7	7	14	14	12
<b>Suriname</b>	<b>15</b>	<b>13</b>	<b>12</b>	<b>13</b>	<b>6</b>	<b>13</b>	<b>8</b>	<b>11</b>	<b>10</b>	<b>14</b>	<b>6</b>	<b>15</b>	<b>14</b>	<b>8</b>	<b>15</b>	<b>14</b>

Individual health care only explains 20% of the level and inequity in population health. The remaining 80% is shaped by a range of social determinants (50%) and individual health behaviours (30%)<sup>2</sup>. Health behaviours, in turn are also shaped by social determinants.

## Dimensions of inequity

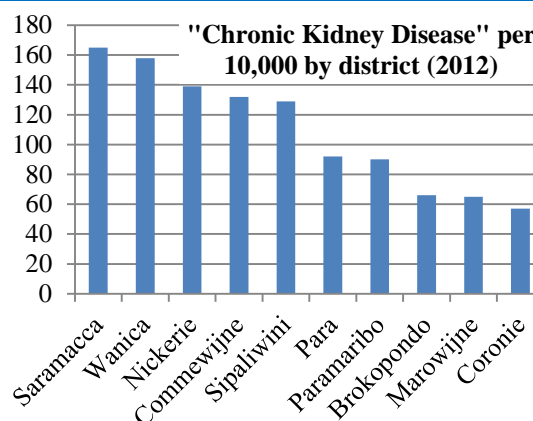
Social determinants are the conditions, in which people are born, grow, work, live, and age. Key forces at play are: social, economic and political systems; development agendas; and social norms. Social determinants cause health inequities and influence health and development via several pathways. They can be addressed through public policy and intersectoral action. The three main dimensions of inequity in Suriname are: geographic location, socio-economic status, and population group and gender.

<sup>1</sup> Adapted from [http://www.healthdata.org/sites/default/files/files/country\\_profiles/GBD/ihme\\_gbd\\_country\\_report\\_suriname.pdf](http://www.healthdata.org/sites/default/files/files/country_profiles/GBD/ihme_gbd_country_report_suriname.pdf)

<sup>2</sup> <http://www.countyhealthrankings.org/>.

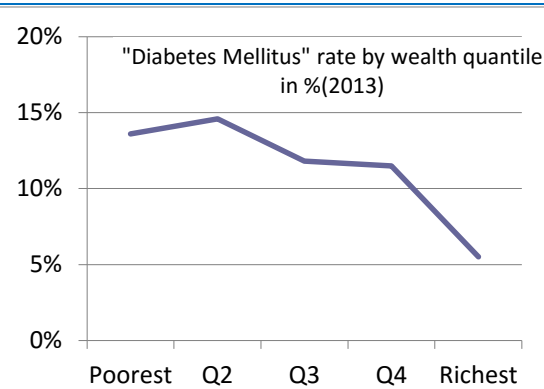
**Geographical location** – For each of the leading causes of burden of disease with data available, there are marked inequities across districts. However, not the same district is ‘worst off’ in all cases. E.g., for diabetes, it is Coronie, for cardiovascular disease it is Sipaliwini, etc. It is likely that inequities also exist across locations within each district and urban / rural.

**Social determinants include:** population composition, clustering of disadvantage, poor infrastructures and housing, proximity to waste sites, smelters or mines, obesogenic environments, etc.



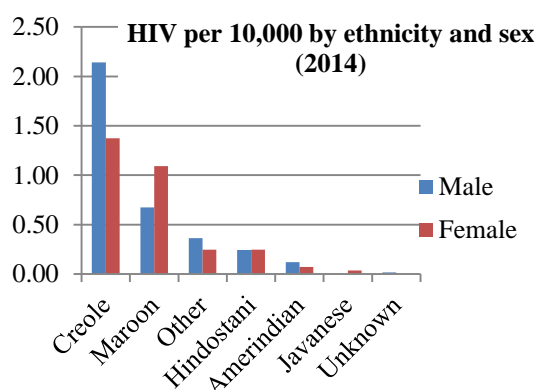
**Socio-economic status** – For diabetes there are clear inequities according to wealth with the poorest being four times more affected than the richest. In Suriname it is only for diabetes such data are available. However, inequities could, with data available be shown for most of the other major diseases also by level of education, age, and migratory status.

**Social determinants include:** lack of jobs and educational opportunities, low knowledge, lack of social capital in families and communities, etc.



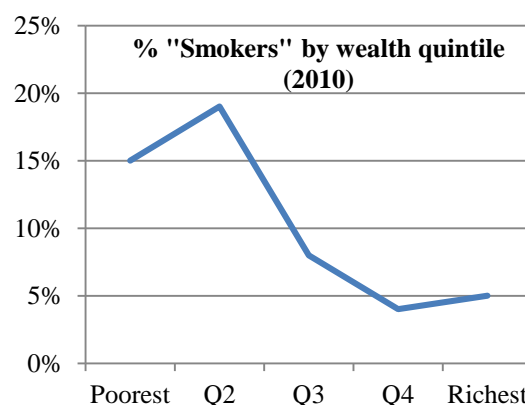
**Population groups and gender** – HIV is unevenly distributed across ethnic groups and between men and women. There are different inequity patterns for different diseases. E.g., for stroke and kidney disease the blunt of burden is borne by Hindustani, for cardiovascular diseases by particularly Maroon women. Limited data exist for groups such as drug users, sex-workers, and LGBT.

**Social determinants include:** social and cultural norms and gender roles, access to social and health services, social stigma and discrimination, marginalisation, intersection with poverty, etc.



**Risk-factors** – Such as smoking, alcohol drinking, unhealthy diet, lack of physical activity, co-existence of other health conditions, etc. are also unevenly distributed across geographical locations, socio-economic status, population groups and gender. However, limited concrete information on population-based risk factors is available.

**Social determinants include:** marketing, pricing and availability of tobacco, alcohol and unhealthy food products, nutritional transition, social and gender norms, lack of knowledge, poverty, etc.



## Promising policy entry points

Health inequities are avoidable and can be reduced by addressing the social determinants causing them. The government, communities, and public and private sectors share the responsibility for action. The National HiAP Consensus Workshop identified promising entry points for first-wave policy action.

**1 Education and jobs** - Poor education and transition into adulthood are strong determinants for health inequity for one self and for one's children, and for responsible participation in society. Proposed policy options include: compulsory education (4 to 16 years); second chance education; aligning education to labour market needs; improve teaching on health, nutrition, water and sanitation, good traditional practices, environment, physical education, entrepreneurship and innovation; and strengthen labour planning, adherence to labour law and health at work place.

*Sectors:* **Education**, regional development, district councils, labour, trade and industry, agriculture, environment, private businesses, civil society organizations, and **health**

**2 Spatial planning and management** - People who are already disadvantaged, e.g., poor or marginalized are more affected by weak spatial planning and management than those better off. Proposed policy options include: coordinate physical planning; strengthen district level structures and capacities; neighbourhood planning and community centres; recognize communal land rights; reduce illegal mining; inventory of harmful facilities and activities; decrease destruction of the environment; etc.

*Sectors:* **Planning office**, regional development, district councils, public works, environment, physical planning, trade and industries, natural resources, agriculture, education, civil society, and **health**

**3 Built environments** - Roads, transportation system, settlements, housing, and infrastructures provide the physical frame for how people live and move. Proposed policy options include: formulate and implement infrastructural norms that consider health and well-being, including for safe walking and physical activities; coordinated policy on low cost housing; adequate and affordable housing as part of district plan; etc.

*Sectors:* **Public works**, regional development, district councils, housing authority, home affairs, transport, planning, police, home affairs, environment, civil society, social affairs, and **health**

**4 Integrated approach at community and household levels** - Disadvantages tend to cluster in certain communities and households where they are mutually reinforcing. Proposed policy options include: increase political and administrative responsibility and accountability at local and community level; multidisciplinary action on gender and domestic violence and child abuse; early child development; link integrated planning at community level to regional and national planning; conditional cash transfer; etc.

*Sectors:* **Regional development**, district councils, public works, education, justice and police, social affairs, planning, spatial planning, sports and youth, gender bureau, civil society, and **health**

**5 Consumables** - There are close links between food, smoking and alcohol consumption patterns and the level of disease and health inequity. Proposed policy options include: taxation according to nutrition and health value; regulation of advertising and marketing (*including targeting of children*), content of processed food (*salt, sugar, trans-fats, and additives*), labelling, alcohol and fast food outlets; and promotion of local healthy food production and distribution

**Sectors:** *Trade and industry*, finance, agriculture, regional development, spatial planning, education, vocational training institutions serving the food sector, private food and beverage sector, civil society, and **health**

**6 Training and employment of staff** – often staff of public and private organizations do not know how their ‘business’ influences health and how they can work with each other to reduce inequity. Proposed policy options include: Assessment and revision of curricula of training institutions (*health and others*); include HiAP in generic and specific post descriptions; incentives and rewards for “desired” behaviour; integration of inequity and social determinant knowledge and skills into in-service training and career paths; integrated training for community workers; etc.

**Sectors:** *Education, professional and higher learning institutions*, regional development, district councils, spatial planning, public works, trade and industry, agriculture, justice and police, social affairs, professional associations, civil society, and **health**

**7 Health system’s governance** - influences how it operates, its ability to work with other sectors, how priorities are set, who benefits; and participation, transparency and accountability mechanisms. Proposed policy options include: make inequity reduction part of the system’s ethics code, budget allocation and success criteria; make contributions of all relevant sectors visible in policy, budget and reporting; structure for participatory, multi-sectoral and culturally appropriate planning and implementation; safe systems for protecting patients’ rights and handling malpractice.

**Sectors:** *Regional development*, district councils, social affairs, insurance, NGO and private health care providers, justice, civil society, and **health**

**8 Health system’s organization and management** - may cause the system to perform below its potential for reducing health inequities due to e.g.: fragmentation, weak administrative and managerial capacity. Proposed policy options include: Enhanced and coherent coordination of the different subsystems of the national health system; enhanced evidence-based managerial effectiveness towards health inequity reduction goals; enforcing Primary Health Care (PHC), including intersectoral action, referral system, telemedicine and the integration of preventive services

**Sectors:** *Regional development*, district councils, social affairs, insurance, NGO and private health care providers, professional associations, civil society, and **health**

## Next steps

- **Intersectoral working groups** on each of the above eight promising policy entry points to feed into sectoral policy making, action and the next National Development Plan / UNDAF.
- A comprehensive rights-based **HiAP Monitoring Strategy** for health and equity with four business lines: (1) administrative data, (2) repeated surveys, (3) *ad hoc* surveys, studies and research projects, and (4) policy adequacy, implementation and effect.
- An **Annual Population Health Report** presenting the newest knowledge on the burden of disease, inequity, risk factors, social determinants at play, and policy action in Suriname.
- A **National Health Forum 2017** providing the opportunity for politicians, sectoral managers, researchers, private sector and civil society to review the newest knowledge and policy and implementation progress, share experience, innovate and discuss the way forward.