Sint Maarten

Country Cooperation Strategy 2015 – 2019

29/07/2015

Abbreviations

ART	Antiretroviral therapy treatment
AVBZ	General Act on Special Medical Expenses
AWW	General Widowers and Orphans Insurance Act
CARICOM	Caribbean Community and Common Market
CCS	Country Cooperation Strategy
Cessantia	Severance Pay Insurance Act
CT	Computed Tomography
EVT	Economic Affairs, Transportation and Telecommunication
FZOG	Governmental Health Insurance Fund
GDP	Gross Domestic Product
Gov APS	General Pension Fund Sint Maarten
GP	General Practitioner
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
IMF	International Monetary Fund
MDGs	Millennium Development Goals
Min VSA	Ministry of Public Health, Social Development and Labor
MSGs	Millennium Social Goals
NAf	Netherlands Antilles Florin-Guilder
NHA	National Health Authority
OV	Accident Insurance
PAHO/WHO	Pan American Health Organization/World Health Organization
PPP	Power Parity Ratio
RX	Radiography
SLS	Sint Maarten Laboratory Services
SMMC	Sint Maarten Medical Center
SZV	Social and Health Insurance
UNDP	United Nations Development Program
UNICEF	United Nations Children Fund
USD	United States Dollar
ZV	Sickness Benefits Insurance

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Executive Summary

Sint Maarten became a constituent country on October 10, 2010 (10-10-10) after being part of the Netherlands Antilles within the Kingdom of the Netherlands for over 50 years. Sint Maarten has been an Associate Member of the Pan American Health Organization/World Health Organization (PAHO/WHO) since September 2012.

In order to support Sint Maarten in strengthening its health care structure, a technical cooperation agenda was developed in the form of a Country Cooperation Strategy (CCS). The agreement signed with the PAHO seeks to provide Sint Maarten's health system with a sustainable fiscal budget and adequate management accountability.

A multi-sectorial approach is required in order to coordinate and reorganize the fragmented health system in line with the targeted outcomes of strengthening and improving the quality of life of the population and enhancing access to accurate health information for planning and decision-making.

Furthermore, reorganization of the fragmented health information system is vital to improving accessibility to accurate health information for effective planning and decision-making.

In mutual collaboration between the Ministry of Public Health, Social Development and Labor (Min VSA) and the PAHO/WHO, the timely formulation of this CCS takes into account the following considerations: a) Political willingness to undertake National Health Reform in order to improve health and the population's quality of life. b) Government's willingness to work with PAHO as a strategic partner to strengthen public health.

The priorities of the Sint Maarten CCS seek to focus PAHO/WHO's technical cooperation with the Ministry of Public Health, Social Development and Labor (Min VSA) based on a participatory process of discussion between the PAHO/WHO and Sint Maarten Min VSA.

1-Introduction

The Pan American Health Organization (PAHO), as the regional office for the World Health Organization (WHO), has a long history of drafting and implementing programs for countries based on the strategic directions of the Organization in order to determine national health priorities. The main challenges for Sint Maarten's health and development were identified and taken into account in order to establish the PAHO/WHO Country Cooperation Strategy (CCS) and the technical cooperation agenda for the 2015-2019 period. The aforementioned challenges were uncovered through a health situation analysis, dialogues, and interviews with key health personnel and national authorities.

Sint Maarten's CCS is aligned with the Pan American Health Organization's Strategic Plan (PAHO/WHO 2014-2019 Strategic Plan), which defines actions required to achieve the Millennium Development Goals (MDGs) by 2015, and the new required strategic interventions for health improvement in the Post-2015 Sustainable Development Goals (SDGs) by 2030.

Sint Maarten's CCS also takes into consideration the Health Agenda for the Americas 2008-2017, under which Governments offered their commitment to the vision of an equitable and healthier region, addressing health determinants and access to public health services, taking into account the United Nations Millennium Development Goals (MDGs) and social determinants of health, and PAHO's Directing Council Resolution 53/5 of October 2014 on Universal Access to Health and Universal Health Coverage. These documents contributed to developing the strategic health policies under a multi-sectorial approach. Furthermore, relevant factors to be highlighted are Sint Maarten's country constituent status, PAHO membership since 2012, and observer status in Caribbean Community and Common Market (CARICOM). As a result, Sint Maarten continues to develop its political and administrative organization and to create its national information systems.

This CCS is a mutual agreement framework that results from an extensive consultation process among Sint Maarten´s Ministry of Health, key health stakeholders and PAHO. The objective is

to coordinate, integrate and facilitate technical cooperation while the country builds and strengthens its health system.

2-Health Development Situation

Sint Maarten is a small country in the Caribbean with less than five years of constituency. It has an open-island economy, driven primarily by the tourism industry, which accounts for 80% of the economy.(27)

There are number of challenges to be addressed such as lifestyle-related health issues and the reorganization of health information to improve Sint Maarten's health system.

2.1 Main Health Achievements and Challenges

2.1.1 Political and Socioeconomic Context

A- Political and Governance Structure

After being part of the Netherlands Antilles for over 50 years, Sint Maarten became a constituent country within the Kingdom of the Netherlands on October 10, 2010, (10-10-10).

Sint Maarten is no longer a Dutch overseas dependence, rather a constituent partner within the Kingdom, alongside the Netherlands, Curaçao and Aruba; and enjoys a degree of internal autonomy.

The Netherlands Antilles Florin (NAf) is the currency used in Sint Maarten, and the United States dollar (US dollar) is widely accepted at a rate of US 1 – NAf 1.82. Each year, approximately 1.9 million tourists visit the island. The tourism industry accounts for the greatest contribution to the island's Gross Domestic Product and employment. Aside from the main industry, stay-over and cruise tourist sectors, economic diversification is being sought in the marine and yachting sector, financial services and Internet-shopping delivery service.

Sint Maarten is now governed by its own Constitution, drafted in 2010. The King of the Kingdom of the Netherlands is the Head of State (government) and represented by the Governor. The Governor, together with the Council of Ministers, makes up the Government of Sint

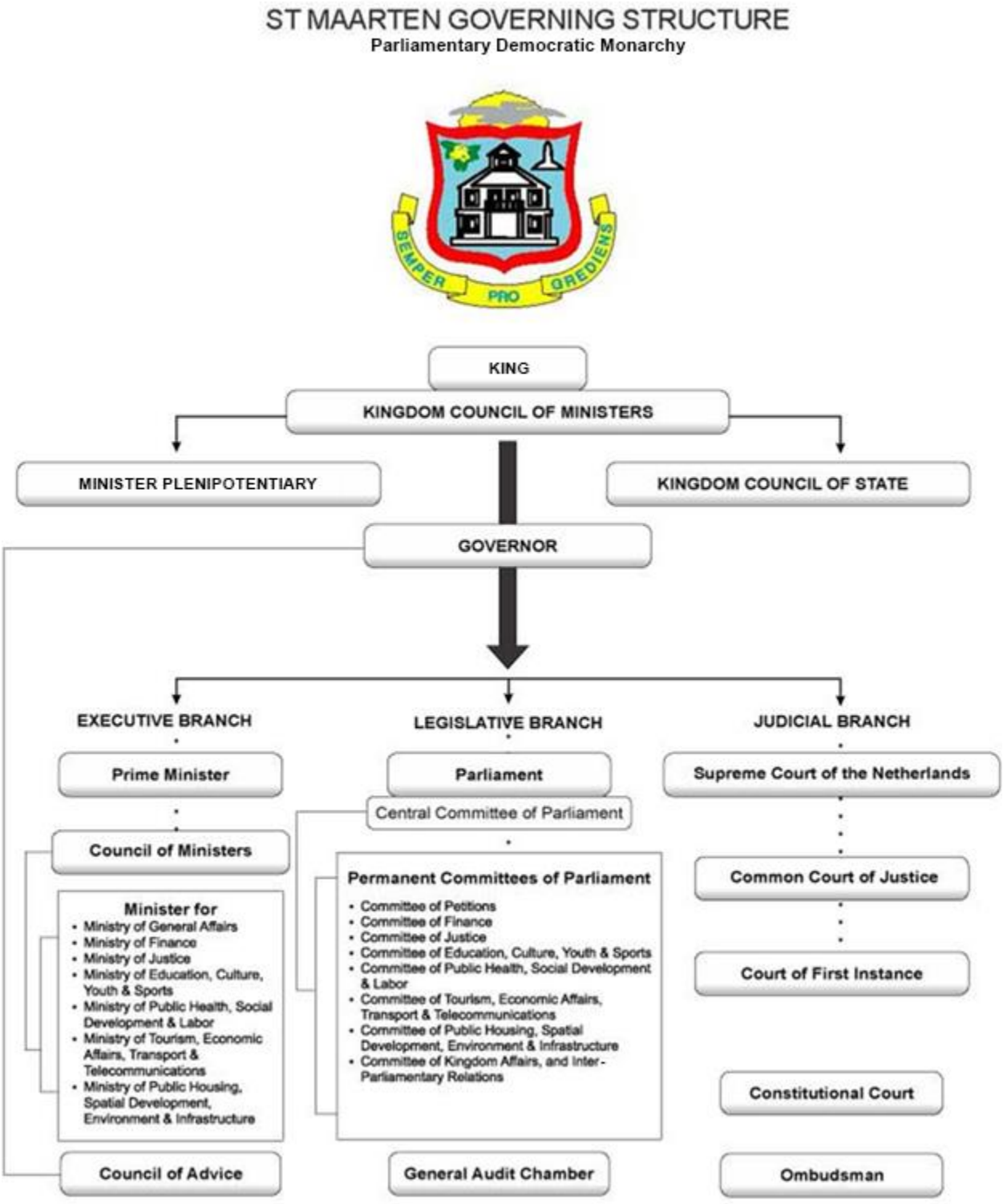
Maarten. The Council of Ministers is headed by the Prime Minister, and consists of seven (7) Ministers who are appointed and overseen by Parliament, including the Minister of Public Health, Social Development and Labor. (Figure-1)

The Parliament of Sint Maarten consists of fifteen (15) members elected for a four-year period that represent the entire population of Sint Maarten. Parliament is the highest legislative body, and together with the government can enact or amend legislation regarding the country's affairs, administration and public policy. However, defense, foreign affairs and the Supreme Court all depend on the central government of the Kingdom of the Netherlands.

Sint Maarten continues to develop its political and administrative organization as well as to create its national information systems. However, there is nonetheless limited information to meet national and international data requests, which justifies the need to develop a comprehensive health information system, crucial in decision-making.

The goal of National Health Reform is to build a Unique National Health Insurance program. This effort is being led by the Min VSA and is in its early stages. The desired outcome is: to provide affordable and sustainable health care; to develop a comprehensive health services package based on the health needs of the population; and to create an integral Primary Health Care Strategy. The policy will promote health services and place focus on prevention, coherent treatment and appropriate use of health technologies.

Figure 1. Sint Maarten, Government Structure



B- Geographic Profile

Sint Maarten is located at 18’01’ N 63’03 W. The island is situated in the northeastern Caribbean Sea, located at the northern end of the Leeward group of the Lesser Antilles, extending about 12 miles (19 km) both from north to south and east to west, including its narrow strip of land that extends westward from the hilly main part of the island. Its closest neighboring islands include Anguilla, St. Barth’s, Saba, St. Eustatius, and St. Kitts and Nevis. Sint Maarten is located some 200 miles east of Puerto Rico. The island is generally surrounded by mountains with volcanic interiors and is separated into two distinct parts. The northern land border is shared with the French overseas Collectivity of Saint-Martin. Together, these two entities make up the smallest landmass in the world shared by two self-governing states.

Figure 2. Map of Sint Maarten

C- Socioeconomic Situation

Sint Maarten is a small and open island economy, and tourism is the major driver of economic activity, and to a large extent vulnerable to global economic developments.

According to the Year-end 2014 Outlook 2015 Report produced by the Tourism and Economic Affairs, Transportation and Telecommunications (TEATT), Sint Maarten’s economic growth accelerated year-over-year (YoY) in 2014 to attain a GDP expansion paced at +1.6%. The result was largely due to a strong performance of tourism, which generated a trickle-down impact into

related sectors. Both cruise and stay-over arrivals posted solid growth in 2014, respectively of +12.1% and +7.1%.

Cruise arrivals reached a record 2-million visitors as the port of Philipsburg received larger ships. Stay-over arrivals for the year amounted to nearly 500 thousand visitors. The occupancy rate trended upward from 69% in 2013 for hotels and timeshares combined. The results were supported by improved conditions in global economies and contributions from private consumption and investment.

The Manufacturing sector made a favorable contribution to economic activity in 2014, particularly benefiting from an increase in yacht repairs. Financial intermediation, to the contrary, detracted from growth as net interest income for commercial banks declined and the construction sector contracted.

In 2014, public spending was mainly the result of the purchase of the Emilio Wilson Estate and the new government administration building. Government consumption of goods and services dropped.

Public and private construction activity declined during the year. The number of building permits issued was down YoY, though the total estimated value increased.

Agricultural activity remained flat YoY, and continues to be a minimal contributor to the economy, with only 10% of land suitable for domestic agricultural production. Over 90% of food products are imported.(1)

Imports are estimated to have grown +1.6% year-over-year as the result of increased tourism activity and consumer demand. Meanwhile, the growth in exports was +6.5%, led by a +12% expansion of tourism exports. The pace of growth in trade figures in both categories accelerated with respect to 2013.

Debt-to-GDP is increasing and closed 2014 at 39.2%. This figure is expected to reach 40.4% at the end of this year.

The economy, overall, delivered favorable results in 2014 and into early 2015 driven by domestic demand and a surge in tourism.(31) Private consumption and investment provided a

boost to private demand, and public investment also picked up in relation to infrastructure and remodeling of public schools in early 2015.

The Central Bank estimates that the economy will grow +1.4% in 2015 and +1.6% in 2016. Tourism is expected to be the main engine of growth, impacting the hotel and restaurant sector as well as the wholesale and retail sector. This exposes vulnerability to the performance of the United States and Canadian economies, which respectively provide around 53% and 10% of total stay-over tourists.

Cruise arrivals rose +7.5% YoY in the first quarter of 2015, reaching 791,537.

New airlift will be key to driving improved results, while the cruise sector is expected to continue to provide a robust level of activity throughout the year. Several new flights have already been announced by airport authorities to be added in 2015 and 2016.

Other economic activities include the financial sector (contracted -1.3% in 2014 and -1/4% in Q1 2015), real estate, rentals and business activities (expanded +1.4% in 2014 and +0.9% in Q1 2015), and transport, storage and communications (expanded +4.1% in 2014 and +0.9% in Q1 2015).

In 2013, 7.8% (USD $19 million) of the national budget was allocated to the health care system. This figure then decreased to 6.3% (USD $15 million) in 2014. Table 1 shows distribution of the national budget in 2013 and 2014. The national budget allocation for education was 18.4% and 19.4% during 2013 and 2014, respectively.[(2)]

Table 1. Total Government Budget Distribution, US dollars, 2013-2014

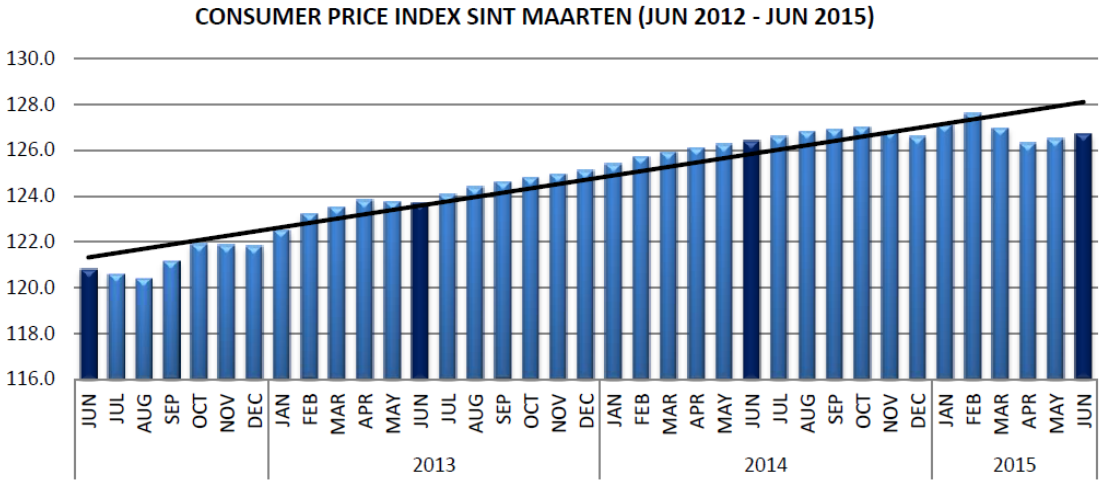
Year	Social Security	Education	Health Care	Other	Total (USD) millions
2013	3	45	19	178	245
2014	2	46	15	174	237

Source: Sint Maarten, annual budget, 2014

It is evident that the consumer price index reflected inflation for the period 2011-2014. Although prices have trended upwards over that period, the pace of the price change did not accelerate significantly. Inflation will ease in 2015 as the result of lower international fuel prices and could pick up in early 2016 as the result of higher food prices.

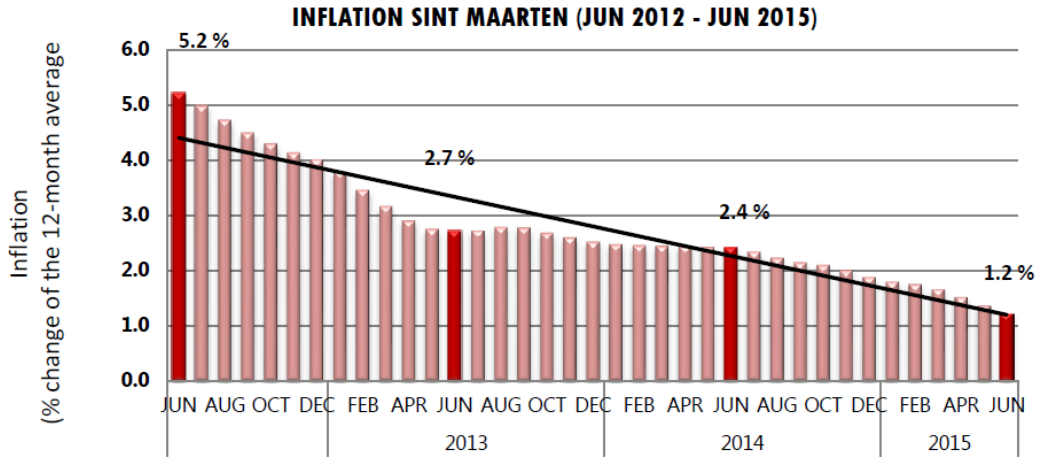
Fluctuations in GDP, as observed in in recent years, were related to the decrease in tourism, consistent with the United States and European financial crisis since 2008.

Figure 3. Consumer Price Index, Sint Maarten (JUN 2012-JUN 2015)



Source: Ministry of Public Health, Social Development and Labor, 2015.

Figure 4. Inflation Sint Maarten (JUN 2012-JUN 2015)



Source: Ministry of Public Health, Social Development and Labor. 2015.

Historic data reveals that in terms of economic activity, Sint Maarten experienced an average annual GDP growth rate of +2.9% between 2006 and 2009 (IMF, 2011). This was followed in

2009 by a significant recession, which turned growth negative to -2.0%. Growth moderated in 2010 and 2011 at -0.1% per year (IMF, 2011 *Public Information Notice: IMF Executive Board Concluded 2011 Article IV Consultation Discussions with the Kingdom of the Netherlands – Curaçao and Sint Maarten*). Since then, Sint Maarten has been experiencing a slow economic recovery, with an annual growth of +1.3% between 2012 and 2014. For 2015, expected GDP growth is forecast to be near +1.3% (IMF, 2014 *Public Information Notice: IMF Executive Board Concluded 2011 Article IV. Consultation Discussions with the Kingdom of the Netherlands – Curaçao and Sint Maarten and Economist Intelligence, Sint Maarten, Feature Analysis, The Economist Group, 2015)*. These results are mainly related to the continued growth in cruise passenger arrivals of +1.9% and the slight increase of +1.8% in projected stay-over arrivals.[2, 24, 28,32]

Table 2. Sint Maarten Macro – Economic Data Estimates 2012-2015

Indicators	***2012***	***2013***	***2014***	***2015 (fcst)***
Inflation	4	3	2	1.4
Unemployment Rate %	12	9.2	9.2	8.5
Employment by enterprises *1000	20	20	21	
Export (mil NAf)	2095	2222	2424	2507
Imports (mil NAf)	1838	2129	2214	2293
Export (%)	11	3.5	6.5	1.3
Import (%)	3.69	0.6	1.6	1.6
Cruise Arrival (*1000)	1754	1787	2002	2040
Stay over Tourist (*1000)	457	467	500	509

Source: EVT, Ministry of Finance, STAT

D- Public and Private Health Expenditure

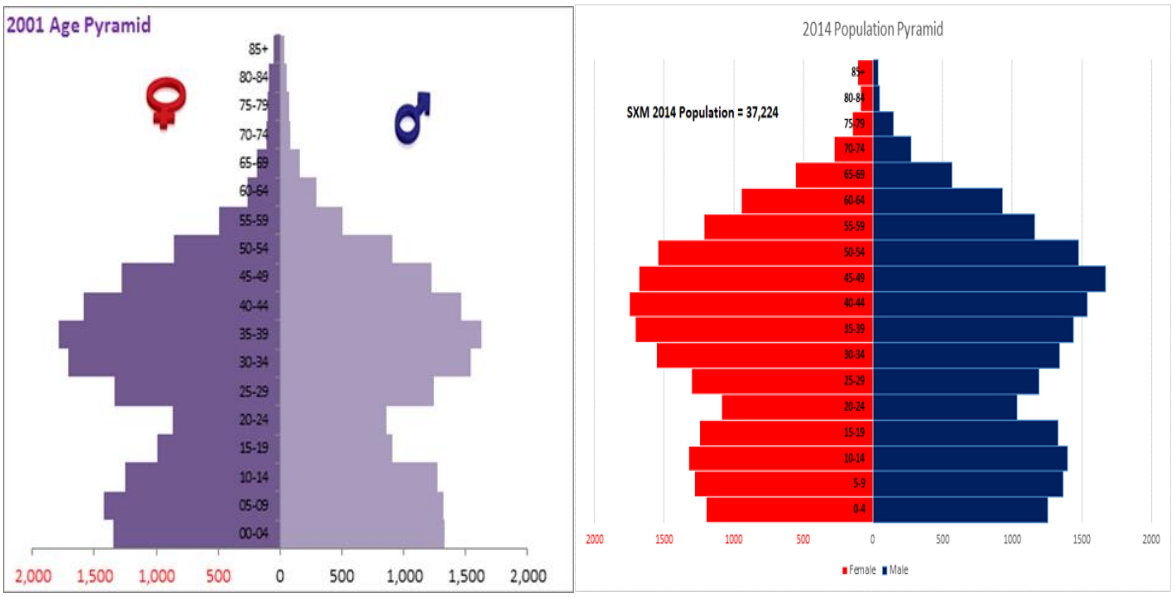
There is no public-private data available on total health spending in Sint Maarten. Gross Domestic Product (GDP) for 2013 was USD $1,021 million (IMF, 2014) and public expenditures on health care reached USD $19 million, representing 2% of GDP. This is only a directional indicator, given that the total public health expenditures should include a mandatory portion for health from social security contributions. Sint Maarten carries a high debt-to-GDP ratio

approaching 40% and increasing, reflecting important constraints for universal health design and development, as well as for access and coverage.

2.1.2 Health Situation Analysis

The 2001 population census showed a total population of 30,440, with a ratio of 14,823 males (48.7%) and 15,617 females (51.3%). By 2014, based on the Household Listing Survey 2014, the population had increased 18 percent, reaching a total number of 37,224, of which 18,201 (48.9%) were males and 19,023 (51.1%) were females. Figure 5 reflects a higher number of females with respect to males, at 105 women per 100 men.

Figure 5. Population Pyramid by Age and Sex 2001 and 2014, Sint Maarten



Source: Bureau of Statistics Sint Maarten, 2014. **Source:** Department of Statistics Sint Maarten's Photos in Household Listing Survey 2014 (www.stat.gov.sx)

In 2014, the productive age group (20-64 years) accounted for the majority of the population at 66%. This group was followed by the 0-19 years category, which represented 27.9% and 65 and over with 6.1%. The elderly population is increasing steadily, which brings consequences in the socio-economic landscape, and has an impact on the consumption of services in the medical field and social areas.[(2)]

A total of 511 births were registered in 2013,[33] more than in 2010 (496), and a significant increase over the 414 registered in 2012. Although mandatory by law, not all births in Sint Maarten are registered.[2] Based on a UNICEF report, this situation may be related to the fact that there are many undocumented immigrants and births to immigrant parents whose children have not been registered.

The total fertility rate was 2.0 children born/woman and the number of live births per 1,000 women in age group 15-44 was 60 births in 2013.[33]

The average life expectancy at birth for total population in 2011-2012 was 77.1 years for females and 69.2 years for males.[33] In 2012, the population was comprised of 91 recognized nationalities with 118 different countries of birth.[4]

Table 3. Nationalities Living in Sint Maarten, 2012

Nationality	**Percentage**
Netherlands	63.69%
Haiti	6.70%
Dominican Republic	5.68%
Jamaica	5.36%
Guyana	3.80%
Dominica	2.93%
India	1.67%
Saint-Martin	1.55%
United States of America	0.86%
Saint Lucia	0.82%
Other	6.94%

Source: Press release Department of Statistics, Sint Maarten 2012. The top ten Nationalities

The arrival of immigrants to Sint Maarten is mainly due to the job opportunities as compared to other Caribbean countries. Many private businesses are owned by immigrants such as hotels, restaurants, and resorts. Additionally, immigrants also meet the labor needs not fulfilled by locals in areas like construction, catering services and cleaning (UNDP, 2011).

Immigration has brought cultural and linguistic diversity to Sint Maarten. Various languages are spoken, though Dutch and English are the official languages. According to the 2001 census, 67.5% of the population spoke English as a first language, 13% Spanish, 8% Creole, 4% Dutch, 2% Papiamento, 1.5% French and 3.5% other languages.

Although immigration is much higher, a tendency towards emigration is observed among young adults between 15 and 29 years old. The younger generation seeks to study abroad in order to obtain a higher-quality education, and in many cases does not return to the country, creating a human resource capacity gap. The main destination countries for this immigration are the Netherlands, Aruba and the United States of America.

The main religion is Protestant 44.8%, which is divided into (Pentecostal 11.6%, Seventh-Day Adventist 6.2%, other Protestant 27%), followed by Catholic (39%), Jewish, Muslim, other religion and no religion practiced with small percentages.[4]

During the period between 2006 and 2010, there were 500 average births per year (13 births/1,000 inhabitants). During this same period, total annual average number of deaths was 140, increasing in 2010 to a total number of 160.[1] The total fertility rate is 2.09 children born/woman and the number of live births per 1,000 women aged 15-44 was 60.[4, 33]

The 2011 household information data shows that over 70% of households were comprised of more than one person, while approximately 30% of the population lived alone. Roughly 19% of the population belongs to a household consisting of a married couple with children, and 15% live in single-parent households. For this latter category, single mothers with one or more children represent 13.18% of the population. The average household has 2.6 members, which is not significantly different from 2001.[33]

-Health Determinants

Poverty

Recent reports suggest that Sint Maarten does not suffer from extreme poverty. However, there are pockets of borderline poverty, apparently related to the cost of living.[25] The poverty line in dollars/day, calculated using the Purchasing Power Parity ratio (PPP), is not relevant given a persistent high cost of living. Poverty thresholds are determined by family size, the number of children and the age of the head of the household. A family's income before taxes is compared to the annual poverty thresholds. If the income is below the threshold, the family and each individual within the family are considered to be in poverty. In 2010, it was reported that the poverty threshold for a family of four was $22,314.[25]

In order to obtain government aid for medical assistance programs, monthly income below 2,000 guilders (USD $1,000) is taken into account for eligibility.[3] It should be noted that in Sint Maarten, 22% of households have no income,[16] mainly due to undocumented immigrants who are attracted to Sint Maarten for work and contribute significantly to the remittance economy.[16]

Education

The Compulsory Education Ordinance has been in force since 1991, through 'Leerplicht Landsverordening' for the 5-16 age group. In 2008, a new law replaced the prior legislation, extending the legal age to 18 (National Compulsory Education Ordinance, July 19, 1991). According to the 2011 census, 51.9% of 18 year-olds are attending school, whereas in 2001 it was only 48.1%. This trend is also visible for the 0-4 year-old age group, where only 4.4% were attending a nursery or day-care in 1992, which has since increased to 12.7% in 2011.

The Compulsory Education Ordinance accomplished mandatory education for all children by extending the age level in 2008. At the secondary and university levels, students are eligible to apply for grants. As a result, Sint Maarten now has the most extensive compulsory education in the Caribbean.[2] Information obtained directly from the Ministry of Education shows that as of

March 2013, there were 18 Primary Schools that received subsidies/assistance from the government, with a total of 4,785 primary school students enrolled at those facilities.[3]

On the other hand, despite public schools now being open to all children, approximately 10 to 15 per cent of the school-age populations are undocumented immigrants (UNDP, 2011). The regular education system has limited absorption capacity for immigrant children whose native language is not English or Dutch, as the human capacity and infrastructure necessary to insert these children into the school system does not exist.

According to UNICEF's *Situation of Children and Adolescents in Sint Maarten 2011 report*, there are some shortcomings in terms of communication among society, given the non-unified country education model (e.g. lack of Sint Maarten history in the curriculum).

Gender, Equality and Women Empowerment

There are certain levels of social equality due to progressive policies in universal education, female representation in politics and employment, and a proper work environment for women. Over the last years, women have increasingly gained access to important positions in the government. For instance, during the 2010-2014 period, women have held positions as high as Prime Minister and President of Parliament.

Nonetheless, official statistics on wages show discrepancies in gender wage distribution; women perceive less income than men, while carrying out the same tasks. Taking into account this information, the country might need to make progress towards equal wage distribution for women and support effective gender mainstreaming initiatives.

2.1.3-Population Health Status

A - Health Service Organization

The health care system in Sint Maarten is rather unique when compared to others in the region. Although the responsibility for securing quality health care falls under the auspice of the

Ministry of Public Health, Social Development and Labor, the health care system is privately managed. The health care organization is described distinguishing the role of relevant health agents who influence the health care systems, such as government, health care providers, and institutions.

In order to guarantee health services, the Min VSA has to play an effective role, including leadership responsibilities, developing regulations and legislations, and monitoring and evaluating essential functions of public health.

Additionally, Min VSA has a crucial role in maintaining and supporting population health, taking into account the following actions:

1) Developing new legislation; 2) Improving and/or implementing existing legislation; and 3) Developing and improving existing guidelines and policies for public health and environmental hygiene. Additionally, it plays a key role in protecting and promoting public health as well as optimizing the distribution, quality and accessibility to health care through policy and legislation.

The role of the health care provider, public or private (for-profit /or non-profit), is to deliver quality care and services geared towards fulfilling the patient/users' needs, engaging patients in treatment decision-making and prognosis, and providing sufficient information with regards to health.

The role of the health insurer (for-profit /or non-profit) is to provide adequate health coverage and secure financing for clients.

Health care delivery in Sint Maarten operates through primary and secondary health services. These are divided into private health care professionals, non-governmental, and governmental health care organizations.

The primary setting consists of organizations and individual groups:

- The General Practitioners/ Family Physicians
- District Nursing
- Dental Care
- Paramedical Care and other Health Care Professionals

- The Turning Point Foundation
- Governmental Organizations (Baby Clinic, Youth Health Care and Ambulance Services)
- The Voluntary Health Care Delivery Services- Health NGOs: St. Maarten Aids Foundation; Diabetes Foundation; The Positive Foundation (Cancer prevention)

The secondary health care level or specialized-care setting consists of clinical and outpatient care provided by nurses and medical specialists within a health care facility. Care provided by medical specialists is mainly accessible through referral by a general practitioner or another medical specialist (within the framework of intercollegiate consultations). Specialized health care is divided in three Health Care Institutions: St. Maarten Medical Center (SMMC) with 66 beds in 2015; the White and Yellow Cross; and the Mental Health Foundation.

The SMMC is a private non-subsidized medical center consisting of two departments:

The Outpatient Care department includes:

- An emergency and radiology department equipped with a computed tomography (CT)-scan and three radiography (X-ray) machines; a dialysis department with seven chairs and dialysis machines; and specialized clinics for the consultation of various medical specialists.

The Inpatient Care department includes:

- Medical, pediatric, and surgical wards; the intensive care unit and delivery room; the operating theater and recovery room with an on-call system in case of emergency operations; admissions department; and patient care department, with 66 beds in 2015.

B - Health Service Finance

Currently, there is no available data on total health expenditures in Sint Maarten's health system. The Ministry of Public Health, Social Development and Labor (VSA) faces major challenges in guaranteeing universal access to health services, ensuring good governance, and fulfilling an effective steering role. Consequently, an important aspect to mention is the fact that 30% of the population is uninsured, and the public health budget is 2% of GDP.

For 2014, the government's total budget was US $237 million (NAf 426 million), showing a decrease compared to 2013, which amounted to US $245 million (NAf 421 million). Figures 6 and 7 present the national budget distribution for 2013 and 2014.

Figure 6 and Figure 7. Sint Maarten National Budget, 2013-2014

Figure 6.

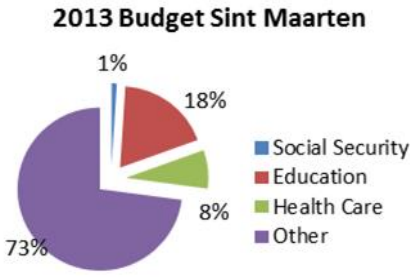
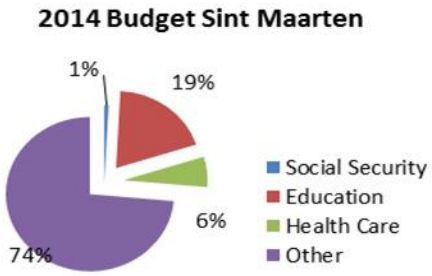


Figure 7.



Source: The National Budget document unpublished

Access to health facilities and services are adequate. Nonetheless, due to the lack of specialized care in certain areas, overseas transfers are required occasionally. The total costs related to medical transfers to other countries were US $6.9 million (NAf 12.5 million) in 2011, compared to US $4.3 million (NAf 7.7 million) in 2012.

This information does not include those that fall under a private insurance structure, which amounts to 10% of the total population.

The Social and Health Insurance (SZV) in Sint Maarten has established official cooperation with organizations abroad in order to facilitate logistics services within countries of referrals. Colombia, Aruba, Saint-Martin, Santo Domingo and Curaçao were among the primary countries of referral. Referrals to the Netherlands and countries outside the aforementioned region will only occur in exceptional situations.

C - Coverage and Social Security System Organization

The current situation is distinguished by a fragmented range of health insurance schemes, which constitutes a critical challenge to increasing equity and efficiency within Sint Maarten's health system. The insurance system itself is regulated by several ordinances. Among them, Ordinance AB 1996 regulates the compensation of medical expenses for low-income workers and the unemployed. The PB 1966 n°15 defines the responsibilities of The Social Insurance Bank **(**SVB**)** that provides coverage for low-income employees. Also, the Ordinance PB1986, n° 15 defines medical coverage for civil servants, and PB75 and n° 249 does the same for retired civil servants. Finally, the General Ordinance on Special Medical Expenses (AVBZ) is focused on non-insurable risks, handicaps and open-ended care.

Sint Maarten's rules and regulations were designed in the Netherland Antilles within The Kingdom and Dutch state principles of social welfare. As of April 2010, the rules and regulations pertaining to social security transferred to Sint Maarten, and these rules and regulations were embedded within the Ministry of Public Health, Social Development and Labor.

Prior to 2010, Sint Maarten enacted a law that established its own Executing Body of Social and Health Insurance (SZV), which is responsible for the execution of the following: General Elderly Pension (AOV); General Widowers and Orphans Insurance (AWW); Accident Insurance (OV); Sickness Benefits Insurance (ZV); and Severance Pay Insurance (Cessantia). For civil servants, the SZV also executes the General Specialized Illness Insurance Act (AVBZ) and the Governmental Health Insurance Fund (FZOG). AVBZ covers the health insurance plan for all civil servants and family members.

Additionally, Sint Maarten installed a pension fund, the APS fund, (General Pension Fund Sint Maarten). This fund executes pensions for elderly, disabled, dependents and orphans, and for former and current government employees. The government funds social affairs through the national budget, providing financial aid for families that cannot afford the costs of their basic necessities, covering medical expenses for nationals and the elderly depending on their income.

The Court of Guardianship has the legal mandate to place children into foster homes. Additionally, children could voluntarily be placed into a foster home on parental will and by referral/suggestion of the Court of Guardianship.

There is a total of four foster homes. All foster homes cater to children between the ages of 0-18, with exception of Ujima, which caters to boys between the ages of 8-14. These are:

- Hope Outreach
- New Start
- I can
- Ujima (boys)

In some instances, where a child is mandated by law to be placed into residential care, the Court of Guardianship provides a monthly subsidy of 500.00 guilders (US $277.77) per child. Further subsidies are available to cover additional expenses via the Court of Guardianship or the St Maarten Development Fund.

In the case of voluntary placement of a child, payment is arranged between the foster homes and the child's parents/guardian.[7]

D - Emergency Services

The Ambulance Department has a total fleet of five (5) ambulances: two (2) fully equipped for mass casualty, with trailers that are equipped to handle 50 patients per mobile trailer; and three (3) rapid-response vehicles including transportation for a medical trauma team, medical equipment, emergencies, accidents, and disasters.

The main tasks of the emergency facility are to guarantee 24-hour ambulance services, to provide medical emergencies with high-quality care as well as disaster management support. Among other tasks are the coordination of aero-medical services, inter-facility ambulance transport, planning and coordination of multi-casualty incidents and disasters. In December 2013, 24 workers were hired and trained, including 8 ambulance drivers, 7 ambulance nurses, 1 operational leader/manager and 6 emergency medical dispatchers.

The Sint Maarten Ambulance Department plays a key role in Public Health service coverage, providing 24-hour service; timely pre-hospital medical care; and transport for the population, health services, hotels or police with five well-equipped and maintained ambulances. The costs of services are covered by insurance.

The ambulances are equipped with latest software system, which registers information for appropriate monitoring, evaluation, and management. The Disaster Preparedness department reports directly to the Office of the Prime Minister; and it is located within the Fire Department. However, supervision and management are independent.

E - Service Coverage

Access to health services is not equal for the entire population. Access to health services are limited to a portion of the population, leading to inequities. Primary and secondary care are provided through private and non-profit facilities. Complex care services are ensured through an arrangement between the insurer, mainly SZV, and facilities in Colombia, Curaçao, Dominican Republic, Aruba, Venezuela, the United States of America and Cuba.

The main health institution on the Island is the Sint Maarten Medical Center (SMMC), a non-profit organization that manages and carries out hospital functions serving the community of Sint Maarten. This facility also supports the surrounding smaller islands such as Saba, Statia and Anguilla, as well as others in the region, attending an estimated 54,000 people. This center is a primary and secondary complexity setting with 66 beds in 2015. At the end of 2014, SMMC had 260 staff, including 21 attending medical specialists. Direct patient care staff reached 157 in 2015. The nursing staff is supported by an in-house, nationally accredited Education Department, whose task it is to offer training, upgrading, and specialization courses in the field of nursing as well as defining patient handling protocols to ensure that SMMC meets the highest standards in patient care.

In 2014, the SMMC attended to 523 deliveries, 1,826 surgical interventions; 13,477 ER visits; 28,239 outpatient consultations and 3,916 admissions with a 4.7-day average length of stay. Outpatient care in 2014 was broken down as follows: Internal Medicine 3,634, Pediatric 5,810,

Ophthalmology 1,673, Dermatology 2,125, Cardiology 1,384, OB/GYN 7,510 and Surgical 6,103.[34]

There is one reference laboratory, the Sint Maarten Laboratory Services (SLS), which provides medical services for ambulatory and hospitalized patients 24/7. The laboratory guidelines, protocols, and external quality controls continue to follow the Netherlands' Health Systems. This is also an environmental laboratory, and provides government with important testing and monitoring capabilities to analyze water surface quality and the sewage treatment plant, using physical, chemical, and bacteriological characteristics, taking into account the Ministry of Public Health's recommendations.[28]

Finally, it is important to highlight the relevant role of the Yellow Cross and the Baby Clinic, a major health care facility providing care for the elderly through nursing home care, geriatric, rehabilitation, a residence for the disabled, as well as maternal and child health services. The facility works with a network system of private practice physicians in Sint Maarten and operates with an annual budget of NAf 12 million.

The Baby Clinic facility serves children 0-4 years old, attending to 90% of all children in Sint Maarten. Private pediatricians cover the remaining 10%. Services provided by the Baby Clinic are mainly: growth control, vaccination, and dental care. The facility's staff is comprised of three (3) nurses, one (1) receptionist, one (1) general practitioner, and one (1) dentist.

The Baby Clinic has one (1) Youth Health Care Physician, two (2) Registered Nurses, and one (1) administrative worker. The Baby Clinic facility also has a dental program that is coordinated by a Dental and Oral Health Promoter. This program caters to school-aged youth.

From a financial standpoint, SZV plays a key role in containing costs and ensuring long-term sustainability of the health system. Nonetheless, there are still many challenges to ensuring access to treatment and adequate use of diagnostic/medical equipment and information technology. An important challenge to point out is the limited health information available for decision-making.

F - Human Resources in Health

The Sint Maarten Medical Center (SMMC)'s hospital staff consisted of two hundred and sixty (260) staff including 157 direct patient care staff,[34] clinical attendants, administrative staff, technicians and others. In 2010, there were ninety-one (91) registered nurses, fifty-one (51) practical nurses, one (1) geriatric nurse, seventeen (17) nurse assistants, and six (6) doctor assistants for one hundred sixty five (165) nursing personnel. In 2014, there were twelve (12) pharmacies and twelve (12) pharmacists. Meanwhile in 2011, there were one hundred and thirty (130) doctors in twenty-six (26) registered specialties.

In 2014, a class of thirty-three (33) students started the Licensed Practical Nursing Course offered by the Sint Maarten Medical Center. The facility, in addition to being a certified institution to provide training and internships at various levels, also offers certification for nursing assistants and professional nursing programs.

G - Health Information System

The health care system in Sint Maarten has particular characteristics when compared to most of those in the region because it is based on a private setting, and its organization depends on the role of the government, health care providers, and health insurers, as main components of the Health Information System (HIS).

Health data collection continues to be paper-based, affecting data consolidation, consequently presenting difficulties for effective and timely decision-making. However, there are some digital reports and surveillance bulletins, with no linkages between administrative and technical health data.

Collective Prevention Services (CPS) has a manual for Communicable Diseases (CD) and uses Excel tables for Dengue and Syndromic Surveillance, as well as publishing weekly and yearly bulletins of Communicable Diseases.

The government is carrying out an appraisal of different software and hardware programs, taking into account needs and priorities of the key health partners such as SZV, General Practitioner, Specialist, Hospital, Laboratory, Non-Government Organizations (NGOs) and other health-related institutions aimed at integrating health information.

As part of Technical collaboration, PAHO Venezuela supports the Collective Prevention Services (CPS), with PAHO Health Information Analysis and an Epidemiology Surveillance System (ViEpi) to improve the Health Information System.

H - Population Health Status

The epidemiological transition in Sint Maarten is similar to the rest of the Caribbean Sub-Region, where communicable diseases continue to present challenges among the population with an upward trend of non-communicable diseases. According to the most recent census, the leading non-communicable diseases were high blood pressure (10.7%) followed by diabetes mellitus (5.3%) and asthma (2.6%). In this 2011 census, diseases such as sickle cell anemia, cancer and Alzheimer's were included for the first time.

Communicable Diseases

To analyze the burden of communicable diseases, the Annual Communicable Diseases Report produced by CPS during the annual periods of 2010–2013 were taken into account.

Vaccine Preventable Diseases

The Ministry of Public Health designed a pro-active community approach, using a mobile bus, to deliver its outreach vaccination program. In addition, in May 2013, the Youth Health Care Section of the Collective Prevention Services introduced the pneumococcal vaccine, and in September 2013, the human papilloma virus (HPV) vaccine was established for pre-adolescent girls ages 9 and 10.

During the period from 2010 to 2013, there were no notified cases of Rubella or congenital rubella. In 2010, CPS reported a single measles case, which was notified by a cruise-ship health declaration. The case was an 18 month-old patient of French nationality who presented "rash and fever." Laboratory tests results from Saint-Martin (French) indicated that the patient was measles IgM positive. Despite the case not fitting the definition for measles for Saint-Martin's health authorities, the sample was sent for further testing. Nonetheless, there were no confirmations of measles cases reported during the period 2011-2013.[8, 9, 10, and 11)]

During epidemiologic week 13 of 2012, CPS received notification of an Acute Flaccid Paralysis (AFP) in a 7 years-old female from St Elizabeth Hospital in Curaçao. The case was later confirmed as a Guillain Barre Syndrome.[(10)]

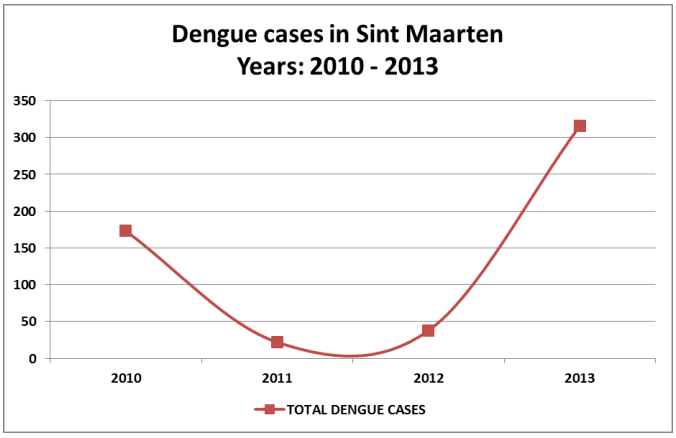
During epidemiologic week 36 of 2012, there was one confirmed case of tetanus reported in a 63 year-old male, flown to the Dominican Republic for further care and treatment. However, it expired in epidemiological week 39 of 2012.[(10)]

Vector Borne Diseases

Dengue

There were 173 dengue fever cases, and no severe dengue cases reported in 2010. In 2011 and 2012, 22 and 38 dengue cases were reported, respectively.[(8, 9, 10, and 11).]

Figure 8. Dengue Cases in Sint Maarten. Years: 2010 – 2013



Source: Annual Communicable Disease Report 2013 (Draft), Collective Prevention Services, Ministry of Public Health Social Development and Labor, May 2014

By 2013, they were 310 dengue fever cases and 6 severe cases reported for a total of 316 confirmed cases. Of these, 44% were females and 52% were males, while 4% were registered as "unknown." The highest case burden for dengue was in the 25–44 age category, comprising 35% of total cases.[11]

Table 4. Dengue fever and severe dengue cases by age group in Sint Maarten, 2013.

DISEASE	TOTAL	<1	1 - 4	5 - 14	15 - 24	25 - 44	45 - 64	65 +	UNKNOWN
DENGUE FEVER	310	0	3	34	58	110	75	22	8
SEVERE DENGUE	6	0	0	0	0	5	1	0	0

Source: Annual Communicable Disease Report 2013 (Draft), Collective Prevention Services, Ministry of Public Health Social Development and Labor, May 2014

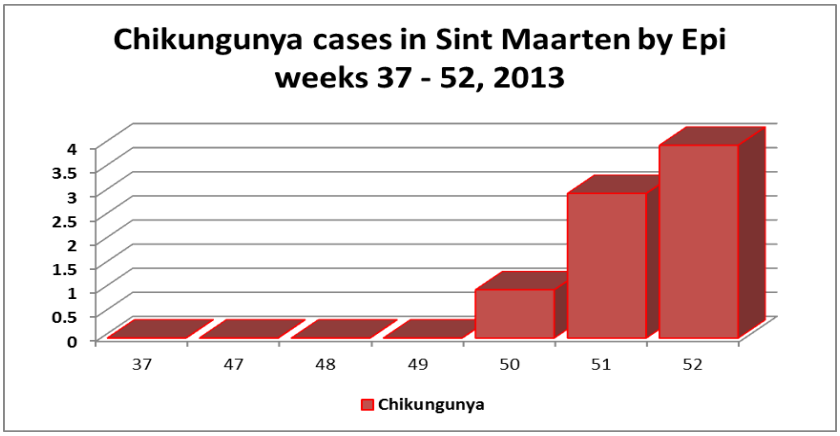
There were 1,238 laboratory tests ordered for dengue in 2013, of which 316 (26%) were positive for type 2, 3 and 4. There were four types of viruses registered between 2010 and 2013.[11]
The Cole Bay district represented the highest percentage of cases, accounting for 8% of the total number. Unknown addresses accounted for 37% of confirmed cases.[11]

Chikungunya

Sint Maarten officially reported its first confirmed case of Chikungunya in epidemiological week 50 on December 6, 2013. The first suspected case was based on symptoms and had registered in epidemiological week 37 as "unknown cause."[11]

The first confirmed case of Chikungunya was male, registered in the District of Cayhill and residing in the Saunders District. The case was reported by one of the general practitioners and subsequently confirmed by the Saint-Martin Laboratory.[11]

Figure 9. Chikungunya cases, Sint Maarten per Epidemiological weeks 37 to 52, 2013



Source: Annual Communicable Disease Report 2013 (Draft), Collective Prevention Services, Ministry of Public Health Social Development and Labor, May 2014

Malaria

There were no autochthonous malaria cases reported during the 2010–2013 period. However, there were two imported cases of malaria: the first in 2011, a 30 year-old female hospitalized and reported as an imported malaria case from Nigeria; the second in 2012, a 25-year-old male was report as an imported case of malaria from India.[8, 9, 10, and 11]

Enteric Diseases

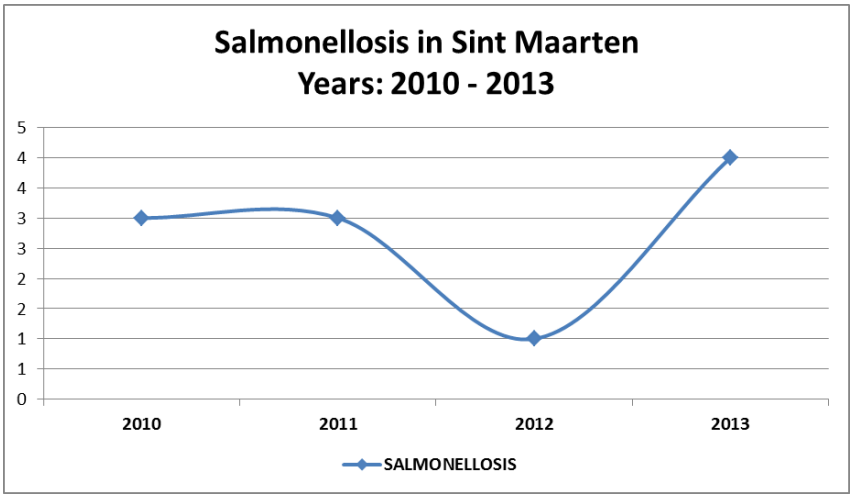
Table 5 reflects Enteric Diseases, during the period from 2010–2013, there were no Cholera cases reported, and Salmonellosis was the main reported enteric disease.[8, 9, 10, and 11]

Table 5. Enteric diseases, Sint Maarten, 2010-2013

DISEASE	TOTAL	2010	2011	2012	2013
CHOLERA	0	0	0	0	0
LISTERIOSIS	1	1	0	0	0
SALMONELLOSIS	11	3	3	1	4
SHIGELLOSIS	2	1	1	0	0

Source: Annual Communicable Disease Report 2013 (Draft), Collective Prevention Services, Ministry of Public Health Social Development and Labor, May 2014

Figure 10. Salmonellosis cases in Sint Maarten, 2010 – 2013



Source: Annual Communicable Disease Report 2013 (Draft), Collective Prevention Services, Ministry of Public Health Social Development and Labor, May 2014

HIV/AIDS

The human immunodeficiency virus (HIV) tests are requested by General Practitioners, and analyzed at the Sint Maarten Laboratory Service. A major concern for the HIV surveillance system was the duplication of laboratory testing. Ongoing centrally-coordinated efforts are necessary to minimize future duplication and ensure proper data reporting to the Min VSA. In 2011, there were 18 new cases of HIV reported. From 1986 to 2011, a total number of 681 HIV infections were reported and 56.4% of them were among males. It is important to highlight that since 2008, there has been an overall downward trend in the number of new HIV cases reported.[3, 12]

Among the HIV cases reported in 2011, 57.1% were males and 49.9% were females. Of these, 4 cases were diagnosed as AIDS, equally affecting both male and female. In terms of age group, the groups most affected by HIV were 20-24 and 40-44. However AIDS also affected older age groups including 25-29, 50-54, 55-59 and 60-64.[3, 12]

In 2013, 83.3% of adults with HIV were under antiretroviral therapy treatment 12 months after diagnosis. Consequently, there were no vertical transmissions from 2 HIV-infected mothers receiving antiretroviral therapy treatment.

Strengthening the HIV/AIDS surveillance system in Sint Maarten, within the framework of the health information system, is also a priority. Therefore, a proposal to identify an appropriate system to collect accurate information is taken into consideration.

Table 6 shows the downward trend from 2005 to 2007, increasing in 2008 and subsequently declining.

Table 6. Cumulative Cases of HIV in Sint Maarten, 2005 - 2011

YEAR	MALE	%	FEMALE	%	TOTAL
2005	21	18	17	20	38
2006	21	18	13	15	34
2007	14	12	15	18	29
2008	21	18	16	19	37
2009	19	16	7	8	26
2010	12	10	9	11	21
2011	10	8	8	9	18
TOTAL	**118**	**100**	**85**	**100**	**203**

Source: Gerstenbluth, Lourents. HIV/AIDS Surveillance, Netherlands Antilles 1985-2007, SLS, Sint, Dr. Gerard van Osch

Syndromic Surveillance

The syndromic surveillance reporting system serves as an important tool for health status monitoring in Sint Maarten. On a weekly basis, sentinel sites report fever and respiratory symptoms cases; undifferentiated fever; gastroenteritis, rash and fever; fever and neurological

symptoms. Fever and hemorrhagic symptoms are reported to the Collective Prevention Services (CPS).

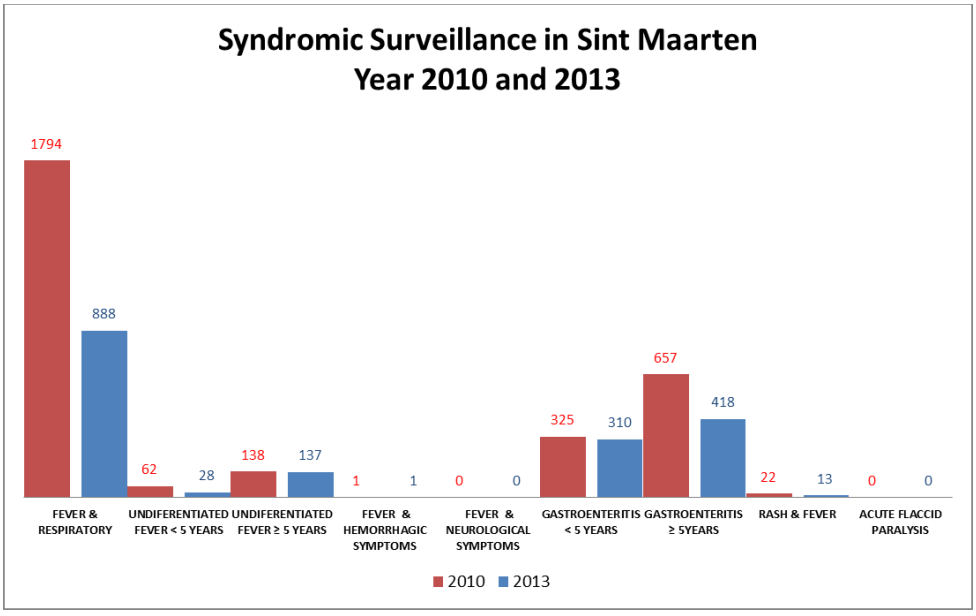
During 2013, there were seven (7) private sentinel sites, six (6) general practitioners, and the Sint Maarten Medical Center (SMMC). Though the rate of reporting has fluctuated over the years, the goal of CPS is to continue recruiting a team of sentinel physicians who will actively participate in the surveillance system.[8, 9, 10, and 11]

Table 7. Syndromic Surveillance, Sint Maarten, 2010 - 2013

YEAR	FEVER & RESPIRATORY	UNDIFERENTIATED FEVER < 5 YEARS	UNDIFERENTIATED FEVER ≥ 5 YEARS	FEVER & HEMORRHAGIC SYMPTOMS	FEVER & NEUROLOGICAL SYMPTOMS	GASTROENTERITIS < 5 YEARS	GASTROENTERITIS ≥ 5YEARS	RASH & FEVER	ACUTE FLACCID PARALYSIS
2010	1794	62	138	1	0	325	657	22	0
2011	1143	45	36	1	0	118	344	101	0
2012	816	11	29	0	0	241	327	76	0
2013	888	28	137	1	0	310	418	13	0

Source: Annual Communicable Disease Report 2013 (Draft), Collective Prevention Services, Ministry of Public Health Social Development and Labor, May 2014

Figure 11. Syndromic Surveillance in Sint Maarten, 2010 and 2013



Source: Annual Communicable Disease Report 2013 (Draft), Collective Prevention Services, Ministry of Public Health Social Development and Labor, May 2014

The Burden of Non-Communicable Diseases

Diabetes and High Blood Pressure

Based on the 13th Annual Diabetes Fair Report, in 2011, The Diabetes Foundation of Sint Maarten carried out glucose testing and blood pressure measurements for a total of 315 persons. Glucose tests reported among females producing a non-diabetic result amounted to 74 (30.6%), undiagnosed 16 (6.6%), and Known Type 2 Diabetes was 152 (62.8%). From this last group, only 5 people presented satisfactory control at the time of testing. The glucose tests on males reported the following results: non-diabetic 34 (46.6%), undiagnosed 22 (30.1%) and Known Type 2 17 (23.3%).

Blood pressure measurements to detect possible hypertension with blood pressure of more than 140/90 mmHg were carried among one hundred twenty five females (125 =51.6%) and thirty-nine males (39=53.4%).[(12)]

Other information reported included alcohol use, at 25.6% among female and 49.3% among males, and smoking 4.5% among females and 13.7% among males.[(13)]

A similar study was performed in 2012 during the 14th Annual Diabetes Fair, where glucose tests and blood pressure measurements were carried out on a total of 324 persons, 250 women and 74 men.[(14)]

Blood glucose level tests for females reported 112 non-diabetic (44.8%), 23 undiagnosed (9.2%) and 115 Known Type 2 (46%). The glucose tests for males reported non-diabetic 36 (49%), undiagnosed 8 (11%) and Known Type 2 30 (40%). [(14)]

Blood pressure measurements were reported for 115 females and 39 males. With blood pressure more than 140/90 mmHg: 54 (46.9%) among females and 27 (69.3%) among males.[(13)]

The same study collected information on alcohol use: which showed 19.6% among females and 48.6% among males. In regards to smoking, results were 2.8% among females and 8.1% among males.[13]

Obesity

A study carried out in 2009 by students from the college Hanze Hogeschool Groningen, the Netherlands, showed that among children 0–4 years old, at least 1/3 of the population studied was overweight, and among that group, almost 45% were obese or severely overweight.[15]

In 2010, the same college conducted another study of the 12–18 age group. The result showed that almost 40% of children were overweight and around 54% were obese. The conclusion of the study was that secondary school students are at risk of becoming obese as a result of their nutritional behavior and lack of physical activity.[16]

Mental Health

In 2014, a national Mental Health Plan 2014–2018 was approved by government. The outdated legislation on mental health regulatory admissions and mandatory admissions at a mental health facility/hospital has been revised. However, the law's content has not changed much. The Ministry of Public Health, Social Development and Labor subsidizes the Mental Health Foundation (MHF). This organization is the sole provider for community-based mental health services on the island. Social Insurance covers 80% of the population, providing total coverage for psychotropic medication. The other 20% is either not insured or has private insurance.[17]

In 2013, the Mental Health Foundation (MHF) had on staff two (2) psychiatrists and one (1) psychologist. In 2012, diagnostic admissions were primarily among two groups: schizophrenia (45%) and mental and behavioral disorders due to psychoactive substance abuse (29%). Psychotropic drugs are available for both inpatient and outpatient facilities.[17]

The Mental Health Foundation at that time had twenty-six (26) staff members, among which twenty-two (22) are nurses with bachelor's degree. An aspect to highlight is that there are no

occupational therapists on staff and there are two private practice psychiatrists in Sint Maarten.[17]

Sint Maarten currently has four (4) resident psychiatrists including child psychiatrists. As a result, it no longer depends on the visiting psychiatrist from Curaçao.[17]

Violence

Ambulance Services reports showed that the number of calls associated with violence has steadily decreased from 2008 to 2010. There were 268 ambulance calls for life-threatening conditions such as wounds, cuts, stabbings, and gunshots in 2008. This figure decreased to 216 in 2009, and by 2010 fell by approximately 50% to a total of 110 ambulance calls.[5]

Although data from the Sint Maarten Ambulance Report seems to indicate that crime and violence are not significant, a number of non-official sources describe violence as a growing concern among citizens. The table below reflects the most recent figures available on crimes reported by type.

Table 8. Number of Crimes Reported to the Police by Type

14.1 Number of Crimes reported to the Police by Type

	2007	2008	2009	2010	2011	2012
Burglary	475	511	412	667	128	112
Burglary (House)	584	548	522	199	519	366
Burglary (Car)	.	.	.	286	225	250
Car Theft	346	190	200	253	215	183
Theft	512	510	494	462	453	429
Robbery	296	281	232	238	296	199
Extortion	26	4	2	1		
Homicide	1	6	7	3	18	10
Attempted homicide	12	10	8	9	9	11
Murder	3	4	0	5	18	10
Attempted murder	4	3	2	3	9	11
Wrongful death	0	0	1	0	0	0
Open violence	46	33	12	9	14	10
Threat	165	166	148	124	187	219
Ill-treatment	134	181	166	171	148	210
Ill-treatment with a weapon	122	85	83	82	71	58
Grievous bodily harm	1	0	6	16	12	8
Destruction	199	223	158	173	118	126
Swindling	14	59	14	8	20	43
Fraud	8	14	15	14	6	16
Blackmail	12	3	7	6	4	6
Rape	13	14	15	8	8	13
Sexual Assault/Molestation	5	4	1	3	0	4
Sexual intercourse with a girl 12-15yrs	4	3	2	0	1	6
Sexual intercourse with a girl under 12yrs	2	4	2	0	0	4
Illicit sexual abuse	2	4	6	6	6	4
Arson	5	6	10	5	16	7
Total	2991	2866	2525	2465	2501	2315

Source: Korps Politie Sint Maarten

Disability

The main causes of disability affecting the population in Sint Maarten were gathered from the Household Listing Survey in 2014.

The total population with different forms of disabilities in Sint Maarten amounts to 3,843 people (11.4%). Once stratified by cause, the visually impaired were the main cause, with a total number of 2,370 (61.7%), followed by multiple disabilities 1,112 (28.9%), physical disability 170 (4.4%), and intellectual/mental disability 61 (1.6%). Blindness was present in a small proportion with only (0.8%).[(2)]

Table 9. Disability in Sint Maarten, 2011

Population with disability by type of disability	
Disability	**Total**
Blind	31
Visually impaired	2,370
Deaf	7
Hearing impaired	80
Cannot talk	12
Cannot use one or both legs	85
Cannot use one or both arms	29
Another physical disability	56
An intellectual / mental disability	61
Multiple disabilities	1,112
No disability	29,766
Total	**33,609**

Source: Department of Statistics Sint Maarten, in Household Living Survey 2014

Health Life Cycle, Sexual, and Reproductive Health

Based on information provided by interviews with authorities and health personnel, exclusive breastfeeding was low and teen pregnancy increased. Also, obesity and being overweight among children and adolescents increased. Nonetheless, maternal and child health institutional delivery coverage was high.

On the other hand, an increase in life expectancy with the growing number of elderly is projected to cause socio-economic consequences in the future, within the Medical and Social field.

There has been a steady increase in the elderly population in Sint Maarten. In 2002, 5% of the population was sixty years or older, compared to 5.9% in 2007 and 11% in 2012. In the last ten years, the elderly population doubled, presenting a major increase over the last five years.[18]

Among the age group 89 years and older, females outlive males, which is congruent with global trends. Among the elderly, there are almost sixty (60) different nationalities. The biggest groups are coming from the Netherlands, Haiti, Dominican Republic and the United States. Over 50% of the elderly in Sint Maarten have Dutch nationality. However, it is important to highlight that 13.4% of those registered during the period from 2000 to 2011 were elderly.[18]

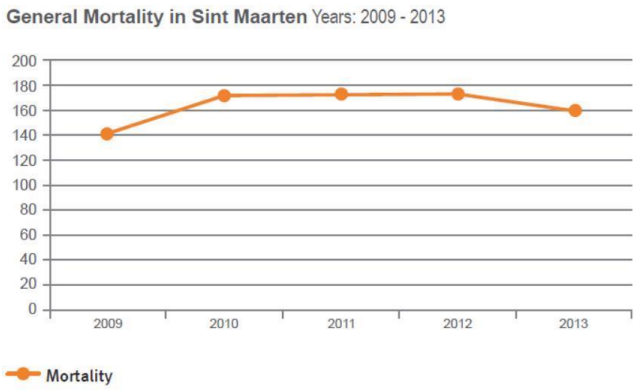
The 50–60 age bracket represented 22% of the population and with the elderly segment projected to grow most. This will become a challenge for limited financial and human resources. This process is often regarded as a major cause of upward pressure on health care costs. However, although an aging population will bring some additional costs, these can be reduced by the application of appropriate and well-coordinated health and social policies.

It is important to highlight Sint Maarten's traditional family network support system in which extended family and friends would take care of the elderly. Even though social support still plays a role in society, the general economic situation is compelling family to join the workforce. Consequently, a growing number of elderly have less family support.

Mortality

In Sint Maarten, to estimate mortality rates, a manual review of death certificates was assessed between 2009 and 2013. Mortality data was coded based on ICD-10 as a classification method. In 2009, 143 deaths were reported. For 2010 to 2013, there were 685 deaths with an average of 171 deaths per year.

Figure 12. General Mortality in Sint Maarten, 2009 -2013



Source: Collective Prevention Services (CPS), Ministry of Public Health Social Development and Labor, 2014

Table 10. Leading Causes of Death on Sint Maarten, 2010 and 2012.

RANKING	ICD-10	Leading Cause of death (2010)	No.	%
1	I20 - I25	Ischaemic Heart Disease	46	27
2	V01 - Y34	External Causes of morbidity and mortality	26	15
3	E10 - E14	Diabetes mellitus	23	13
4	I26 - I28	Pulmonary heart disease and diseases of pulmonary circulation	22	13
5	R95 - R99	III - defined and unknown causes of mortality	19	11
6	C00 - C97	Malignant Neoplasm	14	8
7	I10 - I15	Hypertensive Disease	12	7
8	I60 - I69	Cerebrovascular Diseases	6	3
9	B20 - B24	Human Inmunodeficiency Virus (HIV) Disease	3	2
10	J09 - J18	Influenza and Pneumonia	2	1
TOTAL			173	100

RANKING	ICD-10	Leading Cause of death (2012)	No.	%
1	I20 - I25	Ischaemic Heart Disease	43	25
2	E10 - E14	Diabetes mellitus	28	16
3	R95 - R99	III - defined and unknown causes of mortality	28	16
4	C00 - C97	Malignant Neoplasm	24	14
5	V01 - Y34	External Causes of morbidity and mortality	16	9
6	I26 - I28	Pulmonary heart disease and diseases of pulmonary circulation	10	6
7	I10 - I15	Hypertensive Disease	7	4
8	I60 - I69	Cerebrovascular Diseases	7	4
9	J09 - J18	Influenza and Pneumonia	7	4
10	B20 - B24	Human Inmunodeficiency Virus (HIV) Disease	4	2
TOTAL			174	100

Source: Collective Prevention Services (CPS), Ministry of Public Health Social Development and Labor, 2014

Ischemic Heart disease was the leading cause of death for both 2010 and 2012. Consequently, 1 in every 4 inhabitants of Sint Maarten died from Ischemic Heart disease. Another important non-communicable disease is Diabetes Mellitus, a leading cause of death with 13% (23) in 2010 and 2012.

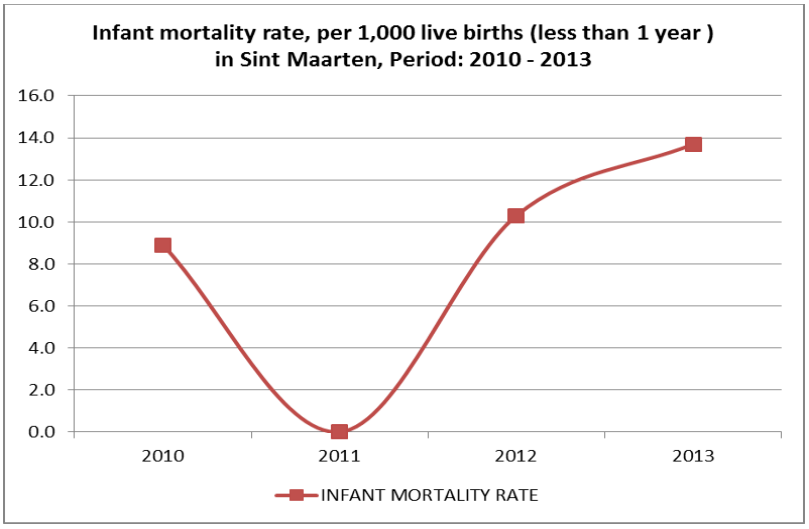
Diabetes Mellitus is ranked second with 28 deaths (16%) an increase of +22% in the number of deaths compared to 2010.

Malignant neoplasm mortality increased by over +71% between 2010 and 2012.[19]

Infant and child mortality

The infant mortality rate per 1,000 live births for the 2010-2013 increased.[20] This was attributable to an improvement in registration. In 2011, there was no official mortality data reported by the Civil Registry of Sint Maarten.

Figure 13. Infant Mortality Rate (per 1,000 live births <1 year old) Sint Maarten, 2010 - 2013



Source: Civil Registry of Sint Maarten

Environmental Health Risks

The main environmental issues in Sint Maarten are water and sanitation, water pollution, garbage collection, hospital waste management, and landfill management.

Drinking water is obtained from seawater through reverse osmosis (desalination) and rain water collection at home.

In regard to sanitation, sewage coverage is scarce, with only 10% of the households in the country connected. In relation to waste management, landfill management is handled through public private partnership (PPP).

The garbage collection system is insufficient and does not meet or satisfy the population's needs. As a result, there are many clogged gutters causing stagnant water.

There is no available information on waste management systems in health facilities.

In regards air quality, the main source of air pollution is burning at landfills, which releases dioxins into the air. This environmental pollution is of concern, given that the quality air measurements in Sint Maarten are limited.

2.2 Development Cooperation, Partnerships and Contributions of the Country to the Global Health Agenda.

Guided by an effective autonomous political, administrative organization agenda, and the strengthening approach of the National Health Systems, Sint Maarten CCS has been strongly endorsed and supported by the key health partners such as SZV, General Practitioners, Specialists, Hospitals, Laboratories, Non-Government Organizations (NGOs) and others health-related institutions.

In step with Health System improvements, Sint Maarten is fully committed to enhancing health effectiveness through strengthening coordination, harmonizing development cooperation, improving fiscal and financial management, and ensuring better management of development results.

Through the General Pension Fund (APS), Social Affairs provides financial aid for families that cannot afford to cover their basic needs Three of the four foster homes accommodate children between the ages of 0-18.

In addition, the Ambulance Department, as one of the executing agencies within the Ministry of Public Health, Social Development and Labor, contributes to the safety and well-being of the entire population.

In 2013, the Collective Prevention Services introduced the pneumococcal vaccine and HPV vaccine for pre-adolescent girls 9-10 years old.

3- Review of PAHO/WHO's past cooperation

Technical cooperation for the 2012-2013 and 2014-2015 biannual periods was focused on the areas considered priorities by the country:

- Reducing the social, economic and sanitary burden of communicable diseases:

  a) placing emphasis on prevention and control of dengue and chikungunya based on the Integrated Management of Dengue Strategy (IMS-Dengue), as well as influenza. The preparation of national plans for the prevention and control of these illnesses and the development of plans to keep the country free from measles, rubella, and Congenital Rubella Syndrome (CRS);

  b) fighting HIV/AIDS and tuberculosis infections; participation in the project to strengthen integration of the British and Dutch countries and territories in the Regional Response to HIV/STDs; support was provided in updating the technical guides and algorithms for diagnosis and treatment of HIV and STDs.

- Promote health and development and prevent non-communicable diseases and their risk factors, such as unhealthy diets, lack of physical activity, consumption of tobacco, alcohol, drugs and other psychoactive substances and mental health. Capacity-building and implementation of the Assessment Instrument for Mental Health Systems WHO-AIMS was provided, resulting in the development of a Mental Health Plan for the country.

- Strengthen leadership, governance, and scientific evidence.

- Support capacity-building to improve financing of universal coverage. The country actively participated in a national consultation of universal access and coverage. A

workshop was carried out to analyze national health insurance in the organization, efficiency and regulation of spending, and outlining steps in the norms and regulations of the healthcare system to extend coverage.

- Strengthen health information systems, epidemiological surveillance and the use of the tenth classification of illnesses based on the International Classification of Diseases (ICD-10).

- Strengthen the capacities of the basic components established in the International Sanitary Regulations (ISR), including the alert and response system for outbreaks and other national and international public health emergencies. Support was provided in the revision and preparation of plans and national strategies for prevention and control of diseases with epidemic potential, such as the Ebola virus. Capacity-building was provided for biological risk management for laboratories and bio-hazardous materials. The country participated in the annual ISR meeting organized by the Dutch government, with participation of PAHO's regional advisor for ISR, in which the strategic pillars were defined for strengthening basic capacities, and a focal point was defined to support the islands and municipalities (2014).

- Training in methodology and analysis of the basic elements to strengthen food safety with emphasis on inspection of imported foods and the implementation of surveillance activities, response, and basic functions of food safety systems.

- As part of the technical cooperation processes, the country participated actively in the National Consultation on the Strategic Plan 2014-2019 and in Biennial Work Plans and the PAHO Biennial Program Budgets (BPB) for 2014-2015 and 2016-2017.

Budget execution by activity is shown below:

Table 11. Areas of Technical Cooperation and Budget Executed 2012-2015

Strategic Objective / Technical Area		BPB 2012-2013	BPB 2014-2015	Total US$
	International Sanitary Regulation	1,494	7,000	8,494
	Dengue and Influenza	2,225	7,000	9,225
02	HIV/AIDS and Others	*	9,000	9,000
	Non-Communicable Diseases		4,000	4,000
06	Health Promotion and Prevention of Risk Factors	11,380	7,000	20,644
11	Health Information System		7,223	11,385
15	Leadership, Governance and Partnerships	9,698	22,500	35,832
03	Maternal Health		5,312	5,312
04	Coverage and Service Access	14,975	7,000	34,250
05	Food Safety		3,465	3,465
	Total US$	39,772	79.500	141,607

Source: PAHO/WHO, Representatives in Venezuela, 2015
*Funds covered by the European Community ECOCT Project

Conclusions

PAHO/WHO is considered a strategic partner for technical cooperation in strengthening Sint Maarten's public health sector. Priorities identified with national authorities include the development and/or consolidation of programs and plans for the prevention and control of communicable diseases, vector control and vector-related diseases, alert and response systems as part of the International Sanitary Regulations (ISR 2005), promotion of health, prevention and control of non-communicable diseases and risk factors, and early detection and treatment of mental illness.

The support of the PAHO during the 2012-2013 and 2014-2015 periods was centered on these priorities. The national plan for prevention and control of dengue was developed, based on the

Integrated Management of Dengue Strategy (IMS-Dengue), and the public health team for control of dengue and chikungunya was strengthened. Cooperation was also provided for the elaboration of the plan for prevention of outbreaks and pandemics, influenza, Ebola virus and others. Cooperation was also provided to strengthen the methods of detection, containment, and efficient response to the main diseases with epidemic and pandemic potential.

Collaboration was provided in the strategic plan for mental health, including in it the information obtained from the application of the methodology from the WHO's Mental Health Gap Action Program (mhGAP).

Support was provided for the analysis of mechanisms that will allow for universal access and coverage to be achieved for the entire population of the country, including undocumented immigrants, through a system of universal insurance and the development of Universal Health Insurance.

Collaboration was provided for the creation of a mortality database from 2009 to 2012 from the death certificates existing in the country.

Recommendations

Sint Maarten is subject to the same accelerated demographic and epidemiological changes that are observed at the global and regional levels. The increase in the elderly adult population and the number of people that develop chronic non-communicable diseases, in addition to existing vector-borne diseases will increase the demand for and opportune response of the health sector, health care services, and a multi-sectoral participation. The country must be prepared to face this situation through legislation, multi-sectoral policies, and integrated strategies based on strengthening primary care with important community participation.

Since tourism is the main source of revenue for the country, it is essential to invest in the country's health so that it may contribute to the nation's socio-economic development. For this reason, it is important to maintain control of communicable diseases and strengthen sanitary control for food safety and environmental health in order to keep Sint Maarten in high standing as a tourism destination.

One of the top priorities is the development of health information systems and epidemiological vigilance for timely decision-making and sustaining health intervention strategies based on scientific evidence obtained through research undertaken locally.

The development and implementation of a National Health Plan for Sint Maarten is fundamental since it will be the guide for achieving the objects and goals established in order to improve the health of the population.

Support should be provided for the elaboration of guides and protocols to contribute to quality care and the safety of patients and health care workers. Moreover, regulations must be strengthened in relation to the rational and safe use of sanitary technologies including medication.

It will be necessary to strengthen agreements and partnerships among the countries of the Kingdom of The Netherlands, and with other countries in the region in order to create systems that provide access and coverage to health care services that are not available locally. These agreements should take into consideration financially sustainable strategies.

4-The Strategic Agenda for PAHO'S Cooperation 2014-2019

The structure of the Strategic Agenda for cooperation is based on priorities and challenges to overcome to achieve PAHO/WHO objectives. These priorities were organized according to categories established in the PAHO/WHO Strategic Plan 2014-2019.

1. Reducing the burden of communicable diseases:

•Improve early detection and control of communicable diseases.

•Improve the reporting system and research for communicable diseases.

•Strengthen the Ministry of Health, Social Development & Labor's ability to collect and use information for decision-making and policy formulation in environmental health with emphasis on solid waste management, safe water, and sanitation.

2. Reducing the burden of non-communicable diseases:

•Promote healthy lifestyles, risk factor prevention, early detection, and adequate treatment of non-communicable diseases (diabetes, hypertension, other cardiovascular diseases and cancer).

•Introduce protocols and guidelines for main non-communicable diseases and risk factors creating appropriate reporting systems.

•Strengthen the Ministry of Health, Social Development & Labor's capability to collect and use information for decision-making and policy formulation regarding non -communicable diseases.

•Improve early detection and treatment of major mental illnesses.

3. Promoting health at crucial stages of life and tackling social determinants of health:

• Promote health including sexual and reproductive.

• Promote health in all the stages of life and through the lifecycle with emphasis on women and adolescents.

•Gather information among vulnerable groups, identify and carry out interventions, according to data analysis.

4. Strengthening of Governance and Health System Development:

• Develop and consolidate the institutional foundations for Ministry of Health, Social Development and Labor and its steering role to regulate, lead, coordinate and commit health system partners with accountability.

• Strengthen its authority to coordinate, implement and enforce policies and legislation to increase equity, efficiency, and quality of health services.

• Identify competencies and gaps among Human Resources in order to improve response to population health needs.

• Develop and strengthen the National Health Insurance ensuring access to quality and universal health services.

• Improve health service delivery by linking providers and financial mechanisms for sustainability.

• Improve the access of the population to medical technologies and ensure the rational use of them.

• Develop a health information system (HIS) and link information technology capacity systems to improved public health decision making, surveillance, management, and financing.

• Promote public health research and evidence for quality response to population`s needs.

5. Emergencies and disasters preparedness, surveillance, and response:

• Support national efforts to strengthen emergency-preparedness efforts and management with a multi-sector approach focusing on hurricanes and other natural disasters.

• Develop the country's core capacities to implement the International Health Regulations (IHR).

6. Coordination and leadership:

- Promote and coordinate health development through strategic alliances and networks.

4.1 Implementing the Strategic Agenda

Medium term achievement priorities for 2015 – 2019

1.Reducing the burden of communicable diseases.

The Technical Cooperation will focus on:

- Reduce the burden of communicable diseases, and improve detection and control of communicable diseases through an effective reporting, data collection system, and research programs.
- Develop, improve and strengthen the use of protocols and guidelines for surveillance and management of vector-borne and other prioritized communicable diseases. Standardize care on Sexual Transmitted diseases (STDs) including HIV/AIDS.
- Develop and implement guidelines for waste management, potable water and recreational water use.
- Develop Human Resource assessment and competency.

2. Reducing the burden of non-communicable diseases, such as heart disease, stroke, cancer, chronic respiratory diseases, and diabetes and promoting healthy behavior including healthy diets, physical activity and tobacco cessation, especially among the disadvantaged population. The major objective is to prevent disabilities among chronic disease patients, and enhance quality care among populations.

The Technical Cooperation will focus on:

- Promote healthy behavior, risk factor prevention, early detection and adequate treatment of main non-communicable diseases (diabetes, hypertension, other cardiovascular diseases, and cancer).
- Develop protocols and guidelines for the main non-communicable diseases and risk factors and introduce appropriate reporting systems.
- Strengthen the Ministry of Health, Social Development & Labor's ability to collect and use information for decision-making and development of policies for prevention of non-communicable diseases.

- Improve early detection and treatment of major mental disorders with emphasis on primary health care.
- Develop a national strategy to prevent and treat childhood obesity.
- Advocate and implement the support of tobacco cessation.
- Establish a National prevention plan for management and control of diabetes, hypertension, other cardiovascular diseases, and cancer.
- Support the implementation of the Mental Health Plan.

3. Promoting health during key stages of life and addressing social determinants of health throughout the lifecycle, with emphasis on women, teens, elderly and the disabled. Gathering information on health needs among vulnerable groups, identifying and carrying out interventions according to data analysis.

The Technical Cooperation will focus on:

- Develop a National Plan to promote health throughout the lifecycle with emphasis on the productive age group, teens, elderly, disabled and sexual and reproductive health, including family planning with emphasis on teen pregnancy prevention.
- Conduct research to identify health needs among vulnerable groups, and analyze associated risks, consequently developing a risk intervention plan for all population groups.

4. Strengthening governance and developing the health system: The Ministry of Health, Social Development & Labor through a National Health Plan, will develop regulatory and leading capacity, coordinating and engaging internal and external key health partners, as well as ensuring accountability of essential public health functions.

The Technical Cooperation will focus on:

- Supporting the Min VSA by developing agreements and legislation/regulations for equity, efficiency, and quality health services compliance by health providers.
- Establishing Care Model-oriented intervention towards preventive services, community interventions, and strengthening of primary care.

- Developing the Health Information System (HIS) and an integrated monitoring plan to obtain evidence-based public health information, health surveillance, management, and financing for decision-making.
- Developing and implement the National Health Strategic Plan for the Ministry of Public Health, Social Development and Labor.
- Strengthening the SZV capacity to ensure accessible and affordable quality health care.
- Supporting the Ministry of Public Health, Social Development and Labor in defining criteria for a comprehensive health package.
- Coordinating current 'Manpower Planning' to strengthen competencies of health care providers and officials.

5. Developing the country's core capacities to implement the International Health Regulations (IHR). Strengthen the national emergency and preparedness efforts, surveillance, response and management through a multi-sectorial approach including special attention to natural disasters, such as hurricanes, and man-made disasters. Develop and increase food security for local population and tourists.

The Technical Cooperation will focus on:

- Support and improve institutional capacities for rapid response based on the IHR with emphasis, control, and community surveillance at primary level as well as increasing national laboratory capacity.
- Develop contingency plans to respond effectively to hurricane risks and other natural and man-made disasters.
- Develop an inter-institutional and inter-sectorial food safety plan.

6- Strengthening the Min VSA leadership and coordination capacity for defining and reinforcing strategic alliances.

The Technical Cooperation will focus on:

- Support the Min VSA in formalizing strategic alliances by developing policy and social dialogue among strategic stakeholders, facilitating institutional coordination as well as identifying, building and maintaining networks, and partnerships for health.

5-Monitoring and Evaluation

The priorities of the Country Cooperation Strategy (2015-2019) are centered in Strengthening of Health Systems within the framework of the Renewed Primary Health Care Approach; Reducing the burden of diseases; Supporting the achievement of the Millennium Development Goals and continuing with the Sustainable Development Goals; Assessing the determinants of health; and Strengthening the PAHO/WHO response to Primary Health Needs by harnessing knowledge.

The developments of monitoring instruments are important components of a successful health system that will be coordinated and in collaboration with internal and external stakeholders.

The National Health Surveillance System Platform is aiming to improve data collection by bringing together accurate and timely information, emphasizing community surveillance.

The Sint Maarten Evaluation and Monitoring methodology will develop as part of the priorities of the Country Cooperation Strategy (2015-2019) to ensure progress toward objectives; data analysis would be guided by a wide variety of information sources.

The ViEpi was an offer from PAHO/CHA/HA through the PAHO Venezuela office to the Collective Prevention Services (CPS) for the Epidemiologic Surveillance System as part of the Technical Cooperation.
Signed:

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Minister of Public Health, Social Development and Labour
Date:

Dr. Carissa Etienne
Director PAHO/WHO

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