**DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK**

**S U R I N A M E**

# SUPPORT THE IMPLEMENTATION OF HEALTH SECTOR

**Operation No. 1537/OC-SU**
**Approved on March 10, 2004**

**HEALTH SECTOR FACILITY**

# SUPPORT FOR THE IMPLEMENTATION OF HEALTH SECTOR REFORM (SU-0028)

## EXECUTIVE SUMMARY

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| **Borrower and Guarantor:** | Republic of Suriname | | |
| **Executing agency:** | Ministry of Health (MOH) | | |
| **Bank's financing amount and source:** | IDB (IFF): | US$ | 5,000,000 |
| | Local counterpart: | US$ | 700,000 |
| | Total: | US$ | 5,700,000 |

**Financial terms and conditions:**

Amortization period: 25 years
Grace period: 4 years
Execution period: 4 years
Disbursement period: 4 years
Currency: US$ from the single currency facility

The interest rate, credit fee, and inspection and supervision fee mentioned in this document are established pursuant to document FN-568-3 Rev. and may be changed by the Board of Executive Directors, taking into account the available background information, as well as the respective Finance Department recommendation. In no case will the credit fee exceed 0.75%, or the inspection and supervision fee exceed 1% of the loan amount.[1]

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| Interest rate: | Adjustable option - 0.25% |
| Credit fee: | 0% |
| Inspection and Supervision: | |

**Objectives:** The objective of the program is to improve health status in Suriname through the implementation of institutional reforms to increase the efficiency, equity and quality of health services, particularly those directed to the poor.

**Components:** **Component 1** will finance technical assistance, training, materials and primary health care team incentives to: (i) assure joint RGD-

[1] With regard to the inspection and supervision fee, in no case will the charge exceed, in a given six-month period, the amount that would result from applying 1% to the loan amount, divided by the number of six-month periods included in the original disbursement period.

BOG delivery of a basic package of primary health care services with a focus on prevention in the coastal region; (ii) develop and implement joint PHC supervision, monitoring and evaluation capacity within financing institutions (MOH, SZF, MSA); (iii) build public health training capacity in primary and preventive health care, with emphasis on providers participating in activity (i); (iv) support the development of quality assurance systems within RGD, as well as the development of self-regulatory mechanisms based on the PHC package treatment guidelines, continuous professional education and peer review; and (v) improve availability and affordability of essential medicines.

**Component 2** will finance technical assistance, training, equipment and materials to: (i) reduce administrative costs and improve accountability and quality of health services financed through the health sector's major financiers, the State Health Insurance Fund (SZF) and the Ministry of Social Affairs (MSA); (ii) improve Ministry of Health (MOH) policy making capacity; and (iii) improve equity through a new mechanism of targeting health subsidies to the poor and the extension of the health card (insurance) program to the entirety of the extreme poor.

**Special contractual conditions:**

Establishment of the Project Execution Unit (PEU) and selection of its key personnel is a condition prior to first disbursement of the program. In addition, the official adoption of the operating regulations, previously agreed with the Bank, is a condition prior to the first disbursement of program resources.

**Relationship to Bank country and sector strategy:**

The Bank country strategy in Suriname for the period 2000-2003 (GN-2080-1) sets out human resource development and social inclusion as one of four goals of the strategy. The proposed program fits with this strategic goal as health is an essential element of human resource development and a pre-requisite to productivity growth. Further, the program supports the maintenance of a stable macroeconomic framework through its emphasis on efficiency improvements within existing budget allocations. Finally, the proposed program was included explicitly in the lending program update approved in 2003 (GN-2257-1).

The Bank's Social Development Strategy (GN-2241-1) proposes four areas of action to support member countries: (i) orient health, education and housing reforms to the specific needs of the population; (ii) carry out a human development program that covers the life cycle; (iii) promote social inclusion and prevent social ills; and (iv) provide integrated services. The proposed operation contributes to areas (i)-(iii) of the strategy, through its thorough foundation in the reality of the Surinamese health sector

and its emphasis on the assurance of health card (insurance) coverage for the poor and preventive and primary health care.

**Environmental / social impact:**

It is expected that the social impact of the program on the poor will be significant. The program will be able to provide health card coverage to all of Suriname's poor population (approximately 215,000 persons). In addition, the program is expected to reduce preventable morbidity and improve health status. It is also expected that women will gain substantially from improvements in the provision of these services. Finally, more than half of project resources will go towards improving access and quality of basic primary health care for the poor.

**Consultation with stakeholders:**

In early 2003, the main findings and recommendations of studies and action plans prepared under the "Support for Health Sector Reform" Technical Cooperation Agreement (ATN/SF/JF-6223-SU) were summarized in the White Paper on Health Sector Reform in Suriname, which was consulted with civil society and public sector decision-makers with the support of the IDB. As a result of the consultation, a Resolution was adopted with a call to both the government and all stakeholders to actively support the health sector reform activities. The consultation is viewed as an enormous stimulus for health sector reform initiatives and has paved the way for implementation of the proposed activities. The Cabinet is currently reviewing the White Paper, with a view to formally adopting the document as government policy.

**Coordination with other agencies:**

The major international donor to the health sector in Suriname is the Netherlands. Continued close coordination between MOH, PLOS, IDB assistance and Dutch assistance is key for future implementation and the MOH has launched a Donor Coordination Unit to support this effort. Other important donors in the health sector are the Government of Japan and the Islamic Development Bank.

In addition to the information gathering efforts reflected in the document, the Bank has carried out a series of coordination meetings with assistance agencies active in Suriname, and sponsored a national consultation on health sector reform in which other assistance agencies participated.

**Potential benefits:**

It is expected that the social impact of the program on the poor will be significant. In 2000, about 50% of Suriname's population fell below the national poverty line. This population experiences insufficient quality of and limited access to health care services. Through improvement of the efficiency and equity of the health system, the program will be able to provide health card coverage to the entirety of Suriname's extreme poor population

(approximately 215,000 persons). Through improvement of preventive and primary health care services in the coastal region and overall availability and affordability of medicines, the program is expected to reduce preventable morbidity and improve health status. Given the focus on primary health care, including pre-natal and post-natal care, it is expected that women will gain substantially from improvements in the provision of these services, as will their children. As more than half of project resources will go towards improving access and quality of basic primary health care for the poor, the project qualifies as a Poverty Targeted Investment, according to the policy guidelines set out in the Eighth Replenishment.

**Potential risks:** Potential risks to the program include fiscal sustainability, timeliness of budgetary transfers to health system agencies, high rates of turnover among trained staff, uninsured non-poor, who will no longer benefit from MSA health card coverage, and lack of donor coordination. In order to minimize the risk to fiscal sustainability, the proposed program does not include any measures that would increase future recurrent expenditure requirements. Rather, it is anticipated that the activities to be financed would contribute to the generation of modest fiscal savings associated with the reduction of administrative costs and leakage. With regard to the budgetary transfers, a timetable of budgetary transfers in the health sector, consistent with the multi-annual budget submitted to the National Assembly, will be evaluated during semi-annual and annual program performance reviews. On issues of staff turnover, the program will focus on specialized, on-the-job training modalities, followed by regular supervision. On the uninsured non-poor, the program will support the development and implementation of a plan for emergency care of this population in the short term, as well as promote voluntary insurance coverage through the SZF. Finally, with respect to donor coordination, the MOH has established a Donor Coordination Unit. The unit will be responsible for coordination, formulation, monitoring and evaluation of the programs supported by donors, such as the Dutch Treaty Funds and Bank assistance.

**Poverty targeting and social sector classification:** This operation qualifies as a social equity enhancing project, as described in the indicative targets mandated by the Bank's Eighth Replenishment (document AB-1704). Furthermore, this operation qualifies as a poverty targeted investment (PTI). The borrowing country will be using the 10 percentage points in additional financing.

**Procurement plan and timeframe:** The procurement of goods and consultancy services will be carried out in consistency with the procedures stipulated in the

procurement policies and procedures of the Bank. International public bidding will be obligatory for purchases partially or totally financed with loan proceeds and whose value exceeds the equivalent of US$200,000 for goods, the equivalent of US$1,000,000 for infrastructure construction or rehabilitation; and the equivalent of US$200,000 for consultancy services.

Procurement below the above amounts will also be carried out in accordance with Bank procurement procedures: for purchases of goods between US$100,000 and US$250,000, national public bidding will be used, for those below US$100,000, public price comparison will be used, and for amounts below US$20,000, three price proposals will be reviewed. These procedures will be detailed in the operating regulations of the program.

For consultancy services below US$200,000, procurement will be carried out in consistency with Bank procedures. For consultancy services below US$50,000, procurement will be carried out through publication of consultancy opportunities at the national level and the establishment of a short list of qualified firms invited to present proposals.

These limits are justified taking into account domestic capacity for the production of the goods and services proposed in the program, as well as potential cost savings available on the international market. Procurement below the above amounts will be also carried out in accordance with Bank procedures.

**Key performance indicators and monitoring benchmarks:**

The monitoring and evaluation of the proposed program will be based on the Logical Framework, which specifies output and outcome indicators. **Outcome indicators** at the goal and purpose level of the logical framework include, among others:

Reducing child mortality rates from 31 per thousand to 25 per thousand.

Reducing frequency of hospitalization for diabetes and hypertension by 20%.

Increasing immunization rates from 54% in 2000 to 80% by end of project.

Increasing percentage of poor covered by health insurance by at least 20% by end of project.

**Output indicators** at the component level of logical framework, among others, include:

Increasing percentage of tracer medicines available from 74% in

2003 to 95% by end of project.

Reducing average BGVS prices for medicines by 25% by end of project.

Achieving 20% of budgetary savings for SZF + MSA by reducing length of stay in hospitals.

Reducing SZF administrative cost per claim processed by 20% by end of project).

Improving equity by reducing Type I errors from 22.9% to 10% and Type II errors from 36.3% to 5% by end of project.

**Reporting arrangements:**

**Inspection and supervision.** The MOH-PEU and the Bank will hold supervisory meetings to assess progress and obstacles in the program's implementation. During the first year of execution, two supervisory meetings will be held. In subsequent years, an annual meeting will be held. The MOH-PEU and the Bank will agree to the dates of these meetings jointly. Based on the findings of these assessments, if needed, corrective measures will be taken promptly to assure the timely execution of the program.

**Progress reports.** The MOH-PEU will present semi-annual reports to the Bank during the execution of the program, which will detail activities and results and recommendations of activities undertaken during the period, as well as progress made in each component and sub-component in terms of disbursements and targets agreed in the logical framework of the program.

**Ex-post evaluation of the program.** The government has agreed to finance an ex-post evaluation of the proposed program, utilizing a simple performance measurement approach, or the regular measurement of results and efficiency of the services and programs included in the operation. The evaluation will be based on the Logical Framework, which specifies output and outcome indicators. Outcome indicators at the goal and purpose level of the logical framework include child mortality rates, utilization rates of preventive health care (immunization) and insurance rates among the poor. Output indicators at the component level of logical framework, among others, include savings to be realized by SZF-MSA integration and reduction in administrative costs, average length of stay in hospitals, use of performance contracts, targeting errors and provider and beneficiary knowledge levels on preventive health care.

Data for baseline and target indicators is drawn from household surveys, hospital admission records, and sector studies financed

under the previous TC. The extent of compliance with target values will be measured using annual reports, special studies, surveys, admission records, and drug registries. The costs of these data collection activities during the period of project execution have been built into the project components. Government has committed to compile the data necessary to track the logical framework indicators, consistent with the Bank's ex post evaluation policy (OP-305).