Suriname

General Information

Suriname is a country with an approximate area of 163 thousand sq. km. (UNO, 2001). Its population is 0.439 million, and the sex ratio (men per hundred women) is 98 (UNO, 2004). The proportion of population under the age of 15 years is 30% (UNO, 2004), and the proportion of population above the age of 60 years is 8% (WHO, 2004). The literacy rate is 90.2% for men and 82.3% for women (UNESCO/MoH, 2004).

The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 9.4%. The per capita total expenditure on health is 398 international $, and the per capita government expenditure on health is 240 international $ (WHO, 2004).

The main language(s) used in the country is (are) Dutch and Surinamese. The largest ethnic group(s) is (are) East Indian and Creole, and the other ethnic group(s) are (is) Javanese and African. The largest religious group(s) is (are) Hindu, and the other religious group(s) are (is) Protestant, Roman Catholic and Muslim.

The life expectancy at birth is 64.4 years for males and 70.8 years for females (WHO, 2004). The healthy life expectancy at birth is 57 years for males and 61 years for females (WHO, 2004).

Epidemiology

There is a paucity of epidemiological data on mental illnesses in Suriname in internationally accessible literature. Hanoeman et al (2002) studied the incidence of schizophrenia among the Surinamese population in order to compare the results with those among Surinamese immigrants in the Netherlands who show a high incidence. The researchers examined the medical records of the sole psychiatric hospital in Suriname and found that the mean annual incidence rate of first admissions for schizophrenia or schizophreniform disorder (DSM-III-R criteria) in 1992 and 1993 was not low (1.6/10 000). These findings constitute a challenge to the hypothesis that selection explains the increased incidence in the migrants. The possibility of an increased incidence of the disorder in Surinam (which might also explain the increased incidence among migrants) could not be ruled out. Mahy (1993) reported on suicidal behaviour in different Caribbean countries where records suggest that the rate of suicide particularly by the use of agrochemicals has been steadily increasing in the East Indian community. Perriens et al (1989) studied records at the University Hospital that manages 83% of all cases of paraquat poisoning occurring throughout the country. For 1985 and 1986 the corrected incidence rates of paraquat poisoning were 211 and 68 cases/million population/year, among the highest reported worldwide. Paraquat poisoning was associated with gender (male) and ethnicity (Hindustani) and availability of the chemical (e.g. volume of monthly import of paraquat). Suicide attempts accounted for 76% of the cases. The overall case fatality rate was 71% and it was associated with gender (male) and age. In 2001, 72 deaths by suicide were noted (Punwasi, 2003). Of the deceased subjects, four-fifths were Hindustani, three-fourths were male and two-thirds were under 45 years of age. Regional variation was marked with projected figures for the population per district ranging from 5.55 to 55.06 per 100 000 population. The analysis in 2000 showed a similar pattern.

Mental Health Resources

Mental Health Policy

A mental health policy is present. The policy was initially formulated in 2000.

The components of the policy are treatment and rehabilitation.

Substance Abuse Policy

A substance abuse policy is present. The policy was initially formulated in 1996.

National Mental Health Programme

A national mental health programme is present. The programme was formulated in 2000.

National Therapeutic Drug Policy/Essential List of Drugs

A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1984.

Mental Health Legislation

There is a Mental Health Act.

The latest legislation was enacted in 1912.

Mental Health Financing

There are budget allocations for mental health.

The country spends 4.2% of the total health budget on mental health.

The primary sources of mental health financing in descending order are tax based, social insurance, out of pocket expenditure by the patient or family and private insurances.

The country has disability benefits for persons with mental disorders. Benefits are present but limited.

Mental Health Facilities

Mental health is not a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level.

Regular training of primary care professionals is not carried out in the field of mental health.

There are no community care facilities for patients with mental disorders.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	5.2
Psychiatric beds in mental hospitals per 10 000 population	5.2
Psychiatric beds in general hospitals per 10 000 population	0
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	1.25
Number of neurosurgeons per 100 000 population	0.2
Number of psychiatric nurses per 100 000 population	15
Number of neurologists per 100 000 population	0.83
Number of psychologists per 100 000 population	0.2
Number of social workers per 100 000 population	0.62

Non-Governmental Organizations

NGOs are involved with mental health in the country. They are mainly involved in advocacy and promotion.

Information Gathering System

There is no mental health reporting system in the country.

The country has no data collection system or epidemiological study on mental health.

Programmes for Special Population

There are no facilities for special population groups.

Therapeutic Drugs

The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenobarbital, phenytoin sodium, sodium valproate, chlorpromazine, diazepam, fluphenazine, haloperidol, lithium, biperiden, levodopa.

Additional Sources of Information

•Hanoeman, M., Selten, J.-P., Kahn, R. S. (2002) Incidence of schizophrenia in Surinam. Schizophrenia Research, 54, 219-221.

•Mahy, G. (1993) Suicide behaviour in the Caribbean. International Review of Psychiatry, 5, 261-269.

•Perriens, J., Van der Stuyft, P., Chee, H., et al (1989) The epidemiology of paraquat intoxications in Surinam. Tropical & Geographical Medicine, 41, 266-269.

•Punwasi , W. (2003) Causes of Death in Suriname 2001. BOG (MOH).