TC Document

I. Basic Information

▪ Country/Region:	Suriname/CCB
▪ TC Name:	Support for Prevention and control of NCDs
▪ TC Number:	SU-T1062
▪ Team Leader/Members:	Ian Ho-a-Shu (SPH/CTT) Team Leader, Frederico Guanais de Aguiar (SPH/SCL); Martha Guerra (SCL/SPH), Naomi Akoy-Bouguenon (CCB/CSU); Roy Parahoo (PDP/CSU); Rinia Terborg-Tel (FMP/CSU); and Mónica Lugo (LEG/SGO)
▪ Date of TC Abstract authorization:	
▪ Donors providing funding:	Japan Special Fund
▪ Beneficiary:	Suriname
▪ Executing Agency and contact name	Ministry of Health; Dr Marthelise Eersel, Director of Health
▪ IDB Funding Requested:	$500,000
▪ Local counterpart funding, if any:	$160,000
▪ Disbursement period (which includes Execution period):	30 months (24 months execution period)
▪ Required start date:	December 2012
▪ Types of consultants:	Firms and Individuals
▪ Prepared by Unit:	SPH/CSU
▪ Unit of Disbursement Responsibility:	CCB/CSU
▪ TC Included in Country Strategy (y/n): ▪ TC included in CPD (y/n):	Yes Yes
▪ GCI-9 Sector Priority:	Yes. (i) TC aligned with the GCI-9 strategic priority: *the needs of the less developed and small countries*; and (ii) TC is consistent with the social policy for equity and productivity sector priority: by supporting the GoS in its efforts *to manage the epidemiological transition.*

II. Objectives and Description

2.1 The TC will support start up implementation of priority areas set out in Suriname's 2012 – 2016 National Action Plan for Non Communicable Diseases (NCDs) Prevention and Control to achieve the following specific objectives: (i) Improved NCDs surveillance and evidence-based NCDs program interventions; (ii) a plan for sustained local management capacity through an integrated primary health/private partnership approach; and (iii) a deepened understanding of wider sector changes required over the next five years for the Government of Suriname (GoS) to effectively manage the epidemiological transition.

2.2 **Addressing NCDs.** NCDs remain the main cause of death in Suriname, as is the case globally. NCDs, especially cardiovascular diseases, diabetes and cancers, were the cause of 60% of the deaths in

Suriname in 2009.[1] Even with the emergence of HIV/AIDS as a major cause of mortality and morbidity in the past decade and the consequent resurgence of tuberculosis, NCDs remain the main cause of death in the country, as is the case globally. NCDs, especially cardiovascular diseases, diabetes and cancers, were the cause of 60% of the deaths in Suriname in 2009, and both hospitalizations and polyclinic visits increased significantly since 2005[2]. In Suriname, cardiovascular diseases occur primarily among men while diabetes and cancers impact both men and women similarly. The majority of cardiovascular diseases and diabetes cases are among the Hindustani population and to a lesser degree within the Creole and Javanese populations while cancers are seen primarily among Creoles, followed by the Hindustani, Javanese and Maroons.[3] The average age of onset of cardiovascular disease is approximately 60, while diabetes and cancers tend to manifest around age 40.[4]

2.3 The high costs of diagnosis/treatment of NCDs are also placing a financial burden on the health system where costs for procedures, namely, kidney dialysis and heart surgery and for medication to control NCDs have also increased significantly in recent years.[5]

2.4 **Public Health Priority.** Recognizing that NCDs prevention and control requires a coordinated multi-sectoral approach, the National Action Plan is addressing the social determinants of NCDs in order to strengthen primary health care delivery, develop enabling healthy environments and support healthy individual behaviors. In addition, the Ministry of Health (MOH) has identified the need for a robust transformation of the Suriname health care system towards service delivery models for chronic care as well as a strong focus on health promotion and partnerships with non-health sectors and communities.[6] This system reorientation involves strengthening the national Primary Health Care system to take on an active role in the prevention, early detection and management of NCDs.

2.5 **Development Challenge.** Like its LAC counterparts, poor and vulnerable persons in Suriname, especially in the Interior are disproportionately affected by NCDs, as a result of social and economic conditions, emphasizing that control of NCDs is not only a health problem, but a development issue which needs to be addressed through a multi-sectorial approach.[7]

2.6 On this basis, the TC will provide advisory support and start up implementation-support in the following priority areas:

---

1 Doodsoorzaken in Suriname. Ministry of Health/Bureau of Public Health- Epidemiology department, 2009.

2 Doodsoorzaken in Suriname. Ministry of Health/Bureau of Public Health- Epidemiology department, 2009.

3 Ibid

4 MoH presentation used in DNA briefing November 2011.

5 Draft National Action Plan for the Prevention and Control of NCDs 2012 - 2016, MOH, Suriname. A conservative cost estimate of cardiovascular disease, including diabetes indicates hospitalization costs of SRD 3,466,400 (per year based on 2476 patients) and dialysis costs of SRD7,488,00 (per year based on 240 patients). A cost estimation of hemodialysis, due to kidney failure caused by diabetes, is SRD79, 200 (depending on the frequency of dialysis) per patient, per year. PAHO, Country Profile: The Republic of Suriname, www.paho.org. The Ministry of Health, Suriname estimates that the annual cost of medication related to the treatment of NCDs has increased from SRD 6.7 Million to SRD 10.6 Million over the last 3 years. Ministry of Health, NCDs Project Unit, 2012

6 Republic of Suriname, Development Plan 2012-2016, Government of Suriname, 2012.

7 As poverty is linked closely to health status and access to health care, both the absolute levels of poverty and its geographic distribution raise challenges to the health system. Higher levels of poverty may create a greater demand for health care services at the same time that available health budgets are reduced. Further, households living in poverty may be less likely to recognize a need for care, particularly preventive care, thereby increasing the chance for economic and personal hardship that an illness might present for a poor household. Suriname's Road to Health Sector Reform- An examination of the health care system and recommendations for change. IDB 2005).

2.7 **Multi-Sectorial Approach.** Informed by two regionally based strategic plans[8] and key regional declarations,[9] the National Action Plan calls for a multifaceted approach and for such an approach to be effective, the plan identifies the need for collaboration with various stakeholders in the health care system – including medical doctors, nurses, pharmaceutical personnel, and public health educators.

2.8 **Primary Healthcare Network.** The strategy of the MOH is to tackle NCDs through its primary health care network where prevention will be the key priority. The prevention approach of the MOH will focus on all levels of care, starting with health promotion for the entire population, health promotion activities for specific target groups such as patients with increased cardio vascular risk (diabetes, hypertension), cancer, etc.

2.9 **NCDs Surveillance.** The MOH is committed to advancing the implementation of its NCDs surveillance system with respect to data collection/analysis/dissemination of findings on incidence, prevalence, morbidity, survival and mortality.

2.10 **Alignment with GCI-9 Priorities.** The TC is aligned with the GCI-9 strategic priority which focuses on *the needs of the less developed and small countries* and in particular, the TC supports the social policy for equity and productivity sector priority by supporting the GoS in its efforts to manage the epidemiological transition.

2.11 **Country Strategy (CS) and Country Programming Document (CPD).** The TC is in line with the health sector priority on improving access to basic services which is identified as a core area for continued strategic dialogue in the current CS[10] for Suriname. In addition and as outlined in the CPD, the TC is in alignment with the Social Protection Support Program (SU-L1013) (2650/OC-SU) which will support a reduction in the high cost of social spending related to the impact of chronic diseases on youth and adults by targeting at-risk populations and focusing on NCD prevention.[11] The TC will also build on the on-going Regional NCDs Surveillance System TC (RG-T1276) (ATN/OC-10756-RG) which is working towards establishing the creation of a Caribbean regional NCDs surveillance system with standard reporting protocols. GoS is an active member in this regional TC.

III. Description of activities/components and budget

3.1 **Component 1. Operationalize the National Action Plan for the Prevention and Control of NCDs.** This component will finance consultant services to assist the MOH to operationalize the action plan by developing disease specific implementation plans, namely, cardiovascular diseases, diabetes, cancer and chronic respiratory diseases. A national multi-sectoral NCDs commission has been established which will provide technical oversight support for the TC and also engage directly with the private sector, including the food industry who will be encouraged to impose self-regulatory measures in terms of nutritional composition of processed foods, and advertising targeted to children. Also, private sector employers will be encouraged to motivate their employees to participate in physical activity, and sponsor exercise facilities.

3.2 **Component 2. NCDs Surveillance System.** This component will finance consultant services (i) to assist the MOH to strengthen its data collection and analysis capability as part the NCDs surveillance

---

[8] Strategic Plan of Action for the Prevention and Control of NCDs: For Countries of the Caribbean Community, 2011 and 2015 (CARICOM) and the Regional Strategy and Plan of Action on an Integrated Approach to the Prevention and Control of Chronic Diseases (PAHO; 2007).

[9] The Nassau Declaration (2001), the Declaration of Port of Spain (2009) and the Mexico Declaration (2011).

[10] Areas for Continued Strategic Dialogue. Country Strategy for Suriname 2011 to 2015.

[11] IDB Country Program Document. Indicative Pipeline, Page 5, Country Program Document, 2012.

system; and (ii) to advise on the reporting and operational requirements to establish CVD, Diabetes and Cancer Registries.

3.3 **Component 3. Public Information Campaign.** This component will finance the consultant services: (i) to design and start-up dissemination activities of a NCDs public campaign; and (ii) to developf disease specific guidelines/protocols for NCDs screening, prevention and control.

3.4 **Component 4. Integrated NCD approach in the Primary Health Care.** This component will finance consultant services to design and early start up activities for the integrated primary health care network model, including tools to help with the introduction of electronic medical records, which are important to help continuity of care.

3.5 **As part of component 4, a pilot program** will be structured incorporating the objectives and activities of components 3.3 and 3.4, in order to assess the early impacts of the interventions. In order to allow for the documentation of the results, a rapid assessment will be conducted in the early stages of the technical cooperation, following a rapid assessment protocol (Beran et al, 2010), and will be repeated in the beginning of the second year. This component will finance consultant services to carry out the following key activities of the pilot project: (i) the implementation of a training of trainers program; (ii) training of specialists; (iii) developing patient education materials; and (iv) organizing events similar to "national day of NCD awareness"; and others.

3.6 **Component 5. Health Sector Study.** This component will finance consultant services to carry out a study to identify whether the essential characteristics of primary care are in place to ensure there is continuity, coordination, and comprehensiveness of care. The study will also look at the elements of primary prevention that go beyond the health system, including, legislation on food product and tobacco taxation, programs to promote physical activity and accessibility of healthy, tasty foods.

Key Activities for Year 1 and 2

Component	Year 1 Key Activities	Year 2 Key Activities
Component 1 *Operationalize the National Action Plan*	(i) Develop NCD implementation plans for diabetes and chronic respiratory illnesses with disease-specific short and medium term targets; and (ii) Training in costing and forecasting NCD treatment and care (iii) training in M & E and NCD program management and (iv) Oncology focal point appointed	Develop NCD implementation plans for certain cancers and cardiovascular diseases with disease-specific short and medium term targets. Develop M & E Framework
Component 2 *NCD surveillance*	(i). review existing, NCD data collection systems throughout the health sector. (ii) modify and strengthen existing NCD data collection systems including hospital discharge registries and design new data collection systems where appropriate. (iii) develop NCDs and cancer registries. (iv) Increase capacity through training etc. for NCD surveillance. (v) Develop an M&E Plan.	(i) modify and strengthen existing NCD data collection systems and design new data collection systems where appropriate. (ii) Increase capacity through training etc. for NCD surveillance. (iii) Kick off Implementation of the M&E Plan.
Component 3 *Public Information Campaigns*	(i) Design concept for a targeted public awareness campaigns promoting a healthy life-style; (ii) Develop health provider pocket guidelines for screening of diabetes and hypertension (iii) training in social marketing and health promotion/education	Media firm contracted to design and manage public awareness campaign; public awareness campaign launched; Sample evaluation of the impact of the campaigns.
Component 4 *Design of Integrated NCDs Primary Healthcare Approach*	Develop a time phased, costed implementation/action plan to improve the quality and accessibility of NCDs services integrated in the Primary Health Care. Treatment care protocols developed for priority NCDs.	Kick off Implementation of the plan to improve the quality and accessibility of NCDs services integrated in the Primary Health Care. Kick off Pilot for a regional one-stop-shop for NCDs treatment.
Component 5 *Health Sector Study*	a. Identify study parameters b. Develop TOR for study	a. Contract consultant b. Complete study

Indicative Results Matrix

Component	Final Deliverable	Intermediate Milestones (if applicable)	Milestone date (if applicable)	Expected completion date
Operationalize NCDs Action Plan	Final Disease Specific Implementation Plans M & E plan developed and operational National policy on oncological screening, treatment and care developed	Presentation of plans at MOH as part of stakeholder workshop	12 months after TC signing	16 months after TC signing
NCD surveillance	Final NCD surveillance action plan Creation of NCDs and cancer registries	Training in chronic disease epidemiology: cancers, diabetes, CVD	12 months after signing of TC	20 months after signing of TC
Public Information Campaigns	Public Information Campaign launched and operating Disease specific Guidelines and protocols (especially for diabetes and hypertension) for screening, prevention and control of NCDS. Public Information material	Media firm contracted Draft guidelines Evaluation instruments for the assessment of health promotion campaigns	12 Months after TC signing	15 months after signing of TC
Design of Integrated NCDs Primary Healthcare Approach	Final model for integrated NCDs Public/Private sector approach Tools for Electronic Records One regional one-stop-shop NCDs treatment center established in Lelydorp district	Consultant contracted and draft model developed	18 months after signing of TC	24 months after signing of TC
Health Sector Study	Final Study reviewed and accepted by MOH	Consultant contracted and draft study completed	8 months after signing of TC	15 months after signing of TC

Output and Outcome Indicators

Indicators	Baseline	Intermediate Target		Final Target	Expected completion Date
Outcome indicator		**Year 1**	**Year 2**	**Year 2**	
% of providers that perceive their knowledge of treating NCDs has improved	**None**		**40%**	**60%**	24 Months after signing of TC
% of public health facilities are using the national guidelines for the prevention and treatments of diabetics and hypertension.	**None**		**45%**	**60%**	24 months after signing of TC
Deliverable (outputs) indicators					
M & E plan for NCDs prevention and control programs developed	**None**			1	24 months after signing TC
Disease registries established for all NCDs and cancers	**None**			**3 (Registries for CVD diseases, cancer and renal dialysis)**	20 months after signing of TC
Public Information campaign on a healthy lifestyle launched and operating	**None**			**1**	20 months after signing of TC

3.7 **Indicative Budget.** As outlined in the table below, the counterpart resources will be provided in cash and in general will fund logistic costs associated with each activity/component.

Indicative Budget

Activity/Component	IDB Funding ($US)	Counterpart ($US)	Total Funding
Component 1 - NCD disease specific implementation plans	60,000	20,000	80,000
Component 2 - NCDS Surveillance	100,000	30,000	130,000
Component 3 - Public Information Campaign and Pilot Program	150,000	50,000	200,000
Component 4 - Integrated NCDs primary healthcare model	60,000	20,000	80,000
Component 5 - Health Study	30,000	10,000	40,000
	Sub Total 100,000	30,000	130,000
Project Administration	76,000		
Final evaluation	12,000		
Financial audit	12,000		
	500,000	**160,000**	**660,000**

3.8 **The designated focal point** in CCB/CSU is Ian Ho-a-Shu, Senior Health Specialist who will also be responsible for project supervision.

3.9 **Monitoring and Evaluation.** At the technical level, the monitoring and evaluation (M & E) function will be part of the rapid assessment of the pilot program which will be conducted in the early stages of the TC, following a rapid assessment protocol and then repeated in the beginning of the second year. Some of the aspects of the intervention that will be assessed include: (i) the implementation of a training of trainers program; (ii) training of specialists; (iii) developing patient education materials; and (iv) organizing events similar to "national day of NCD awareness". The rapid assessment will be funded from TC resources. As part of Component 1, the TC will finance the design, implementation and attendant training for a M & E framework for NCDs program management.

3.10 At the project execution level, the Ministry of Health through its Policy Unit will monitor project execution in line with the deliverables set out in TC Results Matrix. In addition, the Bank will monitor and evaluate project progress as part of its project supervision support. As part of its execution reporting requirements, the PU will submit a number of key reports to the Bank, including: Semi-Annual Reports (due August 30th and February 28th respectively); Annual Operating Plan (Inclusive of Procurement Plan); Audited Financial Statements (Within 120 days following the closing of each fiscal year of the Executing Agency and within the disbursement period of the Financing); and Final Audited Financial Statement (Within 120 days following the date stipulated for the final disbursement of the Financing). A final project evaluation will be done at the closure of the project.

3.11 **Project Sustainability.** In order to assure the sustainability of the interventions, the study in component 3.6 will include a detailed projection of estimated costs generated by the burden of NCD's in the next twenty years. One typical concern about improved prevention and screening of NCD's is that the costs to the health system may increase in the very short run, as more patients are enrolled in prevention protocols and should receive medication as appropriate. However, such costs should be substantially lower than the long run burden of NCD's on the health system. Having the proper financial data to support the cost savings in the medium and long term is an essential tool to convince policy makers to invest in the prevention and management of NCD's.

IV. Executing agency and execution structure

4.1 A Projects Unit (PU) has already been established within the MOH and will have direct responsibility for execution of the TC. The PU has experience in managing projects, having successfully managed the IDB funded Health Sector facility Loan (SU-0028) (1537/OC-SU) and the JSF funded TC: Support for National Strategic Plan for HIV/AIDS (SU-T1007) (ATN/JO-9595-SU). The PU currently supervises a number of other MOH projects. The PU is under the supervision of the Director, Ministry of Health. Resources from this TC will finance a Project Coordinator and Administrative Assistant who will work with the PU team to oversee the execution of the TC. Other support personnel will come from MOH staff.

4.2 Appointed by the Office of the President of Suriname and comprising individuals from Government, Civil Society and the Private sector, a national multi-sectoral NCDs commission has been established which will provide high level technical and coordination oversight support for the TC; and through its influence will also engage directly with the private sector, including the food industry who will be encouraged to impose self-regulatory measures in terms of nutritional composition of processed foods, and advertising targeted to children.

4.3 The PU will be responsible for overall TC administration and oversight, including: (i) administering the resources of the TC, its implementation schedule and expenditure plan; (ii) preparing Terms of Reference and bidding documents; (iii) selection process and awarding of contracts; (iv) administrating and monitoring contracts' execution and compliance with contractual obligations; (v) prepare and submit disbursement requests to the IDB and the corresponding justification of expenses; and (vi) reporting on the financial execution of the project and the achievement of the targets set out in the project Results Matrix.

V. Major issues

5.1 The main potential risks to the TC are the coordination challenges associated with multi-sectoral collaboration, which may affect overall TC implementation. To address this risk, a social communication strategy will be included as part of Component 3. In addition, the NCDs National Commission through its multi- sector composition and influence is expected to facilitate cohesive coordination among stakeholders.

VI. Exceptions to Bank policy

6.1 N/A

VII. Environmental and Social Strategy

7.1 The proposed TC has no environmental impact, given that its activities are mainly of an advisory nature. The long term impact on poor and vulnerable groups should be positive given its focus on improving the efficiency of health care delivery and providing a strategic framework in which NCDs and sector interventions can be prioritized in a transparent manner (See safeguard reports).

Annexes:

- Letter of request
- Procurement Plan
- Terms of Reference

SUPPORT FOR PREVENTION AND CONTROL OF NCDs

SU-T1062

CERTIFICACIÓN

Por la presente certifico que esta cooperación técnica fue aprobada para financiamiento por el Fondo Especial del Japón (JSF) en fecha 1 de noviembre de 2012, conforme a la comunicación subscrita por el señor Yasushi Kinoshita, Director General de la Oficina Internacional del Ministerio de Finanzas de Japón. Igualmente, certifico que existen recursos disponibles en el Fondo Especial del Japón (JSF), hasta la suma de US$500,000 para financiar las actividades descritas y presupuestadas en este documento. La reserva de recursos representada por esta certificación es válida por un periodo de cuatro (4) meses calendario contados a partir de la fecha de elegibilidad. Si el proyecto no fuese aprobado por el BID dentro de ese plazo, los fondos reservados se considerarán liberados de compromiso, requiriéndose la firma de una nueva certificación para que se renueve la reserva anterior. El compromiso y desembolso de los recursos correspondientes a esta certificación sólo debe ser efectuado por el Banco en dólares norteamericanos. Esta misma moneda será utilizada para estipular la remuneración y pagos a consultores, a excepción de los pagos a consultores locales que trabajen en su propio país, quienes recibirán su remuneración y pagos contratados en la moneda de ese país. No se podrá destinar ningún recurso del Fondo para cubrir sumas superiores al monto certificado para la implementación de esta operación. Montos superiores al certificado pueden originarse de compromisos estipulados en contratos que sean denominados en una moneda diferente a la moneda del Fondo, lo cual puede resultar en diferencias cambiarias de conversión de monedas sobre las cuales el Fondo no asume riesgo alguno.