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A Critical Realist Interpretation of a Health Narrative Derived from Young Adults in Suriname During COVID-19:

A Politico-Economic Excavation into The Ideological Substructure of Health

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Disclaimer:

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Dedication

Gi mi Mama en mi Papa
Mi Lobi Yu

Gi mi Kondre
Pe mi kumba-tee beri

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List of Acronyms

LDS	Local Development Strategies
IPE	International Political Economy
CPE1	Critical Political Economy
CPE2	Cultural Political Economy
WHO	World Health Organization
ISS	Institute of Social Studies
COVID-19	Corona Virus Disease – 2019/ 2019 novel coronavirus
NPIs	Non-pharmaceutical Interventions
AZ	Academic Hospital Paramaribo
SZF	The State Health Insurance Fund
MOH	Ministry of Health
ICF	Informed Consent Form
REC	Research Ethics Committee

Abstract

Summary of intent: It is widely accepted that health is important. Its definition, however, is far from uniform and subject to change. This project is committed to exploring and evaluating subjective perceptions, feelings, and attitudes towards the concept of health in attempt to give meaning to such derivates of social reality. The argument developed suggests that contemporary conceptualizations of health are deeply entangled in underlying politico-economic processes which have been found to have shaped experiences, behaviour and policy responses. It is the objective of this paper to present the elements carefully as to underscore the interconnectedness of the matter while scholastically seeking to focus explicitly on two conceptual pairs notable in politico-economic debate: commodification vs decommodification. Though the interest is conceptual – if not philosophical at heart – this excavation is embedded in empirical investigation.

Context: This research has been conducted against the backdrop of the ongoing COVID-19 pandemic within the geo-cultural context of Suriname – a middle income country situated in the South American Caribbean. Furthermore, young adults as a variable, have been operationalized as a distinguishing factor for investigating health conceptualization within a diverse demographic.

Methodology: The design of this study adhered to the ontological positioning of a critical realist. As such, this study was formulated to be evaluative rather than simply descriptive. The methods included 25 semi-structured qualitative interviews followed by 12 research participatory drawing exercises. The findings were supplemented by descriptive inferences of statistical data from relevant literary sources for analytical purposes.

Results: The findings indicate that processes of commodification have little bearing upon the gross majority of health conceptualizations, practices, and policy responses with the exception of conceptualizations derived or infused by depictions from social media. This incurrence is inferred to be the result of the increased commercialization and marketization of healthy lifestyles in digitally established markets which are furthermore induced by neoliberal ideologies.

Relevance to Development Studies

The conceptualisation of health is pertinent to the assessment of health policy legitimacy. Health as a concept has both descriptive as well as evaluative dimensions indicating that health is valued differently in various contexts. In the event that health policies in a given community do not reflect the conceptualisation of health of said community members across the diverse and encompassing strata, it can lead to a decrease of public support and participation, and sequentially, an ineffective addressal of the prompted health concern. This type of conceptual work, therefore, is an applicable prelude to improving health assessments in a multiplicity of contexts and enriches the discussions on various micro-sociological approaches to understanding health while also contributing to the subfields of medical sociology and social policies for development.

Given that this paper seeks to contextualize the micro-assessments of subjective perceptions of health within a larger politico-economic debate, its contents also become of relevance to the analysis of how political economic ideologies manifest at the macro level vis-à-vis locally at the micro level. It is the intent that albeit with a focus on health, this project contributes to the subfields of International Political Economy (IPE) as well as Local Development Strategies (LDS).

Lastly, this body of work can contribute to the ongoing and necessary research on the COVID-19 pandemic. Although the COVID-19 pandemic is adopted as an illustrative case study for the cardinal argument rather than a focal point in and of itself, the data provided could be relevant to the growing field of economic epidemiology wherein the evaluation of patterns of diseases and public interventions are appraised against the context of individuals living in a society with economic constraints.

Keywords

Health, Conceptualization, Political Economy, Ideology, Critical Realism, COVID-19 pandemic, Young Adults, Suriname

Chapter 1
Introduction

There is a long-standing complex relationship between health and development. The impact of one on the other is unambiguous; in fact, interrogating the bidirectional causality between health and development has animated the debate within the field. Some postulate that poor health has a direct negative impact on growth and recommend an exogenous effort to eradicate poverty to address economic concerns; others, however, identify institutional problems as the issue and presume that it is growth that leads to progression in health as opposed to the other way around (Berthélemy and Thuilliez, 2013). While these contrasting currents of thought provide insight into the relationship between health and development, the debate remains largely framed along an economic dominated discourse. The probable cause thereof is the traditional insistence on representing development as a largely economic endeavour – a conception that still remains prevalent. This poses two problems. To begin, the multidimensionality of the concept of development remains unappreciated for as long as the pursuit of economic growth is perceived as the singular worthwhile activity undertaken in order to engender progress. Secondly, viewing the attainment of good health merely as a means to further economic development is a purge upon the intrinsic value of health and disregards health as a constituent component of development in and of itself (Ruger, 2014).

This assessment of the problem is by no means an intent to nullify the importance of economics; after all, the allocation for resources in health care is dependent upon economic processes (Ruger, 2014). The point, rather, is to re-orient the perspective on the objectives of development and identify economics as a necessary as opposed to sufficient factor to the pursuit of development. It is important to acknowledge that broad issues of poverty, well-being, injustices, and the fulfilment of basic needs are not just the nerve centre of the development paradigm but are also of relevance to all other disciplines albeit economic, political, environmental, or technological to name a few. The scholarly separation of disciplines is not to be confused with independence (Sen, 1988). It can therefore be deduced that issues related to health albeit illnesses, access to health care, or the promotion of good health, will also intersect with the aforementioned subject areas and presumably many more.

Nevertheless, given the relevance of economization within the developmental paradigm, the researcher considers it opportune to qualify its relationship with the domain of health to further explicate the interconnectedness of the matter. In other words, the main concern is how the triangulated relationship between health, economics, and development can be understood without disregarding the impact of other factors. It is suggested that in re-conceptualizing what is considered health and economic, the fallacy of disjointedness can be abridged.

In many ways, this project is attempting to tackle ordinary concepts such as health and economics which are in themselves remarkably ambiguous. The researcher holds, however, that valid meaning of elusive concepts such as these can be derived from lived experiences.

The Problem Statement

Health care systems around the world are facing issues related to an imbalance. On the one hand, there is an ever-growing market for medical products and services, complemented by an increase in technological advancements; however, on the other, there persists inequal distribution, lack of access, and challenges related to resource allocation (Wallach, 2005). Given the lack of consensus as to who is responsible for the provision of health care, this becomes as much of a political challenge as it is economic and health delineated.

The configuration of actors involved, and their corresponding responsibility, is to a large extent determined by the politico-economic organization of a particular context (Grit and Dolfsma, 2002). This is exemplified by the ongoing discussion related to the efficiency of a health care system that is run by government deregulation and market principles as opposed to government regulation and centrality. The prominence of this debate is expressed by former IMF economist and Harvard professor, Kenneth Rogoff, when he wrote in an article appearing in Foreign Policy[1] that "….the next great battle between socialism and capitalism will be waged over human health and life expectancy" (2005, republished in 2009, n.p.). Although there is much to say about this conceptualization of socialism and capitalism as neither of these politico-economic systems are essentialized by government regulation vis-à-vis deregulation, respectfully, he makes an interesting observation. Given the relentless advancement of medical technology wherein we have witnessed the medicalization of social afflictions i.e. small noses as a beauty standard, shyness as a disease, and even mortality as a matter to overcome, contemporary societies will have to address the likely trade-off between basic health care needs and lifestyle enhancements especially when resources are scarce and distribution and access are disproportionate. The critical queries of course that arise from this are: why such inequities persist; how the incentive to economize scarce resources is to be balanced with an equalitarian provision of healthcare; whether such is ultimately to be market-determined, bureaucratically determined, or strictly medical-professional determined; and lastly, which politico-economic system subsequently delineates the most appropriate organization.

The Knowledge Gap and Research Objectives

Given that addressing the aforementioned queries would indeed be beyond the scope of this paper, the researcher identified a worthwhile study focus to permeate the overall problématique: investigating the conceptualization of health in a particular context. Understanding what health means to people is an opportune way to understand how health is experienced and what underlying ideas and values are embedded in those conceptualizations. According to Doyal and Pennel (1979), the conventional view of health is problematic. They assert that medicine, health and health care are largely rooted within three problematic assumptions: health is predominantly biologically determined; medicine is solely a science; and scientifically approved medicine is the monopolized mediator between society and disease (Doyal and Pennel, 1979:12). This leads to narrow deductions regarding the health care system as it fails to capture the embeddedness of health within many closely knitted domains such as economics, political science, sociology and anthropology (Doyal and Pennel, 1979; Baer, 1982). As such the linkage between health, the economic and the social is disjointed or often misunderstood.

[1] A US news publication that has publicised articles on global affairs since 1970

According to studies done by Peersman et al (2012) in Ghent, Belgium, and D'Houtaud and Field (1984) in Lorraine, France, notable differences in how health is perceived were found across the varying social strata. The variations in conception were attributed to differing gender, ages, and socio-economic class of which class was the most discriminating variable. According to Stronks et al (2018), the exploration of the various conceptualizations of health is a worthwhile venture as there are limited studies performed utilizing a diverse set of methodologies in various contexts. As a result, there is a lack of empirical knowledge in this area. Moreover, having a better understanding of the various conceptions of health could aid in assessing to what extent the trade-off between basic health care needs and lifestyle enhancements are occurring and qualified among laypeople; to what extent health concerns are competing with economic endeavours; and upon whom the responsibility of health achievement and provisioning is placed. As such, exploring various conceptions of health through subjective feelings and attitudes is the primary research objective of this paper.

The second objective of this paper is to assess how consistent these conceptualizations are with local health practices and responses towards non-pharmaceutical policy interventions (INPs) such as 'social distancing' and 'lockdowns'. At the heart of this undertaking is questioning how conceptualizations are socialized and to what extent the policies in a given community reflect the understanding of health of its community members. A secondary focus hereinto will be the notion of 'solidarity' which along with 'justice' and 'fairness' are ethical categories that are increasingly linked to the discussions surrounding economic considerations in health care according to a report released by the bioethics commission of the Federal Chancellery – Secretariat of Vienna, Austria (2018). The economic relevance of investigating 'solidarity' is rooted in questioning how persons value health services, policies, or interventions; what is considered a necessity as opposed to what is considered excessive; and how disproportionate access and distribution and overall discrimination is viewed in relation to health. These concerns relate to the general economic challenge of dealing with limited resources. In examining people's health practices and their responses to public policies, there is an opportunity to assess how this economic infused concept of solidarity is socialized.

The third objective of this research project seeks to tie in the economic aspects of the two preceding objectives and determine to what extent certain politico-economic processes affect the given conceptualizations and correlating health practices and policy responses. The two main politico-economic processes that will be considered are processes of commodification and decommodification. According to a systematic review study done by McCartney et al (2019), various aspects of political economy impact health outcomes significantly. Moreover, Lysaght (2009) found that there is a rising prevalence of consumer-based conceptualizations of health-related matters which are testimonial to the overall pace of intense commodification and marketization. Within these conceptualizations, the meaning-making process revolved around the consumption of products which were seen as integral to a healthy lifestyle. It is hypothesized that health conceptualizations among young adults in Suriname will also indicate linkage to such processes of commodification.

Study Setting and Main Elements

In attempt to embed the conceptual concern of this paper into a genuinely empirical investigation, this section is dedicated to narrowing down the research objectives to a specific context. The chosen elements are as follows:

The Ongoing Pandemic: COVID-19

It is rather topical to investigate health during a global epidemic caused by the highly contagious corona virus. The corona virus disease belongs to a group of enveloped, non-segmented, positive single stranded ribonucleic acid (RNA) genomes that have a long-standing history as human pathogens dating back to the 1960s. There is still much to ascertain about COVID-19 in regard to its virology, pathogeny, and diagnosis, which, consequently, continues to impact the capacity to manage the spread effectively. Given the novel nature of this pandemic, it is perhaps presumptuous but thought-provoking to consider that the prevailing view of health care might be challenged.

Without discounting the unthinkably deleterious effects COVID-19 has had over the span of a year, it is assumed that this pandemic could offer interesting insights into the relationship between health and politico-economic processes. In many ways, COVID-19 has brought some of the contending issues to the forefront. In studying the impact of NPIs on the virality of the corona virus, Lin and Meissner (2020) demonstrate that the COVID-19 pandemic is as much a shock to public health as it is to the economy. They do not proclaim, however, that the implementation of NPIs results in a trade-off between the economy and public health, at least at a local level. Instead, they posit that the economy endures shocks related to labour supply, products demand, and uncertainties related to financial investments as a result of the labourer's, consumer's and investor's behavioural patterns, respectfully, as opposed to the delimiting mobility impact as a consequence of NPIs. They furthermore claim that the state of a local economy during a pandemic is extremely dependent upon what is happening elsewhere. Due to the interrelated nature of the global economy and the quick spreading of information (and the disease), the traffic of economic activity within particular countries irrespective of their implementation of NPIs is affected by the state of key trading partners and the news which, in turn, affects the behaviour in of people in the receiving context.

There is an increased interest in patterns of behaviour as it relates to infectious diseases and its connection with economic processes in the last few decades as demonstrated by a study published in 2000 by Tomas Philipson. He stipulates that there is a prevalence-elasticity of private demand for the prevention of any given infectious disease. The economic logic hereto follows that as the number of the infection increases, preventative behaviour increases; whereas when the infection rate decreases, the demand for prevention also decreases. The implications hereof are critical. Firstly, if the preventative measures are effective, growth of infectious diseases become self-limiting as preventative behaviour is instinctively induced. Secondly, policy health interventions cannot be inflexible as public behaviour changes in relation to the prevalence of the disease. This also implies that it is progressively more difficult to completely eradicate diseases when the preventative measures rely on individual decision-making and input. Thirdly and finally, if the preventative measure is product based, for example, a vaccination, the demand dissolves as soon as the diseases is eradicated. In other words, quick eradication of diseases is not profitable to patent-protected producers and suppliers of said preventative measure.

Concerning the debate around profitability, an interesting study conducted in June of this year by Francesca Sobande drew correlation between the COVID-19 pandemic, consumer culture, and capitalism. According to her analyses, brands utilize commodified notions of human connection, care, and community to represent themselves as ethically invested in people and thereupon add an additional element of appeal to their product or service which would result in higher profitability on their end. Her biggest critique, however, is not the attempt to increase profitability in and of itself, rather, that brand produced discourses of supposed togetherness disregard socio-economic disparities. Her argument revolves around the perception that not everyone experiences the pandemic in the same way due to structural inequalities that have preceded the pandemic. Both the study conducted by Philipson and Sobande demonstrate the varying ways in which health concerns can be influenced by economic processes.

Suriname

The geo-cultural context upon which this research project will focus on is that of the Surinamese population. Suriname offers a very interesting viewpoint into the triangulated relationship between health, the political economy, and development. As expressed by the senior associate of Centre for Strategic and International Studies in Washington, D.C., Mr. Scott MacDonald, Suriname is politically and economically at a crossroad. Suriname has been undergoing intense periods of economic recessions and inflations in the last few years wherein the national Surinamese currency, the SRD, devalued in the international exchange market. In the month of September of 2020, USD currency was purchased and sold at an exchange rate of 7.396 SRD to 1 USD and 7.520 SRD to 1 USD, respectfully. In the following month of October, the worth of the SRD devaluated by nearly 100% as USDs are now purchased and sold at a rate of 14.018 SRD and 14.290 SRD per USD (Central Bank of Suriname, 2020). In addition to this, Suriname has undergone a change in government administration in the recently held elections in May of this year. Suriname, has thus, experienced a number of changes in its politico-economic climate that could have had bearing upon the experience of the COVID-19 pandemic locally. Moreover, Suriname is a multi-ethnic country that continues to undergo cycles of emancipation processes addressing the shackles of colonialism (Hoefte and Veenendaal, 2019). As such, interesting observations could be derived from the variety of perspectives embedded in differing cultures.

According to Hout (2007), Suriname can be classified as a rentier state wherein which patronage and clientelism is heavily practiced. A rentier state is one whereby the largest income of revenue is generated through external sources such as loans, foreign aid, or resource rents. The presence of patronage and clientelism causes for economic enterprises to function in relatively compromised autonomy in relation to government shareholders. Hout makes reference to the notion that rentier states are often deemed as weaker and less efficient because patrimonialism is sustained and there is a lack of accountability for government expenditure due to the evaded need for domestic taxes as a result of external sources of income. Shambayati (1994), on the other hand, in his investigation into state and business in Iran and Turkey postulates that the rentier state's organization allows for a state-citizen relationship that is defined by non-economic terms and removes the need to exploit the domestic population through taxation. While Shambayati's formulations sounds appeasing, one of the main issues with rentier states is that domestic productive sectors remain largely underdeveloped and the issue of sustainability comes to the forefront. While Suriname has been able to

maintain a status of a small middle-income country in South America, the dependence on foreign aid and resource rents has shown to be highly unreliable as the geo-political relationships continue to be re-configurated and resource revenues have plummeted.

Interestingly enough, a research conducted by Eichler in 1999 for the Inter-American Development Bank was used to contextualize the politico-economic of Suriname within its local health sector. Eichler's results indicated that the Surinamese health system is comprised of relatively autonomous actors in both the public and private spheres; relatively adequate access to primary health services; and nearly a complete population health insurance coverage to mitigate financial strains or barriers to health care. As far as social objectives go, this can be considered fairly positive. However, Eichler cautioned for potential pitfalls as the financial resources to continue these provisions become less and less. The SZF is the largest public payer for health insurance and functions in a rather open-ended funding environment without proper budget constraints. As such, there is little control over billing abuse or any incentives to cease if such is prevalent. Moreover, actors such as the SZF and the MOH lack the institutional capacity to assume a less passive and more effective role. Given that Eichler adopted a largely market-oriented analysis of the situation, it was fitting that one of her recommendations was to introduce a new health payment scheme. Thereupon, the investigation into the conceptualization of health of Surinamese could reveal how such a policy change would be received by the population. Moreover, Hout (2017) suggested that exploring the meso and micro level actors is pertinent to gauging the socio-political dynamics of a particular sector (such as healthcare) relating to the economy.

As it relates to covid, the key fiscal and macro-monetary policy responses to the covid-19 pandemic implemented in Suriname ranged from the adoption of a provisional covid-19 related budget to address health-related issues, unemployment, and local production; the adoption of a covid-19 Exceptional Condition Act which bestowed a greater degree of power to the executive government e.g. the ability to exceed the yearly budget and the ability to prosecute media outlets for false information regarding the pandemic; and a series of deregulatory and regulatory measurements aimed at alleviating liquidity requirements and tightening governance, respectfully ('Policy Responses to COVID-19', 2020).

Suriname has implemented a range of preventative measures including curfews, a stay-at-home order, ban on gathering of large groups of people, the mandatory wearing of masks in public places, limitation of visitations of the elderly and the sick at elderly homes and hospitals, and the closing of all (air)ports and borders for commercial passengers. The main measures that will be focused on in this paper, however, are the lockdowns (partial and full) and the social distancing measure whereby a distance of 1.5 meters is expected to be maintained between people in public places (Khadan, 2020; 'Covid-19', 2020).

Young Adults

There are a growing number of articles indicating that young adults around the ages of eighteen and thirty are increasingly and disproportionately being tested positive for covid-19 (Stone, 2020; Lyons, 2020). Accordingly, a number of studies have begun to investigate age-dependent effects of this pandemic. As it relates to young adults, topics of interest include the growing asymptomatic transmission of the disease as well as the attitudes and practices

that formulate young adults' response thereto (Knight, 2020; Davies et al, 2020; Moghadas et al, 2020). It has been observed that the narrative of young people's health and wellbeing has been undergoing fluctuations and broader efforts beyond strict interventions must be employed to address new emerging health concerns among young adults (Eckersley, 2011).

The median age in Suriname is 29 out of a population of 581,372 people. This indicates that the bulk of the population is at the prime of working age and young adults make up a significant part of the population. Although there are a number of general policies aimed at addressing the health concerns and the socio-economic issues caused by the COVID-19 pandemic, there are none specifically aimed at young adults (Statistics Bureau of Suriname). There was, however, a Knowledge, Attitude, and Practice (KAP) survey disseminated in Suriname in collaboration with UNICEF to gage how the pandemic has impacted their lives. Although the results have not been published, a blog entitled "Kawaka with Youth (How is it going with Youth') was established as a means to further engage the youth in uncovering the impacts of COVID-19. The level of activity, however, is seemingly rather low as less than five blog entries have been posted thus far.

The Research Questions

Given this problématique, the following questions have been formulated to guide this investigation:

1. To what extent are the health conceptualizations of young adults in Suriname influenced by processes of commodification and decommodification and how does this impact social practices and public responses to health policy interventions amidst a health crisis?

a. How do Surinamese young adults conceptualize health?
b. How corresponsive are the Surinamese young adults' conceptualizations of health with their own social practices and responses to covid-19 health interventions?
c. What is the level of 'solidarity' among Surinamese young adults and how is such socialized?
d. Are processes of commodification and decommodification relevant to the conceptualization and socialization of health among Surinamese young adults?

Chapter 2
Critical Realism and Main Theoretical Frameworks

The main philosophical framework underpinning this study is critical realism (CR). At the heart of critical realist research is the intent to understand phenomena as opposed to merely describing it. That is why CR is deemed appropriate for evaluative and causal research, and by extension, this research project.

Critical realism was born out of the work of Roy Bhaskar in the 1970s and is considered an alternative to the methodological strains of positivism and constructivism insofar it is embedded in an ontological positioning that characterizes what is real as intransitive, and what we know as transitive (Karim, 2020; Fletcher, 2016). As such, CR is a perfect marriage between ontological realism and epistemological relativism, respectfully. In CR, the social world we have come to perceive is open and stratified and is comprised of emergent entities (Vincent & Mahoney, 2018). This is a rather complex conceptualization of 'what is' and 'what we know', thus, the following paragraphs will commit to explaining the forementioned statement by using the topic of examination as the prime example i.e. health. In this manner, it becomes clear how CR informed the conceptualization of this project and moulded it methodologically into what it came to be.

According to Bhaskar, entities can be material, immaterial or both; they can be ideational; and they can be hierarchical. In simple terms, entities can exist in different ways at varying levels (Vincent & O'Mahoney, 2018). Health is hereupon a difficult example, delineating the complexity of the matter. While health in itself cannot be bottled up and presented such as a water for example, and is therefore quite immaterial, there are a number of other entities that are material that are deemed healthy, for example, a properly functioning immune system. Furthermore, in explaining health, other entities may be cited in order to offer a definition for health as to break it down into parts, e.g. mental health or bodily health. Bhaskar offers a few explanations to address this. To distinguish between an entity's enabling processes and epiphenomenal features, he stipulates that entities are made up of 'real essences' and 'nominal essences'. Real essences, hereupon, are the 'structures or constitutions in virtue of which [a] thing or substance tends to behave the way it does' (Bhaskar, 2008: 209); i.e. a properly or improperly functioning immune system; a healthy or unhealthy lifestyle; access to health care or the lack thereof. Nominal essences, on the other hand, 'are [the manifestation] … of …properties …which are necessary for the thing to be correctly identified as one of a certain type' (Bhaskar, 2008: 279); i.e. its objective, its targeted audience, its impact, whose responsibility it is, and how it is expressed.

By defining entities as such, Bhaskar implicitly notes that although entities can be made up of other parts, which are entities in themselves, they cannot be essentialized as merely the sum of those parts. As they can each make a difference in their own right, Bhaskar proposes that it is rather the understanding of the relationship between the different parts that offers an interesting entry point into examining an entities' <u>casual powers</u> that may or may not be actualized, for example, a healthy person has the power to live longer. It also gives insights into an entity's <u>mechanisms</u>, which come to the forefront as it interacts with other entities that it may or may not be comprised of, i.e. a healthy person may be bitten be a deadly snake and may potentially die if he does not have access to healthcare. A mechanism refers to that

which needs to be there for said causal power's to be actualized. In investigating specific relationships, particular tendencies or event regularities may appear which gives insight into what could happen and what is not happening, and even, what 'should' happen. For example, given that a power must be preceded by a mechanism actualized – i.e. one must have access to health care to maintain health – explorations into what allows such mechanisms to be actualized or not will surely be evaluative.

The usage of terms such as tendencies and actualization used in CR makes a lot more sense once it is understood how CR is ontologically positioned. A critical realist observes the existence of a 'objective' reality, however, postulates that that reality cannot be observed in the empirical realm. In CR, reality is stratified according to the following levels cited from upper to lower stratum: the empirical, the actual, and the real. The empirical refers to what is observed through the filter of human experienced; the actual refers to what is happening regardless of human interpretation or observation; and the real refers to what must be there in order for all the preceding to occur. An important concept of causality is adhered to at the level of the real insofar it is claimed that the 'object' or 'reference' has properties in and of itself through which causal mechanisms can be determined; thereupon social phenomena can be explained and transformed through the unmasking of such (Karim, 2018; Karim, 2020; Fletcher, 2016).

The movement from upper stratum to lower stratum is seen as necessarily contingent whereas the opposite movement is seen as contingently necessary. This gave rise to the concept of stratified emergence which was central to the critical realist theory of structure and agency of Margaret Archer. The logic here follows that there are contradictions between experience and reality and that there are differences between temporalities and multiple domains, hence structure and agency have distinctive emergent properties. While they may be separate at an ontological level, at a thematic level they cannot be detached. Through the concepts of stratification and trans phenomenality and emergence and counter phenomenality especially, we can infer that structures precede agency, but reflections and actions follow agency – this sidesteps the problem of over-subjectivity and determinism simultaneously (Karim, 2018; Karim, 2020; Fletcher, 2016).

All of this theoretical baggage informs the logic and hypothesis behind this research inquiry. In assessing phenomena, in this case, the way health is expressed and socialized, the researcher assumes that there are structural and agential elements impacting the overall occurrence. Moreover, while structure and agency may have distinctive properties, they interact in a dynamic manner. In other words, although there may be underlying politico-economic substructures underpinning health conceptualizations, that is not considered the end all be all as people have agency and reflective power to assume different empirical phenomena to be actualized.

The CPEs

Given that CR outlines a metaphysical ontology, it is more so applied as an underpinning to guide research as opposed to as a theoretical framework that delineates which societal structures are at play. The decision to excavate politico-economic substructures of health, thereupon, was not a consequence of critical realist positioning, rather, as a result of adopting Critical Political Economy and Cultural Political Economy as the main theoretical frameworks for informing this research. In applied CR, the adoption of various theoretical

frameworks is condoned because CR is compatible with various theoretical explanations of social reality, though not necessarily their ontological implications. To reiterate, various mechanisms and their emergent powers can be actualized in various context which results in various valid explanations. In the event that theory A supposed that X causes Y, and the empirical observation in a particular context contradicts such, it is just as valid to excavate which mechanisms were at play for X not to incur Y. This continual process of puzzle piecing, given the dynamic nature of time and space, is what gives CR its internal validity as a philosophy of science. Moreover, in operationalizing many of the concepts of this paper, existing theoretical frameworks have been utilized although altered to begin at least, in a provisional sense, to organize information.

Political Economy (PE) refers to a theoretical approach that seeks to position the economy within a broader social context (Browing and Kilmister, 2006) much like the sentiment of this project which sought to situate health within a larger politico-economic context. Critical Political Economy (the 1st CPE), thereupon, distinguishes itself from regular PE in emphasizing the need for transformation of narrow concepts of the economy because they would have failed to adequately encompass the social reality of a broader context. Though quite expansive with varied streams of thought, CPE has always had an internal vocation to the theoretical stream of Historical Materialism (Cafruny et al, 2016) which has its origins in the works of Hegel and Marx. Though there are significant differences between the theories of Marx and Hegel, one point of convergence between the two rests upon the notion of contradiction. This contradiction appears both conceptually and empirically, when conventional economics valuing individuality and particularity, fail to address the negative impacts of the divisions of labour, modes of production, and pursuit of market activity due to the isolated notion and practice of what is considered 'economic' from the social and the political (Browing and Kilmister, 2006). This is the notion that will be most relevant to this project.

Cultural Political Economy (the 2nd CPE), on the other hand, signifies a cultural turn within the field that places more emphasis on natural and human relations and the economic systems it produces. While in some streams of CPE2, discernibly, the focus is on the economization of the cultural or the culturalization of the economic in the context of variable manifestations of neoliberalism, the interpretation that is relevant to this project is that of Jessop and Sum. According to their article published in 2019, CRE2 combines critical semiotic analysis with critical political economy in an effort to examine the contingent relationship between political domination through ideology and economic organization. The theoretical reference to expound on the ideas of CPE2, as stipulated by Jessop and Sum (2019), is the work of Karl Polanyi. Polanyi is well known for his notion of 'fictitious commodities' which are entities non-suitable for marketization or commodification – i.e. land, labour, and money – and his analytical distinction between a substantive and formal economy. Whereas in the former the economy is embedded in the social realm, in the latter, it is deemed disembedded (Jessop and Sum, 2019; Jessop, 2010).

Though there are intense differences between Marx and Polanyi, they both offer critiques to capitalistic-organized market economies. As a matter of fact, both Polanyi and Bhaskar have been influenced by the theoretical contributions of Marx although they would have formed varying ontological positionings. Nevertheless, it has been considered that a Marxian-Polanyian synthesis could offer an interesting, complementary take on the limitations of marketization and commodification (Barnes, 2011). Though an extensive conceptual application of a Marxian-Polanyian synthesis would not be feasible for this project, CPE1 and CPE2 have been used, at least, elementarily, for the analysis of the findings.

Chapter 3
Methodology

The Design

Given that CR is not paired with a straightjacketed methodology, it was possible for the research design to be innovative while simultaneously cognizant of the objectives of this project. As such, a qualitative multi-method design was formulated. Although qualitative research is often more associated with constructivist or interpretive research, critical realists, have encouraged the adoption of qualitative research methods. According to Margaret Archer, for example, qualitative research is useful for the exploration of mechanisms by assessing patterns or tendencies that become apparent through human speech, text, or imagery. Furthermore, a multi-method design is corresponsive to the practice of exploratory critique, which was advocated by critical realist, Roy Bhaskar, whereby the extent by which theory corresponds with reality is explored (Olsen, 2009).

Data for this project was obtained from both primary and secondary sources. In accordance with CR terminology, the data consisted of extensive and intensive data. The extensive data in this case refers to statistical data related to the COVID-19 situation in Suriname and the intensive data refers to the in-dept interpretive data as derived from qualitative interviews.

Ethics and Limitations

One major imposing factor upon the proceedings of this project was the COVID-19 pandemic itself. Due to the health risks involved, fieldwork was strongly dissuaded against; however, if conducted must have followed strict protocols adhering to the utmost safety measures. Thereupon, the obtaining of primary data was conducted via a digital medium in order to assure no physical contact. Conducting research via virtual reality, however, brings forth its own limitations and ethical concerns. These concerns relate to the dependency on technology which could be susceptible to malware; moreover, there is an additional potential threat to privacy given the possibility that information could be decrypted by unforeseen third parties. To mitigate these risks, widely used platforms that are well-encrypted were suggested to be employed such as Microsoft Teams. However, in practice, many research participants were unfamiliar with the platform and preferred one that they were comfortable with such as Zoom and WhatsApp video call. Thereupon, the researcher ensured that the risks were known and apprehended and obtained consent to continue prior to each interview.

Additionally, a privacy questionnaire was completed to determine the level of risks this project carried. As such, an ethics review form and a statement of research ethics on behalf of the researcher along with a proposed Informed Consent Form (ICF) was submitted to the ISS Research Ethics Committee. The REC provided suggestions for the improvement of the ICF which were adhered to before the commencement of data collection.

Lastly, the majority of interviews were conducted in Dutch and were thereafter translated into English by the researcher. Although the researcher is a native Dutch speaker and an adept English speaker, a given limitation concerns the possible extent to which meaning could have been lost in translation.

Methods of Data Collection

The three main methods of data collection were: qualitative interviews; research participant produced drawings; and the assessment of statistical data derived from situation reports produced by the Surinamese COVID-19 crisis team.

The interviews were comprised of semi-structured questions to allow a balance between theoretical underpinnings and new emerging ideas, as well as a few quantitative scaling questions to gage perceived relative importance of certain factors related to health. The interview process consisted of five pilot interviews wherein the interview structure was tested in terms of coherence and clarity during which suggestions from the research participants were taken into account. This allowed the research process to be rather collaborative and participatory.

The research participatory drawings were strategically utilized to explore people's understanding of intangible concepts such as health through a form of expression outside of speech or text. The use of visual methods has increasingly been employed in health professions education research (Bowden, et al, 2016; Rees, 2018). Moreover, during the pre-interviews, a few research participants noted that it was rather difficult to respond to certain questions with words. Thereupon, participatory drawings wherein participants could express themselves through self-produced imagery was elected as an innovative addressal thereof.

The recruitment process commenced with a recruitment statement placed on a well-utilized social media platform in Suriname: Facebook. This platform was chosen intentionally to draw in a particular demographic (i.e. young adults) and to maintain adherence to a non-physical means of recruitment. Given that there are no specific regulatory protocols addressing the utilization of social media as a tool for recruitment, the statement dispersed included the request to privately contact the researcher if privacy is wished to be maintained. The inclusion criteria stipulated that:

1. The research participant is of Surinamese nationality.
2. The research participant either lived in Suriname during the majority of the COVID-19 pandemic or has close family and friends who have lived in Suriname during the pandemic with whom they maintain frequent contact.
3. The research participant is between the ages 18 and 30.

Methods of Analysis

In keeping with the spirit of multi-method research (Hunter and Brewer, 2016), the methods adopted for analysis were the result of an unfolding, pragmatic approach to the research process. The table below outlines the methods of analyses employed as correlated with the corresponding data collected methods.

Table 1
Methods of Data Analysis

Method of Data Collection	Method of Analysis	Data Source	Interpretation; Write-up
Qualitative Interviews	Flexible Deductive/Inductive Coding Relational Content Analysis	Research participants	Conceptual Modelling Identification of various discourses
Participatory Drawings	Semiotic Analysis	Research participants	Identification of what is signified, and indexes/or symbols Explanatory Analysis
Assessment of Statistical Data	Descriptive inference	Situation reports/ Relevant Literature	Provision of summary of COVID Situation in Suriname / Insights into context overall

Source: Own construction; Derived from findings, 2020

For clarification of terms, the following explanations are offered:

1. A flexible deductive/inductive coding process refers to a dynamic coding process whereby the data is first organized according to provisional codes derived from theory and is thereafter expanded to include emerging codes derived from the data (Fletcher, 2016).
2. Relational content analysis is a tool by which concepts and themes derived from a variety of sources i.e. an interview, is analysed according to the relationship between said concepts and themes using co-occurrences or explicit references of association (Neuendorf, 2017).
3. Semiotic analysis consists of the study of signs; it is a means by which meaning is derived from representation i.e. an image or a drawing. The scholar Charles Pierce has identified icons, indexes, and symbols as the three dimensions of signs and thus categorical classifications of derived meaning. (Burks, 1949).

Chapter 4
Operalization of Key Concepts

Health

There are numerous definitions of health that each build on the various components related to health albeit the physical, the social or the spiritual to name a few. This has brought upon a dilemma. On the one hand, a too narrow bio-medical definition does not seem to address the interdependent nature of health; however, on the other, a too all-encompassing definition is just as problematic (Van der Geest, 1985). Whereas the former disregards non-psychical areas in life in need of care-taking as to sustain 'wellbeing' and devalues other approaches to health albeit culturally or historically established, the latter induces increased medicalization which as Illich has argued in his renowned book, "Limits to Medicine" leads to increased commodification (Smith, 2002). While the purpose of this research paper is not to define health but rather to assess the conceptualizations present in a particular context, it is useful to organize the given data according to existing streams of thought. Therefore, the four most prevalent models of defining health as organized by Larsen (1999) will be utilized as a frame of reference. The following table outlines the four conceptual models.

Table 2
Conceptual Models of Health

The Medical Model	The WHO Model	The Wellness Model	The Environmental Model
Defines health as the absence of disease or disability	Contests that health is merely the absence of disease	Agrees that health is more than the absence of disease	Essentializes health as the individual adaption to the social and physical environment
Includes the physical and the mental	Defines health as "a state of complete physical, mental and social well-being…" ((United Nations 1984)	Defines health as "optimal personal fitness for full, fruitful creative living" (Goldsmith 1972:213).	The concept of balance, the concept of acceptance and stress minimization, are emphasized
For measurement purposes, disease, illness and health are distinguished	Proponents consider this conceptualization to be holistic	Emphasizes the relationship between the mind and the body and to an extent the spiritual	Ill-health is defined as the inability to 'function' in the given environment
Disease is considered the objective condition; illness is the individual perception of a disease; and health is considered undefinable	Critics deem this conceptualization to be vague and too idealistic. Proponents of the medical model, for example, criticizes its lack of scientific application	Outlines the importance of health promotion and disease preventions. It also considers health maintenance an individual responsibility.	Critics address the moral implications of the supposed acceptance of environmental conditions.
External bio-medical measurements are approved to determine of disease or illness.	Some critics are not convinced that social well-being is an independent dimension of health	Critics address the inclusion of difficult-to-measure concepts such as happiness.	Critics also address the usage of ambiguous and abstruse terms such as 'perfect adjustments'

Own Construction. *Source*: Larson, 1999.

Young Adults

The design of this project became such that young adults were operationalized as a distinguishing factor for investigating health conceptualization within a diverse demographic while simultaneously offering insights into the bearing of age upon said conceptualizations. The

investigation into other socio-economic factors such as class, ethnicity, and education, however, were exclusively considered in the realm of analysis of findings.

The Surinamese Ministry of Youth and Sports considers the concept of youth to be applicable to the age ranging: 0 to 30. Moreover, the majority and voting age in Suriname is legally 18. As such, the age demarcating criterion for young adults adopted in this study is to an extent appropriate and valid as it, at least, coincides with the bureaucratic conceptualization of youth in the country (Statistics Bureau of Suriname; Government of Suriname – Ministry of Sports and Youth, 2014).

Solidarity

The concept of solidarity is of substantial relevance to the objectives of this research. Thematically, reference has been made to the term when António Guterres, secretary-general of the United Nations, described the COVID-19 pandemic as "…a human crisis that calls for solidarity" (The United Nations, 2020). Conceptually, solidarity has been considered necessary for human well-being as proposed by French philosopher, Pierre Leroux. Moreover, Marx, for example, deems it an expression of shared experience among class groupings with shared political needs (Gaztambide-Fernández, 2020); while moral economics consider it a fundamental ethical category in their field– a position influenced by Karl Polanyi. In fact, one of Polanyi's critique of the market society was that its economy was based on the value of self-interest, which if proliferated, occurred at the expense of shared interests (Federal Chancellery – Secretariat of Vienna, Austria, 2018; Jessop and Sum, 2019). Thereupon, the examination of the concept of solidarity in this study was operationalized as a means by which the social significance in terms of shared interests of health was investigated.

A study conducted in Greece examining solidarity during the 2008 world financial crisis, identified conceptualizations, processes, and aspects of solidarity that will be utilized in this paper for the purpose of assessing whether young adults in Suriname practice solidarity during their own economic crisis in addition to the ongoing health crisis. The table below outlines how solidarity will be identified and analysed:

Table 3
Operalization of The Concept of Solidarity

SOLIDARITY		
Aspects	Conceptualizations	Processes
Structural: i.e. division of labour, class-structures alliances, ethnic groupings etc.	**Social interdependence**	**Sharing vital resources**
	Alliance and cooperation	**Involvement in processes of inclusion and exclusion**
Agency: subjective will to pursue interests, feeling of community	**Voluntary**	**Offering or providing help and support**

Own construction. Source: Kantzara, 2014.

Commodification and Decommodification

There is a relatively wide consensus in the literature that healthcare has been increasingly infiltrated by processes of commodification. Commodification implies the infiltration of economic valuation into areas previously unchartered by those terms with the implicitly embedded intent to gain profit. There is much debate about whether healthcare ought to be commodified or not. Whereas some have welcomed this trend, others have been far less sanguine (Song, 2003). Wildes (1999) presumed that addressing the ambiguity surrounding unarticulated assumptions about the nature of health and healthcare would prove antecedent to the conclusions that would be reached in regard to such.

For the reasons stated above, investigating the processes of commodification and its antithesis, decommodification are useful to explore to what extent health and healthcare are deemed as profitable entities. Given that the bulk of empirical data is derived from qualitative interviewing, it was mainly the rhetoric or the reference to processes of commodification that were analysed as opposed to the act of commodifying itself. A study conducted by Hahn et al (2015) identified and constructed six degrees of commodification as it relates to biodiversity and ecosystems in a useful framework for analysis. This framework has been employed within this study albeit altered to the topic at hand. Using the studies of Cavusoglu and Demirbag-Kaplan (2017), Pellegrino (1999) and Lysaght (2009) wherein examples of commodification of health and healthcare are investigation, the following framework has been constructed.

Table 4
Degrees of Commodification of Health

Degree of Commodification	Main Category	Explanation/Examples
0	Intrinsic and relational value of health and healthcare	- Health seen as a right - Health valued based on reciprocity or cyclical processes; or as subsistence
1	Non-monetary instrumental framing of health and healthcare	- Health seen as useful or crucial for something else e.g. as means to be functional or happy.
2	Non-monetary physical metric framing of health and healthcare	- Health seen as the standard by which physicality or vitality is measured - The measurement or maintenance of standard is viewed as investment
3	Health and healthcare framed to maximize economic efficiency	- Health is associated with economic productivity in direct variation i.e. as health increases, economic efficiency also increases.
4	Health and health care framed as non-traded economic instruments	- Health care provisioning subservient to the correction of consumption externalities i.e. taxes on the sale of tobacco cigarettes
5	Health and health care framed as voluntarily market tradable economic instruments	- The value of health set by market actors including government - The access to health care could depend on market position
6	Health and health care framed as financial instruments	- The value of health set by the market e.g. health care derivates - Trade-offs between health insurance and investments in other socio-economic endeavours - The access to health care depends on market position

Own construction. Sources: Hahn et al, 2015; Cavusoglu and Demirbag-Kaplan,2017; Pellegrino, 1999; and Lysaght, 2009.

Bambra (2005) developed a health care decommodification index wherein the financing, provision, and coverage of the private sector was used to indicate the role of the market in the health care system. This was based on her interpretation of health decommodification as "the extent to which an individual's access to health care is dependent upon their market position and the extent to which a country's provision of health is independent from the market" (Bambra, 2005: 201). As such, decommodification was operationalized in inverse variation to the framework above. Rather than employing Bambra's approach, which was purely quantitively, her conception was utilized to analyse qualitative data in the same respect. Where possible, statistical descriptive inference was employed to contextualize the given qualitative findings.

Chapter 5
Presentation of Findings

Part 1: Conceptualizations of Health

At the onset of analysis, the researcher developed 20 provisional codes derived from the dominant theoretical conceptual models of health as stipulated in the previous chapter to organize the data. However, the full scope of the findings could not be neatly fitted into those frameworks; consequently, nearly one hundred more codes were engendered. The presumption hereunto was that the conceptualizations of health among young adults in Suriname extended far beyond the prescribed models in terms of its diversity and complexity.

The table below showcases extracts from the interviews which were associated with the four conceptual models of health.

Table 5
Conceptual Models of Health

	Excerpts
The Medical Model	"I know that I am healthy because I pay attention to my levels. I do my exams with the doctor for check-ups. I do suffer from iron deficiency, but for that I take supplements. I make sure everything is up and running and I make sure that my immune system remains top"
	"When I think of health, I think of a healthy body, a long life without ailments or defects"
	"Health is the mental and bodily capacity to release enough toxic gasses so that then your body functions as it should"
The WHO Model	"General well-being, I was going to say physical well-being, but I guess it also includes mental well-being. And maybe also emotional, but that's part of mental...I am trying to say how you are able to interact with others as well is important."
The Wellness Model	"I think everyone has a different definition of health. Mine is being happy, or not necessarily happy but at least understanding why I am fortunate."
	"When I think of health, I think of mind, body and spirit, and the most important thing is that you're a happy human being. If someone is eating healthy, like less meat trying out vegetarian food, exercising, then they are busy with healthy habits but that doesn't mean you are necessarily healthy. But everything goes hand in hand."
The Environmental Model	"Health has to do with your life. If you're not healthy then you're struggling. I have bad cases of PMS and that is affecting my work negatively. Like two weeks before my period, I would wake up with a migraine or pain all over my body. So, if you're unhealthy it hinders you from functioning but just also in feeling okay. And in the situation, we're in right now, during the pandemic, the risks are higher for you. So, I had to make sure I was making the right decisions to deal with it."

Source: Own Construction; Derived from findings, 2020

The number of exemplary excerpts given for each conceptual model are reflective of the frequency by which reference was made distinctly to each given model by *x* amount of the research participants. It was clear that by means of deduction the models in order of 'frequency of references made' were the medical model, then the wellness model, followed by the environmental and lastly the WHO model. There were instances were a combination of these models could have been identified as underlying the conceptualization. For example, the following excerpt denotes both the wellness model and the environmental model:

"Health has to do with balancing the physical, the mental and the spiritual. It will allow you to manage, to have less stress, be happier, and basically just deal with anything that comes your way."

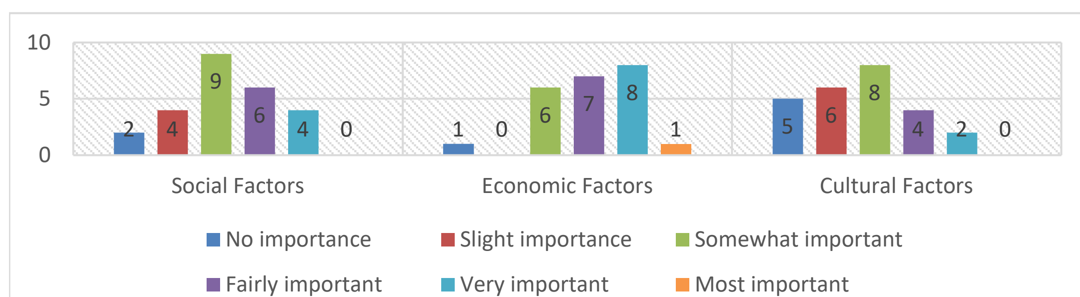
Nevertheless, it was made evident that these models could not encompass the diverse conceptualizations derived from Surinamese young adults. Moreover, it is stipulated in the literature that the WHO model has gained prominence; its criticism, however, has gained validity in these findings. Firstly, in contesting the idea of "complete" or "absolute" health and well-being, reference was made to the impossibility of such a state as exemplified by the following excerpts:

"I think honestly, you know, yeah, there are things you can do to prevent certain things or take care of certain things so, they don't become a problem. But ultimately, disease is a little bit random. And so, you know, I mean, look at the pandemic we're in, you know, what I'm saying? You could be perfectly healthy, do everything right, but be in the wrong place at the wrong time. And, you know, so I still look at disease as being pretty random and not really something that's that we control as much as we'd like to think."

"Health is kind of super pessimistic; It's just it's next to impossible to be completely healthy. It's impossible to be like super healthy everywhere we go to eat, right? exercise this way. Get enough sleep. Make sure you're breathing good air. Don't be around too many radio waves. Be happy all the time. Most things in the world can be unhealthy."

Secondly, the WHO awards social well-being as an independent dimension of health. However, no direct reference was made to social well-being by the research participants during the initial set of questioning with the exception of the example given in table 1.1 where the researcher inferred that the 'ability to interact with others' delineates the social aspect of health. In asking explicitly to all participants if social factors are of relevance to health, however, the answer changed. The average response was that it was of some importance. Hereupon, it was probed whether or not additional factors warrant determinacy as it relates to health and its conceptualization. The social element was asked given the indication in the literature i.e. WHO conceptual model; the economic element was asked in spirit of the topic of investigation; and the cultural element was added on after participants in the pre-interviewing round suggested its importance in the Surinamese context. The following chart exhibits the subjective rankings of social, economic and cultural factors to the overall concept of health.

Figure 1
Degree of Importance of Various Factors to Health



Source: Own Construction; Derived from findings, 2020

Based on the average, economic factors were overall considered of more importance to health, followed by social factors, and lastly cultural factors. The richness of the findings,

however, rested upon the explanations given for the various rankings. The interpretation of 'economic factors' in explaining why it is of a certain degree of relevance to health was largely described in monetary terms which could be further organized into personal financial situations or the macro-financial situation of the state. An example of both follows respectfully:

> "To help yourself, you need the finances, for example, if you're sick. But I think we are forgetting the people that really don't have that, uhm, that much resources they can spare to be healthy. In a way, being healthy costs a lot of money."
>
> "To explain, I would compare China with Suriname during covid. Your government's economy plays an important part. In China, it was a real lockdown, that means everyone was home, working from home, etc. But the government was able to pump billions into the industry to ensure that the economy remained up and running and that people could still produce foods and people weren't going bankrupt. In Suriname, on the other hand, that's not possible…The Surinamese government in that sense isn't capable or doesn't have the means to maintain the economy and by extension the health industry. Like within the health industry, I'm thinking about masks. Like in Suriname there's a shortage on masks, whereas in china its easily accessible everywhere. It can go really wrong if there suddenly are a great number of people that need medical assistance or care and like the country can't pay for it, you then can't go anywhere, there is no money."

What comes forth in these explanations, is an indication of whom is considered responsible for health. Although in many instances, upon a direct questioning, many participants responded resoundingly with it being an individual responsibility, others have mentioned other actors, such as the government, to a secondary degree. It seems as if the desire to be healthy, or the commitment to a healthy lifestyle is considered a personal choice; however, supporting services such as healthcare is deemed to be the responsibility of medical professions and the government. This is supported by the following excerpts:

> "You yourself are important. I guess also the doctor and the ministry of health to get medication. But the most important person is really yourself because you need to want to do something."
>
> "You can't expect someone who makes less money, let's say I make 1000 per month and my neighbour makes 2000, the government can't expect us both to do the same for our health. Because of course he got more, and more financial freedom, so he can do more. At some point, the government has to help."

Many respondents had difficulty understanding what was meant with social factors as it relates to health, indicating either a lack of initial conceptual linkage drawn or initial confusion at the broadness of the concept. In asking if they could guess, the responses ranged from: social groups and the various socio-economic classes they represent; population obedience; education; social work; social contact and interrelationships; and social norms and stigma. As it relates to the former five responses, linkages were drawn to the direct relationship between the socio-economic status of a person or the financial means of a state and his or her access to healthcare, further insinuating that social aspects need attend to economic pitfalls. This is exemplified by the following excerpt:

"I think, you know, coming back to the pandemic, you know, like, stigma played a major role in how all of this unravelled, you know, the idea of people being afraid to get tested, because of the fear of isolation, the fear of being excluded or whatever, you know, um, yeah, social factors play a big role play a huge role. But I still think less than economics. I mean, a big part of modern health has to do with access, right. And so, economic circumstances determine access in many ways but also education and it's very important for people to self-assess and understand rules for public health, for example. And a person with lower education has less of the capacity to do so, often because education is expensive. Medicine is an extremely expensive industry, um, people who struggle with insurance people who struggle with that kind of stuff. You know, there are so many factors that have to do with ultimately people with lower income having higher mortality rates. And socially, I guess something can be done to ensure people are in a better position to afford healthcare."

The latter two responses, however, emphasized the connection between social interaction and the upheaval of certain stigmas to the mental well-being of people evidenced by the following excerpt:

"We kind of need each other, if you don't have social contact, you can't talk about depression and loneliness, and that affects your mental health, not always, so maybe that's why it's not that important. But in Suriname, mental health is a bit taboo, unfortunately, so that's bad. But among friends, at least, talking is possible."

In general, cultural factors were considered the least important of the three; however, there are notable exceptions. In expounding upon why cultural factors are of fair or significant importance to health, three cultural sub-factors directly linked to health were mentioned: traditional non-pharmaceutical medicine; religion; and cultural taboos. The usage of traditional non-pharmaceutical medicine seems to be linked to age and cultural intensity rather than the respondents' trust in its effectiveness. Similarly, in reference to cultural taboos, these linkages seem to rest upon their discouraging authority to utilize pharmaceutical medication. Moreover, upon citing religion as the link between culture and health, one respondent described the difficulty that comes with challenging traditional custom:

"The Hindus, for example, when there is a church service, we eat laddoo and persaad[2] and that's part of the ceremony. It's basically a must. You can't sit across the pandit and say no I don't want laddoo because I don't eat sugar. Its unheard of. This has to do with years of going back, so you do it because that's how it is. So, I eat it too because it's given, but I think to myself it's a lot of sugar. It is honestly unhealthy."

While the respondents may not actively participate in the traditional customs that they have cited, they do emphasize their respect for their cultural background, and the need for it not to be dismissed. This was captured well by the following citation:

"People have a lot of ideas about health derived from their culture and then how to deal with it. So, I think it's important to consider. Also, for example, using the contraceptive pill for some women is a no-go because some cultures think that women are made to make children.

[2] Laddoo and persaad refer to Indo-Surinamese sweets

So, just selling the pill is not going to help. And just saying these people are backwards is disrespectful."

An overall assessment hereinto shows that a fair correlation was established between economic and social factors and their bearing upon health. The association between cultural factors and health was less strong, perhaps due to the prevalent medical conceptualization of health whereunto cultural factors were referred to in secondary comparison to such. Nonetheless, the need to apprehend the diverse conceptualizations remained. Thereupon, the following elements were explored to achieve greater understanding: what is considered unhealthy and reasons as to why one would want to be healthy. The following figures display a portion of the results in tabular form:

Table 6
An Exposition of Ill Health

What is ill health? How do you know if you are unhealthy?	
Inference	Excerpts
Conceptualized in accordance to the Medical Model	**"I'm unhealthy when I'm sick. It will be confirmed at the doctor. I go twice a year, and then they check if something is wrong. I do general check-ups.**
Conceptualized in accordance to the wellness model	**"When there is no balance, when you feel like you're physically tired, when you're often sick or fever, or you often have negative thoughts and can't control your emotions, you would be unhappy as well."**
Conceptualized in accordance to the environmental model	**"I think of surroundings as well. You know, sometimes if someone is in an environment where they can't help it that say they're born in that environment. But you can also you can change your perception of your environment, you know, you can use your environment as a motivation to do better. And this is something I strongly believe in is that they say a mind is a product of his environment. But I also think it comes back down to personal opinions, and it comes down back to personal preference, because you can come if I may say that you can come from the ghetto, but you don't have to stay in the ghetto or unhealthy environments."**
Broader conceptualization not limited to one model	**"Uhm, there are various ways in which someone can be unhealthy. You can be sick, or you can be getting sick; you need to watch what you eat; stress is unhealthy; unhappiness is unhealthy; addiction is unhealthy. So being unhealthy can have various factors"**
Conceptualized as irresponsibility and indiscipline	**"I mean, for me, bad habits. For sure. Um, you know, we know the obvious things like smoking, drinking, not exercising, yada, yada. I'm not eating right. Um, but also just a recklessness. I guess recklessness with your own body is a form of unhealthiness"**
	"But more generally I think someone is unhealthy when they don't look after themselves, when they don't exercise even if it's the minimal – like going for a walk, twice a week, I think that's sufficient."
Conceptualized as sub-optimal functioning	**"If you feel like you're in a state where you can't put yourself in for a 100%. So, like physically, if you feel sick or weak, and mentally if you have any barriers to do what you must"**
	"When you can't do what you want because you have a headache, for example."

Source: Own Construction; Derived from findings, 2020

Table 7
An Exposition of the Main Motivations for Health

Main motivations for health	
Inference	Excerpts
To function/relieve difficulties	"Because if you don't function properly everything becomes more difficult. Life becomes harder, and life is already hard enough. In this day and age, we can't afford to be sick. If you need to go to work to make your money, you can't be at home sick."
To feel good	"To feel good. Because I think at the end of the day, I think that's the end goal. Like if you have a handicap, you can still feel healthy and good, you can breathe on your own, you can talk, but you may not be able to walk so I think it can also depend on how they feel, I think the feeling of being healthy is important."
Idealizations of health	"the idea of imperfections, the idea of complications, the idea of difficulties, the idea of like physical ailments and stuff have never really been as like, they are posed as unappealing. They're opposed. They're polluted as, you know, things that you have to go through things that make your life difficult. I think that someone would want to be healthy because of the ideas that come linked to it. Like people think that healthiness comes linked with vitality, and less problems in life generally."
Peer pressure/social standing	"there are stigmas attached to being sick. Like during the pandemic, if you have covid, I mean yes you are contagious, but it's made people shun people out. Nobody wants to be shunned."
	"People want to go to the gym and exercise and drink smoothies because it looks good on Instagram. It's a trend."
Longevity	"The most obvious reason I can think of is longevity, nobody really wants to die. I think we all would like to imagine living to a nice, ripe age, you know,"
To care for others/responsibility	"This makes me think of our parents because our parents do their very best to stay healthy so that we are healthy. A healthy mindset is needed to be able to make those sacrifices that they do. And that's what, to me, that's what, why someone would want to be healthy, not just for themselves, but also for those around them.
	"A lot of reasons. But for me, I am responsible for my child. So, to take care of your offspring, and secondly to be able to enjoy your life."
Fear	"Nobody wants to die. Like with corona, I know a lot of people that are scared. Being told that you are sick just so is scary. Nobody wants that."

Source: Own Construction; Derived from findings, 2020

Given this exploration, a deeper indication of what is valued came to the forefront. In many instances, concerns such as indiscipline, fear, and responsibility, which to a significant degree embed the conceptualizations of young adults in Suriname, are not represented in the dominant conceptual models of health. Moreover, as exemplified by the following citation, it is not something that is commonly explained or discussed:

> "These questions are interesting. I never had to think about what health means to me. I think everyone sort of assumes its important and everyone wants to be healthy. Elderly people always say eat your vegetables to be healthy, so that's what it is."

The participatory drawing exercise provided useful supplementary insight into what kind of associations the research participants related to their conceptualization of health. Unfortunately, only 12 out of the 25 respondents were able to participate in this portion of the research. The data was analysed according to the elements in visual content. Thereupon, the researcher identified the icons (what is physically represented); the indices (indicating causal relationship between what is drawn and what is signified; and symbols (what is arbitrary i.e.

language). The results show, however, that as an extension to their verbal conceptualization of health, their drawings emphasized food, exercise; rest and nature; love and togetherness; and socio-economic standing, in that order of frequency. One participant likened health to a flower in that it withers but blooms. In explaining himself, he asserted that much like the flower, people will die; so, longevity is an illusion. Life, however, is not, and as such, he considers his health as an opportunity to bloom. The following figure displays a summary of the findings derived from this exercise:

Table 8

Findings Derived from Research Participant Produced Drawings.

	Icons	Indexes	Symbols	Portrayal
1	- Apple - Balancing scale - Smoke	- arm muscles	Text: - Growth - Green - Balance	- Association between food and strength - Smoke association with production factory whereby food consumption and maintaining balance are the activities of the factory; strength is the product - Green is associated with health - Growth is a byproduct
2	- Person lounging in hammock - Sun - Fruits on table - Tree			Association between nature/naturistic environment, rest, and health
3	- Apple - Hearts - Open tap - Water droplets - Glass of water		Text: - Eat healthy	Association between eating fruits/drinking water and a good functioning heart
4	- Dollar sign - Tree - Jogging track - Fence - Houses - Person caricature		Text: - Jogging track - Covid - Social-economic status	Association between money, social/economic status and level of protection from diseases
5	- Pills/medication - Syringe - Covid-19 symbol on a fork - Factory - Antenna tower - Trees - Hills - Opened mouth on a face	- Darkened sun eyes	- Symbol for covid-19 Text: - Consciousness	Association between consumed diseases/medication; production; radio-electronic waves and a filtration of consciousness leading to a clean environment
6	- Facial expressions: sad; happy; uncomfortable; shocked - Sun - Question and Exclamation marks	- Crisscrosses (stitches)	- Continents drawn in the shape of a heart. A symbol for a loved earth. - Symbol for covid-19	Association between the mixture of emotions surrounding the earth given the pandemic and the healing process.
7	- Earth with its continents		- Heart (a symbol for love) Text: - Unity	Association between love, unity and the health of earth.
8	- Caricature person	- The food pyramid	Text: - orange; green; red; blue; purple - flour products; vegetables; fruits; milk & fats; peas and meat	Association between a balanced diet and health
9	- Caricature of three persons holding hands	- arm muscles - six-pack muscles	Text: - Strong together	Association between strength gained through togetherness and health
10	- Caricature of a person - Trees - Sun		Text: - Place of rest	Association with the outdoors, rest and health
11	- A flower		Text: - I think of health as a flower; It wilts, and it dries but it still finds a way to bloom	Representation of health as a flower; wilting and simultaneously blooming.
12	- Caricature of person - Banana	- An opened, widened mouth	Text: - Banana!	Association between the consumption of fruits and happiness, and thereof, health.

Source: Own Construction; Derived from findings

From the given findings, the researcher identified and outlined eight additional discourses on health that came forth from young adults in Suriname. These are:

1. Health as healthy lifestyles.

This is the most prevalent discourse among the research participants. Within this discourse, health is seen as the result of practicing 'good' habits. These habits are mostly, though not limited to, eating healthily and exercising regularly. The responsibility, delineated as the will to be healthy, is considered an individual affair; however, notice is given to the expense associated with healthy food consumption in particular. The focus on consumption, in this particular discourse is of relevance, in the physical and digital landscape. Physically, the consumption refers to the food and drink products bought and consumed; digitally, however, consumption refers to the consumption of media content that emphasizes the importance and appeal of a healthy lifestyle. This is identified by some participants as a trend that preceded and will most likely extend beyond the covid-19 pandemic. Most consider this trend as positive, as it engenders the will to be healthy while also providing opportunity for health experts to make money; while others comment on the dangers of appearing healthy physically but mentally suffering from the pressure and impossibility to be healthy all the time.

2. Health as relative

The sentiment behind this discourse is embedded in the conceptualization that there is no absolute state of health. Furthermore, health is considered as ever changing depending on internal, personal choices, as well as external biological factors, such as the withering of the body with age. Although health is deemed as fluctuating, is it not dissuaded to exercise habits that contribute to positive stability.

3. Health as imitation.

Health as imitation delineates that health is constructed as something that is dependent on what a person is exposed to and taught to imitate. This can overlap with the preceding discourse wherein exposure to media content portraying a healthy lifestyle is consumed and imitated. The emphasis within this discourse, however, is on the lack of personal reflection that occurs as a result of simple imitation. Often this imitation occurs between a person or party that is deemed exemplary or of authoritative status i.e. a parent, a teacher and a person subject to that relationship. For example, a child's exposure to a particular upbringing in a particular environment engenders a given conceptualization of what health is and should be. If health is considered important in the social group, its members will more than likely uphold that; instinctively, the opposite is also assumed. Given the lack of reflection, explanation, or conscious intent, unfamiliar settings can cause fear.

4. Health as self-discipline

Similarly, to the first discourse, a person who practises healthy living as self-discipline will also engage in healthy habits such as regular exercise. However, the emphasis thereunto is embedded in the value of self-control. Unhealthy habits such as consuming junk food or drinking alcohol, for example, is seen is as taunting and enticing. Ultimately, exercising willpower and self-constraint is therefore considered the pathway to a healthy life.

5. Health as a moral imperative

Maintaining health in this discourse is seen as a way in which one expresses and enacts care for oneself and for others. The emphasis is placed on the value of responsibility. Considering being healthy as a moral imperative is derived from the conceptualization that people are part of a community consisting of interrelated and interdependent relationships. For example, within the relationship between parent and child, both parties possess the moral imperative to remain healthy to honour the relationship. The parent remains healthy to take care

of the child, and similarly, the child remains healthy to appease, show gratitude, or take care of the parent.

6. Health as a burden

Within this discourse, good health is in itself seen as positive, and desirable even. However, attaining good health is deemed as burdensome as many of the needed elements to ensure good health require great sacrifice. This is an extended articulation of the inferences made by some of the participants whereby consuming healthy food is considered an expense that leads to possible stressful choices for an individual that cannot afford it. The research participants have stated that there were instances where they were faced with choosing to pay the rent or purchasing healthy foods; or whether the parent should fast while the child eats due to lack of funds; or whether they should attain health insurance and sacrifice some other expense. Viewing health as a burden is jacketed in an economic framework, whereby it is appraised against its monetary cost. This is evidenced by the following:

> "I am now scared to go outside to exercise to stay healthy. That in itself seems like a risk. I can't take risks, but I also can't afford to be healthy. My son is sick and has no insurance card because I can't afford it. This gives me sleepless nights. I know other people that have lost their jobs, when are we supposed to pay attention to health? We have to sacrifice our time, our money. I want to be healthy, but it will cost me my mental health."

7. Health as an ideal

Considering good health as ideal is in many ways constructed upon the four preceding discourses whereby an individual through various sources albeit their immediate environment or social media considers good health as an achievement. Good health is socially recognized and often admired, and as such, has implications for a person's status and identity. Much like the 3rd and 4th discourse, there is a judging element required to establish criteria or degree of accomplishment albeit self-reflective or socially approved. The sense of achievement is considered contributary to the overall sense of achievement in life; whereas the opposite, ill health, is often accompanied by a sense of misfortune, unfulfillment and non-success. This can engender fear for being shunned or disdain for the ill.

8. Health as a feeling

Within this discourse, good or ill health is not exclusively determined by a bio-metric standard, but rather how one subjectively feels– if the feeling is deemed positive, the person is deemed healthy. Bodily reactions, therefore, are not ignored. Forasmuch during a migraine, a person tends not to feel positive, and therefore concedes to accepting a state of ill-health. Much like emotional states, however, these are considered temporary and the state of health can change even if the bodily state does not. The association between positive feelings and health are thereupon causal; as such, if a person aims to feel good, he or she is simultaneously aiming to be healthy.

In assessing what the various mechanisms are that ensure good health, the following factors, in no particular order, have been inferred from the participants' responses: financial income, healthcare and medication, healthy lifestyle, education, maturity with age, rest, social environment, culture, a sense of responsibility, unity and togetherness. Given the various conceptualization, and the identified mechanisms for attaining good health, the following

summative evaluation appraises the findings according to the respective degree of commodification using the framework constructed in Chapter 4.

Figure 2
Summative Evaluation of The Degree of Commodification of Various Health Mechanisms

The right side of the axis indicates that there is a tendency to commodify these factors or that access thereunto is dependent on an individual's market position. The left side of the market, accordingly, indicates the reverse. The degree of commodification overall is relatively low with the exception of the cited instance related to healthcare insurance and the commercialized interpretations of healthy lifestyles.

Part 2: Correspondence Between Conceptualization and Practice

General Health Practices

In asking about what type of health practices the participants adhere to, the answers reflected the medical conceptualization of health, wellness conceptualization of health, as well as the 1st and 2nd discourse as outlined in the preceding segment. This correlation is comprehensible due to the fact that reference to the aforementioned conceptualizations and discourses were the more frequent. Many respondents, however, indicated that these practices were present prior to the pandemic. Yet, the pandemic seemed to have shed light upon health practices that were neglected prior to this specific health crisis. Examples include the washing of hands, and the fixation on mental health. Moreover, reference was made to the commercialization of particular health conceptualizations by media outlets. This is evidenced by the following citations:

"A lot of people have been exercising more it seems like, there are people making more conscious health decisions like, you know, eating more fruits like. I don't know, but it seems like especially on social media, pushing the things of like, better breakfasts, and all of those things seem to have come back. Also, medical marijuana was a big thing for like, the last three years, CBD oil, little things that people think might be more psychologically based things. Also, a lot of people seem to be getting into the whole spiritual life thing for your vitality and trying to maintain some type of mental health state. It's almost like a Tom and Jerry effect with your mental health and your physical health and trying to like, get a grasp on something, get a grasp on your health, get a grasp on your lifestyle, like a lot of people seem to be going for lifestyle changes, not just health. But also, with the pandemic, washing hands is probably the biggest health practice now and sanitizing everything. I mean who used to wash their hands that often? Now it's normal or required even".

"In Suriname a lot is still taboo. And that causes a lot of uncertainty. But with the pandemic, not where it's supposed to be, but I notice a lot more attention is being paid to mental health. It's still not enough. Within the young people, they try to listen, elders, try at least, but there are still too many taboo walls."

The conversations regarding the covid-19 pandemic revealed that the threat the virus posed was obscure to most young adults, however, the belief that it could affect them was not. Acting upon said belief, in addition, seemed to be dependent on proximity.

"I think a big part of the issue is, we as the public we don't really know what the disease does. That's a major problem. I'm in panic, because half the time we don't believe what people say. But then there's also so much sort of contrasting information out there, we are kind of forced to choose what to believe, rather than actually get all the straight up facts. And I think that's messing with a lot of people's perception of what's really going on. It's different when someone actually gets it though lol. Then it's like, oh shit okay."

"I am careful, but in my head I'm like, I won't get it. So, I'm not stressing about my health, but my partner is an employee at the bottling, so she's in contact with a lot more people and I have mentioned it a number of times that she needs to be extra careful. So, in one way I care, but in another I may not be too realistic about it because nobody in my circle has had it, so I feel like it's far away from me. But it's not like I don't know that if I get it, I will be having a lot of problems."

Responses to the NPIs Implemented

The general responses to the lockdown were largely critical and to some extent outright negative. Whenever the measure in itself was deemed positively, the implementation of such was criticised. The response to the social distancing measure, on the other hand, was viewed with more definitive positivity; although, in many instances the execution was cited as a problem. These conclusions are evidenced by the following citations:

"Everyone gets the social distancing. You don't touch me, I don't touch you, we don't get sick. We all get it. But everyone is tired of the lockdown. If we stay in lockdown, we can throw the whole country away. Our economy will collapse."

> "The lockdown is bullshit. It has no impact. Because one way or another people have to go outside, and they'll get into contact with other people so if you want to have measures it's just about focusing on limited the time in which they can so having a curfew from 11 to 5 for example."

In exploring why the respondents presumed there to be an implementation problem, the following reasons in order of prevalence were identified: economic concerns; public nonchalance and stubbornness; culture; upbringing and education; lack of understanding; hypocrisy from the government; and a disdain for authoritarian policies.

The economic concerns cited were principally juxtaposed against the supposed health threat that covid-19 posed and the NPIs sought to control. In many ways, the NPIs were seen as constraining upon economic concerns, resulting in contending health vs economic objectives. This concern is mainly attributed to those of a lower economic standing. This is exemplified by the following quotes:

> "There are different types of people with different types of living situations. Ghetto people live by the day, they need to go on the road every day, they need to find a way to make money. I'm talking about poor people because I'm around the people every day. And then you have the elite people, that also don't care because they're at home in their ac, in their house, not worrying about water or light because their parents have enough money. And then you have the middle-class people that say I'm going to try to adhere to the rules, but if I can't anymore, I have to go on the road. You see, so everyone's living situation is different."

> "For someone who doesn't have money, health isn't their first priority because you need money. Also, money and health go hand in hand, even if you are healthy but you can't eat then what's the point? I think that's why a lot of people have financial things as their number one priority and if you can't work for two weeks for someone who lives day by day in terms of their finances, then you look at it completely differently."

These findings contradict the conclusions drawn by Lin and Meissner (2020) whom claimed that the implementation of NPIs did not result in a trade-off between economic concerns and public health at a local level. This is more than likely attributed to the dissimilar local context in which this was investigated. Principally, the type of work performed for economic income must be considered; it is likely that termed employment where working from home and a monthly based salary is not of applicability in this scenario. As explained by the following citation, the lockdown affected a variety of occupations:

> "I have friends that during the weekend, wash cars, sell at market, so they make extra cash and now they can't. All the hustling during weekend isn't possible anymore."

With respect to the cited hypocrisy, persons elucidated that the government's policy making is non-transparent and unfair. Firstly, it seemed to them that the government supplies insufficient evidence to explain why certain policies are implemented. This also impacted how well the public understands the importance of certain rules. Moreover, it is assumed that some policies are adjusted to benefit the interests of some groups as opposed to others. Secondly, the respondents critique the adherence to the covid-19 rules by the politicians themselves; most notably, as it relates to the keeping of social distancing and the wearing of masks. This can pose a significant problem. If the conceptualization of health as imitation is prevalent, for instance, it can analytically be suggested that the behaviour of political figures

is imitated by the public whom looks to them for exemplary conduct. This is substantiated by the following quotes:

> "I don't think the policies of the government, like the ones for covid, are fair to the people. Like I read that vacation spots outside of the city have to close from next week, but like religious houses are allowed to open with maximum 50 people, and I wonder has the government been pressured by the religious people. Same with casino's, why can the casinos suddenly be open now?"
>
> "When the journalists ask questions to the covid response team during like the public conferences, I really find their answers to be vague. Like they just think it will help, but they don't bring data, like at 10 we have 400 infections as opposed to 8 where we have less. I think they create rules out of nothing."
>
> "Honestly, sometimes I think, not even our own politicians follow the rules they set themselves, why should I? Sir, where is *your* mask?"
>
> "I don't like the feeling I get from the lockdown. It seems so dictator-like or authoritative."

The remaining issues pertaining to the implementation of the NPIs are interrelated. A major part of the respondents asserted that the Surinamese mentality characterized by stubbornness engenders significant resistance to the rules. In some instances, culture was cited as the potential source, and in other cases people attributed the noncompliant behaviour to upbringing or unapplicable forms of education. This is demonstrated by the following:

> "I don't think in Suriname we have a culture where the 1.5-meter social distancing rule can be properly implemented because we are so used to being in company with each other. We love parties, we long hangouts, and we will not deny our family or friends hugs. Its unnatural."
>
> "We have a complaining culture and we feel entitled I don't know maybe because were young. It seems as if, in my eyes, if you tell a Surinamese not to do something they'll go ahead and do it just for that reason. Like for example, there was a weekend lockdown, and young people organized a party out of town. And I was like look at how they're dancing without masks. I feel like they don't consider what kind of consequences that would have. I don't know maybe it is their upbringing."
>
> I don't think there is enough development with young people especially as it relates to health. I don't think the social distancing is effective, because people don't comprehend, I don't think they can really process the information given by the government. But it's not because they are not educated, or dumb, but because it's not explained in the way that makes sense to our way of living."

As indicated by the last citation, two other demographic indicators were cited as a distinguishing factor in how the NPIs were responded to; namely, age and gender. According to two respondents it seems as though their male companions are less fearful of the penalties associated with disregarding the NPIs and, indeed, also of becoming infected. This was inferred from the following:

> "I know, a couple of guys that got arrested for being on the streets during the lock now. But they didn't care. I'm sure they'll do it again."

> "I'm scared of going on the road with people. Boys, I don't know who they think they are, but they are more stubborn than girls. They would be on the road during the lockdown. I don't know if they're not scared of getting sick.

Regarding age, on the other hand, it was indicated that the targeted age group (18 – 30), is not considered monolithic. In fact, many respondents differentiated between those between the ages of 18 – 24, and 25 and upwards.

> "Surinamese are stubborn. Between the 26 – 30 are a bit less, but the 18-year old's are definitely stubborn, they complain a lot."

> "I don't think young people really talk about their health. Particularly between 18 -20, you're still experimenting, I think at the age of 24 that's when they consider their health a bit more. I see it in my friend group. We just realize we can't anymore."

In expounding upon the health practices and responses to the INPs of this particular age group, a lot of the responses could be correlated with the various conceptualizations of health described. Such correspondence is particularly noticeable as it relates to viewing health as healthy lifestyles, health as imitation, and health a moral imperative. The following citation provide verification thereunto:

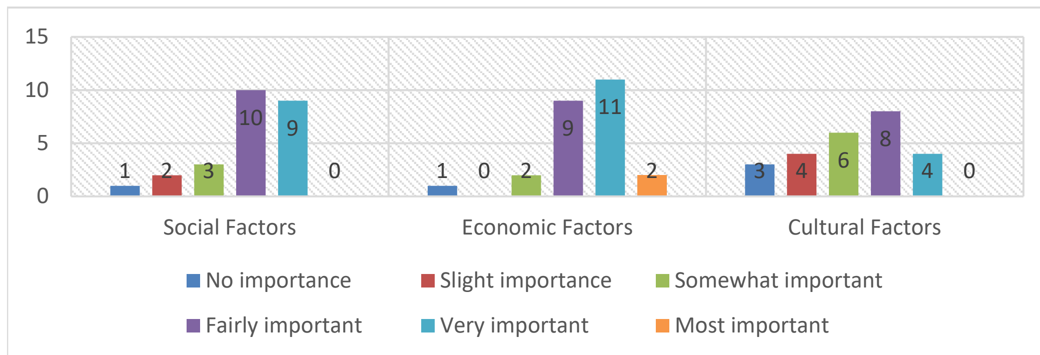
> "Especially in my age group, because then you have those who are dedicated to keeping a healthy lifestyle, and then you have those who don't really care what happens. That's why some follow the rules, and others just don't."

> "Especially young people, if they don't know what to do, they at least have an aunt, or a cousin, or their own parents, that tell them not to go on the road because they will become sick. There's also a lot of peer pressure. So, if someone is exercising, or if someone looks good, like a celebrity, young people are also trying to look good. So, if we see a singer wearing a mask, that's probably how you can get young people to also wear one."

> "In the beginning, young people didn't care much for it because it wasn't taken seriously. But they realized that they may have a generally better immune system, but if you're carrying the disease with symptoms you can infect your elders and they can end up sick or dead, so they try not to."

Unlike in the first part, a lot more references were being made to cultural factors as it relates to health practices and responses to INPs as opposed to health as a concept in itself. This type of discrepancy indicates that the intellectual consideration of health in and of itself is informed by a particular source that considers culture to a lesser degree. In focusing on daily health practices, however, its cultural elements are acknowledged more greatly. Social and economic factors, on the other hand, have remained consistently prevalent. In fact, all three factors have ranked higher on the relevance to policy implementation scale than in the previous segment. The following table showcases the results.

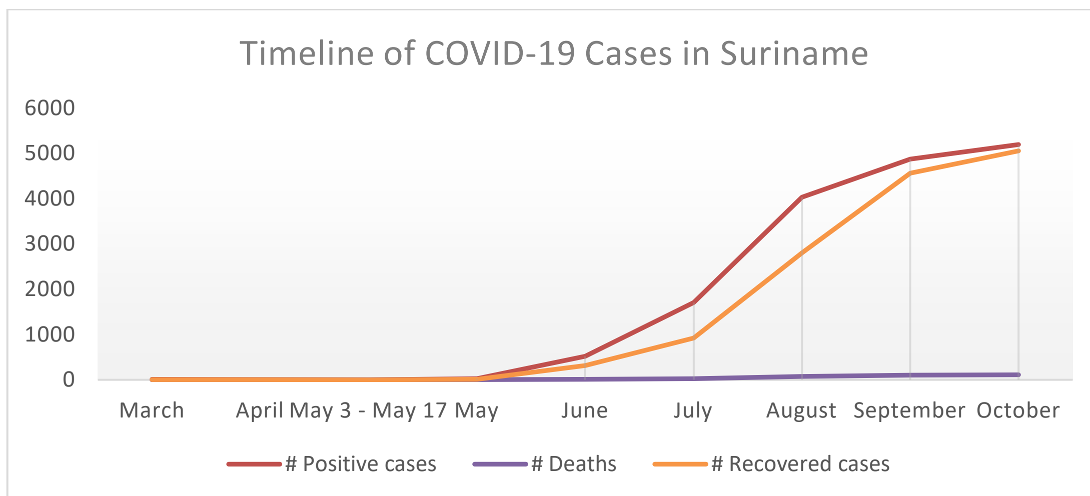
Figure 3
Degree of Importance of Various Factors to the Implementation of NPIs



Source: Own Construction; Derived from findings

Given the generally negative response to the INPs, it becomes noteworthy to appraise the state of covid-19 cases in Suriname to assess to what degree these findings correlate with such empirics. According to the situation reports, Suriname is currently experiencing its second surge of cases since it had zero infections at one point in time. During the short-lived period between May 3rd, 2020 and May 17th, Suriname was officially declared COVID-19 free. In total, there have been 5197 positive cases of which 111 have died and 5053 have recovered completely. Currently, on the 1st of November 2020, there are 20 active cases and 633 persons in quarantine according to the Surinamese COVID-19 crisis team ('Covid-19', 2020). The following figure visualizes the timeline of covid-19 cases between March and October:

Figure 4
Timeline of covid-19 cases in Suriname



Own construction. *Source:* covid-19.sr, 2020

The sudden surge of cases in Suriname could be attributed to environmental factors wherein significant change in population movement, and thus exposure, was warranted such as the national elections held on the 25th of May of this year. It could also, however, be attributed to the logic of prevalence-elasticity of private demand for the prevention of covid-19. As the numbers went down, the demand for prevention went down as well, and people became less cautious, hence the surge in numbers. Given the rise in covid cases, the demand for prevention rose once more, and the number of active cases has correspondingly dropped.

The Socialization of Solidarity

The concept of solidarity was interpreted in different ways correlative to the variety of conceptualizations of health. Those that emphasized the burdensome aspects of being healthy tended to cite the lack of solidarity shown by various actors, but most notably the government. For example:

> "When it comes to all the other things health carries with it, I would say no, because for example, students that are now graduating, its already a stressful period, but now it is even more so, and you still have to pay for your school but where you are getting the money from, nobody really cares. Where is the solidarity there? And the economic situation is not great either. Some people don't have work, and nobody seems to care how you are you eat? Like if you're looking at the mental state of young people, I think there is more the matter than just the physical health aspect of the pandemic. There is a lot the government is overlooking."

On the other hand, those that were consistent in referencing the health as care discourse, interpreted solidarity as providing help voluntarily. In one interview, it was stated:

> I think of how many medical students are putting their lives on the front line. I know, for example, my groups of my group of students that came from Cuba, the first thing we did, when we heard about an opportunity to volunteer at AZ, we went for it. You know, you could say, I, I swapped people, I tested patients, I checked to see if someone had a high temperature or if their sugar was all for the pressure was off, you know, I, I contributed on the front line. And I think that that does show a great level of solidarity.

Those that conceptualized health as healthy lifestyles responded with differing answers. Some interpreted people's behaviour as simply imitative or pressured, and thereof not in the spirit of solidarity. In fact, the appeal suggests a tendency to commodify:

> "Generally, no. Now everything is social media, what someone else has, we want too. That has more influence than solidarity. People are just charitable because it looks good, much like health."

Others, however, interpreted the social media content as encouraging and therefore testimonial to solidarity. The tendency to commodify such, moreover, is considered positively:

> "There are enough support groups. Especially when I go on Instagram, I see everyone is now becoming a health guru or a healthy lifestyle expert with advice on how to stay fit and eat healthy. Its trendy, its healthy, and you can make quick money."

The correspondence, however, was not always as straightforward, as many respondents displayed a mixture of health discourses as their starting point. Nonetheless, it was evident that the majority of the respondents seems to indicate that in terms of solidarity, young adults in Suriname tended to engage in processes of inclusion and exclusion as a way to socialize their interpretation of solidarity which is based on alliance and cooperation. This form of alliance is built most notably upon friend groups:

> "I would say there is solidarity among my own friends' group."

> "If you have a friend group, where one is healthy it helps everyone else. You just don't want to see your friends unhealthy as if they are walking as if they don't have energy or the will to be alive, you are going to help."

In expressing this form of solidarity, one respondent in fact alluded to the competition between solidarity for health consciousness between social groups and the commercialization of unhealthy foods.

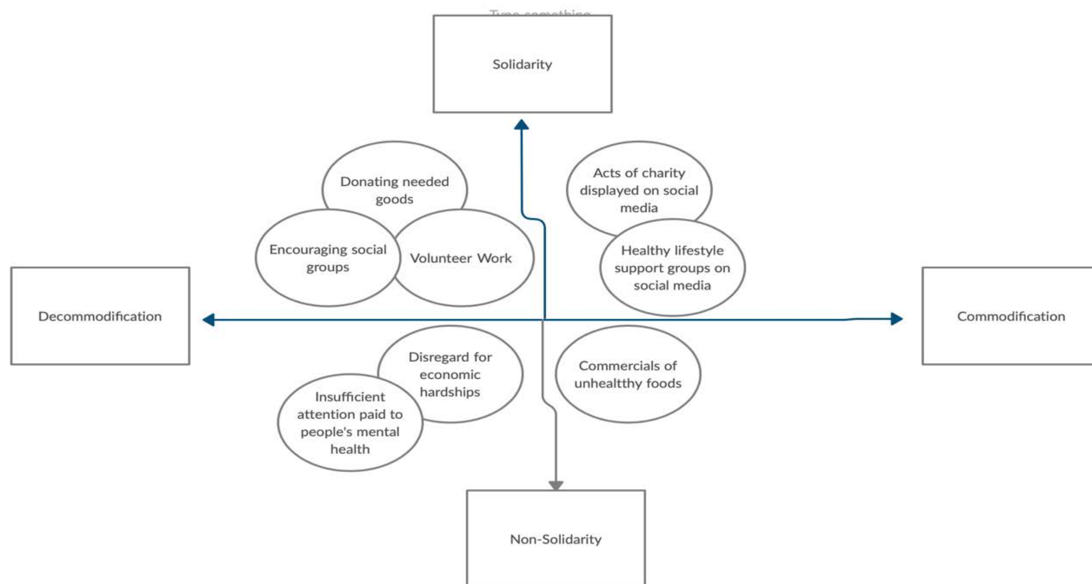
"Solidarity, uh, I think of people around you, your friend groups, your family, but also colleges. If you were the only one that was health conscious, then it would be hard. For example. Look at commercials, there are so many commercials from MacDonald's and stuff, and this is real, but I legit don't know if there are any commercials for fruit or how to make a salad. So, it's easier to be surrounded with things that are unhealthy. Socially, there's a little group that can help, but overall the percentage of people become unhealthy because of that."

To a lesser frequency, references were made to processes of sharing vital resources by respondents that conceptualized health according to the most frequently cited models i.e. the medical and the wellness model. The commonality between these respondents is that they had all stressed the importance of social and economic factors in regard to health. This is exemplified by the following:

"There are organizations like social army that try to gather food packages for people that need it. And there are people, like that doing this before the pandemic even. Like my girlfriend, for her daughter's birthday she asked people to not bring presents but donate stuff for people that need it and she got a lot of stuff. So, it is people that show solidarity, especially for social and economic needs."

Based on the findings, a virtual summative evaluation is presented in the figure below wherein practices of solidarity or non-solidarity are appraised against their tendency to commodify.

Figure 5
Summative Evaluation of Practices of Solidarity



Correspondingly, the overall health practices and responses to INPs demonstrate a low gradation of commodification. However, and once again, references to healthy lifestyles and practices of solidarity upon social media are contoured with terms associated to processes of commodification e.g. 'you can make quick money'.

Part 3: Critical Realist Interpretation of Findings

Identification of Demi-regularities

The first step in CR evaluation is to identify demi-regularities; that which delineates discernible tendencies in the empirical realm. The findings thus far present a number of notable observations such as the diverse conceptualizations of health among young adults that are embedded in varying values; the relative correspondence between their conceptualizations and their health practices and responses to INPs; the consistent higher ranking of economic factors in comparison to social or cultural factors as it relates to their consideration of health in and of itself and the implementation of health interventions; and the fair degree of solidarity practiced by young adults within their own social circles. Moreover, in general, the conceptualizations and correlative health practices seemed to sustain between 1 – 3 degrees of commodification based upon the employed framework. In notably instances, however, whenever participants alluded to being dependent on their market position to access healthcare, or when the building blocks of what sustains health according to their conceptualization is presented as a commodity, the degree of commodification increased to 5. It is in this regard that the prevailing and more relevant tendential pattern was identified. Despite the rather low scaling of degrees of commodification, insinuating that processes of commodification do not intensely impact health conceptualization and practices among young adults in Suriname, it was detectible that in the instances where healthy lifestyles were referenced as portrayed on social media, there was a greater affinity to cite concepts related to processes of commodification i.e. profitability; consumerism; marketization; and commercialization. Interestingly, the supposed variables such as food and smoothies, or gym memberships were products and services are already well-established commodities, and thus, in this scenario, privy to commoditization[3] as opposed to commodification. However, it is the attachment of these entities as foundational elements to the conceptualization of health, that indicates that health in itself could become disposed to interpretative processes of consumerism and commodification.

Theoretical Re-description

In turning to the CPEs, explanations were sought to explain why there is a unique tendency to commodify elements of a healthy lifestyle in a geo-social context where health and healthcare are to a large extent not interpreted in a commodified manner. Given that the institutional factors constituting the health-care system in Suriname are non-market oriented or dependent as indicated by Elcher (1999) – which was further supported by the degree of responsibility to address health care insufficiencies was imposed upon the government rather than private actors by the research participants – it can be induced that this tendency is not derived from the structural move to marketize health care provisioning, as that has not been the case in Suriname, irrespective of the intent to do so. The outstanding variable, thereupon, is social media. The nature of social media as an instrument for market-driven narratives poses a number of concerns as stipulated in the literature.

CPE1, for instance, outlines the weaknesses associated with mode of productions that are intended to achieve surplus rather than equilibrium and the division of labour that is often exploitative in its association thereunto. Yet, in the immaterial realm of social media, there is an emergent duality whereby consumers are simultaneously also becoming

[3] commoditization delineates the increased availability of goods with economic value whereas commodification implies the infiltration of economic valuation into areas previously unchartered by those terms

producers. As such, the manner in which economic value is generated is much more dispersed, and above all occurring at unprecedented speed. Moreover, the concept of labour value is turned on its head; as many consumers are unaware of their contribution to the mode of production wherein capital is accumulated in the financial realm rather than in the physical, commodity exchange domain. In other words, if the interaction that occurs between the consumer and the supposed 'health guru' as cited is conducted online, and thus imitated or consumed by others, the initial consumer would have contributed to the commercialization, if not commoditization, process, most likely unknowingly, and moreover, freely without compensation.

What is more, is that given the opportune platform to integrate international markets and cross-border economic activities, the exposure to such markets are no longer limited to a single physical geographical location. Given the overall non-commodified conceptualizations of health among young adults in Suriname, it is not unfounded to presume that the valorisation process of healthy lifestyles prone to commodification, are drawn from the markets established in a digital realm; furthermore, reflective of health conceptualizations and market ideologies that run rampant in such spaces and not necessarily that of Suriname. Given Suriname's young politico-economic state that has been likened to a rentier state, it is unlikely that advanced processes of commodification would be derived from the state's structural mechanisms. However, being that neoliberal ideologies are referred to as the dominant ideology that permeates many organizations and is quite variegated in nature (Navarro, 2007), it is therefore, again, not ungrounded to solicit that such ideology has infiltrated the digital landscape. In fact, the findings support the indication that process of marketization and commodification are principal within the bounds of social media established markets.

Retroduction: Context (a) + Mechanism (b) = Outcome (c)

The final stage of CR analysis incorporates the simple equation outlined in the subheading. In spirit of re-troducing, the first variable stated will be the outcome (c); in other words, that which was observed in the empirical realm. In relation to the examination of the impact of processes of commodification and decommodification upon health conceptualizations and practices, the following was identified: in general, processes of commodification have an insignificant bearing upon the health conceptualizations and health practices including responses to NPIs and expressions of solidarity of young adults in Suriname with the exception of the discourses related to conceptualizing health as healthy lifestyles as portrayed upon social media.

Subsequently, the second known variable is the context (a), i.e. the spatial-temporal elements. Thereto, this context encompasses Suriname, as the socio-geo-political context, young adults as the distinguishing demographic factor, and the ongoing covid-19 pandemic as the backdrop to the overall impending health concern.

Finally, we come to what processes or relationship must have been activated to engender such a scenario; i.e. what are the mechanisms at play? The low degree of commodification and rather substantial degree of decommodification affecting the conceptualizations of health are attributed to the intricate relationship among the following variables (b+): a fairly young established sovereign country that has the politico-economic composition of a rentier state; a culturally diverse population dissuading monolithic interpretations of social reality; and the prevalent bio-medical conceptualization that delimits that which should be subordinate to medicalization. On the other hand, the incurrence of the tendency to commodify health as it relates to how it is interpreted from social media is anticipated to be result of the increased commercialization and marketization of healthy lifestyles in a digital landscape, infused by neoliberal ideologies (b).

Chapter 6
Conclusion

This project was conducted in spirit of uncovering the ideological substructures according to which health conceptualizations among young adults in Suriname are organized and experienced. This, of course, is rather topical given the enduring covid-19 pandemic we are currently living through. This backdrop served as an inspiration to urge dialogue regarding health rather than just illness or disease; after all, progressive models delineate that health should no longer be perceived as merely the absence of disease.

The main empirical concern of this paper revolved around the extent to which processes of commodification and decommodification influence health conceptualizations and health practices of young adults within the geo-political context of Suriname. The findings indicated that the conceptualizations of health are diverse, intricate, and also embedded in particular norms and values that can be retraced to a number of self-identified sources; namely, education, cultural background, parental figures or other supposed exemplary figures, friends, and social media. Overall, the degree of commodification correlating with the majority of health conceptualization and practices was restricted to a relatively low gradation; however, an exception was detected. In the instances whereby a social media depiction of a healthy lifestyle informed the research participant's perception, there was a noticeable tendency to present elements associated with health as commodities. This has been inferred to be the result of an increased commercialization and marketization of health occurring in digital marketspaces which are, succeedingly influenced by neoliberal ideologies. The implicit conclusion drawn thereto is that the immaterial realm of social media is permeable to economic processes and the intensification of commodification and marketization noticed in IPE. In fact, it can become an instrument thereto.

In addition to addressing the main research question, various notable findings were distinguished and considered relevant to the general intrigue into the triangulated relationship between health, economics, and development. For example, although many of the respondents often cited the traditional bio-medical conceptualizations of health, they also seemed to be able to consistently rank other factors, on average, at least as somewhat important to health. In fact, economic factors were consistently ranked most important, followed by social, and thereafter cultural. Thereupon, a rudimentary interlinkage between various fields was acknowledged. Moreover, in assessing the rich data obtained in regard to the diverse health conceptualizations and health practices, the following recommendations have been formulated:

1. As it relates to macro policy changes, it is dissuaded against imposing a new payment scheme that removes the ensured social protection away from the population. Given the economic hardships faced by the different strata of the population, not only will this not be well-received, but it can further generate a trade-off between their economic and health concerns. However, to address the financial inability of the government to sustain immense subsidies, it is recommended that different basic care packages are given rendering the verifiable need of the individual. This, indubitably, means that the institutional capacity to assert the varying needs of the population must be generated.
2. At the micro-level, it is recommended that comprehensive educational programs addressed at delineating the importance and intricacy of health be implemented into school curriculums. The findings revealed that many young adults were not taught

to consider many of the questions asked; moreover, in citing the various reasons as to why certain NPIs are not well received, or why certain health topics remain taboo, the lack of understanding was cited as one of the culprits. It was certainly telling that none of the respondents mentioned sexual health. Although it was not the main focus of this investigation, it does indicate that many sub-concerns related to health remain unaddressed. It is suggested that the purpose of such educational health programs be to engender greater understanding and self-reflection. Such skill could also prove beneficial as young people venture into various realms, including the digital landscape.

3. With respect to the pandemic, it is recommended to implement NPIs that encourage solidarity. The findings show that there is a significant disdain towards the lockdown as a health preventative measure, for reasons including but not limited to the impact on individual sources of income, the need for social contact, and the existence of a culture that is not compatible with such. However, the findings also demonstrate that there is a moderate level of solidarity experienced among young adults, and more importantly, the attitude to such is highly positive. Given that most respondents had indicated that solidarity is most commonly experienced among their own social groups, it is suggested that NPIs such as the establishment of social bubbles be employed. Social bubbles create the possibility to maintain mobility and social interaction, while providing an effective means to contact trace.

What comes forth in the overall assessment of this paper is that health is multi-dimensional; there is more than one lived truth of how such is experienced and socialized. Given this complexity, it is imperative that conscious self-reflection continues to occur among individuals and transcends onto policy level; such transference, or the interplay rather between policy and lived reality should be, ideally, bi-directional.

Appendices

Appendix 1
Interview Guide

Interview Guide

Date:
Interviewee code:

1. Pre-interview introductions:
   - Personal introductions
   - Statement about the Research
   - Verification of inclusion criteria
   - The Informed Consent Form (emphasize risks and consent)
   - Questions?

2. Demographic information:

   - Age:
   - Gender:
   - Occupation:

PART 1: Health conceptualizations

1. When I mention health, what comes to mind? What is health? What do you think of when you think of health? Have you always thought of health this way? How would you define health?
2. Are you healthy? Would you consider yourself healthy? How do you know if you are healthy?
3. What is ill health? What does it mean to be unhealthy? How would you know if you are unhealthy? How can you tell if someone is unhealthy?
4. Why do you think people would want to be healthy? Why do you want to be healthy? What motivates you to be healthy? What is the biggest motivation for being healthy?
5. Do you think economic/social/cultural factors are of relevance to health? Out of a scale from 1 to 6, whereby 6 means most important, and 1 not important at all, how would you rank these?

PART 2: Health Practices and Solidarity

1. How do you maintain your health? What kind of health practices do you have? How do you account for your health?
2. How have you accounted for you health during this pandemic? Is it any different from before? What kind of health practices have you adopted? Why?
3. Do you know of other people you age that have adopted similar health practices? How do you think people your age in Suriname typically care for their health?
4. Do you talk about your health concerns with others? Do you feel listened to when you do? Whom do you talk to?
5. Do you think there is a sense of solidarity among people in Suriname during this pandemic? How about among young people? How can you tell?

PART 3: Responses to NPIs

1. What do you think about the partial and total lockdowns in Suriname? How have you experienced this? How do you think others have experienced this? How about people your age? Do you think it was effective?
2. What do you think about the social distancing rule in Suriname? How have you experienced this? How do you think others have experienced this? How about people your age? Do you think it was effective?
3. Do you think economic/social/cultural factors are important to consider when implementing NPIs? Out of a scale from 1 to 6, whereby 6 means most important, and 1 not important at all, how would you rank these?

Thank you for your time. Do you have any questions?

Appendix 2
Informed Consent Form

Informed Consent Form

Working Title of Research:

"A Critical Realist Interpretation of a Health Narrative Derived from Young Adults in Suriname during COVID-19:
A politico-economic excavation into the ideological substructure of health care"

Principle Investigator, Affiliation and Contact Information:

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Social Policy for Development Major

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Kortenaerkade 12
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The Netherlands
Telephone: +31 70 426 0460

This Informed Consent Form has two parts:

1: Information Sheet (to share information about the study with you)

2: Certificate of Consent (for signatures if you choose to participate)

You will be given a copy of the full Informed Consent Form

Part I: Information Sheet

Introduction

Dear potential research participant,

I am Reann Kersenhout, a graduate student at the International Institute for Social Studies, Erasmus University. I am conducting research on the (re)conceptualization of health amongst my fellow Surinamese against the backdrop of the COVID-19 pandemic. The purpose of this form is to fully inform you of the intention, scope, methods, and implications of this study and thereafter invite you to participate if it will please you. It is not required to decide whether or not you would want to participate immediately upon receiving this form as you may ponder, ask questions, or receive advice from third parties as to whether or not you should give consent. It is of utmost importance to the researcher and the integrity of the research that you feel comfortable and sovereign in your decision-making process.
You may be confronted with particular jargon or difficult concepts that you do not immediately understand within this form itself or later throughout the study. Please feel at ease to ask me to halt and explain such to you in a manner that you understand so that you are aware of what is being said at all times.

Purpose of the research

This research is concerned with how health is conceptualized given the ongoing coronavirus pandemic. It is therefore my objective to ask you to tell me what you perceive health to be and what kind of health concerns have been brought to the forefront since this pandemic. I would like to know if your perception of what health is has changed during this pandemic and why that would be so. I would also like to know if you consider yourself healthy at the moment, and what kind of health practices you uphold to either maintain or improve your health - if that is of relevance/importance to you. I would also cite a number of health interventions that would have been implemented in Suriname and ask you how these would have affected you. I would also ask you what you would have liked to be addressed either by this research or your local policy interventions regarding the health situation and in which manner. My main concern is your ideas, your perception, and your emotions. There is a lot to say about health, which is why I would like for you, as the research participant, to guide me to what is important to you.

Type of Research Intervention

Your participation in this research will take the form of a one-on-one personal and in-depth interview of approximately one hour. The interview is meant to be as relaxing as possible and will terminate as soon as you indicate discomfort or the simple willingness to do so. At the end of the interview, I will ask you to draw an image which will be shared with others if the research so requires. Your written consent to participate in this study will also indicate your permission to do so. However, during the interview, you may explicitly ask to not draw an image at all, and thus, such would not be shared.

Participant Selection

You have been invited to take part in this research based on the following inclusion criteria: you are of Surinamese nationality; you were living in Suriname during the COVID-19 pandemic thus far or have close contact with family members that have experienced COVID-19 in Suriname; and you are between the ages of 18 and 30.

Voluntary Participation

It is important for you to know that participation in this study is entirely voluntary. It is your own choice as to whether or not you will participate. The choice to participate or not should not have any bearing on your job, education, or cause you any intentional harm albeit physically, psychologically, financially or otherwise. You may change your mind and refuse and/or withdraw at any point.

Procedures

The interview will take place digitally through a video call on the social media application Microsoft Teams. If such is not possible, Zoom will be preferred. It is also possible to indicate that you prefer to use a different video conferencing medium with which you feel more comfortable and such would be adhered to. Furthermore, communication between the research participant and the researcher can extend to Facebook messages, emails, or regular phone calls. In person, physical contact is not required and not permitted given the sensitive nature of the COVID-19 protocols.

Duration

This research takes place over 30 days or 1 month in total. During that time, I will have one in-depth interview with you for approximately 60 minutes and it is possible that I would be required to contact you at a later date for possible follow up questions or clarification.

Risks

Throughout this study, I will be asking you to share personal information with me regarding your personal health, opinions on policy interventions, and other related concerns. It may be that you feel uncomfortable to speak about certain questions in which case you have the right to refuse to answer or withdraw from the study entirely. You would not have to explain why. Additionally, to protect you as the research participant, your personal information is kept private. Your details are only known to the me, the researcher.

Given that these interviews will take place using a digital platform, it is important that you understand that there are some inherent risks involved that I cannot control but will try my best to mitigate. These include but are not limited to issues regarding malware and decrypted information sharing by unforeseeable third parties.

Benefits

There are no direct and immediate benefits to you as research participant, however, your contribution is likely to help the academia to better understand how the Surinamese society views health and how public health interventions can be improved.

Confidentiality

It is possible that this research will draw attention from the larger Surinamese community, particularly because recruitment was done on a public platform. Please be informed that your personal information will not be shared with the public.

As indicated under the section 'risks', the information that you will give during these interviews will be analyzed in a larger context – therefore, your answers will not be presented in a way that it would reveal your identity.

Part II: Certificate of Consent

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Print Name of Participant___________________

Signature of Participant ____________________

Date ____________________________
Day/month/year

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

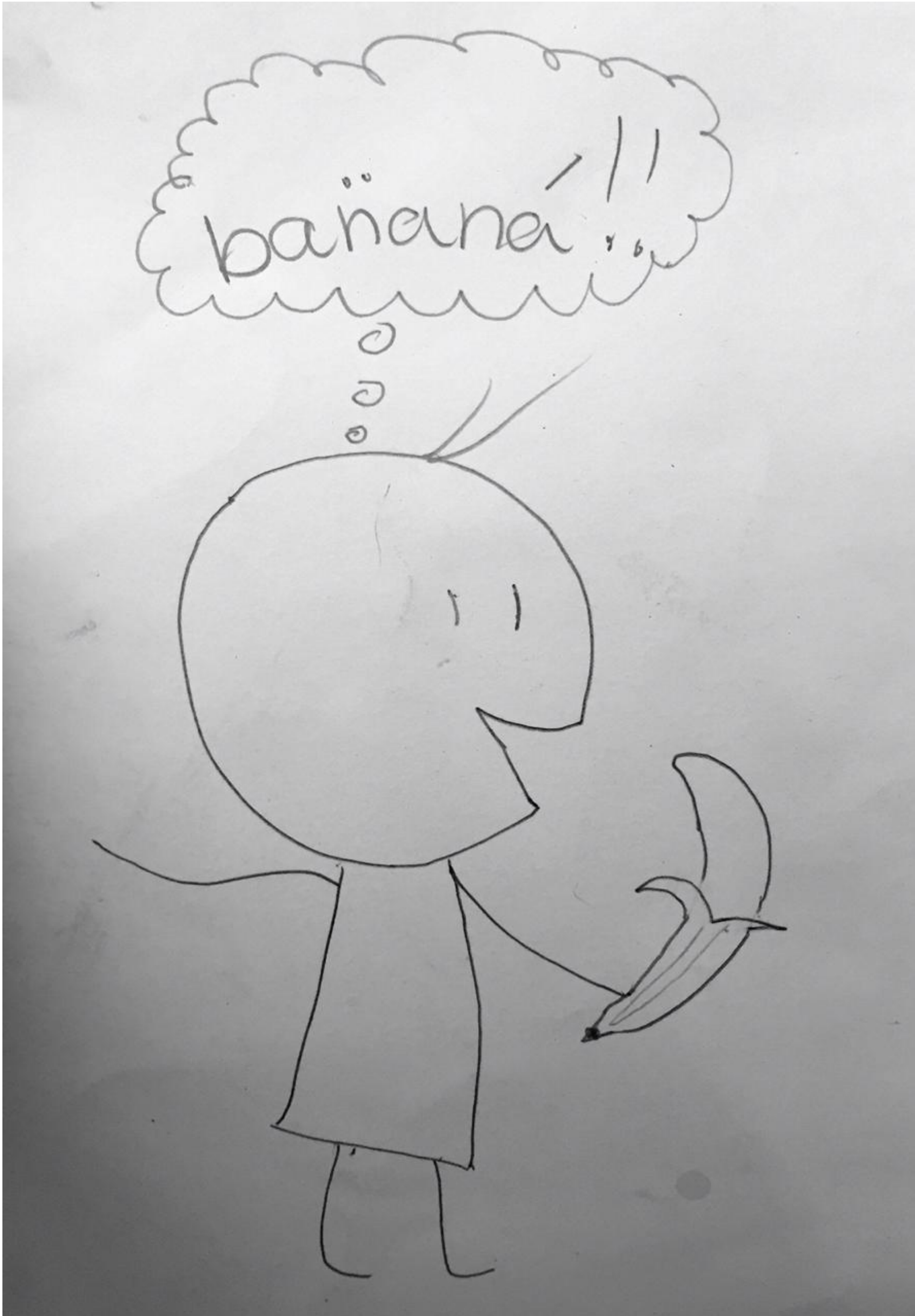
A copy of this form has been provided to the participant.

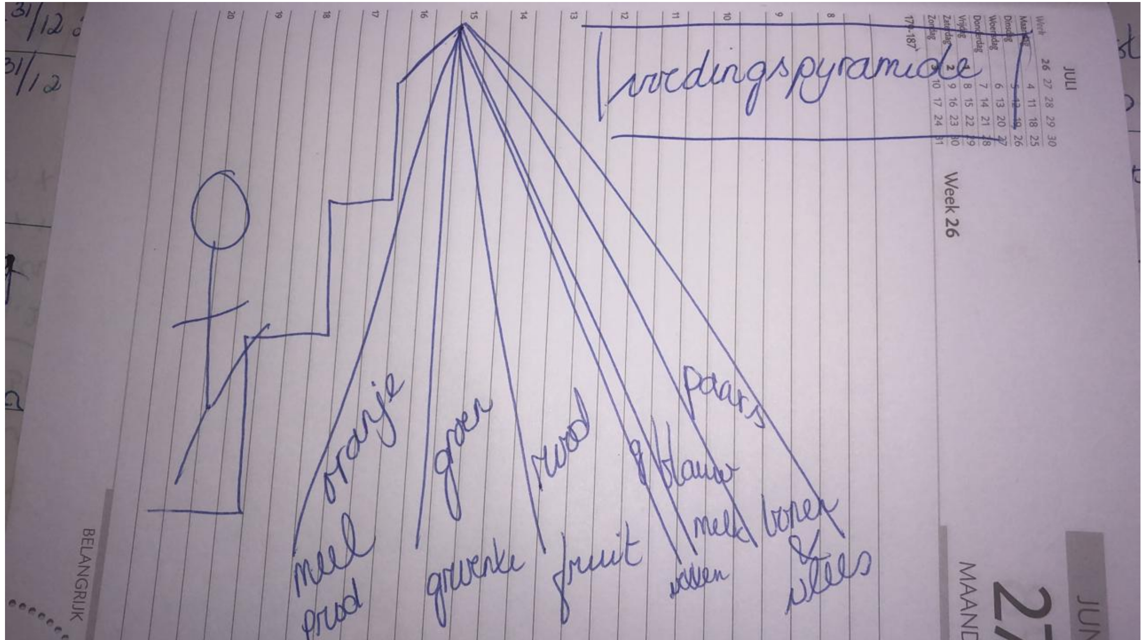
Print Name of Researcher/person taking the consent_________________________

Signature of Researcher /person taking the consent___________________________

Date ____________________________
Day/month/year

Appendix 3
Research Participant Produced Drawings

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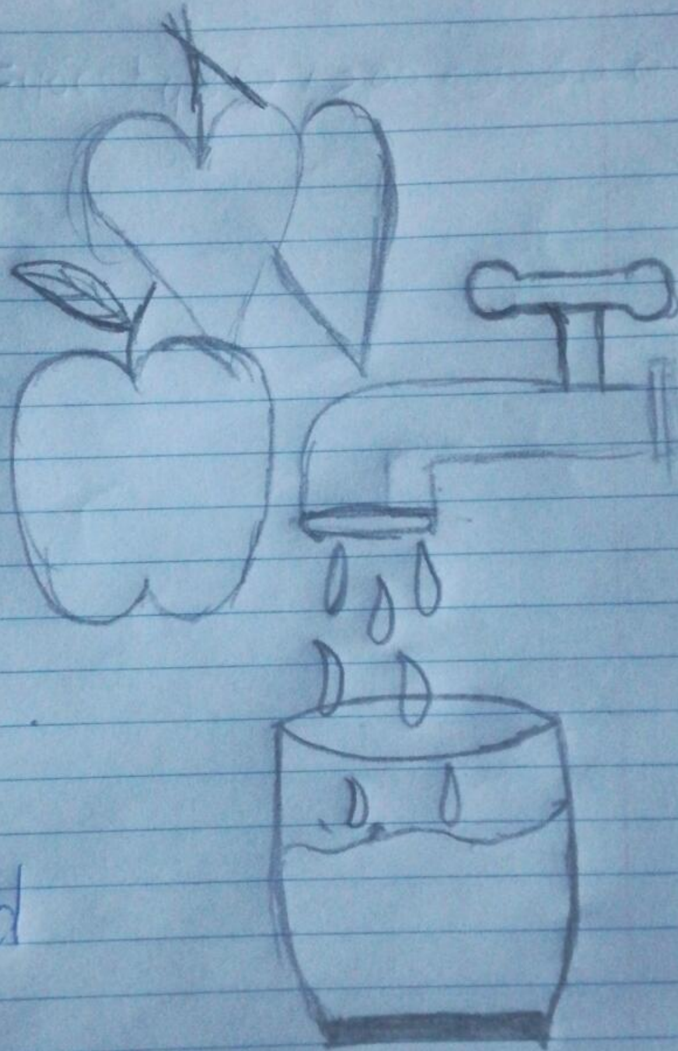
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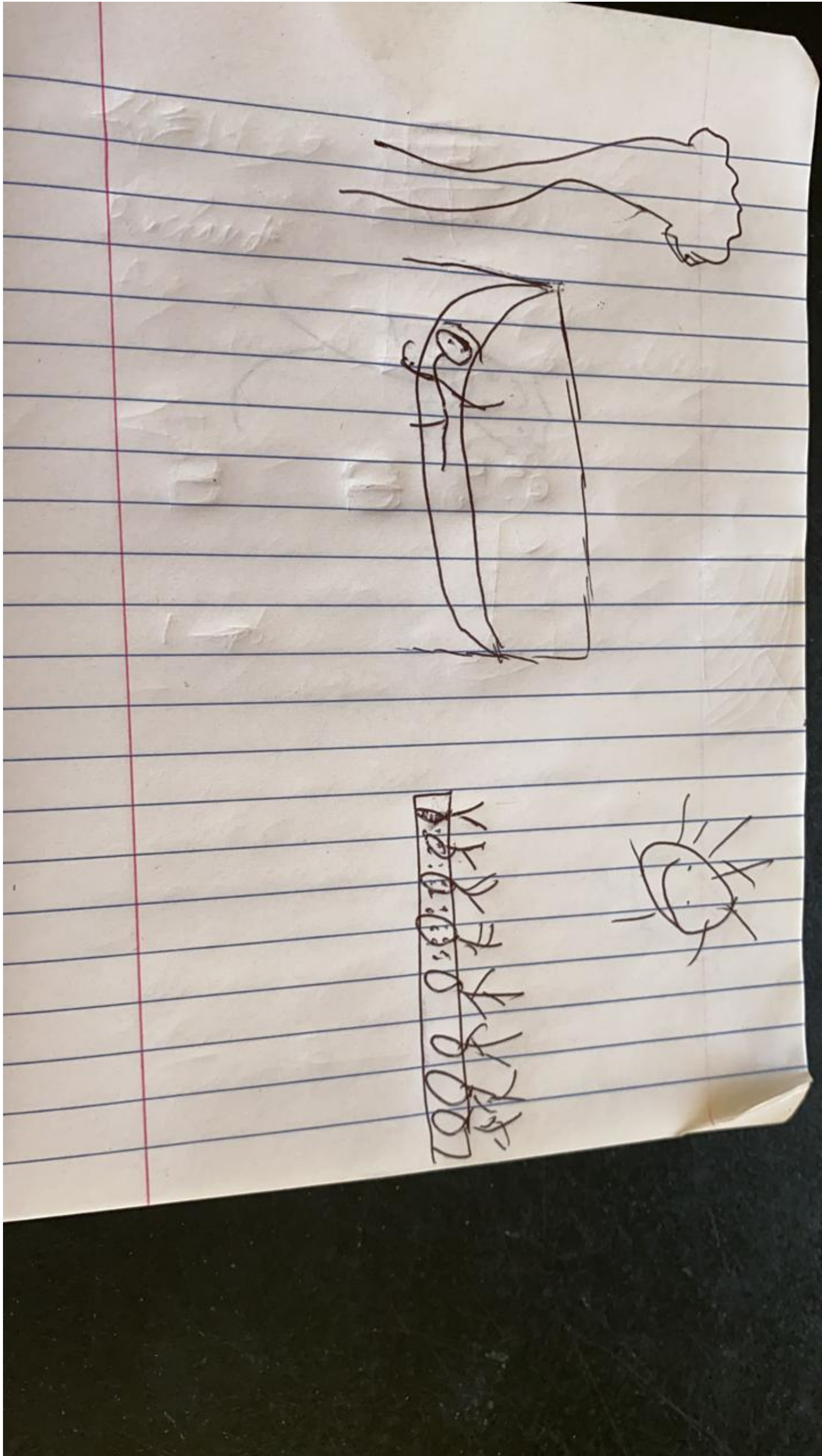

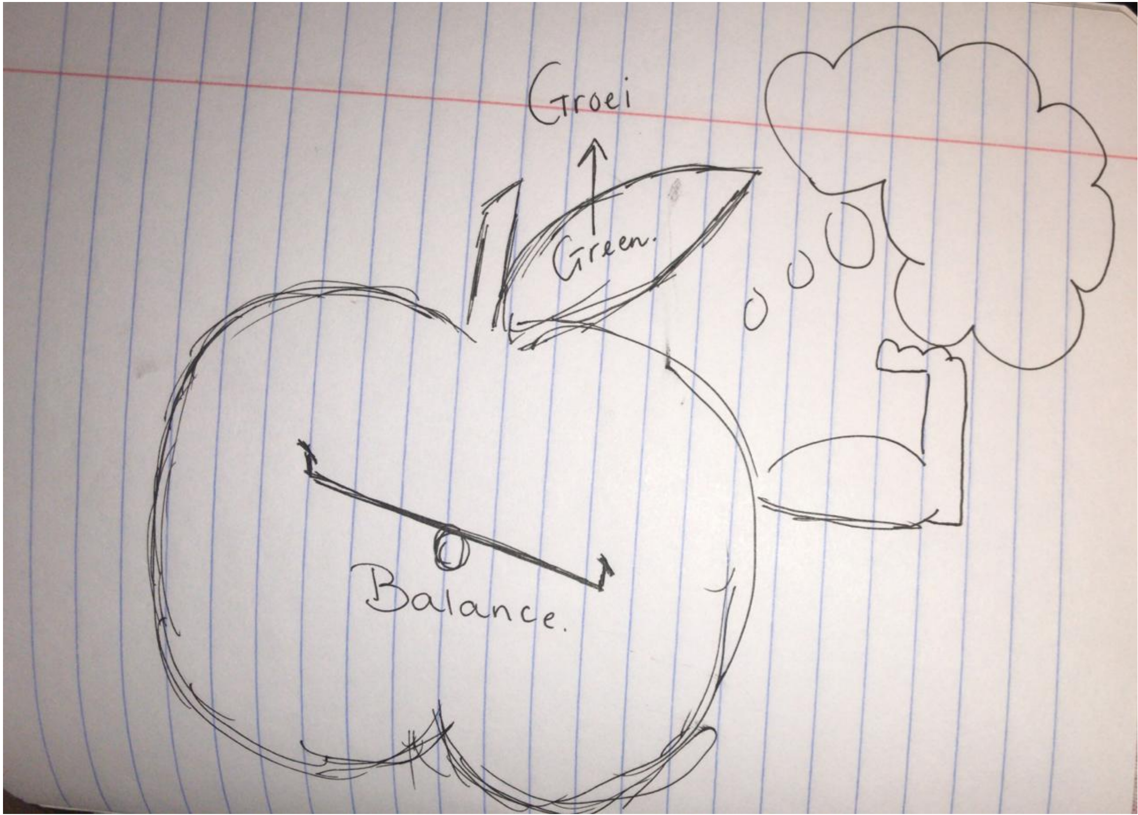
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Appendix 4
List of Interviewees

Demographic information

Table 1: pre-interviews

Research Participants	Age	Gender	Occupation
Interviewee no. 1	26	female	consultant
Interviewee no. 2	24	male	teacher
Interviewee no. 3	25	female	digital marketer and designer
Interviewee no. 4	26	female	saleswoman
Interviewee no. 5	27	gender fluid	unemployed

Table 2: interviews

Research Participants	Age	Gender	Occupation
Interviewee no. 6	22	female	full time medical student
Interviewee no. 7	21	male	writer
Interviewee no. 8	20	female	full time student
Interviewee no. 9	22	female	full time student
Interviewee no. 10	22	female	finance student
Interviewee no. 11	22	female	student/teacher
Interviewee no. 12	24	male	full time student
Interviewee no. 13	22	female	financial associate
Interviewee no. 14	29	female	chef
Interviewee no. 15	30	female	housewife
Interviewee no. 16	27	female	student/camera journalist/musical teacher
Interviewee no. 17	23	female	full time student
Interviewee no. 18	24	male	unemployed
Interviewee no. 19	26	female	optician
Interviewee no. 20	20	female	recently graduated/unemployed
Interviewee no. 21	28	male	activist/entrepreneur
Interviewee no. 22	20	female	full time student
Interviewee no. 23	19	unwilling to specify	full time student
Interviewee no. 24	23	male	programmer
Interviewee no. 25	19	male	electrician

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