Project Completion Report

PCR

Project Name: Health Sector Facility

***Country:** Suriname*

***Sector/Subsector:** Health – Health Services*

Original Project Team: Team Leader: Amanda Glassman (RE3/SO3); other members: Antonio Giuffrida (RE3/SO3); Marcelo Perez Alfaro (COF/CSU); Ethel Muhlstein (RE3/SO3); Leighna Oh Kim (Consultant); and Juan Carlos Perez-Segnini (LEG)

Loan Number(s): 1537/OC-SU

Project Number(s):SU0028

Final Approval Date of PCR:

PCR Team: Bernice U. Dookhan-Khan, Ph.D. Consultant; Ian Ho-a-Shu (SPH/CTT); Priya Ramsumair, Research Fellow (CTT/CTT); and Martha Guerra (SCL/SPH).

Acronyms and Abbreviations

BGVS	Suriname Drug Supply Company (Bedrijf Geneesmiddelenvoorziening Suriname)
BMA	Bureau of Medical Affairs
BOG	Bureau for Public Health
CCT	Conditional Cash Transfer
FL	Foundation Lobi
GOS	Government of Suriname
HSF	Health Sector Facility
IDB	Inter-American Development Bank
JTV	Youth Dental Foundation
MDIS	Medical Declaration Information System
MM	Medical Mission
MOF	Ministry of Finance
MOH	Ministry of Health
MRD	Ministry of Regional Development
MSA	Ministry of Social Affairs
PEU	Program Execution Unit
PHC	Public Health Care
RGD	Regional Health Services
SIS	Social Affairs Information System
SZF	State Health Insurance Fund
TCA	Technical Cooperation Agreement

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Annexes

I. Basic Information

BASIC DATA (AMOUNTS IN US$)	
PROJECT NO: (SU0028) (1537/OC-SU)	**TITLE:** Health Sector Facility
Borrower: Republic of Suriname **Executing Agency (EA):** Ministry of Health	**Date of Board Approval:** March 11, 2004 **Date of Loan Contract Effectiveness:** March 31, 2004 **Date of Eligibility for First Disbursement:** June 24, 2004
Loan(s): USD 5,000,000 **Sector: Health**	**Months in Execution** *** from Approval:** 88 months *** from Contract Effectiveness:** 89 months
Lending Instrument	**Disbursement Periods** **Original Date of Final Disbursement:** 31 March 2008 **Current Date of Final Disbursement:** 30 November 2011 **Cumulative Extension (Months):** 43 months **Special Extensions (Months):** 0 months
	Loan Amount(s) *** Original Amount:** USD 5,000,000 *** Current Amount:** USD 5,000,000 *** Pari Passu (if applicable):**
Poverty Targeted Investment (PTI): Yes/No **Social Equity (SEQ): Yes/No** **Environmental Classification: A, B, or C**	**Disbursements** *** Amount to date:** November, 2011 – 98%
	Total Project Cost (Original Estimate): USD5,000,000
	Redirectioning **Has this Project?** **Received funds from another Project [ ]** **Sent funds to another Project [ ]** **N/A [X]**

To/From Project Number	From Sub-Loan Number	Amount
N/A	N/A	N/A

*** Current amount (adjusted for redirectioning):**

On Alert Status
Is project currently designated "on alert" by PAIS: Yes/No
If yes then why is the project on alert (DO , IP Ratings and/or relevant PAIS indicators):
Comments on relevance of "on alert" status for this project (if applicable):

Summary Performance Classifications				
DO	[ ] Highly Probable (HP)	[x] Probable (P)	[ ] Low Probability (LP)	[ ] Improbable (I)
IP	[ ] Highly Satisfactory (HS)	[x] Satisfactory (S)	[ ] Unsatisfactory (US)	[ ] Very Unsatisfactory (VU)
SU	[ ] Highly Probable (HP)	[x] Probable (P)	[ ] Low Probability (LP)	[ ] Improbable (I)

II. The Project

a. Project Context

Suriname's Road to Health Sector Reform integrates and summarizes the findings of 12 studies that were carried out as part of an agreement between the Government of Suriname and the Inter-American Development Bank (IDB). The first eight are

Health Sector Reform studies1 (2001-2003), funded by the IDB and the Government of Japan, the final four are health sector studies carried out by the IDB.

The recommendations for reform of the Surinamese health care system revolve around the key issues of improving the quality and effectiveness of preventive and primary health care, improving access to medicines, reducing costs and improving efficiency among health system payers, improving equity in the Ministry of Social Affairs (MSA) card system, and strengthening the stewardship function of the Ministry of Health (MOH).

The conceptualization of the Health Sector Reform resulted from the earlier IDB Technical Cooperation Agreement (TCA) "Support for the Health Sector Reform" which was implemented during the period 2001-2003. The studies of this TCA revealed a number of weaknesses in Suriname's health system, stressed the need for reform of the health system, and provided recommendations based on three pillars[2]: to improve the efficiency, equity and quality of the health service.

Following several studies that were performed in the context of the Health Sector Reform in the Republic of Suriname, the government then initiated the implementation phase of the Health Sector Reform Process. On March 31, 2004, the Government of the Republic of Suriname and the Inter-American Development Bank signed a loan contract, 1537/OC-SU for the implementation of institutional reforms to increase the efficiency, equity and quality of health services. The Health Sector Facility (HSF) to support the implementation of health sector reform in Suriname was then executed on June 22, 2004.

The program was initially executed with a predefined goal and objectives[3]. During the course of the program, institutional change activities and some procurement challenges resulted in staggered implementation. In addition, the project faced a number of complex challenges, including, cross cutting public sector implementation capacity constraints coupled with stretched human resources within the Ministry of Health and the absence of a fully functioning Project Execution Unit at critical junctures throughout project execution which resulted in diminished coordination with other actors in the programme, namely the SZF and the Ministry of Social Affairs..

The success of the HSF was ascribed in large measure to the support given by the IDB mission for a high-level re-profiling plan[4] (The detailed re-profiled project activities are outlined in the June 2009 Re-profiling Report- Annex 1) guided by key considerations including sector best practices, consistency with the program's original development objective and indicators, pragmatic considerations as to what can be implemented over the remaining project implementation period and pressing health issues facing the country. The HSF was originally scheduled for completion in 2009, however, with several, unforeseen implementation challenges, it was granted two special extensions, with a final disbursement date of December 2011.

b. Project Description

The aim of the Health Sector Facility was to support health sector reform in Suriname. Its design was intended to mirror an integrated and holistic approach with realistic and pragmatic components that addressed the health sector policies and institutional reforms to increase the quality, efficiency and equity of health services, particularly those directed towards the poor. While the original execution period was 4 years, the project implemented over a total period of seven (2004-2011) years. The total project cost was USD5M. In 2009, the programme was extended and also re-profiled. While the programme objective was not changed, the implementation sequencing of activities was revised and three new indicators were added to accommodate the government priorities at the time.

i. Development Objective

[1] IDB. 2005. Suriname's Road to Health Sector Reform: an examination of the health care system and recommendations for change.

[2] Hindori M. 2003. Health sector reform in Suriname (White Paper). Suriname: Ministry of Health, Suriname and IDB.

[3] IDB. 2004. Operating Regulations & Guidelines, 1537/OC-SU.

[4] See Annex 1- Re Profiling Report.

The objective of the program, "Support for Implementation of Health Sector Reform" is to improve the health sector in Suriname through the implementation of institutional reforms to increase the quality, efficiency and equity of health services, particularly those directed towards the poor.

ii. Components

Component 1: Improve quality and effectiveness of preventive and primary health care

This component is aimed at improving the quality and effectiveness of primary health care services and improving access to medicine.

Subcomponent 1.1: Improve performance of preventive and primary health care services.

The goal of this subcomponent was to improve the performance of the primary health care through reduced dispersion of efforts in the coastal region and increased focus on preventive care and quality assurance measures. Technical assistance, training, materials and salary incentives were to be financed to: (i) assure joint RJD-BOG delivery of a basic package[5] of primary health care services with a focus on the coastal region of Suriname.

Subcomponent 1.2: Improve access to medicine. The objective of this component was to strengthen pharmaceutical policy-making capacity and to improve legislation and procedures for the import and distribution of pharmaceutical products in Suriname, in order to increase the availability of essential medicines in public and private pharmacies and to achieve savings on pharmaceutical expenditures, while maintaining product quality.

Component 2: Improve efficiency and equity of health system

This component was aimed at: (i) reducing administrative costs and improving accountability and quality of health services financed through SZF and MSA; (ii) improving policy making capacity at the central level; and (iii) improving equity through a new mechanism of targeting health subsidies to the poor.

Subcomponent 2.1: Reduce costs and improve efficiency. To reduce costs and improve efficiency, accountability and quality of care, this subcomponent supported the integration and strengthening of State Health Insurance Fund (SZF) and MSA purchasing and purchasing functions.

Subcomponent 2.2: Improve equity. Through the improvement of MSA targeting mechanisms, this subcomponent sought to expand the free health cards program of MSA to all poor households, defined using the national poverty line, while simultaneously reducing the inclusion of non-poor households. Scorecards with clear criteria for eligibility were to be introduced to improve the transparency of the health card awarding system. The project also aimed to introduce a beneficiary administration system to allow for a continuously updated and automated list of persons eligible to receive free health care and other social benefits administered by MSA.

Subcomponent 2.3: Strengthen MOH. This subcomponent had as its objective to improve accountability in primary health care services, develop effective responses to the HIV/AIDS epidemic and monitor national health spending to improve policy-making at the MOH. These efforts sought to complement ongoing institutional strengthening activities financed by Dutch Treaty Funds.

III. Results

a. Outcomes

[5] The definition of the content and treatment guidelines included in the package will be based on WHO and PAHO recommendations for primary health care, as well as cost-effectiveness data collected internationally.

ACHIEVEMENT OF DEVELOPMENT OBJECTIVES (DO)		
Development Objective (s) (Purpose)	**Key Outcome Indicators**	
	Planned Outcomes	**Outcomes Achieved**
Improve the health sector in Suriname through the implementation of institutional reforms to increase the quality, efficiency and equity of health services, particularly those directed towards the poor. Classification: P	By 2011 achieve: **1. 6% reduction in infant mortality** Baseline: 31 per 1,000 live births (MICS 2000) Target: 25 per 1,000 live births **2. 20% reduction in diabetes and hypertension hospitalization** **3. 26% increase in immunization coverage** Baseline: 54% national immunization coverage (MICS 2000; MOH records) Target: 80% national immunization coverage **4. 20% increase coverage of total population by health insurance** Baseline: 69% total population coverage (SZF and MSA records) Target: 89% total population coverage **5. 13% reduction in Type I errors (equity)** Baseline: Type I errors 23% Target: Type I errors 10%	27 per 1,000 live births (UNDP 2010) No data Immunization for DTP – 87% Immunization for Measles – 88%[6] Total population coverage - 80%[7] (MSA reports)

i) Reformulation. i) Was the objective(s) of this project reformulated? [ ] yes [**x**] no
ii) Were there any changes to the outcome indicators or targets? [**x**] yes [ ] no

If yes, indicate the most recent date, and, who approved these changes. Changes made to the indicators in 2009 and agreed to by the Bank and the Government of Suriname (GOS).

Briefly explain any changes resulting from this exercise. In 2009 the HSF was re-profiled and extended for an additional two years. The log frame and respective outcome indicators were updated at the time of the re-profiling in 2009 with measurable baseline and targets established for all specified outcome indicators including the additional three indicators approved after the re-profiling. From a holistic perspective, the HSF did have quantifiable indicators based on data from reliable sources.

The purpose of the HSF is to improve the health sector in Suriname through the implementation of institutional reforms to increase the quality, efficiency and equity of health services, particularly those directed towards the poor. For this report, a combination of outcome indicators was used from both, the original and revised log frames.

i) PPMR Retrofitting. Indicate if and when the PPMR was retrofitted and explain any changes resulting from this exercise.

The PPMR was retrofitted on November 30, 2009 and the revised indicators were redefined accordingly while keeping with the overall scope of the project in order not to deviate from the development objective of the project.

b. Externalities

Positive Externalities

Summary: Despite some early procurement challenges, it was noted that the project had made considerable progress particularly in the pharmaceutical and primary health care areas. The project was able to increase GOS's commitment to the Health Sector and has facilitated institutional strengthening, efficiency and national data collection.

MOH Relations: The Health Sector Facility was aligned with Suriname's national development plan and as such GOS's commitment to the programme has remained consistent; and the relationship between the Bank and Ministry officials has been significantly strengthened during programme implementation.

6 UNDP Human Development Report, 2011.

7 Health and health systems in Suriname, ISAGS, Rio de Janeiro (Eersel, 2011).

Ministry of Health Institutional Strengthening: The HSF Institutional Reform Plan in alignment with its objective, implemented some key activities including: 1) Upgrading services and infrastructure; 2) Skill development and availability; 3) Providing Quality service for access to medicine (Quality Assurance, legislation and relevant protocols were developed and issued to all health facilities in both public and private sectors to improve access to medicine and health service quality); Development of Information and Communication campaigns.
Efficiency at SZF: State Health Insurance Fund (SZF) as of July 2011, covers more than 145,000 persons including 40,000 civil servants and their families as well as 600 companies make use of its service. Also, there is a decentralized system with a branch in every district and improved health card security system which with the necessary political support portends well for deeper collaboration with SZF and MFA.

Country Wide Household Survey: Although not included in the original project activities, the project produced the first ever country wide (including the interior) household budget survey in 2007 which is still one of the main sources of poverty data that is used both by the Bank and Government.

Negative Externalities

Staggered Implementation: Using a holistic perspective, it was not uncommon for projects of this nature to have non-linear implementation and disbursement rates noting that institutional change activities, given their complexity, usually have staggered implementation compared to physical infrastructure projects.

Proxy Means Test: Given Suriname's complex political structure that is driven by the country's multi-ethnic composition, and the several political parties that formed a coalition government, Government was cautious and reluctant to approve the application of the PMT, which not only precluded more effective targeting of the health card programme but also possible application of the PMT for wider social programmes.

c. Outputs

The Health Sector Facility Project was granted two general extensions. With each extension, the GOS and the Bank took the opportunity to refine the outcome and output indicators in order to sharpen reporting requirements and also as a means of maintaining project relevance. As a result the Output indicators used below are those identified in 2009 at the time of the re-profiling and extension.

Components (Outputs):	Key Output Indicators	
	Planned Outputs	**Outputs Achieved**
1. Component 1: Improve Prevention and Primary Health Care Services	Infrastructure strengthened and capacity built as follows:	
	-Primary Health Care Unit (PHCU) established in the MOH	Organizational structure completed; an advisor for the unit has been hired and staff positions in the process of being filled.
	- Counselling room for pregnant teen moms refurbished **(Lands Hospital)**	Computer equipment and office furniture provided; nutrition materials and education program produced and distributed.
	- National Policy for Cervical Cancer developed and implemented **(BOG/MOH)**	National Policy for Cervical Cancer study completed; screening clinics initiated; a Strategic Plan has been developed as well as the establishment of a committee to develop an Action Plan to implement strategic plan and policy;
	- Medical Waste Disposal system improved **(BOG/MOH)**	CEHI provided training in medical waste management; special vehicle for medical waste collection provided. A private public partnership approach will be implemented by mid-2012 to collect and delivery waste from both public and private facilities.
	- Kidney dialysis services improved **(MOH)**	3 dialyses machines and chairs, furniture and hardware procured; training conducted; service in full implementation.
	-Integrated, automated and centralized data management for vaccinations and malaria completed **(RJD/MM/BOG)**	PITS Web-based software program designed and demonstrated. The pilot will be conducted when issues of connectivity and data confidentiality are resolved. Successful Tele-Health pilot project completed in Hinterlands and is ongoing in Coastal areas as well. By mid-2012, MOH expects to complete the expansion of the project to increase wider coverage to the Hinterlands
	-Automated pharmaceutical storage and distribution system implemented	Web-based software system developed; and pilot to be conducted by July 2012 with the technical assistance of a consultant firm.
	- Training conducted; training materials delivered **(MOH, KDC, RDG, MM, BOG)**	Training organized at 47 health centers; 300 persons trained.
	- Communication with hinterland clinics improved **(MM)**	Study completed for MM and based on the study, the MOH is now considering the recommendations for communication improvement.
	- Commewijne Sexual Reproductive Health Clinic upgraded **(FL)**	Mobile clinic and office furnishings provided. Service in full operation.
	- Geyersvligt clinic upgraded **(RGD)**	Ambulance garage & office furnishings provided
	- Youth Dental Foundation **(JTV)** upgraded	3 dental chairs and automated MIS provided; two observation wards and dental Clinic provided. Service in full operation.
	-Brownsweg clinic refurbished and upgrade **(MM)**	Equipment supplied; doctor's offices and waiting area renovated, training conducted.
	- Dermatology Clinic renovated	Internal renovation of polyclinics was completed. Clinics in full operation.

IMPLEMENTATION PROGRESS (IP)		
Components (Outputs) :	**Key Output Indicators**	
Pharmacy Component	Dossier blue print of Quality Structures & Legislation available (after public consultation).	QA dossier & legislation available in Dutch & English for acquisition; equipment for Pharmaceutical Lab facility procured and installed; personnel trained. The Lab is now a qualified member of the PAHO lab network and the process for it to be recognized as the national Lab is now underway.
	Pharmacy Unit at MOH implemented.	PU at MOH implemented and functioning; Pharma House dossier for renovation completed.
	Dossier MIS system BGVS completed; BGVS to procure.	Dossier MIS system BGVS; procurement exercise is currently taking place.
	Support development of assistant Pharmacists training completed (materials & practical laboratory).	Course integrated in vocational trainings school; books and laboratory supplies procured. Curriculum developed; dossier for completion of practical training venue finished.
	Improved availability of (essential) medicines at Central Level (BGVS) (through development SOPs, training, etc.)	Availability Essential Medicines from 55% to 82% (Sept 2011)
	Strengthening of BGVS	BGVS Strengthened through the provision of technical training
	EML (NGK) decision making transparent.	Workshop organized; website developed Personnel trained
	MOH Strengthened	
Briefly explain differences between planned and actual outputs (if applicable). [X] N/A		
Restructuring. Indicate if this component was restructured (date of approval by Manager). Briefly discuss the consequences of these changes. **[X**] N/A		
Summary Implementation Progress Classification: [ ] Highly Satisfactory (HS) [X] Satisfactory (S) [ ] Unsatisfactory(U) [ ] Very Unsatisfactory (VU)		

d. Project Costs

Table 1: Project Cost Table by Components (Planned vs. Actual)

Investment Categories	Cost and Financing Planned(in US$000)				Cost and Financing Actual(in US$000)			
	IDB	Local	Total	% Total	IDB	Local	Total	% Total
Administration	**300.0**	**117.0**	**417.0**	**7.3**	**638.8**	**221.1**	**859.9**	**15.3**
Project Execution Unit	250.0	117.0	367.0	6.4	572.2	221.1	793.3	14.1
External Audit	50.0	0.0	50.0	0.9	66.6	0.0	66.6	1.2
Direct Costs	**4571.0**	**0.0**	**4571.0**	**80.2**	**4280.2**	**4.2**	**4284.4**	**76.0**
Component 1: Improve PHC	1872.0	0.0	1872.0	32.8	2789.6	0.6	2790.2	49.5
Component 2: Improve efficiency and equity	2699.0	0.0	2699.0	47.4	1490.6	3.6	1494.2	26.5
Subtotal	**4871.0**	**117.0**	**4988.0**	**87.5**	**4919.1**	**225.3**	**5144.3**	**91.3**
Evaluation	70.0	0.0	70.0	1.2	20.0	0.0	20.0	0.4
Contingencies	59.0	188.0	247.0	4.3	0.0	0.0	0.0	0.0
Financial Costs	**0.0**	**395.0**	**395.0**	**6.9**		**492.0**	**492.0**	**8.7**
Interest	0.0	382.0	382.0	6.7		458.8	458.8	8.1
Credit Commission	0.0	13.0	13.0	0.2		33.2	33.2	0.6
Credit Supervision	0.0	0.0	0.0	0.0				
***Grand Total**	**5000.0**	**700.0**	**5700.0**	**100.0**	**4939.1**	**717.3**	**5656.4**	**100.0**
% by source	88.0	12.0	100.0		88.0	12.0	100.0	

*Grand Total = Administration +Direct costs + Evaluation + Contingencies + Financial Costs

IV. Project Implementation

a. Analysis of Critical Factors

The original timeframe for program implementation was four years (2004-2008). The program was extended after the re-profiling in 2009 in order to meet the urgent additional priorities of the Government. The following factors affected project implementation:

Programme Complexity. The HSF was designed to include a wide variety of activities that were complementary and integrated but it proved to be too robust for the original four year timeframe given the limited MOH execution capacity coupled with cumbersome public sector administrative procedures.. During the course of the program, some procurement challenges resulted in staggered implementation due to the project's complexity. Accordingly, implementation could have benefitted from carefully designed intervention mechanisms agreed upon between the Bank and GOS in order to identify and work through project bottlenecks, including, monthly project status update meetings, and quarterly reviews.

In addition, funds were transferred from Component 2 to Component 1 based on the Borrower's decision: (i) to defer the implementation of the PMT; and (ii) the need to address urgent emerging demands, namely, improving medical waste disposal and enhancing dialysis treatment. As a result, Component 2 was unable to achieve its outputs as originally outlined.

Procurement Delays. The procurement process was particularly problematic, especially at project start up which affected implementation of the Programme considerably. The IDB-funded activities were required to adhere to IDB procedures, while activities funded by GOS (PHC Unit) adhered to national regulations. Despite Bank led procurement training sessions throughout the life of the project, the procurement function remained a challenge but significantly improved when a dedicated procurement specialist was located at the Suriname IDB office who worked closely with the PEU. In addition, the Ministry found it particularly challenging to develop appropriate Terms of Reference for technical consultancies which was compounded by difficulties in sourcing appropriately skilled and experienced consultants readily available and willing to work in Suriname for both advisory and implementation support functions.

Stakeholder commitment. The lack of a systematic communication framework to facilitate the information sharing among the programme's primary stakeholders and decision-makers led to limited understanding of and agreement on, key issues in a timely way, namely the application of the PMT.

Programme management tools – performance management. The original log frame for the project was very general and lacked specific measurable outputs and outcome indicators that could help to monitor progress. It lacked final and intermediate targets and in some cases baseline measurements, namely there was no baseline for diabetes and hyperextension. There was no development of a results framework or results-based project management framework. As such, it was difficult to both measure the performance of the Programme during its execution and make adjustments or changes to improve implementation based on such evaluation. Accordingly, in 2010 and following the revised PMR parameters, the log frame was formally reformulated based on the successful re-profiling of the programme in 2009.

b. Borrower/Executing Agency Performance

Project Supervision. From the inception, the Ministry of Health was committed to the success of the HSF. However, by mid-way of the project, priorities seemed to have changed in the MOH and some challenges were encountered both logistically and technically on the continued coordination of the project.
Project Coordination. In addition, the PEU had 3 coordinators during the life of the project which affected project execution momentum. While this did not impact the project technically, the time lags which occurred to hire

replacement project coordinators caused logistical challenges especially as there was need for a project of this complexity to have a full time project coordinator for the effective collaboration/coordination that was needed at the district and national level through working groups, health network partners and other networking activities.

Complementary Skills at the PEU. In addition, the Project Execution Unit (PEU) - comprised dedicated programme staff, funded primarily from loan resources and charged with the daily management and implementation of the programme's activities. However, the expertise in the PEU could have been more complementary. It contained strengths in infrastructure and capacity building, but was significantly weaker in the area of institutional/organizational management. These nuances were successfully addressed during the latter part of the project when two local Technical Consultants were installed at the PEU to provide additional technical support.

Shift in Priorities. For the implementation of activities, the Project Execution Unit (PEU) was required to interface with senior officials the MOH who were responsible for guiding overall execution of the Programme at the technical level. However, changes in administration and related shifts in priorities affected the decision making of this group.

Procurement Challenges. Challenges were evident in the lack of agreement over terms of references (TOR) and other parts of the procurement process, including the selection and monitoring of service providers. In some cases this resulted in the termination of contracts and necessitated the re-initiation of procurement for such services, resulting in further delays. Implementation delays were was also affected by the performance of other entities responsible for infrastructure procurement in particular.

Project Re-profiling. It must be noted that between 2009 and 2011 the implementation of the HSF advanced at an increased and steady rate, with a demonstrated commitment by the MOH and stakeholders. In 2009, a more pragmatic and realistic approach was taken for the completion of the project when the project was re-profiled to incorporate new but related project-scope activities. The project made considerable progress in both components and while there is need to complete additional refinements to the IT systems in order to generate maximum efficiency and equity outputs of Component 2, the completion of the other project activities have set the necessary groundwork to better prepare the MOH to make the required sector changes in order to meet the MDG's.

Borrower/Executing Agency			
[ ] Highly Satisfactory (HS)	[X] Satisfactory (S)	[ ] Unsatisfactory (U)	[ ] Very Unsatisfactory (VU)

c. Bank Performance

The Bank worked in collaboration with the Project Execution Unit of the MOH throughout the life of the project. It should also be noted that during the project execution, the Bank's health sector specialists were changed four times and this caused some delays in the project supervision as each new person had to become au fait with the project. Bank resources were deployed at various levels (the Sector Specialist, the Country Office and the IDB Headquarters) to provide support including:

- advice, guidance and recommendations during project implementation;
- familiarization of officials from the MOH and its executing units with the Bank's
- Policies and Procedures to minimize and forestall unnecessary delays in achieving
- project timelines;
- the development and presentation of Requests for Extension in 2009 and in 2010;
- the re-profiling of the HSF.
- Provision of flexible and innovative solutions to challenges and timely 'non-objections';

Two areas of improvement identified are:

-Coupled with the need for more procurement training workshops in Bank procurement policies and procedures, the Bank should facilitate and provide guidance regarding Bank procurement rules especially when innovative approaches or technology are being introduced to tribal cultures such as the communities in the hinterland areas of Suriname

-the Bank's approval process for procurement activities especially, should take five days but in some cases it took considerably longer which caused some delays in project execution.

Bank Performance			
[ ] Highly Satisfactory (HS)	[X] Satisfactory (S)	[ ] Unsatisfactory (U)	[ ] Very Unsatisfactory (VU)

V. Sustainability

a. Analysis of Critical Factors

The Ministry of Health's commitment to Health Reform. Throughout this program, the MOH collaborated closely with the Bank, despite the delays and setbacks, to ensure maximum implementation capacity of all program activities. In 2009, the re-profiling was a joint exercise undertaken by the IDB and the GOS to incorporate the MOH's present priorities which included additional activities that were more realistic, relevant and pragmatic towards achieving the programme's objective.

The Program Drivers or Stakeholder Involvement. Both the GOS and more directly, the MOH's continued emphasis on stakeholder involvement in the Ministry's policy making and program implementation, has strengthened the health sector reform process along with currently increasing awareness and expectation among the target population for equity and efficiency in affordable and accessible health coverage. Such a commendable effort has now led to higher expectations for the health sector by the general public. The MOH's mandate is to continue to create a more client focused approach with the health sector's major financiers, the State Health Insurance Fund (SZF) and the Ministry of Social Affairs (MSA). SZF continues to expand and improved their automated system for health care delivery (including pharmaceuticals) across the entire country thus improving quality care and client satisfaction and reducing visits to private care facilities.

Outstanding/Ongoing activities. Several activities that began under the programme have not yet been completed. These are crucial institutional or 'soft' reforms that are essential to improving the functioning of the sector, prevention and primary health care service delivery, and ultimately the health of the population. These include: (i) The full implementation of the Automated web software for vaccination (to later incorporate malaria) that was developed, needs to be piloted. There is no target date set for completion; (ii) The implementation of the web-based software for the storage and distribution of pharmaceuticals; (iii) implementation of the Proxy Means Test; and (iv) the implementation of Medical Declaration Information System (MDIS) for the Bureau of Medical Affairs (BMA). It should be noted that under the Bank funded- CCT loan, SU-L1013 which was approved in November 2011, the PMT model developed under the HSF will be now updated and used to select beneficiaries for all MSA programs including the health card and implement the SIS.

b. Potential Risks

Five key risks to program implementation were identified in the original project document. The plans to alleviate these risks were put in place and successfully implemented, for most part, in a timely manner. The sustainability of the programme can be viewed in terms of: (a) the government's ability to continue the programme even after Bank funding has expired; and (b) the ability of the reform to continue to benefit the national community and contribute to better the health of the population.

The main risk to sustainability is the continued imbalance between infrastructure development and the introduction of new models of primary health care (the organisational reform). Sustainability is also affected by the ability of the MOH to recruit and keep personnel with the required skills and competencies to manage and direct the implementation of the non-infrastructural components of the programme.

There are several other potential risks to this sustainability which include:

i) Need for continued budget allocation for the efficient maintenance of infrastructure including newly implemented computerized systems and equipment.
ii) Continuing institutional weakness in health facilities. Some officials have expressed concern at their need for resources in areas such as project management, information systems, and the procurement process. Limited capacity in these areas may result in institutional inefficiencies and poor decision making. Technical support with any necessary financial support should minimize such a risk.
iii) Need to implement and strengthen vaccination data management System and Strategy. This strategy remains to be implemented. The implementation of such an essential tracking system is yet to be fully developed with trained staffed to use the proposed software.
iv) Weak Procurement and Contracting Policies and Procedures. As observed during programme execution, problems with procurement and contracting hampered the effective implementation of the HSF. Therefore, it would be advisable to find more streamlined procurement practices that allow transparency and would alleviate the likelihood of such a recurrence in the future.

c. Institutional Capacity

Sustainability Classification SU:			
[ ] Highly Probable (HP)	[X] Probable (P)	[ ] Low Probability (LP)	[ ] Improbable (I)

Institutional capacity has been built as well as strengthened through the HSF in Suriname. The MOH now has an innovative technology to more efficiently serve the healthcare needs of the hinterland region through the Medical Mission who can now increase health service delivery in an efficient way. In addition, the MoH also has a better understanding and a greater focus on national planning and priority setting, policy making, working with the regions on strategies and targets and allocating financial resources. As these institutions continue to develop and strengthen in performance, there is a high probability that programme results will be sustained. Knowledge transfer did take place during project implementation.

VI. Monitoring and Evaluation

a. Information on Results

The logframe and respective outcome indicators were updated at the time of the re-profiling in 2009 with measurable baseline and targets established for the additional three indicators. From a holistic perspective, additional quantifiable indicators were included based on data from reliable sources. Monitoring of the project activities was undertaken by the respective entities (MOH, BOG, MM, RGD, SZF, MSA) responsible for their implementation. Project monitoring included a feedback mechanism where discussions were held and corrective action taken when necessary.

As reflected in the annual progress reports (2006-2010) the PEU experienced some challenges in establishing and following efficient and appropriate project management systems and practices. One such challenge is submitting accurate reports in a timely fashion. Another setback seems to have been the delays in submissions of disbursements with adequate documentation and subsequent follow-up in an expeditious manner. However, this was adequately addressed in the final stages of project implementation.

At the Special Mission meeting, the PEU/MOH presented a brief summary of the key achievements, challenges and experiences with the project to date (May 2009). It was noted that the project had made considerable

progress, particularly in the pharmaceutical and primary health care areas. All project activities were implemented as planned which is a satisfactory indication for success of the program after the Bank's commitment concludes. The Final and Ex-Post evaluations were done at the same time and revealed similar findings and recommendations as stated in this PCR.

b. Future Monitoring and Ex-Post Evaluation

The Ministry of Health developed its own monitoring and evaluation mechanisms which will be used to monitor programme effectiveness in the future. Reporting to the Director of Health, the MOH established a Monitoring and Evaluation Division in 2011 which has direct responsibility for gathering and maintaining data as well as for collecting updated information on agreed process-performance indicators for all Ministry policies, programs and projects. Within the next five year period, the Ministry is working towards conducting program outcome and impact evaluations. A Final Evaluation was successfully completed by a consultant in October 2011.

VII. Lessons Learned

Summary. What is clear from this Health Sector Facility project is that across the spectrum, there is commitment from the MOH to advance the reform of the sector through addressing challenges in the supply of health care services and equipping its workforce with the requisite training. The challenge is to learn from the process of implementing this program to date which used a more pragmatic and realistic implementation plan (2009 re-profiling) whilst building on the obvious progress associated with developing infrastructure towards addressing efficiency and equity in the wider health system. Once this challenge, which started through the HSF, is met then Suriname's Health Reform Strategy will indeed have been far-reaching with satisfactory success and more specifically, of international note with the innovative computerized technology, Telehealth/Telemedicine8, in the hinterland area.

Salient lessons learned are as follows:

From program inception, functioning project management tools should be put in place. This would have been very useful for the complexity of this program and it would have been useful to identify and investigate bottlenecks, document lessons learned and promote project sequence and organizational development when some entities called for this. Evaluations of this nature could be included in the operating manual and in the budget.

Logical framework indicators should be clearly defined from the beginning of the programme with existing reliable data sources and baselines. Both the original and revised log frames needed to modify some of the quantitative and measurable indicators to be more realistic and achievable. Better use of the logical framework would help to monitor and guide the pace of implementation. In addition, survey exercises could have been incorporated into the design phase to establish or update benchmarks which could be measured at mid-term to track progress. For example, child mortality rate, immunization rate, patient waiting time, CND treated etc., could have been tracked in a more efficacious manner. Similarly, such surveys could have provided information at the start, and during implementation, on satisfaction levels of the quality and timeliness of care which patients received.

An overall institutional assessment of all the entities involved in the execution of the programme is needed prior to its commencement. For the HSF the several co-entities charged with the execution of different activities had varied strengths, capabilities and commitment to the goals and objectives of the programme. The PEU and the MOH suffered from insufficient staff and lacked expertise in some areas. In addition, given Suriname's complex political structure that is driven by the country's multi-ethnic composition, and the several political parties that formed a coalition government, there is need for a rigorous analysis of the political context when developing projects in Suriname especially for those projects that require inter-agency coordination and collaboration across ministries. One possible solution could be the signing of MOU's between participating ministries.

[8] Article on Telehealth. New computerized platform revolutionizes healthcare for remote villagers…", DevSur-Paramaribo, September 26, 2011 (see Annex 6)

Project stakeholders must be active participants throughout the project life. After the re-profiling of the HSF, some stakeholders were treated as passive customers when they should rightfully demand the authority to approve project deliverables, either wholly or in part. Along with this authority comes the responsibility to be an active participant in the early stages of the project (helping to define deliverables), to complete reviews of interim deliverables in a timely fashion (keeping the project moving), and to help expedite the project manager's access to essential project documentation.

Comprehensive planning, coordination and feedback mechanisms among the various entities would have been important in driving their collective and individual effectiveness for crucial activities in the health system. A better sequencing design for the implementation of the components of complex programmes is required. The lack of an organized and integrated approach to implementation slowed the commitment for initiating and completing a few activities. As a result, one key activity, the Integrated, Automated and Centralized Data Management system for vaccinations and malaria is presently in the design phase with no completion target date. Such a system is essential to be able to measure and improve performance in MOH as data has to be fed in to the system from Medical Mission and Regional Health Services. In another breath, the new computerized platform, Telehealth, is revolutionizing healthcare for the remote and scattered villagers in the hinterland of Suriname who can now gain a well-deserved access to health services in an efficient and equitable manner. This innovative technology in this part of the world will now help the rural population of the hinterland region (already a highly underserved group) of Suriname to enjoy the advantages that the health system has to offer in a low-cost and efficacious way. In addition, this technology will help in improving the work conditions of isolated health staff to better target the population's real needs in their real environment.

Effective implementation coupled with enthusiastic and dedicated management are essential to effective implementation. The speediness and keenness of senior managers to make decisions in a timely manner can have a significant impact on project implementation rate. Administration and management need to be continuously forceful to ensure performance. Clear measurement of management performance with objective indicators would help.

For the implementation of the components of complex programmes, it is vital to give more attention to a better sequencing design. A more organized and integrated approach to implementation would have enhanced the thrust for initiating and completing some central activities for reduction of administrative burdens and enhancement of updated data distribution and communication. In addition, the technical components lagged behind the physical infrastructure components. One recommendation is that some incentive system be incorporated into project design to encourage progress on the soft components.

Improved understanding of the Bank's fiduciary rules may have led to increase efficiency. The use of two different procurement regimes, one following IDB processes for IDB loan resources and another following the GoS regulations for counterpart funding , invited misunderstanding, delays and unnecessary scrutiny. For future IDB funded projects in Suriname and based on a satisfactory country systems assessment, the Bank can explore with GOS, the greater reliance on national procurement systems.

In addition to the above salient lessons learned, others that are worth mentioning include the need for refresher training for staff due to the significant extensions of the programme; the continued alignment of the programme with Borrower priorities; the need for flexibility and innovation during a lengthy implementation period; and the overarching importance of the level of commitment of the Borrower to the timely and effective achievement of program goals and the need for orientation for those involved in implementation to include training in the policies and procedures especially those related to procurement.

Lessons learned from the HSF must also be considered in the context of: i) an overly ambitious timeframe (seven years) for programme execution combined with the complexity of structural reform in any health sector. ii) Assessing the quality of the achieved as well the partially achieved output indicators of the two project components is intrinsically challenging. In some cases, understanding why some objectives did not happen in some of the activities is typically more complicated than understanding a phenomenon that cannot be observed,

studied and measured. The totality of evidence from the HSF, however, indicates that the prioritized plan undertaken in the re-profiling phase used to achieve the objective of this project, has the potential to improve the health sector in Suriname through the implementation of institutional reforms to increase the quality, efficiency and equity of health services, particularly those directed towards the poor.

Before embarking on the program, a section for data collection and analysis should be incorporated with the relevant budget. Such information will be useful for future planning also.

Annexes:

1. Re-profiling Report, June 2009
2. Article on Telehealth titled Article titled, "New computerized platform revolutionizes healthcare for remote villagers.." (September 26, 2011)
3. Persons interviewed
4. Documents reviewed

HIGH LEVEL RE-PROFILING OF THE LOAN OF THE GOVERNMENT OF SURINAME FOR SUPPORT FOR THE IMPLEMENTATION OF HEALTH SECTOR REFORM (1537/OC-SU), WICH STARTED IN 2004.

June 11, 2009

Plan submitted by the Ministry of Health

HIGH LEVEL RE-PROFILING PLAN

SUPPORT FOR THE IMPLEMENTATION OF HEALTH SECTOR REFORM

DATE: 11TH OF JUNE 2009

I. BASIC PROJECT DATA

1.1

▪ **Country:**	Suriname		
▪ **Program Name/Number:**	Support for the Implementation of Health Sector Reform Program – 1537/OC-SU		
▪ **Executing Agency:**	PIU/MOH		
▪ **Financing:**	Approved IDB:	US$	5,000,000.00
	Amount Disbursed	US$	3,440,140.37
	Available balance 31/05/2009	US$	1,559,859.63
▪ **Current Final Disbursement Date:**			31st of August 2009
▪ **The final disbursement date after extension granted**			31st of March 2010

II. BACKGROUND

2.1

The program had started out with a predefined goals and objectives. During the course of the program the sub-components were somewhat changed due to fact that the priorities had changed. This caused for some delays in the execution of the program since these changes in sub-components had also to be approved by the IDB. As for the late start of certain parts of the project the project was extended for one year to March 31, 2009. Also, due to the change of the sector specialists and him being new to the program, and having little knowledge of procurement and the health sector, there were delays and administrative lengthy procedures and another extension was requested by the government of Suriname to March 31, 2010. The bank requested, after the mission of Mr. Ho A Shu, a reprofiling plan to be submitted to the bank of the loan execution and state the activities to be performed for the remainder of the project without losing sight of the goals and objectives of the project. It should be pointed out that USD 1,265,238.58 IDB Funds had been invested in 2009 which can be pointed out as a record high for the program compared to the previous years.

III. PROJECT ACTIVITIES AND DESCRIPTION

3.1

Project	Description
01.01 Administration	1. Program Coordinator
01.03 Ext.Accountant	1. financial report 2009
02.01.01 PHC Projects	
Dermatology clinic	1. renovation of 4 doctor's room and waiting room and roof
	2. purchase of equipment
	3. training
s Lands Hospital	1. Information and promotion of women and development
	2. Development and providing nutrition information and promotion programs
	3. Development and production of other information and promotion material
	4. Counseling
Foundation Lobi	1. Sexual reproductive health clinic Commewijne
Youth Dental Foundation (JTV)	1. Improve quality of services
Buro of Public Health (BOG)	1. National plan for prevention and control of cervical cancer
	2. Expansion of the number and capacity of environmental inspectors
Regional Health Services	1. Improvement of services

	2. training medical professionals
	3. Upgrading clinic at geyersvlijt
RGD / Medical Mission	1. automated pharmaceutical storage and distribution
	2. Hardware for 10 clinics for the pharmaceutical automated storage and distribution
RGD / MM / BOG	1. Electronic integrated and centralized management system for vaccinations and malaria
MM - improvement of communication with the hinterland	1. Improve communication with the clinics in the hinterland
Medical Mission - expansion of the health center at Brownsweg	1. improve services and access to health
Kidney Dialyses Center	1. support for improvement of dialyses services
Medical waste program MOH	1. coordinate and improve the collection, storage, pick up and disposal of medical waste
Local Consultant R.Brohim	1. until 31st of march 2010
01.01.02 Pharmacy Projects	
Improving quality structures and legislation	1. Improved laboratory capacity for pharmaceutical analysis
	2. Training and improvement in pharmacy regulation
Improving procurement capacity MOH	1. PU at MOH implemented and functioning
Indicators/ policy baseline	1. WHO-HAI price survey implemented
Upgrade and training	1. MIS system BGSV upgraded/ Or dossier

in MIS	available
Pharmacy assistant training development	1. Proposed change Legislation ready; listing priorities and course coordination identified
Quality Assurance & Legislation	1. Finalization of Ongoing project
Attending training/ PV/ Pharma Unit/ EML	1. different trainings
Loeal Consultant Miriam Naarendorp	1. until 31st of March 2010
02.01.01. Amis at SZF	1. 2 servers at SZF
02.02.02 Improve poverty targeting system	1. Office equipment at MSA
	2. upgrade internet connectivity
	3. Promotion of outreach awareness at MSA
	4. Linking BMA and SIS at MSA
	5. consultancy pilot PMT urban area MSA
	6. consultancy pilot PMT interior area MSA
	7. additional component PMT
03.00.00 Evaluation	1. Evaluation of the program
	2. baseline indicators at the end of the program
04.00.00 Contingencies	1. can be used whenever real investments exceed planned budget

01.01 Administration

Hiring a Program coordinator until March 31, 2010

01.03 Ext.Accountant
Renew contract for the external accountant to prepare the financial statement for the year 2009.

02.01.01 PHC Projects:
The objective of all the PHC projects is geared in improving the primary health care services which is part of the core component 1. Improve performance of preventive and Primary Health Care services.

02.01.02 Pharmacy projects:
The objective of all the Parmacy projects is geared in improving access to medicine which is part of the core component 1. Improve performance of preventive and Primary Health Care services.

02.01.01 Implement an administrative and management information system
The objective of this project is to give follow up on the study done at SZF.

02.02.01 Improve poverty targeting system
These projects are geared to finalize the implemented BIPS project at the Ministry of Social Affairs

03.00.00 Evaluation
This includes the final evaluation of the program and the baseline indicators at the end of the program to show progress made after completion of the program.

04.00.00 CONTIGENCIES

This amount can be used in case real investments in projects have exceeded the planned budgeted amount

IV. COST AND FINANCING

4.1 The proposed budget for the program activities is as follow

CATEGORY	IDB USD	GOS USD
01.01 administration	**70,000.00**	**50,000.00**
01.03 External auditor	**10,000.00**	
02.01.01 PHC Projects	**868,400.00**	
02.01.02 Parmacy Projects	**359,200.00**	
02.02.01 SZF	**22,400.00**	
02,02.01 PMT at MSA	**100,000.00**	
03.00.00 Evaluation and baseline indicators consultancies	**70,000.00**	
04.00.00 Contingencies	**59,000.00**	
TOTAL	**1,559.000.00**	**50,000.00**

V. EXECUTING AGENCY AND EXECUTION STRUCTURE

5.1
At the moment the project is missing a coordinator and a procurement Officer.
If the program is to be extended for 1 year (until 31 march 2010) and an amount of USD 1,559,859.63 of IDB Funds has to be invested within this year is advisable to have all these persons on board.

VI. MAJOR ISSUES

6.1 The PEU requests ex post evaluation of procurements after 3 satisfactory procurements have been carried out.

It was agreed during the mission that the Ministry could choose a minimum of 3 baseline indicators out of the baseline study that was carried out by the PAHO in 2006 and the choice of the Ministry on these indicators for the evaluation of this program is as follow:

- C2.10 number of weeks of stock outs of tracer medicines supplied by BGVS
- C2.11 CIF value of tracer medicines by supplier compared to the reference value on the international market
- C1.4 Average processing time per claim per SZF department
- C2.13 Average debt collection period at BGVS
- C2.1 Percentage of poor persons covered by MSA health insurance
- C2.2 Percentage of total population covered by health insurance
- D3.8 Average length of stay in hospitals overall
- D2.2 Number of registered patients with hypertension in PHC

VII. 12 MONTH PROJECT ACTIVITY PLAN

7.1

See Annexes:

Plan R.Brohim

plan M.Naarendorp

Plan Soza

(Original signed)

R.Sowma-(Financial Manager)

(Original signed)

M.Eersel-Director of Health:

ANNEX 2

Article titled: New computerized platform revolutionizes healthcare for remote villagers (DevSur Paramaribo, September 26, 2011)

New computerized platform revolutionizes healthcare for remote villagers September 26, 2011 | Author DevSur PARAMARIBO–

The remote transmigration Maroon village of Brownsweg in Suriname on Monday served as the perfect venue for the launch of a medical project that should bring an improvement in how healthcare is provided to residents of people in the interior. Computer screens at the Medical Mission MZ in Paramaribo were alight with the eager faces of physicians, patients and attendees of the launch ceremony at the medical clinic at Brownsweg in District Brokopondo, when a video conference connected the two places. At the coordinating center there was a collective hum of anxiousness when a doctor there got to diagnosing a rash on a little patient's right arm 100 kilometers away. "It works," the doctor exclaimed with a big smile when he got up after his diagnosis, igniting an eruption of applause. With the launch now behind them, the initiators of the Suriname Telehealth and Exchange Platform (STEP) and Suriname's Government called on stakeholders to lend their support for the **IDB funded pilot project's longevity**.

STEP, explained Dr. Ludmilla Wikkeling-Scott, is a platform that will allow healthcare workers throughout the country to communicate with the medical coordinating center in Paramaribo in "real time". Ultra-modern, computerized, resting on the internet and through video conferencing "it will allow doctors to provide immediate diagnosis and when needed, request immediate care in the city. If used properly, this system will cut cost, and lead to better results in healthcare. Patients will be able to receive immediate as opposed delayed care. Though this system, the data on patients from the interior attention is immediately available to any physician anywhere in the country. Now, a patient who is flown in from the interior to the hospital in town with something urgent, does not have to wait for treatment while the doctor in town does a diagnosis on him. STEP helps healthcare sidestep the various issues of transportation and communication," Wikkeling-Scott explained.

Healthcare to the residents of the hinterland indeed needed a boost, as proper coverage of all corners of the 175,000 kilometer country often proved a challenge. "The Medical Mission in town does its best, but they can only work with what they have available … and let's be honest; technology of these moderns days times makes a lot possible," said Wikkeling Scott. "This system removes the barrier of transportation, which has in the past been a major reason for the lack of access to care. That is what people in areas who need it most always faced."

The Bryant Group in Washington DC of which she and her husband Bryant Scott are principals, wrote the STEP project and presented it to IDB for funding. The platform was built by Isaac Imkumsah of Origo software from California. "The system is designed for patients and physicians, in such a way that it provides real time diagnosis through video conferencing and patient data management, with up to date records," Wikkeling-Scott explained. STEP, she said, allows the healthcare providers throughout the country to keep their fingers on the pulse of the country's "physical condition" and provide the Medical Mission in town with up-to-date reports and alerts on diseases and outbreaks. "And because all data is stored in one location, it is immediately accessible all over the country."

With non-communicable diseases expected to increase over the next years, STEP puts Suriname at the forefront of new age measures against this trend. "President Bouterse, at the recent UN session in New York, called on the world to address non communicable diseases by providing better, persistent care and technology to remote locations. STEP is Suriname's step in in showing the world the way," she said. She hinted that French Guiana already has a system similar to STEP, through which healthcare is provided to residents in remote areas. "It always has been something we could immolate. Suriname is now taking leaps ahead of changing the culture in which healthcare is delivered, using state of the art technology," said Wikkeling-Scott.

As a sign that his Ministry stood firmly behind the Project, Public Health Minister Celsius Waterberg was among the group that undertook the two-hour drive to Brownsweg to witness the launch there. Dr. Gaitree Baldewsingh, who coordinates MZ's radio service, expected STEP to bring improvements in communicating with the field. "We have trained our people who provide healthcare in the villages well, so we have no worries regarding their capabilities. And we have always been able to rely on the shortwave radio system, and that the cell phone companies are penetrating the hinterland helps too. But that was voice. Now we will be able to communicate in

real time with the field, with the added benefit of video," she said. She said STEP would turn out an important cost cutting measure.

The pilot project includes a trajectory as part of which now 56 clinics throughout the hinterland will be equipped with the necessary computers and equipment; in addition healthcare providers in the remote areas of Suriname will be trained. "But this is just a pilot and the funding doesn't actually take the project beyond that," Dr. Wikkeling-Scott said. She urged Government and private entities in the country to help assure that the projects that will take healthcare in the hinterland to the future, proceeds uninterrupted. "TeleSur has meanwhile committed to providing enough bandwidth for this project for the pilot,"Wikkeling-Scott said. "This project is for the residents of Suriname's hinterland and our hope is that more companies that operate in these areas come to its support. It is an opportunity to show their corporate citizenship."

Born from Surinamese parents and now based in the Metropolitan Area of Washington DC, Wikkeling-Scott said STEP is close to her heart. "I always wanted to something for the country where my grandmother has labored," she said. The Bryant Group is a minority owned company that provides biz development and integration services, using information technology.

And for software developer Isaac Imkumsah, the project afforded an opportunity to work on something worthwhile in a country he feels attached to, even as he visits for the first time. "This is an important step for Suriname," he said. "This system provides not only technology; it is a complete reform to the way healthcare has always been delivered in Suriname. That's something i as a software developer have a passion for. Suriname has in the ten days that I have been here, grown on me. I am from Ghana and my understanding is that that is where the slaves that were shipped to Suriname were taken from by the colonizers. I feel a bond with this place, and especially with the Maroons; that they will benefit from a system I developed gives me a great feeling."

ANNEX 3

PERSONS INTERVIEWED

Ms. Naomi Akoy	IADB
Dr. Robert Brohim	Technical Consultant & Coordinator, Primary Health Care, Project Execution Unit
Mr. Stephen Comvalius	Director, State Health Insurance Fund (SZF)
Dr. Marthelise Eersel	Director of Health, Ministry of Health
Ms. Wendy Emanuelson	Project Coordinator (Part-Time), Project Execution Unit
Dr. Leslie E. Resida	Director, Bureau for Public Health (BOG)
Dr. Leslie Sabajo	Director, Dermatology Clinic, MOH
Dr. Maaltie Sardjoe	Director, Regional Health Services (RGD)
Mr. Ian Ho A Shu	Social Sector Specialist, IADB
Ms. Monique Soekrasno	Policy Official, Ministry of Social Affairs & Housing, Subdirectorate General Social Service (MSA)
Mr. Roy Sowma	Financial Adminsistrator/Manager, Project Execution Unit
Dr. Edward Van Eer	Director, Medical Mission (MM)
Ms. Miriam Naarendorp	Technical Consultant & Coordinator, Pharmacy, Project Execution Unit

ANNEX 4

DOCUMENTS REVIEWED

Hindori M. Health sector reform in Suriname (White Paper). MOH, Suriname and IDB, 2003

IADB. Project Progress Monitoring Reports (PPMR), 2010

IADB. Country Strategy with Suriname, 2007 – 2010, June 2007

IADB and Government of Suriname. Loan Contract Agreement for Health Sectot Reform Programme, No. 1537/OC-SU, 2004.

IADB. Operations, Regulations and Guidelines, Support for Implementation of Health Sector Reform, 1537/OC-SU, May 2004

IADB Progress Monitoring Report, SU0028-Health Sector Facility, September 2011

IADB. Suriname's Road to Health Sector Reform: an examination of the health care system, 2005

IADB. Suriname Health Sector Assessment, August 1999

Ministry of Health. Extension and Re-Profiling Plan For Support For The Implementation Of Health Sector Reform, Plan submitted by the MOH, June 11, 2009

Bureau of Public Health & Medical Mission. Consultant's Report on the Integrated, Automated and Centralized Data Management for Vaccinations and Malaria at the Regional Health Services, 2011

Data Management for Vaccinations at the Regional Services, 2011

Pan-American Health Organisation, Health Data, http://www.paho.org/English

World Health Organisation, World Health Statistics 2007, http://www.who.int/research/en/

Project Execution Unit, Project Status Reports, 2009

Suriname Draft Aide Memoire. Special Mission: Health Sector Reform Program, LO-1537/OC-SU, May 2009

PROJECT PERFORMANCE MONITORING REPORT (PPMR)

I. BASIC DATA (AMOUNTS IN US$)

PROJECT NUMBER: SU0028
TITLE: Health Sector Facility

LOAN NUMBER(S): 1537/OC-SU
Lending Instrument: Investment
Borrower: REPUBLIC OF SURINAME
Executing Agency (EA): MINISTRY OF HEALTH
Sector: HEALTH

Date of Board Approval: 11 Mar 2004
Date of Contract Effectiveness: 31 Mar 2004
Date of Eligibility for First Disbursement: 24 Jun 2004

Contacts:
Executing Agency:
Team Leader: HO-A-SHU, IAN

Date of Current Update: 24 Jun 2009
Date Validated by Representative or Division Chief: 24 Jan 2009

PTI: [X] Yes [ ] No
SEQ: [X] Yes [ ] No
Environmental Classification:

Months in Execution:
* from approval: 64
* from contract effectiveness: 63

Loan Proposal, as approved by the Board: PR-2835

Disbursement Periods
Original Disbursement Expiration Date: 31 Mar 2008
Current Disbursement Expiration Date: 31 Aug 2009
Cummulative Extension (months): 17
Special Extension (months): 0

Loan Amount(s):
* Original amount: 5,000,000
* Current amount: 5,000,000
* Pari Passu: 90.39%

Disbursements:
* Amount to date: 3,355,723
* Percent: 67.11%

Total Project Cost:
* Original estimate: 5,700,000

Redirecting Of Resources:
* Has this project:
[ ] Received funds from another Project?
[ ] Sent funds to another Project?
[X] N/A

To Project Number	Via Sub-Loan Number	Amount
From Project Number	Via Sub-Loan Number	Amount

On Alert Status:
Is project currently designated "on alert": [ ] Yes [X] No

HISTORICAL AND CURRENT PPMR RATINGS:

Month Year	Dec 2007	Jun 2008	Dec 2008	Jun 2009	Current
Implementation Progress	S	S	S	U	U
Risk	H	H	H	H	H
Development Objectives	P	P	P	LP	LP

II. ACHIEVEMENT OF DEVELOPMENT OBJECTIVES (DO)

If the operation has multiple purposes (DOs) then enter each one in a separate field. In such a case, each DO must have individual DO ratings. *Progress towards achieving each DO should be rated individually based on the corresponding outcomes achieved. The relative weight of each individual DO in the summary DO classification should be discussed with the Executing Agency.*

Development Objective(s)/Purpose(s)

1. Goal

Contribute to improvement of health status of the Surinamese population.
Classification: Probable

Key Planned Outcome Indicators	Outcomes Achieved
1.1. Description: Reduce child mortality rate **Unit:** per thousand **Baseline Target:** 31 (11 Mar 2004) **Annual/Intermediate Target:** **EOP Target:** 25 (31 Mar 2009)	27.90 (31 Dec 2006)
1.2. Description: Reduce frequency of hospitalization for diabetes and hypertension (no intermediate results reported) **Unit:** percent **Baseline Target:** 0 (31 Mar 2004) **Annual/Intermediate Target:** **EOP Target:** 20 (31 Aug 2009)	0 (30 Jun 2009)

2. Purpose

Improve the quality, efficiency, and equity of health system.
Classification: Probable

Key Planned Outcome Indicators	Outcomes Achieved
2.1. Description: Increase in national complete immunization rate. **Unit:** percent **Baseline Target** 54 (11 Mar 2004) **Annual / Intermediate Target** **EOP Target** 80 (31 Aug 2009)	85 (30 Dec 2006)
2.2. Description: Percentage of poor (measured by poverty line) covered by health insurance (MSA) (no intermediate results reported) **Unit:** percent **Baseline Target** 28.79 (31 Dec 2004) **Annual / Intermediate Target** 0 (_____) **EOP Target** 34.55 (31 Aug 2009)	0 (30 Jun 2009)
2.3. Description: Percentage total population covered by health insurance (no intermediate results reported) **Unit:** percent **Baseline Target** 65.50 (31 Dec 2004) **Annual / Intermediate Target** 0 (_____) **EOP Target** 80 (31 Aug 2009)	0 (30 Jun 2009)

Reformulation: Was the objective(s) of this project reformulated? [ ] Yes [X] No

If yes, indicate date of Board Approval: _____

Briefly describe the consequences of these changes. (If any changes were made to the outcome indicators/targets, describe it under the next section.):

Hyperlink: _____ (Hyperlink through IDBDOCS to documentation approved by the Board.)

Were there any changes to the outcome indicators or targets? [X] Yes [ ] No

If yes, indicate most recent date _____ and who approved these changes: A few indicators were changed/modified during the preparation of the baseline either because they were not practical, or because the modification was more appropriate..

Briefly explain any changes that were made. (If this was part of a retrofitting exercise, see below.)
The indicator related to 'availability of tracer medicines improved' has been modified. The original indicated intended to monitor the availability of a basket of 20 medicines. MOH has modified the basket and has developed an essential medicines list in consultation with importers and included much more than the basket of 20. They have established a minimum stock level of 56% for all the items on the list.

Hyperlink: _____ (Hyperlink through IDBDOCS to documentation approved by the Representative.)

Retrofitting: Was this PPMR retrofitted? [ ] Yes [X] No

If yes, indicate most recent date _____

Briefly explain any changes resulting from this exercise.

Summary Development Objective(s) Classification (DO):

[ ] Highly Probable (HP) [ ] Probable (P) [X] Low Probability (LP) [ ] Improbable (I)

Briefly justify the Summary DO Classification based on the degree planned targets were met, explaining the difference between planned and actual outcomes, as well as any other relevant factors. Cite reference for evidence that supports these results.
It will be difficult to establish the succes of the program, as the PIU and the MOH have reported that they do not have the infomration on the indicators as defined in the Program. As these indicators were not reported during the life of the project, this came to light only during the semester 2009-1, when the Specialist asked for standard reporting on the indicators. The PIU stated that, in previous years, these figures were not monitored or reported. It is unclear why the problem with the data is coming to light only now, at the end of the program period. This should have been monitored and flagged at the beginning of the program.

A Special Mission in May, 2009, agreed to replace the original indicators with only three indicators, citing the impossibility of the information gathering of the original indicators. There was no clarificatino as to why the original information could not be gathered, as the indicators seem standard and straighforward in a health sector framework.

Country Strategy: At the time of approval this project was expected to contribute to the following Country Strategy objective(s):
This program was prepared consistent with the 2000 country strategy (GN2080-1) the core of which was to support policy and institutional reforms in order to improve institutional and incentive framework and the promote of human resource development and social inclusion. The program continues to be consistent with the 2006-2010 country strategy which seeks to support Suriname's effort to modernize and transforn the economy from the current dominance of public sector to a new emphasis on private sector-led growth. public sector efficiency and social integration.

This program fits in with the strategic goal of the strategy as health is an essential element of human resource development and a pre-requisite to productivity growth.

Given the results described above, briefly discuss how the project has contributed or will contribute to the Bank's strategy in this country:
The program will contribute to several areas of the country strategy for Suriname.

1. The health sector in Suriname comprises several key care providers - private sector such as some hospitals, semi-automonous agencies (eg the Bureau of Public Health); NGOs (eg the Medical Mission and RGD); and central government. With support from the program, the MOH is positioning itself to provide strategic support and direction to the sector with inter alia, the setting up of the primary health care department that will set standards for primary care, including the clinical protocal development for chronic diseases. Plans are in train to set up a M & E Unit within the Ministry to monitor standard set for both primary and secondary care. A hospital coordinator and a primary health care coordinator are being recruited paid for by project resources to strengthen capacity. These are two of several initiatives aimed at improving the efficiency of MOH to oversee the sector and to improve public/private partnerships in the sector.

2. The program addresses social inclusion by supporting improvement and increase access to health care of the residents in the interior. This is being done through improving the services provided by the medical mission.

3. Human resource development is an area of the program that is consistent with the strategy. Public health training capacity will be strengthen with the desgn of new curriculum.

Hyperlink to Country Strategy: http://CSU-APPS-01.reg.iadb.org/WSDocs/getDocument.aspx?DOCNUM=20241

Sustainability Analysis:
The most important factors that would contribute to the sustainablilty of the results of this project are: (a) GOS commitment to improving the performance of the health sector; (b) availabliity of resources to implement planned activities : and (c) availability of staff within the Ministry of Health. With regard to its commitment, this program is consistent with the GOS health sector plan. Resources to implement the plan come from the government budget and Euro 11.9 million from the Dutch Treaty Fund.. In terms of availablilty of staff within MOH, the commitment is not clear, as decisionswit hregards ot the PHC department seem to change regularly.

Sustainability Classification:

[ ] Highly Probable (HP) [X] Probable (P) [ ] Low Probability (LP) [ ] Improbable (I)

Externalities:
none

III. IMPLEMENTATION PROGRESS (IP)

Components (Outputs):

Component Title: 1. IMPROVE QUALITY AND EFFECTIVENESS OF PREVENTATIVE AND PRIMARY HEALTH CARE

Description: This component finances activities in two sub components: 1.1 Activities to improve performance of preventive and primary health care services: this will deliver a basic package of primary health care services to approxamitely 47 health centres and clinics (126,000 beneficiaries) with a focus on prevention.

1.2 Activities to improve access to medicines. This sub-component will strengthen pharmaceutical policy-making capacity and improve legislation and procedures for import and distribution of pharmaceuticals.

Total cost of Component	1,790,000	Counterpart:	0	IDB:	1,790,000	Co-financing:	0
IDB Disbursement:	1,162,600	Total amount committed:	__				

Classification: Unsatisfactory

Key Indicators for Planned Outputs	Actual Outputs
1. Description: Provider knowledge levels increased (no % increase specified - no intermediate results reported). **Unit:** percent **Baseline Target:** 0 (_____) **Annual / Intermediate Target:** **EOP Target:** 0 (31 Aug 2009)	0 (30 Jun 2009)
2. Description: Availability of tracer medicines improved (no intermediate results reported). **Unit:** percent **Baseline Target:** 74 (11 Mar 2004) **Annual / Intermediate Target:** 0 (_____) **EOP Target:** 95 (31 Aug 2009)	0 (30 Jun 2009)
3. Description: Reduce time for registration of new medicines (no intermediate results reported) **Unit:** days **Baseline Target:** 99 (11 Mar 2004) **Annual / Intermediate Target:** **EOP Target:** 60 (31 Aug 2009)	0 (30 Jun 2009)
4. Description: Average BGVS prices for medicines reduced (no intermediate results reported) **Unit:** percent **Baseline Target:** 0 (_____) **Annual / Intermediate Target:** **EOP Target:** 25 (31 Aug 2009)	0 (30 Jun 2009)
5. Description: Percent of mothers in target communities receiving health education that are breastfeeding exclusively at 6 months and diarrhea decreased. (no specific decrease target determined - no intermediate results reported). **Unit:** percent **Baseline Target:** 0 (_____) **Annual / Intermediate Target:** **EOP Target:** 0 (31 Aug 2009)	0 (30 Jun 2009)

In the case of unsatisfactory or very unsatisfactory ratings for this component, provide comments on its status focusing on the problems identified in attaining planned outputs. Other pertinent information may also be entered here:
Due to implementation problems, this component experienced significant delays which reflected in low disbursements until 2007, when the July 2007 Administration Mission reached agreement with the MOH on a plan of action to improve implementation performance. Benchmarks related to committing the resources for the key consultancies were set for achievement by Dec 31, 2007. A review of those benchmarks in February 2008 shows that MOH achieved most or all of the benchmarks. (See review Aide memoire dated March 26, 2008)

1.1 Improve Performance of prevention and primary Health care - MOH insisted that a basic package of primary health care is already delivered to patients so the focus of this component was on improving the existing package, developing protocols for treatment of diseases such as hypertension and diabetes; identifying the main health problems by analyzing morbidity and mortality; development of a national comprehensive primary health care strategy; development of a strategy for national health promotion and improving the Ministry's capacity to monitor and evaluate the sector. Given that health care is delivered by varied providers, including NGOs, private sector and the government itself, MOH is using the resources of the loan to improve the delivery of PHC by providing strategic direction to the sector, setting standards to address the inconsistency in data collection and analysis of data and the overall delivery of care and setting up systems within the ministry to monitor and evaluate the standards set. 11 PHC projects, comprising of training activities, and investments in equipment and imited infrastructure, were approved and included in the recently approved Procurement Plan. A medical waste management plan was also included in the updated procurement plan at the last instance. All are being implemented.

1.2 Improve Access to Medicines: Several consultancies are underway in this component and further activities in 2009 will depend on the recommendations that will feed into the policy of the MOH. The Ministry is implementing results of the procurement and supply management consultancy with the establishment of a procurement unit to facilitate open and competitive tendering procedures for importing medicines. A Pharmaco-vigilance unit has already been established. The Medicine Board, a semi-autonomous agency which lacked a functioning Board of Directors, is more effective with the appointment of a new Board. However, lack of capacity in BGVS has resulted in delays in the consultancy. The consultancies are now scheduled to finish February 2009. This last quarter the resources were used to financed Human Resource Development and Policy strengthening. Key staff attended a WHO-organized pharmacological conference in Sweden.

As the PIU reports that there are no data on the indicators related to this component, the component's performance cannot be considered satisfactory.

Restructuring: Indicate if this component was restructured (approved by Operational Department): [X] Yes [ ] No

If yes, date: 30 Jun 2009

Briefly describe the consequences of these changes:
It is not clear how the reprofiling plan, product of the Special Mission in May 2009, will change the indicators andthe content of this component. This needs to be decided.

Hyperlink to documentation approving restructuring, if relevant: _____

Component Title: 2. IMPROVE EFFICIENCY AND EQUITY OF HEALTH SYSTEMS

Description: The loan resources under this component are directed towards three sub-components: 2.1 Reduce costs and improve efficiency, accountability and quality of care of health service providers and health financing providers namely SZF and MSA; 2.2 Improve equity through expanding MSA health card program to all poor households defined using the poverty line; and 2.3 Strengthen MOH and improve accountability in primary health care services.

Total cost of Component	2,581,000	Counterpart:	__	IDB:	2,581,000	Co-financing:	__
IDB Disbursement:	1,364,593	Total amount committed:	__				

Classification: Unsatisfactory

Key Indicators for Planned Outputs	Actual Outputs
1. Description: SZF administrative cost per claim processed reduced (no intermediate results reported) **Unit:** Percent **Baseline Target:** 0 (31 Mar 2004) **Annual / Intermediate Target:** **EOP Target:** 20 (31 Mar 2009)	0 (31 Mar 2009)
2. Description: Reduce type 1 error (no intermediate results reported) **Unit:** Percent **Baseline Target:** 22.90 (31 Mar 2004) **Annual / Intermediate Target:** **EOP Target:** 10 (31 Mar 2009)	0 (31 Mar 2009)

3. Description: Reduce Type II error (no intermediate results reported) **Unit:** Percent **Baseline Target** 36.30 (31 Mar 2004) **Annual / Intermediate Target** **EOP Target** 5 (31 Mar 2009)		0 (31 Mar 2009)
4. Description: MSA programs using targeting systems (no intermediate results reported) **Unit:** percent **Baseline Target** 0 (31 Mar 2004) **Annual / Intermediate Target** **EOP Target** 100 (31 Mar 2009)		0 (31 Mar 2009)

In the case of unsatisfactory or very unsatisfactory ratings for this component, provide comments on its status focusing on the problems identified in attaining planned outputs. Other pertinent information may also be entered here:

2.1. Overall implementation progress was affected by several issues in the SZF sub-component. The management of the beneficiary agency, SZF, was initially dissatisfied with the budget for the sub-component and had decided not to utilize the resources. The MOH then made a request to reallocate the budget of US$1M to improving the kidney dialysis centre, which the Bank denied. Management of the SZF has since changed and this development opened the door for new discussions. During an administration mission in July 2007, the Bank and MOH agreed that the funds would remain in the category and that, given the lapse of time since the initial assessment of SZF, a detailed assessment would be commissioned in the context of GOS priorities, to implement a national health insurance plan. The utilization of the remaining funds in the category would depend on the results of the SZF needs assessment. The final draft report for the needs assessment of the SZF being completed, the MOH has informed the Bank that the Ministry decided to finance the reform activities identified in the SZF study with Sector funds, not with loan resources, to improve the systems for processing and payment of claims and to procure ICT systems to automate SZF's administration, operations and claims processing.

Sub-component 2.2. Improved efficiency and equity of health systems, focused on improving the efficiency of the health card distribution system and improving targeting. Implementation progressed very well with the social information system (SIS) in its final stages of completion. The consulting firm has recently completed the household survey. SOZAVO has finalized the field testing of the PMT information collection instrument with the consultancy firm Bitran. The update on the MIS component is also continuing. Completion of PMT is aimed at improving the targeting of all MSA social programs and should, in particular, address significant targeting problems with the health card. However, the decision to implement the targeting module (the PMT) is deemed to be very sensitive, and various implementation decisions reside at the political level. Furthermore, the absence of a Project coordinator since August 2008 has resulted ina lack of coordination between the PIU and the Ministry of SoZaVo. This was established during a meeting in January 2009 between the Bank, MOH, and SOZaVo, when SoZaVo staff confirmed that they had not met with the PIU since June 2008.

As the PIU reports that there are no data on the indicators related to this component, the component's performance cannot be considered satisfactory.

Restructuring: Indicate if this component was restructured (approved by Operational Department): [X] Yes [ ] No

If yes, date: 30 Jun 2009

Briefly describe the consequences of these changes:

It is not clear how the reprofiling plan, product of the Special Mission in May 2009, will change the indicators and the conents of this component. This needs to be decided.

Hyperlink to documentation approving restructuring, if relevant: _____

Implementation Progress Summary Classification (IP):

[ ] Highly Satisfactory (HS) [ ] Satisfactory (S) [X] Unsatisfactory (U) [ ] Very Unsatisfactory (VU)

Briefly justify the Summary IP Classification based on the degree planned targets were met , explaining the difference between planned and actual outputs as well as any other relevant factors. Cite reference to evidence that support these results.

It is impossible to assess the components' success if data on indicators are not available, as the PIU states. It is unclear why the problem with the data is coming to light only now, at the end of the program period. This should have been monitored and flagged at the beginning of the program.

Check off critical factors / reasons for Unsatisfactory / Very Unsatisfactory IP Classification or Low Probability / Improbable DO classification, and reflect in section IV (Risk Profile), as needed:

[ ] Legislative approvals	[X] Inter-agency coordination	[ ] National policy changes
[X] Borrower/executing agency commitement	[ ] Supplier/contractor performance	[X] Executing agency policy changes
[ ] Counterpart funding shortfall/fiscal ceilings	[ ] Project/component design	[ ] Bank policy changes
[X] Executing agency institutional capacity	[ ] Bank efficiency (response delays)	[X] Lack of monitoring/evaluation system
[ ] Community/politial opposition	[ ] Environmental issues	[ ] Other:
[ ] Consultant services performance	[ ] Cost overrun	

FIDUCIARY ISSUES PROFILE

[X] **Contractual Condition Compliance Delays.** List any delay and/or other problems in compliance with other important contractual conditions:
Contractual clause Article 7.03(a)(iii) of the Loan Contract is pending fullfilment by the PEU.

[X] **Audited Financial Statements (AFS).** List any important qualified options of the auditor presented in the AFS:
Unqualified opinion given by the Auditor on the 2007 audited financial statements. The Auditor's opinion is that the Financial Statements present fairly in all material respects, the cash received and disbursements made and the cumulative investments. Notwithstanding, the Auditors noted certain matters involving the system of internal control and its operation which they reported in the Management Letter to the PEU. The PEU provided adequate explanations to each observation cited by the Auditor. The AFS were submitted 2 days after the contractual due date.

Observations of Financial Specialist, including comments on AFS and/or factors affecting the development objectives:
Financially this project is well managed CSU assessed financial management, internal control and external control on the basis of CESI and determined the project to be Low Risk. Consequently the project is placed on Ex-Post modality for disbursements.

Observations AFS 2007

In general the report is prepared in accordance with Bank's requirements as outlined in AF-100 and 300, however the Bank observed that the Notes to the Financial statements and Parts of the supplementary Financial Information could be improved or added to the Report. There are no significant differences in figure reporting between the AFS and the Bank's financial records except for Interest and Credit fee.

The Bank, the PEU and the auditor met to review the AFS. The PEU, in collaboration with the Auditor, has submitted additional information to validate the 2007 AFS.

Relevant Hyperlinks:

Qualified opinions given by external auditors (AFS): _____

Project AFS Review Guide(AF320): _____

Timeliness of AFP Submission(LMS40): http://ops/lms/lms40.asp?UDRCode=CSU&LoanType=LON&AuditYear=2008

Documents/correspondence to and from the EA regarding non-compliance, if applicable: http://CSU-APPS-01.reg.iadb.org/WSDocs/getDocument.aspx?DOCNUM=24661

[X] **Procurement difficulties, if applicable.** Briefly list any major procurement issues affecting implementation progress:
Recently the PEU embarked on several procurement and was in breach of the Bank's procurement procedures. A letter dated May 13, 2008 #CCB/CSU/2008/618 was sent to the PEU advising them of possible consequences. This situation has resulted in delays. Though the PEU has now recruited a Procurement Assistant it seems as though the problem is not resolved completely since the source of the problem still exists. The Bank understands that Primary Health Care Coordinator, who is responsible for

implementation of several PHC projects continues to intervene in the procurement process.

Any additional observations of Financial, Sector and/or Procurement Specialist(s):
No significant financial issues have been identified.

IV. RISK PROFILE

Key Risk:	Category	(a) Severity of Impact	(b) Likelihood of Ocurrence	(a x b) Classification
1. A change in priorities in MOH with respect to project components, has continued from 2007, when the MOH started favoring larger infrastructure projects instead of institutional capacity of reform activities. This change, probably fueled by 2009 being a pre-elections year, may result in a lessening commitment to reform.	Development effectiveness	3	50	150
2. The Proxy Means Test methodology for establishing the eligibility of beneficiaries for the Health Card - and other programs - is a sensitive issue, as more effective targeting may exclude current beneficiaries from the system. This may be a critical factor which may obstruct political decisions to adopt this system in a pre-elections year.	Development effectiveness	4	80	320
3. The absence of a fully functioning PEU with a clearly designated Project Coordinator has resulted in a diminished coordination with other actors in the program, like the SZF and the Ministry of Social Affairs.	Fiduciary and operational	3	75	225
4. PEU may not conform to the Bank's procurement procedures, whch may result in operational and contracting delays.	Fiduciary and operational	3	60	180
5. The Project Coordinator tendered her resignation in September 2008 after being on the job for about two months. She replaced the previous coordinator, who worked in IDB financed projects for 15 years. The changes in Project Coordinator and the decision not to replace the Coordinator, combined with absences of key personnel, result in delays due to a lack of coordination and follow up among PEU staff.	Fiduciary and operational	3	75	225

Summary Risk Classification (RI):

[ ]Very High [X]High [ ]Moderate [ ]Low

ALERT STATUS PROJECTS

Comments on relevance of "on alert" status for this project (if applicable):

V.PLAN OF ACTION FOR RISK MANAGEMENT AND TO ADDRESS IMPLEMENTATION PROBLEMS

RISKS

Risk:	Response:
2	Continuing discussions with SOZAVO, PLOS, Minister of Finance, and ABS need to clarify the precise task division and critical path to adopting the Proxy Means Test as main targeting instrument of social programs. Results of these discussions are also critical for other programs, like the recently approved LISP-II, and the Social Protection new initiative to be developed. **Responsible unit:** SOZAVO/IDB **Date Action to be completed:** 31 Jul 2009 **Date Action Completed:** _____
3	In August 2008, the MOH decided to not replace the departing Project Coordinator in the Health Sector Reform Program PIU. This decision was based on the imminent end of both the Health Sector Reform program and the HIV/AIDS TC. However, as both programs seem to be extended beyond original plans and discussions had in December 2008, the absence of a Project Coordinator should no longer be accepted by the Bank. Both the Health sector Reform program and the HIV/AIDS TC have suffered long periods of inaction under a lack of coordination among actors like the NAP, MOH, Social Affairs, and SZF, and the absence of adequate management since August 2008. **Responsible unit:** IDB **Date Action to be completed:** 31 Jul 2009 **Date Action Completed:** _____
4	The Bank is initiating a renewed initiative to organize round-table discussions on procurement with all executing agencies, and formal procurement training. This is aimed at reducing the problems around interpreting Bank rules. The PEU participates in this process. **Responsible unit:** PEU/IDB **Date Action to be completed:** 28 Feb 2009 **Date Action Completed:** _____
5	The delays in project implementation are the main reasons why the MOH has communicated the need to request an extension for the project. This extension phase, discussed during the Special Mission in May 2009, and to be studied in the reprofiling plan agreed during that Mission, will need an active follow-up mechanism between the Bank and the PEU to ensure that implementation targets are met within the period. **Responsible unit:** MOH/PEU **Date Action to be completed:** 15 Jul 2009 **Date Action Completed:** _____

IMPLEMENTATION PROBLEMS

Implementation Problem:	Action Plan:
1. The MOH and the Bank agreed on replacing the mid term review, which did not take	**Responsible unit:** IDB/PEU

place, with a final evaluation at the end of the program. This final evaluation would concentrate on result achievement of the program, the design of the expost evaluation foreseen in the original project design, and the possibility of financing follow-on activities to enhance impact of this program. The TORs of theis evaluation need to be finalized by February 2009.	**Date action to be completed:** 31 Aug 2009 **Date action completed:** _____
2. In order to prepare for the final evaluation, the PEU needs to report the latest intermediate results, which were not included in semi annual reports until now.	**Responsible unit:** IDB/PEU **Date action to be completed:** 30 Jan 2009 **Date action completed:** _____

VI. LESSONS LEARNED

Add or fine-tune lessons learned that can be used to improve the programming, design, execution, as well as the monitoring and evaluation of other operations in the sector or country, as needed.

1. The program is implemented by and benefits agencies not under the purview of MOH, eg Ministry of Social Affairs. The MOH has not been satisfied with this design and feels that all the loan resources should have been directed towards PHC. Now MOH is willing to suspend further spending on MSA and SZF activities. Given the political structure of Suriname, future design has to consider the special characteristics of interministerial and interagency relationships.

2. Both the HIV/AIDS TC and the Health Sector Reform program have suffered from inadequate management since August 2008, when the departing Project Coordinator of the PIU was not replaced by the MOH, due to the supposedly imminent end of both programs. This led to uncoordinated plans and project ideas, that were neither finalized nor coordinated with MOH departments. This in turn led to long periods of inaction. As the consultants in the PIU had time-based contracts with very high salaries relative to the Surinam market, they did not mind extending these lucrative contracts for as long as the programs needed to be extended because of program delays. This conflict of interest exacerbated program delays.

Attempts by the Bank to change the contracts into results-based contracts were met with strong and vehement resistance from both the consultants and the Director of Health., Dr. Eersel, who had given the consultants a very positive evaluation despite the lack of results.

Recommendation:

The Bank needs to handle the inherent conflict of interest of highly paid consultants in PIU with regards to their time-based contracts at a structural level with the Ministry of Finance, not on an ad hoc basis. When political support from the Ministry of Finance is ensured , the Bank and the Ministry of Finance can make an implementation timetable, taking advantage of contract termination dates, so that all projects, within not much more than a year, can be moved to the new results-based system. Trying to do this in a different, ad hoc, way, will result in failure, as illustrated by the Health Sector example.

3. From the beginnning, this program was not managed based on results or program indicators. This was made clear when the PIU was asked to report on the program¿s indicators as part of the Semi Annual Report semester 2-08. The PIU reported and insisted that they could not produce the information on the indicators, though these are fairly standard and not complicated. As a result, the Special Mission of May 2009, agreed to do away with the original indicators and to ask to report on three indicators. This will be studied in a reprofiling plan, as agreed during this Mission.

VII.MONITORING AND EVALUATION

When was the baseline information gathered for at least one outcome indicator?

[ ] Before Board Approval [X] Other Date: 31 Dec 2006

When was the baseline information gathered for at least one output indicator, if applicable?

[ ] Before Board Approval [X] Other Date: 31 Dec 2006

Does the borrower have a defined data gathering system in place?

[X] Yes [ ] No

Is the borrower maintaining performance data on agreed outcome indicators?

[X] Yes [ ] No

Is the borrower maintaining performance data on agreed output indicators?

[X] Yes [ ] No

Are there any *issues* or problems related to the quality, validity and timeliness of the data gathering system?

[ ] Yes [X] No

Start-up Mission:

[ ] Yes [X] No If yes, date: _____

Hyperlink(s) to relevant Aides Memoire(s): _____

Administration or Other Relevant Missions:

[X] Yes [ ] No If yes, date: 23 Jul 2007

Hyperlink(s) to relevant Aides Memoire(s): _____

Mid-Term Evaluation (MTE):

[X]N/A [ ]Planned [ ]Completed Date: _____

Briefly describe the main findings and results, as well as the principal conclusions/recommendatios of this evaluation:

Hyperlink(s) to MTE: _____

Final Evaluation: Is a final evaluation for this project foreseen?

[X] Yes [ ] No If yes, date: 31 May 2009

Hyperlink(s) to relevant Aides Memoire(s)and/or report: _____

Ex-Post Evaluation: Is an ex-post evaluation for this project foreseen?

[X] Yes [ ] No If yes, date: 30 Jun 2009