PAHO/ WHO
Country Cooperation Strategy
Republic of Suriname

2023 - 2025
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Foreword

The Pan American Health Organization, which also serves as the Regional Office for the Americas of the World Health Organization (PAHO/WHO), seeks to provide technical cooperation to its Member States in support of implementation of their national development plans and specifically their national health strategic agenda. Suriname’s Multi-year Development Plan 2022-2026 and the National Health Policy Plan 2021-2025 have both identified the achievement of Universal Health Coverage, the reduction of morbidity and mortality and addressing the determinants of health as some priority areas for action. The COVID-19 pandemic highlighted the need to strengthen health systems and to build capacity for implementing the essential public health functions to ensure resilience and sustainability of the health sector.

It is within this context that PAHO/WHO has, through a strong collaborative process, developed this Country Cooperation Strategy (CCS) for Suriname for the period 2023-2025. The CCS outlines the medium-term vision that will guide PAHO/WHO’s technical cooperation with Suriname in support of its national health strategic priorities over the next four years. Through this strategy, PAHO/WHO will also continue to work and collaborate with United Nations agencies, international development partners and other relevant stakeholders to achieve universal health coverage and the Sustainable Development Goals, in particular goal number 3.

Suriname has made advances in healthcare and is working towards reforming the public health system to build on existing structures and strengthen capacities including for health promotion and preventive care. However, the Ministry of Health faces challenges with the double burden of non-communicable diseases and mental health disorders including suicide and communicable diseases. The country is on track to eliminate Malaria by 2025 but is at risk of the re-importation of vaccine-preventable diseases due to non-homogeneous and relatively low national coverage. The country has also been impacted by financial challenges and the emigration of specialist healthcare workers especially nurses. There are also challenges in addressing the determinants of health and risk factors. The planned focus on renewing the Health in all Policies approach and the attention to promotion of healthy lifestyles should contribute to improvements in health and well-being of the citizens and residents of Suriname.

This new 2023-2025 CCS supports the national strategic priorities and commitments and was developed using a participatory, results-based approach that involved national counterparts and stakeholders from across several sectors. It builds on previous achievements and ongoing support and is well aligned with key global and regional development and health agendas including the Sustainable Development Goals and the PAHO Strategic Plan 2020-2025. PAHO/WHO seeks to implement this CCS in partnership with the Ministry of Health and thus further deliver on our commitment to working towards achieving sustainable development, health equity and universal health in support of the health and well-being of the people of Suriname.

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PAHO/WHO Director
Acknowledgements

The PAHO/WHO Representative (PWR) and the team of the Suriname PAHO/WHO country office would like to thank the Minister of Health, the Director of Health, the Planning Department of the Ministry of Health (MOH), focal points, the CCS Working Group Members including representatives from the Ministry of Health, the Suriname National Planning Office, the Ministry of Foreign Affairs and PAHO staff of Suriname for the provision of information, coordination and execution of stakeholders’ meetings and review of the document. These activities proved invaluable to the preparation of the Country Cooperation Strategy (CCS) 2023-2025 for Suriname.

The PWR further acknowledges with gratitude the invaluable support and contributions of all the persons, organizations and agencies which participated in the development of the CCS 2023-2025 for Suriname. The time taken to participate in the stakeholders’ consultations as well as the knowledge and experiences shared, is highly appreciated.

Special thanks to the Country and Sub-regional Coordination (CSC) team of Rufus Ewing, Country Program Advisor Caribbean; Lorraine Thompson, Country Program Advisor; and Claudia Pescetto, Advisor Health Systems and Services who provided technical guidance and support throughout the CCS development process. The time taken to respond to requests for information and to provide feedback on drafts of the document, given the busy schedules and other commitments, is very much appreciated.

We look forward to the continued involvement and participation of all in the implementation and monitoring of the CCS, and its contribution to the health sector in Suriname.
Abbreviations

AMR  Anti-microbial Resistance
BOG  Bureau of Public Health
BWP  Biennial Work Plan
CARICOM  The Caribbean Community
CCS  Country Cooperation Strategy
CIP  Country Implementation Plan
CO  Country Office
FA  Focus Areas
FAO  Food and Agricultural Organization
GBS  General Bureau of Statistics
GDP  Gross Domestic Product
GF  Global Fund
GWP 13  WHO 13th Global Programme of Work
HIAP  Health in All Policies
HIV  Human Immunodeficiency Virus
HDI  Human Development Index
HRH  Human Resources for Health
IDB  Inter-American Development Bank
IHR  International Health Regulations
IICA  Inter-American Institute for Cooperation on Agriculture
ILO  International Labour Organization
IOM  International Organization for Migration
IS4H  Information Systems for Health
MOH  Ministry of Health
MZ  Medical Mission
NAP  National Adaption Plan
NCDs  Noncommunicable Diseases
NGO  Non-governmental Organization
OAS  Organization of American States
PAHO/WHO  Pan American Health Organization, Regional Office for the Americas of the World Health Organization
PEPFAR  U.S. President’s Emergency Plan for AIDS Relief
PHC  Primary Health Care
PWR  PAHO/WHO Representative
RGD  Regional Health Services
SDGs  Sustainable Development Goals
SHAA2030  Sustainable Health Agenda for the Americas 2018-2030
SP  Strategic Priority
SRD  Surinamese Dollar
SZF  State Health Insurance Foundation
UHC  Universal Health Coverage
UN  United Nations
UNAIDS  The Joint United Nations Programme on HIV/AIDS
UNEP  United Nations Environment Programme
UNESCO  United Nations Educational, Scientific and Cultural Organization
UNDP  United Nations Development Programme
UNFPA  United Nations Population Fund
UNFCCC  United Nations Framework Convention on Climate Change
UNICEF  United Nations Children’s Fund
USAID  United States Agency for International Development
VBD  Vector-borne diseases
WASH  Water, Sanitation and Hygiene
WHO  World Health Organization
Executive summary

The Pan American Health Organization (PAHO) is the specialized health agency of the Inter-American system and also serves as Regional Office for the Americas of the World Health Organization (WHO), the specialized health agency of the United Nations system. The PAHO/WHO Country Office in Suriname was established in 1969 and has been providing technical cooperation to Suriname in close collaboration with the Ministry of Health (MOH) for approximately 70 years. Suriname became an independent Member State of the PAHO in 1976. The Country Cooperation Strategy (CCS) for Suriname covering the period 2023 to 2025, provides a clear understanding of the medium-term vision that will guide the implementation of the PAHO’s technical cooperation at the national level. The development of the CCS was based on a consultative and participatory process with strong commitment and support from the Ministry of Health (MOH).

The CCS is aligned with several national, regional and international frameworks as follows:

- Multi-year development plan 2022-2026 of Suriname
- Ministry of Health Policy Plan 2021-2025
- National Plan for the Renewal of Healthcare, Suriname 2025
- WHO 13th General Programme of Work (GWP)
- Sustainable Health Agenda for the Americas 2018-2030 (SHAA2030)
- PAHO Strategic Plan 2020-2025

The main challenges in the health sector in Suriname based on the situation analysis are:

- The continued threat of emerging and re-emerging diseases, especially the re-importation of vaccine-preventable diseases due to non-homogeneous and relatively low national coverage.
- The growing prevalence of NCDs and premature mortality, especially cardiovascular diseases, and cancers.
- The growing concerns of the social and environmental determinants of health and the need to address these through an accelerated Health in All Policies approach.
- Mainstreaming of the cross-cutting issues such as violence including gender-based violence
- The need to strengthen strategies for climate change and environmental health.
- The need to improve the effectiveness and resilience of the health system and its components.
- The ongoing challenges with recruitment and retention of specialist healthcare workers especially nurses
- The need to find equitable and sustainable solutions for financing the health sector and financial protection of the population.
- The need to strengthen accountability with a focus on stewardship and governance to lead health sector transformations and respond to the changing needs in public health.

1 PAHO, December 2021, Evaluation of Essential Public Health Functions in Suriname – Situation Analysis of health services in Suriname
The strategic agenda of the CCS lays out four Strategic Priorities (SP) where PAHO/WHO will focus its technical cooperation over the period 2023 to 2025. Each Focus Area (FA) is linked to the MOH Policy Plan 2021-2025, PAHO Strategic Plan 2020-2025, the Sustainable Development Goals and the UNMSDCF 2022-2026. The four SPs and related FAs are:

**Strategic Priority 1: Stewardship and governance strengthened to advance the essential public health functions**

1.1 Strengthen information systems for health to support evidence-informed decision making, accountability, monitoring and evaluation.

1.2 Strengthen national capacity for health research and knowledge management.

1.3 Support strategies for sustainable Human Resources for Health.

1.4 Strengthen policies, strategies and plans to improve the essential public health functions.

**Strategic Priority 2: Advanced implementation of universal health coverage and access through the strengthening of health systems**

2.1 Increase access and utilization of quality and people-centered health services for all using an integrated service delivery approach.

2.2 Strengthen the health financing system through sustainable, equitable and efficient funding and financial protection.

2.3 Support the renewal and strengthening of Primary Health Care with a focus on a community-based approach.

**Strategic Priority 3: Reduction in morbidity and mortality utilizing an intersectoral and inclusive healthy life course approach and promotion of health**

3.1 Promote health throughout the life course including policies and programmes on newborn, child, adolescent, women’s, men’s, and elderly health; maternal, sexual and reproductive health; and workers health.

3.2 Strengthen the prevention and control of NCDs and their risk factors and improve equitable access to quality mental health services including suicide prevention and substance abuse.

3.3 Support a One Health approach to strengthen prevention, surveillance, and control of communicable diseases and (re-)emerging diseases including Malaria, HIV, TB, vector borne illnesses and address Antimicrobial Resistance.

3.4 Renew and implement the Health in All Policies initiative to place health at the center of sustainable development with a focus on health education and promotion for healthy lifestyles.

**Strategic Priority 4: Disaster preparedness and emergency response strengthened**

4.1 Strengthen the development of IHR core capacities including surveillance systems and response management to prevent and control high-threat infectious hazards.

4.2 Strengthen national preparedness and response with multi-hazard approach to deal with natural hazards, climate change and environmental health threats and others.

4.3 Promote and implement policies, strategies and initiatives to strengthen the resilience of the health sector through disaster risk reduction and health preparedness.
1. Introduction

1.1 Overview of PAHO Policy Framework

The PAHO/WHO Country Cooperation Strategy (CCS) for Suriname provides a clear understanding of the medium-term vision that will guide the implementation of the PAHO/WHO’s technical cooperation at the national level. Through this three-year CCS for Suriname, PAHO/WHO will continue to support national health policies, strategies and plans while working and collaborating with other United Nations (UN) and development partners to advance universal health and sustainable development.

The Pan American Health Organization (PAHO), the Regional Office for the Americas for the World Health Organization (WHO) provides the overall program of work and development framework for the countries, based on the PAHO Strategic Plan 2020-2025. The CCS is aligned with the national health priorities, the national development agenda, the PAHO Strategic Plan 2020-2025, the United Nation’s Multi-Country Sustainable Development Cooperation Framework for the Dutch and English-speaking Caribbean 2022-2026 (UNMSDCF 2022-2026) and the Sustainable Health Agenda for the Americas (SHAA2030).

The PAHO Country Office in Suriname was established in 1969 and has been providing technical cooperation to Suriname in close collaboration with the Ministry of Health (MOH) for approximately 70 years since its first cooperation in 1952 to support the fight against Malaria. Technical Cooperation is derived through a bottom-up approach and is based on the core functions of PAHO as shown in figure 1.

![Figure 1 – PAHO’s Core Functions](https://example.com/corefunctions.png)

*Source: PAHO, 2020, Strategic Plan of the Pan American Health Organization 2020-2025: Equity at the Heart of Health.*

1.2 CCS development process

The development of the CCS was based on a consultative and participatory process with strong commitment and support from the MOH. The CCS is also built on the national health agenda, as laid out in the MOH’s Health Policy Plan 2021-2025 and the Suriname Multi-Year Development Plan 2022-2026,
which focus on guaranteed access to universal and quality healthcare for the entire population through a sustainable system of quality and integrated health services.

The CCS development was conducted according to the WHO and PAHO guidelines. A Working Group (WG), chaired by the PAHO/WHO Representative for Suriname comprised of the key PAHO/WHO Technical Officers, representatives from the Ministry of Health, the Suriname National Planning Office, and the Ministry of Foreign Affairs, and it provided oversight and coordinated the process to develop the CCS.

The CCS development process included:

1. **A health situation analysis.** This analysis was conducted as part of the assessment of institutional capacities of the Essential Public Health Functions\(^2\), reviewing the context and current state of the health system and public health priorities. The situation analysis is based upon the dimensions of the framework for Monitoring Universal Health\(^3\): (1) impacts (health status and well-being); (2) outcomes (universal access to health); (3) outputs (universal health coverage); and (4) strategic actions (policies, plans, programmes).

2. **The review of key documents.** The review included an analysis of the health priorities at the national, regional and global levels in alignment with the SDGs.
   - Regional and global documents and frameworks. The key documents for the regional framework which were included: UNMSDCF 2022-2026, WHO 13th General Programme of Work (GWP 13), Sustainable Health Agenda for the Americas 2018-2030 (SHAA2030) and the PAHO Strategic Plan 2020-2025.

3. **Consultation sessions with key national stakeholders.** PAHO Suriname in collaboration with the MOH facilitated six consultative sessions with the objective to collect input from stakeholders for PAHO/WHO’s collaboration with Suriname in the medium term by identifying the priority areas for the CCS. The findings of these sessions were used to formulate a draft strategic agenda for the CCS. Stakeholders were engaged from all fields in the health care sector, non-health related government ministries and institutions, UN agencies, and key Ministry of Health stakeholders/partners from civil society organizations, vulnerable groups, and patient advocacy organizations.

4. **National multi-sectoral stakeholder consultation.** A multi-sectoral national consultation in which the summarized findings of the previous consultation were presented, and discussions was engaged to prioritize and finalize the CCS Strategic Priorities (SPs) and Focus Areas (FAs). The stakeholders consulted were the same as in the previously held consultation sessions. A list of all stakeholders consulted is included in Annex 1.

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\(^2\) PAHO/WHO Suriname, December 2021, Evaluation of Essential Public Health Functions in Suriname – Situation Analysis of health services in Suriname

\(^3\) PAHO/WHO Suriname, 2021, Monitoring Framework for Universal Health in the America’s
1.3 Country context and timing of CCS

Suriname (figure 2) is the smallest independent country in South America, with a relatively small population of approximately 598,000\(^4\). The country is divided into ten administrative districts. Suriname is situated between French Guiana to the east and Guyana to the west. Suriname has a land area of 63,000 square miles (163,000 sq. km.). The northern, lowland coastal area has been cultivated. Most of the population (66.3\%) reside in the urban area in Paramaribo and Wanica. The southern part consists of tropical rainforest and sparsely inhabited savannah along the border with Brazil, covering about 80\% of Suriname’s land surface. The southern border is shared with Brazil and the northern border is the Atlantic coast.

The previous CCS was signed in 2013 for the period of 2012-2016 and officially extended for one year in 2017. The PAHO/WHO CCS 2012 – 2017 was implemented through Biennial Work Plans (BWP) that covered the period from 2012-2017. The CCS was continued to be used to 2019 pending the development of the National Health Strategic Plan. The CCS evaluation was conducted at the end of 2019 through engagement with a large range of stakeholders. The evaluation report\(^5\) highlighted the importance of having strong technical capacity in all entities, good knowledge and understanding of the planning processes of PAHO/WHO and the Ministry of Health, the alignment of the BWP to the CCS but with the

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\(^4\) General Bureau of Statistics, February 2021

flexibility to address the changing priorities and context of the country. Another important finding was also the need to ensure awareness of the CCS, ongoing communication with all stakeholders and periodic reviews or assessments on the achievements and challenges to be addressed.

In 2020 there was a change of government and the leadership of the MOH was replaced in the midst of the COVID-19 pandemic. Due to the focus on managing the pandemic, the development of a new CCS was postponed. The initiation of the CCS development was based on the new Ministry of Health Policy Plan 2021-2025, which was published in late 2021. The main policy areas are the prevention and reduction in morbidity and mortality and improving availability and accessibility of quality health care for the entire population. In addition, the Government of Suriname published its Multi-Year Development Plan 2022-2026 in late 2021 as well and emphasizes the importance of the Health in all Policies approach.

Suriname is currently in the process of reforming the health sector. This will be done through the Nationaal Herstelplan Zorg – NHZ (National Health Reform Plan). Its aim is to mitigate the acute health crisis, as well as redesigning and/or improving those sections of the health system that will provide sustainable, high-quality healthcare and promote health and well-being for all. In so doing, the NHZ will employ a holistic approach, adhering to the principle of Health in All Policies and achievement of the Sustainable Development Goals. The programs also incorporate the recommendations from previously published expert reports. The National Health Reform Plan is made up of nine programs, spanning various key health priority areas including health promotion and prevention, integrated healthcare and improved hospital care, strengthening of primary healthcare, improved access to medicines and health technology and establishing a Public Health Authority of Suriname among others.

The BWP 2022-2023 was drafted in consultation with national counterparts and approved early 2022 to provide technical cooperation to the Ministry of Health in keeping with the identified priorities. It is expected that the BWP will be further aligned to the new CCS, as necessary.
2. Health and development situation
2.1 Political, macroeconomic and social context

Political
Suriname, a former colony of the Netherlands, became independent in November 1975. The political system is a constitutional democracy using a one-chamber proportional representation system as laid down in the 1987 Constitution. The members of all legislative bodies (National Assembly, District Councils, Local Councils) are elected simultaneously for a five-year term. There are 10 District Councils and 62 Resort Councils at the sub-district level.

In elections held in May 2020, the Progressive Reform Party (VHP) won the Suriname parliamentary elections, ending the ten-year administration of President Dési Bouterse and the National Democratic Party (NDP). President Chandrikapersad Santokhi was elected President by the National Assembly in July 2020. Ronnie Brunswijk, of the General Liberation and Development Party (ABOP), was selected as Vice President.

In the 2020-2025 Coalition Agreement, the government term is divided into three phases: the Crisis or Urgency phase (9 months), the Stabilization or Recovery Phase (24 months), and finally the Growth and Modernization Phase (last period of government). In October 2021, the Multi-Year Development Plan 2022-2026 was published, which outlines the direction, priorities and implementation for the Growth and Modernization Phase, and builds on the Recovery Plan 2020-2022.

Macroeconomic
The economy of Suriname has contracted in the past several years. Since 2015 Suriname has been in an economic crisis due to a serious debt burden. In addition, revenues from export have decreased in recent years due to setbacks in some sectors during the past 5 years among others; the bauxite industry has ceased to exist and there has been a drop in oil and gold prices.

In the period from 2005 to 2014 there was a steady growth of the Gross Domestic Product (GDP) per capita of circa 21% per year. However, since 2015 the GDP per capita has decreased significantly. Per 2020 the total GDP is measured at 3.81 billion US dollars and the GDP per capita is measured at 7068.26 US dollars. The GDP development indicates that since 2015 the GDP growth was negative, followed by a modest recovery. In 2020 there was an exceptional decrease of -13.5% which was exacerbated by the effects of the COVID-19 pandemic. The impact of the COVID-19 pandemic has amplified the existing financial crisis. With the implementation of the Recovery Plan during 2020 to 2022 the Government took measures to counter the financial and economic crisis and to make government finances manageable.

The declining economic situation also reflected in the devaluation of the Surinamese Dollar (SRD). Since 2015, the official exchange rate has been adjusted by the Central Bank of Suriname several times. In 2015

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6 Constitution of the Republic of Suriname, S.B. 1987 no.116), as it reads after the amendment made to it by S.B. 1992 no.38.
7 VHP-ABOP-NPS-PL, 13 July 2020, Coalition Agreement 2020-2025: Working together on a sustainable future for Suriname
8 Recovery Plan 2020-2022, Ministry of Finance & Planning
9 World Bank 2021; https://tradingeconomics.com/suriname/gdp
the official exchange rate was SRD 3.35 to USD 1.00 in 2021 it was adjusted to a flexible rate of around SRD 21. One of the main reasons for devaluation of the SRD since 2015, is the lack of foreign currency. As part of the Recovery Plan, the new government put an end to the parallel market and introduced a new system of flexible exchange rates based on supply and demand in an attempt to stabilize the SRD exchange rate.

In late December 2021, the International Monetary Fund (IMF) approved a $688 million loan programme for Suriname to be disbursed from 2022 to 2024. The IMF financial arrangement supports the Government of Suriname’s economic plan aiming to restore fiscal sustainability through a discretionary fiscal consolidation of 10 percent of GDP during 2021-24, while protecting the vulnerable by expanding social safety net programmes. The IMF-supported programme is also expected to help bring public debt down to sustainable levels, upgrade the monetary and exchange rate policy framework, stabilize the financial system, and strengthen institutional capacity to tackle corruption and money laundering and improve governance.

Given the above-mentioned macroeconomic situation, the fiscal space to increase healthcare spending is limited. A fiscal space study, conducted by PAHO in 2018, confirmed there is a need for increased allocation of resources for the health sector accompanied by a change in the model of care and organization of health services. This study resulted in several recommendations regarding the capacity of the government to create fiscal space. Funding sources with most potential included economic growth, together with the increase in efficiency in health spending. In addition, the investment cases for tobacco control and NCDs including mental health suggest increasing taxes on all tobacco related products and introduce tax for sugar sweetened beverages. The approach towards taxation based on WHO guidelines would position Suriname to better align financing for NCDs/tobacco control with disease burdens, strengthen UHC, and pursue broader investments in health and development.

Social
The conditions in the environment where people are born, grow, live, work and age can affect a wide range of health risks and outcomes. These conditions are called the social determinants of health.

Suriname’s Human Development Index (HDI) value for 2019 is 0.738 — which put the country in the high human development category — positioning it at 97 out of 189 countries and territories. Between 2005 and 2019, Suriname’s HDI value increased from 0.686 to 0.738, an increase of 7.6 percent.  

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12 PAHO, 2019, Fiscal Space Study, Suriname


Poverty continues to be a major challenge for Suriname. The Sustainable Development Goal indicators of 2021 report a decreasing trend of poverty at 22.5% based on $1.90/day and 33.5% based on $3.20/day\(^\text{16}\). Previous estimates of poverty measures, based on the Survey of Living Conditions of the Inter-American Development Bank (IDB) with data from 2016-2017, illustrate a higher overall national poverty rate of 26.2% and an extreme poverty rate of 1.7%\(^\text{17}\).

The UNDP Multidimensional Poverty Index identifies multiple overlapping deprivations suffered by individuals in 3 dimensions: health, education and standard of living. In 2018, 2.9 percent (16,000 people) of the population in Suriname was multidimensionally poor while an additional 4.0 percent are classified as vulnerable to multidimensional poverty (23,000 people). The breadth of deprivation (intensity) in Suriname, which is the average deprivation score experienced by people in multidimensional poverty, is 39.4 percent\(^\text{18, 19}\).

After a peak in 2016 at almost 10%, the unemployment rate has increased from 7% in 2017 to 11% in 2019\(^\text{20}\). The COVID-19 Pandemic has also adversely impacted the labor market in terms of unemployment. During the COVID-19 pandemic the unemployed population has increased by approximately 3% in 2020 based on a working population of 140,000\(^\text{21}\). In addition, there has been an attrition of healthcare workers, mainly specialist doctors and nurses due to outward migration.

2.2 Health status of the population

Demographic trends
The last official Census was conducted in 2012. However, the General Bureau of Statistics (GBS) recently presented demographic data based on data of the Civil Registry Office, a department of the Ministry of Home Affairs. The total population in Suriname according to the mid-year population estimates in 2019 was at 598,000\(^\text{22}\). Compared to July 2018, the annual growth rate is at 1.34%. The distribution of age groups was as follows: 26% for 0-14 years old, 62% for 15-59 years old and 12% for the 60+ population. The demographic transition in Suriname is ongoing, with a population structure which has shifted since 1980\(^\text{23}\). This transition shows a decline in youth population and a rise of the older age population (figure 3).

Most of the population (66.3%) reside in the urban area. The demographic transition remains concentrated in the urban area of Suriname and to a lesser extent the rural area, whereas the interior area still has a pre-industrial age structure.

\(^{17}\) IDB, 2018, Suriname Survey of Living Conditions 2016-2017
\(^{18}\) UNDP, 2020, Human Development Report, Briefing note for countries on the 2020 Human Development Report, Suriname
\(^{19}\) UNDP, 2020, Human Development Report, *The next frontier Human development and the Anthropocene*
\(^{20}\) Recovery Plan 2020-2022, Ministry of Finance & Planning, table 8
\(^{21}\) Recovery Plan 2020-2022, Ministry of Finance & Planning
\(^{22}\) General Bureau of Statistics, February 2021,
\(^{23}\) PAHO, Country Cooperation Strategy Suriname 2012-2016
Life expectancy in Suriname has increased over the past decade. In 2019, total life expectancy was an average of 71.7 years (75.1 years for women and 68.5 years for men), whereas the total life expectancy in 2008 was 69.8 years (71.9 years for women and 67.7 years for men). The total fertility rate in 2019 was 2.2 births per woman. In addition, migration is another important trend in shaping the demographic dynamics and the population structure. Immigration has increased over the past years. In 2019, the migration rate was positive 0.85% (male 0.49%, female 0.36%), illustrating more people came to Suriname to settle, than left the country.

The highest amounts of immigrants were shown to be in the age range between 25 and 39 years old with the number of male immigrants higher than females.

Non-communicable diseases

In line with the global trend as well as the ageing population in Suriname, the burden of non-communicable diseases (NCDs) has been evident. However, there are challenges with the availability of current data on NCDs. The NCD mortality rate of 616.5 per 100,000 population in 2016, which was almost 15% higher than the average among Non-Latin Caribbean countries. NCDs were estimated to account for 76% of all deaths in Suriname in 2016. Cardiovascular diseases (33%), Cancers (16%), Diabetes (6%) and chronic respiratory diseases (2%) are among the leading causes of NCD related mortality. The risk of premature death due to NCDs between 30 and 70 years of age is 22%.

These diseases share four common behavioral risk factors: tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol. These risk factors lead to physiological changes such as raised blood pressure, overweight and obesity, raised blood glucose and high cholesterol, which in turn increase the risk of NCDs. Prevalence of lifestyle and behavioral risk factors in Suriname illustrate that these risk factors are remaining challenges. PAHO reported based on 2016 data that 53% of the male population and 64% of the female population were classified as overweight or obese, among adults aged 18 years and older the prevalence of insufficient physical activity is 44%, among adults aged 15 years and older 25% use tobacco, and an alcohol consumption in adults of 5 Liters per person per year. The prevalence of raised

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24 PAHO, Core indicators 2019, Health trends in the Americas
26 General Bureau of Statistics, February 2021, page 45-50
27 PAHO, Core indicators 2019, Health trends in the Americas
28 WHO, 2018, Noncommunicable Diseases Country Profiles 2018
29 PAHO, Core indicators 2019, Health trends in the Americas
30 WHO, 2018, Noncommunicable Diseases Country Profiles 2018
blood pressure in adults was 22% in 2015 and the prevalence of raised blood glucose in adults was 12% in 2014.

In response to the above-mentioned challenges related to NCDs and its risk factors, the MOH recently approved its 3rd NCD plan covering the period 2021-2028 which includes a framework that will enable a coordinated and integrated approach in the fight against NCDs for the country.

Cancer-related mortality rates have increased considerably in the past decade, and since 2010 cancer has been the second leading cause of death, only preceded by cardiovascular diseases. The most common cancer types in the period 2013-2014 were breast (18% of all cases), prostate (12%), colorectal (11%) and cervical cancer (10%). Although the overall incidence of cancer in Suriname is lower than in more developed countries, the mortality burden is greater. This is mainly due to presentation at more advanced stages, and partially related to access to cancer care. The development of official screening programmes for cancer is still in the planning stages such as cervical cancer screening. The MOH has formulated its response to cancer prevention and control in the Cancer Control Plan 2019-2028 and the recently published National Strategic Plan for the Control and Prevention of Cervical cancer.

Mental health
Mental, neurological and substance use related disorders account for 17% of all disability adjusted life years and 34% of all lost years of disability. The top three disorders that account for more than half of mental, neurological, and substance use-related disorders differ for men and women. For example, men are most affected by suicide, alcohol use disorders and depressive disorders; in women, depressive disorders, headaches, and anxiety disorders are most common.

In addition, suicide is also an important challenge. Suriname had one of the highest rates of suicide in the region of the Americas with an age-adjusted suicide rate of 35.85 per 100,000 population (female: 19.14; male: 53.45) compared to an age-adjusted suicide rate of 9.3 per 100,000 population for the Region of the America’s for the period 2010-2014.

In response to mental health illnesses including prevention and control of suicides the MOH has implemented its National Mental Health Plan Suriname 2015-2020. The formulation of a renewed national plan for mental health covering the period 2022-2030 as well as a national suicide prevention plan are in the final stages of approval.

COVID-19
Since the onset of the COVID-19 pandemic in Suriname, there have been five waves. As of 29 July 2022, Suriname reported a cumulative total of 80,966 confirmed cases with 1380 deaths. It should be noted that since April 2022 there is a revised testing strategy implemented and the reporting of cases on a weekly rather than daily basis. Surveillance continues for the early detection, isolation, and management

31 PAHO & Ministry of Health, National Cancer Control Plan 2019-2028
32 PAHO, 2020, Mental Health Profile Suriname 2020
33 PAHO, 2021, Suicide Mortality in the America’s. Regional report 2010-2014.
34 PAHO, 30 May 2022, COVID-19 Situation Report 116 Suriname
of cases as well as contact tracing although on a limited basis. PAHO continues to provide support with surveillance activities, data gathering, and analysis as required.

The country is making efforts in strengthening immunization for COVID-19, in the interior and in the coastal area of the country. As of 24 June 2022, a total of 554,588 vaccine doses have been administered. 267,820 persons are vaccinated with at least one dose and 237,879 persons fully vaccinated (~43% of the population).

**Communicable diseases**

The HIV prevalence rate in Suriname is 1.1% with an estimated 5200 persons living with the virus of which 50% of these know their status. In the past decade the HIV programme has contributed to the decline in HIV mortality (-22% from 2010 to 2020), a decline in new infections (-44% from 2010 to 2020) and a coverage of 35% of antiretroviral therapy in 2020. While the Government of Suriname provides the majority of funding for HIV care, treatment, and commodities, prevention and support services for key populations have been almost entirely dependent on funding from the Global Fund (GF) and the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR). Since 2019 there has been a decline in donor funding for the HIV programme. In early 2019, GF funding was significantly reduced, and PEPFAR funding ended. The MOH is now in the process of developing and implementing strategies for sustainable funding.

**Vector-borne diseases (VBD)**

Mosquito-borne diseases such as Malaria, Dengue, Zika and Chikungunya have posed a serious threat to Suriname in the past. The Malaria Program is dealing with a population at risk estimated to be around 80,000 people, mostly living in and around the gold mining areas. In the last decade with support from the GF and applying the best practices generated by the AMI-RAVREDA network (USAID-PAHO) Suriname has reached the Roll Back Malaria and the Millennium Development Goals for Malaria. WHO has reported a decline in the total number of Malaria cases in the past decade with an average annual decrease of nearly 10% between 2010 and 2020. The Malaria Program of the MOH reported the total number of Malaria cases decreased from 214 in 2019, of which 100 cases were locally acquired, to 75 in 2021 of which 24 were locally acquired. The decline of Malaria cases is in line with the elimination goal of the Malaria Program. For other VBDs such as Chagas, Leishmaniasis, Onchocerciasis, Filariasis, there is no reliable national data available at this time. However, the country continues efforts at prevention and management of these diseases.

**Antimicrobial resistance (AMR)**

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37 Health Policy Plus Policy Brief, October 2019, 10 Milestones: Advancing CSO Social Contracting for HIV Services in Suriname
38 Malaria Program, 2022. Source: [https://www.malariasuriname.com/achievements/](https://www.malariasuriname.com/achievements/)
39 WHO, 2022, Global Health Observatory data. Source: [https://www.who.int/data/gho](https://www.who.int/data/gho)
40 Malaria Program, June 2022, Suriname National Malaria Report 2022
A national action plan for AMR covering the period 2019-2022 was published with response strategies towards AMR in Suriname\(^\text{41}\). Due to a lack of an AMR surveillance system, data on AMR infections at the national level is not available. Since the implementation of this plan, some progress has been made towards AMR stewardship and infection prevention and control by assessing the required institutional capacities and mechanisms\(^\text{42}\). Due to limited resources, all objectives of the AMR national action plan have not been implemented yet.

**Immunization**

Suriname experienced an estimated decrease of 17\% of DTP3 between 2010 and 2019 and is reported to be among the eight countries in Latin America and Caribbean with a 10-percentage point decrease or greater in DTP3 coverage during that period\(^\text{43}\). The reported coverage rates for immunization for children under 1 year of age were below regional averages of Latin America and the Caribbean in 2020. For IPV1 the average reported coverage rate in Suriname was 72\% compared to a regional average of 86\%, for Polio3 the average reported coverage rate in Suriname was 65\% compared to a regional average of 77\%, for DTP3 the average reported coverage was 65\% compared to a regional average of 82\%, and for MMR1 the average reported coverage was 66\% compared to a regional average of 88\%\(^\text{44}\).

**Environmental health**

**Climate change**

Research and scenario analysis demonstrate that climate hazard risks are projected for the future. Among these are temperature rise, rainfall decrease, increase of weather extremes, including wind and sea level rise\(^\text{45}\). Recently conducted projections in the State of Climate Report confirm changes in climate condition in Suriname in its future projections\(^\text{46}\). Broadly expected climate change impacts are decrease of freshwater availability in aquifers and surface water bodies, saltwater intrusion in rivers and aquifers, increased frequency of flooding and drought, pollution of surface water resources, coastal retreat, damages to coastal infrastructure, development of hypersaline conditions in areas along the coast and decrease in turtle-nesting sites\(^\text{47}\).

Suriname is fully committed to a transparent implementation of the United Nations Framework Convention on Climate Change (UNFCCC), which was ratified on 14 October 1997, and the Paris Agreement, which was ratified on 13 February 2019. Recent developments in this field include the National Adaption Plan (NAP) published in 2020, by the Government of Suriname with support of UNDP.

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42 Radboud University, November 2021, Anti-Microbial Resistance (AMR) and Infection Prevention and Control (IPC) strengthening in Suriname (Interim Report)  
43 WHO & UNICEF, 2020, Immunization coverage: are we losing ground?  
44 PAHO, 2021, Immunization in the Americas: 2020 Summary  
45 Government of Suriname, 2016, Second Communication to the United Nations Framework Convention on Climate Change  
46 IDB, 2021, State of the Climate Report: Suriname  
47 Government of Suriname, 2019, Suriname National Adaptation Plan (NAP) 2019-2029
with the objective to enable Suriname to conduct comprehensive medium and long-term climate adaptation planning.

Environmental public health is within the scope of activities of the BOG of which are air quality, water, sanitation and hygiene, solid waste and climate change are key areas. There is limited data available on developments and trends related to environmental health specifically. PAHO/WHO provides support with respect to climate change and health by strengthening capacities in terms of training and providing technical support in this area. A health adaption plan for climate change is in development with the objective to incorporate this in the NAP.

**Health emergencies and disaster preparedness and response**

Suriname experiences two rain seasons - a major rain season when most of the country receives an estimated 250mm rain per month between May and July, and a minor rain season bringing around 150-200mm per month in November to January. After a previous major flooding in 2006, the March 2022 flooding has affected Indigenous and Maroon settlement areas in the eastern part of Suriname, mainly Brokopondo and surrounding areas and was declared as a natural disaster. The National Coordination Center for Disaster Management (NCCR) in charge of responding to all disasters worked extensively with Government ministries and international partners to strengthen its capacity and financial resources by appointing a National Crisis Team with multisectoral participation. The exact impact on public health of the population in the affected areas due to the flooding is still unknown.

Suriname has yet to develop a comprehensive Health Disaster Risk Management (HDRM) programme to implement and sustain priorities. A review of the country’s HDRM programme in 2020 indicated that there is a need to establish and resource a Health Disaster Management office/unit in the Ministry of Health and to update roles, functions and structure to reflect required mandates including that for preparedness and response to outbreaks, pandemic and Public Health Emergencies of International Concern (PHEIC). Health disaster risk reduction strategies needs to be developed, including the resilience strengthening of the health facilities.

The COVID-19 pandemic, however, provided the opportunity to strengthen emergency response and preparedness capacities in Suriname. The government was forced to act quickly in driving its emergency response, engaging partners, reaching remote communities through primary health care.

**Water, sanitation and hygiene**

Access to safe drinking water, sanitation and hygiene (WASH) is essential for good health, welfare and productivity and is widely recognized as a human right. Overall, 98.2 percent of the population in Suriname has access to improved drinking water sources - 99 percent in the urban region, 98 percent in the rural coastal region and 91 percent in the rural interior region. Especially the rural interior still faces challenges with access to safe drinking water. In Brokopondo and Sipaliwini, the main source of drinking water for 8 percent of the households is surface water (rivers and ponds), which is generally considered an unsafe

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48 Government of Suriname, 2019, Suriname National Adaptation Plan (NAP) 2019-2029
source. The government has been implementing strategies and projects to improve WASH and the implementation of a WASH committee at national level is in process.

2.3 Health systems

Health services

The MOH is in charge of ensuring the public health in the broadest sense and supervising the promotion of the public health in particular, including health education and upbringing and to guarantee the quality, availability and accessibility of healthcare across the country.

Suriname has a fragmented health system that covers the urban, coastal and interior regions of the country. A dedicated primary health service exists both for the population in the interior, Medical Mission (MZ); as well as the urban-coastal area, Regional Health Services (RGD). In the most densely populated areas (Paramaribo, Wanica, Nickerie), primary health care (PHC) is delivered by either the RGD or general practitioners.

The MZ provides PHC based on PHC principles, through a total number of 53 health clinics covering roughly 85% of the geographical area of the country populated by approximately 54,000 people\(^{50}\). The geographic work area is divided into five regions: East-Suriname, Brokopondo, Upper-Suriname, Middle Suriname and Upper Amerindians. Care by MZ is being provided by health assistants which in most cases are persons from the local community, who have been trained by the MZ. MZ offers a broad range of prevention, treatment and care services and also implements programmes targeted at specific groups such as HIV/AIDS, mother and childcare, chronic and elderly care.

The RGD was established by the Government of Suriname as a result of the participation of Suriname in the Alma-Alta declaration in 1978 and was set up to strengthen primary healthcare. In 1981 the RGD became an autonomous entity providing multidisciplinary primary healthcare to residents of Suriname’s coastal areas. The RGD service delivery model is structured in 8 rayons with a total of 45 health clinics spread throughout the districts\(^ {51}\). The RGD has 7 health centers which have expanded opening hours providing primary health care and emergency care for residents with either basic or private health insurance. RGD offers a wide range of care services such as community health, diabetes care, HIV/AIDS education and treatments, mother and childcare (consultation bureau), screening and vaccination for children from birth to 15 years of age, emergency care, laboratory services and pharmacy.

Implementation of projects and public health programmes including health trend monitoring takes place through the Ministry of Health’s BOG. Furthermore, the BOG oversees the national immunization programme of the MOH, conducts disease surveillance activities and owns the Central Laboratory which is the reference laboratory in country for malaria, TB, and HIV/AIDS and does quality control and confirmation of tests done by other labs. The BOG plays a leading role in COVID-19 prevention, surveillance, testing and vaccination since the onset of COVID-19 in March 2020.

\(^{50}\) Medische Zending, 2021, www.medischezending.sr

\(^{51}\) General Bureau of Statistics, 2019, statistical yearbook 2019-2020
Six hospitals serve the population, four located in the capital Paramaribo and two serving the coastal and interior regions (Wanica and Nickerie). In addition, two regional hospitals located in the rural area are planned to be fully operational in the short term (Atjoni in Sipaliwini and Marwina in Marowijne). The Psychiatric Center Suriname (PCS) is a specialized hospital for psychiatric care. There are a total of 1812 inpatient beds and 71 ICU beds. Three hospitals have an emergency department, the Academic Hospital Paramaribo and ’s Lands Hospital in Paramaribo and Mungra Medical Center in Nickerie. MZ and RGD also provide emergency care in the rural areas.

The Youth Dental Foundation (JTV) is a public institution which falls under the Ministry of Health and provides dental prevention, education and treatment services for youth aged 0-18 years and general dental services to the population at large. JTV runs 24 service locations spread throughout 6 districts. In addition, JTV also provides a training programme for youth dental care.

**Health workforce**

The number of critical human resources for health (HRH) provides information on the capacity of human resources in the country. Like other countries in the subregion, Suriname has a shortage of health care professionals to meet its needs, and this challenge has increased over the past few years. In 2020, there were 172 medical specialists and 1569 nurses, a decrease of 19% and 34% respectively since 2017. The density per 100,000 population in 2020 for physicians is 11.3, for nurses 23.3, for dentists 0.7, for midwives 1.6, and for pharmacists 0.7. Based on the WHO minimum staffing recommendations, Suriname has not yet reached this level.

In recent years, the shortage of specialized healthcare personnel has increased significantly which is generally referred to as the “brain drain” in the health sector. The MOH has acknowledged the urgency of the shortage in healthcare workforce and is searching for structural solutions. On the short term the MOH is mainly looking into the possibility of adjusting employment conditions. As a medium- and long-term solution, a trajectory has been mapped out to train general healthcare personnel through practical training in order to sustainably support the specialist healthcare workers in their daily work.

**Health financing**

**Basic Health Insurance**

Suriname has gone through important policy reforms in the last few years to advance in the direction of Universal Health. In 2014 the Basic Health Care Insurance Act was implemented with the aim of providing health insurance coverage for the population and intended to improve access to services across all levels of care. This law ensures that “every resident has access to basic health insurance.” An important

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52 Ministry of Health, 2021
53 PAHO, October 2021, Assessment of Frontline service readiness
56 PAHO, Core indicators 2019, Health trends in the America’s
57 PAHO, 2020, The Essential Public Health Functions in the America’s, A Renewal for the 21st Century, Conceptual Framework and Description. WHO minimum staffing requirements established in 2015: 44.5 physicians, nurses, and midwives per 10,000 population.
58 Wet Basiszorgverzekering (Basic Health Insurance Act), 2014
note is that the Basic Health Insurance law governed by the Ministry of Home Affairs, while governing the health system as a whole is the task of the Ministry of Health.

The basic health care package includes access to primary health care services, secondary care, and a defined package of tertiary services (e.g., oncology, renal dialysis, cardiology, and surgery) and is the same for all of those insured for the basic health care. However, there are payment caps for specialized services such as renal dialysis, MRI, cancer medication, different surgical treatments (such as neurosurgery, cardiac and vascular surgery), medical instruments (knee and hip replacement prothesis, pacemaker), mental health, ambulance transport and paramedical care such as a psychologist. Long term care at home or in a nursing home is included for a maximum period of 3 months. The limitations in coverage lead to limitations in access to treatment and health care services based on the individual needs of the population and cause constraints in the promotion of financial protection in health care.

In 2016, due to financial difficulties experienced by private insurance companies that managed part of the insurance scheme, the management of this entire public scheme was transferred to the State Health Insurance Foundation (SZF), covering over 70% of the population in 2020. SZF was established as a fund in 1980 with the objective to finance healthcare costs of government employees and provide care by establishing contracts with health care providers. With the transition of the basic health insurance to SZF, SZF became the national fund for the Surinamese population for the Basic Health Insurance; however, financing still comes from different sources mainly within the government and from households. The transformation of SZF implied a social insurance model that overlaps with what used to be the Ministry of Social Affairs’ public health insurance.

In the current model the Ministry of Finance contributes 8% of the public employee’s salary towards the basic health insurance, whereas the public employees themselves pay a contribution of 4% of their salary. According to the basic health insurance law, the government subsidizes children under 16 years, those over age 60, and pregnant women. This subsidy comes from the budget of the Ministry of Home Affairs. Persons who are employed privately pay up to 50% of the premium and their employers cover the other half; the government pays the coverage of those unable to pay. The Ministry of Social Affairs covers premium for the population between the age of 17 and 59 years, who cannot afford to pay the premium. An income test is performed to determine eligibility for this government subsidy.

Health expenditures
Suriname is classified by the World Bank as an upper-middle income country. The total health expenditure in 2018 was estimated at SRD 2.04 billion (approximately USD 272 million), 8% of GDP, while the government expenditure on health was 5.4% of GDP in the same year. Based on trend data there has been an increase over the past 10 years of approximately 0.3% per year in health spending. However,

59 SZF, BZV & BAZO package policy conditions, July 2019
60 www.szf.sr
61 Decreet Oprichting Staatsziekenfonds, S.B. 1980 no. 120
62 PAHO, fiscal space study, 2018
64 Ministry of Health, NHA data 2018 (approved but not published). It should be noted that the last official National Health Accounts date was from 2016.
the WHO Global Health Expenditure database for 2019 estimated a total health expenditure of 9.7% of GDP and public health expenditure of 7.01% of GDP.

Data from the WHO Global Health Expenditure database for 2019 indicated that the distribution of health spending was 72% of expenditures made by the government schemes and compulsory social health insurance, 7% of expenditures made by compulsory private insurance schemes, 16.1% out-of-pocket payments (OOP) and 5.4% from voluntary healthcare payment schemes and external sources. It was expected that the OOP would decline with the introduction of the Basic Health Insurance act in 2014. The Global health expenditure data shows a decline of 12.9 percentage points on OOP as percentage of Total (Current) Health Expenditure (from 29% to 16.1%) between 2014 and 2019\(^65\).

Although a significant transition was made with the introduction of the Basic Health Insurance law in 2014, the financial challenges in the Suriname health care system remain. The Healthcare Council\(^66\) and Implementing entity\(^67\) both indicate that the control of implementation / execution of this law is missing\(^68,69\). These challenges have been shown to pose a threat to achieving universal health coverage, as the increase of OOP payments indicates that more people are paying for healthcare services with direct payments at the point of service. One of the top priorities of the Ministry of Health is to implement a structural solution for the health financing system by transformation from open financing to a programmed budget system together with measures aimed at improving the (cost)efficiency.

**Health information system**

Strengthening of health information systems has been on the agenda of the MOH over the past decade. The implementation of a national health information system for Suriname is currently in process. The Information Systems for Health (IS4H) project funded through a loan with the IDB is ongoing with technical support from PAHO. The IS4H Steering Committee was commissioned by the Minister of Health in April 2021. The plan of action and roadmap for IS4H for 2020-2025 has been defined which is aligned with the Regional Plan of Action for Strengthening Information Systems for Health 2019-2023 adopted by PAHO Member States in 2019\(^70\). The main objective of the IS4H project has been defined as: to establish information systems for health that contribute to the reduction of the burden of disease, enable high quality, integrated primary care services and enhance the effectiveness of the health sector to address priority epidemiological challenges. The roadmap consists of three consecutive phases from 2020 to 2025. However, COVID-19 has impacted project delivery and timelines will need to be re-baselined.

\(^{65}\) WHO Global Health Expenditure Database.
\(^{66}\) Tasks of the Health Care Council (Zorgraad) are laid out in the Basic Health Insurance Act 2014
\(^{67}\) Tasks of the Implementing entity (Uitvoeringsorgaan) are laid out in the Basic Health Insurance Act 2014
\(^{68}\) SER, 2019, Pijn in de gezondheidszorg
\(^{69}\) Zorgraad, jaarrapport 2019
\(^{70}\) IDB, PAHO, August 2022, Overview IS4H Plan of Action
2.4 Cross-cutting themes

**Equity, gender, ethnicity, and human rights**

The four cross-cutting themes are central to PAHO’s Strategic Plan and aim to ensure that all health sector policies, programmes, and plans, including intersectoral action, address the persistent inequities in health that affect the enjoyment of the highest attainable standard of health by all people and population groups\(^71\). The MOH endorses these cross-cutting themes in its Policy Plan 2021-2025 and is committed to providing healthcare which is accessible to every citizen regardless of income, race, gender, religion, age or geographic location.

Suriname’s Global Gender Gap Index score in 2020 was reported to be 0.71, ranking it at 77 out of the 153 countries\(^72\). This index measures the gaps between women and men in four key areas: health, education, economy, and politics. The distance to parity (i.e. the percentage of the gender gap that has been closed), scores highest in the area of health and survival (0.97) and educational attainment (0.99) and poorest in Economic participation and opportunity (0.64) and political empowerment (0.23).

The principle of equality between men and women is laid down in article 8 of the Constitution of the Republic of Suriname. In addition, Article 35 of the Constitution also states that men and women are equal before the law. The Government of Suriname is committed to promoting gender equality. Throughout the past decades Suriname has ratified a number of international agreements related to gender equality. Among these are the Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1993, the Beijing Declaration and Platform for Action (BPfA) in 1995 and the Convention Belém do Pará in 2002.

The Gender Policy Document, from the Ministry of Home Affairs, sets a gender policy for a longer term, focusing on a number of priority areas for the period 2021 - 2035\(^73\): labor, income and poverty reduction; education, upbringing and training; health care; power and decision-making; gender-based violence, legislation; environment and climate change. Based on this policy document, there are a number of interventions defined for health related to maternal mortality, sexual and reproductive health rights, traffic safety, health for all, particularly young people and senior citizens and for men and women living with HIV/AIDS, with special attention for communities in the interior.

\(^71\) PAHO, 2020, Strategic Plan of the Pan American Health Organization 2020-2025: Equity at the Heart of Health.
\(^72\) World Economic Forum, 2019, Global Gender Gap Report 2020
\(^73\) Ministry of Home Affairs, Bureau of Gender Affairs, 2019, Gender vision policy document 2021-2035
3. Partnership environment
3.1 Partnership and development cooperation

Aid environment
Historically the Netherlands was the principal development partner for Suriname. At the Independence on November 25th, 1975, the Dutch Government Donated 2.5 billion Dutch Guilders (~ 1.5 billion USD) to ease the political transition. The funds were expected to be finished in 1985, however due to political instability during the 1980s and 1990s, the aid flow was interrupted. After negotiations in 2001, the funds were re-established, and the aid finished in 2010.

Since then, there has been an increased presence of other development partners in Suriname, including bilateral cooperation. The current Government has focused on renewing bilateral relations with the Netherlands, the United States of America, China, and also regionally with Brazil, Guyana and Barbados. These countries continue to offer technical and financial support and donations in different sectors such as infrastructure, agriculture, and also in response to crises such as the COVID-19 pandemic and the recent floodings of the Brokopondo area.

Suriname has taken over as the Chair for the Caribbean Community (CARICOM) for the period of July through December 2022. In July 2022 the Forty-Third Regular Meeting of the Conference of Heads of Government was held in Paramaribo in which two special guests participated. The United Nations Secretary-General, His Excellency Antonio Guterres, and the Secretary-General of the Organization of African, Caribbean and Pacific States, His Excellency Georges Rebelo Pinto Chikot. This platform offers Suriname opportunities for expanding and strengthening its strategic position within the Caribbean Community and to advance its development agenda in partnership with others.

United Nations System in Suriname and the health sector
The United Nations (UN) has supported the people and the Government of the Republic of Suriname through development aid and technical cooperation, ensuring respect for human rights, as outlined in the Universal Declaration of Human Rights for over 60 years.74

Several UN agencies are represented in Suriname; the Food and Agriculture Organization (FAO), The International Labour Organization (ILO), International Organization for Migration (IOM), The Pan American Health Organization, Regional Office for the Americas of the World Health Organization (PAHO/WHO), The United Nations Environment Programme (UNEP), UN Women, UNAIDS, United Nations Development Programme (UNDP), United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Population Fund (UNFPA), and United Nations Children’s Fund (UNICEF). Of these agencies, FAO, PAHO/WHO, UNDP, UNESCO, UNFPA and UNESCO have physical presence in Suriname. PAHO/WHO has the longest presence in Suriname since its first cooperation in 1952 in the fight against Malaria. The PAHO/WHO Country Office was established with appointment of the first Representative in 1969. The other UN agencies have intensified their presence in Suriname over the past

several years. The United Nations system in Suriname is represented by the UN Resident Coordinator for Suriname, Trinidad and Tobago, Aruba, Curaçao and Sint Maarten.

In February 2022, the UNMSDCF was signed by Suriname. The 2022-2026 UNMSDCF is the strategic framework that represents the UN’s collective response to addressing the common development challenges of the English- and Dutch-speaking Caribbean. The framework prioritizes outcomes in the region in four areas: economic resilience and shared prosperity; equality and wellbeing; resilience to climate change shocks and sustainable natural resource management; and peace, safety, justice, and the rule of law. Following the UNMSDCF, the Country Implementation Plan (CIP) 2022-2023 was signed in June 2022 and serves to operationalize the new MSDCF at the local level.

In addition to the technical cooperation of PAHO/WHO in the health sector, other UN agencies also support technical cooperation in health-related areas. The approach of UNICEF Guyana and Suriname (with an office operating under one integrated Country Program in the two countries) to health focuses on child health, immunization, nutrition, social protection, education and emergency response in the light of the COVID-19 pandemic including Water, Sanitation and Hygiene (WASH)\textsuperscript{75}. The UNDP (with a country office in Suriname) focuses on democratic governance, improvement of the position and living conditions of vulnerable groups, poverty reduction, digital innovation and inclusion, and climate and environmental change\textsuperscript{76}. UNFPA (with a country office in Suriname under representation in Jamaica) focuses on gender-based violence, sexual and reproductive health and adolescent/youth health. FAO has conducted projects in the area of food safety, quality and certification systems and food and nutrition security\textsuperscript{77}.

\textbf{Multilateral Agencies and Health}

The Organization of American States (OAS), the Inter-American Institute for Cooperation on Agriculture (IICA) and the Inter-American Development Bank (IDB) are present in Suriname as PAHO partners of the Inter-American system.

The OAS efforts and support are aimed at promoting and strengthening democracy, human rights, multidimensional security and integral development. IICA has significant expertise to provide technical cooperation for sustainable agricultural development, food security, and rural prosperity.

As one of the largest and long-established sources of development funding in Latin America and Caribbean countries, the strategic position of IDB enables their focus on sustainable, climate-friendly development to reduce poverty and inequality. The IDB has been present in Suriname since 1953, as the country was one of the founding members. In late 2021 the IDB launched its new country strategy 2021-2025 for Suriname. The five-year strategy is coordinated with other lending partners and is expected to reach $450 million. Under the strategic area of “Basic Services and Social Protection”, the new strategy focuses on strengthening the health care response to non-communicable diseases by improving the PHC sector, addressing human resource constraint, improving the health system’s organization and management processes; strengthening the infrastructure, institutions and governance frameworks to improve the reliability and supply and quality of public utilities and services, particularly in rural areas and

\textsuperscript{75} UNICEF, February 2022, Country programme document Guyana and Suriname 2022-2026
\textsuperscript{76} UNDP, February 2022, Country programme document for Suriname (2022-2026)
\textsuperscript{77} FAO, 2019, Suriname and FAO - Partnering for sustainable food and agricultural systems
with emphasis on sustainable solutions and energy efficiency improvements; strengthening the social protection system; and reducing violence against women\(^\text{78}\).

The GF to fight AIDS, TB and malaria is an important partner for Suriname. Since 2004, the GF has granted more than US$17 million to support HIV, TB and malaria in Suriname. With the support of the GF Suriname has started the process of developing sustainable strategies to prepare for the transition away from GF assistance. In January 2021 the HIV/TB Sustainability Action Plan was published which includes sustainability strategies for the period 2021-2024 to ensure that the gains achieved with GF support are preserved and progress is sustained following donor exit.

3.2 Review of PAHO/WHO’s cooperation over past CCS cycle

The previous CCS for Suriname initially covered the period 2012 to 2016 and was extended to 2017. There were three strategic priorities in the CCS 2012-2017, A fourth priority (number 4) was added with the extension in 2017.

1. **Reducing the burden of disease**: Reducing the burden of both non-communicable diseases and communicable diseases; strengthening community-based mental health; enhancing family health over the life course; reducing violence and injuries.

2. **Strengthening health systems and services based on primary health care**: Strengthening health planning and health services; optimizing health financing, enhancing human resources for health; increasing the strategic production and use of health information.

3. **Addressing the determinants of health**: Strengthening national response to environmental health threats; strengthening capacity and coordination to address workers’ health; improving the management of emergencies and disasters; advancing on social determinants of health.

4. **Mainstreaming the 2030 Agenda for Sustainable Development within the Ministry of Health’s Policies, Strategies and Plans**

The CCS was however still used for the period 2018-2019 and the final review of the CCS took place in late 2019 and the evaluation report was finalized in March 2020\(^\text{79}\). The methodology for the review of the CCS was based on two components: 1) internal, quantitative: Only PAHO/WHO Country Office and 2) external, qualitative through an evaluation workshop and evaluation survey. The evaluation survey was developed to widen the engagement with stakeholders and engage with other partners within the development sector in Suriname which had not taken part in the CCS evaluation workshop. The survey was administered to representatives from the UN Agencies, development agencies, bilateral partners, patient advocacy organizations and NGOs.

The evaluation results indicate that the health system and policies have made great improvements with technical support from PAHO/WHO Suriname. Some of these include the National Cancer Plan, which is now available, the passing of the Tobacco Law, the National Action Plan for the prevention and control of Non-Communicable Diseases 2015 – 2020, Capacity Building in different technical areas, Health in All policies, mainstreaming the SDGs in the Ministry of Health policies and plans.

\(^{78}\) IDB Group, 2021, IDB Group Country Strategy with Suriname (2021–2025)

One of the main outcomes of the evaluation was that key partners indicated that they were not familiarized with the CCS. This was also due to the timeline for execution of the previous CCS and due to the high turnover of staff within the Ministry of Health and the PAHO/WHO country office. Some focus areas of the CCS were also highlighted as not achieved due to challenges in implementation. Key stakeholders confirmed that these focus areas, which were not achieved and are part of priority 2 and 3, are still identified as health priorities in Suriname and include: enhancing human resources for health, increasing the strategic production and use of health information, strengthening national response to environmental health treats, and strengthening and coordination to address worker’s health.
4. The Strategic Agenda 2023-2025

The Strategic Agenda reflects the strategic priorities (SPs) and focus areas (FAs) for the PAHO/WHO cooperation strategy with Suriname covering the period of 2023 to 2025. The strategy takes into account the health priorities at the global, regional and national levels. It incorporates the national health priorities of the Ministry of Health and builds on the strengths and achievements of the previous CCS. The Strategic Agenda lays out 4 SPs and 14 FAs where PAHO/WHO will focus its technical cooperation in the coming years.

Achieving the Strategic Agenda is a shared responsibility of PAHO/WHO and the Government of Suriname, with the Government having the leadership role. Country ownership has been integral to the development of the strategies, and these were defined through multisectoral national consultations. The Strategic Agenda is aligned to national health policy plans as well as the PAHO Strategic Plan 2020-2025. It is expected that implementation of these strategies will also contribute to achieving the SDGs.

4.1 Strategic priorities and focus areas

**Strategic Priority 1: Stewardship and governance strengthened to advance the essential public health functions**

This strategic priority focusses on strengthening the stewardship role of the MOH enabling them to lead health systems transformation and implement the essential public health functions for universal health. Strengthening crucial components of the health system, within the scope of this strategic priority, will support the MOH to strengthen accountability for the health system and the wellbeing of the population by fulfilling health system functions, assuring equity, and coordinating interaction with government and society.

A well implemented health information system at the national level as well as a strengthened health research function will enable the MOH to develop and implement evidence-based policies. It is an important condition for implementation of a monitoring and evaluation framework which will support the promotion of accountability and transparency in the health sector. Developing a sustainable health workforce is key for the overall sustainability of the health system in Suriname. Finally, strengthening the regulatory framework of the essential public health functions will contribute to the better outcomes of the public health system.

The focus areas for this strategic priority are:

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Strengthen information systems for health to support evidence-informed decision making, accountability, monitoring and evaluation.</td>
</tr>
<tr>
<td>1.2</td>
<td>Strengthen national capacity for health research and knowledge management.</td>
</tr>
<tr>
<td>1.3</td>
<td>Support strategies for sustainable Human Resources for Health.</td>
</tr>
<tr>
<td>1.4</td>
<td>Strengthen policies, strategies and plans to improve the essential public health functions.</td>
</tr>
</tbody>
</table>
Strategic Priority 2: Advanced implementation of universal health coverage and access through the strengthening of health systems

Universal Health Coverage (UHC) means that all people have access to the health services they need, when and where they need them, without financial hardship. Access is an essential condition to achieve UHC meaning that people and communities have access, without any kind of discrimination, to comprehensive, appropriate and timely, quality people-centered health services determined at the national level according to needs while ensuring that the use of such services does not expose users to financial difficulties, especially groups in conditions of vulnerability. This strategic priority focusses on strengthening the current health financing system and addressing financial protection especially for vulnerable groups; implementing integrated service delivery networks in a way that ensure people receive a continuum of health services, at the different levels and sites of care within the health system; and implementing a primary healthcare (PHC) model which supports the provision of care in and through the community.

The focus areas for this strategic priority are:

| 2.1 | Increase access and utilization of quality and people-centered health services for all using an integrated service delivery approach. |
| 2.2 | Strengthen the health financing system through sustainable, equitable and efficient funding and financial protection. |
| 2.3 | Support the renewal and strengthening of Primary Health Care with a focus on a community-based approach. |

Strategic Priority 3: Reduction in morbidity and mortality utilizing an intersectoral and inclusive healthy life course approach and promotion of health

Adopting the life course approach means identifying key opportunities for minimizing risk factors and enhancing protective factors through evidence-based interventions at key life stages, from preconception to early years and adolescence, working age, and into older age. As part of the healthy life course approach, this priority area aims at decreasing morbidity and mortality of communicable and non-communicable diseases including mental health by strengthening health services and addressing risk factors. The One Health approach will support interventions taken at the human-animal-ecosystem interface in to prevent, control and manage (re)emerging diseases and antimicrobial resistance. The scope of this strategic priority includes the continuation of joint efforts by the health and other sectors to address the determinants of health – those conditions in which people are born, grow, live, work, and age. This strategic priority addresses the need for an integrated national health promotion strategy which moves beyond a focus on individual behavior towards a wide range of social and environmental interventions. Finally, addressing determinants of health requires an intersectoral approach in which governments and other stakeholders proactively address the determinants for health inequities. Reviving the Health in All Policies (HiAP) approach will enable the MOH to collaborate with other sectors in addressing intersectoral policy areas like health education, violence and injuries among others.
The focus areas for this strategic priority are:

3.1 Promote health throughout the life course including policies and programmes on newborn, child, adolescent, women’s, men’s and elderly health; maternal, sexual and reproductive health; and workers health.

3.2 Strengthen the prevention and control of NCDs and their risk factors and improve equitable access to quality mental health services including suicide prevention and substance abuse.

3.3 Support a One Health approach to strengthen prevention, surveillance and control of communicable diseases and (re-)emerging diseases including Malaria, HIV, TB, vector borne illnesses and address Antimicrobial Resistance.

3.4 Renew and implement the Health in All Policies initiative to place health at the center of sustainable development with a focus on health education and promotion for healthy lifestyles.

Strategic Priority 4: Disaster preparedness and emergency response strengthened

The COVID-19 pandemic and the 2022 flooding have emphasized that disaster preparedness and emergency response are an essential public health function that needs strengthening and therefore building capacities to prepare and respond to “all hazards” is key. This includes strengthening the regulatory framework as well as institutional capacities to detect, assess, report, and respond to public health events in alignment with the International Health Regulations (IHR). Strengthening national health emergency management capacity including surveillance systems for infectious diseases will be vital to monitor disease trends and to identify outbreaks and new pathogens, particularly those with pandemic potential.

The risk and frequency of shocks appear to be increasing globally whether from global warming, new epidemics, or economic uncertainty and changing geopolitics, creating a new volatile era. Climate change has substantial impacts on human health and is strongly mediated by environmental, social and public health determinants. This strategic priority also focuses on the adaptation to climate change requiring a particular focus on disaster preparedness and risk reduction. In addition, the scope of this priority includes strengthening of the resilience of core capacities and infrastructures of the health sector to enable the MOH to prepare for, steer and manage the health system during emergencies.

The focus areas for this strategic priority are:

4.1 Strengthen the development of IHR core capacities including surveillance systems and response management to prevent and control high-threat infectious hazards.

4.2 Strengthen national preparedness and response with multi-hazard approach to deal with natural hazards, climate change and environmental health threats and others.

4.3 Promote and implement policies, strategies and initiatives to strengthen the resilience of the health sector through disaster risk reduction and health preparedness.
### CCS Suriname Strategic Agenda 2023-2026 - Strategic Priorities and Focus Areas

<table>
<thead>
<tr>
<th>Strategic Priority</th>
<th>Focus Area</th>
</tr>
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</table>
| **Strategic Priority 1:**  
Stewardship and governance strengthened to advance the essential public health functions | 1.1 Strengthen information systems for health to support evidence-informed decision making, accountability, monitoring and evaluation.  
1.2 Strengthen national capacity for health research and knowledge management.  
1.3 Support strategies for sustainable Human Resources for Health.  
1.4 Strengthen policies, strategies and plans to improve the essential public health functions. |
| **Strategic Priority 2:**  
Advanced implementation of universal health coverage and access through the strengthening of health systems | 2.1 Increase access and utilization of quality and people-centered health services for all using an integrated service delivery approach.  
2.2 Strengthen the health financing system through sustainable, equitable and efficient funding and financial protection.  
2.3 Support the renewal and strengthening of Primary Health Care with a focus on a community-based approach. |
| **Strategic Priority 3:**  
Reduction in morbidity and mortality utilizing an intersectoral and inclusive healthy life course approach and promotion of health | 3.1 Promote health throughout the life course including policies and programmes on newborn, child, adolescent, women’s, men’s and elderly health; maternal, sexual and reproductive health; and workers health.  
3.2 Strengthen the prevention and control of NCDs and their risk factors and improve equitable access to quality mental health services including suicide prevention and substance abuse.  
3.3 Support a One Health approach to strengthen prevention, surveillance and control of communicable diseases and (re-)emerging diseases including Malaria, HIV, TB, vector borne illnesses and address Antimicrobial Resistance.  
3.4 Renew and implement the Health in All Policies initiative to place health at the center of sustainable development with a focus on health education and promotion for healthy lifestyles. |
| **Strategic Priority 4:**  
Disaster preparedness and emergency response strengthened | 4.1 Strengthen the development of IHR core capacities, including surveillance systems and response management to prevent and control high-threat infectious hazards.  
4.2 Strengthen national preparedness and response with multi-hazard approach to deal with natural hazards, climate change and environmental health threats and others.  
4.3 Promote and implement policies, strategies and initiatives to strengthen the resilience of the health sector through disaster risk reduction and health preparedness. |

*Table 1 – CCS Suriname: Strategic Agenda 2023-2025*
### 4.2 Aligning the strategic agenda to national, regional and global policies and frameworks

#### Strategic priority 1: Stewardship and governance strengthened to advance the essential public health functions

<table>
<thead>
<tr>
<th>CCS focus area</th>
<th>1.1 Strengthen information systems for health to support evidence-informed decision making, accountability, monitoring and evaluation.</th>
</tr>
</thead>
</table>
| MOH Policy Plan 2022-2025 | Policy area 2: Availability and accessibility of quality health care for the entire population  
Key objective: Design and implement a national Information System for Health |
| PAHO Strategic Plan 2020-2025 | Outcome 9: Strengthened stewardship and governance  
Outcome 20: Integrated information systems for health  
Outcome 21: Data, information, knowledge, and evidence |
| SDG targets | SDG 17 - Strengthen the means of implementation and revitalize the global partnership for sustainable development  
Target 17.18: By 2020, enhance capacity-building support to developing countries, including for least developed countries and small island developing States, to increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts |
| UNMSDCF 2022-2026 | Priority area 2: Equality, Well-Being and Leaving No One Behind  
Outcome 3: National governments and regional institutions use relevant data and information to design and adopt laws and policies to eliminate discrimination, address structural inequalities and ensure the advancement of those at risk of being left furthest behind |

<table>
<thead>
<tr>
<th>CCS focus area</th>
<th>1.2 Strengthen national capacity for health research and knowledge management.</th>
</tr>
</thead>
</table>
| MOH Policy Plan 2022-2025 | Policy area 2: Availability and accessibility of quality health care for the entire population  
Key objective: Strengthen the institutional capacity for health research and the use of research in policy development |
| PAHO Strategic Plan 2020-2025 | Outcome 22: Research, ethics, and innovation for health |
| SDG targets | SDG 9 - Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation  
Target 9.5: Enhance scientific research, upgrade the technological capabilities of industrial sectors in all countries, in particular developing countries, including, by 2030, encouraging innovation and substantially increasing the number of research and development workers per 1 million people and public and private research and development spending |
| UNMSDCF 2022-2026 | Priority area 2: Equality, Well-Being and Leaving No One Behind  
Outcome 3: National governments and regional institutions use relevant data and information to design and adopt laws and policies to eliminate discrimination, address structural inequalities and ensure the advancement of those at risk of being left furthest behind |
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<tr>
<th>CCS focus area</th>
<th>1.3 Support strategies for sustainable Human Resources for Health.</th>
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</table>
| MOH Policy Plan 2022-2025 | Policy area 2: Availability and accessibility of quality health care for the entire population  
Key objective: Develop HRH strategy and strengthening institutional HRH capacity |
| PAHO Strategic Plan 2020-2025 | Outcome 7: Health workforce |
| SDG targets | SDG 3 - Ensure healthy lives and promote well-being for all at all ages  
Target 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all |
| UNMSDCF 2022-2026 | Priority area 2: Equality, Well-Being and Leaving No One Behind  
Outcome 4: People in the Caribbean equitably access and utilize universal, quality and shock-responsive social protection, education, health, and care services |

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<thead>
<tr>
<th>CCS focus area</th>
<th>1.4 Strengthen policies, strategies and plans to improve the essential public health functions.</th>
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</table>
| MOH Policy Plan 2022-2025 | Policy area 2: Availability and accessibility of quality health care for the entire population  
Key objectives:  
- Strengthen leadership and good governance in health care  
- Establish a modern legislative framework for healthcare  
- Strengthen the quality management framework for health services |
| PAHO Strategic Plan 2020-2025 | Outcome 9: Strengthened stewardship and governance |
| SDG targets | SDG 3 - Ensure healthy lives and promote well-being for all at all ages  
Target 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all |
| UNMSDCF 2022-2026 | Priority area 2: Equality, Well-Being and Leaving No One Behind  
Outcome 4: People in the Caribbean equitably access and utilize universal, quality and shock-responsive social protection, education, health, and care services |
### Strategic priority 2: Advanced implementation of universal health coverage and access through the strengthening of health systems

<table>
<thead>
<tr>
<th>CCS focus area</th>
<th>2.1 Increase access and utilization of quality and people-centered health services for all using an integrated service delivery approach.</th>
</tr>
</thead>
</table>
| MOH Policy Plan 2022-2025 | Policy area 2: Availability and accessibility of quality health care for the entire population  
Key objectives:  
- Availability and accessibility of quality health care at all levels for the entire population  
- Improve access and availability of essential medicines and consumables and implement new PHC models of care based on health technology  
- Restructuring of the organization of the health care system for more efficient, cost-effective and patient-friendly services |
| PAHO Strategic Plan 2020-2025 | Outcome 1: Access to comprehensive and quality health services  
Outcome 2: Health throughout the life course  
Outcome 3: Quality care for older people  
Outcome 5: Access to services for NCDs and mental health conditions  
Outcome 8: Access to health technologies |
| SDG targets | SDG 3 - Ensure healthy lives and promote well-being for all at all ages  
Target 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. |
| UNMSDCF 2022-2026 | Priority area 2: Equality, Well-Being and Leaving No One Behind  
Outcome 4: People in the Caribbean equitably access and utilize universal, quality and shock-responsive social protection, education, health, and care services |

<table>
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<tr>
<th>CCS focus area</th>
<th>2.2 Strengthen the health financing system through sustainable, equitable and efficient funding and financial protection</th>
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</table>
| MOH Policy Plan 2022-2025 | Policy area 2: Availability and accessibility of quality health care for the entire population  
Key objective: Restructuring of the organization of the health care system for more efficient, cost-effective and patient-friendly services |
| PAHO Strategic Plan 2020-2025 | Outcome 10: Increased public financing for health  
Outcome 11: Strengthened financial protection |
| SDG targets | SDG 3 - Ensure healthy lives and promote well-being for all at all ages  
Target 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. |
| UNMSDCF 2022-2026 | Priority area 2: Equality, Well-Being and Leaving No One Behind  
Outcome 4: People in the Caribbean equitably access and utilize universal, quality and shock-responsive social protection, education, health, and care services |
| CCS focus area | 2.3 Support the renewal and strengthening of Primary Health Care with a focus on a community-based approach. |
| MOH Policy Plan 2022-2025 | Policy area 2: Availability and accessibility of quality health care for the entire population Key objective: Improve access and availability of essential medicines and consumables and implement new PHC models of care based on health technology |
| PAHO Strategic Plan 2020-2025 | Outcome 1: Access to comprehensive and quality health services Outcome 2: Health throughout the life course Outcome 3: Quality care for older people Outcome 6: Response capacity for violence and injuries Outcome 15: Intersectoral response to violence and injuries Outcome 16: Intersectoral action on mental health Outcome 18: Social and environmental determinants Outcome 19: Health promotion and intersectoral action |
| SDG targets | SDG 3 - Ensure healthy lives and promote well-being for all at all ages Target 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. |
| UNMSDCF 2022-2026 | Priority area 2: Equality, Well-Being and Leaving No One Behind Outcome 4: People in the Caribbean equitably access and utilize universal, quality and shock-responsive social protection, education, health, and care services |

**Strategic priority 3: Reduction in morbidity and mortality utilizing an intersectoral and inclusive healthy life course approach and promotion of health**

| CCS focus area | 3.1 Promote health throughout the life course including policies and programmes on newborn, child, adolescent, women’s, men’s and elderly health; maternal, sexual and reproductive health. |
| MOH Policy Plan 2022-2025 | Policy area 2: Availability and accessibility of quality health care for the entire population Key objectives:  - Availability and accessibility of quality health care at all levels for the entire population  - Reduction in maternal and child mortality |
| PAHO Strategic Plan 2020-2025 | Outcome 2: Health throughout the life course Outcome 3: Quality care for older people Outcome 18: Social and environmental determinants Outcome 19: Health promotion and intersectoral action |
| SDG targets | SDG 3 - Ensure healthy lives and promote well-being for all at all ages Target 3.1: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births Target 3.2: By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births Target 3.7: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes |
| UNMSDCF 2022-2026 | Priority area 2: Equality, Well-Being and Leaving No One Behind Outcome 4: People in the Caribbean equitably access and utilize universal, quality and shock-responsive social protection, education, health, and care services |
### MOH Policy Plan 2022-2025

**Policy area 1: Prevention and reduction of morbidity and mortality**

**Key objective:** Reduction in morbidity and mortality of NCDs and mental health by improving access to and availability of health services and by addressing the risk factors

**PAHO Strategic Plan 2020-2025**

- **Outcome 5:** Access to services for NCDs and mental health conditions
- **Outcome 13:** Risk factors for NCDs
- **Outcome 14:** Malnutrition
- **Outcome 16:** Intersectoral action on mental health

**SDG targets**

- **SDG 3:** Ensure healthy lives and promote well-being for all at all ages
  - **Target 3.4:** By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being
  - **Target 3.5:** Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
  - **Target 3.a:** Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate

**UNMSDCF 2022-2026**

- **Priority area 2:** Equality, Well-Being and Leaving No One Behind
- **Outcome 4:** People in the Caribbean equitably access and utilize universal, quality and shock-responsive social protection, education, health, and care services

### MOH Policy Plan 2022-2025

**Policy area 1: Prevention and reduction of morbidity and mortality**

**Key objective:** Strengthening the response capacity and control of communicable diseases

**PAHO Strategic Plan 2020-2025**

- **Outcome 4:** Response capacity for communicable diseases
- **Outcome 12:** Risk factors for communicable diseases
- **Outcome 17:** Elimination of communicable diseases
- **Outcome 18:** Social and environmental determinants
- **Outcome 19:** Health promotion and intersectoral action

**SDG targets**

- **SDG 3:** Ensure healthy lives and promote well-being for all at all ages
  - **Target 3.3:** By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases

**UNMSDCF 2022-2026**

- **Priority area 2:** Equality, Well-Being and Leaving No One Behind
- **Outcome 4:** People in the Caribbean equitably access and utilize universal, quality and shock-responsive social protection, education, health, and care services

### CCS focus area

#### 3.2 Strengthen the prevention and control of NCDs and their risk factors and improve equitable access to quality mental health services including suicide prevention and substance abuse.

**MOH Policy Plan 2022-2025**

**Key objective:** Strengthen the prevention and control of NCDs and their risk factors and improve equitable access to quality mental health services including suicide prevention and substance abuse.

**PAHO Strategic Plan 2020-2025**

- **Outcome 5:** Access to services for NCDs and mental health conditions
- **Outcome 13:** Risk factors for NCDs
- **Outcome 14:** Malnutrition
- **Outcome 16:** Intersectoral action on mental health

**SDG targets**

- **SDG 3:** Ensure healthy lives and promote well-being for all at all ages
  - **Target 3.4:** By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being
  - **Target 3.5:** Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
  - **Target 3.a:** Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate

**UNMSDCF 2022-2026**

- **Priority area 2:** Equality, Well-Being and Leaving No One Behind
- **Outcome 4:** People in the Caribbean equitably access and utilize universal, quality and shock-responsive social protection, education, health, and care services

### CCS focus area

#### 3.3 Support a One Health approach to strengthen prevention, surveillance and control of communicable diseases and (re-)emerging diseases including Malaria, HIV, TB, vector borne illnesses and address Antimicrobial Resistance.

**MOH Policy Plan 2022-2025**

**Key objective:** Support a One Health approach to strengthen prevention, surveillance and control of communicable diseases and (re-)emerging diseases including Malaria, HIV, TB, vector borne illnesses and address Antimicrobial Resistance.

**PAHO Strategic Plan 2020-2025**

- **Outcome 4:** Response capacity for communicable diseases
- **Outcome 12:** Risk factors for communicable diseases
- **Outcome 17:** Elimination of communicable diseases
- **Outcome 18:** Social and environmental determinants
- **Outcome 19:** Health promotion and intersectoral action

**SDG targets**

- **SDG 3:** Ensure healthy lives and promote well-being for all at all ages
  - **Target 3.3:** By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases

**UNMSDCF 2022-2026**

- **Priority area 2:** Equality, Well-Being and Leaving No One Behind
- **Outcome 4:** People in the Caribbean equitably access and utilize universal, quality and shock-responsive social protection, education, health, and care services

### CCS focus area

#### 3.4 Renew and implement the Health in All Policies initiative to place health at the center of sustainable development with a focus on health education and promotion for healthy lifestyles.

**MOH Policy Plan 2022-2025**

**Key objective:** Implement HiAP initiative including health promotion and intersectoral action

**PAHO Strategic Plan 2020-2025**

- **Outcome 6:** Response capacity for violence and injuries
- **Outcome 13:** Risk factors for NCDs
- **Outcome 15:** Intersectoral response to violence and injuries
- **Outcome 18:** Social and environmental determinants
- **Outcome 19:** Health promotion and intersectoral action

**SDG targets**

- **SDG 3:** Ensure healthy lives and promote well-being for all at all ages
  - **Target 3.3:** By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases

**UNMSDCF 2022-2026**

- **Priority area 2:** Equality, Well-Being and Leaving No One Behind
- **Outcome 4:** People in the Caribbean equitably access and utilize universal, quality and shock-responsive social protection, education, health, and care services
| SDG targets | SDG 3 - Ensure healthy lives and promote well-being for all at all ages  
Target 3.6: By 2020, halve the number of global deaths and injuries from road traffic accidents  
Target 3.9: By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination  
SDG 4 - Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all  
Target 4.7: By 2030, ensure that all learners acquire the knowledge and skills needed to promote sustainable development, including, among others, through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence, global citizenship and appreciation of cultural diversity and of culture’s contribution to sustainable development  
SDG 5 - Achieve gender equality and empower all women and girls  
Target 5.2: Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation  
Target 5.6: Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences  
SDG 6 - Ensure availability and sustainable management of water and sanitation for all  
Target 6.1: By 2030, achieve universal and equitable access to safe and affordable drinking water for all  
Target 6.2: By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations  
Target 6.3: By 2030, improve water quality by reducing pollution, eliminating dumping and minimizing release of hazardous chemicals and materials, halving the proportion of untreated wastewater and substantially increasing recycling and safe reuse globally  
SDG 9 - Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation  
Target 9.1: Develop quality, reliable, sustainable and resilient infrastructure, including regional and transborder infrastructure, to support economic development and human well-being, with a focus on affordable and equitable access for all  
SDG 11 - Make cities and human settlements inclusive, safe, resilient and sustainable  
Target 11.2: By 2030, provide access to safe, affordable, accessible and sustainable transport systems for all, improving road safety, notably by expanding public transport, with special attention to the needs of those in vulnerable situations, women, children, persons with disabilities and older persons  
SDG 16 - Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels  
Target 16.1: Significantly reduce all forms of violence and related death rates everywhere  
Target 16.2: End abuse, exploitation, trafficking and all forms of violence against and torture of children |  

UNMSDCF  
2022-2026 | Priority area 2: Equality, Well-Being and Leaving No One Behind |
### Strategic priority 4: Disaster preparedness and emergency response strengthened

<table>
<thead>
<tr>
<th>CCS focus area</th>
<th>MOH Policy Plan 2022-2025</th>
<th>PAHO Strategic Plan 2020-2025</th>
<th>SDG targets (continued)</th>
<th>UNMSDCF 2022-2026</th>
</tr>
</thead>
</table>
| 4.1 Strengthen the development of IHR core capacities including surveillance systems and response capacities to prevent and control high-threat infectious hazards. | Policy area 1: Prevention and reduction of morbidity and mortality  
Key objectives:  
▪ Strengthen surveillance and disease outbreak management of infectious diseases  
▪ Strengthen the prevention and control of COVID-19 | Outcome 4: Response capacity for communicable diseases  
Outcome 23: Health emergencies preparedness and risk reduction  
Outcome 24: Epidemic and pandemic prevention and control  
Outcome 25: Health emergencies detection and response | SDG 3 - Ensure healthy lives and promote well-being for all at all ages  
Target 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases  
Target 3.9: By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination  
Target 3.d: Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks  
SDG 6 - Ensure availability and sustainable management of water and sanitation for all  
Target 6.2: By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations  
SDG 9 - Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation  
Target 9.1: Develop quality, reliable, sustainable and resilient infrastructure, including regional and transborder infrastructure, to support economic development and human well-being, with a focus on affordable and equitable access for all  
SDG 13 - Take urgent action to combat climate change and its impacts  
Target 13.1: Strengthen resilience and adaptive capacity to climate-related hazards and natural disasters in all countries  
Priority area 2: Equality, Well-Being and Leaving No One Behind  
Outcome 4: People in the Caribbean equitably access and utilize universal, quality and shock-responsive social protection, education, health, and care services | 4.2 Strengthen national preparedness and response with multi-hazard approach to deal with natural hazards, climate change and environmental health threats and others.  
Policy area 1: Prevention and reduction of morbidity and mortality  
Key objective: Implement HiAP initiative including health promotion and intersectoral action  
Outcome 4: Response capacity for communicable diseases  
Outcome 12: Risk factors for communicable diseases  
Outcome 17: Elimination of communicable diseases  
Outcome 18: Social and environmental determinants  
Outcome 23: Health emergencies preparedness and risk reduction |
| SDG targets | SDG 3 - Ensure healthy lives and promote well-being for all at all ages  
Target 3.9: By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination  
SDG 6 - Ensure availability and sustainable management of water and sanitation for all  
Target 6.1: By 2030, achieve universal and equitable access to safe and affordable drinking water for all  
Target 6.2: By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations  
SDG 11 - Make cities and human settlements inclusive, safe, resilient and sustainable  
Target 11.5: By 2030, significantly reduce the number of deaths and the number of people affected and substantially decrease the direct economic losses relative to global gross domestic product caused by disasters, including water-related disasters, with a focus on protecting the poor and people in vulnerable situations  
SDG 13 - Take urgent action to combat climate change and its impacts  
Target 13.1: Strengthen resilience and adaptive capacity to climate-related hazards and natural disasters in all countries  
Target 13.2: Integrate climate change measures into national policies, strategies and planning  
Target 13.3: Improve education, awareness-raising and human and institutional capacity on climate change mitigation, adaptation, impact reduction and early warning |  
| UNMSDCF 2022-2026 | Priority area 2: Equality, Well-Being and Leaving No One Behind  
Outcome 4: People in the Caribbean equitably access and utilize universal, quality and shock-responsive social protection, education, health, and care services |  
| CCS focus area | 4.3 Promote and implement policies, strategies and initiatives to strengthen the resilience of the health sector through disaster risk reduction and health preparedness. |  
| MOH Policy Plan 2022-2025 | Policy area 2: Availability and accessibility of quality health care for the entire population  
Key objective: Restructuring of the organization of the health care system for more efficient, cost-effective and patient-friendly services |  
| PAHO Strategic Plan 2020-2025 | Outcome 23: Health emergencies preparedness and risk reduction |  
| SDG targets | SDG 3 - Ensure healthy lives and promote well-being for all at all ages  
Target 3.d: Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks  
SDG 11 - Make cities and human settlements inclusive, safe, resilient and sustainable  
Target 11.5: By 2030, significantly reduce the number of deaths and the number of people affected and substantially decrease the direct economic losses relative to global gross domestic product caused by disasters, including water-related disasters, with a focus on protecting the poor and people in vulnerable situations  
SDG 13 - Take urgent action to combat climate change and its impacts  
Target 13.1: Strengthen resilience and adaptive capacity to climate-related hazards and natural disasters in all countries |  
| UNMSDCF 2022-2026 | Priority area 2: Equality, Well-Being and Leaving No One Behind |
5. Implementation of the CCS

5.1 Implementation and implications

Implementation coordination

The PAHO/WHO Country Office in Suriname will coordinate the implementation of the Strategic Agenda. The responsibility of the implementation, however, lies with the entire PAHO organization. Technical cooperation will be coordinated by the Country Office but can also be provided through the sub-regional office in the Caribbean, at the regional level through the technical departments at the headquarters in Washington D.C. (USA), and from the global level WHO in Geneva as needed. To avoid duplication and increase efficiency in the implementation, efforts will be made to use existing agreements, protocols, guidelines and other frameworks of health and build upon previous initiatives where possible.

The CCS is implemented through the BWP. As part of the implementation, a separate exercise will be conducted to see whether the current BWP 2022-2023 needs to be modified to reflect the SPs and FAs of the CCS Strategic Agenda accordingly. The subsequent BWP 2024-2025 will be developed in alignment with the CCS Strategic Agenda.

Resource mobilization

The Country Office is headed by the PAHO/WHO representative who is supported by technical advisors in the areas of Health Systems and Services, NCDs and Mental Health (currently vacant), a technical officer for Family, Health promotion and Life Course (currently vacant), a short term international professional specialist for Malaria and Vector Borne Diseases, and national consultants for NCDs and mental health and Public Health Emergencies. Furthermore, there are 2 PAHO administrative positions (Administrator and Executive Assistant) and 3 MOH administrative assistant staff seconded to the PAHO/WHO Country Office.

The implications for the PAHO Organization were reviewed to ensure the successful implementation of the CCS strategic agenda 2023-2025. Based on the implications analysis the following competences and skills mix were identified as conditions to successfully implement the SPs and FAs:
**Strategic Priority 1:** Stewardship and governance strengthened to advance the essential public health functions

- Information systems for health (IS4H) including M&E frameworks and data governance and management.
- Human resources for health
- Health research and knowledge management
- Regulatory frameworks and policy development, especially in the area of Essential Public Health Functions

**Strategic Priority 2:** Advanced implementation of universal health coverage through the strengthening of health systems

- Health systems including health financing, medicines and health technology
- Health services including Universal Health Care, primary health care, family and community health, integrated health service delivery networks and quality of care

**Strategic Priority 3:** Reduction in morbidity and mortality utilizing an intersectoral and inclusive healthy life course approach and promotion of health

- Noncommunicable diseases and risk factor prevention and control including mental health, suicide prevention and substance use disorders, injuries and violence prevention and response.
- Communicable diseases and risk factor prevention and control, including HIV, STIs, TB and vaccine-preventable diseases.
- Emerging and re-emerging diseases and the human-animal interface of One Health, vector prevention and control, and antimicrobial resistance.
- Health throughout the life course, including interventions targeting specific population groups, multi-sectoral approaches, health promotion and social determinants of health.
- Health in all policies (HiAP), and cross-cutting themes of gender, equity, human rights and ethnicity.

**Strategic Priority 4:** Disaster preparedness and emergency response strengthened

- Public health emergencies, disaster preparedness and risk management including an “all-hazards” response, IHR and disease surveillance systems
- Environmental health and sustainability and climate change

A detailed analysis of technical cooperation required will be elaborated based on the BWPs and will indicate where the Country Office will need to contract specific experts/consultancies and where to mobilize expertise within the PAHO organization. Resource mobilization efforts to secure grant or project funding will also be done where needed and feasible.

**Communication and partnerships**

An important factor to address, based on the lessons learned from the evaluation of the previous CCS, is the awareness and communication of the CCS. Aiming at increased visibility and strategic positioning, the PAHO/WHO Suriname Country Office will more proactively communicate PAHO/WHO’s role as technical cooperation partner in the Suriname health sector and will improve its external communication regarding PAHO/WHO’s work and the impact both locally and regionally. As part of the launch of the CCS for Suriname 2023-2025, a digital leaflet will be produced highlighting the Strategic Agenda. This leaflet will be distributed to all stakeholders involved in the implementation of the CCS. As mandated by PAHO/WHO’s Member States, engagements with non-State actor stakeholders are subject to due
diligence and risk assessment review under the Framework of Engagement with Non-State Actors (FENSA).

**Financial and other implications**

PAHO obtains its funding from several different sources including Contributions from Member States (Assessed Contributions); Voluntary Contributions from donor countries, as well as other donor agencies and non-state actors; and Investment Interests from administration of the Revolving Fund and Strategic Fund. The PAHO Strategic Plan guides the programme and budget developed to determine resources needed. The BWP will indicate the required financial resources at the country level for the implementation of the SPs and FAs.

Other implications of political and administrative character were also assessed during the development of the CCS. The CCS is flexible enough to absorb any changes in the political and socio-economic environment given that the strategic priorities in health are expected to remain over the period even though focus areas may shift. Careful consideration has been given to the capacity and fiscal space of the Ministry of Health to implement the SPs and FAs, as this was a lesson learned from the previous CCS implementation.

**5.2 Risk management**

The implementation of this CCS will occur in an uncertain environment which can both pose threats to success as well as offer opportunities for increasing success. This uncertainty (whether positive or negative) of outcome, is defined as a risk. The PAHO Country Office Suriname will use the PAHO Enterprise Risk Management (ERM) programme to monitor the risks of achieving the desired results of the CCS 2023-2025. This programme uses a strategic process to proactively and continuously identify and manage real and potential threats and opportunities. The core of risk management is to assess the level of probability and impact of those potential events that may affect PAHO’s political, managerial, administrative and technical cooperation objectives since it is fully incorporated in the strategic planning and budgeting process. Through this programme the risks are identified, categorized, described, and the impact and probability of the risk occurring estimated with mitigation plans developed as needed.
6. Monitoring and evaluation

6.1 Monitoring
The monitoring and evaluation methodology for the CCS will be in keeping with the PAHO/WHO results-based management approach used for monitoring and evaluating programs. It will assess PAHO/WHO’s performance in Suriname and will be led by the PAHO/WHO Country Office with support of the sub-regional office and PAHO headquarters. A participatory approach is applied which involves key stakeholders such as decision-makers within the Ministry of Health, implementers of the CCS and partners.

Monitoring will be ongoing and focus on:

- Ensuring that the CCS SPs and FAs are reflected in the BWP
- How SPs and FAs are implemented
- The required core staff of the PAHO/WHO Country Office with the appropriate competences for delivering the results of the FAs

The strategic agenda of the CCS will be monitored in tandem with the BWP 6-monthly performance assessment as well as the PAHO Strategic Plan Monitoring System (SPMS) which is jointly monitored by the PAHO Secretariat and the Member States. The SPMS allows for the joint assessment of outcome and output indicators by the MOH in coordination with PAHO/WHO. Each Focus Area of the Strategic Agenda of the CCS is linked to related outcomes in the PAHO Strategic Plan (refer to section 4.2). These indicators reflect the commitment of the Organization to the attainment of the targets in the SHAA2030, the health-related SDGs, the GPW13 Impact Framework, and other regional and global mandates.

6.2 Mid-term and final evaluation
The evaluation of the CCS consists of a systematic review of the processes and results of the PAHO/WHO technical cooperation in Suriname. This review is carried out in the middle and at the end of the period covered by the CCS.

The purpose of the mid-term evaluation is to determine the progress made in the areas of action of the CCS and to identify the obstacles and possible risks for its implementation. The results of the mid-term evaluation will guide decisions on adjustments to the CCS as required. The final evaluation is more exhaustive, focusing on the identification of factors that facilitated or impeded the implementation of the CCS, identifying the contribution of the CCS to the country’s health development and identifying measures that may be applied in the subsequent CCS cycle.

Both the midterm evaluation and the final evaluation are done in a participatory manner, involving as much as possible all the staff of the Country Office, national counterparts and relevant partners for PAHO/WHO technical cooperation. The mid-term and final evaluation both focus on the evaluation of relevance, effectiveness, efficiency and results.
Annex 1: Stakeholder overview

Senior policy officers and/or executive level representatives of the following organizations have participated in the stakeholders’ consultations for the development of the CCS Suriname 2023-2025.

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<td>1</td>
<td>Academic Hospital</td>
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<td>Bureau of Public Health (Bureau Openbare Gezondheidszorg)</td>
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<td>3</td>
<td>Central Training Institute for Nurses and Related Professions (COVAB)</td>
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<td>Executive Office of National Anti-Drug Council</td>
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<td>General Bureau of Statistics</td>
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<td>HIV program</td>
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<td>Inter-American Development Bank</td>
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<td>Inter-American Institute for Cooperation on Agriculture</td>
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<td>Kidney Foundation (NSS)</td>
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<td>Malaria Program</td>
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<td>Medical Mission (Medische Zending)</td>
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<td>14</td>
<td>Ministry of Agriculture, Livestock and Fisheries</td>
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<td>Ministry of Economic Affairs, Entrepreneurship and Technical Innovation</td>
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<td>39</td>
<td>Women’s Right Centre</td>
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<td>40</td>
<td>Ypsilon Foundation (mental health NGO)</td>
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PAHO/WHO
Country Cooperation Strategy
2023 - 2025
Republic of Suriname

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