Board of Executive Directors

For consideration

On or after 7 January 2015*

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Simultaneous Disclosure

To: The Executive Directors

From: The Secretary

Subject: Brazil. Proposal for a loan for the "Program to Strengthen the Unified Health System in São Bernardo do Campo"

Basic Information:

Loan type .....Specific Investment Operation (ESP)

Borrower..... Município of São Bernardo do Campo

Amount ..... up to US$80,050,000

Source .....Ordinary Capital

Inquiries to: Marcia Rocha (telephone Country Office in Brazil 5561-3317-4265) or Francisco Ochoa (telephone Country Office in Brazil 5561-3317-4105)

Remarks: This operation is not included in Annex I of document GN-2756-2, "2014 Operational Program Report. Update", approved by the Board of Executive Directors on 30 July 2014. Therefore, it does not qualify for approval by Simplified Procedure.

Reference: GN-1838-1(7/94), DR-398-14(6/13), GN-2756-2(6/14)

* This term is in accordance with the information contained in document CS-4040, concerning the interruption of advance-distribution periods for documents.

PUBLIC
SIMULTANEOUS DISCLOSURE

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

BRAZIL

PROGRAM TO STRENGTHEN THE UNIFIED HEALTH SYSTEM IN SÃO BERNARDO DO CAMPO

(BR-L1415)

LOAN PROPOSAL

This document was prepared by the project team consisting of: Marcia Rocha (SPH/CBR), Project Team Leader; Pablo Ibarrarán (SCL/SPH); Rita Sório (SPH/CUR); Francisco Ochoa (SPH/CBR); Marília Santos (FMP/CBR); Leíse Estevanato (FMP/CBR); Krysia Ávila (LEG/SGO); José Luis de la Bastida (VPS/ESG); and Martha Guerra (SCL/SPH).

CONTENTS

ANNEXES	
Annex I	Development Effectiveness Matrix (DEM) – Summary
Annex II	Results Matrix
Annex III	Fiduciary Agreements and Requirements

ELECTRONIC LINKS

REQUIRED

1. Project execution plan (PEP)
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=39173352
2. Monitoring and evaluation plan
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=39173911
3. Full procurement plan
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=39173337
4. Environmental and social management report
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=39173794

OPTIONAL

1. Urgent and emergency care networks in São Bernardo do Campo
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=39173608
2. Study of the maternal and child health network in São Bernardo do Campo
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=39172459
3. Profile of the polyclinics
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=39172471
4. Profile of the Urgent Care Hospital
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=39172478
5. Profile of the Women's Hospital
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=39172487
6. Risk management
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=39172778
7. Institutional capacity analysis
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=39173371
8. Economic analysis
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=39173894
9. Safeguard policy filter report and safeguard screening form
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=39229719

ABBREVIATIONS

ACS	Agente comunitário de saúde [community health care worker]
AWP	Annual work plan
CNCDs	Chronic noncommunicable diseases
CNES	Cadastro Nacional de Estabelecimentos de Saúde [National Register of Health Facilities]
CRC	Central de Regulação [Regulation Center]
DATASUS	Departamento de Informática do SUS [SUS Information Technology Department]
IBGE	Instituto Brasileiro de Geografía e Estatística [Brazilian Institute of Geography and Statistics]
PAHO	Pan American Health Organization
POR	Program Operating Regulations
PRM	Project risk management
PSF	Programa Saúde da Família [Family Health Program]
RAA	Relatório de avaliação ambiental [environmental assessment report]
RAS	Rede de Atenção à Saúde [Health Care Network]
SBC	São Bernardo do Campo
SEADE	Sistema Estadual de Análise de Dados [State Data Analysis System]
SMS	Secretaria Municipal de Saúde de São Bernardo do Campo [São Bernardo do Campo Municipal Health Department]
SUS	Sistema Único de Saúde [Unified Health System]
TCE/SP	Tribunal de Contas do Estado de São Paulo [State of São Paulo Audit Office]
UCH	Urgent Care Hospital
WHO	World Health Organization

PROJECT SUMMARY

BRAZIL
PROGRAM TO STRENGTHEN THE UNIFIED HEALTH SYSTEM IN SÃO BERNARDO DO CAMPO
(BR-L1415)

<table>
<tr><th colspan="4">Financial Terms and Conditions</th></tr>
<tr><td colspan="2" rowspan="5">Borrower: Município of São Bernardo do Campo
Guarantor: Federative Republic of Brazil
Executing agency: Município of São Bernardo do Campo, acting through its Municipal Health Department (SMS)</td><td colspan="2">Flexible Financing Facility*</td></tr>
<tr><td>Amortization period:</td><td>25 years</td></tr>
<tr><td>Original WAL:</td><td>15.25 years</td></tr>
<tr><td>Disbursement period:</td><td>5 years</td></tr>
<tr><td>Grace period:</td><td>5.5 years</td></tr>
<tr><td>Source</td><td>Amount</td><td>Interest rate:</td><td>LIBOR-based</td></tr>
<tr><td>IDB (OC)</td><td>US$ 80,050,000</td><td>Inspection and supervision fee:</td><td>**</td></tr>
<tr><td>Local</td><td>US$ 80,050,000</td><td>Credit fee:</td><td>**</td></tr>
<tr><td>Total</td><td>US$160,100,000</td><td>Currency:</td><td>U.S. dollars from the Bank’s Ordinary Capital (OC)</td></tr>
<tr><th colspan="4">Project at a Glance</th></tr>
<tr><td colspan="4">Project objective: The principal objective of the program is to improve the health conditions of the population of São Bernardo do Campo (SBC). This objective is expected to be met through expanded access to medium- and high-complexity services in the município and an improvement in their quality, integrating them with the primary care level, thus consolidating the health care networks (RAS) model of care in the município.</td></tr>
<tr><td colspan="4">Special contractual conditions:

Precedent to the first disbursement: The following activities will be conditions precedent to the first disbursement: (i) publication in the SBC official gazette of the decree creating the program management unit (PMU) and appointing its coordinators; (ii) Bank approval of the terms of reference for individual consultants to support program management; and (iii) submission of the program Operating Regulations on the terms previously agreed upon with the Bank (see paragraph 3.3).

Execution: (i) evidence of entry into force of the program Operating Regulations, on the terms agreed upon with the Bank, within 90 days after the loan contract signature date; (ii) evidence that a computerized financial management system for the program is up and running, within nine months after the loan contract signature date; and (iii) compliance with the programs, requirements, and guidelines established in the environmental and social management plan (ESMP) and environmental assessment report (RAA) during the project disbursement period (see paragraph 3.4).</td></tr>
<tr><td colspan="4">Exceptions to Bank policy: None.</td></tr>
<tr><td colspan="4">Project qualifies as: SEQ [X] PTI [X] Sector [X] Geographic [ ] Headcount [X]</td></tr>
</table>

* Under the Flexible Financing Facility (document FN-655-1), the borrower has the option of requesting changes to the amortization schedule, as well as currency and interest rate conversions, subject in all cases to the final amortization date and the original weighted average life (WAL). The Bank will take market conditions as well as operational and risk management considerations into account when reviewing such requests.

** The credit fee and inspection and supervision fee will be established periodically by the Board of Executive Directors as part of its review of the Bank’s lending charges, in accordance with the applicable policies.

I. DESCRIPTION AND RESULTS MONITORING

A. Background, problems to be addressed, and rationale

1.1 **Health conditions in São Bernardo do Campo.** The Município of São Bernardo do Campo (SBC) is the fourth largest in the state of São Paulo. It is part of "Grande ABC,"[1] a subregion of the Metropolitan Region of São Paulo that has the fourth highest GDP in the country. The estimated population of SBC is 776,884 (Brazilian Institute of Geography and Statistics (IBGE), 2012), the majority urban (98%). Although SBC's score on the Human Development Index is higher than the averages for São Paulo state and the country as a whole (0.805),[2] 11.4% of the population lives in highly vulnerable conditions,[3] well above the average for the state (4.4%).[4] Around 60% of SBC's population uses the Sistema Único de Saúde [Unified Health System] (SUS) exclusively, and this proportion rises significantly in areas of high vulnerability to near 80%. The município is also at an advanced stage of demographic transition, meaning that there is a growing need to provide health care to the over-60s (who are expected to increase from 12% of the population in 2012 to near 20% in 2030),[5] and there is a need to address the growing burden of chronic noncommunicable diseases (CNCDs) through promotion, prevention, and ongoing treatment.

1.2 **Epidemiological profile.** SBC's epidemiological profile is similar to the one seen at the national and state levels with a marked prevalence of CNCDs, which, in an urban context with an aging population, account for more than half of deaths among residents.[6] The World Economic Forum projects that the growing burden of CNCDs will create economic costs for Brazil of approximately 0.5% of GDP per year in the coming decades.[7] Other projections put the annual cost to Brazil for

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1 The population of the ABC region of São Paulo is 2,546,135. The name comes from the original three constituent municípios: Santo André, São Bernardo do Campo, and São Caetano. The municípios of Diadema, Mauá, Ribeirão Pires, and Rio Grande da Serra were subsequently incorporated.

2 United Nations Development Programme (UNDP), 2010.

3 São Paulo Social Vulnerability Index (IPVS), 2010, produced by the SEADE Foundation. The IPVS is computed at the municipal level and has two main dimensions: socioeconomic (measuring the per capita income of the household and of women and literacy) and demographic (age structure and dependency ratio). See http://www.iprsipvs.seade.gov.br/view/pdf/ipvs/metodologia.pdf.

4 For more information regarding the cause-and-effect relationship between vulnerability and health, see "Macroeconomía y salud: Invertir en salud en pro del desarrollo económico" [Macroeconomics and health: investing in health for economic development], World Health Organization (WHO), 2001, p. 25.

5 State Data Analysis System (SEADE).

6 WHO (2014), Noncommunicable diseases: 2014 country profiles. Available at http://www.who.int/nmh/countries/en/.

7 Bloom D.E., Cafiero, et al. *The global economic burden of noncommunicable diseases*. Geneva. World Economic Forum, 2011.

treatment and lost productivity due to the five main CNCDs at US$72 billion.[8] In SBC, cardiovascular disease in particular is of growing significance. It is the main cause of death for both men and women, and the main cause of hospitalization among those under age 60.[9] In 2012, 31% of deaths in the município were caused by cardiovascular complications, followed by tumors (20%), respiratory disease (12%), and external causes (accidents and homicides, 9%). The deterioration in these indicators in recent decades, affecting progressively younger age groups, is a central issue for public health. This is particularly the case in the metropolitan context, where there has been a significant increase in risk factors such as obesity, smoking, and alcohol consumption.[10] There is ample evidence that risk factors lead to physiological and metabolic changes that contribute significantly to the incidence and burden of CNCDs. There is also evidence of the importance of taking gender factors into account in strategies to combat CNCDs. Biological differences and gender roles create differences in access to and use of health services by men and women, as well as different behaviors with respect to self-care. These differences affect both the incidence of CNCDs and their nature and consequences. Determining effective treatments for CNCDs in men and women requires health systems to have the capacity to analyze gender determinants and the different risk factors associated with them.[11]

1.3 Another health challenge in SBC, common in metropolitan areas, involves the recent increase in mortality and morbidity due to external causes, mainly accidents (particularly traffic) and events resulting from acts of violence. As in the rest of the country,[12] external causes are the main cause of death in the SBC population under age 39, leading to 67% of deaths in the 20-29 age group in 2013 (DATASUS). The social and economic impact of premature mortality due to external causes is

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[8] The five main CNCDs are cardiovascular diseases, cancer, chronic respiratory diseases, diabetes, and mental health problems. Fuster, V., and B.B. Kelly (Eds.), 2010. *Promoting cardiovascular health in the developing world: a critical challenge to achieve global health*. Washington, D.C.: The National Academies Press.

[9] Source: Mortality Information System, SUS Information Technology Department (DATASUS).

[10] The VIGITEL national telephone survey for risk factor surveillance confirms the prevalence of hypertension (22.5%) and diabetes (5.9%) among the São Paulo population over age 18. Ministry of Health, 2012.

[11] WHO (2009). "Global health risks: mortality and burden of disease attributable to selected major risks;" Schramm, J., et al. "Gender inequalities in noncommunicable disease mortality in Brazil." Stevens, A., et al. Ciência & Saúde Coletiva, 2012, Vol. 17(10), p. 2627; Barker, Gary, Christine Ricardo, and Marcos Nascimento. 2007. "Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions." WHO, Geneva, 2007; Pathania, V.S. "Women and the smoking epidemic: Turning the tide." 2011. Bulletin of the World Health Organization 89:162-162; DeVon H.A., et al. "Symptoms across the continuum of acute coronary syndromes: differences between women and men." 2008. American Journal of Critical Care.

[12] External causes are the primary cause of death for those aged between 1 and 39 in Brazil, with a cost of almost 5% of GDP (Reinchenheim et al., 2011).

significant. The economic cost of life lost in SBC due to external causes (using the indicator of potential years of life lost) is more than US$1 billion per year.[13]

1.4 Child mortality in SBC is on a clear trend downward, from 15.99 deaths per 1,000 live births in 2000 to 9.51 in 2012. This puts SBC below the averages for both Brazil as a whole (13 deaths per 1,000 live births in 2012) and São Paulo state (11.48 in the same year) and (DATASUS). Despite this progress, 54% of child deaths from 2012 to 2013 were from avoidable causes,[14] which are closely related to the quality and timeliness of health care. For example, 62% of child mortality stemmed from the infant mortality component.[15] Of the latter, occurrences in the perinatal period accounted for 53% of deaths, pointing to weaknesses in care during delivery and in the neonatal and postpartum periods, as well as transmission as a result of inadequate hygiene practices.

1.5 Maternal mortality in SBC has not changed in recent years. However, from 2000 to 2009 the average maternal mortality rate in the município was twice that of the Grande ABC area.[16] Although the percentage of pregnant women attending seven or more prenatal checkups rose from 64% to 75% between 2006 and 2012, the high number of caesarean births in recent years is cause for concern. The rate reached 61% in 2012—far above recommended levels (15% according to the WHO)—creating inefficiencies and unnecessary risks for both mothers and newborns. The proportion of live births to mothers under 18 years of age is high, averaging 27% from 2006 to 2012,[17] which partly explains the 50% increase in premature births (less than 37 weeks of gestation).

1.6 **Brazil's Sistema Único de Saúde [Unified Health System] (SUS)** was created under the 1988 Federal Constitution, with associated regulations introduced in 1990. It is based on the principle of universal and equitable access to health promotion, protection, and recovery services, integrated within a regionally based, hierarchical network for service delivery. Responsibility for the network and its financing is shared among the federal, state, and municipal levels of government, supplemented by private sector involvement. The Ministry of Health is the lead agency for policy, and sets guidelines for the SUS. The states promote integration of services between regions and act as supplemental health care providers. The

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[13] Pimenta, M. "Estudo sobre a rede de urgência e emergência do Município de São Bernardo do Campo" [Study of the urgent and emergency care network in the Município of São Bernardo do Campo].

[14] List of deaths from avoidable causes by intervention within the SUS. SEADE Foundation, São Paulo, 2007.

[15] There are two main components within the child mortality rate: the neonatal mortality rate (0-27 days old) and post-neonatal mortality (28 days and over).

[16] The main causes of maternal deaths in SBC are related to cardiovascular complications.

[17] The rate in SBC is almost as high as in regions with a high prevalence of this problem, such as Western and Central Africa. United Nations Population Fund, 2013.

municípios deliver services directly to the population, and are solely responsible for primary health care services.[18]

1.7 **Organization of the SUS in São Bernardo do Campo, and the challenge of implementing a care model tailored to the município's epidemiological profile.** In recent years, the SUS has emphasized health care networks (known by their Portuguese-language acronym, RAS) as a model for the organization of services to meet the challenges of the advanced epidemiological transition. The RAS are organizational arrangements for health care actions and services of varying complexity, integrated through technical and logistical support systems seeking to improve spending efficiency and ensure comprehensive health care. The RAS model identifies primary health care services as the gateway to the system and as a method of structuring care, which has shown positive results in the case of the Family Health Program (PSF).[19] International evidence shows that to address the risk factors that cause CNCDs and treat patients already suffering from a chronic condition, the best alternative is to provide care through solid, integrated networks (with a consolidated, treatment-focused first level, and other, more complex levels of service that ensure continuous, timely care).[20] In 2009, SBC launched a restructuring of its health system along these lines, substantially expanding access to primary health care and strengthening this level as a gateway to the system. Bank support under the Health Care Modernization and Humanization Program (loan 2586/OC-BR)[21] was key in this context. The program financed the expansion, renovation, and construction of 22 basic health units,[22] as well as the construction of two psychosocial health care centers and clinical and management training for health care teams.

1.8 **Strengthening and integration of the more complex levels of care.** The strengthening of primary health care has led to the successful expansion of SUS coverage in SBC, putting new demands on the municipal health care system. Thanks to the significant boost provided by the Health Care Modernization and Humanization Program, the proportion of the population covered by the PSF rose

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[18] The Bank is supporting the strengthening of the Unified Health System in São Paulo with a state-level operation (loan BR-L1376) to increase sector stewardship and regulatory capacity at the state level, complementing this operation, which focuses on implementation responsibilities at the municipal level.

[19] The PSF model focuses on primary health care and gives priority to facilitating access. It is a starting point for the consolidation of networks. For information regarding the results of the PSF, see Macinko, et al., 2006. "Evaluation of the impact of the Family Health Program on infant mortality in Brazil, 1999-2004," Soc Sci Med. Nov: 65(10): 2070-80.

[20] Pan American Health Organization (PAHO) (2012), "Improving chronic illness care through integrated health service delivery networks" (http://www.paho.org/hq/index.php?option=com_docman&task=doc_view&gid=21400&Itemid); Health and Nutrition Sector Framework Document (document GN-2735-3).

[21] This operation was declared eligible in September 2012 and had reached 70% execution as of June 2014. The program is expected to achieve its objectives before the scheduled completion date in September 2016.

[22] Basic health units are the service centers for the PSF.

from 19% to 45% between 2010 and 2013 (DATASUS). The mean annual number of doctor's visits rose from 1.6 to 1.97 over the same period, and the level of coverage provided by community health care workers (ACS) rose from 54% to 100%.[23] Now that the first level of care has been strengthened, the second and third levels need to be strengthened under the RAS model, to ensure continuity and quality of care that addresses SBC's epidemiological profile.[24] There are waiting lists in SBC of more than 18 months for cardiology examinations and specialist consultations in hematology and ophthalmology,[25] which is evidence of saturation and fragmentation in specialized services, and that these services are not operating on an integrated health care network model.[26] With respect to health care services of moderate complexity, the number of specialized outpatient or diagnostic support clinics is insufficient in SBC given current clinical protocols and the município's population and epidemiological profile.

1.9 In the context of the RAS, specialized health care services need to be strengthened in order to ensure continuity of care. That is the primary objective of this operation. The continuity of care approach is implemented using lines of care. These are comprehensive strategies for major health care issues, from health promotion and preventive activities through to treatment using the most cost-effective approaches. In the health promotion area, SBC has been conducting various activities related to the risk factors for chronic diseases. Expanded access to primary health care was crucial for implementation of health promotion programs such as, for example, nutritional guidance, counseling centers, and support groups for smoking and alcohol problems. The Health in School Program offers health education sessions in schools, play activities that encourage healthy lifestyles in children and teenagers. There has also been investment in "academias da saúde," public gyms with facilities, equipment, and staff qualified to provide guidance in these activities.[27]

1.10 **High-complexity health care.** As part of its 2009 health reform, SBC has been reorganizing hospital care around the RAS model, which will be the springboard for this operation. The reorganization has supported an expansion of the existing structure and the creation of innovative management instruments.[28] However, there

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[23] The community health care workers (ACS) provide family health education, promotion, prevention, and support services through home visits in the areas under their responsibility.

[24] Mendes, E. "O cuidado das condições crônicas na atenção à saúde" [Care of chronic conditions in health care], pp. 341 and 343. Brasília, 2012.

[25] Sistema de Regulação do Acesso [System for Regulating Access] (Município of São Bernardo do Campo), 2014.

[26] As discussed in the 2010 PAHO document, "Integrated health services delivery networks," continuity of care is fundamental for network operations; long wait times are symptomatic of ineffectiveness and breaks in the continuity of health care processes.

[27] See http://dab.saude.gov.br/portaldab/ape_academia_saude.php. In terms of the prevention of external causes in SBC, an IDB transportation program in the município (loan BR-L1315) has a road safety component.

[28] As provided in the 2013 National Hospital Care Policy, "núcleos internos de regulação" [internal regulation units] have been set up, to facilitate greater control and the efficient use of hospital services.

are still significant gaps in the supply of high-complexity health care services, particularly specialized hospital-based treatment in two main areas: urgent care (to address morbidity due to external causes and acute CNCD-related conditions) and care for women (including maternal and child health care). São Bernardo do Campo Municipal Health Department (SMS) data show that the main cause of admittance to urgent health care facilities in the município is acute cardiovascular events (25%), which are almost double the level for the second cause, external events (15%).[29]

1.11 Infrastructure at SBC's urgent care facility, the Hospital de Pronto Socorro Central (HPSC), is both inadequate in the light of health legislation and insufficient to meet current demand. The HPSC has an open-door policy and ends up absorbing walk-in cases of low complexity that put pressure on services. For example, occupancy rates in emergency rooms have averaged 300%, and in intensive care units over 103%, in the last year.[30] Overcrowding of emergency wards has important consequences for patient care and safety. It raises mortality rates, the length of stays, and costs, and it reduces employee and user satisfaction.[31] Emergency and urgent hospital services[32] are a crucial component of the RAS as they constitute a key care point, especially in the case of external causes, acute CNCD-related conditions, and mental health emergencies, all of which are high-demand health conditions in SBC.

1.12 Hospital-based services for women and maternal and child health also show considerable deficits in terms of offerings and quality. The current hospital occupies an old building that does not meet current health standards, and this puts pregnant women and newborns at serious risk due to the high likelihood of contamination.[33] Infrastructure for childbirth services is also inadequate. In contrast to other municípios of similar size in the country, the supply of these services in SBC is insufficient to meet demand, and approximately 23% of patients in labor have to be

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[29] See Pimenta, Moris. "Estudo sobre a rede de urgência e emergência de SBC" [Study of São Bernardo do Campo's urgent and emergency care network], 2014.

[30] This occupancy rate would be even higher if those that could not be admitted—remaining instead with the pre-hospital emergency services—are included in the figures. See Pimenta, Moris. "Estudo sobre a rede de urgência e emergência de SBC" [Study of São Bernardo do Campo's urgent and emergency care network], 2014.

[31] Bittencourt, R. "A superlotação dos serviços de emergência hospitalar como evidencia do baixo desempenho organizacional" [The overcrowding of hospital emergency services as evidence of low organizational performance]. National School of Public Health, Doctoral thesis.

[32] Urgent and emergency care are differentiated as follows: Urgent: serious cases in need of prompt medical attention. Emergency: very serious cases in need of immediate medical attention. Ministry of Health of Brazil.

[33] The SMS in SBC recorded and investigated a series of infectious disease outbreaks in recent years, mainly affecting newborns. The root of the problem lies in overcrowding and poor organization of the different sectors, resulting from the physical limitations of the current building. See Canonici, Emerson. "Estudo sobre a rede materno-infantil de São Bernardo do Campo," [Study of the maternal and child care network in São Bernardo do Campo], 2014.

transferred to the neighboring Município of Diadema. This uncertainty as to where the birth will take place and the difficulties for family members in accompanying the mother-to-be are incompatible with the service guidelines of the "Rede Cigonha" [Stork Network][34] and humanized childbirth. Moreover, the Município of Diadema also faces restrictions on its service capacity; SBC has only managed to establish temporary agreements until it upgrades its own services.

1.13 **Policy options and the proposed consolidation of RASs in SBC.** Under its Municipal Health Plan 2014-2017, the SBC government has requested the Bank's support to deepen the health sector reorganization launched in 2009 and to strengthen the supply and quality of universal public services. To address the challenges described above, the evidence supports implementation of a health care model based on integrated service networks that promotes continuous, comprehensive, and curative patient care[35] through streamlined organization of the different levels of care, and clear structures for referral and counter-referral. The international literature also indicates that the most cost-effective health systems are those in which care is organized in a continuous manner[36] with strong coordination between the different levels,[37] and organized around primary health care.[38] This evidence has been corroborated in studies of Brazil's SUS.[39]

1.14 In light of the evidence analyzed and the progress SBC has made in reorganizing its health system (particularly in terms of strengthening access to primary health care), the program proposes to continue supporting the município in its efforts to consolidate the RASs. Specifically, the new operation will undertake key investments in specialized health services of medium and high complexity, as well as in strengthening the clinical and management skills of personnel, with the objective of promoting coordination and integration among the levels and enhancing system efficiency. This will help to consolidate the health care model based on integrated networks, and ensure that critical elements that determine effective network operation are in place. To ensure greater coherence and consistency between basic and medium-complexity health care, new polyclinics will be established to expand the supply of specialized medical consultations, diagnostic support testing, and therapies. This is aimed at improving treatment capacity at the primary level, as well as strengthening referral and counter-referral

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[34] "Rede Cigonha" [Stork Network] is a national strategy for organizing care flows. It also establishes clinical guidelines for maternal and child health.

[35] Nolte, E. and M. McKee (2008). *Caring for people with chronic conditions. A health system perspective.* Copenhagen: WHO-McGrawHill. European Observatory on Health Systems and Policies.

[36] Health spending efficiency is higher in countries that have integrated service networks (Kringos et al., 2013). Franks, P., and K. Fiscella "Primary care physicians and specialists as personal physicians: health care expenditure and mortality experience." Journal of Family Practice. 1998.

[37] Hurley, R., D. Freund, and D. Taylor. "Emergency room use and primary care case management: evidence from four Medicaid demonstration programs." American Journal of Public Health. 1989.

[38] Starfield et al., 2005.

[39] Mendes, Eugenio. 2013.

structures within the network. SBC will have three polyclinics, covering 100% of the município's territory and demand for these services. This will reduce waiting times and enhance system effectiveness. The polyclinics' portfolio of services will be organized according to the population's epidemiological profile and existing gaps (particularly in relation to medium-complexity care for CNCDs, maternal and child health, and respiratory diseases).[40]

1.15 To ensure continuity of care, and as part of the strengthening of the urgent care system and the line of care for chronic conditions, construction of a new Urgent Care Hospital (UCH) is planned under the program. The UCH will provide care mainly for events related to external causes and acute exacerbations of chronic conditions, and will have more advanced technological infrastructure and greater capacity to perform more complex procedures.[41] The UCH will be authorized as a high-complexity case referral service for the SBC Urgent and Emergency Care Network, and will operate on a "closed-door" model; in other words, it will not handle walk-in cases, but only cases referred by the Regulation Center (CRC),[42] which is responsible within the SUS for organizing access to health care services based on risk levels and protocols. To expand the population's access to "open-door" urgent care services (which are also important points of service within the network), a prompt care unit will be built alongside the UCH that will handle walk-in cases of lower complexity, which may still be referred to the UCH as warranted, via the CRC. This reorganization will help to consolidate the Urgent and Emergency Care Network, reducing the pressure of unreferred cases and improving the cost-effectiveness of services.[43]

1.16 The program will also support rehabilitation and expansion of the Women's Hospital, which will take on a new role within the maternal and child health care network and also in relation to women's health. It will handle 100% of deliveries in SBC, ensuring self-sufficiency of the hospital and comprehensiveness in maternal and child health care services. It will act as a referral service for obstetrics, postnatal care, and gynecology.[44] For this, it will expand its general and intensive hospitalization capacity in obstetrics and neonatology, and its diagnostic and surgical capacity in relation to women's health. The program will also support the implementation of a humanized model of care, incorporating good practices in labor and delivery and neonatal intensive and intermediate care, based on evidence from within Brazil (in this case, from public maternity wards).[45] This is expected to

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[40] See Profile of the Polyclinics.

[41] See optional annex, Profile of the Urgent Care Hospital.

[42] The Regulation Center (CRC), comprised of a medical team, organizes the allocation of higher-complexity services based on risk levels and protocols. See "SUS de A a Z" [SUS from A to Z], p. 199.

[43] Bittencourt and Hortale, 2009. "Intervenções para solucionar a superlotação nos serviços de emergência hospitalar: uma revisão sistemática [Interventions to solve overcrowding in hospital emergency rooms: a systematic review]." Cadernos de Saúde Pública, No. 25, 2009.

[44] See optional link, Profile of the Women's Hospital.

[45] Vogt et al., 2001; Borges et al., 2011.

lead to a reduction in the proportion of cesareans, as well as an improvement in infant and postpartum health.

1.17 **Support for the management and efficiency of the RASs.** Investments will also be made under the project to ensure smooth operation of the network service model, particularly as regards the improvement of clinical practices. The international evidence shows that improvements in clinical management[46] lead to greater service efficiency.[47] Studies done within the SUS in Brazil show that health outcomes improve where care is organized into flows based on a patient's treatment plan, and where responsibilities and coordination are defined among the different levels and grounded in clinical guidelines and protocols, which constitute the lines of care.[48] The program will support the entire process of organization, validation, and implementation of lines of care for priority conditions in SBC (diabetes, hypertension, and maternal and child health).[49]

1.18 **Lessons learned and related operations.** This program complements other operations in Brazil, particularly the Health Care Modernization and Humanization Program (loan 2586/OC-BR), which strengthened primary health care in SBC. One of the key lessons learned that has been built into this operation is the importance of simultaneously strengthening the secondary and tertiary levels of care, to accommodate the increase in consultations and reorganization of care flows generated by the increased coverage of primary health care. This has been the guiding principle in defining the profile of the health units to be financed under Component 1. Another important lesson that has been incorporated is the need to develop management aspects of the network service model, so as to ensure continuous, integrated, and quality health care, reducing inefficiency and overlap. A key requirement for the effective operation of these networks is a robust, centralized information system that facilitates integration among the different levels of care. This lesson was learned in the Ceará operation (loan BR-L1177), and is incorporated here as a priority under Component 2. In terms of the health portfolio

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46 Robinson, R., and A. Steiner. *Managed health care*. Buckingham: Open University Press, 1989.

47 Clinical management can be understood as a collection of micromanagement technologies, constructed on the basis of scientific evidence and aimed at providing high-quality, safe, efficient, timely, and equitable health care, offered in a humanized manner. Mendes, E., 2011.

48 Magalhães, Jr., M. Gariglio, Teixeira et al., "Proposta de estruturação da atenção secundária para o SUS-BH" [Proposal for the organization of secondary care in the Belo Horizonte SUS]. Belo Horizonte Municipal Health Department (SMSA), 2002.

49 In the line of care relating to sexual, reproductive, and maternal and child health, training of health care personnel will be included with a view to strengthening the delivery of services for CNCD prevention, promotion, and control. Personnel within the reproductive and maternal health services will also be trained in the use of screening protocols and tools to facilitate identification of women that have experienced domestic violence. The response to this problem will be strengthened in terms of psychological and physical treatment and referral to external legal assistance and social protection services, in accordance with the country's policies, laws, and regulations. In the case of CNCDs, the training of health personnel will include knowledge of the social determinants of CNCDs (gender, race, socioeconomic status), the various risks, and access to preventive and control services among these segments of the population, with a view to improving the quality (or effectiveness) of services.

in the country, the Bank has been strategically positioning itself, as in other countries in the region, through its support for consolidation of the RASs, in close coordination with Pan American Health Organization (PAHO) and Ministry of Health guidelines in Brazil. The opportunities for cross-fertilization have been expanded by recently approved operations to strengthen the network model in the Brazilian states of São Paulo (BR-L1376), Sergipe (BR-L1378) and Bahia (BR-L1389). This will help to promote knowledge creation and innovation within the framework of the SUS. These opportunities solidify the Bank's role in catalyzing and promoting knowledge of RAS practices.

1.19 **Strategic alignment.** Within the framework of the Ninth General Capital Increase (GCI-9) (document AB-2764), this program will contribute to the lending program priority target of poverty reduction and equity enhancement. It also contributes to the regional development goals for infant mortality and maternal mortality, and to the output for individuals receiving health services. It is aligned with the dimension of success relating to universal access to continuous, high-quality health services included in the Health and Nutrition Sector Framework Document (document GN-2735-3), which also supports the use of integrated networks for treatment of CNCDs. The operation adheres to the principles of the Strategy on Social Policy for Equity and Productivity (document GN-2588-4), and supports the following objectives of the Bank's country strategy with Brazil for 2012-2014 (document GN-2662-1): (i) expanding the supply of chronic-degenerative disease prevention services; and (ii) improving access to, and the coverage and quality of, maternal and child health care services, and reducing regional disparities.

B. Objectives and components

1.20 The principal objective of the program is to improve the health conditions of the population of São Bernardo do Campo (SBC). This objective is expected to be met through expanded access to medium- and high-complexity services in the município and an improvement in their quality, integrating them with the primary care level, thus consolidating the health care networks (RAS) model of care in the município. The program has the following components:

1.21 **Component 1: Support for the structuring of specialized medium- and high-complexity care (IDB: US$73,804,784; local counterpart: US$59,843,569).** The objective of this component is to expand access to services of medium- and high-complexity and improve their quality, with a view to ensuring that care is comprehensive consistent with the RAS model. The activities to be financed include: (i) rehabilitation and expansion of infrastructure and purchase of equipment for the Women's Hospital; (ii) construction of the new Urgent Care Hospital (UCH) and purchase of equipment; (iii) construction of a polyclinic; and (iv) purchase of equipment for the three polyclinics.[50]

[50] The Central Polyclinic, the Rudge Ramos Polyclinic, and the Alvarenga Polyclinic.

1.22 **Component 2: Strengthening of the health care networks model (IDB: US$1,716,933; local counterpart: US$18,885,321).** The objective of this component is to strengthen health service management capabilities by reorganizing processes and improving clinical practices, thus ensuring greater efficiency in health care. The activities to be financed include: (i) development and implementation of lines of care for the areas of maternal and child health, systemic arterial hypertension, and diabetes mellitus;[51] (ii) information technology systems for the health sector and training in their use; (iii) training in the implementation of lines of care; and (iv) technical studies and consulting services to support the development of strategies in priority areas such as teenage pregnancy.

1.23 **Component 3: Program administration and evaluation (IDB: US$4,528,283; local counterpart: US$1,321,110).** The objective of this component is to assist the Municipal Health Department (SMS) in the efficient execution of the program and monitoring of its outcomes. Financing will be provided for the contracting of a works supervision firm, specialized technical services, consulting engagements,[52] audits, and operational and impact evaluations.

Table I.1: Costs of the Operation

Component	IDB (U$)	Local (U$)	Total (U$)	%
1. Support for the structuring of specialized medium- and high-complexity care	73,804,784	59,843,569	133,648,353	83.48
2. Strengthening of the health care networks model	1,716,933	18,885,321	20,602,254	12.87
3. Program administration and evaluation	4,528,283	1,321,110	5,849,393	3.65
TOTAL	**80,050,000**	**80,050,000**	**160,100,000**	**100**

C. Key results indicators

1.24 The impact indicators for the operation involve CNCD-related morbidity and mortality in SBC: premature death (less than 60 years of age) from diabetes and cardiovascular accidents. Also included are the rate of avoidable hospitalizations (which are expected to fall as a result of strengthening of the RASs) and institutional neonatal mortality. Intermediate outcomes that reflect consolidation of the RASs include the rate of hospitalization from complications related to the lines

[51] In formulating the lines of care, special attention will be paid to the gender determinants of health,, mentioned in paragraph 1.2, and WHO recommendations regarding gender approaches to treating noncommunicable diseases (PAHO, 2011, "Noncommunicable diseases and gender: success in NCD prevention and control depends on attention to gender roles;" Bonita and Beaglehole, 2014, "Women and NCDs: overcoming the neglect," Global Health Action, 7: 23742. In the line of care for maternal and child health, guidelines will be developed for the health team to ensure that the package of services necessary to reduce maternal mortality and morbidity is provided, including counseling, family planning information and education, pre- and postnatal care, qualified medical attention for childbirth, and safe abortion in the cases allowed by law, based on a gender and life cycle approach.

[52] Consulting services will be provided to support program planning and management.

of care to be supported under the project, as well as the percentage of births that take place within the município, the percentage of births via cesarean, and waiting times for specialized treatments. These indicators will be monitored using the official health data system in Brazil, DATASUS, which is managed by the Ministry of Health.[53]

1.25 Based on specific evidence for Brazil, the economic analysis quantifies the incremental benefits resulting from the investments. These are measured in terms of disability-adjusted life years stemming from a reduction in avoidable hospitalizations, as well as productivity gains resulting from the reduction in morbidity and mortality under the service model supported by the operation, and gains from the implementation of the lines of care in the context of the RASs. In the base case scenario, with conservative assumptions in terms of effectiveness of the interventions, the benefit-cost ratio over a ten-year period is 2.49. Sensitivity analyses show that this ratio varies between 1.07 and 4.45 depending on the scenario.[54]

II. FINANCING STRUCTURE AND RISKS

A. Financing instruments

2.1 The Bank's financing for this operation will be through an investment loan from the Ordinary Capital (OC) resources under the Flexible Financing Facility (document FN-655-1). The planned disbursement period is five years.

B. Environmental and social safeguard risks

2.2 The program has been classified as Category "B" under the Bank's Environment and Safeguards Compliance Policy (Operational Policy OP-703). In compliance with Operational Policy OP-703, the municipal government prepared an environmental assessment report (RAA) during preparation of the operation that identified the main potential socioenvironmental impacts and risks, emphasizing the actions under Component 1 (Support for the structuring of specialized medium- and high-complexity care), as well as prevention and mitigation measures and environmental impact control. In compliance with the Bank's Operational Policy OP-102, the program has been made public via the SMS website: http://www.saobernardo.sp.gov.br/secretariadesaude. The RAA was also made available for consultation and public feedback on the SMS website, and will be presented and discussed at a public meeting to be organized by the executing agency.

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[53] DATASUS provides national data disaggregated by federative entity (states and municípios). It is the main source of public health data owing to its vast store of information, the long time series available, and the reliability of its data.

[54] The base case scenario uses a 6% discount rate. As discussed in the economic analysis, the WHO recommends use of a 3% discount rate for health projects. A 12% rate was included for reference, showing that under most scenarios for investment effectiveness, coverage, and maturity times, the benefit-cost ratio is greater than one, even with that rate.

2.3 The precautions and measures to control, prevent, and mitigate potential adverse impacts are described in the environmental and social management plan (ESMR) included in the environmental and social management report (ESMR, required electronic link 5). The ESMR describes the procedures, actions, and responsibilities for proper socioenvironmental management of the program. One important point is that the município already has clear title to the land where the works are to be built under the program.

2.4 The positive impacts of the program will stem from improvements in the health of the population, mainly the most vulnerable segment, the majority of whom depend exclusively on the SUS. The program will have a particular impact on women (not just pregnant women), since investments are planned to improve the health of this group, and a gender approach will be used in the lines of care. A diagnostic assessment of teenage pregnancy in SBC is planned, as an essential input for the município's development of a comprehensive strategy to address the problem, which has an extreme impact on the future of girls in this situation.

C. Fiduciary risks

2.5 An institutional capacity analysis of the SBC Municipal Health Department classified the level of risk as low. The SMS has performed well as the executing agency for operation 2586/OC-BR. However, the analysis identified the current structure of the program management unit (PMU) as a risk, indicating that it is inadequate given the volume of investments under the new operation. The following measures are proposed to mitigate these risks: (i) expansion of the current PMU structure and the addition of funding to engage individual consultants; (ii) Bank training of the team involved in execution; (iii) preparation and entry into force of the program Operating Regulations; and (iv) close sector and fiduciary supervision based on the planning instruments agreed upon in the project execution plan and procurement plan.

D. Other risks

2.6 There is a risk that a government changeover in January 2017 may affect the pace of program execution. The experience under the current operation, which experienced a government changeover between 2012 and 2013, showed that the team managed the transition well, and the pace of execution was not affected. Nonetheless, as a mitigation measure it is proposed that the execution plan be adjusted to reflect these limitations. The Bank will also provide support during the handover, ensuring good communication, visits, and technical meetings.

2.7 Other risks identified as medium (along with their respective mitigation measures) include (i) the possibility that the quality of detailed designs for the works will be insufficient to allow construction to be fully completed; to address this, a work plan will be prepared to ensure that technical specifications are met within the estimated time frames, including support for preparing the terms of reference for these contracts; (ii) a macroeconomic risk of exchange rate variations that may affect

execution of the planned activities; this will be mitigated by adapting planning instruments to this scenario.

2.8 Lastly, another risk is the operational sustainability of the new services. SBC has already ensured that funds will be available to operate the services and for the local counterpart contributions under the program. These resources were set aside in the Município's Multiyear Plan for 2014-2017, which is also aligned with the priorities of the federal government and the State of São Paulo.

III. IMPLEMENTATION AND ACTION PLAN

A. Summary of implementation arrangements

3.1 **Executing agency.** The borrower will be the Município of São Bernardo do Campo (SBC). The Federative Republic of Brazil will be guarantor of the financial obligations arising from the loan contract.

3.2 The program executing agency will be the Município of São Bernardo do Campo, acting through its Health Department, which will establish a program management unit (PMU) pursuant to the applicable legal instrument, reporting directly to the Office of the Secretary of Health. The PMU will comprise (i) a general coordination unit; (ii) an administrative/financial coordination unit; (iii) a technical coordination unit; and (iv) a works coordination unit. The PMU will receive support from the município's Department of Administration for project procurement and contracting.

3.3 **The following activities will be conditions precedent to the first disbursement: (i) publication in the SBC official gazette of the decree creating the PMU and appointing its coordinators; (ii) Bank approval of the terms of reference for individual consultants to support program management; and (iii) submission of the program Operating Regulations on the terms previously agreed upon with the Bank.**

3.4 The **special execution conditions** will be as follows: (i) evidence of entry into force of the program Operating Regulations, on the terms agreed upon with the Bank, within 90 days after the loan contract signature date; (ii) evidence that a computerized financial management system for the program is up and running, within nine months after the loan contract signature date; and (iii) compliance with the programs, requirements, and guidelines established in the environmental and social management plan (ESMP) and environmental assessment report (RAA) during the project disbursement period.

3.5 Program execution will be governed by the program Operating Regulations (POR), the terms of which will be negotiated and approved by the Bank. The POR will cover environmental issues and establish rules and procedures for the executing agency in terms of programming, accounting/financial management, procurement, audit, and monitoring and evaluation.

3.6 **Procurement.** The procurement of goods, works, and consulting services will be conducted in accordance with the Bank's "Policy for the procurement of works and goods financed by the Inter-American Development Bank" (document GN-2349-9) and "Policy for the selection and contracting of consultants financed by the Inter-American Development Bank" (document GN-2350-9). Based on the institutional capacity analysis of the executing agency, the procurement processes indicated in the procurement plan to be financed in whole or part by the Bank, and all processes with an estimated cost above the thresholds for international public bidding will be subject to ex ante review.

3.7 **Disbursements.** Disbursements will be made under the advance of funds modality, based on the project's actual liquidity needs for a maximum period of six months. Disbursements will be made into a special bank account in the name of the project for exclusive use of the loan proceeds, as established in document OP-273-2 "Financial management policy for IDB-financed projects."

3.8 **Audit.** The project's financial statements will be audited annually by an independent firm acceptable to the Bank, to be engaged by the executing agency, or by the State of São Paulo Audit Office (TCE/SP), when eligible. The audited financial statements will be delivered to the Bank no later than 120 days after the close of the each fiscal year of the entity, in accordance with the procedures and terms of reference previously agreed upon with the Bank. The audit will include an ex post review of disbursement and procurement processes, additional to the Bank's own actions and reviews.

3.9 **Retroactive financing and recognition of expenditures.** To support continuity in the process of consolidation of the health care network (RAS) model in SBC, and to meet the project objectives, the Bank may recognize retroactive expenditures of up to US$16 million (20%) against the loan, and up to US$16 million (20%) against the local contribution, for the planned investments under project Components 1 and 2, including the detailed designs for the works. To be eligible for recognition, the procurement processes must be substantially similar to those under Bank policies, and consistent with the "Bank policy on recognition of expenditures, retroactive financing and advance procurement" (Operational Policy OP-507, document GN-2259-1). Expenditures that meet the following requirements will be recognized: (i) all expenditures and payments related to program activities incurred during the 18 months prior to the date of loan approval by the Bank's Board of Executive Directors, but subsequent the project profile approval date (5 September 2014); (ii) procurement processes conducted under local legislation (Law 8666/93) and consistent with the terms of Operational Policy OP-507; (iii) the purposes, processes, and amounts to be recognized are identified and reported in the program documents (annual work plan and procurement plan); (iv) total recognized value limited to 20% or less of the counterpart (US$16 million); and (v) payments sourced from the municipal treasury.

B. Summary of measures for monitoring results

3.10 The PMU will deliver six-monthly reports regarding: (i) fulfillment of the objectives and outcomes agreed upon in each annual work plan (AWP) and in the program monitoring report (PMR), including analysis and monitoring of the risks affecting them and mitigation measures; (ii) the status of execution and the procurement plan; (iii) fulfillment of contractual conditions; and (iv) the financial execution status of the program budget. The report for the second half of each calendar year will also include: (i) the AWP for the following year; (ii) the updated procurement plan; and (iii) where necessary, the actions planned to implement the audit recommendations. The PMU will also be supported by monitoring and evaluation advisory support services, which will be responsible for implementing the monitoring and evaluation plan. The indicators included in the Results Matrix and those used in the economic analysis will be monitored using the health data generated by the SMS and reported in DATASUS, and compared both with periods before the project and with other metropolitan municípios in the State of São Paulo with similar sociodemographic and epidemiological characteristics (synthetic cohort method).

C. Design activities post approval

3.11 Work with the SMS team is expected to continue in the period between approval of the loan and contract signature, to follow up on (i) the discussions regarding the physical and functional profile of the new units and their service models; (ii) the preparation of terms of reference for PMU consultants; and (iii) monitoring and support for the preparation of studies and detailed designs for the two hospitals.

Development Effectiveness Matrix			
Summary			
I. Strategic Alignment			
1. IDB Strategic Development Objectives	Aligned		
Lending Program	Lending for poverty reduction and equity enhancement.		
Regional Development Goals	i) Maternal mortality ratio, and ii) Infant mortality ratio.		
Bank Output Contribution (as defined in Results Framework of IDB-9)	i) Individuals (all, indigenous, afro-descendant) receiving a basic package of health services, and ii) Municipal or other sub-national governments supported.		
2. Country Strategy Development Objectives	Aligned		
Country Strategy Results Matrix	GN-2662-1	i) Expand the supply of chronicdegenerative disease prevention services, and ii) Improve the access, coverage, and quality of mother-child services and reduce regional inequalities.	
Country Program Results Matrix	GN-2756-2	The intervention is not included in the 2014 Operational Program.	
Relevance of this project to country development challenges (If not aligned to country strategy or country program)			
II. Development Outcomes - Evaluability	Highly Evaluable	Weight	Maximum Score
	9.8		10
3. Evidence-based Assessment & Solution	10.0	33.33%	10
3.1 Program Diagnosis	3.0		
3.2 Proposed Interventions or Solutions	4.0		
3.3 Results Matrix Quality	3.0		
4. Ex ante Economic Analysis	10.0	33.33%	10
4.1 The program has an ERR/NPV, a Cost-Effectiveness Analysis or a General Economic Analysis	4.0		
4.2 Identified and Quantified Benefits	1.5		
4.3 Identified and Quantified Costs	1.5		
4.4 Reasonable Assumptions	1.5		
4.5 Sensitivity Analysis	1.5		
5. Monitoring and Evaluation	9.3	33.33%	10
5.1 Monitoring Mechanisms	2.3		
5.2 Evaluation Plan	7.1		
III. Risks & Mitigation Monitoring Matrix			
Overall risks rate = magnitude of risks*likelihood	Medium		
Identified risks have been rated for magnitude and likelihood	Yes		
Mitigation measures have been identified for major risks	Yes		
Mitigation measures have indicators for tracking their implementation	Yes		
Environmental & social risk classification	B		
IV. IDB´s Role - Additionality			
The project relies on the use of country systems			
Fiduciary (VPC/PDP Criteria)	Yes	Financial management: Treasury. Procurement: i) Information System, ii) Shopping Method, and iii) National Public Bidding.	
Non-Fiduciary	Yes	i) Strategic Planning National System, and ii) Statistics National System.	
The IDB's involvement promotes improvements of the intended beneficiaries and/or public sector entity in the following dimensions:			
Gender Equality	Yes	A gender focus will be added to the implementation of mother-child health and chronic diseases capacity building.	
Labor	Yes	A benefit of the program is to reduce working days lost due to morbidity associated with preventable causes.	
Environment			
Additional (to project preparation) technical assistance was provided to the public sector entity prior to approval to increase the likelihood of success of the project			
The ex-post impact evaluation of the project will produce evidence to close knowledge gaps in the sector that were identified in the project document and/or in the evaluation plan	Yes	The impact evaluation method used is synthetic cohorts, and it will allow to generate evidence on the impact of the consolidation of integrated health care networks in urban municipalities, with a pattern of rapid epidemiologic transition.	

The main objective of the program is to improve the health conditions of the population of São Bernardo do Campo. To achieve this goal, the program expands access and improves the quality of health services of medium and high complexity in the Municipality, ensuring integration with the primary care level, and consolidating the Health Care Network (RAS) model in the municipality.

The logical framework presented in the POD is consistent, covering inputs, outputs, outcomes and impacts. The results matrix includes indicators for major outputs, outcomes and impacts of the program. The indicators in the results matrix meet the SMART criteria and include baseline values and goals. The final impact indicators are early mortality rate for diabetes mellitus and its complications, cerebrovascular accidents, hospitalization rates by selected causes sensitive to basic care and institutional neonatal mortality rate.

The project has a cost-benefit analysis that supports the economic viability of the proposed activities. The executing agency will be the Municipality of São Bernardo do Campo, through the Ministry of Health, which will also conduct part of the monitoring activities, under the Bank's supervision. The monitoring and evaluation activities have been planned and budgeted. The data sources for monitoring include administrative data registries of the Municipal Health and Health System (DATASUS, SIM-SUS). The program proposes a quasi-experimental impact evaluation using the synthetic cohort method, and midterm and final operational evaluations.

RESULTS MATRIX

Project objective	The principal objective of the program is to improve the health conditions of the population of São Bernardo do Campo (SBC). This objective is expected to be met through expanded access to medium- and high-complexity services in the município and an improvement in their quality, integrating them with the primary care level, thus consolidating the health care networks (RAS) model of care in the município.

Impact indicators[1]	Baseline (2013)	Target (2019)	Source	Calculation method
Early mortality rate (30-59 years of age) due to diabetes mellitus and its complications			DATASUS SIM-SUS (Mortality Information System)	Number of deaths due to diabetes mellitus and its complications among SBC inhabitants aged 30-59 / SBC inhabitants aged 30-59 X 100,000 population in reference year
All	4.81/100,000 pop.	4.50/100,000 pop.	Brazilian Institute for Geography and Statistics (IBGE)	
Women	4.01/100,000 pop.	3.75/100,000 pop.		
Men	5.70/100,000 pop.	5.30/100,000 pop.		
Early mortality rate (30-59 years of age) due to cerebrovascular accidents			DATASUS SIM-SUS (Mortality Information System)	Number of deaths due to cerebrovascular accidents among the SBC resident population aged 30-59 / SBC resident population aged 30-59 per 100,000 population in reference year
All	20.76/100,000 pop.	19.50/100,000 pop.		
Women	19.48/100,000 pop.	18.30/100,000 pop.	IBGE	
Men	22.18/100,000 pop.	20.8/100,000 pop.		
Proportion of hospital admissions for selected causes treatable through primary care (BHC)			DATASUS SIM-SUS (Mortality Information System)	Number of hospital admissions for selected conditions causes through primary care[2] / Total number of clinical hospital admissions among SBC population per 100,000 population in reference year

[1] For a detailed description of the indicators, see the descriptive annex in the monitoring and evaluation plan. Prior to the project launch workshop a technical note will be prepared on the impact and outcome indicators, to be discussed and reviewed at the workshop with a view to establishing final definitions and targets based on an analysis of the data.

[2] See the causes in the descriptive annex of the indicators.

Impact indicators[1]	Baseline (2013)	Target (2019)	Source	Calculation method
All *Women* *Men*	21.54% 21.65% 21.45%	19% 19.05% 18.88%		
Institutional neonatal mortality rate (Women's Hospital)	10.01/1,000 live births	6.74/1,000 live births	DATASUS SIM and SINASC (Live Birth Information System)	Number of deaths among infants aged less than 28 days at the Women's Hospital / Number of births in the Women's Hospital per 1,000 in the reference year
Annual rate of hospital admissions due to diabetes mellitus and its complications among SBC resident population aged 30-59	2.89/10,000 pop.	2.70/10,000 pop.	DATASUS SIH-SUS (Hospital Information System) Brazilian Institute for Geography and Statistics (IBGE)	Number of hospital admissions due to diabetes mellitus and its complications among SBC resident population aged 30-59 / SBC resident population aged 30-59 per 10,000 population
Annual rate of hospital admissions due to cerebrovascular accidents among SBC resident population aged 30-59	4.58/10,000 pop.	4.25/10,000 pop.	DATASUS SIH-SUS (Hospital Information System) Brazilian Institute for Geography and Statistics (IBGE)	Number of hospital admissions due to cerebrovascular accidents among SBC resident population aged 30-59 / SBC resident population aged 30-59 per 10,000 population
Percentage of SUS births to SBC residents in the municipal SUS network	80.96%	97%	DATASUS SINASC (Live Birth Information System)	Number of SUS births to SBC residents in the municipal SUS network / Total number of SUS births to SBC residents

Intermediate outcome indicators	Baseline (2013)	Target (2019)	Source	
Number of individuals receiving health services	585,000	670,000	DATASUS – Basic Health Care System (SIAB) Brazilian Institute for Geography and Statistics (IBGE)	Number of individuals registered with the Basic Health Units in São Bernardo do Campo[3]
Percentage of normal births in the municipal SUS network	56.38%	62%	Source: SINASC (Live Birth Information System)	Number of normal births in the municipal SUS network / Total number of births in the municipal SUS network
Average waiting time (in days) between being placed on the waiting list and receiving confirmation of an appointment in the relevant specialty (adult cardiology)	43.6	30	Municipal Regulation System - HYGIA	Average waiting time (in days) between being placed on the waiting list and receiving confirmation of an appointment in the relevant specialty. The waiting time between being placed on the waiting list and attending the medical appointment will also be calculated at the project launch workshop.
Average waiting time (in days) between being placed on the waiting list and receiving confirmation of an appointment in the relevant specialty (adult endocrinology)	52.6	40	Municipal Regulation System - HYGIA	
Average waiting time (in days) between being placed on the waiting list and receiving confirmation of an appointment in the relevant specialty (adult neurology)	99.4	45	Municipal Regulation System - HYGIA	

[3] When a user is registered with the Basic Health Unit, the Family Health team automatically conducts a screening of his/her health (the first service provided). Thereafter, different types of health care may be indicated on a case-by-case basis, from health promotion activities to referrals for treatments or therapies offered at units in the system that handle higher-complexity cases. The Basic Health Unit is the point of entry to the SUS and organizes care. As such, it maintains health surveillance of its registered population.

Component 1: Structuring of specialized medium- and high-complexity care	**Unit of measure**	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Target**	**Comments**
Geotechnical studies and detailed and supplementary designs completed for works	Studies and designs	0	2	0	0	0	0	2	Means of verification: SMS monitoring systems (budgetary and physical targets)
Urgent Care Hospital built according to SUS technical specifications	Hospital	0	0	1	0	0	0	1	Means of verification: SMS monitoring systems and the National Register of Health Facilities (CNES)
Urgent Care Hospital equipped according to SUS technical specifications	Hospital	0	0	1	0	0	0	1	
Plot acquired for the Women's Hospital	Plot	0	1	0	0	0	0	1	Means of verification: SMS monitoring systems (budgetary and physical targets) and CNES
Women's Hospital rehabilitated and expanded according to SUS technical specifications	Hospital	0	0	0	1	0	0	1	
Women's Hospital equipped according to SUS technical specifications	Hospital	0	0	0	1	0	0	1	
Rudge Ramos Polyclinic rehabilitated and expanded according to SUS technical specifications	Polyclinic	0	0	1	0	0	0	1	Means of verification: SMS monitoring systems and CNES
Polyclinic equipped according to SUS technical specifications	Polyclinic	0	0	1	2	0	0	3	Means of verification: SMS monitoring systems (budgetary and physical targets)

Component 2: Strengthening of the health care networks model	**Unit of measure**	**Baseline**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Target**	**Comments**
Health data center solution purchased	Modules	0	4	5	0	0	0	9	Means of verification: SMS monitoring systems (budgetary
Hardware and wiring infrastructure	Phases	0	2	1	1	0	0	4	

Component 2: Strengthening of the health care networks model	Unit of measure	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5	Target	Comments
installed									and physical targets)
Health information management system implemented	Modules	0	0	4	5	0	0	9	
2.2 Qualification of care processes									
Hypertension and diabetes line of care prepared	Line of care	**0**	1	0	0	0	0	1	Line of care approved by SMS
Clinical guidelines printed for hypertension and diabetes	Clinical guidelines	**0**	1	0	0	0	0	1	Means of verification: SMS monitoring systems (budgetary and physical targets)
Maternal and child health line of care prepared	Line of care	0	0	1	0	0	0	1	Line of care approved by SMS
Clinical guidelines printed for maternal and child health	Clinical guidelines	0	0	1	0	0	0	1	Means of verification: SMS monitoring systems (budgetary and physical targets)
2.3 Training and education									
Network management specialization courses completed	Courses	0	0	1	0	0	1	2	Means of verification: SMS monitoring systems (budgetary and physical targets)
2.4 Technical studies									
Diagnostic assessment on teenage pregnancy in SBC completed	Study	0	0	1	0	0	0	1	Means of verification: SMS monitoring systems (budgetary and physical targets)
Diagnostic assessment on patient flows in maternal and child health care services completed	Study	0	0	1	0	0	0	1	

Component 3: Program administration and evaluation	Unit of measure	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5	Target	Comments
Financial management system developed	Management system	0	1	0	0	0	0	1	Means of verification: SMS monitoring systems (budgetary and physical targets)
Intermediate and final operational evaluations completed	Report	0	0	0	1	0	1	2	
Impact evaluation completed	Report	0	1	0	1	0	1	3	

FIDUCIARY AGREEMENTS AND REQUIREMENTS

Country:	Brazil
Project name:	Program to Strengthen the Unified Health System in São Bernardo do Campo
Project number:	BR-L1415
Prepared by:	Leise Estevanato (Financial Management Specialist) Marilia Santos (Procurement Specialist)

I. EXECUTIVE SUMMARY

1.1 The institutional evaluation for program's fiduciary management was based on: (i) the country's current fiduciary context; (ii) the results of an assessment of the main fiduciary risks (project risk management (PRM)); (iii) an institutional capacity analysis using the Institutional Capacity Assessment System (ICAS); and (iv) working sessions involving the project teams of the IDB and the São Bernardo do Campo Municipal Health Department (SMS). As a result of this work, fiduciary agreements have been prepared for procurement and financial management, for use in executing this program.

II. FIDUCIARY CONTEXT OF THE COUNTRY AND THE EXECUTING AGENCY

2.1 The Bank's fiduciary strategy for Brazil remains focused on strengthening external control systems, with 13 audit offices authorized to perform audits for programs partially financed by the Bank as of end-2014, and two more in the process of authorization. This is made possible by Brazil's good country fiduciary systems, which enable effective management of administrative, financial, control, and procurement processes in compliance with the principles of transparency, economy, and efficiency.

2.2 It should be noted that the Bank has been working with the three levels of government with a view to using existing management tools. This would support the ongoing strengthening process while simultaneously lowering transaction costs.

2.3 The Bank has been substantially increasing the use of country public procurement systems, primarily ComprasNet (an electronic reverse auction system administered by the federal government), Banco do Brasil's Licitações-e system, the State of São Paulo's BEC e-procurement systems, the State of Rio de Janeiro Integrated Procurement Management System (SIGA/RJ), and the State of Minas Gerais procurement portal.

2.4 The following systems are used in the Município of São Bernardo do Campo (SBC): the Integrated Financial Administration System for States and Municípios (SIAFEM); the Integrated Management, Operational, and Maintenance System (SIGOM); and the Budget and Accounting System (ORCON), which is used to prepare, execute, and monitor the Municipal Multiyear Action Plan (PPA). Municipal agencies use the following country management support tools to plan and organize program and project activities: (i) the Government Multiyear Action Plan (PPAG); (ii) the Multiyear Plan (PPA), which establishes the public administration's guidelines, objectives, and targets; (iii) the Budgetary Procedure Law (LDO), which sets rules for government budgetary allocations; (iv) the Annual Budget Law, which projects and establishes the public administration's expenditures for the current year; (v) the Fiscal Responsibility Law, which sets limits on the public administration's spending; and (vi) the management support information systems discussed above (planning, accounting, financial management).

2.5 Procurement and contracting are governed by the National Competitive Bidding Act (Law 8666/93).

2.6 The State of São Paulo Audit Office (TCE/SP) exercises control of municipal entities/bodies, and continually tracks their financial transactions and processes by monitoring financial management systems on a daily basis. External control of resources transferred by the federal government to Brazil's municípios is exercised by the Audit Office of the Union (TCU).

2.7 The SBC Municipal Health Department (SMS) will be the executing agency for the program. A program management unit (PMU) will be created within it that will be responsible to the Bank, for the preparation, management, and monitoring program activities. The PMU will comprise (i) a general coordination unit; (ii) an administrative/financial coordination unit; (iii) a technical coordination unit; and (iv) a works coordination unit.

2.8 The PMU will be supported by a Special Bidding Commission (CEL) at the Department of Administration, which will be responsible for conducting processes for the procurement of goods, services, works, and consulting services.

III. Fiduciary Risk Assessment and Mitigation Measures

3.1 The results of the analyses conducted (ICAS, PRM, etc.) showed a low level of fiduciary risk for execution of the operation by the SMS. The following fiduciary risks were identified: (i) the possibility of execution setbacks due to delays in launching program operations, limited monitoring of investments, procurement delays, or weaknesses in program information, given the absence of a computerized system for control of resources; (ii) the possibility of personnel changes owing to government changeover and, consequently, in the government's strategy; and (iii) the limited availability of people for the PMU. The following mitigation measures are being proposed: (i) creation of the PMU and appointment of its coordinators; (ii) establishment of the Special Bidding Commission;

(iii) Bank approval of the terms of reference for individual consultants to support program management; and (iv) evidence that a computerized financial management system for the program is up and running (within 180 days after the loan contract signature date).

3.2 The plan for mitigation of these risks will be implemented as part of loan preparation and the fulfillment of conditions precedent.

IV. Considerations for the Special Provisions of the Contract

4.1 The special fiduciary conditions precedent to the **first disbursement** are as follows:

1. Publication in the SBC official gazette of the decree creating the PMU and appointing its coordinators.
2. Bank approval of the terms of reference for individual consultants to support program management.
3. Submission of the program Operating Regulations on the terms previously agreed upon with the Bank.

4.2 The following will be special **execution** conditions for the program:

1. Evidence of entry into force of the program Operating Regulations, on the terms agreed upon with the Bank, within 90 days after the loan contract signature date;
2. Evidence that a computerized financial management system for the program is up and running, within nine months after the loan contract signature date.
3. Compliance with the programs, requirements, and guidelines established in the environmental and social management plan (ESMP) and environmental assessment report (RAA) during the project disbursement period.

V. Agreements and Requirements for Procurement Execution

5.1 The fiduciary agreements and requirements for procurement establish the rules governing the execution of all procurement processes planned under the project.

5.2 **Procurement execution.** Procurements will be conducted through the PMU. Goods, works, and nonconsulting services will be procured in accordance with the "Policies for the procurement of works and goods financed by the Inter-American Development Bank" (document GN-2349-9, March 2011). The selection and contracting of consultants will be conducted using the "Policies for the selection and contracting of consultants financed by the Inter-American Development Bank" (document GN-2350-9, March 2011). Procurement processes will be reviewed by the Bank in accordance with the provisions of the procurement plan (see link, Procurement plan).

5.3 **Procurement of works, goods, and nonconsulting services.** Contracts for works, goods, and nonconsulting services[1] generated under the project and subject to international competitive bidding (ICB) will be executed using the standard bidding documents (SBDs) issued by the Bank. Procurements subject to national competitive bidding (NCB) will be executed using country bidding documents agreed upon with the Bank (or satisfactory to the Bank, if not yet agreed upon). For the procurement of off-the-shelf goods and services, the Bank will accept the use of electronic procurement systems already evaluated and accepted by the Bank: ComprasNet, Licitações-e, the State of São Paulo's BEC e-procurement system, the State of Rio de Janeiro's Integrated Procurement Management System (SIGA/RJ), and the Minas Gerais Procurement Portal. Any price lists established in these systems may also be used.

5.4 **Selection and contracting of consultants.** Consulting service contracts generated under the project will be executed using the standard request for proposals (RFP) issued by the Bank. The sector specialist will be responsible for review of the terms of reference for the contracting of consulting services.

5.5 **Selection of individual consultants.** Individual consultants will be selected on the basis of their qualifications to perform the work, based on comparison of the qualifications of at least three candidates. When circumstances so require, notices may be published in the local or international press, to obtain résumés of qualified consultants.

5.6 **Retroactive financing and recognition of expenditures.** To support continuity in the process of consolidation of the health care network (RAS) model in SBC, and to meet the project objectives, the Bank may recognize retroactive expenditures of up to US$16 million (20%) against the loan, and up to US$16 million (20%) against the local contribution, for the planned investments under project Components 1 and 2, including the detailed designs for the works. To be eligible for recognition, the procurement processes must be substantially similar to those under Bank policies, and consistent with the "Bank policy on recognition of expenditures, retroactive financing and advance procurement" (Operational Policy OP-507, document GN-2259-1). Expenditures that meet the following requirements will be recognized: (i) all expenditures and payments related to program activities incurred during the 18 months prior to the date of loan approval by the Bank's Board of Executive Directors, but subsequent the project profile approval date (5 September 2014); (ii) procurement processes conducted under local legislation (Law 8666/93) and consistent with the terms of Operational Policy OP-507; (iii) the purposes, processes, and amounts to be recognized are identified and reported in the program documents (annual work plan and procurement plan); (iv) total recognized value limited to 20% or less of the counterpart (US$16 million); and (v) payments sourced from the municipal treasury.

[1] Under the Bank's procurement policies, nonconsulting services are treated as goods.

5.7 **Exchange rate.** The exchange rate agreed upon with the executing agency for accountability is the rate in effect on the date the respective payments are made to the contractor or vendor.

5.8 **Direct contracting.** No contracting is planned under this modality.

5.9 **Thresholds for procurement processes.** The threshold for the use of ICB will be made available to the borrower or the executing agency, as applicable, online at www.iadb.org/procurement. Below this threshold, the selection method will be determined according to the complexity and characteristics of the procurement or contracting, which will be reflected in the approved procurement plan.

5.10 **Domestic preference.** No margins of domestic preference will be applied.

5.11 **Procurement plan.** The current proposal is included as an annex. The version agreed upon may be updated during project execution, as circumstances require (see Procurement plan).

5.12 **Procurement supervision.** All ICB processes will be subject to ex ante review. Considering the features of the project and the operational capabilities of the SMS, other processes will be reviewed as established in the procurement plan and its updates.

5.13 **Records and files.** Records and files will be kept at the offices of the SMS and the Special Bidding Commission, with appropriate levels of security agreed upon with the Bank.

VI. Financial Management Agreements and Requirements

A. Programming and budget

6.1 The SMS, acting through the PMU, will be responsible for planning the execution of activities as provided in the program execution plan (PEP), the budgets, and the annual work plan (AWP). The budget for the program activities will be approved through the municipal budget law. The SMS will use planning tools such as the PPA and the LOA. The budget for the program activities is part of the LOA.

6.2 The SMS team will ensure that the budgetary resources for the program, both the IDB and local contributions, are duly budgeted each year, and earmarked for execution as per the operational programming. The program resources will be employed in the execution of the entity's budget. These budgetary resources must be recorded in the year of execution in the SIAFEM system as an external source of funds in the year of execution. The LOA will include the funds for execution for both the external loan and the local counterpart.

B. Accounting and information system

6.3 The SMS uses the following information and management systems: the Integrated Financial Administration System for States and Municípios (SIAFEM); the Integrated Management, Operations, and Maintenance System (SIGOM); and the

Budget and Accounting System (ORCON), which is used to prepare, execute, and monitor the Municipal Multiyear Action Plan (PPA).

6.4 With respect to loan funds, all project accounting and financial information will be recorded in the SIAFEM system and in the system to be purchased for the purposes of the program. This system currently does not allow project reports to be issued in dollars or by investment category and source of financing, as required by the Bank. The SMS will therefore submit evidence within 180 days of loan contract signature of the implementation and operation of a computerized program financial management system, consistent with Bank requirements.

C. Disbursements and cash flow

6.5 The program will use the município's treasury system. Expenditures will be subject to the budgetary and financial execution process, and will be duly registered in the SIAFEM and the program's computerized financial management system.

6.6 IDB funds used to pay program expenditures will be administered through an account that will allow the independent identification of loan resources. This includes disbursements received and payments.

6.7 Disbursements will be made in U.S. dollars in the form of advances of funds. These will be based on the project's actual liquidity needs over a period of up to six months. To this end, the executing agency's requests for advances of funds will be accompanied by a financial plan reflecting funding requirements for the period concerned. For subsequent advances, it will be necessary to provide a rendering of accounts for at least 80% of previously advanced funds.

6.8 Expenditures deemed ineligible by the Bank must be repaid from local counterpart resources or other resources, as the Bank sees fit, depending on the nature of the ineligibility.

D. External control and reports

6.9 Project financial statements and expenditure eligibility will be audited annually by an independent audit firm, or by the TCE/SP, when eligible. In addition to the Bank's actions and reviews, the auditor will submit a report on program expenditure eligibility and perform onsite physical inspection visits, as established in the "Financial management policy for IDB-financed Projects" (document OP-273). The program's audited financial statements will be delivered to the Bank no later than 120 days after the close of the executing agency's fiscal year, in accordance with the procedures and terms of reference previously agreed upon with the Bank.

E. Supervision plan

6.10 The supervision plan may be modified during project execution, according to the observed risk circumstances or based on additional oversight needs as determined by the Bank.

Supervision activity	Supervision plan			
	Nature/Scope	Frequency	Responsibility	
			Bank	Executing agency
Procurement	Review of procurement and contracting of works and consulting services	As indicated in the procurement plan	Sector and procurement specialists	PMU/SMS
	Review of processes above thresholds for ICB and single-source selection	Throughout execution period	Sector and procurement specialists	PMU/SMS
	Supervision visit	Annual	Sector specialist and fiduciary team	
Financial	Ex post review of disbursements and procurement	Annual	Fiduciary team	PMU – Audit firm
	Annual audit	Annual	Fiduciary team	Audit firm
	Review of disbursement requests	Periodic	Fiduciary team	
	Supervision visit	Annual	Sector specialist and fiduciary team	

F. Execution mechanism

6.11 The executing agency will be the São Bernardo Municipal Health Department (SMS). It will create a PMU that will be responsible to the Bank, for the preparation, management, and monitoring program activities. The SMS will be responsible for institutional and technical coordination of the operation, and it will be made up of a multidisciplinary team to be appointed. Special contractual conditions precedent to the first disbursement consist of evidence of publication of the legal instrument establishing the PMU and appointing the corresponding coordinators, and Bank approval of the terms of reference for individual consultants to support program management (as indicated in the organizational chart and profiles proposed in the institutional capacity assessment report).

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-___/__

Brazil. Loan ____/OC-BR to the Municipality of São Bernardo do Campo
Program to Strengthen the Unified Health System
of São Bernardo do Campo

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the Municipality of São Bernardo do Campo, as Borrower, and with the Federative Republic of Brazil, as Guarantor, for the purpose of granting the former a financing to cooperate in the execution of the Program to Strengthen the Unified Health System of São Bernardo do Campo. Such financing will be for an amount of up to US$80,050,000 from the Ordinary Capital resources of the Bank, and will be subject to the Financial Terms and Conditions and the Special Contractual Conditions of the Project Summary of the Loan Proposal.

(Adopted on ___ _____ 20__)

LEG/SGO/CSC/IDBDOCS: 39163178
Pipeline No. BR-L1415