TC DOCUMENT

I. BASIC INFORMATION

Country:	Republic of Suriname
TC Name/Number:	Support for Active Malaria Case Detection Program/ SU-T1072
Associated Loan/Guarantee Name and number:	N/A
Team Leader/Members:	Ian Ho-a-Shu (SPH/CSU) Team Leader; Tiphani Burrell-Piggott (SPH/CTT); Lucas Hoepel (CCB/CSU); Mariska Tjon a Loi (PDP/CSU); Rinia Terborg-Tel (FMP/CSU); Javier Bedoya (LEG/SGO); and Martha Guerra (SCL/SPH).
Date of TC Abstract authorization:	February 2014
Donors providing funding:	Japan Special Fund (JSF)
Beneficiary	Republic of Suriname
Executing Agency and contact name	Ministry of Health; Dr Marthelise Eersel, Director of Health
IDB Funding Requested:	$400,541
Local counterpart funding, if any:	$250,000
Disbursement period (which includes Execution period):	15 months (execution period: 12 months)
Required start date:	14 April 2014
Types of consultants:	Firms and Individuals
Prepared by Division:	SPH/CSU
Unit of Disbursement Responsibility:	CCB/CSU
TC Included in Country Strategy (y/n):	No[1]
TC included in CPD (y/n):	Yes
GCI-9 Sector Priority:	Yes. (i) The TC is aligned with the Ninth General Capital Increase (IDB-9 [CA-511]) strategic priority which focuses on the special needs of the less developed and small countries.

II. OBJECTIVES AND JUSTIFICATION OF THE TC

2.1 General objective: This TC is to support the Ministry of Health (MOH) in its efforts to eradicate malaria in the small gold mining areas of the Suriname Interior, the geographical focus of the TC is on the high risk small gold mining areas which are concentrated in the eastern Marowijne region of the Suriname Interior. **The specific objectives** of the TC are to: (i) Strengthen the health system to provide malaria treatment services in the gold mining areas; (ii) Provide and create a common space for the use of rapid diagnosis and prompt adequate treatment for the gold miners; and (iii) Selective Vector control in the gold mining areas.

[1] While the TC is not included in the current Country Strategy (CS), the health sector has been identified as priority sector in the current CS.

2.2 **Small-scale Gold Mining Areas.** The current rapid growth of small-scale gold mining as well as increasing mobile population has promoted the spread of malaria in the Suriname interior. Malaria flourishes in small-scale gold mining areas because: (i) Mining activity creates large puddles of standing water, which is conducive to mosquito breeding; and (2) Mining workers are highly mobile, and this movement encourages disease spread. The small-scale gold mining areas are largely concentrated in the Eastern forested areas of Suriname and at present, an estimated 13,000 small-scale miners are mining for gold in these areas.[2] In addition, gold miners who work in these isolated places, far removed from health posts, tend to take malaria medication in the context of suspected malaria infection. However, this self-diagnosis/self-medication often occurs in the absence of professional medical oversight and is devoid of proper testing, diagnosis, or treatment guidelines. Therefore, effective treatment is compromised.

2.3 **Target Group: Gold Miners.** While malaria has mostly been contained within Suriname Interior villages, small-scale mining areas remain sources of disease transmission.[3] Malaria cases are no longer being reported predominantly in the Interior village communities, but almost all cases originate from gold mining areas. In previous malaria campaigns, it was difficult to infiltrate gold miners with public health messages and interventions because travel to the mining areas is difficult, and because the population consists largely of migrants who do not speak the local languages. There are also Medical Mission health centers, which have wide area coverage, but are often out of reach of gold miners. Therefore, the community that is considered most at-risk is the mining population. The challenge is to further reduce malaria by expanding on strategies that were successful in the key affected areas and populations. This requires a deep understanding of transmission dynamics which will inform the effective interventions.[4]

2.4 **Searching for gold, finding malaria.** In 2011, the MOH of Suriname with financial support and technical guidance from the Global Fund began executing its "Searching for gold, finding malaria" anti-malaria project which targets small-scale gold mining areas as the remaining point sources of malaria transmission in the Suriname interior. The main project activities are testing/treatment of the gold miners; a public awareness campaign; and the free distribution of Insecticide Treated bed nets. The main project goal is to reduce morbidity in gold mining areas by at least 70% in the next five years.

2.5 **Maintaining Project Momentum.** The **Searching for gold, finding malaria** anti-malaria project is now faced with a budget shortfall and the MOH with the endorsement of the Global Fund has requested funding in the sum of US$400,541 to successfully complete key project activities as outlined in Section III, which includes the training of Malaria Service Deliverers (MSDs), conducting updated surveys/research and the design/implementation of a behavioral change communication program targeted to the gold miners. The TC funding will allow the Ministry under the technical supervision of the Global Fund[5] to maintain

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[2] Searching for gold, finding malaria. Baseline Study in three small-scale gold mining areas in the Suriname Interior. Heemskerk, M. June 2010.

[3] Recommendation for Active Case Detection, PAHO. Suriname. 2012.

[4] Malaria in Suriname: a New Era, Hélène Hiwat – Van Laar, 2011.

[5] Global fund will assist the PU to plan, monitor and coordinate activities by providing expert advice and practical experience in helping the PU and other in-country malaria stakeholders (including the Medical Mission, the

project momentum, facilitate smooth project wrap up and provide the Ministry with key technical inputs to prepare a new proposal for a wider regional Global Fund Malaria project (Suriname, Brazil and Guyana) which is expected to be approved by 4th quarter 2014.

2.6 **Public Health Priority.** Although the MOH has made significant efforts to bring reliable diagnosis and effective treatment to these remote areas through the establishment of the MSDs system,[6] some emerging gold mining areas are not yet afforded these services. These gold mining areas, which have no proper access to malaria diagnosis/treatment, can only be reached through the strategy of Active Case Detection (ACD). The strategy of ACD attempts to identify and treat symptomatic cases as well as cases of asymptomatic malaria and gametocyte carriers, which, if untreated, continue to transmit the infection. With continuously expanding gold mining areas (due to an increase in the price of gold), the gold mining population that is at risk of acquiring malaria, continues to expand.

2.7 **Intensify Screening.** As part of the ACD, the MOH wishes to increase the number of individuals screened for malaria. Providing access to effective malaria diagnosis/treatment may discourage the use of self-diagnosis/self-medication and increase the likelihood of accurate diagnosis/treatment with appropriate medication and professional medical guidance. Proper malaria treatment will also reduce the incidence of anti-malarial drug resistance, which is a major barrier to effective malaria control.

2.8 **Difficult Access.** The particular conditions in small-scale gold mining areas in the Interior complicate the eradication of malaria. Access to these areas is complicated due to their geographic isolation, and language barriers. In the interior, access to public services is limited. Most mining areas are not connected to roads, have little access to a reliable source of drinking water and electricity, do not receive national radio and TV, and lack adequate sanitary facilities. Also educational and medical services in these isolated areas remain far below national and international standards.

2.9 **Country Strategy (CS) and IDB-9.** The TC is consistent 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[7] for Suriname. In addition, the TC is aligned with the Ninth General Capital Increase (IDB-9 [CA-511]) strategic priority, which focuses on the special needs of the less developed and small countries.

2.10 **Country Programming.** As set out on in the **2014 Technical Cooperation Pipeline Projects** on page 3 of the signed Aide Memoire for the Portfolio Review and Programming Mission of September 2013, Government and the Bank agreed[8] to the TC funding of the malaria detection and treatment project targeted towards the goal miners. See The Portfolio Review and Programming Mission Aide Memoire.

MOH and the MSDs) to monitor inputs and outcomes, progress towards goals, and how to execute the TC in a collaborative manner. The Global Fund and the IDB will convene a minimum of 3 meetings over the execution period of the TC to discuss and streamline coordination issues.

6 Searching for gold, finding malaria. Baseline Study in three small-scale gold mining areas in the Suriname Interior. Heemskerk, M. June 2010.

7 Areas for Continued Strategic Dialogue. Country Strategy for Suriname 2011 to 2015.

8 The TC is included in the 2014 Country Programming Document for Suriname

III. DESCRIPTION OF ACTIVITIES

3.1 **Component 1. Training of Malaria Service Deliverers (MSDs) in diagnosis, treatment, prevention and Long-lasting Insecticidal Nets (LLINs) in gold mining areas.** The MOH as part of its active case detection efforts deployed MSDs; essentially, persons who have received training in malaria diagnosis and treatment, and can provide these services to the target gold mining population in their location. Further, diagnosis and treatment are provided to the gold miners who require it the most. The TC will fund the training of an additional 2,000 MSDs. The gold mining areas are visited by MSDs, who assess and report the incidence of malaria in the specific location. The MSDs are local persons who are trained by medical practitioners of the Malaria Control Program of Suriname (MCP). Training is conducted in a workshop setting at the Medical Mission Health Posts in the Interior under the supervision of the MCP. MSDs are trained in diagnosis, treatment, assessment, and reporting of malaria and provide free services in the remote areas. The intervention of the MSDs is critical to treating and preventing malaria in these remote areas and it is important that the training of the MSDs be continued in order to widen treatment coverage.

3.2 **Component 2. Active Case Detection (ACD) and Rapid Diagnostic Tests (RDT).** The use of ACD and RDT will improve the diagnosis and treatment of malaria in these remote areas. The TC will fund the logistical costs associated with carrying out and reporting on the ACD in these remote mining communities.

3.3 **Component 3. Distribution of Long-Lasting Mosquito Insecticidal Nets (LLINS) to gold miners.** The TC will fund the purchase/distribution of LLINS to the gold miners. While the mining areas are mainly located in remote areas that are difficult to access, a number of temporary check points have been established in these areas where miners normally access to stock up on basic goods. These check points will be used as LLINS distribution areas.

3.4 **Component 4. Updated Studies/Surveys and focused Behavior Change Communication (BCC) campaigns.** The TC will fund health and demographic surveys to capture population and epidemiological changes, which will be useful to establish targets, assign priorities and refine the approach to treating malaria in the target communities. The studies/surveys will be done in coordination with Component 1 to ensure that the results of the studies inform the scope, timing and relevance of the training for the MSDs.

3.5 The studies/surveys will be conducted at 3 distinct stages: (i) prior to the MSD intervention in order to measure baseline Malaria rates and to also inform the general scope and format for the training of the MSDs; (ii) 3 months after the onset of the MSD intervention to measure rapid impact of the MSD intervention; and (iii) at end of 12 months as part of an overall assessment of the impact of the MSDs.

3.6 **Communication Campaign.** This component includes a communication campaign to promote awareness among the miners with respect to seeking proper malaria treatment interventions. To be effective, the communication campaign will be delivered in the local dialect languages common to the gold mining areas.

IV. RESULTS MATRIX

Component	Final Deliverable	Intermediate Milestone (if applicable)	Expected completion date
Training of Malaria Service Deliverers (MSDs)	2000 MSDs trained	500 trained by 2nd quarter 2014	December 2014
Active Case Detection (ACD)	Number of exposed population reached by ACD in target locations	TBD based on existing trend and expected increase of available resources	November 2014
	M&E framework		December 2014
Long-Lasting Insecticidal Nets (LLINs)	15,000 treated bed nets distributed by November 2014	5,000 treated bed nets distributed by 3rd quarter of 2014	November 2014
Behavior Change Communications (BCC)	20,000 people reached with effective malaria prevention and control/ health promotion messages	10,000 people reached with effective malaria prevention and control/ health promotion messages	November 2014
Updated Survey/Studies	Updated epidemiological profile		3rd quarter-2014

V. INDICATIVE BUDGET

5.1 As outlined in the table below, the counterpart resources will be provided in kind. The counterpart contribution under Component 3 will fund the purchase of 8,000[9] LLINS and six ATVs (All Terrain Vehicles)[10] vehicles which are required to transport the LLINS into the mining areas. The contribution of Components 1, 2 and 3 and Project Administration covers essentially, MOH staff time and associated logistic costs.

Indicative Budget

Activity/Component	IDB Funding ($US)	Counterpart resources	Total
Component 1 - Training of MSDs	79,870	30,000	109,870
Component 2 – Active Case Detection and increased reporting capabilities	90,096	40,000	130,096
Component 3 – Distribution of LLINS	35,000	100,000	135,000
Component 4 - Updated Studies/Surveys, BCC public awareness campaign	95,425	30,000	125,425
Component 5 - Project Administration	80,150	50,000	130,150
- Staff Costs	50,000	-	
- Audit	5750	-	
- Final Evaluation and M & E	10,000	-	
- Office Expenses	6,000	-	
- Repairs and Maintenance	8,400	-	
Component 6 - Contingency	20,000	-	20,000
Total	**400,541**	**250,000**	**650,541**

5.2 The detailed budget is enclosed.

[9] Estimated unit cost of the LLIN is US$5.00.
[10] Estimated unit cost of the required ATV is US$10,000

5.3 **The designated focal point in CCB/CSU** for project supervision is Ian Ho-a-Shu. (SPH/CSU).

5.4 **Monitoring Project Progress.** At the project execution level, the MOH through its Projects Unit (PU) will monitor project execution in line with the TC Results Matrix. The Bank will monitor and evaluate project progress as part of its project supervision. 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); a Final Audited Financial Statement submission (Within 120 days following the date stipulated for the final disbursement of the Financing). A project evaluation will be performed at the closure of the project. The IDB or the PU will contract independent auditors to carry out the ex-post reviews of procurement processes and of supporting documentation for disbursements. Ex post reviews will include an analysis of the Financial Statements that the EA should prepare annually as part of its financial management. The costs associated with this contract will be financed with the IDB resources according to IDB procedures.

5.5 **Monitoring and Evaluation Framework.** The TC will support the development of a monitoring and evaluation framework to measure the impact of the TC. Key malaria control indicators of the M & E framework will include: See Malaria Control Indicators

5.6 **Project Innovation.** The malaria reporting and surveillance system established around the cadre of MSDs who will act as early warning notification points is a unique innovative mechanism of this project. This approach allows the MOH to address case management as the malaria transmission shifts from the stable village communities to the mobile gold mining communities.

5.7 **Project Sustainability.** The training of additional MSDs and the resultant increase coverage in early warning malaria notification points, the foundation elements of a sustained and aggressive method of addressing malaria in remote mining communities.The Ministry is also in dialogue with French Guiana on how best to replicate the above interventions along the French Guiana border.

VI. EXECUTING AGENCY AND EXECUTION STRUCTURE

6.1 **A Projects Unit (PU)** has already been established within the MOH and will execute the TC.The PU has experience in managing internationally funded projects, having successfully managed the Global Fund Malaria project. The PU reports to the Director, MOH. TC resources will finance a Financial Assistant 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. The Global fund will assist the PU to plan, monitor and coordinate activities by providing expert advice and practical experience in helping the PU and other in-country malaria stakeholders (including the Medical Mission, the MOH and the MSDs) to monitor inputs and outcomes, progress towards goals, and how to execute the TC in a collaborative manner. In that sense, the MOH and the Global Fund will sign a cooperation agreement to reflect the assistance aforementioned. The signature of this agreement will be established as a special condition of execution of this operation.

The Global Fund and the IDB will convene a minimum of three meetings over the execution period of the TC to discuss and streamline any coordination issues.

6.2 **Project Administration.** The PU will be responsible for: (i) managing TC resources, its implementation schedule and expenditure plan; (ii) preparing Terms of Reference and bidding documents; (iii) selection process and awarding of contracts; (iv) managing contracts' execution; (v) preparing disbursement requests to the IDB; and (vi) reporting on the financial execution of the project and the achievement of the targets set out in the Results Matrix. The PU shall take as reference to estimate in kind contributions for goods and services, the market price of the purchased goods and to estimate the value of personnel, the base salary of the employee. The PU will establish and will be responsible for maintaining adequate accounts of its finances, internal controls, and project files according to the financial management policies of the IDB. TC funds will be available for the purchase of an off-the-shelf- accounting-package.

6.3 **Procurement Policies.** The procurement of works and goods and the contracting of consulting services under the TC will be carried out according to the Bank's policies and procedures set forth in documents GN-2349-9 and GN-2350-9, respectively.

VII. MAJOR ISSUES

7.1 **The constant mobility of the small-scale gold miners** is the key implementation risk. The main foci of malaria transmission are related to mining activity. Malaria cases are highly related to population movement and mining activities, coupled with being in a remote location and lack of access to health services. This risk will be mitigated by providing malaria diagnosis, treatment, mainly through the deployment of MSDs.

VIII. EXCEPTIONS TO BANK POLICY

8.1 N/A

IX. ENVIRONMENTAL AND SOCIAL STRATEGY

9.1 The safeguard policy filter report categorized the TC as a "C" project indicating that this component's net environmental and social impacts are likely to be positive for those beneficiaries which will have increased access to health treatment (See ESR filters).

ANNEXES:

- Letter of Request
- Terms of Reference
- Procurement Plan

SUPPORT FOR ACTIVE MALARIA CASE DETECTION PROGRAM

SU-T1072

CERTIFICATION

I hereby certify that this operation was approved for financing under the Japan Special Fund (JSF) through a communication dated February 3, 2014 and signed by Tatsuo Yamasaki, Director-General, International Bureau, Ministry of Finance of Japan. Also, I certify that resources from the Japan Special Fund (JSF) are available for up to US$400,541 in order to finance the activities described and budgeted in this document. This certification reserves resources for the referenced project for a period of four (4) calendar months counted from the date of eligibility from the funding source. If the project is not approved by the IDB within that period, the reserve of resources will be cancelled, except in the case a new certification is granted. The commitment and disbursement of these resources shall be made only by the Bank in US dollars. The same currency shall be used to stipulate the remuneration and payments to consultants, except in the case of local consultants working in their own borrowing member country who shall have their remuneration defined and paid in the currency of such country. No resources of the Fund shall be made available to cover amounts greater than the amount certified herein above for the implementation of this operation. Amounts greater than the certified amount may arise from commitments on contracts denominated in a currency other than the Fund currency, resulting in currency exchange rate differences, for which the Fund is not at risk.

(Original signed)	04/14/2014
Sonia M. Rivera Chief Grants and Cofinancing Management Unit ORP/GCM	Date

APPROVAL

Approved:

(Original signed)	04/15/2014
Ferdinando Regalia Division Chief Social Protection and Health Division SPH/CSU	Date